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The Association Between Shelter Rules and Psychosocial Outcomes Among Homeless Youth Residing in Family Shelters

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Abstract

Despite growing numbers of homeless youth living in shelters with caregivers, little research has explored the impact of the shelter environment on emotional well-being. As such, this study assesses the relationship between shelter rules and two psychosocial outcomes among youth in New York City family shelters. Additionally, the direct effect of trauma and the moderating effect of difficulty following shelter rules on psychosocial outcomes was assessed. Youth with difficulty following shelter rules reported significantly more depressive symptoms, but less substance use. Trauma was found to be associated with increased depression and substance use. Difficulty following shelter rules was found to moderate the association between trauma and substance use. Recommendations for future interventions and the creation of shelter policies are discussed.

The United States is experiencing rates of homelessness among children that have not been seen since the Great Depression. An estimated 2.5 million children, or one in every 30, are currently experiencing homelessness in the United States (E. L. Bassuk, DeCandia, Beach, & Berman, 2014). In New York City, there are similarly high levels of homelessness among children living with their families in shelters. According to the New York City Department of Homeless Services, the number of school-aged children residing in family shelters grew from 11,905 to 13,403 between 2013 and 2014, representing a 12.6 percentage point increase. Homeless families also compose 80% of the homeless population residing in municipal shelters in New York City (Markee, 2015). In February 2015, an average of 14,386 homeless families (25,105 children and 22,357 adults) slept in municipal shelters each night (Markee, 2015). This rate is up 12% from the previous year and up 58% since the start of the recession in 2008. In addition, the length of stay in shelters is increasing, along

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with the number of homeless families, with the average shelter stay for homeless families now over one year (435 days; Markee, 2015).

This current level of homelessness among children is a serious public health problem, as both homelessness and poverty are shown to put them at increased risk for emotional and behavioral difficulties (Buckner, Bassuk, Weinreb, & Brooks, 1999; Shinn, Samuels, Fischer, Thompkins, & Fowler, 2015). The negative impact of homelessness can be enduring, resulting in increased prevalence of mental illness, even after brief episodes of homelessness (Shinn et al., 2008). In addition, poor mental health (e.g., depression, anxiety, posttraumatic stress disorder) has also been shown to be significantly higher among homeless children relative to their housed counterparts (E. Bassuk, DeCandia, Beach, & Berman, 2011; E. Bassuk & Rubin, 1987; E. L. Bassuk, Rubin, & Lauriat, 1986; Lynn et al., 2014; Rafferty & Shinn, 1991). Trauma and life stressors have also been shown to be disproportionately higher among homeless children when compared to their housed counterparts (E. L. Bassuk et al., 1986; Masten, Miliotis, Graham-Bermann, Ramirez, & Neemann, 1993). This is significant to the life trajectories of children experiencing homelessness, given that childhood traumatic experiences have been shown to be associated with subsequent social, emotional, and cognitive impairments, as well as adolescent risk behaviors (e.g., substance use; E. Bassuk et al., 2011; E. L. Bassuk et al., 2014; Guarino & Bassuk, 2010).

Nationally, housing types are largely categorized into four types of shelter: emergency shelter, transitional housing, permanent supportive housing, and rapid rehousing. As of January 2014 there were approximately 762,945 beds available for all individuals (including children) experiencing homelessness. The approximate breakdown of the percentage of the total beds in each housing type is 33%, 23%, 39%, and 5%, respectively (National Alliance to End Homelessness, 2015). Emergency shelters provide immediate housing to those typically fleeing a highly negative situation (e.g., domestic violence). Transitional housing programs provide shelter typically for up to a year for those experiencing homelessness, and these programs are usually combined with what are known as wraparound services to aid residents in developing stability in their lives overall (Substance Abuse and Mental Health Services Administration [SAMHSA], 2016). Permanent supportive housing provides longer periods of housing in addition to intensive services aimed at reducing chronic homelessness (SAMHSA, 2016). Separate housing within each of these categories is provided for families with children, households without children, and “only-child” households (e.g., runaway youth). Last, rapid rehousing programs provide short-term rental assistance and services, which end once rental assistance terminates and are designed for individuals with lower service needs.

Despite the fact that the link between poor mental health and the social environment has been well established (E. L. Bassuk & Beardslee, 2014; Berkman & Kawachi, 2000; Cohen & Wills, 1985; Mayberry, Shinn, Benton, & Wise, 2014; Taylor & Stanton, 2007), no study to date has looked at whether shelter rules and the governance within these family homeless shelters specifically are associated with poor psychosocial outcomes among youth residents. However, recent research related to shelter rules has suggested that while they can potentially provide needed structure in the lives of homeless individuals, as well as protect

residents, they have often been found to be detrimental to homeless women, depending on their restrictiveness and mode of enforcement (Deward & Moe, 2010; Krane & Davies, 2007). This is commonly due to their potential to diminish personhood and autonomy, which are integral to overall well-being and to the recovery process from trauma. In addition, shelter rules have been found to be an impediment to parenting practices and family routines that can support mental and emotional well-being (Fiese, 2006; Schultz-Krohn, 2004).

Much of the literature on psychosocial outcomes among homeless youth focuses almost exclusively on homeless runaway youth who are not residing with their caregivers. However, there could potentially be a significant difference between the experience of runaway homeless youth living on their own and homeless youth residing with their caregivers. As such, the study described in this article aims to fill some of the gaps in this literature by focusing on the relationship between shelter rules and psychosocial outcomes among a sample of homeless youth residing with their caregivers. More specifically, the first aim of the study is to test the association between difficulty following shelter rules, as well as trauma, with two psychosocial outcomes (namely, depressive symptoms, and substance use) among youth residents of family shelters. The second aim is to assess the moderating effect of difficulty following shelter rules on the association between past trauma and psychosocial outcomes among the same sample of youth.

Methods

Data Source

The parent study for the analysis, HIV prevention Outreach for Parents and Early adolescents (HOPE), was a 5-year study funded by the National Institute on Drug Abuse. The overall goal of this research was to examine family functioning, HIV risk, and substance-abuse risk among homeless families in New York City. Data on 243 youth (ages 11–14) and 209 caregivers residing within 10 privately run supportive housing sites for families across New York City were collected from April 2006 to May 2008. The eligibility criteria for the HOPE study were that the family be residing in the shelter at the time of recruitment, and that they had children ages 11–14 living with them who were willing to participate. The only exclusion criterion for the study was that the participant did not have the mental capacity to fully comprehend the consent process. There were no inclusion criteria related to the length of time in a particular shelter. Therefore, the length of time any one family had spent in the shelter varied. The data were collected via self-administered questionnaires completed by both caregivers and their youth concurrently. Institutional review board (IRB) exemption was granted by the CUNY Graduate Center for the secondary data analysis of the de-identified data set. Only the youth data were included for the analysis in this article. Findings related to caregivers can be found in a previously published manuscript (Beharie, Lennon, & McKay, 2015).

Measures

Youth experiences of trauma (independent variable)—Trauma was measured via 16 items, seven of which originated from the City Stress Index (Ewart & Suchday, 2002). All the items captured sources of traumatic experiences and highly stressful events that may

have occurred in the participants' lives in the past year. Each of the 16 items, including the first seven items from the City Stress Index subscale, were dichotomized to be coded the same (1 = *experienced the event*, and 0 = *did not experience the event*) and added to produce a sum score related to traumatic events that ranged from 0 to 16, with 0 representing *no experience of the traumatic events listed within the past year*, and 16 representing *having experienced all events during the past year*. These 16 items collectively measure three forms of traumatic events during the past year. The first form of trauma was measured via six items related to physical and sexual violence to friends, family, or themselves (e.g., family member was attacked or beaten, or respondent was raped/sexually assaulted). The second category of five items was related to community-level trauma (e.g., saw people dealing drugs in the neighborhood, family member was robbed or mugged). The third category consisted of five items measuring traumatic life changes (e.g., death of a family member, or mother or father lost job).

Difficulty following rules (independent variable/potential moderator)—The item used to measure difficulty with shelter rules was, “Do you have trouble following these [shelter] rules?” The answer categories were yes/no.

Children’s Depression Inventory (CDI; dependent variable)—Depression was measured using 16 items from the Children’s Depression Inventory (CDI) scale, and each item contained three response categories (Kovacs, 1985, 1992). One represented the most positive response to the item (e.g., “I am sure that somebody loves me”); one represented a more neutral response (e.g., “I am not sure if anybody loves me”); and the third represented the most negative response category (e.g., “nobody really loves me”). Higher CDI raw scores (computed by summing all values of item responses) indicated higher levels of depression. This total raw score was then divided by the number of valid responses to give an index or average score.

Number of substances used during the past month (dependent variable)—Items from the Monitoring the Future Survey (Johnston, Bachman, & Schulenberg, 2011) were used to measure substance use. The items covered usage within the past month of cigarettes, alcohol, and marijuana. Given the low frequency of substance use among the youth, a combined score was created that reflected the overall number of substances used in the last month. This variable was created by combining the responses for each substance into those who did not use in the past month (0 = *did not use in the past month*) and those who did (1 = *did use the substance in the past month*) with reports of number of substances used. The resulting variable was a continuous variable that ranged from 0 to 3.

Length of stay in shelter (covariate)—Length of time in the shelter was measured by one item “How long have you been living in this shelter?” The responses categories were ordinal: “1 week–1 month,” “2–4 months,” “5–7 months,” “8–10 months,” “11–12 months,” and “over 12 months.” The last four answer categories were collapsed in the final analysis due to their relatively low frequency in the respective categories. Thus, the last answer category was combined to be “5 months and over.”

First time in shelter (covariate)—First time in shelter was a dichotomous variable that was measured with the item, “Is this your first time staying in a shelter?” The answer categories were yes/no.

Demographics (covariates)—Youth age was measured as a continuous variable and calculated from their date of birth at the time of the assessment. Gender was a dichotomous variable (male/female). The variable capturing the number of children ages 11–14 represented the number of children in the family that were eligible to participate in the study and ranged from one to three. The variable was dichotomized, given the low frequency of youth in the third category, to “one youth” and “two or more youth.” Caregiver race was a categorical variable with three answer categories “White Hispanic/Latino,” “Black,” and “mixed or other.”

Analysis

Descriptive statistics (e.g., frequencies of categorical variables, means, and standard deviations) were first run to assess for any needed recoding. Next, Pearson correlation coefficients were conducted for the continuous variables (e.g., age and depression score), and point-biserial correlations were conducted to assess relationships between continuous and dichotomous variables (e.g., depression score and first time in the shelter). For the multivariate analysis, two models were tested for each psychosocial outcome. For Model 1, substance use and depressive symptoms were regressed on difficulty following shelter rules, trauma, and additional covariates (i.e., age, gender, race, number of youth, first time in the shelter, and time in the shelter) in order to determine direct associations. Model 2 included all of the variables in the first model, but also included an interaction term to assess for the moderating effect of difficulty following shelter rules (i.e., trauma \times difficulty following shelter rules).

To account for the fact that the respondents were nested within shelters and within families (i.e., between two youth from the same family), regression analyses were performed using PROC SURVEYREG in SAS (SAS Institute, 2011), a procedure that performs regression analysis for sample survey data. PROC SURVEYREG is designed for complex survey sample designs, such as the one employed in this study, that samples respondents within clusters (i.e., shelters, families). Such clustering generally results in responses that are not independent of one another. In such circumstances, employing ordinary least squares (OLS) without taking clustering into account could potentially lead to standard errors that are too small, with resulting confidence intervals that are too narrow and p values that are too low (i.e., inflated Type I error rates). In addition, the categorical variable for race was included as a “CLASS” variable. This produces an overall F test of the significance of the variable as well as specific coefficients for each level of the variable compared to a reference category.

Results

Sample Description

Table 1 summarizes the demographic characteristics of the sample, youth reports of their shelter experience, and psychosocial outcomes. The mean age of the youth was 12.87 years

(*SD* 1.17), and there was almost an equal number of males and females (52% and 48%, respectively). The majority of the 243 youth included in the study identified as being White Hispanic/Latino (39%) or Black (45%). In addition, 68% of the families had only one youth in the family between the ages of 11 and 14 who participated in the study. For approximately half of the youth (52%), this was their first time in any shelter. Over half of the youth (60%) had been in the same shelter from 1 week to 4 months, and only 25% of the youth reported having difficulties following shelter rules. The large majority of youth reported not using any drugs (88%) in the past month. Of those who did report using drugs, the most common drug used in the last month was alcohol (8%), followed by marijuana (4%), and cigarettes (4%). The average CDI score was 0.27 (*SD* 0.26) with a possible range of 0 to 2. Last, the average score on the trauma scale was 6.91 (*SD* 4.13) with a possible range of 0 to 16.

Results of Bivariate Analysis

Correlations between the demographic variables and the psychosocial outcome measures (i.e., depressive symptoms and substance use) are shown in Table 2. These indicated that greater depressive symptomatology was correlated with using more substances within the past month among the youth participants ($r = 0.31$; $p < .001$). Being female was correlated with greater depressive symptomatology ($r_{pb} = 0.15$; $p = 0.02$), and youth age was positively correlated with the number of substances used in the past month ($r = 0.19$; $p = 0.00$). Difficulty following shelter rules was also correlated with increased depressive symptomatology ($r_{pb} = 0.14$; $p = 0.03$). Last, trauma among the youth was correlated with using more substances within the past month ($r = 0.14$; $p = 0.03$), and difficulty following shelter rules ($r_{pb} = 0.22$; $p = 0.00$).

Results of Multivariate Analysis

Results related to the multivariate analysis (see Table 3) for the first aim of the study revealed that difficulty following shelter rules was associated with higher levels of depressive symptomatology ($B = 0.07$, $p < 0.001$), but was found to be associated with lower levels of substance use ($B = -0.09$, $p = 0.004$). More specifically, those who reported having difficulty following shelter rules reported, on average, a depression index score that was 0.07 points higher than those youth who reported not having difficulty following shelter rules. Similarly, those youth who reported having difficulty following shelter rules had, on average, a drug use score that was 0.09 points lower (range = 0–2) than those youth who reported having no difficulty following shelter rules. The results of the multivariate analysis for the first aim of the study also found trauma to be significantly associated with youth substance use in the first model such that for each increase in experience of trauma, there was an average increase of 0.01 points in the youth substance use score (range = 0–2). Trauma was also significantly associated with higher reports of depressive symptoms among youth such that each increase in traumatic events was associated with an average increase CDI index score of 0.01 points (range = 0–2). While the interaction term for depression was not found to be significant, the interaction term for substance use was found to be significant. This interaction effect indicated that while trauma was associated with using more substances, this effect was reduced (or nonexistent) among those who reported having difficulty following shelter rules.

Discussion

While the specifics of the rules are not included in the data or in the analysis, examples of rules that the youth had to follow included curfew times (i.e., time that they had to be back in the building), being accompanied at all times, and signing in and out of the building. Findings revealed that difficulty following shelter rules was associated with higher levels of depression and lower levels of substance use. Difficulty following shelter rules was not found to moderate depressive symptoms, but was found to moderate substance use among youth. More specifically, there was a significant positive association between trauma and substance use among those who reported not having difficulty following shelter rules. Despite the lack of significant moderation findings, given that this is a cross-sectional study, the direct association between difficulty with rules and depression could also indicate a buffering effect of ease with shelter rules that would be better revealed with longitudinal data.

The association between difficulty following shelter rules and depressive symptoms among homeless youth could potentially be explained by the fact that conduct disorders and oppositional defiant disorders have been found to be associated with various facets of mental health (e.g., depression and anxiety), as well as with substance use among youth, which would hinder their ability to comply with the rules (Burke, Hipwell, & Loeber, 2010; Greene et al., 2002; Maughan, Rowe, Messer, Goodman, & Meltzer, 2004). Thus, past literature is aligned with the findings related to youth depression and suggests that they reflect a response to authority rather than a response to a specific rule.

Conversely, those youth who reported having difficulty with shelter rules had lower substance use scores (i.e., used less substances in the past month). One possible explanation for the findings related to substance use is that the shelter rules are effectively preventing youth from engaging in substance use. Data were not available to include the level of enforcement of the rules or level of monitoring and supervision of the youth by shelter staff as a covariate in the model, which could influence substance use behavior among youth. It is possible that those youth who are being more closely monitored have more opportunities to engage with rules that are causing higher levels of depressions and serve as reminders of where they are living, thus causing them further stress and depression.

It is also interesting to note the low levels of substance use (i.e., 12% ever used alcohol or marijuana). This is most likely due to the youth being in their younger years of adolescence (i.e., 11–14 years of age) and not having experimented with substance use yet. It could also imply that this age range would be good to target in future programming related to substance use prevention with youth in shelters. Similarly, it is noteworthy that only 25% of the participants reported having difficulty with the shelter rules. This could be reflective of the overall success that the shelters had in fostering positive governance within the shelters, given that they were all privately run, supportive housing sites.

Strength and Limitations

One of the strengths of this study is that the sampling of participants came from 10 family shelters in New York City, which aided in enhancing the generalizability of the study. Thus,

having a sample drawn from numerous family shelters allowed for the findings to be interpreted more broadly to privately run family shelters in New York City. Another strength of the study is that it focused on homeless youth who were residing with their caregivers, given that much of the literature focuses on homeless youth residing on their own. This is important from the perspective of gaining better understanding of how the experiences of homelessness impact this particular, vulnerable group of individuals. Such understanding can help providers begin to determine what can be done to support caregivers in raising their children during challenging and tumultuous situations such as episodes of homelessness.

Despite its many strengths, this current study has some limitations. Most notably, these findings are a result of a cross-sectional analysis, which makes it impossible to infer causation. More specifically, it cannot be assumed that the instances of trauma preceded the depressive symptoms or substance use. However, this is most likely the case, given that the measures for trauma were captured in the past year, and the measures related to depressive symptoms and substance use were in reference to the past 2 weeks and the past month, respectively. Another limitation of the study also relates to the measurement of the rules within the shelter. Specifically, a more nuanced measurement of the rules was not available, as there was only one item measuring the respondent's difficulty with shelter rules. For example, a list of the rules was not provided to refer to specifically when responding to whether they had difficulty with them. In addition, there was no measurement of mode of enforcement for the rules within the shelter. Both of these can vary considerably, and future research would do well to incorporate such a focus.

Implications for Practice

A social ecology model focuses attention on contexts when critically evaluating behavior. The application of a social ecology framework to substance use among youth in particular suggests that prevention approaches should include interventions effective in improving home and school climate for youth, in addition to improving self-efficacy, school bonding, and peer relations (Kumpfer & Turner, 1990). The findings from this study overall support this model by suggesting a relationship between one facet of the social environment of the shelter (i.e., governance) and psychosocial outcomes.

The findings related to the direct relationship between trauma and both depression and substance use also imply that implementing trauma-informed care in shelters could improve psychosocial outcomes. SAMH-SA conceptualizes a trauma-informed approach as one that “1) *Realizes* the widespread impact of trauma and understands potential paths for recovery; 2) *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system; 3) *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and 4) *Seeks* to actively resist re-traumatization.” (SAMHSA, 2014) Furthermore, a trauma-informed approach can be implemented in a wide range of service settings, including shelters, and is distinct from trauma-specific interventions or treatments that are designed specifically to address the consequences of trauma.

According to SAMHSA, a trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. The six principles are (a)

safety; (b) trustworthiness and transparency; (c) peer support; (d) collaboration and mutuality; (e) empowerment, voice, and choice; and (f) cultural, historical, and gender issues. From SAMH-SA's perspective, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Consistent with SAMHSA's definition of recovery, services and supports that are trauma-informed build on the best evidence available as well as consumer and family engagement, empowerment, and collaboration.

One means of implementing such an approach would be to establish groups within the shelter comprising both staff and residents (including youth) tasked with jointly developing policies and procedures for the shelter. Such groups could change as the residents move in and out of the housing site, and rules could be voted on periodically to ensure that they reflect the opinions of current residents. As mentioned above, one of the main tenets of trauma-informed care is a shift from a typical top-down approach within service provision to one that reflects more shared decision making with regard to organizational policies and procedures. These efforts are potentially of great importance, given that autonomy is deemed critical to the recovery process from trauma as well as to overall emotional well-being (Hopper, Bassuk, & Olivet, 2010). Further research that incorporates both quantitative and qualitative methods should be conducted to better understand the relationship between shelter rules and the mental and emotional well-being of residents. Interventions informed by these findings could then be applied in shelters to address the needs of this growing population.

To this end, the first author has just submitted a grant application for funding to carry out a mixed methods study to assess both quantitatively and qualitatively more specifically how shelter governance impacts psychosocial outcomes for both caregivers and youth. In addition, research aims to identify potential points of intervention to enhance the rules and policies within the shelter in ways that lead to optimal psychosocial outcomes.

Last, the counterintuitive findings related to youth substance use, suggesting that the rules could be successfully preventing youth from engaging in higher levels of substance use, is supported by previous research related to the effect of parental monitoring among housed families (Borawski, Ievers-Landis, Lovegreen, & Trapl, 2003; Li, Feigelman, & Stanton, 2000). Thus, shelter staff should continue to develop ways of monitoring and supervising youth behavior within the shelter and should, more importantly, empower caregivers themselves to monitor and supervise their youth, as enhancing this aspect of family functioning has been shown to reduce substance use among housed youth (Li et al., 2000; Steinberg, Fletcher, & Darling, 1994). Qualitative aspects of this monitoring, however, should be given close attention. It would be important for shelter staff to support caregivers in fostering positive and trusting relationships with their youth in order for these young people to perceive caregiver efforts in a more positive manner, given that relationship building has also been shown to be an integral piece to the success of monitoring and supervision among housed families (Laird, Pettit, Dodge, & Bates, 2003).

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IMPLICATIONS FOR PRACTICE

- Inclusion of trauma-informed care in shelter governance could potentially enhance psychosocial well-being and reduce substance use among youth residing in family shelters.

TABLE 1

Youth Participant Demographics (N = 243)

Demographics	<i>M (SD)</i>	Range
Youth age (years)	12.87 (1.17)	11.01–14.98
Trauma score	6.91 (4.13)	0.00–16.00
CDI score	0.27 (0.26)	0.00–1.29
	%	<i>N</i>
Gender		
Male	52	127
Female	48	116
Race		
White Hispanic	39	94
Black	45	109
Mixed or other	16	40
No. of youth (ages 11–14)		
1	68	166
2 or more	32	77
First time in shelter		
No	48	115
Yes	52	125
Time in shelter		
One week–4 months	60	146
5–7 months	19	47
8–12+ months	21	51
Difficulty with shelter rules		
No	75	181
Yes	25	59
Substance use in past 30 days		
Cigarettes	4	10
Alcohol	8	18
Marijuana	4	10
No. drugs past month		
0	88	196
1	9	20
2	2	5
3	1	2

Note. CDI = Children's Depression Inventory.

TABLE 2

Correlation Matrix

	1	2	3	4	5	6	7	8	9	10	11
1. Trauma	1										
2. CDI	0.10	1									
3. No. drugs past month	0.14*	0.31***	1								
4. First time in shelter	-0.14*	0.08	-0.02	1							
5. Age	0.05	0.05	0.19**		1						
6. Difficulty with shelter rules	0.22***	0.14*	-0.02	0.03	-0.16**	1					
7. Time in shelter	0.04	0.07	0.03	0.17**	-0.16*	0.14*	1				
8. Gender	0.06	0.15*	0.07	-0.11	0.05	-0.06	-0.07	1			
9. White Hispanic	0.02	0.05	-0.01	0.13*	0.07	-0.00	-0.03	0.00	1		
10. Black	0.01	-0.05	-0.03	-0.14*	-0.04	-0.05	0.07	0.00	-0.67***	1	
11. Mixed or other	0.06	-0.10	0.02	0.02	-0.02	0.16	0.02	0.04	0.12	0.07	1

* $p < 0.05$;

** $p < 0.01$;

*** $p < 0.001$.

Table 3

Multivariate Analysis of the Relationship Between Shelter Rules, Trauma, and Psychosocial Outcomes

	Youth depressive symptoms		Youth substance use	
	Model 1 <i>B (SE)</i>	Model 2 <i>B (SE)</i>	Model 1 <i>B (SE)</i>	Model 2 <i>B (SE)</i>
Intercept	0.02 (0.10)	0.03 (0.11)	-0.76 (0.24) **	-0.73 (0.23) **
Age	0.01 (0.01)	0.01 (0.01)	0.07 (0.01) ***	0.06 (0.01) ***
Gender ^a	0.09 (0.02) ***	0.09 (0.02) ***	0.03 (0.04)	0.03 (0.04)
Race ^b				
Black	-0.02 (0.02)	-0.02 (0.02)	0.01 (0.04)	0.00 (0.04)
Mixed or other	-0.10 (0.01) ***	-0.10 (0.01) ***	0.04 (0.02)	0.05 (0.02) *
No. of youth ^c	0.01 (0.03)	0.01 (0.03)	0.02 (0.05)	0.03 (0.05)
First time in shelter ^d	0.06 (0.02) **	0.06 (0.02) **	0.00 (0.03)	0.00 (0.03)
Time in shelter	0.02 (0.01)	0.02 (0.01)	0.01 (0.02)	0.01 (0.02)
Trauma	0.00 (0.00) *	0.01 (0.00)	0.01 (0.01) **	0.02 (0.01) **
Difficulty with shelter rules ^e	0.07 (0.02) ***	0.08 (0.05)	-0.09 (0.03) **	0.06 (0.05)
Trauma × Difficulty with shelter rules		-0.00 (0.01)		-0.02 (0.01) **

^aGender: 0 = male, 1 = female.^bRace categories dummy coded (0 or 1), using “White Hispanic/Latino” as comparison group.^cNumber of youth in each family: 0 = one youth, 1 = two or more youth.^dFirst time in shelter: 0 = no, 1 = yes.^eDifficulty following shelter rules: 0 = no, 1 = yes.* $p < 0.05$,** $p < 0.01$,*** $p < 0.001$.