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## Consumer behavior and customer relationship management in mental health services

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**Abstract.** Mental health services are perceived differently in different socio-cultural settings. The connotations accorded to mental health, especially in terms of need awareness and evaluation of alternatives, vary from culture to culture. Understanding these differences is critical to attract and retain patients suffering from mental conditions. Generic literature on consumer behavior does not provide direct answers to many of the problems in this regard, primarily because such literature does not take into account the deviant mental states of these patients. In this paper, we review findings from mental health specific studies conducted in both Western and Asian countries, evaluate the importance of decision-making factors for both public and private service providers, and offer directions for future research. Interdisciplinary literature on customer relationship management, consumer behavior, mental health, and healthcare marketing, guided by the principles of systematic literature review constituted the methodology of this study. The research methods are analysis, synthesis, classification and grouping. The empirical base included about 250 peer-reviewed articles on the topic under consideration. We find that doctor-led service provision is still the most prevalent form of relationship building in the Eastern societies, especially in the less developed countries of South East Asia. Consumer-initiated mental health treatment schemes are more common in more developed Western economies. We also observe that, among the innovative set of providers, there is a trend of increased use of telehealth. Among other things, this includes more proactive and digitally-savvy identification, acquisition, and retention of patients. The results of the study can be used as the basis for marketing strategies of drug manufacturers and mobile application designers in the field of online medical services.

**Keywords:** consumer behavior; customer relationship management; mental health services; mental health marketing; healthcare strategy.

**JEL Classification:** I10, I12, M31

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### INTRODUCTION

The World Health Organization ranked suicides as the second most pervasive cause of death among people aged 15–29 with the highest suicide rates in low-middle income countries<sup>1</sup>. Within the South East Asia region, the incidence of suicidal ideation was highest in Vietnam, especially among those aged 14 to 19, as the rate more than doubled from 5 % in 2000–2004 up to 12 % in 2009–2010 [Le et al., 2012; Tran, 2017]. By 2013, over 16 % of Vietnamese teenagers aged 13–17 had expressed suicidal thoughts or intentions<sup>2</sup>. By comparison, results from Cambodia were almost one third of Vietnam's rate of suicidal ideation at 6 % occurrence<sup>3</sup>, and Thailand's was almost two thirds of Vietnam's rate of suicidal ideation at 12 % prevalence<sup>4</sup>, respectively. Among adults, the prima-

ry motive for attempted suicide was a personal conflict with spouse or parent, often involved violence (frequent corporal punishment or domestic violence) and occasionally had the background of an alcoholic father or husband, gambling, or drug addiction [Wasserman et al., 2008]. Additionally, most of the respondents mentioned being constantly criticized, blamed, or shamed by family or at school; yet, the majority chose not to seek help or directly express their suicidal intentions as they perceived "it is sick to harbor suicidal thoughts". Afraid of being exposed or ridiculed, they felt it was acceptable only to use euphemistic vocabulary such as "talk about feelings of unhappiness, despair and distress" [Wasserman et al., 2008, p. 49].

To be successful in attracting and retaining mental health (MH) users, MH service providers need to understand what potential users know and do not know about MH, how they look for information and compare alternatives, as well as any misconceptions and barriers stopping them from approaching MH service providers. To illustrate, MH service providers need to understand the factors influencing perceptions, trial and usage of MH services, which is not well reflected in the literature.

Based on a systematic review of literature, this study aims to: 1) identify levels of awareness, knowledge, per-

<sup>1</sup> Mental health: Suicide data, 2016, para. 2-3. The World Health Organization. Retrieved from: [https://www.who.int/mental\\_health/prevention/suicide/suicideprevent/en/](https://www.who.int/mental_health/prevention/suicide/suicideprevent/en/).

<sup>2</sup> Global school-based student health survey. Vietnam 2013 fact sheet, 2013. The World Health Organization. Retrieved from: [http://www.who.int/chp/gshs/2013\\_Viet\\_Nam\\_Fact\\_Sheet.pdf?ua=1](http://www.who.int/chp/gshs/2013_Viet_Nam_Fact_Sheet.pdf?ua=1) WorldHealthOrganization.

<sup>3</sup> Global school-based student health survey. Cambodia 2013 fact sheet, 2013. The World Health Organization. Retrieved from: [www.who.int/chp/gshs/2013\\_Cambodia\\_GSHS\\_Fact\\_Sheet.pdf?ua=1](http://www.who.int/chp/gshs/2013_Cambodia_GSHS_Fact_Sheet.pdf?ua=1).

<sup>4</sup> Global school-based student health survey. Thailand 2015 fact sheet, 2015. The World Health Organization. Retrieved from: <http://www.who.int/chp/gshs/2015-Thailand-GSHS-FactSheet.pdf?ua=1>.

ception, and attitude of potential users towards mental health, 2) understand consumer factors that act as drivers and barriers to trial and usage and 3) realize the effectiveness of various marketing communication tools for attracting, recruiting, and retaining users.

### DEFINITIONS OF KEY TERMS

This section describes key terminology as it applies in the current study. The definitions are as follows:

**Mental health.** The World Health Organization defines mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community”<sup>1</sup>. As the organization points out, health is “not merely the absence of disease or infirmity”<sup>2</sup>, but has a positive, empowering dimension emphasizing human fulfillment.

**Mental health care.** Defined as “services devoted to the treatment of mental illnesses and the improvement of mental health in people with mental disorders or problems”<sup>3</sup>, the terms *mental health care* and *mental health services* were used interchangeably for the purpose of this study.

**Mental health service providers.** From a legal standpoint, they are “individuals, licensed or unlicensed, who perform or purport to perform mental health services, including a licensed social worker, chemical dependency counselor, licensed professional counselor, licensed marriage and family counselor, member of the clergy, physician who practices medicine, psychologist offering psychological services and nurses who provide mental health services to patients”<sup>4</sup>. For the purpose of the current study the terms *mental health service provider/supplier* and *mental health care provider/supplier* were used interchangeably.

**Marketing activities.** This is a comprehensive term to cover all related processes and actions taken by a business or organization for “creating, communicating, delivering, and exchanging offerings that have value for customers, clients, partners, and society at large”<sup>5</sup>. Throughout the text, related terms such as *marketing initiatives*, *marketing strategies*, *marketing activities* and *marketing practices* were used interchangeably.

### THE RESEARCH METHOD

At its core, this is a study framed around literature review. Methodology for this research included the analysis and synthesis of interdisciplinary publications on the topic of customer relations, consumer behaviour, mental health and healthcare marketing, guided by systematic literature reviews. We examined original research papers and existing reviews in order to develop the nomological network of ideas and relationships in the field. This scoping review helped us identify weak or non-existent ideas or connections and also became the starting point for further probe. Propositions were developed to explain what is missed in the existing knowledge.

In practical terms, the articles gathered were analyzed, core and supplementary themes were found, and later their interrelationships were propositioned. In the scoping phase, a more creative and less critical analytical approach was used. This ensured exhaustive and comprehensive searching and that we would not filter out any key concept of interrelationship. In the synthesis phase, we focused on specific elements, more critically, to gain deeper perspectives, based primarily on the citation intensity of these concepts. This pruning helped us unearth the central themes in the field of study, which are elaborated in the subsequent sections.

To identify relevant studies, about 250 peer reviewed articles were consulted, varying from consumer-centric to supplier-focused.

This paper reviewed core articles related to how troubled teens express suicidal ideation in social media [Andreasen, 2004], how prospects react to being reached through social media [Sigall, 2004], case studies on MH providers developing and promoting new services [Bogen, 1997], barriers to patient responding to marketing in the context of managed care [Thomas, 1994], consumer reactions to mass campaigns against stigma on MH [CalMHSA, 2012], consumer response to communication tools to support mental health [Wellness..., 2018], potential patients being influenced by direct-to-consumer advertising of antidepressants [Donohue, 2004], and consumer attitude towards technology-enabled MH service delivery [Depp, Mausbach, Granholm, 2010].

To supplement, the review included selected studies on the effectiveness of social marketing campaigns with a mental health element [Chapman Walsh et al., 1993] and learnings from how patients respond to hospital advertising in general [Aggressive Television..., 2006]. Among the core articles, primary drivers to mental health seeking on the user's side have been linked to personal and vicarious experience of mental health services as past experience or when trusted peer recommendation acted as a driver to usage [Kessler, Agines, Bowen, 2015].

To better understand factors that influence the awareness, trial, and repeat usage of mental health services, the remaining part of this paper starts with operational definitions surrounding mental health, followed by a dis-

<sup>1</sup> Mental health: A state of well-being, 2018, para. 2. The World Health Organization. Retrieved from: <https://www.who.int/en/home/>.

<sup>2</sup> Ibid, para. 3. The World Health Organization. Retrieved from: <https://www.who.int/en/home/>.

<sup>3</sup> Definition of Mental Health Care, 2018, para. 2. Collins Dictionary. Retrieved from: <https://www.collinsdictionary.com/dictionary/english/mental-health-care>.

<sup>4</sup> Mental Health Services Provider Information, 2018, p. 1. Baylor College of Medicine. Retrieved from: [https://www.bcm.edu/pdf/e\\_mentalhealth\\_release9.12.05.pdf](https://www.bcm.edu/pdf/e_mentalhealth_release9.12.05.pdf).

<sup>5</sup> Definition of Marketing, 2018, para. 1. American Marketing Association. Retrieved from: <https://www.ama.org/AboutAMA/Pages/Definition-of-Marketing.aspx>.

cussion of theories of consumer-decision making [Belch, Belch, 2012] as they apply to mental health, the influence of internal factors of perception, attitude, motivation, personality, and learning style [Belch, Belch, 2012; Kotler, Keller, 2009; Schiffman, Kanuk, 2010] and external factors of culture, sub-culture, and reference groups [Belch, Belch, 2012; Kotler, Keller, 2009; Schiffman, Kanuk, 2010] at each step and how marketers can influence the buyer behavior. Next is a review of core literature on consumer responses to various marketing initiatives in the area of mental health, from its roots in social marketing [Andreasen, 2004; Chapman Walsh et al., 1993; Fox, Kotler, 1980] to contemporary digital-based approaches [Brohan, 2017; Chang, 2005; Guo et al., 2017] for CRM in Mental Health Care (MHC), direct-to-consumer advertising of MH pharmaceuticals [Donohue, 2004; Reeves, 1998], and patient-led initiatives [Hawn, 2009].

### CONSUMER PERCEPTION AND BEHAVIOR IN MENTAL HEALTH

Understood as “the process of making purchase decisions based on cognitive and emotional influences such as impulse, family, friends, advertisers, role models, moods, and situation that influences a purchase” [Schiffman, Kanuk, 2010, p. 513], models of consumer decision-making explain the reasons and manners in which buyers make purchases. The first step, *Need recognition* [Schiffman, Kanuk, 2010] or *Problem recognition* [Belch, Belch, 2012] is triggered by stimuli that awaken the consumer’s realization that there is a gap between current and desired reality, e.g. a college student may find herself spending a large amount of time feeling sad or crying for no apparent reason. Next, during the *Information Search*, the consumer gathers data on possible products and services that can solve the tension, e.g. by scanning commercials sources and collecting non-commercial feedback. Simultaneously or shortly afterwards, the consumer is undergoing *Evaluation of alternatives*, which implies comparing suppliers and evaluating the pros and cons of various offers. As key purchase criteria will have become clearer by now, the potential buyer may move on to *Purchase decision*, i. e. selecting the most suitable offering from the evoked set or even interrupt the decision-making altogether [Kotler, Keller, 2009]. In case a ‘purchase’ was made, the *Post-purchase evaluation* stage may bring about satisfaction if the service encounter successfully filled the gap, or may result in dissonance and a possible repeat of the decision-making process in case the experience was not satisfactory [Belch, Belch, 2012].

**Internal factors.** Along similar dimensions, Kotler and Armstrong [2010] developed the Black Box model to illustrate internal factors that influence the buyers’ mind through the various decision-making stages. The authors identified beliefs e.g. the student may suffer from self-stigma and reject seeking treatment to avoid feeling ‘crazy’, perception e.g. the student may perceive medica-

tion to be bad, motives e.g. she may not want the school to inform her family about the visit, values e.g. the student may value privacy and be uncomfortable to share very personal details with a stranger, and lifestyle e.g. she may be working part-time while studying and therefore have limited time for face-to-face counselling sessions. The consumer’s learning style and personality can also play a role in the decision-making, e.g. if she is more of a cautious follower and prefers modelling or observational learning [Schiffman, Kanuk, 2010], the student may ask her friend to go first or may choose only authoritative MH professionals that are endorsed (see below for a more detailed discussion).

In line with the purpose of this report, a major part of the analysis will be dedicated to understanding Psychological factors such as consumer Motivation, Perception, Attitude, Learning Style, and Personality and especially how marketing activities can interact with each factor. External influences such as Culture, Sub-culture, and Reference groups will also be included as they often play a key part in shaping prospects’ attitude towards the MHC sector [Priest, Baxter, Hayes, 2012].

For regular consumer purchases such as soft drinks or liquid soap, Problem or Need recognition may come from mundane sources which can be easily impacted by timely marketing activities [Belch, Belch, 2012]. While recognizing that there is a problem for daily necessities such as biological needs for food, shelter, or thirst are often basic, marketers of MH must pay more attention to “the way a consumer perceives a problem and becomes motivated to solve it” [Belch, Belch, 2012, p. 116], that is the tension created in the person who acknowledges that s/he may need MH care. For instance, a peer who received therapy may perceive visiting a psychologist as a perfectly normal and indeed much-needed service [Symoens, Colman, Bracke, 2014], another peer from a low-income rural area may have misconceptions that therapy is only for major mental illnesses such as schizophrenia or paranoia [Corrigan, 2004], while a third peer who migrated from Sub-Saharan Africa may follow his/her home beliefs that mental issues are the result of being possessed by a spirit and thus exorcism is needed [Percy, 2013]. In each situation, the marketer’s challenge is to understand the background of the potential patient so as to better tailor the communication tone, message, and appeal as well as the delivery source. As long as the issue is related to lack of awareness or insufficient knowledge, the MHC marketer can use one-way mass communications such as print advertising and self-help websites to increase openness and understanding toward MH [Kotler, Keller, 2009]. In the case of misconceptions or deeply rooted mistrust, the MHC marketer may benefit more from two-way marketing media such as internet forums and highly persuasive community-oriented events (e.g. sharing and workshop sessions) as such media can foster an interactive environment where

potential patients can identify with the experiences of others and receive proper guidance [Le, 2017].

When examining consumer motivation, the literature distinguished motives as “those factors that compel a consumer to take a particular action” [Belch, Belch, 2012, p. 116] as illustrated in *Maslow's Hierarchy of Needs* applied to psychological health [Lester et al., 1983]. For MH, potential users may seek help to correct a physiological imbalance, for their own safety, to solve relationship issues, to boost self-esteem, or to satisfy self-actualization needs, which echoes WHO's definition of mental health as individuals realizing their own potential<sup>1</sup>.

Unlike regular products and services, health and particularly mental health needs may be less straightforward to identify, compare suppliers, and gain fulfillment for due to the complexity of personal factors involved in the process. Defined as “the process by which an individual receives, selects, organizes, and interprets information” [Belch, Belch, 2012], *perception* reflects internal factors from the consumer's mind, such as religious belief, past experience with mental health care providers and mood. Perception is strongly influenced by how intense the stimulus is, and the life context in which it is received. During the comparison stage, consumers narrow down to several offers and attempt to predict functional outcomes and their psychosocial consequences [Belch, Belch, 2012].

By combining objective service attributes such as distance traveled and convenience of service delivery, and subjective factors such as self-image or perceived psychosocial risk, the consumer builds a set of expectations collectively known as attitudes, i.e. “learned predispositions to respond to an object”, i.e. MH service [Belch, Belch, 2012, p. 126]. The risk is heightened by the patient's inability to easily assess an intangible service such as health care, where the long-term potential benefits may or may not materialize [Lanjananda, Patterson, 2009]. A more recent study identified attitude elements as a summary construct that represents an individual's overall feelings towards or evaluation of a product or service [Vranica, 2005]. For instance, Hammer and Vogel [2009] found that more men suffered from self-stigma and were less likely than women to acknowledge their symptoms of depression and seek MH help. By applying knowledge from the psychology of masculinity and mental health marketing to develop a male-sensitive brochure about depression, the authors were successful in improving the participants' attitude towards seeking counseling for their condition [Hammer, Vogel, 2009]. In contrast, women were easier to target as they routinely bought over-the-counter and prescription medicine, spent more money on health care services, and often too the primary role as decision-maker for the family's health care [Braus, 1996].

The *multi-attribute attitude* model can also be applied to measure a patient's attitude towards specific MHC pro-

viders rather than the sector as a whole, for instance by measuring the prospect's beliefs about one supplier's performance on an attribute, the importance attached to that attribute, and the number of attributes considered [Belch, Belch, 2012]. For general hospitals in developed economies, the main attributes under evaluation were quality of care, cleanliness, delivery of specialized services, price/insurance coverage, and the hospital's reputation [Taylor, Cosenza, 1999; Tengilimoglu, Yesiltas, 2007]. When distinguishing between public and private health care, a Turkish study found that patients preferred private hospitals for their accessibility, image, and physical appearance [Akinci, Esatoğlu, 2004]. Elsewhere, prospects had a favorable attitude towards providers with high clinical scores and established reputation of the medical services [Jung, Feldman, Scanlon, 2011], while an Italian survey uncovered low doctor-to-patient ratios as a key enhancer of attitude [Moscone, Tosetti, Vittadini, 2012]. In developing economies such as India, the family played a major role in the decision-making and considered the HC provider's equipment and amenities [Kamra, Singh, De, 2016; Singh, 2013], while Bangladeshi patients' attitude was influenced by the amount of kickback needed to access the hospital in excess of the published rates [Andaleeb, 2001]. By gaining this insight, marketers at the HC providers mentioned above could narrow down salient beliefs “concerning specific attributes or consequences that are activated and form the basis of an attitude” [Belch, Belch, 2012, p. 127] to ensure implementation of the right activities and appeals for attitude formation and change, e.g. promote their hospital's clinical scores (if high), include doctor-to-patient ratios in brochures, visually display modern equipment and state-of-the-art facilities on their website, or instruct the hospital staff to explain the institution's transparent payment system with no hidden fees. If a prospect's perception was not favorable from the onset, health care providers could employ various strategies for attitude change, such as 1) increasing or changing the strength rating on a key attribute, 2) modifying the consumer's view of the importance of a certain attribute, or 3) adding a new criterion to the process of attitude formation [Belch, Belch, 2012].

Another key factor in the consumer black box is the individual's learning style as “the decisions a consumer makes to purchase products and services are based on a process of learning” [Sproles, Sproles, 1990, p. 134]. As defined by Dunn [1984, p. 12], a consumer's learning style is “the way each person absorbs and retains information and/or skills”. As each prospect has an “enduring, patterned, and preferred mode of learning” [Sproles, Sproles, 1990, p. 134], MHC marketers should take into account the various learning styles when designing marketing activities 1) to trigger a conditioned response [Schiffman, Kanuk, 2010], or 2) operant or instrumental conditioning, in which “the individual must actively operate or act on some aspect of the environment for learning

<sup>1</sup> Mental health: A state of well-being, 2018. The World Health Organization. Retrieved from: <https://www.who.int/en/home/>.



to occur" [Belch, Belch, 2012, p. 134], e.g. campus poster urges prospect to call the suicide help-line, the prospect calls and feels more optimistic about the future as a result of the interaction, which acts as a *positive reinforcement* (favorable consequence) and increased likelihood of calling the help-line again in the future. To target prospects who learn by 3) trial and error, MHC communications can emphasize finding the right therapist and treatment for their unique needs; for individuals who prefer 4) vicarious learning by hearing or observing the behavior of others [Schiffman, Kanuk, 2010], the clinic can advertise 'bring-a-friend' events where socially anxious individuals can safely observe and internalize the behavior of their peers. As Sproles and Sproles [1990] pointed out, an individual's general learning style greatly influences his/her style of consumer decision-making, enabling marketers of MHC services to create more effective consumer education and informational programs, i.e. awareness and prevention campaigns or anti-stigma initiatives.

Lastly, an individual's personality traits also play a role in their attitude towards and ultimately acceptance or rejection of MH treatment [Schiffman, Kanuk, 2010]. For instance, a Tunisian study on graduate students' reaction to smoking cessation ads found "a personality pattern, such as trait reactance proneness" to be a strong predictor of the smoker's rejection of fear-based communications [Boukamcha, 2016, p. 446]. Based on the VALS Framework<sup>1</sup>, consumers can be segmented into eight personality types, each group with its typical primary motivators and set of resources available: *Innovators* (highest resources), *Thinkers* and *Believers* (driven by ideals), *Achievers* and *Strivers* (motivated by achievement), *Experiencers* and *Makers* (drawn to self-expression), and *Survivors* (lowest resources).

**External factors.** Although insightful, psychological factors are only one side of the equation in MH help-seeking behavior, with external factors such as Culture, Subculture, and Reference groups accounting for significant weight especially at the initial stages of need recognition and motivation triggers [Priest, Baxter, Hayes, 2012]. Understood as "the complexity of learned meanings, values, norms, and customs shared by members of a society" [Belch, Belch, 2012, p. 136], culture has been found to occasionally act as a barrier to MHC seeking, especially in relation to deculturation, outmigration, alienation, and distrust in MHC delivery [Rodenhauser, 1994]. In contrast, more individualistic Western societies such as the US and the Anglo-Saxon world appear to embrace psychology and therapy as part of the modern identity as evidenced by the multitude of self-help books, TV shows, and MH-related groups [Illouz, 2009]. One step further, detractors even pointed to the emergence of 'therapism' or over-reliance on MH professionals instead of strengthening oneself to deal with life's challenges [Sommers, Satel, 2007].

<sup>1</sup> US Framework and VALS™ Types. (2015). Retrieved from: <http://www.strategicbusinessinsights.com/vals/ustypes.shtml>.

Bringing Hofstede's dimensions to the discussion, in more feminine societies such as Norway and Sweden, seeking MH help may be encouraged by one's employer because such nurturing cultures exhibit preference for "caring for the weak and quality of life" [Hofstede, 2018, para. 10]. In contrast, individuals living in high masculinity cultures such as South Korea, Hungary or Austria would be disinclined to appeal to a HMC professional for fear of being seen as an underachieving employee [Hofstede, 2018].

In relation to sub-cultures i.e. "smaller groups or segments whose beliefs, values, norms, and patterns of behavior set them apart from the larger cultural mainstream" [Belch, Belch, 2012, p. 137], it has been found that awareness of and openness towards MHC may vary based on an individual's age, gender identity, religious affiliation, ethnic background, or geographic location. For example, Harris [2000] urged HC practitioners in the US to develop formal strategies to tap into the country's 100 million-plus racial and ethnic minority members as these segments were underserved. Social class, which is often judged on a combination of occupation, education, and income [Schiffman, Kanuk, 2010] is also a differentiator, as buyers from various social classes were less likely to adopt certain products, had different activities during leisure time, and exhibited different shopping patterns and distinctive media habits than their more or less wealthy counterparts [Belch, Belch, 2012]. To capitalize on such distinctions, marketers adapted their intended positioning, advertising appeals, and media strategies to suit each segment's expectations [Kotler, Keller, 2009]. As a corollary, an individual's position in the social strata has been found to impact MHC usage, with affluent individuals more likely to be well-informed, proactively seek and pay for therapy and the lower income bracket to be less aware, more prone to misconceptions and less willing to invest in MH [Rasch et al., 2009].

On the topic of group affiliation, a consumer uses various reference groups as "the basis for his/her judgements, opinions, and actions" [Belch, Belch, 2012, p. 138], among which the literature distinguishes three main types: associative reference groups, aspirational, and dissociative groups. Expanding to an MHC supplier campaigning against bullying, marketers may use an associative group appeal to promote a sense of belonging e.g. by promoting a support group ("You are not alone in this."), an aspirational message to envision a self-confident, bully-free future ("You too can overcome fear and change your life like so many others!") or a dissociative appeal to not identify with undesirable groups ("Do not see yourself as a powerless victim. Stand up for yourself."). Such groups have been found to exert strong influence – both positive and negative – in various circumstances, such as family joint decision to select their child's MH therapist [Lipscomb, Root, Shelley, 2004] and even peer pressure against accepting MH help among street-involved youth in a UK study [McCay, Carter, Aiello, 2017].

## STRATEGIES TO ATTRACT AND RETAIN MENTAL HEALTH CUSTOMERS

As Chapman Walsh et al. [1993] pointed out, the marketer should educate consumers on the skills and experience necessary to follow through the campaign message: for example, an anti-drug campaign offered workshops to teach teens how to resist peer pressure and trained parents and community leaders to identify drug abuse and deal with it. Similar to popular consumer products that are endorsed by celebrities, 'social products' such as cardiovascular risk reduction also benefitted from the high visibility and credibility of campaign ambassadors and community opinion leaders [Chapman Walsh et al., 1993]. Further, stakeholder mobilization was found to improve the chances of a campaign's success when incentives were offered to program partners such as media gatekeepers, distributors, employers, community leaders, family members and teachers. In support of stakeholder involvement, a study in an American University experimented with curriculum infusion as a strategy to promote MH on campus [Mitchell et al., 2012]. To make faculty more aware and engaged in suicide prevention, a group of counsellors, health educators, and medics worked with university faculty, staff, and students to develop MH promotion programs as part of the curriculum. According to the authors, after the training, faculty had a better understanding of MH issues, were more aware of MH resources available on campus, and were more involved in promoting MH programs [Mitchell et al., 2012].

According to the 2011 study, most WHO member states offered health call centers, emergency toll-free numbers, and mobile telemedicine. Some barriers to growth included lack of integration with eHealth, issues with data security, and insufficient cost evaluations to move legislation forward. While national health systems were plagued by limited budgets and bureaucratic inertia, more nimble private MHC providers were capitalizing on mobile phone-based and computer-assisted technologies to provide patient CRM. A comparison experiment by Depp, Mausbach and Granholm [2010] monitored three ongoing clinical trials using mobile device relationship management for patients with bipolar disorder or schizophrenia, respectively. Patients in Project 1 used a PDA for self-management, Project 2 received SMS for case management and Project 3 was based on group support alternating with therapist mobile-phone contact in-between sessions. In all cases, patient loyalty and satisfaction were high, although cost effectiveness and safety issues needed further attention [Depp, Mausbach, Granholm, 2010]. In an international multi-center trial, another MHC provider successfully piloted computer-assisted communication to patients being treated for panic disorder [Kenardy, Dow, 2003] and found that effectiveness of delivery was not statistically significant between subjects in the therapist-delivered vs. computer-assisted group, suggesting that technology-enabled MH communications were a re-

liable replacement for traditional methods. As far as digital platforms are concerned, Internet sites and particularly social media networks such as Twitter and Facebook were used across all stages in the MH journey. For instance, Canberra state authority used Facebook to combat cyber bullying<sup>1</sup> while one university tracked the Facebook and Twitter feeds of its student body to find potential signs of depression and suicide ideation [Ross, 2017]. Similarly, Johns Hopkins university mined over 2 billion tweets to find patterns in HC information and used #MentalHealth hashtag to identify typical language from users suffering from post-traumatic stress disorder and depression [Mook, 2011]. By using the site to monitor MH cases, HMC providers and government authorities were better able to forecast the market size and nature for MH, allocate counselling resources, and secure sample language to be used in targeted consumer communications [Mook, 2011].

In a recent success story, Hello Health, a Brooklyn-based primary care practice used weblogs, instant messaging platforms, video chat, and social networks to attract and retain patients [Hawn, 2009]. To enhance the human aspect of the practice, the hospital's website created Facebook-inspired profiles for its doctors, including details about the medical staff's hobbies and interests. This and the multitude of convenient communication platforms helped to build trust and triggered trial, e.g. by letting potential patients send an email, reach the doctor through instant messaging, or even elicit a 'cyber-visit' with the doctor at an extra fee. Beside patient-directed communications, the practice also launched B2B marketing initiatives, by selling its proprietary technology to brick-and-mortar HC providers and allowing individual doctors to 1) register their profiles in the Hello Health network, 2) 'friend' other doctors and 3) deliver paid services to HH's already enrolled patients [Hawn, 2009]. Similarly, a children's MH hospital in Canada organized an interactive Facebook event<sup>2</sup> to increase engagement, a MH Foundation used a viral Facebook campaign to attract donors<sup>3</sup> and one author even encouraged medical practices to post articles and jokes for more views [Lamberts, 2016].

Attracted by the benefits of social networks, some individual MH doctors took matters into their own hands: in a Romanian study, MH doctors themselves were taking initiative to develop their personal brand on social networks in response to Romanian consumers' tendency to sift through online forum discussions when searching for a practitioner [Ioan, Luca, 2014]. Elsewhere, Chinese doctors shared their expertise through online health care communities to build an online reputation while at the same time consolidating their offline economic value i.e. earning more income from their hospitals [Guo et al., 2017].

<sup>1</sup> International Business Times. (2012, November 1). Canberra Teams up with Facebook, Mental Health Group to Battle Cyber Bullying.

<sup>2</sup> Canada Newswire. (2011, April 28). Kinark kicks off Children's Mental Health Week with Interactive Facebook event. Canada Newswire.

<sup>3</sup> Mental Health Foundation adopts viral strategy to extend database. (2002, April 5). Precision Marketing.

*Select findings on patient perceptions and effective CRM activities*  
*Услуги по охране психического здоровья: восприятие пациентов и эффективные меры CRM*

Authors (in order of mention)	Results
Symoens, Colman, Bracke, 2014	Patient with prior experience of MH counselling may perceive the service as normal and much-needed
Corrigan, 2004	Patient from low-income or rural area more likely to perceive MH service as exclusively for major illness
Percy, 2013	Patient from less developed country more likely to attribute mental illness to superstition
Le, 2017	Sharing sessions and workshops suitable for overcoming self-barriers
Lanjananda, Patterson, 2009	Patient's inability to assess an intangible service where the long-term benefits may not materialize
Hammer, Vogel, 2009	More men suffered from self-stigma and were less likely than women to seek MH help
Braus, 1996	Women were easier to target as they often were the primary decision-maker on family health
Rodenhauser, 1994	Culture may be a barrier to MHC and result in distrust in MHC delivery
Illouz, 2009	Western societies appear to embrace psychology and therapy as part of modern identity
Rasch, Hodek, Runge, Greine, 2009	More affluent individuals are more likely to be well-informed and proactive in seeking MH help than lower income individuals
Lipscomb, Root, Shelley, 2004	Family joint decision to select the child's therapist
McCay, Carter, Aiello, 2017	Peer pressure to reject MH care among street-involved youth
Mitchell, Darrow, Haggerty, Neill, 2012	Curriculum infusion of MH into non-medical studies resulted in increased awareness and knowledge
Kirkwood, Stamm, 2006	Anti-stigma campaigns in rural areas resulted in improved community awareness
Boehnlein, 2006	Religious institutions such as churches did not appear to have strong links to MH care
Depp, Mausbach, Granholm, 2010	Mobile devices used for MH relationship management
Ross, 2017	Using social media to proactively track students' mental well-being from posts
Mook, 2011	Similar to Ross [2017], but using hashtag #mentalhealth to better forecast MH market size, issue, and define key terminology to be used in future communications
Hawn, 2009	Private clinic in Brooklyn used weblogs, instant messaging and video chat to attract and retain patients, but had issues with privacy
Ioan, Luca, 2014	Romanian doctors developed personal brands on social media and forums
Guo, Guo, Fang, Vogel, 2017	Chinese doctors shared their expertise through online health care communities
Reast, Lindgreen, 2011	Physicians feared that consumers are not sophisticated enough to correctly assess direct-to-consumer advertising of MH drugs

Despite the many benefits, e-health care and the use of social networking sites for MHC delivery were found to pose a few important challenges: first, securing patient privacy was an issue as MH practices had to comply with legal guidelines for protecting personal medical data [Hawn, 2009]. Second, Hawn pointed out that, from a legal standpoint, doctors were licensed by state or territory, which would make the practice of delivering remote Internet-based MH therapy in other states illegal. Then came the issue of variability of quality of care, i.e. whether a video-delivered session or an instant-messaging exchange was sufficient to correctly assess and diagnose the patient [Hawn, 2009]. See summary of results in Table.

## CONCLUSION

The last 10 to 15 years have witnessed another radical change in MH medical communications by shifting away from the traditional pharma – doctor – patient sequence towards patient empowerment and self-care. To clarify, past practice involved doctor detailing, i.e. a medical representative (sales person) would visit a doctor to explain ('to detail') the benefits and side effects of a new antidepressant drug, after which the doctor decided whether to prescribe the product or not [Donohue, 2004]. Although

physicians from Europe, the Middle East, and Taiwan welcomed unbranded MH illness campaigns to the public [Reast, Lindgreen, 2011], when the pharmaceutical companies were allowed to practice direct-to-consumer (DTC) advertising of new drugs, much controversy arose in the medical community. For example, doctors from cultures high on Power Distance such as Greece and SE Asia greatly opposed the idea, highlighting the fact that unsophisticated patients could never match a doctor's skill and training to correctly assess medicines [Reast, Lindgreen, 2011].

In other environments, academics pointed out that TV commercials did not spend enough time on discussing a drug's side effects to provide the 'fair balance' required by the regulator [Kaphingst, DeJong, 2004]; others found drug-accompanying communications too opaque for the reading understanding of the general public [Root, 1999]. In the case of Prozac, an FDA-imposed warning label led to an unintended drop in usage of the anti-depressant due to consumer misunderstanding [Busch, Barry, 2009] and a few authors even hinted at 'manipulative' intent of ads for vulnerable MH populations [Reeves, 1998] and condemned pharmaceutical firms for using company-sponsored disease information websites that consumers could not easily identify as commercial sources [Shin, 2015].

Since awareness and knowledge are key drivers to service consumption in the consumer buying behavior, the study reviewed the steps in decision-making mapped against marketing tools and communications strategies that mental health care providers use to attract and retain local patients. In detail, providers' marketing activities were matched with steps in the buying behavior process developed by Schiffman and Kanuk [2010], Kotler and Keller [2009], EBM model [Engel, Blackwell, 2001], Belch and Belch [2014]. In particular, the concepts of 'need awareness', 'need recognition' and 'information search' were investigated to show how trial and usage of mental health services were influenced by external commercial and non-commercial sources (hospital's advertising, culture, sub-culture, reference groups), and consumer-specific factors such as psychographic profile, perceptions, attitude, motivation, personality and learning style [Schiffman, Kanuk, 2010].

On the consumer side, primary drivers to mental health seeking on the user's side have been linked to personal and vicarious experience of mental health services as past experience or when trusted peer recommendation acted as a driver to usage [Kessler, Agines, Bowen, 2015]. On the supply side, studies on marketing for mental health were found to be limited and relatively outdated focusing mainly on patterns of service utilization [McGuire, Fairbank, 1988], competitor analysis [Scheuerman, Fallon, 1988], market segmentation [Enthoven, 1988], and market size forecasting [Ambry, 1988], which points to the dearth of investigations into marketing communications and promotional activities for MH.

In spite of the controversy, contemporary MH marketing in developed economies has seen much growth in informing, involving and empowering the consumer with both drug and illness knowledge. For instance, Calfee

[2002] found that patients who had been exposed to drug and illness-related information were more discerning and had a higher chance of complying to the therapy. Next, Chang [2005] noted that a growing number of Americans were already using the Internet for psychoeducation, self-help, and mutual help, and thus encouraged MHC providers to offer online counseling and high-quality web content for this purpose. More recently, Hawn [2009] highlighted ways that MHC providers could capitalize on the Internet's new ways of communication from one-to-many (e.g. health weblogs) and many-to-many (online health communities) to increase MH awareness and engage in dialog with those at risk. Quite recently, Jones and Patel [2014] extolled the virtues of a MH mobile app that could weave psychological self-care into people's lives and reduce the need for costly one-on-one therapy sessions. As a doctor adeptly noted, "These types of tools [online patient portals] are ultimately empowering for patients because we're giving them what they need to care for themselves" [Hawn, 2009, para. 8 of section 'Improving Quality Through Better Communication'].

Mental health issues invalidates a nation's some of the most productive intellectual resources and proactive investments to deal with this crisis should be one of the key distinguishing features of a sustainably developing country. In this paper, we discussed the factors affecting consumer behavior towards mental health services. Both patient and service provider initiated mental health provisions were compared and contrasted. It was found that doctor-led service provision remained the most prevalent form of relationship building in Asia where as consumer-initiated mental health treatment scheme were the norm in the Western world. We also discussed trends such as digitally-savvy identification, acquisition, and retention of the mental health patients. ■

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## Поведение потребителей и CRM в сфере охраны психического здоровья

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**Аннотация.** Восприятие услуг по охране психического здоровья и их содержания варьируется в зависимости от социокультурной среды. Понимание этих различий играет решающую роль в привлечении пациентов, страдающих психическими расстройствами, и обеспечении их лояльности. В научной литературе о поведении потребителей уделено недостаточно внимания ментальным особенностям данной группы населения, а потому многие вопросы о специфике их потребления остаются открытыми. Статья посвящена анализу как западных, так и азиатских научных разработок в области психического здоровья, а также оценке главных факторов, влияющих на решения государственных и частных организаций о предоставлении данных услуг. Методологической базой исследования выступили положения теории потребительского поведения, концептуальные положения теории маркетинга в сфере здравоохранения. Основными методами исследования являлись методы анализа и синтеза, классификаций и группировок. Эмпирическая база исследования включала 250 оригинальных и обзорных статей по исследуемой проблематике. Как показывают результаты исследования, для обществ с восточным укладом, особенно наименее развитых стран Юго-Восточной Азии, при выстраивании коммерческих отношений с пациентом основной маркетинговый фокус приходится на лечащего врача. В то же время практика обращений, инициированных самими пациентами под влиянием маркетинговых кампаний, более характерна для развитых западных стран. Необходимо также отметить, что среди инновационно-ориентированных провайдеров наблюдается тенденция к увеличению доли медицинских услуг с использованием телекоммуникаций, которые, помимо прочего, подразумевают проактивную и гибкую цифровую идентификацию, а также привлечение и удержание клиентов. Результаты проведенного исследования могут быть использованы в качестве основы для разработки маркетинговых стратегий фирм-производителей лекарственных препаратов, а также производителей мобильных приложений в сфере медицинских онлайн-консультаций.

**Ключевые слова:** поведение потребителей; CRM; услуги по охране психического здоровья; маркетинг в сфере охраны психического здоровья; стратегия здравоохранения.

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