ATTITUDES TOWARD MENTAL HEALTH SERVICES
AMONG HOMELESS, RUNAWAY AND HOUSED YOUTH

By

Jared K. Martin

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Committee Membership
Dr. Tasha Howe, Committee Chair
Dr. Brent Duncan, Committee Member
Sheri Johnson, Committee Member
Dr. Chris Aberson, Graduate Coordinator

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ABSTRACT

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Youth homelessness is a serious concern in the United States that is commonly influenced by family conflict and parental maltreatment leading youth to flee their homes. Early traumatic experiences, combined with high rates of victimization, contribute to elevated levels of depression, post-traumatic stress disorder, substance abuse, and suicidality among homeless and runaway youth. A small number of studies have been conducted on mental health service use among homeless and runaway youth, with the majority of those studies reporting an under-utilization of services.

The current study provides an analysis of homeless and runaway youths’ attitudes towards mental health services in order to identify possible factors that can assist service providers with understanding and increasing service engagement. Variables examined included help seeking propensity, psychological openness, concern for mental health stigma, parental maltreatment, street victimization and services needs assessment. The current study also examines the relationship between social support and attitudes toward mental health services. A comparison sample of housed youth was obtained in order to determine if mental health attitudes are unique to homeless youth.

Fifty-six youth who identified as homeless were recruited through youth drop-in centers and a shelter in Northern California, and 97 housed youth were recruited from alternative community continuation schools in the same region. Analysis of variance
showed that homeless and housed groups did not differ significantly on attitudes toward mental health services, help seeking propensity, psychological openness, and concern for mental health stigma. Additional findings revealed that, for homeless youth, the more perceived friend support, the more their concern for mental health stigma decreased and the more supportive individuals available, the more positive attitudes toward mental health services and help seeking propensity increased. Comparison of correlations between homeless and housed groups revealed only one significant difference; the association between perceived family support and help seeking propensity was strongest for the housed group than for the homeless group.

Results demonstrated that homeless youth and housed youth share similar attitudes toward mental health services, help seeking propensity, psychological openness, and concern for mental health stigma. Mean scores obtained on these measures were comparable to the only existing study on adolescents’ attitudes toward mental health services, which suggested that these attitudes might be typical across multiple youth populations. Findings also indicate that higher social support is associated with increased attitudes toward mental health services, increased help seeking propensity, and decreased concern for mental health stigma for homeless youth and high perceived family support is associated with increased help seeking propensity for housed youth. Service providers can benefit from these results by modifying programs or outreach efforts to include assistance with transportation to services (a key barrier youth identified), target social support and emphasize positive youth development practices in order to increase positive attitudes toward service providers and increase service use.
ACKNOWLEDGEMENTS

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INTRODUCTION

Among the world’s most developed nations, the United States has some of the highest rates of homelessness (Tompsett et al., 2003; Toro et al., 2007). In 2010, 649,917 individuals lived in a shelter or on the street and over 1.59 million people resided in a homeless shelter for a minimum of one night (United States Department of Housing and Urban Development [HUD], 2010). Moreover, homeless rates are continuing to rise in the U.S. The number of individuals who were living on the street or in a shelter increased 1.6% from the 2009 to 2010 count (HUD, 2010). A particular concern is the population of youth who are homeless and on their own. Of the 1.59 million individuals who stayed in a shelter, approximately 21.8% were youth under the age of 18 (HUD, 2010). It is estimated that between 300,000 and 1,682,900 youth are homeless each year (Hammer, Finkelhor, & Sedlak, 2002; Ringwalt, Greene, Robertson, & McPheeters, 1998).

These estimates call to question the causes of youth homelessness. Youth frequently cite severe family conflict as a reason for being homeless (Ferguson, 2009; Hyde, 2005; Whitbeck, 2009). Youth describe their homes as dangerous, dysfunctional, harsh, and disorganized. Parental drug abuse and witnessing verbal abuse and violence between family members are all experiences cited by homeless and runaway youth (Ferguson, 2009). Domestic violence, mental illness or disability of a caregiver, social isolation, alcohol and other drug problems in the family, and family involvement in gangs are all significant predictors of youth running away from home (Sullivan & Knutson, 2000).
Youth also commonly report leaving their home due to physical abuse, sexual abuse or neglectful caregivers (Fergusson, 2009; Hyde, 2005; Thrane, Hoyt, Whitbeck, & Yoder, 2006; Tyler & Cauce, 2002). Rates of maltreatment show physical abuse ranging from 16% - 81% and sexual abuse ranging from 5% - 50% in homeless and runaway youth samples (Baron, 2003). In fact, neglect and sexual abuse are the two biggest risk factors for running away at an earlier age (Thrane et al., 2006). In one study, 22.3% of youth who ran away from home both witnessed domestic violence among family members and were themselves maltreated (Sullivan & Knutson, 2000).

Many youth also report leaving or being forced out of their home by their caregivers due to their sexual orientation or gender status. Lesbian, gay, bisexual, and transgender (LGBT) youth are more likely to have experienced every type of maltreatment in the home than non-LGBT youth (Cochran, Stewart, Ginzler, & Cauce, 2002; Tyler & Cauce, 2002). Due to their dangerous living situations and rejecting caregivers, LGBT youth have a greater risk of being homeless than their heterosexual or gender congruent peers (Corliss, Goodenow, Nichols, & Austin, 2011). National estimates range from 240,000 to 400,000 LGBT youth who are homeless for at least one night each year (National Alliance to End Homelessness, 2008).

While the decision to run away may be seen as impulsive, leaving the home can be best understood through the lens of social exchange theory (Homans, 1958). Social exchange theory states that individuals evaluate costs and benefits during decision-making processes. For youth who are homeless, the cost of staying in an abusive and chaotic home is too much to handle. Interviews of these youth reveal that they feel “fed
up” with their home situation, leading them to leave their home (Hyde, 2005). Once gone, they are free from experiencing continued harm and stress from their home life. Youth report that they gain more control and freedom over their lives once they leave home. Youth also describe their life on the street as no more difficult than what they had dealt with in their home (Martinez, 2006).

Unfortunately, the threat of danger is still present in youths’ lives even after they leave home. Once on their own, youth commonly face street victimization (Stewart et al., 2004). While living on the street, homeless youth are at risk for experiencing sexual or physical abuse, which is an even greater risk for females and LGBT youth (Cochran et al., 2002; Whitbeck, Chen, Hoyt, Tyler, & Johnson, 2004). Street victimization also includes being bullied, robbed, threatened, sexually coerced, and assaulted with a weapon. In one study, 83% of youth surveyed stated they experienced either physical or sexual abuse while on the streets, while 31% reported experiencing both types of victimization (Stewart et al., 2004).

Physical and mental health are further jeopardized when considering the frequency and severity of homeless youths’ risk-taking behaviors. A significant concern is the rate of alcohol and other drug use among youth who are homeless. Although drug experimentation is normative for the developmental period of adolescence, alcohol and other drug use has been shown to be considerably higher among homeless youth than youth who are housed (Baer, Ginzler, & Peterson, 2003). Of 193 youth interviewed, 93% reported tobacco use, 93% used marijuana, 87% used alcohol, 51% used amphetamines, and 25% used heroin within the past month (Baer et al., 2003). It is commonly reported
that these youth engage in substance abuse not as a recreational activity but as a means for coping with stress, anxiety, mental health problems and social isolation (Thompson, Barczyk, Gomez, Dreyer, & Popham, 2009; Whitbeck, 2009).

Another serious concern among this population is unsafe sexual behaviors. Living without adequate resources like food, shelter and warmth can make trading sex for commodities an advantageous necessity. Youth who are homeless often engage in sexual behaviors with multiple partners, increasing their risk for sexually transmitted infections (Halcon & Lifson, 2004). One in five youth who engaged in survival sex behaviors were found to have more than one partner and/or fail to use condoms during intercourse (Halcon & Lifson, 2004). Furthermore, youth who engage in survival sex are also significantly more likely to be sexually victimized, which could be due to their increased exposure to unsafe people and locations (Tyler, Hoyt, Whitbeck, & Cauce, 2001).

With the dangers involved in living on the street, combined with the early traumatic and chaotic living situations, these youth show elevated levels of conduct problems, depression, post-traumatic stress disorder, substance abuse, and suicidality when compared to youth who are housed (Cauce et al., 2000; Ryan et al., 2000; Whitbeck, Johnson, Hoyt, & Cauce, 2004; Yoder, Longley, Whitbeck, & Hoyt, 2008). The Midwest Longitudinal Study of Homeless Adolescents found that 76% of the sample met the diagnostic criteria for conduct disorder, 30% met criteria for major depressive episodes, 43% met criteria for lifetime alcohol abuse, 40% met criteria for lifetime drug abuse, and 35% met criteria for post-traumatic stress disorder, which are all considerably higher than the national averages (Whitbeck, 2009). Additionally, 41% of the youth in the
The Midwest Longitudinal Study had made a serious suicide attempt, which is significantly greater than the national average of 6.3% among high school age youth (Centers for Disease Control, 2010). In fact, Roy et al. (2004) found that suicide was the number one cause of death in their sample of homeless youth.

With the frequency and severity of mental health problems among youth who are homeless, the need to address their mental health is vital. Existing research shows that there is both a high need for mental health services for these youth and an underutilization of available services (Berdahl, Hoyt, & Whitbeck, 2005; Reid & Klee, 1999). In one study, of the 164 youth who reported severe mental health problems, including 86 who attempted suicide, half of those youth did not seek out mental health services (Reid & Klee, 1999). Similarly, in another study, only 40% of 556 youth had seen a mental health professional after leaving their home (Berdahl et al., 2005). Furthermore, 20% had never seen a mental health professional in their entire life.

Current research on service utilization among youth who are homeless has shown a wide range of barriers to engaging with mental health services. The primary barriers include lack of knowledge about services, thinking services wouldn’t help, feeling uncomfortable talking about personal problems, costs of services and extremely negative and stigmatizing experiences with previous service providers (Collins & Barker, 2009; Darbyshire, Cochrane, Fereday, Jureidini, & Drummond, 2006; Reid & Klee, 1999; Solorio, Milburn, Anderson, Trifskin, & Rodriguez, 2006). Youth are more likely to seek services when they include caring, respectful and empathetic mental health staff; in addition, the assurance of confidentiality, staff encouragement for youth involvement in
treatment decisions, free services, and high levels of perceived social support increase service utilization (Berdahl et al., 2005; Christiani, Hudson, Nyamathi, Mutere, & Sweat, 2008; Hudson, Nyamathi, & Sweat, 2008).

However, the majority of research on utilization of mental health services by homeless youth employs semi-structured or unstructured interviews with small samples. In addition, the existing literature features no comparison group to demonstrate whether these attitudes or experiences are unique to the homeless youth population. The current study addresses these issues through two main goals. First, it examines the attitudes of homeless and runaway youth, including aspects of psychological openness, help seeking propensity and concern for mental health stigma, compared to similar youth who are housed. Second, it examines the link between social support and attitudes toward mental health services. The current study adds to the paucity of literature on a vulnerable population and identifies possible factors that could increase the likelihood of youth receiving the services they need.
REVIEW OF THE LITERATURE

Relatively little research has been conducted on homeless youths’ attitudes towards mental health service utilization. However, research on homeless adults has yielded interesting results. Homeless adults were surveyed on what needs were most important to them. The two highest ranked needs were physical safety and education, which rated higher than any formal services, such as job placement, medical, dental, or mental health treatment, and even affordable housing services (Acosta & Toro, 2000). The majority of the participants ranked formal mental health services as unimportant and easy to access when needed. Many participants who listed formal mental health services as an important need also rated them as dissatisfying, when received, on a client satisfaction questionnaire. However, those who were high in perceived social support were more likely to indicate positive service satisfaction and were more likely to recommend formal services to others.

While homeless adults report mental health needs as unimportant, it is unknown whether homeless youth would feel similarly. Inquiring about the level of perceived need for mental health services can provide a glimpse into the overall attitudes of homeless youth toward mental health services. The current study examines perceived service needs in homeless youth.

Barriers to Services

Although the above study reports that homeless adults found mental health services easy to access, studies on homeless youth show the opposite. The number one identified barrier to mental health services in the existing literature is the lack of
knowledge regarding the availability and location of such services (Reid & Klee, 1999; Solorio et al., 2006). Even when aware of such services, homeless youth often report lack of transportation as a common barrier (Christiani et al., 2008). However, these findings are from samples in large cities where services can be quite difficult to locate or reach. Solorio et al. (2006) also reported additional barriers for youth who are homeless, including feeling too uncomfortable talking about their problems and thinking mental health services wouldn’t help.

These findings highlight two important variables for research on attitudes toward mental health services. Both the likelihood of seeking out services and openness to discussing psychological problems are key aspects of accessing professional help. The current study utilizes measures of psychological openness and help seeking propensity to assess homeless youths’ attitudes toward mental health services. Furthermore, Solorio et al. (2006) only surveyed barriers to mental health services among participants who were not currently or have never searched for mental health services. The current study expands on the literature by surveying youth who both have and have not utilized mental health services previously.

**Negative Experiences with Service Providers**

Additional studies on attitudes toward mental health services report that youth who are homeless encounter mild to severe negative experiences when utilizing mental health services (Christiani et al., 2008; Collins & Barker, 2009; Darbyshire et al., 2006; Hudson et al., 2008). A significant source of aggravation for youth is confusing paperwork, care providers’ need to view identification documents, excessive wait times
and being “lumped together” with homeless adults (Christiani et al., 2008). Youth also expressed feeling lost in the health care system and the fear of confidentiality being broken, resulting in police, social workers or family members being contacted. Commonly reported experiences for these youth were negative interactions with mental health staff, including feeling disrespected and dehumanized by care providers. In addition, lack of empathy, trust issues, feeling manipulated, or communication that was not mutually engaging are all significant barriers to receiving services as reported by homeless youth (Hudson et al., 2008).

Collins and Barker (2009) interviewed 16 homeless youth in the United Kingdom to assess perceptions of their own mental health, the benefits and the disadvantages of seeking help and the type of help desired. Interviewees reported commonly feeling betrayed and shamed by service providers. Most participants voiced a high need for autonomy while living on the streets, instead of being dependent on service providers. Similarly, Darbyshire et al. (2006) interviewed 10 homeless youth in Australia and reported their experiences of being in the mental health care system. The most common experiences were mental health staff immediately labeling their behaviors, ‘drive by’ assessments, and lack of personal control over treatment planning. Participants described situations where they were seen for only a few moments and then immediately or inaccurately diagnosed, or only given medication, and then quickly rushed out of the clinic. Feeling judged and stigmatized were common experiences for youth in both studies.
These stigmatizing experiences contribute to overall attitudes toward mental health services. Stigma against services generates negative stereotypes and prejudices about individuals receiving mental health treatment, which greatly harms their self-esteem, decreases their chances of obtaining employment, and increases the likelihood of being incarcerated (Corrigan, 2004). Furthermore, self-stigma occurs when an individual who experiences mental illness also has negative attitudes toward mental health problems and turns these negative attitudes toward himself/herself (Corrigan, 2004). Both forms of stigma make individuals less likely to access mental health services throughout the course of their lives (Heflinger & Hinshaw, 2010). These studies highlight the negative impact of such experiences for youth, but small samples and non-standardized interviews limit generalizability. The current study expands upon the previous research by employing a measure assessing participants’ concern for mental health stigma.

The previous findings demonstrate how early experiences can shape our views of service providers and treatment. Excessively negative views of health care providers, who can offer potentially life-saving services, may reduce the likelihood of accessing such services. Fortunately, these studies also report on some positive experiences youth had with mental health services. Many youth report caring, non-judgmental, listening, trustworthy, empathetic and authentic feelings from care providers as increasing their use of mental health services (Christiani et al., 2008; Collins & Barker, 2009; Darbyshire et al., 2006; Hudson et al., 2008). Also, the assurance of confidentiality, availability of free services, being included in treatment planning and respect for patient’s time increased use of services (Christiani et al., 2008).
The Role of Social Support in Service Utilization

Research on service utilization also shows that social support is an important variable to study. As mentioned earlier, perceived social support was an important indicator for homeless adults’ satisfaction with services and increased the likelihood of referring others to formal agencies (Acosta & Toro, 2000). However, two studies on homeless youth show mixed results. First, Reid and Klee (1999) conducted semi-structured interviews with 200 homeless youth in Manchester, United Kingdom. They found that more youth participants relied on friends and relatives for counseling, information and advice, than on any formal agencies, indicating that social support might decrease service utilization.

Contrary to Reid and Klee (1999), however, Berdahl et al. (2005) found that higher levels of social support indicated greater likelihood of accessing mental health services.

Berdahl et al. (2005) employed quantitative measures to examine mental health service utilization among homeless and runaway youth. They surveyed 602 homeless and runaway youth in shelters, drop-in centers and on the streets in Nebraska, Kansas, Iowa, and Missouri. Youth were asked about their mental health service use before and after leaving their home. Additional variables included family socioeconomic status, caretaker rejection and abuse, level of social support, shelter use and street victimization. Results showed that variables such as female gender, street victimization, abusive caregivers, and previous shelter stays predicted higher rates of utilizing mental health services while on the streets.
The current study utilizes an established measure of perceived social support for two purposes. First, it examines the link between perceived social support and positive vs. negative attitudes towards mental health services. Secondly, expanding on Berdahl et al. (2005), the current study examines the role that social support plays in youth accessing mental health services.
THE CURRENT STUDY

The current study surveyed both homeless and housed youth on measures of perceived social support, perceived service needs, and attitudes toward mental health services. The goal of the study was to provide a comprehensive examination of the attitudes toward mental health services among homeless and runaway youth compared to housed youth who are also multiply stressed. The current study includes several enhancements over previous research to provide key information to service providers. Benefits include informing service providers of the likelihood of homeless youth seeking out services on their own, the likelihood these youth will talk about personal issues, their concern for mental health stigma, the role of social support in accessing services, and the perceived need of mental health services for homeless youth. Services providers may apply this information to modify and improve service delivery, which may increase service use, for this highly vulnerable population.

Based on the reviewed literature, the following research questions were investigated:

1) Youth who are homeless experience a high degree of mental health problems and suicide has been found to be the number one cause of death (Roy et al., 2004; Whitbeck, 2009). Current research on homeless and runaway youth shows there is both a high need for mental health services and an underutilization of these services (Berdahl et al., 2005; Reid & Klee, 1999). The current study examined the overall attitudes of homeless and runaway youth, compared to a matched sample of housed
youth, in order to aid service providers in understanding and increasing service utilization for these youth.

2) Youth who are homeless report experiencing elevated levels of mental health problems (Roy et al., 2004; Whitbeck, 2009). A common barrier to mental health services for youth who are homeless is thinking mental health services wouldn’t work for them (Solorio et al., 2006). The current study examined homeless youths’ help seeking propensity compared to a matched group of youth who are housed. Results may aid service providers in understanding the likelihood of youth seeking out services on their own and developing strategies to increase service use for runaway and homeless youth.

3) Extensive research shows that homeless youth experience elevated rates of mental health problems and suicidality (Roy et al., 2004; Whitbeck, 2009). Previous research has shown a common barrier to mental health services for youth who are homeless is feeling uncomfortable when talking about personal problems (Solorio et al., 2006). The current study examined homeless youths’ level of openness to discussing psychological problems compared to a matched group of youth who are housed. Results may aid service providers in understanding runaway and homeless youths’ level of psychological openness and assist in developing strategies to increase service use for these youth.

4) Previous research documents a variety of negative and stigmatizing experiences for homeless youth in the mental health care system (Christiani et al., 2008; Collins & Barker, 2009; Darbyshire et al., 2006; Hudson et al., 2008). The current study utilizes a measure of an individual’s concern for mental health stigma compared to a
similar group of youth who are housed. Results will inform service providers on the extent of concern for mental health stigma among youth who are homeless and guide service providers toward reducing these negative experiences in order to increase service utilization for these youth.

5) Previous research has found an under-utilization of mental health services among youth who are homeless (Berdahl et al., 2005). Given the mixed findings on perceived need for mental health services for both youth and adults who are homeless (Solorio et al., 2006), the current study used a subjective needs assessment to determine homeless youths’ level of perceived need for mental health services compared to a matched group of youth who are housed. These findings will aid in understanding which services are rated the most important to homeless youth.

6) Previous findings on the variable of perceived social support show contradictory findings regarding predicting mental health service utilization (Acosta & Toro, 2000; Berdahl et al., 2005; Reid & Klee, 1999). The current study utilizes an established measure of perceived social support to examine its link to homeless youths’ attitudes toward mental health services. With this information, service providers can create or enhance service delivery that addresses homeless youths’ level of social support, which may increase service utilization for these youth.
METHOD

Participants

Participants included 56 youth who identified as either living on the streets, couch surfing, or living in a shelter. They were recruited through youth drop-in centers and a youth shelter in Northern California. Ninety-seven youth were recruited for the comparison group, who were from non-traditional alternative community schools in Northern California. Power analysis indicated that a sample of 64 participants per group was needed in order to detect medium effects. The current study’s small sample in the homeless group is discussed in the Limitations section.

Participants identifying as residing with a supportive parent or caregiver, with family in an alternative living situation, or temporarily with friends or extended family, were placed in the housed group. Participants were placed in the homeless group if they indicated they were residing in an unstable location without a supportive parent or caregiver, such as couch surfing or on the streets. Youth who identified as living in a shelter were placed in the homeless group.

To determine the level of match between groups, demographic differences were examined using chi square analysis. See Table 1 for demographic differences by group. Homeless and housed groups did not differ significantly in gender, $\chi^2 (2) = 26.35, p = .11, V = .13$ or sexual orientation, $\chi^2 (1) = 1.55, p = .21, V = .10$. Homeless and housed groups did significantly differ in age, $\chi^2 (2) = 26.35, p < .001, V = .42$, and ethnicity, $\chi^2 (1) = 12.84, p < .001, V = .29$, with more older youth in the homeless group and more youth of color in the housed group.
Table 1

Demographic Comparison of Homeless vs. Housed

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<tr>
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<th>Homeless (n = 56)</th>
<th>Housed (n = 97)</th>
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<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
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<tr>
<td><strong>Gender</strong></td>
<td></td>
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</tr>
<tr>
<td>Male</td>
<td>27 (48.2)</td>
<td>56 (61.5)</td>
</tr>
<tr>
<td>Female</td>
<td>29 (51.8)</td>
<td>37 (38.5)</td>
</tr>
<tr>
<td><strong>Sexual Orientation</strong></td>
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<tr>
<td>Heterosexual</td>
<td>41 (75.9)</td>
<td>80 (84.2)</td>
</tr>
<tr>
<td>Gay/Lesbian/Bisexual/Questioning</td>
<td>13 (24.1)</td>
<td>15 (15.8)</td>
</tr>
<tr>
<td><strong>Age</strong>*</td>
<td></td>
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<tr>
<td>12 – 14 years old</td>
<td>8 (14.3)</td>
<td>22 (22.7)</td>
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<tr>
<td>15 – 17 years old</td>
<td>15 (26.8)</td>
<td>57 (58.8)</td>
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<tr>
<td>18 – 21 years old</td>
<td>33 (58.9)</td>
<td>18 (18.5)</td>
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<td><strong>Ethnicity</strong>*</td>
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<tr>
<td>Youth of Color</td>
<td>12 (21.8)</td>
<td>50 (51.5)</td>
</tr>
<tr>
<td>European-American</td>
<td>43 (78.2)</td>
<td>47 (48.5)</td>
</tr>
<tr>
<td><strong>Parents’ Highest Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some Grade School</td>
<td>5 (12.8)</td>
<td>1 (1.2)</td>
</tr>
<tr>
<td>Some High School</td>
<td>7 (17.9)</td>
<td>14 (18.2)</td>
</tr>
<tr>
<td>High School Diploma or GED</td>
<td>10 (25.6)</td>
<td>19 (24.7)</td>
</tr>
<tr>
<td>Some College</td>
<td>9 (23.1)</td>
<td>23 (29.9)</td>
</tr>
<tr>
<td>College Graduate</td>
<td>8 (20.6)</td>
<td>20 (26.0)</td>
</tr>
</tbody>
</table>

*Note.* *p < .05
Parents’/caregivers’ highest education did not differ significantly between groups, $\chi^2 (4) = 7.41, p = .12, V = .25$.

Because groups differed in age and ethnic composition, analysis of variance was used to determine differences between age groups and ethnic groups on the study’s dependent variables, attitudes toward mental health services and social support. See Table 2 for means and standard deviations. Attitudes toward mental health services did not differ between the age groupings of 12 to 14, 15 to 17, and 18 to 21 years, $F(2, 118) = 0.55, p = .58, \eta^2 = .01$. Perceived social support also did not differ by age groups, $F(2, 136) = 0.66, p = .52, \eta^2 = .01$.

Table 2

*Means and Standard Deviations on Key Dependent Variables by Age and Ethnicity*

<table>
<thead>
<tr>
<th></th>
<th>Attitudes toward Mental Health Services</th>
<th>Perceived Social Support</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$M$ ($SD$)</td>
<td>$M$ ($SD$)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 – 14 years old</td>
<td>53.38 (13.19)</td>
<td>5.37 (1.58)</td>
</tr>
<tr>
<td>15 – 17 years old</td>
<td>53.65 (12.37)</td>
<td>5.39 (1.19)</td>
</tr>
<tr>
<td>18 – 21 years old</td>
<td>56.14 (13.54)</td>
<td>5.11 (1.47)</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth of Color</td>
<td>52.76 (12.76)</td>
<td>5.26 (1.28)</td>
</tr>
<tr>
<td>Euro-American Youth</td>
<td>55.88 (12.96)</td>
<td>5.29 (1.44)</td>
</tr>
</tbody>
</table>

*Note.* No significant differences.
Attitudes toward mental health services did not differ between youth of color and European American youth, $F(1, 118) = 1.72, p = .19, \eta^2 = .01$, nor did perceived social support differ by ethnicity, $F(1, 136) = 0.02, p = .90, \eta^2 = .00$. These findings suggest that while comparison group matching was not perfect, it did not result in systematic differences that affected study outcomes.

Procedure

For youth residing in a shelter, consent was obtained from the primary legal guardian, including the youth’s parent or social worker. Parental consent was obtained during the shelter intake process for all incoming shelter youth. Once guardian consent and youth assent were established, all participants were offered a private, confidential, and quiet room in which to complete the survey.

For youth at drop-in centers, the University’s Institutional Review Board (IRB) approved the use of youth assent in lieu of parental consent (IRB number 11-202). Extensive past research has been conducted on homeless and runaway youth without parental consent. For example, of the seven studies involving minors in the above literature review, six used youth self-consent to authorize participation and one study used host agency consent for minor participation (Berdahl et al., 2005; Christiani et al., 2008; Collins & Barker, 2009; Darbyshire et al., 2006; Hudson et al., 2008; Reid & Klee, 1999; Solario et al., 2006).

Support for the exception to parental consent among studies on homeless and runaway youth can be found in the United States Department of Health & Human Services’ Code of Federal Regulations (Protection of Human Subjects, 2009). Section
46.408(c) states that the IRB may determine that research may be “designed for conditions or for a subject population for which parental or guardian permission is not a reasonable requirement to protect the subjects (for example, neglected or abused children; p. 13).” Given that the majority of youth who are homeless come from dangerous or neglectful homes, it is reasonable to assume that requiring parental consent would place these youth into potentially hazardous or jeopardizing situations.

In addition, section 46.116(d) states that the IRB may approve an alteration or waiver to the requirements of consent to research when “the research could not practicably be carried out without the waiver (p. 7).” Informing youth that caregiver consent is required may dissuade them from participating because of their desire for no family contact (Meade & Slesnick, 2002). Surveying youth who are in drop-in centers and on the street is vital for capturing the diversity of experiences in the homeless youth population. Research has demonstrated that homeless youth in the United States are an extremely heterogeneous population (Toro, Lesperance, & Brachiszewski, 2011). Relying solely on data from participants who reside in shelters, while excluding youth who have spent extensive time on the street, will produce results not representative of the homeless youth population. This will, in turn, lead to less effective program development for programs meant to serve this very population.

Lastly, section 46.407(i) claims that research “not otherwise approvable” may be conducted if the “research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of children (p. 13).” As mentioned earlier, homeless youth demonstrate high levels of mental health
problems, and suicide is the number one cause of death for youth who are homeless. The proposed study seeks to provide an understanding of the underutilization of mental health services by youth who are homeless. Service providers will be able to use this information to create or modify programs that address mental health needs, such as mental health stigma reduction efforts, in order to increase mental health service use for homeless and runaway youth.

Participants in the youth drop-in centers were offered a private and quiet office area to take the survey. Results were kept anonymous, with no identifying information or names provided and consent/assent forms were stored separately from completed surveys. Youth received one free drink coupon for a local coffee kiosk after participation. For youth surveyed in alternative community schools, legal guardian permission was obtained. Guardians signed consent forms during school enrollment sessions at the beginning of the 2012 school year. School officials then administered the surveys to youth who received permission from their legal guardian. Participants obtained from alternative school sites received a soda after participation. See Appendix A for consent and assent forms.

**Measures**

**Street victimization and parental maltreatment.** Both parental maltreatment and street victimization assessments were based on items in previous studies (Berdahl et al., 2005; Whitbeck et al., 2004). The victimization scale contains five items asking if youth had experienced various aggressive and violent acts directed at them while being on their own (robbery, assault, threats, sexual assault, and assault with a weapon).
Responses range from zero (never) to three (more than five times), for a total possible score of 15. Cronbach’s alpha for previous work was reported at .73 (Berdahl et al., 2005). Measurement of parental maltreatment was assessed using an 11-item scale. Items assess various types of abuse, including physical assault, threats with weapons, assault with weapons, sexual abuse, food neglect, or if the caregiver had ever been absent from the home for more than 24 hours. Responses range from zero (never) to three (more than five times), for a total possible score of 33. Cronbach’s alpha was reported at .84 for the parental maltreatment scale (Whitbeck et al., 2004). The current study’s alpha levels for the street victimization and parental maltreatment scales were .76 and .82, respectively. See Appendix B for these measures.

**Life history and service utilization.** Basic life history information was obtained, including living situation, length in living situation, length of time on own, the number of changes in the youths’ home living environment, history in foster care or juvenile probation, current school enrollment, and the last grade completed. Participants were also asked the number of supportive individuals available to them if needed. Responses ranged from zero supportive individuals to five or more supportive individuals.

Mental health service use was also assessed through multiple questions. Participants were asked if they had ever used mental health services, if they were satisfied with the mental health services, the perceived difficulty in accessing mental health services, and the primary barriers to mental health services, if any. Perceived difficulty of accessing mental health services used a 4-point Likert scale. Responses
ranged from “very difficult” to “very easy.” Higher scores indicated an easier level of
difficulty to accessing mental health services.

Additionally, a subjective needs assessment listed nine services, including
education, transportation, medical/dental, job training/placement, government welfare
assistance, alcohol and other drug treatment, free meals, and mental health services.
Participants were asked to rate how often they would use each service if it were easily
available, using a 4-point scale ranging from one (never) to four (a lot). See these
measures in Appendix C.

Twenty-five participants freely responded to item number 40 “If mental health
services are difficult to access, why?” and responses were coded into five inductively
derived themes. Cohen’s measure of agreement was calculated, $\kappa = .78$, $p < .001$. Themes
included lack of openness to discussing psychological problems, limited or no resources
(money or transportation), no knowledge of how to access mental health services, and no
interest in seeing a counselor.

The Inventory of Attitudes Toward Seeking Mental Health Services Scale
includes 24-items comprising three subscales: psychological openness, help seeking
propensity, and concern for mental health stigma. Help seeking propensity measures an
individual’s willingness and ability to seek out mental health services. Psychological
openness measures the comfort level with discussing mental health problems. Concern
for mental health stigma measures a participant’s overall concern with friends, family,
and neighbors discovering that he/she is utilizing or seeking out mental health services.
Higher scores on the IASMHS and the help-seeking and psychological openness subscale represent more positive attitudes toward mental health services. Concern for mental health stigma was reverse coded. Higher scores on the concern for stigma subscale mean more negative attitudes toward mental health services and greater concern about mental health stigma. See this measure in Appendix D.

Initial development of the IASMHS presented psychometric properties on a random community sample of 206 adults in Ontario, Canada (MacKenzie et al., 2004). Cronbach’s alpha for their sample was .87. The help seeking propensity scale α = .76, psychological openness α = .82, and concern for mental health stigma subscale α = .79. Test-retest reliability was established, using a sample of 297 college students, for the entire scale after a three week interval, $r = .85, p < .01$. Test-retest reliability for psychological openness was $r = .86, p < .01$; for help seeking propensity, $r = .64, p < .01$; and for concern for stigma, $r = .91, p < .01$. Criterion and convergent validity were calculated by scoring each participant’s past use of mental health services and intentions to use mental health services in the future (MacKenzie et al., 2004). Discriminant validity was calculated by correlating attitudes toward mental health services with the likelihood of participants seeking non-professional help (i.e. friends, family, or dealing with the problem by themselves). Attitudes toward mental health services was positively correlated with past use of mental health services, $r = .33, p < .01$. Intentions to use mental health services was also positively correlated with attitudes toward mental health services, $r = .38, p < .01$. Intentions to talk to friends or family were weakly correlated with attitudes toward mental health services, $r = .08, p$ value not provided, while
intentions to take care of problems independently was negatively correlated with attitudes toward mental health services, $r = -0.37, p < 0.01$, indicating adequate convergent and discriminant validity. Degrees of freedom were not provided for these analyses.

The current study obtained a Cronbach’s alpha of .71 for the entire IASMHS. The IASMHS subscale, help seeking propensity, had an alpha level of .80. Psychological openness and concern for mental health stigma had alpha levels of .56 and .70, respectively. The low alpha for psychological openness was examined through inter-item correlations and missing data. The psychological openness scale featured few missing data and alpha did not significantly improve through select item deletion, leaving alpha at .56 for psychological openness.

For concern for mental health stigma scale, item 3 “I would not want my boyfriend or girlfriend to know if I were suffering from emotional or behavioral struggles” and item 23 “Had I received treatment for emotional or behavior struggles, I would not feel that it ought to be “covered up” were dropped. These were reverse scored items, which may have been too confusing for youth to understand due to word phrasing, which required youth to provide opposite responses. After item deletion, alpha increased to .77 for the concern for mental health stigma subscale.

The Multidimensional Scale of Perceived Social Support [MSPSS]. The MSPSS (Zimet, Dahlem, Zimet, & Farley, 1988) features 12-items that consist of three domains: significant other, friends, and family. The scale uses a 7-point Likert response format. Responses range from “very strongly disagree” to “very strongly agree.” Higher scores on the MSPSS indicate higher levels of perceived social support. See this measure
in Appendix E. Psychometric properties for the MSPSS have been reported on a diverse sample of 222 adolescents (Canty-Mitchell & Zimet, 2000). Cronbach’s alpha for the entire scale was .93. For the significant other, family, and friends subscales, alphas were .91, .89, and .91, respectively. Validity was determined by correlating the MSPSS with another scale developed to measure family support among adolescents called the Adolescent Family Caring Scale (AFCS). As expected, the MSPSS family sub-scale correlated strongly with the AFCS, $r = .76, p < .001$. The friends subscale was correlated with the AFCS, $r = .33, p < .001$, and the significant other subscale was correlated with the AFCS, $r = .48, p < .001$. Degrees of freedom were not provided for these analyses. Discriminant validity was established for the family subscale only. This was conducted by comparing means between the AFCS to the MSPSS friends subscale and the MSPSS friends subscale to the MSPSS significant other subscale, which differed significantly for both analyses. The current study obtained a Cronbach’s alpha of .91 for the entire scale. The family, friends and significant other subscales obtained Cronbach’s alphas for the current study of .92, .91, and .88, respectively.
RESULTS

Results are organized with descriptive results presented first. Descriptive results include participants’ life history, mental health service use, service satisfaction, referral source, reason for accessing services, perceived difficult accessing services, and service needs. Following descriptive results are the current study’s inferential results, which include differences in attitudes toward mental health services between groups and the association of perceived social support with attitudes toward mental health services for both homeless and housed groups.

Descriptive Results

Life history. Youth who identified as living on the streets, couch surfing, in a shelter, or temporarily with friends or family completed additional questions on life history. Questions included length of time they have been on their own (reported in days), their age when they were first on their own, the estimated number of changes that had occurred when they were living with their family (i.e. moving to a new home or changes in the number of adults or children living with them), and street victimization. See Table 3 for means and standard deviations. These findings showed that homeless youth in the current study have spent an average of almost 10 months on their own and their average starting age for being on their own was 15. Homeless youth also reported experiencing an average of almost 12 major changes occurring in their home. This finding is consistent with the literature stating that homeless youth experience a high degree of instability while living in their home. Level of street victimization is reported in Table 3. Results are explored in the discussion section.
Table 3

*Means and Standard Deviations for Descriptive Results*

<table>
<thead>
<tr>
<th></th>
<th>Homeless</th>
<th>Housed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M (SD)</td>
<td>M (SD)</td>
</tr>
<tr>
<td>Age When First On Own</td>
<td>14.84 (3.17)</td>
<td>---</td>
</tr>
<tr>
<td>Length of Time On Own by Number of Days</td>
<td>294.24 (560.66)</td>
<td>---</td>
</tr>
<tr>
<td>Major Changes In Home Environment While Youth Was Housed</td>
<td>11.78 (10.80)</td>
<td>---</td>
</tr>
<tr>
<td>Parental Maltreatment Rating*</td>
<td>0.74 (.70)</td>
<td>0.44 (.51)</td>
</tr>
<tr>
<td>Street Victimization Rating</td>
<td>0.80 (.73)</td>
<td>---</td>
</tr>
<tr>
<td>Perceived Difficulty of Accessing Mental Health Services</td>
<td>2.91 (.89)</td>
<td>3.00 (.84)</td>
</tr>
<tr>
<td>Service Would Use Most If Readily Available</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td>3.40 (.95)</td>
<td>3.30 (.95)</td>
</tr>
<tr>
<td>Medical/Dental</td>
<td>3.26 (.91)</td>
<td>3.13 (1.00)</td>
</tr>
<tr>
<td>Free Meals**</td>
<td>3.25 (1.04)</td>
<td>2.52 (1.30)</td>
</tr>
<tr>
<td>Government Assistance*</td>
<td>3.13 (1.06)</td>
<td>2.66 (1.15)</td>
</tr>
<tr>
<td>Educational</td>
<td>2.96 (.94)</td>
<td>2.82 (1.00)</td>
</tr>
<tr>
<td>Vocational</td>
<td>2.93 (1.04)</td>
<td>3.04 (1.13)</td>
</tr>
<tr>
<td>Mental Health</td>
<td>2.31 (1.20)</td>
<td>2.31 (1.15)</td>
</tr>
<tr>
<td>AOD Treatment</td>
<td>1.58 (.90)</td>
<td>1.91 (1.08)</td>
</tr>
</tbody>
</table>

*Note. *p < .05, **p < .001.*
Parental maltreatment was assessed for youth in both groups and differences were examined using analysis of variance. There were significant differences in parental maltreatment levels between homeless and housed youth, $F(1, 142) = 8.75, p = .004$, $\eta^2 = .06$. Homeless youth reported experiencing more parental maltreatment than housed youth, which is consistent with the findings reported in the literature review. See Table 3 for means and standard deviations.

Furthermore, homeless and housed youth were surveyed on current school enrollment, their last grade completed, foster care/juvenile probation history, their parents’/caregivers’ full-time employment status, and if their parent/caregiver receives welfare assistance. Chi square analysis was used to examine possible differences on these variables between homeless and housed groups (see Table 4). Current school enrollment differed significantly between homeless and housed groups, $\chi^2 (1) = 31.05, p < .001$, $V = .29$. More housed youth were currently in school than youth in the homeless group. Last grade completed was categorized into three groups, 8th grade or less, 9th grade through 11th grade, and completed high school. Homeless and housed groups differed significantly on last grade completed, $\chi^2 (2) = 14.38, p < .001$, $V = .32$. More homeless youth had completed high school than housed youth, while more housed youth completed 8th grade or less and 9th grade through 11th grade than homeless youth. These differences are explored in the Discussion section.

History in the foster care system and juvenile probation system was also compared between groups. Chi square analysis revealed that homeless and housed groups differed significantly on being in the foster care system, $\chi^2 (1) = 6.12, p < .001$, $V = .20,$
Table 4

*Frequencies and Percentages for Descriptive Results*

<table>
<thead>
<tr>
<th></th>
<th>Homeless</th>
<th>Housed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Currently in School*</td>
<td>24 (42.9)</td>
<td>83 (86.6)</td>
</tr>
<tr>
<td>Last Grade Completed*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8&lt;sup&gt;th&lt;/sup&gt; grade or less</td>
<td>10 (18.86)</td>
<td>27 (30.0)</td>
</tr>
<tr>
<td>9&lt;sup&gt;th&lt;/sup&gt;-11&lt;sup&gt;th&lt;/sup&gt; grade</td>
<td>23 (43.40)</td>
<td>53 (58.89)</td>
</tr>
<tr>
<td>High School Graduate</td>
<td>20 (37.74)</td>
<td>10 (11.11)</td>
</tr>
<tr>
<td>Foster Care History*</td>
<td>19 (33.9)</td>
<td>16 (16.5)</td>
</tr>
<tr>
<td>Juvenile Probation History</td>
<td>15 (26.8)</td>
<td>35 (36.1)</td>
</tr>
<tr>
<td>Parent Employed Full-time*</td>
<td>16 (28.6)</td>
<td>47 (48.5)</td>
</tr>
<tr>
<td>Parent Receives Welfare</td>
<td>24 (42.9)</td>
<td>54 (55.7)</td>
</tr>
<tr>
<td>Mental Health Service History*</td>
<td>67 (83.6)</td>
<td>46 (69)</td>
</tr>
<tr>
<td>Mental Health Service Satisfaction*</td>
<td>42 (64.6)</td>
<td>27 (58.7)</td>
</tr>
<tr>
<td>Why Mental Health Services are Difficult to Access</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited Financial Resources</td>
<td>2 (40.0)</td>
<td>4 (50.0)</td>
</tr>
<tr>
<td>No Knowledge of Services</td>
<td>1 (20.0)</td>
<td>1 (12.5)</td>
</tr>
<tr>
<td>Lack of Psychological Openness</td>
<td>2 (40.0)</td>
<td>2 (25.0)</td>
</tr>
<tr>
<td>No Interest in Services</td>
<td>0 (00.0)</td>
<td>1 (12.5)</td>
</tr>
</tbody>
</table>

*Note:* *p* < .05
more homeless youth experiencing being in foster care. Juvenile probation history did not differ between groups, $\chi^2 (1) = 1.23, p = .27, V = .09$. The number of youth who had been on juvenile probation was similar between homeless and housed groups. See Table 4 for frequencies and percentages of descriptive results.

Finally, parent/caregiver full-time employment status and welfare assistance was compared between homeless and housed groups using chi square analysis. Homeless and housed youth differed significantly on parents’/caregivers’ full-time employment status, $\chi^2 (1) = 4.67, p = .03, V = .18$. More housed youth had parents/caregivers with full-time employment than parents/caregivers of homeless youth. Lastly, groups did not differ significantly on parent/caregiver welfare assistance, $\chi^2 (1) = 0.83, p = .36, V = .09$. See Table 4 for frequencies and percentages of descriptive results.

**Mental health service experience and satisfaction.** Chi square analysis was used to examine differences between groups on mental health experience and satisfaction with mental health services. Experience with mental health services was marginally significantly different, with a moderate effect size, between the homeless and housed group, $\chi^2 (1) = 3.90, p = .048, V = .16$. This finding indicated that homeless youth had slightly higher rates of mental health service use than youth who were housed. For those who had received mental health services, groups did not differ on service satisfaction, $\chi^2 (1) = .40, p = .53, V = .06$. Homeless and housed youth report similar levels of satisfaction with the mental health services they receive. See Table 4 for frequencies and percentages of descriptive results.
Mental health referral source and reason. Chi square analysis was used to examine differences between groups on mental health referral source and the reason for accessing mental health services. The source of referral to mental health services did not differ significantly between groups, $\chi^2 (7) = 8.14, p = .32, V = .27$. The top three most common referral sources for youth in the homeless group were social workers/probation officers, parents, and teachers/school counselors. For youth in the housed group, the three most common referral sources were parents, extended family members, and teachers/school counselors. The most common reasons for youth in the homeless group to be referred to mental health services included family conflict, depression, stress, school problems, anxiety, and suicide ideation/attempts. For youth in the housed group, the top reasons for referrals included family conflict, stress, depression, anxiety, and school problems.

Difficulty accessing services. Difficulty accessing services was examined using analysis of variance. Difficulty accessing mental health services did not differ between homeless youth and housed youth, $F(1, 107) = 0.27, p = .60, \eta^2 = .00$. These findings demonstrated that homeless and housed youth perceive the same low level of difficulty in accessing mental health services. See Table 3 for group means and standard deviations.

However, of the 11 youth in the homeless group who identified mental health services as being difficult to access, five youth provided a reason. They cited a lack of openness to discussing psychological problems, limited or no financial resources and no knowledge of how to access mental health services. Of the 14 housed youth who indicated mental health services were difficult to access, eight provided a reason. They
identified a lack of openness to discussing psychological problems, no interest in mental health services, limited or no financial resources, and no knowledge of how to access services. See Table 4 for percentages to each response theme.

**Service needs.** Homeless youth identified transportation services as the service they would use most frequently if readily available, followed by medical/dental services, free meals, government assistance, educational services, and job training/job placement. Mental health services and alcohol and other drug treatment services were identified as services they would use least often. See Table 3 for means and standard deviations.

Analysis of variance revealed no significant differences between homeless and housed groups on the desire for transportation services, $F(1, 149) = 0.37, p = .55, \eta^2 = .00$, or medical/dental services, $F(1, 148) = 0.66, p = .42, \eta^2 = .00$. Groups also did not differ on the need for educational services, $F(1, 148) = 0.74, p = .39, \eta^2 = .01$, vocational services, $F(1, 147) = 0.39, p = .54, \eta^2 = .00$, mental health services, $F(1, 147) = 0.00, p = .99, \eta^2 = .00$, or alcohol and other drug treatment services, $F(1, 149) = 3.57, p = .06, \eta^2 = .02$. See Table 3 for group means and standard deviations.

However, groups did differ significantly on the need for free meals, $F(1, 148) = 12.90, p < .001, \eta^2 = .08$. Homeless youth identified free meals as a service used more frequently if readily available compared to housed youth. Lastly, groups differed significantly on the use of government assistance, $F(1, 149) = 6.22, p = .01, \eta^2 = .04$. Homeless youth identified government assistance as a service used more frequently if readily available compared to housed youth. See Table 3 for group means and standard deviations.
Inferential Results

**Attitudes toward mental health services.** Groups did not differ significantly on overall attitudes towards mental health services, $F(1, 119) = 1.88, p = .17, \eta^2 = .02$. Help seeking propensity did not differ significantly between groups, $F(1, 138) = 0.03, p = .86, \eta^2 = .00$. Psychological openness did not differ significantly between groups, $F(1, 126) = 2.67, p = .10, \eta^2 = .02$. Groups did not differ significantly on concern for mental health stigma, $F(1, 139) = 1.56, p = .21, \eta^2 = .01$. Results demonstrated that both homeless and housed at-risk youth have similar attitudes toward mental health services. See Table 5 for means and standard deviations. Results are explored in the Discussion section.

**Social support.** Total perceived social support significantly differed between homeless and housed groups, $F(1, 137) = 7.87, p = .01, \eta^2 = .05$. Perceived family support also differed significantly between groups, $F(1, 143) = 13.86, p < .01, \eta^2 = .09$. Perceived friend support was the only social support variable that did not differ significantly between groups, $F(1, 143) = 0.12, p = .74, \eta^2 = .00$. Perceived significant other support differed significantly between groups, $F(1, 144) = 4.89, p = .03, \eta^2 = .03$. Lastly, number of supportive individuals available differed between groups, $F(1, 146) = 7.64, p = .01, \eta^2 = .05$. Results demonstrated that homeless youth identify less perceived family support and less perceived significant other support than housed youth. Additionally, homeless youth have fewer supportive individuals available to them than housed youth. See Table 5 for means and standard deviations.
Table 5

Means and Standard Deviations for Attitude Variables and Social Support Variables

<table>
<thead>
<tr>
<th></th>
<th>Homeless M (SD)</th>
<th>Housed M (SD)</th>
<th>Score Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitudes Toward Mental Health Services</td>
<td>56.43 (13.08)</td>
<td>53.17 (12.67)</td>
<td>0 – 96</td>
</tr>
<tr>
<td>Help Seeking Propensity</td>
<td>19.00 (6.13)</td>
<td>19.20 (7.19)</td>
<td>0 – 32</td>
</tr>
<tr>
<td>Psychological Openness</td>
<td>15.87 (5.31)</td>
<td>14.22 (5.71)</td>
<td>0 – 32</td>
</tr>
<tr>
<td>Concern for Mental Health Stigma</td>
<td>7.75 (5.80)</td>
<td>9.01 (5.79)</td>
<td>0 – 24</td>
</tr>
<tr>
<td>Perceived Social Support</td>
<td>4.87 (1.37)</td>
<td>5.53 (1.32)*</td>
<td>1 – 7</td>
</tr>
<tr>
<td>Perceived Family Support</td>
<td>3.92 (2.11)</td>
<td>5.11 (1.70)*</td>
<td>1 – 7</td>
</tr>
<tr>
<td>Perceived Friend Support</td>
<td>5.38 (1.52)</td>
<td>5.47 (1.64)</td>
<td>1 – 7</td>
</tr>
<tr>
<td>Perceived Significant Other Support</td>
<td>5.28 (1.54)</td>
<td>5.85 (1.49)*</td>
<td>1 – 7</td>
</tr>
<tr>
<td>Number of Supportive Individuals Available</td>
<td>3.23 (1.79)</td>
<td>3.96 (1.47)*</td>
<td>0 – 5</td>
</tr>
</tbody>
</table>

Note. *p < .05

Bivariate correlations showed that, for homeless youth, social support was not related to attitudes toward mental health services in general. However, perceived friend support was associated to reduced concern for mental health stigma. In addition, the number of supportive individuals available was linked to overall positive attitudes toward mental health services, increased help seeking propensity and lower concern for mental health stigma. See Table 6 for correlations between mental health attitudes and social
support in the homeless group. Comparison of correlation sizes between homeless and housed youth were conducted using the correlation comparison coefficient (see Table 6). Analysis revealed correlation strength between groups differed significant for only one set of correlations. Perceived family support is more strongly associated with help seeking propensity for housed youth than homeless youth. No other correlations differed significantly in size between groups. These results are explored in the discussion section.
Table 6

Comparison of Correlations between Groups

<table>
<thead>
<tr>
<th></th>
<th>Attitudes Toward Mental Health Services</th>
<th>Psychological Openness</th>
<th>Help Seeking Propensity</th>
<th>Concern for Mental Health Stigma</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Perceived Social Support</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homeless</td>
<td>.20</td>
<td>-.07</td>
<td>.23</td>
<td>-.21</td>
</tr>
<tr>
<td>Housed</td>
<td>.23</td>
<td>-.13</td>
<td>.38**</td>
<td>-.07</td>
</tr>
<tr>
<td>( z )</td>
<td>-0.16</td>
<td>0.32</td>
<td>-0.90</td>
<td>-0.77</td>
</tr>
<tr>
<td><strong>Perceived Family Support</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homeless</td>
<td>.15</td>
<td>.07</td>
<td>.04</td>
<td>-.11</td>
</tr>
<tr>
<td>Housed</td>
<td>.25*</td>
<td>-.05</td>
<td>.38**</td>
<td>-.06</td>
</tr>
<tr>
<td>( z )</td>
<td>-0.54</td>
<td>0.64</td>
<td>-1.98*</td>
<td>-0.28</td>
</tr>
<tr>
<td><strong>Perceived Friend Support</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homeless</td>
<td>.20</td>
<td>-.13</td>
<td>.25</td>
<td>-.28*</td>
</tr>
<tr>
<td>Housed</td>
<td>.14</td>
<td>-.19</td>
<td>.25*</td>
<td>-.04</td>
</tr>
<tr>
<td>( z )</td>
<td>0.32</td>
<td>0.33</td>
<td>-0.02</td>
<td>-1.37</td>
</tr>
<tr>
<td><strong>Perceived Significant Other Support</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homeless</td>
<td>.16</td>
<td>-.19</td>
<td>.25</td>
<td>-.12</td>
</tr>
<tr>
<td>Housed</td>
<td>.19</td>
<td>-.08</td>
<td>.28*</td>
<td>-.04</td>
</tr>
<tr>
<td>( z )</td>
<td>-0.16</td>
<td>-0.60</td>
<td>-0.18</td>
<td>-0.44</td>
</tr>
<tr>
<td></td>
<td>Homeless</td>
<td></td>
<td>Housed</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>----------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>Number</td>
<td>.31*</td>
<td>-.08</td>
<td>.33*</td>
<td>-.27@</td>
</tr>
<tr>
<td>statistic</td>
<td>z</td>
<td>1.57</td>
<td>1.00</td>
<td>-1.58</td>
</tr>
</tbody>
</table>

*Note.* @p < .06, *p* < .05, **p < .001. Z scores indicate differences in correlation size between groups.
DISCUSSION

Overall Attitudes toward Mental Health Services

The first research question focused on examining differences in attitudes toward mental health services between homeless youth and housed youth. No significant difference was found and results yielded a small effect size, indicating that homeless and housed groups shared similar attitudes towards mental health services. Raw scores on the attitudes toward mental health services scale range from 0 – 96. Both homeless and housed groups obtained mean scores of 56.43 and 53.17, respectively. Scores were interpreted by creating score ranges that encompassed positive attitudes (96.00 – 64.00), neutral attitudes (64.00 – 32.00), and negative attitudes (32.00 - 0.00).

Only one other study has reported on adolescents’ attitudes toward mental health services using the same measurement scale (Munson, Floersch, & Townsend, 2009). Munson et al. (2009) had a sample of 70 youth who were actively engaged in mental health services for treatment of a mood disorder and these youth were surveyed on their attitudes toward mental health services. In Munson et al. (2009), youth had a higher mean score on overall attitudes toward mental health services ($M = 60.1$, $SD = 12.3$) than both groups in the current study, but in both studies all groups appear to have moderately neutral toward positive attitudes toward mental health services.

The current study showed that homeless youth do not demonstrate extremely negative or positive attitudes toward mental health services. These results can still be beneficial for service providers. Providers should focus their efforts to conduct and promote their services in a more positive manner. Previous research has shown that a
youth-centered approach among homeless and runaway youth programs (i.e. positive youth development) increased the quality of experiences between youth and service providers and increased youths’ overall satisfaction with service providers (Heinze, Jozefowicz, & Toro, 2010). Positive youth development characteristics included program policies that reflect youth efficacy and mattering, supportive relationships from the program staff and peers, extensive opportunities to belong and build skills, positive social norms, and the integration of school and community efforts. Outreach efforts that promote youth centered practices may foster positive attitudes toward services and, in turn, increase youths’ service use.

The similarity in mean scores across studies is also revealing. Similar scores across multiple studies could suggest the general youth population has neutral toward positive attitudes toward mental health services; however, more research is needed on diverse and larger samples. The results from the current study may have been influenced by ecological factors unique to the current study’s geographic location, such as progressive or open attitudes, in Northern California. These ecological factors may increase homeless youths’ positive attitudes toward mental health care, which may not be representative of the general homeless youth population.

In addition, homeless youth from the current study had relatively high levels of education, which could also influence their attitudes toward mental health services. It is also important to note that the majority of youth who received mental health services were satisfied with their services. The service providers used in the current study have a high focus on positive youth development within program practices, which may have
contributed to youths’ positive service satisfaction and moderately neutral to positive attitudes toward mental health services. More research is needed, using the same standardized measurement, on larger and more diverse samples in order to determine if these results hold across youth populations.

**Help Seeking Propensity**

The second research question focused on differences between homeless and housed groups on help seeking propensity. No significant difference were found and results yielded a small effect size, which indicates that homeless youth and housed youth share similar attitudes towards help seeking propensity. Scores on the help seeking propensity subscale can range from 0 – 32. Homeless and housed youth reported mean scores of 19.00 and 19.20, respectively. Scores were interpreted by creating score ranges that encompassed positive attitudes (32.00 – 21.33), neutral attitudes (21.33 – 10.66), and negative attitudes (10.66 - 0.00). Mean scores for homeless and housed groups indicated that these youth had neutral to somewhat positive attitudes toward seeking out services. Homeless and housed youth were relatively similar in help seeking propensity to youth in Munson et al. (2009), who reported positive attitudes toward help seeking propensity in their sample ($M = 21.4$, $SD = 5.6$).

Existing literature on runaway and homeless youth shows that these youth regard autonomy and personal freedom as important to their lifestyles, which greatly influences their decision to access services (Collins & Barker, 2009). Service providers can use this information by tailoring their outreach efforts to give youth autonomy to choose, without pressuring them into accessing services. Furthermore, programs that emphasize a youth
centered, positive youth development approach also show high youth satisfaction with those programs (Heinze et al., 2010). Youth centered program characteristics include program policies that reflect youth efficacy and mattering, supportive relationships from the program staff and peers, extensive opportunities to belong and build skills, positive social norms, and the integration of school and community efforts. Service providers may increase runaway and homeless youths’ help seeking propensity by utilizing outreach strategies that emphasize a youth centered approach. Strategies may include peer-to-peer outreach in order to develop supportive relationships and bridge the gap between youth and service providers. In addition, providing these youth with extensive opportunities that will make them feel like they belong and matter may increase their positive attitudes toward help seeking, in turn, increase their use of services.

Help seeking attitudes found in the current study may be influenced by ecological factors. The current study demonstrated low levels of caretaker full-time employment. Parents’ lack of full-time employment decreases the amount of financial resources available to a family, which may contribute to youth seeking out services in order to meet their needs. Additionally, a small number of youth in the current study reported barriers to mental health care, suggesting that positive attitudes toward help seeking may be due to youths’ perceived ease in accessing services. Continued research is needed, using larger and more diverse samples, in order to fully capture an accurate picture of homeless and runaway youths’ attitudes toward help seeking.
Psychological Openness

The third research question focused on the differences in psychological openness between homeless and housed groups. No significant differences were found, and results yielded a small effect size, indicating that homeless and housed youth share similar attitudes towards psychological openness. Scores on psychological openness can range from 0 – 32. Scores were interpreted by creating score ranges that encompassed positive attitudes (32.00 – 21.33), neutral attitudes (21.33 – 10.66), and negative attitudes (10.66 - 0.00). Scores from the current study indicate that the homeless group ($M = 15.84$, $SD = 5.31$) and the housed group ($M = 14.22$, $SD = 5.71$) have moderate levels of openness to discussing psychological problems. In Munson et al. (2009), youth had similar scores on psychological openness ($M = 17.8$, $SD = 5.2$). Similar scores across studies could suggest that these neutral attitudes toward discussing psychological problems are normative for the general youth population, however, additional research is needed on more diverse and large youth populations in order to clarify this finding.

Previous research has shown that a common barrier to mental health services for homeless youth is feeling uncomfortable when talking about personal problems (Solorio et al., 2006). In the current study, both homeless youth and housed youth reported that a lack of openness to discussing psychological problems was a barrier to accessing services. These finding have important implications for service providers. Service providers should not immediately expect these youth to be receptive to discussing personal problems with program staff or formal counselors.
As mentioned earlier, programs that emphasize a youth centered, positive youth development approach are shown to increase runaway and homeless youths’ satisfaction with those services (Heinze, et al., 2010). Positive youth development characteristics included program policies that reflect youth efficacy and mattering, supportive relationships from the program staff and peers, extensive opportunities to belong and build skills, positive social norms, and the integration of school and community efforts. Programs and outreach efforts should emphasize a positive youth development approach by first developing supportive relationships between youth, their peers and program staff before encouraging youth to engage in formalized counseling services. Youth centered program approaches may gradually increase youths’ openness to discussing personal problems and, in turn, increase their use of services.

Findings for psychological openness among homeless, runaway and housed youth may have been influenced by ecological factors unique to the current study’s geographic location, such as progressive or open attitudes, in Northern California. These ecological factors may increase youths’ feelings toward discussing personal problems, which may not be representative of the general homeless youth population. Additional, homeless youth in the current study had a high level of education, which may have influenced their willingness to discuss psychological problems. Lastly, the shelter and drop-in center where youth were recruited focus heavily on positive youth development practices. These practices may have influenced homeless and runaway youths’ willingness to discuss psychological problems. More research is needed to include more geographically diverse areas and larger samples in order to clarify these findings.
Concern for Mental Health Stigma

The fourth research question addressed the differences in concern for mental health stigma between homeless and housed groups. No significant differences were found between groups and the effect size for concern for mental health stigma was small, suggesting that homeless and housed youth share similar concern for mental health stigma. Scores on concern for mental health stigma range from 0 – 24. Homeless and housed groups obtained mean scores of 7.74 and 9.00, respectively. Scores were interpreted by creating score ranges that encompassed positive attitudes (0.00 - 8.00), neutral attitudes (8.00 - 16.00), and negative attitudes (16.00 - 24.00). Mean scores for the homeless and housed groups indicate these youth have a low concern for mental health stigma, however, it is difficult to compare these scores to results from Munson et al. (2009) due to the current study using item deletion to improve alpha reliability for this subscale.

The literature on mental health service use among homeless youth reports extremely negative and stigmatizing experiences with mental health providers. While these experiences can be detrimental for continued service use and mental health outcomes, the youth from the current study do not demonstrate a high concern for negative or stigmatizing experiences from providers. Additionally, the majority of youth from both groups reported being satisfied with the services they received.

Current research has demonstrated that programs with more youth centered, positive youth development approaches predict increased satisfaction with those services (Heinze, et al., 2010). Positive youth development approaches include program policies
that reflect youth efficacy and mattering, supportive relations from the program staff and peers, extensive opportunities to belong and build skills, positive social norms, and integration of school and community efforts. It is possible that the positive youth development practices used by the agencies in the current study mitigated homeless and runaway youths’ concern for mental health stigma. Additional ecological influences of youths’ concern for mental health stigma may include the geographic area of Northern California, which features relatively progressive and open attitudes, as well as homeless youths’ relatively high level of education. More research is needed on this topic to include larger and more diverse samples.

**Service Needs**

The fifth research question addressed the service needs of both housed and homeless youth to determine which services were the most important to them. Transportation was identified as the most used service if readily available by both homeless and housed groups. See the Table 3 for the complete listing of services. Mental health services rated seventh for both homeless and housed youth. Similar to the results for homeless adults in Acosta and Toro (2000), homeless youth in the current study rated mental health services as less vital than services that address basic needs, such as food, medical/dental care, and welfare assistance. This finding has important implications for service providers. Promotion of services should emphasize the types of services homeless youth consider the most important, including services that meet basic needs and, when possible, assistance with transportation. Once homeless youth access the services they need, providers can then educate youth on the availability of mental health services.
Additionally, the mean scores for mental health service use in the service needs assessment were identical in both the homeless and housed youth (see Table 3). This finding suggests that attitudes toward mental health services may indeed be consistent across at-risk youth populations. However, these findings should be replicated to be certain.

Social Support

The final research question addressed the link between social support and attitudes toward mental health services. For homeless youth, perceived social support was only associated with one attitudes variable; as perceived friend support increased, their concern for mental health stigma decreased. Previous studies have suggested that homeless youth rely more on friends for advise, counseling, and referrals than formal agencies or institutions (Reid & Klee, 1999). Having high levels of friend support, in the form of advice, counseling, and information, may be what decreases homeless youths’ concern for mental health stigma. Additionally, the number of supportive individuals available was related to two attitude variable for homeless youth; the higher number of supportive individuals available was associated with more positive attitudes toward mental health services and increased help-seeking propensity. This finding fits with previous research that shows more supportive individuals increases service use for homeless and runaway youth (Berdahl et al., 2005).

While a causal relationship cannot be established between these variables, results can still be informative for service providers during their street outreach efforts. As mentioned earlier, current research shows that youth centered, positive youth
development practices increases youth satisfaction with those services (Heinze, et al., 2010). Among the practices that demonstrate increased satisfaction are supportive relationships from the program staff and peers. Establishing relationship with homeless youth who have yet to access service, can include rapport building activities and continued follow-ups, which may increase the likelihood these youth decide to access services.

In addition, it is important for service providers to recognize the potential influence of homeless youths’ peer relationships on stigma perceptions. The use of peer-to-peer outreach may benefit homeless youth by decreasing stigma perceptions and increasing service use. Providers may also connect homeless youth to opportunities in the community to establish and foster supportive relationships. These strategies increase the number of supportive individuals in a homeless youth’s life and may increase their chances of accessing services. More research is needed to fully understand the role of social support on service use and to inform service providers on evidenced-based strategies to increase service engagement among homeless and runaway youth.

When correlations between social support and attitudes were compared between homeless and housed groups, the only significant difference between these groups in correlation strength was the link between perceived family support and help seeking propensity. The association between perceived family support and help seeking propensity was strongest for the housed group than for the homeless group. In the current study, housed youth experienced significantly more perceived family support than
homeless youth. The link between family support and help seeking propensity may be due to those youth who perceive higher family support also rate high on seeking out help.

While the current study is unable to determine a causal relationship between these two variables, results can still be useful for service providers. This finding highlights the importance of working with families while youth are housed. Service providers conducting family systems interventions that increase family support for youth may also be increasing the youths’ help seeking propensity as a collateral benefit. More research is needed in order to clarify this finding in order to aid service providers with developing strong evidence-based outreach strategies.

**Mental Health Service Use**

Eighty-two percent of the homeless youth in the current study had accessed mental health services, which closely matched the 80% of homeless youth reported by Berdahl et al. (2005). While multiple studies report an under-utilization of mental health services among homeless and runaway youth, in Berdahl et al. (2005), researchers were able to distinguish whether youth had seen a mental health professional before or after leaving the home. In Berdahl et al. (2005), only half of those youth who saw a mental health professional accessed those services after leaving their home. In the current study, it is unknown what percentage of homeless youth saw a mental health professional before or after leaving their home. Future research on attitudes toward mental health services among homeless youth should include timing of mental health service use in order to fully understand how timing of mental health service access influences continued service
utilization, which may assist service providers with identifying factors that can increase service use among homeless youth.

Among the 80% of homeless youth who have accessed mental health services, almost 69% rated positive satisfaction with their services. Additionally, mental health service satisfaction did not differ between the homeless group and the housed group. High mental health service satisfaction suggests that the negative and harmful experiences reported by homeless youth in the literature may only apply to a smaller percentage of the homeless youth in the current study. However, it is possible that service experience and satisfaction varies for homeless youth who have seen multiple mental health service providers. Unfortunately, the current study is unable to determine service satisfaction across multiple episodes of mental health use.

Ecological factors may influence the homeless youths’ satisfaction with services. The relatively open and progressive attitudes of the geographic location in Northern California, where the current study took place, may have influenced how youth experience and perceive mental health care. Additionally, the emphasis of positive youth development characteristics used by the service providers in the current study can influence the findings. As mentioned earlier, current research shows that positive youth development practices increases youth satisfaction with those services (Heinze, et al., 2010). The high levels of service satisfaction may not be representative of the general homeless youth population. Additional research is needed on larger and more diverse samples in order to replicate these findings.
The top three most common referral sources for youth in the homeless group were social workers/probation officers, parents, and teachers/school counselors. The top reason for referrals for homeless youth included family conflict, depression, stress, school problems, anxiety and suicide ideation/attempts. It is unknown whether social workers, parents, and teachers/school counselors provided the referral before or after the youth left the home. The reasons listed by youth for being referred to mental health service confirms the well-documented mental health characteristics of homeless and runaway youth, with suicidal ideation/attempts occurring more often among homeless and runaway youth than the general youth population (Roy et al., 2004; Whitbeck, 2004).

Difficulty accessing mental health services did not differ between homeless and housed groups. For those homeless youth who indicated services were difficult to access, reported reasons included a lack of openness to discussing psychological problems, limited or no financial resources, and no knowledge of how to access mental health services, which were also barriers listed by homeless youth in Solario et al. (2006). Mental health service utilization may increase if service providers offer educational outreach to homeless youth on the availability of free or low-cost counseling services in their community. Homeless youth in the current study also identified the inability to pay for bus passes or other transportation to mental health services. Service providers may offer transportation to and from mental health service which will assist youth with increasing their service use.
Differences in Life Experiences

The current study found that homeless youth and housed youth differed on important life experiences. First, more homeless youth were not attending school because more homeless youth had graduated from high school than the housed youth who were attending alternative community schools. The high level of education in the homeless group is most likely due to more youth who were 18 years old and over in the homeless group. In addition, the majority of the youth in the homeless group resided in a youth shelter, which makes school enrollment and school completion easier than while youth are living on the streets or couch surfing. This experience may not necessarily be representative of the entire homeless youth population.

History in the foster care also differed between groups, with more homeless youth reporting experience in the foster care system. This finding is consistent with the extensive literature on homeless youths’ abusive and unstable living situations, which can lead to the involvement of child protection agencies and placement of these youth in the foster care system. History in the juvenile probation system was similar for both youth in the homeless and housed groups, which is inconsistent with the literature that states homeless youth demonstrate higher levels of conduct problems than housed youth. This may be due to most studies not having a match comparison group. The comparison youth were all at risk for academic failure and attending alternative community schools.

Finally, parental/caregiver employment and parental/caregiver welfare assistance was examined for differences. More housed youth had parents/caregivers who had full-time employment than parents/caregivers of homeless youth. Lack of parental/caregiver
full-time employment decreases the amount of available resources to support a family and may influence a youths’ decision to leave the home in order to meet their needs. Parental/caregiver welfare assistance did not differ between groups, with about half of youth in each group reporting that their parents/caregivers receive welfare assistance, indicating an adequate, although imperfect, match between comparison and homeless youth.

**Limitations and Future Directions**

Power analysis indicated 64 participants would be required per group. The current study recruited 56 youth who identified as homeless and 97 youth who were housed. Unfortunately, insufficient statistical power presents problems with the current study’s findings. Results should be interpreted with caution and should be replicated on larger samples. In addition, the low alpha reliability of the concern for mental health subscale is problematic. Results for this subscale should be interpreted with caution as low alpha reliability inhibits the current study’s ability to generalize its findings.

Another limitation included the sample’s relatively small numbers of youth of color (21.4%) and lesbian, gay, bisexual, and transgender youth (23.2%). Both youth of color and LGBT youth are nationally overrepresented among homeless youth who are receiving emergency shelter services (National Clearinghouse on Families and Youth, 2009). In addition, the experience of homelessness has been shown to differ among youth of color and LGBT youth (Auerswald & Puddefoot, 2012; Cochran et al., 2002). It is vital for studies on runaway and homeless youth to capture the unique experiences of
diverse youth if service providers are to embrace studies for effective program
development.

Lastly, youth in the homeless group were obtained solely from sites (drop-in
center and shelter) where youth were already receiving services. To truly gain an accurate
representation of homeless youths’ attitudes towards mental health services, future
research should include youth who are not actively engaged in receiving services.
Unfortunately, homeless youth who are not engaged with service providers can be
extremely difficult to find and reach.

The current study also suggests avenues for future research. As mentioned earlier,
more research on attitudes toward mental health services among adolescent populations is
needed in order to determine if homeless youth differ from the general youth population.
Furthermore, future research on service utilization should incorporate timing of mental
health service use, location(s) of service use, and frequency of service use in order to
fully capture and understand what influences homeless youths’ attitudes and perceptions
toward mental health services. Lastly, the relationship between social support and service
use should be further studied in order to inform and aid service providers of effective
ways to increase service use through social support.

Conclusion

This was the first study to examine the attitudes toward mental health services
among homeless and runaway youth and the first to examine the link between their
attitudes and multiple domains of perceived social support. The current study is also the
first to look across studies to find similar attitudes toward mental health services among
different youth populations. Continued research is needed on runaway and homeless youths’ attitudes and perceptions of services in order to include larger and more diverse youth samples, which will better inform services providers on the most effective way of delivering care.

The current study is a step toward understanding service utilization among homeless and runaway youth. The current study sought to provide homeless and runaway youth with the opportunity to voice their attitudes and perceptions toward issues that pertain to their health and well-being. The merit of consulting young people on the issues that affect their lives serves to benefit service providers in effective program development and, ultimately, benefits the youth themselves. The preliminary conclusions presented in the current study can help guide future work on youth attitudes toward mental health services and the association between social support and attitudes toward mental health services. Continued research will aid service providers in the development of evidence based outreach strategies and programs that will foster positive attitudes towards services and increase service use for runaway and homeless youth.
REFERENCES


Heflinger, C. A., & Hinshaw, S. P. (2010). Stigma in child and adolescent mental health services research: Understanding professional and institutional stigmatization of
youth with mental health problems and their families. *Administration and Policy in Mental Health, 37*, 61-70. doi: 10.1007/s10488-010-0294-z


Appendix A

Parental Consent to Participate in Research
(for youth in shelters and schools)

I hereby consent for my child to complete the following survey regarding their feelings toward mental health services. Completion of the survey is entirely voluntary and no consequences will occur if I decline my child’s participation. It will take about 20 minutes to complete the entire survey. The purpose of this survey is to examine the attitudes and experiences of youth toward mental health services.

I understand that the survey does not contain questions requiring identifying information about my child (name, date of birth, etc.). All information will be strictly confidential and anonymous. These surveys will be used entirely for research purposes and only trained researchers will see this information. All surveys will be securely stored in a locked filing cabinet in the Developmental Psychology laboratory at Humboldt State University and completely destroyed upon completion of the study. I may contact the researchers if I desire to know the combined study results for all participants (my child’s individual scores will not be available as the surveys are completely anonymous).

I understand that some of the questions are personal and may make my child uncomfortable or bring up some emotional memories. All participants are able to skip any questions they do not wish to answer. Youth are also able to withdraw from the study at any time without consequence. For participating in the survey, my child will receive a $5.00 gift card to a local restaurant as compensation. My child will still receive compensation even if he/she skips any questions or withdraws from the study. I also understand that the researcher may terminate my child’s participation in the study at any time. If my child requires assistance with processing their thoughts or feelings, I can find a counselor or mental health service provider in my area by using the website URL: http://store.samhsa.gov/mhlocator or by calling 1-877-SAMHSA-7. This study will help service providers better understand the needs of the youth population and aid providers with improving their services. The only risk from taking the survey is that some questions on family history and victimization may make my child uncomfortable.

If I have any questions regarding the survey and/or my child’s participation, or desire a copy of the results, I can contact Jared Martin at jkm38@humboldt.edu or 707-443-8322 x206 or the supervising Professor Dr. Tasha Howe at th28@humboldt.edu or 707-826-3759. If I have questions regarding my child’s rights as a participant, or any concerns regarding this project, or any dissatisfaction with any part of this study, I may report them confidentially — to the Dean for Research & Sponsored Programs, Dr. Rhea Williamson at Rhea.Williamson@humboldt.edu or (707) 826-4189.

Please keep this page for your records
I have read the above informed parental consent sheet. I understand the risks and benefits of allowing my child to participate in the study. I do hereby consent to my child completing the survey, knowing that they may skip any questions or cease participation at any time.

________________________
Parent/Legal Guardian/Primary Caregiver Name Printed

______________________________
Name of Child Participant

________________________
Parent/Legal Guardian/Primary Caregivers Signature

________________________
Date
Informed Assent to Participate in Research  
(for youth at drop-in centers)

I, _____________________________________, agree to participate in the following survey. Participation in completing the survey is voluntary and no consequences will occur if I decline to participate. I understand that refusing to participate will not jeopardize my ability to receive services from any local youth programs. It should take about 20 minutes to complete the survey. The purpose of the survey is to better understand how youth feel about mental health services.

I understand that I am free to skip any questions that I do not want to answer and that I may stop taking the survey if I do not want to continue. All surveys are anonymous and confidential; which means no information asked will reveal my identity. I may contact the researchers below if I desire to know the combined study results for all participants (my individual results will not be available as surveys are anonymous). All surveys will be securely stored in a locked filing cabinet in the Developmental Psychology laboratory at Humboldt State University and completely destroyed upon completion of the study.

I understand that some of the questions may make me feel uncomfortable or bring up emotional memories. I am free to skip any questions. For participating, I can receive a $5.00 gift card to a local restaurant as compensation. Even if I skip any questions or withdraw from the study I will still be compensated. If I need to process any thoughts or feelings, I can find a counselor or mental health service provider in my area by using the website URL: http://store.samhsa.gov/mhlocator or by calling 1-877-SAMHSA-7. This study will help service providers better understand the needs of the youth population and aid providers with improving their services. The only risk from taking the survey is that some questions on family history and victimization may make me uncomfortable.

If I have any questions regarding the survey, or desire a copy of the results, I can contact Jared Martin at jkm38@humboldt.edu or 707-443-8322 x206 or the supervising Professor Dr. Tasha Howe at th28@humboldt.edu or 707-826-3759. If I have questions regarding my rights as a participant, any concerns regarding this project, or any dissatisfaction with any part of this study, I may report them confidentially —to the Dean for Research & Sponsored Programs, Dr. Rhea Williamson at Rhea.Williamson@humboldt.edu or (707) 826-4189.

<table>
<thead>
<tr>
<th>24-hour Youth Crisis Hotline</th>
<th>Mental Health Crisis Line:</th>
<th>Humboldt State University Community Clinic:</th>
</tr>
</thead>
<tbody>
<tr>
<td>707-444-2273</td>
<td>707-445-7715</td>
<td>707-826-3921</td>
</tr>
<tr>
<td>Raven Project Drop-In Center</td>
<td>National Suicide Hotline</td>
<td>Victim Witness Services</td>
</tr>
<tr>
<td>523 T Street in Eureka</td>
<td>1-800-784-2433</td>
<td>707-445-7417</td>
</tr>
<tr>
<td>707-443-7099</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children, Youth and Family Services</td>
<td>North Coast Rape Crisis Team</td>
<td>Child Welfare Services</td>
</tr>
<tr>
<td>1711 3rd Street in Eureka</td>
<td>707-445-2881</td>
<td>445-6180</td>
</tr>
<tr>
<td>707-268-2800</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Ravens Project Drop-In Center
523 T Street in Eureka
707-443-7099

Children, Youth and Family Services
1711 3rd Street in Eureka
707-268-2800

North Coast Rape Crisis Team
707-445-2881

National Suicide Hotline
1-800-784-2433

Victim Witness Services
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Website URL: http://store.samhsa.gov/mhlocator

Contact Jared Martin
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707-443-8322 x206

Contact Dr. Tasha Howe
th28@humboldt.edu
707-826-3759

Contact Dean for Research & Sponsored Programs
Rhea.Williamson@humboldt.edu
(707) 826-4189
I have read the above informed assent sheet. I understand the risks and benefits of participating in the study. I do assent to completing the survey, knowing that I may skip any questions or cease participation at any time.

_________________________________________________
Name Printed

_________________________________________________
Your Signature                      Date
Appendix B
Parental Maltreatment and Street Victimization Scales

1. Since you have been on your own, have you ever been physically assaulted?
   □ Never    □ Once    □ Two-Five times    □ More than five

2. Since you have been on your own, have you ever been robbed?
   □ Never    □ Once    □ Two-Five times    □ More than five

3. Since you have been on your own, have you ever been sexually assaulted?
   □ Never    □ Once    □ Two-Five times    □ More than five

4. Since you have been on your own, have you ever been threatened with a weapon?
   □ Never    □ Once    □ Two-Five times    □ More than five

5. Since you have been on your own, have you ever been assaulted with a weapon?
   □ Never    □ Once    □ Two-Five times    □ More than five

6. When living with your caregiver, have you ever punished by being made to go a day without food?
   □ Never    □ Rarely    □ Sometimes    □ Many times

7. When living with your caregiver, have you ever been left home alone for at least 24 hours?
   □ Never    □ Rarely    □ Sometimes    □ Many times

8. In the past, has your caregiver ever physical assaulted or thrown something at you because of your gender identity or sexual orientation?
   □ Never    □ Rarely    □ Sometimes    □ Many times

9. In the past, has your caregiver ever insulted or verbally attacked you because of your gender identity or sexual orientation?
   □ Never    □ Rarely    □ Sometimes    □ Many times

10. In the past, has your caregiver ever ignored you or neglected any of your important needs because of your gender identity or sexual orientation?
    □ Never    □ Rarely    □ Sometimes    □ Many times

11. In the past, has your caregiver ever thrown something at you in anger?
    □ Never    □ Rarely    □ Sometimes    □ Many times

12. In the past, has your caregiver ever pushed, shoved, or grabbed you in anger?
    □ Never    □ Rarely    □ Sometimes    □ Many times
13. **In the past, have you ever been slapped in the face or head by your caregiver?**
   - Never  
   - Rarely  
   - Sometimes  
   - Many times

14. **In the past, have you ever been hit with an object by your caregiver?**
   - Never  
   - Rarely  
   - Sometimes  
   - Many times

15. **In the past, have you ever been beaten with fists by your caregiver?**
   - Never  
   - Rarely  
   - Sometimes  
   - Many times

16. **In the past, has your caregiver verbally or physically threatened you with a gun or knife?**
   - Never  
   - Rarely  
   - Sometimes  
   - Many times

17. **In the past, have you ever been wounded with a gun or knife by your caregiver?**
   - Never  
   - Rarely  
   - Sometimes  
   - Many times

18. **In the past, has your caregiver asked you to do something sexual?**
   - Never  
   - Rarely  
   - Sometimes  
   - Many times

19. **In the past, have you ever been forced to do something sexual by your caregiver?**
   - Never  
   - Rarely  
   - Sometimes  
   - Many times
Appendix C
Demographics and Service Utilization

1. **Age:** ___________________
2. **Gender:** □ Male □ Female □ Other: ______________________________
3. **Sexual Orientation:**
   □ Heterosexual □ Homosexual □ Bisexual □ Not Sure
4. **Race/Ethnicity:**
   □ Native American □ Caucasian/European-American □ Hispanic/Latino(a)
   □ Asian-American □ Hawaiian Native/Pacific Islander □ Mixed Ethnicity
   □ Black/African-American □ Other: _________________________________
5. **What was the last grade you completed?** __________________________
6. **Are you currently attending school?** □ Yes □ No
7. **Have you ever been or are you currently in foster care?** □ Yes □ No
8. **Have you ever been on or are you currently on probation?** □ Yes □ No
9. **Does your primary caregiver/parent have a full-time job?** □ Yes □ No
10. **What is your primary caregiver/parent’s highest level of education**
    □ Don’t Know □ Has GED
    □ Some Grade school □ Some College
    □ Some High School □ College Graduate
    □ Finished High School Diploma □ Graduate School
11. **Has your primary guardian ever received government welfare assistance?**
    □ Yes □ No □ Don’t Know
12. **What is your **CURRENT** living situation?**
    □ Living at home with parent(s)
        If checked “living at home with parents”, skip to question #21
    □ With family in an alternative living situation (motel, shelter, etc.)
        - If checked “with family in alternative living”, skip to question #21
    □ Temporarily with friends or extended family
        - If checked “temporarily with friends or extended family”, skip to question #21
    □ Couch surfing
    □ Shelter or Transitional Housing for youth
    □ On the street
    □ Other: _______________________________________________________
13. **How long have you been in your current living situation?** __________
14. **At what age were you on your own for the first time?** ___________
15. **In total, how many times would you estimate you had a major change in your home living environment?** (example: moving to a new home or changes in the number of adults or children living with you) __________
16. **Have you ever seen a counselor, therapist or psychiatrist?** □ Yes □ No

*IF NO, skip to question #43*
17. Were you satisfied with the service(s)? □ Yes □ No

18. Who referred you to the counselor, therapist or psychiatrist?
   □ Self-referral □ Law enforcement □ Social worker /Probation Officer
   □ Extended Family □ Friend □ Parent □ Teacher/School Counselor
   □ Other: ____________

19. For what reason(s) did you see a counselor, therapist or psychiatrist? (Check any that apply)
   □ Relationship problems □ Family problems □ Suicidal thoughts/behaviors
   □ Anxiety □ Stress □ Bipolar
   □ Conduct Disorder □ School problems □ Depression
   □ PTSD □ ADHD □ Sexual identity or gender
   □ Other: ___________________________________________________________________

20. If you wanted to see a counselor, therapist, or psychiatrist, how easy or difficult would it be?
   □ Very difficult □ Difficult □ Easy □ Very easy

21. If mental health services are difficult to access, why?
    __________________________________________________________________________

22. Have you ever felt pressured or forced to see a counselor, therapist, or psychiatrist? □ Yes □ No

23. Are you currently using medication for any emotional or behavioral needs? □ Yes □ No

24. Do you have any family members or close friends who are experiencing any emotional or behavioral struggles? □ Yes □ No

25. If yes on #43, do they see a counselor, therapist or psychiatrist? □ Yes □ No

26. Have you ever used alcohol or any other non-prescribed drugs or to deal with an emotional, behavioral or psychological struggles? □ Yes □ No

27. How many people do you currently have available who would help you with your emotional problems or feelings if you needed it? (Circle One)
   0 1 2 3 4 5 or more
<table>
<thead>
<tr>
<th>Instructions: For each service, rate how often you think you would use the service if it were easily available:</th>
<th>Never</th>
<th>Rarely</th>
<th>At times</th>
<th>A lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Educational Services (tutoring, school supplies, etc.)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Transportation Services (bus tickets, car/bike repair, etc.)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Medical/Dental Services (medications, contraception, dental supplies, etc.)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Job Training &amp; Job Placement (Job Market, Job Training)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. Alcohol and Other Drug Treatment</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. Government Assistance (food stamps, cash aid, social security, etc.)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. Free meals</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. Mental Health Services (help with stress, family problems, depression, anxiety)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Appendix D

The Inventory of Attitudes toward Seeking Mental Health Services scale

<table>
<thead>
<tr>
<th>Please read each question carefully. Circle the number that indicates your level of agreement for each question.</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Undecided</th>
<th>Somewhat Agree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Emotional or behavioral struggles can include constantly feeling sad, angry, having extreme mood swings, anxiety, stress, alcohol and other drug use, harming yourself, etc.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. There are certain problems that should NOT be discussed outside of one’s immediate support group (friends, romantic partner or family).</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. I would have a very good idea of what to do and who to talk to if I decided to seek professional help for emotional or behavioral struggles</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. I would NOT want my boyfriend or girlfriend to know if I were suffering from emotional or behavioral struggles</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Keeping focused on school, work, or hobbies are all good solutions for avoiding personal worries and concerns.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. If good friends asked my advice about an emotional or behavioral problem, I might recommend that they see a professional</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. People who are experience emotional or behavioral struggles carry a burden of shame</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. It is probably best not to know everything about myself.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. If I were experiencing a serious emotional or behavioral struggle at this point in my life, I would be confident that I could find relief in seeing a counselor, therapist, or psychiatrist.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. People should work out their own problems; getting professional help should be a last resort.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. If I were to experience emotional or behavioral struggles, I could see a counselor, therapist, or psychiatrist if I wanted to.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
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<td>---</td>
<td>---</td>
</tr>
<tr>
<td>11. Important people in my life would think less of me if they were to find out that I was experiencing emotional or behavioral problems</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. Emotional or behavioral problems, like many things, tend to work out by themselves</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. It would be relatively easy for me to find the time to see a counselor, therapist, or psychiatrist for emotional or behavioral problems</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. There are experiences in my life I would not discuss with anyone.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15. I would want to see a counselor, therapist, or psychiatrist if I were worried or upset for a long period of time.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16. I would be uncomfortable seeking professional help for emotional or behavioral struggles because people close to me might find out about it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17. Someone who is diagnosed with a mental disorder has a stain on their life.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18. It’s admirable for people to cope with their conflicts and fears without resorting to seeing a counselor, therapist, or psychiatrist for help.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19. If I believed I was having an emotional breakdown, my first thought would be to see a counselor, therapist, or psychiatrist.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20. I would feel uneasy going to a counselor, therapist or psychiatrist because of what some people would think.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>21. People with strong personalities can deal with emotional or behavioral struggles by themselves and they would have little need for a counselor, therapist, or psychiatrist.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>22. I would share personal details about myself if I thought it might help me, a friend, or a member of my family.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>23. Had I received treatment for emotional or behavior struggles, I would NOT feel that it ought to be “covered up.”</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>24. I would be embarrassed if someone I know saw me going into a counselors’, therapists’, or psychiatrists’ office.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Appendix E

Multidimensional Scale of Perceived Social Support

Instructions: Read each statement carefully. Indicate how you feel about each statement by using the following responses:

<table>
<thead>
<tr>
<th></th>
<th>Very Strongly Disagree</th>
<th>Strongly Disagree</th>
<th>Mildly Disagree</th>
<th>Neutral</th>
<th>Mildly Agree</th>
<th>Strongly Agree</th>
<th>Very Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. There is a special person who is around when I am in need.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>2. There is a special person with whom I can share my joys and sorrows.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>3. There are people in my family who really try to help me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>4. I get the emotional help and support I need from my family.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>5. I have a special person who is a real source of comfort to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>6. My friends really try to help me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>7. I can count on my friends when things go wrong.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>8. I can talk about my problems with my family.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>9. I have friends with whom I can share my joys and sorrows.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>10. There is a special person in my life who cares about my feelings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>11. My family is willing to help me make decisions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>12. I can talk about my problems with my friends.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>