Selected Papers of William L. White

www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. L. (2013). Contrasting perspectives on recovery: An interview with Larry Davidson, PhD, Department of Psychiatry, Yale University School of Medicine. Posted at **www.williamwhitepapers.com**

Contrasting Perspectives on Recovery: An Interview with Larry Davidson, PhD, Department of Psychiatry, Yale University School of Medicine

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

Introduction

Recovery has become a conceptual fulcrum for transforming both mental health and addiction treatment services in the United States and globally. Pioneers within each of these fields have tried to shift the organizing focus from one of pathology and professional intervention to the long-term lived solutions to these problems that exist in the lives of millions of individuals and families. There have also been pioneers who have sought to use recovery as a conceptual bridge toward greater integration of the fields of mental health and addiction treatment. One of the most effective of these pioneers is Dr. Larry Davidson of Yale who, among other prominent achievements, played critical roles in the recovery-focused systems transformation processes in the State of Connecticut and the City of Philadelphia that have become models for the whole country. Dr. Davidson and I have had numerous opportunities for professional collaboration, and I have been consistently struck by his passion for promoting recovery, his insatiable curiosity about the personal and family recovery experience, and his deep insights into how to move behavioral healthcare to a much more person-centered, recovery-focused process. In late 2012, I had the opportunity to interview Dr. Davidson about key aspects of his work and his views on the future of recovery-focused system transformation processes. Please join us in this engaging interview.

***Bill White*:** You were one of the earliest pioneers in studying and promoting the concept of recovery related to severe mental illness. How did you first get interested in the phenomenology of recovery?

***Larry Davidson*:** I was trained in phenomenology first in graduate school, but was totally unprepared to meet and work with persons with serious mental illnesses. All that I had been taught about them up to that point were caricatures of what life was like in the over-crowded back wards of state

hospitals. When I got to Yale for my clinical internship, I had the great fortune of meeting and then working with John Strauss, MD, who was the first American investigator to conduct longitudinal studies of persons with serious mental illnesses and to find that many people actually improved over time, despite the long-standing pessimism in the field. Most of the research John had conducted up to that point had been quantitative, and he was frustrated that these methods weren't allowing him to learn about the factors that seemed to really help people get better. Research participants told John things like "It was having someone believe in me, even when I didn't believe in myself," "what was key for me was having hope," or "it was that nurse who told me that I could get better if I tried who made the biggest difference in my recovery." Yet the methods John was using didn't allow him access to these kinds of experiences. At the same time, I was working intensively with people with serious mental illnesses for the first time and finding them to be nothing like my textbooks had described them. So my training in phenomenology seemed to me to be a perfect way to bring qualitative methods to the longitudinal studies that John had been doing and for us both to gain a better and deeper understanding of what these folks were talking about.

***Bill White*:** How would you summarize as of 2013 what we know from the standpoint of science about recovery from schizophrenia and other severe mental illnesses?

***Larry Davidson*:** While we continue to know very little about what causes serious mental illnesses or what they in fact are (i.e., in terms of pathophysiology), we do know considerably more about processes and outcomes. We know, for example, that between 45 – 65% of persons diagnosed with schizophrenia—which is the most severe of the mental illnesses—experience significant improvement over time, with many of them recovering fully. Less than 25% experience the chronic, deteriorating course that we were all taught about in graduate and medical schools, so that 75% will experience some clinical and functional improvement. Just as important, however, we also know that "recovery" is possible even for people who may not recover in a clinical or medical sense. People may not be cured, but they nonetheless can figure out ways to manage the symptoms or impairments that medications don't eliminate and can have self-determined lives of their choosing—which is what has come to be referred to as "being in recovery" or "personal recovery" as distinct from clinical/medical recovery. In other words, we now know that serious mental illnesses are conditions that most people can live meaningful lives with, and from which many people can recover fully over time.

***Bill White*:** How is the emergence of recovery as a new organizing paradigm changing the design and delivery of mental health services in the United States?

***Larry Davidson*:** I think the biggest change that the recovery paradigm has introduced, and the change that poses the most difficulty for traditional clinicians to understand and accept, is that recovery is primarily the responsibility of the person rather than the practitioner. In the past, we practitioners thought we were responsible for "treating" people, for fixing people, and that after we fixed them, or cured them, they would then go back to their lives and go about their business. What the recovery paradigm has taught us is that people are active agents in their own lives whether well or ill, and that recovery does not come about through their passively following the instructions or guidance of others, no matter how well-trained or well-intended those others may be. We cannot "do" recovery to or for other people. We cannot make decisions for people and expect them to learn how to make better choices for themselves. So practitioners need to move from an expert/authority position to that of a consultant or coach, and while these roles are much more effective and gratifying, they are not the role that most practitioners were trained for.

***Bill White*:** What have you found to be the major sources of resistance to the emergence of recovery as an organizing concept?

***Larry Davidson*:** In addition to needing to cede power and authority over the person's life back to the person him or herself, the other major sources of resistance seem to stem from the discriminatory attitude our respective disciplines, or the field as a whole, has had toward persons with serious mental illnesses. Pat Deegan has described this attitude as one of "mentalism," as it parallels other "isms" like racism and sexism, and other forms of prejudice. Practitioners have a hard time believing that persons with serious mental illnesses can still be competent, intelligent, mature adults. They have a hard time viewing people with serious mental illnesses as worthy of love and capable of loving others. It's as if accepting that people with psychotic disorders are still human beings—with all of the rights to respect, dignity, and autonomy that come with that —poses some fundamental challenge to how people understand the meaning of their own lives. If this person can be irrational, can talk nonsense (either by not making sense or by describing experiences I and others don't typically have, like hearing voices), and cannot seem to complete school or hold down a respectable job, and if he or she is still worthy of dignity and respect, then what do I work so hard for? It seems like in some ways, persons with serious mental illnesses may be one of the few remaining groups of people who it is acceptable to look down on in order to feel good about ourselves. We can no longer discriminate against people of different races or sexual orientations, and we can no longer discriminate against women, even though of course we still do. But it can be very difficult for practitioners to understand that we have, and continue to, discriminate against persons with serious mental illnesses in the same way. And because practitioners seldom have the opportunity to see people recover over time, they remain skeptical of the possibility of recovery, not believing that you can lead a normal life while still having a mental illness. But this, too, is changing, as more practitioners see more and more people in recovery, and as more people in recovery become visible role models.

***Bill White*:** We have often discussed that the mental health field has held out the promise of partial recovery but until recently lacked the concept of full recovery, whereas the addictions field extolled full recovery but has had no concept of partial recovery. Could you elaborate on this comparison and its effects?

***Larry Davidson*:** Yes, this is very consistent with what I was just saying about discrimination. While folks in the addiction field thought that you have to recover completely and be totally abstinent in order to no longer have an addiction, folks on the mental health side were being taught that full recovery was impossible. People might show some improvements in some aspects of their lives, fewer symptoms perhaps, but the belief that "once a schizophrenic, always a schizophrenic" was handed down from Emil Kraepelin back in 1904 and was unquestioned until very recently. In fact, when John Strauss first starting publishing his studies, which showed that many people with schizophrenia recovered over time, one of the main criticisms launched against his research was that these people must have been misdiagnosed to begin with because "we know that people with schizophrenia can't recover." This has been an incredibly damaging, as well as untrue, belief that led to people wasting their lives away in over-crowded custodial institutions and to generations of practitioners telling people, and their families, that they would never recover and should give up all hope for having a decent life. While many people got better despite these devastating predictions, and outside of the treatment system, many others believed these pronouncements, which tragically became self-fulfilling prophecies.

What is interesting about the difference between mental health and addictions is that it may turn out not to be a real difference after all. The belief that only

total abstinence can qualify as "recovery" reflects a similar belief that "once an addict, always an addict." It is because of such a deeply-entrenched belief that many people believe that someone who was once addicted to alcohol will never be able to drink again without becoming re-addicted. This is a belief that is equally ***not*** supported by the research evidence, even though it remains a tenet of the 12-step fellowship. In both cases, hard and fast, black and white, distinctions were drawn between "the mentally ill" or "the addicted" on the one hand, and "normal" people on the other, when in reality it is a matter of degree on a continuum and an ever evolving picture. People can have more or less severe a mental illness and a more or less severe addiction, depending on a number of factors (only a few of which we actually know), and likewise, there can be many different degrees and types of recovery. While the two fields may be coming at it from opposite ends of the spectrum, they are finally converging on an understanding that behavioral health conditions are things that happen to normal people (i.e., all of us) and from which many different forms of recovery are possible. In both cases, we are faced with overthrowing the destructive legacy of believing that either a mental illness or an addiction can define who a person is and will be for the remainder of his or her life.

***Bill White*:** You have suggested for many years that recovery could be a bridge to help integrate mental health and addiction treatment services. What common ground does use of the recovery concept create?

***Larry Davidson*:** I guess I was anticipating this next question in my last answer. What I have argued is that as long as the two fields focus on the nature of the pathology in question, they will remain distinct and separate from each other. There are important ways in which addictions are different from mental illnesses in terms of their disruptive effects in people's lives. But when we turn our attention to processes of recovery, the number of commonalities and parallels vastly overshadows these differences. In this way, recovery and the requirements of recovery-oriented care (e.g., being strength-based, person-centered, etc.) provide a bridge for integrating the two fields that has been missing as long as efforts focused on diagnoses and disorders. And that is because the people battling back from these conditions are much more alike than different from each other, as are their paths for healing. The "common factors" (to borrow a term from the field of psychotherapy research) such as hope, resilience, courage, determination, social support, and valued social roles—the various components of recovery capital—matter to all people, regardless of their particular health conditions. We can much more readily join forces and integrate our efforts, especially for people who experience both conditions, when we focus on these basic human processes as the foundation for any efforts in addressing the specific disorders.

***Bill White*:** How would you critique the present state of integration of mental health and addiction services in the U.S.?

***Larry Davidson*:** Outside of a few innovative systems, I don't know that much progress has been made in integration thus far. Most of the states I have been working with recently are just beginning the process of integration, and are facing considerable challenges. In some states, the mental health systems are embracing recovery and the addiction systems are not even aware of the new meaning of the term, while in other states, the opposite is true. It is hard to find a system in which the two fields are converging around this new paradigm, with the exception of the State of Connecticut and the City of Philadelphia. I am hopeful that health care reform will bring these fields together, along with integrating them with primary care. It is time that all of these various subfields were brought together under health care broadly defined, as long as primary care learns from behavioral health as well as vice versa.

***Bill White*:** What do you see as the most important next step toward such integration?

***Larry Davidson*:** In addition to health care reform, which is now moving ahead with some momentum, I look to the U.S. Substance Abuse and Mental Health Services Administration to better coordinate, if not more fully integrate, the work of two of its centers: the Center for Mental Health Services (CMHS) and the Center for Substance Abuse Treatment (CSAT). Each Center has its own history and its own perspective, but if the notion of an integrated "behavioral health" approach is to replace these two historical silos, more work needs to go on at the federal level first before such expectations can be placed on the states. For example, CSAT has promoted the notion of "recovery-oriented systems of care" (ROSC, which we first introduced in Connecticut in 2002), but they have promoted this concept as relevant to substance use services only, leaving the mental health component of the system untouched and unintegrated. At the same time, CMHS funded about ten mental health state transformation infrastructure grants that would only fund infrastructure changes for mental health services, not addiction services. SAMHSA needs to lead by example by bringing the two fields together at the federal level.

***Bill White*:** You have served as a senior policy consultant to the two most iconic recovery-oriented systems of care in the U.S.: the State of Connecticut and the City of Philadelphia. In your view, what has made these two systems of care so special?

***Larry Davidson*:** Leadership has certainly been key. Tom Kirk, Commissioner in Connecticut from 1999 to 2009, had a very clear vision of the kind of service system he thought persons with behavioral health disorders deserved even before the President's New Freedom Commission on Mental Health released its report or the new addiction recovery movement had gathered much momentum. And it was the same kind of system that he and his loved ones would want for their own care. To this day, Tom still claims not to understand how anyone could expect anything less for the folks relying on public sector care. He brought his commitment to this vision, and a belief in the power of the recovery community, to his job as Commissioner, and that made a huge difference. A hallmark of the Connecticut approach was to involve the recovery community early and throughout the system transformation process, from the initial drafting of a slate of common values and principles that both the mental health and addiction recovery communities could agree on, to the development and funding of peer recovery support services and the involvement of service users and family members in quality improvement and outcomes monitoring.

As you know, Arthur Evans was the Deputy Commissioner under Tom who was responsible for the recovery initiative in Connecticut from 2000-2004, when he left to become the Director of Behavioral Health for the City of Philadelphia. Arthur has led the Philadelphia transformation process in the same participatory and inclusive way, with the recovery community playing a prominent role in articulating the vision and guiding the process along with practitioners, family members, and community stakeholders. The Philadelphia process has been somewhat different from Connecticut's, in that it started a bit later and could build on both the New Freedom Commission on Mental Health and the growth of recovery support services funded by CSAT. Also, given Arthur's interest in evidence-based practice and professional education, the Philadelphia transformation has paid more attention to clinical care and the ways in which clinical practice needs to change to be recovery and resilience-oriented. Practitioners were primarily skeptical and reluctant to change their own practices early on in the Connecticut process, but have been extremely innovative in Philadelphia. In both cases, though, it has been a matter of the combination of visionary and charismatic leadership from the top down with extensive grassroots involvement of the recovery community from the bottom up.

***Bill White*:** What lessons have you drawn from your work helping facilitate the development of recovery-focused systems of care?

***Larry Davidson*:** I always come back to the need for persons in recovery to play leadership roles at the top and throughout the system of care. Most often, system leaders who are looking to transform their system to a recovery orientation bring their old habits with them, meaning they initially view the transformation process as one that they must lead and in which persons with behavioral health conditions are expected to play a passive and subordinate role. While leadership from the top is obviously important, it is equally important that that leadership recognize the transformative value of inviting and including the recovery community to be intimately involved. In the language of the New Freedom Commission, there is no way to achieve a "consumer- and family-driven system of care" without consumers and families driving the process itself. Just like with recovery, you can't wait until some mythic time "later" when you'll be "ready" for consumer and family input. But persuading system leaders that the people they are accustomed to "treating," accustomed to viewing as "mental patients" or "addicts," are actually the ones with the best ideas of how to improve the system has been difficult. So the main lesson I have learned, I think, is the unfortunate one that addressing and eliminating stigma and discrimination are really the most important and essential challenges that have to be tackled before much other progress will be made. In fact, once those issues are adequately addressed, the rest of the work follows relatively smoothly.

***Bill White*:** You have conducted reviews of the scientific evidence on peer-based recovery support services that have become such a visible component of efforts to create recovery-oriented systems of care. What conclusions can be drawn from your reviews of studies on peer recovery support services?

***Larry Davidson*:** More research has been done thus far on the mental health side, but I'm confident that the addiction recovery research getting underway will find similar results. Thus far, we know that peer staff can deliver conventional mental health services as effectively as non-peers performing the same functions (e.g., case management). In addition, we know that peer support has been associated with a decreased use of hospital days and emergency room visits and improvements in a range of outcomes, particularly in quality of life domains, as well as enhanced care processes, including people taking on a more active role in their care and self-care and finding care to be more culturally responsive and collaborative. On the addiction side, thus far recovery support services have been associated with decreased systems' use of high-cost, acute care services and improved client outcomes in terms of both sustained abstinence and quality of life domains. We don't know yet what precisely are the "active ingredients" of peer support, but we still don't know that in terms of clinical care either, and that has been researched for 50 years.

***Bill White*:** ROSC efforts extoll the value of person-centered care and the importance of personal choices. How can this be reconciled with the increased role of external coercion in bringing people with substance use and/or mental health disorders into treatment?

***Larry Davidson*:** I'm not aware of an increase in coercion in mental health in the recent past. In fact, since the 1999 Dodd-Lieberman restraint and seclusion legislation was passed, there has been a significant decrease in the use of coercive measures within mental health settings. There may still be the same degree of coercion in getting people into care, but that will likely only change once we have recovery-oriented services to engage them. In any case, it seems to me that health care reform pushes back against coercion by stressing the importance of person-centered health care homes that are collaborative and incorporate

shared-decision making. I also am an eternal optimist, so I'm always seeing the half of the glass that is full. In this case, choice and the incorporation of recovery support services are important components of health care reform and should fare well over at least the next 4 years.

***Bill White*:** You have published a couple of hundred articles in peer-reviewed journals, and you have been a popular speaker on the professional conference lecture circuit for almost 20 years. Have these been effective forums to influence the quality of behavioral health care?

***Larry Davidson*:** I know that the research literature suggests that conference and other one-time presentations are limited in their impact, but I've been heartened by the changes I have seen over the last 20 years in behavioral health and would like to think that I've played some role in that. Culture change happens in often invisible ways, or behind the scenes, and presentations and conferences seem to be important components of such change. In terms of the 200+ peer-reviewed articles, they reach a smaller, but presumably influential, community of policymakers as well as fellow academics.

***Bill White*:** As you look back over your career to date, what activities stand out as most important and most gratifying to you?

***Larry Davidson*:** Drafting the first Commissioner's Policy on developing a recovery-oriented system of care in 2001 in Connecticut was probably the first opportunity that I had to see the recovery vision that had been developing slowly since the 1970s be put into policy and then practice. That was enormously gratifying, to see research and advocacy result in actual and substantial changes in people's everyday lives. More recently, visiting different communities around the U.S. and other countries, and seeing how far this vision of recovery has come toward being realized has also been very meaningful. I am fond of pointing out how when I came into the field in the 1980s, CPS was a term that was used all of the time in mental health settings as shorthand for "chronic paranoid schizophrenic." Now that term, which is still used almost as frequently—and may even be used to refer to the same person—is shorthand for "certified peer specialist." While we still have a long way to go, I think that shift captures for me the degree of change we've already seen in the field, and that is a really wonderful way to capture what has been gratifying to me.

***Bill White*:** Is there a particular goal that will be the focus of your future work in the field?

***Larry Davidson*:** I am primarily focused on two areas that still need a lot of work. The first is what to do once you have developed a person-centered recovery plan with someone. You have identified strengths to build on and goals to pursue, but how do you best support the person in his or her going from point A to point B? We need more tools and we need a better understanding of what gets in the way and what kinds of resources and strategies are needed to overcome the barriers posed by mental illnesses and addictions. We've looked at the occupational therapy concept of "activity analysis" to help with this, but it needs to be adapted and expanded for use in behavioral health along with existing and yet-to-be-developed clinical skills. The second is the nature of helping and healing relationships. While we know something about the so-called "common factors" underlying psychotherapeutic relationships—factors like empathy, positive regard, and active listening—there is still a lot we do not know in terms of how to teach people how to cultivate such relationships and how to refashion these relationships to be more fully recovery-oriented. For example, I was trained to leave my work at the office at the end of the day so that I could have a gratifying personal life and not "burn out." This view was based on the premise that I could, and would, curtail my emotional response to my patients' suffering by viewing them as "schizophrenics" and "borderlines" (i.e., fundamentally different from me). We

can no longer afford the luxury of such a defense in recovery-oriented practice, and this leaves us without ready-made ways to deal with the secondary or vicarious trauma that is part and parcel of this work when it is carried out in recovery-oriented ways. I hope to make some progress in developing new models for these relationships that allow for reciprocity and yet also allow for practitioners to preserve their own well-being and personal lives while they do this work.

***Bill White*:** Larry, thank you for taking this time to share your experience and thoughts on these important issues.

***Larry Davidson*:** It's been my pleasure. I feel very honored to have been included.

Acknowledgement: Support for this interview series is provided by the Great Lakes Addiction Technology Transfer Center (ATTC) through a cooperative agreement from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT). The opinions expressed herein are the view of the authors and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA, or CSAT.

Selected Publications

Bedregal, L.; O'Connell, M.J.; & Davidson, L.: The Recovery Knowledge Inventory: Assessment of mental health staff knowledge and attitudes about recovery. *Psychiatric Rehabilitation Journal*, 2006, 30(2), 96-103.

Bellamy, C.D.; Rowe, M.; Benedict, P.; & Davidson, L.: Giving back and getting something back: The role of mutual aid groups for individuals in recovery from incarceration, addiction, and mental illness. *Journal of Groups in Addiction & Recovery,* 2012, 7:223–236.

Borg, M. & Davidson, L.: The nature of recovery as lived in everyday experience. *Journal of Mental Health*, 2008, 17(2): 129-140.

Borg, M.; Sells, D.; Topor, A.; Mezzina, R.; Marin, I.; & Davidson, L.: What makes a house a home? Perspectives of people in recovery from psychosis. *American Journal of Psychiatric Rehabilitation,* 2005, 8(3): 243-256.

Chinman, M.; Rosenheck, R.; Lam, J.A.; & Davidson, L.: Comparing consumer and non-consumer provided case management services for homeless persons with serious mental illness. *The Journal of Nervous and Mental Disease*, 2000, 188: 446-453.

Chinman, M.J.; Young, A.S.; Hassell, J.; & Davidson, L.: Toward the implementation of mental health consumer provider services. *Journal of Behavioral Health Services and Research,* 2006, 33(2): 176-195.

Davidson, L.: *Living Outside mental illness: Qualitative studies of recovery in schizophrenia*. New York: New York University Press, 2003.

Davidson, L.: 'Recovery' as a response to oppressive social structures. *Chronic Illness,* 2008, 4: 305-306.

Davidson, L.: Us and them. *Psychiatric Services*, 2001, 52: 1579-1580.

Davidson, L.: Recovery from psychosis: What's love got to do with it? *Psychosis*, 2011, 3(2): 105-114.

Davidson, L.: Use of coercion in recovery-oriented care: Staying vigilant. *Psychiatric Services*, 2012, 63(8): 834.

Davidson, L.; Andres-Hyman, R.; Tondora, J.; Fry, J.; & Kirk, T.: From "Double Trouble" to "Dual Recovery": Integrating models of recovery in addiction and mental health. *Journal of Dual Diagnosis*, 2008, 4(3): 273-290.

Davidson, L.; Bellamy, C.; Guy, K.; & Miller, R.: Peer support among persons with severe mental illnesses: A review of evidence and experience. *World Psychiatry*, 2012, 11(2): 123-128.

Davidson, L.; Borg, M.; Marin, I.; Topor, A.; Mezzina, R.; & Sells, D.: Processes of recovery in psychosis: Findings from a multi-national study. *American Journal of Psychiatric Rehabilitation,* 2005, 8(3): 177-201.

Davidson, L.; Chinman, M.; Sells, D.; & Rowe, M.: Peer support among adults

with serious mental illness: A report from the field. *Schizophrenia Bulletin,* 2006, 32: 443-450.

Davidson, L.; Flanagan, E.; & Styron, T.: Designing policies to foster the community inclusion of people in recovery. In Ryan, P.; Ramon, S.; & Greacen, T. (Eds.), *Empowerment, lifelong learning, and recovery in mental health: Towards a new paradigm*. London: Palgrave Macmillan, 2012, pp. 85-98.

Davidson, L.; Harding, C.M.; & Spaniol, L.: *Recovery from severe mental illnesses: Research evidence and implications for practice*. *Volume 1.* Boston, MA: Center for Psychiatric Rehabilitation of Boston University, 2005.

Davidson, L.; Harding, C.M.; & Spaniol, L.: *Recovery from severe mental illnesses: Research evidence and implications for practice*. *Volume 2.* Boston, MA: Center for Psychiatric Rehabilitation of Boston University, 2006.

Davidson, L.; Kirk, T.; Rockholz, P.; Tondora, J.; O'Connell, M.J.; & Evans, A.C.: Creating a recovery-oriented system of behavioral health care: Moving from concept to reality. *Psychiatric Rehabilitation Journal,* 2007, 31(1): 23-31.

Davidson, L.; Lawless, M.R.S.; & Leary, F.: Concepts of recovery in mental illness: Competing or complimentary? *Current Opinion in Psychiatry,* 2005, 18: 664-667.

Davidson, L.; Miller, R.; & Flanagan, E.: What's in it for me? The utility of psychiatric treatments from the perspective of the person in recovery. *Epidemiologia e Psichiatria Sociale*, 2008, 16(3): 177-181.

Davidson, L.; O'Connell, M.; Tondora, J.; Staeheli, M.R.; & Evans, A.C.: Recovery in serious mental illness: A new wine or just a new bottle? *Professional Psychology: Research and Practice,* 2005, 36(5): 480-487.

Davidson, L.; O'Connell, M.; Tondora, J.; Staeheli, M.R.; & Evans, A.C.: Recovery in serious mental illness: Paradigm shift or shibboleth? In Davidson, L.; Harding, C.M.; & Spaniol, L. (eds.), *Recovery from severe mental illnesses: Research evidence and implications for practice*. *Volume 1.* Boston, MA: Center for Psychiatric Rehabilitation of Boston University, 2005, pp. 5-26.

Davidson, L.; O'Connell, M.J.; Tondora, J.; Styron, T.; & Kangas, K.: The top ten concerns about recovery encountered in mental health system transformation. *Psychiatric Services,* 2006, 57(5): 640-645.

Davidson, L.; Rakfeldt, J.; & Strauss, J.S.: *The roots of the recovery movement: Lessons learned*. London: Wiley-Blackwell, 2010.

Davidson, L. & Ridgway, P.: The Community Support Movement and its demise. In Rowe, M.; Lawless, M.; Freeman, R.; Thompson, K.; & Davidson, L. (Eds.). *Classics of community psychiatry*. New York: Oxford University Press, 2009.

Davidson, L.; Ridgway, P.; Schmutte, T.; & O'Connell, M.: Purposes and goals of service user involvement in mental health research. In Wallcraft, J.; Amering, M.; & Schrank, B. (Eds.), *Handbook of service user involvement in mental health research*. London: Wiley, 2009, pp. 87-98.

Davidson, L.; Ridgway, P.; Wieland, M.; & O'Connell, M. A capabilities approach to mental health transformation: A conceptual framework for the recovery era. *Canadian Journal of Community Mental Health,* 2009, 28(2): 35-46.

Davidson, L. & Roe, D.: Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health,* 2007, 16(4): 1-12.

Davidson, L.; Sells, D.; Sangster, S.; & O'Connell, M.J.: Qualitative studies of recovery: What can we learn from the person? In Ralph, R. & Corrigan, P. (Eds.), *Recovery in mental illness: Broadening our understanding of wellness*. Washington, D.C.: American Psychological Association, 2004, pp. 147-170.

Davidson, L.; Tondora, J.; & O'Connell, M.J.: How to recognize a recovery-oriented

practice. World Association for Psychosocial Rehabilitation (WAPR) *Bulletin*, 2010, 26/27, 17-19.

Davidson, L.; Tondora, J.; O'Connell, M.J.; Lawless, M.S.; & Rowe, M.: *A practical guide to recovery-oriented practice: Tools for transforming mental health care.* New York: Oxford University Press, 2009.

Davidson, L.; Tondora, J.; & Ridgway, P.: Life is not an "outcome": Reflections on recovery as an outcome and as a process. *American Journal of Psychiatric Rehabilitation,* 2010, 13(1): 1-8.

Davidson, L.; Tondora, J.S.; Staeheli, M.R.; O'Connell, M.J.; Frey, J.; & Chinman, M.J.: Recovery guides: An emerging model of community-based care for adults with psychiatric disabilities. In Lightburn, A. & Sessions, P. (Eds.), *Community based clinical practice*. London: Oxford University Press, 2006, pp. 476-501.

Davidson, L; Weingarten, R.; Steiner, J.; Stayner, D.; & Hoge, M.: Integrating prosumers into clinical settings. In Mowbray, C.T.; Moxley, D.P.; Jasper, C.A.; & Howell, L.L. (Eds.), *Consumers as providers in psychiatric rehabilitation*. Columbia, MD.: International Association for Psychosocial Rehabilitation Services, 1997, pp. 437-455.

Davidson, L. & White, W. The concept of recovery as an organizing principle for integrating mental health and addiction services. *Journal of Behavioral Health Services and Research, 2*007, 34: 109-120.

Davidson, L.; White, W.; Sells, D.; Schmutte, T.; O'Connell, M.; Bellamy, C.; & Rowe, M. Enabling or engaging? The role of recovery support services in addiction recovery. *Alcoholism Treatment Quarterly*, 2010, 28(4): 391-416.

Kidd, S.A.; George, L.; O'Connell, M.; Sylvestre, J.; Kirkpatrick, H.; Browne, G.; Odueyungbo, A.; & Davidson, L. Recovery-oriented service provision and clinical outcomes in Assertive Community Treatment. *Psychiatric Rehabilitation Journal,* 2010, 34(3): 194–201.

Le Boutillier, C.; Leamy, M.; Bird, V.J.; Davidson, L.; Williams, J.; & Slade, M.: What does recovery mean in practice? A qualitative analysis of international recovery-oriented practice guidance. *Psychiatric Services*, 2011, 62:1470-1476.

Marin, I.; Mezzina, R.; Borg, M.; Topor, A.; Lawless, M.S.; Sells, D.; & Davidson, L.: The person's role in recovery. *American Journal of Psychiatric Rehabilitation,* 2005, 8(3): 223-242.

Mezzina, R.; Borg, M.; Marin, I.; Sells, D.: Topor, A.; & Davidson, L.: From participation to citizenship: How to regain a role, a status, and a life in the process of recovery. *American Journal of Psychiatric Rehabilitation*, 2006, 9(1): 39-62.

Mezzina, R.; Davidson, L.; Borg, M.; Marin, I.; Topor, A.; & Sells, D.: The social nature of recovery: Discussion and implications for practice. *American Journal of Psychiatric Rehabilitation*, 2006, 9(1): 63-80.

Mourra, S.; Sledge, W.H.; Lawless, M.S.; Sells, D.; & Davidson, L.: Pushing, patience, and persistence: Characterizing the common experiences of peer support providers. *American Journal of Psychiatric Rehabilitaiton.*

O'Connell, M.J. & Davidson, L.: Recovery-oriented care and choice. *Psychiatric Services,* 2010, 61(8): 845.

O'Connell, M.J.; Tondora, J.; Evans, A.C.; Croog, G.; & Davidson, L.: From rhetoric to routine: Assessing recovery-oriented practices in a state mental health and addiction system. *Psychiatric Rehabilitation Journal*, 2005, 28(4): 378-386.

Peebles, S.A.; Mabe, P.A.; Davidson, L.; Fricks, L.; Buckley, P.F.; & Fenley, G.: Recovery and systems transformation for schizophrenia. *Psychiatric Clinics of North America*, 2007, 30:567-583.

Pelletier, J.F.; Davidson, L.; & Roelandt, J.L. Citizenship and recovery for everyone: A global model of public mental health. *International Journal of Mental Health Promotion*, 2009, 11*(*4): 45-53.

Roe, D. & Davidson, L.: Recovery. In

Mueser, KT. & Jeste, D.V. (Eds.), *Clinical handbook of schizophrenia*. New York: Guilford Publications, Inc., 2008, pp. 566-574.

Rowe, M.; Lawless, M.; Freeman, R.; Thompson, K.; & Davidson, L.: *Classics of community psychiatry*. New York: Oxford University Press, 2009.

Schrank, B.; Hayward, M.; Stanghellini, G.; & Davidson, L.: Hope in psychiatry. *Advances in Psychiatric Treatment*, 2011, 17: 227-235.

Sells, D.; Andres-Hyman, R.; Lawless, M.S.; Borg, M.; Topor, A.; Mazzina, R.; Marin, I.; & Davidson, L.: Contexts and narratives of recovery. *American Journal of Psychiatric Rehabilitation,* 2005, 8(3): 203-221.

Sells, D.; Borg, M.; Marin, I.; Mezzina, R.; Topor, A.; & Davidson, L.: Arenas of recovery for persons with psychosis. *American Journal of Psychiatric Rehabilitation,* 2006, 9(1): 3-16.

Sells, D.; Davidson, L.; Jewell, C.; Falzer, P.; & Rowe, M.: The treatment relationship in peer-based and regular case management services for clients with severe mental illness. *Psychiatric Services,* 2006, 57(8): 1179-1184.

Shahar, G.; Kidd, S.; Styron, T.; & Davidson, L.: Consumer support and satisfaction with mental health services in severe mental illness: The moderating role of morale. *Journal of Social and Clinical Psychology,* 2006, 25(9): 945-962.

Storm, M. & Davidson, L.: Inpatients' and providers' experiences with user involvement in inpatient care. *Psychiatric Quarterly*, 2010, 81: 111-125.

Tondora, J. & Davidson, L.: *Practice guidelines for recovery-oriented behavioral health care.* Hartford, CT: Connecticut Department of Mental Health and Addiction Services, 2006. Second edition released in 2008.

Tondora, J.; Miller, R.; & Davidson, L.: The top ten concerns about person-centered care planning in mental health systems. *International Journal of Person Centered Medicine*.

Tondora, J.; Pocklington, S.; Gorges, A.; Osher, D.; & Davidson, L.: *Implementation of person-centered care and planning. From policy to practice to evaluation*. Washington D.C.: Substance Abuse and Mental Health Services Administration, 2005.

Topor, A.; Borg, M.; Di Girolamo, S.; & Davidson, L.: Not just an individual journey: Social aspects of recovery. *International Journal of Social Psychiatry*, 2009, 57(1): 90–99.

Topor, A.; Borg, M.; Mezzina, R.; Sells, D.; Marin, I.; & Davidson, L.: Others: The roles of family, friends, and professionals in the recovery process. *American Journal of Psychiatric Rehabilitation*, 2006, 9(1): 17-38.

White, W. & Davidson, L. Recovery: The bridge to integration? Part one. *Behavioral Healthcare,* 2006, 26(11): 22-25.

White, W. & Davidson, L. Recovery: The bridge to integration? Part two. *Behavioral Healthcare,* 2006, 26(12): 24-26.