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Life Goals Over Time Among Homeless Adults in Permanent Supportive Housing

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Abstract

Permanent supportive housing (PSH) is a widely-accepted solution to the challenge of chronic homelessness. While housing support and retention, physical health, and healthcare continue to be important for formerly homeless persons in PSH, “higher-order” and humanistic needs such as thriving have received less attention and as a result are less well understood in this population. One important indicator of thriving is the ability to establish and articulate life goals. This study utilizes longitudinal data from 421 formerly homeless adults prior to their move into PSH, and at 3-, 6- and 12-months after move-in (369 respondents completed all four interviews), to examine what life goals are articulated by this population and how those goals change over time. Prior to housing, most respondents articulated housing attainment as their primary life goal, whereas at follow-up interviews health goals, housing relocation, and financial goals became more prevalent. Aspirational goals (e.g., independence, self-improvement, artistic pursuits) were also common, but demonstrated a decrease over time in housing. Relationship goals remained common and consistent over time. Findings indicate that housing is a necessary, but perhaps not sufficient, step for improving thriving among formerly homeless adults. Implications for practice and future research are discussed.

Keywords

Homelessness; Permanent Supportive Housing; Life Goals; Thriving

Introduction

Permanent Supportive Housing

As a matter of federal policy for the past decade, the nation has prioritized the provision of non-temporary housing coupled with supportive services – permanent supportive housing (PSH) -- as a solution to the troubling and persistent challenge of chronic homelessness (Byrne et al., 2014; National Alliance to End Homelessness, 2016; Rog et al., 2014, Smelson et al., 2016). A principal metric of success in this strategy to address homelessness, and the charge to local entities seeking federal support to address chronic homelessness in

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their jurisdictions, has therefore been the retention of these formerly homeless persons in housing. Providing PSH and maintaining persons in housing is an important objective, as experiencing homelessness is associated with higher levels of morbidity and mortality as well as utilization of high-cost acute health care and other services (Fazel, Geddes & Kushel, 2014; Hwang & Burns, 2014; Gulcur, Stefancic, Shinn, Tsemberis & Fischer, 2003).

Beyond Housing: The Need to Understand Thriving for Formerly Homeless Persons

While housing support and retention, health, and healthcare access continue to be important for formerly homeless persons, “higher-order” and humanistic needs such as thriving (Feeney & Collins, 2014) have received far less attention and emphasis in this population. Hopper (2012) issued a caution against the use of housing as a means of warehousing persons experiencing homelessness, a process antithetical to the right of every human being to realize his or her potential -- this caution underlines the relevance of focusing on and promoting thriving. Emerging research with formerly homeless persons in community psychology has begun to address this concern by emphasizing the importance of psychological integration (Ecker & Aubry, 2016), sexual and romantic intimacy (Ecker, Cherner, Rae & Czechowski, 2017), and centering client voices (Pruitt et al., 2018), though the concept of “thriving” has yet to gain significant traction in the published literature with this population. Recent findings that compassion for persons experiencing homelessness have increased among the public in the past two decades (Tsai et al., 2017) suggest that efforts to promote thriving and greater life fulfillment among formerly homeless persons may now be met with improved understanding and acceptance.

Moving into permanent housing after experiencing homelessness represents an important time of transition, and obtaining housing may enable persons to subsequently pursue non-subsistence-focused, aspirational needs. As Henwood, Derejko, Couture and Padgett (2015) hypothesize utilizing Maslow’s theory of hierarchy of needs, formerly homeless persons in permanent housing will have a better chance of thriving than those without permanent housing, given that meeting basic needs is, in Maslow’s theory, a prerequisite for subsequent pursuance of a fulfilling life and other higher-order needs.

What is Thriving?

In the past two decades, a growing body of research and evidence demonstrates that subjective wellbeing can and should be measured as part of a comprehensive understanding of quality of life (OECD, 2013). Feeney and Collins (2014) provide a conceptual paradigm for understanding thriving as a measure of subjective wellbeing, proposing a model comprised of five components: hedonic wellbeing (e.g., subjective life satisfaction, quality of life), eudaimonic wellbeing (e.g., meaning and purpose, moving toward meaningful life goals), psychological wellbeing, social wellbeing, and physical wellbeing.

Research has shown that providing low-barrier housing with services for persons experiencing homelessness has been associated with increased hedonic wellbeing – operationalized most commonly as quality of life (Aubry et al., 2015; Bean, Shafer & Glennon, 2013; Chung et al., 2017; Henwood, Matejkowski, Stefancic & Lukens, 2014; Patterson et al., 2013), as well as improvements in social wellbeing (Henwood et al., 2015;

Henwood et al., 2017a), and better physical health outcomes (Crisanti, et al., 2017; Fitzpatrick-Lewis et al., 2011; Russolillo, Patterson, McCandless, Moniruzzaman & Somers, 2014; Sadowski, Kee, VanderWeele & Buchanan, 2009). Psychological wellbeing has also been fairly extensively studied among homeless persons moving into permanent housing, although findings as to whether housing improves mental health outcomes have been mixed (Benston, 2015; Crisanti, et al., 2017; Brown, Jason, Malone, Srebnik, & Sylla, 2016; Chung et al., 2017). However, among the components of thriving conceptualized by Feeney and Collins, eudaimonic wellbeing, which includes a central aspect of meaningful life goals, is largely absent from the literature on outcomes among persons who are living in permanent supportive housing.

Permanent Supportive Housing and Eudaimonic Wellbeing: Life Goals

While the literature cited above provides evidence of a growing understanding of wellbeing and quality of life as important for persons experiencing homelessness and permanent supportive housing, there remains limited research regarding eudaimonic concepts of thriving (e.g., both the articulation of meaningful life goals and the ability to pursue such goals) in this population, although these have been identified as cornerstones in the recovery movement that has been the impetus for mental health service transformation (New Freedom Commission; 2003; Anthony, 1993).

Several studies have examined the presence of meaningful life goals as outcomes among persons who are currently experiencing homelessness, including among youth (Usborne, Lydon & Taylor, 2009), mothers (Tischler, & Vostanis, 2007), and adults utilizing homeless shelters (Laan et al, 2017; Schwend, Cluskey & Cordell, 2015). Additionally, one previous publication examined life goals of homeless men and women just before they transitioned into permanent supportive housing (Bird, Rhoades, Lahey, Cederbaum & Wenzel, 2017).

To our knowledge, however, only one study has examined life goals among currently-housed, formerly homeless persons: Henwood et al.'s qualitative study of 63 persons experiencing homelessness and serious mental illness (SMI) who were entering either Housing First or treatment first programs (2015). While hypothesizing that housing would provide a platform for the articulation of higher-order life goals in the specific context of SMI recovery, Henwood et al. found that there was not a straightforward path between meeting basic needs and the subsequent ability to pursue higher-order goals.

Study Purpose

The current study collected large-scale longitudinal data on major life goals as articulated by persons experiencing homelessness prior to moving into PSH, and at several time points over their first year in PSH, building on earlier studies that described goals among persons while experiencing homelessness. Expanding on Henwood et al.'s qualitative exploration of goals, we utilize quantitative analysis techniques, adjusting for individual demographic characteristics that may affect life goals, to explore how the formulation and achievement of important life goals changes over time as formerly homeless persons transition to and reside in PSH. This study is necessary to more fully understand the experiences of persons living in

PSH, and to ensure that programs are best meeting the range of potential needs and aspirations of this population and can support opportunities to thrive,

Although it seems reasonable to expect that housing attainment may provide a platform for enabling persons to pursue higher-order or aspirational life goals, as Henwood et al. (2015) identified, this progression may not occur in the expected, step-wise fashion. As such, we aim to understand and contextualize the life goals of formerly homeless persons during their first year in PSH. Toward this end, this paper will explain the following:

1. The types of life goals articulated by homeless adults prior to and during their first year living in PSH.
2. How these life goals change over time in PSH.
3. How formerly homeless adults describe the impact of housing on their life goals.
4. What needs are articulated by formerly homeless adults in PSH to help them effectively meet their life goals.
5. And finally, because changes in life goals among persons in PSH (#2, above) may indicate changing needs for services to help persons reach these goals (#4, above), this paper will discuss services and programmatic suggestions to best meet these needs.

Methods

Study

This study draws from a sample of homeless adults who moved into permanent supportive housing in Los Angeles between August 2014 and January 2016. The research team partnered with 26 housing providers in Los Angeles to recruit participants moving into housing via agency referrals and direct recruitment at lease-up events. Chronically homeless adults are placed in PSH in LA County through the Coordinated Entry System (CES) with the aid of a housing or social service agency staff member. The CES uses the Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT) and then matches clients to available PSH units, prioritizing the most vulnerable, based on VI-SPDAT score and housing voucher type (United Way of Greater Los Angeles, n.d.). Clients have higher VI-SPDAT scores if they report a chronic health condition, physical or mental disability, being HIV-positive, and/or substance abuse (United Way of Greater Los Angeles, 2016).

Participants in this study recruited at baseline (N=421) were very similar to all individuals age 39 or older without dependent children who were entered into the Los Angeles County Homeless Management Information System (HMIS) within the Los Angeles Continuum of Care during the same time period as study recruitment. The age and race/ethnicity distributions of both samples were nearly identical; however, our sample was 27.8% women, whereas the County HMIS reflects a higher proportion (33.4%) of women (LAHSA, 2016).

Participants were initially screened for eligibility via phone or in person. Participants were eligible for the longitudinal study if they were 39 years old or older (turning 40 during the year of participation in the study), spoke English or Spanish, and were considered currently

homeless unaccompanied adults (without minor children). These data were collected as part of a larger longitudinal study examining changes in HIV risk behavior over time; as such, the age and non-parenting requirements were implemented to maximize our ability to detect changes in HIV risk outcomes by minimizing variability due to developmental life stage or current parenting status. An additional eligibility criterion required a confirmation by agency personnel that the participant moved into PSH within 20 miles of downtown Los Angeles. Due to the substantial number of homeless adults who moved into permanent housing in a neighboring city, Long Beach, an exception was made to include participants moving into this geographic region if it exceeded the 20-mile radius.

Prior to their participation, homeless adults completed the signed informed consent process in English or Spanish. Participants were interviewed prior to or within 5-days of PSH move in and at three months after their interview (additional data collected at 6- and 12-months post move-in are not analyzed in this paper). Each interview was administered by a trained study interviewer and took between 1 and 1.5 hours to complete. At baseline, 421 persons were enrolled in the study, with 405 completing 3-month interviews (96.2% retention), 400 completing 6-month interviews (95.0% retention), and 383 completing 12-month interviews (91% retention). Reasons for loss at each time point included death, incarceration, withdrawal, and loss of contact. Persons not interviewed at any survey mid-point were still eligible for completing later interviews (excluding those persons who passed away or withdrew from the study). Analyses in this sample include only persons who completed all four study time points (n=369). All study procedures were approved by the authors' university's institutional review board. Additionally, the study received a certificate of confidentiality from the U.S. Department of Health and Human Services to protect participant data from subpoena.

Measures

Participant demographic characteristics (age, gender, race and ethnicity, achievement of high school education or GED, and whether the respondent has children) were assessed using items adopted or adapted from previous research (CITATIONS BLINDED FOR REVIEW). Because of our interest in life goals among persons moving into PSH and the lack of existing quantitative measures to assess this outcome, we chose to ask short, open-ended questions about goals at the end of each quantitative interview. At each time point, the interview ended with an open-ended qualitative question asking participants to briefly describe their life goals ("Tell me in a sentence or two, what is your most important goal in life right now?"). At the 12-month interview, respondents were asked two additional open-ended questions about life goals: 1. "What is the most important thing you need to help you reach that goal?" and, 2. "How have your life goals changed since you first moved into housing about 12 months ago?" Trained interviewers were instructed to record all open-ended responses verbatim.

Analysis

All short-answer, open-ended responses were coded using a directed content analysis approach (Hsieh & Shannon, 2005), wherein open-ended responses were reviewed and specific and general themes were identified (Padgett, 2008; Seidman, 1998). While

expecting we would see certain categories during in these analyses (housing, health, social relationships, etc.), all responses were inductively coded and additional thematic categories arose and were coded during the process. For purposes of data reduction, these themes were operationalized as a series of specific variables quantifying life goals (e.g., health, mental health, financial goals), goals changes (e.g., no change, evolving goals), and resources needed for meeting goals (e.g., personal effort, money). This approach was undertaken because of a lack of existing quantitative measures that could adequately assess a wide (and mostly unknown) range of potential life goals and themes related to achieving life goals. Two researchers co-coded all responses and reviewed the resulting thematic variables together; any discrepancies were resolved through discussion until consensus was reached. For the main life goals question asked at each time point, participants could mention multiple goals and dichotomous variables were created to indicate the presence or absence of each thematic goal at each time point; as such, goals are not mutually exclusive. An additional variable was created to indicate when a participant had discussed two or more life goals.

To examine whether there existed statistically significant changes in life goals over time, generalized estimating equations (GEEs) controlling for demographic and goal characteristics (age, race/ethnicity, gender, education, and total number of goals) were modeled in Stata 14 (StataCorp, 2015). Goals identified at each time point were tested as compared to goals identified at baseline (prior to housing). Given the large number of relationships examined in these analyses, we utilized the Holm-Bonferroni method for multiple comparison adjustments (Holm, 1979); only relationships that reached statistical significance ($p < 0.05$) or trend-level significance ($p < 0.10$) in Holm-Bonferroni adjusted p -values are indicated in the results.

Results

Respondent characteristics are shown in Table 1 (included are descriptives for all persons retained in the study at the 12-month interview; $n=369$). The average age of participants at study enrollment was 54.5 years and 69% identified as male. More than half of participants were Black/African American (55%), more than three quarters had a high school education (76%), and 62% reported that they had any children. The average number of reported life goals at each time point was approximately two.

Life Goals and Life Goal Changes

When we interviewed persons prior to their move into PSH (baseline), the most common goal, by far, was the desire to obtain housing (53%). The goal of housing attainment virtually disappeared at subsequent interviews, as the vast majority of respondents remained in housing at 12-months (96%). The other most common goals articulated by respondents at baseline included aspirational goals (34%), vocational goals (33%), health goals (22%), and relationship goals (20%).

As a combined category, aspirational goals were cited by more than one third of respondents at baseline, and tended to decrease over time, falling to 22% at 6- and 12-month interviews. A large number of different types of aspirational goals were articulated, the most common

being giving back to the community (8%; e.g., “help others out of their addiction,” “become a foster parent”), rebuilding life (7%; e.g., “re-obtain my previous lifestyle,” “re-establish myself within the community”), self-improvement (6%; e.g., “become a better person,” “keep moving forward and becoming successful”), independence (6%; e.g., “make choices for myself,” “pay for my own apartment and car”), and religion (6%; e.g., “to get closer to God”, “tap into God and get rid of evil spirits hindering me”). There is no clear pattern as to which specific aspirational goals account for the overall decrease in aspirational goals; however, once people were housed, the number of persons naming rebuilding life or independence as primary goals decreased (to 3% and 1% by 12-months, respectively; results marginally statistically significant). Most other aspirational goals remained consistent over time, including self-improvement (6% at baseline and 7% at 12-months), travel (1% at both baseline and 12-months), artistic pursuits (4% at baseline and 3% at follow-up), and religion (6% at baseline and 5% at 12-months).

While vocational goals tended to decrease over time (falling to 23% at the 12-month interview, perhaps driven by the decrease in employment goals from 24% at baseline to 16% by 12-months post-housing), this was not a statistically significant change in adjusted longitudinal models.

Goals related to health increased over time, peaking at 40% at the 6-month interview. This change appears to be driven primarily by statistically significant increases in persons articulating goals focused on mental health (2% at baseline and 8% at 12-month follow-up) and physical health (14% at baseline and 22% at 12-months). Substance recovery goals remained relatively low and consistent over time (5% at baseline and 4% at 12-months), as did goals related to mortality (4% at baseline and 12-months; e.g., “To stay alive.”).

Relationship goals remained stable over time, including those relationship goals related to specific categories of persons, such as friendships/social relationships (2% at baseline and 1% at 12-months), relationships with children (9% at baseline and 8% at 12-months) or grandchildren (4% at baseline and 5% at 12-months), and relationships with romantic partners (3% at baseline and 2% at 12-months; a small jump to 6% at 6-months was not statistically significant).

Thirteen percent of respondents cited financial goals at baseline, and the rate of persons naming financial goals demonstrated a statistically significant increase over time, topping out at 22% at the 3-month interview. While the most common financial goals were general in nature (e.g., “To become financially stable” or “To not have to worry about money”), financial goals related to obtaining public benefits (5% at 12-months) and possessions (4% at 12-months) were also cited.

At 3-months after PSH move-in, respondents began mentioning housing retention (11%), and housing relocation (10%) as important life goals. Housing retention as a goal decreased again at 12-months (6%; not statistically significantly different from baseline), while relocation increased to 22% by 12-months (statistically significant). When talking about relocation, the most commonly-cited reason participants gave for their desire to relocate was wanting to live in a better neighborhood (13% of respondents at 12-months), followed by a

desire for better housing (7% at 12-months; e.g., “To live in a better apartment,” “To get an apartment with a balcony, bathroom, and kitchen”).

Legal goals were the least commonly cited by participants (1% at baseline and 4% at 12-months); this category included being law abiding (e.g. “staying out of trouble,” or “get off probation”) and gaining U.S. citizenship.

We identified several demographic characteristics that were associated with increased or decreased likelihood of naming particular life goals (not presented in a table). As people aged, they were less likely to name employment (OR=0.96; 95% CI: 0.93–0.99) or mental health (OR=0.95; 95% CI: 0.90–0.99) as life goals. Female respondents were more likely to report health (OR=1.56; 95% CI: 1.01–2.39) and relationships with children as goals (OR=1.93; 95% CI: 1.02–3.64), and less likely to report substance recovery goals (OR=0.37; 95% CI: 0.15–0.89). Those with high school or more education were less likely to name housing retention (OR=0.36; 95% CI: 0.20–0.66) or substance recovery (OR=0.45; 95% CI: 0.22–0.95) as life goals. Those who had children were more likely to report recovery from substances as a goal (OR=1.19; 95% CI: 1.06–1.34), as were white respondents (OR=2.37; 95% CI: 1.14–4.95). Not surprisingly, having children was associated with naming relationships with family (OR=1.22; 95% CI: 1.07–1.38), children (OR=1.47; 95% CI: 1.30–1.66) or grandchildren (OR=1.29; 95% CI: 1.11–1.50) as life goals.

Reflections on Changing Life Goals

At their 12-month interview, respondents were asked to reflect on how their life goals had changed since they moved into housing (Table 3). Nearly one-third (32%) reported that neither their goals nor their ability to reach them had changed measurably since they moved into housing, while 31% reported that their goals had changed for the better since PSH move-in. The latter group primarily expressed a transformation from pre-housing survival-focused goals to post-housing higher-order goals, such as quality of life or “becoming a better person.” Nearly 19% of respondents reported that their original goals had not changed since housing (and remained unmet), but that they perceived they had an increased ability to pursue those goals, as housing provided a platform for accessing previously unattainable goals.

Similarly, 17% of respondents reported that housing enabled them to finally achieve long-held goals (e.g. “Everything changed for the better.”). A smaller group of people (5%), reported instead that they felt less able to pursue major life goals now that they were in housing. A primary theme among these respondents was that their current housing situation was negatively impacting their mental health (e.g., “I’m more depressed.”).

Reflections on What is Needed to Reach Goals

When asked at 12-months what they thought was the most important resource they needed to meet their existing life goals, the most common theme related to expending personal effort (36%), for example, staying focused, paying rent on time, or improving diet and exercise (Table 3). The next most commonly-cited necessary resource was money (22%), followed by general instrumental assistance (18%; this code encompassed a wide variety of instrumental needs, including clothing, documentation, vouchers for non-PSH housing, etc.). Other needs

included help with obtaining needed services (10%), improved health (9%), changes/improvement in social support (8%), religion-related needs (5%), education (5%), employment (5%), and relocation (1%). About 11% reported needs that could not be easily categorized, including large-scale or unattainable goals, such as “a miracle” or “to find the cure for HIV.”

Discussion

In this paper, we have provided an overview and context regarding an important aspect of thriving -- the ability to articulate and pursue life goals (i.e., eudaimonic wellbeing) -- among formerly homeless adults living in PSH. Toward this end, we first examined which goals were most frequently cited by adults in PSH, then how those goals changed over time. We found that housing-related goals, aspirational goals, health goals, and financial goals were common and evolved over a 12-month period, while vocational and relationship goals were also common, but did not change significantly over time. Goals that were not frequently cited by participants included those pertaining to substance recovery, basic survival, and legal issues; further research may be needed to understand whether these goals are uncommon because those in housing do not need such assistance, or whether there is some other factor at play (e.g., persons in PSH not viewing substance use recovery as necessary for meeting other important life goals).

We also assessed how formerly homeless adults who had lived in housing for 12-months described the impact of housing on their life goals, as well as what they described as their existing needs for meeting major life goals. Overall, most respondents felt that housing enabled them to meet long-held or previously unattainable goals, improved their prospects for meeting existing unmet goals, or facilitated the transformation of life goals toward larger-order, less survival-based goals. Most participants cited money, services, education, healthcare, employment, or other instrumental needs as the primary resources that would help them to meet their life goals.

Our final aim in this paper was to ascertain what services and programs might be most important in helping persons in PSH achieve their major life goals. This aim is undertaken in part because the intended design of permanent supportive housing is to incorporate service-delivery that assists with these needs (Sun, 2012), and the persistence of such needs at 12-months post-housing suggests the need for continued intensive services for persons within PSH.

More than one-third of respondents felt the major missing piece they needed to attain their life goals was personal effort. As such, interventions which utilize client-centered approaches aimed at resolving ambivalence and facilitating personal change, such as motivational interviewing (Rollnick & Miller, 1995), may prove useful in assisting PSH residents with meeting major life goals, and therefore enabling thriving. We caution that this finding may also suggest that these formerly homeless residents of PSH have internalized the still too-common societal attitudes towards persons experiencing homelessness that center on blaming these persons for their hardships (Belcher & DeForge, 2012). To the extent that this perception of needing more personal effort is based in internalized societal

stigmas rather than in a need for additional skills to navigate a challenging environment to achieve the resources necessary for life fulfillment, it may be appropriate for clinicians and other staff to help clients achieve more skills and a more balanced view of personal versus societal responsibilities.

Other services and programs that might be useful for adults in PSH include programs specifically targeted toward those life goals for which we identified change over time. For example, our findings that financial goals tended to increase while in housing may indicate that residents' financial resources as well as financial responsibilities (e.g. rent, home furnishings, etc.) increased over time in PSH. To aid residents in meeting financial goals, and to ensure residents engage in responsible household budgeting and avoid predatory financial practices, providers may consider offering financial education programs for residents. Such programs may also be important for the maintenance of housing, as prior research has identified money mismanagement as a risk factor for subsequent homelessness among military veterans (Elbogen et al., 2013).

Articulation of life goals related to general physical health and mental health also increased over time in housing. While future research may be needed to understand whether such changes are due to increasing physical or mental health symptoms while in housing, or simply an increased ability to focus on mental or physical health needs once the basic need of housing has been achieved, these results suggest a continued need for efforts focused on improving mental or physical health after receiving housing. This finding may also lend support to the assertion that stable housing serves as a foundation for improved health promotion behaviors and health status (Crisanti, et al., 2017; Fitzpatrick-Lewis et al., 2011; Russolillo, Patterson, McCandless, Moniruzzaman & Somers, 2014; Sadowski, Kee, VanderWeele & Buchanan, 2009).

Housing retention as a primary life goal among persons in this study peaked at 6-months and then declined again at 12-months. One possible explanation is that persons became more comfortable with the prospect of retaining their housing once they had been stably housed for a full year, as the first year in housing can be stressful for both residents and service providers (Center for Urban Community Services, n.d.). Alternatively, residents may have been moving the focus of their life goals from housing retention to housing relocation, as relocation as a goal increased considerably by 12-months. Many PSH residents are eligible for more flexible housing vouchers after one year in PSH, which allow them to choose from a wider array of housing options (HACLA, 2017). One previous study found that 50% of those in a PSH program for adults with mental illness left the housing program within 2.5 years, and the majority of those persons relocated voluntarily into stable, positive living environments (Wong et al., 2006). The transition over time from housing retention to relocation as a major life goal in this study may thus reflect a desire among residents to move forward in their recovery from homelessness, and relocation assistance may therefore be an important aspect of well-rounded services within PSH.

Social relationship goals remained relatively consistent over time among persons in this study, which may indicate an unmet need for programs that facilitate re-connection with family or improvement of social relationships among persons within PSH. Social isolation is

damaging to health and well-being (Steptoe, Shankar, Demakakos & Wardle, 2013), yet literature indicates that social integration may remain a persistent challenge among formerly homeless persons in permanent supportive housing (Yanos, Barrow, & Tsemberis, 2004; Tsai, Mares & Rosenheck, 2012; Ecker & Aubry, 2016). Given that social relationship goals remain consistently common among persons in PSH, promotion of social integration is an area where service providers could potentially focus interventions and programs that might be well-received among persons within PSH. There is extant evidence that strengths-based programs, such as critical time interventions, may improve family support and psychological distress for persons transitioning into housing (de Vet et al., 2017). Such programs may be most effective if they are peer or community driven; however, further research is necessary to understand the ideal mechanisms for improving social integration.

While disparate in their specific manifestation, aspirational goals were common among persons prior to moving into PSH; however, such goals were less frequently cited over time. It is difficult to definitively articulate whether this suggests persons are meeting aspirational goals while in PSH or whether persons are giving up on aspirational goals over time, though findings that many respondents identify housing as the platform from which they were able to attain (or move toward) larger life goals lends credence to the former as a probable explanation. Further, life goals related to rebuilding life or gaining independence decreased slightly over time as people lived in PSH (marginally statistically significant), which may be due to the simple fact of being housed after experiencing the devastation of homelessness. This transition to relative permanence and stability may make people feel intrinsically that they are meeting goals related to rebuilding life and gaining independence. Alternatively, housing may provide a platform for persons to help achieve goals related to independence and rebuilding. The finding that many respondents at 12-months reported that they had met their goals (17%) or found goals easier to achieve once in housing (19%) suggests the possibility that housing itself was a primary driver allowing persons to meet goals related to independence and rebuilding (and possibly other aspirational goals as well). Other aspirational goals remained relatively consistent over time, suggesting there is a need for programs within PSH that focus on helping persons pursue personal aspirational goals related to creativity, self-improvement, and giving back to the community. Overall, these findings provide preliminary evidence to suggest that while housing is necessary for survival, stability, and independence, housing in and of itself may not be enough to ensure persons can meet aspirational life goals and achieve other aspects of thriving which may be taken for granted among non-homeless persons. Intervention and research efforts that prioritize resident perspectives and provide innovative opportunities for collaboration, such as Photovoice and other qualitative methods, may be helpful in exploring aspirational goals and empowering persons transitioning into housing with new ways to achieve meaning and creativity (Brown et al., 2017; Pruitt et al., 2018).

Although the results of this study indicate a need for efforts within permanent supportive housing that focus on enabling residents to thrive, existing research with PSH providers suggests that, due to limited provider capacity and high resident-to-provider ratios, program staff typically perceive their jobs to be primarily focused on keeping people in housing (Henwood et al., 2017b). Other needs of PSH residents, for example, HIV prevention (Wenzel et al., 2017), receive less attention in this context of competing priorities. This

current context is therefore likely to limit the time and attention available for providers to address higher order needs and achievement of life goals with residents.

Limitations

These analyses utilize data collected from a cohort of homeless adults moving into PSH in Los Angeles, and are therefore not necessarily representative of all persons in PSH. The context of Los Angeles, a dense, urban area that is home to the largest population of homeless persons in the U.S., may be different from that of rural or other urban settings. Further, the current study sample excluded persons under the age of 39 and those moving into PSH with minor children; developmental life stage and parenting may impact life goals in ways that cannot be addressed with these data. We also did not follow up with respondents at each time point to discuss their previously-reported goals and whether or not they had met them during the intervening time period; future qualitative research may be needed to explore such changes in greater depth. Additionally, the explanation of our finding that mental health goals increased over time may point to either increased ability of individuals to focus on their mental health needs, or worsening mental health symptoms over time. This is an area where future research may also be warranted. Finally, given the limited capacity of PSH providers to provide intensive support for residents in articulating and pursuing life goals, some persons in PSH may not have spent much time considering goals; as such, our simple, open-ended question asking participants to describe major goals may not be wholly adequate in assessing goals for these persons.

Conclusion

Overall, these findings contribute to the literature on thriving among persons in PSH by describing and contextualizing how eudaimonic wellbeing (Feeney & Collins, 2014) may be of key importance to persons transitioning out of homelessness and while living in permanent supportive housing. We also suggest some areas where focused services may help persons in meeting their major life goals and further improving general wellbeing. Within this context, it may be important to also consider the small group of persons who did not feel housing improved their ability to meet life goals, but instead reported feeling affected by negative aspects of their housing situation and therefore less able to pursue goals. Such persons are deserving of future research attention to better understand how housing can meet their specific eudaimonic wellbeing goals.

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References

- Anthony WA (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16(4), 11.
- Aubry T, Tsemberis S, Adair CE, Veldhuizen S, Streiner D, Latimer E, ... & Hume C (2015). One-year outcomes of a randomized controlled trial of Housing First with ACT in five Canadian cities. *Psychiatric Services*, 66(5), 463–469. [PubMed: 25639993]

- Bean KF, Shafer MS, & Glennon M (2013). The impact of housing first and peer support on people who are medically vulnerable and homeless. *Psychiatric Rehabilitation Journal*, 36(1), 48. [PubMed: 23477651]
- Benston EA (2015). Housing programs for homeless individuals with mental illness: Effects on housing and mental health outcomes. *Psychiatric Services*, 66(8), 806–816. [PubMed: 25873027]
- Belcher JR, & DeForge BR (2012). Social stigma and homelessness: The limits of social change. *Journal of Human Behavior in the Social Environment*, 22(8), 929–946.
- Bird M, Rhoades H, Lahey J, Cederbaum J, & Wenzel S (2017). Life goals and gender differences among chronically homeless individuals entering permanent supportive housing. *Journal of Social Distress and the Homeless*, 26(1), 9–15.
- Brown M, Chodzen G, Mihelicova M, & Collins K (2017). Applying a time-patterned typology of homelessness among individuals with mental illness. *American Journal of Community Psychology*, 59(3–4), 306–315. [PubMed: 28471489]
- Brown MM, Jason LA, Malone DK, Srebnik D, & Sylla L (2016). Housing First as an effective model for community stabilization among vulnerable individuals with chronic and nonchronic homelessness histories. *Journal of Community Psychology*, 44(3), 384–390.
- Chung TE, Gozdzik A, Lazgare P, Luis I, To MJ, Aubry T, ... & Stergiopoulos V (2017). Housing First for older homeless adults with mental illness: a subgroup analysis of the At Home/Chez Soi randomized controlled trial. *International Journal of Geriatric Psychiatry*.
- Clark A & Senik C, (2011), Is happiness different from flourishing? Cross-country evidence from the ESS, Working Paper 2011–04, Paris, School of Economics
- Conrad KJ, Yagelka JR, Matters MD, Rich AR, Williams V, & Buchanan M (2001). Reliability and validity of a Modified Colorado Symptom Index in a national homeless sample. *Mental Health Services Research*, 3(3), 141–153. [PubMed: 11718206]
- Center for Urban Community Services, Corporation for Supportive Housing, and U.S. Department of Housing and Urban Development (n.d.). Issues in the First Year: Supportive Housing Training Series. <https://www.hudexchange.info/resources/documents/SHPIssuesFirstYear.pdf> (last accessed September 2017).
- Crisanti AS, Duran D, Greene RN, Reno J, Luna-Anderson C, & Altschul DB (2017). A longitudinal analysis of peer-delivered permanent supportive housing: Impact of housing on mental and overall health in an ethnically diverse population. *Psychological Services*, 14(2), 141. [PubMed: 28481599]
- de Vet R, Beijersbergen MD, Jonker IE, Lako DA, van Hemert AM, Herman DB, & Wolf JR (2017). Critical time intervention for homeless people making the transition to community living: a randomized controlled trial. *American Journal of Community Psychology*, 60(1–2), 175–186. [PubMed: 28872196]
- Ecker J, & Aubry T (2016). Individual, housing, and neighborhood predictors of psychological integration among vulnerably housed and homeless individuals. *American Journal of Community Psychology*, 58(1–2), 111–122. [PubMed: 27422121]
- Ecker J, Cherner R, Rae J, & Czechowski K (2017). Sexual intimacy, mental illness, and homelessness. *American Journal of Community Psychology*. Advance online publication. doi: 10.1002/ajcp.12213
- Elbogen EB, Sullivan CP, Wolfe J, Wagner HR, & Beckham JC (2013). Homelessness and money mismanagement in Iraq and Afghanistan veterans. *American Journal of Public Health*, 103(S2), S248–S254. [PubMed: 24148067]
- Feeney BC, & Collins NL (2015;2014;). A new look at social support: A theoretical perspective on thriving through relationships. *Personality and Social Psychology Review*, 19(2), 113. doi: 10.1177/1088868314544222 [PubMed: 25125368]
- Fitzpatrick-Lewis D, Ganann R, Krishnaratne S, Ciliska D, Kouyoumdjian F, & Hwang SW (2011). Effectiveness of interventions to improve the health and housing status of homeless people: a rapid systematic review. *BMC Public Health*, 11(1), 638. [PubMed: 21831318]
- Gulcur L, Stefancic A, Shinn M, Tsemberis S, & Fischer SN (2003). Housing, hospitalization, and cost outcomes for homeless individuals with psychiatric disabilities participating in continuum of care

and housing first programmes. *Journal of Community & Applied Social Psychology*, 13(2), 171–186.

Henwood BF, Derejko KS, Couture J, & Padgett DK (2015). Maslow and mental health recovery: A comparative study of homeless programs for adults with serious mental illness. *Administration and Policy in Mental Health and Mental Health Services Research*, 42(2), 220–228. [PubMed: 24518968]

Henwood BF, Matejkowski J, Stefancic A, & Lukens JM (2014). Quality of life after housing first for adults with serious mental illness who have experienced chronic homelessness. *Psychiatry Research*, 220(1–2), 549–555. doi:10.1016/j.psychres.2014.07.072 [PubMed: 25129560]

Henwood BF, Stefancic A, Petering R, Schreiber S, Abrams C, & Padgett DK (2015). Social relationships of dually diagnosed homeless adults following enrollment in housing first or traditional treatment services. *Journal of the Society for Social Work and Research*, 6(3), 385–406. [PubMed: 26635919]

Henwood BF, Rhoades H, Hsu HT, Couture J, Rice E, & Wenzel SL (2017a). Changes in social networks and HIV risk behaviors among homeless adults transitioning into permanent supportive housing: a mixed methods pilot study. *Journal of Mixed Methods Research*, 11(1), 124–137.

Henwood BF, Harris T, Woo D, Winetrobe H, Rhoades H, & Wenzel SL (2017b). Availability of comprehensive services in permanent supportive housing in Los Angeles. *Health & Social Care in the Community*.

Holm S (1979). A simple sequentially rejective multiple test procedure. *Scandinavian Journal of Statistics*, 65–70.

Hopper K (2012). Commentary: the counter-reformation that failed? A commentary on the mixed legacy of supported housing. *Psychiatric Services*, 63(5), 461–463. [PubMed: 22549534]

Housing Authority of the City of Los Angeles (HACLA). (2017). HACLA Homeless Initiatives. <http://www.hacla.org/homelessinitiatives> (last accessed August 2017).

Hsieh HF, & Shannon SE (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, 15(9), 1277–1288. [PubMed: 16204405]

Hubley AM, Russell LB, Palepu A, & Hwang SW (2014;2012;). Subjective quality of life among individuals who are homeless: A review of current knowledge. *Social Indicators Research*, 115(1), 509–524. doi:10.1007/s11205-012-9998-7

Huppert FA, Marks N, Clark A, Siegrist J, Stutzer A, Vitterso J and Wahrendorf M (2009), Measuring well-being across Europe: Description of the ESS well-being module and preliminary findings. *Social Indicators Research*, 91, 301–315.

Hwang, & Burns. (2014). Health interventions for people who are homeless. *The Lancet*, 384(9953), 1541–1547. doi: 10.1016/S0140-6736(14)61133-8

Laan J, Boersma SN, Straaten B, Rodenburg G, Mheen D, & Wolf JR (2017). Personal goals and factors related to QoL in Dutch homeless people: what is the role of goal-related self-efficacy?. *Health & Social Care in the Community*, 25(3), 1265–1275. [PubMed: 28122408]

Los Angeles Homeless Services Authority. (2016). Homeless Management Information System Data, Los Angeles Continuum of Care (LA CoC HMIS). Los Angeles, CA.

Mastropieri B, Schussel L, Forbes D, & Miller L (2015). Inner resources for survival: Integrating interpersonal psychotherapy with spiritual visualization with homeless youth. *Journal of Religion and Health*, 54(3), 903–921. doi:10.1007/s10943-015-0044-3 [PubMed: 25862338]

Organization for Economic Co-operation and Development (OECD). (2013). OECD guidelines on measuring subjective well-being. Paris: OECD. doi:10.1787/9789264191655-en

Padgett DK (2008). *Qualitative methods in social work research* (2nd ed.). Thousand Oaks, CA: Sage.

Patterson M, Moniruzzaman A, Palepu A, Zabkiewicz D, Frankish CJ, Krausz M, & Somers JM (2013). Housing first improves subjective quality of life among homeless adults with mental illness: 12-month findings from a randomized controlled trial in Vancouver, British Columbia. *Social Psychiatry and Psychiatric Epidemiology*, 48(8), 1245–1259. doi:10.1007/s00127-013-0719-6 [PubMed: 23748928]

President's New Freedom Commission on Mental Health. (2003). *Final Report to the President*, Rockville, MD: New Freedom Commission on Mental Health.

- Prins A, Ouimette P, Kimerling R, Cameron RP, Hugelshofer DS, Shaw-Hegwer J, ... Sheikh JI (2003). The primary care PTSD screen (PC-PTSD): Development and operating characteristics. *Primary Care Psychiatry*, 9(1), 9–14.
- Pruitt AS, Barile JP, Ogawa TY, Peralta N, Bugg R, Lau J, ... & Mori V (2018). Housing First and Photovoice: Transforming Lives, Communities, and Systems. *American Journal of Community Psychology*. Advance online publication. doi: 10.1002/ajcp.12226
- Rollnick S, & Miller WR (1995). What is motivational interviewing?. *Behavioural and Cognitive Psychotherapy*, 23(4), 325–334.
- Russolillo A, Patterson M, McCandless L, Moniruzzaman A, & Somers J (2014). Emergency department utilisation among formerly homeless adults with mental disorders after one year of Housing First interventions: a randomised controlled trial. *International Journal of Housing Policy*, 14(1), 79–97.
- Sadowski LS, Kee RA, VanderWeele TJ, & Buchanan D (2009). Effect of a housing and case management program on emergency department visits and hospitalizations among chronically ill homeless adults: a randomized trial. *Journal of the American Medical Association*, 301(17), 1771–1778. [PubMed: 19417194]
- Schwend KA, Cluskey M, & Cordell M (2015). Lifestyles and goals of homeless male shelter users. *SAGE Open*, 5(1) doi:10.1177/2158244015572504
- Seidman I (1998). *Interviewing as qualitative research: A guide for researchers in education and social sciences* (2nd ed.). New York, NY: Teachers College Press.
- Steptoe A, Shankar A, Demakakos P, & Wardle J (2013). Social isolation, loneliness, and all-cause mortality in older men and women. *Proceedings of the National Academy of Sciences*, 110(15), 5797–5801.
- Sun AP (2012). Helping homeless individuals with co-occurring disorders: The four components. *Social Work*, 57(1), 23–37. [PubMed: 22768626]
- StataCorp. (2015). *Stata Statistical Software: Release 14*. College Station, TX: StataCorp.
- Tischler VA, & Vostanis P (2007). Homeless mothers: Is there a relationship between coping strategies, mental health and goal achievement? *Journal of Community & Applied Social Psychology*, 17(2), 85–102. doi:10.1002/casp.879
- Tsai J, Lee CYS, Byrne T, Pietrzak RH, & Southwick SM (2017). Changes in Public Attitudes and Perceptions about Homelessness Between 1990 and 2016. *American Journal of Community Psychology*, 60(3–4), 599–606. [PubMed: 29027669]
- Usborne E, Lydon JE, & Taylor DM (2009). Goals and social relationships: windows into the motivation and well-being of “Street Kids”. *Journal of Applied Social Psychology*, 39(5), 1057–1082.
- Ware JE, Jr., Kosinski M, & Keller SD (1996). A 12-item short-form health survey: Construction of scales and preliminary tests of reliability and validity. *Medical Care*, 34(3), 220–233. [PubMed: 8628042]
- Wenzel SL, Henwood B, Harris T, Winetrobe H, & Rhoades H (2017). Provider perceptions on HIV risk and prevention services within permanent supportive housing. *AIDS Care*, 1–5.
- Wong YLI, Hadley TR, Culhane DP, Poulin SR, Davis MR, Cirksey BA, & Brown JL (2006). Predicting staying in or leaving permanent supportive housing that serves homeless people with serious mental illness. *Departmental Papers (SPP)*, 111.

Table 1.

Transitions to Housing Study Respondent Characteristics (N=369)

<i>Demographics</i>	<i>%(n)/mean(SD)</i>
Age	54.5 (7.4)
<i>Gender</i>	
Male	69.4 (256)
Female	30.6 (113)
<i>Race/Ethnicity</i>	
Black	55.3 (204)
White	24.4 (90)
Latino/Hispanic	9.2 (34)
Another race/ethnicity	11.1 (41)
HS education	75.9 (280)
Any children	61.6 (226)
Total number of reported goals	
Baseline	2.11 (1.08)
3-months	1.95 (1.00)
6-months	2.00 (1.13)
12-months	1.89 (1.16)

Table 2.

Transitions to Housing Study: Endorsement of Life Goals by Interview (n=369)

Goal	% (n)			
	Baseline	3-month	6-month	12-month
<i>Health</i>				
Any health goal	22.0 (81)	35.5 (131) **	39.6 (146) **	31.4 (116) **
Mental health	2.4 (9)	9.2 (34) **	8.1 (30) **	7.6 (28) *
Physical health	13.6 (50)	23.3 (86) **	27.4 (101) **	21.7 (80) **
Substance recovery	4.6 (17)	6.2 (23)	3.8 (14)	4.1 (15)
Mortality	3.8 (14)	3.5 (13)	6.0 (22)	4.3 (16)
<i>Legal</i>				
Any legal goal	1.1 (4)	4.6 (17)	2.2 (8)	3.5 (13)
Law abiding	0.8 (3)	3.3 (12)	1.9 (7)	2.2 (8)
Gaining citizenship	0.3 (1)	1.4 (5)	0.3 (1)	1.4 (5)
<i>Vocational</i>				
Any vocational goal	32.5 (120)	31.2 (115)	31.2 (115)	23.3 (86)
Education	13.8 (51)	14.4 (53)	16.8 (62)	10.3 (38)
Employment	23.9 (88)	20.1 (74)	19.8 (73)	16.0 (59)
<i>Financial</i>				
Any financial goal	13.0 (48)	21.7 (80) **	15.7 (58)	19.2 (71) *
Public benefits	1.9 (7)	5.2 (19)	3.5 (13)	4.9 (18)
Possessions	2.7 (10)	4.6 (17)	3.8 (14)	3.5 (13)
Employment for financial gain	0.8 (3)	2.4 (9)	0.3 (1)	1.6 (6)
Retirement	0.0 (0)	1.1 (4)	1.4 (5)	0.8 (3)
Other financial	8.9 (33)	10.8 (40)	8.4 (31)	8.1 (30)
<i>Housing</i>				
Any housing goal	54.5 (201)	14.1 (52)	13.3 (49)	11.1 (41)
Attainment	53.1 (196)	0.5 (2) **	0.8 (3) **	0.5 (2) **
Retention	4.3 (16)	11.4 (42) **	8.4 (31)	6.0 (22)
Ownership	0.8 (3)	1.6 (6)	3.5 (13)	4.1 (15)
<i>Relocation</i>				
Any relocation goal	1.9 (7)	10.3 (38) **	14.9 (55) **	22.0 (81) **
To be closer to family	0.5 (2)	0.8 (3)	0.8 (3)	1.4 (5)
For better housing	0.0 (0)	2.4 (9)	3.0 (11)	7.1 (26)
For better neighborhood	0.8 (3)	6.0 (22) **	7.6 (28) **	12.7 (47) **
<i>Relationships</i>				
Any relationship goal	19.8 (73)	14.6 (54)	19.0 (70)	19.2 (71)
Social relationships/friendships	2.2 (8)	1.9 (7)	2.2 (8)	1.1 (4)
Children	9.2 (34)	6.2 (23)	7.3 (27)	7.6 (28)
Grandchildren	4.1 (15)	3.0 (11)	3.8 (14)	4.6 (17)
Other family	5.7 (21)	2.7 (10)	3.0 (11)	6.2 (23)

Goal	Baseline	% (n)		
		3-month	6-month	12-month
Romantic partner	3.3 (12)	3.3 (12)	6.0 (22)	2.2 (8)
<i>Aspirational</i>				
Any aspirational goal	34.2 (126)	29.5 (109)	21.7 (80) **	22.0 (81) *
Independence	6.0 (22)	4.6 (17)	1.1 (4) *	1.4 (5) *
Rebuilding life	7.3 (27)	2.2 (8)	2.2 (8) *	3.0 (11)
Finding meaning	0.8 (3)	1.9 (7)	2.4 (9)	0.3 (1)
Self-improvement	6.0 (22)	7.9 (29)	3.8 (14)	6.5 (24)
Travel	1.4 (5)	1.6 (6)	1.9 (7)	1.1 (4)
Artistic pursuits	3.8 (14)	2.2 (8)	3.5 (13)	3.0 (11)
Religion	5.7 (21)	7.1 (26)	7.1 (26)	5.2 (19)
Giving back	7.9 (29)	6.5 (24)	3.8 (14)	2.7 (10)

** indicates % is statistically significantly different (using Holm-Bonferroni adjusted p-values of <0.05) from baseline in adjusted multivariable models;

* indicates trend toward statistical significance (Holm-Bonferroni adjusted p-value <0.10).

Table 3.

Transitions to Housing Study: Reflections on Life Goals in PSH (12-Month Interview; n=369)

	%(n)	Exemplar Quotes		
How have your goals changed since you first moved into housing? (codes not mutually exclusive)				
No change	31.5 (115)	“It has not changed. I have always just wanted some peace of mind.”	“Still need more money.”	“Goals have not changed. Getting into my current apartment was just a step.”
Evolving/improving goals since housing	30.7 (116)	“I was thinking about getting off the streets now I’m focused on being a good person.”	“Not worried about finding a safe place to stay anymore. That was my only focus before moving into my apartment. Now I’m thinking about the more distant future.”	“My goals were based on survival issues now they’re focused on my quality of life.”
More able to pursue original goals	18.5 (68)	“My goals have been the same. The apartment has allowed me to focus more on them.”	“My goals seem more reachable now.”	“I can’t really say that my goal has changed but my capacity to reach my goal has changed.”
Met goals	17.1 (63)	“I now see my life as more perfect. I feel blessed.”	“I feel more relaxed and I don’t sleep in my car. I’m not around people who purposely want to say hurtful things to me. I take my meds now.”	“Everything changed for the better.”
Less able to pursue goals	5.2 (19)	“Goals have changed poorly. It was better when I first moved in here. I’m more depressed.”	“I’m less goal-oriented now. Moving into supportive housing makes people lazy. My pride is hurt. Even if you want to move out it is difficult to get out.	“I thought I would want to stay here for a couple years but now I want to get out of here as soon as possible. It keeps me depressed.”
What is the most important thing you need to help you reach your goal? (codes not mutually exclusive)				
Personal effort	36.1 (134)	“Try to improve my life. Not letting things get me down.”	“To just keep paying my rent on time.”	“I need to stay focused mentally and watch the people who I associate with.”
Money	21.6 (80)	“College funding for the next three years.”	“Need more money to buy more music equipment.”	“To earn more money to help some of my grandchildren that are struggling financially.”
General instrumental assistance	18.1 (67)	“To wait for [my] name to come to the top of the housing list.”	“Clothing to be presentable at church.”	“Taking care of and getting my license back.”
Services	10.0 (37)	“I need to find a better doctor.”	“Better case management and legal representation.”	“Guidance from case manager.”
Health	8.6 (32)	“Get surgery and physical therapy.”	“To continue heaving healthcare, following up with my doctors regularly.”	“Recover from my anxiety.”
Social support/relationships	7.8 (29)	“To be around better people.”	“Support from my family.”	“Access to my grandchildren. They’re far away.”
Religion	4.9 (18)	“To maintain a connection to God.”	“To study the Bible and pray.”	“Pray and ask Jesus what to do.”
Education	4.9 (18)	“To finish school and get my degree in music.”	“To go back to school.”	“Getting into the LAPD academy.”
Employment	4.9 (18)	“Have a really good job come my way.”	“To get a job.”	“Get a better job.”

	%(n)	Exemplar Quotes		
Relocation	1.3 (5)	"Find a better neighborhood."	"A safer environment to live in."	"To move first. Once I move I can get my life back on track."
Other	10.5 (39)	"To investigate to find the cure for the sickness (HIV)."	"I need the cooperation of the universe."	"Miracle."