In Australia, around one in five people will experience a mental illness at some stage of their lifetime. This shows how prevalent mental illness is in our society today; in this paper the author will discuss issues surrounding mental health services and there benefits for the client and the rest of society, in the treatment packages they offer. The author will be highlighting points related to behavioural and violent issues in mental health institutions and the society, specific treatments including medication administration and management strategies, the evident problem of homelessness and mental illness and the concern surrounding drug and alcohol abuse, and the negative effects. The consequence of societies stigmatizing and stereotype views of mental illness. As well as the problem of the mentally ill becoming institutionalised in facilities and losing their independence.

Our society has become very judgemental and prejudice towards areas which we do not fully understand, or are seen to be different. In particular the mentally ill are looked down upon; this notion has been formed by stereotype beliefs and fearful attitudes (Corrigan & Wassel, 2008). Numerous people with a psychiatric disorder find it hard to be accepted into society. Finding work is difficult for them as many employers discriminate because they may need to take days off due to doctors appointments, and some may not have a maintained personal appearance (Golberstein, Eisenberg & Gollust, 2008).

Caring for a family member who suffers from a mental illness can be an extremely challenging situation for the family, in coping with the role of a full time carer. In some cases family members are caring without appropriate understanding or skills in the person’s diagnoses (Parker, Leggatt & Crowe, 2010). This can put a lot of pressure and tension on the family’s relations to this member and each other. In many cases there can be a breakdown of interpersonal relationships due to argument and disagreement over the well fare of the family member (Parker, Leggatt & Crowe, 2010). In these cases Psychiatric wards can be an appropriate option for the family to relinquish care of their family member, to qualified professionals in order to provide appropriate care and relieve family pressure (Parker, Leggatt & Crowe, 2010).

In past history the mentally ill were severely mistreated and victimised in society. (Golberstein, Eisenberg & Gollust, 2008). They were not treated humanely and rejected by the general public. Many mentally ill patients who were admitted into ‘Correctional institutions’ are today still living in these wards, as they have become their homes (Hodge, 2007). Sadly, they have grown to become institutionalised losing their life skills, as they have become highly dependent on the routine of daily living in the institute (Hodge, 2007). Many Mentally ill sufferers would not benefit from long term psychiatric ward stay and are better off living in the community where there independence can be maintained (Hodge, 2007). Mentally ill people may only have occasional crisis periods where they need short stay treatments to get ‘back on track’ or community resources other then institutions for management.

Medication use to manage mental illness is a complex process of decision making and an opportunity for the client and the general practitioner to work together in the resolution to decisional conflicts (Deegan & Drake 2006). Mental health facilities have benefits for the client in the treatment of their mental illness. Professional practitioners and nurses work together to manage the desired beneficial therapeutic levels of medication and there administration in a safe environment (Deegan & Drake 2006). Finding the suitable drug or drugs for the individual can be a very prolonged process of trial and error. Their health and behaviours are monitored in relation to the medications they are administered and the contra indicators on the individual (Deegan & Drake 2006). Many administered medications for mental illness such as Clozapine need them to have regular chest X-rays, ECG’s (Electrocardiography) of the heart and blood tests taken to monitor the body’s response to the medication (Deegan & Drake 2006). Being in psychiatric care means that these tests can be taken on site and monitored closely if needing any changes. Specific interventions and strategies are put in place to increase compliance and assist in the control of the negative behaviours of their mental illness (Richard, Hudson, Thrush, Purushottam, Armitage & Reid, 2008). This may assist in their recovery and enable them to live life in the community, and manage their mental illness.

Today, there are a high proportion of mental illness sufferers that are linked with homelessness (Sullivan, Burnam & Koegel, 2000). Mentally ill homeless people are seen to make up around twenty five percent of the homeless population (Sullivan, Burnam & Koegel, 2000). There are numerous reasons why they come to be in this situation, as there are many vulnerabilities including mental illness which are contributing factors. Among the homeless

mentally ill, those who were on the streets before becoming mentally ill had the highest rates of disadvantage and disturbance. While those who became homeless after becoming ill have a particularly high prevalence of alcohol dependence (Johnson & Chamberlain, 2009). These vulnerabilities to becoming homeless include a breakdown of family support that generally precipitates homelessness (Johnson & Chamberlain, 2009). The unhoused who suffer a mental illness were more likely to have a background marked by sexual or physical abuse as a child. Another factor includes experiencing considerable poverty as a child. Where there family was on a welfare allowance, and there primary care giver was rarely or never employed (Sullivan, Burnam & Koegel, 2000). Once they are at the point of discharge from mental illness facilities, there is increased opportunity of receiving stable accommodation. As they have professional liaison with government and community services to organise appropriate housing (Johnson & Chamberlain, 2009).

There is a stigmatising ideology created around mental illness, that they are all dangerous and violent people (Golberstein, Eisenberg & Gollust, 2008). This is a very biased and generalised comment as it is not an accurate description at all. There are many contributing variables that impact on violence in mental health. Some may have come from a background of past violence in families, and there is an evident link between violence levels in the general population, compared with mental patients in an institutionalised environment (Elbogen & Johnson, 2009). Within a psychiatric ward setting there are measures established to manage and treat disruptive and violent behaviour (Sailas & Wahlbeck, 2005). These measures include seclusion and restraint in the most severe circumstances where all other actions have been taken to remedy the situation. In these cases they are at risk to themselves for self harm or surrounding staff, clients and visitors (Sailas & Wahlbeck, 2005). A past history of substance or illicit drug use combined with their psychiatric diagnosis has been seen to increase their amounts of violent behaviour (Hodgins, Alderton, Cree, Aboud, & Mak 2007). Some individuals suffering from violent outbursts are difficult to manage in the community as there is no known trigger or warning of the behaviour, which is problematic as they are at risk to themselves and the public’s safety (Choe, Teplin & Abram, 2008).

Due to this association between violence and mental illness there is a significant effect on the criminal justice system for those that suffer a mental illness (Elbogen & Johnson, 2009). In the community their aggressive behaviours are not tolerated, as they disrupt society. This serves as the basis for imposing compulsory mental health treatment in order to protect the public’s wellbeing at the expense of the patient’s self- determination and autonomy (Elbogen & Johnson, 2009). Evidence shows there is a high demand for psychiatric treatment of individuals suffering a serious mental illness. Although, currently there are not enough psychiatric beds to supply these demands, and they are not receiving adequate care and management of their illness in a psychiatric ward (Torrey, Kennard, Eslinger, Lamb & Pavle, 2010). This leaves the overflow of mentally ill people who need treatment living in society. They may be at risk of committing a crime as well as self harm and suicide. In some cases these individuals are being incarcerated in prisons as their anti-social behaviour and violent crime which is not accepted in society (Torrey et al, 2010).

Many people with a mental illness also have problems surrounding drug and alcohol abuse. When they are living in the community there is a higher risk of abuse as there is more accessibility for them (Elbogen & Johnson, 2009). In these cases, if an overdoes occurs they rely on public health services, such as paramedics and hospitals to treat them in recovering. Therefore, there is a greater strain on the resources of these services, which then adds to the burden and pressure on services (Elbogen & Johnson, 2009).

In past history there was a movement in deinstitutionalisation of mental health patients. As professional’s had discovered more adequate medications that where managing their illness, it was thought that a large majority could be discharged into the community (Olafsdottir, 2010). This meant less funding for the government to put into psychiatric wards. Although they had the best interests at the time, there was no real testing of its philosophic bases, and the lack of planning for alternative facilities and services (Olafsdottir, 2010). They assumed people where much better off to be treated in their own communities where they had natural ties. There was an underlying belief that community care is a good option for most patients, and that communities not only can but are willing to assume responsibility and leadership in care and that tasks fulfilled in hospitals can be equally performed or better in the community (Olafsdottir, 2010).

The ultimate desire is for the mentally ill to be living independently in the community while successfully managing their illness (Sachs-Ericsson, Debrody & Paniucki, 1999). If relapse or breakdown occurs short stays in services and hospitals are the optimal choice to get back on track. Although, living independently is a complex challenge as many of these people are in the situation where they are unable to work or become employed due to the side effects of the medication they are taking and symptoms of their mental illness (Sachs-Ericsson, Debrody & Paniucki, 1999). Leaving them in a situation where they have to rely on government funding due to poor finances (Sachs-Ericsson, Debrody & Paniucki, 1999).

Providing a person with a mental illness has enough support from services in the community, ideally it is better for their own self determination and autonomy to be living independently within the community. Although, it is necessary for some to be admitted into Institution’s in order to manage their symptoms of the mental illness. Currently the evidence shows there is an enormous shortage of beds to facilitate for the growing mentally ill population. More funding needs to be directed into this area, so that there are more resources and services readily available so that support and assistance is always on hand.

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