Letters from readers are welcome. They will be published at the editor's discretion as space permits and will be subject to editing. They should not exceed 500 words with no more than three authors and five references and should include the writer's e-mail address. Letters commenting on material published in *Psychiatric Services*, which will be sent to the authors for possible reply, should be sent to Howard H. Goldman, M.D., Ph.D., Editor, at psjournal@psych.org. Letters reporting the results of research should be submitted online for peer review (mc.manuscriptcentral.com/appi-ps).

Supported Housing and the Lamppost—or Supported Housing in the Spotlight?

To the Editor: Hopper's eloquent argument in the May issue regarding supported housing's failure to remedy the social exclusion of people with serious mental illness (1) places the spotlight on one approach to the exclusion of other approaches that are far more powerful and commonly found. This purported failure, moreover, is heightened by his equating supported housing with institutions of control over the poor: "It is no reproach to note the structural kinship of supported housing and abeyance mechanisms" (1). Yet "abeyance mechanisms" such as prisons and long-stay hospitals bear a much closer resemblance to the opposite of supported housing—that is, to congregate care settings where residents share close quarters under strict house rules. By comparison, supported housing, which offers consumers their own apartment on the basis of their preferences, is a form of personal liberation.

Of course, liberation does not mean salvation. And recovery from mental illness cannot be achieved (as Hopper notes) by an individual's force of will. Social isolation is but one entrenched problem that the newly housed must confront. Cumulative life adversity—a benign-sounding term that obscures the raw brutality of being beaten or sexually assaulted—is an all-too-common precursor to the adult problems of mental illness, substance abuse, homelessness, and poor health (2). Social networks depleted due to drugs, incarceration, premature death, and mutual estrangement reduce opportunities for reuniting, and finding new social relationships is more difficult when trust in others is in understandably short supply (3).

For a small minority of homeless adults who cannot or do not wish to live independently, there is no likelihood that supervised congregate care will disappear anytime soon. Indeed, philanthropic donations and government funding have overwhelmingly favored visible edifices over the smaller scale and "invisibility" of scatter-site living (an ironic commentary on the greater presumed potential for social integration associated with such edifices). Yet the preponderance of research shows that consumers of psychiatric services prefer having their own domicile over living with strangers who share their troubled histories (4). Shouldn't this play some role in considering what has gone wrong and what is going right (or at least going in the right direction)?

To be sure, supported housing is not a panacea, but its limitations lie more in the larger context than in its raison d'être. This recalls the oft-told parable of the drunken man looking for his keys under the lamppost "because that's where the light is" when he had actually dropped them in the vast dark area around him. Hopper and others who are seeking to broaden the conversation beyond individual agency are spot-on. But looking for the keys (to social inclusion) under the street light (of supported housing) puts the emphasis in the wrong place and narrows the focus to the least problematic of what is a complex and troubling reality.

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In Reply: Padgett's observations are well taken. I agree: supported housing is a step "in the right direction"; that is why I tried to bracket an inquiry into its limits within a pair of tributes to its achievements.

But that said, in sociological terms, abeyance denotes a function, not a facility, and "control over the poor" is too loaded a characterization for the range of institutions that historically have served that function. (Intact families and regular work, as Piven and Cloward [1] pointed out some time ago, also serve important "social control" functions.) Not all abeyance institutions confine or consign to second-class citizenship. Prisons do both miserably and stigmatize for life. But think instead of the G.I. Bill, the Civilian Conservation Corps during the Depression, or, for that matter, intentional communities and religious orders. Some offer a liminal time-out that prepares one for a better equipped second try. Others supply nonmarket alternative livelihoods that revolve around and contribute to collective life. Still others, like the *beguinages*, make inventive use of default options. Founded in the aftermath of population growth and ruinous wars in 12th century Europe,

these segregated communities of "surplus" unmarriageable women managed not only to thrive but to reproduce themselves over the centuries by attracting new recruits to what became valued academies of learning (2). (I had the good fortune to meet the last surviving resident of one in Kortrijk, Belgium.)

The problem with mental health versions of abeyance is that, devised as stop-gap expediencies and assigned what many consider essential "dirty work" (3,4), their day-to-day operations tend to escape scrutiny and their effects (by design or default) go uninterrogated. So one might (as Padgett does) read "visible edifices" as "ironic commentary" on the industry's benighted view of social integration. New York's hulking "adult homes" come to mind. But there are other "congregate settings"—Dorothy Day Apartments in West Harlem, for example—that offer striking evidence of effective designs that integrate secure housing with neighborhood benefit (in Harlem, early childhood learning, tutoring, and arts programs).

More to the point, social segregation is a question not of place but of participatory parity—social arrangements that permit adult members of society to interact with one another as peers (5). And so a more tempered version of my screed would have inquired into tacit assumptions behind largely invisible scatter-site housing to ask what less happy purposes might they serve. In any event, Padgett's letter gives me an opportunity to correct a misimpression: mine was meant as backhanded compliment, not frontal assault.

Kim Hopper, Ph.D.

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Performance Measures for Schizophrenia Research

To the Editor: In developing of a set of performance measures for assessing schizophrenia treatment services, Addington and colleagues (1) have undertaken an important task and put a truly impressive effort into it. A more systematic approach to understanding a broader stakeholder assessment of care is much needed and timely, nowhere more than in schizophrenia. Schizophrenia has a range of fluctuating effects on patients, families, and society, and efforts to identify a single, self-evident measure for evaluating the effectiveness of services have not met with success.

The Delphi approach is an excellent technique for developing consensus and ranking consensus opinions and priorities. We have used it in a number of situations and have found it invaluable to understand treatment priorities (2,3) and outcome measures (4,5). It is, however, just a tool and should not be treated with too much respect. The instructions given must be detailed but also clear and precise, tailored to both the aim of the exercise and to the specific group engaged.

A clear understanding of the ultimate goal of the exercise is key. Although a Delphi process can be used solely for measuring consensus, users of the process are usually seeking consensus on judgments or priorities. This needs to be made clear, and the following statement is an attempt to do so: "Our aim is to identify the two most important performance measures in each domain. To achieve this, the whole range of the assessment ratings must be used." Academics are generally comfortable giving a low rating to items, but clinicians and nonprofessionals need strong encouragement to do so. Many service user and caregiver advocacy groups struggle with assigning a low rating to any item and need constant encouragement to rank the importance of service elements. In our previous work, we had to keep reminding service users and caregivers that rating everything "important" or "essential" effectively wasted their vote: "If you rate everything important, then your ratings cancel each other out and you have no influence on the outcome."

Addington and colleagues' Delphi process reduced 97 items to 36 that participants identified as essential. But this hardly moves us on, especially when one of the eight domains (appropriateness) ended up with 31 performance measures. I do not see how I could change my clinical practice on this basis—and promoting change in clinical practices must surely must be the ultimate purpose of the exercise. Addington and colleagues have got this far, and I would encourage them to return to the group to further refine the results. That way they would produce a focused consensus statement on schizophrenia care performance measures that nobody could ignore.

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In Reply: Burns has made three general points in his letter about our article on performance measures for schizophrenia services. First, he has endorsed the use of the Delphi process for engaging multiple stakeholder groups. Second, he has made

pertinent observations about the process of using the Delphi based on his considerable experience working with multiple groups, including consumers. More specifically, he has pointed out the potential problem that occurs when groups rate many items as essential, and he has made several practical suggestions about how to encourage the group to be more focused and selective. We recognize the value of his suggestions and, in retrospect, we could have improved our Delphi process.

We have a different perspective on his third suggestion, to return to the Delphi group with improved directions in order to obtain a more focused group of performance measures with the goal of changing the practice of individual clinicians with a set of "performance measures that nobody could ignore." The reason underlying our perspective is that we see the identification of measures as only a small step on the path to implementing performance measures in mental health services. In a prior systematic review, we examined the facilitators and barriers to implementing performance measures (1). The review identified seven broad factors that influenced the implementation of performance measures, including indicator characteristics, promotional strategies, implementation strategies, resources, individual factors, organizational factors, and external factors. In our article on performance measures, which is the subject of Burns' letter, we focused on one factor only, indicator characteristics.

We have previous experience with use of the Delphi process as part of the process of identifying performance measures for first-episode psychosis services (2). When we moved to implement these measures, we found that some measures rated as essential were, in practice, hard to specify with precision, and some were difficult to collect. When we studied the use of the available measures to compare services, only one measure, hospitalization, was sufficiently robust and widely available to be considered suitable for setting standards (3). We have since sought to increase the potential value of hospitalization as a performance measure for first-episode psychosis services. First, we developed a risk adjustment formula for hospitalization (4), and second, we tested the validity of hospitalization as a performance measure by demonstrating that it correlated with two other important outcome measures, quality of life and global psychopathology (5).

In conclusion, we see the systematic review and rating of evidence as essential first steps in developing performance measures. The Delphi is a useful next step to narrow the number of measures, but it reflects only opinion evidence, one of the weaker levels of evidence in evidence-based medicine. Further practical steps include the rigorous definition of measures and further research to validate the measures. All these steps would still address only one of the seven factors (indicator characteristics) that we identified as facilitators and barriers to implementing performance measures in mental health services.

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