



Mental Health  
and Illness

## Newsletter

### Vol. 21, Issue 1, January 2021

Dear RC49 Members and Friends.

Wishing you and your loved ones a healthy and peaceful New Year!

One year ago, we announced the IV ISA Forum of Sociology in July 2020 in Porto Alegre, Brazil. However, at that time, COVID-19 had already started to spread around the world, resulting in millions of deaths and confirmed cases as well as major impacts on all societal spheres.

The ISA executive decided to postpone the IV ISA Forum of Sociology and finally turned it into a virtual meeting from February 23–28, 2021. In spite of the challenges that go along with huge international virtual meetings, I am glad to inform you that all 10 RC49 sessions will be held as originally intended. A big thanks to the colleagues, who managed to confirm their attendance and contribute to a slightly revised program in spite of all organizational difficulties, including different time zones and pandemic-related funding problems. Please find the RC49 time plan in this newsletter. The RC49 board expresses deep regrets to our Brazilian colleagues who worked so hard to prepare the ISA Forum in Porto Alegre. We very much hope to have an ISA Forum in Porto Alegre in the near future!

The pandemic serves as a magnifying glass for social disparities in terms of class, ethnicity, gender, and age with well-known impacts on health, employment, and education. Socially disadvantaged groups, including people with mental disorders and disabilities, face substantial barriers to essential services. In this newsletter, our board member, Jorge Chuaqui from Chile, describes the meaning of social inclusion for people with mental health problems with a focus on the situation in Chile. Obviously, the pandemic puts vulnerable groups under increased pressure. Compared to socially privileged groups, the burden of the lockdown is heavier for families living in small houses with limited access to recreation areas and secure (remote) jobs. Board member Bronwen Lichtenstein draws our attention to the social consequences of lockdown for older people; Dirk Richter introduces a critical view of the (supposed) increase in mental illness, including the role of COVID-19. Surely, there remains a lot to learn about the coronavirus-related impacts on mental health and illness.

Finally, you will find information on some of the RC 49 Board Members' activities in 2020, and we are happy to share the abstract of a doctoral thesis on community treatment from Deborah Martin, University of Bath, Department of Social and Policy Sciences.

Please stay safe - and looking forward to meeting you next year.

Silvia Krumm (RC 49 President)

## Online IV ISA Forum of Sociology February 2021: RC49 Oral Sessions

1. Mental Health and Social Situation of People with Different Kinds of Disabilities. Session organizer: Kjeld Hogsbro, Aalborg University, Department of Sociology and Social Work, Denmark
2. Mental Health in Latin America: A New Social Question?  
Session organizer: Alvaro Jimenez, University of Chile, Chile
3. Social Services for People with Mental Health Problems / Joint Session Institutional Ethnography (host committee)
4. Mental Health and the Family.  
Session organizer: Kevin Stone, University of the West of England, United Kingdom
5. Violence and Mental Health.  
Session organizer: Silvia Krumm, Department of Psychiatry II, Ulm University, Germany
6. Risk Factors and Protective Factors of Mental Health in Adolescents and Young Adults. Session organizer: Takashi Asakura, Tokyo Gakugei University, Japan
7. Social Relationships and Mental Health and Illness.  
Session organizer: Reinhold Kilian, Psychiatry and Psychotherapy II, Ulm University, Germany
8. The Sociology of Global Mental Health.  
Session organizer: Jeremy Dixon, Social and Policy Sciences, University of Bath, United Kingdom
9. Economic Inequality, Intersectionality, Mental Distress and Related Health Outcomes Among Women in Developing and Industrialized Areas.  
Session organizers: James Linn, Optimal Solutions in Healthcare and International Development; Michele Kadri, Oswaldo Cruz Foundation--Leonidas e Maria Deane Research Center, Brazil
10. Obstacles For Social Inclusion of Mentally Ill Persons.  
Session organizer: Jorge Chuaqui, Universidad de Valparaiso, Chile
11. Studies in Health Care and MH 3 [#14921]; Joint Session RC49 and WG06 (Host)

## Online IV ISA Forum of Sociology February 2021: Timetable

<i>Porto Alegre</i>	09:00-10:30	10:45-12:15	12:30-14:00	14:15-15:45	16:00-17:30	17:45-20:00
<i>Los Angeles</i>	04:00-05:30	05:45-07:15	07:30-09:00	09:15-10:45	11:00-12:30	12:45-15:00
<i>New York</i>	07:00-08:30	08:45-10:15	10:30-12:00	12:15-13:45	14:00-15:30	15:45-18:00
<i>Amsterdam</i>	13:00-14:30	14:45-16:15	16:30-18:00	18:15-19:45	20:00-21:30	23:45-00:00
<i>New Delhi</i>	17:30-19:00	19:15-20:45	21:00-22:30	22:45-00:15	00:30-02:00 (+)	02:15-04:30 (+)
<i>Melbourne</i>	23:00-24:30	00:45-02:15 (+)	02:30-04:00 (+)	04:15-05:45 (+)	06:00-07:30 (+)	07:45-10:00 (+)
<b>Tuesday Feb 23</b>	Large RC sessions	Large RC sessions	Large RC sessions	Large RC sessions		Opening Plenary Session
<b>Wed. Feb 24</b>	Violence and Mental Health [#13930]	Mental Health and the Family. [#12558]	Semi-Plenary Sessions LOC-SBS, ALAS *** PDS Publications	Social Relationships and Mental Health and Illness [#13184]	Studies in Health Care and MH 3 [#14921] Joint Session; WG06 (Host)	Common Sessions
<b>Thur Feb 25</b>	Risk Factors and Protective Factors of MH in Adolescents [#13103]	The Sociology of Global Mental Health [#13034]	Semi-Plenary Sessions LOC-SBS, CLACSO *** PDS Publications	MH and Social Situation of People with Disabilities [#14904]	RC49 Business Meeting [#15291]	Common Sessions
<b>Fri Feb 26</b>	Economic Inequality (...) and Related Health Outcomes in Women [#12289]	Obstacles For Social Inclusion of Mentally Ill Persons [#12256]	Semi-Plenary Sessions LOC-SBS, ISA *** PDS Publications	Mental Health in Latin America: A New Social Question? [#14581]		Common Sessions
<b>Sat Feb 27</b>			Semi-Plenary sessions ISA *** PDS Publications			Closing Plenary Session
<b>Sun Feb 28</b>	Research Council Business Meeting 2	Research Council Business Meeting				

The instructions and deadlines for Session Organisers are also posted at the Forum website <https://www.isa-sociology.org/en/conferences/forum/porto-alegre-2021/guidelines-for-program-coordinators-and-session-organizers-2021>

## THE MEANING OF SOCIAL INCLUSION

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**ABSTRACT:** What is social inclusión? Some theorists define it as social integration, which is attained through compliance with all norms, while others maintain that it consists of adaptation to society. This leaves the subject in a passive and subordinated position. This is especially the case if coercive means are used to achieve adaptation to society. According to this perspective, the social system has greater importance than the individual.

But there are other alternatives. If we consider the social structure of contemporary societies historically, a "normal" adult who has a "good quality of life" usually has a substantial employment that produces sufficient income to support a family and have an active social and political life. To achieve this, he/she must use all of their initiative and creative resources. A "normal" person is not dominated by the social system but instead realizes personal fulfillment.

Social inclusión has to be conceptualized and measured with three criteria:

1. The degree to which the person achieves valued social goals;
2. The degree to which a person is permitted to follow their most cherished values;
3. The degree to which an individual can utilize all their creative potential and initiative.

Among the valuable social goals are to have a good job, to have a good partner, to live in a suitable home. We know that for mentally ill persons it is often difficult to achieve their basic goals. However, it is a matter of degree. It is better to live in a suitable home than to live in a hospital. Also, it is better to have a loyal partner than to be alone and so on. Being able to live by their cherished values and use their creative abilities to the highest degree is far better than "social adaptation," which usually results from compulsory conformism.

**KEY WORDS:** social inclusion – mental illness – social adaptation – social integration

### SOCIAL INTEGRATION AND SOCIAL INCLUSION

Usually social inclusion is used synonymously with social integration. Let us refer to the concept of social integration first. The concept of social integration puts emphasis on fulfilling norms, fulfilling others' expectations, and to have good communication with others. This is a psycho-social process for a person to be accepted by the group. If this process is applied with coercion, in the sense that the person must accept forcefully the evaluations of others, it is a radical form of social control.

Let us examine the problem of power in this context. We must say that this social control is in the behavior of the person, but if it undermines the capacity of the individual in realizing their own interests, then it weakens the power of the individual.

The consequences of the processes of "integration," which involve applying rigorous social control which decreases power, is apathy or passivity. It can also be the opposite, i.e., disruptive or aggressive behavior. This behavior is common in persons experiencing psycho-social processes of adaptation, which in our opinion is natural or expected consequence.

If we understand inclusion as the realization of our interests through occupancy of a position in a social system or through contexts of interactions, it can be achieved in two ways:

1. Getting a valuable position, and
2. Exerting power from the position with minimal possible constraints.

What are the valuable positions universally required in our societies? They are to have a good job, to have a highly qualified employment or economic position, to have a beloved partner who gives you love and understanding, and to have an active and satisfactory social life and a sense of social solidarity. These are the structural positions that persons must achieve to be included.

But there is the other question: How are these desirable positions attained? To get these social positions requires power – sufficient power to fulfill their own interests. If one does not have a good job or economic position, it is not possible to finance personal needs, nor be independent of others who have power.

If one does not have the possibility to have a beloved partner and does not have the possibility of experiencing adult love, which is one of the most cherished goals of most persons, they are limited in life satisfaction. An active and satisfactory social life is a dimension of empowered behavior and also an end in itself for most people. This requires an open attitude in relation to solidarity sentiments without which social relationships are damaged.

When we emphasize social adaptation, we create a safety net of dependence, which is the opposite of empowerment. Social inclusion is synonymous with empowerment. It enhances creativity and initiative, and sometimes produces disruptive behavior. Given that the attainment of valuable life goals many times requires struggling against common sense or consensual norms, if we cut out any disruptive behavior, we are putting constraints that transform the person into a docile and apathetic person.

## **PERSONAL FULFILLMENT**

A person's achievements are important, but how they achieve their goals is also of great consequence to them. Each person is embedded in social relationships. Even isolation is a type of social relationship in which the person rejects social connections or stigma erects a social barrier. When an individual has his or her first psychotic crisis, it destroys social connections and creates the problem of exclusion. There are different ways of promoting inclusion. One way is to consider existing systems as sacred systems to which the person must be adapted. This approach creates a dilemma: we have to conform compulsively to a fixed system or we must take into consideration each individual's personal goals. We must ask what is the situation of the person after the psychotic crisis? The person probably is confined in a hospital for a short or long period and then returns to his or her family. In some cases they may return to work or academic studies or not. How does this transition occur?

According to our research, families tend to be overprotective of children with mental illness and do not believe in their capacities. The person is judged according to "common sense" standards in which many behaviors or personal preferences tend to be seen as "not normal" because of social prejudices associated with social stigma. The combination of the perception of incapacities and associated stigma means that the "adaptation" to the family blocks in practice the possibility of social inclusion as we characterized it in this paper. The problem is similar, or greater, if the person lives in a hospital or group home in which the person has to follow institutional rules that can impoverish personal life.

In this sense, we argue that the person should not be deprived of most of his or her personal decisions. Given that recent research shows most of them want to work, although they and the social environment do not have trust in them. As things operate in practice, the concept of social adaptation means a new jail that blocks the possibilities of social inclusion because families do not believe in his/her work capacities and do not believe in the possibility that they can have a beloved partner and make an independent life.

The person with mental illness has to be empowered rather than making them adapt to the social milieu. It is necessary that they struggle for their personal fulfillment, in the sense that they use all their creativity and initiative to achieve socially valuable goals. It is preferred that they are a fulfilled person with their success defined in relation to social values, capacities, and vocation.

Therefore, we believe that inclusion has two dimensions: an objective one as indicated by the attainment of a quality employment, a beloved partner and a sense of social solidarity, and a subjective aspect that is experienced as a feeling of personal fulfillment and not personal adaptation.

However, in reviewing actual situations, we find that the most common outcome for persons with mental illness is that they achieve degrees of inclusion, that is, the person may live with their family (instead of living in a hospital), have a precarious job (rather than being unemployed), but they are not capable of having a solid relationship with a beloved partner, and so on. In principle, if we measure the different aspects of inclusion and give them arithmetic value, there is the possibility of designing a valid scale of social inclusion.

### **SOME EMPIRICAL DATA: THE SITUATION OF COMMUNITY PSYCHIATRY IN CHILE<sup>1</sup>**

In Chile, more than two thirds of persons with schizophrenia are single, more than 80 percent do not have a normal paid job, only a minimal quantity have constituted their own family.

Taking a less critical approach, we have to recognize that there are advances. There are various community centers and workshops that ameliorate the confinement, and most of the schizophrenics live with their original families even if those families do not promote their independent living. Inclusion is not black or white. There are several degrees of exclusion/inclusion.

Community psychiatry tries to normalize behavior by applying psychosocial and drug treatments as a way to exert social control over potentially disruptive behavior. According to the psychiatric paradigm, if you have more mentally ill persons under control, you will diminish the prevalence of abnormal behavior. In this sense, for psychiatric paradigm, the more extensive the availability of psychiatric services, the better will be the mental health of the population.

We wish to discuss some data regarding the extent of psychiatric coverage in Chile. First to meet the standard of community mental health centers, it is necessary that a center have, or potentially have,

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<sup>111</sup> The information are oficial data of the Ministry of Health and research conducted by the author with state funds.

40,000 beneficiaries in the surrounding area. Today, despite a significant development from zero existing centers in 1990 to 83 centers in 2012, we are far from meeting the need for mental health services in Chile. Currently, to meet the estimated need for community health centers in the cities and territories we would need four times as many centers.

In the year 2012, 5.3 percent of the beneficiaries of public health services received at least one mental health treatment/visit that year. In the same year, a WHO-AIMS 2012 study showed that twice the people receiving private health care (12.2 percent) benefited from at least one mental health treatment or visit. These data highlight the inequity in access to mental healthcare in Chile, where private affiliates have an access level similar to the level in high-income countries, while public health beneficiaries have much lower access to care.

The evidence shows the importance of psycho-education of the user and their family in adherence to treatment and the evolution of mental illness. These programs are especially important for schizophrenics and their families. The Chilean Ministry of Health points out that psycho-education must be made with all patients and their families after the first episode of schizophrenia. However, a study by Alvarado (2006) showed that this psycho-education was only carried out in about half of the cases. In Chile, a 2009 study in the public health system showed that more than two-thirds of people with schizophrenia abandon treatment before the end of the first year. This abandonment is much higher than the 21.3 percent of abandonment of psychiatric treatments reported in a WHO study from various regions of the world. A recent study conducted in Chile by applying the instrument, "Quality Rights," showed that 86.7 percent of the evaluated outpatient centers met in full the standard for psychotropic medication, but only 6.7 percent did for access to psychosocial intervention in the social support network.

#### **WHAT IS DONE BY COMMUNITY PSYCHIATRY?**

There are now developed daytime hospitals which try to avoid confinement of closed hospitalization, group homes which do the same, psychiatric rehabilitation centers which attempt to give social, cultural, and elemental work skills to patients that need them, clubs of integration that offer enhanced sociability for psychically handicapped persons, sheltered workshops providing work discipline as a substitute for competitive (real) work. In the last case, participants receive a small monetary incentive for doing craftsmanship, bakery, making candy etc.

In empirical research that we have done, the data show that families believe that persons with schizophrenia cannot live independently, perform adequately in a normal job, and have a good partner. In sum, families that are over-protective and frustrate their members (those with mental illness) desire to work in a real job. The community centers perpetuate psychiatric institutionalization, and they do not support real inclusion. I think that the problem is that those policies go against real empowerment. Their focus is on achieving social control for normality and not for personal fulfillment. This situation of mentally ill persons in Chile goes in the opposite direction of the Convention of Human Rights of Disabled Persons of the United Nations which asserts the right of labor inclusion and independent living.

(References can be requested from the authors)

**Should Older People be Locked Away?**  
**Responses to Covid-19 in the United Kingdom, United States, and Australia**

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Ageism infuses policy and public responses to Covid-19. In the UK, US, and Australia, three English-speaking countries with divergent paths to coronavirus control, mortality is highest among older adults, and age-graded policies have been introduced to reduce the burden of illness. The UK and US have relied on partial lockdowns, including self-isolation orders for older adults. Australia has opted for hard lockdowns and border closures across the country. These contrasting approaches have seen high death rates in the UK and US, matched by Australia's much lower levels of illness and mortality. Society undeniably benefits from strict lockdowns designed to protect the public's health. The question remains as to the efficacy of these approaches in each country, and whether older adults have been helped or harmed by targeted policies for prevention.

Ageist policies for Covid-19 control evoke images of frailty, dementia, dependency, and nursing home care for older adults. This stereotype defies reality. Around 95% percent of people aged 65 and older in each country live independently rather than in nursing homes and other forms of aged care. These independent elders do not frequent workplaces, bars, parties, friends' homes, and restaurants at the same rate as younger people and are less likely to be diagnosed with Covid-19. Research also shows that 82% of older adults in the US and Australia have been healthy and satisfied with quality of life prior to Covid-19, but that their mental health and well-being plunged under isolation orders. Policies that assume poor health and functioning do not fit this population, either in terms of assumed frailty or ability to manage the risks of Covid-19.

For the 5% of very old or infirm adults in residential care in the UK, US, and Australia, ageist policies and practices abound. Nursing home bans on visitors, room confinement, and dying alone without the presence of family, were instituted without input from residents, or independent risk assessments by regulatory bodies. The lack of transparency in aged-care industry operations, dearth of advocacy by and for residents, and societal invisibility all masked the dangers of aged care homes as incubators of Covid-19. Around 40% of Covid-19-related deaths have occurred in this sector. Chief among the dangers were cost-cutting measures, such as hiring casual staff to work in two or three shifts at different facilities (where they unknowingly carried the virus from place to place), low staff-resident ratios, loss of nursing capacity, and lack of protective equipment or PPEs for staff. Alone in their rooms and attended by overstretched staff, aged care residents were sitting ducks for Covid-19. It is unlikely that these practices would be tolerated for children or young adults in similar living conditions.

These examples highlight the role of ageism in public health responses for Covid-19. Norms for age segregation have gained pace in Covid-19, creating islands of death in the three countries in which aged care is normalized and privatized with little regulatory oversight, and where deep pockets of social isolation have occurred at the community level. Remedies for reducing Covid-related deaths in aged care include improved staffing levels in nursing homes and greater oversight of the industry. Tackling ageism itself will take other measures, such as educational campaigns to improve awareness of ageism's deadly toll and beefed up enforcement of age discrimination laws in employment and other areas of social life. The pandemic is an opportunity to re-think attitudes toward



ageing, ageism, and age segregation for more enlightened policies involving older adults in the pandemic era.

## **The supposed increase of mental illness - Social change and mental health<sup>2</sup>**

Dirk Richter

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The presumed increase of mental illness has also been a concern in academic and popular discourses in German-speaking regions [1-3]. To this day, the media and other sections of the public are persistently convinced of the rising incidence of mental health problems in modern societies. The background to this is usually reports of the significant increase in the use of psychiatric or psychological therapies and of absences or pension claims caused by mental illness, as regularly reported by health insurance companies.

In psychiatric epidemiology, on the other hand, we can almost speak of a consensus that does not confirm the presumed increase. This has recently been demonstrated by two meta-studies. In the latest Global Burden of Disease (GBD) study, the increasing importance of the burden of disease from mental illness was again highlighted, but the picture is quite different for prevalence [4]. Taking demographic changes (e.g. migration, ageing) in the populations into account, the study even showed a decline. In another meta-analysis, which analysed the prevalence rates from 44 studies worldwide, there was a slight increase at the global level. However, it was not possible to adjust for demographic changes, so the authors concluded that the increase was due to this [5].

The effects of demographic change become particularly clear when we look at the clinical picture of dementia. If the effects just reported were primarily for adults below the age of 65, the GBD data for dementia (Alzheimer's and other forms of dementia) do not show any change in prevalence when age is adjusted [4]. The results of another meta-analysis that looked at the incidence of new dementia cases are along the same lines. Here, too, the incidence rates were found to be stabilising or slightly declining, especially in wealthy western countries [6].

The global trends are also reflected in Germany. Various studies led by the Robert Koch Institute in Berlin have shown no change in depression in adults [7] and in various disorders in children and adolescents [8-10], although some studies have even shown decreases in certain groups. In contrast, the self-reported use of the service increased [11].

All in all, therefore, there is an increase in the use of mental health services, but no increase in the prevalence of mental illness. According to various authors, the increase in use in recent decades should actually lead to a decrease in prevalence [12, 13]. But this is not the case either. We can only speculate about the reasons for this: (1) the therapeutic interventions are not strong enough, (2) the interventions reach only a small proportion of people in need of treatment, (3) the improved accessibility of therapeutic services is counteracted by increasing morbidity due to social developments (pressure to perform, etc.).

All of the above-mentioned reasons may apply. But the problem is probably much more complicated. With mental illnesses it is different from many physical illnesses, where, according to epidemiological doctrine, a certain prevalence rate meets treatment, which then lowers the prevalence. Here we must take into account the social changes that are having an impact in different directions.

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<sup>2</sup> This is a machine translation of an Editorial for the German-speaking scientific journal "Psychiatrische Praxis", see DOI 10.1055/a-1228-9503

Two important and interrelated social trends of recent decades are the technological change of the deindustrialisation of the labour market and social individualisation. The change from an industrial society to a service society has immense consequences for the cognitive and emotional characteristics of modern man. According to the so-called Flynn effect, it can be assumed that the measured intelligence in modern society will increase, which will have a positive effect on cognitive performance in old age (cognitive reserve) [14]. However, it is not only cognitive performance, but also emotional well-being that has a positive relationship with cognitive reserve [15]. The Flynn effect was caused by trends towards higher education, more complex working conditions and improvements in hygiene and medical care.

Connected with this social development is a second effect, known in sociology as 'psychologisation'. This means that with the individualisation of living conditions and the dissolution of traditional workers' or peasants' milieus, an increased attention to the individual psyche has emerged, as early empirical studies have shown [16]. At the same time, psychology has become the secret leading science of modern society, informing numerous areas of life from legal issues to pedagogy to intimate relations, which has manifested itself not least through an extensive 'therapy culture' [17].

Psychologisation is accompanied by considerable changes in professional concepts dealing with psychological problems, for example the concept of trauma or the understanding of mental illness in general. These concepts are becoming increasingly broad and now include features that were previously considered less serious [18]. This development has been viewed with increasing scepticism in psychiatry in recent years [19].

In the philosophy of science, the effects of changed professional concepts on the self-perception of laypersons (i.e. patients) are assumed. At the same time, changed perceptions of lay people are also associated with concept expansions - this is called a 'looping effect' [20]. Examples of this are the inclusion of post-traumatic stress disorder in DSM-III due to political pressure [21] or the recognition of burnout as a legally acknowledged work-related stress syndrome in various European countries [22].

It should have become clear to what extent the answers to the questions of whether mental illness is on the increase and why the prevalence is not falling due to the sharp rise in utilisation depend not only on considerable social imponderables and social trends, but also on problems of definition and perception. Social change has had some positive effects on mental health. At the same time, the perceived burden as well as the willingness in the population to seek psychiatric treatment has increased significantly. However, in some cases this has also led to an increase in the care of "lighter" cases, which were not previously classified as requiring psychiatric treatment [23] - these cases are called "worried well" in the English-speaking world [24].

The mixture of social change, changes in concepts and perceptions and changed demands can be assessed as both overuse and underuse. Epidemiology and care planning, however, face considerable challenges in this situation, which urgently need to be better understood empirically, but also theoretically. This is of particular importance in the light of the current pandemic. Up to now it is not clear whether the pandemic will eventually lead to increasing prevalence rates of mental illness. A recent review study has demonstrated that distress in the general population has increased from pre-pandemic times to the first lockdown wave and has slightly decreased after lockdown. This decrease, however, has not reached pre-pandemic levels [25].

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## Contributions from Junior Researchers

### Community Treatment Orders: what do they tell us about the exercise of power over the psychiatric patient?

Deborah Martin, University of Bath, Department of Social and Policy Sciences

**Abstract:** Community Treatment Orders (CTOs) provide a means by which treatment for mental disorder may be imposed upon some psychiatric patients once they are discharged from detention in hospital. They are intended to prevent patients disengaging from treatment, avoiding a deterioration in their condition which may result in harm and readmission to hospital. Although initially intended for a small number of patients who posed most risk, their uptake far exceeded Government expectation, yet research has questioned their effectiveness in achieving their intended aims. This study explores the exercise of professional power over the psychiatric patient by analysing professional decision-making in the use of CTOs to better understand the reasons for their use. To do this, the theory of governmentality was used as a means of analysing professional actions. This analysis adds to the existing body of knowledge by examining the factors influencing professional decision-making. The findings highlight professional justification for CTO use and reveal the balance of care and control over the psychiatric patient.

This study employs qualitative methods to gather data from the two professional groups involved in the CTO decision-making process: responsible clinicians (RCs) and approved mental health professionals (AMHPs). Individual and joint interviews allowed the gathering of rich, contextualised data from 18 participants. The findings show that medical discourse is dominant among RC and AMHP participants. This is evident in participant accounts of mental disorder and its associated behaviours and in professional responses to mental disorder. In addition, some more socially orientated considerations form part of CTO consideration. These social factors are not, however, concerned with the patient, but with interdisciplinary dynamics and resources. These findings indicate that the balance of power rests with professionals, as opposed to patients, and that CTOs are being used to protect professionals, ahead of patients and the public.

Access at: <https://researchportal.bath.ac.uk/en/studentTheses/community-treatment-orders-what-do-they-tell-us-about-the-exercis>