

# **Designing Policies to Foster the Community Inclusion of People in Recovery**

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## Abstract

Drawing on their last decade of experiences in managing and beginning to transform both local and state-wide systems of mental health care, the authors outline a number of policy initiatives that aim to foster the community inclusion of individuals living with serious mental illnesses. These policies address settings both inside and outside of the mental health system, and share the common goal of viewing and treating people with serious mental illnesses first and foremost as citizens of the community. Examples from within mental health settings include a prohibition of having segregated (“staff only”) bathrooms, understanding that diagnoses refer to psychiatric conditions and not people, and including within treatment, service, or care plans, the individual’s goals that would constitute a life in the community. Several strategies for creating a more porous interface between the mental health system and the broader community are offered, and examples that extend to settings beyond the mental health system include a prohibition against creating artificial environments that seek to replicate naturally occurring community activities, laws that prohibit discrimination against persons with serious mental illnesses, and community education campaigns that target stigma. We conclude that much work remains to be done in salvaging the contributions people in recovery can make to their communities.

For the purposes of this chapter, we would like to begin by drawing an important distinction between community *integration* and community *inclusion*, explaining why we have chosen the latter for the current task at hand. Community integration is the notion that has been used more often in the history of community mental health, and its use reflects the limited success of that movement. Briefly stated, community integration refers to the process of assisting a person to become re-engaged in community life, and the reciprocal process of assisting a community to accept and welcome back persons who have been extruded from community life, *once the person's condition has been resolved*. In this sense, community integration can refer equally well to offenders returning to the community from prison or immigrants becoming acculturated to the community they have chosen to adopt, and be adopted by. In each of these cases, what marked the person as different and accounted for his or her need *to be* integrated (i.e., what caused his or her extrusion or alienation in the first place) is no longer present. In the case of mental illness, this has meant be cured of your illness first, recover from or overcome the symptoms and deficits associated with the illness first, and then we will welcome you back within our community. The problem with applying this model to mental illnesses is that we do not yet have a cure for these conditions.

Community inclusion, on the other hand, comes primarily from the disability community, and assumes that certain conditions will not go away, at least for the foreseeable future, if not for the remainder of the person's life. For such people whose conditions cannot yet be resolved, a community integration paradigm makes little sense, as they do not want to wait—nor should they be made to wait—to recover from or overcome their disability in order to enjoy all of the rights and responsibilities of full community membership. The community inclusion paradigm argues instead that people with long-term disabilities—including people with long-term *psychiatric*

disabilities—should be accepted and welcomed by their communities as they are, with whatever conditions they may have, without having to be cured, fixed, or otherwise made to conform to select societal norms first. The prototype for community inclusion is thus people with a range of physical disabilities for which accommodations have been successfully developed, such as people who use wheelchairs to compensate for mobility impairments, people who use Braille or service dogs to compensate for visual impairments, and people who use sign language and visual cues (e.g., for phones and doorbells) to compensate for auditory impairments. In these cases, the community bears a share of the responsibility for accommodating the person's disability, for making its own changes (e.g., installing handrails in bathrooms and Braille signs on elevators) in order to facilitate the person's full access to and involvement in community life. It is the person's responsibility to learn, or figure out, how to compensate for the disability and to take advantage of the accommodations provided in order to pursue a full and contributing life.

Since the field of psychiatry has yet to discover or develop a cure for serious mental illness, and since the treatments that currently exist are extremely limited in their effectiveness even in containing the illness, we argue in this chapter that community inclusion represents a more appropriate and promising approach for persons living with serious mental illnesses than the traditional approach of community integration. Consistent with at least some camps within the international Mental Health User/Consumer/Survivor Movement, we argue that the adoption of a disability paradigm opens up new opportunities and creates access to a range of new and more effective supports for people who have yet to recover from the illness. In response to the remaining camps within this Movement who reject a disability paradigm, it is important to add that adoption of a community inclusion paradigm need not consign a person to a life of dependency and disability. It does not indicate or require a giving up of hope or effort toward full

recovery. Rather, it is based on research and accumulated clinical experience that suggests that recovery is more likely to be promoted by the person's efforts to reclaim his or her life despite symptoms or impairments, rather than by waiting for the symptoms or impairments to disappear. In other words, a person is more likely to go from learning how to live fully *with* a disability to no longer being disabled at all (i.e., to "full" recovery) than to go directly from being ill to being well. In terms of (albeit imperfect) medical analogies, serious and prolonged mental illnesses are more like chronic illnesses such as asthma than like acute illnesses such as the flu or an infection.

How, then, to design social policies to foster the community inclusion of persons with serious and prolonged psychiatric disabilities? How to create accommodations, or make what are called "environmental modifications," to facilitate the inclusion of people who are "in recovery" with a serious mental illness? We use "in recovery" in this context to refer to that form of "recovery" introduced and advocated for by the User/Consumer/Survivor movement, which we distinguish from the traditional medical/psychiatric concept of "recovering from" the disorder. Being "in recovery" refers to living a safe, dignified, gratifying, self-determined life in the face of an ongoing mental illness, rather than to no longer experiencing the signs, symptoms, and impairments associated with the disorder. In this way, being in recovery parallels the notion of living with a psychiatric disability, with the added connotation that the person has taken charge of his or her life and is actively pursuing ways of managing and compensating for the disability (rather than living a life of despair or resignation). Readers who are interested in learning more about this distinction between recovering from and being in recovery are referred to a previous publication on this topic (Davidson & Roe, 2007).

We suggest that there are at least three different foci for policies to foster community inclusion for people "in recovery." The first of these is a focus on the mental health system itself,

and on how it can better promote community inclusion through the services and supports it offers. The second focus is on the interface between the mental health system and the broader community, and on innovative strategies the mental health system can adopt to be make this interface more porous in both directions. The third and final focus is on the broader community, the locus of the inclusion to be achieved, and on how it can better facilitate and accommodate the involvement of people with psychiatric disabilities. We will take each in turn.

### **Policies Focused on the Mental Health System**

In terms of the mental health system, it is an unfortunate reality that most mental health services currently pose more of an obstacle to community inclusion than facilitate it. This is due to a number of factors, but stems primarily from the history of institutionalization and its effects, leaving a legacy of prejudice and discrimination against persons with serious mental illnesses that has lingered within community-based service systems. This legacy can be found on three levels within the mental health system: the institutional level, the level of the individual client or service recipient, and the level of individual providers.

By “institutional level,” we refer to the fact that many of the current policies of mental health systems inhibit rather than promote the community inclusion of people in recovery. Some of these may be attributed to the legacy of secrecy and neutrality fostered by the psychodynamic paradigm, which has created rigid and hierarchical boundaries between practitioners and their patients or clients. While intended to protect the person’s privacy and allow for projection of the person’s internal conflicts onto a practitioner well-prepared and trained to make therapeutic use of these projections, these boundaries have instead created a static, two-class system in which people seeking services are made to feel inferior to their care providers and often end up viewing themselves as having nothing of value to offer in interpersonal relationships—relationships

which then come to be characterized as one-directional (Davidson, Haglund, & Stayner, 1998). Rather than serving as the bridge to mutual relationships in the broader community that the psychotherapeutic relationship was originally intended to be, such asymmetrical relationships serve instead to keep people stuck within the mental health system, convinced that they are not fully people and that they have nothing to offer others as a basis for mutuality. A related, if unintended, result of this attitude is having separate staff and patient/client bathrooms in outpatient settings—reminiscent of the “White” and “Colored” only bathrooms and drinking fountains in the segregated American South prior to the 1960’s—reinforcing the message that people with mental illnesses are fundamentally different from (and less than) those without.

Other policies that serve as impediments to inclusion are based on the problematic assumption described above that people need to be cured of, or recovered from, a mental illness prior to resuming other social roles (more valued than that of mental patient) such as student, worker, friend, lover, tenant, neighbour, congregant, voter, etc. Within the service setting, this assumption has led mental health practitioners to view their patients/clients as incompetent to make their own decisions, set their own goals, or pursue their own dreams and aspirations ... until and unless they have recovered. One of the several important things missing from such an approach is any recognition that making one’s own decisions, setting one’s own goals, and pursuing one’s own aspirations are all crucial components of the recovery process itself. By disallowing, at worst, or discouraging, at best, the person from making his or her own choices and pursuing his or her own interests, mental health services have unfortunately relegated the person to and kept him or her trapped within a passive, dependent, disabled, and despondent role. If I need to “get better” before I can reclaim a life in the community, and yet I have to take steps toward reclaiming a life in the community as a core component *of* “getting better,” then I become

and remain stuck; a fate we have tragically seen befall generations of individuals with serious mental illnesses.

To reverse these destructive practices, policies focused on promoting community inclusion would therefore begin with examining the status and role of the person in recovery within the mental health system itself. We, within the mental health system, cannot reasonably expect the community to reject stigma and discrimination against people in recovery if we cannot get our own house in order first. Doing so will require opening up opportunities for people with mental illnesses to take on a variety of proactive and constructive roles in reviewing, monitoring, evaluating, governing, improving, staffing, and otherwise giving their input into the mental health system. People in recovery will be invited to participate in, and eventually will comprise the majority of, boards of directors, governing bodies, advisory councils, steering committees, quality improvement teams, and other workgroups focused on designing and improving the functioning of mental health agencies and systems. They will be offered the opportunities and supports to become effective mental health practitioners, evaluators, and researchers as well as advocated, and their contributions will be increasingly valued as services and systems become more responsive as a result.

An excellent example of the kinds of steps involved in increasing the involvement of people in recovery in these and other ways can be found in the substantial amount of user input and participation recently encouraged by the policy unit of the Royal College of Psychiatrists in England (e.g., “Fair Deal for Mental Health” manifesto for mental health; Fitch, Daw, Balmer, Gray, & Skipper, 2008). Experiences such as these within the mental health system have the added benefit of preparing people in recovery for similar roles in the broader community.

Once established at the organizational level, such a framework of inclusion can then extend to the level of the individual service recipient. Increasing self-determination and self-direction at the level of the individual requires people in recovery to be placed in charge of their own treatment, or recovery, plan. Rather than remaining the passive recipient of the ameliorative efforts of caring others (Davidson, 1997) who are limited to adhering (or not) to the prescriptions formulated by experts, people in recovery will need to become active, and leading, participants in formulating their own action plans for their unique recovery journeys (Tondora, Pocklington, Gorges, Osher, & Davidson, 2005). Like health care consumers for other conditions, they will need to become educated about their condition and the options of treatments and other interventions available to them, and empowered to make their own decisions about which of these resources will be most useful to them in pursuing their life goals.

Experience suggests that when people in recovery become active in these ways, they become much more likely to identify goals for their recovery plans in the various domains of community life such as housing, jobs, education, and social and recreational activities than when limited to a subordinate role in treatment planning. Pursuing these goals without having to wait for symptom reduction, or without having to ‘prove’ their compliance with practitioners’ wishes regarding various treatments, inevitably (if not by definition) requires services to become more oriented to promoting community inclusion. And, as above, taking charge of their own treatment and recovery planning within a mental health setting may provide valuable learning experiences for people in recovery that can then encourage them to pursue and accept leadership roles in various community organizations and activities, all of which may contribute to their becoming valued citizens of their community.

Finally, it will be equally important to intervene at the practitioner level to ensure that self-determination and community inclusion are encouraged and supported within the mental health system. Previous research has shown that the assumptions described above have led mental health practitioners to stigmatize and limit people in their recovery, and therefore in their efforts toward community inclusion (Brody, 2007; Davidson, Stayner, & Haglund, 1998). In addition to those assumptions described above, such stigma includes beliefs that people with mental illnesses are infantile and in need of care or are responsible for their illness and frequently dangerous. Mental health systems will need to enact policies that indicate zero tolerance for such beliefs and prevent a provider from acting upon those beliefs in a discriminatory fashion.

A related, and potentially damaging, provider attitude about people in recovery derives from common misunderstandings and/or misapplications of diagnostic practices. It remains the case that, thirty years after publication of the third edition of the *DSM*, diagnosis still dictates treatment in psychiatry much less than it does in most other medical specialties and, as a result, seldom plays a central role in the care of persons with serious mental illnesses. By not taking the time to properly identify, diagnose, and offer education about a person's condition, either simply by "treating the chart" (i.e., doing only what one is required to do for billing purposes; e.g., Flanagan, Miller, & Davidson, 2009) or by giving a person the diagnosis he or she will need in order to qualify for services, people are denied the opportunity to understand what they are up against or what they can do to enter into and pursue recovery and community life.

Similarly—and again thirty years after publication of the third edition of the *DSM* in which it was made clear that diagnoses refer to psychiatric *conditions* rather than to people—practitioners, researchers, family members, and people with mental illnesses themselves often refer to people by their diagnosis (e.g., "schizophrenics," "borderlines"), suggesting that the

disorder is a permanent part of the person and one that defines his or her personhood (Flanagan & Davidson, 2007). While there is considerable longitudinal evidence to the contrary (e.g., Davidson, Harding, & Spaniol, 2005), and while the *DSM* and professional organizations deny that diagnoses are referring to people rather than to conditions, this widespread cultural phenomenon continues to contribute to stigma and discrimination against people with mental illnesses, constituting one of the more formidable barriers to community inclusion that exists.

Additional ways in which practitioners impede the community inclusion of people in recovery may have been implicit in the discussion above, but are nonetheless worth explicating. For example, encouraging a person who has just been diagnosed with a mental illness for the first time to give up his or her hopes and dreams for a contributing life, and to accept instead the life of a mental patient, remains a surprisingly common practice. As a corollary, practitioners also often encourage people with mental illnesses to withdraw from the community and to socialize and enjoy their recreational hobbies in social clubs, day programs, or other artificial settings that keep them segregated from the community.

For example, rather than encouraging a person in recovery who likes bowling to join a bowling league at the local lanes, practitioners may suggest that the person go bowling with the staff and fellow patients of his or her day program. Or rather than encouraging a person in recovery who likes to read to join a book group at the local library, providers may encourage the person to start a book group at his or her local clubhouse—in both cases viewing the person as too “sick” or “low functioning” to join in community activities. In countries that have relevant legislation to prohibit discrimination in the work place, practitioners similarly seldom encourage people with mental illnesses to actively seek employment and even more rarely educate people

about their right to request the job supports to which they are entitled, for example by the 1990 Americans with Disabilities Act.

To combat the inertia inherent to these established practices, it will be necessary for mental health systems to implement policies that require practitioners to examine their own potentially damaging beliefs about people in recovery, to make and communicate accurate diagnoses of the conditions people in recovery face and to understand that the diagnosis refers to what the person is up against and not to the person him or herself (Davidson & Strauss, 1995), and to offer incentives for practices that enhance, rather than impede, the community inclusion of the people they are entrusted to serve.

### **Policies Focused on the Interface between the Mental Health System and the Community**

Little thought has been given to the interface between the mental health system and the broader community beyond the basic assumption that people who need care will be referred to the mental health system and people who benefit from care and recover will rejoin community life. One exception to this customary view has been explored within the last half century, however, largely within Western European countries and beginning, at least by some accounts, with the work of the Basaglias and the Democratic Psychiatry movement they help to found in Italy in the 1960s. A review of this movement, and the resulting mental health reform in Italy, is beyond the scope of this chapter, and has been described in detail elsewhere (e.g., Corbascio & Henry, 1994; Crepet, 1988; Crepet & Pirella, 1985; De Salvia & Williams, 1987; Glick, 1990; Hanvey, 1978; Mangen, 1989; Mosher, 1983a & 1983b; Ramon, 1983). For the purposes of this chapter, we will limit ourselves to four of the key strategies developed by the Basaglias and their colleagues to create more two-way traffic between the mental health system and the community as a step toward closing mental asylums and ensuring “a life in the community” for all persons

with serious mental illnesses—the vision since adopted by the U.S. President’s New Freedom Commission on Mental Health (DHHS, 2003; cf. also Davidson, Mazzina, Rowe, & Thompson, in press).

Before closing the asylum in Trieste, and as one way of helping the asylum residents to become comfortable being around community people, as well as community people becoming comfortable being around asylum residents, the hospital staff planned public events that would create two-way traffic between the asylum and the community. In addition to taking patients out of the asylum on community visits, community members were invited onto the grounds of the asylum for a range of publicized cultural, recreational, and social events such as soccer matches, festivals, art exhibits, music concerts, lectures, and other public gatherings. Among this range of activities, those that involved children were especially of interest, both for the salutary effect that the presence of children had for the patients and for the strong challenge this posed to any concerns community members might have had about the potential dangerousness of the patients. Of note, for example, was that a day care center was established for the children of the staff on the grounds of the asylum and eventually became a valuable asset for the town as a whole.

Uninhabited or recently vacated parts of the asylum were put to other uses as well. This became a second key strategy for community inclusion (as well as a step toward honoring the rights of the residents), when the Basaglias terminated the ‘work therapy’ program through which residents had cooked meals, done laundry, helped to take care of the physical facilities, and performed other menial tasks but for which they were paid only in ‘tokens’ which could be cashed in for cigarettes or other small items. Rather than promoting an artificial ‘token economy’, a program was instituted that encouraged residents who were able and interested in working to take on jobs for which they would receive the same level of pay they would have

received for the same or similar jobs in the community. This transformation of passive or indentured residents into competitive workers yielded an enormous capacity for employment in a range of industries beyond janitorial and food service, with approximately half of the resident population expressing interest in working. From this modest beginning, and consistent with the principle that citizens have the right to a decent wage for their meaningful labor, the model of social cooperatives was born.

Social cooperatives are industries that employ a mixed workforce, some employees having disabilities and others not. These companies are able to compensate their employees comparable wages to the rest of the business sector based either on government subsidies used to compensate for reduced productivity or, when possible, on their own self-sustaining productivity. Beginning with their inception in the Trieste asylum, social cooperatives have since become highly visible across the Trieste business sector, at one point numbering 45 different functions. These include cleaning and building maintenance, furniture and design, hotel, cafeteria and restaurant services, agricultural production and gardening, handicraft, carpentry, photo, video and radio production, computer service, theatre, administrative services, and home assistance. It is, in fact, difficult to spend any amount of time in Trieste and not come into contact with a social cooperative in some form. This model has since been replicated in various forms in numerous European countries and Australia and New Zealand, with a 1999 survey finding about 2,000 social firms in Europe alone, employing approximately 47,000 workers, of whom 40-50% were disabled (Leff & Warner, 2006, p. 139).

A third strategy explored in Trieste was working with organizations and groups that represented other marginalized or disenfranchised people within the community. At the time (i.e., the early 1970's), this included the students' movement, the workers' movement, and the

feminist movement. Joining forces with such sympathetic movements brought people with mental illnesses into contact with community members, cultivating again two-way traffic between the mental health system and the community. People in recovery discovered that they had much in common with, and could socialize with, students, workers, and women, who as a result also found out that people with mental illnesses were in many ways just like them.

A final strategy for promoting inclusion took place at the level of the individual service recipient and was effective only for one person, one family, or one group at a time. Anticipating perhaps the more recent advances that have been made with supported housing and supported employment, staff worked with each individual to determine the person's interests and needs, and then accompanied the person in his or her efforts to meet his or her needs and pursue his or her interests within the broader community. To do this work, the staff not only had to become adept at recognizing and managing the deleterious effects of the illness, but also had to become socially and instrumentally adept at assisting the person in navigating and negotiating the community terrain, whether this be in securing a person's disability pension, resolving conflicts between a person and his or her family, or obtaining the leverage needed to get an unresponsive landlord to repair a leaking sink.

Rather than doing these tasks for the person, which would engender and perpetuate dependence and disability, it was important in such circumstances for the staff's role to be more that of a mediator, who would help community members understand and be responsive to the person with the mental illness while also helping the person with the mental illness to understand how the world works and what it requires from him or her. This kind of *in vivo* mediation, coupled with coaching or mentoring, has since become a core part of the role of the recovery-

oriented practitioner (e.g., Davidson, Tondora, O'Connell, Lawless, & Rowe, 2009; Davidson, Tondora, Staeheli, O'Connell, Frey, & Chinman, 2006).

### **Policies Focused on the Broader Community**

In terms of the broader community, many of the steps required to foster the inclusion of persons with mental illnesses are similar to, if not the same as, steps that have been taken to foster the inclusion of persons with other illnesses and disabilities, and/or from other historically oppressed minority groups. These steps have included ongoing and aggressive efforts to fight stigma and discrimination in the courts of public opinion and law, and have resulted in some countries in such landmark legislation as the 1990 Americans with Disabilities Act. Through this law, persons with serious mental illnesses were extended the same rights and protections as persons with physical disabilities, including most fundamentally the right to full inclusion in community life. In addition to these kinds of breakthroughs inspired by the Civil Rights, Feminist, and Gay Rights movements, efforts to promote the community inclusion of persons with mental illnesses can learn from and emulate the relatively recent and successful campaigns for breast cancer awareness and for educational opportunities for children with special needs.

For example, as Jimmie Holland, Chief of Psychiatry of Memorial Sloan-Kettering Cancer Center and a founder of the field of psycho-oncology, points out in her book with Sheldon Lewis (2000), up through the 1960s, cancer carried a powerful stigma for patient and family alike and, indeed, was called the "Big C" because the word itself was so unacceptable. Holland tells of a watershed event in the 1950s, when two socially prominent New York women, both of whom had radical mastectomies, decided they would try to reach other women to provide a forum in which women could feel free to talk about having breast cancer. They felt that a notice in the *New York Times* was the best way to announce this effort. However, when they

called the *Times*, they were told that the paper would not accept a notice using the words “breast” and “cancer.” “Perhaps you could say there will be a meeting about ‘diseases of the chest wall,’” they were told. Undaunted, the women persisted and their devoted efforts resulted in what is widely known now as Reach to Recovery, a worldwide support program for women with breast cancer, administered today through the American Cancer Society.

The history of societal attitudes toward children with special needs also parallels in important ways the history of attitudes toward adults with serious mental illnesses. In the past, it was customary for children with physical, medical, and/or emotional challenges to be locked away in distant institutions or at least to be segregated in separate schools or classrooms. They were denied essential opportunities for social and educational development as enjoyed by their more typical peers. It wasn’t until 1975 that the U.S. Congress finally enacted the Education for All Handicapped Children Act (which has since been refined and improved many times over the years and is currently known as the Individuals with Disabilities Education Act). This law, among other things, requires that public school districts throughout the nation place any child with special needs into the regular educational environment unless it is demonstrated through rigorous assessment that education in the regular environment with the use of supplementary aides and services cannot be achieved satisfactorily.

### **Conclusion**

We suggest that similar steps to those described above for cancer and children with special needs can and should be taken to ensure optimal community inclusion of adults with serious mental illnesses. To do so requires communities to view and treat people with serious mental illnesses first and foremost as citizens rather than as patients, clients, or service users, and to recognize and value the gifts, strengths, skills, talents, interests, and other contributions such

people can make to the life of the community. Shortly before his death, Franco Basaglia (1979) suggested that the community itself was enriched through the inclusion of persons with serious mental illnesses and their contributions; a sentiment with which we wholeheartedly agree, but for which we have yet to be able to provide any empirical justification (primarily because it has yet to happen). We can at least end, however, by invoking the spirit of Philippe Pinel, who, in his 1794 address to the Society for Natural History here in Paris, bemoaned the “many talents lost to Society” due to mental illness and who then suggested that “great efforts are needed to salvage them!” (cited in Weiner, 1992, p. 728). It is unfortunate that now, over two hundred years later, these efforts remain to be made.

### **References**

- Basaglia, F. (1979). The therapeutic vocation, in *Scritti*. Torino: Einaudi.
- Brody, D. (2007). Strategies for transformation: Identifying, reducing and ending discrimination and stigma in mental health and primary care settings. *Improving Provider Attitudes, Behaviors and Practices Toward People with Mental Illness. Teleconference Sponsored by the SAMHSA Resource Center to Address Discrimination and Stigma*, November, 2009.
- Corbascio, G., & Henry, P. (1994) How can psychiatry survive without psychiatric hospitals? The Italian experience. *International Journal of Social Psychiatry*, 40: 269-75.
- Crepet, P. (1988) The Italian mental health reform nine years on. *Acta Psychiatrica Scandinavica*, 77: 5-23.
- Crepet, P., & Pirella, A. (1985) The transformation of psychiatric care in Italy: Methodological premises, current status and future prospects. *International Journal of Mental Health*, 14: 55-73.

- Davidson, L., Harding, C.M., & Spaniol, L. (2005). *Recovery from severe mental illnesses: Research evidence and implications for practice. Volume 1*. Boston, MA: Center for Psychiatric Rehabilitation of Boston University.
- Davidson, L., & McGlashan, T. (1997). The varied outcomes of schizophrenia. *Canadian Journal of Psychiatry*, 42: 34-43.
- Davidson, L., Mezzina, R., Rowe, M., & Thompson, K. (in press). 'A Life in the Community': Italian Mental Health Reform and Recovery. *Journal of Mental Health*.
- Davidson, L., & Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health*, 16(4): 1-12.
- Davidson, L., Stayner, D., & Haglund, K. E. (1998). Phenomenological perspectives on the social functioning of people with schizophrenia. In K. T. Mueser, & N. Tarrier (Eds.), *Handbook of social functioning in schizophrenia* (pp. 97-120). Boston: Allyn and Bacon.
- Davidson, L., & Strauss, J.S. (1995). Beyond the biopsychosocial model: Integrating disorder, health and recovery. *Psychiatry: Interpersonal and Biological Processes*, 58: 44-55.
- Davidson, L., Tondora, J., O'Connell, M.J., Lawless, M.S., & Rowe, M. (2009). *A practical guide to recovery-oriented practice: Tools for transforming mental health care*. New York: Oxford University Press.
- Davidson, L., Tondora, J.S., Staeheli, M.R., O'Connell, M.J., Frey, J., & Chinman, M.J. (2006). Recovery guides: An emerging model of community-based care for adults with psychiatric disabilities. In Lightburn, A. & Sessions, P. (Eds.), *Community based clinical practice* (pp. 476-501). London: Oxford University Press.

- Davidson, L., Tondora, J., O'Connell, M. J., Kirk, T., Rockholz, P., & Evans, A. C. (2007). Creating a recovery-oriented system of behavioral health care: Moving from concept to reality. *Psychiatric Rehabilitation Journal*, 31(1): 23-31.
- DeSalvia, D., & Williams, P. (1987) The Italian experience and its implications. *Psychological Medicine*, 17: 283-289
- Fitch, C., Daw, R., Balmer, N., Gray, K., & Skipper, M. (2008). *Fair deal for mental health: Our manifesto for a 3 year campaign dedicated to tackling inequality in mental healthcare*. London, England: Royal College of Psychiatrists.
- Flanagan, E. H., & Davidson, L. (2007). "Schizophrenics," "borderlines," and the lingering legacy of "misplaced concreteness": The persistent misconception that the DSM classifies people instead of disorders. *Psychiatry: Interpersonal and Biological Processes*, 70(2): 100-112.
- Flanagan, E. H., Miller, R., & Davidson, L. (2009). "Unfortunately we treat the chart": Sources of stigma in mental health settings. *Psychiatric Quarterly*, 80(1): 55-64.
- Glick, I. D. (1990) Improving treatment for the severely mentally ill: implications of the decade-long Italian psychiatric reform. *Psychiatry*, 53: 316-323.
- Hanvey, C. (1978). Italy and the rise of democratic psychiatry. *Community Care*, 25: 22-24.
- Holland, J., & Lewis, S. (2000). *The human side of cancer*. New York: Harper Collins.
- Leff, J., & Warner, R. (2006). *Social inclusion of people with mental illness*. Cambridge, UK, Cambridge University Press.
- Mangen, S.P. (1989). The politics of reform: Origins and enactment of the Italian experience. *International Journal of Social Psychiatry*, 35:7-19.
- Mosher, L.R. (1983a). Radical deinstitutionalization: the Italian experience. *International Journal of Mental Health*, 11:129-136.

Mosher, L.R. (1983b). Recent developments in the care, treatment, and rehabilitation of the chronic mentally ill in Italy. *Hospital and Community Psychiatry*, 34:947-950.

Ramon, S. (1983). Psichiatria Democratica: A case study of an Italian community mental health service. *International Journal of Health Services*, 13(2): 307-324.

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

Weiner, D.B. (1992). Pinel's "Memoir on Madness" of December 11, 1794: A fundamental text of modern psychiatry. *American Journal of Psychiatry*, 149:725-732.