previously experienced the common side effects of psychotropic medication, such as extreme sedation, inability to think clearly, sexual difficulties, and excessive weight gain. Others do not seek treatment because the symptoms of their mental illnesses make them unduly suspicious of the treatment system. As a result, some people who have severe and persistent mental illnesses become homeless or are quickly returned to the hospital when their symptoms recur.

To address the shortage of inpatient beds discussed earlier, and the gaps in community treatment, 45 states and the District of Columbia have developed assisted outpatient treatment (AOT) programs (Stettin, 2014). AOT, also known as outpatient commitment (OPC), allows someone with a serious mental illness and a history of medical noncompliance to be released into the community with a court-ordered treatment plan. The plan is created by a psychiatrist and includes case management, group or individual therapy, medication management, and substance abuse treatment. AOT programs have been found to be cost effective for the states (Swanson, 2013), but are not a substitute for inpatient treatment when it is needed. Some mental health professionals argue that additional psychiatric hospitals are still needed.

Multidisciplinary Aspects of Mental Health Care

In most mental health settings, social workers are members of teams that include colleagues from a variety of other professional disciplines. Table 10.1 lists disciplines whose members practice in mental health settings and shows their educational and professional qualifications and common professional roles. Clinical

Table 10.1 More about Professional Disciplines in Mental Health Settings

Discipline	Qualifications	Role
Psychiatrist	MD plus psychiatric residency, board certification in psychiatry	Prescribes psychotropic medication; diagnoses mental disorders
Psychologist	Doctorate (PhD or PsyD), state licensure	Conducts psychological testing; provides psychological treatment
Social Worker	MSW/BSW; MSW plus state licensure or certification required for independent or clinical practice	Provides assessment, clinical treatment
Professional Counselor or Marriage and Family Therapist	MA/MS; state licensure	Provides psychotherapeutic treatment
Nursing: Psychiatric Nurse Practitioner	Master's degree from psychiatric nurse practitioner program; state license	Prescribes and monitors medication
Psychiatric Nurse	RN or BSN; sometimes master's degree	Monitors medication and medical needs; with master's degree, provides psychotherapy

Source: Elizabeth A. Segal, PhD

social workers have a minimum of two years or 3,000 hours of post-master's experience in a supervised clinical setting. They must have a clinical license in the state where they practice. Paraprofessional workers in the mental health system include **peer counselors**, consumers who have recovered from psychiatric disorders and who now assist other consumers. Social work students often gain experience as part-time psychiatric technicians under the supervision of professionals. They are involved in a variety of tasks, including providing ongoing support to consumers in residential settings, carrying out behavioral programs designed by professionals, and monitoring consumer needs in inpatient settings.

The multidisciplinary nature of mental health care is particularly notable in terms of diagnosis. The standard for identifying and categorizing symptoms into diagnosed disorders is the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, Text Revision (2013) (**DSM-5**). This manual lists all currently recognized mental disorders, provides a detailed description of each diagnostic category, and specifies the diagnostic criteria practitioners should use to make reliable diagnoses. The diagnostic categories of the *DSM* are used by all mental health providers and insurance companies. Box 10.2 discusses controversies about some of the definitions and Table 10.2 provides additional information about various diagnoses. Also see Box 10.3.

Box 10.2 Point of View

A diagnostic system like the *DSM* can be used to distinguish between mental disorders and the problems in living that all people encounter. It helps practitioners and researchers develop a better understanding of conditions and effective treatments. However, some mental health practitioners, consumers, and consumer advocates are troubled by certain aspects of the *DSM*. Some are concerned that those who write the *DSM* are academics too removed from work with consumers to understand the day-to-day reality. As one clinician notes about the *DSM-5*, "[I]t's like the people on the Task Force have never sat in the room with a client. They're up in an ivory tower somewhere, dictating how we should be diagnosing our clients, but the changes they've made don't match up with what I see in my office with real people" (Teater, 2014, n.p.). Another complaint is that people in a position of power have decided whether certain behaviors are symptoms of mental illness. The result is diagnoses that some believe unfairly stigmatize behaviors seen more frequently in nondominant groups. Others argue that the *DSM* provides "scientific" justification for the oppression of members of marginalized groups, including women, people of color, lesbians, gay men, and poor people. "psychological 'evidence' has been invoked as a rationale for locking us up in mental hospitals and prisons, breaking up our relationships with our lovers, taking our children away, denying us jobs, and blatantly discriminating against us in law and social policy" (Kitzinger, 1997, p. 203).

People within and outside the mental health field have raised concerns that the *DSM* pathologizes normal human emotions and behaviors. One example of this is grief and depression that can follow a big loss. In the *DSM-4* there was a "bereavement exclusion" stating that grief and symptoms of depression should not be considered a psychiatric disorder when grieving the loss of a loved one. This exclusion has been removed from the *DSM-5*. This means that normal grief after a loss that is accompanied by symptoms of depression, can now be categorized as a mental disorder. One psychiatrist suggests that the *DSM-5* will lead to "massive over-diagnosis and harmful over-medication. Making grief a mental disorder will be a bonanza for drug companies, but a disaster for grievers" (Levine, 2013, n.p.). Additionally, there was never an exemption in the *DSM* for other types of loss, such as the loss of a job or the end of a significant relationship. Many would argue that grief and depression are normal

(continued)