

Prescribing Under Management: Psychotropic Drug Networks in Community Mental Health in Southern Chile

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Research Article

Keywords: Community mental health, psychotropic drugs, Chile, Actor-Network Theory

Posted Date: October 15th, 2026

DOI: <https://doi.org/10.21203/rs.3.rs-11221715/v1>

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Additional Declarations: No competing interests reported.

Abstract

Since the second half of the twentieth century, psychiatry has undergone profound transformations associated with deinstitutionalization processes, in which psychotropic drugs have played a central role. Distancing ourselves from the customary biomedical/psychosocial dichotomy in mental health and psychiatry, we understand psychotropic drugs as part of the interplay between human and non-human actors that configures hybrid approaches. We ask what networks form around psychotropic drugs and what effects they generate. In dialogue science and technology studies (STS) and governmentality studies, we conducted an assemblage ethnography in two community mental health and psychiatry centers in southern Chile. Through thematic analysis, we examined interviews with 15 professionals and participant observation in the waiting room. Our main findings show that psychotropic drugs become an actor around which a network unfolds that incorporates documents, professionals, electronic platforms, spaces, and other objects, which sustain their prescription, ongoing dispensation, and the forms and agents of treatment surveillance. Unwanted effects, by contrast, play a limited role within this network, without the capacity to modify it. Thus, knowledge about their effects—both expected and unwanted—forms part of the expert knowledge that professionals transfer to users and families for decision-making.

Introduction

Since the second half of the twentieth century, psychiatry has undergone profound transformations associated with deinstitutionalization processes, the expansion of community-based approaches, and advances in rights (Amarante and Guljor, 2005; Saraceno, 2018; Desviat, 2020). These transformations, as part of the “anti-asylum struggle,” made it possible to shift away from the asylum model historically centered on confinement, toward open-door facilities oriented toward social integration and the recognition of service users as rights-bearing subjects (Dimenstein, 2013). The development of national and international human rights regulations has played a key role, calling into question practices typical of asylum psychiatry and promoting principles of autonomy, participation, and informed decision-making (Gill, 2019; Herrman, 2019).

In Chile, the shift away from the asylum-based model was implemented mainly through a series of National Mental Health and Psychiatry Plans, the first of which dates back to 2000 (MINSAL). These instruments have promoted the transition toward a community-based model of care inspired by a rights-based approach. However, this process was not accompanied by legislative reform that would provide a legal framework guaranteeing the effective exercise of rights (Minoletti et al., 2018), nor by funding for its implementation.

Only in 2021 was Law 21.331 enacted, aimed at harmonizing national legislation with international human rights standards in mental health. Its content sought to strengthen the autonomy and participation of service users. Nevertheless, despite representing a legislative advance, this law has been questioned for various reasons, chief among them its lack of funding and of a complete set of

regulations that would ensure its implementation and fulfill the effective guarantee of the rights it recognizes (Galindo, 2023; Morales, 2026). Furthermore, this legislation must be harmonized with other norms that have shaped the Chilean health system into a dual public-private structure—a legacy of the neoliberal reforms of the 1980s—organized around per capita funding and performance-based management (Tetelboin, 2003).

We understand that the replacement of the psychiatric hospital with so-called “open-door” facilities did not necessarily entail the elimination of forms of control, but rather their rearticulation along neoliberal lines, such that confinement gave way to practices and strategies of government that articulated freedom and control in the remote conduct of conduct, thereby generating new subjectivities (Carrasco & Arruda Leal Ferreira, 2018).

Psychotropic drugs have been central both to enabling forms of intervention as an alternative to indefinite confinement and, at the same time, to sustaining psychiatry's status as a branch of medicine with a reach beyond asylum institutions (Rose, 2018). The publication of the DSM-III in the 1980s, which established a clinical logic centered on the description of diagnostic categories, was key in this regard, instituting pharmacological prescription within health services (Mármol, Inchauspe & Valverde, 2018; Davis, 2021). Psychiatry's status as a branch of medicine has been consolidated by this shift up to the present day, on the basis of a biological understanding of mental illness—analogous to chronic disease—that permeates the discourse of health teams and the way people understand and narrate their own suffering, as a biological imbalance that the drug comes to correct (Martínez-Granados, Briones-Vozmediano & Ronda, 2024).

Psychotropic drugs are currently the main intervention strategy in mental health and psychiatry (MHP) (Correa-Urquiza & Pié Balaguer, 2017), even though evidence shows that they entail multiple unwanted effects, a greater risk of hospitalization (Law et al. 2025) and the displacement of other strategies, such as culturally and territorially relevant social supports (Müller and Ortega, 2024; Osborne, 2026) or psychological therapy (Berna, Musso, Weibel and Brunn, 2026).

In the Chilean case, the relationship between psychiatric reform and psychotropic drug prescription is evidenced in the progressive increase in spending on psychotropic drugs that has accompanied the implementation of the community model in place of the asylum model (Cea- Madrid, 2018). This is not free of controversy: narratives from users of MHP services in Chile reveal an ambivalence between the effectiveness of symptom control and a sense of coercion over daily life (Castillo-Parada, 2018; Castro, 2024); an ambivalence that Marquis (2022) also identifies among professionals, for whom the psychotropic drug is at once a therapeutic resource and an agent of dependence, a tension that entails constant negotiation between both actors. The psychotropic drug can therefore not be regarded as a neutral therapeutic tool, but rather as a node within a broad network of practices, forms of knowledge, and power relations situated in a specific context (Osborne, 2026).

These controversies surrounding psychotropic drug prescription have tended to be interpreted, within critical currents of psychiatry, as a tension between two opposing models: one that privileges the

advancement, maintenance, and proliferation of pharmacological prescription over psychosocial and/or community-based approaches, and another that questions it from a different understanding of illness (Saraceno, 2018). In the words of Huertas, this is the opposition between “a positivist, quantitative, simplified, essentialist, organicist psychiatry, and another psychiatry (...) that understands so-called mental illnesses as discursive constructions that are revisable and subject to social and cultural change” (2017:8).

This dichotomy becomes embedded in the discourses and practices of professionals and users of MHP services, who find themselves in the midst of an unresolved process of transition between two forms of approach, and who confront controversies between differing logics (Carrasco and Yuing, 2014; Gomes Da Silva, Aciole and Loncman, 2017; Jara-Ojeda, Grandón & Leyton, 2025) and even ethical and political dilemmas (Ortiz-Lobo, 2022). These dichotomous interpretations limit our understanding of contemporary MHP practices by obscuring the concrete, situated ways in which such practices are materialized and negotiated (Müller & Ortega, 2024; Pinto, Jiménez-Molina & Carreño-Hernández, 2026).

Therefore, in this research we distance ourselves from a dichotomous reading and propose to analyze mental illness and its forms of approach as a field of sociotechnical assemblages (Latour, 2001) in which multiple actors interact, among them professionals, users, diagnoses, regulations, institutional devices, and psychotropic drugs (Balfe, 2023). From this perspective, and in dialogue with governmentality studies, we understand mental health governance systems and the reform of the psychiatric institution as a socio-scientific problem (Edquist, 2022), that is, a dynamic among government, science, and technology entities in which all of these actors have a stake.

Far from regarding psychotropic drugs as mere therapeutic instruments, we understand them as a technology that is part of the interplay of multiple actors (professionals, users, family members, norms, protocols, among others) that combine contingently to orchestrate the imperatives of freedom characteristic of liberal logics of government (Brodwin, 2010; Brodwin & Velpy, 2014). As mediating technologies, psychotropic drugs participate in the organization of practices, in the production of veridiction regimes concerning mental illness (Davis, 2021) and in the configuration of specific forms of subjectivation (Gilabert, 2026). Therefore, we could argue that the walls of the psychiatric hospital have been displaced by other, now liberal, technologies of government, of which the psychotropic drug is a central component (Brodwin, 2010).

In this research, we bring governmentality studies into dialogue with elements of Actor-Network Theory (ANT), owing to its critique of the dichotomy that modern science has assumed between the social/subjective and the natural/objective as opposing domains. By not assuming from the outset the social or natural origin of phenomena, ANT allows us to position ourselves without taking sides between two opposing options: the biological origin of mental illness and the need for pharmacological treatment, or its social origin and the need for psychosocial interventions.

We also assume that sciences and technologies are a construction mediated by human agency, but built from elements and materials that pre-exist and over which those who build them have no control (Latour,

2001). This introduces a degree of uncertainty to the outcome of the act of constructing, and makes it possible to grant agency to both subjects and objects, which cease to be seen as neutral and come to be understood as part of assemblages that introduce their own effects. From this perspective, the field of mental health is understood as multiple networks of humans and non-humans (assemblages) that produce effects both in the understanding of health and in the provision of care (Balfe, 2023).

In these assemblages, psychotropic drugs are not tools used according to a plan or strategy in human hands, but rather elements that generate effects and introduce new possibilities (Tirado and Domenech, 2001; Tirado and Mora, 2004). Their effects, therefore, cannot be deduced a priori, because technical objects “simply offer occasions, circumstances, and precedents,” in a process in which “many unexpected allies may appear” (Latour, 2005, p. 59). Thus, the question of agency—that is, what psychotropic drugs can do—ceases to be an a priori and becomes a research question.

In Chile, research along these lines has incorporated technologies specific to New Public Management (NPM) into the analysis of psychosocial and health interventions, showing how such tools form part of socio-technical assemblages and act as relevant agents, modifying professional practices and program orientations (Schöngut-Grollmus 2017; Carrasco & Medina, 2019). Another study examined how bodies are produced within Chilean mental health services, linking psychotropic drug prescription to the emergence of a “psychophysiological body” (Betancur, 2026); along the same line, the analysis of the drug-human relationship in self-medication practices (Gilabert-Vio et al., 2026) shows that drugs are not tools that act as simple channels transmitting, without alteration, psy knowledge about subjectivities and the brain, but rather as mediators that transform what passes through them and whose actions, therefore, cannot be ignored or taken for granted.

Accordingly, we aim to analyze the network that sustains psychotropic drug prescription in two community mental health centers in southern Chile; to describe the actors and relations that compose it and the effects it introduces, as well as its relationship with expert knowledge and liberal logics of government.

Method

The results we present are part of a broader research project (FONDECYT No. 1241022) that analyzes MHP facilities, in which psychotropic drug prescription plays a central role. Inspired by STS as applied to psy practices (Arruda Leal Ferreira and Carrasco, 2022; Carrasco, 2021), we adopted assemblage ethnography as our design (Wahlberg, 2022). This type of ethnography distances itself from a monolithic, deterministic, and linear understanding of liberal logics of government (Brady, 2014), and instead attends to how heterogeneous human and non-human elements connect, mutually define one another, establish positions relative to each other, and produce practices and subjectivities. Following Latour (2001), we assume that scientific knowledge and its technologies (in this case, psychotropic drugs) are constructions that mediate human and non-human agency, without this implying reducing them to a mere artifice or denying them their own capacity for action. Likewise, the rigor of the study is

established around the criteria of credibility, transferability, and critical reflexivity, characteristic of qualitative research.

Following Brodwin (2010), we understand the psychotropic drug network (our object of interest) as an assemblage in which psychiatric diagnoses, drugs, and expert discourses about their use and effects are articulated with one another without being reduced to one another. Under this design, the field is not delimited *a priori*; rather, it is composed according to the elements that sustain the network, and it extends beyond the two centers analyzed, including norms, protocols, guidelines, and forms of knowledge on a larger scale, such as national policy and expert knowledge at the global level, as well as intermediate decisions made by the local health service (Carrasco, 2021). Thus, we assume that the network we reconstruct is part of a broader web, since for a psychotropic drug to come to be prescribed and dispensed, articulations that exceed our findings intervene—such as tenders, ministerial benefit packages, inventories, and transport and safekeeping protocols which operate,—before it reaches storage and dispensation at each center's pharmacy.

Fieldwork

The data presented in this article comes from fieldwork conducted between March and December 2025 (ten months) in two secondary-level Community Mental Health and Psychiatry Centers (hereafter, CMHPC) that are part of the Mental Health Network of the Health Service of a region in southern Chile. A detailed characterization of both centers is presented in the “Study context” section, preceding the results.

Techniques and participants

We present the analysis of 15 interviews with staff from both centers, together with field notebook records from the observation carried out in the waiting room of one of the two centers. Participants included center coordinators (2), nurses (3), psychologists (4), psychiatrists (3), pharmacy staff (2), and administrative personnel (1). Recording was carried out through audio recording and transcription performed by FONDECYT project support staff, totaling 22 audio files equivalent to 18 hours and 57 minutes.

For the interviews, we used differentiated guides according to participant type, organized around three thematic axes: the actors that make up the network (clinical teams, pharmacy, suppliers and laboratories, administrative staff); the material circuit of the medication (request and purchase, storage, registration, delivery protocols, and tests associated with specific pharmacological treatments); and the expert knowledge that sustains prescription (training in psychopharmacology, understanding of mental health problems, and the role of psychiatric diagnosis as a threshold for access to treatment).

Analysis of material

The analysis followed a thematic coding approach inspired by the proposal of Braun & Clarke (2021), supported by Atlas.ti software (version 26.1.0), based on a codebook organized into thematic families, with a total of 295 codes applicable to interviews (174) and field notebooks (121). For this article, we worked with a subset of 98 codes (55 from interviews, 43 from field notebooks), selected according to three criteria: a) codes that explicitly name the relationship with psychotropic drugs, b) codes that record positions of expert knowledge around the prescription, administration, and consent involved in psychotropic drug use, and c) codes that record actors' relationship with expert knowledge in MHP.

Positioning and reflexivity

The ethnographic fieldwork in the waiting room was carried out by one of the project's researchers, who had a prior relationship with one of the centers. This relationship facilitated access and a deeper understanding of the space's everyday dynamics, but it also entailed a certain prior familiarity with some of the staff, which may have affected the teams' disposition toward her presence. The interviews with professionals, on the other hand, were conducted by other members of the study team who had no prior relationship, which provides a situated yet distanced perspective on expert discourse. Finally, it is worth noting that all the researchers reside in the city where the study was conducted, allowing for territorial and disciplinary closeness to the mental health network in that setting.

Ethical considerations

As stated in Official Document No. 146 of 2024, the FONDECYT project was reviewed and approved by the Scientific Ethics Committee of the territory where the study was conducted. The committee is accredited under Law No. 20.120, ensuring that the study complies with the regulations governing research with human subjects in Chile. Participation in interviews and observations was voluntary and took place after participants reviewed and signed an informed consent form, in which they were informed about the conditions of participation and their right to withdraw at any time without consequences. To ensure the confidentiality and privacy of the data, all identifying information was removed.

Study context

The characterization of the context studied was developed on the basis of the national regulatory framework, including the National Mental Health Plan and the Mental Health Network Management Model (MINSAL, 2018), complemented with field notes and interviews with the coordination teams of both centers.

The centers analyzed differ in the type of territory they cover; one is located in an area of higher urban density, while the other covers a territory with more dispersed population sectors, including rural areas. The territorial boundaries and beneficiary population of each center are defined by the regional Health

Service according to territorial and population criteria. Each center is assigned a reference territory made up of the population enrolled in the corresponding primary care Family Health Centers (CESFAM), plus an additional intake mechanism via referral from the tertiary network, which includes the hospital, day hospital, and day center. According to their reference territory, the population covered by each center ranges from approximately 52,000 to 110,000 inhabitants.

Each center has a team led by a health professional who acts as coordinator, and a psychiatrist who serves as Technical Director. The teams are organized into sub-teams: one for the general adult population and another for the child and adolescent population, in addition to a specific program addressing problematic substance use (PAI). Each team includes: psychiatrists, a pharmaceutical chemist and pharmacy technician, psychologists, nurses and nursing technicians, occupational therapists, social workers, a psychopedagogue, and a speech therapist.

Services are organized through benefit packages associated with specific care programs, also differentiated between the general population and PAI. Funding is heterogeneous, since there is no dedicated budget for this type of center, but rather operates through program execution. Accountability is carried out through a “management agreement” negotiated between the Ministry of Health and each center, comprising two components: the number of monthly services provided and the percentage of new intakes, both defined in relation to the national reference target and the CMHPC's historical performance. In this regard, both centers fall below the national ministerial target on this indicator, a situation shared among facilities with similar characteristics. Compliance with these targets is reported to the central level through semi-annual service reports. Together, the centers under study report a volume of services for between 600 and 900 active users, and both maintain waiting lists that can exceed 300 people pending intake.

Regarding record-keeping, both CSMYPC operate with paper clinical records and are in the process of transitioning to electronic records.

Results

The story of the abandoned garden symbolizes the latent risk that community activities become fragile projects, dependent on certain professionals, rather than being built as solid collective networks. When these figures are absent, whether due to leave, staff turnover, or work overload, initiatives tend to collapse. (Excerpt from Field Diary)

The waiting space

The waiting room of the CMHPC is, as its name indicates, a space of waiting. There, people remain while they wait to be seen by a mental health specialist. However, this space takes on specific forms that combine materialities typical of a hospital environment with others that evoke a homelike, communal setting. The ambivalence we found in the discourses of professionals and users seems to materialize in

this place, where the furniture and its arrangement resemble a home's living room; there is a community library, yet everything remains lit and sanitized like a hospital; on the walls, murals that emulate street art mix with a chalkboard for free use, but also with institutional posters informing about laws and protocols.

When there was no one around, I got up intending to explore the waiting room in more detail. At first glance, what most caught my attention was the arrangement of the furniture, which breaks with the usual rigidity of traditional clinical spaces: instead of chairs lined up in rows or cold benches, one sees sofas, cushions, and a semicircular arrangement, suggesting an intention to create a warmer, less hierarchical atmosphere.

Despite efforts to distance itself from the traditional architecture of a health center, it does not escape the impersonal atmosphere that characterizes such spaces. As I walked through the place, I noted its details: uniform white lighting, gray ceramic flooring, rigorous cleanliness, and a furniture arrangement that, although asymmetrical, reinforced that institutional essence. (...) armchairs that speak more of a place of transit than of a space of welcome or emotional containment. (Field note, March 24, 2025).

The arrangement of objects in this space follows the institutional context of a public health center, but it subtly shifts to produce an effect on those who inhabit it: fostering the comfort of home and, at the same time, the collectiveness of the street. However, like every “open-door” center, it is a space of transit rather than permanence, in which the agency of objects allows for an efficient use of waiting time.

The greatest influx of people in the CMHPC waiting room occurs during the mornings, during psychiatrists' consultation hours, unlike the afternoons, when appointments with “psychosocial” professionals predominate.

Much of the waiting in this space, then, corresponds to waiting for the appointment with the psychiatrist and, more specifically, for the prescription he or she issues, which subsequently allows medications to be collected at the pharmacy. After this wait in the homelike, street-inspired room, people are seen in a consultation booth and then make their way to the pharmacy—an adjoining space, restricted to CMHPC staff, where users exchange their prescription for drugs through a hatch window. Many users, however, do not pass through the waiting room at all, heading directly to the pharmacy to collect medications once they already have the prescription.

This is consistent with the fact that the possibility of being seen at the CMHPC depends on psychiatric diagnosis: “in fact, the psychiatric diagnosis sets the tone for whether or not the person stays at this center” (Interview, Psychologist). This aligns with the intake and retention criteria imposed by the health system, according to which the most complex pathologies are the ones that must be referred to this type of center. Clinical protocols, in turn, define a basic package of services delivered according to diagnosis, which treats the drug as the first element.

(...) what would happen if (...) those who supervise me—because I don't call the shots alone—said to me: “but this person isn't on any medication, so let's review this.” Because deep down, what the system cares about is that there be turnover. What gets criticized is that a lot of people come in, but few are discharged, and that's because we can't keep up with demand (...) (Interview, Psychiatrist).

The system—always overwhelmed—requires discharges in order to allow new admissions and thereby reduce the waiting list. In this sense, not using medication becomes a criterion for determining that a person does not need to be seen at the CMHPC and can therefore be discharged.

The waiting room is the prelude to the consultation with the psychiatrist, who makes the diagnosis and prescribes medication. The prescription is then obtained and, finally, the psychotropic drug itself, which in turn grants access to the actions carried out within the CMHPC.

The consultation with the psychiatrist

What takes place in the consultation with the psychiatrist is not visible to us. As a clinical space, it must safeguard privacy, so we access it through interviews with the psychiatrists, who assume that their main role is to prescribe drugs: “I know that my role here is mainly that, being the prescriber” (Interview, Psychiatrist). Despite taking on this role, the psychiatrists hold positions on mental illness that call into question diagnoses and their biological foundations—that is, the scientific grounding of drug prescription.

(...) I [couldn't] tell you it's a neurotransmitter or whatever, because that would be very, very reductionist. (...) I very much agree that it has to do with questioning the validity of diagnoses, thinking that psychiatric diagnoses aren't like cardiological ones. A heart attack is a heart attack and has a negative T wave and so on and so forth. Here there is none of that (Interview, Psychiatrist).

As part of their training, psychiatrists mention psychotherapy, meditation, phenomenology, and the social sciences, among others, as foundations that lead them to understand diagnoses as a reduction that nonetheless becomes operative within health systems. They assume that diagnosis functions as a key granting access to the CMHPC and to the psychotropic drug, and that the latter can help navigate complex situations such as poverty, long working hours, lack of support, or histories of abuse, among other causes of mental illness.

The psychiatrists also recognize a shift, relative to asylum psychiatry, in psychotropic drug prescription, insofar as they must now consider users' needs and perceptions, unlike what happened before, when only the physician's judgment counted. This becomes especially relevant when considering the number of unwanted effects these medications carry, a factor that makes it necessary for users to know what those effects are and to be able to choose.

I think the great majority of the drugs we use are drugs that cause weight gain, that alter metabolism, I don't know, and that have a lot, a lot of adverse effects in general. Much more than other specialties. (...)

it's also good for the patient to be able to choose, for example, certain alternatives. I mean, if they can choose a medication that's going to be good but is going to leave them without sexual appetite, maybe they'll prefer one that upsets their stomach more but keeps their sexual appetite intact. That's a decision that belongs to the patient, not to the doctor, right? (Interview, Psychiatrist).

Passing on information about adverse effects entails, at the same time, passing on to the user part of the responsibility for the unwanted effects that may occur. The psychiatrist accompanies these decisions from a position of expert knowledge about psychotropic drugs, but this capacity for accompaniment depends, in turn, on the user being honest about how they take the medication and what effects it produces in them.

Still, I'd rather that if they're not taking it, they tell me, or if the person isn't comfortable, they tell me and we talk, we talk, we have a dialogue. Because the idea is that someone undergoing this kind of treatment should feel comfortable, not going around doped up, not going around drooling (...). It's more like the person should feel that what they're given works for them and doesn't harm them too much, or doesn't harm them at all. (Interview, Psychiatrist).

Psychotropic drug prescription entails a series of aspects, among them the establishment of a relationship in which the user can learn about the adverse effects of the options offered and choose the most suitable one. In this relationship, the psychiatrist's subjectivity becomes relevant, as they must be capable of building a bond of trust as a significant part of the medical act.

"A doctor 'A,' who doesn't look at you, gives you the same medication as a doctor 'B,' who looks at you, listens to you, treats you—that alone already generates a change in how the person's improvement unfolds. So, I couldn't say that the psychotropic drug alone is the complete act" (Interview, Psychiatrist)

In the private space of the consultation, although the central element is psychotropic drug prescription, the groundwork must be laid for a close relationship that is relevant to the improvement process, as well as for the trust that will allow the psychiatrist to learn the truth about the user's decisions

The pharmacy network

The pharmacy is where medications are stored and dispensed. Through a hatch window, users request from pharmacy staff the drugs the psychiatrist has prescribed. Prescriptions indicate the frequency of delivery depending on the psychotropic drug: for example, prescriptions with quarterly renewal that include monthly collection of the drug; or cases requiring closer monitoring, with a one-month or 15-day prescription whose renewal requires a new consultation with the psychiatrist. There are also different safeguards depending on the type of psychotropic drug, whether greater storage restrictions due to its potential to generate dependence, or greater surveillance due to the serious adverse effects it could produce.

Pharmacy staff must ensure proper dispensation: verifying that the medication matches what was prescribed by the physician, that the quantity is correct according to the dosage and sufficient for the

period the prescription covers, and that it is delivered to the user authorized to collect it.

[Medications are handed over] (...) in an envelope. And the envelope comes with a label, and the label has the user's name, the quantity of drug being given to them, the instructions, for how many days, and at what time they have to take it. And also the name of the center and the time at which it was given to them (Interview, Pharmacy Staff)

Prescriptions and drugs dispensed are also recorded on a computer platform—the RAS system—that enables stock management.

[The psychiatrist] issues the prescription through RAS, and we automatically dispense it as if it were placing an order, really, but it's clearly a prescription because it's part of a prescribing act, part of a medical consultation, so the quantity we give to users is automatically deducted through RAS, and it's already subtracted from stock... (Interview, Pharmacy Staff).

Prescriptions, the computer platform, the paper envelope, the identity card, and pharmacy staff make up a web that makes the management of psychotropic drugs possible. However, for dispensation to be possible, there must also be a flow of information with whoever supplies the pharmacy: the information entered into RAS when the psychiatrist prescribes a drug must be transferred to another computer platform (CENABAST), through which the center's pharmaceutical chemist requests drugs at the central level. This request is made monthly, and the quantity requested is calculated based on historical stock and on the prescriptions issued, which are translated into replenishment requests for the following month.

Within this flow of prescriptions and psychotropic drugs, incidents can occur that must be addressed.

(...) errors in the pharmacotherapeutic chain, whether in the prescription process, the dispensation process, or the administration process. (...) when there's a bad dispatch of a drug, for example, a smaller or larger quantity is dispatched, or a drug is left out. (...) this adverse event is reported and, depending on its origin, we carry out an analysis and an improvement plan to prevent it from happening again (Interview, Pharmacy Staff).

In addition to these adverse dispensation events, pharmacy staff must deal with another type of adversity: the unwanted effects of medications. Users often describe, at the pharmacy hatch window, problems that arose after starting a pharmacological treatment. However, pharmacy staff have little influence over these effects:

We don't have much say over the adverse effects of medications, I mean, we should have a bit more, but due to time constraints we really don't. That's more focused on the work of the physician together with the nursing team—the adverse reactions themselves, properly speaking. (Interview, Pharmacy Staff).

Although adverse effects should also be reported through registration platforms, this does not happen in practice: “it's a really big form, so who really takes care of that? How can we manage it? My intention is

that we can incorporate it further down the line, but we really do need more human resources” (Interview, Pharmacy Staff).

The CMHPC's response to this falls on the information provided by the physician, and if that is not enough, it is the nurse who reinforces what effects can be expected from psychotropic drug use:

“(…) psychoeducation is provided to explain to the user whether the side effect they're describing is or isn't part of what's expected, because sometimes they know, sometimes they don't. Sometimes there are effects that aren't very common, so all that education has to be given, because there are users who know, whom the doctor has already told that they might gain weight or have discharge, milk, for example, things like that.” (Interview, Nurse).

Unlike the multiple connections generated to sustain the prescription and dispensation of psychotropic drugs, side effects do not activate any major connections or flows that modify prescription. Most of these effects are inscribed simply as facts that professionals and users must know.

Psychotropic drugs, as part of this assemblage, also exert agency over users' bodies: they produce bodily changes and alterations that, although they do not generate information flows within the network that sustains prescription and dispensation, do trigger new referrals and enable new diagnoses and prescriptions. In this way, the psychotropic drug reconnects the user to the very logics of diagnosis and medication that it itself helped to generate.

(...) for example, lithium users, who've been on lithium for a long time, develop hypothyroidism, which is secondary to the medication's use. And so they start taking medication for the “hypo,” that is, Eutirox (...). Weight gain, for example—almost all antipsychotics affect the system somehow, producing a metabolic syndrome that raises blood glucose, raises cholesterol, and turns them into patients with cardiovascular risk” (Interview, Nurse).

Only in exceptional cases can side effects introduce changes to the pharmacy's functioning, as described in a field note following a conversation with pharmacy staff:

They bought boxes from a different laboratory and some users reported adverse effects. They are now waiting for instructions on what to do with the remaining boxes. She also explained to me that the medication purchasing process can be cumbersome. For example, if a user needs a medication that isn't part of the center's arsenal, the pharmaceutical chemist has to submit a very well-justified request so that the Health Service authorizes the funds to acquire it. (Field note, March 24, 2025)

The explanation for the adverse effects reported by users, in this case, is not related to the medication itself but to a change of laboratory. Laboratories, then, also take part in this network, and exert agency by introducing alterations to the pharmacy's usual functioning—for example, when there is a change of laboratory, which explains the users' accounts.

How is the arsenal managed by the pharmacy defined? And how is a distinction made between drugs from different laboratories? This is explained below.

In theory, what defines a center's arsenal is the pharmacy committee, which unfortunately we don't have, and which we're precisely trying to get up and running (...). But the pharmacological arsenal isn't decided just because the doctors decide it, or I decide it—there have to be certain technical grounds (...). It's discussed in the pharmacy committee, the doctor is called in to provide all the available evidence, an analysis is done—not very in-depth, clearly, because there isn't much time for that—but more or less a fairly rigorous analysis is done as to whether it's really cost-effective, and finally it's decided whether or not to buy the drug and add it to the arsenal (Interview, Pharmacy Staff).

Lacking a Pharmacy Committee, the arsenal managed at the centers studied is defined at the central level, according to cost-effectiveness criteria. Thus, professionals assume that the drugs users receive are not “the best drugs because they're the cheapest” (Interview, Coordinator), and may therefore have even more adverse effects.

But medication is not everything

The tension between the biomedical model, which underpins diagnoses and drug prescription, and other social or psychosocial models, is also expressed among CMHPC professionals:

(...) there's a really important tension between the more traditional medical models and all the more community-oriented issues. I think sometimes they're two worlds that don't meet much. (...) it seems that some actors, at least, understand the issue as situated at the neuronal level, and others understand it only at the social level. (...) I think that dialogue has sometimes been difficult (Interview, Psychologist).

Despite these tensions, there seems to be a consensus: psychotropic drugs are important and serve to relieve distress. Even when that distress does not originate at the neuronal level but rather from “broader social factors (...)” (Interview, Psychologist). These professionals also recognize the role that diagnosis and psychotropic drug prescription play in delimiting and managing the population they must attend to.

In this context, the professionals referred to as psychosocial (psychologists, occupational therapists, and social workers) define their actions as those that must be carried out beyond the psychotropic drug, especially through psychotherapeutic support and interventions with families and the community. However, through these very same actions, they also become part of the network that sustains and maintains medication. For example, several of them interpret part of their role as inquiring into how users feel about their treatments and encouraging them to talk to the doctor when problems arise. This reinforces an honest, trusting relationship with the psychiatrist. The expansion of these professionals' scope of action, moreover, also constitutes an opportunity to verify symptoms and follow up on treatment:

(...) on a home visit, there are cross-cutting questions we should all be asking: whether they're taking the medications, how they've been sleeping, and how they've been feeling (...) So from there you bring back

the information, hand it over to your colleague [the psychiatrist], and you can coordinate (Interview, Coordinator).

Discussion

By following the connections within two MHP centers in southern Chile, we see how psychotropic drug prescription comes into existence and, with it, an understanding of mental illness grounded in the biological (Inchauspe and Valverde, 2018). This existence, however, is not anchored solely in the expert knowledge of psychiatry, as is often claimed. In fact, the psychiatrists adopt a critical stance toward claims that attribute mental illness solely to biological factors and its treatment solely to the use of psychotropic drugs. Nor can we attribute psychotropic drug prescription solely to the mandates and technical guidelines that come from higher levels of health management, since these only become operative through the actions of professionals and technicians who share expert knowledge. Thus, forms of governance in this field can be understood as a socio-scientific problem (Edquist, 2022) that entails a dynamic among government, science, and technology entities in which all of these actors have a stake.

We can say that part of psychiatric expert knowledge—diagnosis and psychotropic drug prescription—is articulated with certain logics of health management, especially those of cost-effectiveness and consultation times. The psychiatrists, even when they attribute mental health problems to aspects other than purely biological ones, agree that psychotropic drugs can offer timely relief for distress produced by social conditions, and they see diagnosis as the key to access. This is what Mol (2008) describes with regard to diabetes when she states that illness is put into action (*enacted*), that is, set into circulation through the everyday practices of professionals that couple with technologies to create fields of action. In this *enactment*, diagnosis, rather than a totalizing category, functions as a provisional response that gives way to concrete alternatives for improvement, deposited in the psychotropic drug, even when its coherence is debatable in general terms, even for those same professionals who prescribe them.

Psychiatrists translate complex problems into diagnostic categories: they objectify fragments of reality so that these can enter into social dynamics. From an ANT perspective, this process cannot be understood solely as the action of the psychiatrist, but rather as an inscription device (Latour and Woolgar, 1979/1995; Law, 2004/2020 in Betancur, 2026) that articulates particular logics of government, psychiatric knowledge, and technologies—a network that makes mental illness become such to the extent that it manages to translate it into a concrete ontology or reality.

From an ANT perspective, the reality of the diagnosis would lie in the socio-material practices with which it comes into contact and which constitute, update, or transform it. In health, these practices enable ways of framing problems that determine courses of action, while at the same time defining bodies and shaping lives. This is what Mol (2002) refers to with the notion of ontological politics.

Thus, the psychotropic drug network is sustained by diagnostic categories that are translated into *prescriptions* and into *dispensation*. However, for action to take place, it must connect with computer

platforms that enable its management and supply. These platforms connect psychiatric knowledge with the medical act of *prescribing*, and it is the prescription that becomes the actant that sets the network in motion (Betancur, 2026).

The pharmacy is also part of the network. Here is where dispensation of psychotropic drugs takes place, which entails a series of translations: prescriptions are translated into the envelope in which the medications are delivered along with instructions, and dispensations are translated into supply requests. New actions are also introduced when the delivery does not match what the platform reports. Thus, we see how information systems perform professional and technical activity, defining roles and limiting actions (Carrasco and Medina, 2019). At the same time, these systems connect actors and objects located within MHP centers to the decision-making centers of the health governance system, under the promise of managing information transparently and according to cost/benefit. In this way, they enable the calculation of the normal or average value of an operation and its projection over time (Miller, 2001 in Soto et al., 2017); in this case, the value of the drugs dispensed.

The constant prescription of psychotropic drugs, rather than an effect attributable solely to the reductionism of psychiatry, is the result of the combined action of professionals, scientific knowledge, physical spaces, computer platforms, and government guidelines.

The psychotropic drugs dispensed also act upon users' bodies, generating symptom relief but also unwanted effects. However, these do not translate into information that affects *prescription*. Although information-flow systems allow for the possibility of reporting them, in the centers studied this does not happen due to lack of time; professionals are forced to prioritize supply, displacing the entry of information about these effects. There is no time to record information on cumbersome platforms, nor do they have a Pharmacy Committee, where adverse effect reports could be analyzed to decide which drugs to purchase. This finding can be read as a form of epistemic injustice (Fricker, 2007), that is, as the outcome of processes that leave certain subjects out of knowledge generation—something that has already been described in the international literature with respect to the knowledge that users can contribute about their own experience in MHP services (Grim et al., 2022).

Thus, the unwanted effects of medications are inscribed as information that circulates within MHP centers, corroborates scientific knowledge, and becomes part of professionals' expert knowledge. This knowledge introduces modifications in professionals' actions, but has no agency within the assemblage that sustains *prescription*. Psychiatrists seek to establish an honest, trusting relationship with users, in order to explain unwanted effects to them, jointly seek better options, and follow up so that they do not abandon treatment. Moll (2008) links this form of relationship to the idea of a citizen who freely chooses to enter into an implicit contract, in which the patient commits to telling the “truth” about their illness and the physician commits to respecting whatever the patient decides.

Pharmacy and nursing staff, for their part, receive reports of these effects, inscribe them as part of what is expected, and direct users to convey this discomfort to the treating physician in order to seek alternatives, new diagnoses, and prescriptions. Other professionals, by contrast, the *psychosocial*

professionals, extend surveillance over the psychotropic drug's effects toward the home, the family environment, and other areas of users' lives, urging them to talk about these effects with the psychiatrist.

The user emerges as a rights-bearing subject insofar as they have the right to know the unwanted effects of psychotropic drugs and to choose among the available alternatives, yet without any say over the information flows that sustain supply, nor any real possibility of avoiding those effects. This knowledge, which circulates as expert truth within MHP centers and must be given to the user, becomes part of the inscription device and of the political ontology surrounding the user-subject: the diagnosis is associated with a treatment, and this, in turn, with unwanted but expected effects. At the same time, this reinforces the liberal logic of rights, by transferring to the subject this expert knowledge so that they may choose among options with knowledge of their implications, but without control over the conditions that produce them.

Thus, psychotropic drugs become an actant around which broad networks are articulated, despite the negative consequences and the harm they generate to the health of users (Hojlund et al., 2025; Lindekilde et al., 2022). Likewise, its leading agency persists despite the criticisms of professionals and the governmental mentality embodied in official documents, insofar as it displaces other ways of intervening in situations of distress or suffering. Thus, we see that in these centers the dichotomy that opposes a biologicist psychiatry that prescribes psychotropic drugs to other forms of intervention is both maintained and rebuilt.

We propose that this opposition can be understood as the difference between what remains inside and outside the psychotropic drug network. What is part of the network we have already described; what remains outside are the actions called *psychosocial*, characteristic of the community-based identity of these open-door centers, among which we find *the abandoned community garden*, mentioned in the field note that opens the results section. Unlike psychotropic drugs, *the garden* never came to be part of a network that would sustain it and ended up abandoned; it had no professional in charge, no medical or other professional indication to attend to it, no platforms to manage its stock, nor a committee of experts to discuss its effects or the evidence regarding it. This, which may sound absurd, brings to light the problems involved in incorporating and sustaining psychosocial or community-based interventions within contexts mediated by biomedical technologies and scientific knowledge. Unlike the garden, psychotropic drugs have indeed come to be part of sociotechnical networks articulated and sustained by psychiatric knowledge and government management logics, despite all the criticisms.

Declarations

Author Contribution

All authors listed on the submitted work made substantial contributions. JC: conception or design of the work
JC and MA: acquisition of data
JC, MA, and TC: analysis and interpretation of data
JC: drafting the work
MA: critical revision for important intellectual content
TC: translation of the manuscript from

Spanish to English and review of the English version JC, MA, and TC: approved the submitted version and agree to be accountable for all aspects of the work, ensuring that any questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Acknowledgement

We thank the professional teams at the centers where this research was conducted. We also thank the Health Service to which these centers report for facilitating access and supporting our work.

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