



HOW PEOPLE GET INTO MENTAL HEALTH SERVICES: STORIES OF CHOICE, COERCION AND "MUDDLING THROUGH" FROM "FIRST-TIMERS"^{*}

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Abstract—Previous work examining how individuals enter mental health treatment comes either from the health services utilization tradition, which implicitly assumes that clients make decisions to seek care, or from the socio-legal perspective, which examines how clients are forced into care. This paper draws from the Network-Episode Model to systematically consider the different social processes through which people come to enter psychiatric treatment by exploring the "stories" told by individuals making their first major contact with the mental health system. We combine the use of qualitative and quantitative methods to examine data from the Indianapolis Network Mental Health Study, a longitudinal study of individuals in treatment at the largest public and voluntary facilities in the city. We analyze detailed self-reports of how they came to use mental health services, classifying these stories as "choice," "coercion," or "muddling through." Using multinomial logit analyses, we examine how factors such as gender, race and diagnosis shape the types of stories that individuals tell. The preliminary results indicate that fewer than half of the stories (45.9%) match the notion of choice underlying the dominant utilization theories. Almost a quarter of respondents (22.9%) report coercion and nearly one-third (31.2%) tell stories that lack a clear agent. Diagnosis and social networks tap differences in how individuals experience entry into care. Individuals diagnosed with bipolar disorder or who have larger, closer social networks are more likely to tell stories of coercion. We discuss the theoretical, methodological, and clinical implications of findings drawn from this examination of clients' stories © 1998 Elsevier Science Ltd. All rights reserved

Key words—mental health, utilization, coercion

INTRODUCTION

How do individuals, especially those who are mentally ill, come to enter formal psychiatric care? Prior research has addressed this issue from two different perspectives. The first applies general medical utilization models (e.g. Andersen's Sociobehavioral Model; Andersen, 1968, 1995) to the problem of mental health services. The second explores an issue specific to mental illness: legal coercion (e.g. Hiday, 1992; Matthews, 1970; Monahan *et al.*, 1996). These literatures conceptualize the use of mental health services in different ways. Though some researchers have argued that utilization models allow for the impact of broader contextual factors (Mechanic, 1975; Mechanic *et al.*, 1991), most dominant models still implicitly view individuals as rational decision-makers. In most utilization studies, the underlying image of

entry into care is "choice." The socio-legal literature, on the other hand, explores how people with mental illness are forced into the treatment system by the actions of police, judges, and family members. Here, the underlying theme is "coercion."

But these two images may not adequately characterize the full spectrum of how individuals enter psychiatric care. In this paper, we combine these two themes with a third as yet unexplored in mental health services research: "muddling through." When people muddle, they "bounce around" and "off" circumstances and others as they attempt to deal with problems, engaging in successive, limited comparisons between alternatives (Lindblom, 1959; see also Pescosolido, 1992). They neither resist nor do they seek treatment.

Previous conceptions of the use of services have not made room for these various images of system entry. Recently, however, researchers have begun to develop process-oriented models of health services use that attempt to capture the dynamic nature of mental health system entry, repeat use, adherence and outcome (Pescosolido, 1991). Because of their focus on process, they explicitly allow for a range

*Revised version of a paper presented at the NIMH International Conference on Mental Health Service Research, September 11-12, 1995, Bethesda, MD.

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of entry possibilities. Within this process-oriented framework, we systematically investigate the images which characterize individuals' first major contact with formal psychiatric care.

Specifically, in the first part of the paper, we explore the extent to which each of the three themes characterizes the experiences of a group of people with mental health problems. The data come from the Indianapolis Network Mental Health Study, an on-going, longitudinal study of how "community" networks influence the early illness careers of individuals with mental health problems and their families. We draw on lengthy transcriptions of the clients' stories of how they ended up in the hospital or clinic and ask to what degree choice, coercion, and muddling underlie their accounts of system entry. In the second part of the paper, we combine the stories with closed-ended responses to sociodemographic, health status, and social network survey questions to investigate whether there are systematic differences among individuals who give different accounts of system entry. That is, are the experiences of individuals with different types of mental health problems and from different corners of the community characterized by different routes of entry into care? Finally, we address some theoretical, methodological, and policy implications of findings drawn from the examination of clients' accounts. We explore the extent to which our findings offer insight for the dominant approaches to service use, for health care policy, and for future research. Our aim is to help build the empirical and theoretical foundation for the next generation of mental health services utilization research.

THEORETICAL BACKGROUND

Prior research has addressed mental health services use from one of two perspectives. Either it has examined entry into care as a subset of medical services use by applying medical utilization models (e.g. Koos, 1954; Lynd and Lynd, 1929; Leighton *et al.*, 1963; Hollingshead and Redlich, 1958; Kohn and White, 1976; Anderson, 1963) or it has focused on the legal, coercive mechanisms which force people into care against their will (e.g. Hiday, 1992; Lidz and Hoge, 1993). Medical care utilization theories, developed originally in social psychology and sociology, see utilization as conditioned on individuals' beliefs about medical care, and their need for help, their access to economic and geographic resources, and their subjective evaluation of the potential outcomes of their health care use (Eraker *et al.*, 1984; Rosenstock, 1966; Andersen, 1968, 1995). For example, Goldsmith *et al.*'s Help-Seeking Decision-Making Model (Goldsmith *et al.*, 1988) focuses on charting the stages of decision-making and examines how these are influenced by enabling characteristics. In these approaches, the implicit—

and sometimes explicit—view is that individuals are decision-makers choosing to seek medical care.

Studies focusing on legal "holds" and court-ordered treatments indicate that many individuals with mental health problems are "pushed" into care by friends, relatives, and co-workers. Clients come into the treatment system not by their own volition but by the actions of police or other institutional agents (e.g. teachers), or through mechanisms of emergency detention and involuntary commitment (Bennett *et al.*, 1993; Hiday, 1992; Matthews, 1970; Miller, 1988; Perelberg, 1983). In this image of service use, individuals have little control over what happens to them. Recently, researchers in this tradition have argued that the legal classifications of "involuntary" and "voluntary" hospitalization do not capture the fundamental distinctions between clients who are and are not coerced. Many hospitalized individuals are persuaded to "sign themselves in" ostensibly to increase their freedom in leaving the hospital by avoiding court proceedings (Lidz and Hoge, 1993; Lewis *et al.*, 1984). Staff may also attempt to get patients to sign voluntary admission papers as a way of managing their caseloads (Reed and Lewis, 1990). To clarify this situation, researchers have settled on a distinction between *legal coercion* (i.e. formal measures such as involuntary hospitalization used to compel service use and compliance) and *extra-legal coercion* (i.e. pressures from family, clinicians, and friends to get and stay in treatment; Gardner *et al.*, 1993). In a series of recent studies, we begin to get a sense of the nature, meaning and source of coercion in treatment. Monahan *et al.* (1996) find that 46% of individuals entering care report no pressures, 38% report efforts to "persuade," and 10% report the use of "force." Ironically, Hoge *et al.* (forthcoming) report that 10% of individuals admitted voluntarily to psychiatric hospitals reported coercion while 35% of patients who had a legally involuntary status indicated that they came voluntarily. Finally, Estroff (1981) documents how this coercion can be indirect when government disability payments require patients to continue using services.

One approach that takes a broader view of individuals with mental health problems and their entry into care than either of these approaches is the Network-Episode Model (NEM; Pescosolido, 1991, 1992). It makes no single assumption about how clients come into the treatment system. Rather, it focuses on the dynamic processes underlying the use of services, making problematic the mode of entry into the service sector. The NEM targets the importance of social influence (exerted through "community" social networks) on when, how and if individuals receive care. This social influence can operate as a utility in an active, "rational" choice by individuals or may take the decision out of the individual's hands and place it with family members or others in the community including the police. As

such, it does not negate the role of the individual or theories that focus on the correlates or contingencies of service use. Rather, it suggests that there may be a difference between how individuals perceive and report what they do in the face of illness and what they *actually* did. The NEM suggests that only by exploring both the dynamic processes of service use as well as its correlates can we understand use, adherence and outcomes. In Britain, for example, when Furstenberg and Davis (1984) asked elderly individuals discrete questions about the influence of others in their decision to seek care for medical problems, they responded in very individualistic terms, downplaying any significant role of others, and in a manner very consistent with the help-seeking and decision-making theories. However, when the researchers then asked the same individuals to recount the open-ended "story" of their entry into care, they told stories that included many others who suggested, cajoled, nagged, pressured, and brought them into the treatment system.

The NEM has its roots in earlier, more descriptive studies on the "illness career" that followed individuals from the community into the treatment system (e.g. Clausen and Yarrow, 1955; Janzen, 1978; Young, 1981). Because the NEM is primarily concerned with the illness career and the process through which clients enter treatment, the model allows for system entry to take a variety of forms, including choice, coercion, and muddling through. This focus on the underlying dynamics does not replace a concern for understanding how different contingencies like need or predisposing characteristics affect service use. Rather, the NEM provides a bridge, bringing together the strengths of illness career models and multifactor contingency models. It does this by describing and documenting processes while at the same time elaborating the range and nature of factors that shape use. The bridge that the NEM provides lies in the idea that even if contingencies like age, race, and sex cannot help us understand how, when, and why individuals enter services, they do mark important limits on the kinds of contacts that individuals have, for example, by setting limits on the emotional, informational and financial supports that individuals can access in the community. In the NEM, social influence processes marked by social network contacts replace the isolated, individualistic, decision-making image as the mechanism through which illness careers move. However, contingencies in traditional service use models demarcate the larger context within which social networks and illness careers exist. The NEM provides a model that simultaneously examines the dynamics of individuals responding to health problems over a period of time and the larger social, psychological, economic, cultural, medical, and even system factors that push illness careers in one direction or another (Pescosolido, 1991, 1992, 1996).

In sum, even where services researchers acknowledge the importance of the family, social networks, or the community, traditional utilization approaches often implicitly conceptualize service use as an individual choice, based in a elective image. Researchers who study law and mental health remind us that a significant number of individuals enter the mental health system against their will or at least under pressure. Alternatives like the Network-Episode Model, while challenging both the voluntary tone and rational choice logic of the dominant theories, make room for other possibilities. To understand how individuals get into treatment, we must consider simultaneously the various ways they come to obtain care, their roots in community-based influences, and the impact of contingencies that may shape both modes of entry and social network ties.

Reconsidering the image of mental health services use

We use the following theoretical definitions of choice, coercion, and muddling through. Stories of individuals entering treatment are considered to be accounts of *choice* if, at any point, the person indicates making a decision that they want, or at least explicitly agree, to seek care. Accounts of *coercion* reflect an active resistance to treatment throughout the story. *Muddling through* occurs where individuals end up in mental health treatment though they indicate neither an active choice nor any resistance in their stories. In some cases, respondents are unclear as to how they got into the mental health system at all.

Following the examination of process through clients' stories, we investigate the impact of contingencies of the situation, the illness, and the individual on mode of entry to see which factors and characteristics influence the accounts they give. In an attempt to synthesize previous work and expand our conception of use, we focus on five of the most consistent predictors of mental health service use: need, gender, race, age, and social networks (Pescosolido and Boyer, forthcoming). First, we expect that "need" will influence accounts. Since, in this data, all stories end up in the mental health system, we examine whether individuals who receive different diagnoses report different experiences (Mechanic, 1990; Shapiro *et al.*, 1985). Second, because women are more likely than men to receive treatment for mental health distress or mental illness and are suspected to recognize and acknowledge psychiatric symptoms more readily, we consider the impact of gender (Gove, 1984; Greenley and Mechanic, 1976; Horwitz, 1977; Kessler *et al.*, 1981, 1994; Veroff, 1981). Third, past research indicates that African-Americans' rates of use are lower than other groups' (Cole and Pilisuk, 1976; Hough *et al.*, 1978; Leaf *et al.*, 1985; Padgett *et al.*, 1994; Sussman *et al.*, 1987; Wells *et al.*, 1988). Fourth, since our sample does not include

children or adolescents and focuses only on first major contact, we confine our concern to how age affects experiences for adults rather than to the documented non-linear impact across the life course (Shapiro *et al.*, 1985; Horgan, 1984). Finally, given our emphasis on the community, we consider whether the structure and content of individuals' social networks influence the kinds of experiences they report. Past research indicates that networks matter, though these studies are more limited and less consistent than the sociodemographic ones. For example, some studies (e.g. Kadushin, 1966) describe how social networks increase the resort to the treatment system while others (e.g. Suchman, 1964) imply that they discourage formal service use. We follow Freidson (1970) and Pescosolido (1991) who suggest that the structure of networks (e.g. size) and their content (e.g. affect, beliefs) be considered simultaneously.

DATA, METHODS AND MEASURES

Data

Data for this analysis come from the Indianapolis Network Mental Health Study (INMHS), an ongoing study of individuals making their first major contact with the mental health treatment system. Individuals were recruited for the study if they met criteria for a research diagnosis (using the SCID) of serious mental illness, primarily schizophrenia, major depression or bipolar disorder. A comparison sample of individuals with a research diagnosis of adjustment disorder was also recruited. The SCID is based on criteria from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R; American Psychiatric Association, 1987) and relies on standardized information collected about the patient's past history, current social functioning, and symptoms (Spitzer *et al.*, 1990).

As a study that focuses on how social networks change and are changed by mental illness, the INMHS targets only "first-timers," that is, individuals early in their "illness career" who are making their first contact with the largest public or voluntary hospital of a large urban catchment area in Indianapolis. Individuals must live in the greater urban area (defined as a driving distance of no more than two hours) and have an "acute history" of no more than two years. Recruitment of cases at the two sites began in December of 1990 and continues to date. In this study, we examine the cases ($n = 109$) included through December 1994.

The INMHS follows these individuals (the focal respondents or FRs) and others they mention as their network ties (the network respondents or NRs) over a four-year period. Here, we restrict our analysis to FRs in Wave 1. This first wave of data collection documents individuals' "story" of entry into care and their understanding of their situation,

their sociodemographic characteristics, and a variety of other aspects of their lives and social networks. In this paper, we examine their accounts of how they came to enter psychiatric treatment. Included are 109 individuals, of whom 81 (74.3%) are seriously mentally ill as defined above and 28 (25.6%) are in the comparison group diagnosed with adjustment disorders. All respondents were told about the study, its potential contributions and risks and all signed informed consent statements. Human subjects approval was obtained for all portions of the INMHS.

The data have some important limitations. First, we specifically included a probe in the "story" section to gather information on the timing of entry into the mental health system because we were concerned with issue of delay. This question was "When did this all start?" Unfortunately, the wide ranging frames of reference that respondents provided did not offer meaningful data on the issue of delay. For example, one respondent indicated that her depression had started when she was a child and her father took away her tricycle. Another respondent, who was experiencing hallucinations, indicated that the day before she came to a hospital for care, she noticed characters on the television who told her she was ill. Second, this study is limited to those who ended up in the mental health system. Given our focus on understanding "illness careers," it was important to locate and recruit individuals who were in the early stages of such a career (i.e. not chronic) and to focus on in-depth stories of how they entered treatment in this first wave of data collection. To find the sample included in this analysis, we screened over a thousand records since the beginning of the study and used the SCID in a pre-interview to determine eligibility. While an ideal design would also include a matched sample of individuals who did not end up in the treatment system, locating counterparts who met criteria but who did not use services would present major, if not insurmountable, logistical problems. Importantly, the strength of the Indianapolis Network Mental Health Study is not to provide efficient estimates of correlates of use or non-use but to understand the underlying dynamics of utilization, adherence, and outcomes, i.e. the process and contingencies affecting chronic illness careers.

Methods

From the INMHS, we obtained accounts of entry by asking individuals to tell us their story of how they "ended up" in the mental health treatment system. This phrasing is crucial since asking them either about their help-seeking or when their "problem" started sets up a trajectory that would bias their responses. In our early fieldwork observations, many of our respondents indicated that their only "problem" was that they were now in a hospital ward, crisis unit, or emergency room. Reports were

transcribed verbatim and used as the basis of the qualitative analysis and quantitative coding.

For the qualitative portion, we started with working definitions of choice, coercion, and muddling through in order to estimate the frequency of different themes. We then refined the definitions and developed explicit coding criteria. Finally, we coded each case as an instance of choice, coercion, or muddling through. The second author, trained in qualitative analysis, worked with the first author to develop the coding scheme. The first and third authors then coded the cases separately with an 85% reliability. The final 15% of cases were reviewed and classified when both coders agreed on the most appropriate category. We found that the majority of the discrepancies occurred in cases where the individual, throughout much of the story, could be described as "muddling," but in the end made a decision to go or was forced into treatment.

The quantitative portion of the analysis focuses, first, on a descriptive and, second, on a multivariate analysis of the images of health service use and their correlates. Given the categorical nature of the dependent variable (i.e. choice, coercion, or muddling through), we use multinomial logit analysis to examine the structure of accounts. Multinomial logit analysis provides estimates of the effect of each independent variable on all the possible contrasts of the dependent variable categories (e.g. how race affects the likelihood that individuals told stories of choice versus stories of coercion; Long, 1997).

Measures

We measured the contingencies through respondents' self-reports in a face-to-face interview using standard items. Of the 109 cases, 35 (32.1%) were males; 74 (67.9%) were females. Entered as a dummy variable in the model specification, females are coded 1, males 0. Respondents range in age from 18 to 72 years (mean age, 30.5 years). Most respondents are Caucasian (82 or 75.2%); the remainder are African-American (27 or 24.8%). African-Americans are coded 1 and Caucasians 0 in a dummy variable. There are no other racial and ethnic groups represented in the study. This reflects the profile of the greater Indianapolis area

*In the city of Indianapolis, the 1990 Census reports 21.3% African-American and 1.5% "other" non-white, non-Hispanic. In Marion County (the county that encompasses Indianapolis), the comparable figures are 22.6% and 1.6%, respectively (U.S. Bureau of the Census, 1992).

†For example, an individual who has "high" average closeness and five ties in their network would have a 0 in the "low" closeness variable, a 0 in the "medium" closeness variable, and a 5 in the "high" closeness variable. This specification implies that the effect of the number of ties is only estimated where the individual has a particular level of closeness, thus representing the interaction.

according to the 1990 U.S. Bureau of the Census (1992).*

Research diagnoses were determined through the use of the SCID, as described earlier. In the sample, 13 persons (11.9%) were diagnosed with bipolar disorder, 53 (48.6%) with major depression, 15 (13.8%) with schizophrenia or other psychotic disorders, and 28 (25.7%) with adjustment disorders. These are entered into the multinomial logit analysis as a set of dummy variables with adjustment disorders as the omitted category.

We measured social networks using the question from the General Social Survey Network Module, "Who are the people in your life with whom you discuss important matters? Who are the people you can really count on?" Respondents reported an average of 3.93 "important matters" ties, with the actual number ranging from 0 to 13 people. In the logit analysis, we use the natural log of the number of network ties under the assumption that the difference between having one or two ties is more important than the difference between having 12 or 13. To estimate the "closeness" of each tie, respondents were asked, "How close are you to this person?" (very close, "sort of" close, or not very close). We compute the average degree of closeness across all ties reported by each respondent to obtain a single measure.

Because previous research indicates that the effects of the structure and content of social networks may work together (Freidson, 1970; Pescosolido, 1991), we consider two different models, one that does not include an interaction specification (the base model) and one that does (the interaction model). Due to the relatively small number of cases and the possible problem of collinearity among the lower order and interaction terms, we take a different approach to modeling the interaction effects than is usually done. That is, we do not multiply the structure of the network (number of ties) by the content of the network (closeness of ties) to create the interaction term. Rather, we divide the sample into three groups based on the average closeness of ties, "high," "medium," or "low" closeness. We then create three new variables which correspond to these closeness categories. Each of the new variables contains the individual's number of ties if they are in that closeness group, 0 if they are not.† These variables capture the interaction between the structure and content of each individual's social networks (Long, personal communication). The current analysis is based on 103 cases since six individuals declined to provide information on their social network ties in the community. The models were estimated using the program Gauss. We present the results from both the base and the interaction specifications.

Table 1. Percentage of individuals reporting different accounts of initial entry into the mental health system, INMHS 1990-1994
(n = 109)

Story theme	n	%
Choice	50	45.9
Coercion	25	22.9
"Muddling through"	34	31.2

RESULTS

Accounts of entry into care

Table 1 presents the frequency distribution for the classification of stories into accounts of choice, coercion and muddling through. In fewer than half of the stories (45.9%), respondents indicated that they came into care through a "decision" where they played, in full or in part, an active and positive role. Almost one-quarter of respondents (22.9%) told stories of active resistance. They came into the mental health system against their will, brought in by the police or under pressure from family, friends, and co-workers. Almost a third (31.2%) of respondents reported stories in which they played no active role in seeking out or resisting treatment. Generally, they either vacillated about seeking treatment or they simply tried coping with their immediate circumstances and did not consider themselves in need of psychiatric care. Often, it was difficult to uncover where the muddling individual stood on the issue of treatment since they told their story as bystanders to the decision-making process.

The qualitative analysis revealed themes within each of these broad categories. While the whole story (i.e. the full transcript) was analyzed, we report here only short portions to provide a flavor of the accounts and the themes within them.

Accounts of choice

Within the category of "choice" the analysis revealed two different types of stories. The first type, called *individual choice*, is consistent with rational choice models. In these accounts, respondents describe making a decision on their own to seek help. For example, Janet,* a white woman diagnosed with an adjustment disorder, reported a series of life events and situations (grandfather's death, house burned down, lost her job, father's heart attack, husband's stressful job) that began in August. In May of the next year, she visited a local community mental health center while her son was hospitalized nearby, in part because she felt she got "bent out of shape quicker than I used to." When the interviewer asked whether anyone had suggested the treatment site, she responded:

No, I just did it. No, I just did it on my own.

Carol, a white woman diagnosed with major depression, reported that while she had felt depressed

all of her life, she began to be concerned after plans of marriage failed, she was evicted, contacted by Child Protective Services, and ended up in a homeless shelter with her children. As she recounts:

I was depressed, I've been depressed probably all of my life and didn't realize it was depression. But after he left it was like everything was just too...I couldn't deal with anything. There was no rational decisions being made. I wasn't sleeping. I wasn't eating. I was very short-tempered with the kids. And I really never had been short-tempered with the kids. And I decided before I did anything to hurt my kids I was going to seek help for me. And then I just walked into the crisis center and said: "Here I am and I need help."

Even in this account of individual choice, Carol describes the critical role of others in the decision-making process. When asked, "...[W]hen was it that you first recognized that you were depressed or that something was wrong with you emotionally?" Carol replied:

I guess when I got here [the homeless shelter] and people kept saying: "What's wrong? You look sad." And they would be sittin' and talkin' to me and I'd be staring at like into a distance. I don't know...the future or whatever. I don't know what it was. And they would say, "Carol, we're talking to you." And it was like "I'm sorry. I didn't hear you." They'd say I had a very distant look on my face and they could tell I wasn't with everything. I was...I guess I would have to say the people here were tellin' me I was depressed. I needed to find help too and I decided, well if this many people are saying I'm depressed and need help, there's something to it.

This case rests on the borderline between what we saw as accounts of *individual choice* and *supported choice*. The latter is more consistent with the Network-Episode Model which sees even rational choices as embedded within a social network process. Other cases provide a clearer illustration of this second type of choice. For example, Jack, a white man diagnosed with major depression, recounts his decision to seek care but makes it clear that the inspiration to do so came from others around him. When his father died, Jack began having "problems" with other people, his sister in particular. He reports that six months later:

Uh, I sat down...me and my mom talked about it. And she told me I should uh call, go somewhere, have someone sit down and just talk to someone....Uh, we went up to [hospital name] to talk to one of the psychiatrists up there.

In sum, within the theme of choice, we see that individuals report, at minimum, active agreement with and often active participation in their use of health services. Sometimes they do so without much explanation, and often social networks instigate the use of services and exert a good deal of influence.

Accounts of coercion

The chord running through all accounts of coercion is the active resistance to using services. Like the research from the MacArthur Law and Mental Health Network (e.g. Gardner *et al.*, 1993; Grisso and Applebaum, 1995; Hoge *et al.*, forthcoming;

*All respondent names are pseudonyms.

Monahan *et al.*, 1996), we found different themes in the mechanisms that might be seen as coercion. We distinguish between "hard" (in their terms, legal) and "soft" (or "extra-legal") coercion. Prototypical cases of *hard coercion* involve family, judges, lawyers, and police. For example, Sam, a white man diagnosed with bipolar disorder, entered the mental health system through an "emergency detention," i.e. a 72-hour hold on a locked inpatient unit, and was there several weeks later. As he tells his story:

I was going through a divorce with my wife and in about two months prior to my stay here [hospital] I was living out of the house so that I could quit having sex with her so that I could take myself away from her emotionally and begin to make rational choices about my decisions. But at the same time I also had business opportunities that were arising so that led me to leave my full-time job and start working on my self-employed companies which I'd been running anyways on a part-time basis since May 1987. And through some money mismanagement and help from others to go under I began having trouble paying my bills...And basically she [mother-in-law] used that situation against me. On 03-06-1991 I called my wife and told her to pack my clothes, that I was going to get a divorce...I'm not positively sure, but I suppose [she went] to her mother's because her mother, then, on 03-07, went down to the court system and not only did she twist the truth, she in fact lied by stating that I held a gun to my wife's head. And so they pulled me in here for basically attempted murder and the fact that I was stressed out.

But coercion also came from a number of other, non-legal sources. For example, Shana, a young African-American woman diagnosed with bipolar disorder, who reported that she had "all kind of energy" and "hadn't slept for like seven days," recounted her experience of her mother pushing her into treatment:

...my mom was like, "Come on, you're going to the doctor." I was like, "Wait a minute." I said, "I got an appointment next Thursday on the 14th at 4:00." She said, "Well I want you to go now." Then she started crying and making me feel all guilty so I went ahead and did it.

Later, Shana continues her story:

If I knew they was gonna try to keep me here, 'cause when they first signed the papers, the first set of papers, I just initialed them. I told my mother she had to sign them 'cause they were like, "You have to pay for this" and I was like, "No, I'm not." They tried to get me to pay my doctor bill and I told them, "No, I'm not"...They only charged me \$34. I had it. Why should I pay for it? You wanted me to go to the doctor. I know when I gotta go. So I'm not paying for something that you wanted me to do.

Like Clausen and Yarrow's (1955) classic study, we find that co-workers or supervisors were often the first to suggest that respondents seek care. They had some degree of "official" power to compel care seeking, even when the respondent resisted. For example, Terry, a young white man diagnosed with bipolar disorder, was "sent" to see the "department psychologist" by his immediate supervisor. In turn, the psychologist arranged a transfer to the local

public hospital where Terry spent the next "two weeks and six days." After a series of difficulties in his personal relationship, Terry reported to us:

...I went to work...that's when [supervisor's name] talked and said, "Terry." He started asking me about things with Alice [girlfriend]. Started asking me about things that have happened in my life lately. He wanted to talk about this and talk about that. And then that's when he said, "We're going to see [name of department psychologist]"... And then basically [psychologist] conceded that I was a mania... I was in uniform and they took me to my apartment so I could change. And then I changed into my personal clothes. And then I was admitted.

Terry actively resisted the definition of the situation being imposed:

I said, "I'll pass any test that you give me. I don't have any problems."

And upon being asked by the interviewer "whether anyone was against your coming to the hospital," Terry replied:

Me at first, but then I submitted because, you know.

In general, stories of coercion display the active negation of the role of the individual. Social control, rather than free choice, is the dominant mechanism that pushes the patient into the health system. Through some combination of family, friends, employers, judges, and police, these individuals come into treatment despite their continual and active resistance.

Accounts of muddling through

In the end, many, if not most, of the accounts had some component of muddling. Like Clausen and Yarrow (1955), we found that quick and efficient entry into care did not characterize how individuals ended up in the mental health system. In the final determination, we relied on the degree to which the individual actively participated in seeking or resisting mental health treatment to distinguish muddling accounts from choice or coercion accounts. This criterion was especially important for classifying cases of individuals who attempted suicide. Some respondents called 911 or agreed to go to the emergency room (*individual or supported choice*), while others continued to resist others' efforts to get them to the hospital (*hard or soft coercion*). In a number of suicide attempt cases, however, individuals continued to express ambivalence toward going to the hospital, neither accepting nor resisting. For example, Ronny, a white man diagnosed with major depression, was brought by ambulance to a local emergency room after his mother, a nurse, called a poison control line when she realized that her son had taken a bottle of over-the-counter sleeping pills. He expressed his ambivalence eloquently:

...it was like in the back of my heart, you know, "Somebody help me!" But in the front of the heart, "I can't bear this pain anymore."

He goes on to recount the story of his *mother's* decision-making, telling the story from her point of view but without quoting her:

Mom began to get worried because she wanted to handle the situation...if we can confine this and handle it here, that's, you know, great, we'll do it that way. She said she got me outside and tried to walk....She said the main thing that convinced her that we needed to go to the hospital was the Poison Control said that the stuff might be able to lead to some convulsions....And ah, she put me in the car...

Like Ronny, Lora, a African-American woman diagnosed with a psychiatric disorder (NOS), almost removes herself from the story in talking about her entry into treatment:

I just knew something was wrong with me. I didn't know what I could do for it. So she [sister] didn't even ask me did I want to come. She just drove me here. Then when I came to myself I was just here. Sitting over in that chair.

In many of the accounts of muddling, like Ronny's and Lora's, family and friends acted as agents of choice without the participation of or resistance from the focal respondent. Sometimes family members relied on relatives or acquaintances who had some medical expertise to take over and manage the situation. In other cases, however, a clear picture of agency by others is absent. Tamara, an African-American woman diagnosed with major depression, "caught a phobia about AIDS," in her words. Shying away from her small and conflicted family, she found a friend suggesting she seek care. Tamara tells her story dramatically, but without a frame of agency or coercion:

And it just seems like everything was closing in on me. Like I'm the only one here with my parents and everything. They know I have to do what they can't do. I have to do everything that's just like... It was just getting tough and I got to the point where I cried. I couldn't stop crying, and one day went to church with my friend and I cried. And I cried and I prayed and asked the Lord for help and he walked me into [name] Mental Health Center.

In sum, stories of muddling reveal two general possibilities. A strong, central agent from the respondent's social network may "take over" the

situation. When available, that agent is likely to be someone who the individual's other ties see as having the most relevant experience and information. Alternatively, we found that, in many cases, there was no clearly discernable agent. This formulation, the lack of agency, is particularly interesting because it challenges both the decision-making and coercive views of system entry. Muddling through stands as a distinct category because nowhere in these stories did respondents portray an active resistance to care nor did they indicate that they agreed with or actively consented to seek care.

Correlates of accounts

To examine the structure of accounts, we rely on the trichotomy of choice, coercion, and muddling through as the dependent variable. Unfortunately, we cannot estimate the model using the refined themes (*individual vs supported choice, hard vs soft coercion*) because there are not enough cases to yield stable estimates of the effects of social correlates on accounts. As mentioned previously, we use the multinomial logit technique because the dependent variable is categorical. This technique generates two kinds of significance tests: first, a χ^2 indicating whether the independent variable is related to differences between accounts overall; and second, a *t*-test of each logit coefficient indicating if the variable distinguishes between particular contrasts of account themes.

Table 2 presents the χ^2 tests for both the base and interaction models. The first two columns, the base model, reveal that type of mental health problem and social networks affect the nature of accounts told. In particular, individuals with bipolar disorder tell different kinds of stories than people with other disorders; and the size of individuals' social networks influences accounts ($\chi^2 = 9.18$, $P \leq 0.01$; $\chi^2 = 4.91$, $P \leq 0.09$, respectively). The last two columns, which provide the results for the interaction model, show similar results for diagnosis: having bipolar disorder significantly affects accounts ($\chi^2 = 9.33$, $P \leq 0.01$). Additionally, the interaction

Table 2. χ^2 tests of effects of accounts of entry into the mental health system on independent variables, base and interaction models, INMHS 1990-1994 ($n = 103$)

Variables	Base model		Interaction model	
	χ^2	<i>P</i> -value	χ^2	<i>P</i> -value
Sex (female)	0.07	0.97	0.18	0.91
Age	3.12	0.21	2.94	0.23
Race (African-American)	0.13	0.94	0.00	1.00
Diagnosis (vs adj. disorder)				
Bipolar disorder	9.18**	0.01	9.33**	0.01
Major depression	1.81	0.40	1.89	0.39
Schizophrenia/other psychosis	3.14	0.21	3.29	0.19
Number "important matters" ties (log)	4.91*	0.09		
Number "important matters" ties (log) for individuals with low closeness			0.84	0.66
Number "important matters" ties (log) for individuals with medium closeness			2.86	0.24
Number "important matters" ties (log) for individuals with high closeness			5.05*	0.08
Avg. degree of closeness among ties	2.18	0.34	1.30	0.52

* $P \leq 0.10$; ** $P \leq 0.05$.

model suggests that individuals who have large, close networks are the ones most likely to give different accounts of their entry into the mental health system ($\chi^2 = 5.05$, $P \leq 0.08$). That is, while size of the network affects story themes in the base model, the interaction model shows that the effect of size is only significant for people who have very close networks.

How these factors distinguish between specific story themes is presented in Table 3. Table 3 contains factor change scores which indicate whether and how each independent variable affects particular entry contrasts. Following Long (1987), we present the standardized factor change scores where the independent variable is measured at the ordinal level and the unstandardized factor change scores where it is categorical (i.e. in non-ordered categories). Factor change scores greater than 1 indicate that increases in the independent variable—or a positive condition, in the case of a dummy variable—correspond to an increased likelihood of the first option (e.g. coercion rather than choice). Similarly, a score lower than 1 corresponds to an increased likelihood of second option. The overall χ^2 for each model is significant ($\chi^2 = 36.47$, $P \leq 0.01$; $\chi^2 = 35.72$, $P \leq 0.02$, respectively). Results in the base model (columns 1 and 2) indicate that individuals with bipolar disorder are significantly more likely to give accounts of coercion as opposed to choice (f.c. = 21.84, $P \leq 0.05$) but just as likely to give accounts of muddling through as choice (f.c. = 2.08, n.s.). Individuals with larger social networks are significantly more likely to tell stories of coercion (f.c. = 1.79, $P \leq 0.10$) or muddling (f.c. = 1.65, $P \leq 0.10$) rather than choice. It would be incorrect to conclude that these findings are tautological (i.e. that individuals must have others around them in order to be forced into care and that only when isolated are they compelled to make an explicit decision). The qualitative data suggest

otherwise. Recall that choice in our conceptualization and coding includes "supported" choice where individuals like Carol make a decision to seek care with advice, encouragement, and even pressure from others. However, they do so actively, agreeing at some point to seek care. Others are coerced into care even with a local network as small as two individuals (case not quoted).

The findings from the interaction model (columns 3 and 4) are consistent with the interpretation from the base model. Individuals with bipolar disorder remain most likely to tell stories of coercion (f.c. = 24.56, $P \leq 0.01$). Few other factors matter, and the sign, size, and significance of coefficients remain relatively stable. However, this model provides greater insight into where and, perhaps how, social networks work in shaping accounts. Individuals with larger social networks are significantly more likely to give accounts coercion only when their ties are very close (f.c. = 2.45, $P \leq 0.05$). When social networks have both the size and affective power to exert influence, they are more likely to push their members into care for mental health problems, even over the client's active resistance.

DISCUSSION AND CONCLUSION: IMPLICATIONS AND FUTURE DIRECTIONS

The foregoing analysis reveals the importance of analyzing the stories of individuals with mental health problems and how they actually experience entry into the treatment system. We find that some people clearly make decisions about seeking treatment, either on their own or with support from others; some people are coerced into treatment; and some people muddle their way into the system, letting others push them into treatment without their agreement or resistance. Rather than privileging choice-based utilization approaches or the coercion-based legal perspective, we find support for both

Table 3. Multinomial logit factor change scores of individuals accounts of entry into the mental health system on sociodemographics, diagnosis, and social network variables, base and interaction models, INMHS 1990-1994 ($n = 103$)

Independent variables	Base model		Interaction model	
	Coercion vs choice	"Muddling" vs choice	Coercion vs choice	"Muddling" vs choice
Sex (female)	0.85	0.98	0.76	0.99
Age ^a	0.68	0.65	0.69	0.66
Race (African-American)	1.19	0.92	0.98	0.99
Diagnosis ^b				
Bipolar disorder	21.84**	2.08	24.56**	2.08
Major depression	2.17	1.97	2.37	1.92
Schizophrenia/other psychosis	4.57	0.79	5.10	0.80
Social networks				
Number of "important matters" ties (log) ^a	1.79*	1.65*		
Number "important matters" ties (log) for individuals with low closeness ^a			1.51	1.29
Number "important matters" ties (log) for individuals with medium closeness ^a			1.02	1.70
Number "important matters" ties (log) for individuals with high closeness ^a			2.45**	1.80
Avg. closeness in ties ^a	0.69	0.76	0.60	0.76
Overall χ^2			$\chi^2 = 36.47$, 16 df, $P \leq 0.01$	$\chi^2 = 35.72$, 20 df, $P \leq 0.02$

* $P \leq 0.10$; ** $P \leq 0.05$.

^aStandardized factor change scores presented as appropriate; all other factor change scores are unstandardized.

^bOmitted category: adjustment disorder.

images. In addition, a substantial proportion of clients' experiences fit neither profile.

Further, clients' accounts are shaped both by the type of mental health problems they have and the nature of their communities. From both the qualitative and quantitative analyses, we find that patients with bipolar disorder are more likely than patients with other mental health problems to come into conflict with the people around them: respondents with bipolar disorder often report feeling "high" when in the manic phase; others around them have difficulty convincing them that this is a problem. Often the conflict results in a coercive push into treatment.

Community ties are particularly important in coercion. Social networks that are large and closely tied together have the social capacity to get individuals into mental health treatment, even in the face of resistance. Whether the social response is intended to control or to cure, our results suggest that certain kinds of behaviors combined with living in a certain type of community (defined as a particular social network configuration) shape pathways to care.

Our findings have important theoretical, methodological, and clinical implications. First, we currently have two unconnected strands of research on service use that do not speak to one another and which portray individuals and how they get care in dramatically different ways. Rather than conceptualizing a single underlying social process, we must develop more sophisticated approaches that envision different possible mechanisms within a unified framework. Multifaceted approaches will allow us to examine the impact of the different processes on social and clinical outcomes. The Network-Episode Model, which attempts to bridge process and contingency models and which explicitly considers the role of social influence, offers a potential foundation for future theoretical development.

Second, if there is not one but several underlying social processes, then models which lump them together are likely to produce biased or erroneously insignificant results. This addresses the issue of the "collapsibility" of categories (Long, 1997, pp. 162–163). Even in a general population study, where the focus is on those who use services and those who do not, the question that arises is whether "use" is a homogeneous category. Both our analysis where use is separated into different modes of entry and Frank and Kamlet's (1989) multinomial logit analysis of no use, use of the general medical sector, or use of the specialty mental health sector suggests that the correlates within the "use" category are not the same. If choice and coercion, for example, are shaped by different contingencies, and those differences remain unaddressed, the effects of correlates may cancel each other out. This kind of phenomenon may account for the low levels of explained variance and lack of consistent findings

typical of service use models. We need to develop more sophisticated methodological approaches so we can understand more clearly how patients, their family members, and their friends interact with the treatment system. For example, large scale surveys can include existing measures of "coercion" (e.g. Bennett *et al.*, 1993) as a way to separate individuals who may have a different pathway into treatment. In methodological terms, this represents the problem of "endogenous switching" (Mare and Winship, 1988) where the mode of entry into care itself is both the result of a process that "tracks" individuals and goes on to affect later stages of the illness career (e.g. adherence, treatment, and quality of life outcomes).

Third, as Rogers (1993) found, we suspect that clinical outcomes for individuals may be tied to the nature of the accounts they give. Individuals who do not come by choice are less likely to be open to care, to accept any recommendations or treatments offered, to return for subsequent appointments, or to hold positive attitudes toward psychiatric services. Because individuals are tied to their social networks in the community, negative treatment experiences may also have a ripple effect: the attitudes that individuals hold as a result of their experiences can influence their advice to others with mental health problems. Theories of treatment adherence, continuity of care and outcome, not just theories of utilization, need to take these considerations into account.

It is also important to note that a person's account of entry does not indelibly set their path through the treatment system. Some individuals who are coerced may come to "understand" the importance of care. Others, who come by their own choice, may leave with negative views of mental health treatment. In this paper, we have taken a preliminary step toward addressing these issues, beginning with how patients enter the mental health treatment system. Because the INMHS follows individuals through their illness careers (at present, for four years after initial contact with the system) and interviews both the respondent's "supporters" and "hasslers," our future work can explore changes in the tone of service use over time, compare stories told by focal respondents and their social network ties, and address how accounts of entry shape future pathways through the system.

The implications of this research hold particular import in the current context of the changing structure of health care in the U.S., particularly the spread of managed care. Clearly, managed care changes our understanding and images of the medical system and how people will come to use it. As Mechanic *et al.* (1995) point out, managed care takes treatment decisions that have been historically in the hands of patients or providers and transfers them to utilization review personnel and managed care administrators. Ironically, at the same time,

many of the proposed or implemented policies in managed care plans have the latent effect of shifting greater responsibility for providing medical and mental health care to the community and to individuals outside the formal system. This "hidden assumption" rests on requirements that hospital days for everything from childbirth to radical mastectomy to serious mental illness be cut and moved to community-based programs, home care, or other, less well-specified options outside the formal system (Pescosolido and Kronenfeld, 1995).*

The social and sociomedical sciences have developed systematic theories of how individuals come into treatment for medical and mental health problems. These theories have set the groundwork for empirical studies and interventions since the late 1960s. Armed with both conceptual tools and empirical studies, researchers across the sociomedical sciences have played a central role in critiques of when and where these theories work and, by doing so, have set up the possibility of fashioning new theories for this new era of managed care. With the change in how mental health services are provided comes both a corresponding change in what we need to know about how individuals use services and a basic challenge for health services research.

Acknowledgements—We acknowledge financial support from the National Institute of Mental Health Grants K01MH00849, R29MH44780, and R24MH51669. We thank Carol Boyer, Ann Hohmann, Eric Wright, Norman Furniss, John Monahan, Partha Deb, J. Scott Long, William Gronfein, and Julie Artis for their helpful comments on various versions of this paper. We also thank Susan Duke, T. Chris Martindale, Susan Platter, Terry White, Vanessa Stiles and Melanie Stiles for their field, administrative and clerical assistance.

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*For example, in 1995, the actual number of days in the hospital following either vaginal or caesarean delivery in childbirth fell below the recommended guidelines of the American College of Obstetrics and Gynecology. As in the now-famous case of the Burkhalter family in New Jersey—who in 1995 lost their three-day old daughter from streptococcus septicemia—resulting mortality and morbidity problems are tied to: reimbursement limitations placed on tertiary care under managed care plans; and the failure to provide or problems with the logistics of home-based, follow-up care.

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