

How Do People Come to Use Mental Health Services? Current Knowledge and Changing Perspectives

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This chapter focuses on how people come to seek help from mental health services. Services can include: (1) the formal system, consisting of specialty mental health care and general medical care; (2) the lay system, including friends and family as well as self-help groups; (3) the folk system of religious advisors and alternative healers; and (4) the human-social service system of clergy, police, and teachers. The authors provide a review of the research on mental health-care use and describe and contrast the dominant theories of help-seeking behavior (the sociobehavioral model, the health belief model, and the theory of reasoned action). These models provide a profile of users of services; more recent dynamic approaches also focus on when care is received and develop models of illness careers. For example, the help-seeking decision-making model assumes that individuals pass through each stage laid out in the model. The authors propose an alternative, the network-episode model, which views help seeking as a social process managed by the social networks people have in the community, the treatment system, and social service agencies. The network-episode model incorporates four components: the illness career, the social support system, the treatment system, and the social context. Students may want to investigate their own communities to discover what types of services are available for people who need help for their mental health problems.

I had felt this way before, but this started just before Thanksgiving. I went into a depression The feeling that I have is that I've been feeling this way for years and years but to tell somebody about it was, it was silly or it was being childish and And a couple of times I called help lines or stress centers and talked to somebody on the phone and they would always either pray with me or just give me enough strength to keep going on. . . . Well the first person I talked to was Rita. I work with her. And it was just the same day that I came in here. I hadn't done anything prior to that. . . . I remember going to work so angry inside And in my job I have to talk to people all day long on the phone, you know, and I couldn't do it that day . . . so Rita asked what was the matter. She goes, "I know something's wrong with you. You don't even have make-up on." So we talked and I just told her, you know. And that's when she told me she'd try to find me some help. "You need help. You don't need to go through this alone."

(Pam, diagnosed with major depression, 1991)

When people experience mental health problems – whether stresses associated with the normal ups and downs of life or serious problems diagnosed as a mental illness – two basic questions arise: “How are these problems seen by people? What kinds of help exist, and when do people use different sources of care?” In this chapter, we go beyond how clinicians define mental illness and examine how people give meaning to psychiatric symptoms and act on them. We pay particular attention to the social processes involved in responding to mental health problems and if, when, and how individuals receive care from a wide range of people in the community – their friends and family, physicians, and mental health specialists. We consider how the new fiscal and organizational contours of the medical system brought on by health-care reform affect how society allocates the quantity and quality of mental health services and what this means for how people and professionals respond to illness.

Generally, research in mental health utilization or “help seeking” involves the study of how individuals make contact with the *formal* system of care. Much of what we know about the use of services has focused on the two separate but overlapping sectors that characterize this formal medical system:

- (1) specialized mental health care – professionals including psychiatrists, psychologists, psychiatric nurses, and social workers, as well as specialized hospitals, inpatient psychiatric units of general hospitals, and outpatient mental health programs; and
- (2) general medical care – including primary care practitioners, community hospitals without specialized psychiatric services, and nursing homes.

Even within these sectors, there is considerable variety in the scope and nature of the clinical resources available to ill individuals and the providers who care for them.

As Pam's story makes clear, whether individuals eventually receive formal care often depends on three other “systems”: the *lay* system of care, including friends, family, co-workers, and an increasingly visible set of support or self-help groups (Regier et al. 1993); the *folk* system of religious advisors and alternative healers (Kleinman 1980); and the *human-social service* system that includes police, clergy, teachers, and social security clerks (Larson et al. 1988). Together, these systems of care form a complex web of community resources for dealing with mental health problems. There is remarkably little evaluation of how these various services affect outcomes for the people who use them.

Challenges in Understanding the Utilization of Mental Health Care

To understand the behavior of individuals suffering from mental health problems and their entry into treatment, three basic ideas are important. First, only a small

percentage of people with mental health problems ever receive formal treatment. Even fewer people are treated by specialized mental health professionals. With the increasing recognition of the high prevalence of mental disorders, their disabling nature, and the distress they cause for individuals and families (Mechanic 1996), it may seem surprising that the majority of people with psychiatric disorders remain untreated or, if they make contact, do not stay in care. Yet many large studies show this gap between need and care (e.g., Shapiro et al. 1985; Ware et al. 1984). In the United States, the most common estimate is that only 20% of individuals (one in five) with mental health problems receive treatment. The National Comorbidity Survey, which administered structured psychiatric interviews to a national probability sample, found the prevalence of psychiatric disorders to be higher – but the percentage of people who received professional treatment to be even lower (by at least 25%) – than that commonly held estimate (Kessler et al. 1994). This higher prevalence of psychiatric disorders, when coupled with lower treatment rates, suggests considerably more unmet need for mental health services than previously thought.

Second, the treatment of mental health problems, as well as the public's view of mental illness, has changed dramatically over the last century. The turn of the last century saw the coming of the "asylum" that was intended to be a place of respite for those suffering from mental illness. Following World War II, a transfer of care occurred for persons with severe and persistent mental disorders from long-term treatment in these mental institutions to treatment anchored in the community (Bachrach 1976; Bell 1989a; Brown 1985; Morrissey & Goldman 1986). Today, these large, old state mental hospitals continue to close or decline in size. Outpatient mental health programs are struggling to meet the increased need for community care for those in greatest need. However, these kinds of services are also available to and used more by individuals suffering from less severe psychological problems, signaling a greater public acceptance of mental health care (Kulka, Veroff, & Douvan 1979). This increase in use by the "worried well" and a longstanding reluctance (at times, an unwillingness) to provide ongoing care for those with severe mental illness produces a system under great strain.

Third, a major change is now occurring in how mental health services are organized and financed in the United States. Although the Clinton Health Security Act (based on managed competition, a global or capped national budget, and universal access to care) failed, it was followed by a "silent revolution" that continues to shift fee-for-service arrangements to various managed care strategies. Different forms, financing arrangements, and regulations may be labeled "managed care," but every version is designed to control costs, access to care, and the types and amount of care delivered (Wells et al. 1995; see Chapters 22 and 23 in this volume). As Mechanic and colleagues (1995) explain, managed care organizations make treatment decisions that previously were made by individual patients or their medical care providers. Managed care introduces an additional party into models

of utilization – an organization that allocates care and may even provide that care. At the same time, managed care plans also place greater responsibility for providing care on those outside the formal system, shifting more of the burden of care to families and neighborhoods (Pescosolido & Kronenfeld 1995). We are only beginning to understand the extent of the impact of such plans on individuals' access to care, use of services, quality, and outcomes.

Contributions of Sociology to the Study of Utilization

A substantial body of good theory and relevant findings illustrate how social science theory and methods provide insight into who uses medical or psychiatric care. This research offers an important part of the story of what happens to ill individuals, a part that cannot be known from clinical research. In a perfect world, the mere presence of symptoms would be sufficient for people to desire and obtain treatment. Since this is not the case, knowing who receives care or who has a propensity to seek care informs us about what happens to people with mental health problems.

Sociologists contribute to understanding the use of mental health services in three ways. First, sociologists have documented that "users" and "nonusers" of mental health services have different sociodemographic characteristics and hold different views of medical and mental health treatment. This systematic difference between people who tend to get treatment and those who do not illustrates a major sociological concept, that of social selection (Greenley & Mechanic 1976; Mechanic 1975). The extent to which individuals and social groups with similar psychiatric symptoms ("need") suffer different fates with regard to the use of medical care poses questions about their personal and social lives quite apart from their symptoms. Many of the earliest (and now classic) studies surprised clinical researchers and medical providers by showing that socioeconomic status is predictive not only of who came to treatment but also of how they were treated by the medical system. For example, Dunham (1959) found that individuals from poorer neighborhoods in Chicago had higher rates of first psychiatric admissions to hospitals than those from wealthier areas. Hollingshead and Redlich (1958) found that individuals from lower social classes were more likely to be brought to Yale–New Haven hospital by the police than others. Once hospitalized, these patients were more likely to be given serious diagnoses than individuals from other social classes. It may be tempting to conclude that these actions reflected real differences in mental health problems, but a long tradition of research shows that mental health professionals see problems of the lower social classes differently (i.e., more seriously) and respond to them with more invasive treatments (see e.g. Loring & Powell 1988).

Second, sociologists, as well as anthropologists, focus on understanding individuals in their social contexts. Whereas early clinical researchers looked at the social

and clinical profiles of individuals in care, sociologists were the first to follow individuals from the community into the treatment system. This distinctly social science approach provided new and important information. For example, a classic study by Clausen and Yarrow (1955) examined how and when men, later diagnosed with schizophrenia, came to be cared for at St. Elizabeth's Hospital in Washington, D.C. To the surprise of many treatment staff, the authors documented that even individuals with serious mental illness entered care only after years, sometimes decades, of displaying severe and disabling symptoms of schizophrenia. Clausen and Yarrow provided a stunning picture of how these men and their wives struggled, often for years, to understand and normalize strange behaviors before talking to family or friends. Rather than documenting a social process of quick and efficient entry into care for men with serious mental health problems, Clausen and Yarrow described how puzzling mental health symptoms were to families and how the quality of the marriage shaped the responses of wives. These researchers also showed that, beyond extensive and painful delays in getting into treatment, other people in the community – from family and friends to the police and the clergy – played crucial roles in getting these men into care.

Third, sociologists, along with psychologists, have organized psychological, cultural, and medical characteristics into comprehensive theoretical frameworks of who enters care and why they seek care. These theories laid the groundwork for empirical studies and interventions that have been conducted since the late 1960s. Subsequent revisions of these theories improved their sensitivity to measuring new challenges in access, quality, and equity. The current shift in how mental health services are organized and financed will require sociologists to reconsider once again how we conceptualize and study individuals' use of services. As the organizations providing mental health care (e.g., hospitals, outpatient programs, health maintenance organizations, and office-based professionals) undergo radical transformations, pressures for more cost-effective care alter the types and amount of services available as well as referral patterns. For example, many managed care plans prohibit individuals from going directly to psychiatrists. Their primary care physicians serve as "gatekeepers" to the mental health system. Insurance companies now routinely require prior authorization for emergency care or psychiatric hospitalization. Less expensive forms of outpatient treatment, such as group therapy, are being substituted for more expensive individual therapy, and mental health professionals are being encouraged to use drug therapy exclusively or to avoid more lengthy care plans that include "talk" therapy of any sort. Private insurance plans that specialize in managing services for individuals with severe and persistent problems are enhancing outpatient programs and case management to reduce hospital stays and re-admissions. Many states are restructuring their Medicaid programs in order to control the usual 20% of their budget that goes to the care of individuals with serious mental illnesses. At the same time, advocates for persons with mental illness have raised expectations for treatment and

alternative services based on self-help and empowerment philosophies (Cook & Wright 1995). All of this restructuring of health care changes how people come into the treatment system, whether and for how long they stay there, and what services they receive.

An Overview of Prior Research on Mental Health-Care Use

Not surprisingly, the single best predictor of the use of mental health services is the need for care. Whether "need" is defined by the level of psychological distress, one or more psychiatric symptoms, limitations in mental health functioning, self-reports of mental health, risk factors associated with mental illness, or a psychiatric diagnosis, individuals with greater need are more likely to enter treatment (Greenley & Mechanic 1976; Gurin et al. 1960; Leaf et al. 1985; Portes, Kyle, & Eaton 1992; Scheff 1966b; Ware et al. 1984).

This research finding illustrates how the larger social context influences entry into treatment. "Need" is a relative concept shaped both by the people who use the term and by their social and cultural circumstances (Cleary 1989). For individuals, need may mean the extent to which psychiatric symptoms cause distress and disrupt work, family, and other social activities. Symptoms causing embarrassment, fear, inconvenience, and uncertainty are more likely to lead to help than other psychiatric symptoms (Mechanic 1978). For families, need reflects the degree of bizarre and dangerous behavior, aggressiveness, or suicidality (Clausen & Yarrow 1955; Lefton 1966). Under strained conditions, families are more likely to report higher need and pressure their family members into treatment. For health professionals, need frequently translates into whether symptoms or disorders can be treated with available knowledge and technology (Cleary 1989). For researchers, need is variously defined as a minimum score on symptom scales or through measures of distress, life events, risk factors, self-reports, diagnostic instruments, or proxies (e.g., expenditures).

Because fewer than one fourth of all individuals with mental health problems receive care, the relationship between need and use of services is far from perfect. If the magnitude and seriousness of psychiatric symptoms alone do not lead to treatment, what other factors are important? Drawing on much of the social science literature that examines social selection into treatment, we discuss four main factors – gender, race and ethnicity, age, and social class – that have been shown to be the strongest and most consistent predictors of outpatient mental health-care utilization.

Gender

Most studies show that women are more likely to receive treatment than men for distress or mental illness (Gove 1984; Greenley & Mechanic 1976; Kessler,

Brown, & Broman 1981; Veroff 1981). Although this gender difference may reflect the higher prevalence of psychiatric symptoms and disorders in women (Kessler et al. 1994), gender differences may also be due to (i) the greater propensity of women to recognize, acknowledge, or report psychiatric symptoms or (ii) gender biases in the measures used or in the judgments of clinicians (Horwitz 1977a,b; Kessler et al. 1981). Recent evidence suggests that gender differences in the use of services may also be related to sources of care. Women make more mental health-related visits than men to physicians in the general medical sector, but women and men do not differ significantly in their rates of use of outpatient specialty mental health care. The higher level of outpatient mental health service visits reported by women may stem from their greater use of medical practitioners overall (Horgan 1984; Leaf & Bruce 1987).

Race and Ethnicity

The gap between need and the actual use of outpatient mental health services is greatest among blacks and Hispanics (Hough et al. 1978; Padgett et al. 1994; Sussman, Robins, & Earls 1987; Wells et al. 1988). When the level of symptoms or distress is controlled, significantly fewer blacks, Mexican Americans, and Asian Americans receive outpatient mental health treatment than do whites (Cole & Pilisuk 1976; Leaf et al. 1985; Mechanic, Angel, & Davies 1991; Neighbors et al. 1992; Scheffler & Miller 1989; Sue 1977; Wells et al. 1988). For example, in a study of federal employees, blacks and Hispanics reported both significantly lower probabilities of one mental health visit and lower total visits overall than whites (Padgett et al. 1994). But some studies show that, once treatment begins, no significant differences exist across ethnic and racial groups in the number of times services were received (Hu et al. 1991; Wells et al. 1988).

Among minority groups, there are greater economic barriers to getting into care as well as greater suspicion about how they will be treated once in the system and whether treatment will help them (Rogler & Cortes 1993; Rogler et al. 1989). For example, when asked about the primary reason for not seeking treatment for a major depressive episode, blacks were significantly more likely than whites to fear being hospitalized (Sussman et al. 1987). The racial and ethnic background of clinicians also may be important, especially for retaining people in long-term care. For example, Asian Americans whose care providers matched their ethnic background were significantly less likely to drop out of treatment than individuals treated by professionals with different racial or ethnic backgrounds (Sue et al. 1991).

Age

For the most part, age shows a curvilinear relationship with entering outpatient mental health treatment. Younger and older age groups have the lowest rates

of use, while the middle-aged (25–64 years old) use the most outpatient mental health services (Horgan 1984; Shapiro et al. 1984). Precisely the opposite occurs for physical ailments, where the very young and the elderly are the highest consumers of services (Anderson & Andersen 1972). It is possible that, when these groups visit physicians for physical ailments, emotional and psychological problems are treated as related distress. However, it may also signal poor detection of mental problems by physicians, parents or schools, and caretakers (Morlock 1989; Wells et al. 1986). Some studies report that general practitioners diagnose psychiatric disorders less often but are twice as likely to report a mental health reason for visits, whether or not they provided psychotherapy, therapeutic listening, or prescriptions for psychotropic drugs (Allen, Burns, & Cook 1983; Morlock 1989; Regier et al. 1979).

Social Class

Social class is perhaps the most intriguing of social selection factors and the most problematic to study. Early researchers constructed summary measures of social class (using occupation, income, and residence) and documented important differences in the utilization of mental health services by social class. In Hollingshead and Redlich's (1958) study, individuals in upper social classes were more likely to use outpatient mental health services than those in lower social classes. Similarly, Kadushin (1966) showed that upper-class individuals were more likely to support the use of psychotherapy.

Since these early studies, research has focused on components of social class — education and income. The effects of education on use of services are rather consistent. People with better education have a higher probability of using outpatient mental health services (Greenley, Mechanic, & Cleary 1987; Veroff, Kulka, & Douvan 1981). The effects of income on the use of mental health services are far from clear. Several studies have reported that income is not significantly related to the use of mental health services (Leaf et al. 1985; Veroff et al. 1981). When high use rates are shown among the more affluent, this may reflect their ability to pay for more services, their better insurance coverage, or their self-selection of better insurance coverage (Wells et al. 1986). Medicare, Medicaid, and expanded private insurance coverage for mental health services have made psychiatric services more financially accessible to greater numbers of people. Almost all private insurance plans include some coverage for outpatient mental health services, although higher co-payments, special deductibles, and lower limits of reimbursable services than for general medical care are likely. The most recent research from the RAND Health Insurance Experiment, where effects of insurance and income were separated, show that higher-income groups are more likely to use specialty mental health providers than general medical practitioners or services for mental health problems (Wells et al. 1986).

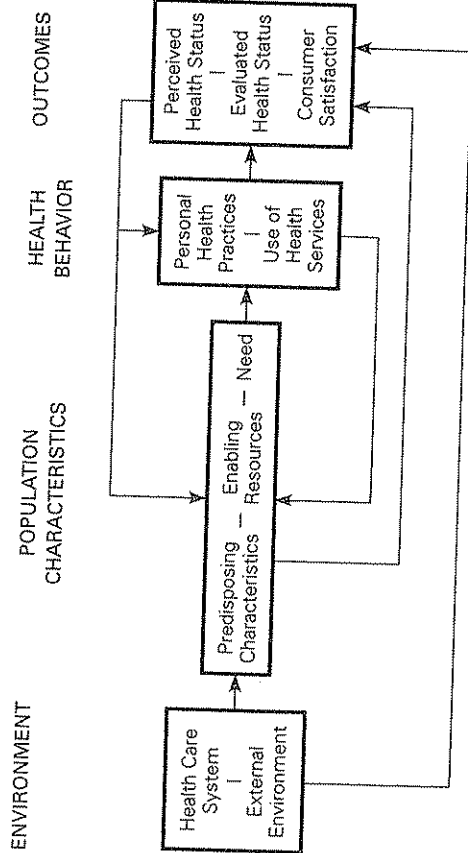


Figure 21.1. Andersen's (1995) revised sociobehavioral model. Source: Reprinted with permission from the *Journal of Health and Social Behavior* 36: 1-10.

Combining Social Correlates: Dominant Theories of Help Seeking

Although listing social correlates is informative, a more comprehensive picture of service use emerges through theories of utilization that posit how and why these factors work together. Three dominant theories of utilization guide research in the use of health services: the sociobehavioral model, the health belief model, and the theory of reasoned action.

In the late 1960s, Ronald Andersen (1968; Andersen & Newman 1973) developed the *sociobehavioral* model (SBM). The original model (and still its core) detailed three basic categories: need, predisposing, and enabling factors (see Figure 21.1). Some need for care must be defined or individuals are not likely to consider whether or not to use services, what services to use, and when to go. The nature of the illness and its severity (e.g., the "hurt," "worry," "bother," or "pain" that it causes) reflect not merely a biological imperative but also how people perceive this need and how they experience symptoms.

Mental health researchers have developed an extensive array of symptom scales and structured clinical interviews to measure psychiatric need for care. For psychiatrists, the "gold standard" is based on criteria from the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM-IV; APA 1994). In order to establish a reliable and valid diagnosis according to DSM, standardized information is collected about the person's past history, current social functioning, and symptoms, using one of several structured interviews - for example, the Diagnostic Interview Schedule (DIS; Robins et al. 1981), the Composite International Diagnostic Interview (CIDI; WHO 1990), or the revised CIDI (Kessler et al. 1994).

Some researchers argue that this diagnostic approach alone misses a great deal of social phenomena surrounding symptoms, especially how individuals and professionals socially construct mental health problems (Leaf et al. 1985; Mirowsky & Ross 1989a). In an interesting study, Mechanic and his colleagues (1991) combined interview and claims data from the RAND Health Insurance Experiment to create a measure of "risk" defined as the threat of danger or disruption. This risk measure was more important than psychiatric symptoms in explaining referrals from general medical practitioners to specialty mental health professionals.

In the SBM, gender, race, age, education, and beliefs (to name but a few) are defined as *predisposing* characteristics - those social and cultural factors that are associated with an individual's tendency to seek care. However, even in the presence of need and a profile of predisposing social characteristics, individuals must be able to act on a desire to receive care: *enabling* characteristics are the means and knowledge to get into treatment. Geographical availability, having a regular source of care, travel time, and financial ability (via income, insurance, or the existence of public clinics and programs) limit or facilitate the use of services.

Because Andersen and his colleagues (see Aday, Andersen, & Fleming 1980) were fundamentally concerned with issues of access, organizational characteristics of the health system and types of health insurance benefits figured prominently among enabling characteristics. Managed care arrangements, for example, tap into an important part of enabling characteristics because they are designed to control access to care, types and amounts of care available, and the costs of care. The bulk of research on managed care shows that individuals in both prepaid or managed care plans and fee-for-service arrangements have a similar likelihood of making a single outpatient mental health visit, but those in prepaid plans are less likely to have long-term, continuous care (Diehr, Williams, & Martin 1984; Norquist & Wells 1991; Wells et al. 1986). In the Medical Outcomes Study conducted in Boston, Chicago, and Los Angeles, depressed persons covered by prepaid plans had five fewer outpatient visits in a six-month period (Sturm et al. 1995). In the public sector, where more disadvantaged individuals with severe mental illnesses are treated, the results are more mixed. In Hennepin County (Minnesota) and in the Utah Prepaid Mental Health Plan, individuals with serious mental illnesses who participated in the prepaid versus fee-for-service plans had no significant decreases in inpatient or outpatient use of services (Manning et al. 1993; Moscovice et al. 1993). However, in a capitated program in Monroe County (New York), inpatient psychiatric admissions and days hospitalized decreased while the use of outpatient services increased (Babigian et al. 1992). Finally, in Massachusetts, inpatient admissions from emergency rooms and length of stay declined in both managed care and comparison groups (Stroup & Dorwart 1995).

Over time, Andersen has revised the sociobehavioral model by incorporating more variables measuring the organizational structure, goals, and policies of health-care systems, the insurance industry, and state regulation (Andersen 1995).

Furthermore, the revised SBM considers the effects of service use and, in particular, how previous experience alters need, predisposing, and enabling characteristics. These revisions mirror growing policy concerns about "effective" (i.e., having actual health benefits) and "efficient" (i.e., having the least cost) care. Figure 21.1 shows Andersen's more complicated and complete contextual model of how individuals evaluate their problems (need), their own tendency to seek care as shaped by social and cultural circumstances (predisposing characteristics), and the kinds of access they have or perceive they have to the formal system (enabling characteristics). The environment shapes these population characteristics as well as health behaviors and outcomes.

A second influential theory of help seeking, the *health belief* model (HBM; Rosenstock 1966) came originally from social psychology. It has been revised several times by a multidisciplinary team including sociologist Marshall Becker. In a recent version, this model includes the same kinds of factors as the sociobehavioral model, but its emphasis and intent are quite different. Where the SBM focuses on the influence of the system and issues of access in attempting to understand the use of curative services, the HBM examines the meaning of "predisposing" characteristics. As depicted in Figure 21.2 (from Eraker, Kirscht, & Becker 1984), rather than looking generally at social and cultural factors, the HBM analyzes how individuals' general and specific health beliefs (e.g., beliefs about the severity of symptoms) and preferences (e.g., perceived benefits of treatment), as well as their experiences (with health problems and providers) and knowledge, all affect decisions to seek care, health behavior, and outcomes.

The most recent model in this tradition is Ajzen and Fishbein's (1980) theory of *reasoned action* (TRA). "Expectancy" becomes key as individuals rate how current and alternative actions can reduce health problems. Like the HBM, this model focuses primarily on motivations, assessment of risk, and avoidance of negative outcomes. Individuals evaluate whether or not to engage in healthy (e.g. exercise) or risky (e.g. smoking) behaviors and whether to seek preventive (e.g. mammography) as well as curative medical services. Like the SBM, it takes into account access to the system.

In sum, these utilization models provide a comprehensive listing of contingencies that affect an individual's decision to use services. The contingencies range from the psychological (e.g., patient preferences in the HBM) to the system level (e.g., external environment in the SBM). Over time, each model has broadened its focus to include factors considered central in other approaches. For example, the HBM originally focused heavily on social psychological factors (e.g., general and specific beliefs) to the near exclusion of measures of access to system resources. Developed within the disciplines of sociology and health services administration, the SBM included structural factors and consolidated the sociopsychological detail of the HBM into the residual category of predisposing factors. Revised versions of all the models have been more inclusive and, in keeping with policy concerns, now incorporate a focus on outcomes (Weinstein 1993).

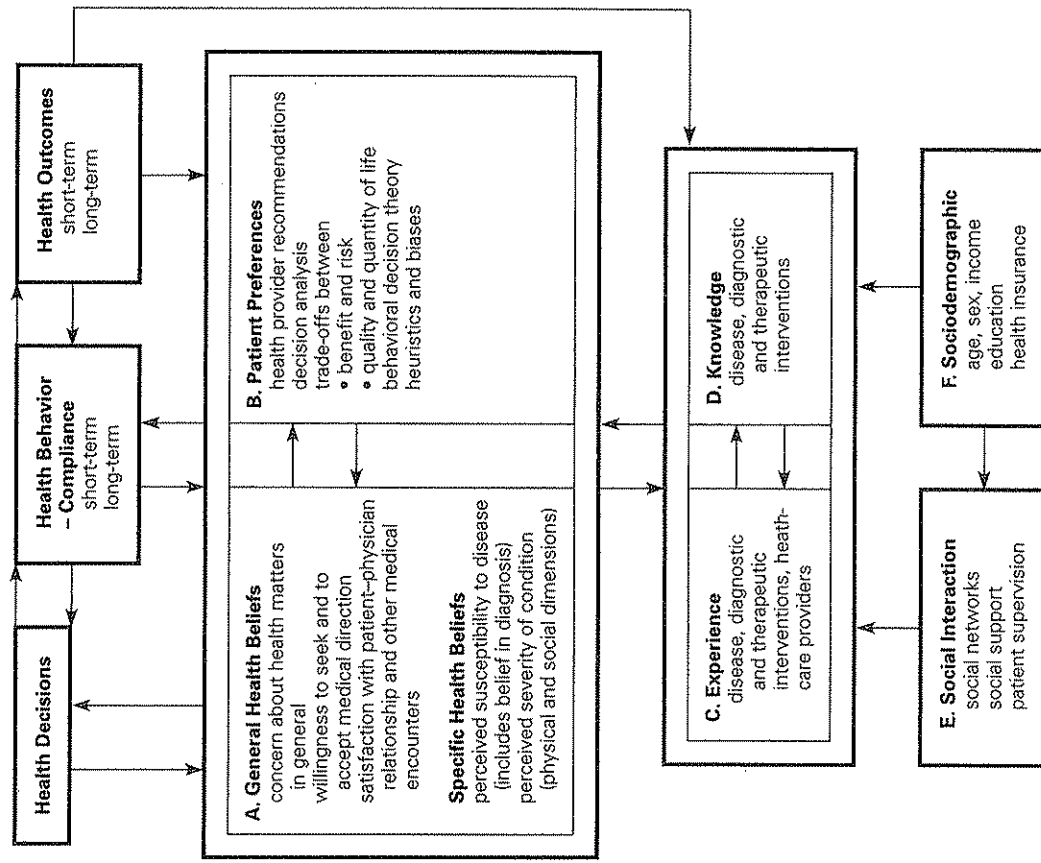


Figure 21.2. Eraker and associates' (1984) revised health belief model. Source: Reprinted with permission from the *Annals of Internal Medicine* 100: 258-68.

These theories depend on certain assumptions about service use: *individuals decide whether or not to use medical services by weighing costs and benefits of treatment, given their own assessment of their health profile and the options open to them* (Pescosolido 1992). The first assumption is that the underlying mechanism is rational choice. Individuals are seen as weighing in their minds whether their need can be met by the resources available (in the SEM) or whether their risk of illness is offset by the health-care system treating them (HBM and TRA). The

second assumption is that service use is "help seeking," a voluntary choice made by individuals. These are issues to which we will return.

Dynamic Approaches to Studying Utilization in a Changing Health-Care System

The models just described have provided some strong and consistent findings about who uses services and some interesting explanations of why they do so. In essence, these models have provided a profile of service users. A more process-oriented approach to studying the use of services complements these traditional models and is uniquely sensitive to the challenges raised by recent reforms in the health-care system. In general, dynamic approaches focus not only on *who* receives care but also on *when* care is received and *how* the whole episode of illness proceeds. Such approaches treat the use of services more as a socially embedded process, tied not only to the decision making of individuals with psychiatric problems but also to the communities in which they live and the people who surround them in their daily lives and in the treatment system.

Dynamic models challenge the underlying image of traditional models in examining mental health utilization. The very nature of mental illness (and the stress of many other major illnesses) calls into question individuals' ability to engage in the complicated cognitive processes on which some theories rely. Psychiatric symptoms of confused thinking, cognitive disorganization, delusions, and surges or deficits in affect make a "rational choice" approach a poor candidate for understanding the mechanisms underlying use of health services. What happens to these individuals rarely happens as part of a subjective process in people's heads. Individuals who use services may have chosen to do so, may have been forced into treatment, or may have struggled haphazardly (like Pam) in trying to cope with psychiatric problems. But they rarely do this in isolation. Family, police, or other institutional agents (e.g., judges, teachers) suggest that they go for care; such agents bring them in at their own request or use "emergency detentions" and "involuntary commitments" to initiate treatment (Bennett et al. 1993; Grisso & Appelbaum 1995; Hiday 1992a; Matthews 1970; Miller 1988; Perleberg 1983; Suchman 1964). People can be hospitalized involuntarily and treated over their objections, including an outpatient treatment plan of regular, court-ordered injections of such antipsychotic medications as Prolixin or Haldol. For some people, then, the term "help seeking" and the image of individual choice assumed in some utilization models does not fit with their experiences. In fact, fewer than half of the stories people told us about how they came into the mental health system revealed an individual cost-benefit assessment where the individual made the decision to seek care, even when it was suggested by supportive friends and relatives (Pescosolido, Gardner, & Lubell 1995). This issue may be more pronounced in the area of mental illness, but it is not limited to this health problem. Prior research

suggests that, in general, traditional utilization models are better adapted to acute than to chronic problems, and they offer better answers to questions about whether individuals ever use services than about when they go, how they get there, whether recommendations are followed, and whether they stay in care (Apsler & Rothman 1984; Haug & Lavin 1983; Pescosolido 1991, 1992; Wolinsky & Arnold 1986).

These concerns raise some important additional questions: How do we move from a static to a dynamic model of utilization? How do we track the pathways from the community through the medical system and the social service system? What is the underlying mechanism at work? Fortunately, we have a start in some early work that developed the idea of an "illness career."

Attempts to Model Illness Careers and the Use of Services

Research looking at the use of services as a social process dates back to the studies by John Clausen and his colleagues at the Socio-Environmental Laboratory at the National Institute of Mental Health. They developed the concept of "pathways" into care, framed the use of health services as part of an "illness career," and described the sequence of lay people, professionals, and agencies seen during the course of an illness (see also Horwitz 1977a; Janzen 1978; Young 1981). Clausen and his research team talked about different patterns of the recognition of a mental health problem by family and friends. In each case, the wives of the men that they studied tried to understand and adapt to their husbands' changing pattern of behavior until some "trigger" event forced them to recognize that something was wrong. Of course, for many of these men, there were periods in which everything seemed to go smoothly, to be normal. Only a few of the wives thought that the problem might be mental illness; many tried to explain away strange behaviors with different theories (e.g., stress at work, after-effects of service in the military, character flaws, or physical illness).

Other studies in anthropology and sociology described and conceptualized these careers in different ways. Romanucci-Ross (1977) defined "hierarchies of resort" — how individuals set priorities to move from one type of medical system to another. For example, those who followed "acculturative" patterns went first to the formal medical care system, then used folk healers as a back-up, and eventually depended only on their family, friends, or others in the community. Some health researchers defined "stages" that defined points or phases that individuals pass through as they cope with illness (Parsons 1951; Roth 1963). Figure 21.3 shows an update of a stage model, the *help-seeking decision-making model* (HDM; Goldsmith, Jackson, & Hough 1988). Symptoms appear, the problem is recognized, services are used, and particular types of providers are accessed. More recently, Alegria and her colleagues (1991) added a stage that extends the social process to what happens after people make initial contact with help or treatment. Individuals may continue in treatment, change practitioners or services, or discontinue care. The

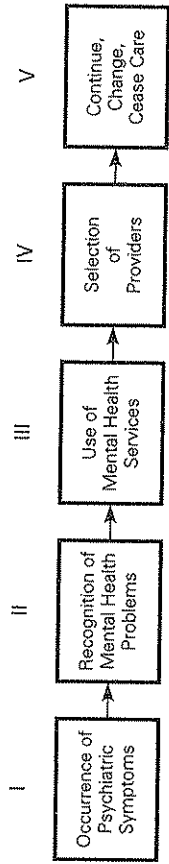


Figure 21.3. Goldsmith and associates' (1988) revised help-seeking decision-making model. *Source:* M. Alegria, "Mental health care utilization among Puerto Ricans," NIMH grant no. R01 MH 42655.

HDM blended this idea of the stages of a career with the sociobehavioral model, suggesting that at each stage we need to consider how enabling, predisposing, and need contingencies affect the movement from one stage to the next.

The problem with many stage models is that they are rigid – individuals logically passed through every stage laid out in the model. The case of mental illness showed how often this did not fit with what actually happens to people. For many of the men in Clausen's study, the first indication of a serious mental illness was *not* recognizing it but rather wondering why and how they ended up in a psychiatric hospital, sometimes after the police brought them there. More recent models, such as the one shown in Figure 21.3, adopt a broader and more flexible view. Individuals might skip over stages or repeat them; "advisors" include friends, family, and folk healers as well as general and specialty providers in the formal medical sector (see also Twaddle & Hessler 1977).

Another proposed model is the *network-episode* model (NEM; Pescosolido 1991, 1992), which draws from the strengths of the dynamic and contingency models described earlier. The NEM starts with a basic idea: dealing with health problems is a social process that is managed through the contacts (or social networks) that individuals have in the community, the treatment system, and the social service agencies (including support groups, churches, and jails – where we know many individuals end up for the disruptive behavior associated with their illnesses; see Teplin 1994 and Teplin, Abram, & McClelland 1996). How people respond to illness is as much a process of social influence as it is a result of individual action. In the NEM, individuals are seen as pragmatic users of common-sense knowledge and cultural routines as well as seeking out and responding to others when psychiatric symptoms or unusual behaviors occur. The NEM does not suggest that people are not rational, but it questions whether every action in coping with illness is a result of a complicated, cost-benefit calculus. There may be times when people have to weigh the costs and benefits of a whole list of factors (e.g., when faced with the decision to "pull the plug" on a relative on a respirator). In general, however, people are social. That is, they face illness in the course of their day-to-day lives by interacting with other people who may recognize (or deny) a problem, send them to (or provide) treatment, and support, cajole, or nag them

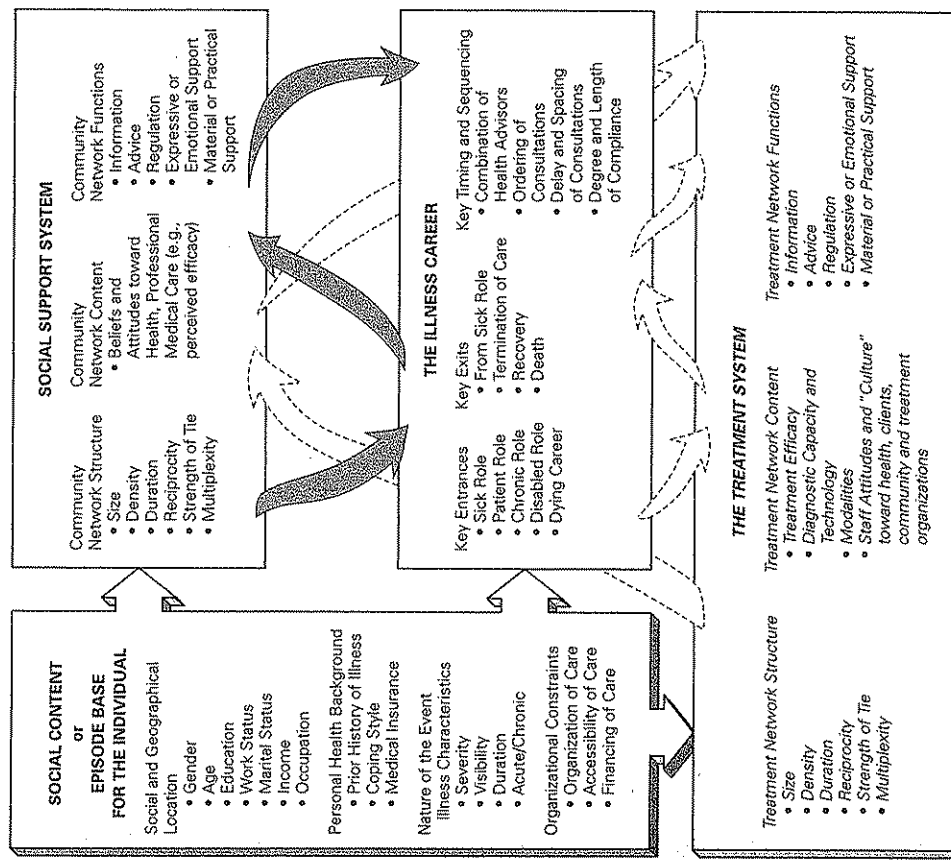


Figure 21.4. Revised network-episode model.

about appointments, medications, or life-style. Figure 21.4 shows a revised version of the NEM and its four basic components: the illness career, social support system, treatment system, and social context.

From career and stage models, the NEM conceptualizes service use not as a single, yes-no, one-time decision but rather as the patterns and pathways of practices and people consulted during an episode of illness. Pictured as the "middle stream" (right side of Figure 21.4), the illness career marks all the individuals' attempts to cope with the onset of an episode of mental health problems, charting what they do and when they do it. Patterns of care describe the combination of advisors and

practices used during the course of an illness. For example, some individuals may go only to a psychiatrist; others may visit both their family physician and a psychiatrist. Pathways add the element of order – that is, the sequences of advisors and practices used over the course of an illness. For example, some individuals may pray for help, then go to their pastor, and then to a counselor. Others might have their family try to help them through a bad time and eventually see a physician but never end up in the mental health system. For some individuals, the illness career might begin when the police bring them to an emergency room where they are transferred to the psychiatric unit and nurses contact their family.

We have little information about either patterns or pathways to care, but such knowledge could inform us about whether and when individuals with mental health problems agree to treatment or are willing to take the advice of nurses and doctors. For example, there is an important and continuing debate about the merits and limits of involuntary treatment. Some mental health professionals, policy makers, and advocates argue that these legal measures ensure that patients receive needed care, that the length of hospitalization is reduced, the quality of life improves, rehabilitation is more likely to happen, and debilitating symptoms lessen (Gardner et al. 1993). Others believe that the use of coercion undermines the therapeutic relationship and is not successful in ensuring compliance with treatment (see Mulvey, Gelber, & Roth 1987). Only by following individuals and mapping the nature of their contacts, experiences, and resulting outcomes can we address this important issue.

Whatever the patterns or pathways, the NEM does not assume that illness careers occur in a vacuum. Rather, they are embedded in personal lives and changing communities. The NEM conceptualizes the idea of “community” through the idea of a dynamic social support system (top stream of Figure 21.4). It does this by breaking down the community into individuals’ social ties or social networks. The structure (e.g. size), content (e.g. beliefs about and experiences with the medical system), and functions (e.g., support or coercion) of social networks capture that all communities hold vast reserves of people who might be consulted during the course of an illness. At any time in the illness career, network advisors may or may not be consulted, may or may not change over time, and may or may not be consistent in their advice.

In any case, the nature of the encounters people have in their day-to-day lives help to provide meaning to the symptoms of illness. If individuals see mental health problems as crises of faith, as bad marriages, or as any of a number of other things besides illness, they may consult faith healers, spiritualists, the clergy, or other people (Lubchansky, Egri, & Stokes 1970; Rogler & Hollingshead 1961). If they, or others around them, see the problem as “bad behavior” rather than illness, then they might seek out police and lawyers (Cumming & Harrington 1963; Hiday 1992a). If they conceptualize their problem as physical illness (e.g., “fatigue” associated with depression), then they may visit physicians, try an exercise regime,

or start taking vitamins. As we would expect, studies find that when the social network ties around ill people – especially friends and relatives – hold positive attitudes toward psychiatry or have been in treatment themselves, ill people are more likely to use medical services (Fisher 1988; Greenley & Mechanic 1976; Greenley et al. 1987; Weinstein 1993). However, social networks also may deter the use of services or have no effect (Geertsen et al. 1975; McKinlay 1972; Salloway & Dillon 1973; Suchman 1964). Following Freidson (1970a,b), the NEM evaluates the power of social networks in terms of how their structure (e.g., their size and amount of support) and the kinds of advice they offer (e.g., supportive or resistant to mental health treatment) work together. Among studies of the middle and upper classes in New York City (e.g., Kadushin 1966), networks facilitated use. Among the poor in Puerto Rico, however, large and supportive networks substituted for informal care and harbored negative beliefs about the efficacy of the mental health system, thus lowering the probability of using formal providers (Pescosolido et al. 1996a). The NEM suggests that both of these characteristics of social networks must be taken into account in order to provide a sense of how much influence is being exerted on the ill person and to determine the trajectory of that “push” – for example, into or away from formal medical or mental health treatment.

Although every society has some kind of treatment system, what that system looks like, who has access to it, what it offers, and how difficult it is for people to get care can vary substantially even within a given society (Andersen 1995). As we have described, our medical system is currently undergoing very dramatic changes. The NEM conceptualizes the medical system as a changing set of providers and organizations with which individuals may have contact when they are ill (bottom stream, right-hand side, Figure 21.4). Like the community and the episode of illness, the elements of this set change over time in response to the health problems people have, to the technology and medical knowledge that exists, to the resources that society makes available, and to community preferences and demands. In the same way that social networks can help us break down the community into the set of contacts people have, the network perspective allows us to unpack what happens to people when they go for treatment and to think about how their experiences affect whether they stay in treatment, take their medications, and get better. The treatment system shapes a set of network contacts for ill people, their families, and other people who become involved in the illness career (e.g., police or social service workers). Like the community, the treatment system can provide a rich set of helpful, supportive people for individuals or can allow for contacts that are only brief, impersonal, and antagonistic. The kinds of social networks that exist in the treatment setting create a climate of care, affect the work of medical providers, and shape reactions of individuals who come for treatment (Pescosolido 1996, 1997; Pescosolido, Wright, & Sullivan 1996b).

The left side of Figure 21.4 represents the foundation: the larger social context for the dynamic streams of the illness career, the social support system, and the

treatment system. All are anchored in the social locations, histories, and problems that people have. For example, in studies showing the effects of predisposing characteristics, women tend to have more social network ties, to be more involved in caretaker networks, and to use more formal services than men (Cook 1988; Mechanic 1978; Thoits 1995a). In research that looked at the differences in service use between the Mariel Cubans and Haitian refugees arriving in southern Florida during the early 1980s (Portes et al. 1992), it became clear that *where* the immigrants came from mattered a great deal. The Mariel Cubans had greater mental health problems, but these needs were also more likely to be met. Their past experience with the Cuban health system (a socialized set of services) combined with the strong and supportive ties in the vibrant Cuban community in southern Florida to provide them with mental health treatment. The Haitian refugees, who did not have a history of using mental health facilities before immigration and who found only a small and limited ethnic community upon their arrival, had a lower use of services after arrival. The severity and nature of mental health problems also shape the illness career and the extent to which individuals in the social support and treatment systems experience burnout (Tausig 1992; Wright 1994).

The NEM and other process models provide a more complex picture of what happens when people experience mental health problems. They raise questions concerning how we think about, study, and collect data on the complicated and often messy realities of dealing with illness, particularly as society and treatment systems change.

Conclusion

In this chapter we have provided an overview of the issues, theories, ongoing changes, and challenges that surround efforts to understand how, when, and why individuals enter or fail to come for treatment of mental health problems. A great deal is known about the use of mental health services by different social groups, but we are far from understanding the nature of the process and timing by which people reach treatment in the mental health system. We have suggested that one way to proceed is to tie together the community, the illness career, and the treatment system. This link between the day-to-day lives of individuals and their interactions in the community or the treatment system cannot be ignored. Such interactions shape how individuals who may need care — as well as those who provide care — view mental health problems, how they embrace or scorn what the treatment system offers, and whether they are encouraged or dissuaded to receive or provide care.

One issue that we did not explore in detail was the impact of different kinds of “need” — social, financial, or medical — that mental health problems raise for individuals and their families. We have focused on medical or mental health needs and, for the most part, on how individuals get into care. However, the onset of a serious mental illness, such as schizophrenia, interferes with schooling, employment,

and intimate relationships. Further, even for individuals who are hospitalized in acute psychiatric units, where stabilization or resolution of the acute symptoms may occur, ongoing psychiatric treatment and rehabilitation is critical. We know relatively little about what happens after people get into the system. We have addressed the issue of pathways to care, but there should be a parallel focus on pathways *from* care. We do know that the likelihood of following through with aftercare in the community is quite low (Boyer & Mechanic 1994). We need to ask how different sectors (e.g., psychiatric and medical care, housing, employment, substance abuse) work smoothly or erratically, and in coordination or in opposition, to address individuals' mental health and related social problems (see Bachrach 1980; Morrissey et al. 1994; Pescosolido 1996; Rosenfield 1991).

After decades of concentrating on who used what types of mental health services, social scientists have now turned toward addressing other challenging sociological questions about the patterns and pathways into care and about how incentives (financial or otherwise) affect use of services and their allocation in a radically changed health-care environment. As reforms are implemented and as communities react to these and other changes, the experiences individuals confront, their perceptions of mental health problems, and their response to them and use of services may be different than in the past. With managed care rapidly becoming a mainstay of health-care delivery in the United States, a process approach may better capture how service use changes over time, how managed care allows or limits the use of specialty mental health services, and how families and other social service agencies assume the added burden of care resulting from decreased hospital stays and limits on outpatient services.