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Recovery-Oriented Care and Choice

To the Editor: Recent publications in this journal (1) and elsewhere (2) suggest that the capabilities approach offers a new conceptual framework for understanding the nature of recovery in serious mental illness and for translating the implications of this notion of recovery into innovative practices. In our work, we have found that the capabilities approach—derived primarily from the work of Amartya Sen (3)—offers especially useful responses to the increasingly pressing questions of what makes a practice recovery oriented and how such an orientation differs from current care.

Now that recovery has moved to the forefront of policy, the focus has shifted to how we are to transform our practice. An answer was offered several years ago by two leaders in the recovery movement. As early as 1992 Deegan (4) suggested that “the concept of recovery is rooted in the simple yet profound realization that people who have been diagnosed with a mental illness are human beings.” Anthony (5) more recently argued that recovery draws our attention to the fundamental “personhood” of people with mental illnesses. Thus one answer is to suggest that a practice can be considered recovery oriented to the degree to

which it engages the personhood of the person with the illness.

But what is entailed in engaging someone's “personhood”? How can we tell when a practitioner is, or is not, treating a person with a mental illness first and foremost as a human being? It is here that the work of Sen is especially needed and, we suggest, especially helpful. In a capabilities approach, personhood is defined by two interrelated concepts—freedom and agency. Liberty is essential to what makes us human, as having liberty allows us to exercise our personal agency. Being free requires both being free from political, economic, social, and material deprivation and being free to make our own decisions. It is for this reason that Sen (3) suggests that “‘choosing’ itself can be seen as a valuable functioning.” In fact, a capabilities approach suggests that it is precisely in freely exercising our personal agency, in making decisions and pursuing those activities that we choose to value, that people are most fully human.

Putting the pieces together, a capabilities approach suggests that a practice can be judged to be recovery oriented to the degree to which it engages and is based on an appreciation of the fundamental role of choosing, of making our own decisions, in making us who we are. Such a position may have been implicit in Drake and Deegan's (6) recent commentary on the ethical imperative to honor patient choice. We suggest that according this position an explicit and central role will provide an essential criterion for judging whether practices are oriented to promoting recovery. Meeting this criterion is a key way in which such practices differ from repackaged versions of traditional practices (that is, old wines in new bottles).

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Changes in Prescription of Psychotropics After an Earthquake in Italy

To the Editor: On April 6, 2009, at 3:32 a.m., an earthquake struck L'Aquila, Italy, a town with a population of 72,000 residents and a health district of 105,000 residents. The L'Aquila earthquake (magnitude 6.3) caused the deaths of 309 people. More than 1,000 individuals were injured, and 66,000 were displaced. This disaster provided a unique opportunity to explore the effects of severe stress and its treatment (1,2). In this study we sought to determine whether the survivors experienced symptoms that led to an increase in psychotropic drug prescription in the six months after the earthquake.

We obtained data from the Pharmacy Unit of the Health Care Public System, which monitors reimbursed drug prescriptions for people living in a certain area, even those who have been displaced, through their Social Security Number. Information on prescriptions of antidepressants and antipsychotics was obtained for one year before and six months after April 6, 2009. Data for benzodiazepines were not obtained because these prescriptions are not reimbursed. To control for possible seasonal variation in drug prescription, we analyzed two comparable half-

years—April 1 to September 30 in 2008 and 2009. Data were collected with ATC/DDD methodology (Anatomical Therapeutic Chemical Classification System with defined daily doses) (www.whocc.no). Chi square analysis was used to determine the significance of differences between the two periods.

In the population of 105,000 residents, the number for whom antidepressants (ATC N06 A) were prescribed increased from 6,350 to 6,836 ($\chi^2=17.91$, $df=1$, $p<.001$). For antipsychotics (ATC N05 A) the number increased from 1,646 to 2,551 ($\chi^2=195.14$, $df=1$, $p<.001$). The higher percentage increase in antipsy-

chotic prescription (55% versus 8%) could be attributable to off-label indications. Prescription of these agents should be monitored, and guidelines for primary care providers should recommend caution.

These data confirm the pervasive effects of disasters on the mental health of a population (2) and demonstrate the need to include mental health as a key component of public health response to mass traumas.

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