Mental health needs and access to mental health services in Portugal: Some optimism, some pessimism

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This essay assesses the relationship between the need for and use of mental health services in Portugal. It particularly explores the complex issues that beset mental health services in the country, along with the factors that potentially contribute to mental health problems. Three discrete predictive factors emerged: (i) sociodemograhphic; (ii) intercultural contact; and, (iii) psychosocial adjustment. As earlier studies have revealed, these were linked to youth's mental health. Training professionals in a shared care model is theoretically not linked with consistent improvements in the recognition or management of mental health services in Portugal. A mental health service system based on the recovery concept incorporates the services of a community support system organised around the rehabilitation model's description of the impact of severe mental illness. Despite the instabilities the landscape of mental health service in Portugal may have contributed to the lack of effects, wider changes in the mental health services is necessary to improve training and to encourage changes in behaviour, and more specific proved models. Lastly, routine screening for mental health need and increasing access to mental health professionals for further evaluation and treatment should be a priority for Portuguese in their initial contact with the welfare system.

Keywords: mental health, mental health services, service development

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BACKGROUND

One of the most critical issues in mental health services research is the gap between what is known about effective treatment and what is provided to consumers in routine care. Concerted efforts are required to advance implementation science and produce skilled implementation researchers. This paper seeks to advance implementation science in mental health services by over viewing the emergence of implementation as an issue for research, by addressing key issues of language and conceptualization, by presenting a heuristic skeleton model for the study of implementation processes, and by identifying the implications for research and training in this emerging field (Proctor et al., 2009).

By and large, comprehensive information about access and patterns of use of mental health services in Europe is lacking. In Portugal, particularly the counsellor figure is yet to exist – where the orders connected with mental health eclectically, and bears an elitist seal among them, but also where status seems to be more essential that the patient's health – it has become difficult to effectively deal with this subject. This is not unique in Portugal. For instance, one study (Alegria et al., 2002) on the mental health care of Latinos has found significant differences between ethnic groups were found in demographic characteristics, geographic location, zone of residence, insurance status, income, wealth, and use of mental health services. The results indicated that poor Latinos have lower access to specialty care than poor non-Latino whites. African Americans who were not classified as poor were less likely to receive specialty care than their white counterparts, even after adjustment for demographic characteristics, insurance status, and psychiatric morbidity.

Indeed, this is a pressing issue, but one that seems attainable. For instance, one study (Watts & Van Esbroeck, 2000) has outlined the main trends in the development of such services including the results of a task analysis covering the main guidance and counselling roles. Implications for professionalisation and for training and professional development are reviewed.

All the relevance of the delicate and serious problems that haunts the community with some sort of mental disease, seem to be pushed away from politics and professional groups in a country, small both in size and mentality. Moreover, much was already discussed about this Portuguese characteristic of looking only to 'one's yard' and alienating themselves from the greater good, respect or common interest, no matter the area (great writers took this state of being as a central question in masterworks of Portuguese literature), reality maintains itself. And in reality, mental health, for being at the present moment remains a very little discussed subject both in media and society; it is still taboo and stigmatised. However, it is suggested that a European master's degree could be a valuable complement to national training and qualification structures.

Despite the publication of high-profile reports and promising activities in several countries, progress in mental health service development has been slow in most low-income and middle-income countries. One study (Saraceno et al., 2007) reviewed barriers to mental health service development through a qualitative survey of international mental health experts and leaders. Barriers include the prevailing public-health priority agenda and its effect on funding; the complexity of and resistance to decentralisation of mental health services; challenges to implementation of mental health care in primary care settings; the low numbers and few types of workers who are trained and supervised in mental health care; and the frequent scarcity of public-health perspectives in mental health leadership. Many of the barriers to progress in improvement of mental health services can be overcome by generation of political will for the organisation of accessible and humane mental health care. Advocates for people with mental disorders will need to clarify and collaborate on their messages. Resistance to decentralisation of resources must be overcome, especially in many mental health professionals and

hospital workers. Mental health investments in primary care are important but are unlikely to be sustained unless they are preceded or accompanied by the development of community mental health services, to allow for training, supervision, and continuous support for primary care workers. Mobilisation and recognition of non-formal resources in the community must be stepped up. Community members without formal professional training and people who have mental disorders and their family members need to partake in advocacy and service delivery. Population-wide progress in access to humane mental health care will depend on substantially more attention to politics, leadership, planning, advocacy, and participation.

Statistical data that are revealed to us about mental diseases in Portugal is still scarce and unreliable, controlled by small groups that dominate this area of health. These same groups of professionals, however, defend themselves by granting efficiency and general care, for the fear of losing their 'status' is what in fact matters the most. Mental health is a no-subject not only in the newspapers and magazines, but also in television and radio programmes. However, if by any reason or report show up, they are always the same professionals to be heard, so that democratisation of reality always stands properly guarded, that is occult.

Each country's health system is different. Your care in Portugal might not include all the things you would expect to get free of charge from the NHS. This means you may have to make a patient contribution to the cost of your care. The healthcare system in Portugal is similar to the NHS in the UK. The Portuguese Serviço Nacional da Saúde (SNS) is the equivalent of the UK's NHS, providing hospital and local health centre service (National Health Service, 2017).

The Portuguese National Health Service does not take care of addictions. It solves the issue by delivering these patients to psychologists who know nothing about this specific disease (though claiming otherwise) and the general public who has absolutely no idea of what to do when hosting an alcoholic, a drug, internet, gambling or sex addict. The disease is unknown, even in hospitals.

However, it has not always been clear what is meant by equity and health and this paper sets out to clarify the concepts and principles. This is not meant to be a technical document, but one aimed at raising awareness and stimulating debate in a wide general audience, including all those whose policies have an influence on health, both within and outside the health sector (Whitehead, 1991).

Santa Casa da Misericórdia (Holy House of Mercy) is a Portuguese charity founded in Lisbon in 1498 by the Queen Leonor of Portugal. And the one who rules and have the monopoly of gambling, like lotteries and so on, they have to advertise (even when Portuguese are watching to football, saying, 'No too early for gamblers', or a similar statement. And the image is the traditional rooster game.

Apart from that, it has been revealed that in Portugal, oral health services are provided by private dental practitioners. Patients pay 100% of the fees or may be reimbursed by their private insurance scheme if dental care is included in the package of benefits. School-linked preventive oral care programmes for children were introduced during the late 1980s. Children are encouraged through health education to adopt regular oral hygiene habits and to pay regular visits to the dentist. Moreover, the children are offered preventive services such as fluoride supplements and fissure sealing (de Almeida, Petersen, Andre, & Toscano, 2003).

Although it is known that the suicide rate has increased (we cannot speak about numbers, since they are not credible enough to the researchers) and, despite the fact that mental health is still carving lives, what the researchers consider to be most important is the public judgement that is being made to thousands of patients that either are not aware of their disease, or are not understood and helped in a

professional way as well. Fear and ignorance still keep the Portuguese in a wild state of enlightenment, helped by pseudo-elites' connivance of almost all the professionals of the area.
Surely Portugal suffers from a scary unemployment rate. And all the professionals are poorly paid for their labour. Thus, this fact makes each and every one to hold on to what they still have, to promise to take care of what they do not really know and having the fear of losing a patient. But while all this conjecture still exists and the institutions and private practice professionals keep closing on each other's, mental health will go on the way it is: closed, stigmatised, ignored and far from being talked and discussed about by the general public in an open and healthy way. The Portuguese way of thinking is still, to a large extent, is still in the phase of denial.

Hence, in view of the earlier theses pointed above, this paper sought to identify the utilisation of mental health services in Portugal. The central goal of this paper is to contribute to the stock of knowledge about the disadvantages, the current mental health situation of the most vulnerable groups in Portuguese society – those who are struggling due to poverty, deprivation and social exclusion – and to identify the barriers on access to mental health services.

Theory and Practice: The landscape of Portuguese health services

People in Portugal have never been so healthy. Nevertheless, there are great differences in health status between social groups and regions. In 1994, Portugal was the country with the second worst level of inequality in terms of income distribution and with the highest level of poverty in the European Union (EU). Poverty in Portugal affects mainly the elderly and women (especially in single parent families). Beyond these groups, there are the children, the ethnic minorities and the homeless. Substance abusers, the unemployed, and ex-prisoners are also strongly affected by situations of social exclusion and poverty. Although poverty has been an important issue on the political agenda in Portugal, it shows a worrying tendency to resist traditional Social Security interventions. In the late 1990s, however, welfare coverage rates appear to have risen. To what extent can poverty cause a worsening of health status? Is there any sustainable positive association between welfare and improved health status? How, to whom and when should actions to improve the health status of the disadvantaged be addressed, without subverting the health status of the rest of the population. It is also necessary to reveal the consequences of poor health to individuals, families and communities in terms of income, social empowerment and the ability to fulfil other needs (Santana, 2002).

Portugal is a country where ethnic minorities are well protected. Anyone can be assisted by the National Health Service and get a doctor. On the other hand, you have a huge community of gypsies, that can manage to live a whole life in Portugal, with all the resources, including home, low bills, support for the National Insurance, and so on. They can live a life doing just nothing at all. So they are substantially privilege and everyone is afraid to say a word.

One study confirms the connection between alcoholic beverages' promotion and drinking during adolescence. A study published in the scientific magazine *Addiction* concludes that 'the exposition to several types of alcohol commercialisation, is associated both to quantity as well as consumption frequency between teenagers in Europe'.

These results support the demand for legal restrictions regarding the amount of alcoholic beverages' advertising campaigns in the European Union, where the Audiovisual Media Services Directive (AVMSD) is the only EU regulation currently operative. The AVMSD regulates alcohol's commercialisation content in the audiovisual media, yet does not restrict the quantity of campaigns of alcohol commercialisation in televisions or other advertising media.

The study includes more than 9.000 adolescents in Germany, Italy, The Netherlands and Poland. The average age was 14 years. Students spoke about the frequency in which they drink, about the excessive consumption of alcohol, as well as their exposure to a wide range of alcohol commercialisation campaigns, including television ads, online marketing, sport events' sponsors, musical events or festivals, free advertising samples and exposure to offers and promotional prices. The data shows that the exposure to alcoholic beverages' advertising campaigns of all sorts was positively associated with the use of alcohol by adolescents over time. This interconnection was found in four countries with different cultural, regulating and drinking contexts.

Sadly, there is yet to be a cause-effect connection strong enough to force a legislation change. But the results are clearly a cause of concern. It is, at least primordial, to face this reality. Avalon de Brujin from the European Centre for Monitoring Alcohol Marketing (EUCAM) states that 'Europe is the world's heaviest region'. He also says that youth drinking is particularly problematic in the continent.

This recent study, which was presented to the press, highlights the necessity to drastically restrict the amount of alcoholic drinks advertising campaigns which youngsters are exposed in their daily lives. He also adds that it is not just a question of restricting television ads anymore. Lawmen must re-evaluate in a scathing and exhaustive way the whole 'alcohol's industry marketing scheme', for it is indeed a scheme, full of lobbies and little transparency and an evident indifference towards public health and especially youngsters.

New regulations must be developed in order to reduce all kinds of campaigns to this legal drug, otherwise in a few years all of us will be confronted with the unbelievable negligence. No one intends to be 'holier than thou', nor to start a graceless prohibition where everyone is forced not to drink and ads would be totally abolished. What is in fact urgent is to have a bigger awareness of the real and perverse effects that these campaigns can generate. We cannot keep 'washing our hands off' in order to sell beers like no tomorrow, by for example keep associating it with the noble concept of friendship. That is, if on one hand brands refute this negative influence on youngsters and others. On the other hand, they cannot refute any influence at all. Hence why they are being paid and that is why, technically, campaigns are produced and answered to briefings.

Any sort of ingenuity here is indefensible. As for adults, once again the friendship association arises: this time older, sometimes by the format of "eternal youngsters", ever-adventurous, who place themselves on boats and roam towards islands fully packed with pallets of whiskey bottles, or curled up in their blankets, in the comfort of their homes, ever with an aura of someone who is happy and in good company (Pinto-Coelho, 2016).

Connecting the dots: Utilisation of mental health services in other countries

Mental health services in Portugal, and elsewhere, demonstrate how physical health can be enhanced by improved monitoring and lifestyle interventions initiated at the start of and during continuation of treatment.

People with a mental illness are more likely to get diseases such as respiratory problems, asthma, heart disease and diabetes. Here are some reasons: (1) People with mental illness are more likely to lead unhealthy lifestyles such as lack of motivation, reduced nutritional quality, insomnia, lower social contact, poor judgement, increase in risk-taking behaviour etc.; (2) Mental illness and physical health can have similar risk factors such as stress, substance abuse, lower economic status; (3) Additionally, mental and physical symptoms are more likely to be picked up in advanced stages of disease because of diagnostic overshadowing, stigma, isolation.

The question then is: how can physical illnesses are prevented among people who are already suffering a mental health condition? (1) More community interventions and understanding to help those suffering with mental health problems lead healthy and active lives. The role of charities and support groups; (2) Increased training for clinicians monitoring the health of people with a mental health condition. Understanding that symptoms may go unreported, there may be issues with communication, the patient may be experiencing unusual symptoms for the physical condition, they may have altered pain thresholds, etc.; (3) Understanding the possible triggers of the mental health condition and whether this could present risk factors for other diseases. If an association is identified, increased monitoring of the person to detect onset of physical conditions early; (4) Accelerated public health campaigns, education about mental health problems to reduce stigmatisation

People with a long-term physical illness are more likely to develop mental illness. Clinicians should understand that the mental illness may mask self-report symptoms that might otherwise be important for detecting changes in physical illness. They should be aware of possible risk factors with the physical condition and organise regular health check-ups to monitor progress. Another option would involve using public health campaigns and education to reduce stigma and discrimination in the community and among the medical profession so that there is better recognition of the physical health problems of the person. There should also be an increased general monitoring of people who may lack capacity owing to mental illness. It is also vital that there is recognition that during symptoms of mental illness, signs of physical pain/discomfort may be distorted. It should be suspected if abnormal behaviours arise during periods where rational communication may be impaired. It is also beneficial to have an increased community engagement through education and the role of charities will help to manage both the symptoms of mental illness and help to identify changes in the physical state of the person.

Mental disorders in low- and middle-income countries (LAMIC) do not often attract global health policy attention. Consequently, the majority of people with mental disorders do not receive evidence-based care, leading to chronicity, suffering and increased costs of care (Patel, 2007).

In middle-income countries primary mental health care would be supported by general adults' mental health services. Growing up in the slum in Manila, in the Philippines, the secondary author have witnessed first-hand how discussions about mental health is being considered as a luxury, which is understandable given that there are numerous health issues deemed to be more threatening. Aid spending remains selectively allocated on the "big three" communicable diseases of HIV/Aids, malaria and tuberculosis, with many other health conditions receiving only a fraction of the attention. In terms of mental health, The Philippines lacks sufficient mental health law and funding support and that the mental health programmes and services are not evenly distributed in the country.

While the continuing development of newer and more sophisticated medical techniques for evaluating the functions of kidney diseases, it is expected that patients would have a better survival rate, and consequently a more positive outlook. However, such is not always the case as some patients have demonstrated poor coping skills (Gagani, Gemao, Relojo, & Pilao, 2016).

By and large, the mental health landscape among LAMIC and high-income countries (HIC) is just about the same – it remains a killer disease; people suffering from mental illnesses die earlier than everybody else.

However, the disparities in investment in mental health between LAMIC and HIC is evident. In low-income countries mental health care would be provided mainly through primary care and limited specialist staff would support with training, consultation for most complex cases, and in-patient assessment and treatment. Cambodia's health system, for instance, struggles to cope with a high incidence of mental disorders, a festering legacy of the Khmer Rouge regime. In 2012, the Royal

University of Phnom Penh conducted the first large-scale study of mental health in Cambodia. The results were alarming. The findings revealed that 27% of the 2,600 respondents experienced symptoms of acute anxiety, 16.7% suffered from depression and 2.7% exhibited symptoms of post-traumatic stress disorder (PTSD), prevalence of the latter being seven times higher than the worldwide average (Hruby, 2014).

By contrast, in high-income countries, mental health care benefits from specialised mental health services. In the UK for instance, its National Health Service (NHS) offers free mental health services. There are also some mental health services that will allow people to refer themselves. This commonly includes services for drug problems and alcohol problems, as well as some psychological therapies (National Health Service, 2016).

NGOs and advocacy groups provide much of the support and education for people with mental illness, and their families and carers. There are many NGOs and advocacy group throughout world. However, No matter the scale of the NGO operation or wherever they are in the world, this report finds similarities in the core concerns these organisations face, including: (1) Stigma and discrimination and how this can be as bad as the illness itself. It can prevent people with mental health problems from seeking help when they need it and impact their life chances; (2) Human Rights abuses and fighting for the rights of people with mental health problems who are often marginalised and excluded from society. For some NGOs these are extreme human rights violations such as shackling, starvation and denying access to any basic mental health help and support. For others it might be repealing or refining existing mental health laws; (3) Lack of funding for mental health which means there aren't appropriate facilities and services to refer people to. (4) Limited, unstable funding for NGOs hindering their ability to support the communities they serve and meet their aspirations; and, (5) A shortage of trained mental health staff, for example in Indonesia there is only one psychiatrist for every couple of hundred thousand people (Mind, 2014).

Walking the talk: Potential interventions that could be implemented in Portugal

Recent data on the burden of mental disorders worldwide demonstrates a major public health problem that affects patients, society, and nations as a whole. Research must be done to find effective ways to deal with the increasing burden of mental disorders. Given the growing evidence that mental disorders are disorders of the brain and that they can be treated effectively with both psychosocial counselling and psychotropic medications, intervention packages could be developed to deal with the increasing burden. Such packages should be tested for real-world effectiveness and their cost-effectiveness should be demonstrated to guide policymakers to choose from among many other non-mental health interventions. The transportability and sustainability of intervention packages should be studied in public health research and a link between efficacy, effectiveness, cost-effectiveness, generalisability, and sustainability should be demonstrated. The World Health Organization's initiative on the World Mental Health 2000 Survey will provide the first basic epidemiologic data. Together with other data, the initiative will provide solid evidence for including mental disorders into essential treatment packages. In this way, parity can be achieved for mental disorders and mental health can be mainstreamed into health and public health practice.

Alleviating social isolation and loneliness among the elderly is a vital area for both policy and practice. However, the effectiveness of various interventions has been challenged due to lack of evidence. Twenty-four institutionalised geriatric residents from an institution in Manila were recruited. Using a non-experimental research design, participants completed questionnaires to measure their feeling of loneliness. Findings revealed that blurring of vision was the most common physical agony. While in terms of common emotional agony, feeling of irritability has been identified. No notable mental agony has been revealed by the present study. Findings support earlier studies that emphasise the social

isolation and loneliness encountered among this age group. Results are intended to serve as a framework for intervention (Pilao, Relojo, Tubon, & Subida, 2016).

In general, the elderly exhibit conflicting feelings about their daily lives in the geriatric residence. While they refer to positive aspects as the good relationship between residents and the possibility of getting involved with activities of daily living, they also describe a feeling of isolation and loneliness, especially when talking about their relatives. Living at institutionalised residences is deemed as a hiatus from life lived so far. For many elderly, coming to these institutions makes their home, their family, and their friends to become just a story to be told, a life event which becomes alive only in their memories. Hence, with all the fragility and limitations inherent in the life cycle, they still need to find strength to start a new life in their new home, where they meet new friends, and simply live on their lives without their family (Pilao et al., 2016).

Expressive writing could be one intervention that could be implemented in Portugal. Images portraying idealised slender bodies are here to stay. They are already a staple of magazines and music videos; and existing literatures are rich in evidence which confirm that exposure to these images can impact one's psychological well-being. The field of psychology has already proven its adverse effects—the next goal is to discover new and effective interventions to address those negative impacts. In light of the results of this study, two strong conclusions can be drawn with regard to the benefit of EW. Firstly, drawing on the literature, EW may result in a host of health benefits. The results of this study offer insights into what factors contribute to ensure the efficacy of EW as an intervention tool. This may be attributable to the fact that EW affects people on a number of aspects—biological, cognitive, emotional and social—making a single explanatory theory unlikely. Secondly, a variety of mechanisms can be posited as to ensure its efficacy. Needless to say, future research should further explore its boundary conditions, including potential moderating variables. In addition to addressing theory-relevant questions, researchers and therapists must now address how, when and with whom this form of therapy is most beneficial and, at the same time, further evaluate how and why this intervention produces positive outcomes (Relojo, 2015).

On top of that, we cannot discount the potential of positive thinking as illustrated in an earlier study: positive thinking, in conjunction with a robust attitude, can affect one's well-being and coping strategies under stressful events. The study sought to identify the role of Emotional Quotient (EQ) to Work Attitude Behaviour (WAB) of selected faculty members from three higher educational institutions in the Philippines. Using a non-experimental research design, participants were asked to complete questionnaires to obtain their EQ and WAB scores. EQ was gauged using the Emotional Quotient Test while WAB was measured using a self-made survey questionnaire. A chi-square test revealed that there was no significant relationship between EQ and WAB, $F(1, 24) = 2.469$, $p>0.05$. Although no significant relationship has been observed, it is argued that findings from this study will highlight the need for teacher-training programmes to raise awareness of the emotional demands of teaching (Relojo, Pilao, & dela Rosa, 2015).

However, Payment for services is typically based on just the number of hours or days and the location of the services (e.g., hospital, outpatient clinic). Occasionally more experienced or educated providers will be paid more. In general, however, one unit of mental health service, be it a visit or a day, is equivalent to another, thus making it a commodity. Because there is no widespread use of measures of effectiveness or quality of services, the commoditization process results in competition being based primarily on price. This is an advantage to funders since it should result in lower prices. However, it also may result in less effective services and a disincentive for improving services. Although pay for performance (P4P) schemes are growing in popularity in the general health sector, they are rare in mental health. However, P4P should not be undertaken unless a mature measurement system with high

integrity and security is in place. It is likely that MFSs will not succumb to a similar commoditization process because of the existence of indicators of measurement quality such as validity and reliability.

CONCLUSIONS AND IMPLICATIONS

As pointed out by de Almeida (2009) there are many difficulties and insufficiencies that should be given due consideration. However, there are also at present some opportunities that could help to overcome many of these difficulties, including: the new National Integrated Continuous Care Network (aiming at the creation of facilities by collaboration between the health and social sectors); the development of new family health units; and the creation of mental health units in new general hospitals under construction or in the planning stages.

Negative opinions indiscriminately overemphasise social handicaps that can accompany mental disorders. They contribute to social isolation, distress and difficulties in employment faced by sufferers. A campaign against stigma should take account of the differences in opinions about the seven disorders studied (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000).

Whereas for children and adolescents it has been asserted by Costello, Burns, Angold, & Leaf, (1993) that epidemiology, the study of patterns of disease distribution in time and space, can help to improve mental health services for children and adolescents by increasing understanding of the causes, development, and course of psychiatric disorders. For the purpose of service delivery, epidemiologic research on child psychopathology can provide information on need for services, availability of services, and effectiveness of services. For both scientific and planning purposes, epidemiologic research can inform us about (1) the developmental course of psychiatric disorders during childhood and adolescence, (2) the effect of psychiatric disorder on the course of normal childhood development, and (3) the effect of childhood development on the developmental course of psychiatric disorder. Information about prevalence and incidence is useful for planning primary, secondary, and tertiary prevention and treatment services. The same information is scientifically useful to the extent that it helps to answer questions about causation, course, and outcome.

For developmental as well as epidemiological reasons, young people need youth-friendly models of primary care. Over the past two decades, much has been written about barriers faced by young people in accessing health care. Worldwide, initiatives are emerging that attempt to remove these barriers and help reach young people with the health services they need. Key models of youth-friendly health provision and review the evidence for the effect of such models on young people's health have been outlined. Unfortunately, little evidence is available, since many of these initiatives have not been appropriately assessed. Appropriate controlled assessments of the effect of youth-friendly health-service models on young people's health outcomes should be the focus of future research agendas. Enough is known to recommend that a priority for the future is to ensure that each country, state, and locality has a policy and support to encourage provision of innovative and well assessed youth-friendly services (Tylee, Haller, Graham, Churchill, & Sanci, 2007).

De Almeida further explained that some measures planned for the coming years could also help overcome the difficulties identified in research. This point is particularly important: the increase in research capacity in psychiatry and mental health, particularly in epidemiological and services research, is an extremely effective factor in the development of a public health culture, and for the constitution of a critical mass, essential for the improvement of mental health care. Finally, opportunities offered through international cooperation should be used. The WHO, which has already made a valuable contribution in the preparation of this plan, can provide technical cooperation in its implementation and assessment. The EU, for its part, following the approval of the Helsinki Declaration

and of the Green Paper on mental health, will certainly be able to make important contributions to the development of reforms and to help integrate Portugal into the modernisation movement of mental health services currently under way on a European level.

And as Rosenstock (2005) has argued, it is a matter of personal philosophy of the author is that the goal of understanding and predicting behavior should appropriately precede the goal of attempting to persuade people to modify their health practices, even though behaviour can sometimes be changed in a planned way without clear understanding of its original causes. Efforts to modify behaviour will ultimately be more successful if they grow out of an understanding of causal processes. Accordingly, primary attention will be given to an effort to understand why people behave as they do. Only then will brief consideration be given to problems of how to persuade people to use health services.

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