SOCIAL MARKETING : A NEW APPROACH IN MENTAL HEALTH RESEARCH

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ABSTRACT

Social marketing has a proven role in marketing and many manufacturing establishments/organizations have been marketing their products incorporating social marketing research. Social marketing has its root in the ground fact that the perceptions and expectations of the consumers are important in influencing buying behaviour. The principles of social marketing, therefore, have been extensively utilized in the areas of consumer products. These are also used in several other fields for modifying behaviours such as civil administration, public establishments etc. In health sector social marketing has not found appropriate application whereas it could be utilized in an effective way for creating awareness, formulating health related policies, their implementation and for preventing a variety of illnesses/abnormal behaviours etc.

With this background knowledge about social marketing, the author hypothesized that abnormal behaviours could be modified, health education packages could be developed to make more acceptable and effective and desired behaviours could be induced if perceptions and expectations of the community (consumers) are known a priori and their expectations are incorporated in programmes and policies. Thus, the author utilizing the concepts of social marketing for understanding community’s perceptions and expectations regarding issues of health, and for incorporating the same in health related programmes and policies, introduced this research concept in medical field in this country.

The important findings of three research projects based on the concepts of social marketing research and their implications have been discussed.

Key Words : Social marketing, mental health research

In India, there is an unending list of programmes/activities launched by Central and State Governments in the fields of Social Welfare, Education, Health, Civilian conducts, population etc. However, except for small pox eradication programme, non others have been effective and successful. Why? The answer to why is not readily available with these programme/activity planners; neither it seems they are concerned for finding out the answer. Perhaps, they prefer continuing in myth of falsely perceived and wrongly documented effectiveness of these programmes/activities. This situation is more relevant to those areas where the desired changes operate through the medium of the behaviour of the individual/community. Probably, this is the answer to why? As a result several programmes viz. National Family Planning Programme, National Leprosy Eradication Programme, Programmes to improve civilian behaviours, National Mental Health Programme, Drug Abuse Prevention Programme, Literacy Programme etc. which required changes in behaviour for their effectiveness, have either been a failure or have met with limited success. The poor knowledge about perceptions and expectations of the consumers (community) and its non-incorporation in
these programmes are important reasons contributing to this. Martin (1968) observed about limited success of the National Family Planning Programme for India that "where no manufacturer would contemplate developing and introducing a new product without a thorough understanding of the variables of the market, planners in the highest circles of Indian Government have blithely gone ahead without understanding the marketing principles which determine the character of any campaign of voluntary control. The Indians have done only the poorest research".

The idea being born: All of the above mentioned programmes suffered with a common ailment: non-incorporation of consumer's (community's) perceptions and expectations in these programmes. It is this area that requires careful study and market (community) shopping of perceptions & expectations which could be incorporated while designing/developing the programmes to make them more acceptable and effective. This activity is popularly known as "Social Marketing".

Social marketing, a component of marketing management, is the design implementation and control of programmes calculated to influence the acceptability of social ideas and involving considerations of product planning, pricing, communications, distribution and marketing research (Kotler & Zaltman, 1971). Thus, it is the explicit use of marketing skills to help translate the present social action efforts into more effectively designed and communicated programmes based on shopped perceptions and expectations from the market (community) that elicit desired consumer (community) response.

The author confronted with limited success of National Mental Health Programme, Drug Deaddiction Programme, various Health Education Programmes could underline only one common cause behind this: non-incorporation of consumer's (community's) perceptions and expectations into these programmes while developing/designing the same. The author, therefore, thought it worthwhile to apply the principles of social marketing to find out answer to solve some of the problems related to mental health care and delivery. Following is the brief outline and results of various projects undertaken, till date by the author incorporating the concepts of social marketing.

The beginning

Project -1: A study to evolve an alternative model of mental health care in rural Uttar Pradesh.

The background: Utilization of the principles and concepts of social marketing in mental health research was initiated for the first time in country through a research project entitled "A study to evolve an alternative model of mental health care in rural Uttar Pradesh". The project was funded by International Development Research Centre, Ottawa, Canada.

This work was conceived following our experience of facing enormous difficulties in implementation of National Mental Health Programme in two districts (Lucknow & Lakhimpur Kheri in years 1984-85 and 1987-88 respectively) and our knowledge of limited success of the National Mental Health Programme and that provided impetus to study the perceptions and expectations of the consumers (community) as to what do they perceive and expect in regard to delivery of mental health care services. A project based on the principles of social marketing was thus developed to shop the perceptions and expectations of the community regarding delivery of mental health care services and to evolve an alternative model of mental health care incorporating the perceptions and expectations of the community if so required and suggested by the community.

MATERIAL AND METHOD

The study was carried out in the geodemographic universe covered by Mohanlalganj Primary Health Centre (PHC) which is situated 22 Kms. away from K.G.'s
Medical College and only 4 Kms. from Sanjay Gandhi Post Graduate Institute of Medical Sciences. The PHC is part of a reserve parliamentary constituency. Mohanlanganj Block has a total area of 35,460 hectares, has 97 villages and 62 gram-sabhas. Out of the 97 villages randomly selected 9 villages with total population of approximately 18 thousands were chosen for the study. In the targeted villages, house to house survey was carried out and the head of the family and his/her spouse were interviewed. In case of non-availability of the spouse (either deceased, or absent for other reasons), the senior most adult of the same sex was interviewed. A semistructured proforma comprising of following schedules was administered.

* Geodemographic details of the study area
* Socioeconomic details of households
* Schedule for assessment of available models of psychiatric care
* Community expectation schedule

The study sample comprised of 2164 subjects. This was arrived at as following: Out of the total population (17827) of 9 villages, 8926 & 8901 were adults and children respectively. During study visits in each village only a total of 8318 (4672 adults and 3646 children) could be contacted. Nearly 50% of the adults and children could not be contacted due to their non-availability during research team visits on working days. Of these children were not studied. Out of 4672 adults, there were 2435 males and 2237 females. The female heads were nearly equal in number as male heads because the adults from female headed household had moved out of the village for jobs and were staying and working mostly in cities. Of the total males and females, 1230 males and 1212 females were heads of the households (total 2442 heads). During evaluation it was found that 278 heads of households did not know or did not respond about mental illness and hence they were not studied further. Thus the remaining 2164 heads of households were finally studied and this formed the study sample.

The catchment villages were dichotomized into advantaged and disadvantaged villages. Villages having following facilities were categorised as advantaged and those not having these facilities as disadvantaged. Schooling facilities were equally present in both types of villages.
1. A brick “Pucca” house rather than a mud one.
2. A primary health centre, post office and primary school within 2 km. radius
3. Having an electrical supply.
4. Connected by metalled roads.

The generated data was computer analysed using percentage and $X^2$ test of significance as and where applicable.

RESULTS

The community was largely aware of mental symptoms (88.21%) as is evident from table -1 indicating overall good awareness in the community about mental illnesses and thus expelling the myth that people are not aware about mental illnesses.

Most of the subjects investigated reported drugs to be the main treatment (86.28%). Majority thought Govt. Hospitals to be place of treatment (52.59%) followed by mental hospitals (26.71) and faith healers (10.86%). Only odd 2.40 though psychiatrist to be treating doctors. Majority (55.31%) reported location of treatment facilities to be far from villages. They were uncertain about effectiveness of treatment (mostly effective -39.65%, partially effective -18.52%, did not know- 19.09% and only 17.98% reported it to be totally effective. Regarding utilization of available services 61.28% subjects utilized, 18.30% did not utilize at all and 20.43% did not know about it. It was eye opening to note that 80.08% were totally dissatisfied with the available treatment facilities for mentally ill, 10.72% satisfied to great extent and 9.20% to some extent. The subjects perceived only medicines to be the best treatment for mentally sick (66.96%) followed by combinations of all available treatments.
TABLE 1
STUDY SAMPLE AND AWARENESS ABOUT MENTAL SYMPTOMS (N=2442)

| Awareness| Male | Female | Total |
|----------|------|--------|-------|
|          | N    | %      | N     | %    |
| Aware about mental symptoms and seen the patients| 1168 | 94.96 | 986   | 81.33 | 2154 | 88.21 |
| Aware about mental symptoms but not seen the patients| 4    | 0.33  | 6     | 0.50  | 10   | 0.41  |
| Unaware| 58   | 4.72   | 220   | 18.15 | 278  | 11.36 |

(26.71%). Surprisingly only 0.14% perceived ECT to be the best treatment (Table -2)

The community's expectation regarding location of treatment facility revealed that the majority expected treatment facility for mentally sick to be located in village itself (56.70%) followed by PHC/sub centre (34.20%), medicine with health visitors (3.33%) and mental hospitals (2.83%). Most of the subjects desired free consultation and medicines (75.23%) followed by free consultation and medicines paid for (14.33%) and paid consultation but free medicines. They expected clinic based case management by the psychiatrist (95.29%), remaining available once a week (54.44%) and some wanted once a fortnight (17.01%). The camps & exhibitions were reported and desired the best media for health education programmes by majority (81.38%) followed by Radio/TV (8.36%). The observations are tabulated in table -3.

The perceptions and expectations of this rural community when translated into the activities of the National Mental Health Programme, it was found that NMHP was far from being able to meet the expectation of the community. The NMHP lacked community perceptions and what community expected from such a programme. As a result, an alternative model of mental health care delivery was proposed incorporating most of the expectations as shopped from the community. It is a three tier model as detailed below.

The new model offers a streamline approach, involves significant community participation, is least dependant on government agencies, utilizes maximum infrastructure and minimum manpower of the health centres and lays greater emphasis on changing health seeking behaviour of the community.

This model is the result of social
marketing research applied to one very important aspect of mental health care. This model is being studied to establish its feasibility, efficacy and acceptability. The use of social marketing technique for mental health research proved to be eye opening for the author & encouraged by the response and participation of the community in the above project, two new projects were planned in 1995-1996 relating to two important issues in psychiatry requiring immediate attention. The first being the problem of drug treatment noncompliance in schizophrenics and second relating to ineffectiveness of available visual preventive materials aimed at preventing substance abuse in the community.

**Project 2: A clinical study of factors associated with drug treatment noncompliance in schizophrenics.**

The background: In our culture, though systematic studies are lacking, it is a common clinical observation that in majority of schizophrenics relapses occur due to drug treatment discontinuation. In view of the fact that there exists geodemographic, socioeconomic, and cultural differences between our patients and western patients, the drug treatment

### TABLE 3

| Expectations/Suggestions of the Community (N=2164)* | N  | %    |
|--------------------------------------------------|----|------|
| Expectation about location of treatment           |    |      |
| In the village                                    | 1225 | 56.70 |
| At PHC/subcentre                                 | 740  | 34.20 |
| Medicines with health visitors                   | 43   | 3.33  |
| Expectation about cost of treatment              |    |      |
| Free consultation & free medicines               | 1628 | 75.23 |
| Free consultation but the medicines paid for      | 310  | 14.33 |
| Paid consultation but free medicines              | 211  | 9.75  |
| Expectation about role of psychiatrist           |    |      |
| Clinic based management                          | 2061 | 95.24 |
| Home visit management                            |    | 4.39  |
| Frequency of psychiatrists visit/availability    |    |      |
| Once a week                                      | 1178 | 54.44 |
| Once a fortnight                                  | 368  | 17.01 |
| Can not say                                      | 124  | 5.73  |
| Suggestions about methods of creating awareness  |    |      |
| Camps/exhibitions                                | 1761 | 81.38 |
| Radio/TV                                         | 131  | 8.36  |

*The % do not add up to 100 as less frequently reported variables have not been included in the table.
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noncompliance data from western countries cannot be extrapolated onto our patients. We need to carry out systemic search as to why our schizophrenics become drug treatment non-compliant. This issue of immediate concern to psychiatrists required shopping of consumers (schizophrenics and their relatives) on the principles of social marketing to evaluate factors associated with this phenomenon, so that strategies could be developed to prevent drug treatment noncompliance in schizophrenics and to ensure compliance.

MATERIAL & METHOD

The sample was drawn from out patients department of psychiatry, King George's Medical College, Lucknow 84 drug noncompliant patients were screened during the period of the study and 41 were selected fulfilling the following selection criteria.

1. Age 17 years or more
2. Informed consent
3. Discontinuation of prescribed drug for 7 or more days without medical advice.
4. Availability of an adult family member

A total of 11 patients were dropped out for various reasons and 30 patients completed the study. Drug treatment noncompliance was defined as discontinuation of the prescribed drug for 7 or more days without advice from consultant. ICD-X was used for making diagnosis and a specially prepared structured proforma was used to study the subjects. The proforma contained questions to evaluate: (i) Patients related; (ii) illness related; (iii) drug related; (iv) therapy related; (v) sociocultural and (vi) mental health care related factors.

RESULTS

The average duration of the illness was 6.83±5.69 years during which an average 4.77±4.15 relapses had occurred and drugs were discontinued on an average 5.37±4.15 times for an average duration of 12.57±14.61 week across cases.

Majority of the subjects (83.27%) reported that more than 50% improvements does occur in symptoms with medications but failed to understand that after the subsidence of symptoms, drug were still required (73.33%). In descending order, the major reasons of drug discontinuation were financial hardship (46.66%), patients stopping the drugs on their own (43.33%), discontinuing drugs by family members as the patients had improved (20%), and due to side effects of the prescribed medicines (13.33%). These and other factors are detailed in table 4.

A lack on part of consultant in imparting sufficient information to patients and/or attendants is reflected in the finding that 83.3% informants were not told the name of illness by the consultants and were ignorant of the consequences of stopping the drugs without advice. In majority of cases the consultants did not provide any information regarding the duration of drug treatment, side effects, what they should do for side effects etc. Dissatisfaction with psychiatric OPD services was expressed by half of the informants mainly in the area of excessive (2 hrs. 5 min.) waiting period. However, majority 76.67% understood of consultants but 93.33% subjects wanted instructions in written for and 23.33% subjects were found dissatisfied with the time given to them by the consultants. Informants desired an increase in time devoted to the individual patients, decrease in OPD waiting time, greater interval between visits, cheaper or free drugs, group psychoeducation, and written information about their patients illness and its treatment.

This study was uncontrolled descriptive inquiry with a very small sample size. The results, therefore, can not be generalised. However, findings are indicative of the thrust areas which need to be understood, explained to the patient and relatives and monitored in follow-ups to prevent drug treatment noncompliance in schizophrenics. Clinical applications of identified factors by the author appears showing encouraging results.

Project 3: A study to evolve visual material for prevention of drug/alcohol/tobacco (substance) abuse through social marketing.
TABLE 4
FACTOR ASSOCIATED WITH DRUG TREATMENT NON-COMPLIANCE

| Reasons                                           | N  | %    |
|--------------------------------------------------|----|------|
| 1. Financial hardship                             | 14 | 46.66|
| 2. Patients refused taking drugs                  | 13 | 43.33|
| 3. Patients improved, so stopped                  | 6  | 20.00|
| 4. Family member became careless                  | 4  | 13.33|
| 5. Family member responsible for giving drugs went away | 3  | 10.00|
| 6. Family member responsible for giving drugs became very busy | 2  | 6.67 |
| 7. Patients ran away from home                    | 2  | 6.67 |
| 8. Drugs are not available nearby                 | 4  | 13.33|
| 9. Did not follow-up as hospital is a long distance| 2  | 6.67 |
| 10. Drugs were hot, caused drowsiness/uneasiness and side effects | 4  | 13.33|
| 11. Patients got married and husband refused to get treated | 1  | 3.33 |
| 12. Patient was jailed and police threw the medicines | 1  | 3.33 |
| 13. Patient became medically ill, so treatment stopped | 1  | 3.33 |
| 14. Drugs stopped working                         | 1  | 3.33 |
| 15. Could not bring patient for follow-up for some reason | 1  | 3.33 |
| 16. Death occurred in the family                  | 1  | 3.33 |

The background: The magnitude of the substance abuse problem in this country has no limits. It is widespread and pervades through all castes, cultures and human beings. Since a well defined definition to quantity and quality substance abuse is not available, it is difficult to make an exact assessment of the substance abuse problem. But the problem is growing like jungle fire- a fact admitted by all. The problem, thus, requires immediate attention. A number of activities have been initiated by Central, State Government agencies and non-government organizations to prevent substance abuse but the problem is showing no downward trend.

The author was particularly surprised to note that a variety of visual materials were displayed as hoardings, posters, stickers, handbills, banners etc. educating community about ill consequences of substance abuse and thus aiming at preventing the same. These visual materials are developed by Govt. & non-Govt. organizations, voluntary bodies etc. However, the data is testimony to the fact that the substance abuse has not shown any decline, rather it is showing a spiral rise. Obviously, these preventive packages aimed at prevention of substance abuse are proving ineffective. Once again the reason can be traced to consumers (community) perceptions of and expectations about these visual preventive packages. Non-incorporation of community’s perceptions and expectations into these visual preventive materials could be a reason for their being ineffective. This realization provided the ground to plan a study on the principles of social marketing with objectives to buy community’s perceptions and expectations for incorporating the same in developing visual preventive materials.

The study was carried out in two phases:

The objective of the phase -1 was to shop out the community’s opinion about and expectations from the available visual preventive materials and too develop visual preventive materials (Posters, stickers & handbills) for substance abuse incorporating community’s expectations. The second phase of the study was the intervention phase, aimed at intervention and to study the effectiveness/acceptance of developed visual materials in prevention of substance abuse.

MATERIAL AND METHOD

The sample for the study was drawn from both urban and rural communities. In the first phase of the study 1197 male heads of the households were selected through two stage random sampling technique. A door to door survey was carried out. Semistructured proforma was prepared comprising items pertaining to: (a) Background characteristics of the respondents; (b) awareness about drug abuse; (c) status of community participation in drug abuse prevention programmes; (d) opinion of subjects on various available visual materials & (e) opinion about existing procedures of display of materials and expectations from and changes suggested in the existing visual materials.
In the final phase of study two villages and two mohallas (other than those included in phase -1) were selected employing a similar field selection process. A door to door survey was carried out and both male and female heads of the households were surveyed. Later due to practical problems survey of females had to be discontinued and replaced by males. A semistructured proforma was utilized, having following parts: (a) Background characteristics of the respondents; (b) awareness about the drug abuse & (c) pattern of drug abuse.

Once the benchmark survey were completed, the community was exposed to preventive visual materials. One rural and one urban area were exposed to existing preventive materials and one rural and one urban area were exposed to developed materials. All the areas were resurveyed after the gap of three months using another semistructured proforma containing following additional areas.
1. Efficacy of drug abuse preventive materials (existing/developed)
2. Impact of drug abuse preventive materials on substance abuse behaviour.
3. Motivating factors to change substance abuse behaviour.

RESULTS

The results of the phase -1 indicated that the community was largely aware of drug abuse. 74.6% heads in rural and 50% heads in urban area were found drug abusers. Very few subjects (9.56%) in rural and slightly higher in urban areas were taking part in drug abuse prevention programmes. Only few subjects (11.5% in rural, 15.86% in urban) had seen promotional and preventive visual materials regarding drug abuse (poster, sticker, handbills). When asked about the effectiveness of the visual preventive materials by those who had seen such materials, majority of the subjects reported that these materials are not effective. In table 5 the opinion of respondents regarding existing visual preventive material is shown.

An inquiry about the comparative impact of visual preventive materials (posters, stickers and handbills) on drug abuse prevention, majority (63.2% in rural, 73.96% in urban) of the subjects reported that posters are likely to be highly effective followed by stickers. The handbills were reported to be least effective. Majority of the subjects (80.00%) desired changes in existing visual preventive materials to make them more effective. Out of the total 1197 rural and urban subjects interviewed regarding changes in existing visual preventive materials, varying numbers as shown in table 6 reported for changes in posters, stickers and handbills. The important changes suggested by the community were: (i) Incorporation of socio-culture background and religious feelings of the community; (ii) legal consequences should be highlighted and (iii) shown ill effects of abuse should involve areas such as health, occupation, family, service, prestige, religious feelings etc. The changes suggested by the respondents in existing visual preventive materials are shown in table 6.

Regarding expected impact of these changes the subjects felt that these changes will cause decrease in number of abusers (86.7% & 78.8%), of fresh abusers (73.7% & 45.2%) and of repeat abusers (66.9% & 50%) and more people would be aware of the associated ill effects due to substance abuse (56.1% & 47.1%) in rural & urban areas respectively.

The community also suggested methods of displaying the developed visual materials. The majority favoured: (i) Increase in quantity of the visual materials (73.6% & 84.1%); (ii) displaying these at places of large public gatherings (64.2% & 84.3%) & (iii) displaying in premises of hospitals, clinics, nursing homes,
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TABLE 6
COMMUNITY'S SUGGESTIONS OF CHANGES IN EXISTING VISUAL MATERIALS
(N=1197; RURAL 617 AND URBAN 580)

| Expected changes                                                                 | Posters Rural (N=600) | Urban (N=530) | Stickers Rural (N=520) | Urban (N=515) | Handbills Rural (N=210) | Urban (N=245) |
|----------------------------------------------------------------------------------|-----------------------|---------------|------------------------|---------------|-------------------------|---------------|
| 1. Should be made according to socio-cultural background and feelings of the community | 590 98.33            | 530 100       | 520 100                | 515 100       | 210 100                 | 220 89.79      |
| 2. Displayed ill effects of abuse should involve areas such as health, occupation, family, prestige, religious feelings etc. | 575 95.83            | 503 94.9      | 520 100                | 510 99.2      | 197 93.8                 | 212 88.3       |
| 3. Legal consequences should be highlighted                                      | 600 100              | 410 77.3      | 511 98.2               | 515 100       | 209 99.5                 | 230 93.03      |

schools, colleges, (52.8% & 65.7%) by rural and urban subjects respectively.

The results of the phase -1 study helped in developing visual materials based on the perceptions and expectations of the rural and urban community. This was a good and unique experience. Three different types of posters and stickers were developed: (i) substances consumed in the form of tablets/injections; (ii) substances consumed in the form of liquid; (iii) substances consumed by smoking, inhaling & chewing. The handbills were not developed as it was reported to be ineffective by the community.

In phase II of the study, the developed visual materials were tested to evaluate its efficacy and acceptability. One each randomly selected urban (Paper mill colony and Badshah nagar colony) and rural area (Mangtaiya and Khajauli) were exposed to existing and developed visual preventive materials after a benchmark survey. A second survey was carried out after three months of exposure. It was found that the developed materials were more effective in comparison of existing preventive materials. Out of the total drug abusers, 23.78% in rural community and 16.61% in urban left one or more than one substance of abuse. Of these 3.40% were found to be totally de-addicted. Further, 14.74% rural and 25.61% urban drug abusers reduced the quantity of one or more than one substances of abuse. The study clearly established superiority of the developed materials over existing ones as only few subjects (7.65%) reported any kind of change in their substance abuse behaviour when exposed to existing visual materials. The impact of visual preventive materials (Poster/sticker) are shown in table 7.

An important inquiry was carried out by asking the rural and urban abusers (1560 & 1210 respectively; total 2770) who were exposed to developed materials as to what motivated them for changes in substance abuse behaviour. The findings are depicted in table 8. The subjects indicated; (i) Increased knowledge about social and economic consequences of substance abuse; (ii) induction of horrifying religious and other fears and (iii) fears of getting socially boycotted as factors motivating them for changes in substances abuse behaviour.

The phase 1 of the study provided leads and guideline as perceived important by the community for incorporating the same into existing preventive visual materials for substance abuse. The leads were primarily in three areas relating to (1) sociocultural background of the community, (2) health, occupation, religious feelings, prestige etc. and (3) legal consequences of substance abuse. These issues were incorporated in developing posters & stickers.
### TABLE 7

**IMPACT OF VISUAL PREVENTIVE MATERIALS (POSTERS/STICKERS)**

| S. no | Urban (N=5420) | Rural (N=4364) |  |
|-------|----------------|----------------|---|
|       | Existing material displayed | New material displayed | Existing material displayed | New material displayed |
|       | (Paper mill colony) | (Badshah N. colony) | (Mangtaiya) | (Khajauli) |
|       | N | % | N | % | N | % | N | % |
| 1. Total number of drug abusers | (N=1990) | (N=3430) | (N=1774) | (N=2570) |
| Before display - abusers | 650 | 32.66 | 1210 | 35.27 | 1005 | 56.65 | 1560 | 60.23 |
| non-abusers | 1340 | 67.33 | 2220 | 64.73 | 769 | 43.34 | 1030 | 39.76 |
| After display - abusers | 648 | 32.56 | 1200 | 34.98 | 1003 | 56.53 | 1518 | 58.61 |
| non-abusers | 1342 | 67.43 | 2230 | 65.01 | 771 | 43.46 | 1072 | 41.39 |
| 2. Number of drug abusers leaving substance abuse | (N=650) | (N=1210) | (N=1005) | (N=1560) |
| left | 21 | 3.23 | 201 | 16.61 | 1003 | 1.49 | 371 | 23.78 |
| did not | 629 | 96.76 | 1009 | 83.38 | 990 | 98.50 | 1169 | 76.22 |
| 3. Number of drug abusers reduced the quantity of substance abuse | (N=2570) |
| reduced | 12 | 1.84 | 310 | 25.61 | 11 | 1.09 | 230 | 14.74 |
| did not | 638 | 98.15 | 900 | 74.38 | 984 | 98.90 | 1330 | 85.25 |

### TABLE 8

**ABUSER'S PERCEPTION OF THE EFFECT OF DEVELOPED VISUAL MATERIALS ON MOTIVATING FACTORS FOR CHANGES IN SUBSTANCE ABUSE BEHAVIOUR (N=2770)**

| Number of substance abusers | Urban (N=1210) | Rural (N=1560) |
|-----------------------------|----------------|----------------|
| N | % | N | % |
| Changes in substance abuse behaviour : |
| 1. Changed (left/reduced quantity) | 356 | 29.42 | 370 | 23.71 |
| 2. Not changed | 854 | 70.57 | 1190 | 76.28 |
| Motivating factors : |
| 1 Drug abuse preventive materials increased knowledge about physical problems due to substance abuse | 268 | 75.28 | 295 | 79.92 |
| 2 Increased Knowledge about social & economic consequences of substance abuse | 201 | 56.46 | 247 | 66.75 |
| 3 Created fear in the community about substance abuse |
| 1. General fear, | 152 | 42.69 | 198 | 53.51 |
| 2. Legal fear, | 286 | 80.33 | 274 | 74.50 |
| 3. Religious fear, | 345 | 96.91 | 358 | 96.21 |
| 4. Social fear | 172 | 48.31 | 190 | 93.76 |
These visual materials were then field tested in phase II of the study. The developed visual materials proved to be quite effective as against existing materials in preventing/minimizing substance abuse.

This paper is summary report of the three projects based on the applicability of social marketing concepts and principles to the problems of mental health. Too often social advertising rather than social marketing is practiced by social campaigners; examples being almost all National and State Health related campaigns. Their limited success/failure can be attributed to absence of consumer's (community) views, perceptions, and expectations in these campaigns. Social marketing differs from social advertising as it takes into account community's views in designing and developing programmes (campaigns) aimed at bringing desired social/health changes. Thus, social marketing concepts call for most of the effort to be spent on discovering the wants of the target consumers and then creating the goods and services to satisfy them. This to a great extent has been attempted by the author in developing programmes based on community's expectation to find solutions to important problems in mental health, viz. mental health care delivery services, drug treatment noncompliance in schizophrenia and substance abuse prevention. The results have been encouraging though further evaluations need to be done to substantiate the same.

A social marketing approach does not guarantee that the social/health objectives will be achieved or that the costs will be acceptable. Yet social marketing appears to represent a bridging mechanism which links the behavioural scientists knowledge of human behaviour with the socially useful implementation of what knowledge allows. It offers a useful framework for effective social and health planning at a time when these issues have become more relevant and crucial, particularly in the field of Mental Health Research as most of our approaches, aetiological considerations and therapeutic strategies to help the mentally sick involves behavioural perspectives. Social marketing has the potential to offer answers and solutions to many of these issues in the arena of mental health and therefore, its concepts and principles need to be incorporated in designing mental health research and programmes. The future of this kind of research looks promising.

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