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Research Article

Eliciting Life Priorities of Older Adults Living in Permanent Supportive Housing

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Abstract

Background and Objectives: Adults who have experienced chronic homelessness are considered to be "old" by age 50 due to accelerated aging. While permanent supportive housing (PSH) has been found effective for these individuals, there is limited focus on the needs of adults "aging in place" in PSH. This study examined (1) how older adults in PSH identify and rank their life priorities, (2) how they describe these priorities in their own words, and (3) how life course adversity deepens an understanding of these priorities.

Research Design and Methods: A convergent parallel mixed methods design was used in which qualitative case study analyses informed by a life course perspective provided a deeper understanding of how 14 older residents of PSH viewed their life priorities using quantitative card-sort rankings of 12 life domains.

Results: Housing, family, mental health, physical health, and partner were the most frequently endorsed life priorities. Four themes emerged from the cross-case analyses: "aging in, aging out," "carefully restoring relationships," "life goes on," and "housing is fundamental." Convergent findings indicated that life adversity—social losses and interrupted lives—influenced both the high- and low-ranked card-sort priorities.

Discussion and Implications: This study demonstrated that participants were aware of their advancing years yet they sought to overcome adversity and losses through maintaining mental health and sobriety, improving physical health, and cautiously rebuilding relationships. As the numbers of older homeless rise, the inclusion of age-related services will be an important component of PSH services for residents as they age.

Keywords: Serious mental illness, Life course perspective, Mixed methods, Homelessness

Recent increases in the number of older homeless adults have been attributed to the Baby Boomer cohort's maturation in combination with a deepening crisis in the availability of affordable housing (Culhane et al., 2019). Sporadic attention to older homeless persons in earlier years (Cohen, 1999) has given way to awareness that their numbers are growing disproportionately and that their needs are distinctly different from those of younger homeless adults as well as from their non-homeless aging counterparts (Ferraro & Shippee, 2009; Sudore et al., 2018). For example, geriatric conditions are present among older homeless adults at rates comparable to their housed counterparts who are 20 years older (Brown et al., 2016). Considered to be "old" at age 50 due to a reduced life span, these individuals are too young for Medicare and other aging services, yet their health and other needs are a poor fit with homeless services

designed for younger clients (Cohen, 1999; Grenier, Barken & McGrath, 2016; Murphy & Eghaneyan, 2018). This experience, known as accelerated aging, refers to the rapid progression of age-related mortality and morbidity, the latter including physical disease, functional limitations, and decreased cognition (Cohen et al., 2018).

Approximately two-thirds of older homeless adults have histories of chronic homelessness and are thus more likely to have had a serious mental illness, history of substance abuse, health problems, and experiences of cumulative adversity beginning in childhood (Ferraro & Shippee, 2009; Padgett, Tran Smith, Henwood, & Tiderington, 2012). For most, being alive is itself a major accomplishment even as accelerated aging is their fate (Henwood, Katz, & Gilmer, 2014).

Permanent supportive housing (PSH) has emerged as an effective and humane option for these individuals (National Academies of Sciences, Engineering, and Medicine, 2018). However, as PSH providers grapple with serving this aging population, they frequently have little training or programmatic latitude to address such needs, including palliative and end-of-life care (Henwood et al., 2014; Hudson et al., 2017). As awareness of the need for aging services in PSH grows, so does the obligation to listen to PSH service users in describing their needs and future goals.

Using a mixed methods convergent parallel design (Creswell & Plano Clark, 2011), we report on life priorities of 14 older adults recently housed in PSH who have experienced chronic homelessness, serious mental illness, and substance abuse. Drawing upon life course and cumulative adversity perspectives (Elder, 1994; Slopen, Koenen, & Kubzanski, 2014), we used an ordinal card-sort technique and qualitative case study analyses to address (1) how these individuals identify and rank their life priorities, (2) how they describe these priorities in their own words, and (3) how life course adversity plays a role in their perspectives on these priorities. Listening to these individuals is an important step in ensuring that PSH support services go beyond a one-size-fits-all-ages approach to address aging in place after having no place.

Chronic Homelessness and Aging

The intersection of homeless chronicity, aging, and PSH—the focus of this paper—requires definitional clarity. First "chronically homeless" adults are defined as persons with a disability who have been living on the streets or in shelters for the previous 12 months or for a total of 12 months over the previous 3 years (Department of Housing and Urban Development [HUD], 2018). The HUD defines PSH "as community-based housing without a designated length of stay in which formerly homeless individuals and families live as independently as possible" (HUD, 2018). Ongoing support services are provided in PSH "appropriate to the needs of the tenants" (National Academies of Sciences, Engineering, and Medicine, 2018, p. 33).

The growing disproportion of persons over age 50 in PSH is due to a convergence of factors. First, the U.S. single adult homeless population in general has become older (Culhane et al., 2019). Second, this demographic transition has been intensified by HUD policies of "vulnerability indexing" that give PSH entry priority to chronically homeless persons with more severe health problems (Henwood, Lahey, Rhoades, Winetrobe, & Wenzel, 2017).

Since age 50 is considered to be the beginning of old age for these individuals, this phenomenon presents a challenge to PSH programs originally designed without reference to the needs of older adults (Henwood et al., 2017; Sudore et al., 2018). These needs—which range from falls prevention to palliative care—typically come under the jurisdiction of local aging programs serving persons in their 70s and 80s and far removed systemically from homeless services programs.

PSH has been considered responsible for a 27% decrease in chronic homelessness since 2007 along with substantial cost savings via reduced hospitalizations and jail stays (National Alliance to End Homelessness, n.d.). Chung and coworkers (2018) found that older residents benefited more from PSH than their younger (age 18–49) counterparts in mental health status and quality of life. Such gains associated with housing stability risk being undermined by support services unable to keep pace with the growth in the numbers of PSH tenants experiencing accelerated aging (Baggett et al., 2013).

Normative Aging and Homeless Services

The life course perspective provides a framework for examining the "timing of lives" based upon normative expectations (Elder, 1994, p. 6). In this context, the lives of older adults living in PSH represent a multi-faceted deviation from the idealized scenario of middle-class aging, for example, retirement, leisure time spent with family, and the pursuit of hobbies and travel. Already having endured the ordeals of being homeless, the addition of serious mental illness and substance abuse adds to the detrimental effects of cumulative adversity (Ferraro & Shippee, 2009) and accelerated aging. In applying a life course perspective to this population, an earlier study noted that these men and women enter their later years "out of sync," having missed normative milestones (college education, job or career, marriage, parenting) and encountering old age with the long-term effects of severe poverty and depleted social networks (Shibusawa & Padgett, 2009).

While each life course trajectory is unique, a pattern has been found for this group in which substance use/abuse begins with early adolescent exposure in poverty-ridden environments, followed by late-adolescent onset of serious mental illness, followed by episodes of homelessness (Padgett et al., 2012). Health problems can arise from any of these antecedents and their effects are compounded by lack of access to medical care (Baggett et al., 2013; Doran & Raven, 2018).

The relevance of these observations for aging in place comes into focus when considering not only current health needs but projecting such needs into the future (i.e., reduced mobility, social isolation, and palliative care). PSH support services typically include treatment and referrals for health, mental health, and substance abuse problems, job training, and social activities (National Academies of Sciences, Engineering, and Medicine, 2018). Without attention to the effects of premature aging, these services may be missing the mark or at the least falling well short.

Methods

A convergent parallel mixed method design was used (Creswell & Plano Clark, 2011) in which quantitative analyses of card-sort rankings by participants were followed by independently and consensually selecting quotations to illustrate the "thinking aloud" that accompanied the rankings. Next, we conducted cross-case analyses drawing upon the life course perspective to add temporal depth to understanding the quantitative findings.

Sample

Fourteen older participants were selected from a larger sample of 38 participants in the New York Recovery Study (NYRS), an 18-month longitudinal qualitative study of formerly homeless adults recently placed into one of two PSH programs (Padgett, Tiderington, Tran Smith, Derejko, & Henwood, 2016). NYRS participants had to have a prior diagnosis of serious mental illness (schizophrenia, bipolar disorder, or major depression) and a history of co-occurring substance abuse. Inclusion criteria for this study sample targeted the subset of all NYRS participants 48 years of age or older at baseline who completed all four in-depth interviews (baseline, 6 months, 12 months, and 18 months). These interviews were audio-recorded and transcribed verbatim. We chose participants aged 48 and older to include those who were on the cusp of older adulthood as well as those who had already entered it as of age 50 (Cohen, 1999).

Card-Sort Data Collection

Card-sort techniques have frequently been used to elicit preferences and priorities (Rugg & McGeorge, 2005). This study used an ordinal card-sorting technique, which allows for the ranking of preferences without needing to identify the degree to which one is preferred over the other (Ali & Ronaldson, 2012). Ordinal card-sort techniques offer the benefit of straightforward administration and require less abstract reasoning than other sorting methods (Ali & Ronaldson, 2012).

As part of the 18-month interview, participants were asked to complete the card-sort exercise to assess their life priorities in 12 domains: physical health, mental health, substance abuse, partner, friends, family, PSH program, work, school, hobbies, housing, and neighborhood. The rationale for these domains was that they represented different facets of mental health recovery (Whitley & Drake, 2010). Thus, having a partner, family, and friends were considered social dimensions of recovery; work, school, and hobbies were vocational dimensions; physical health, mental health, substance abuse, and PSH program were program or treatment-related domains; and housing and neighborhood quality were environmental domains.

Each participant was given 12 laminated cards and asked to endorse those deemed important, then rank the selected domains with regard to how important they were. While doing so, participants were asked to explain their reasoning using a "Think Aloud" method (Choy-Brown, Padgett, Tran Smith, & Tiderington, 2016; Fonteyn, Kuipers, & Grobe, 1993). Interviewers asked open ended questions including "Can you tell me about these topics and why you put them in this order? What makes this [name of domain] important? What made you leave these cards out?" Responses were audio recorded and subsequently transcribed and entered into ATLAS/ti for data analysis.

Qualitative Data for Case Study Analyses

As mentioned above, participants were interviewed over a period of 18 months with each interview focusing on mental health status, substance use, social supports, housing stability, and physical health status. While interviews typically lasted 45–90 min, the baseline interview was approximately 30 min longer to ensure capturing the participant's life history prior to entering the PSH program.

For the case study analyses, the transcripts were reviewed independently by the first and second author along with the interviewer feedback forms (observations of the participant completed within 24 hr after each interview) and case study matrices summarizing the life course experiences of each participant including onset and treatment of mental illness, substance abuse episodes, family and partner relationships, incarcerations, physical health problems, traumatic experiences, and housing history. As with the interview transcripts, the interview feedback forms and case study matrices were derived from the earlier parent study.

Data Analysis

The first research question was addressed by use of descriptive statistics calculated for the frequency that each domain was endorsed as the top priority, within the top three, and ranked versus not ranked at all. The emphasis on "top three" priorities is in keeping with previous card-sort studies showing that reliability is eroded after the first few rankings are made (Rugg & McGeorge, 2005).

For the second research question, the co-authors examined each participant's top three priorities and returned to the interview transcript to independently then consensually select representative quotes describing why and how each priority was ranked. The last stage of the data analyses—corresponding to the third research question—entailed in-depth case study analyses of each of the 14 participants and cross-case thematic analyses. According to Stake (1995), cross-case thematic analyses are used to identify commonalities and interpret themes. The purpose of these analyses was to identify life course perspectives that could expand understanding of the priority rankings in the context of aging in PSH.

Following a prior study that examined a similar population (Shibusawa & Padgett, 2009), the principle areas of the life course approach found to be relevant were normative and non-normative life transitions (the "timing of lives") and social relationships ("linked or interdependent lives") (Elder, 1994, p. 5). We took note of normative expectations (life transitions such as marriage, parenting, higher education, job) as well as social relationships over the life span. In this manner, normative transitions and social relationships constituted "sensitizing concepts" (Charmaz, 2006) but did not preclude other themes from being identified during the analyses across cases.

Following case study analyses prescribed by Stake (1995), the researchers independently read the interview transcripts, interview feedback forms, and case study matrices and then recorded analytic memos documenting patterns in the life courses of the participants. Using repeated meetings and discussion, the researchers consensually found four salient themes in the data with no new themes emerging and saturation reached. These themes had the most "grab" (Charmaz, 2006) within the data and offered a deeper understanding of the priority rankings.

Findings

Card-Sort Priorities

Table 1 shows that members of the sample had an average age of 53 years (*SD* = 5.26) and were primarily African American (86%) and male (86%). Their previous homelessness experiences ranged from 0 to 204 months in length, with an average length of homelessness of 52.86 months (*SD* = 68.31). The participant with 0 months of homelessness spent much of his adult life in prison and was placed in PSH to prevent imminent homelessness.

Table 1 also shows the top three priorities for each participant as identified during the card-sort activity (all names are pseudonyms). As shown, participants endorsed a variety of domains as a top priority, with mental health, family, and partner most common.

Table 2 presents the frequency that each domain was endorsed by participants as first priority, within the top three priorities, and ranked at all. Within the top three, housing situation (57%), physical health (43%),

Table 1. Characteristics of Study Participants and Top Three Priorities

Name (pseudonym)	Sex	Race/ethnicity	Age	# children	Months lifetime homeless	#1 Priority	#2 Priority	#3 Priority
Carl	Male	African American	48	1	8	Mental health	Physical health	Housing
Juan	Male	Latino	48	0	2	Family	Neighborhood	Friends
Stephen	Male	African American	48	0	24	Partner	Housing	Program
Sheldon	Male	African American	49	2	72	Family	Neighborhood	Housing
Walter	Male	African American	51	4	24	Partner	Program	Family
George	Male	African American	50	2	12	Substance use	Physical health	Mental health
Harlan	Male	African American	51	0	36	Housing	Family	Partner
Edwin	Male	African American	51	0	4	Partner	Housing	Physical health
Jane	Female	White	52	2	54	Physical health	Mental health	Partner
Serena	Female	African American	52	6	204	Family	Partner	Program
Brian	Male	African American	57	1	72	Housing	Substance use	Work
Darren	Male	African American	60	2	24	Substance use	Program	School
Nathan	Male	African American	62	2	0	Mental health	Physical health	Housing
Wally	Male	African American	63	0	204	Mental health	Physical health	Housing

Table 2. Participant Card-Sort Rankings

	Ranked 1st		Ranked Top 3		Ranked at all	
Domains	*N*	%	*N*	%	*N*	% (Ranking)
Partner	3	21	6	43	10	71 (6)
Mental Health	3	21	5	36	14	100 (1)
Family	3	21	4	29	10	71 (6)
Housing Situation	2	14	8	57	12	86 (3)
Substance Use	2	14	3	21	9	57 (12)
Physical Health	1	7	6	43	13	93 (2)
Program	0	0	4	29	9	64 (10)
Neighborhood	0	0	2	14	11	79 (4)
Friends	0	0	1	8	11	79 (4)
School	0	0	1	7	8	67 (9)
Work	0	0	1	7	6	43 (11)
Hobbies	0	0	0	0	10	71 (6)

and partner (43%) were the most frequently endorsed priorities. We note that every need/priority domain was endorsed and ranked by at least one participant, but mental health was the only domain unanimously endorsed. Overall, a large majority of participants ranked physical health (93%) and housing situation (86%) as important in their lives, if not a top three priority.

Talking About Priorities

In addition to identifying priorities, participants were encouraged to explain their choices as part of the "Think Aloud" process during the original card-sort interviews. While endorsing physical health as a priority, participants reported a variety of health problems including diabetes, arthritis, Hepatitis C, and asthma. They also wanted to be more active and physically fit. Comments made included: "…think if I start working out and live a healthier…life…I can repair it, live a long time" (Edwin). Carl stated, "I'd like to be able to walk around and not have to limp or huff and puff to breathe so that's important."

Participants reflected on the hoped-for permanency of their housing, stating "[m]y housing situation is stable, and I like where I am at. Hopefully I can stay there for a while." (Stephen). Others described PSH as a stepping stone, "I'm not going to stay here for the rest of my life. Eventually I want to end up moving out on my own" (Edwin). One participant stated "…housing to me goes hand in hand with peace of mind." (Carl).

Having a life partner was ranked in the top three priorities by 43% of participants and 71% ranked it as a priority at all. Serena, whose partner lived in a nearby men's shelter, stated, "…he's a good listener. It's good to have a partner whether it's male or female. Someone you can talk to. It could be your outlet." Jane noted the troubled status of her common-law marriage to an abusive husband of over 20 years: "My partner is important, but only when he's doing the right things."

Only two of the men claimed to have a partner at the 18-month interview, and, for most, the inclusion and ranking of this life priority were largely in aspirational terms. As Stephen explained, "I need somebody I miss, somebody I want back in my life." Edwin described his ideal partner, "I'd like to find a partner that's probably a former drug addict herself, that understands and can really relate to everything I've been through…".

Mental health was endorsed by all 14 participants. As George stated, mental health is important to "keep it steady…on a steady level…where I don't end up in a mental institution...". Carl noted that mental health is "… the cornerstone. You have to be cognitive as to what's going on with you." At the same time, we note that mental health was ranked only 36% of the time within their top three priorities.

It is noteworthy that some priorities—program, work, school, friends, and neighborhood—received fewer endorsements. In the following section, we seek a deeper understanding of these findings.

Case Study Findings

Our cross-case analysis revealed four themes: aging out, aging in; carefully restoring relationships; life goes on; and housing is fundamental. These are described below along with quotations illustrating their significance to participants.

Aging out, aging in

Participants described their experiences of "aging out" of acute mental health and substance abuse problems while "aging in" to concerns about health and premature mortality. Juan said he was "taking my medication, when I'm supposed to take it and I don't [go] looking for trouble." Wally reported still hearing voices but said he had learned how to minimize their impact, saying, "I don't pay 'em [the voices] no mind, and that's the best thing to do... Sometimes

I talk back to 'em, you know, tell 'em to get away from me…" Carl, who had a previous suicide attempt after the death of his mother and multiple hospitalizations, finally felt as though things were moving forward. He explained, "I'm doing a whole lot better, not where I want to be but as a whole you know…[better] than how I was and where I was, both mentally and physically."

Participants reflected on "aging out" of other problems besides serious mental illness. Serena felt that she could no longer pursue criminal behavior,

> I got tired of going to jail. It got so embarrassing. Especially when…your hair is turning gray, and it's like, embarrassing. I was like … I'm too old for this. I'll be 55. I can't be going to jail.

Also common were participants' descriptions of ending their substance abuse as they grew older. After years of drug use starting at the age of 12, Walter explained his sudden decision to stop smoking crack: "I just stopped. …the day I came to New York, I had a [crack pipe] stem in my pocket, I took my last hit in a gas station…and I haven't smoked since."

Brian, who began drinking at age 7, explained his commitment to sobriety, "As soon as I become 60, I am going to have a party, a clean and sober party, if I make it to be 60." Sheldon wanted to gradually end his methadone maintenance dependence, "…I am going to start getting my doses down…, and just be living a normal life, and just deal with the illnesses that I got to deal with you know."

Sheldon's invocation of physical illness as a priority was repeated by other participants who acknowledged they were entering a phase of life where health was paramount. Reflecting on decades of heavy drinking, Brian said,

> I got a gym card. I work out. …but the worst is yet to come, 'cause as I get old, arthritis is gonna set in... You wanna really know the real truth? I wanna live to be 60. … Twenty years ago somebody told me, '…if you stop drinking now you got a chance.' I wish I would've listened. That's where the stomach problems come in.

Darren was concerned about injuries, as he had recently fallen in his bathtub and fractured several bones in his foot. He said "[the fractures are healing] slowly… Before I couldn't walk that well. I can walk much better, but I still have difficulty …"

Carefully restoring relationships

Participants acknowledged a desire to develop new and restore old social relationships, but they also recognized that some relationships were problematic. The social losses accumulated by participants were substantial and rebuilding family relationships was a priority for many. Stephen's mother died shortly after his birth and the later deaths of both of his brothers made family all the more important to him as he sought to reunite with his sister and her family:

> I told my sister the other day to make sure you call them up and give them my number and have them call me. …I want to see my nieces and nephews. I don't care if they don't like me… I need to see them.

Restoring relationships with family members was often contingent on making life changes and finding new ways to get along. Caution was preferred by Wally, who explained that while he was in touch with his family, he "love[s] 'em from a distance." Brian explained, "I get along with my family… [but] I can't go to their house 'cause they use drugs."

Serena, who reported long periods of incarceration throughout her adult life, had lost custody of her children. She explained, "I have four sons and two daughters… The three oldest I don't really have too much correspondence with and that was because of my drug use and going to jail." Walter had a similar experience stating, "I stayed in jail, numerous times…I lost my kids… My daughter, she's real upset with me, she don't talk to me no more."

In contrast to repairing family ties, making friends and finding a partner were viewed with more caution. Nathan said, "I don't really have many friends right now because people I know either want to smoke marijuana or drink at the minimum… I can't do neither one." Sheldon said "I don't go out with any guys…keep it just like that. I can barely take care of myself. I can't take care of anybody else right now."

Similarly, although it was ranked as a priority, finding a partner was deferred to the future (if at all). Harlan's previous marriage and subsequent divorce left him open to, but not actively seeking, future relationships. He explained, "… I'm not gonna chase after it… if the Lord sees fit … okay. But I'm not going out there looking for nobody, you know." Sheldon had similar views, saying, "[a relationship] is not even close to my mind now. I have been through so much all of that junk over the years...it is a waste of time."

Some participants reported that their support networks had been depleted through untimely deaths. When asked about his seven siblings, Walter stated, "They [all] died of natural causes, AIDS, car crash, murdered." Brian's family losses started at age 7, with the accidental death of his 5-year-old brother while under his care. He added, "No one in my family ever lived to be 66. My immediate family, my mother, father, brothers, I have 18 brothers and sisters. … no one in my family ever lived."

Life goes on

This theme captures participants' cautious optimism about their prospects for the future after so many years of hardship. Normative goals such as finding a job and going to school were discussed but physical health limitations and non-normative life transitions (lack of education or work experience) were also acknowledged.

Participants spoke of the importance of living a healthy lifestyle and engaging in meaningful activities while

remaining cognizant of their age. Wally stated, "I do like to run, and I like to walk. I try to stay fit, much fitter, but I [will] be 65 … I ain't 16 you know?" Serena longed for the freedom that came with owning a car, saying, "Hopefully, one day I get a car. Hopefully before I'm sixty. God willing.".

Other participants had educational and employment goals. Juan said "I want to get a GED…". Nathan said: "I am thinking about … college and finishing my degree… I don't know if I will be able to do that." Participants recognized their limitations in a competitive job market. Wally wanted to return to his job as a golf caddy, "I'm an older guy, …ain't nobody hiring no 63 [year old] but I know about golf, so I may just go …and see if I can caddy." George explained his desire to become a chef, "… where I should be coming close to retiring, I have to go and look for employment (laughs). So, I like cooking, that's what I'd like to do." However, he also noted his own limitations: "… I ain't trying to work full time, you know. I'm not ready for that yet." Sheldon said that his physical limitations and the lack of a high school diploma hindered reentering the workforce, "I can't work, nobody will hire me. …I never worked in like an office desk … never did that in my whole life."

Housing is fundamental

Participants viewed their housing status as fundamental to their future but the PSH program type differentiated their responses. Those in the PSH program with multiple rules and requirements expressed hope in making the "final step" into their own apartment. For participants in the low-barrier "housing first" program, having their own private apartment was a stabilizing force that they hoped to retain for the long term.

Having to live with roommates was problematic for Harlan who stated: "I'd rather have an apartment by myself. … you've got privacy! You don't have nobody messin' with your stuff." Juan simply stated, "I'd prefer living alone." Wally spent over 10 years in prison and a year in the shelter system and wanted to be on his own, "I need to be independent …I'm ready to live on my own …because I have to be responsible, you know?" Sheldon echoed this, saying, "I want to …get my own place, take care of my own bills."

Those living in housing first units expressed more contentment and a sense of security. Serena stated, "I have a key to turn and I'm on my own. I got my mailbox. I get mail addressed to me. I feel more important. I feel um, exuberant… I feel like I'm doing something." Others noted that having their own apartment was a first in their lives. George said, "[a]t the age of 50, I just started living again …because I wasn't living before. I was just existing. You know…I'm in love with my apartment." Jane's many periods of life instability, including 4 years in adolescent inpatient treatment, 3½ years in federal prison, and 14 months in the shelter system, made her transition a defining moment. She said, "My house is a home. It is not just somewhere I lay my head."

Juxtaposition of priorities and thematic findings

In this final stage of analysis, we examined the qualitative themes and quotations as a means of adding temporal depth and deeper understanding of life priorities as ranked by the participants. In juxtaposing the five top priorities (the most frequently first-ranked and most frequently top three ranked) with the case study themes, we note concordance in prioritizing mental health, physical health, family, partner, and housing situation. However, there was also some discordance, that is, the absence of work, school, and substance abuse in the top rankings despite their presence in the case study themes. The desire to return to work and school was part of "life goes on" but closer scrutiny revealed that participants qualified these aspirations by acknowledging their limited employment and educational histories. Similarly, controlling their substance abuse was part of "aging out" but not prioritized because participants had more immediate concerns such as "aging in" to physical health problems. The greater emphasis on mental health vis-à-vis substance abuse—when examined in the context of participants' life trajectories—revealed that avoiding drugs and alcohol was more easily managed in old age compared to an ongoing concern about emotional instability that lingered long after the more disruptive symptoms of psychosis had receded. A deeper meaning of physical health as a priority can be seen in their interviews where they spoke candidly of age-related health problems but balanced this with expressed hopes for attaining a healthier lifestyle ("life goes on").

Participants described family and partner relationships as important but viewed having friends as a lesser priority. Yet all forms of social relationships were considered as warranting caution. The ambivalence evident in "carefully restoring relationships" was a product of the years participants spent estranged and separated from family members, including their own children. Similarly, while having a partner was strongly endorsed as a priority, the case study analyses revealed that this was more a cautious aspiration than an immediate goal.

While the housing domain in the card-sort drew out concerns with keeping one's apartment or longing for an independent apartment, the 'housing is fundamental' theme provided a detailed articulation of the importance of having a home after long periods of homelessness. Indeed, housing instability and poverty were common refrains throughout their life course beginning in childhood. Having one's own home with the autonomy and privacy of living "normally" was, for many, a new life experience.

Discussion and Implications

This mixed method study used qualitative case study analyses to afford a deeper understanding of how older persons in PSH viewed their life priorities while "aging in place." From the case study analyses, we note that nonnormative life transitions and estranged social relationships

were affirmed as critical to understanding the effects of life adversity and social isolation. Missing out on higher education, marriage plus stable parenting, and gainful employment meant a depletion of human capital that trailed participants into later adulthood, making it difficult to succeed as "life goes on." Meanwhile, long stretches of substance abuse and struggles with serious mental illness had begun to recede in importance. Participants aged out of these problems while "aging in" to a greater awareness of their mortality and the need to preserve their health. While previous research has reported on the prevalence of geriatric conditions in older adults living in PSH (Brown et al., 2015; Henwood et al., 2014), our findings explore in depth the ways in which these individuals self-identify and prioritize their needs more broadly.

Our participants were aware of their advancing years yet had a cautiously optimistic appraisal of their prospects for the future. This meant avoiding some things, including drug-using friends or family members, and pursuing new (or renewed) interests in improving their physical health, restoring positive social relationships, and seeking part-time work. Similar to previous findings (Shibusawa & Padgett, 2009), participants were aware that normative aging transitions such as retirement and leisure time had eluded them just as normative transitions in earlier life had been interrupted. In adjusting to life in PSH, they sought incremental improvements—exercise to increase mobility, reaching out to their children (especially if allowed to have them visit their apartment), entering or reentering the workforce, or tapering off of methadone.

This study has a few limitations. First, we acknowledge that our sample was drawn from a parent study in which aging, and its effects, were not central components. While the interviewers asked about health and well-being, they did not explicitly ask participants about the services they might need as they age. Second, it is possible that social desirability bias affected how participants ranked their priorities. Finally, diversity within the sample in life experiences and current living situation may underlie differences in priorities and experiences that were not explicitly addressed. Study strengths include its mixed methods design making use of innovative data sources such as card sorts and the incorporation of a life course perspective guiding analyses and interpretations. The study also made use of multiple strategies for rigor, including prolonged engagement via multiple interviews over 18 months, multiple sources of data for case study analyses, and independent then consensual cross-case thematic analyses (Padgett, 2017).

The cumulative effects of life adversity and losses in human and social capital point to complex needs for aging adults living in PSH (Padgett et al., 2016). While PSH programs provide housing and basic support services, the inclusion of age-related services—preventing falls, supporting activities of daily living, and offering access to palliative and hospice care—would greatly enhance the quality of life of persons as they age in place. Our findings also show the significance of social relationships even as participants longed to live independently and embark on such relationships with caution.

Policy and organizational changes are needed to ensure adequate funding and staff training (or re-training) for geriatric care in PSH. For example, innovative home-based assistance programs developed specifically for low-income elders (Szanton, Leff, Wolff, Roberts, & Gitlin, 2016) show promise for adaptation in PSH where interprofessional teams might work with existing support services. Such assistance is cost-effective as it prevents unnecessary injuries, emergency room visits, hospitalizations, and nursing home placements (Culhane et al., 2019). As the number of older adults experiencing homelessness is expected to grow dramatically over the next 15 years, the need for PSH—and aging services—will expand accordingly (Culhane et al., 2019).

Having survived life course adversity followed by accelerated aging, our study participants were committed to maintaining their stability and moving beyond losses to focus on gains, however incremental. PSH is a stable platform for achieving these goals. With the addition of age-related accommodations, such housing can make aging in place a safer, healthier experience.

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Conflict of Interest

None reported.

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