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Factors in Decisions to Seek Help From Self-Help and Co-Located Community Mental Health Agencies

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Abstract

This study examined 673 new users of co-located mental health self-help agencies run by consumers and community mental health agencies to evaluate the relative importance of predisposing, enabling, and need factors in site selection. Although need dominated help site choice, clients' attitudes toward the helpfulness of mental health treatment and their fears of coerced or inadequate care played an important role in setting choice, a choice indicative of a more complex motivational dynamic in help seeking.

Heightened emphasis on self-help activities has led to increasing requirements for consumer participation in mental health services (U.S. Department of Health and Human Services [USDHHS], 1999). Self-help agencies (SHAs), incorporated as voluntary organizations and managed and staffed by former patients, are often funded as adjuncts or referral sources for community mental health agencies (CMHAs). In fact, when serving the same geographic areas, SHAs represent alternative service sites (Kaufmann, Ward-Colasante, & Farmer, 1993; Mowbray & Tan, 1993; Nikkel, Smith, & Edwards, 1992; USDHHS, 1999). Limited knowledge is available as to how such organizations, in geographic proximity, interact; who they attract as prospective clients; and what needs their clients bring to the service situation (Davidson et al., 1999; Segal, Hardiman, & Hodges, 2002). Likewise, little is known about those factors that influence the prospective client's choice of service (Bauer, Shea, McBride, & Gavin, 1997). Given the same target population, why do some clients choose to seek help at the SHA versus the CMHA?

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The Co-Located Settings

SHAs

SHAs vary in program focus, their functions including drop-in centers, case management programs, outreach programs, consumer-operated businesses, employment and housing programs, and crisis services (Long & Van Tosh, 1988; National Resource Center on Homelessness and Mental Illness, 1989; Van Tosh & del Vecchio, in press). SHAs functioning as drop-in centers, the primary focus of this study, offer social support and assistance. They involve high levels of client participation in organizational decision making and provide vocational opportunities ranging from volunteer roles to SHA staff positions. Staff members who are former clients gain meaningful work and act as role models. Relative to CMHA professionals, they are considered more empathic and capable of engaging their peers in services (Mowbray et al., 1996). The SHA drop-in provides easy access to a nonthreatening environment with concrete resources, social support, network-building opportunities, and day shelter. The setting requires minimal disclosure of personal information and allows the client to accept help at his or her own pace (Segal & Baumohl, 1985).

CMHAs

CMHAs are frontline professional mental health treatment organizations for those with serious mental illnesses. They provide inpatient and outpatient treatment, medication management, and case management services. In recent years, CMHAs have been impacted by budget cuts under the constraints of managed care. Because studies have found little difference between consumer and professional case-management efforts (Solomon & Draine, 1995), cost-conscious mental health governing bodies are delegating socially based interventions to SHAs, leaving CMHAs to focus primarily on clinical interventions (Allness & Knoedler, 1999). Our study addresses how this division of labor affects the combination of factors influencing new clients to seek help at one or the other organization.

Factors in Help Seeking

Using Andersen’s (1968, 1995) help-seeking model, which divides factors influencing such decisions into predisposing, enabling, and need categories, we consider how such factors influence choice of service setting among adults with psychiatric disabilities.

Predisposing Factors

Researchers have found ethnicity (Flaskerud, 1986; Neighbors, 1985; Rosenheck, Leda, Frisman, & Gallup, 1997; Sullivan, Bulik, Forman, & Mezzich, 1993), diagnosis (Howard et al., 1996), and functional impairment (Segal, Silverman, & Temkin, 1995a) to be patient characteristics associated with mental health service utilization. African Americans, for example, may be less at home in the formal system of care and might be more predisposed to favor the SHAs over the CMHAs (Lieberman & Snowden, 1993; Neighbors, 1985). The shift to managed care and the use of medical necessity criteria for offering service has forced CMHAs to focus on limited cognitive, behavioral, and medication regimens. From a prognostic perspective this seems more suited to major affective disorders than to

schizophrenia (Dinaker & Sobel, 1999; Mays & Croake, 1997; Roy-Byrne, et al., 1998). Individuals with schizophrenia might thus be more predisposed to seek out the social support emphasis of the SHA, whereas those with major depression might be more likely to seek service at the CMHA.

Enabling Factors

Enabling factors traditionally address issues of availability, accessibility, and cost (Benda, 1993; Simon, VonKorff, & Durham, 1994). However, in this study, the two agency types were located in the same geographic areas, with the same transportation and access issues, and both were offering care to a Medicaid-eligible population. Thus, we considered more nontraditional enabling factors, such as referral system involvements, motivation, and past service experience (Banziger, Smith, & Foos, 1982; Kiernan, Toro, Rappaport, & Seidman, 1989; Sachs-Ericcson, Ciarlo, Tweed, Dilts, & Casper, 1994). People choosing the SHA versus the CMHA are most likely to be enabled in terms of accessibility and availability by their linkage with informal referral sources; those coming to the CMHA tend to be enabled by their qualifications within the formal system of care (Horwitz, 1987; Neighbors, 1985; Rogler & Cortes, 1993; Segal, Silverman, & Temkin, 1995a; Wikler, 1986). Previous experience with helpers would also be an enabling factor (Friedman & West, 1987). Those having received help from social services (and from social workers in particular) would be more likely to see the appropriateness of the SHA broad-based support service model in meeting their needs, because of its emphasis on natural helping networks, client strengths, and service referrals. These SHA values are core to the social work profession. Given the more intrapsychic focus of psychology (Payne, 1997), those having a history of involvement with psychologists would likely seek the CHMA’s focus on counseling and treatment.

Mental health services may be viewed as potentially harmful, shameful, or simply unnecessary (Mulkern & Bradley, 1986; Stefl & Prosperi, 1985; Wikler, 1986). Recognizing the presence of a mental health problem has been cited as an enabling factor in helping the mentally ill seek services (Howard et al., 1996). Because SHAs have their roots in the antipsychiatry movement, those with more positive attitudes toward professional help might choose the CMHA. Alternatively, fear of involuntary hospitalization or other professional treatment might lead to SHA selection (Campbell & Schraiber, 1989), whereas fear of unskilled care might lead to avoidance of the SHA.

Need Factors

We begin with the assumption that people approach a mental health setting with a particular service need in mind and that this need should be the primary factor in utilization choice (Rapaport & Zisook, 1987). These needs are the actual services individuals want from the agency, that is, counseling, medications, or social support services. We expect those seeking counseling and medications to choose the CMHA and those seeking social support services, the SHA. However, the majority of those with an objectively defined need for treatment do not end up in any sort of formalized care arrangement (Rogler & Cortes, 1993). Thus, considerable variance in help seeking may be attributed to other aforementioned factors (Horwitz, 1987; Rogler & Cortes, 1993). This study addresses the relative importance of

predisposing, enabling, and need factors in explaining why individuals seek help at an SHA versus a CMHA service site located in the same area.

Method

Description of Agencies

Twenty-one co-located organizations in six counties of the greater San Francisco Bay Area of Northern California participated in the study. Ten CMHA–SHA pairs were chosen for their geographic proximity (one CMHA was associated with two SHAs in its area). Co-location of agencies (agencies within the same area and often within walking distance of each other) allowed for meaningful comparisons of help seekers' choice of service site.

An SHA was defined as an organization with a consumer as director, with a governing board consisting mostly of consumer members, and in which the consumers had the right to hire and fire any employed professionals. The SHA was a consumer-operated service. CMHAs were community mental health organizations, either run by or contracted to the county department of mental health.

Participating SHAs served persons with psychiatric disabilities based on a broad application of consumer-centered principles. All SHAs emphasized the exchange of mutual support between members and were characterized by a high degree of participatory governance. Although there was variation in organizational structure and function among SHAs, common elements included the provision of peer support groups, material resources, drop-in socialization, and direct services. The range of direct services at SHAs included assistance in obtaining survival resources (such as food, shelter, and clothing), money management, counseling, payeeship services, case management, peer counseling, and information/referral. SHAs also provided physical space for socialization and the development and maintenance of peer support networks through both formal and informal means. As an outgrowth of the mental health consumer movement (Chamberlin, 1990), SHAs offered members opportunity for involvement in local, state, and national advocacy efforts.

The co-located participating CMHAs were those sites in the area providing outpatient mental health services for the psychiatrically disabled population of public sector patients, the same target population of the paired SHA site. Regardless of setting differences, services provided at all CMHAs included assessment, medication review, individual therapy, group therapy, and case management. Social support, vocational services, and material resources were generally provided through a traditional referral system.

Sample

A total of 673 adults with psychiatric disabilities who were new to the system and sought services from an SHA or a CMHA in one of six northern California counties were recruited for the study between 1996 and 2000 (226 new SHA users and 447 new CMHA clients). A new case was an individual who had not received services in such an organization for at least the 6 months prior to their entry to the agency. Cases were recruited at their intake interview following a determination of eligibility for service at the agency. All entering individuals were asked to participate in the study, and 86% ($N = 673$) agreed. Among the 114 who

refused participation, reasons varied from simply not being interested to having no available time to experiencing too many psychiatric symptoms (e.g., being too depressed or anxious to be interviewed). No significant differences were found when study participants were compared with the refusal group in terms of gender, ethnicity, and housing status.

Assessment

Interviews were conducted by former mental health consumers and professionals trained by the Center for Self-Help Research in Berkeley. Initial interviews were completed following intake to either the SHA or the CMHA. Informed consent for human investigation was obtained from all study participants. The Center for Self-Help Research's comprehensive assessment was administered to all study respondents using two interview schedules, which had been pretested on a sample of 310 long-term users of SHAs in northern California (Segal, Silverman, & Temkin, 1995a) and on a sample of 30 CMHA clients. The first interview schedule was assembled as part of a process in which the total construction of the assessment, including individual items and standardized measures, was reviewed, edited, and discussed by a panel consisting of researchers and consumer leaders in collaborative meetings. The interview uses a question–answer format, along with some interviewer ratings of observed and reported interviewee behavior. The interview includes questions about demographics, pathways to services, service use, lifetime history of disability and service use, and agency environments. The second interview schedule includes a slightly modified version of the Diagnostic Interview Schedule—IV (DIS–IV; Robins et al., 2000; Robins, Helzer, Cottler, & Goldring, 1989), excluding only redundant health information and questions regarding diagnoses considered infrequent in this subject population (e.g., eating disorders).

Predisposing factors.—Among measures of predisposition were assessments of functional status and race (African American vs. other). Social and psychological functioning were assessed, respectively, with the Independent Social Functioning Scale (ISFS; Segal & Aviram, 1978) and the Overall and Gorham (1962) Brief Psychiatric Rating Scale (BPRS). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.) diagnoses were obtained from the Diagnostic Interview Schedule.

The ISFS is a modified version of Segal and Aviram's External Social Integration Scale (Segal & Aviram, 1978). It measures "the extent to which an individual participated in and made use of the community in a self-initiated manner and without the help of others" (Segal & Kotler, 1993). The scale includes a number of related dimensions: The amount of time spent in community-related activities; the ease with which the person engages in social contacts, uses community services, or obtains basic resources; the amount of contact with family, friends, and acquaintances; involvement in income-producing activities or educational activities that might lead to employment; and the amount of time spent in purchasing activities (e.g., shopping). In the current sample, the ISFS's internal consistency was .949.

The BPRS was used as a measure of psychological disability (Overall & Gorham, 1962). The scale is a symptom-based index that has been used frequently in drug trials (Rhoades &

Overall, 1988) and used by Segal and colleagues (Segal & Aviram, 1978; Segal & Kotler, 1993) in their studies of former psychiatric patients in residential board and care. We used training films and dictionaries to standardize assessments on these symptom ratings. Staff members, both consumers and mental health professionals, were trained with the aid of the Clinical Research Center for Schizophrenia and Psychiatric Rehabilitation at the University of California, Los Angeles to complete an expanded, 24-item version of the BPRS assessments developed by this research center. Interrater reliabilities were in the .80 to .90 range during training. The scale's internal consistency in the study sample was .84.

Enabling factors.—Enabling factors measured in the study included whether the client came to the organization as a result of contact with friends, relatives, or street network, or just dropped in as opposed to having had a referral from a social service or professional helper (considered as a binary variable). We assessed whether the client had in the past received help from a social worker or a psychologist (entered as two binary variables) and whether the client had a past service history with the agency (i.e., one occurring prior to the 6-month no-contact period defining the "new client" status).

Three attitudinal measures were developed by our group to assess attitudes toward services utilization: (a) the client's attitude toward the helpfulness of mental health treatment (higher scores indicating greater helpfulness), (b) the client's fear of being subjected to coerced treatment (higher scores indicating greater fear); and (c) the client's fear of being subjected to inadequate treatment (higher scores indicating greater fear). In addition, we considered the interaction between fear of coerced treatment and the client's perception of treatment helpfulness (the interaction of fear of inadequate treatment and perceived helpfulness of treatment was also considered but found nonsignificant).

The Perceived Helpfulness of Mental Health Treatment Scale assesses client beliefs about the helpfulness of various therapeutic interventions, including psychoactive medications, group therapy, individual counseling, money management, peer counseling, housing assistance, peer-run services, advocacy, case management, and outreach services. This 10-item, five-response-category Likert-type scale, in which higher scores imply greater perceived helpfulness of the given service, had an internal consistency of .90.

Following the findings of Campbell and Schraiber (1989) indicating that significant numbers of people avoid care for fear of coercive treatment, the Fear of Coercive Care Scale assesses client concerns that staff would act to hospitalize for psychiatric reasons; would require unwanted actions, forced medications, or restriction of freedom; and/or would call police to enforce such care. This five-item, five-response-category Likert-type scale, in which higher scores imply greater fear, had an internal consistency of .86.

The Fear of Inadequate Care Scale addresses client concerns that staff would be inattentive, have insufficient training, have too many problems of their own, or be too busy and that the organization would be too disorganized to offer adequate care. This five-item, five-response-category Likert-type scale, where higher scores imply greater fear, had an internal consistency of .90.

Need factors.—Need factors were assessed by specific questions related to the actual services that the individuals indicated they were seeking. Individuals were asked what they wanted in coming to the agency. They checked as many items as were relevant to them. These included housing, counseling, medications, a place to be inside or drop in, a place to socialize or meet other people, and self-help. Each item was included in the analyses as a binary variable.

Analysis

Univariate and bivariate.—The demographic characteristics of the sample are reported along with bivariate analyses on all help-seeking measures distinguishing those seeking care at SHAs versus CMHAs. Bivariate relationships are evaluated using *t* tests for differences in means and chi-square analyses for categorical variables.

Multivariate.—We used our theoretical model of help-seeking behavior to complete a two-stage logit regression to determine the importance of need, enabling, and predisposing conditions in the selection of one service setting versus the other. The previously noted variable groups are entered in the first stage, and a second stage includes a group of dummy variables describing the county of empanelment.

Results

Sample Demographic, Housing, and Income Characteristics

Both mean and median ages of respondents were 39 years. Over half of the sample was male (54%); 52% had never married. The sample's educational distribution was bimodal, that is, 35% had less than a high school education and 32% had some college. No between-group differences were observed on any of the aforementioned demographics.

At time of interview, 33% ($n = 219$) of the total sample were homeless, that is living in shelters, in cars, or on the street. Thirty-two percent ($n = 218$) were in stable housing. The remaining 35% ($n = 235$) of the total sample were marginally housed, referring to individuals who were currently in housing but also had a history of recent homelessness (within the past 5 years). Though members of the CMHA group were more likely to have been homeless in the past 5 years than members of the SHA group (65% vs. 56%), $\chi^2(1, N = 235) = 5.23$, $p = .022$, no significant differences were found between the SHA and CMHA groups in regard to current homelessness rate.

The respondents' median income was $609 per month. The SHA and CMHA groups differed in sources of income. SHA users were more likely to receive Supplemental Security Income (49% vs. 34%), $\chi^2(1. N = 264) = 13.63$, $p < .0005$, and more likely to receive both Supplemental Security Income and Social Security Disability Insurance (22% vs. 13%), $\chi^2(1, N = 106) = 9.10$, $p = .003$, but were less likely than those in the CMHA group to receive Aid to Families with Dependent Children/Temporary Assistance to Needy Families (4% vs. 8%), $\chi^2(l, N = 42) = 4.24$. $p = .039$. Nine percent of the sample were working for pay, 14% worked as volunteers, and 31% reported that they were currently looking for work. The SHA and CMHA groups differed on employment characteristics in only one aspect: The

CMHA group had worked more weeks at a paid job in the previous year, with a mean of 10 weeks, compared with 7 weeks for the SHA group, $t(1) = 2.19$, $N = 614$, $p = .029$.

Univariate and Bivariate Analyses of Factors in the Model

Predisposing factors.—Over half of the respondents were Caucasian (54%), 29% African American, 10% Latino, 3% Asian, 2% Native American, and 3% of other ethnicity. Members of the SHA group were more likely to be African American than those in the CMHA group (36% vs. 25%), χ^2 (1, $N = 218$) = 7.72, $p = .005$.

The overall sample showed multiple and severe psychiatric disabilities, with 85% having had an active disorder in the past year. When considering primary Axis I diagnosis, 63% reported major depression; 16% schizophrenia; 10% anxiety disorders, panic disorders, or posttraumatic stress disorder; and 4% bipolar disorders. CMHA group members were more likely to be diagnosed with major depression than those in the SHA group (68% vs. 54%), $\chi^2(1, N = 423) = 7.32$, $p = .007$. Though only approaching significance, there was a tendency for more people with schizophrenia and schizoaffective conditions to use the SHA than the CMHA: 20% ($n = 45$) versus 14% ($n = 64$), $\chi^2(1, N = 109) = 3.17$, $p = .075$. The SHA group evidenced lower BPRS psychiatric symptom severity scores than the CMHA ($M_{SHA} = 34.71$ vs. $M_{CMHA} = 39.37$), $t(1) = 5.02$, $N = 663$, $p < .000$. The SHA help seekers were functioning better than those who chose the CMHA as measured by the ISFS ($M_{SHA} = 214.23$ vs. $M_{CMHA} = 204.45$), $t(1) = 3.21$, $N = 671$, $p = .002$.

Enabling factors.—The most common ways in which respondents had heard about the agencies were through outpatient mental health workers (18%), other clients (14%), social service referrals (13%), and mental health crisis team workers (11%). Sixty-two percent came through formal referrals, and 38% through informal mechanisms. The SHA group made greater use of informal versus formal pathways to the agency (64% vs. 23%), $\chi^2(1, N = 583) = 94.000$, $p < .0005$. Whereas the CMHA group was more likely to have heard about the agency through a mental health crisis worker or through a social services referral, the SHA group was more likely to have heard about the agency from another client or through word of mouth.

Summary statistics for the attitudinal measures are as follows: Perceived Helpfulness of Mental Health Treatment Scale, $M = 38.76$, $SD = 7.62$; Fear of Coercive Care scale, $M = 8.74$, $SD = 4.44$; and Fear of Inadequate Care scale, $M = 9.86$, $SD = 4.75$. The SHA group scored higher on the Perceived Helpfulness of Mental Health Treatment Scale than the CMHA group ($M_{SHA} = 39.65$ vs. $M_{CMHA} = 38.22$), $t(536) = 2.097$, $p < .036$. The SHA group had lower Fear of Coercive Care Scale scores and lower Fear of Inadequate Care Scale scores than the CMHA group, respectively, $M_{SHA} = 7.46$ versus $M_{CMHA} = 9.34$, $t(410) = -5.09$, $p < .000$, and $M_{SHA} = 9.07$ versus $M_{CMHA} = 10.25$, $t(648) = -3.025$, $p < .003$.

Need factors.—Regardless of programmatic offering, the prospective clients in our sample came to the different settings seeking services often outside of the primary focus of the organization. They came seeking counseling (58.4%), medications (47%), drop-in services (20%), socialization (22.5%), self-help (17.0%), and housing (11.7%).

The CMHA respondents were more likely to have come to the agency for counseling (77% vs. 23%), $\chi^2(1, N = 649) = 176.507$, $p < .0005$, and medications (71% vs. 2%), χ^2 (1, $N = 649) = 277.158$, $p < .0005$, whereas SHA respondents were more likely to have come to the agency for drop-in services (55% vs. 2%), $\chi^2(1, N = 648) = 253.629$, $p < .0005$; socialization (60% vs. 2%), $\chi^2(1, N = 648) = 283.857$, $p < .0005$; self-help ideology (44% vs. 3%), $\chi^2(1, N = 648) = 178.613$, $p < .0005$; and housing assistance (24% vs. 11%), $\chi^2(1, N = 647) = 21.329$, $p < .0005$.

Multivariate Model Analyses

The model results were highly significant, model $\chi^2(19, N = 530) = 579.78$, $p = .0000$, and correctly classify 96.2% of the sample into their respective groups (see Table 1). Because none of the service area site locations were found to significantly contribute to agency selection, results are reported for only the first stage of the model. Five of the six need factors were significant, as were six of the eight enabling factors and none of the predisposing factors (see Table 2). Seeking self-help services is the most important factor in choice of the SHA, making one more than 17 times more likely than others to choose this agency. Seeking a place to drop in and to socialize, respectively, made one more than 9 and 7 times more likely than others to choose the SHA over the CMHA. Alternatively, seeking counseling and medications made one 90% and 99%, respectively, more likely to choose the CMHA over the SHA.

With all other factors taken into account, people were enabled in their choices by the referral system and their experience with past social worker assistance. Informal system referrals made one more than 5 times more likely to choose the SHA over the CMHA. Social worker assistance in the past made one more than 5 times more likely to choose the former agency over the latter.

Motivation and attitude were also significant enablers. For each single-point increase in one’s Perceived Helpfulness of Mental Health Treatment Scale score (a 50-point scale), a client was 17% more likely to choose the CMHA. For each single-point increase in their Fear of Coerced Care Scale score (a 25-point scale), the client was 30% more likely to choose the CMHA. For each single-point increase in their Fear of Inadequate Care Scale score (a 25-point scale), the client was 15% more likely to choose the SHA. For each increase of one standard deviation in the interaction of the coerced care score and perceived helpfulness score, the client was 177% more likely to choose the SHA.

Discussion

The results indicate that help seeking for adults with psychiatric disabilities is both a simple fulfillment of need and a complex process influenced by client attitudes and fears about services. When all factors were taken into account, the predisposing factors (i.e., diagnosis, ethnicity, and functional status) were of least import (see also Gamache, Rosenheck, & Tessleri, 2000). It is in fact likely that none were significant in the model because both organizations served the same areas and population groups.

Individuals seem to choose between these co-located organizations on the basis of the differential technologies offered to meet their needs. The primary reasons for going to the SHA are to seek self-help services and socialization opportunities. The major reasons for going to the CMHA are to receive medication and counseling.

Enabling factors fostering the use of the SHA are first related to one's use of informal versus formal referral systems. It also appears that past experience with the broader-based service perspective of social workers (one that values self-help and social support) enables clients to make use of the self-help perspective.

The clients' perception that mental health services were indeed helpful enabled them to choose the CMHA. Yet the findings regarding fear of receiving coercive care are somewhat contrary to those we might have expected from work previously reported in the literature. Given previous findings, we believed such fear would be associated with avoidance of CMHA services (Campbell & Schraiber, 1989). Our results indicate that it is in fact associated with a greater propensity to use the CMHA. It seems that this is due to the dominance of *need* in service choice. Potential clients are afraid of the types of services available to help them at the CMHA, but their fear is perhaps a function of their self-awareness of the problems they are experiencing. This fear then contributes to clients' willingness to use the CMHA rather than being associated with their avoidance of such services. The realization of need brings all of the associated fears of what seeking help might entail. No one fears medical treatment more than the patient who is in need of it.

This same process seems to prevail with respect to the fear of inadequate care. One might expect that peer-operated care would solicit more fear that staff would have insufficient training or too many problems of their own and that the organization would be too disorganized to offer adequate care. Yet greater fear of receipt of inadequate care is associated with the use of the SHA, again indicating that need seems to dominate fear.

The significant interaction, influencing clients in the direction of the SHA, between fear of coerced care and perceived helpfulness of mental health treatment, however, suggests a more complicated process. It seems that despite the client's higher perceived helpfulness of mental health treatment scores when such helpfulness is associated with high fear of coerced care, the agency choice is the SHA over the CMHA. Given these results, we hypothesize that the following dynamic is at work. First, given the results of Campbell and Schraiber (1989), we expect that there are those who fail to seek care out of fear of coercive treatments. Yet we assume that for many of these individuals, both need and fear of coerced care have as yet to reach a level where, as for our client group, they become motivating and push the client in the direction of seeking service. At some point the fear becomes so great that alternatives are sought, such as the SHA, thus explaining the significant interaction effect. Finally, we assume, again on the basis of Campbell and Schraiber's findings, that there are those whose fear is so great that they will simply avoid all care.

This hypothesized dynamic suggests a direction for future research into help-seeking enabling factors that are related to client motivation and attitudes. Because our study included only individuals already coming to treatment, we cannot confirm it. Further, our

results reflect thé newly emerging cooperative division of labor emerging between northern California CMHAs and co-located SHAs. Although these findings may have limited generalizability, they are instructive as to how such a system might operate to better serve the diverse needs of mental health clients.

Use of the SHA versus the CMHA is a choice dominated by the growing specialization of these organizations and their respective ability to deliver the types of services sought by clients. Prospective CMHA clients seek medications and counseling; prospective SHA clients seek self-help services, drop in, and socialization. Clients' choice of service is influenced by their attitudes regarding the helpfulness of mental health treatment, their fear of coerced care, and their fear of the receipt of inadequate care. For this sample of help seekers, these last fears are generally dominated by client need for a given service and therefore are associated with an increased probability of using the services the agency offers. Yet the significant interaction between client attitudes toward the helpfulness of mental health treatment and their fear of coerced care, in combination with previous findings in the literature, lead us to hypothesize the presence of a more complex help-seeking dynamic, in which increased fear of coerced care may lead to the avoidance of necessary care. This study provides evidence, from the voices of clients themselves, that the mental health service system needs to better understand how, why, and where clients choose to enter the service system to address their mental health needs.

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Table 1

Accuracy of Predictions Based on a Help-Seeking Model (N = 530)

	Predicted		
Observed	**CMHA**	**SHA**	**Percentage correct**
CMHA	311	10	96.9
SHA	10	199	95.2
Overall			96.2

Note. Actual *N* for regression due to missing data. CMHA = community mental health agency; SMA = self-help agency.

Table 2

Factors in Choosing Help at Self-Help Agencies (SHAs) Versus Community Mental Health Agencies (CMHAs) for New Users

Variable	*B*	*p*	Exp(*B*)
Need factors: Type of Help Sought			
Housing	0.843	.147	2.324
Counseling	−2.270	.000	0.103
Medications	−4.707	.000	0.009
Place to be inside/drop-in	2.218	.001	9.186
Social/meet other people	2.025	.001	7.576
Self-help	2.860	.001	17.465
Enabling factors			
Past help from psychologist	0.064	.908	1.066
Past help from social worker	1.682	.007	5.374
Informal (vs. formal) referral	1.706	.001	5.506
Received help at setting in past	−7.487	.714	0.001
Perceived helpfulness of MH treatment	−0.181	.025	0.834
Fear of coerced care	−0.357	.008	0.700
Fear of inadequate care	0.141	.030	1.151
Interaction of fear of coerced care and perceived helpfulness of MH treatment	0.007	.047	1.007
Predisposing factors			
Schizophrenia diagnosis	−0.976	.282	0.377
Major depression diagnosis	−0.523	.389	0.593
BPRS score	−0.005	.834	0.995
Independent social function score	0.009	.187	1.010
African American (vs. other)	0.089	.881	1.093

Note. Model $\chi^2(19, N = 530) = 579.78$, $p = .00$. SHA was coded in the dependent variable as 1; CMHA was coded as 0. MH = mental health; BPRS = Brief Psychiatric Rating Scale.