The 'Big Picture', India: Understanding mental health research-to-policy pathways in Assam

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The candidate confirms that the work submitted is their own, except where work which has formed part of jointly authored publications has been included. The contribution of the candidate and the other authors to this work has been explicitly indicated below. The candidate confirms that appropriate credit has been given within the thesis where reference has been made to the work of others.

Details of which chapters are based on work from jointly authored publications	**Details of the publications which have been used (title, authors, date, journals)**	**Details of the work within the publications which is directly attributable to you**	**Details of the contributions of the other authors to the work**
Chapter 2 – Literature Review	Brooks, C., Mirzoev, T., and Madill, A. (2022). Use of evidence for mental health policy agenda-setting in LMICs: What can be learned from a systematic *review of reviews* of health evidence-to-policy frameworks? [Manuscript in preparation]	Literature review	Commenting on drafts of the literature review

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Abstract

The use of evidence to inform policymaking offers the best chance for actions to address the needs of the population they address, and with efficiency of public expenditure. Mental health has been recognised as a global development priority; and in Assam stakeholders have identified the need for a standalone state mental health policy. Therefore, this PhD aimed to create an in-depth understanding of the extent, and ways, in which research evidence informs the mental health policy agenda in Assam.

A *review of reviews* was conducted to understand current knowledge on key theories and frameworks for evidence-informed health policymaking and explore their applicability to mental health agenda-setting in LMICs. A resultant conceptual meta-framework specific for mental health agenda-setting in LMICs was developed, then applied to, and refined through, empirical application to the case study of Assam using: semi-structured interviews, observations, an online survey, and document analysis.

A key finding was that informal evidence (based upon personal experience) needs to be considered in addition to formal research evidence, to reflect the available evidence, and accordingly the scope of this study was expanded. Furthermore, as often considered, it was found policymakers should not be the only key users of evidence; stakeholders agreed the agenda should be co-created to reflect community priorities and needs. Reflecting the broader range of evidence and actors, more diverse approaches to strengthening the use of evidence are likely to be useful, including community-targeted approaches. Whilst evidence is critical, agenda-setting is complex, and evidence cannot be considered in isolation. Therefore, approaches that indirectly strengthen the use of evidence, by creating a conducive environment, are needed in addition to direct approaches which focus on the evidence itself. Further research should explore the potential approaches proposed and evaluate their effectiveness.

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Abbreviations

AYUSH = Ayurveda, Yoga and Naturopathy, Unani, Siddha, Sowa-Rigpa and Homeopathy

BeHEMoTh = Behaviour of interest; Health context; Exclusions; Models or Theories

DALYs = Disability-adjusted life years

EVITA = EVIdence To policy Agenda setting

GDP = Gross Domestic Product

GRADE-CERQual = Grading of Recommendations Assessment, Development, and Evaluation - Confidence in the Evidence from Reviews of Qualitative research

HIC(s) = High-income country(ies)

HMIS = Health Management Information System

HIV = Human Immunodeficiency Virus

HPSR = Health Policy and Systems Research

KT = Knowledge Translation

LGBRIMH = Lokopriya Gopinath Bordoloi Regional Institute of Mental Health

LMIC(s) = Low- and Middle-Income country(ies)

MDGs = Millennium Development Goals

MOBCs = More Other Backward Classes

n.d. = no date

NGOs = Non-governmental Organisations

NIMHANS = National Institute of Mental Health and Neurosciences

NMHS = National Mental Health Survey

OBC = Other Backward Classes

PTSD = Post-Traumatic Stress Disorder

SDG(s) = Sustainable Development Goal(s)

STs = Scheduled Tribes

UN = United Nations

WHO = World Health Organisation

YLDs = Years Lived with a Disability

YLLs = Years of Life Lost

CHAPTER 1: INTRODUCTION - The need to explore the role of evidence for mental health policy agenda-setting in Assam

Firstly, this chapter will provide the rationale for this thesis by arguing the of importance evidence-informed policymaking. Secondly, the key concepts of 'policymaking' and 'evidence' will be explored. Thirdly, the reasons for selecting mental health agenda-setting in Assam as a case study will be detailed. Fourthly, the research question, aims and objectives of this PhD will be stated. In short, this study aims to create an in-depth understanding of the extent and ways in which research evidence informs the mental health policy agenda in Assam. Lastly, contextual background will be provided.

1-1. The importance of evidence-informed health policymaking

Evidence-informed policymaking occurs when governments base their plans on the highest quality available information (Brownson et al., 2009; Green & Bennett, 2007). The use of evidence to inform policymaking offers the best chance that actions address the needs of the population and with efficiency of public expenditure (Allen, 2017). Meeting needs effectively and thriftily is particularly important in low resource settings. However, in developing countries there is a dearth of research on many key topics relevant to government planning, including health provision and the creation of health policy (Martin et al., 2019), which therefore raises the opportunity and the need for diversifying the types of evidence to inform policy decisions beyond just formal research.

With regards to health, it follows that evidence-informed policy can lead to population level improvements in physical, mental, and social wellbeing (Brownson et al., 2009). However, there is often a significant gap between health research and policy (Martin et al., 2019). Research is an important component of evidence, and often considered to be the highest quality evidence. The research to policy gap is often compounded by a research gap (Yegros-Yegros et al., 2020). Evidence-informed policymaking may not happen due to the absence of evidence, or the failure to utilise evidence.

The Mexico Ministerial Health Summit, held in 2004 by the World Health Organisation (WHO) in Mexico City, was a key landmark in the field of health systems and policy research (HSPR) (Bennett, et al., 2018). The Summit highlighted the evidence-to-policy gap as an area where action was needed (Ministerial Summit on Health Research, 2004). It reflected and amplified the calls for more attention to be given to the utilisation of evidence in health policymaking. The effects of the Summit have been

seen in an increase in the number of studies which specifically focus on the role of evidence in health policymaking (Hanney & González-Block, 2017).

Whilst evidence-informed policymaking is seen as the gold standard in policymaking and something to be aspired to (Oliver et al., 2014) it should be acknowledged there are limitations to what research can offer policymaking. For instance, it is rarely able to provide an answer per se of what the right solution is for a particular problem, what the desired outcomes of a successful policy are, or determine which issues should be higher up the agenda (Greenhalgh & Russell, 2009; Kemm, 2006). Value-judgements are also required; the values of society must be taken into consideration when deciding which issues are the most important, or what is the most desirable outcome. However, evidence still has an important contribution to make to the policymaking process.

The problem, therefore, is that there is often a gap between policy and evidence, meaning that policies are less effective than they perhaps could be, as evidence-based policies are understood to lead to better outcomes (Sutcliffe & Court, 2005). Although there are limitations to what evidence-informed policymaking can achieve, narrowing the research to policy gap is important in order to best meet the health needs of a population in a cost-effective manner.

1-2. Key concepts: policymaking and evidence

Policymaking and evidence are two important concepts for evidence-informed health policymaking and will be defined and explored in more depth.

1-2.1 Policymaking

Policymaking will be further distilled, with the ‘policy’ component first considered before integrating this into a discussion of policymaking.

There is no fixed definition for ‘policy’ that emerges from the field of political science, and a variety of definitions have been proposed. Some scholars simply define policy as the ‘the plan’ or ‘the law’ (Breton & De Leeuw, 2010), that enters the public domain. Dye defined policy as “Anything a government chooses to do or not to do” (Dye, 1972, p. 2). This definition recognises government as the actor, and that both action and inaction constitute a policy response. A more extensive definition has been put forward by (de Leeuw et al., 2014, p. 2) defining policy as "the expressed intent of government to allocate resources and capacities to resolve an expressly identified issue within a certain timeframe".

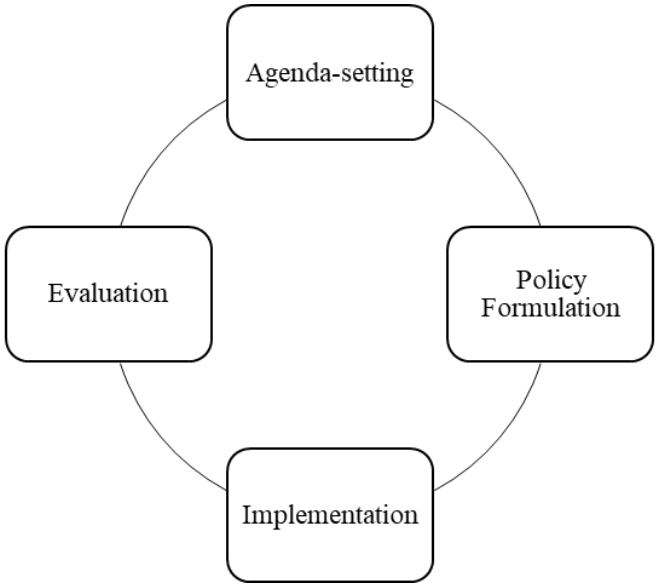
The above definitions focus on policy at a governmental level. A distinction has been noted between so-called “big P” and “little p” policies (Brownson et al., 2009). “Big P” policies refer to those made by elected governments, including formal policies, laws, rules, and regulations. On the other hand, “little p” policies concern those at an organisational level, such as organisational guidelines and internal decisions. Anderson (1997, p. 10) proposed the definition “a purposive course of action followed by an actor or a set of actors in dealing with a problem or a matter of concern”, which names no specific actor and could therefore include both “big P” and “little p” policies. Furthermore, the process is considered to be goal-orientated towards resolving a specific issue.

Despite the variety among the definitions in use, the following definition could be considered to capture most of the common elements of the definitions in use and the different types of policies recognised: an issue to be solved, the choices, and the proposed action to resolve the issue.

It therefore follows that ‘health policy’ aims is to improve physical, mental, and social wellbeing at the population level (de Leeuw, 1989). For example, the WHO defines ‘health policy’ as referring to “decisions, plans, and actions that are undertaken to achieve specific health care goals within a society.” (WHO, n.d., para 1).

Policymaking is the process of how policies are developed. The Stages Heuristic Model developed by Lasswell (1956) is the prevailing conceptualisation of the policymaking cycle (Walt et al., 2008). Four stages are posited: agenda-setting, policy formulation, implementation, and evaluation. Together these form the policymaking cycle, which is depicted in Figure 1. Agenda-setting is where an issue receives attention and priority, amongst a backdrop of various competing issues (Sutcliffe & Court, 2005; Sutcliffe & Court, 2006). Policy formulation is where different policy solutions are determined, and the preferred option is selected. The activities of the policy are carried out in the implementation stage. During the evaluation stage the process and impact of the policy is monitored and assessed.

Figure 1. The policymaking cycle.



The diagram uses lines instead of arrows, to indicate that the process is multi-directional and that the stages can occur non-sequentially and concurrently. This non-linear model of the policymaking cycle better reflects the messy nature of the real-world policymaking process than the simple policymaking cycle (not depicted). This helps address the criticism sometimes levelled at this policymaking cycle around the fact that policymaking does not always occur in distinct stages in practice (Hallsworth, 2011). Although the policymaking cycle, is the predominant model used for explaining the process of policymaking, it should be noted other models have been developed as alternatives. The policymaking cycle is a useful conceptualisation, in part due to its simplification. However, this can also be viewed as a limitation as it is not necessarily discrete in practice. Each stage of the policymaking cycle represents different processes that seek to achieve different outcomes. Consequently, the role of evidence in each of the four stages is different (Sutcliffe & Court, 2005). Table 1 shows the different types of evidence and the characteristics of evidence suggested to be particularly important for each stage of the policymaking cycle.

Table 1. The role of evidence in the different stages of the policymaking the cycle (based on (Sutcliffe & Court, 2005)).

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1-2.2 Evidence

To understand the role of evidence in policymaking the term 'evidence', and related terms which are often used including 'research' will now be discussed.

Different conceptualisations of evidence, and its related terms, are used within the health literature (Scott-Findlay & Pollock, 2004). The definitions presented in Table 2 will be used as a starting point for this study. 'Research evidence' is also commonly used, denoting a subset of evidence to differentiate from non-research evidence, for example, expert opinion (Innvaer et al., 2002). Much of the literature of the use of evidence in health policy focuses specifically upon research evidence (Oliver et al., 2014).

Whilst academic researchers are likely to use the definitions in Table 2 in some form, stakeholders outside academia may define these terms differently, and hence this study will also explore how evidence can be conceptualised. Previous research has found policymakers tend to consider 'evidence' as a broad concept, incorporating opinion-based components, such as public consultations (Sohn, 2018). Similarly, both frontline and management staff from public health departments have been found to use a broad definition of evidence, which encapsulates both research and less formal data (such as stories and prior experiences) (Higgins et al., 2011). There was also some variation found between how frontline staff and management defined evidence; frontline staff more frequently mentioned community-level process information as key pieces of evidence as opposed to research evidence (Higgins et al., 2011).

Table 2. The definition of 'evidence' and its related terms.

Term	**Definition**	**Types**
Data	Unprocessed facts.	/
Information	A set of data which is processed and organised in a useful way.	/
Knowledge	Information in the public domain becomes knowledge once it has been up taken by an individual and integrated with their experiences and beliefs (Scott-Findlay & Pollock, 2004).	• Explicit – can be codified; • Tacit – cannot be codified (therefore difficult to transfer).
Research	Any creative, systematic activities carried out to expand the body of knowledge, and the utilisation of this knowledge to concoct new applications (OECD, 2008).	• Quantitative; • Qualitative; • Mixed methods.
Evidence	Knowledge generated from a range of sources that has been demonstrated to be credible (Higgs et al., 2001).	• Indicates a need for something to be done; • Demonstrates what needs to be done; • Demonstrates how something should be done (Rychetnik et al., 2004).

1-3. Mental health policymaking in Assam

This PhD will explore the role of evidence in policymaking specifically for mental health policy in Assam. There were several factors behind the rationale for selecting this focus area.

1-3.1 Why mental health?

Mental health is defined by the WHO (2004, p. 10) as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". Recognised as a global development priority (Patel et al., 2018), mental health policy provision is receiving greater attention, particularly in the context of LMICs. This is demonstrated by the inclusion of mental health within the Sustainable Development Goals (SDGs) (United Nations, 2015). Targets (3.4 and 3.5) for SDG3 'Good Health and Well-Being' mark significant progress in the prominence of mental health compared to the preceding Millennium Development Goals (Mills, 2018):

- Target 3.4 "By 2030, reduce by one third premature mortality from Non communicable diseases through prevention and treatment and promote mental health and well-being";
- Target 3.5 "Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol." (United Nations, 2015).

The inclusion of mental health within the SDGs should reinforce the growing momentum and result in increased attention, and therefore action, on mental health where urgent solutions are needed (Thornicroft & Votruba, 2016). There is additional recent focus on mental health due to the COVID-19 pandemic (Torales et al., 2020) and this presents an opportunity to advance mental health policymaking (Goldman et al., 2020). Hence, this study's focus on mental health is timely and needed due to the currently acknowledged global importance and historical neglect on this subject.

Mental health is responsible for a large proportion of the global burden of disease. Mental and addictive disorders are estimated to affect in excess of 1 billion of the world's population (Rehm & Shield, 2019), and are responsible for 32% of all years lived with disability (YLDs), and 13% of disability-adjusted life years (DALYs)[1] (Vigo et al., 2016). In addition, the relative share of mental and addictive disorders has grown in recent years (Rehm & Shield, 2019). Consequently, this has led for calls for mental health to be raised on the policy agenda (Gil-Rivas et al., 2019); many developing

[1] According to the (World Health Organization, 2022b), "one disability-adjusted life year (DALY) represents the loss of the equivalent of one year of full health. DALYs for a disease or health condition are the sum of the years of life lost to due to premature mortality (YLLs) and the years lived with a disability (YLDs) due to prevalent cases of the disease or health condition in a population".

countries do not have a stand-alone mental health policy (WHO, 2018). Effective evidence-informed agenda-setting can be particularly instrumental in bringing and maintaining mental health as a priority policy issue.

Progress in establishing evidence-informed mental health policy tends to be behind that of wider health policy (Williamson et al., 2015). For example, in Commonwealth countries with a mental health policy, only 8% refer explicitly to within-country data and to research that informed policy development (Bhugra et al., 2018). The mental health evidence-to-policy gap, referring to the translation of evidence into policy, is in part, due to the widely documented lack of mental health evidence (Mackenzie, 2014; Omar et al., 2010; WHO, 2018), universal but most acute in LMICs (Saraceno & Saxena, 2004). However, in addition the research that exists is often not being used to inform policy in LMICs (Wei, 2008; Williamson et al., 2015).

Acknowledging such issues, the WHO has summarised the problem of a lack of evidence-informed policymaking for mental health: "A lack of urgency, misinformation, and competing demands are blinding policy-makers from taking stock of a situation where mental disorders figure among the leading causes of disease and disability in the world" (WHO, 2001, para. 6).

1-3.2 Why India?

India, located in South Asia, was chosen as the country for this case study because of the significance of India in terms of the global problem of mental health. In India, mental disorders affect one in seven people, which equates to 15% of the global disease burden from the mental, neurological, and substance use disorders (Charlson, Baxter, Cheng, Shidhaye, & Whiteford, 2016). There is a large treatment gap[2] which ranges from 28% to 86% for mental health disorders, with at 86% for alcohol use disorder at the highest end of this range (Gururaj et al., 2016c), further highlighting the magnitude of the issue of mental health in India. Furthermore, it is thought the problem is growing. According to one analysis, the proportion of the total disease burden attributable to mental disorders has nearly doubled over the last two decades; in 1990 2.5% of the total DALYs in India were due to mental disorders, by 2017 this had risen to 4.7% (Sagar et al., 2020).

Alongside the growing burden of mental health, in India psychiatry is a specialty that is not viewed in particularly high regard (Prasad, 2016), contributing towards the low number of psychiatrists in India

[2]The treatment gap is defined as "the number of people with active disease who are not on treatment or on inadequate treatment and is expressed as a percentage of the total number of people with active disease" (Gururaj et al., 2016b, p. 121).

for treating mental health. This has led to calls for mental health to be made a priority in India (Milner, 2016).

However, despite the challenge that the issue of mental health in India poses, simultaneously, the global momentum on action for mental health is being mirrored in India (Lahariya, 2018). In 2014, the Ministry of Health and Family Welfare of the Government of India introduced the country's first National Mental Health Policy. This suggests that this study has the potential to make a positive contribution to the knowledge base in this area.

India is classified as a lower-middle-income economy (World Bank, 2020). In LMICs, mental health and poverty interact to result in a vicious reinforcing cycle (Lund, De Silva, et al., 2011; Patel & Kleinman, 2003). Poverty, and other social, structural and environmental determinants of mental health make certain populations more at risk of challenges to mental health (WHO & the Calouste Gulbenkian Foundation, 2014). Poor mental health then further traps individuals, families, and communities into poverty due to inability to work and the need for care (Lund, De Silva, et al., 2011). Generating a more in-depth understanding of the role of evidence in mental health policymaking in India, should enable use of the best available evidence in mental health policy, and ultimately should lead to improved mental health outcomes and a reduction in the level of poverty.

1-3.3 Why Assam?

The State of Assam, in northeast India (shown in red in Figure 2), was chosen as the specific geographical area of focus for this study. Selection of a state within India made sense as an approach for this study as although the federal government sets national health policy in the country, the Indian Constitution accords primary responsibility for healthcare, including public health, to state governments.

Figure 2. Map showing the location of the State of Assam in India (Source: (Wikimedia Commons contributors, 2017) - CC BY-SA 4.0).

There were five main reasons which underpinned the rationale for focusing on Assam for this study:

1) its inclusion in India's most recent National Mental Health Survey;
2) despite recommendations, a lack of standalone mental health policy;
3) the consequent potential for the role of evidence in informing mental health policymaking to be strengthened;
4) importance of effective policies given the poor economic performance of Assam.
5) the Big Picture project

1-3.3.1 Inclusion of Assam in the National Mental Health Survey

Out of the 29 states that constitute India, 12 were included in the National Mental Health Survey, which took place between 2015-16 (Gururaj et al., 2016c). As part of the National Mental Health Survey, a dedicated Assam State Report was produced (Pathak et al., 2017). The availability of this data is important given the lack of mental health research in India (Ransing et al., 2021) for this study to explore the role of evidence for informing mental health policy.

1-3.3.2 Lack of a standalone state mental health policy

Currently, the State of Assam does not have a standalone mental health policy, meaning it is at the agenda-setting stage of the policymaking cycle shown in Figure 1. Importantly, the Assam State Report of the National Mental Health Survey recommended a comprehensive state mental health policy in line with national policies (Pathak et al., 2017). This Report was commissioned by the Government of India, indicating the recommendation has a strong steer from the National

Government and local stakeholders. Consequently, the recommendation for a state mental health policy makes it a useful time to conduct this study; the recommendation would suggest that there is a window of opportunity to study mental health agenda-setting in action.

1-3.3.3 Potential for the role of evidence to be strengthened

According to the 2015-16 National Mental Health Survey, "(m)ental health activities at the state level are not information driven" (Gururaj et al., 2016c, p. 31). Furthermore, the report states that, "(w)hile the information available at the state level was grossly inadequate, even the available data was of limited help; decisions taken were rarely based on information" (Gururaj et al., 2016c, p. 31). This is an example of a key stakeholder identifying a need to strengthen the use of evidence in mental health policymaking. This highlights the importance of developing an enhanced understanding of the role of evidence in mental health policymaking at the state level in Assam and to explore ways in which this could be strengthened.

1-3.3.4 Poor economic performance of Assam

A further reason for the selection of Assam for this study is that evidence-informed policymaking helps address the needs of the population and maximises the effectiveness of public expenditure. This is of great importance in Assam because Assam remains less economically developed than many other states in India. Assam is characterised as having a "lagging" economy, given its low average level of income and its slow economic growth (the slowest of the 19 larger states in India) (World Bank, 2017). Additionally, Assam has a high level of income inequality (World Bank, 2017).

1-3.3.5 The Big Picture Project

The Global Challenges Research Fund 'Big Picture' project commenced in 2018, focusing on understanding the lived experience of young Assamese people around risk, recovery and resilience in relation to substance use and mental health using participatory visual methods. Again, an increased research focus on mental health in Assam meant an exploration of the role of evidence in mental health policymaking timely. In addition, there would be the potential to provide useful and actionable insights for the 'Big Picture' project team as to how best to communicate their findings. Importantly, as the PhD researcher is not from India, the project team, partners, and network facilitated the research by providing practical assistance and providing introductions to key stakeholders.

1-4. What this study sought to achieve

This section will define the research question, aim and objectives. Building on these, the expected outputs will be outlined.

1-4.1 Research Question, Aim, and Objectives

The **research question** for this study was: *To what extent, and in what ways, does research evidence inform the mental health policy agenda in Assam?* Hence, the **aim** was to create an in-depth understanding of the extent and ways in which research evidence informs the mental health policy agenda in Assam. The **objectives** were to:

1) understand current knowledge on key theories and frameworks for evidence-informed health policymaking and explore their applicability to mental health agenda-setting in LMICs;
2) undertake a stakeholder analysis for mental health agenda-setting in Assam, and develop an understanding of the key actors and their roles;
3) identify and analyse the processes and approaches for mental health-related agenda-setting in Assam through an analysis of the literature and through interviews with key stakeholders;
4) identify effective research-policy pathways for mental health agenda-setting in Assam.

This PhD, whilst a distinct study, was a part of the Global Challenges Research Fund 'Big Picture' project. A further implicit objective was that the findings of this PhD would support the Big Picture project to effectively target the communication of new research evidence to key stakeholders and to help plan policy-directed activities. The 'Big Picture' project focuses on understanding the lived experience of young Assamese people around risk, recovery and resilience in relation to substance use and mental health using participatory visual methods. The overall goal of the Big Picture project is to increase knowledge, enhance the voice of young people, and inform practice. PhotoVoice is an evolving method of inquiry that incorporates still and moving images created by the participants. It will centralise the lived experience of young people, conveyed by them, in efforts to understand, prevent and intervene at both a service and policy level, in substance use related mental health difficulties in India.

1-4.2 Outputs

The **outputs** this study expected to produce through successful completion of the objectives were:

1) a *review of reviews* of the key frameworks to help explain, assess and strengthen the use of evidence in health policymaking;

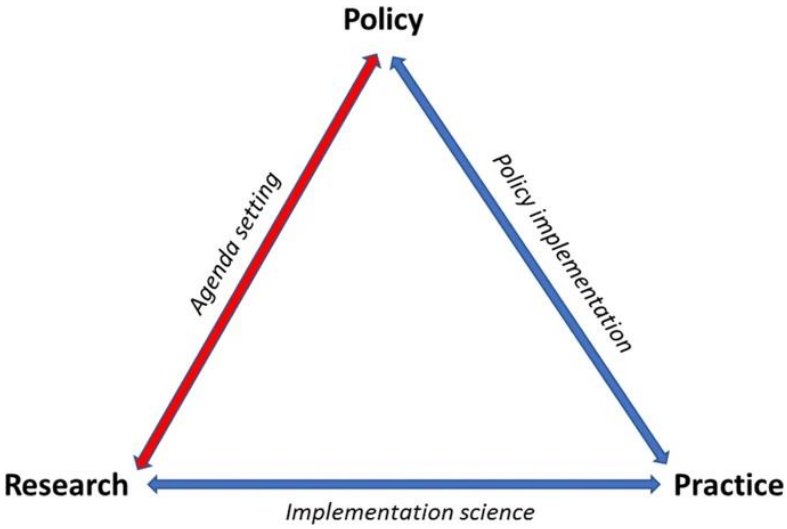
2) a stakeholder map for mental health policymaking in Assam;
3) a conceptual framework of the role of evidence in mental health policymaking in Assam, based on the literature and interviews with key stakeholders; and
4) a research-policy pathways map for mental health policymaking in Assam.

1-4.3 Scope

The research question, aim, and objectives of this PhD focused specifically on 'agenda-setting', rather than 'policy' or 'policy and practice'. The justification for this will now be set out.

This study takes policy to mean 'an issue to be solved, the choices of the government, and the proposed action to resolve the issue', as discussed in section 1-2.1. Practice is interpreted as being the enactment, or implementation, of these action plans. 'Policy' is often considered together alongside 'practice' when considering the role of evidence (e.g. Bowen & Zwi, 2005), or research (Votruba, Ziemann, Grant, & Thornicroft, 2018), the latter as shown in Figure 3, below. This diagram is a simplification, and the links between policy, practice, and research are complex. While policy and practice represent distinct processes, they lie on a continuum, and are interrelated. This PhD primarily focused on how evidence informs policy as it was not feasible within this PhD to adequately consider practice in addition to policy, however it is not possible to completely isolate policy from practice.

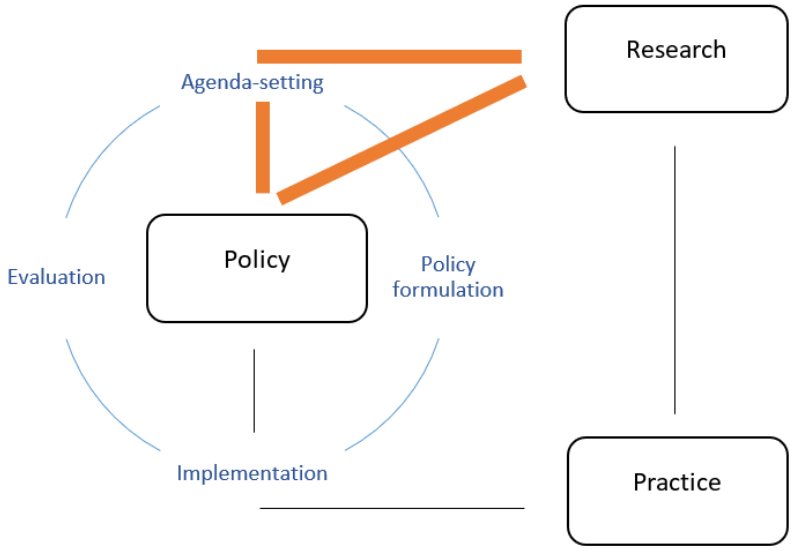
Figure 3. The research, policy, and practice triangle (taken from (Votruba et al., 2018) - CC BY 4.0).



Specifically, this PhD concentrated on the agenda-setting stage of the policy process. The reason this focus area was chosen was because it most accurately reflects the current state of progress in Assamese mental health policymaking: the State of Assam does not yet have a standalone mental health policy (Gururaj et al., 2016a). The stages of the policy cycle are, however, not necessarily

mutually exclusive, and so there was naturally some inclusion of the other stages of the policy cycle in this study. Figure 4 shows how the policymaking cycle (Figure 1) can be combined with the research, policy, and practice triangle (Figure 3). Figure 4 clearly demarcates the boundaries of this study, shown by the orange triangle encompassing policy, research, and agenda-setting.

Figure 4. The policymaking cycle contextualised within the evidence (research), policy, and practice triangle.



1-5. Contextual background of mental health policy Assam

1-5.1 Policymaking in Assam

India is a federal republic and has a parliamentary democracy where power is distributed between the central and state governments. Although the national government sets national health policy and provides support to the states, state legislatures have the power for law-making on health and hold the responsibility for the provision of health services to their populations (Mossialos et al., 2017). The Ministry of Health and Family Welfare is responsible for national health policy in India. The national government launched India's first national mental health policy in 2014 (Government of India, 2014).

The State of Assam is yet to have a dedicated mental health policy (Gururaj et al., 2016a). Mental health has to date been included under the broader category of public health by the Government of Assam. Most notably, the Assam Public Health Act 2010, which came into effect in January 2011, outlined the obligations of the State Government in the Health and Family Welfare Department to "take appropriate legal steps to[…] specifically address the following[…] mental illness" ("The Assam Public Health Act," 2010, Chapter II, 4(I), pp. 988-989).

1-5.2 The health system in Assam

India has a complex health system consisting of a mixture of public and private provision. Government spending on health is low; health constituted only 3.5% of gross domestic product (GDP) in 2018 (World Bank, 2019). This has increased little since the 2000 figure of 3.4% and is not in line with the political declaration made at Universal Health Coverage High Level Meeting in New York in September 2019 where countries reaffirmed a commitment to increase health spending by at least 1% of GDP. Correspondingly, out-of-pocket health expenditure is high, constituting 54.8% of total health expenditure in 2019 (WHO, 2022a). This situation arises because only 15% of the population have health insurance (Pandey et al., 2018). Within India, Assam has one of the highest proportions of out-of-pocket spending on health (Devi, 2019). This is especially poignant for low-income groups who may face catastrophic health expenditure[3].

The health system in Assam operates under and alongside the national health system. In 2016, 79% of health expenditure in Assam was private expenditure, almost identical to the national average of 80% (Paul et al., 2019). The national and state, as well as district and primary healthcare centre levels, interact in myriad ways. Another complexity to the health system in India is the alternative systems of healthcare are recognised by the Government of India in addition to allopathic medicine, overseen by the Ministry of AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha, Sowa-Rigpa and Homeopathy).

The level of expenditure can be taken as an indicator of the priority of healthcare to a state. In 2014-15 state health expenditure in Assam was 5.2%: slightly below the national benchmark of 6%. However, in recent years, Assam has been recognised as making the largest improvement in state health spending across India (Berman et al., 2017). However, despite this growing investment, state spending on health has fallen behind the *total* increase of expenditure of the State of Assam (Dutta, 2018).

Despite recent increases in state health spending in Assam, indicators suggest that the health system in Assam does not perform as well as that of other states[4]. For instance, Assam was estimated to have the second highest rate of under-five mortality per 100,000 live births of all the states in India in 2017 (Dandona et al., 2020).

[3] Catastrophic health expenditure refers to financial hardship caused by health payments, or "out-of-pocket payments that are especially large relative to a family's total income or consumption" (Wagstaff et al., 2018, p. 169). Here these were defined as "whether an individual is incurring a catastrophic expenditure exceeding 10 percent of total consumption expenditure of the households or not" (Devi, 2019).

[4] Under-five mortality is considered a key indicator of the performance of a health system because the causes of death among this age group tend to reflect level of access to basic health interventions of the whole community (United Nations, 2018).

1-5.3 The mental health system in Assam

In Assam, the Department of Health & Family Welfare has the remit for mental health within the Directorate for Health Services. The Department of Sports & Youth Welfare and the Department of Social Welfare also cover relevant areas of mental health, youth mental health and substance abuse, respectively.

Prevalence of mental, behavioural and substance use disorders has been identified as a major public health issue in Assam (Pathak et al., 2017), in line with India as a whole. Interestingly, of the 12 states included in the National Mental Health Survey of India 2015-2016, Assam has the lowest current prevalence of mental disorders: 5.8% against the national figure of 10.6%. However, there is a large treatment gap reported of 82.6% (Pathak et al., 2017), and the consequent economic impact of mental disorder in the state is significant (Chaturvedi et al., 2016; Pathak et al., 2017). While mental health-related activities do occur, most likely due to the lack of a state-wide mental health policy, these activities tend to be fragmented and, often, are poorly organised (Pathak et al., 2017).

The number of mental health workers per 100,000 population can be used as an indicator of the performance of a mental health system. Although the estimates are from different sources and may not be directly comparable, Assam has 0.55 mental health workers per 100,000 population (Pathak et al., 2017), fewer than 1.93 for India as a whole (WHO, 2018).

1-5.4 Stigma and conflict

In Assam stigma and conflict are important considerations for mental health.

Mental health remains a sensitive issue, with high levels of stigma reported in Assam (Pathak et al., 2017), reflecting the picture across India (Gururaj et al., 2016b), other LMICs (Javed et al., 2021) and globally (Sartorius, 2007). Stigma can be defined as the social injustice that individuals with mental illness, and their families, experience in terms of stereotypes, prejudice and discrimination (Corrigan & Bink, 2016). Public stigma, defined as stigma enacted by society, can be internalised when individuals apply this stigma to themselves, and institutionalised, resulting in structural stigma (Corrigan & Bink, 2016). In India, traditional beliefs, which include the idea that mental health challenges can be caused by black magic and that there is no medical cure (Gururaj et al., 2016b), have been reported to contribute to the levels of stigma seen.

In Assam, stigma stemming from these traditional beliefs has been reported in the form of the use of derogatory terms (Pathak et al., 2017). Such negative language and descriptions are also used by the media and in public discussions. The media is seen as “stereotyped, judgmental, insensitive and non-

compassionate" (Pathak et al., 2017, p. 25) towards people suffering mental health challenges. As a result, individuals with mental illness are reported to often socially isolate themselves.

Different levels of stigma have been reported across different demographic groups within Assam. Higher levels of stigma and discrimination have been shown to be exhibited by men compared to women, those in older age groups than younger age groups, and in urban as opposed to rural areas (Borooah & Ghosh, 2017). Interestingly, negative attitudes do not necessarily correlate with knowledge and exposure to people with mental health problems. That is, men had lower levels of knowledge and exposure; however older people had higher levels of knowledge and exposure, and those in an urban setting had the same levels as those in rural settings. These findings have implications for initiatives seeking to reduce stigma related to mental health issues.

The pervasive stigma surrounding mental health has been proposed to be a key barrier to the use of evidence for mental health policymaking (Botticelli, 2019). It is likely that policymakers are influenced by their own personal perceptions (Corrigan & Watson, 2003), and stigma around mental health, which is often implicit, may affect the decisions they make.

Unfortunately, Assam has been troubled by conflict for many decades (Rajbangshi et al., 2021). There is a rich diversity of ethnicities in the state, and tensions between ethnicities have led to ethnic-conflict. Large-scale internal and international migration, particularly from neighboring Bangladesh, has been reported to have created anxiety among the smaller indigenous communities (Sharma, 2012). The issue of migration has been recently re-ignited by the Citizenship Amendment Act (2019) which makes it easier for some non-Muslim migrants to gain citizenship, and the National Register of Citizens for Assam, a list of those who can prove their citizenship and thus help identify illegal migrants. In 2019 protests against the bill led to curfews being imposed and the death of five protesters (Doley, 2020). The high burden of mental health disorders in populations affected by conflict has been well-documented (Charlson et al., 2019). Whilst the trend has been an overall decline in the level of conflict in recent years, the reverberations are long-lasting, and poses another challenge to mental health, and mental health policy in Assam.

CHAPTER 2: LITERATURE REVIEW - Use of evidence in mental health policy agenda-setting in low- and middle-income countries: a systematic review of reviews and proposed conceptual framework

A *review of reviews* was conducted to understand current knowledge on key theories and frameworks for evidence-informed health policymaking and explore their applicability to mental health agenda-setting in LMICs. Based on the findings of the review, a conceptual meta-framework specific for mental health agenda-setting in LMICs was developed. In later chapters, this framework will be applied to, and refined through, empirical application to the case study of Assam.

2-1. Abstract

Agenda-setting for mental health is highly relevant and of increasing significance; many countries are currently establishing and implementing mental health policies, and the importance of mental health and evidence-informed agenda-setting have been particularly highlighted by the on-going COVID-19 pandemic. Multiple frameworks exist for understanding, strengthening, and assessing the role of evidence in health policymaking, including to some extent the agenda-setting stage. However, there is paucity of frameworks specifically for mental health agenda-setting in low- and middle-income countries (LMICs), which has often been treated as a distinct policy issue to physical health. A systematic *review of reviews* of evidence-to-policy frameworks was conducted to explore their applicability for evidence-informed agenda-setting for mental health policies in LMICs. A meta-framework was consequently developed, comprising of four factors relating to evidence: the nature of evidence; the perception of evidence; demand and supply; and the use of evidence. These were linked to four other concepts (actors, context, process, approach) and four cross-cutting dimensions (politics and power; capacity; trust and relationships; and beliefs, values and interests). Two key recommendations were developed for application of this framework in examining and improving evidence-informed mental health agenda-setting in LMICs. First, there is a need for a greater focus on informal evidence (based on personal experience such as expert advice and community narratives) and formal evidence is often less abundant particularly for mental health agenda-setting. Furthermore, the only framework aimed at mental health agenda-setting in LMICs identified in development exclusively focuses on formal research evidence. Second, there is a need for the inclusion of broader range of stakeholders in agenda-setting, particularly local communities given the marginalisation and

stigmatisation surrounding those affected by mental health. This can also enhance the use of informal evidence in the agenda-setting.

2-2. Introduction

Headway is being made in conceptualising the intricate relationship between evidence and policy (Smith & Joyce 2012). Theory is particularly useful for health systems and policy research due to the complexity of the phenomena under investigation (Gilson, 2012). Specifically, frameworks can provide a structure within which to organise and describe the relationship between variables (Nilsen, 2015). Moreover, frameworks provide a scaffold on which theory can be synthesised and summarised to aid application (Kivunja, 2018).

An initial scoping search revealed that there are multiple frameworks, and reviews of frameworks, for understanding, strengthening, and assessing the role of evidence in health policymaking. Yet only one framework was developed specifically in relation to mental health agenda-setting in LMICs: the EVITA (EVIdence To policy Agenda setting) framework (Votruba et al., 2020, 2021). However, EVITA has a narrow remit and focuses on research evidence. Evidence comes in a multitude of forms including both formal evidence produced by scientific research, such as academic studies and national surveys, as well as informal evidence based upon personal experience, such as expert opinion and community narratives (Mirzoev et al., 2017; Mirzoev et al., 2013).

Abimbola (2021) argued that recognising only published academic literature is a barrier to achieving equity in global health, as this formal evidence is not necessarily aligned with this goal. Similarly, it could be argued that a pure focus on formal mental health evidence may prevent effective agenda-setting for mental health. The primary aim of the academic literature is to discover universal truths and build a shared knowledge pool (Abimbola, 2021). But for informing agenda-setting, revealing particular truths for particular contexts should take precedence before testing universal applicability. Formal research often distils, and therefore potentially distorts, complex realities. Furthermore, most relevant knowledge resides outside formal channels, for example with individuals and organisations at the grassroots level, thus highlighting the importance of informal evidence. Hence, in the current article, we are interested in the full range of relevant evidence.

EVITA has been tested empirically but has been applied only to the South African context (Votruba et al., 2021). Context is especially important in relation to mental health (Montenegro & Ortega, 2020) given heterogeneity of local understandings and implications (Krendl & Pescosolido, 2020), including stigma (Gopalkrishnan, 2018). Votruba et al. (2018) argued that frameworks from other health/policy areas can offer lessons for strengthening the role of evidence in mental health agenda-setting in LMICs and the value of synthesising learning across settings in relation to evidence-informed

policymaking has been demonstrated (Langlois et al., 2016). Hence, it is appropriate to survey frameworks from the wider health policy literature for insights (Buse, 2008). However, the insights from general health frameworks and frameworks from other areas are limited as they do not capture the unique context of mental health policy and evidence use. Mental health is an extremely broad policy area, with 'mental, neurological and substance use disorders' encompassing a wide range of policy issues that often require cross-sectoral solutions (Mackenzie, 2014; Votruba et al., 2018). Evidence for mental health is highly divergent, with a lack of global consensus on the classification, cause and treatment of mental health (Mackenzie, 2014). In this study we review applicability of current theorisations and frameworks for evidence-informed policy agenda-setting to mental health.

In summary, the aim of this article is to report results of a *review of reviews* of evidence to health policy frameworks to glean insights into mental health agenda-setting in LMIC. Our review sought to answer the following research question: What can be learnt from health evidence-to-policy frameworks for the use of evidence in mental health agenda-setting in LMICs? Based on our review, we propose a meta-framework for the role of evidence in agenda-setting for mental health policymaking in LMICs.

2-3. Methods

2-3.1 Review of reviews approach

Given the existence of multiple reviews of health evidence-to-policy frameworks (e.g. Graham, Tetroe, & Group, 2007; Ward, House, & Hamer, 2009), for efficiency instead of conducting a systematic review of primary sources we conduct a *review of reviews*. We conducted a systematic *review of reviews* (Smith et al., 2011), also referred to as an 'overviews of reviews' (Hunt et al., 2018) or an 'umbrella review' (Aromataris et al., 2015). Systematic reviews of reviews are a newly established and distinct form of evidence synthesis which aims to integrate the findings of different reviews on the same topic (Oliver et al., 2014). Comparing and contrasting the findings of individual reviews enables assessment of the consistency of research findings, identification of ambiguities, and discovery of insights adding value beyond restating previous findings (Hasanpoor et al., 2019). Reviews of reviews are particularly beneficial where there are multiple reviews of the same topic that differ in quality, scope, and exact focus. To our knowledge, the reviews of reviews published to date have been on empirical studies. Ours is therefore likely the first providing a review of framework reviews. Our approach allows us to identify relevant theories, assess their importance, and to offer a synthesis with respect to evidence to health policy frameworks to glean insights into mental health agenda-setting in LMICs (Campbell et al., 2014).

2-3.2 Search strategy

2-3.2.1 Database selection

Four health-related academic databases were searched in November 2018 with alerts for later relevant publications until October 2020: Medline, Global Health, HMIC (Health Management Information Consortium) and PsychINFO, and alerts set-up for subsequent publications. The HMIC database includes grey literature (Paez, 2017) which increased the comprehensiveness of our review.

2-3.2.2 Search terms

The BeHEMoTh framework (Booth & Carroll, 2015b) was used to define the key components of the research question (Table 3) as recommended for this purpose (Votruba et al., 2018, p. 13), as well as by Cochrane for reviews on choice and use of social theory in complex intervention (Noyes et al., 2015). A concept map was subsequently developed setting out the key components of the search terms for the database search, consisting of: review; frameworks; evidence; policymaking; and the pathway of evidence-to-policy. It was particularly challenging to devise adequate search terms for the latter given the large number of potential synonyms, including for 'policy' (McKibbon et al., 2010). The search strategy was only modified for each database where required for technical reasons such as differences in subject headings.[5]

Table 3. BeHEMoTh framework for specification of theory-related review questions and its application to the present review.

	BeHEMoTh Framework	**Applied to present review**
Be	Behaviour of interest	Evidence-to-policy.
H	Health context (service, policy, programme, or intervention)	Health policy (including agenda-setting, formulation, implementation, and evaluation).
E	Exclusions	Non-theoretical models.
MoTh	Models/Theories	Underlying theories will be analysed but reviews of frameworks are the focus. Search will include reviews of models due to the inconsistent terminology.

To complement the electronic database search, hand searching in the form of forward and backward citation tracking (Campbell et al., 2014) was conducted of the reviews that met inclusion criteria. The citation index Google Scholar was used to aid this process and, where there were a large number of citations to screen manually, a keyword search was conducted using the key terms already identified for the database search. The citation search was intended to supplement the database search, but not to

[5] The full search strategy and results of the electronic databases conducted in November 2018 is available on request.

be exhaustive, due the limited ability of citation searchers to identify further relevant studies reported (Wright et al., 2014). Alerts were set up to identity and include more recently published reviews.

2-3.2.3 Inclusion Criteria

Our inclusion criteria were: existence of theoretical/conceptual frameworks in the review; focus on the role of evidence and the process of health policymaking; and are in English; and published in or after 2004. Although we are primarily interested in the agenda-setting stage of the policymaking cycle and/or LMIC contexts, our scoping search suggested that such a narrow focus in the first instance would yield insufficient results to elicit meaningful findings. We followed the definition of frameworks as structures that describe the relationship between variables (Nilsen, 2015). Results were limited to reviews published in or after 2004 because this was the year of the landmark WHO Mexico Ministerial Health Summit (The Lancet, 2004) which increased attention on evidence-informed policymaking (Bennett et al., 2018). Reviews that focused on assessing the use of evidence in health policymaking, were identified but excluded from the analysis due to the limited relevance for mental health in LMICs, where mental health is not yet a policy priority (Votruba et al., 2021) and over one-quarter (28%) of WHO member states do not have a standalone mental health policy (WHO, 2018).

2-3.3 Screening and quality assessment

Results were first screened by titles and abstracts, then full texts were reviewed by the PhD researcher. For any results where there was ambiguity around whether the inclusion criteria were met, these were raised, discussed and agreed upon at supervision meetings for 100% inter-rater agreement. The full text of any reviews found to meet the inclusion criteria were reviewed in full by two reviewers.

Quality assessment of the included reviews was conducted by at least two researchers (one being the PhD researcher) who worked independently and then compared results and resolved disagreements through discussion (and a third person where applicable).

No tools exist specifically for assessing the quality of reviews of frameworks or theory. Therefore, an adapted version (available on request) of GRADE-CERQual was used (Grading of Recommendations Assessment, Development and Evaluation - Confidence in the Evidence from Reviews of Qualitative research). This provides an assessment of confidence in the evidence from systematic reviews of qualitative research or syntheses of qualitative evidence (Lewin et al., 2018) and is used widely (Pollock et al., 2020). CERQual can be applied to findings from syntheses that are based on any type of qualitative data, synthesis methods, or questions and is suitable for adaptation because it can incorporate other tools such as the Critical Appraisal Skills Programme (CASP, 2018). CERQual

assessment has four components: relevance of the data of the primary studies to the context of the review; methodological limitations of the primary studies; adequacy of the data that supports the review; and coherence of the findings.

The developers of GRADE-CERQual recommend assessing the primary studies included in each review (Munthe-Kaas et al., 2018). We were not able to do this for the following reasons: limited tools and guidance are available for assessing the quality of theoretical papers (Votruba et al., 2018); the primary studies in the selected review articles do not allow meaningful application of more established tools (Contandriopoulos et al., 2010); and authors, on the whole, did not attempt to assess the quality of their primary studies. The present study is interested in the quality of the reviews themselves, in how well they synthesise findings, and less on quality of the primary studies. Hence, if a review provides insufficient detail on primary studies to enable CERQual assessment, or presents an appropriate quality appraisal, these are notable findings. In consequence, rather than assess the level of confidence that can be placed in the body of data directly, we have assessed how reviews have evaluated the quality of primary studies included in their own review and consider the confidence that can be placed in the conclusions authors have drawn from their findings.

To reduce bias, all included reviews were scored independently by the first author and an independent assessor. Inter-rater reliability was high, with the two independently rating 15 of the 19 reviews at the same level of confidence (80%). The rating difference for three reviews were discrepant in only a single rating, and one review was discrepant in two ratings. All disagreements were resolved at a consensus meeting. About half the reviews, 9 of 19 (47%), were awarded a high level of confidence in their findings (Appendix 1): the highest score under the GRADE-CERQual approach. Only one review (5%) was awarded a very low level of confidence: the lowest level possible. Following the GRADE-CERQual approach, no review was excluded on the basis of their score. However, the level of confidence was considered in our findings. Few reviews sufficiently assessed and/or documented the quality of the frameworks, or studies that produced these frameworks, included in their review. Additionally, few reported the source of funding of the frameworks, or studies. This is relevant because frameworks produced outside of academia, for example by charities and non-governmental organisations, may be more likely to use a broader definition of ‘evidence’ beyond that of research alongside their remit.

2-3.4 Analysis and synthesis of results

For the analysis of our data and synthesis of results we were guided by the ‘best fit’ framework synthesis approach (Carroll et al., 2013): an established method for the systematic review of qualitative evidence which has been applied predominantly in relation to healthcare (Booth & Carroll,

2015a). The ‘best fit’ framework synthesis approach builds upon the more established framework synthesis method (Brunton et al., 2020). The value of the ‘best fit’ framework synthesis approach is that it enables an existing published model, originally devised for a distinct but related purpose, to be built upon (Carroll et al., 2013).

Under this approach, an *a priori* framework is used to aid the analysis of the data of the review. New concepts that cannot be incorporated under the initial framework can also be generated. A new ‘meta-framework’ was therefore created based on the *a priori* concepts along with any new concepts; *a priori* concepts can be removed. Potential relationships between the components were also explored. Revisiting the data to explore relationships was an important part of developing the new framework, and the removal or addition of any concepts must be explained.

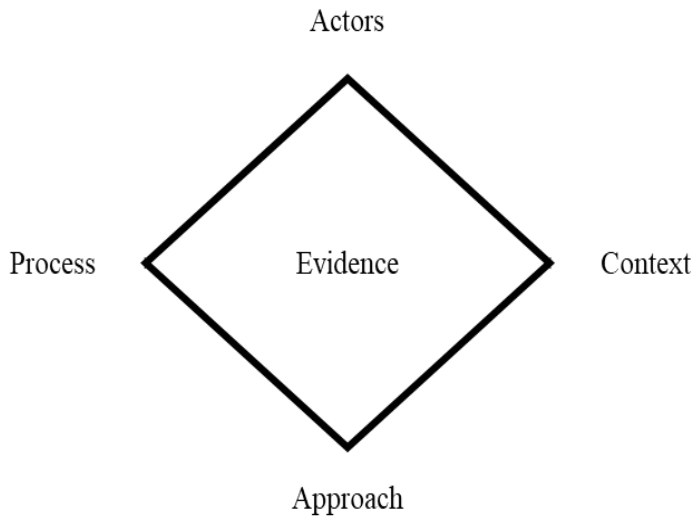
An approach that combines inductive and deductive analysis and starting with pre-determined concepts was appropriate because the field of health evidence-to-policy has been theorised extensively. Hence, it is reasonable to anticipate that concepts suggested by classic previous literature will be relevant. This will also help us connect our findings to the extant research while adding nuance through iterative refinement and development of these concepts via inductive analysis of the data. For the review papers included in the sample the full article was analysed with the narrative synthesis of the reviews, and any frameworks produced from the reviews as data. Our *review of reviews* therefore seeks to unite common and unique elements of existing frameworks into a meta-framework.

We identified an existing comprehensive framework that was an obvious candidate for the initial *a priori* framework and our pre-determined key concepts are based on the policy triangle (Walt & Gilson, 1994). This is a general framework ubiquitous in health policy analysis (O'Brien et al., 2020). The gross simplicity of the framework is one reason the policy triangle has become a seminal framework (Gilson et al., 2008). By itself it offers insufficient detail; but helps to make sense of the huge complexity involved with policymaking, and provides a useful way to structure the later chapters of this thesis. The policy triangle is not overly prescriptive and is often used alongside other frameworks (O'Brien et al., 2020). Moreover, the policy triangle was designed primarily for health policy reform in LMIC settings, with 40% of studies applying the framework in LMIC contexts, and three in the analysis of mental health policy (O'Brien et al., 2020). All this makes it a particularly appropriate starting point for our analysis.

The policy triangle consists of four concepts: actors, context, content, and process. At the outset, we replaced ‘content’ with ‘evidence’ due to our specific interest in how evidence informs policy. During the analysis it was apparent that a fifth concept, ‘approach,’ was needed to capture this aspect of our findings and enable actionable recommendations. The resultant concepts that form the initial framework (Figure 5) are defined as follows. ‘Evidence’ is the available body of facts or information

indicating whether a belief or proposition is true or valid (Oxford University Press, 2020). ‘Actors’ are individuals and groups directly or indirectly involved in policymaking. ‘Context’ is the setting in which policymaking takes place, including historical, political, economic and socio-cultural. ‘Process’ is the way in which policies are made. Approach’ are the strategy(ies) used to strengthen the role of evidence in policy.

Figure 5. The initial framework used in the analysis.



The adapted health policy triangle was used to guide the analysis of the data which consisted of the findings of the included reviews of frameworks, including any new frameworks developed by the authors. Thematic analysis was applied to identify patterns in the data (Braun & Clarke, 2006) to enable the frameworks to be compared and contrasted. First familiarisation took place with the data, the findings and any new frameworks, if produced, of the included reviews. Then the data was inputted into the data extraction table, which was composed of five columns with the headings of the five key concepts (evidence, actors, process, context and approach). The data was then coded inductively by the first author under the concepts of the *a priori* framework. The codes were then grouped together to form higher level descriptive factors. Higher-level interpretation of these descriptive factors enabled the components of the framework to be linked together.

From the codes, patterns were identified and key factors affecting the use of evidence under each concept were iteratively developed. Both common and unique factors were included. Multiple links between the different concepts were noted by the first author and explored, with the data being continually revisited to ensure that the data supported the links and the significance ascribed to them. These links were used to extend the initial framework and link the concepts together, with a meta-framework being developed from the multitude of frameworks. At regular stages the first author discussed the analysis with the other authors, who gave critical feedback to ensure that the framework represented the data and was as useful as possible to the intended audience. This meta-framework was

then considered alongside existing knowledge about the mental health agenda-setting in LMICs to explore how the framework might be usefully tailored to this specific context.

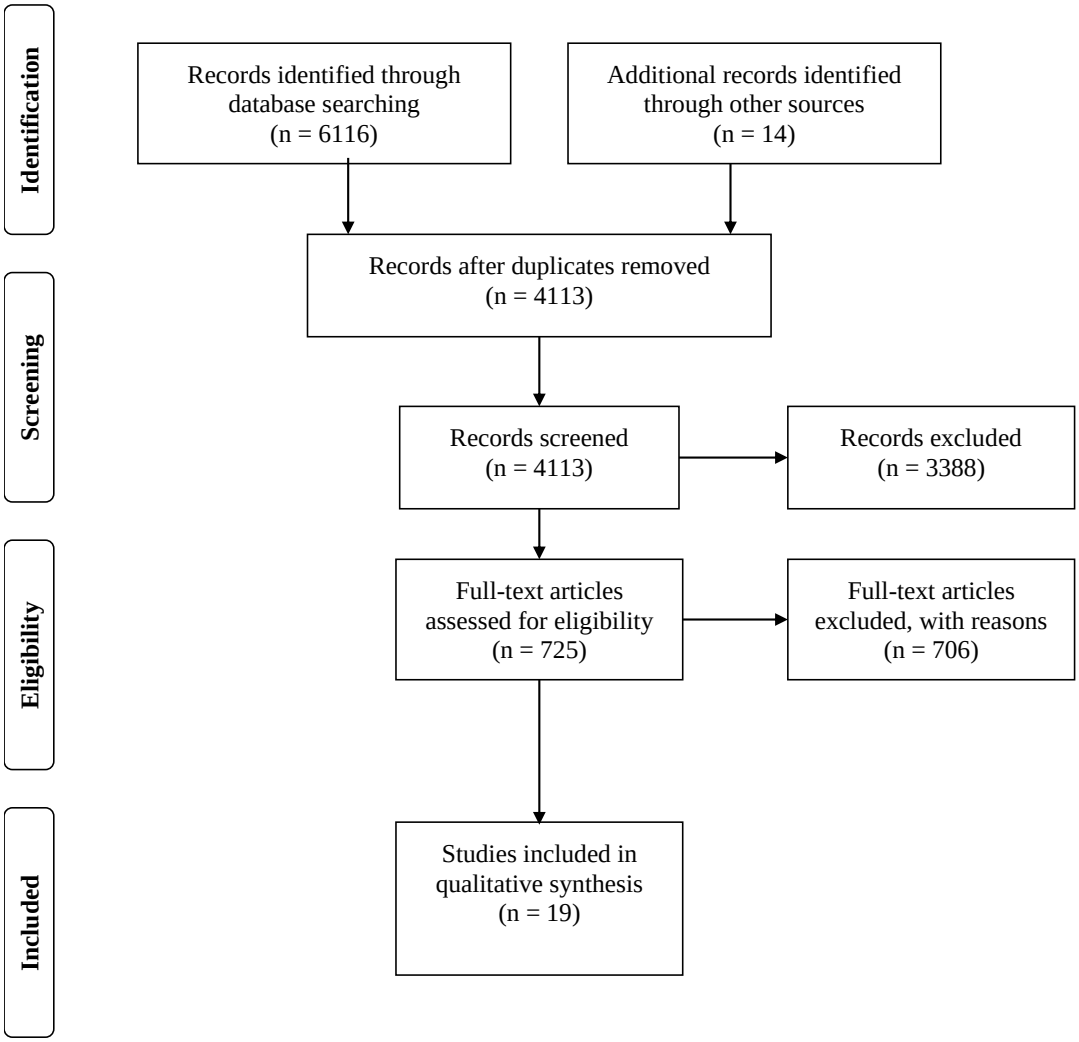
2-4. Results

The next sections will explore the included reviews, including the key factors identified for the use of evidence, culminating in the development of a meta-framework for the role in evidence in agenda-setting for mental health policymaking in LMICs.

2-4.1 Overview of included reviews

The PRISMA flow diagram (Figure 6) shows the initial database search yielded 6,116 articles. A further 32 articles were included from the citation search and 1,060 duplicates were removed. After title and abstract screening, 725 articles were retained and the full text assessed for eligibility. Nineteen met the inclusion criteria. No eligible reviews were identified via alerts after the initial search in November 2018.

Figure 6. PRISMA flow diagram.

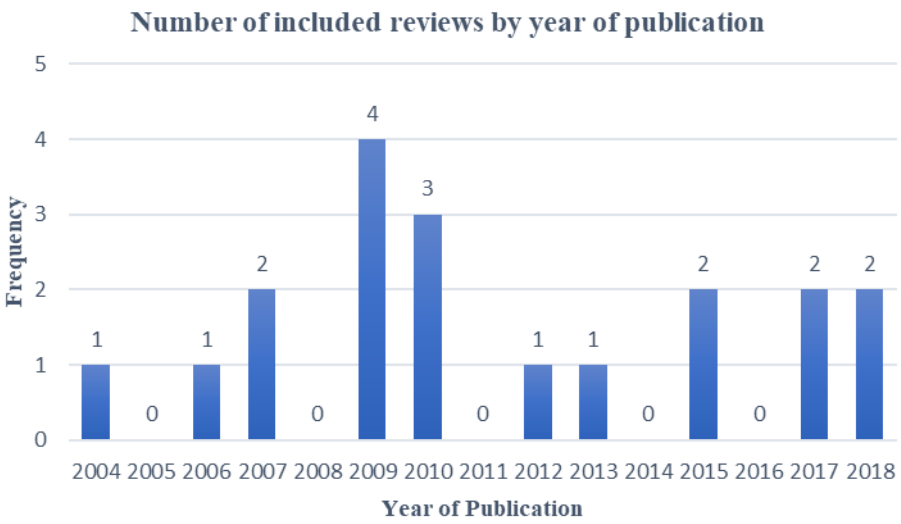


The summary of key features of all included reviews is provided in Appendix 1. The origin and scope of the reviews of general health evidence-to-policy frameworks was important to ascertain in to understand the applicability and relevance of these frameworks to mental health policy agenda-setting in LMICs, and to identify areas that might need further development. The reviews included both systematic (N = 6; 32%) and non-systematic (narrative) reviews (N = 13; 68%). Greenhalgh, Thorne, and Malterud (2018) argued that narrative reviews should not be considered per se lower in the evidence hierarchy that systematic reviews and, although our quality appraisal tended to assign them a lower level of confidence, some narrative reviews were rated 'high'. The only review not authored from the Global North was by Almeida and Báscolo (2006) situated in Brazil and Argentina. The dominance of authorship from the Global North was also reflected for the individual frameworks. For example, even though Votruba et al. (2018) focused on mental health in LMICs, all frameworks reviewed were led by authors from high-income countries (HICs). Although our review involved only publications in English, two of the included reviews (11%) contained insights from the literature in

three other languages: Spanish and Portuguese (Almeida & Báscolo, 2006), and French (Graham et al., 2007).

There was a peak in publications 2009-2010 (N = 7; 37%) (Figure 7). This may have been the result of activity post the landmark WHO Mexico Ministerial Health Summit (The Lancet, 2004), or prior to the first international conference held with a focus on health policy and systems research: the First Global Symposium on Health Systems Research, November 2010 (Bennett et al., 2018). Most frameworks were produced from the health policy and systems research (HPSR) field, including implementation science, and did not appear focused on a particular area of health. Reviews that originated from a particular area of health were situated in health surveillance, nursing, emergency medicine, and mental health, but reviewed general health evidence-to-policy frameworks. The review situated in mental health limited the frameworks included to those applied to mental health policymaking in an LMIC setting (Votruba et al., 2018). However, they were still all general health evidence-to-policy frameworks.

Figure 7. Number of included reviews by year of publication.



Some reviews built upon the work of previous reviews included in our study. For example, Damschroder et al. (2009) used the findings of Greenhalgh et al. (2004) as a base for their snowballing strategy. In turn, Moullin et al. (2015) built on Damschroder et al. (2009) to produce their own framework. Ten of the 17 reviews that focused on frameworks to explain or strengthen the use of evidence in health policymaking listed studies in an easily-accessible tabular format. Analysis of this subset indicates a reasonably high percentage of unique frameworks in each review ranging from 18% to 59% (Table 4). Even though there was variation in the foci and inclusion criteria of the reviews, this cannot fully explain why some frameworks were included by some reviews and not others. Moreover, discrepancies were observed with regard to managing different versions of a framework.

Some reviews treated different versions as distinct frameworks whilst others considered the different versions as one.

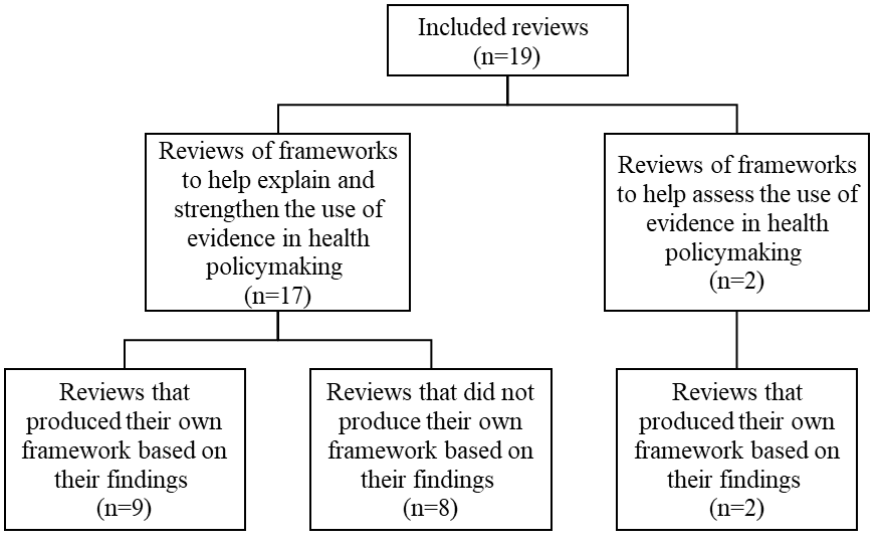
Table 4. Proportion of unique frameworks within each review.

Review	% of frameworks not included by other reviews within this subset*
1. (Ward et al., 2009)	9/18 (50%)
2. Damschroder et al. (2009)	5/19 (26.3%)
3. (Mitton et al., 2007)	2/5 (40%)
4. Votruba et al. (2018)	3/4 (75%)
5. Milat & Li (2017)	24/41 (58.5%)
6. Moullin et al. (2015)	23/49 (46.9%)
7. Tabak et al. (2012)	11/61 (18.0%)
8. Mitchell et al. (2010)	11/47 (23.4%)
9. Wilson et al. (2010)	13/33 (39.3%)
10. Nilsen (2015)	13/35 (37.1%)

* The subset of reviews used for this piece of analysis were reviews that focused on frameworks to explain or strengthen (not assess) the use of evidence in health policymaking **and** listed studies in an easily accessible tabular format.

Each review did one or more of the following: described, categorised, compared and contrasted (including from different fields), and critiqued existing frameworks of (at least some part of) the evidence-to-policy pathway. The level of detail provided on included frameworks varied greatly as did the level of analysis. Some reviews presented a list of available frameworks, some provided a categorisation, and some identified common factors. Seventeen focused on explaining and strengthening the use of evidence in health policymaking (Figure 8). Of these, eight provided a synthesis to summarise development of the current evidence base and to aid the selection of relevant frameworks and 9 produced a new framework intended to guide action, research, and discussion. These 17 reviews were analysed to identify which of our priori key concepts were included in the synthesis or framework produced (the full analysis is provided in the Supplementary Information). ‘Actors’ were a major concept in the lowest number of reviews (47%), with ‘approach’ included by the greatest number of reviews (77%). This suggests that recommendations for strengthening the role of evidence is a greater focus of the frameworks than understanding how evidence is used.

Figure 8. Summary of included reviews.



Two reviews focused on assessing the use of evidence in health policymaking (Cruz Rivera et al., 2017; Newson et al., 2018). Each identified multiple frameworks and metrics (Appendix 1), investigated how the impact of research on policy is measured, compared different approaches, and produced a new framework to help researchers identify different types of impact and how these can be assessed and communicated. Both highlighted the need for impact, not just dissemination, and the importance of assessing indirect research impact on policy, such as change in awareness or attitude, due to lag between the research and the policy impact observed. However, the difficulties measuring indirect impact were recognised and that this may represent potential, as opposed to actual, influence on policy. Challenges identifying the impact of specific research were also noted, given that information is assimilated from multiple sources, and how it is important not to over-emphasise the influence of research on policy. As explained in the methods, these two reviews will not be analysed further due limited relevance for mental health in LMICs, which are often not yet at a stage where such assessment of the use of evidence in policy would be of value.

2-4.2 Underlying Theories

Theories explain the relationship between variables, whereas frameworks are structures to describe the relationship between variables (Nilsen, 2015). Understanding the theories that underpin frameworks, is thus useful to help assess the extent of the applicability of health evidence-to-policy frameworks to mental health policy agenda-setting in LMICs.

The theories underlying individual frameworks included in each review were rarely presented. Mitton et al. (2007) is an exception, although they had the advantage of including only five frameworks. Most reviews noted that some frameworks were based on existing theories, others on empirical

studies, and some on the authors' personal experience. The nine reviews which produced a new framework were analysed to understand what theories contributed to their development (further results of the analysis are available on request). Relevant information was often alluded to indirectly but was sometimes dealt with explicitly, for example in the discussion.

Six key theories, as shown and briefly explained in Table 5, apparent in the frameworks produced by the reviews were identified: Theory of Diffusion of Innovations (N = 5, 56%) (Rogers, 2010); Two Communities Theory of Research Utilisation (N = 4, 44%) (Caplan, 1979); Theory of Opinion Leadership (N = 5, 56%) (Katz & Lazarsfeld, 1955); Social Network Theory (N = 6, 67%) (Barnes, 1954); Complex System Theory, or Complexity Theory (N = 5, 56%) (Thompson et al., 2016); and Punctuated Equilibrium Theory (N = 2, 22%) (Baumgartner & Jones, 1991). Interestingly, many of these are interdisciplinary social science theories. None of the nine new frameworks were influenced by all six theories. As expected, the Two Communities Theory is reflected less in frameworks focused on the implementation stage of policymaking where policymakers have a reduced role. In many frameworks, conceptualisations were extended to include three communities: researchers, policymakers, and intermediaries.

Table 5. Key theories apparent in the frameworks produced by the reviews.

Reviews that produced a framework (N=9)						
		Theory of Diffusion of Innovations (Rogers, 2010)	**Two Communities Theory of Research Utilisation** (Caplan, 1979)	**Theory of Opinion Leadership** (Katz & Lazarsfeld, 1955)	**Social Network Theory** (Barnes, 1954)	**Complex System Theory** (Thompson et al., 2016)	**Punctuated Equilibrium Theory** (Baumgartner & Jones, 1991)
		Encompasses categories of adopters, the stages of adoption of an innovation, and factors that influence adoption.	Researchers and policymakers reside in distinct spheres; there is a gap that needs to be bridged.	Messages reach users via 'opinion leaders', other users with influence that interpret the information, and pass on this information as well as their interpretation.	The relationships between actors, represented by ties, are viewed to be more important than the characteristics of individual actors, represented by nodes.	Complex systems are greater than the sum of their individual components. Predictions are difficult, as due to feedback mechanisms, small actions can affect the whole system.	Rather than undergoing gradual change, policies experience long periods of stability that are interspersed with shorter periods of dramatic change.
1	*(Contandriopoulos et al., 2010)*	x	✓	x	✓	✓	x
2	*(Damschroder et al., 2009)*	✓	x	✓	✓	✓	x
3	*(Gold, 2009)*	x	✓	✓	✓	x	✓
4	*(Graham et al., 2007)*	x	x	x	x	x	x
5	*(Green et al., 2009)*	✓	x	✓	x	x	x
6	*(Greenhalgh et al., 2004)*	✓	x	✓	✓	✓	x
7	*(Moullin et al., 2015)*	✓	x	x	✓	✓	x
8	*(Votruba et al., 2018)*	x	✓	✓	✓	x	✓
9	*(Ward et al., 2009)*	✓	✓	x	x	✓	x
Total (% of reviews)		5 (55.6%)	4 (44.4%)	5 (55.6%)	6 (66.7%)	5 (55.6%)	2 (22.2%)

2-4.3 Key Concepts

The key factors will now be presented under the five main concepts (evidence, actors, process, context, and approach). The specific relevance of these factors for mental health policy agenda-setting in LMICs will also be highlighted. Table 6 shows the extent to which the reviews focused upon each of the components.

Table 6. Components of the new frameworks produced by the reviews, or considered by the reviews where a new framework was not produced.

		Evidence	Actors	Process	Context	Approach
Reviews that produced a new framework (N=9)						
1.	(Contandriopoulos et al., 2010)	✓	✓	X	✓	✓
2.	(Damschroder et al., 2009)	✓	✓	✓	✓	✓
3.	(Gold, 2009)	✓	✓	✓	✓	✓
4.	(Graham et al., 2007)	✓	x	✓	x	X
5.	(Green et al., 2009)	✓	-	✓	✓	X
6.	(Greenhalgh et al., 2004)	x	✓	✓	✓	✓
7.	(Moullin et al., 2015)	x	x	✓	✓	✓
8.	(Votruba et al., 2018)	✓	✓	✓	✓	✓
9.	(Ward et al., 2009)	✓	x	✓	✓	✓
Reviews that did not produce a new framework (N=8)						
10.	(Almeida & Báscolo, 2006)	✓	✓	✓	✓	✓
11.	(Milat & Li, 2017)	x	x	x	✓	x
12.	(Mitchell et al., 2010)	x	x	✓	-	✓
13.	(Mitton et al., 2007)	x	x	x	x	x
14.	(Nilsen, 2015)	✓	✓	✓	✓	✓
15.	(Oborn et al., 2013)	✓	✓	✓	✓	✓
16.	(Tabak et al., 2012)	x	x	x	✓	✓
17.	(Wilson et al., 2010)	x	x	x	x	✓
	Total	10 (58.8%)	8 (47.1%)	12 (70.6%)	13 (76.5%)	13 (76.5%)

2-4.3.1 Evidence for mental health in agenda-setting

We define evidence as the available body of facts or information indicating whether a belief or proposition is true or valid. The concept of 'evidence' was often not defined explicitly in the reviews and related terms, such as 'knowledge', used interchangeably. Almeida and Báscolo (2006) do provide a discussion of terminology and offer Bardach & Patashnik's (2000) definition of evidence as "information that affects existing beliefs by important persons about significant features of the problem under study and how it might be solved or mitigated" (Almeida & Báscolo, 2006, p.12). This definition emphasises the importance of the compatibility of evidence with the beliefs of the people using it. Four key findings emerged from our analysis relating to evidence: nature, perception, supply and demand, and use.

1. Nature of evidence

The nature of evidence consists of both the types and characteristics of evidence. Different types of evidence were identified by the reviews to be explored in current health evidence-to-policy frameworks including *tacit*, *implicit*, and *explicit*. However, evidence from *formal* research was generally prioritised over *informal* sources, such as expert opinion. In contrast, because of the evidence gap with regard to mental health, especially in LMICs (Mackenzie, 2014; Omar et al., 2010; WHO, 2018), informal sources may be particularly important in these contexts currently due to availability. One review discussed how research evidence originating from different *disciplines* are perceived differently, with the social sciences sometimes viewed as providing 'shallow' insights (Contandriopoulos et al., 2010). Interestingly, though, the review that incorporated management literature alongside health literature discussed in most detail the broader remit of evidence and knowledge (Oborn et al., 2013). Finally, some reviews highlighted a need to understand how research evidence is considered and integrated alongside other sources of information (Almeida & Báscolo, 2006; Contandriopoulos et al., 2010).

Important characteristics identified for evidence, although not specifically for agenda-setting, include *relevance*, *applicability*, and *salience* (Gold, 2009). Hence, evidence is assessed within the context of its intended use. Some reviews also emphasised how stakeholders appraise the *quality* and *value* of evidence (e.g Damschroder et al., 2009). Accordingly, the capacity of stakeholders to appraise evidence featured in the reviews (Green et al., 2009; Mitton et al., 2007). This is particularly important in mental health agenda-setting to avoid stigma-related prejudice introducing bias and knowledge synthesis is considered a useful mechanism to improve the robustness of evidence (Graham et al., 2007).

2. Perception of evidence

Evidence is encountered often in a social context and is open to debate and interpretation (Oborn et al., 2013) influenced by the beliefs, values, and biases of the audience. As argued elsewhere, destigmatising of mental health therefore warrants greater focus (Botticelli, 2019). Reviews tended focus on the how policymakers and researchers may interpret the evidence differently. One review also highlighted how discrepancies between researchers can undermine confidence in the evidence (Almeida & Báscolo, 2006).

For mental health agenda-setting in LMICs, the influence of stigma of perceptions of evidence are likely to heightened: stigma may mean, counterintuitively that the widespread perception that formal research evidence as more robust than informal evidence, based on personal experience, that comes directly from communities may not always hold (Mackenzie, 2014). Communities are also recognised as important users and sources of mental health evidence (WHO, 2005) and therefore understanding

the factors that shape the perception of a wide-ranging array of stakeholders is likely to be useful given the important influence of different beliefs, values, and biases.

3. Supply and demand of evidence

Supply and demand was often framed in terms of the mismatch between the availability of evidence and demands of policymakers (Milat & Li, 2017). An area of exploration for mental health agenda-setting in LMICs is the evidence needs of other stakeholders, such as communities and service users. On the other hand, information overload was raised as a potential challenge, although this may be less relevant to mental health policymaking in LMICs given the evidence gap (WHO, 2018). Finally, the dynamic nature of knowledge generation was noted (Milat & Li, 2017) with the rate of change of evidence in the context of mental health policymaking in LMICs an unknown.

4. Use of evidence

Different uses of evidence were recognised including: *conceptual*, *direct*, *tactical*, *political*, *imposed*, and *procedural*. Prior identification of the way in which evidence is intended to be used is likely to enable evidence to be communicated effectively, allowing the intended audience to be better defined and the most appropriate medium selected (Graham et al., 2007; Green et al., 2011). Two types of barriers to using evidence were identified: the *evidence itself*, and *external barriers*. With regard to evidence itself, the quality and quantity of evidence influences its utility in policymaking, often evaluated in terms of its practical value for policymakers rather than for the full range of stakeholders. With regard to external barriers, evidence needs to be adapted to context (Milat & Li, 2017; Mitchell et al., 2010) and premature use of research may have unintended negative consequences and ethical costs Graham et al. (2007). Hence, the availability of suitable evidence is a necessary but not sufficient condition for its use in policymaking.

Barriers and facilitators arising from the environment in which evidence is used are covered under the remaining concepts: actors, context, process, and approach.

2-4.3.2 Actors that use evidence in mental health agenda-setting

Actors are individuals and groups directly or indirectly involved in policymaking. Interestingly, actors was the least featured component by the reviews (see Table 6). Three key factors relating to actors were identified from the analysis: categories, characteristics, and relationships.

The three predominant categories of actor identified were *researchers* (producers of evidence), *policymakers* (users of evidence), and *intermediaries* (knowledge brokers). Some reviews acknowledged that their classifications were a gross simplification (Contandriopoulos et al., 2010; Gold, 2009) and that the categories were not necessarily mutually exclusive (Gold, 2009). Other

reviews, however, noted the large cultural differences between researchers and policymakers (Oborn et al., 2013). Interestingly, one review suggested that frameworks were often researcher-focused (Wilson et al., 2010). Intermediaries were often disaggregated. For example, Green et al. (2009) suggest connectors, mavens (i.e., experts), and salespeople. Terminology sometimes suggested directionality with some categories of actor implied to have more knowledge and expertise than others (Mitchell et al., 2010).

These characteristics, important for categories of actors received attention in many frameworks. *Knowledge* and *capacity* were discussed within the context of the ability and power to use evidence (Contandriopoulos et al., 2010; Moullin et al., 2015). Capacity of individuals and organisations was a recurring factor, and often shaped by the context in which they operate. Human and financial resources often constrained the ability of actors to use evidence in policy processes, including advocacy and agenda-setting. Thus, capacity in turn shapes the 'process'. Additional actor characteristics were mentioned but without complexity. Although the focus tended to be on actors as individuals, their position within organisations and the characteristics of those organisations were reflected upon to varying degrees.

Softer' characteristics, including the *beliefs*, *values*, and *interests* of individual and organisational stakeholders was a recurring factor, largely relating to actors, but cuts across the other concepts, predominantly 'context.' Beliefs shape how actors understand the world, what they value as important, and hence what their interests are. The beliefs, values, and interests of actors are influenced by the prevailing social norms and directly shape how evidence is used. As a negative belief about people with mental health challenges, stigma is likely to affect how evidence is used determine the policy agenda and, hence, needs to be tackled. Much of the conceptualisation of the influence of beliefs, values, and interests has come from outside the field of health policy (Jones et al., 2013). The power and position of actors were important factors shaping the use of evidence, and the dynamic between actors.

The fit between actors and the relationships between them was viewed as potentially more important than their individual characteristics, with *trust* being key. *Unequal power* relations between stakeholders (Oborn et al., 2013) alongside the *culture gap*, most frequently referred to between researchers and policymakers, was often noted to be a barrier to good relationships. On the other hand, *long-term relationship building*, *bi-directional interaction*, and establishing *stable networks* – both formal and informal - were argued to be conducive for strengthening the use of evidence in policymaking. Whilst the range of networks in relation to mental health policymaking may be restricted in LMICs, those that exist tend to be stronger than for other health policy issues (Mackenzie, 2014). This may be because widespread stigmatisation of people with mental health challenges can produce solidarity in mental health networks and members tend to have personal

motivation to work in this field (Mackenzie, 2014). On the other hand, *poor financial investment* in mental health can be a barrier to network activities and existence.

2-4.3.3 The context in which actors use evidence in mental health agenda-setting

We define context as the setting in which actors make policies, including historical, political, economic and socio-cultural. Few reviews defined context and it appeared to be used as an umbrella term or catch-all concept such that there was greater divergence on context than any other concept. Tabak et al. (2012) divided frameworks into those developed for a *specific* context and those for application to a *broad* range of contexts. Others divided the concept into *inner* and *outer* context. Greenhalgh et al. (2004) define inner context as '*organisational'* and outer context as '*inter-organisational.'* Others conclude that the boundary is not so clearly defined and that, rather than focus on the different aspects of context, it is the way they interact that is important (Damschroder et al., 2009). Context was, however, widely stated to be important, increasingly so in recent frameworks (Nilsen, 2015), although Milat and Li (2017) conclude that '*real-world'* context is still lacking. The key factors relating to context identified from the analysis of the reviews are now presented under three levels: micro (individual-level), meso (organisation-level), and macro (systems-level).

Micro-context (at the level of the individual) includes personal *values*, *attitudes*, and *beliefs*. These were given little focus in the frameworks and where included lacked detail, possibly because they appear less tangible and more difficult to assess than other contextual factors with regard to policymaking (Damschroder et al., 2009). Interestingly, in the review focused on frameworks for mental health (Votruba et al., 2018), of the four relevant to LMIC only one has a component on actors' beliefs, values and interests, and these are included only implicitly in the other three. Due to the potential for stigma-related bias, micro-context in relation to mental health seems an area for greater framework development.

Meso-level factors (at the organisational level) centred on two components: *capacity* and *motivation*. Capacity includes *resources* and *support*, and motivation encompasses *culture* and *leadership* (Graham et al., 2007; Mitton et al., 2007; Moullin et al., 2015; Votruba et al., 2018). Damschroder et al. (2009) reflected on the importance of *interplay* between individuals and organisations and highlighted this as an area needing more work.

The *political* and *economic* were the predominant macro-, or systems-level, contexts included in the reviews. Broader *social* and *cultural* contexts, including language and socio-demographics, were reflected on, but to a lesser extent (Tabak et al., 2012; Votruba et al., 2018). *Technological* context, such as digital connectivity (Tabak et al., 2012), may be important yet under researched, particularly in relation to LMICs. The influence donor countries exert through development aid was noted in the review focused on mental health in LMICs (Votruba et al., 2018), suggesting an area that may be

missing from general health evidence-to-policy frameworks that largely originate from donor rather than recipient countries. Furthermore, mental health is often a cross-sectoral policy issue (Mackenzie, 2014) and this may broaden the contexts relevant to include.

2-4.3.4 The process of mental health agenda-setting in which evidence is used

Policy process is the way in which policies are made, often conceptualised to occur in the stages of agenda-setting, development/formulation, implementation, and evaluation (Walt et al., 2008). Understanding how policies are made is important to discern the role of evidence for mental health agenda-setting. Many closely-related terms were used to describe the movement of evidence into policy. These include translation, exchange, diffusion, dissemination, integration, implementation, use, and utilisation. Occasionally, phrases were used such as 'interrelationships of evidence and policy' (Votruba et al., 2018) and 'pathways to the use of research in policy' (Gold, 2009). Terms such as 'translation' suggest a *uni-directional* movement from evidence-to-policy whereas 'exchange' implies a *multi-directional* process. Terminology also reflects the specific focus of a review, such as use of evidence in policy and practice or specific stages of the policymaking cycle. Policy processes were, however, rarely considered explicitly. Often the terms used did not distinguish between policy and practice. This is an important distinction as policymaking, and particularly agenda-setting, is influenced by public perception (Bernardi, 2021), which for mental health is shaped by stigma. The key factors relating to process identified from the analysis of the reviews are now presented, and include: nature, characteristics, and types.

Although mentioned in two reviews (Milat & Li, 2017; Votruba et al., 2018), the role of evidence in the different stages of the policymaking cycle were given limited consideration. Furthermore, policy was rarely the sole focus and usually considered alongside practice. For example, Tabak et al. (2012) found that only eight of the 61 frameworks analysed addressed policy activities (i.e., creation or use). As already mentioned, policymaking is usually conceptualised by the Stages Heuristic Model (Walt et al., 2008). Although a simplification, the key stages are agenda-setting, development/formulation, implementation, and evaluation. These stages were not always evident or explicitly covered in the reviews. Implementation, however, received the most attention (Moullin et al., 2015; Greenhalgh et al., 2004; Damschroder et al., 2009) and agenda-setting the least. Moreover, in terms of mental health in LMICs, none of the four frameworks identified by Votruba et al. (2018) specifically targeted the agenda-setting stage although, due to the lack of mental health policies, this is where most LMICs, need to focus. Where a focus on agenda-setting was included, Kingdon's Streams of Policy Process framework (Kingdon & Stano, 1984) was heavily relied upon; Tabak et al. (2012) reported that Kingdon's framework was the most highly cited framework that addressed policy issues by over an order of magnitude. Under this seminal framework issues rise to the top of the policy agenda when the

problem, policy and politics streams converge. Evidence has a clear role in opening the window of opportunity for this to occur.

Although explicit consideration was infrequently given to the different stages, the complexity of the policy process was, however, still frequently emphasised. One review noted that newer frameworks gave greater recognition to this complexity (Almeida & Báscolo, 2006), although Gold (2009) concluded that frameworks still require greater detail. Specific characteristics identified in the reviews are *lengthiness*, *unpredictability*, and the *dynamic* and *evolving* nature of the policy process. These characteristics were reported to present a challenge to the use of evidence as a sustained investment of time and effort is required, with no guarantee of a positive outcome due to the complexity involved, and many factors that are often outside the influence of researchers.

Alongside the stages, two main types of policy process, were identified in the reviews: *linear* and *non-linear*. More recent conceptualisations tend to show the process as non-linear with older frameworks more often depicting the process as linear. When conceptualised as linear, there is a defined start and end to the process which occurs in a sequential fashion. Linear processes can be sub-divided into *uni-directional* or *bi-directional.* A uni-directional process is one-way and suggests a 'supplier' and a 'receiver' of evidence. Uni-directional models may therefore reinforce power differentials, as described between actors above. A bi-directional process, on the other hand, suggests a more equal distribution and transfer of evidence and therefore of power. Older frameworks tend to be uni-directional and more recent ones to depict a bi-directional process. Non-linear processes can be sub-divided into *cyclical* or *multi-directional.* A cyclical process can be viewed as sequential until it folds back on itself and restarts. In a multi-directional process, the stages can occur in any order and coincide. Multi-directional models emphasis interaction between researchers and policymakers and, in this way, tend to be people-centred (Ward et al., 2009).

Power and politics was a recurring, cross-cutting factor that emerged from the analysis. One of the complexities of the process, a characteristic described above, is that the process is inherently political and shaped by the power dynamics between actors. For mental health policymaking this is particularly pertinent because people with mental health challenges are often marginalised. Approaches that make more diverse kinds of evidence more widely available, can help to redress power inequalities.

2-4.3.5 Approaches to strengthen the use of evidence in mental health agenda-setting

Approaches are the strategies used to strengthen the role of evidence in policymaking. These were described using a variety of terms including *strategies*, *efforts*, and *activities*. The extent to which reviews focused on approach varied and was covered most comprehensively by Gold (2009). It was also the only review to use the concept of '*pathway'* which, through implying a number of components, may be particularly helpful; multiple approaches are likely to be beneficial for

strengthening the use of evidence. The two key factors relating to approach identified from the analysis of the reviews are now presented: types, use, and trust and relationships.

Three types of approach were identified: *effort (passive* or *active)*, *direction (push* or *pull)*, and *linkage (linear* or *bi/multi-directional)*. Greenhalgh et al. (2004) argued that the different approaches represent a continuum rather than discrete types and that there is no singular best approach. Gold (2009) suggests that best approach depends on context, that a combination of approaches is likely to be most effective, and to be cognisant that only some determinants of evidence use can be influenced by researchers. However, there was broad consensus that uni-directional communication was less likely to be successful, possibly due to the importance of interaction and dialogue between researchers or intermediaries and policymakers (Almeida & Báscolo, 2006; Contandriopoulos et al., 2010; Mitchell et al., 2010; Ward et al., 2009; Wilson et al., 2010).

When using approaches, tailoring them to intended audience was deemed critical (Almeida & Báscolo, 2006; Greenhalgh et al. 2004; Mitton et al., 2007; Wilson et al., 2010) with communication featuring prominently as a key component. Good communication involves avoiding jargon (Almeida & Báscolo, 2006; Mitton et al., 2007) and delivering an actionable message (Mitton et al., 2007). In LMIC, insufficient skill for communicating research has been documented, especially to non-specialist audiences (Murunga et al., 2020). This may be compounded in relation to mental health research because of cultural differences in the understanding of distress and disorder (Mackenzie, 2014). The person delivering the message (Mitton et al., 2007) and its timing are additional factors to be considered (Almeida & Báscolo, 2006).

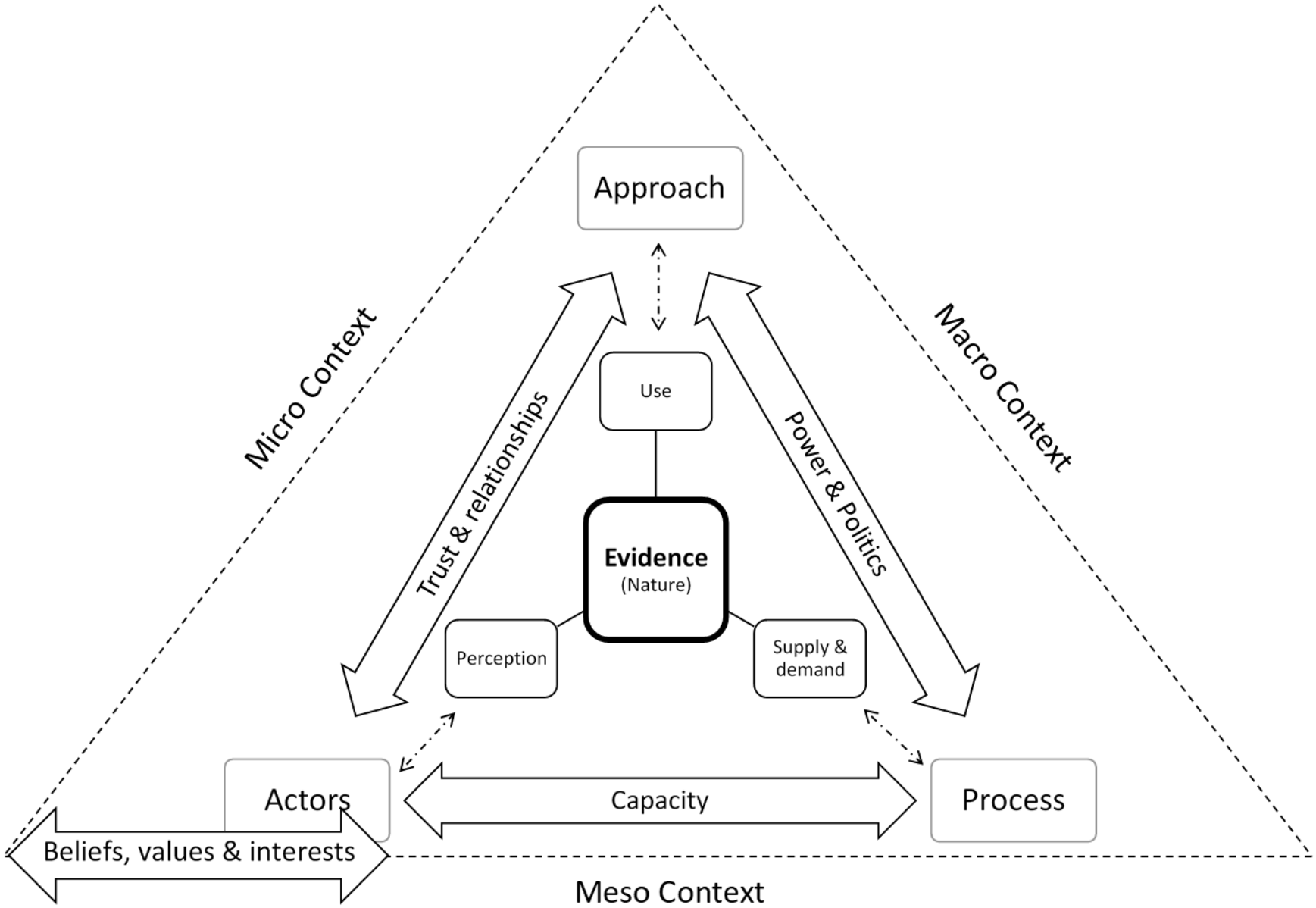
As already emphasised under the actors section, the relationships between and within stakeholder groups are important for facilitating the use of evidence in policymaking. Trust is needed to create receptivity to the evidence and genuine relationships facilitate evidence sharing, discussion, and use. Good relationships are also the foundation for the generation of formal and informal evidence, including participatory research. Approaches need to consider, and be tailored to, the stakeholder community and provide opportunities for networking. Given the sensitive nature of mental health, trust between stakeholders is likely to be a particularly important, especially when engaging marginalised communities who might be wary of researchers, medical professionals, and policymakers.

2-4.4 Meta-framework for the role of evidence in agenda-setting for mental health policymaking in LMICs

As described in the Method, our *review of reviews* seeks to unite common and unique elements of existing frameworks into a meta-framework, tailored for the role of evidence in agenda-setting for

mental health policymaking in LMICs. Our framework (Figure 9) differentiates five inter-related components: evidence, actors, process, context, and approach which altogether determine the role of evidence in mental health agenda-setting. Given the focus of this study on the role of evidence, 'evidence' is naturally at the centre. The use of evidence is multifactorial, and therefore the framework also includes four outer components: actors, process, context, and approach. The latter component being key for *strengthening* and not just *understanding* the use of evidence. The inclusion of all five components and their placing ensures that sufficient emphasis is given to the evidence *per se*, whilst incorporating all relevant factors.

Figure 9. Meta-framework for the role of evidence in agenda-setting for mental health policymaking in LMICs.



Four key aspects are worth noting in relation to 'evidence' in our framework: the nature of available evidence on the topic; perceptions of useful evidence by stakeholders; supply and demand for evidence from stakeholders; and degree of use of evidence in agenda-setting. Nature encompasses intrinsic factors, whilst the other three factors link evidence to the other four concepts (actors, process, context, approach). The *nature* of the evidence is central as it: shapes how it is *perceived* and whether it is deemed to constitute robust *evidence*; influences the level of *demand* for such evidence and the ease with which it can be *supplied*; and has a strong link to the *use* for which it is most suited, for different purposes, audiences, and at different times.

The availability of evidence is not sufficient to ensure its use in agenda-setting and leveraging effectively links to the other concepts of the meta-framework is essential. Only the most pertinent links are displayed in the framework. Evidence is perceived by actors differently, the supply and demand for evidence is shaped by processes, and the way in which evidence is used effects which approaches may more be more effective. All the concepts, however, link together in complex ways.

Second, barriers and facilitators arising from the environment in which evidence is to be used are covered under these other four concepts in the framework: actors, process, context and approach. *Actors*, *process*, and *approach* form a triangle linked to the factors relating to evidence (perception, supply and demand, and use*)*. The use of double headed arrows indicates the bi-directional influence, which are now explained in turn.

Actors can *perceive evidence* differently due to the nature of their personal, professional and/or cultural positioning with respect to that *evidence*. On the other hand, the ways in which *actors* relate to *evidence*, such as the role they play in the policy process, can also be influenced by their *perception of evidence*. The agenda-setting *process*, including stage, influences the *demand* for, and consequent *supply* of *evidence*. On the other hand, the *supply* of evidence can influence the agenda-setting *process*. Appropriate a*pproaches* to strengthening the use of evidence in agenda-setting are influenced by the intended *use of evidence* in agenda-setting. On the other hand, *approach* can also influence how *evidence is used*.

Third, the outer sides of the triangle that encloses the framework represent the three interlinking sub-levels of *context*: *micro* (individuals), *meso* (organisations) and *macro* (systems). Whilst context is a distinct concept it permeates all other components of the framework. The positioning of actors, process, and approach at the corners of the triangle highlights the most pertinent links between these components and the sub-components of context. *Actors* sit at the intersection of *micro* and *meso context* because *actors* engage with agenda-setting as individuals and through their organisational role. *Approach* sits at the intersection of *micro* and *macro context* because *approach* involves individuals seeking to have systemic impact, often through their organisational role. *Process* sits at

the intersection of *meso* and *macro context* because *process* involves organisations, and therefore individuals within these organisations, working within systems.

Fourth, the framework links these concepts via four cross-cutting dimensions that capture pertinent interrelations between concepts: beliefs, values and interests; capacity; politics and power; and, trust and relationships.

Whilst initially falling under the four main components (evidence, actors, process, context, and approach) as how the results are presented, as the analysis proceeded it became apparent these dimensions were apparent under several, if not all, of the components. How these dimensions could link the different components together were explored further. Whilst the framework was developed and the relationships explored, the data was continually revisited to ensure that the framework was grounded in the data. Whilst there are multiple links across the components, the most significant of these links are presented in the framework, displayed as arrows.

While *context* influences all aspects of *evidence* in policy agenda-setting, the predominant influence is via the *beliefs, values, and interests* of *actors* as individuals (*micro context*) and through their organisational role (*meso context*). On the other hand, the *beliefs, values, and interests* of *actors* also influences the *context* in which agenda-setting is undertaken.

The extent of *trust*, and nature of the *relationships* between *actors*, influences the extent to which *approach* can be effective in strengthen the *use of evidence*. On the other hand, the kind of *approach* used can influence the extent of *trust* and nature of the *relationships* developed between *actors*. The policy *process* is inherently *political* and deciding the *approach* needs to take into account the *power* dynamics at play. On the other hand, the *approach* taken can influence the distribution of *power* in the policy *process*. *Actors' capacity* is a key determinant of their involvement in the policy *process*. On the other hand, involvement in the policy *process* can magnify *actors' capacity* to engage, such as through increasing their experience and skills.

2-5. Discussion

2-5.1 Key issues for mental health agenda-setting in LMICs

Whilst there was overlap between the findings of the different reviews, none comprehensively covered all the elements we identified. Our meta-framework therefore advances the literature through collating in a novel way a vast body of relevant information and tailoring it to mental health agenda-setting. Additionally, our meta-framework fills gap in health evidence-to-policy frameworks given the predominant focus on physical health, on implementation, and in HIC(s).

The findings of the current *review of reviews* will now be discussed with specific reference to their application to mental health agenda-setting in LMICs. Our study complements the existing EVITA framework for mental health agena-setting in LMICs (Votruba et al., 2020, 2021) by expanding the scope of our framework to explicitly include informal evidence in addition to formal research evidence. The usefulness of using a broad range of theories from multiple disciplines, including outside of health systems and policy, has been advocated by other authors for prospective policy analysis (Buse, 2008). More specifically, it has been suggested that frameworks from other health and policy areas could offer lessons on agenda-setting and new approaches for creating policy impact for mental health and to tackle the translational gap in LMICs (Votruba et al., 2018).

2-5.1.1 Informal evidence

Several of the reviews identified a need to understand how research is combined with other forms of knowledge, with some recognition of tacit (that which is difficult to codify) knowledge as an important form of knowledge, alongside explicit knowledge. However, formal research evidence tended to be the predominant, sometimes implicit, focus. A further distinction of explicit knowledge, between formal research evidence, and informal evidence is likely to be useful. For mental health LMIC contexts this is particularly pertinent as formal evidence is often less abundant. Furthermore, the only framework aimed at mental health agenda-setting in LMICs identified in development exclusively focuses on formal research evidence.

There is limited focus on the role of informal evidence in frameworks is often compounded by policy analysis of existing policies to assess the use of evidence is also often limited the assessment of formal research evidence in policy (Bhugra et al., 2018), presumably due to the methodological challenges of doing so. Furthermore, because as argued by Greenhalgh and Russell (2009) – research evidence can inform, but not determine, political decision-making, where value based decision about ‘what to do’ are needed. Informal evidence based on personal experiences may therefore be a key consideration for agenda-setting in LMIC where there are multiple other competing demands.

2-5.1.2 Communities

The reviews largely agreed that frameworks mostly focus on the ‘two communities’ of researchers and policymakers, and, increasingly, intermediaries who bridge this gap (Tantivess & Walt, 2008). Policymaker is a broad category and is often used ambiguously (MacKillop et al., 2020); due to the importance of the receivers of evidence highlighted by this review, this term would benefit from distilling.

Beyond these two communities, the findings of the current review support (WHO, 2005) who advocate for the importance of a wide range of stakeholders, including communities, for each stage in

the process, including agenda-setting. Other scholars have argued that it is important to consider all relevant mental health policy stakeholders as they may have the potential of introducing policy windows or barriers (Makan et al., 2015). From such involvement of a greater range of actors it would be expected that this would lead to a more indirect flow of evidence from researchers to policymakers, broadening the range of potential approaches. Recent attention to the importance of communities for strengthening the use of evidence for global health policies has been evoked by the COVID-19 pandemic (AlKhaldi et al., 2021).

Widening the range of actors considered in frameworks is particularly important for LMIC settings where, as argued by Malekinejad et al. (2018), the role of intermediaries and advocates are especially important for marginalised communities, such as the working poor and undocumented migrants, who are often neglected in the policy agenda, and hence service delivery. The importance of advocates is compounded for mental health by the stigmatisation that surrounds the topic, and of those affected including substance users (Malekinejad et al., 2018). Furthermore, in LMICs, a significant proportion of health treatment occurs in the informal sector, including for mental health (Mackenzie, 2014), again broadening the range of stakeholders.

It has been argued, including for example in Brazil, that there has been exponential growth in participation of citizens in decision-making processes due to decentralisation (Suárez, 2006). Decentralisation has featured in the health sector reforms of a majority of LMICs (Muñoz et al., 2017), the consideration of a broader range of actors is also likely to be increasingly important.

Different actors, however, often do not have the same power. People living with mental illness, recognised as important participants, may face barriers to engaging in policy processes due to their health status (Abayneh et al., 2017). A lack of treatment and support can reduce the motivation and ability of service users to engage (Kleintjes et al., 2010).

2-5.1.3 Policy and practice

Policy is often grouped with practice by current frameworks. Although interrelated, and changes in practice are ultimate aim of policy change, policy and practice are distinct (Jansen et al., 2010). A criticism levelled at the health literature exploring the role of evidence in policy is that policy theory, and knowledge of the policy process, is seldom used (Cairney & Oliver, 2017). Frameworks which consider policy and practice could be expected to be less likely to utilise theory and knowledge related to policy. Cairney and Oliver (2017) highlight the difference between evidence-based policy and evidence-based medicine, in the way that evidence is valued and used. In addition, the lack of distinction between the different stages of the policy cycle often leads a significant proportion of the complexity being missed (Oliver et al., 2014).

2-5.2 Key considerations for application of the framework

Although frameworks by their nature are a simplification of the phenomenon of interest, a criticism by the author of one of the reviews is that current frameworks treat the use of health evidence in policy as a 'black box' (Gold, 2009). It is likely that in trying to increase understanding of the role of evidence in agenda-setting, a specific framework for mental health would be useful. Mental health, including as a policy issue, has been argued to be a 'wicked problem' that is inherently complex (Hannigan & Coffey, 2011). Mental health differs from other health policy issues due to the historic distinction between mental and physical health reflecting that of the mind and body. Despite recent calls for greater integration in research, policy, and practice (Collins, Insel, Chockalingam, Daar, & Maddox, 2013), mental health is still often considered separately to physical health, with the aim to deliver mental health services that are as good as those for physical health rather than as part of health services (Naylor et al., 2016). Evidence for mental health is also polarising, with a lack of a global consensus on the classification, cause and treatment of mental health (Mackenzie, 2014). In LMICs, there are even more contentions, with criticisms of top-down impositions of Western models of mental illness (Whitley, 2015).

Our meta-framework aims to incorporate some of this complexity through the four cross-cutting dimensions. Reviews have noted the increasing inclusion of soft factors (e.g. beliefs, values, and interests), as well as hardware (e.g. human and financial resources). However, the social and political context of decision making, the next layer in representing the complexity of health policy and systems (Sheikh et al., 2011) has been identified as an area that could be further developed for evidence-to-policy frameworks. The four cross-cutting dimensions therefore incorporate the soft factors into the meta-framework, together with the social and political context in order to highlight areas for further research.

Our review has developed a framework for understanding and enhancing the role of evidence in the agenda-setting for mental health policies in LMICs. However, three further specific areas have been identified whereby frameworks need to be further developed to aid their usefulness in application to mental health agenda-setting in LMICs.

Firstly, the findings of this review suggests greater attention needs to be given to informal evidence, evidence based on personal experience, e.g. expert opinion and stakeholder consultations (Mbachu et al., 2016). This echoes calls by other authors have argued for evidence-based health policy research more broadly to consider evidence to be defined more broadly (Oliver et al., 2014). For the focus this review, this is a particularly poignant finding as the only framework developed for mental health agenda-setting in LMICs, EVITA 2.0, exclusively focuses on formal scientific evidence (Votruba et al., 2020, 2021).

Secondly, the findings of this review suggest a broader range of actors should be included by frameworks to fully understand and maximise the use of evidence to inform policymaking; an increased focus on informal evidence is likely to facilitate this. Nascent frameworks are beginning to include a broader array of actors (Votruba et al., 2020, 2021), including advocacy coalitions. However, some authors simultaneously caution that the role of communities should equally not be overstated to unduly burden resource constrained groups and people (Tebaldi, Tschöke, & Castro, 2017). Bi-directionality should be a key component of their inclusion in frameworks, given the importance of genuine engagement (Conklin et al., 2010). However, the real world practicalities of such an endeavour are said to represent a significant endeavour (Tebaldi et al., 2017). Due to the likely differences of the individuals involved, the recommendation by Oliver et al. (2014) to understanding the daily lives of individuals to understand how this shapes evidence use is likely to be of greater significance.

Thirdly, this review identified a need for frameworks to focus more specifically on policy, as well as the specific stage of agenda-setting. Greater distinction between policy and practice, and the different stages of the policy cycle. Including agenda-setting will allow more nuanced understanding of how evidence is used. Moreover, this will facilitate a greater focus on the political nature of policymaking, and the role of power that is especially pertinent for mental health, that is often shied away from.

2-5.2 Study limitations

Due to the large number of existing frameworks, and the diverse terminology used, it is possible that some relevant reviews, and therefore frameworks, were missed by the search strategy. However, the reviews were found to have broadly similar findings, despite each having a slightly different focus. It was not possible to analyse all of the frameworks individually as a result of the large number of frameworks included within the reviews, and the analysis of the authors of the reviews had to be relied upon. To mitigate this, individual sources were followed up in instances where needed. The large proportion of shared findings between the reviews suggested robustness of the analysis of the reviews.

The restriction of the review to English reviews may have led to some reviews being excluded, exacerbated by the same issue in the included reviews only including frameworks from English language publications. As illustrated by (Almeida & Báscolo, 2006), translation can obscure the meaning particularly in relation to power and politics. Given the low proportion of health research published on LMIC originating from local authors and instead from HICs (Busse & August, 2020), a trend that has also been observed for mental health (Razzouk et al., 2010), key factors influencing the

role of evidence for mental health agenda-setting in LMIC may therefore be overlooked by general health evidence-to-policy frameworks.

2-6. Conclusion

Due to the multitude of evidence-to-policy frameworks, but a lack of specific frameworks for mental health agenda-setting in LMICs, this review firstly has attempted to draw together the larger number of health evidence-to-policy frameworks through a *review of reviews* and produced a resultant meta-framework. Second, the current frameworks were critically analysed from perspective of mental health agenda-setting in LMICs to develop recommendations of how current frameworks could be further developed to be tailored to this specific context. In order for effective approaches to strengthen the use of evidence for mental health agenda-setting in LMICs to be developed, it is recommended that future studies should (1) place a greater emphasis on informal evidence, in addition to formal research evidence; and (2) a broader range of stakeholders including communities. These are important because (1) formal evidence is often less abundant for mental health and LMIC contexts, and is not a specific focus of the singular framework aimed at mental health agenda-setting in LMIC identified in development; and (2) given the importance of informal evidence based upon personal experience, the lack of mental health as a priority, as well as the stigmatisation of mental health resulting in the marginalisation and exclusion of groups from decision making.

CHAPTER 3: METHODS - The need to explore the role of evidence for mental health policy agenda-setting in Assam

This Chapter will detail, and set out, the rationale for the methods used in the empirical component of the research. The overall case study approach will be discussed, before each of the data collection methods in turn. How the data was analysed will then be presented. The last part of this Chapter will provide a critical reflection on the credibility of the research and the methodological rigour, as well as any ethical issues that were encountered and how these were mitigated.

3-1. Research Purpose

The research question of this PhD study *"To what extent, and in what ways, does research evidence inform the mental health policy agenda in Assam?"* together with the intended outputs and overall research purpose determined the study design and approach taken. The purpose of a study ought to reflect the current state of knowledge on the topic (Gilson & WHO, 2012) and this also informed the methodology.

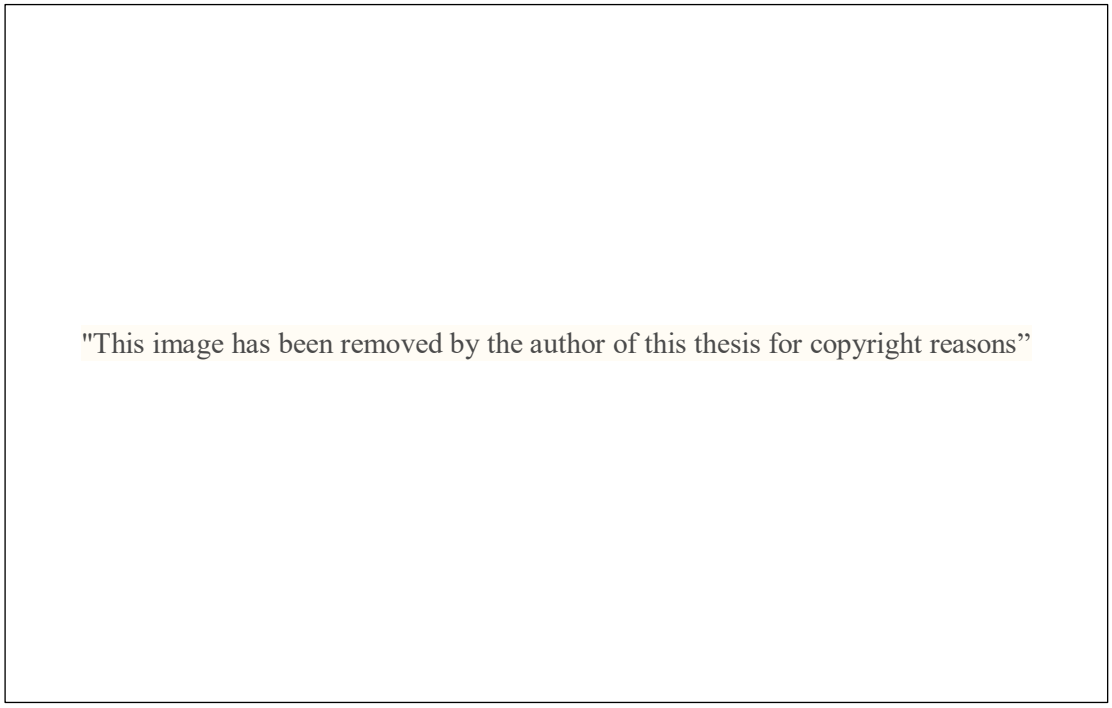
More broadly, the region of Assam is an understudied location, both in terms of health policy and other academic studies, within India. This is for several reasons, including instability and perceived differences between Assam and the rest of India (Sharma, 2011). Consequently, the purpose of this research is predominantly exploratory, and aims to both increase understanding and to propose areas for future research. The purposes of different types of research are shown in Table 7.

Table 7. Different research purposes (based on (Gilson & WHO, 2012) – Open Access).

Type of research		**Purpose**
Exploratory		To discover what is happening in poorly studied situations and assess phenomena in new light; to generate new insights and identify areas for further research.
Descriptive		To give an accurate profile of the phenomenon of interest.
Explanatory		To explain a situation (a causal relationship is only one such way) and patterns surrounding the phenomena of interest.
Emancipatory		To make opportunities and increase motivation to participate in social action.
	Critical research	Research that seeks to benefit marginalised groups and investigating how research into inequities results in action.
	Action research	Action and research are conducted simultaneously, where participants are the agents of change.

The types of research are not mutually exclusive, as Figure 10 shows. Therefore, although this research will be largely exploratory, it also has some descriptive and explanatory elements. Descriptive components include the production of a stakeholder map. Explanatory elements include the third objective of the study, which is to identify and analyse the processes and approaches for mental health-related policymaking in Assam.

Figure 10. How multiple research purposes can overlap (taken from (Gilson & WHO, 2012)).



3-2. Case Study Approach

3-2.1 Qualitative research

Broadly, there are two main types of research: quantitative and qualitative. Quantitative and qualitative are not dichotomous types of research; the distinction between qualitative and quantitative research is not absolute, and there are crossovers between the two.

Qualitative research is difficult to define due to the diversity within qualitative research which encompasses a wide range of data collection, analytical methods, and epistemological perspectives. The generalisations therefore needed to provide a definition may not be useful as they may mask this diversity (Guest et al., 2013; Madill & Gough, 2008). Simplified definitions, including "*Qualitative research involves any research that uses data that do not indicate ordinal values."* (Nkwi, Nyamongo, & Ryan, 2001, p. 1), have been used by some authors, although such definitions are limited in their utility.

Although there is overlap between qualitative and quantitative research, qualitative research can allow for deeper and more open-ended investigation and is often used to understand 'why' and 'how' questions surrounding people's beliefs, experiences, behavior and interactions. The research questions of this study are predominantly exploratory in nature and are centered on understandings people's experience and beliefs in relation to the role of evidence in mental health agenda-setting.

Qualitative research has often been given, many prominent voices argue unfairly, a lower priority than quantitative research within the health field (Greenhalgh et al., 2016). This has also been seen within the mental health field (Davidson et al., 2008). However, the emerging consensus among scholars is that neither type of research is inherently better (Greenhalgh et al., 2016). Rather, the research questions dictate which type is better suited to providing an answer, with qualitative and quantitative research able to offer complimentary perspectives (Greenhalgh et al., 2016).

3-2.2 Overall case study approach

A qualitative case study approach (Given, 2008) was the methodology selected to explore, in-depth, the role of evidence in setting the agenda for mental health policy in Assam. The rationale for choosing mental health policymaking in Assam as a case study was provided in Chapter 1. This case study was then narrowed to focus on agenda-setting, in particular, as part of the policy cycle, based on the findings of the literature review.

A qualitative case study design was used because it allows for an extensive and multi-dimensional investigation of complex phenomenon (Crowe et al., 2011), and the exploratory nature of the research questions of this PhD therefore can be addressed by this approach. A case study entails a naturalistic approach where the real-world context of the phenomenon is observed and studied. The case study approach is widely used in health policy research (Walt et al., 2008), and other similar topics, for instance: exploring evidence to mental health policy in Vietnam (Harpham & Tuan, 2006); and the media and political agenda-setting for mental health in Lithuania (Šumskienė et al., 2016).

3-2.3 Types of case study

3-2.3.1 Prospective case study

The majority of published health policy research to date has used retrospective case studies as opposed to prospective case studies (Buse, 2008; Pearson et al., 2010). As the State of Assam is yet to have a dedicated standalone state mental health policy, and an aim of this study was to identify potential research-to-policy pathways, this policy analysis was prospective. Although prospective

health policy analysis is recognised as being more challenging to conduct, it can potentially provide suggestions to policy issues, and help enable various stakeholders to engage more productively in policy agenda-setting.

Buse (2008) argues prospective policy analysis should meet two criteria: firstly, that a policy process should already be underway; and secondly, that it is 'demand-led' from local stakeholders. These criteria are both met in this case as nationally mental health has risen up the policy agenda: India has recently introduced a National Mental Health Policy (Government of India, 2014) and Mental Health Act (India, 2017). Stakeholders at the state-level in Assam have also called for a standalone mental health policy (Pathak et al., 2017).

3-2.3.2 Intrinsic case study

This PhD aims to explore a singular case study, the specific case of mental health policymaking in Assam. Therefore, a mainly intrinsic case study approach (Stake, 1995) was used. The case study approach has been criticised for producing findings that are not transferable (e.g. Campbell & Stanley, 2015), however as this is primarily an intrinsic case study, transferable findings are not a specific aim of this PhD. Knowledge generated does not necessarily need to be formally transferred to provide a valuable contribution (Flyvbjerg, 2006).

Nevertheless, it is possible to transfer findings from a single case (Flyvbjerg, 2006; Tsang, 2014; Yin, 1994), and case studies in particular are useful for theoretical transferability and falsification (Tsang, 2014). Instrumental case studies aim to contribute to a general understanding of a phenomena from a single case (Stake, 1995). Although not an explicit aim of this study, the discussion chapter considers the extent to which the findings of this PhD are transferable to similar contexts, for example mental health policymaking in other North Eastern states in India, or other areas of health or social policymaking in Assam. In the future, this case study could be broadened into a collective case study (Goddard, 2010), using additional cases to further explore the potential transferability of the findings.

3-2.3.3 Cross-sectional case study

The aim of the case study was to acquire a detailed understanding of mental health agenda-setting in Assam at one moment time through a cross-sectional case-study. Under this design, data is collected at one time period, as opposed to a longitudinal design which seeks to explore changes over time (Mills, Durepos, & Wiebe, 2010). However, due to the limited duration of the data collection period (about one year), and the changes that occurred within this period, most notably the COVID-19 pandemic, there will be some exploration of changes during this time period.

3-2.4 Use of theory

Although primarily exploratory in nature, this case study makes use of, and further develops, theory in an iterative manner. The empirical research builds upon the findings of the literature review, and the resultant conceptual meta-framework, reported in the previous chapter. Exploratory case studies are used for distinctions phenomena where detailed preliminary research has not been conducted (Mills et al., 2010). Although there is a large amount of general theory, its application has been limited and it is not known to what extent the existing theory applies to this particular case. This study explores whether existing theory applies to a specific case, in addition to what aspects of this case cannot be understood and explained with existing theory, with a view to theory development. Hence a combined inductive/deductive approach is used, involving an inductive approach where theory emerges from the data, and a deductive approach where a hypothesis developed from existing theory is tested with data approach. This is in line with what has been termed an iterative-inductive approach, where there is an iterative cycle between theory and data and its analysis and interpretation (O'Reilly, 2009).

The use of theory is of particular value for health systems and policy research due to the complexity of the phenomena under investigation (Gilson & WHO, 2012). For prospective policy analysis Buse (2008) recommends that when using theory *ex ante* for prospective studies, a broad range of theories from multiple disciplines, including outside of health systems and policy, should be used. This was the approach taken as the literature review was a *review of reviews*, which produced a meta-framework.

3-3. Ethical Considerations

The potential ethical issues encountered by this case study, and the range of data collection methods used were considered from the outset in the study design in order to minimise any potential risk to participants. The four main potential ethical issues identified were the need to avoid harm to participants by maintaining both anonymity and confidentiality in the data collection methods; to eliminate any pressure felt by participants to partake in the research, and to ensure their informed consent for the use of their data. How these four issues were addressed by this study, with specific strategies to mitigate them, will now be covered in turn.

3-3.1 Anonymity

Anonymity is a key ethical consideration that prevents individuals or groups being identified from their contributions to the research (Pope & Mays, 2020). This is important due to the sensitivity of the

topic of mental health, and the social stigma and discrimination which surrounds it in the context of this research in Assam, India[6] (Pathak et al., 2017). The limited number of mental health stakeholders and organisations in Assam thus poses a risk to anonymity. To mitigate this risk participant personal data was anonymised by the PhD student. Data was assigned a unique identifier, created by the participant according to given (retrievable) instructions, known only to them and the Research Team. The exceptions to this was when this information (i.e., roles, institutions and work contact details) was in the public domain, for example the policy mapping database. Direct and indirect identifiers (age, community, family, etc.) and any other sensitive material were removed from interview transcripts and field notes prior to storage.

3-3.2 Confidentiality

Confidentiality is a related but distinct ethical consideration to anonymity and regards the protection of identifiable information (Wiles, 2012). No identifiable information about individuals collected during the process of research was or will be disclosed and the identity of research participants was protected through various processes designed to anonymise them. Participants' personal details (e.g. email, mobile number), where necessary to record, were stored safely and separately from research data, and deleted once the person's participation in the study ended. A professional company was used to type-up audio recordings into written transcripts where needed, and the company agreed to adhere to a confidentiality agreement.

3-3.3 Pressure to participate

Due to the relatively small number of professionals working in mental health in Assam, there was a risk stakeholders may have felt under pressure to take part in the research. This pressure may have been more acute for individuals who are affiliated with Big Picture's partner organisations in Assam, or who are part of the networks of the research team. However, it was made clear to participants they were able to make an independent decision about participation without fear of negative consequences and this was clearly explained in the participant information sheet.

Additionally, the COVID-19 pandemic may have placed extra pressure on participants, in terms of an increased workload, both professionally and personally. This was a particular concern for those involved in the coronavirus response, such as policymakers in the Ministry of Health and clinicians. Recruitment, and the timing, was therefore sensitive to the ongoing situation in order not to place

[6] As documented by the National Mental Health Survey India 2015-2016 Assam State Report (Pathak et al., 2017).

undue burden onto participants. When conducting further interview after the first fieldwork visit, the choice of an email interview, was also added, together with phone and Skype interviews.

3-3.4 Informed consent

Informed consent is a key aspect in conducting research that enables participants to make a free and educated choice to partake in research, fully informed of the what the research will involve and its potential risks and benefits, and in the absence of undue pressure as described above (Salkind, 2010). Informed consent helps to protect participants from any harm that could result from research participation and can also aid in enhancing participants experience of involvement in the study.

Informed consent was obtained from all participants by the PhD student before partaking in any element of the study. Consent was audio recorded item-by-item, or written consent obtained. Written information on the consent procedures was provided in the study information sheet. This was emailed to the participants, along with the consent forms at least one week before their participation. All participants were provided with the opportunity to discuss or ask questions about the consent form before giving their consent. Although obtaining signed or verbal informed consent was a key part of the process, informed consent is a continued process of communication between the participants and the researcher (Salkind, 2010). Participants were also given the opportunity to withdraw their data from the study, one week after their data was collected.

3-4. Reflexivity

Before setting out the approach to data collection for this case study, the positions of the researcher and the audiences, and their effect on the research process and outcomes will be considered through the process of reflexivity. Reflexivity is the ongoing internal discussion and critical self-evaluation of the researcher's position in the social and political context of the study, as well as the explicit appreciation that their position has the potential to affect the research process and outcome (Berger, 2015). Consequently, reflexivity can enhance the transparency and credibility of research (Berger, 2015). Reflexivity is put into practice when researchers convey their recognition of the links between themselves as researchers, the participants, data, and methods of analysis (Mills et al., 2010). The findings of this study, conducted from this position, will be considered in combination with the positions of the audience, in order to consider the relevance and the framing of these findings to different audiences, where the interpretations, and the salience, of different findings, may differ.

3-4.1 Position of the researcher

The position of the researcher is sometimes described using an insider/outsider dichotomy, however a continuum is more realistic conceptualisation (Dwyer & Buckle, 2009). Neither position is necessarily better, but rather offers different insights, each associated with different advantages and disadvantages. In this study, the PhD student is a conspicuous 'outsider' as coming from the UK, a Western high-income country, in contrast to the location of the case study, India, a lower middle-income country. The historical relationship between the UK and India, in particular British Colonialism in India, adds an extra dimension to the different income-levels of the setting of the research, and the location of the researcher.

An outsider position has been considered to be advantageous in that not belonging to the group gives the ability to ask 'naive' questions, probing assumptions an insider may hold or overlook (Hayfield & Huxley, 2015). However, as an outsider the ability to understand and accurately interpret the contribution of participants may be constrained (Hayfield & Huxley, 2015). The use of triangulation, and stakeholder workshops as a credibility check of the findings was built into the design of this case study to help mitigate these limitations.

Numerous further characteristics are involved with the positionality of the researcher including, but not limited to gender, age, race, personal experiences, and beliefs (Berger, 2015). Participants may be more inclined to share their insights and aid with further access to potential participants with a researcher viewed as more sympathetic, or with shared interests. In this case, demonstrating an interest and passion about mental health may elicit greater participation.

The position of the researcher along this insider-outsider can change during the period of the research and so this was continuously reflected upon (Ritchie et al., 2009). Although the PhD student remained a conspicuous outsider throughout, as familiarity and knowledge with the context expanded over time, they may have mover slightly along the continuum from outsider to insider. A reflexive diary was kept throughout the research period by the PhD student to facilitate critical consideration of their positionality and the biases and assumptions that they hold, and how this may have influenced the empirical research, including the interpretation of the data.

For this study, the PhD student, a researcher with experience of working in health policy, became aware that they had their own beliefs about what constituted robust evidence, for example. Being aware of this helped leading questions to be avoided during data collection, and enabled consideration of how the perspective of the PhD student may have influenced the data analysis. The reflexive diary was a useful aid during the fieldwork, a busy and intense time. Writing down what was surprising helped the PhD student to identify their own subconscious beliefs and assumptions, for example on what priority issues should be. In particular, the diary was found to be useful during the fieldwork

when the evolving pandemic required research decisions to be made at short notice. Documenting the thought process was helpful to ensure that there was a clear justification for any decisions made.

3-4.2 Positions of the audience

As well as considering the position of the researcher, Abimbola (2019b) stresses the importance for reflexivity of simultaneously considering the positions of the intended audience for the research. Abimbola (2019b) argues the position of the researcher and the audience of research in the field of global health should be made explicit to explore the affect this has on the understanding of the topic of research given the power and information imbalances that exist in global health and to help address these.

Under Abimbola's (2019b) authorial reflexivity framework, shown in Figure 11, the position of the researcher is labelled the 'pose', and the position of the audience is termed the 'gaze'. Abimbola (2019b)'s authorial reflexivity framework serves as a theoretical basis for reflexivity in this thesis, which is produced from a foreign pose for a foreign gaze. As per the intended outputs of this PhD, some of the findings will also be aimed a local audience. These different intended audiences, or 'gazes' bring different considerations.

Figure 11. The authorial reflexivity matrix (taken from (Abimbola, 2019b) - CC BY-NC 4.0).

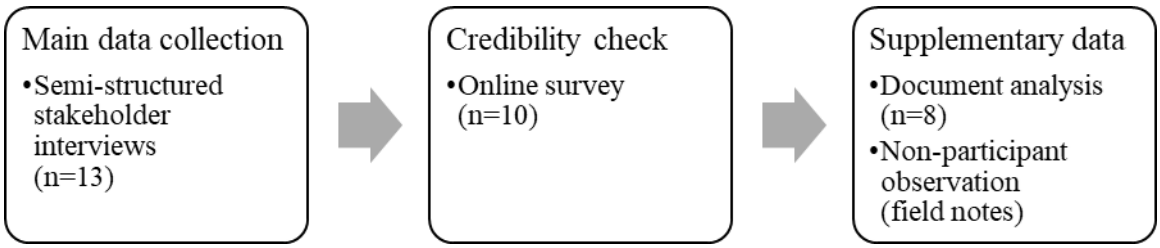
	Gaze	
Pose	Local	Foreign
Local	**"Ideal"**	**Corrupting?**
Foreign	**Consequential?**	**Necessary?**

One issue identified by Abimbola (2019b) is foreign experts who produce research on local issues without acknowledging how and why their audience is foreign experts, rather than local experts. The interests of a foreign audience can be different from those of a local audience. For outputs aimed at a foreign audience, for example articles in peer-reviewed journals, it is important to be clear about which aspects of the local reality have not been included. The challenge is to recognise which local insights are useful at a foreign level. For outputs aimed at a local audience, it is important to acknowledge that the local audience are the experts about the local realties. Therefore, considering the audience is an important consideration when producing research outputs.

3-5. Approach to Data Collection

As summarised in Figure 12. An overview of the data collected., this case study used a range of methods to collect data: semi-structured interviews; an online survey; document analysis; and non-participant observation. The interviews formed the primary data of the current study, and these formed the main body of the results chapters (Chapters 4 – 8). The findings from the other methods of data collection (online survey, document analysis, and observation) are woven throughout the results chapter and presented where relevant to either support or challenge the findings from the interviews, rather as a stand-alone section. The online survey was largely used as a credibility check of the interpretations of the interview data. The document analysis and observation provided supplementary data that was mainly used for triangulation, as well as to further enrich the findings. Whilst interviews are a useful means of providing rich data, these additional and complimentary methods of data collection also help address a limitation of interviews as a research method is that the data concerns what participants say, and not what they do (Guest et al., 2013).

Figure 12. An overview of the data collected.

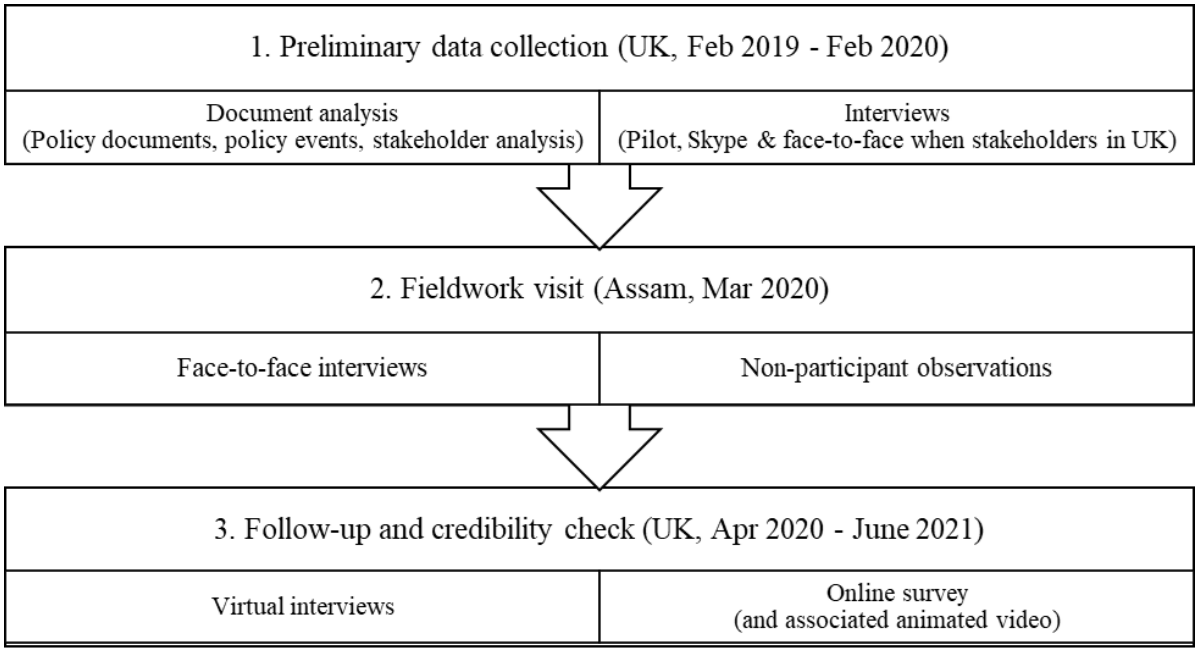


The sample sizes obtained for each method of data collection were: interviews (n=18), online survey (n=10), document analysis (n=8). In addition, field notes were produced from informal observations during the fieldwork period in Assam. Qualitative scholars have argued the use of numerical sample size guidelines and guidance is of limited use and, rather, contextual knowledge is key to appraising sample size with consideration of data adequacy and saturation (Vasileiou et al., 2018). The study aimed to recruit 10-15 purposefully sampled participants for an interview and 10-15 participants for the survey. This sample size was thought sufficient to allow saturation to be achieved (i.e., little additional information is likely to be gleaned through interviewing more participants). Knowledge of the context and scope of the research was therefore used to determine the target sample size; qualitative scholars have argued the use of numerical sample size guidelines and guidance is of limited use and that rather contextual knowledge is key to appraising sample size with consideration of data adequacy and saturation (Vasileiou et al., 2018).

The sample size was based on the scope and specificity of the research question. Due to the small number of stakeholders working in mental health in Assam, this sample should be sufficient to represent a diverse range of views within this group. For online surveys, it has been argued that richness needs to be considered for the dataset as a whole, rather than from individual accounts (Braun et al., 2021). As data collection and analysis took place iteratively, this sample size was continuously reviewed. Although the upper bound of the target samples were not met, saturation was deemed to have been reached.

Data was collected over the period from August 2019 to June 2021. Within this period there were two main phases of data collection: UK-based data collection, and one fieldwork visit to Assam. Figure 13 illustrates when each data collection method was conducted relative to the overall study period. The data collection period, which extended beyond the fieldwork visits, allowed for iterative date collection and analysis whereby initial findings could be fed back and used to inform data collection, for example to identify further interview questions or participants.

Figure 13. Timeline of the three main phases of data collection.



3-5.1 UK-based data collection

Secondary data for the document analysis commenced once ethical approval for the study had been obtained and continued alongside the primary data collection. Some primary data collection was able to take place remotely. Pilot interviews to test the interview schedule were conducted from the UK before the bulk of the interviews were conducted on the fieldwork visits. In-person interviews in the UK were held when the opportunity arose (when four stakeholders visited the country). Data for the

credibility check of the initial findings was also conducted from the UK subsequent to the fieldwork visit to Assam.

3-5.2 Fieldwork visits to Assam

Two fieldworks visits to Assam were planned and budgeted for, in order to allow primary face-to-face data collection. This included semi-structured interviews, observations and stakeholder workshops; the latter two were limited to fieldwork visits as they required the researcher to be physically present in Assam. The visits were planned approximately one year apart, in March 2020 and March 2021 due logistical factors including to avoid the monsoon season from June to October in Assam.

It was anticipated the first visit would enable the bulk of the primary face-to-face data collection, including interviews and observations. The second visit was intended provide the opportunity to share and credibility check the emerging findings through the use of stakeholder workshops. However, due to the international travel restrictions brought about by the COVID-19 pandemic the second was not possible, and the first was heavily impacted.

3-5.2.1 First fieldwork visit

The first fieldwork visit took place between the 4th-31st March 2020, following ethical approval for the study from both the Lokopriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH) and the University of Leeds) and once the appropriate research visa had been obtained. The main aim of this visit was to conduct primary data collection including face-to-face interviews, and observations. Secondary aims were for the researcher to build a network for this and future research, and also to gain first-hand experience of the region to generate a deeper understanding of the context of the case study.

The PhD student was based in Guwahati, and hosted by MIND India, Institute of Positive Mental Health & Research, a Big Picture partner organisation, who provided office space. MIND India offers counselling services and is also involved in a range of educational and research activities, providing an opportunity for the PhD student to become familiar with different aspects of the mental health context in Assam. MIND India, along with the Big Picture Research Fellow, helped with introducing the PhD researcher into the relevant professional and social circles.

A visit to Tezpur, in the Sonitpur district of Assam was made. Primarily, this was to visit the Lokopriya Gopinath Bordoloi Regional Institute of Mental Health, the main psychiatric facility in North East India. This visited was coordinated by an advisor to the Big Picture project who is based at LGBRIMH.

The COVID-19 pandemic coincided with the first fieldwork visit to Assam, and this had an adverse impact on the data collection. Data collection was directly limited by the period of quarantine that the PhD student was required to undergo, as well as the lockdown imposed on the 24th March 2020. There was an also indirect effect through increased challenges for recruitment, with the extra workload and stress, both professional and personal, faced by potential participants. This impact was minimised by adapting the individual data collection methods where possible, and by adapting the balance of the methods used.

3-5.2.2 Second fieldwork visit

The aim of the intended second fieldwork visit was to primarily to share and conduct a credibility check of the initial findings from the first fieldwork visit and the UK based data collection, through stakeholder workshops. Secondary aims were to conduct any more face-to-face interviews or observations as identified by the data analysis completed so far to address any gaps or further questions that are raised. However, due to the COVID-19 pandemic and the resultant international travel restrictions the planned second fieldwork visit to Assam was unable to proceed.

3-5.3 Modifications to data collection due to the COVID-19 pandemic

As a consequence of the cancellation of the second fieldwork visit, the data collection approach was adapted in order to meet the original aims as closely as possible, using online instead of face-to-face methods. First, more of the stakeholder interviews took place over Skype rather than being face-to-face. Second, an online survey with an associated animated video was used in lieu of stakeholder workshops. Third, document analysis was used more extensively, particularly documents that gave accounts of relevant policy-related events.

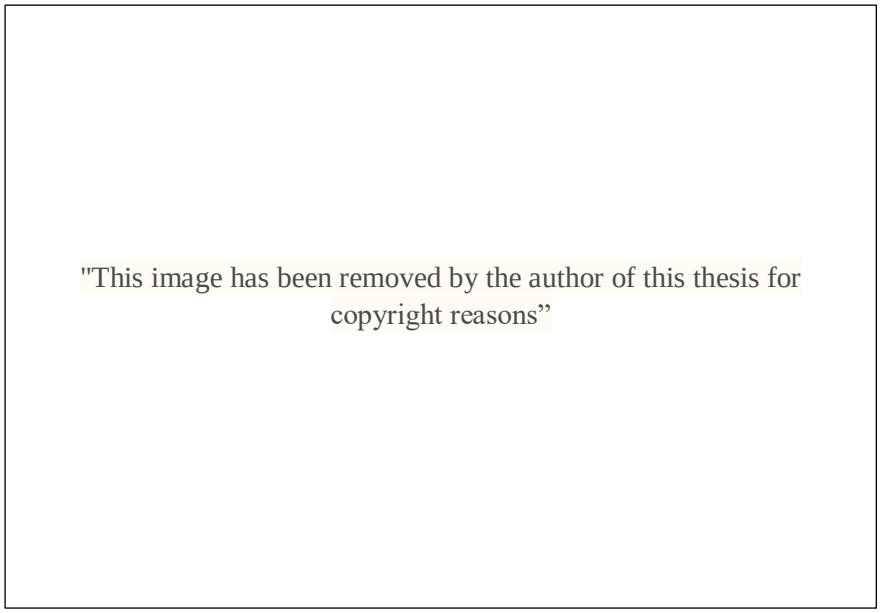
3-5.4 Main data collection: Semi-structured interviews

Semi-structured key stakeholder interviews were the main form of primary data collection for this study; data took the form of verbatim transcripts.

3-5.5.1 Interview typology

A typology of interviews along two axes, shown in Figure 14 has been proposed by (Bernard, 2017), with interview structure on the x axis, and interview depth on the y axis.

Figure 14. A typology of qualitative interviews (taken from (Guest et al., 2013)).



Qualitative interviews exist on a continuum from structured to unstructured interviews (DiCicco-Bloom & Crabtree, 2006; Given, 2008; Qu & Dumay, 2011). Semi-structured interviews, where there an interview schedule is used flexibly and adapted according to the participant's responses, were used as they suit the exploratory nature of this the study. They allow for a combined inductive/deductive approach, allowing specific questions of interest to the researcher to be posed as well as for the interview to generate new lines of questioning. The flexibility they offer, unlike structured interviews, is useful as the participants consisted of many different types of stakeholders, and this allowed the interviews to be tailored to each individual. Semi-structured interviews, in comparison with unstructured interviews, help ensure that the topics of interest are covered. They also help in gatekeeping during the interview, which was of use for these interviews where many participants were more comfortable talking about mental health practice than policy.

Qualitative interviews can be broad or narrow in scope. The semi-structured interviews for this study are in narrow in scope, focusing specifically on the role of evidence for setting the mental health policy agenda in Assam. Accordingly, in-depth interviews can be used for the latter to collect rich data and gain an in-depth understanding on a specific topic from “experts” on that topic (Guest et al., 2013). In-depth interviews were used for this study as they are well suited to case study designs, which aim to gain an in-depth insight into a multi-dimensional, complex phenomenon. In-depth interviews are suited for exploratory research due to their open-ended nature. They also utilise inductive probing and therefore match well with a semi-structured interview approach.

However, the extent to which interviews could be in-depth was limited by practical constraints, most notably the amount of time that participants were able to spare. In-depth interviews can be time-consuming; interviews strictly in-depth in nature are cited as requiring between 45 minutes to 2 hours,

depending upon how broad the scope of the topic is (Guest et al., 2013). Some participants held senior management positions in large institutions, others had high clinical and multiple other demands, and even more junior participants had many demands on their time including studying and multiple roles. This was also exacerbated the by the COVID-19 pandemic which increased personal and professional workloads of participants. The interview medium may also influence the depth of the interview, and this will be explored below.

In-depth interviews are typically conducted in a one-to-one setting (Guest et al., 2013). Unlike focus group discussions where multiple participants are present, this is to help maintain the confidentiality and anonymity of participants and reduces pressure on participants to give what they perceive to be as politically or socially correct answers, particularly for sensitive topics. It also allows the interview to delve deeper into one particular individual's insights.

However, in this study, with the consent of the participants involved, two interviews each with two interviewees alongside one another were conducted face-to-face when participants were visiting the UK. This was due to the time pressure of the participants, and the practicalities of their schedule. The presence of another participant in the interview may have influenced the responses given, especially concerning sensitive topics such as power relations. But again, it was decided the priority was to recruit more stakeholders to give as many perspectives as possible given the challenges with recruitment. Furthermore, the participants in these two interviews bounced ideas off each other, akin to a focus group discussion, and thus perhaps added different insights that might not have been gained if all the interviews had been conducted in a one-to-one setting.

3-5.5.2 Interview medium

Face-to-face interviews were conducted wherever possible because they are advantageous compared to other mediums, and considered to provide the highest quality data (Lavrakas, 2008). The key advantage is that the conversation is able to flow more naturally, due to being synchronous in time and space, and both sides are easily able to ask for clarification.

However, due to the international nature of this research, face-to-face interviews were not always possible and other mediums were used when this was the only way to facilitate the recruitment of participants into the study. Phone and Skype (including video) interviews with stakeholders based outside of Assam were conducted from the UK as these stakeholders would not be accessible during the fieldwork visit. Phone and Skype interviews are synchronous in time but, unlike face-to-face interviews, not space. The flow of the interview can be disrupted and is reliant upon a good internet connection.

Whilst the option of virtual interviews by Skype/phone was always intended for participants, this became the default option when face-to-face ceased being possible due to the pandemic. A negative consequence of this is that it restricted participation to those with access to the required technology, thus limiting the sample (Varma et al., 2021). In addition, the use of virtual research methods can affect researcher positionality and exacerbate the 'outsider' position of the researcher by increasing physical distance (Roberts et al., 2021).

Email interviews are asynchronous in both time and space, and therefore have certain advantages and disadvantages over face-to-face and phone/Skype interviews (Meho, 2006). There is more room for misinterpretation by both the interviewee and the interviewer and there is less scope for clarification on both sides. Tone and any emphasis placed on certain words and expression is also absent. Although not recorded in the transcript, the researcher would be aware of these in other mediums during the interview, and through any familiarisation by listening to the recording.

Email interviews were offered as an option to participants in light of the coronavirus pandemic. Stakeholders working at home due to the lockdown may have a poor internet connection, be without a suitable private room, or due to an increased workload (personally and/or professionally) may prefer to answer the questions in smaller time chunks. Additionally, as there is no fixed end time to the interview, there is the potential from more in-depth probing, that face-to-face or Skype interviews. Email interviews also allow participants a longer period of time to reflect on their answers. However, no participants chose an email interview.

3-5.5.3 Interview schedule

An initial interview schedule was developed (Appendix 2), based on the findings of the literature review and the meta-framework developed, and tailored for each interviewee. The interview schedule was intended as a guide for the interview, whilst allowing flexibility for the interviewer to follow-up on different lines of enquiry, go into greater depth on certain topic, or to ask the questions in a different order to improve the flow of the interview (Given, 2008).

3-5.5.4 Pilot interviews

Piloting is a standard procedure to trial a research instrument (Chenail, 2011; van Teijlingen & Hundley, 2002); in this case an interview schedule, and can help improve the clarity and wording of the interview questions and improve time management of the interview. As the PhD student had limited prior experience with qualitative interviewing, this 'trial-run' was particularly useful.

Piloting is particularly important where there are cultural considerations (i.e. where the interviewer and interviewee are from different cultures) and it allows for the researcher to become aware of any

preconceptions or biases that they might have unknowingly held (Kim, 2011). The pilot interview revealed some questions would benefit from a different wording with greater explanation, and that there was differing understanding of key terms such as ‘evidence’.

Pilot interviews are not usually included in main data set (van Teijlingen & Hundley, 2002), because if there were revisions that needed to be made to the research instrument, this could render any data collected with a version prior to this update inaccurate. But due to the purposive sampling strategy and the challenge in accessing and recruiting a limited number of key stakeholders, with the consent of the participants, the pilot interviews were included as data in this study as they represented valuable data. Moreover, as this was an exploratory study, a more iterative approach was taken to development of the research instrument throughout the data collection period, alongside data analysis, and as such the instrument tool is not as fixed as perhaps in evaluative studies (Malmqvist et al., 2019).

3-5.5.5 Power dynamics

A range of power dynamics between the interviewer and interviewees resulted from the range in the status of the interviewees.

Some interviewees were on a similar level to the interviewer in terms of age and seniority, which allowed the interviewer to develop a closer rapport. Conversely, some interviewees were more senior than the interviewer in terms of age and position and could be considered ‘elites’, for example highly esteemed individuals or those in senior management level roles. For these interviews the normal power dynamics between the interviewer and interviewee were reversed and the interviewees may have been perceived to have greater power than the interviewer. The PhD student could therefore ask more “unauthorised and naïve” questions, adopting the role of a student to elicit fuller and richer response from participants (Vähäsantanen & Saarinen, 2013). Moreover, an advantage which arose from the researcher’s position as an outsider was that participants explained many concepts in their own words rather than assuming that the interviewer had knowledge about the local context.

Although this power dynamic can be beneficial, on the other hand it can lead an interviewer to feel intimidated. To minimise this, the recommendation to help portray a more equal distribution of knowledge was followed (Edwards & Holland, 2013). To achieve this, the PhD student was well prepared in the background of the ‘elite’ individual, and the wider topic and context, in order to ask knowledgeable and tailored questions. The interviewee may also have their own agenda for the interview; the use of an interview schedule was used to help the PhD student to stick to their own research agenda.

Age and gender can also affect this power dynamic (Edwards & Holland, 2013), and as the PhD student was a relatively young female this may have exacerbated the power dynamic of interviewing

'elites'. However, young females may have certain advantages as interviewers as they can be viewed as less threatening and are therefore able to elicit more open responses (Edwards & Holland, 2013).

3-5.5 Participant recruitment

Participants were purposefully-sampled from key mental health stakeholders in Assam, and nationally where relevant. An overview of the characteristics of the participants are displayed in Table 8. Although, as shown in the table, the types of stakeholder categories are not discrete. In the results chapters where quotes are presented these are attributed to the most pertinent type of stakeholder (policymakers, researcher, or intermediary) in each case.

Table 8. Characteristics of study participants.

		Interviews (n=13)	**Online survey** (n=10)
		N (%)	
Gender			
	Male	9 (69.2%)	6 (60.0%)
	Female	4 (30.8%)	4 (40.0%)
Geographic extent of role			
	Familiar with Assam context	8 (61.5%)	8 (80%)
	Not specifically familiar with Assam context (but at an All-India level)	5 (38.5%)	2 (20%)
Type of stakeholder			
	Significant research experience	6 (46.2%)	6 (60.0%)
	Policymaking experience (adviser to policymaker)	2 (15.4%)	2 (20.0%)
	Neither research nor policymaking experience	5 (38.5%)	2 (20.0%)

The stakeholder map produced (see section 5-5.4) was used to identify suitable individuals. Networks of the research team, and the 'Big Picture' project partner organisations were also used to assist with recruitment, as key informants and host organisations are vital in the success of cross-national qualitative fieldwork, and capitalising upon their social capital (Boggiano et al., 2015). A snowballing strategy was used to identify further potential participants.

There was significant overlap between the roles of stakeholders (see Chapter 5). Therefore, rather than stakeholders being placed into three discrete types – researcher, policymaker, and intermediary – stakeholders were categorised by their research and policymaking experience (Table 8).

A limitation of this study is limited description of the policy processes was offered by some participants. This was due to difficulties with the recruitment of 'policymakers' fewer participants were recruited who had experience with policymaking, either as policymakers or by working with

policymakers, for example in an advisory capacity. Limited insights from this group were, therefore, obtained. Recruitment of policymakers as an 'elite group' has been widely documented to be challenging particularly in LMIC settings and for sensitive topics (Deane et al., 2019), and is therefore not unique to the present study, but was exacerbated by the COVID-19 pandemic. Whilst some of the 'researchers' and 'intermediaries' had some involvement in, and knowledge of, policy processes, some participants, were less familiar with the policy processes. So, the findings of the current study are largely limited to how the policymaking process is perceived. Whilst perceptions of the policy processes offer interesting and important findings, such as the insights reported by Corluka et al. (2014), the current study offers more limited the insights on the processes themselves. Given that Assam does not yet have a standalone mental health policy, participants drew on their knowledge and experience of broader health policy processes that include mental health.

Interview participants were later invited to also participate in the online survey to check that the interpretations of the interview data were correct. Further stakeholders were also invited to gain further and more diverse views. There is therefore some, although not complete, overlap between the interview and survey participants. A higher percentage of survey respondents, compared to interview participants, (80.0% vs. 61.5%) were familiar with the context of Assam. Although the sample size was small, the video of initial findings, which unlike the interviews, was not tailored to participants may have appealed more to these stakeholders.

3-5.6 Credibility check: Online survey and animated video

At the outset of this PhD in 2018 it was envisioned that stakeholder workshops would be conducted to provide a credibility check of the initial findings from the interviews. Stakeholder workshops are a data collection tool which centre on the engagement and collaboration between participants, and thus offer the potential for the collection of highly rich data and a shared learning experience (Ahmed & Asraf, 2018). The intended stakeholder workshops were planned to be conducted during the second field visit. However due to the COVID-19 pandemic it was not possible to effectively carry out stakeholder workshops in person, due to international travel restrictions, or online for practical reasons. Although stakeholder workshops were the focus predominantly of the planned second field visit, the opportunity also arose during the first field visit to Assam to hold two stakeholder workshops due to the kind facilitation of project partners (of the wider Big Picture project of which this PhD is a part of). However, these were cancelled at short notice due to the rapidly developing COVID-19 situation.

Whilst other PhD scholars reported successfully conducting online stakeholder workshops due to the pandemic (Gibbs, 2020), this study decided this approach was unlikely to be successful in Assam.

Many stakeholders in Assam were facing an increased workload and it would have been challenging to schedule a workshop for multiple participants, many of whom often had changes to their schedule at short notice. In addition, internet speeds may not have been supportive of a video call. The video was used as a stimulus for the online survey; the video briefly shared the initial findings which the associated online survey asked for feedback on. In addition, the video also explained the aims of the study; it was important to give background to the study as some viewers were not previously familiar with the study. Video remains underutilised as a tool to disseminate the findings of qualitative research in spite of the vast impact of technology in society (Tascona et al., 2021). Recent work, although not yet peer-reviewed and therefore must be interpreted with caution, has signified that video may be useful for knowledge translation for health research (Deliv et al., 2021).

Online surveys are an established research method, but have become more widely used for health research in recent times due to the COVID-19 pandemic (Hlatshwako et al., 2021). Online surveys can be used as a qualitative research tool, and can provide both richness and depth, however they have not been as widely utilised as quantitative online surveys (Braun et al., 2021). A key advantage of qualitative online surveys that make them particularly useful for the current exploratory study is that they enable a range of perspectives from different stakeholder groups, particularly useful for under-researched topics (Braun et al., 2021). Online surveys also enable both the ability to explore the big picture as well as to zoom in with the potential for rich and focused data (Braun et al., 2021), important for evidence-to-policy and complex and multi-faceted phenomenon. In addition, given the time constraints of participants, exacerbated by the COVID-19 pandemic, an online survey can be completed in sections, making it easier for stakeholders to fit participation around their schedule; a challenge noted during the scheduling of interviews was that schedules were often liable to change at short notice.

3-5.6.1 Aims

The intended aims of the planned, but no longer possible, stakeholder workshops for this PhD were to provide a credibility check of the initial findings from the interviews and provide the opportunity to explore topics and questions that arose in more depth. This would help minimise the risk of misinterpretation, ensuring the validity and rigour of the research. The workshops were also intended to enable the initial findings to be shared with stakeholders, important not all participants were already familiar with the study, and maximise the usefulness of the outputs.

Credibility checking the results is especially important for this case study because of the cross-cultural component, including the language the study was conducted in. Language is entwined with cultural context (Gubrium & Holstein, 2001; Tsai et al., 2004). Although all the participants were professionals who were proficient in English, and happy to participate in the research through the

medium of English, there are still issues that arise from the cross-cultural design of this study. English will be participant's second or third language, and there is the possibility that some concepts/words would not translate well into English, leading to participants not clearly expressing an opinion because no comparative term exists in English. Even subtle changes could have an impact on the findings.

When the stakeholder workshops were no longer possible, a qualitative online survey, with an accompanying online video, was chosen as an alternative method in lieu of the stakeholder workshops that would still help meet the research aims, and enable a credibility check of the initial conceptualisations, in a different way. Whilst there are some areas where an online survey is limited in comparison to stakeholder workshops, an online survey has its own advantages and is an alternative rather than an inferior method. For instance, an online survey has the potential to gain broader range of views.

3-5.6.2 Survey and video design

A short (~3 minute) whiteboard style animated video was produced[7]. The video involves an image being drawn upon a white background during the video, and the continual anticipation throughout the duration of the video of what is going to be drawn next has been proposed as the reason behind why audiences find them engaging (Air et al., 2015). This style of video was chosen as it is both simple and effective; there are free tools available that facilitate their quick production, without the need for extensive training.

The whiteboard style animated video was created using 'simpleshow video maker' (Simpleshow, 2021), and online tool for producing explainer videos. First the script for the video was written by the PhD student. Then the tool provided suggested key words in the text and associated animations. Although not all suggestions were used, these were used a basis for the video and edited in order to make them more for the intended use and audience, thus making the creation of the video a lot less time intensive. A voiceover of the script was then recorded by the PhD student. Whilst this was more time-consuming than using automated options, it was felt that it would be more engaging and personable for all viewers, including participants unfamiliar with the rest of the study. In particular, however, it would capitalise upon the relationships established with stakeholders that the PhD student had met (face-to-face or virtually) previously.

[7] The video can be viewed by accessing the following link (https://videos.simpleshow.com/sMCeR9pCiu).

Correspondingly, whiteboard animation style videos remain novel research, and subsequently there is minimal guidance as to its use. Most of the limited research to date on whiteboard animation videos has been in educational settings, where they have been shown to be engaging (Türkay, 2016).

Emerging research appears to suggest potential for whiteboard style animated videos in disseminating the findings of health research in particular (Scott et al., 2021)[8]. Furthermore, whiteboard animations have been suggested to be a viable and culturally appropriate means of disseminating the findings of research on health and environmental policy issues back to participants, members of indigenous communities (Bradford & Bharadwaj, 2015). However, no formal evaluation was conducted to support this. Despite this, the feedback for participants of the current study was also positive, with the video described as engaging. Therefore, the findings of this thesis further suggest that videos may be a useful tool for knowledge translation and the dissemination of research. Moreover, videos have been shown to be useful as an engaging introduction in supporting difficult discussions among a diverse group of stakeholders (Bradford & Bharadwaj, 2015). This was likely to be useful given that wide range of stakeholder types that the purposive sampling identified.

'JISC Online Survey' (formerly Bristol Online Survey - BOS) was used to design, distribute, and analyse the online survey, as this tool was recommended by University of Leeds Research and Innovation Service to help ensure compliance with the Data Protection Act. The survey was intended to take no more than 30 minutes to complete, to minimise the time burden on participants. Participants we asked to provide some demographic details and the broad type of their job/role, but were not be asked to provide their name. The survey questions asked for feedback on the initial findings, and the extent to which participants agreed them[9]; the responses were used to refine the initial findings. An updated video will be subsequently made based on the refined findings and disseminated to stakeholders, including participants.

The survey was comprised of a mixture of closed and opened ended questions in order to allow participants to give their full feedback, whilst also providing prompts. Supervisors and members of the research team familiar with the participant pool suggested that purely open questions, although the 'gold-standard' for qualitative survey questions might not elicit any, or detailed, responses from participants. Similarly, Braun et al. (2021) have suggested that closed questions followed by open-ended questions might help to improve the clarity of the questions, and thus the data received. Respondents engaged to different extents with the open-ended questions, with some more forthcoming than others.

[8] This study is still pending peer-review and therefore must be interpreted with caution.
[9] The survey can be accessed here: https://leeds.onlinesurveys.ac.uk/evidence-the-mental-health-policy-agenda

3-5.7 Supplementary data: Observations

Qualitative observation is a method of systematically and purposefully collecting data about how people behave, what they say and do, in their natural setting (Given, 2008). Observation enables the researcher to gain first-hand understanding of the context in which the phenomenon of interest occurs. Additionally, it facilitates investigation of the subconscious insights of interviewees, insights that they might not deem to be important or interesting, or not willing to discuss.

Observations, which are time-intensive and can be difficult to secure access, often do not provide rich enough data as a standalone method of data collection. However, observations can powerfully complement other data collection methods and so are often used as part of a case study design (Given, 2008), like the current study, provide an additional layer of detail, enriching the data can help capture insights from anticipated sources and places (Phillippi & Lauderdale, 2018). Non-participant observation, where the researcher does not interact with participants, is widely used in case study designs to observe events to help understand a phenomenon in its natural setting (Mills et al., 2010). Non-participant, rather than participant, observation was more suitable for this study as the researcher an 'outsider' and therefore not a stakeholder for the agenda-setting process.

The observation data were used to triangulate the interview data and helped ensure the validity of the findings. Observations also enabled greater insights into the interview data, particularly as the researcher was an 'outsider' and not from the location of the study and this can aid in understanding participant meaning. Additionally, the observation data was used to help guide the interviews and ensure the cultural relevance and appropriateness of the questions asked, where scheduling allowed observations to take place before the interviews are conducted. Furthermore, it also enabled better facilitation by the PhD student of the interviews, through understanding of specific cultural cues.

3-5.7.1 Informal observations

It was originally aimed for five (n=5) formal non-participant observations, by the PhD student, of relevant events or meetings, depending upon the opportunities available during the period of fieldwork. However, the pandemic exacerbated the challenge of gaining access to relevant policy and agenda-setting events. Relevant events are infrequent due to the low priority of mental health as a policy issue which needed to coincide with the short (month long) fieldwork field work period. Due to the pandemic policymakers, as well as other stakeholders, saw an increased workload, the ability of the PhD student to travel was also restricted.

However, informal observation took place over the course of the fieldwork period, during both professional and social contexts. Time spent at both MIND India in Guwahati and Lokopriya Gopinath Bordoloi Regional Institute of Mental Health, Tezpur (LGBRIMH) provided opportunities

for informal observation. Although perhaps not necessarily immediately directly policy-related, these observations proved to be relevant given the finding of the current study of the importance of context and the need for efforts to strengthen the use of evidence in setting the mental health policy agenda in Assam to focus on a greater range of stakeholders (see Chapters 3, 7, and 8).

All observations were overt, i.e. the PhD student presented themselves as an observer-researcher to all participants to make them aware of the PhD student's role; no deception was used. Although intended for the research to be a non-participant observer, the researcher was invited to be an active participant in an arts workshop for counselling students, which was accepted as this was not a direct policymaking activity and would help build good relations. The use of unstructured observation suited the non-participant nature of the observations which allow the researcher to sit anywhere on the participant-observer continuum, unlike structured observations where the researcher strives to lie on the complete observer end of the continuum (Mulhall, 2003). The observations conducted were also unstructured. In unstructured observations, the researcher has no pre-defined idea of what will be observed, rather a broad notion of what may be important before they reach the field (Given, 2008). This allows for the discovery of unanticipated findings.

3-5.7.2 Field notes

Data from the informal observations was collected in the form of the PhD student's written field notes, based on the researcher's interpretation of the event. The observations were not audio or video recorded. There is limited specific guidance about what to include in field notes (Phillippi & Lauderdale, 2018), and so the researcher tried to include as much detail as possible, and iteratively identifying what was most relevant. A suggestive observation guide was used containing an account of events, how people behaved and interacted, what was said in conversation, physical gestures, and my subjective responses to what was observed. As an unstructured observation, the guide was only suggestive and not restrictive, to allow for unexpected elements and insights to be captured. When interpreting the data it was important to be cognizant of the observer effect, whereby people change their behavior when they know they are being observed (Frey, 2018).

Field notes consisted of both descriptive and reflective field notes (Johnson, 2017). The initial notes were largely descriptive and written by hand during the observation, these were written up in full as soon as possible afterwards. Reflective field notes were developed over time during the analysis process. The field notes were analysed alongside the interview data, and each was used to inform understanding of the other.

Any notes were purely the PhD student's interpretation of what was being observed, no direct quotes were used as data. Research settings involving individual(s) in workplace environments, such as observations, poses particular issues. It was not always possible to gain consent from everyone who

may have been in the observation setting and would be very disruptive to the normal workings of the group setting (Watts, 2011). However, as far as possible, consent was gained from all parties, often verbally. Efforts were made to ask participants who were the focus of my observations to introduce me to people with whom they spend significant time to enable consent to also be gained from them.

3-5.8 Supplementary data: Document analysis of policy-related information

Existing (academic and grey) literature was already analysed by this study for the *review of review*s to understand existing theory and develop a conceptual framework that this study utilise and further develop (see Chapter 2). Grey literature was further used in the empirical component of the research for this PhD. Policy-related information in the public domain was used via internet mediated document analysis. The policy-related information collected was in the form of published documents in multiple forms, produced in the absence of any involvement from the researcher. Document analysis is the systematic review of written documents, and analysis of the publicly-available policy-related information was used for two aims: (1) to supplement the primary interview data and provide context to the findings; and (2) to contribute to the stakeholder mapping. Some of the data for these two aims overlapped.

Document analysis is an established qualitative method that utilises secondary data and provides a systematic approach for reviewing documents in the public domain (Bowen, 2009). Document analysis has been argued to be central to the field of health policy research, and thus widely utilised (Dalglish et al., 2020). Document analysis is well suited to the current study, a qualitative case study, in addition to the other data collection methods as it can be combined with other research methods to triangulate, add depth to, and provide context to, other findings (Bowen, 2009; Dalglish et al., 2020). Moreover, document analysis is also useful to the predominantly exploratory nature of the research as it can help generate further research questions (Bowen, 2009; Dalglish et al., 2020).

Although secondary data can lack detail or specificity as it not produced specifically to answer the research question, it is valuable for exploratory research in order to help establish what is already known about the topic and generate further research questions. Also, it helps to avoid unnecessary duplication of data that already exists. The use of secondary data posed challenges to obtaining informed consent. Secondary data involved documents publicly available on the internet, such as the minutes of policy meetings. These could be argued as being in the public domain and open to research scrutiny (British Psychological Society, 2017).

However, there are still issues, for instance, communication in the meetings may have been private when it was conducted, even if it is now publicly available. Potentially damaging effects include perceived reputational damage to committee members and their respective organisations. This was

mitigated by the policy meeting minutes being publicly available documents, created for public purpose and to allow for public accountability. These are discussion minutes and not verbatim minutes. Furthermore, the contributions of individuals were not analysed, rather the process, and the role of evidence was assessed.

3-5.8.1 Policy-related events

A specific focus of the document analysis were documents that gave accounts of relevant policy-related events. Initially document analysis was conducted more broadly to include material related to relevant policies (state or national) or key evidence to help understand the role of evidence for mental health policy in Assam (and at an all-India level). As suggested by Dalglish et al. (2020) the role of document analysis evolved over the study; a more focused role for document analysis was sought. Written documents (in the form of minutes, blogs, and reports) detailing policy events (policy seminars, minutes of policy group meetings etc.) became the main focus when opportunities observations, especially formal, became limited due to the COVID-19 pandemic. The pandemic exacerbated the existing difficulty of securing access to relevant agenda-setting events during the fieldwork period. As such, secondary observations of policy-related events were useful in terms of how, largely for policies in other health areas in Assam.

Google, an internet search engine, was used to search for key documents rather than a database search as most documents were retrieved from government or institutional websites. Given the narrow scope of the topic, documents were also identified by knowledge of the topic, or with suggestion of other members of the research team and local input. The internet search was used to ensure no relevant documents were missed, and to help minimise bias. The search was limited and not made as exhaustive as it could have been, in order to attempt to ensure that documents retrieved were intended for public use and scrutiny. This may not have been the case for documents that were hard to find, or were hosted on small websites. For practical reasons the search was only conducted in English, which is a limitation given that some relevant documents are likely to have been published in other languages, particularly in Assamese, Bodo, and Bengali – the official languages of the State of Assam.

A data extraction table was used to systematically collect the relevant data on the nature of the policy documents, and the role of evidence. The document analysis was used to understand the role of evidence in policymaking processes; rather than the contribution of individuals. A summary of the documents that provided a secondary observation of relevant policy-related events is given in Table 9.

Table 9. The documents analysed to elicit secondary observations of policy-related events.

Policy-related Event	**Relevance to mental health agenda-setting in Assam**	**Type(s) of document**
'*Transforming Food and Nutrition Landscape in Assam*' Policy Seminar 29th March 2017, Guwahati, Assam	Similar to mental health, the policy issue falls under the remit of the Health and Family Welfare Department of the Government of Assam and therefore there is some crossover of stakeholders.	n=2 • One report (The Coalition for Food and Nutrition Security, 2017) • One blog (Raykar, 2017)
Seminar on Health Condition of Women in Rural Assam 30th August 2010, Guwahati, Assam	Similar to mental health, the health of women in rural Assam is low on the policy agenda despite clear evidence of need. Again, the policy issue falls under the remit of the Health and Family Welfare Department of the Government of Assam and therefore there is some crossover of stakeholders.	n=1 • Press release (C-NES, 2010)
Mental Health Policy Group The Ministry of Health and Family Welfare, Government of India appointed a Policy Group in 2011 to prepare a National Mental Health Policy and Plan	There is a complex relationship between central and state governments for health policy issues.	n=5 • Three minutes (Mental Health Policy Group, 2012a, 2012c, 2012d) • Two reports (Government of India 2012; Mental Health Policy Group 2012b)

3-5.8.2 Stakeholder analysis

Stakeholder analysis is a widely applied tool in health policy research, including in LMIC contexts (Hyder et al., 2010) that provides a systematic approach to identify, and increase the understanding of, persons who affect and are affected by the phenomena of interest (Brugha & Varvasovszky, 2000). The stakeholder analysis has two roles for this study. First, the analysis itself will facilitate insight into the role and potential roles of actors in the agenda-setting process. This includes the role of power, thereby improving understanding of the research to policy terrain and help to identify potential research to policy pathways. Second, it has a role in informing other data collection methods, in particular the sampling and recruitment of the semi-structured interviews.

The stakeholder map was initially constructed using information collected from the document analysis. However, the number of publicly available documents was minimal, and the documents that were available were of varying publication dates. It became apparent after conversing with stakeholders that some of this information was not up to date. The stakeholder interviews were

therefore used to iteratively inform the stakeholder map (which in turn also identified useful participants). A limitation of stakeholder maps is that they are time limited as they are cross-sectional in nature. Subsequent to the production of a map, new stakeholders may have entered the space, and some may have left (Hyder et al., 2010).

Firstly, all relevant stakeholders were identified. Categories of stakeholders identified in Makan et al. (2015), shown in Table 10, for another LMIC mental health context were used as a starting point. Researchers were added as a category as they are a key group of stakeholders for understanding the role of evidence in setting the agenda for mental health policy. Stakeholders were identified from the range of documents already analysed as part of those included under the policy document and policy events. Input from local partners and the interviews, was also used to identify further stakeholders.

Table 10. Categories of stakeholders (based on (Makan et al., 2015) - CC BY 4.0).

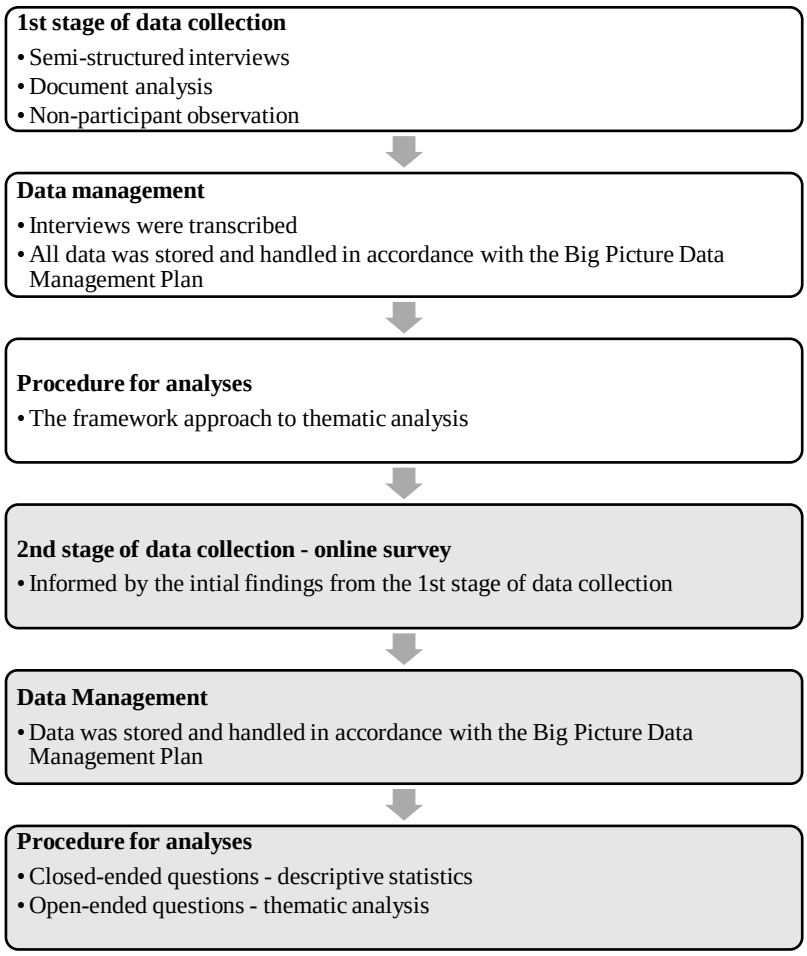
Type of stakeholders	**Definition and examples**
Health practitioners	mental health specialists, general primary health care workers including doctors and nurses, and community health workers
Persons affected by mental illness	including those with psychosocial disabilities, their families, carers and service user groups
Civil society organisations	including Non-Governmental Organisations (NGOs), Community Based Organisations (CBOs) and Faith Based Organisations (FBOs)
The media	at all levels (international, regional, national, state and district)
Donors	including DFID UK, DFID regional or country offices, and other funding agencies
Policymakers	including WHO and Ministries of Health, other intersecting Ministries or government departments (such as social development, economic development, correctional services, police services, peace and reconciliation) and parliamentary committees such as health, and related sector committees
Researchers	including those involved in any research related activities

Secondly, as recommended by the WHO (Schmeer, 2000), identified stakeholders were plotted on two axes: influence on mental health agenda-setting in Assam on the x axis; and interest on the y-axis. The level of power and influence, and interest was assessed as one of three categories: low, medium, and high. This matched the level of detail that can be gained from the limited documentation. Assessing the level in greater detail using a five-point scale by Hyder et al. (2010) would also be of limited practical value, especially given that the level is liable to change over time.

3-5.9 Data collection, management, and analysis

The flow diagram, shown in Figure 15, illustrates how the data collection, data management, and data analysis occurred. The subsequent section will detail the procedure followed for data analyses. As highlighted by Figure 15, the analysis of the survey data occurred subsequent to the main analysis of the interview data, as well as the observation data and document analysis.

Figure 15. Flow diagram of the empirical research process.



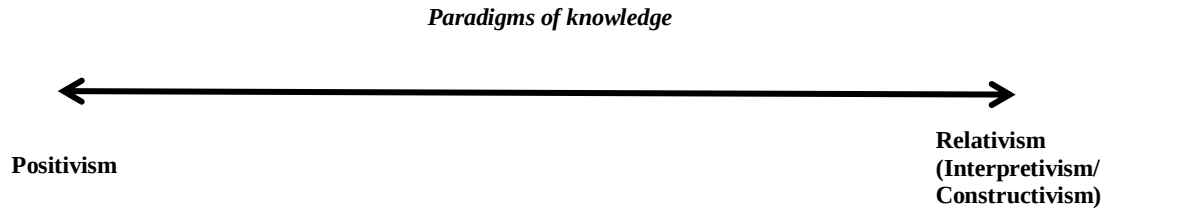
3-6. Data Analysis

Data were analysed using the framework approach to thematic analysis, with critical realism the most compatible knowledge paradigm for this study and its analysis.

3-6.1 Knowledge paradigm

Research can be conducted from within a range of paradigms, which have different stances on ontology - the nature of reality - and epistemology - the nature of knowledge. The field of health policy and systems research (HPSR) draws on many disciplines and, therefore, knowledge paradigms. Within health policy and systems research, as depicted in Figure 16, there are two dominant knowledge paradigms that can be conceptualised as existing at either end of the spectrum positivism/realism-relativism/constructionism (Gilson et al., 2011). This conceptualisation is a simplification to illustrate the range of knowledge paradigms and key divergences between them.

Figure 16. Dominant knowledge paradigms in health policy and systems research (adapted from (Gilson et al., 2011) – CC BY).



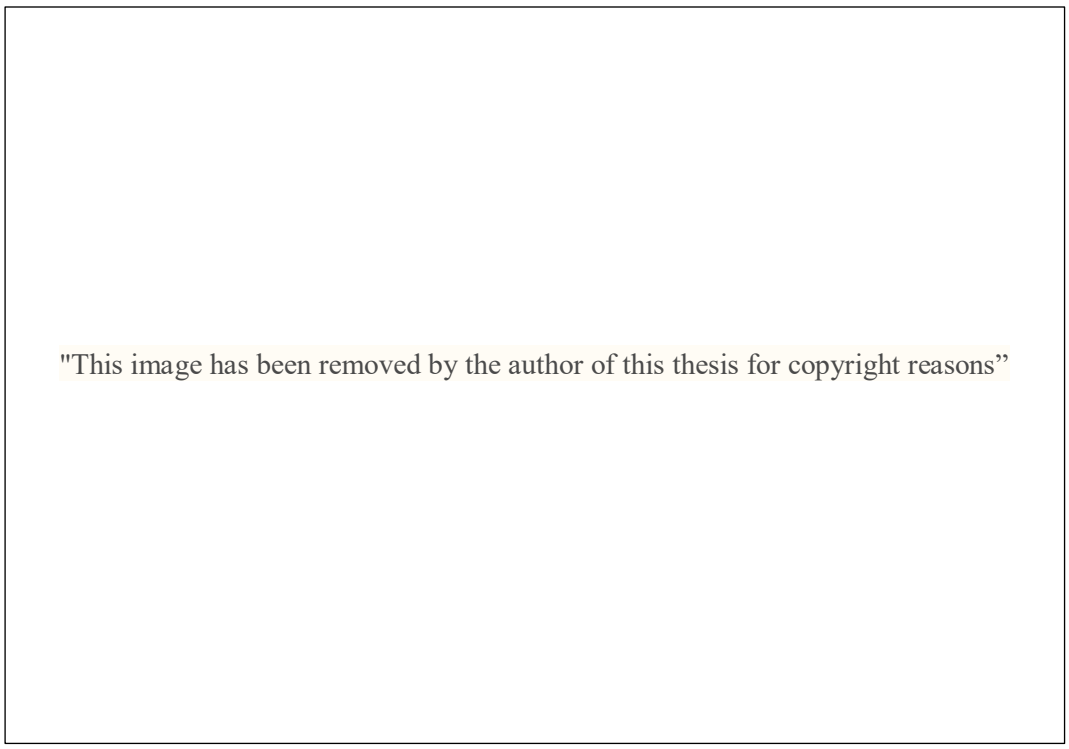
Key differences between paradigms	
• Single reality	• Multiple realities
• Reality as observable and measurable	• Reality as social construction
• Knowledge generated by observation and measurement of facts	• Interpretations created in interaction between researcher and respondents
• Experimental methodology involving hypothesis testing	• Studying issues in their natural environment

Positivism is the prevailing knowledge paradigm in the natural and medical sciences whereby a single reality is held to exist (Gilson et al., 2011). Within this reality, its different aspects (realist ontology) are quantifiable objectively (i.e., independently of the researcher) and in a value neutral way (realist epistemology). On the other hand, much social science research is located nearer the relativism end of the spectrum. Relativism is centred on the understanding of the world being contingent upon human interpretation (epistemology), and therefore that multiple realities exist (ontology). Social actors produce phenomena, in this case health policy, through interpretations of their experience, not independent of them.

3-6.1.1 Critical realism

Multiple knowledge paradigms exist in addition to positivism and relativism, falling between positivism and relativism. These include the position of critical realism, as shown in Figure 17. Critical realism originated from the work of Bhaskar (1979) and is the most compatible knowledge paradigm with this study and its research questions.

Figure 17. Critical Realism (taken from (Gilson & WHO, 2012)).

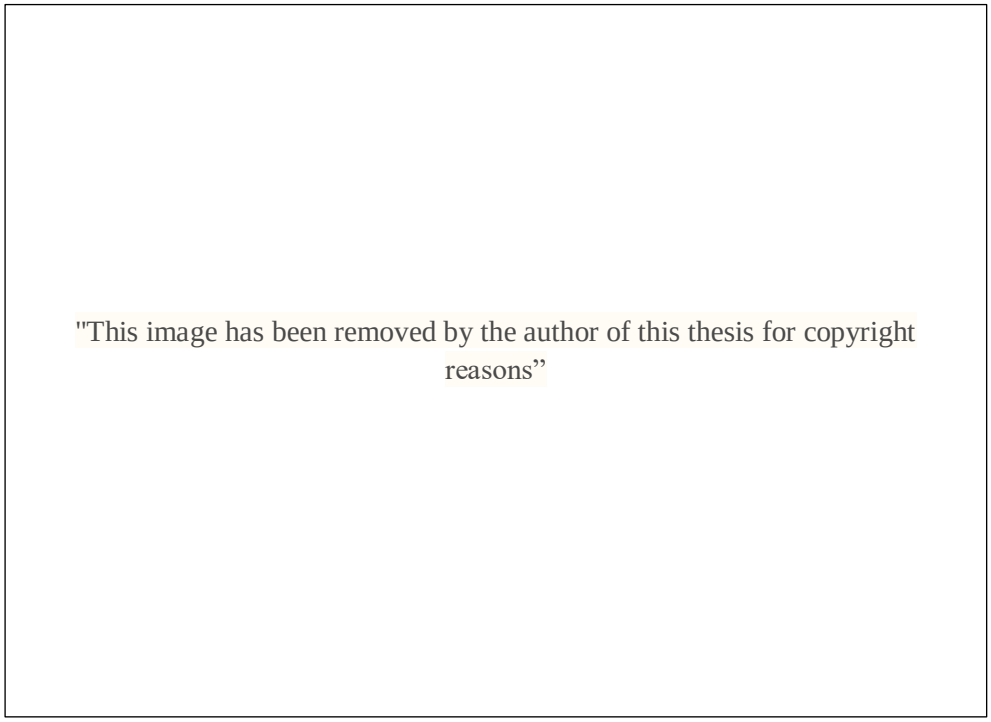


Critical realism is centred on the view that ontology is different to epistemology. The ontological stance of critical realism broadly realist that the physical world social entities/structures are held to exist and to have constraining and facilitating impacts (Madill, 2008). However, how these entities are perceived and theorised are held to be influenced by the beliefs and expectations of the researcher: that is, a broadly relativist epistemology (Gilson & WHO, 2012; Madill, 2008).

Critical realism can be understood with the aid of an iceberg metaphor (Fletcher, 2017), illustrated in Figure 18. This describes three levels to reality: empirical, actual and real levels. The top of the iceberg, the portion above water which can be seen, is the empirical level where phenomena are measured, but are understood through the lens of human interpretation. Just below the water is the actual level where phenomena occur, measured or not. At this level, there is no element of human interpretation. This gives rise to differences between observations at the empirical level. The bottom portion of the iceberg is the real level where causal mechanisms occur. Inherent properties of entities work as causal forces that result in phenomena.

The iceberg metaphor is useful for critical realism as it posits that reality cannot be observed directly observed and is independent of human beliefs. However, unobservable entities cause phenomena that are observable, and so social reality can only be understood if the entities that underlie these phenomena are also understood. Furthermore. actors' interpretations of reality are important as these influence social change (Gilson & WHO, 2012).

Figure 18. An iceberg metaphor for critical realism ontology (taken from (Fletcher, 2017)).



3-6.2 Thematic analysis

Thematic analysis is a prevalent method of qualitative data analysis that enables the identification, analysis and documenting of patterns, or themes, present in data, providing a rich description of a data set (Braun & Clarke, 2006). Unlike other approaches to data analysis, thematic analysis is flexible and can be used across knowledge paradigms (Mills et al., 2010), and so is compatible with, and can be tailored to the, critical realist position. Thematic analysis can be applied to a large dataset and draw out similarities and differences across the data. Furthermore, it enables the generation of unanticipated insights, useful for exploratory research.

Other types of analysis that would have offered useful insights include critical discourse analysis which facilitates analysis of power relations (Evans-Agnew et al., 2016). However, this approach is more time intensive and power relations are only one area of interest of this case study, and this approach would therefore not provide a systematic and holistic analysis of the data.

Narrative policy analysis attempts to develop a meta-narrative of the policy issue or debate from gaining an understanding of the different narrative surrounding the issue (Roe, 1994). Narrative policy framework provides a systematic approach to narrative policy analysis (Jones & McBeth, 2010), and can be applied at the micro and meso level. However, narrative policy analysis is well suited to complex, uncertain, and polarised policy issues (Roe, 1994). Although mental health in Assam is a complex policy issue, it is not suited to narrative policy analysis as it not a particularly uncertain or polarised issue. This form of analysis would have required narrative interviewing, where a story is elicited from the interview with the roles of narrators, who narrate their experience and listeners instead of the conventional question and answer format, as opposed to the conventional question and answer format with interviewee-interviewer roles (Allen, 2017).

3-6.3 Framework analysis

As thematic analysis is a flexible approach, there are multiple approaches to thematic analysis; including the framework method. Framework analysis (Ritchie & Spencer, 2002) has its origins in social policy research but has been widely applied in health research (Gale et al., 2013). It allows for the inclusion of interview and non-interview data, including field notes.

Framework analysis, like the broader thematic analysis the approach falls under, is also congruent with the critical realism knowledge paradigm used by this study. Framework analysis is flexible and an approach on either end of the inductive-deductive continuum can be used dependent upon the research question. Thus, framework analysis fits with the combined inductive/deductive approach taken to allow the analysis to be grounded in theory and utilising the conceptual framework developed from the literature review. In addition, it allows for anticipation and development of novel themes and codes from the data. This is important as this study is a specific case study and there may be important factors unique to the mental health agenda-setting in Assam not considered in the existing evidence-to-policy theory.

Under an inductive approach the researcher aims to minimise the extent of pre-conceived ideas that they begin with. Hence, with a combined inductive/deductive approach, there will be some limitations as the researcher will be aware of the existing theory, and therefore inevitably will have some pre-conceived ideas. The framework approach can be applied to complex issues and aids in understanding complex layers of meaning (Gale et al., 2013); critical realism aims to understand rather than simplify complexity (Given, 2008).

A purely inductive, or grounded theory approach (Glaser et al., 1968) would not have allowed the use of theory identified in the literature review. Similarly, a purely deductive approach would not have

allowed the data to 'speak for itself' and may have led to important factors unique to this case to be missed if theory developed from other settings is inflexibly and rigidly imposed.

3-6.3.1 Stages of framework analysis

As presented in Figure 19, there are three main phases to framework analysis: data management, descriptive accounts, and explanatory accounts (Smith & Firth, 2011). First the large amount of data is organised, which then allows for descriptive accounts of the data set to be produced, where the data is synthesised. From this, explanatory accounts of the data can then be given where the themes and concepts, and links between them, are interpreted. Framework analysis can be used with an inductive or deductive approach, these stages were tailored to this study to reflect the combined inductive/deductive approach taken and the use of the conceptual framework.

Figure 19. The stages of framework analysis (taken from (Smith & Firth, 2011) – Open Access: https://eprints.hud.ac.uk/id/eprint/18884/).

An Overview of Framework Analysis

Processes	Stages		
	Data management	**Descriptive accounts**	**Explanatory accounts**
	• Becoming familiar with the data (reading and re-reading) • Identifying initial themes/ categories • Developing a coding index • Assigning data to the themes and categories in the coding index	• Summarising and synthesising the range and diversity of coded data by refining initial themes and categories • Identify association between the themes until the 'whole picture' emerges • Developing more abstract concepts	• Developing associations/ patterns within concepts and themes • Reflecting back on the original data and analytical stages in order to ensure participant accounts are accurately presented thereby reducing the possibility of misinterpretation • Interpreting and explaining the concepts and themes • Seeking wider application of concepts and themes
	← Continuum →		

The three main phases can be further broken down into six distinct practical steps: transcription, familiarisation, developing the data coding framework, application of the data coding framework, charting data into the framework matrix, and interpreting the data. These will now be discussed in turn:

1. *Transcription*

The interviews were transcribed *verbatim* by a professional transcriber. The PhD student transcribed two of the interviews due to the familiarity with the content of the audio where the strength of the

accents posed a problem for the transcriber. A more denaturalised approach was taken along the naturalised to denaturalised continuum of transcription, as conceptualised by Oliver et al. (2005). This approach, where the focus is on the meanings and perceptions shared rather than the language used to do so, was suitable because it is the informational content of the interviews that is of interest. 'Nonstandard' accents were standardised and idiosyncratic elements of speech were removed.

2. *Familiarisation*

The transcripts were read over, and the audio listened back to. For interviews not transcribed by the PhD student, further time was spent familiarising with the data, before coding took place.

3. *Data coding framework*

A working data coding framework was produced, initially using a top-down approach, from the conceptual framework developed from the literature review. The coding framework consisted of three levels: categories, sub-categories, and codes. Each category and code was defined. This was applied to the first few transcripts to ensure its relevance and suitability to the data.

4. *Application of the data coding framework*

The data coding framework was then applied to the remainder of the transcripts. In line with the combined inductive/deductive approach taken to the data analysis, the initial coding framework was continually reviewed and refined to reflect the data, utilising a bottom-up approach. Revisions to the data coding framework were only made if there was a strong rationale for doing so. Accordingly, any changes to the coding framework were discussed with both supervisors to ensure there was a clear justification in place for any changes made.

5. *Charting data into the framework matrix*

The data from each transcript was summarised in the framework matrix by each category. Also included in the matrix are illustrative quotations. Due to the volume of interviews and other data collected, it was necessary to summarise the data in order to make it manageable for the analysis. In the process of reducing the data, there is the potential for the meanings of the participants to be altered or lost (Gale et al., 2013). To avoid this, during the charting the original data was constantly revisited to ensure the original meanings were retained.

6. *Interpreting the data*

Descriptive and explanatory accounts of the data are developed. Concepts and themes are developed with an increasing level of abstraction, and the links between them are explored. NVivo 12 Plus (QSR International, 2018), a computer-assisted qualitative data analysis software (CAQDAS) package, was used to aid the storage, management, and analysis of the large amounts of data, and assisted the data

management and descriptive accounts stages. Unlike statistical analysis software packages, qualitative analysis software does not conduct any actual analysis of the data. Some of the analysis was also done by hand, in addition to the use of NVivo, to ensure the software did not restrict the analysis.

3-6.4 Iterative data analysis

As stated earlier, data collection was staggered in time to allow for iterative data analysis. Iterative data analysis enables the data collection and analysis to be tailored to the requirements of the study (Mills et al., 2010). An iterative framework for qualitative data analysis proposed by Srivastava and Hopwood (2009), shown in Table 11, was used to help guide this process.

Table 11. Questions to aid iterative qualitative data analysis (taken from (Srivastava & Hopwood, 2009) - CC BY 2.0).

Questions to aid iterative data analysis		
	Question	**What this means in practice**
1.	What are the data telling me?	Explicitly engaging with theoretical, subjective, ontological, epistemological, and field understandings.
2.	What is it I want to know?	According to research objectives, questions, and theoretical points of interest.
3.	What is the dialectical relationship between what the data are telling me and what I want to know?	Refining the focus and linking back to research questions.

3-7. Credibility

The criteria for assessing the credibility of qualitative findings, and the extent to which they have been met by the current study and through what means will now be set out.

3-7.1 Criteria to assess credibility

Unlike in quantitative research, where there is consensus that validity, reliability, and generalisability are key criteria to assess the quality of research, no such consensus has been reached to assess the credibility of the findings of qualitative research (Rolfe, 2006). Furthermore, debate still exists about whether standard criteria applied to all qualitative research would be useful (Rolfe, 2006).

Two main approaches for qualitative research have been used: applying criteria used for quantitative research, and using criteria specific for qualitative research (Rolfe, 2006). Validity, reliability, and generalisability are the key criteria used for quantitative research that have been adapted and applied to assess the credibility of qualitative research findings (Leung, 2015). Different criteria have also

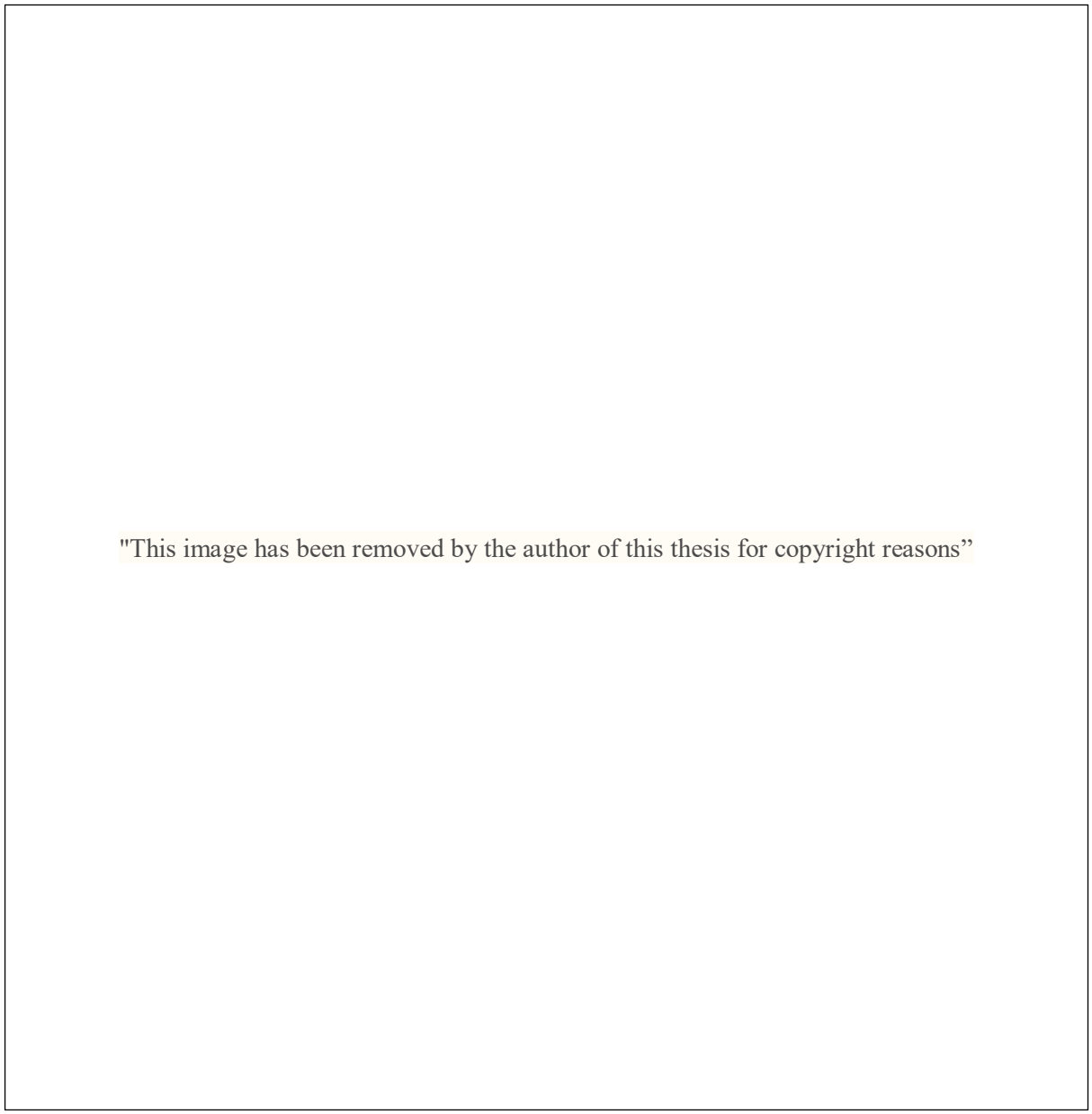
been proposed for qualitative research, these fall into two main categories: those that asses the quality of the research outcomes produced and those that focus on the quality of the process of research (Reynolds et al., 2011).

Although the use of outcome-based quality criteria appears to be more prevalent, such criteria have been criticised for not facilitating quality throughout the research process (Reynolds et al., 2011). Conversely, this is a strength of process-based quality criteria. Additionally, the use of checklists to assess outcome-based criteria, although easy to apply, is not flexible enough to accommodate the range of qualitative research. This could also lead to strategies to improve credibility being applied without critical consideration. The limitation of process-based quality criteria is that specific guidance on how to strengthen the quality of research is lacking due to flexibility of qualitative research.

Process focused criteria are therefore the most useful to apply for this case study to help strengthen the quality of the research process, and to demonstrate this. Multiple process focused criteria have been conceptualised. Lincoln and Guba (1985) proposed four criteria: truth value, consistency, neutrality, and transferability. These criteria were developed for qualitative research but have been mapped to the terms used and adapted from quantitative research (Noble & Smith, 2015).

These criteria are useful and will be adopted for this case study as they provide a middle ground between using criteria from quantitative research, and those specific to qualitative research. Table 12 defines these criteria and their relation to their quantitative counterpart. Noble and Smith (2015) use the term applicability in place of transferability by Lincoln and Guba (1985). For this case study, the original term transferability is used as it is the term used by most authors for this concept. Although often considered together and each not always clearly defined (Burchett et al., 2011), applicability and transferability are commonly understood to have related yet distinct meanings (Wang et al., 2005). Applicability is more commonly used synonymously to feasibility, as opposed to transferability, and to refer to consideration of whether an intervention process could be implemented in other contexts.

Table 12. Criteria to assess the credibility of the findings of qualitative research (adapted from (Noble & Smith, 2015)).



3-7.2 Strategies to strengthen credibility

Multiple strategies have been proposed to help strengthen the credibility - the truth value, consistency, neutrality, and transferability - of the findings of qualitative research (Noble & Smith, 2015), helping to mitigate one of the disadvantages of process-based criteria. The strategies are presented in Table 13 alongside the extent to which they have been incorporated by the current study. Some of the individual strategies will be discussed in further detail. A critical reflection of the effectiveness of these strategies will be provided later in the thesis.

Table 13. Strategies to strengthen the credibility of qualitative research, and how they will be used in this study (based on (Gilson et al., 2011; Noble & Smith, 2015)).

	Strategy	**The use, and discussion of, the strategy for this study**
1.	Acknowledging personal biases which may have influenced findings;	A reflexive component was included in the study. The position of the researcher as an 'outsider' was considered using Abimbola's (2019b) authorial reflexivity framework for global health. A reflective diary was kept during the fieldwork.
2.	Acknowledging biases in sampling and ongoing critical reflection of methods to ensure sufficient depth and relevance of data collection and analysis;	Potential bias may have been introduced through purposive sampling and a component of convenience sampling arose due to the practicalities of recruitment, particularly as some of the interviewees were known to members of the research team. However, a rationale for each participant was provided. Data collection methods were continually reviewed; a larger document analysis component was incorporated to ensure sufficient depth and breadth of data due to challenges with recruitment due to the COVID-19 pandemic.
3.	Demonstration of a clear decision trail (for methods, data collection and analysis) and ensuring consistent and transparent interpretations of data;	Attempts were made to make the decision trail as transparent as possible within the relevant chapters. Decisions and interpretations were often challenged by the PhD supervisors.
4.	Establishing a comparison case/seeking out similarities and differences across accounts to ensure different perspectives are represented;	Framework analysis was used for data analysis which facilitates comparisons across cases.
5.	Including rich and thick verbatim descriptions of participants' accounts to support findings;	The five results chapters in this thesis (evidence, actors, process, context, and approach) made extensive use of verbatim quotes from the stakeholder interviews to support the findings, supplemented (and contrasted) where relevant by verbatim quotes from survey responses.
6.	Demonstrating clarity in terms of thought processes during data analysis and subsequent interpretations	During the data analysis and subsequent interpretations attempts were made to clearly detail each stage, particularly when moving from descriptive accounts of the data to high-level abstraction. These was often challenged by the PhD supervisors if there was any ambiguity, which helped to ensure clarity.
7.	Engaging with other researchers to reduce research bias, peer debriefing and support;	Although this thesis is primarily the work of the PhD student, during the PhD there was constant, close engagement with the two supervisors, as well as further engagement with the rest of the 'Big Picture' team. Journal articles and conference poster presentations were also submitted (or in submission) in order to undergo the peer-review process.

	Strategy	The use, and discussion of, the strategy for this study
8.	Prolonged engagement with the subject of inquiry;	Time in the field was maximised, but was limited by the available funds and the COVID-19 pandemic. The use of multiple data collection methods (interviews, online survey, and document analysis) allowed extensive engagement with the topic of interest, and multiple interactions with stakeholders. Informal engagement with stakeholders in the field also took place, and this contributed to the data through the use of field notes.
9.	Respondent validation: includes inviting participants to comment on the interview transcript and whether the final themes and concepts created adequately reflect the phenomena being investigated;	The online survey were built into the research design to enable a credibility check of the findings shared to participants via an animated video.
10.	Data triangulation whereby different methods and perspectives help produce a more comprehensive set of findings;	Multiple types of triangulation were used, including: method, data source, investigator, and theory triangulation. These are further discussed below in section 3-7.2.1.
11.	Negative case analysis, to look for evidence that contradicts the proposed explanations and theory, and refining them in response to this evidence;	Framework analysis was used for data analysis which facilitates comparisons across cases. It was discussed when participant's responses contrasted with that of each other or what was expected based upon existing theory. A combined inductive/deductive approach to the analysis was taken. This allowed the data to speak for itself, and for the framework initially developed form the literature review to be refined in accordance to the findings of this study.
12.	Use of theory;	Theory was used extensively; the framework used to guide the analysis of the data was developed from a 'review of reviews' of frameworks. This framework was refined in light of the empirical findings of this thesis.
13.	Case selection, purposive selection to allow prior theory and initial assumptions to be tested or to examine "average" or unusual experience.	Mental health agenda-setting in Assam was selected as a case study to explore the role of evidence in policy to explore the extent to which general health evidence to policy theory is applicable to mental health agenda-setting in LMIC settings at the state level. Mental health is an important global health policy issue that has not received much research attention, and with many idiosyncrasies that make it distinct from other health policy issues.

3-7.2.1 Triangulation

Triangulation is one of the main strategies to strengthen the credibility of qualitative research. It entails the use of multiple data sources and methods of data collection are used in order to allow a more thorough investigation of a phenomenon, and to minimise bias through the inclusion of findings

that may have otherwise been missed. Thus it aims to improve the credibility and validity of a study (Carter et al., 2014; Given, 2008). Denzin (1978) proposed four types of triangulation; how each type has been applied and achieved in this study are shown in Table 14.

Table 14. Types of triangulation (adapted from (based on Denzin, 1978)).

	Type of triangulation	**Definition**	**How it will be used in this study**
1.	*Method triangulation*	The use of multiple methods of data collection.	Semi-structured interviews, an online survey, non-participant observation, and document analysis was conducted.
2.	*Data source triangulation*	The collection of data from a variety of sources and people.	Different types of stakeholders were recruited through purposive sampling (including high-level figures at major organisations, and those working at the grassroots level). The documents included in the analysis were also of different natures, purposes and sources.
3.	*Investigator triangulation*	The involvement of multiple researchers in the study.	Although the PhD student was the lead researcher and the sole data collector, other researchers were involved, particularly in the analysis of the data. The two supervisors brought perspectives from different disciplines (psychology and health policy and systems).
4.	*Theory triangulation*	The use of multiple theoretical perspectives in the analysis of the data.	The framework used to guide the analysis of the data was developed from a 'review of review' of frameworks.

Method triangulation, however, is the most frequently referred type of triangulation in qualitative research (Flick, 2018). On the whole, it can be considered that the methodological triangulation (online survey, document analysis and fieldwork observations) confirmed the findings from the interview data are credible, and that the interpretations of the data are largely correct. Notwithstanding, some useful clarifications and additional nuances were gained, some findings were advanced, and a greater proportion of the heterogeneity among stakeholders was captured.

Although the online survey largely confirmed the findings from the interviews, there were occasions when the online survey highlighted contrasting views not captured by the interviews. However, it was more common that the survey supported, and in some cases, extended, the findings of the interviews. Therefore, whilst not reaching saturation it appears as though saturation was approached. If there had been more resources and recruitment difficulties, including access to policy 'elites', had been overcome a greater number of interviews may have been useful. However, it is acknowledged these would provide diminishing returns and would not have altered the key findings of the current study too greatly.

Document analysis provided useful insights from attendees of policy-relevant events. Although, not for mental health, they were for other health related issues – (1) nutrition, and (2) the health of women in rural Assam - that shared a lot of similarities. There is an overlap of stakeholders, particularly

policymakers as under the remit of the Health and Family Welfare Department of the Government of Assam. This was particularly useful as non-participant observations by the PhD researcher as envisioned were unable to take place due to the COVID-19 pandemic. Whilst not directly applicable to mental health, they did help to provide a ‘sense-check’ of the results given the similar context. Similar to the online survey, the document analysis largely supported the findings from the interview data. However, unlike the online survey, whilst the document analysis generated some interesting questions that would be useful for future research to explore, it was not able to extend or clarify the findings from the interviews.

CHAPTER 4: RESULTS (Evidence) – The role of evidence for mental health policy agenda-setting in Assam

4-1. Introduction

This chapter will focus on evidence: the central component of the conceptual meta-framework, and how the key actors identified in the previous chapter utilise evidence in policymaking.

There is clear consensus in the literature of the importance of evidence-informed policymaking., particularly for mental health (Williamson et al., 2015), and LMIC contexts (Sutcliffe & Court, 2005). However, there is no agreement on how it is defined, among scholars or different stakeholders, or what evidence should be, given priority in policymaking (Rose et al., 2006). As context is important in shaping the meaning of evidence across space and time (Rose et al., 2006; Rychetnik et al., 2004), it is important to understand what counts as evidence in the context of mental health agenda-setting in Assam, and for whom.

The findings will be presented under the four key issues from the meta-framework. These sections will cover: (1) what stakeholders understood by 'evidence' and what they considered robust evidence to be; (2) the desire for, versus the production of, evidence; (3) awareness of evidence and how it is received and interpreted; and (4) the ways and extent to which stakeholders use evidence for various aspects of agenda-setting.

4-2. Understanding evidence

What constituted evidence varied between actors and different types of evidence were valued for agenda-setting, particularly when used together. Statistics were generally seen as the most influential type of evidence for mental health policymaking, although informal forms of evidence were also recognised and valued. Moreover, different types of evidence, when used together, were viewed by many as having potential to play a particularly important role in the policy process. Despite limited familiarity with the evidence, stakeholders generally viewed the available evidence as robust, suggesting a high degree of trust in research. Characteristics of evidence important to stakeholders fell under two main categories: the breadth of the available evidence; and its pragmatic nature in

policymaking. However, the actual existence of evidence was often valued over any of these particular characteristics.

4-2.1 Multiple meanings of 'evidence'

Two dominant meanings of the term 'evidence' were used unprompted and simultaneously by participants: (1) scientific evidence and (2) evidence acquired from personal experiences. Participants tended to equate scientific evidence with formal evidence, and evidence from personal experience with informal evidence. Although not exclusively, the former tended to be drawn on by researchers and decision makers, and the latter by intermediaries.

The first definition used by participants was 'scientific evidence', evidence that supports or opposes a hypothesis is produced via the scientific method (Taper & Lele, 2010). Examples given by participants included peer-reviewed journal articles and national surveys and reports. Formal evidence was understood by stakeholders in a reasonably consistent way, the subtle differences summed up by one participant researcher as follows:

"Broadly evidence seems to be understood in the community I work with [previously defined: 'includes implementors, researchers, and a bunch of other sort of public health actors'] *as being some kind of well proven scientific, or if not scientific at least something that's coming out of a very careful systematic objective examination of information or data. […] Typically I think researchers tend to frame it as coming, as being a product of scientific method, or scientific enquiry."* (researcher – national, M)

Of the different types of formal research evidence, participants largely expressed a preference for statistics such as the magnitude of the mental health burden and service costs. Notably, this preference was also perceived to be true for policymakers:

"*Typically, the policymakers are interested in numbers."* (researcher – national, M).

Qualitative research evidence, *"very robust"* (researcher – national, M), was also seen to be of value for policymaking by researchers who stated, *"definitely there is a role for qualitative evidence"* (researcher – national, M). The majority of respondents of the online survey disagreed that policymakers value informal evidence (only 20% agreed). However, one interviewee reported that there is an emerging recognition of the value of qualitative research by policymakers, at least at the national level:

"Many people have started recognising that qualitative evidence is more robust, more realistic, more the need of the hour." (policymaker – national, M)

Formal evidence was not limited to research evidence; legal evidence was another type of formal evidence recognised by participants. As well as evidence being an input in the policy process, i.e. evidence-informed policymaking, evidence was used by researchers in another context to mean the outcome of the process, as a change in policy or legislation. Furthermore, even though an approved policy is an outcome of the process of agenda-setting and development of that policy, it can pave the way to implementation (and agenda-setting of further policies). Therefore, an approved policy also becomes an input:

"One [type] is the legal evidence because if the National Parliament[…] passes something that becomes an evidence." (researcher – Assam, F)

Participants often used a different definition of 'evidence' to scientific evidence; the second definition based upon personal experience tended, although by no means exclusively, to be used by intermediaries. One participant offered the following example from working with young people, where evidence is personal knowledge of the mental health. They reflected that their privileged background allowed them to gain knowledge about the issue, highlighting context-specificity of the evidence. In conjunction, they referred to facility-level or Health Management Information System (HMIS) data, another type of evidence:

"I think evidence is like today I'm talking to you[…] this is because of the fact that I'm perhaps more privileged and aware of the problem[…] And the second category is perhaps[…] someone seeking professional help is surely an evidence of a problem but then again how do you sort of take evidence of all the people who are going through such problems, they don't acknowledge it in the first place, so I think evidence is again that it's the disparity in the numbers." (intermediary – Assam, M)

Notably, informal evidence reflecting people's experiences was also valued by some researchers. The interpretation of one researcher of 'objective' evidence appeared to centre around the experience of each individual being objective, even though it involves their 'subjective' reflections on their experiences rather than independent observations. However, it perhaps may not represent the wider trend from a statistical perspective:

"I understand evidence to be much more rooted in experience, in how communities, people experience health systems. So, in that sense it need not be objective, it needs to be felt, experienced by people and communities, and for me I think that's already important evidence." (researcher – national, M)

Policymakers, particularly high-level decision-makers, were also perceived to recognise informal evidence, derived from personal experience. Whilst formal research evidence appears to be preferred over informal evidence, this was seen to be due to how informal evidence is synthesised and presented and so can be mitigated to some extent.

Notably, researchers also valued tacit knowledge from local communities, especially from more disadvantaged communities. However, documenting these through appropriate methods, i.e. formal research methods, presents a challenge:

"If a few, or many people, in the communities I work with experience challenges and difficulties in accessing care for some reason, even if that is not demonstrable by systematic enquiry or science or, you know, sort of high end research methods, that still counts as evidence." (researcher – national, M)

The online survey, used as a credibility check of the findings from the interviews, further supported the value of informal evidence: 70% of respondents of the online survey agreed that informal evidence can be as robust as research evidence. A more nuanced view was given by a respondent of the online survey. It was cautioned that informal evidence may not necessarily help inform the policy agenda with community priorities. On the contrary, there is the potential the greater use of informal evidence could actually exacerbate the absence of community voices from the policy agenda:

"The critical issue here is how we define 'informal' evidence. If it tries to fulfil the gap in the nature of evidence generated by being perceptive/sensitive to the 'absent voices' in the evidence, then the 'informal' evidence becomes valuable. However, the danger lies in identifying whose 'informal' evidence it is- as it would potentially continue the vicious cycle of being exclusive in what it thinks are important or not important!" (researcher – Assam, M)

4-2.2 Synergy of different types of evidence

Not all participants displayed a hierarchical preference and, in fact, multiple interviewees asserted that different types of evidence can be most powerful when used together. Specifically, researchers referred to the benefits of mixed methods studies:

"There is a lot of scope for qualitative data[…] I am not saying numbers are not important, but along with that actually we should use the mixed methods kind of thing and the qualitative evidence. Also, we'll have to develop an approach, or feedback to a policymaker saying that look these are also important." (researcher – national, M)

Furthermore, an intermediary stated that by using lived experience narratives alongside statistical evidence, some of the potential disadvantages of statistics can be mitigated and could lead to better policy solutions:

"*Sometimes numbers sort of dehumanises a problem […] so I think research statistics, along with like human stories could perhaps tackle the problem better."* (intermediary – Assam, M)

One respondent summed up the tension between the different needs that policymaking required from evidence, of which a singular type of evidence is unlikely to fulfil. Hence, there is a need for a range of evidence types which can add complementary insights:

"The critical issues here are (i) 'relevance' of the available research evidence and (ii) their 'robustness' in capturing the complex realities of (public) mental health. Since most of the evidence generated belongs to the realm of 'objective' and are driven by 'brief survey', the 'voices' of the public remain largely missing!" (intermediary – Assam, M)

4-2.3 Breadth of evidence

Participants first evaluated the robustness of evidence against the following criteria centred upon the extent and range, namely with regards to: epidemiology; timespan; perspective; and the inclusion of social-cultural factors. Against all of these criteria, participants felt that further improvements were needed.

Participants stated that evidence by geographic, demographic, and mental illnesses category, (such as psychotic and neurotic disorders), needed to be disarticulated:

"The problem is there but accurate data we do not have. In our study [the National Mental Health Survey in Assam] we only consider three districts [out of 34…] and we only considered adult populations. So, if there is an in-depth study among the whole populations, something like census, then that will give us a very clear idea." (researcher – Assam, M)

Further breadth in terms of the timespan was said to be important for informing policy, with longitudinal studies needed to provide evidence on long-term outcomes:

"If you want to give evidence for policy changes then a certain type of social interventions have to come into place based on the research work that we have done, no? And so it has to be so it cannot be short-term interventions because if you do not have longitudinal studies then you will not be able to get those outcomes. At least a minimum two-year process has to go into a project for the community to see that." (intermediary, Assam, F)

Moreover, participants identified a need for evidence using different perspectives, with an emphasis on broad perspectives. This includes more integrated approach centred on wellbeing, as opposed to the siloed focus on specific disorders, to reflect the shift in focus from treatment to prevention:

"I would prefer a kind of research work where we talk about the holistic and the emotional wellbeing of people, rather than only looking at the focus of the disorders. So, I think we have to go beyond the

disorder to talk about more on the prevention area because we are looking at wellbeing nowadays rather than just talking about being mentally sick." (intermediary – Assam, F)

Finally, additional breadth is needed to include a range of outcomes from these different perspectives was highlighted by a researcher from Kerala, a state that has had a stand-alone mental health policy since 2003 (Shibukumar, 2003).

"Public health interventions cannot be planned just based on the efficacy, they also need to consider other factors like feasibility, cost-effectiveness, reproducibility, all kinds of cultural factors also." (researcher – national, M)

Sociocultural factors were recognised as important in the Assam context. This type of evidence, *"valid for public health"* (researcher – national, M), was identified as a need to complement biomedical and epidemiological studies, particularly for more severe mental illnesses such as schizophrenia:

"Mental health is also always it is influenced by the local sociocultural issues.[…] The presentation it is very, very different because it is entrenched with so many other family factors, cultural factors, so there is scope of doing already established findings in other area because it can give us a lot of new ideas, new things. So, there is very much scope of doing some research in mental health in this part" (researcher – Assam, M)

4-2.4 Pragmatic nature of evidence for use in agenda-setting

The second category of characteristics of evidence valued by participants focused upon the utility of evidence for 'real-world' policymaking, and included: (1) persuasiveness, (2) relevance and (3) applicability. First, persuasiveness was defined as the ability of evidence to convince policymakers, and relevant stakeholders, to prioritise an issue and, ultimately, to take action. One policymaker stressed the need, in particular, for qualitative evidence to be persuasive:

"Any qualitative evidence, when demonstrated, has to be taken to the real world and the policymaker, the administrator and significant others in the community looks at this as a way forward to support. Whatever that may be, the administrators, policymakers, will have to say 'yes, for some groups of people something is a priority'." (policymaker – national, M)

Second, relevance, defined as evidence being *"connected to relevant purposes"* (researcher – national, M) emerged as a predominant characteristic for both researchers and policymakers. However, the two stakeholder groups stressed two different aspects of relevance. Policymakers placed a premium on the ability to make an immediate impact due to economic constraints:

"When a country is restrained by resources, it is always good for them to focus on research which has immediate impact on a utility point of view. Impact has to be apparent and it has to be seen, observed, because research can be of many things, which may be immediately relevant, which may be relevant for another twenty years later […] Remote future we can't even think about." (policymaker – Assam, M)

On the other hand, researchers emphasised geographical relevance due to the apparent invalidity of generalising mental health evidence across region:

"You cannot use data regarding like outcomes in another country [or region]." (researcher – national, M).

Third, the applicability of mental health evidence to the real world was highly valued. Specifically, *applied* research was highlighted as having particularly strong potential to provide evidence that could impact society and, hence, worth engaging with by policymakers:

"When we talk about mental health and the community at large, if you're looking at the impact that you want to have on the society, then we have to talk about applied research." (intermediary – Assam)

In the formal processes for assessing and approving research topics, the terms utility and feasibility are used. Arguably, these two terms cover very similar ground to the three characteristics of valued evidence mentioned by participants: persuasiveness, relevance and applicability:

"Once it [the regulatory bodies] is satisfied that this is something which is feasible, this is something which is useful and this is something which is doable, then the committee agrees saying you can go ahead with that. So, this has two or three components, one is the ethical component, another one the technical component and the third thing is that the utilitarian component." (policymaker – Assam, M)

Practitioners took a pragmatic viewpoint, and valued the existence of evidence, above any particular characteristic:

"At least we have some data, no? I think it's more important just to, you know, use it." (intermediary – Assam, F)

Similarly, a policymaker felt that the value of research was determined by how it is used, rather than by its inherent characteristics:

"No research can be measured in terms of say utility. Everything is useful. No research is useless. It depends on what status your society is in to reap the benefit of the particular research." (policymaker – national, M)

Intermediaries, too, were pragmatic and focused on getting research evidence on mental health communicated to society. However, there were concerns on maintaining the accuracy of evidence when shared for potential use. Checking with mental health professionals was one solution suggested when using social media to engage with the younger demographic:

"I think it's very important to use that tool of social media to sort of reach out to people, I think that's great in today's world. But of course without sort of making bigger problems out of that, so when we publish our content in our pages we make sure we run it by through a professional counsellor[…] so then we don't really like, we don't do false information." (intermediary – Assam, M)

4-2.5 Evaluation of the available evidence

Despite the identification of shortcomings in the available evidence, a range of different stakeholders still judged key pieces of evidence to be largely robust. In particular, the Assam State Report of the National Mental Health Survey (NHMHS) 2015-16 (Pathak et al., 2017) was held in high regard due to its *"well planned"* (researcher – Assam, F) method, and the people involved. However, it was acknowledged the large scale of the survey could potentially have introduced inconsistencies, although this risk was considered minimal:

"Most of us, I am sure, in our set we all definitely tried to do the maximum possible [for the National Mental Health Survey in Assam]. A slight variation is definitely, there could be, regional variation, state-wise, community-wise variation." (researcher – Assam, F)

Likewise, confidence in the overall findings was expressed by other stakeholder groups: *"the numbers, I think are not accurate, but the conclusions are"* (intermediary – Assam, M). That is, although the research was largely trusted, the specific details and statistics were viewed with caution.

Interestingly however, the online survey, used to triangulate the findings from the interviews, suggested there were a wider range of views held by stakeholders on the quality of the available formal evidence. 60% of respondents disagreed the available research evidence on mental health is robust. In particular, the suitability of the national survey for the context of Assam was questioned in terms of the practicalities of conducting it and having the necessary human resources:

"Surveys including the National survey, I feel may not be very much realistic for a marginalised state like Assam, where choice and availability of surveyors are limited." (intermediary – Assam, M)

The importance that stakeholders place on the robustness of evidence is illustrated by an intermediary with an example of potential consequences of using incomplete evidence:

"Sometimes what happens when there is no such good evidence, we sort of try to tackle the problem, but then because even we are not like fully aware of the problems, sort of let's say like in I'm talking about the worst case scenario, sometimes just made the problem larger, right? So as people say half information leads to like more problems." (intermediary – Assam, M)

4-3. Demand and supply

Demand and supply of evidence can be conceptualised as a reinforcing feedback loop: lack of evidence contributes to the low priority of mental health policy development, and this low priority contributes to a lack of urgency to produce evidence. Although a significant evidence gap is evident, concurrent limited awareness of the evidence that is available may exaggerate this perception. There was agreement that quantity of evidence has increased in recent years, however perceived progress varied across evidence types, and stakeholders identified significant gaps. Participants mentioned three barriers that help explain this gap: a lack of mental health awareness and the existence of mental health stigma; financial constraints; and regional instability.

4-3.1 Insufficient, but increasing supply of evidence

The generation of research evidence has, reportedly, accelerated in recent years. In particular, the pan-India National Mental Health Survey 2015-16 (Gururaj et al., 2016c) was said to be a key development at the national and state level and represented a step-change in the availability of large-scale research evidence. Accordingly, increasing research evidence for Assam was said to be reflective of, and intertwined with, the national trend. One participant even judged Assam to be ahead of the curve and that the evidence available for the Assam context was better relative to other states in India:

"In Assam actually this [Mental Health] programme is going in a very well manner. This is only because we could provide good data to the Government of India regarding the mental health issues, regarding the level of illness in Assam. So, in fact, yeah, Assam is doing good in this respect." (researcher – Assam, M)

The acceleration in the rate of research produced for mental health is a trend that appears to be ongoing; participants frequently referred to a range of planned research projects nationally and within Assam, and some noted their intent to apply for funding from the Indian Council of Medical Research in collaborations with other departments and universities. Moreover, requests received by researchers

to make their data available for re-analysis suggests a potential snowball effect, further increasing this acceleration.

Drivers of this increased research activity were said to include The National Human Rights Commission of India: a statutory public body. Additionally, increased community awareness of mental health has resulted in more people seeking services, expanding the pool of research participants. This trend was most marked for mild and moderate mental illnesses:

"Because of all these activities, now that awareness is there, people are knowing that this is a disease, they should come to the hospital. So, that is why earlier the research was very uncommon, unheard of. And particularly research limited to only certain disorders, which are very apparent like schizophrenia. Like minor mental illness like anxiety, substances, usually research was very, very poor." (researcher – Assam, M)

Despite agreement of a relative increase of evidence in recent years, in absolute terms the supply of evidence was still reported to be very limited: *"we do not have a complete data of the mental health scenario about Assam"* (intermediary – Assam, F). Moreover, with the exception of the pan-India National Mental Health Survey 2015-2016 (Gururaj et al., 2016c), most current research was said to have relatively small sample sizes. Finally, the lack of policy-related and qualitative research was said to be particularly acute, lagging behind the overall trend of increased evidence production:

"Very less qualitative evidence has been generated over the years in these areas" (researcher – national, M)

Participants felt a stronger evidence base, encompassing multiple types of evidence, would enable them to more effectively fulfil the policy advocacy function of their role, whether as a researcher or an intermediary:

"Me or[…] any other advocate could perhaps advocate better if he has better stats, and by stats I don't only mean numbers, but the whole human reflection of those statistics" (intermediary – Assam, M)

Accordingly, more evidence would allow participants to take advantage of the window of opportunity currently identified:

"To advocate upon, because you know you have to have a strong base[…] If we have evidence definitely, we can push forwards, and this is an opportunity for us to push forward." (researcher – Assam, F)

Although the findings from the interviews stressed the importance of informal evidence based upon personal experience, and the National Mental Health Survey for mental health agenda-setting, the online survey helped clarify this does not detract from the need for formal research evidence for

Assam. This suggests that the importance of informal evidence and the National Mental Health Survey is in part due to an absence of research evidence, and that research evidence generated would have the potential to make a positive contribution to the policymaking process:

"Lack of scientific studies, over dependence on National and International documents are situations which need to be corrected. Meaningful research on all service provisions could result in more meaningful policy in Assam." (intermediary – Assam, M)

4-3.2 Limited awareness of the available evidence

Researchers expressed optimism that policymakers were aware of the key evidence, including the pan-India National Mental Health Survey (Gururaj et al., 2016c), due to its availability online. However, this optimism was often paired with doubt:

"We hope so because you know we are not sure but you know that it is in the public domain or the indexes so definitely, if somebody wants to make something on that definitely people will google and get through the idea, picks out the place where research is going on. Most of the time it happens." (researcher – Assam, F)

The lack of uniformity among policymakers' awareness of mental health was highlighted by the online survey. Some practitioners acknowledged their lack of familiarity with key pieces of evidence: *"Honestly I have not really read through the [National Mental Health Survey Assam State Report]"* (intermediary – Assam, F). This suggests that accessibility may be a further key characteristic of evidence valued for use in policymaking, in addition to persuasiveness, relevance, and applicability highlight above (2.4 Pragmatic nature of evidence for use in agenda-setting). Responsibility for raising awareness of evidence among relevant stakeholders was assigned to producers of evidence: research institutions, and their leadership. However, such institutions were not considered to be adequately accomplishing this role:

"We are not aware of what Tezpur Mental Health Hospital is doing […] They are doing a lot of research work, but if you're not sharing your evidences and the outcome of the research with the civil society bodies[…], I think we are not fulfilling that gap." (intermediary – Assam, F)

The online survey, used as a credibility check of the findings of the interviews, further stressed the importance of the availability of evidence. Furthermore, it suggested that improving the awareness of the available evidence is in fact more of a priority than increasing the supply of evidence: 80% of participants agreed or strongly agreed that improving the awareness of the available mental health evidence is a greater need than producing more mental health evidence. Given the costs and time needed to generate new evidence, particularly significant in the resource-constrained environment of

Assam, this suggests that there is the potential for feasible approaches to strengthen the use of evidence in agenda-setting.

4-3.3 Barriers and facilitators to the supply of evidence

Whilst recognised that current research efforts are ongoing to help address some of the aforementioned evidence gaps, these are incipient. Due to the magnitude of the evidence gap, it is expected that narrowing this gap will take some time:

"[A colleague] has been very keen on starting some sort of projects regarding some mental health care issues of old people[...] It's not like the people are not talking about it, people are talking but again it's just like the mental health in the national stage, okay, people are not thinking anything about it. Now people are talking about it, so maybe it will take time, but people start to speak up." (researcher – Assam, M)

On the other hand, the evidence gap may also be an opportunity, and individual researchers were keen to influence priority-setting. In particular, their position as researchers could enable them to respond flexibly to emerging issues and associated evidence demands by policymakers:

"Sometimes some questions or some queries come up suddenly in the society[…] So, this depends on the researcher. So, what happens is a researcher comes up with an idea, he makes the protocol." (policymaker – Assam, M)

Even so, many researchers are reluctant to work in mental health due to it being perceived as a low priority for policymakers and, as mentioned above, the existence of a vicious cycle in which this low priority reinforces the lack of research which further contributes to low policy priority:

"[Mental health] is not seen as a priority area, and so when it comes to research very few people across the country, they take it up as one of the research areas." (researcher – national, M)

Three barriers to the generation of evidence were identified: mental health awareness and stigma; financial constraints; and regional instability.

An increase in mental health awareness was specified as a driver for the recent growth in people seeking mental health services. This has, in turn, triggered a growth in research. However, mental health awareness is still low and mental health stigma remains a significant barrier to developing mental health policy:

"[The statistics] was the tip of the iceberg because only those who are having some problem, they usually come to us, but if you go to the community the problem is much higher. Those who are having

only minor problems they are not coming to us[…] If there is some emergency that led to some seeking for mental health related issues, then they come to us." (researcher – Assam, M)

It was also suggested that mental health stigma could, potentially at least, lead to incomplete or inaccurate research data:

"The evidence would have been collected from the doctors[…] but some they ignored the one who are treating the mentally ill patients, so that is the biggest issue." (researcher – Assam, M)

Mental health data collection has also been impacted negatively due to civil unrest and conflict in parts of Assam which has made research extremely difficult in certain areas, thus limiting the geographic comprehensiveness of the evidence:

"In the first initial stage we got a very troubled area for data collection. So, we projected that doing data collection in that area, because there were ethnic riots going on during that time. So, then they did a re-sampling in which a nearby you know district came up. So, which was, I mean one had to see the local realities also." (researcher – Assam, F)

Finally, financial constraints were raised by policymakers who, due to their role, were particularly aware of funding priorities which can place severe limits on what can be achieved in resource-constrained settings such as Assam. Financial constraints affect some topics more than others with, for instance, high prestige biomedical research often requiring expensive equipment. Community engagement and involvement is also absent from research due to a lack of ear-marked funding.

"*[In] very limited times these professionals also reach out to the other people, unless there is some mechanism, like for example if say in certain kinds of research actually this is funded[…] for example if I work with the healthcare worker who is there in the[…] rural area, and say if you give me some[…] amount[…], I will go to some places in Assam and collect the data and all those things, I'll interact. But because of this depth of these findings, and depth of this time and all these kinds of gaps, we don't have a dialogue with them around mental health, we don't know what is happening there. And we are sitting here and also this feedback doesn't reach the policymakers.*" (researcher – national, M).

4-4. Perception

The perception of evidence – how evidence is understood, interpreted and viewed - by stakeholders was reported by stakeholders to vary greatly within and between stakeholder groups. Therefore, the interaction between the evidence itself and actors, is an important consideration in addition to the evidence itself. Alongside the evidence itself, how stakeholders – and which stakeholders - become

acquainted with evidence is key to its uptake. Receptiveness to evidence differed among policymakers due to individual background and interests. However, skill development was identified as a need across stakeholder groups to facilitate engagement with evidence, and ultimately its use in policy.

4-4.1 A need for greater knowledge and skills

Unequal distribution of knowledge and skills necessary to interpret and engage with evidence was also said to be behind differences in how stakeholders view evidence. Specifically, stakeholders having the relevant skills and knowledge was deemed necessary for the effective use of evidence. Not only was this recognised as important by researchers, but across the range of stakeholders:

"I think research is only good when it's applied properly, right, and it can be applied properly when people actually understand it." (intermediary – Assam, M)

Researchers were of the opinion that they had by far the best skills and knowledge in this regard and that, consequently, this posed a challenge for collaborative agenda-setting:

"We [researchers] are people who claim to be having access to knowledge, data, and we have tools which helps us better understand what the data and knowledge is telling us. So, but at the same time we must realise that we operate in a setting where the data and knowledge and tools are often not available to the other people that we work with. And so, they are […] often not in sync with us when we are talking to them about oh how a certain problem has to be solved." (researcher – national, M)

Lack of relevant knowledge and skill to utilise evidence was thought to be true of a wide range of stakeholder groups, including mental health professionals, and, of note, policymakers: *"the policymakers also most of them are like not really trained enough or educated enough"* (researcher – national, M). For elected representatives, i.e. Ministers of Health, this lack of specialised knowledge was expected as they are democratically elected and with broad portfolios. Moreover, the lack of mental health information within formal education was suggested to contribute generally poor 'mental health literacy'. Due to the long legacy of education, this poses a challenge to the speed of progress:

"Even I was not aware about mental health because there is no mention of mental health of any sort in our textbooks, right, so until I passed out at school I had no knowledge of like this is a problem." (intermediary – Assam, M)

However, an improvement in knowledge has been observed in recent years, apparent across all stakeholder groups, including mental health professionals:

"Previously psychiatry wasn't given that much of an importance but gradually the importance has increased. So that way the undergraduates and the graduates, the medical graduates, they know more than we used to do about mental health." (researcher – Assam, M)

The population-wide improvement in mental health awareness was said to be due to: an increase in trained mental health professionals; the media; and Government of India and Assam awareness programmes. However, this improvement has not been universal, and it was said that awareness programmes needed to be conducted on a larger scale:

"If you consider about say our elected representative[…] the judiciary people, the policy person [, schoolteachers, administrators]… unfortunately the awareness was very, very less til recently. But[…] changes are happening in recent years, at least last few years because, mainly because of the awareness programmes.[…] But the number is not that much, so we could not cover everyone.[…] Again it varies depending on a personal interest. I am not saying that everyone is not having the awareness, some of them might be having that, but some still have perhaps some misconception with mental illness." (researcher – Assam, M)

A further skills gap was identified surrounding the communication of evidence. This was seen as an important part of the role of researchers and mental health professionals. However, these skills are omitted by the current curriculum:

"Especially the trainee level, discussion about this policy or discussion about this advocacy training, collection of evidence, so there is hardly any training. And so, by the time the trainees finish their training actually what happens is they are very much ill-equipped with this." (researcher – national, M)

4-4.2 The sender and receiver of evidence

Both the 'sender' and the 'receiver' of evidence determine the acceptance of evidence. Firstly, who the 'sender' is, and how they communicate the evidence, was said to be a predominant factor in how successfully evidence is taken up by policymakers:

"[How evidence is received] would depend for example on which community this is, which geography this evidence is coming from, and most importantly who is presenting it to him or her: is it coming through the system, is it coming through an NGO, is it coming through the community based organisation based in that community, or is it coming in through mass media like newspaper? So, the medium will enormously affect how state level Ministers of Health would treat this information." (researcher – national, M)

Secondly, individual 'receivers', notably policymakers, were reported to differ in their openness to evidence: *"A lot will depend on […] which official"* (researcher – national, M). Specifically, policymakers were perceived to vary in their motivation and interests. Therefore, targeting policymakers with both influence and relevant interest, for example on particular mental illnesses and populations, was recommended:

"When there is a person with, at an official level, who is committed towards any topic, he or she can really remove barriers, and knowledge products of the sort we were talking about earlier, may make sense. But if not then, you know, it's as good as falling on deaf ears." (researcher – national, M)

4-4.3 Differences in how evidence is valued and interpreted

In addition, researchers and communities were recognised to treat, and value evidence differently, demonstrating the fundamental differences in perceptions between stakeholder groups. This is poignant when considering the importance of community-directed as well as policymaker-directed approaches (Chapter 8).

"We [researchers] tend to privilege knowledge much more than they [communities] do. And so in that, while it is an important element of being a researcher, it's also a barrier for us, because societies are often not knowledge driven. They may be but they're often not, implementers are often knowledge driven." (researcher – national, M)

Stigma, patterned by socio-cultural context, was raised as an important potential counter-point that might lead to the ignoring of research evidence. Although mental health stigma is not unique to India, it was highlighted to be particularly acute:

"I think that stigma is globally there, but in India it is particularly there, because there are a lot of beliefs and like unscientific beliefs." (intermediary – Assam, M)

A researcher from Kerala added that stigma should itself be an area on which evidence is generated and used to inform policy:

"Another important data […] for policymaking, planning etc […] What are the cultural, attitudes and what are the awareness of people? All these are relevant data when deciding public health policies and interventions." (researcher – national, M)

These influences on how evidence is received are not the only barrier to its uptake because mental health is not always a priority:

"Whatever insights we gain into practice and apply it for the larger scenario, ok? And many people are believed to accept it. But acceptance of our insights is not necessarily uniform because many people will say, we are, this is not a priority support." (policymaker – national, M)

Opinions were said to be strongly entrenched and polarised, making it difficult to agree priorities:

"I would think that there will be challenges in trying to bring to convergence everyone's opinion." (policymaker – national, M)

Among researchers, one reason behind the variable use of evidence was said to be different disciplinary perspectives, including anthropology and languages. These were stated to be particularly important in the field of mental health, which is perceived as having a stronger socio-cultural component than physical illnesses. However, one policymaker recognised the value of multiple perspectives in gaining a holistic understanding:

"For me I will try to see at it from all lenses. If possible, I will try to ask people from other disciplines also for their input. Okay, this is what it is, for me, the person whose culture is this research, which is basically to understand in a cultural context a particular issue." (policymaker – Assam, M)

4-5. Use

Mixed views were expressed on the extent to which mental health evidence guided policymaking, specifically the agenda-setting stage, which was said to be constrained by both a lack of evidence, and the available evidence not being fully utilised. Suggested factors influencing the use of evidence identified were: (1) individual motives, and (2) the political and economic environment. Overcoming these is a continual challenge requiring sustained commitment. Although important, the perception is that, by itself, evidence is not sufficient to create policy change.

4-5.1 Differing views on the extent to which evidence is used in policy

The importance of evidence for mental health policy was widely recognised, most strongly by researchers. Predominately its importance was seen to be focused on agenda-setting and policy formulation, where policy *"needs to be based on evidence"* (researcher – national, M). Some interviewees further stressed that evidence is, in fact, necessary for policy development, so the formulation of a policy signifies the use of evidence:

"Everything is based on research only, without doing research so we cannot make any sort of policy." (researcher – Assam, M)

One participant felt that current mental health policy is strongly informed by research evidence due to what has been achieved by the implementation of existing policies, and appears to suggest that mental health is given appropriate priority by the policy agenda:

Current policy is viewed by researchers as largely informed by research evidence due to the resources that have been allocated to mental health and the successful execution of policies through programmes:

"I think this [research] is properly reflected [in policy] only because of the amount of resources that is provided nowadays is good actually. Because when I see the national mental, our district mental health projects that are running, I think they are very good[…] I can say that the research that was done, it has been well reflected in the policy that has been made by the government." (researcher – Assam, M)

Furthermore, confidence was displayed that research evidence will be used in future national and state policymaking. A counterexample, however, was the National Mental Health Care Act 2017, which was thought to be lacking an evidence-base. However, this was stressed not to be representative of policymaking. Within Assam, according to some stakeholders, the findings of the National Mental Health Survey (Pathak et al., 2017) have not yet sufficient time and opportunity to, through influencing the policy agenda, lead to an evident change in policy. However, optimism was expressed: "*it is bound to happen"* (researcher – Assam, F).

Conversely, other stakeholders felt that evidence use could be strengthened, in Assam and nationally. For instance, the extent to which the findings of the Assam State Report of the National Mental Health Survey (Pathak et al., 2017) has influenced agenda-setting has been questioned: *"[the] National Mental Health Survey has been done, okay, but after that what?"* (intermediary – Assam, F). Moreover, the lack of evidence in policymaking was said to be apparent throughout the policymaking cycle, encompassing the enactment of policy into practice:

"When we finally want to look at the evidence, what is available with regards to existing policies on the ground, and also the implementation of those policies, the effectiveness of those policies, how it has to translate into the practice of the mental health professionals and, you know, the impact of it on the larger community, we see a lot of gaps." (researcher – national, M)

4-5.2 The barriers and facilitators of evidence use

Robust evidence was seen as necessary, but not sufficient, for evidence-informed policy. Moreover, enduring barriers may still prevent evidence, even of sufficient quality and quantity, from its translation into policy:

"Despite robust evidence many, many may find it still difficult to implement this program because teachers may say "we don't have time" or teachers may say "you appoint a specialist facilitator or a life skills educator for this purpose". This not necessarily gets translated into a policy action, by creating specific results. So, this continues to be a challenge." (policymaker – national, M)

Some participants questioned the extent of what approaches to strengthen the use of evidence can achieve, with some barriers outside the scope of what can be feasibly achieved:

"I mean I can perhaps go on for half a day on this[…] There are a lot, and I think a lot of those barriers, of course there are a lot of barriers, broadly far away from our ability to change them, for example what is the kind of culture for knowledge or evidence within officials or within bureaucracies, or within governments, or within communities?" (researcher – national, M)

Factors thought to influence the use of evidence included: individual motivation, and the political and economic environment: that is, to be dependent upon highly motivated individual policymakers, and often *"the will to take evidence to be implemented in the real world, is lacking in most places."* (policymaker – national, M). This motivation may be shaped by the culture for knowledge, mentioned above, in which these actors operate. However, even highly motivated policymakers were said to be constrained by the political environment in which they operate. Accordingly, this suggests that how evidence is communicated may be of greater importance than its contents:

"I would not see a state level Minister of Health[…] as being driven by a scientific enquiry necessarily. Although, presenting something to him or her as a product of regular scientific enquiry can give that legitimacy of evidence. I know that the kind of political considerations a Minister of Health is in, he or she would also accept various other kinds of input as evidence, including certainly things like denial of care, and public testimonies." (researcher – national, M)

A lack of financial resources was also suggested to hamper the implementation of policy solutions derived from evidence, including recommendations from the National Mental Health Survey Assam State Report (Pathak et al., 2017):

"So that recommendations [from the Assam National Mental Health Survey], some of them they have adopted but they have some inherent problem. One massive problem in implementing these policies are the budget." (researcher – national, M)

4-5.3 The importance of contextual influences on evidence use

Despite some use of evidence in current mental health policies, those working at the grassroots level were critical of policy truly reflecting the needs and priorities of communities:

"In India I think there is a massive, massive gap between what from you the population wants and how the policies are framed. Of course, there are market surveys and of course there is a lot of research that goes into these policies, but more often than not there is a huge gap." (intermediary – Assam, F)

Therefore, it was also stated that the role of research evidence in policymaking should not be the sole focus, and other inputs, such as media and community participation, in the policy process are also seen as being equally, if not more, important:

"I think right now we are gearing towards a world where cultural mediums work more effectively in policymaking than say for example just heavy scientific research. Of course[…] that's the foundation for it. But, I think we are also looking at things a little bit more differently and not as conventionally as say probably like ten/twenty years ago, where someone somewhere will decide it and it will become a policy and then it will be just propagated." (intermediary – Assam, F)

In Assam, participants often emphasised the importance of the National Mental Health Survey. However, Kerala - often described as a leading state in India for mental health (Madore et al., 2018; Shibukumar, 2017) - has had a stand-alone mental health policy since 2003, pre-dating the 2015-16 National Mental Health Survey (Gururaj et al., 2016c; Shibukumar, 2017). This further highlights the importance of other sources and types of evidence, such as informal evidence including community narratives, together with other factors alongside evidence, such as the media, for agenda-setting:

"Actually, this mental health policy that is there in Kerala was formulated prior to the mental health survey.[…] So, we cannot say that the National Mental Health Survey had, played an important role in deciding the direction of the state mental health policy in Kerala." (researcher – national, M)

Multiple contextual influences were identified as shaping the role of evidence including: financial resources; sustained political commitment; and media and community participation. These will be further described in Chapter 7.

4-6. Discussion

The significance of the findings will be discussed in relation to the literature, followed by the resultant implications for theory and practice.

4-6.1 High levels of individual-level variation

In terms of how evidence was understood, valued, and therefore used in agenda-setting, a high level of individual variation with and between types of stakeholders (researchers, policymakers, and

intermediaries) was apparent. Context-specificity of interpretations of evidence are an important consideration.

4-6.1.1 Variation in how evidence is understood

Variation in how stakeholders understand and use the term ‘evidence’ was displayed. This variation reflects the findings of other studies in other LMIC health policy contexts. For example, in Nigeria, Onwujekwe et al. (2015) found definitions of evidence held by policy stakeholders to be largely synonymous with ‘research’ but varied in broadness with a minority including also potentially less formal evidence, such as personal experience. However, the current study found that different kinds of stakeholders, including of note researchers, often used fundamentally different understandings of evidence. Concomitantly evidence was used in another context: to show a change, for example a change in policy or legislation, rather than a body of evidence to inform policy. Therefore, it cannot be assumed that when the term ‘evidence’ is used by stakeholders that they are referring to the same concept. The definition of evidence appears to be context dependant, and a universal or singular definition of evidence may not be appropriate. The ‘nature of evidence’ sub-component of the meta-framework developed from the literature review was changed to ‘understanding evidence’ to reflect these larger variances.

4-6.1.2 Variation in how evidence is received

The poor quality of available evidence has been noted previously in other LMIC mental health contexts (Omar et al., 2010). However, in the current study a high level of individual variation was noted in the receptivity of stakeholders to evidence, including policymakers. Personal contact with a person suffering mental illness has been shown in HIC settings to be an important variable explaining differences in support for government spending on mental health (McSween, 2002). In the current study, participants generally recognised a high level of mental health stigma in Assam and it seems important to understand if stigma may be moderated by familiarity with the real suffering and variability of presentation of mental health challenges in the population.

Even if receptivity to mental health evidence is increased, a gap in skills to engage and use evidence was identified in the current study for all categories of stakeholder. This finding is consistent with a systematic review that identified policymaker research interpretation skills as one of the most frequently reported factors associated with the use of evidence (Oliver et al., 2014). In India, whilst individual administrative officers often have extensive knowledge from field experience, at an institutional level the skills needed to use evidence is often lacking (Kattumuri, 2015). Recent theoretical developments on the capacity of policymakers have included a conceptual framework devised to assess the capacity of Ministries of Health in LMICs to use research evidence in decision-

making at the individual, organisational, and systems (Rodríguez et al., 2017: in relation to health professionals see Hamel & Schrecker, 2011). However, the current study extends the importance of research interpretation skills for other intermediaries and the wider community, in particular, for increasing the use of evidence at the agenda-setting stage.

Another important finding was that, for researchers, the ability to package and communicate evidence to policymakers was highlighted as a barrier and a skills gap for knowledge translation has been highlighted by reviews of LMIC contexts (Malla et al., 2018; Murunga et al., 2020). Interestingly, Murunga et al. (2020) suggest that researchers tend to overstate their skills for knowledge translation while the current study provides some evidence that researchers recognise, at least collectively, this as an area for skills development for their profession.

4-6.2 Diverse demands for evidence

Demand for evidence was apparent among a wide range of stakeholders, and for a broad range of evidence.

4-6.2.1 Demand by a wide range of stakeholders

Participants in the current study expressed a demand for further evidence; a lack of data for use in agenda-setting has been reported by other studies for mental health in LMICs (Mackenzie, 2014; Omar et al., 2010; WHO, 2018). Demand for health evidence by stakeholders is not universal, limited demand for evidence has been reported to inform decision-making in other LMICs (Inguane et al., 2020). Demand for evidence by stakeholders is needed for evidence-informed policymaking (Newman et al., 2013). The one-way transfer of evidence from researchers to policymakers, with the aim of attaining a particular policy outcome, is policy influence; evidence-informed policymaking on the other hand further requires a multidirectional process whereby there is also demand from policymakers and other stakeholders, with the aim of a change in culture of the way in which evidence is used.

The demand for evidence by stakeholders in Assam demonstrated by the current study, is consistent with The Assam State Report of the National Mental Health Survey 2015-16 (Pathak et al., 2017). Therefore, this supports the rationale of the aims of current study that understanding, with a view to strengthening, the role of evidence has the buy-in of local stakeholders, and not just outside ‘experts’.

4-6.2.2 Demand for a wide range of evidence

The current study observed that stakeholders tended to emphasise the National Mental Health Survey (Pathak et al., 2017). This mirrors previous studies that report the importance of national surveys in other contexts given their methodological rigor, availability of reports, timeliness, relevance to local context, and ability to reflect what is happening 'on the ground' (Onwujekwe et al., 2015). As the current study has noted, from the case of the State of Kerala which already has a standalone state mental health policy, these national surveys are not necessary for the development of such policies. However, they have been shown to be helpful for raising maternal health in Madhya Pradesh on the state-level policy agenda in India (Jat et al., 2013). National surveys can be particularly influential in tandem with the launch of high status practical initiatives (such as the National Rural Health Mission of India), advocacy by civil society, government aspiration (such as India's increasing importance and leadership on the world stage), and media coverage (Jat et al., 2013).

However, demand for a more diverse range of evidence was apparent in the current study for Assam. This is shared globally for mental health and substance-use disorders (Baingana et al., 2015), where most research focuses on health care delivery and implementation. The specific call in the current study for research with a wellness approach, echoes recent similar calls made for mental health research that takes a wellness approach, as well as the current dominant medical, for the Indian context (Porandla, 2020). The findings of the current study are generally consistent with those of Sharan et al. (2009) who found that mental health research priorities were found to be broadly consistent in multiple LMICs among different types of stakeholders, including researchers, policymakers, professional associations, non-governmental organizations, and associations of users. The absence of certain groups from research and non-research evidence has been argued, in the UK context, to contribute to the neglect of policy issues concerning these groups (Gardiner et al., 2021).

However, the current study found little value was placed on international evidence. Although perceived as robust, it was not seen to be applicable in the context of Assam. This finding differs from some published studies of national mental health contexts, such as Uganda, where international evidence such as WHO publications and reports are influential in placing mental health on the policy agenda (Omar et al., 2010). Moreover, whilst internationally-endorsed evidence-informed policies was identified by Dodd et al. (2019) as an important driving factor in Bangladesh for the prioritisation certain issues, the current study found that these internationally aligned policies may be inappropriate for the context of Assam. The importance of local over global evidence is, however, consistent with the findings of reviews focusing more broadly on health. Malla et al. (2018) report that, in LMICs, recognition of the value of local evidence for the local context is increasing among decision-makers, and this has been confirmed by a systematic review focusing on Bangladesh (Dodd et al., 2019). This finding was echoed in a review focusing on African health systems where the availability of robust

locally relevant research was the most reported facilitator of knowledge translation (Edwards et al., 2019). Other studies have also documented the importance of local over global evidence in the Indian health policy context (Mirzoev et al., 2013; Reddy & Sahay, 2016). This could help account for the relative amenability to informal evidence in India as discussed above, with the addition that local *relevance* may be the deciding factor.

4-6.2.3 Importance of informal evidence

As well as formal scientific evidence, in the current study participants stressed the importance of informal evidence acquired from personal experience. The online survey, conducted as part of this thesis to provide a credibility check of the findings from the interview data, confirmed the importance of a wide range of evidence being used to inform the mental health policy agenda in Assam; an overwhelming majority (90%; n=9) of survey respondents agreed that informal evidence is as important as research for setting the mental health policy agenda.

Recognition of multiple evidence types by the current study is congruent with the argument made by Abimbola (2021) that recognising evidence beyond just that which has been published in the academic literature is vital for to achieving equity in global health. In addition, a systematic review reported multiple evidence types to be important inputs for public health policymaking (Orton et al., 2011). For setting the global mental health agenda, a need for knowledge to be seen more pluralistically has been argued for, and for different forms of evidence to be incorporated (Melluish & Burgess, 2019).

In the UK public health context, policymakers were reported to use information obtained through their professional and personal networks in addition to formal research evidence (Oliver & de Vocht, 2015). Moreover, Greenhalgh and Wieringa (2011) have proposed that in determining the 'right and reasonable' policy solutions research evidence can be used to support value-based positions informed by other types of evidence. It is argued that this especially the case when there is substantial diversity among stakeholders as to what the salient issue is and how it can be solved true for mental health in Assam and many other locations.

However, the findings of the current study also suggest that the differences in how stakeholders view and value evidence is more complex than has been reported by other studies for health policy in a range of LMICs (Hawkes et al., 2015; Nabyonga-Orem & Mijumbi, 2015; Onwujekwe et al., 2015; Ssengooba et al., 2011), Hawkes et al. is particularly relevant in that they include India as one of their case studies. Studies in other LMICs contexts report a relatively clear distinction between researchers and other stakeholders (Hawkes et al., 2015; Nabyonga-Orem & Mijumbi, 2015; Onwujekwe et al., 2015; Ssengooba et al., 2011). Researchers (and civil society organisations in the case of (Onwujekwe et al., 2015) tend to favour formal research evidence in line with the evidence hierarchy (Evans,

2003). On the other hand, other stakeholders, including policymakers, often placed greater value on more informal evidence. In contrast, the current study found a more complex picture with researchers acknowledging the limitations of formal evidence and the advantages of informal research in certain contexts. This is interesting given that in India informal evidence has been reported to have a greater influence in setting the policy agenda than for other LMICs, namely Nigeria (Das et al., 2014).

The current findings seem to be consistent with, research, albeit more limited, which has focused on mental health (Rose et al., 2006). For mental health, the divergence has been argued to be more nuanced across stakeholders, such as service users, families and informal carers, professionals (practitioners and researchers), policymakers, and taxpayers, are reported to have differing and complex views on what evidence consists of. Intriguingly, Rose et al. (2006) considered practitioners and researchers together, presumably due to their similar perspectives and, in the context of Assam, these roles did often overlap. Further research would be needed to explore the diversity of meanings of mental health evidence for the stakeholder types that fall outside the remit of this thesis.

As noted by a recent scoping review, there has been comparatively less research on the role of informal evidence than formal evidence in policymaking in LMICs (Koon et al., 2020). Koon et al. (2020) further report that the articles included in their review collectively consider technical advice and civic participation in particular as types of informal evidence important for health policymaking in LMICs, and hence are argued warrant further attention. Other authors have suggested that field visits may constitute useful informal evidence in the absence of formal research evidence (Dodd et al., 2019).

To add to this, participants in the current study also mentioned public testimonies and personal narratives, for example of denial of care, as important types of informal evidence. Specifically, personal narratives were suggested to be potentially useful for indirect evidence to policy approaches: that is, via communities and the potential of narratives to positively influence health policies has been documented (Davidson, 2017; Fadlallah et al., 2019).

Although there is a wealth of grey literature, robust studies on the usefulness of informal evidence are lacking (Davidson, 2017; Fadlallah et al., 2019). This is important because there is some evidence to suggest that narratives could potentially have unintended negative effects and present ethical issues (Fadlallah et al., 2019). For example, certain diseases such as cancer are said to lend themselves to more ‘tragic’ narratives and, due to their affective nature, may therefore be ascribed greater policy priority than other diseases with a comparable disease burden, such as cardiovascular diseases (Fadlallah et al., 2019).

However, positive influences were also reported by an expert forum specifically for the mental health context, albeit in a HIC, which concluded that personal narratives have the potential to help engage audiences and therefore increase public support for mental health related policies (McGinty et al.,

2018). Hence, the current study supports Koon et al.'s conclusion that further research is needed to understand how informal evidence is perceived and used by different stakeholders and its role in relation to formal evidence in policymaking in LMICs. How narratives are used as a type of evidence is covered in further detail in Chapter 8.

4-6.2.4 The sum of evidence rather than individual pieces of evidence important

In addition, a range of stakeholders in the current study demonstrated appreciation of different evidence types being used together, in particular, storytelling forms in combination with statistical studies. This finding supports the hypothesis of McCall et al. (2019) that using both types of evidence may enhance each other. The current study contrasts the position of an empirical study in relation to health more broadly in Nigeria, another LMIC, where only a minority of stakeholders valued combined forms of evidence (Onwujekwe et al., 2015). However, the findings of the current study support prior research in India which found no singular 'ideal' type of evidence identified by stakeholders (Mirzoev et al., 2013). This recognition of a broad range of evidence types has been shown to be enacted in policymaking; in particular, the agenda-setting stage has been reported to be informed by a broader range of evidence types than other stages, such as policy formulation (Mirzoev et al., 2013).

Furthermore, prior research has demonstrated empirically that the use of narrative and statistical evidence together can be more persuasive together than separately, at least in an HIC setting among a narrow sample population of students (Allen et al., 2000). This tentative 'proof of concept' gives credence to exploring ways in which informal evidence could be better utilised and used in combination with more formal research evidence as a potentially powerful approach in an LMIC setting. The case study of The Banyan, a non-profit organisation working in the Indian state of Tamil Nadu to deliver mental health services to people living in poverty, gives some validation to this proof of concept for mental health at the state-level in India (Narasimhan et al., 2019). Quantitative indicators together with qualitative narratives detailing lived experience were reported to aid in advancing the mental health system, including policy at multiple levels. Thus, the findings of the present study appear to further confirm the hypothesis of the synergy of narrative and statistical evidence, and suggest it may be generalisable to other contexts than in context of Tamil Nadu.

4-6.3 Distinguishing between accessibility and availability

From the analysis it was apparent that sufficient availability of evidence is important, but insufficient by itself for evidence to inform agenda-setting. In addition, other barriers must be overcome,

including those relating to the qualities of the evidence itself, but also external barriers arising from the context in which it is used, including stigma.

4-6.3.1 Perceived availability

What remains unclear is whether stakeholders demand for further evidence is due to the evidence not being adequately communicated and therefore *accessible*, or if the desired evidence has not been produced and so is not *available*. Although the existence of a significant evidence gap is not disputed, the magnitude of the gap may be compounded the concurrent lack of awareness identified by the current study. This conflation is in line with a systematic review that identified the top barrier to evidence use by policymakers as: 'the availability and access to research/improved dissemination' (Oliver et al., 2014). Furthermore, the lack (or perceived lack) of availability of research evidence, may be a potential reason why informal evidence can be more valued, as highlighted by other studies (Onwujekwe et al., 2015). Greater accessibility of mental health evidence and the need for mental health information systems to be strengthened for informing mental health policies as been argued as a need for India. (Arvind et al., 2020).

4-6.3.2 Availability of evidence necessary, but not sufficient

Robust evidence was seen as a necessary, but not sufficient criteria, for the suitability of evidence to inform the mental health policy agenda in Assam. This findings is consistent with the Indian National Mental Health Survey 2015-16, which concluded that decision making at the state-level was often not based on the, albeit limited, available evidence (Gururaj et al., 2016a). The findings of the current study also supports previous research for health policy more broadly in other LMIC settings, including in Bangladesh, which concluded the robust research evidence by itself is insufficient for evidence-informed policymaking (Dodd et al., 2019). Despite evidence demonstrating the magnitude of the issues, relative cost-effectiveness of treatment, and appreciation of the importance of mental health by policymakers, mental health remains low on the policy agenda in the majority of LMICs (Saxena et al., 2007). A range of factors appear to have resulted in the low priority of mental health in the first place, including stigma (Omar et al., 2010), which has been previously reported for mental health in other LMICs and multiple competing priorities. These are further compounded by barriers to the use of evidence identified, that help prevent evidence from being used to increase the priority of mental health.

4-6.3.3 Internal and external factors influence the use of evidence

Key factors influencing the use of evidence for mental health in Assam identified by this thesis encompassed (1) *internal* factors relating to the evidence itself, and (2) *external* factors, i.e., those not

directly relating to the evidence *per se* but regarding the context in which it is used. Moreover, factors included *barriers* impeding the use of evidence, or *facilitators* enabling the use of evidence.

1) Internal factors

The characteristics of evidence identified by stakeholders to be important for policymaking in the current study are broadly similar to other studies (Oliver, 2014; Onwujekwe et al., 2015; Orem et al., 2012). That is, applicability to the real world was emphasised, and applied research was cited as particularly important. Additionally, differences between stakeholders were highlighted by the current study, including different aspects of relevance valued by different stakeholders: geographic and immediacy. The immediacy component builds upon the importance of geographic relevance noted by other scholars, including the *local* relevance of evidence for community actors (Colvin et al., 2018). Recognition of their village or neighbourhood elicited much stronger engagement with evidence on HIV in South Africa. Accordingly, developing a shared meaning of relevance among users of evidence in the Assam context as suggested in general by Dobrow et al. (2017) may embrace the subjectivity of this characteristic, that has been widely noted for health research, whilst maintaining an element of objectivity.

Interestingly, some participants perceived who the evidence was delivered by to be as important, if not more, than the characteristics of the evidence itself when looking at the extent to which evidence is utilised by policymakers. That is, in some ways the *medium* can be more important that the *message*. Therefore, despite acknowledgement of lack of familiarity with mental health evidence, participants largely appeared to place value and trust in the evidence. Similarly, Green et al. (2011) found in the context of maternal health that in multiple countries, including India, that the status and credibility of those conveying evidence influence the perceived quality of that information. Malla et al. (2018) speculated that such indirect assessment based around the trustworthiness of the conveyer of evidence may be used in the absence of, as a proxy for, direct appraisal of the evidence perhaps due to a lack of skills, or confidence in these skills. Given the lack of skills noted earlier by the current study, this too could be a potential explanation for Assam. This apparent importance of who the conveyor of evidence is for how such evidence is received lends support to the people-centred approach argued for by Sheikh et al. (2014) in health systems and policy research.

One unanticipated finding of the current study is that some participants valued the existence of evidence above any particular characteristic. This contrasts with the findings of a systematic review of all health policy areas and locations, where characteristics of research - encompassing clarity, relevance, and reliability – was the second most frequently reported barrier to the use of evidence by policymakers (Oliver et al., 2014). Possible explanations why research characteristics appear to be less important to stakeholders in the current study include differences in evidence availability and/or awareness, or the fact that the current study included a broader range of stakeholders (including

intermediaries) than other studies included in the review, or represents different values in different contexts.

2) External factors

External barriers and facilitators identified by the current study accord with those of a systematic review across health policy areas and locations (Oliver et al., 2014). 'Timely access to good quality and relevant research evidence, collaborations with policymakers and relationship- and skills-building with policymakers' (Oliver et al., 2014, p. 1) were identified as the most important factors influencing evidence use. These were also reported in the current study. However, the order of importance of these factors differs, with individual motives, and the political and economic environment seemingly more prominent in Assam. In general, it seems that there are some broad similarities between the main barriers to the use of evidence in the context of mental health in Assam.

Similarities were found in the barriers to the use of knowledge in policy and practice faced by LMIC African health contexts: a lack of skills and capacity for knowledge translation activities, and limited time and resources (Edwards et al., 2019). More surprisingly, barriers to the use of evidence for mental health in Assam also showed commonalities with those reported in HICs across different health policy issues (van de Goor et al., 2017). Shared barriers include: a lack of locally useful evidence; theoretical rather than applied evidence; characteristics of the senders and receivers of evidence, including the 'will' of policymakers; and financial resources. Although there are differences in the barriers to the use of evidence between settings, such as in the order of importance, this overlap implies that some aspects of existing evidence-to-policy frameworks are broadly applicable with refinement to the context of Assam, and potentially other understudied contexts.

In the current study, there were some differences in the barriers to the use of evidence that researchers, intermediaries, and policymakers reported. However, these differences are less marked that those described in other contexts (Ellen et al., 2018). In Israel, a HIC, policymakers were reported to be more likely than were researchers to cite practical implementation constraints as a barrier to health policy and systems research use (Ellen et al., 2018). Although, in Assam researchers also often cited practical barriers, including financial implications. Perhaps this is due to the crossover between research and practice that has been noted by the current study for Assam, meaning that individuals often are involved or have experience of both research and practice. Researchers may therefore be more cognizant of practical barriers. The crossover between research and practice has been noted to be greater for LMICs than HICs (Jessani et al., 2020), suggesting that this finding for Assam may be applicable to other LMIC contexts. This overlap of 'researcher', 'practitioner', and 'policymaker' roles, and how it may facilitate the use of evidence, is further discussed in Chapter 5.

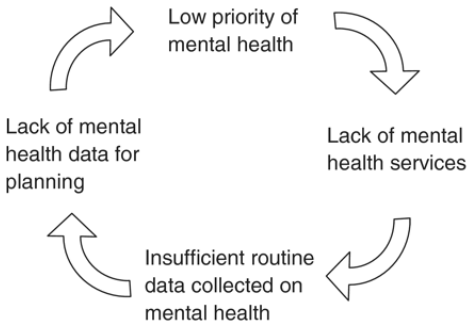
Whilst participants often commended the design of programmes implementing mental health policy, and noted the use of evidence was evident, intermediaries were critical of the disjunct often existing between community priorities and the policy agenda. Although the use of evidence to inform policy does necessarily translate into the priorities of communities being incorporated, the lack of reflection of community priorities apparent in policies does suggest an apparent way in which evidence can inform policymaking, and in particular agenda-setting. Informal evidence in particular, such as community narratives, as earlier findings indicated may help to facilitate the inclusion of community priorities. The process of producing such narratives through community participation, also well as the output, may also provide a potential pathway to ensure the incorporation of community priorities in policy: Kattumuri (2015) argues, in India, a more informed and politically active electorate strengthens incentives for policymakers to address the needs of communities.

Other studies in India have reported that evidence, has been more frequently used to assist the priority-setting of policy issues, rather in the design of policies (Das et al., 2014). Surprisingly the findings of the current study are more similar to those from other HIC settings, where studies have reported that the use of research is perceived to be greater for deciding upon the policy solution, rather than in the prioritisation of policy issues, or the evaluation of policy solutions (Campbell et al., 2009). More research is needed to understand to what extent the use of evidence to inform policy, correlates with the extent to which community priorities are represented.

4-6.3.4 Stigma drives a cycle reinforcing insufficient evidence

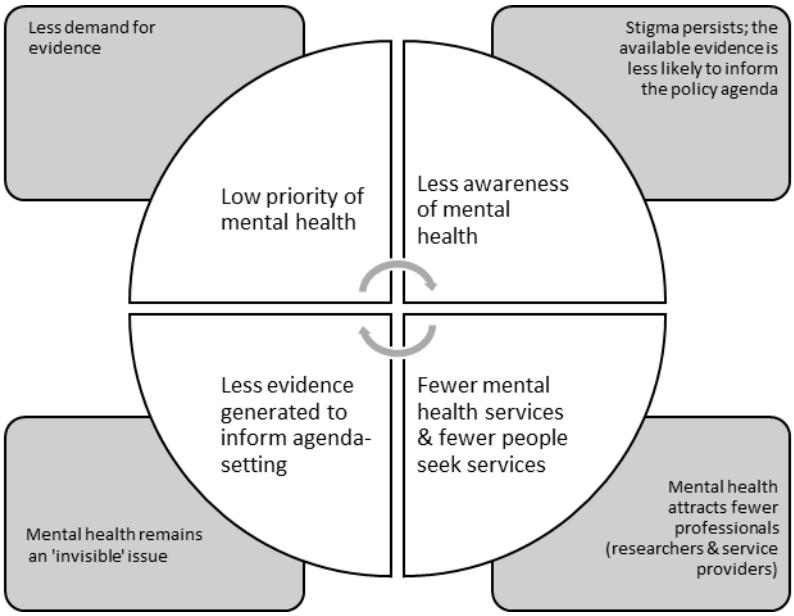
Stigma was identified from the analysis as a key external barrier to the use of evidence and impacted its use in multiple ways. The importance of stigma was also recognised by Bird et al. (2010), who proposed a cycle of how low priority and insufficient data on mental health, (Figure 20) based on their study of four African countries, including LMIC contexts. A vicious cycle is set up as the low priority of mental health results in a lack of mental health services. Consequently, there is a lack of routine mental health data used in agenda-setting process, and so mental health remains a low priority:

Figure 20. Cycle of low priority and insufficient data on mental health (Taken from (Bird et al., 2010)).



From the analysis of the present study, this cycle has been expanded for mental health in Assam (Figure 21), to also include others forms of evidence, as well as routine data. Moreover, the updated cycle captures the role the stigma plays. In addition, the component of mental health services is expanded to incorporate the provision of, as well the demand for mental health services. The low policy priority feeds into the difficulty of attract professionals to the field of mental health, both for conducting research and providing services. In turn, this results in fewer advocates for mental health, contributing to the low priority of mental health, as well as the supply of informal evidence based on personal experience, such as expert opinion.

Figure 21. Updated cycle of low priority and insufficient evidence on mental health.



4-6.4 Implications for theory and practice

The findings reported in this chapter have implications for the improvement of actor engagements in evidence-informed agenda-setting.

Due to the range of meanings and values ascribed to evidence, for collaborative policy development and implementation involving a wide range of stakeholders, a shared understanding of ‘evidence’ is likely unfeasible. Therefore, an implication for theory is that it is recommended that efforts should be made to recognise the diversity of views and perspectives on the understanding of evidence.

Specifically, a further important implication of this study for practice is the potential role highlighted for informal evidence, such as narratives, alongside other types of evidence to inform policy, particularly for agenda-setting. Taken together, the findings support the idea that approaches to strengthen the use of evidence in policy should integrate informal and formal types of evidence. A key

recommendation from the findings is the need for community priorities to inform the mental health policy agenda-setting in Assam much more strongly. It is therefore important that evidence conveys and reflects community priorities; informal evidence may be well-suited to help facilitate this.

As well as the potential direct role of informal evidence to inform policy decisions, informal evidence may indirectly act by making the wider policy environment more conducive to the use of evidence, for example by reducing stigma. There are some indications that informal evidence can act by personalising mental health suffering, and so in this way help reduce stigma and raise interest in developing positive policy interventions. Further research on the role of informal evidence would be worthwhile to confirm the preliminary body of work, and to guide approaches of its use.

An area identified requiring further research is the need to disentangle the concepts of evidence availability and accessibility, both in Assam and in other contexts. Consequently, this too has important implications for practice; for successful approaches to be developed to strengthen the use of evidence in agenda-setting, the reasons why evidence is not used need to be understood. This is a particularly important issue for future research as unlike other factors, such as the political environment, awareness of evidence is a factor amenable to researchers and consequently could be the potential focus of an actionable approach to strengthen the use of evidence.

In addition to exploring evidence *per se*, it is recommended that extrinsic factors are also considered in parallel. One important area to further explore is why despite increasing evidence mental health remains a low policy priority, stigma is potentially one such factor. These extrinsic factors are likely to be entwined with and exacerbate the barriers to the use of evidence for mental health policy. It would appear this is an area for investigation not just for Assam, but in other contexts too. Furthermore, actors, chiefly the conveyors of evidence, appear equally important to the evidence itself. Due to the critical importance of who conveys the evidence, community and personal experience narratives may need to be conveyed by high status individuals, at least in the first instance, to have a hope of being heard.

The importance of intrinsic factors supports the equal precedence given in the meta-framework to the four additional components (actors, process, context, and approaches) as ‘evidence’, the central component of the conceptual framework. For instance, skills and capacity at the community-level seem to also be important considerations.

4-7. Conclusion

In summary, the important finding regarding evidence is the potential role highlighted for informal evidence, such as narratives, alongside other types of evidence such as formal scientific evidence to

inform policy, particularly for agenda-setting. The potential role of informal evidence is both direct by informing policy decisions, and indirect by making the wider policy environment more conducive to the use of evidence, for example by reducing stigma. A key recommendation of this chapter was the need for community priorities to inform mental health policy agenda-setting in Assam much more strongly, informal evidence may be well-suited to help facilitate this.

Evidence, however, is not the only factor that affects policymaking and agenda-setting (Sutcliffe & Court, 2005). The role of evidence in agenda-setting is complex and its role is also determined by the four other components of the conceptual meta-framework (i.e., actors, process, context, and approach). These will be explored in the subsequent chapters.

CHAPTER 5: RESULTS (Actors) – Who the key actors are and how they use evidence

5-1. Introduction

This chapter will focus on actors: one of the four main components of the meta-framework alongside evidence. A growing recognition of the importance of actors has occurred in health policy and systems research (HPSR) more broadly, where calls have been made for a more human-centric approach, with human agency and social structures key determinants of how systems work (Sheikh et al., 2014).

Ultimately, evidence is used in agenda-setting by people, and interacts with individual and societal values (Cairney & Oliver, 2017). Thus the role of evidence in policy cannot be viewed in isolation from the human element. A broad range of individuals and groups are involved in policymaking (Popoola, 2016), and different actors use evidence in different ways (Jones et al., 2013). Moreover, how evidence is framed and communicated by stakeholders is key (Sohn, 2018),

This Chapter aims to understand how the key actors identified use evidence in setting the mental health policy agenda for Assam. After the terminology used in this thesis to describe different actors is set out, this chapter will cover: who the key individuals and groups are for the use of evidence in policymaking, what part they play, and how they operate alongside each other.

5-1.1 Terminology used

Policy actors can be defined as individuals, groups, or organisations directly or indirectly connected to or impacted by any part of the policymaking process, whether in a formal or informal way (Shannon, 2003). Actors are a closely related construct to stakeholders; according to the WHO, stakeholders are actors "with a vested interest in the policy being promoted" (Schmeer, 2000, Section 2, p. 1). So, whilst there is a significant degree of overlap between actors and stakeholders, not all actors are necessarily stakeholders.

In this thesis three main groups of actors (set out in Table 15) relevant for the use of evidence in mental health agenda-setting in Assam were identified. It is important to note that the actor groups are not mutually exclusive. Hence, participants were assigned the category that best described their role that was of interest during the interview. Intermediary is the least clearly defined category of actor; a precise definition is difficult due to the multiple types of and range of functions of intermediaries

(Bullock & Lavis, 2019). Actors can also be considered to have 'formal' or 'informal' roles. Formal roles are those with constitutional or legal power to make policies, these include the Government and the Courts (Cahn, 2012). On the other hand, informal roles, although lacking any explicit power, influence the policymaking process and thus shape policies.

Table 15. Definition of stakeholder groups as applied to participants.

Stakeholder group	**Definition – Applied to participants**
Researchers	Actors for whom generating mental health research evidence forms a significant part of their role.
Policymakers	Actors responsible for, and empowered to decide, mental health policy, including elected ministers as well as officials. Given the predominant, but not exclusive, focus of this thesis on the agenda-setting stage of policymaking, this includes advisers in addition to politicians (elected representatives) and officials (non-elected). For example, advisers can be members of a policy group appointment by the Government of India.
Intermediaries	Actors who in the area of mental health "work in between existing system structures in order to facilitate communication or to achieve a particular goal" (Bullock & Lavis, 2019, p. 2).

A binary classification was used for geographical group. Participants were designated as providing insights at the 'Assam' or 'national' level. Even if a participant has had a national-level role, where relevant, the Assam label will take precedence to indicate their familiarity with the Assam context. Consequently, participants familiar with the context of Assam were assigned the geographical category 'Assam', even if they were involved with national-level mental health policies, to highlight their knowledge regarding this case study.

5-2. Key Actors

5-2.1 Range and importance of actors

Participants highlighted a wide range of actors were important for evidence-informed mental health agenda-setting in Assam. In particular across: (1) the type of role that individuals perform; and (2), the geographic level(s) in which they operate.

Interestingly, the combined action of a range of stakeholders is reported to have resulted in raising the priority of mental health within the policy agenda. This suggests that the synergistic influences of less powerful actors can result in meaningful policy change:

"Because of all these pressures from different stakeholders now government is thinking about increasing the budget." (researcher – Assam, M)

5-2.1.1 Types of actors by role

The three key types of roles (policymakers, researchers, and intermediaries) were recognised by participants, however these roles were not seen as mutually *exclusive*.

Policymakers

As expected, policymakers were seen as central actors for evidence-to-policy processes. 'Policymaker' was a term commonly, but far from exclusively, used by participants. However, as this was the term used by the interviewer, a priming effect may have driven some use of this term. This is more likely to be the case in instances where a participant used two terms consecutively, for instance *"the power people, or the policymakers"* (researcher – national, M). 'Policymaker' as the second term may have been included by the participant as a way of relating their own terminology back to that used in the question by the interviewer. Inconsistent application of the term 'policymaker' was also observed among participants; some exclusively referred to politicians, others to officials in the civil service, the Indian Administrative Service, to policy boards appointed by the health ministry, or to a mixture of these. Interestingly, one researcher reflected upon the limited utility of the conceptualisation of 'policymakers', despite its widespread use, due to the oversimplification and broadness of the categories in use:

"In this whole policymaker basket we really have a very diverse range of actors and roles, to the extent that I sometimes find the policymaker label to be very clunky[…] It's not a useful label, it's actually a very confusing label for us to make sort of some generalisations to policymakers." (researcher – national, M)

Researchers

'Researchers' were recognised as important stakeholders for policymaking, including agenda-setting: *"the role of researchers is the most vital"* (researcher – national, M). Simultaneously, it was stressed that their importance for achieving evidence-informed policymaking should not be overstated, particularly at the expense of other stakeholders, including communities. Participants concurred that The National Institute of Mental Health and Neuro-Sciences (NIMHANS) was the leading research institute that exerts the most influence on mental health policy in India. Within Assam, and the North-East Region, participants unanimously agreed that the Lokopriya Gopinath Bordoloi Regional Institute of Mental Health was the "*prominent*" (researcher – Assam, M) institution for mental health and assumes a leadership role:

"[The Lokopriya Gopinath Bordoloi Regional Institute of Mental Health] is looked up [to] as the main place for leading the mental health initiatives." (researcher – Assam, F)

Interestingly, research is not the core function of the institute: *"slowly [the Lokopriya Gopinath Bordoloi Regional Institute of Mental Health] are also coming to the area of research"* (researcher – Assam, M). This would suggest that their role and influence in the policymaking process extends beyond the generation of research evidence, and through their role in service provision and teaching.

Intermediaries

A wide range of 'intermediaries' were identified by participants, both organisations and individuals. This included those whose role in the policymaking process was exclusively as intermediaries, i.e. resided outside of the researcher and policymaker communities. Their influence was reported to be largely determined by what type of organisation they belong to, ranging from large intergovernmental organisations such as the WHO, to small NGOs.

Crossover between actor types

In addition, the 'intermediaries' identified by participants included certain individual researchers who simultaneously act as intermediaries by bridging the gap between the research and policymaker communities. This suggests the 'researcher' and 'intermediary' categories are not mutually exclusive. One participant emphasised the importance and influence the researchers exert on the policymaking process, and the agenda-setting stage, although this is determined to an extent by the organisation to which they belong and varies across individual researchers:

"Who is doing this matters a lot, I think, so the reception for agenda-setting efforts by researchers will vary depending on who it is who is doing it, and what their position is in that state." (researcher – national, M)

A range of other actors were recognised who could be viewed as indirect intermediaries, i.e. actors not conventionally viewed as intermediaries. Whilst they may not specifically aim to facilitate communication between researchers and policymakers, this may nonetheless be achieved through their activities. For example, the judiciary is another key actor purported to drive mental health up the policy agenda in Assam. Monitoring by the Supreme Court of India and the National Human Rights Commission of mental health issues was starting to accelerate action:

"The delay we had in so many years but now after this, after the role played by the Apex body and Human Right Commission, I think variation will likely to have state level mental health policy." (researcher – Assam, M)

Whilst users of mental health services and communities were recognised as key actors, at present they are not viewed as influencing the policy process. They were reported to lack the necessary power; illiteracy was highlighted as a key barrier by the online survey. However, strengthening their

influence in the use of evidence in the agenda-setting process is seen as necessary for policy agendas that reflect the needs and wants of communities:

"Unfortunately, the user is voiceless, and he does not demand, and therefore there are problems. So, we are also working towards disseminating evidence among the user" (policymaker – national, M)

5-2.1.2 Types of actors by geographic level

Actors at different geographic levels were also key according to participants for evidence-informed policymaking in Assam, including agenda-setting. Participants could be grouped across several major levels; notably national and state level as well as regional and district levels.

National actors were perceived to be influential in Assam but limited by the size and heterogeneity of India. For example, even though the Lokopriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH) can be considered both a state and regional institute, it chiefly operates as a national institute and is one of three major institutes within India. This demonstrates the interconnectedness of the different geographic levels:

"[The Lokopriya Gopinath Bordoloi Regional Institute of Mental Health] is an autonomous institute[…] under the Government of India, so all the states have no rule practically, they do not fund, they do not have any rule, though the name is regional but it is access in all functionality it is working as a national institute." (policymaker – Assam, M)

One participant encapsulated the importance of understanding the full range of the different types of actors, at multiple geographic levels, due to the diversity of viewpoints they exhibit. In addition, this highlights the heterogeneity of mental health stakeholders, and the challenges of understanding the role of evidence in the agenda-setting process for different actors:

"Because we are working in a tertiary level, primary institute kind of thing, our perspective will be completely different. So if you go to the district hospital, you know, or even if you go to a primary healthcare centre things will be different, or if you go to especially people who are health workers and this kind of grassroot level workers, or even people like lay counsellors and all these people, their perspectives will be different. Actually, if you talk to people who have a family member with mental illness, like a parent or somebody who you talk to them, their perspective will definitely differ." (researcher – national, M)

5-2.2 Characteristics of actors

The analysis revealed the following key characteristics of policy actors: expertise, professional experience, and effective communication skills. These determined two impact routes to evidence–informed policymaking: (1) to increase the likelihood of being invited to contribute to policy processes; and (2) to facilitate an advocacy role in agenda-setting.

5-2.2.1 Characteristics to facilitate invitational involvement in policymaking

Key characteristics reported by participants to determine the invitational involvement in, and thus the ability to use evidence, in policymaking (including agenda-settting) were: (1) perceived mental health expertise and (2) professional experience. Both characteristics suggest the voices of more established actors can be favoured in the policymaking process.

1) Expertise

First, expertise was identified as a key characteristics which was generally seen to be exclusively possessed by researchers. Their position as *"experts in the field"* (researcher – Assam, F) was identified by a researcher as the perceived key criterion by which actors in Assam were invited to participate at the national and regional level, including meetings for the Mental Health Care Act of 2017. Expertise was also identified by one participant as an important attribute for some types of policymakers, officials in particular and with regards to policy formulation. Simultanously, this implies that elected politicians lack mental health expertise. This exemplifies the ambiguity of the term 'policymaker,' as mentioned above, by another participant:

"The policymakers they're a different set of people [to politicians], who are expert in this field who already know something about the mental health, they formulate these policies regarding the mental health." (researcher – Assam, M)

Remaining unbiased was also seen by one researcher as an important attribute of their professional expertise, *"giving the real feedback about what evidence is there on the ground"* (researcher – national, M). Again, this stresses the importance of informal evidence based on personal experience, in this instance namely expert opinion. In this regard, a distinction between the role of researchers and policymakers was highlighted whereby, researchers must remain apolitical when communicating evidence to maintain their credibility:

"Researchers has [sic] a very, very unique role where it can have very impartial non-judgemental, or non-influenced by the power people, or the policymakers" (researcher – national, M)

Interestingly, other stakeholders outside the research community perceived expertise to be exclusive to academics. This highlights the value placed on formal expertise with grass-roots level experience not assigned the same prestige. Additionally, this also supports the finding of Chapter 4 that informal evidence not based on the scientific method but on personal experience is less valued:

"I don't come from a research background so I'm not an expert." (intermediary – Assam, M)

(2) Professional experience

Second, professional experience was cited by researchers in Assam as a key characteristic determining who is invited to be involved in, and thus have the potential to use evidence to inform, policymaking. Both the type and nature of professional experience were seen as key. For the types of professional experience, participants considered both experience of mental health work more broadly, and with regards to policymaking in specific, to be important. In particular, experience was mentioned by some participants for the policy formulation stage, but also for the agenda-setting stage in terms of advocacy efforts. A potential consequence of the perceived requirement for substantial experience means that certain actors may be excluded from the invitiational processes, suggesting a 'closed' space. For the nature of professional experience, experience with the relevant population, and the length of experience were components of experience specified to be important, and often seniority within key institutions are equivalent to professional experience:

"Is the entity or group or individual for example a member of the community itself, who is affected, […] is the person having a long, many years of experience of working in that state, will matter. Whether the person has already a body of work[…] legitimacy matters." (researcher – national, M)

The results of the online survey support the finding of the above interviews, with position and seniority cited as being important characteristics. However, it was also highlighted how this may be a barrier to a comprehensive policy, informed by evidence from a range of stakeholders, including informal evidence (based on personal experience) from communities:

"Stakeholders are mostly senior professionals who may often lack information on ground realities of common man" (researcher – Assam, F)

5-2.2.2 Characteristics to facilitate individuals having an advocacy role in agenda-setting

Advocacy can be defined as 'action directed at changing policies' (The Collaborative Training Program, 2004), and is particularly relevant for agenda-setting. Communication was seen as an important skill for effective advocacy, and increasing the extent to which evidence informs the

agenda. As well as the ability to present relevant evidence, effective listening was deemed equally important due to how stakeholders value evidence in different ways:

"So how do we have then a communication with groups who do not privilege or prioritise knowledge that way we do? So that requires enormous flexibility among the researchers ourselves: it needs for us to be more humble; it needs for us to be more listening; and it needs for us to be able to engage with people who might strike as being too, you know, indifferent, arrogant, etc, you know. This is the reality, they often strike us being arrogant or indifferent because we believe that the knowledge we have or the evidence we have is, ought to have higher elements for them as well which is often not the case." (researcher – national, M)

No singular set of ideal characteristics were, however, identified. This suggests that a variety of attributes can aid being an effective 'intermediary'. Moreover, some traits were viewed as potentially both advantageous and disadvantageous depending upon use. For example, the effecivenss of charisma was said to vary over the policy cycle. This underlines the importance of exploring the impact of actor charactersitics over the different stages of the policy cycle:

"Charismatic can go multiple ways, it can get us a positive win in agenda-setting, but it may distort, disrupt overall processes." (researcher – national, M)

5-2.3 The dynamic nature of actors

The number of mental health actors, individuals and organisations, in Assam with the potential to use evidence to inform the agenda was said to have increased in recent years, albeit from a low starting point. This includes mental health practitioners, their increase largely attributed to the revised National Mental Health Programme. An increase of organisations working in the mental health space has also occurred, and there has been expansion of some of those already in existence. Intermediaries and, in particular, researchers already working in the mental health space reported having greater individual and organisational capacity to use evidence to inform the agenda. This includes community engagement and awareness-raising which can be time- and resource-intensive, as well as the direct lobbying of policymakers. Interestingly, this suggests there may be potential and appetite for certain actors to engage more strongly in agenda-setting and this may represent a 'window of opportunity':

"As of now we've been putting our house in order. Because we established our department, we set these training courses in place[…] So now things have settled down, so now we feel that we are at a stage when we can impact the social systems around policymaking to some extent, and you know push forward for various kinds of services." (researcher – Assam, F)

Concurrently, however there was reported to be *"a high turnover of staff"* (researcher – national, M) with numerous individuals also leaving or changing positions. Due to variation in interest in mental health, as noted above, key personnel changes, particularly among policymakers, affects the way in which evidence is used in agenda-setting, and what approaches may be successful to stregnthen the use of evidence:

"If you have, let's say, a new principle secretary of health[…] I have seen in my experience somebody who has a huge commitment towards mental health, who comes and occupies that chair and then suddenly, you know, there's a sudden energy into mental health work. And he or she is setting up new committees, and there's an openness to work with NGOs, and new kinds of evidence make it into the system, various things start off. And then, two or three years later the person leaves and then that the incumbent who comes in is not so interested in mental health[…] So in that sense if the agenda-setting has happened at the political level, at the ministers level, the officials will implement it so they cannot become a barrier, but they themselves will set agendas depending heavily on considerations that are often not accessible to people like us." (researcher – national, M)

5-3. Roles

The duties of policymakers, researchers, and intermediaries, as determined by themselves and by other stakeholders, will now be covered. This will be followed by a discussion of the extent to which these roles are fulfilled, and the barriers and facilitators to doing so.

5-3.1 Perception of role

Individuals concurrently holding multiple roles and functions were often reported: *"I have to have my legs between two: academics and service."* (researcher – Assam, F). This suggests that in Assam, the following categories of actors should not be conceptualised as mutually exclusive.

Policymakers

Although 'policymaker' is a broad term, participants tended to use it to refer to officials rather than politicians. Whilst the policy process was recognised as complex, participants did not expand much on the role of policymakers. As expected, policymakers were seen by respondents across different stakeholder groups to be responsible for mental health policies, and in particular policy formulation. This may explain the high level of mental health expertise identified above as an important characteristic for policymakers. Whilst they were seen to lead the development of policies, a central part of their role was seen to be working with, and drawing the input from, all relevant stakeholders:

"The people who make the policy they should be expert in the subjects, okay, and they should take the opinion of everybody." (researcher – national, M)

Researchers

Researchers did not always immediately acknowledge their individual role in policymaking, despite doing so later on over the course of the interview. The topics and questions covered in the interview may have given participants an oppurtunity to reflect upon, and evolve, their perception of their role. When participants did acknowledge their role, they often emphasised the *indirect* and collective team nature of their involvement through their research institution. This may be particularly relevant for informal evidence based, such as expert opinion, that was highlighted in Chapter 4 as an especially pertinent type of evidence for informing the mental health policy agenda in Assam:

"We are not directly, very directly involved in [the] policymaking process […] though [in an] indirect way we are involved, but not in a direct way." (researcher – Assam, F)

Researchers perceived their dominant role in policymaking to be supplying evidence. Generating such evidence with professional integrity at all stages was stressed, such as *"collecting the data in an honest manner"* (researcher – national, M). Policymakers shared the view that the principal role of researchers in the policymaking process is the supply of evidence and to *"constantly generate evidence which can be implemented in the real world"* (policymaker – national, M). Interestingly, this implies not all evidence is seen to have 'real world' relevance, a characteristic of evidence highly valued by policymakers (see Chapter 4).

In addition to supplying evidence, some researchers thought that they were responsible for communicating evidence to policymakers. Moreover, some researchers also saw themselves as advocates, using their access to evidence, and research evidence in particular to inform and influence the policy agenda. Researchers differed in the extent to which advocacy comprised their role, from a secondary function "*a very strong component*" (researcher – national, M). One researcher stated they were *"the spokesperson for that area"* (researcher – Assam, F), which included discussing the findings of research with policymakers and suggesting changes to policy. All the researchers at one institution were reported by a participant to advocate for mental health generally as well as for specific areas, for example mental health in children or the elderly, highlighting shared and individual interests among individual researchers. Tension between the two main roles of researchers, as apolitical communicators of evidence and as advocates, was apparent. Given the overlap of roles, and that most 'researchers' are involved in service provision, remaining politically neutral is likely to be unrealistic.

As well as using their voice to use evidence to inform the policy agenda, according to another researcher an integral part of their role is to provide fora for the voices of other actors where the exchange of evidence can take place:

"*I see the role of researchers as people who ought to create spaces, or environments where the kind of dialogue and discussion I mentioned earlier, happen."* (researcher – national, M)

Intermediaries

Intermediaries viewed a key element of their role as being *"facilitators"* (intermediary – Assam, F) in the agenda-setting process and a link to the community. However, limited capacity often required being selective in where they focused their advocacy, with one intermediary stating *"we have to pick our battles"* (intermediary – Assam, F). Similarly to researchers, intermediaries displayed appreciation of the role and contribution of other stakeholders. One intermediary also reflected on elements of policymaking their role did not include, such as devising potential policy solutions:

"We are trying to build a bridge, that's our job; our job is not to solve the problem." (intermediary – Assam)

In a similar vein to researchers, an intermediary also mentioned the importance of being impartial so as to be seen as credible. This involved being inclusive in order to support all members of the community, important to fulfil their role of being a link to the community. One intermediary alluded to the tension between staying impartial whilst also working towards making a real change on a topic they are passionate about:

"I won't be stupid to say that like, you know, like my political orientation or like my standpoint in life doesn't affect the space, but like we try and be as neutral as possible and create a safe space for people to talk no matter what you like to talk about but then also try and guide them to a way where you have a more I think informed opinion of certain things." (intermediary – Assam, F)

Similar to researchers, intermediaries perceived their role in communicating evidence for agenda-setting, as well as other stages of the policy cycle, as a responsibility or duty. However, in comparison to researchers, they focused more on informal evidence (based upon personal experience) such as expert opinion or community narratives:

"That is definitely one of our agendas, taking it to the policymakers, or people who are in power, because we have the privilege or the knowledge to sort of portray that, or to conceive that idea. But it's also our responsibility to sort of connect to the policymakers, or the people in power to sort of work on this issue." (intermediary – Assam, M)

5-3.1.1 Perception by other actors

Variations exist, however, in how these key actors are perceived by communities. In rural areas, stigma was seen to pejoratively affect how medical professionals, including mental health professionals, are viewed and in certain areas there is violence against doctors. This negative perception suggests communities do not necessarily trust researchers and intermediaries, who are often also involved with service provision, to represent their community and advocate for their needs:

"Still the people they consider the doctors to be some sort of pariah figure, okay, and there are many violent persons." (researcher – Assam, M)

The extent to which policymakers and the media fulfilled their role with respect to mental health evidence-informed policymaking was questioned by other stakeholders. It was recognised that the media at state and national levels, both via print and online media, have increased their coverage of mental health over the last decade. This includes the dissemination of evidence, and has resulted in greater awareness of mental health issues amongst the public. However, it was felt that the media could be doing much more in this respect. Policymakers, including elected politicians, were criticised far more strongly. Some stakeholders felt that those in a position to raise the profile of mental health in the community were not doing so which, as discussed later, is a seemingly important step in raising mental health on the policy agenda:

"I have never seen any policymaker, not policymaker, or politician, or like people in high power talking and like publicly about this whole issue of this, yeah." (intermediary – Assam, M)

Researchers, particularly those holding senior leadership positions at the state-level, were seen as having the potential to use evidence much more actively for advocacy in order to drive changes to the policy agenda:

"The director of mental, the Tezpur Mental Health Hospital [the Lokopriya Gopinath Bordoloi Regional Institute of Mental Health], right, so he is in a position where he can actually take some calls, is it not? But a lot of times we do not see our leaders in mental health fraternity really taking those calls." (intermediary – Assam, F)

5-3.2 Fulfilment of role

Participants across the range of actors (including researchers) felt that they were unable to contribute as much as they would like in setting the mental health policy agenda. As a result, participants described the need to prioritise which aspects of the agenda to focus their attention on.

Barriers and facilitators to fulfilling the 'ideal' roles outlined above were identified from participant's responses. The 'ideal' roles of the three main types of actors can be simplified to be considered as follows. 'Policymakers' take responsibility for the development of policies and for including all relevant stakeholders in this process. 'Researchers' were primarily seen to be suppliers of evidence, as well as communicators of evidence, advocates, and providing a fora for other actors. 'Intermediaries' were seen to be a link between different types of actors and facilitate communication.

The three key barriers and the three key facilitators identified were largely focused upon researchers and intermediaries rather than policymakers, due in part to these actors being over-represented in the sample. Potentially, this may also imply that approaches to strengthen the use of evidence in policymaking need to not only be directed at policymakers, but to also consider the role of other actors and how to support them in their efforts to strengthen the use of evidence in agenda-setting.

5-3.2.1 Barriers

Barriers to the fulfilment of roles identified by participants were: (1) lack of appropriately trained staff, (2) a perceived glass ceiling, and (3) multiple concurrent individual roles.

1) Lack of appropriately trained staff

A recurrent theme across interviews from all stakeholder groups was insufficient appropriately trained personnel for mental health. As noted above (in section 5-2.3), despite the improvements in the numbers of trained staff, it is not sufficient due to the concurrent increase in the demands on personnel. This was mentioned by a participant from a Department of Psychiatry in Assam:

"In our department of psychiatry[…] we had only two/three psychiatrists in about twenty years back. Now gradually our manpower increased, so now we have modest numbers[…] but if you ask me about whether this sufficient or not, I'll say definitely no. Because when we were around two/three people in the department, then our attendance was something around seventy or eighty, now we are around thirteen faculties in our department, our attendance is around five hundred and six hundred. You see the difference? Still we need more." (researcher – Assam, M)

Researchers expressed that they were not as involved in policymaking and agenda-setting as they would like, primarily due to time limits given their other commitments. The multiple roles of researcher, service provider, and teacher, whilst highlighted above (2.1 Range and importance of actors) as being beneficial at an institutional level, exacerbates the demand and burden on the limited number of trained individuals:

"To give the quality services[…] mental health service is very time consuming so we need more manpower, it is not sufficient. We have so many different activities, teaching, surveys, research,

advocacy as I rightly said, going to the community, so we have different roles to play." (researcher – Assam, M)

Limited mental health personnel was also reported to contribute to the low policy priority ascribed to mental health; there are fewer voices who can use evidence for advocacy. With fewer individuals to share the workload, there is even less time for advocacy which is often viewed as an 'extra'. In fact, it was suggested that a lack of appropriate staff to push the mental health agenda leads to mental health being a low policy priority, leading to a vicious cycle which does not help improve the level of personnel:

"There are reasons why mental health is not given importance, main problem was the lack of manpower, trained mental health professionals were very less." (researcher – Assam, M)

Lack of appropriately trained staff was stated to be especially acute at the district-level where there is a *"crisis of manpower"* (intermediary – Assam, F). It therefore seems likely that a lack of staff is a major barrier to grass roots involvement in agenda-setting. A lack of financial resources was proposed by one participant to be the key factor limiting the number of personnel:

"I think the policy has to focus on that [advocacy and awareness] and to do so again it has to have adequate manpower who is going through that job. And who will be paying for that? I think we at least got that kind of people interested to come for that job." (intermediary – Assam, F)

2) Perceived glass ceiling

Second, intermediary organisations reported being unable to undertake advocacy on the large-scale they aspire to due to being 'young organisations' with limited power and influence due to age and inexperience. As noted above (in section 2.3), many organisations working on mental health in Assam have been founded relatively recently and participants reported feeling a pressure to demonstrate their ability in order to gain recognition and legitimacy as actors among policymakers. Experience, acquired over time, was one of the characteristics of key actors highlighted above (2.2 Characteristics of actors) for being invited to participate in policymaing. Similarly to researchers, as these new organisations become more established, there may be greater potential for advocacy efforts:

"I think one of the bigger challenges that we have been facing over the last one year is because we're very nascent, so it's this like constantly having to prove our self at every step of the way." (intermediary – Assam, F)

At the individual-level, intermediaries described their role being limited by their demographic. This 'glass ceiling' may limit the participation of some groups in agenda-setting, particularly for youths and youth-run organisations, and their use of evidence. However, there is hope that this 'glass ceiling' may be broken through:

"We're just students, what can we do? So, let's do something at least." (intermediary – Assam, M)

Such barriers were mentioned by both male and female intermediaries, suggesting age is a more important than gender for participation in evidence-to-policy processes. Gender was not explicitly or implicitly reported as a barrier in the interviews. Interestingly however, in the online survey although 50% disagreed or strongly disagreed gender is a barrier to participation in the policymaking process, 30% strongly agreed. This suggests that gender may indeed be an issue for women under-represented in the policy process, but not perhaps one that is seen as important to discuss. However, it may have also not have been raised due to the small sample size of the current study.

3) Multiple concurrent individual roles

Third, multiple demands on individuals were seen by participants as mainly as a hindrance which was seen as additional challenge to over-stretched individuals, minimising the time available for evidence-to-policy activities, including advocacy, despite their willingness to engage. Demands on individuals were also said to have been exacerbated by technology, including WhatsApp:

"It is definitely limited resources, because we are just a few. And you know we have regular work which keeps us pretty occupied in our institute[…] Of course, we have a role in impacting the various social systems, the governmental systems, which we do partly[…] Each of us you know, we as heads of department and professors of departments you know we have to do a lot of juggling[…] We don't completely shut off our work at all. There's no way we can." (researcher – Assam, F)

5-3.2.2 Facilitators

Despite the barriers, some participants felt able to fulfil, to some extent, their 'ideal' role in evidence-informed policymaking and agenda-setting and articulated examples of how they had used evidence to influence policy:

"We were involved in the changing of the definition of 'psychiatric social worker' in the Act, national, that is the Mental Health Care Act of 2017." (researcher – Assam, F)

Participants also described factors that aided the fulfilment of the 'ideal' roles outlined above. These facilitators were: (1) multiple concurrent organisational roles; (2) individual-level freedom; (3) prior involvement in policymaking processes; and (4) social media.

1) Multiple concurrent organisational roles

Unlike at the individual level, organisations playing multiple roles was seen to be more advantageous, presumably as the collective expertise from the different roles could be shared without additional

burden on individuals. Provision of research, teaching and service provision concurrently was perceived to be integral to the success of each individual component:

"[The Lokopriya Gopinath Bordoloi Regional Institute of Mental Health] have all type of services […]this means automatically[…] a lot of people across the society[…]and they are good material for clinical study[…] And at the same time because we have this huge number of patients and they're coming across from different type of background, they're also, with their permission, used as material for teaching, demonstration and teaching[…] So that way you need to have all the three components together when you want to improve the services in this particular way." (policymaker – Assam, M)

2) Individual-level freedom

Researchers expressed a *"large amount"* (researcher – Assam, F) of freedom within their institute, albeit subject to oversight. This enabled them to implement their research findings into practice, in the form of interventions for service delivery, for example nursing care. Policymakers further saw the independence of researchers as a key factor in their influence of the research agenda and this shapes the mental health research evidence available to inform the policy agenda:

"Sometimes some questions or some credits come up suddenly in the society saying that it may be related to say treatment, it may be related to say understanding diseases in a better way, or it may be related to the special presentation in a particular area. So, this depends on the researcher. So, what happens is a researcher comes up with an idea, he makes the protocol." (policymaker – Assam, M)

3) Prior involvement in policy

It was stated that prior involvement in the policymaking process helped enable further involvement by researchers in policymaking and agenda-setting. Hence, policy involvement appears to act in a positive feedback loop whereby initial involvement leads to further invitations to participate. This could be due to the boost in reputation and increased visibility to policymakers. For mental health, this may be particularly important due to the relatively small numbers of researchers in Assam. Additionally, this feedback loop could be driven by the encouragement researchers experience being able to influence policy:

"It is something that we projected that has come about into the Act. I mean we feel very proud about it and feel and a sense of confidence follows us, and in all our professional dealings you know. And we stand by it, and we literally take it up as a mandate, you know, to push forward wherever possible. Like, for example, I have been, whenever advertisement comes up, when any of the institutes across. India, somehow it happens that people send the advertisement to me. Right. And it'll say "Now Madam won't you please give your opinion on this. You were the one who pushed forward the definition of psychiatric social worker". I am speaking specifically because that is, I took up that

advocacy role for psychiatric social work in various institutions[…] And we have been able to impact the systems, you know because of that initial level that we did, we had the confidence to impact the system." (researcher – Assam, F)

The online survey further elicited the mechanism by which previous involvement in policy provides a positive feedback cycle:

"Contribution and recognition of various professionals gives a sense of identity, achievement and connectedness. Thereby fostering the motivation to impact policy building." (researcher – Assam, F)

4) Social media

Social media was mentioned by participants as a way of making and sustaining relationships over a large geographical area. This is important to allow intermediaries between mental health professionals and communities to fulfil their role, especially young people who often are not participants in policymaking processes:

"We formed an organisation[…] right now it's online community, so basically we operate through Instagram and Facebook, so we try to build a network of people who would be willing to help other people as well, so right now we have volunteers all over the country, including Delhi, Bombay, Bangalore, Guwahati, then Kolkata and other parts of the countries, so what we basically do we is we try to be the bridge between professional health and youth and young people." (intermediary – Assam, M)

5-4. Relationships

Forming and maintaining relationships with other actors constitutes an important part of the roles of actors for using evidence in agenda-setting. Different types of relationships serve different purposes and influence the use of evidence in different ways. The two kinds of relationships, identified by participants, were differentiated by whether they were formed within or between different types of actors: (1) relationships between different types of stakeholders, inter-stakeholder relationships; and (2) relationships within stakeholders of the same type, intra-stakeholder relationships. The types of actors are categorised according to their 'stake' in mental health and are thus termed as stakeholder groups.

5-4.1 Inter-stakeholder group relationships

The importance of stakeholders working together in order to positively influence agenda-setting was stressed by participants:

"Unless the care provider, the policymaker, administrator work together to implement issues on a priority basis, to say some of these things are non-negotiable, then only things can change. So, this can happen at the level of a program, at the level of the state, and the level of central government." (policymaker – national, M)

Limited, but improving, inter-stakeholder group relationships

Although recognised as important, the interaction between different types of stakeholders (policymakers, researchers, or intermediaries) was stated to be very limited and something *"that really won't happen most of the time"* (researcher – national, M). This was seen as an institutionalised problem nationally that will be difficult to improve and therefore described as *"the biggest kind of challenge"* (researcher – national, M).

Nonetheless, improvements in recent times in the level of interactions between stakeholder groups in Assam was reported, especially in the efforts made by policymakers. In particular, the state government was reported to have a close working relationship with the medical colleges. Notably, this increased interaction between policymakers and other groups of stakeholders, and thus potential for the exchange of evidence, was thought to improve policymaking and have led to a higher position of mental health on the agenda:

"Earlier policymakers remain isolated maybe in the capital and they have no touch with the ground level worker or to different sectors. So that is most of the policies formulated earlier was failure [sic], but now things are changing. Now in developing the policy the opinions of all the stakeholders are taken[…]and in implementing also now they are taking the stakeholder into confidence[…]So that is why things are changing very rapidly." (researcher – Assam, M)

A need for stronger inter-stakeholder group relationships

Intermediaries expressed a desire for closer relationships with a range of stakeholders, including public-private partnerships. In particular, intermediaries expressed the belief that researchers could more actively work with other actors and build upon each other's strengths and weaknesses. Notably, the strength of relations between different groups was seen to affect how evidence is used in the policymaking process. Civil society organisations were highlighted as a group that researchers were recommended to work more closely with, due to them reportedly being key to strengthening ties with the community making them an important conduit for researchers to have impact:

"There has to be a lot more synergy between the institutional research that happens and the civil society bodies because we are not at sync. There is a huge gap. We are not communicating with each other[…] There has to be a flow from the research work that the institutions are doing. Institutions are able to do it because they're also funded by the government and by the other bodies, so they have a greater chance of doing better research than us[…]But they also have to understand that we also have the skills to train, make some better research because we are also in link with the communities. So I think we have to build up on each other's strengths, which we are not doing" (intermediary – Assam, F)

The potential of the collective power resulting from different actors working together was illustrated by a participant using the LGBTQ movement in India, who emphasised that such synergy was instrumental in bringing about policy change. Individually, actors may have little power or influence, particularly those at the grassroots levels, but in an organised fashion they can directly shape the policy agenda:

"Homosexuality was still illegal in India three or four years ago and now it's legal, right so what led to it, it led to a lot of movements, and it led to a lot of pressure from different parties[…] like college kids and like people who are working on those lines, professionally or like at least locally, right, so I think there needs to be movement, like I don't think a guy can go to a policymaker and then be like, oh do this, do this, do this, of course he can do, it's possible, but if you're talking about like a mass change in policymakers in India I'm talking about like people in power, are in like the state, then I think it's, it has to like be a movement first." (intermediary – Assam, M)

Thus, when looking at which actors are important for agenda-setting, it is important to consider relationships between actors as well the actors themselves. Furthermore, the importance of the collective role of actors supports the argument made earlier in the present study (2.1 Range and importance of actors) that a broad range of actors need to be considered when looking at the role that evidence plays in setting the mental health policy agenda in Assam.

Relationships reported to be needed among actors were not restricted to those working in mental health, or even the health sector more broadly. For practitioners, a multi-disciplinary approach was seen to be necessary for mental health, and therefore greater inter-sectoral relationships and integration was identified as an important need, which was currently lacking. This was seen to be important for service provision, and mental health professionals *"should be based in all different sectors"* (intermediary – Assam, F). Therefore, it is likely that mental health policy also needs the input of actors in a range of sectors.

Building stronger inter-stakeholder group relationships

Some elements of blame culture, largely directed by researchers as well as by practitioners, towards policymakers, was said to exist. However, one participant acknowledged that although some of this blame was deserved, policymakers were not exclusively responsible, with both sides needing to take responsibility for working together in a more constructive fashion:

"We often keep blaming the policymakers for the, any, problems we have, but part of the blame, the professionals themselves have to take, mental health professionals, and some of these institutions." (researcher – national, M)

Some intermediaries acknowledged the greater level of interaction with researchers they felt was needed, was not seen to be the sole responsibility of researchers and that *"researchers should talk to advocates more[…]and vice-versa"* (intermediary – Assam, M). Thus, it was implied that the responsibility for greater interaction is on both sides, and this should be factored into any approach to strengthen the use of evidence in policymaking.

In order to build relationships across a broader range of actors, critical due to the reported absence of some groups from agenda-setting, similarities between individuals may facilitate relationship building due to a shared background and common interests. For mental health, due to the stigma involved, lived experience of the issues faced was seen to be advantageous and empathy particularly important. Understanding service users and their communities was considered important in order to involve them in agenda-setting processes:

"I think to tackle the stigma, I think for me I picked my own battle, in the sense that I am a [young male], right, so I think I understand my problems better, pertaining to my, related to my age group, right, because I know, because our problems are a lot similar, if not completely similar[…] So I pick my battle and like we founded an organisation and we are trying to sort of reach out to people." (intermediary – Assam, M)

5-4.1.1 Networks

As well as relationships between two sets of actors, participants discussed the importance of the sum of these relationships which, when taken together, form a social structure or network. An array of networks was apparent from the accounts of participants, and these could be categorised as one of two types: (1) policy networks and (2) advocacy networks. Policy networks consist of those who lead policymaking and their connections, whereas advocacy networks or coalitions are those with a shared interest in influencing policy. Both types of networks can be of a formal or an informal nature. Formal networks are those with an established aim, structure, leadership, membership and processes, while

informal networks often lack these and are those based upon personal relationships. These different networks will be discussed at the national-level and then at the state-level.

1) Policy networks

Formal policy networks, including knowledge translation platforms[10] such as the National Knowledge Platform[11] for public health, were said to be lacking for mental health at the state and national levels. The absence of formal policy networks and consequent lack of opportunities for relationship building was said to contribute to the *"very limited I feel, frankly"* (researcher – national, M) interaction between researchers and policymakers. As a consequence, informal networks based on personal connections, and perhaps an established reputation, are perceived to be key in determining the level of policy influence of researchers:

"There is no formal network, and see basically everything, you know, happens more of an ad-hoc thing, like where in like suppose if I'm the ministry person who is sitting in Delhi, and if say he is working on suicide prevention and he is knowing someone at NIMHANS [The National Institute of Mental Health and Neuro-Sciences] or some institute, or whatever it is, I will just contact his team. I will say that, you know, please draft something as a policy." (researcher – national, M)

The impact of the lack of formal policy networks, including the reliance on personal networks, was discussed by one participant. One outcome reported was that policy influence is conferred through privilege and power rather than relevant experience and expertise, characteristics deemed important above. The establishment of knowledge translation platforms were proposed to help connect researchers and policymakers by providing an opportunity for frequent, sustained interaction by a body perceived to have the required legitimacy. Due to the differences in culture between researchers and policymakers such interactions were thought unlikely to occur organically, and a platform would develop the specialist skills to engage effectively with both groups. Hence, this would help to avoid the reliance on informal, personal networks which are perceived to be less effective for strengthening the use of evidence in policy. However, as recognised by the participant, the establishment of any mandated knowledge platforms are often outside the control of researchers and need to be instigated by policymakers:

"It's two-way, I wouldn't sort of lay the blame entirely on the research community, it's also the fact that there are no knowledge platforms that are part of public policy or government entities currently […] If there were the researchers could very easily speak with or exchange with such entities, because of their mandate they would have been better prepared to deal with researchers. So

[10] Knowledge (translation) platforms are formal networks that are often government or institutional entities created for the purpose of sharing evidence among different types of actors (Lavis et al., 2006).
[11] A National Knowledge Platform was formed by the Government of India's Ministry of Health and Family Welfare for health systems and public health research to increase its use in policy (Sheikh et al., 2016).

currently[…] researchers are directly, you know, interfacing with decision makers and these too are coming from very different frameworks and lack a common language, they lack systematic or you know, frequent consistent engagement with each other. So relationships don't exist, etc. So these are very big barriers, you know, I mean so the net result is that often these are left to social networks, or privileged preferred prioritised contacts of the researcher or the NGO, and things like that, which is not necessarily often the best way." (researcher – national, M)

2) Advocacy networks

Advocacy networks were reported to be more abundant and used more effectively by actors, both at the national and state levels, for promoting evidence use. At a national level, there were said to be many networks fundamental for advocacy within India: *"without networks we will not be able to do any advocacy work in the country."* (policymaker – national, M). Formal advocacy networks include national-level professional associations, the Rehabilitation Council of India and the Indian Society of Psychiatric Nurses were given as examples by participants. Advocacy networks were also said to exist at the state-level, however these tended to be more informal in nature. By providing a platform, networks were said to be able to function as spaces where evidence is shared and discussed among actors. Networks can also be valuable as mechanisms for shaping the mental health policy agenda due to the combined power and influence of its members:

"Where do the research reach the people it is mostly being presented, it's also being talked. So, there are some platforms where research, evidence are coming up and you know sometimes from that also, because they are being, when some new policy are coming up for nursing, for that kind of thing they have been called[…] So the councils have a major role to play in mental health, and they are called upon." (researcher – Assam, F)

In addition to formal advocacy networks, informal networks based upon personal relationships were often cited by participants as enabling interaction, and the sharing of evidence, between actors. One example of an informal network was between researchers and alumni. It was reported this enabled both formal research evidence (based on the scientific method) and informal evidence (based on personal experience) to spread. Due to geographic mobility of actors observed, informal networks at the state-level often evolved into networks at the national-level:

"Many of my students who passed out from me are working in different parts of the country, at different institutes, so where I see they are trying to take these models and implement them." (researcher – Assam, F)

Other types of actors, who are not researchers or mental health practitioners, also reported the absence of formal networks within Assam. Although networking was recognised as an important activity, it was said to occur only on a small-scale, at a personal level. This was in part perceived to be a

consequence of mental health being a nascent, relatively unorganised, and under-resourced sector. Similar to policymakers relying on personal connects, this has resulted in personal relationships predominating:

"We just will accept our like closest friends who are probably as aware as us, or would like to work on such things." (intermediary – Assam, M).

5-4.2 Intra-stakeholder group relationships

As well as the relationships between different groups of stakeholders, the relationships within the same groups of stakeholders (policymakers, researchers, or intermediaries), participants stated, could also be improved.

Policymakers

Among policymakers there were reported to be limited relationships and communication, and hence sharing of evidence, across policymakers in different departments. Due to the complexity and diversity of mental health as a policy issue, participants emphasised the need for mental health to be an inter-sectoral issue and not the sole remit of the health department, reported to be largely the case at present. This has resulted in inefficient working and missed opportunities for relevant evidence to be shared and used in policy. Another point raised was that in addition to relationships being conducive to generating policy change, including the agenda, policies themselves can facilitate the strengthening of relationships:

"The education department and the health department, they are doing everything in silos, you know. They are not talking to each other. So, what we are doing is that we've giving them information from the same group of people, right, and they are getting confused about, you know, what they are supposed to do actually, no? So, I think there has to be a common platform to talk about mental health by the different departments. And the policy has to state that." (intermediary – Assam, F)

Researchers

Likewise, participants felt there could be a greater level of collaborative working among researchers. Unlike between policymakers, researchers showed signs of greater inter-institutional and multi-disciplinary interaction in recent times. However, these are often yet to move beyond the planning stage, with financial resources appearing to be a barrier:

"We're also trying to collaborate with different, we have a central university here that we're, that the molecular biology department is very good, so also trying to integrate with those departments so that

we can conduct some collaborative study. Now we are also thinking about asking for funds, finance from Indian Council of Medical Research, so that is only in planning level." (researcher – Assam, M)

Intermediaries

Among researchers who are simultaneously also often practitioners, such as nurses and social workers, having the endorsement and backing of peers and colleagues was said to be a key component enabling influence on policy development. Hence this highlights the importance of strong intra-stakeholder relationships:

"We impacted the national-level policymakers in order to project what was the required thing. So that's, that's the way we have impacted policy and development. Of course, with the mandate of people who have been trained in this line." (researcher – Assam, F)

5-5. Discussion

The significance of the findings will be discussed in relation to the literature, followed by the resultant implications for theory and practice.

5-5.1 Importance of a wide range of stakeholders

As expected, policymakers were identified as key stakeholders for agenda-setting. Curiously, participants, including those involved in policymaking, did not always immediately acknowledge their role in the policy process. Similarly, Haq et al. (2017) in their study of evidence-informed health policymaking in Pakistan, reported that some participants did not recognise their role in policymaking, seeing 'others' as policymakers.

However, a lack of consistency in use of the term 'policymakers' was evident among participants. MacKillop et al. (2020) argue that the amalgamation of politicians and the civil service within the term 'policymakers' neglects the structural and cultural differences between these two actors and obscures the heterogeneity of policymaking. In the current study, one consequence of the ambiguity of the term 'policymaker' is that it may account, at least in part, for some inconsistencies in the perceptions of policymakers such as their level of mental health knowledge. Fafard and Hoffman (2020) argue that a shared understanding of 'policymakers' is a requisite of being able to design approaches that effectively target them. Further, the overlap between the categories of different types of actors noted in the current study, supports the general finding for LMICs (Jessani et al., 2020).

Policymakers were not the only key actors that need to be considered for evidence-informed agenda-setting, but a broad range of actors including local stakeholders and organisations. This finding of this thesis reflects the conclusions of prior studies (Cummings et al., 2018; Mbachu et al., 2016; Orem et al., 2012; Tantivess & Walt, 2008). The involvement of a wider range of actors in policy processes may lead to policies being more strongly informed by evidence and the inclusion of more diverse forms of evidence (Huss et al., 2014; Mbachu et al., 2016). For mental health, the role of intermediaries and advocates has been argued, in the HIC context of the US, to be highly significant, given the existence of stigma and of underserved communities whose voices may otherwise be unheard in policy processes (Malekinejad et al., 2018), including agenda-setting. Moreover, a systematic review, including both LMICs and HICs, suggests that families of people with mental illnesses in particular should have a greater role in the policymaking process (Carbonell, et al., 2020).

The invisibility of disadvantaged communities across a range policymaking issues, beyond healthcare, has also been reported in India (Pande, 2003). Accordingly, Peters et al. (2003) argue that increasing the role of communities in determining priorities for state health systems should be a priority for the Indian government. It has been contended elsewhere, including Brazil, that communities are increasingly important for the decision-making processes due to decentralisation (Suárez, 2006). As decentralisation is a trend in the Indian context, the consideration of a broader range of actors is also likely to be increasingly important (Rao Seshadri & Kothai, 2019) and approaches targeting a limited range of stakeholders less likely to be successful (Fafard & Hoffman, 2020). Greater involvement of communities for health research-to-policy has been advocated for more strongly recently, highlighted as a need by COVID-19 (AlKhaldi et al., 2021).

Community organisations have been proposed to have a crucial role in involving under-represented population groups, but that funding is barrier to doing so more extensively. Notably, the current study found funding to be a major constraint for such organisations. Furthermore, research in India focusing on disability as a policy issue, has shown that advocacy for people with disabilities by national-level activists did not represent the needs of people with disabilities at sub-national levels (Schedin, 2017). This is accentuated by the varying and divergent viewpoints of stakeholders on policy issues and solutions.

The document analysis, used to triangulate the interview data, included an online news article of the seminar ‘Health condition of women in rural Assam’ hosted by the Centre for North East Policy Studies and Research (C-NES). The reported conclusion of the seminar suggests that empowering village committees were seen as key to enabling, in particular rural, communities to “play a much more vigorous role in leading the health movement in the state” (C-NES, 2010). Moreover, it lends support to the finding of this thesis of the need to enable communities, and particularly rural communities, to utilise their potential power for informing the mental health policy agenda. Inclusion

of stakeholders from rural communities in the participatory agenda-setting process has been argued by Schroth et al. (2020), in the German context, to be particularly important as most research evidence originates from universities that are predominantly located in cities. In particular, these stakeholders include the general public, in addition to civil-society organisations. The current study suggests that these findings also apply in Assam, and are particularly important given the heterogeneity and the logistical challenges of working across the whole state (see Chapter 7).

In Assam, tea tribe communities, despite being a marginalised group, are recognised as politically significant due to constituting a significant proportion of the population of Assam (17%). (Saha, 2021). Limited formal research has been conducted on the tea tribes of Assam (Sharma, 2018), and informal evidence may therefore be beneficial.

A limitation of the current study is that all participants were recruited from urban Assam due to practical constraints. Therefore, convenience bias may introduce some uncertainty in the findings of the present study. This is particularly pertinent because in contrast to the findings of this thesis, lower levels of stigma and discrimination, and higher levels of acceptance, of mental illness have been reported in rural areas than urban areas of Central Assam (Borooah & Ghosh, 2017). This is likely to affect how evidence is used.

Young people are another subgroup who are reported to have limited engagement in mental health policy development and implementation in India (Roy et al., 2019). This is consistent with the finding of the current study that experienced actors are perceived to have greater influence and input in policymaking processes. A ‘young leader’s award’ may be a potential way of increasing the perceived legitimacy of the voices of younger actors (Jessani, 2020).

This thesis noted that the judiciary and the media were influential actors for using evidence in mental health agenda-setting at the state-level in India. The influence of the media found in by this thesis contrasts with prior studies which found that both the judiciary and the media lacked an important role in evidence-to-policy processes in India (Huss et al., 2014), suggesting a recent increase in their involvement. The findings of a systematic review, suggest the mechanisms through which the media can influence agenda-setting are through promoting accountability and raising the awareness of policymakers (Bou-Karroum et al., 2017). Additionally, for substance abuse, a sub-set of mental health, the media can have influence through determining the topics of public debate and shaping public attitude (Lancaster et al., 2011), thus affecting what evidence is used and how it is perceived.

Curiously, international actors India were rarely mentioned by participants, with the exception of the WHO. External actors have been argued to be important for advancing mental health, including policy development in LMICs, largely due to the potential funding (Iemmi, 2019). Whilst local ownership is stressed, the findings of the present study suggest that local actors need to drive policy change, and any involvement of external actors should therefore support local actors, not displace them.

5-5.1.1 Potential for unintended negative consequences when focusing on communities

Marginalised women often bear the brunt of the burden of efforts to increase community participation for mental health, and in the absence of power and support to effect change, can paradoxically reduce mental health outcomes for this group (Campbell & Burgess 2012). Therefore, there appears to be a tension between the importance of communities for evidence-informed agenda-setting without placing the burden on disadvantaged groups to solve their own problems. Although not directly stated by participants, this tension was alluded to through the issues on both sides prominently featured in the responses of participants. Other scholars have highlighted the need to navigate this tension within health systems in LMICs (George et al., 2016). The challenge is to utilise local expertise and political clout possessed by communities, key for evidence-informed agenda-setting, without over-burdening them, entrenching inequality, and removing responsibility from those in power.

5-5.1.2 Overlaps between different actor types

When conceptualising categories of actors, the current study revealed that mutually exclusive categories are not reflective of the multiple concurrent roles performed by individuals and organisations. Methodological triangulation of the interview data using document analysis supports the finding in Assam that the different roles of mental health actors (researcher, policymaker, and intermediary) often do not represent discrete categories, but rather are highly overlapping in nature with actors often falling under multiple categories. Secondary analysis of published accounts of participation at a nutrition policy event supported the finding from the interviews that in Assam there is significant overlap between categories of actors. Nutrition, like mental health, falls under the Health and Family Welfare Department of the Government of Assam. Two separate reports of attendance from the 2017 ‘Transforming Food and Nutrition Landscape in Assam’ policy seminar reported that officials presented key statistics to other stakeholders, and are also engaged in research activities. Therefore, in addition to being ‘policymakers’, these officials concurrently acted as ‘researchers’ and ‘intermediaries’.

The current study extends the finding which has already been stressed in LMICs for policy implementation (Campos & Reich, 2019), and extends it to the agenda-setting stage of policymaking. Campos and Reich (2019) argue that understanding the different groups of actors is important for resolving differences and enabling co-operation. This is pertinent for the current study where differences between categories of actors were prominent: the gulf between researchers and policymakers is widely acknowledge in the literature and, reportedly, a major barrier to the use of

evidence in policymaking (Orton et al., 2011). In addition, the current study highlights differences between researchers and intermediaries also seem pronounced.

5-5.1.3 No single set of individual characteristics desirable for evidence-informed agenda-setting

The individuals involved were reported by participants to be key to the extent to which evidence informs agenda-setting; this has been noted in Kerala, another Indian state, for evidence-informed priority-setting where seen personalities were seen to be instrumental (itad, 2016). Expertise and experience were agreed upon by participants as vital individual characteristics, with a positive correlation with the level of policy influence. However, even among individuals of the same stakeholder group the present study found significant variation, similar to previous research (Greenhalgh et al., 2004).

In addition, personality traits were also recognised are important, a finding in line with previous research (Mallidou et al., 2018). However, the relationship between personality traits and the ability to influence policy was found by the present study to be more complex and variable than for expertise and professional experience. One example was charisma and interestingly in the current study charisma was not necessarily always advantageous. This extends the findings of previous studies which have reported charisma as a desirable skill for individuals in the brokering of knowledge between researchers and policymakers (Jessani et al., 2016), and even closing the research-policy gap (Decoster et al., 2012). However, this thesis also noted potential disadvantages to charisma, highlighting the complexity of human interactions, and the importance of understanding the relationships between actors. This may explain the lack of a single desirable skill set for knowledge brokers, and highlights the important of context.

Other scholars have argued that the focus on individual actors may give characteristics and personality greater weight than deserved over factors relating to the organisational actors as well as context and process (MacKillop et al., 2020). Power and influence has been conceptualised for health actors in trade policy agenda-setting to have four sources: institutional authority; legal authority; networked authority; and expert authority (Townsend et al., 2019). Such conceptualisation may reflect important nuances in understanding the power of individuals and groups of stakeholders, useful for mental health.

The stakeholder terrain of individual and organisational actors is constantly evolving. COVID-19 may potentially exacerbate the rapid staff turnover due to the task shifting and sharing, and the redeployment of staff. This seems likely due to the multiple roles often held by stakeholders, including by medical professionals who are often involved in both research and policy (Orkin et al., 2021). In the UK context, frequent staff turnover, also reported by the current study, was purported to

have reduced institutional memory, and lead to inefficiencies in work being repeated (Smith, 2013), which may have adverse ramifications for what evidence is used. High staff turnover also gave the appearance of more sustained interaction between researchers and policymakers, when in actuality it can become repetitive in nature (Smith 2013). As engagement between policymakers and researchers was already perceived by participants to be minimal, we might surmise this is relevant for Assam.

5-5.1.4 Mixed picture on gender

Gender might have been expected to be identified by this thesis as an important issue. Whilst it was not raised by interviewees to be an important factor, the online survey gave polarised results. One potential reason why it might not have been raised by interviewees is that the situation for women in Assam is sometimes reported to be better than in other parts of India (Nayak & Mahanta, 2009).

To date there has been limited research on the effect of gender on the evidence-to-policy process (Soha et al., 2021; Tannenbaum et al., 2016). Although a recent (pre-print) study identified no significant perceived gender barriers to knowledge, transfer, and exchange activities in vaccination-related research in LMICs or HICs (Soha et al., 2021), structural efforts to reduce gender differences were recommended. However, Tannenbaum et al. (2016) argue that gender should always be considered in the implementation process and may be an important determinant of knowledge use. It would be reasonable to assume that this applies to policymaking more generally, including agenda-setting, and not just implementation.

Further exploration of the effect of gender on the role of evidence in policy is warranted for Assam given that mental health stigma (see Chapter 7) is also patterned by gender in the North East Region, where Assam is located. For example, women with substance use disorders face higher levels of stigma than men (Kermode et al., 2012). Furthermore, such stigma appears to affect the available evidence. For example, during fieldwork, it was suggested that the magnitude of the issue among women appears underrepresented in the current statistics. This view is supported by Lal et al (2015) who argue that there is a knowledge gap around substance use in women in India.

Gender is likely to be a pertinent factor in Assam due to the apparent slow progress of gender equality (World Bank, 2017). Assam has the highest maternal mortality ratio in India; gender gaps in schooling have widened among some younger groups; and female participation in the labour force is among the lowest of the states in India (World Bank, 2017). Moreover, there is a low proportion of women in government services and women have a low level of political participation, with neither indicator demonstrating recent meaningful improvement (Nayak & Mahanta, 2016). The continued lack of elected females is true for Assamese women at the state and federal levels of government (Haloi, 2015), and has major consequences for the lack of women's voice, and use of evidence, in policy decision-making processes (Gupta, 2021; Haloi, 2015). Economic empowerment of women in

rural areas of Assam has been argued to be necessary to enhance the ability of women, particularly rural areas, to drive social change (Saikia, 2020), and this seems likely to extend to the use of evidence.

5-5.2 Importance of a wide range of skills

Multiple roles were identified for actors for strengthening the use of evidence in agenda-setting, requiring a range of skills, soft as well as technical. Sharing, as well as generating, evidence was seen to be an integral part of the role of researchers thus adding further support to the argument above that categories of actors, in particular 'researcher' and 'intermediary', are not necessarily mutually exclusive. Moreover, some of the skills perceived to be useful for intermediaries to broker knowledge between researchers and policymakers were also skills seen to be useful for researchers, this overlap was also identified by a scoping review by Mallidou et al. (2018). However, evidence communication skills are seen to be needed to be developed to a greater extent for actors whose role is specifically devoted to knowledge brokering than for researchers. However, in Assam the large degree of crossover between these roles, suggests that these skills are likely to be equally useful for researchers who often simultaneously fulfil the knowledge broker role.

There appears to be some mismatch between the training researchers receive and how this maps onto their role for using evidence to inform agenda-setting. Researchers often felt ill-equipped with the necessary 'softer' skills, such as people management and communication, because they are awarded less importance than technical skills. This thesis found that the limited skills was exacerbated in Assam by limited personnel. Previous studies have highlighted insufficient human resources across India, including 'mental health policy people' as well as mental health professionals (Roy et al., 2019). Moreover, the limited number of those working in mental health policy were reported to have inadequate mental health knowledge.

5-5.2.1 Capacity of organisations as well as individuals key

The findings of this thesis chime with those of a review exploring knowledge translation in LMICs in terms of the greatest barriers to researcher involvement in knowledge translation being individual and institutional capacity constraints (Murunga et al., 2020). The current study extends this finding to intermediaries. More exploration of the capacity of institutional actors may be useful (Hamel & Schrecker, 2011) as well as individual actors on which the participants focused. In addition to the high rate of staff turnover, also reported in the current study, it has also been argued that approaches to strengthen the use of evidence in policymaking, such as training or relationship building, should be

targeted at organisations and aim to influence organisational culture, rather than specific individuals (Liverani et al., 2013). Organisational incentives may help encourage involvement (Jessani et al., 2020), and provide greater recognition of individuals who impact policy. Feasible incentives in the resource-constrained environment of Assam may include professional recognition rather than financial incentives.

5-5.3 A need for greater communication between actors

Within the policymaker category, relationships between different government departments at the state level were perceived to be sub-optimal. A similar picture in India for adolescent mental health policy has been reported by Roy et al. (2019) who argue that communication between and within different governmental departments needs improvement. Better communication is likely to facilitate greater inter-sectoral policy integration for mental health, a similar need has been documented in South Africa, another LMIC context (Lund et al., 2011; Skeen et al., 2010). The absence of inter-sectoral policy integration may result from the interconnection between mental health and wider socio-economic factors being under-appreciated by policymakers and the wider public, as suggested by Lund, Kleintjes, et al. (2011) for South Africa. This implies a lack of evidence may hinder inter-sectoral relationships, as well as a lack of inter-sectoral relationships being a barrier to the flow, and use of, evidence.

Significant differences between researchers and policymakers were reported by this thesis, these differences have been widely recognised across different contexts (Brownson et al., 2006; Oxman et al., 2009). Policymakers and researchers are recognised to come from different cultures, in which different characteristics of evidence are valued (see Chapter 4). Policymakers also often have different motivations and shorter-term interests than researchers due being bound to election cycles. Consequently, these differences hinder close relationships between these groups, and thus the spread of evidence.

In the current study, social media was viewed as a useful tool to build relationships and strengthen communication for awareness raising and the sharing of evidence with communities. Other authors have suggested that as social media enables the rapid sharing of information to large audiences, it may facilitate the use of evidence in agenda-setting (Grande et al., 2014). However, social media may further exclude already marginalised communities and groups, such as the elderly, who lack access, or the skills or desire to access, online platforms. Further research is needed on the use of social media for evidence-to-policy activities, a relatively unexplored area (Bou-Karroum et al., 2017; Grande et al., 2014).

Using social media to communicate with policymakers was however absent as a suggestion in the present study. In the United States, researchers have been found to be hesitant to use social media to communicate with policymakers (Grande et al., 2014). Hesitancy was reported due a lack of familiarity with the multiple platforms and the conciseness needed, leading to a perceived risk to their professional reputation resulting from controversy or misinterpretation. It is possible that the participants of the current study may share some of these concerns.

5-5.3.1 Networks influence which actors have power in using evidence

A key finding of this thesis was the importance of networks and the structure of the relationships, between actors for the use of evidence in agenda-setting. Other studies have found the networks between stakeholders can explain to some extent how research evidence is exchanged and used in policy (Shearer et al., 2014). Distinct advocacy and policy networks, as identified by participants, resonate with the distinction between the 'policy communities' and broader 'issue networks' types of policy networks described by Marsh and Rhodes (1992). Policy communities lead policy decision making and tend to be small, tight-knit groups with an equal balance of power. Conversely, issue networks tend to be large, to contain diverse views and values, and have power imbalances. Issue networks have limited access to the policy process and are most influential during the agenda-setting stage of the policy cycle.

Application of the policy network lens to the health policy field is argued by Tantivess and Walt (2008) to be an important area for further research. The distinction between policy communities and issue networks may be useful for understanding Assam given the recognition of a broad range of relevant actors, including communities. In particular, the role of non-state actors (those unaffiliated with the government) on agenda-setting has been identified by other scholars as an area where further research would be useful, based on their research of health HIV policy in Thailand (Tantivess & Walt, 2008).

Non-state actors include civil society organisations, and a recent review, albeit of a limited number of studies, found a common array of factors affecting the policy influence of civil society actors in LMICs (Smith, 2019). Policy influence was greatest when civil society constituted strong networks that have sufficient financial and technical resources, and stronger networking was reported to be required to enable stronger user advocacy. However, additional research is needed to understand the role of network dynamics (Smith, 2019). A study exploring the priority of mental health in four African countries, including LMIC contexts, found that mental health advocacy has been impeded due to mental health users being voiceless, exacerbated due to users forming a fragmented group (Bird et al., 2010). For understanding the use of evidence in agenda-setting, the role of network dynamics is

important as greater policy influence is likely to increase the likelihood that any evidence shared will inform the policy agenda.

Informal networks were reported to by participants to be more heavily relied upon than formal networks, restricting what types of evidence, and from whom, inform policy. The establishment of knowledge translation platforms was a suggestion by participants in the present study. This suggestion is supported by a recent systematic review which found that there was strong evidence to suggest that knowledge translation platforms in LMICs offer encouraging potential to support the use of evidence in policymaking (Partridge et al., 2020).

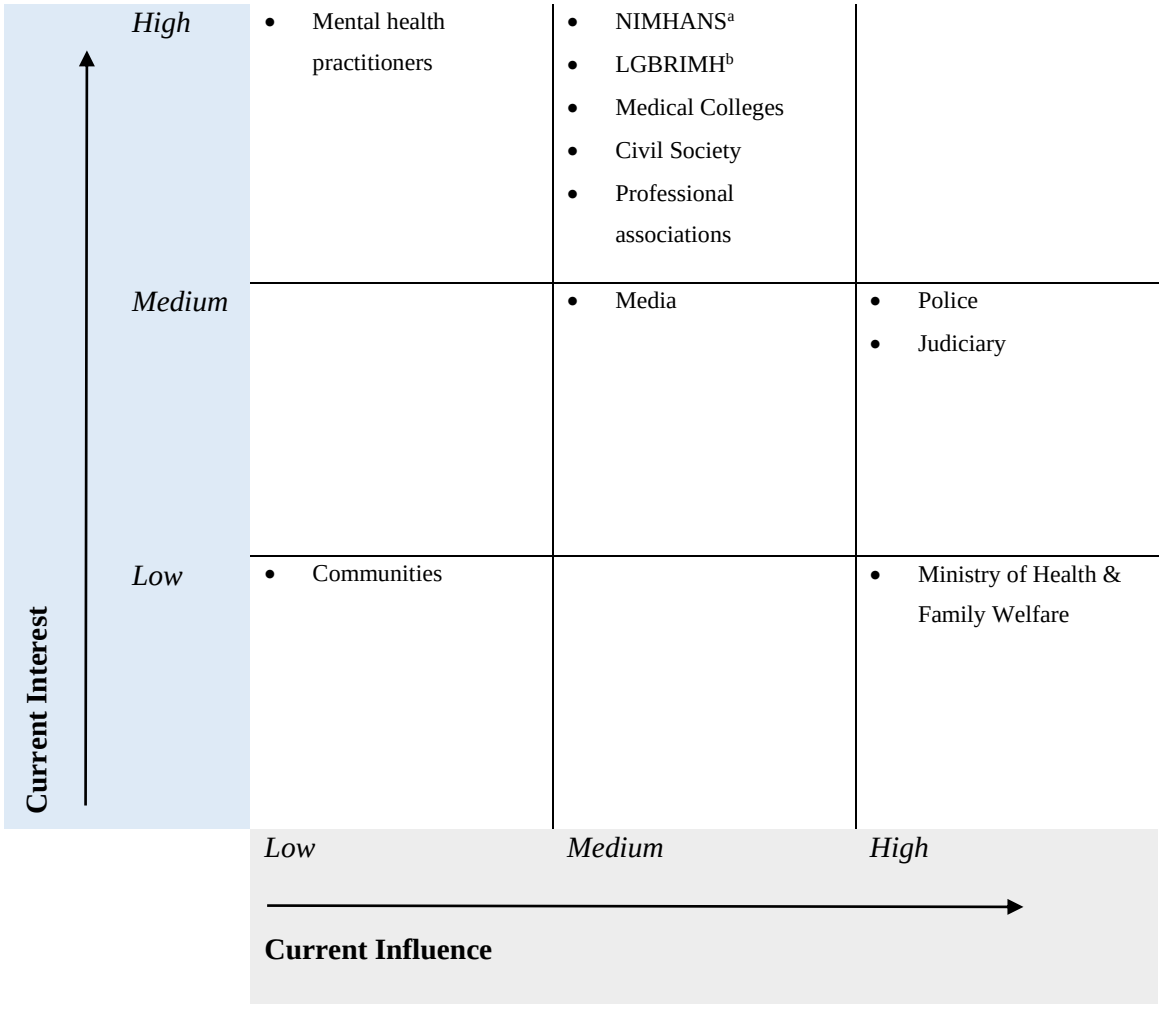
However, there is currently insufficient evaluative evidence on knowledge transfer platforms and this limits what can be drawn upon about on what works in different contexts (Partridge et al., 2020). A recommendation from the experience of the Indian National Knowledge Platform[12], is that the complexity surrounding health policymaking and evidence-to-policy processes are important considerations for any platforms (Sriram et al., 2018). Sriram et al. (2018) further highlighted a need to ensure both legitimacy and independence, often competing factors. Such considerations are likely to be also relevant for mental health at the state level, with legitimacy an important characteristic of evidence highlighted by the current study.

5-5.4 Stakeholder map

A stakeholder map (Figure 22), plotting the current level of interest of stakeholders in the mental health policy agenda in Assam (y-axis) against their current influence (x-axis), as detailed in Chapter 3 was produced as an output from the stakeholder analysis using data from the interviews and document analysis. Due to the high-level of staff turnover, and consequent change in interest and influence, stakeholder groups were the unit of stakeholder used, with the exception of a few notable actors such as LGBRIMH (Lokopriya Gopinath Bordoloi Regional Institute of Mental Health).

[12] The National Knowledge Platform was established in 2016 by the Ministry of Health and Family Welfare, the Government of India, for public health and health systems (Sriram et al., 2018).

Figure 22. Stakeholder map for mental health in Assam.



[a]= National Institute of Mental Health and Neurosciences

[b]= Lokopriya Gopinath Bordoloi Regional Institute of Mental Health

5-5.4.1 Identification of new stakeholders

Makan et al. (2015) reflected upon the usefulness of stakeholder mapping for the identification of relevant non-health public policy actors. Interestingly, the current study found the stakeholder analysis to be useful for identifying two stakeholder groups often not included in mental health stakeholder maps: (1) the Supreme Court and the judiciary; and (2) the Police.

First, the Supreme Court and the judiciary were identified as actors with both a high-level of influence and interest; they have not been explicitly identified by stakeholder analysis previously conducted for mental health policy and systems research in LMICs (Makan et al., 2015). Of the seven key stakeholder groups identified by Makan et al. (2015), the judiciary may fall under 'policymakers' through the sub-section "Parliament/other democratic institutions". However, the current study suggests that a greater focus on this stakeholder group is warranted. This may be particularly true for

agenda-setting, due to the requirement for policies to align with legislation (Gupta, 2021). The Supreme Court of India and the National Human Rights Commission have been documented to be key national-level institutions with a high-level of influence and, a growing, interest by the media (Shastri et al., 2021) and scholars (Murthy et al., 2016).

Second, the police were identified as a key stakeholder, again a group often absent from mental health stakeholder maps. Again the Assam Police could be considered to loosely fall under the "Parliament/other democratic institutions" of Makan et al. (2015). However, they are sufficiently distinct to warrant their own stakeholder category. In Assam, the police are often the first to respond to the consequences of mental health issues (Hazarika, 2021). The role of the police as a key agency in dealing the consequences of mental illness has been reported in many other settings (Puntis et al., 2018), and therefore the inclusion of the police in mental health stakeholder maps for other contexts may be worth considering.

5-5.4.2 Ongoing need for stakeholder analysis

Whilst the map shows the interest of stakeholder groups as a whole, interest and influence was found to be highly dependent on the individual. When taken together with the high turnover of staff discussed above, including policymakers, the stakeholders map is therefore highly dynamic in nature. New actors are emerging particularly in the online space. This is blurring the distinctions between actors at different levels, for example organisations originating in Assam may work in other states. Internal and external influences also contribute to the dynamic nature of the stakeholder map, for example new personal experience with mental health may increase levels of interest. Whilst individual stakeholders in Assam are important, collectively, for example, as professional organizations they can exert much greater influence.

Given the dynamic nature of stakeholders, stakeholder analysis must be an ongoing process in order for any mapping produced to remain useful. Due to the high turnover of staff, the inclusion of details of individuals would require continual updating. The level of interest, even for stakeholder groups, is also highly dynamic. For example, the interest of international media fluctuates with interest sparked by crises and tragedies or tracks a calendar of awareness days such as World Mental Health Day, with the former being harder to predict than the latter.

5-5.4.3 Extending the analysis

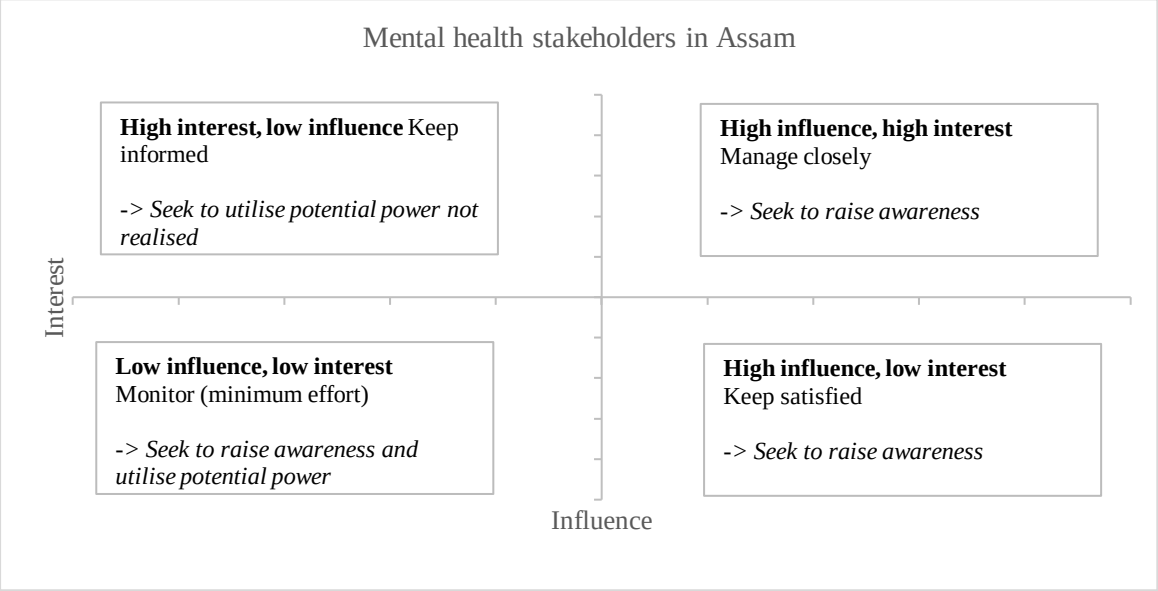
Two components, in addition to interest and influence, which are useful to include in stakeholder analysis were identified for developing approaches to strengthen the role of evidence for mental health agenda-setting: (1) the level of independence of actors; and (2) the capacity of actors.

First, independence could also be a useful to assess, as the extent to which stakeholders can use evidence to inform agenda-setting can be restricted by their limited independence. For example, the Lokopriya Gopinath Bordoloi Regional Institute of Mental Health, a key mental health institute in the state, has a high level of interest and influence, but limited independence.

As well as mapping current influence, assessing potential influence could also useful. Stakeholders may be in a position to influence the agenda, but not have the capacity to utilise this. Resources of actors is sometimes considered under power in stakeholder analyses (Schmeer, 2000). However, it may be useful to separate out and report the two as distinct concepts to help differentiate between current and potential power; this may shape how stakeholders are managed and what approaches may be most effective for strengthening the use of evidence. Assessing the gap between current and potential influence can help determine how to best tailor approaches to strengthen the use of evidence.

Conventionally, as shown in Figure 23, the strategy of how to manage stakeholders decrees that most effort is given to stakeholders in the upper right-hand quadrant, i.e. those with both high influence and interest in the mental health agenda. Interestingly, in the current study no stakeholders were judged to have both a high current level of interest and influence. Conversely, minimum effort is given to those stakeholders that fall under the lower left-hand quadrant, i.e., those with both low influence and interest. However, as a finding of this thesis is that for strengthening the use of evidence for mental health agenda-setting, it is important that evidence from different groups contribute to the setting of the agenda. A further aim, as stated by participants, with regards to the use of evidence in setting the mental health policy agenda is to have a truly co-created agenda. As a consequence, more, rather than less, effort may need to be given to those stakeholders with low interest and/or influence.

Figure 23. Management of stakeholders.



5-5.5 Implications for theory and practice

The findings reported in this chapter have theoretical and practical implications for the improvement of actor engagements in evidence-informed agenda-setting.

An implication for theory is the roles of mental health policy actors in Assam, and other LMIC contexts, are likely to require a different conceptualisation to those in HICs. It is recommended that current frameworks are expanded to consider a broader range of relevant stakeholders, not just policymakers or those traditionally viewed as being involved in or influencing policy.

Indeed, the main categories of stakeholders traditionally used in the field of health policy – policymaker, researcher, and intermediary – (Ward et al., 2009) may not be appropriate for Assam, and potentially other LMIC contexts. The overlap of roles at the individual and organisational level mean that some actors undertake elements of all three roles, and therefore these categories are not mutually exclusive. Frameworks are necessary simplifications, and most evidence-to-policy frameworks acknowledge the conceptualisation of actors under these categories as a simplification (Contandriopoulos et al., 2010; Gold, 2009). Frameworks that are too complex often lose their utility; greater complexity regarding actors is likely to be a useful level of additional for mental health agenda-setting in Assam. Interestingly, in other areas of policy, i.e. not focused on evidence-to-policy, frameworks have started to recognise the overlapping nature of actors types, including the framework of policy implementation stakeholders by Campos and Reich (2019).

Additionally, a more clearly defined shared understanding of ‘policymaker’ needs to be developed in order to facilitate effective targeting of actors within this group by approaches. ‘Users’ and

communities need to be more prominent in evidence-to-policy frameworks as key actors, alongside researchers, policymakers, and intermediaries. Furthermore, rather than a fixed list of desirable characteristics for conveyors of evidence, a more nuanced approach needs to focus on context and the stage of the policymaking process.

An implication for practice is that a more equal focus on community-targeted and policymaker-targeted approaches may be beneficial. Consequently, further research on the effect of gender on research-to-policy efforts is important given that communities in rural areas, in particular, have made limited progress on gender equality. In Assam there appears to be: a large amount of socio-cultural diversity; variation in the interests, skills, and attributed of individual stakeholders for mental health; and a high level of staff turnover at the individual level. Therefore, in Assam approaches tailored according to the individuals involved, rather than just the broad stakeholder groups, may be most effective. The recommendation for tailored approaches and communication methods follows calls made by other scholars for this to be central for improving the use of evidence in primary child health care policies in European countries (Zdunek et al., 2020), where there is less diversity among stakeholders than in Assam for mental health.

5-5. Conclusion

In conclusion, a key finding of this chapter is the importance of considering the full range of actors, including communities, for determining how the mental health policy agenda is set in Assam. Due to the significance, and large potential influence, of communities, evidence therefore needs to be shared more widely amongst all stakeholders. Therefore, approaches to strengthen the use of evidence for mental health policy should target communities as well as just policymakers. Mental health stakeholders in Assam constitute a vast, divergent and dynamic group, and individuals can be hugely influential. Nonetheless, how actors work together is equally important; collectively institutions and communities, consisting often of individuals with limited voice, can exert much power. Power imbalances are often exacerbated by the tendency to rely on personal networks in the absence of formal networks, and this limits evidence sharing. Capacity, however, is a major barrier to engagement for all stakeholders, despite often high levels of motivation. Actors often have multiple roles and demands; formal advocacy and policy networks, stronger leadership and incentives should be explored as ways to help overcome this. For individual conveyors of knowledge, there does not appear to be a definitive list of desired characteristics, as these can be both strengths and weaknesses. Contextual factors including the stigma surrounding mental health, power imbalances and a lack of capacity, were seen to influence how actors trust, interpret and use mental health evidence in agenda-setting processes.

CHAPTER 6: RESULTS (Process) – The policy process in which evidence is used

6-1. Introduction

This Chapter explores the findings in relation to the mental health policy processes in Assam which evidence is used to inform. Given that Assam does not yet have a stand-alone mental health policy, despite this being recommended by the Assam State Report of the latest National Mental Health Survey of India in 2015-16 (Pathak et al., 2017), this thesis, largely but not exclusively, focuses on the role of evidence in agenda-setting stage of the policymaking cycle. The role of evidence varies over the different stages (agenda-setting, implementation, policy formulation, and evaluation) (Sutcliffe & Court, 2005). However, the stages can occur simultaneously, as shown in Figure 1 with lines instead of arrows used to connect the four stages.

Health policymaking processes are complex, however there is scant literature that focuses on health policy *processes*, with research tending to focus on policy content instead, a trend which also applies to mental health policy in, African, LMICs (Omar et al., 2010). A failure to understand and address this complexity has been argued to have limited the success of prior approaches to increase the use of evidence in health policymaking (Langlois et al., 2016). Some scholars have argued that agenda-setting is the most important stage of the policy cycle due to determining the policy issues that are carried through to the other stages of the policy cycle (Shroff, 2018). However agenda-setting, and especially the role of evidence in agenda-setting processes for mental health in LMICs, has received limited attention in the literature (Votruba et al., 2018).

This chapter will explore the role of evidence in relation to the types and stages of mental health policy processes in Assam, with a focus on agenda-setting. First, the levels, stages and nature of policy processes, and how evidence influences these will be explored. Finally, the perceived role of actors and their use of evidence in the policy process will be discussed.

6-2. Mental health policymaking in India

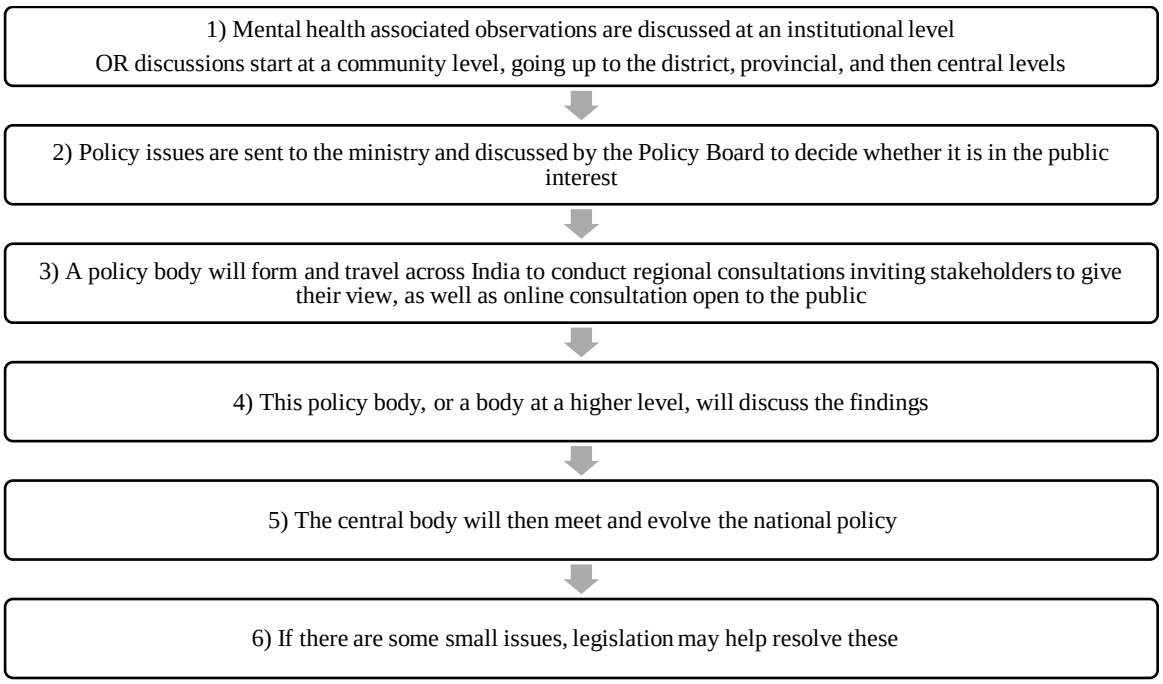
Participants described policy processes at two levels: national (all-India) and state (Assam) levels.

6-2.1 National-level policy processes

The document analysis revealed many details about how mental health policy is made in India at a national level. Documents analysed included the published policy (the first national mental health policy), as well as reports and minutes from the Mental Health Policy Group appointed by the Government of India. The policy group were tasked to "prepare an evidence based National Mental Health Care Policy for the Ministry of Health and Family Welfare stating guiding values, principles and objectives of such a policy and identifying priority areas for action". It is interesting to note the prominence given to evidence in terms of reference for this group, explicitly request an "evidence based" policy. This highlights the importance for the policy, at least be perceived, to be strongly informed by evidence. The policy group drafted the policy, after discussions and evidence gathering, which included stakeholder consultation. After "minor amendments" (Government of India, 2014, p. 1) the policy was accepted.

The interviews offered further detail as to how the policymaking process took place. It was perceived, by a participant involved in the policy process, to start at the bottom-up rather than being directed from the top-down, How the policy questions and issues are generated at the national level was described by one participant involved in the process to occur in several steps, as shown in Figure 24. The process was described as being initiated at a local level, either by institutions or communities. The policy issues would then be discussed by central policymakers, before being checked at a local level again.

Figure 24. The steps of national mental health policymaking.



6-2.2 State-level policy processes

Within India's national policymaking processes, Assam was reported to have a key role by hosting regional meetings for the North East region. Moreover, at the state level, policy processes are established in Assam and *"already systems exist as to how to make policies"* (researcher – Assam, F). However, not all participants displayed the same level of familiarity with the processes, especially those who are not members of mental health institutions. One participant argued that state-level policy processes are in fact more important that national-level processes:

"[Policy] is not about the nationally, you have to start with the state, right, so you can actually make a model state, make your own policies on mental health and actually showcase to the national level to see that, you know, this is the kind of way we have done it and this is how it can be done."
(intermediary – Assam, F)

Whilst the district-level was seen to be a potentially important level, there was reported to be no established process in place: *"district level, there is nothing set there,"* (intermediary – Assam, F). A lack of appointed personnel at the district level was said to be one contributing factor to the lack of a district-level process.

6-3. Stages of policy processes

The use of evidence for mental health policymaking will now be explored under the different stages of the policymaking. First, agenda-setting will be considered, the focus of this study. Second, the use of evidence in the other stages of the policy cycle (policy formulation, implementation, and evaluation) will be briefly explored, where relevant. Although understanding the use of evidence in agenda-setting is the focus of this study, as the participants stressed, agenda-setting cannot be completely isolated from the other stages of the policy cycle. Therefore, the other stages are interrelated and also important.

6-3.2 Agenda-setting

Participants from a range of stakeholder groups broadly agreed the appropriate level of priority is not currently given to mental health on the policy agenda in Assam. The online survey also confirmed that this belief was widespread. The lack of priority was still seen to hold true even when the multiple competing other health, and non-health related, policy issues are taken into consideration:

"There is a disparity between policies and the magnitude of the problems." (intermediary – Assam, M)

The importance of the agenda-setting stage, and the prioritisation of mental health as a policy issue that this stage leads to, was stressed by participants for effective mental health policies. However, policy formulation, and implementation, was said to be able to occur without mental health being given political priority. Moreover, policy formulation by itself was seen as insufficient for policy to translate into meaningful outcomes without the associated level of importance assigned to the issue of mental health politically. This highlights that the policy cycle is not necessarily sequential. Interestingly, it is also suggested that prioritisation, currently, largely occurs after policy development rather than prior to it:

"It's more about prioritising it. It is not enough to put a policy up, right, you know? And so, the prioritising mental health automatically will put the policy in place, and it will turn into action. So, unless the government prioritises it is not going to happen and that is what I have always seen." (intermediary – Assam, F)

Participants displayed a lower familiarity with stage of agenda-setting than with the other stages of the policymaking process, including formulation and implementation. Even those participants who were familiar with the formal procedures of policymaking stated that they were unsure of what factors shaped the decision-making. Agenda-setting was perceived to be a more opaque process than the other stages of the policymaking cycle, including formulation, and thus the role of evidence in setting the agenda and how it interacts with other factors was surrounded by ambiguity:

"*They themselves [policymakers] will set agendas depending heavily on considerations that are often not accessible to people like us."* (researcher – national, M)

6-3.2 Policy formulation, implementation, and evaluation

Simply raising mental health on the policy agenda and having a policy in place is not sufficient if the policy developed is not fit for purpose. Furthermore, the development of evidence-based policies, whilst important, was not seen as sufficient. A *"disconnect"* (intermediary – Assam, F) was stated to exist between policies and how they are implemented by a participant, with people not always being able to take advantage of policies that have been developed. The downstream issue of the implementation of policies was also flagged as a key issue in the online survey. Successful implementation of these policies is therefore also required:

"*Many states they already developed their policy, but it is not properly implemented.*" (researcher – Assam, M)

A policy that does not adequately reflect the local realities will in turn likely mean the policy will be ineffectively implemented. Therefore, the needs of communities need to be incorporated during the agenda-setting stage in order for appropriate policies to be developed and effectively implemented:

"There are more NGOs do what the people would like [sic] *or what the people would have an opinion about in just in terms of relay information and community building. I think that would work a long way, rather than just having this policy which just sits there because nobody understands it, nobody actually applies it. What's the point of a policy like that?"* (intermediary – Assam, F)

The evaluation stage of the policy cycle consists of the monitoring and assessment of the process and the impact of the programmes or interventions that are implemented as part of the policy. Despite recognition of the value of evidence based on personal experience (see Evidence Chapter), a remaining criticism is that it is rarely incorporated into the evaluation of policies and programmes. As a consequence, this limits the potential for informal evidence to influence the entire policy cycle, including agenda-setting:

"Often we see that once a programme is launched[…] we see just in terms of some financial terms saying that the government has allocated so many rupees[…] but actually we don't get into[…] on the ground what is happening[…] the end users, their perspectives are not taken, and that is not inbuilt in the programme. And at different levels actually this kind of systematic assessment is not done." (researcher – national, M)

For evidence-based evaluation which informs the rest of the policy cycle, participants indicated that a purely top-down approach to gathering and directing the generation of evidence is unlikely to be effective. A bottom-up element is also needed, in order to capture evidence at the community-level on the effectiveness of policies, and any programmes that they are implemented as:

"This communication needs to happen in different directions. It's not like the policymakers sitting at the top and then they direct the health professional in saying that you gather the evidence[…] the mental health professionals in collaboration with the other interdisciplinary teams, they are developing that evidence and giving a feedback to the policymakers saying[…]on the ground what is happening and how it can be improved, so there is a large gap with regards to that, like this feedback to policymakers." (researcher – national, M)

6-4. Nature of policy processes

At both national and state levels, two key types of processes emerged from participants accounts: formal and informal policy processes. The formal policy processes outlined above are the standard procedures for policymaking. However, the formal processes were reported to be protracted, and, on occasion, more timely policy solutions were needed. To achieve this, informal policy processes were therefore used in some instances. Evidence was reported to be used differently in formal and informal processes; formal processes often attempt to gather evidence from a wider range of stakeholders than informal processes.

6-4.1 Formal policy processes

Participants emphasised the continual and changeable nature of the policymaking process. Participants expressed the belief that policymaking should be an *"ongoing process"* (researcher – national, M), and that it is not a *"step-change"* (researcher – national, M). This was seen to be reflected in the formal procedures for policymaking and therefore, policy *"evolves"* (policymaker – Assam, M) over time. Although formal policy processes were perceived by participants to be lengthy, participants felt that this was necessary, and was needed to enable the input of all relevant stakeholders and evidence and therefore effective policies. Contrariwise, despite informal policy processes having the potential to generate change more quickly, there was not seen to be sufficient input, and evidence, of from relevant stakeholders:

"*The mechanism itself* [*of informal policy processes…*] *is a huge limitation*." (researcher – national, M)

The changeable nature of the policy process was also highlighted by participants, and it is *"very erratic, it's unpredictable"* (researcher – national, M). Although the overall policy process was lengthy, due to the unpredictable nature of the process, requests for inputs and invitations to participate in the process were often reported to be at short notice making it difficult for stakeholders to optimise their contribution:

"Suddenly, you know, a government asks[…] it could be in a given state like in Assam they call the, you know, government, might be institution, they might say prepare something on, say depression." (researcher – national, M)

The protracted yet unpredictable nature of the process made it hard for stakeholders to plan and focus their engagement with the process and their use of evidence. Notwithstanding, in Assam, mental health was perceived to be moving slowly up on the policy agenda over the past couple of years.

Although there was little certainty regarding future developments displayed, most participants remained optimistic about the raised priority of mental health leading to the next stages of the policy cycle with the development and implementation of a standalone state mental health policy:

"Now that it's in the line they are working we hope, it is very difficult to say and, you know, what timeframe they are going to do it because in government it takes a lot of time. So, I think the way mental health is getting prominence in the last few years, so maybe in next two/three years there will be a lot of things coming out." (researcher – Assam, M)

There was still seen to be room for improvement in how policies are made, for example increasing stakeholder engagement. However, at both state and national levels, participants agreed that the policymaking process was said to have improved in recent times and whilst *"it's not up to the mark but again it's improving as compared before."* (researcher – Assam, M). Participants, including those not directly involved in the policy processes and thus more likely to have an objective opinion, viewed these changes to be positive and enable more effective policies. Previously, policies were seen to be developed in a very top-down approach with limited, or no, stakeholder engagement, meaning that lots of informal evidence was missed in the top-down policymaking:

"Ten/twenty years ago, where someone somewhere will decide it and it will become a policy and then it will be just propagated." (intermediary – Assam, F)

6-4.2 Informal policy processes

Certain events or stimuli were found to accelerate policy processes. These included crises where a quick policy solution is of vital importance, such as COVID-19, and judicial intervention. As well as directly leading to changes in the policy agenda, these events can also change the policy processes involved. Due to the lengthy nature of formal policymaking, these catalysts were reported to sometimes lead to different processes being used, and accelerated, informal, processes were used that circumvented the standard, formal processes:

"Suppose there is a sudden something like coronavirus has come now, it has to be, it cannot wait for such a long time to have a policy, so what happens is some of the experts will sit, they were called up as government experts, they will have some guidelines from other places and they will sit and say 'this is what has to be done immediately'." (policymaker – Assam, M)

Whilst the use of these accelerated, informal policy processes were seen as necessary in certain crisis situations, the limitations of this type of process was also noted by participants. Often the input of a limited number of 'experts' was heavily relied upon along with the absence of stakeholder

engagement. Interestingly, in terms of the evidence used to inform policy decisions, informal evidence (evidence based upon personal experience) in the form of expert opinion was seen by respondents to have an important influence on informal policy processes. However, the range of evidence, and who from, used to inform policy is much more limited. This suggests that informal evidence can be seen to be rigorous alongside formal evidence:

"It becomes sometimes a very skewed kind of approach, like where they devote very short time and they would pick up two or three experts in the country and quickly they'll develop something and they say that this is the policy, rather than involving stakeholders." (researcher – national, M)

Thus, there appeared to be a trade-off between the speed of policy change and the effectiveness of such policy. Attempts to speed up the process, where informal policy processes were used can lead to less efficient policymaking through a lack of stakeholder engagement, and limited evidence from different groups of stakeholders. For the agenda-setting stage of the policy cycle, participants judged that the trade-off was clearer cut in terms of favouring a slower, more thorough process.

Protected crises may have a different effect on evidence. A respondent of the online survey further elaborated on the way in which political attention has increased as a result of COVID-19 which *"has given impetus to the area of mental health being made visible"* (researcher – Assam, F). Contrariwise to the convention view that crises can narrow the scope of evidence used, this was seen to be positive in terms of broadening the range of stakeholders, and evidence, engaged in the agenda-setting conversation:

"Discussion on mental health within the public has received significant momentum." (intermediary – Assam, F)

Interestingly, getting mental health to the top of the policy agenda as quickly as possible was not seen as a desired outcome, a point cautioned by multiple participants. One participant raised the point that increasing the speed of which issues are raised on the policy agenda not necessarily a desired outcome as this can result in a *"knee-jerk response"* (researcher – national, M). This can be counterproductive to increasing the extent to which policies are evidence based as desire to develop and implement a policy solution and pace can lead to less time for the use of evidence. Farmer suicide was given as an example of a mental health policy issue which received a lot of national media attention. However, this did not necessarily result in the most effective policy solutions, nor ensure sustained prioritisation and action on an issue:

"As a crisis kind of thing, they just quickly touch base with us and just say, hey, tell us something like and we will frame something and we will implement it, no. But often times what happens is there is no continuity." (researcher – national, M)

6-5. Role of actors in policy processes

As suggested above, although recognised to be time-consuming, stakeholder inclusion in policy processes was seen as vital for effective policies. The involvement of key stakeholders was directly attributed to the success, or lack of success, of certain policies:

"Those policies which to some extent have been successful in our scenario is that where they have made an attempt to, at least to some extent involve the stakeholders." (researcher – national, M)

The importance of stakeholder engagement was also particularly stressed for the agenda-setting stage of the policymaking cycle. Moreover, a broad range of stakeholders need to be included, and their involvement needs to feel genuine:

"Agenda-setting is an exercise that has to be done together with diverse range of people, it need not always, that does not always mean that they all have to be in one room together, I just mean that very different bunch of people need to feel like they are a part of this agenda-setting, and what, and that means that this agenda frankly has to be co-created." (researcher – national, M)

Participants expressed a range of different opinions on the level of inclusivity of policy processes, and there appeared to be a discrepancy between how inclusive those involved felt the process was versus those not involved. At one end of the spectrum the process was described to be *"an open forum"* (policymaker – national, M). This view was echoed by some researchers who not only felt that their voices were heard, but that those of a range of stakeholders were too:

"The New Act [the Mental Health Care Act 2017], when it was being formulated there were regional meets, whole of North-East. So, we had various people, psychiatrists, social workers, psychologists, nursing persons[…]Everybody's represented." (researcher – Assam, F)

Other participants took a middling view; one researcher felt that whilst there was some stakeholder involvement, this is still limited to certain stakeholder groups. The inclusion of the voices of a broader range of stakeholders was seen to be valuable in terms of their input into the policy process, and it was felt that they should be consulted:

"You need to involve various stakeholders, I think what happens like, you know, with a presumption we went and do some interviews with some people but I think we ignored many key people wherein we might get a good data, or good information." (researcher – national, M)

Intermediaries also gave diverse views as to whether they were included in the policy process. One participant felt they were not. Notably, as a result, this was said to be a crucial factor in ensuring the needs and wants of local communities and those working at the grassroots level are included:

"Though they are saying that mental health policies, our state policies are going to be developed, now how involved are the civil society bodies? We are not involved, we are not asked to come in, so what happened is that sometime we are just getting a lopsided vision because they are only looking from the government sector, you know, from the government areas. So, what are the needs of the local bodies and the communities? Sometimes this may get missed out." (intermediary – Assam, F)

The online survey revealed that other intermediaries felt differently about their own involvement. However they felt that that process was not inclusive for other stakeholders, particularly communities:

"[My organisation] being a pioneering civil society in mental health activity in Assam, I am usually consulted for policymaking exercises, but perhaps more community stakeholders should be involved." (intermediary – Assam, M)

In particular, for effective *mental health* policies the voices of service users and those affected by mental illness were said to be actors whose involvement in the agenda-setting process were key. In addition, this provides an example of how global insights can be useful at local levels; lessons from other contexts may potentially be useful for incorporating the local context.

"How can we better include people who are affected by mental health problems, within the agenda-setting? And I think that's extremely, the experience of people with self-harm that I read about in many parts of the world, tells us that it's very difficult to make appropriate policies and programmes without involving people who know what it is like to be in a situation of self-harm, and this again works for a range of mental health conditions." (researcher – national, M)

The involvement of a broad range of stakeholders was seen as important *"rather than just seeing your perspective as the only perspective"* (researcher – national, M). In the Context Chapter, the heterogeneity of Assam and of mental health was highlighted and this may make the broad stakeholder involvement even more important in this context. However, it was stressed by participants that the engagement of stakeholders needs to be *ongoing*, and that this needs to be built into the process as currently it is perceived to be intermittent:

"There is no ongoing process of, no, this dialogue or some kind of thing, the mechanism, like saying that involving the professionals from that side." (researcher – national, M)

For the agenda-setting process in particular, the inclusion of all stakeholders was stressed to be especially important. Priority-setting was said to only be able to reflect the needs of the community if, not only are all relevant stakeholders involved in the process, but that they work collectively together. Shared priorities that have the buy-in of all stakeholders are needed for successful policies to be developed and implemented:

"In mental health prioritization does happen, and the prioritization is a realistic understanding of what the community needs, unless the care provider, the policymaker, administrator work together to implement issues on a priority basis, to say some of these things are non-negotiable, then only things can change." (policymaker – national, M)

Consequently, for agenda-setting, where policies are made using processes that rely heavily on personal contacts, this was also reported by participants to be a barrier to advocacy efforts, and the affects the extent to which, and why types of evidence inform policy:

"Because the policies are made in parliament and all those things, as he said it will be kind of given to someone who is close to the minister, health ministry that feel that okay this, and they draft it and discuss with a couple of people, and the mechanism itself is although we do a lot of advocacy work, there is a huge limitation." (researcher – national, M)

6-6. Discussion

The significance of the findings will be discussed in relation to the literature, followed by the resultant implications for theory and practice.

6-6.1 Prioritisation does not necessarily precede policy development

A key finding of this thesis is that the development of policies was not necessarily seen as an indicator an issue had been prioritised on the policy agenda. However, the effectiveness of policies was reported to be weakened without such prioritisation. Distilling the stages of agenda-setting, and how agenda-setting interacts with the other stages of the policy cycle is important for the role of evidence in order to understand how evidence is used and for what aims.

In a similar manner to the role of evidence differing over the different stages of the policy cycle, within agenda-setting, the role of evidence is likely to be different for these different components. Differentiating between the separate elements of agenda-setting may help explain the disconnect found by the current study between the level of priority given to mental health and the policy status of mental health within Assam, where there is a policy in the process of being developed without prioritisation of the issue. Identifying which aspect of agenda-setting evidence is intended to inform, will help to develop effective approaches to strengthen the use of evidence.

Scholars in the field of nutrition have conceptualised agenda-setting to occur as a number of different elements, which appears to be also usefully applied to mental health policy. According to Pelletier et al. (2011), based upon research of agenda-setting in relation to nutrition including in LMIC contexts,

agenda-setting can be conceptualised as consisting of three elements: political *attention* and political *commitment*, and *system-wide* commitment. Political attention is gained when the issue receives high-levels of public coverage, for example through the inclusion of the topic in speeches by ministers. Political commitment was said to include the provision of the required authority, accountability and resources to relevant ministries. System-wide commitment is the broader commitment, which includes all relevant actors including communities, as well as across government.

Pelletier et al. (2011) state that political attention alone is insufficient for an issue to be prioritised, a finding that the current study appears to support. As discussed in Chapter 5, mental health receives minimal political attention in Assam, with politicians reported not to publicly talk about the issue. Although still inadequate, mental health was seen to be given a growing amount of political commitment despite the lack of political attention. The findings of the present study would appear to suggest garnering broader-system wide commitment to mental health is needed in Assam in order to advance on the growing political commitment. In turn, this may help to drive political attention and thus further political commitment. Furthermore, this thesis found that the agenda-setting process is unpredictable. Similarly, chance was reported to be a factor in why youth mental health made it onto the policy agenda in Australia (Whiteford et al., 2016).

6-6.2 Accelerating prioritisation of mental health may reduce the role of evidence

Although stakeholders unanimously agreed mental health should be further prioritised as a policy issue, the findings of the present study suggests that rapid acceleration could cause negative unintended consequences resulting in ineffective policies. For suicide, other authors have described such knee-jerk policy responses as “iceberg solutions” that only deal with the visible problem and not, often more complex, root causes (Baum, 2009). The present study further suggests that the limited ability to use evidence in accelerated processes may result in such “iceberg solutions”. The limited time available in accelerated processes may result in the limited ability to include relevant stakeholders and therefore different types of evidence. Furthermore, it may reduce the extent to which evidence can be considered, thus resulting in sub-optimal policies.

Another finding of the present study was that mental health policy processes, and the means by which evidence informs policy, are a mixture of formal and informal processes. This finding aligns with a previous study which determined that the translation of research evidence to policy occurred via both informal and formal mechanisms, for health policy processes in LMICs (Hyder et al., 2007). The current study, however found that informal policymaking processes were perceived to lead to less effective policymaking in part due to the limited inclusion of the full range of relevant stakeholders.

Other studies suggest the formality of the policy process influences how evidence is used; whether policy processes are formal or informal was found to affect how evidence was used for a poverty reduction policy in Ontario, a Canadian state (Sohn, 2018). Although in a different, HIC, context and with a different policy issue, it was found that informal policy processes which involved an intimate and unofficial group of actors engaged with evidence via debate which was influenced by their personal values-based agendas. Formal processes, on the other hand, where the involvement of actors was due to their professional associations and evidence contributions, evidence used depended less heavily on personal beliefs but more heavily by the policy process itself and its aims. Thus, this would suggest that a second reason that informal policy processes tend to be less effective than formal processes is the way in which evidence is used, depending more on beliefs and values, in addition to the limited inclusion of stakeholders, and therefore evidence, previously identified. Further research would, however, be needed to confirm this finding for Assam.

Informal policy processes were frequently, but not always, associated with crises. Grindle and Thomas (1989) recognised the important of the distinction between crisis and non-crisis driven policy change for agenda-setting. In line with the current study, the former was associated with a limited number of policy 'elites' and more significant policy changes. For understanding the use of evidence this is important because it has been suggested by this PhD study, and supported by the findings of Agyepong and Adjei (2008) in the context of Ghana, that evidence has a much weaker role in these crisis-driven policy processes.

Due to the constraints of being able to involve a range of stakeholders and evidence, participants therefore favoured a slower change to the policy agenda resulting in a gradual change. This was how most policy change was said to occur; a finding of the current study is that policy was said to evolve over time, rather in large step changes, unless for crisis-related policy issues where rapid changes are needed. Under the incrementalism theory of policymaking, significant policy change occurs, if at all, through a gradual accumulation of small changes (Lindblom, 1965). This appears to be a useful theory for mental health policymaking in Assam, alongside the theory of punctuated equilibrium (Baumgartner & Jones, 1993) which applies to instances of crisis-related policymaking. Under, punctuated equilibrium policy change occurs rapidly, interspersing long periods of policy stasis.

6-6.3 The engagement of stakeholders needs to be sustained to ensure evidence-informed agenda-setting

In Chapter 5, a key finding was the importance of a wide range of stakeholders for mental health agenda-setting in Assam, and who therefore are users, or potential users, of evidence. In the Process Chapter, this finding is extended to consider *the ways in which* stakeholders are involved in the

policymaking processes and therefore how evidence is used. The extent to which current processes were reported to be inclusive varied markedly, even among the same groups of stakeholders, including researchers. This is important for the use of evidence as it influences whose evidence is used and by whom.

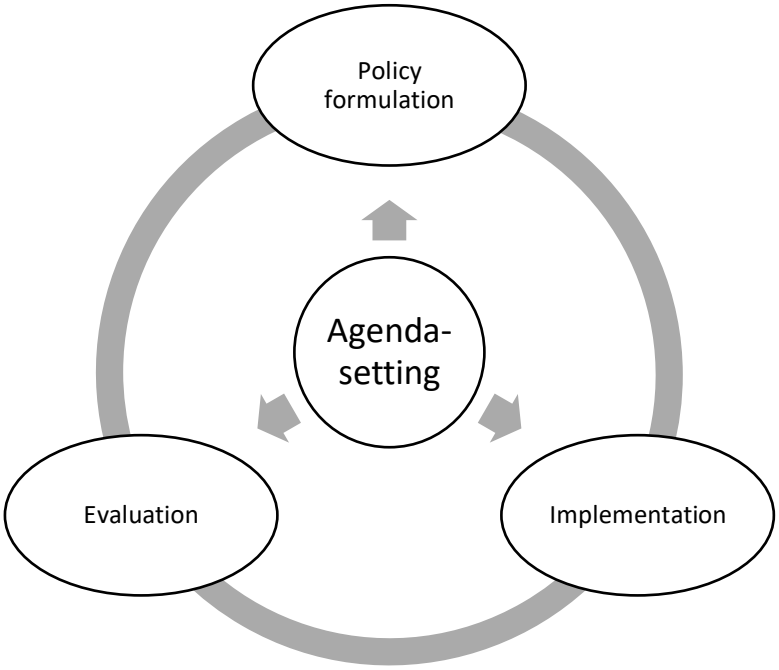
Inclusive and *meaningful* engagement were two components highlighted as important for stakeholder participation in health policy in Malawi, another LMIC context (Masefield et al., 2021). Although Masefield et al. (2021) did not specifically explore stakeholder engagement in terms of how evidence in used health policy, it provides some preliminary findings that are interesting to compare to those of the current study. It is important to note that the study by Masefield et al. (2021) has yet to go through the peer-review process and must therefore be interpreted with caution. Masefield et al. (2021) reported that civil society organisations, in particular, in Malawi felt their participation was important to ensure that the priorities of the communities they represent are reflected in policies. Furthermore, Masefield et al. (2021) found that engagement in the process by stakeholders was often considered as tokenistic; in contrast the present study found that those actors who had been involved in the policy process felt that they had been listened to and impacted the process. However, there is a chance this finding of the present study is due to the limited sample size and the limited nature of policy opportunities to date due to the lack of a standalone mental health policy in Assam, with most participants from civil society organisations reporting that inclusive engagement first needs to be accomplished. A key finding of this thesis study is that *sustained* engagement appears to an important element of stakeholder engagement, in addition to inclusive and meaningful engagement.

Other researchers have suggested that whilst the need for greater – inclusive and sustained – stakeholder engagement identified by the present study is an important step, it may not necessarily be sufficient to strengthen the use of evidence in setting the mental health policy agenda. Invitational involvment in the policymaking process has been suggested to be more likely to have an impact, than on advocacy and lobbying efforts (Kleintjes et al., 2010), and this may be true for the extent to which evidence informs policy. However, a previous study in South Africa has demonstrated that inclusion of stakeholders in the mental health policy process through policy consultations does not necessarily lead to any substantive policy changes (Marais et al., 2020). This suggests that having stakeholder engagement built into policy processes does not necessarily ensure that any evidence used in such processes is also used to inform policy. Furthermore, evidence from certain groups may be seen as less valuable and robust.

6-6.4 Implications for theory and practice

An implication for theory is that for considering the role of evidence in agenda-setting, frameworks may need greater specificity towards agenda-setting to determine the intended role of evidence for any approaches developed to strengthen the use of evidence. Moreover, agenda-setting appears to occur alongside, and feed into, policy formulation, implementation, and evaluation rather than the agenda for the current policy being continuously re-affirmed, as illustrated in Figure 25. Although the stages heuristic model of the policy recognises that stages can occur concurrently, the findings of the current study recommend the need for this to be emphasised. Both incrementalism (Lindblom, 1965) and the theory of punctuated equilibrium (Baumgartner & Jones, 1993) are useful theories to apply to models of mental health policymaking in Assam, depending upon the nature of the policy processes and whether they are formal or informal in response to a crisis.

Figure 25. The policymaking cycle updated with agenda-setting as an ongoing process.



An implication for practice is that it may be more useful for any approaches to strengthen the use of evidence in mental health agenda-setting to aim to gradually raise mental health on the policy agenda. Approaches that seek to accelerate the prioritisation of mental health too rapidly may inadvertently lead to the subsequent formulation of policies being less evidence informed. The reduced stakeholder engagement due to a lack of time in any accelerated processes may further limit the range of evidence used. It was apparent that participants valued improvements in the process and the extent to which stakeholders are engaged, rather than the desired outcome of mental health as a policy issue being prioritised in a timelier manner at the expense of a rushed process which may not effectively address

the needs of communities. In addition, this supports the recommendation for the sustained engagement of actors in the policy process.

Crises such as COVID-19 have led to rapid and significant health policy changes. Whilst the pandemic has highlighted the importance of using evidence to inform policy, the challenges of doing so have simultaneously been brought to the fore (Kuchenmüller et al., 2021), From the findings of this thesis, it would appear that due to the accelerated processes, the level of stakeholder engagement may be reduced due to the need to save time. Additionally, informal evidence based upon personal experience such as expert opinion may be more heavily relied upon. For crisis-related policy issues where opportunities for input are often sudden, policymaker-targeted approaches are therefore more likely to be effective than community-targeted approaches, despite the importance of the role of communities as argued by this thesis in Chapter 5. It appears likely that there is a trade-off to some extent between the speed of prioritisation of mental health on the policy agenda and the extent to which policies are evidence-informed. Therefore, efforts to accelerate the rise of mental health on the policy agenda may be distinct from, with the potential to conflict with, efforts that aim to strengthen the role of evidence. Approaches must be carefully designed to address the exact needs of stakeholders, ensuring that potential positive and unintended negative effects on the role of evidence and mental health prioritisation are carefully considered.

6-7. Conclusion

The policymaking processes that affect mental health in Assam, in which evidence is used, are complex. Although interrelated, agenda-setting is seen as sufficiently distinct from the other stages of the policy cycle to warrant a specific focus from frameworks developed to understand and strengthen the role of evidence. Although stakeholders wanted mental health to be prioritised, trying to raise mental health on the policy agenda was cautioned not to necessarily be a useful goal, as this can lead to subsequent policy formulation being rushed with less stakeholder engagement and a limited extent and range of evidence used. Whether policy change is gradual or sudden affects which types of evidence have a greater influence, with the latter more likely to rely on evidence from a limited range of stakeholders, namely expert opinion. Sustained, inclusive stakeholder engagement in agenda-setting was seen as important so that communities can use evidence in the process, and that evidence from these groups can be incorporated. Ultimately, this enable policy agendas to be reflective of community needs. For agenda-setting, the formulation of policies was not necessarily seen as indicative of the prioritisation of mental health, or that agenda-setting has been evidence informed.

CHAPTER 7: RESULTS (Context) – Contextual influences on the use of evidence

7-1. Introduction

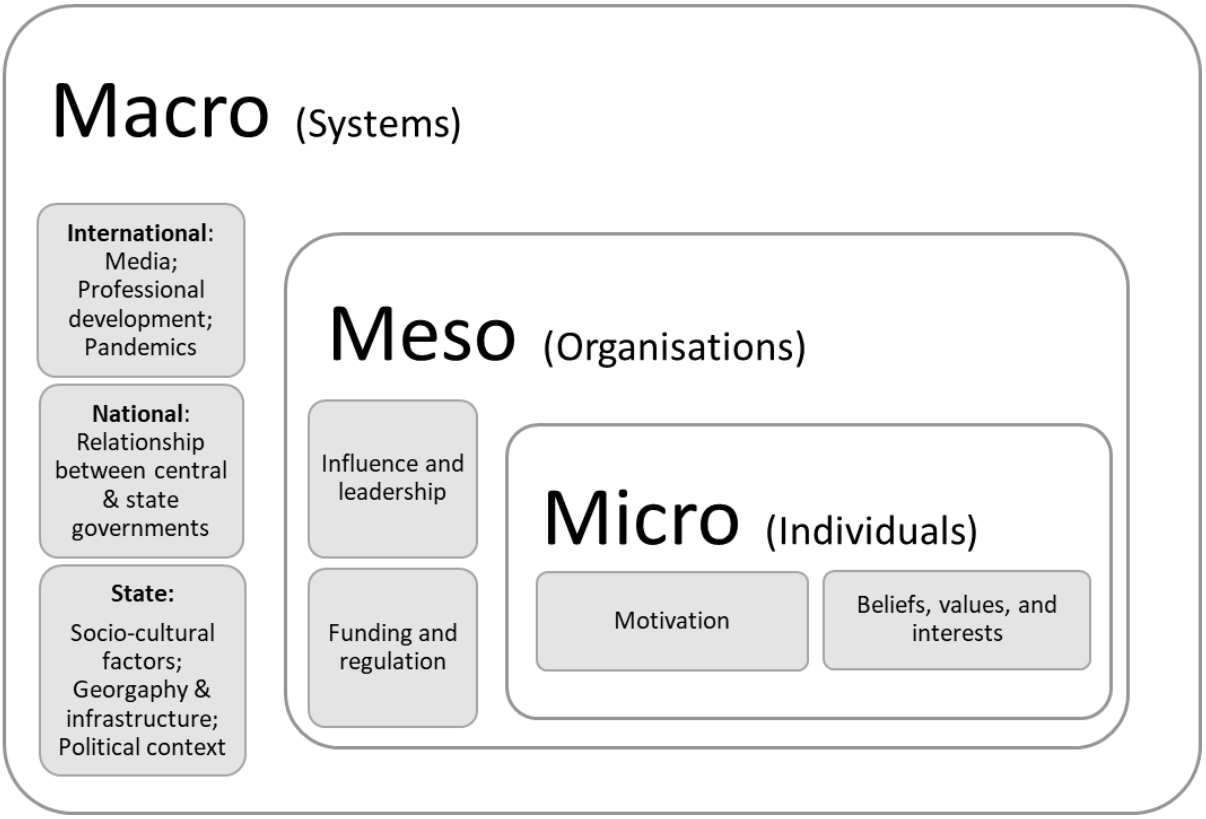
This chapter will focus on context: the third of the four main components of the meta-framework in addition to evidence, and the wider environment in which evidence is used in policymaking.

It has been argued that is critical to understand the context within which evidence is used in policy (Koduah et al., 2015; Malekinejad et al., 2018; Mbachu et al., 2016; Weyrauch, 2016). As stated by one participant in the current study, context *"matters a lot"* (researcher – national, M) in how evidence is used. However, there is a lack of consensus in how to define this broad and complex concept, arising from the inherent complexity of how context operates (McCormack et al., 2002). Context may influence the agenda-setting stage of policymaking differently, in part because of the wider political priorities (Liverani et al., 2013).

In line with the meta-framework (Figure 9), a macro-meso-micro multi-level approach was used in the current study to guide the analysis and to structure the reporting of the findings. Such an approach also follows a number of health policy studies (e.g. Caldwell & Mays, 2012; Kapiriri et al., 2007; Mirzoev et al., 2017), including for mental health policy in LMICs (Awenva et al., 2010). Definitions for the micro and macro levels of contexts are largely agreed upon, however different definitions of meso-level context have been used by different scholars undertaking policy analysis in different areas (Mirzoev et al., 2017). In the current study, macro context is used to refer to the wider international/national/state context, meso to the organisational level, and micro to the individual level.

This chapter will explore the importance of the each of these levels of context, as shown in Figure 26 nested inside one another, along with the key contextual factors identified from the analysis of the interview data under each level.

Figure 26. Key contextual factors identified from analysis of the interview data.



7-2. Macro-level context

In this thesis, the macro context is considered to be at a systems-level. Systems are how different components work together. According to the WHO "A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health" (2007, p. 2). Therefore, this includes micro (individuals) and meso (organisations) levels, alongside how they operate together in the broader environment.

Macro factors were often recognised by participants to be complex and operating at a 'higher level', and perceived to be outside of their control or influence. However, this did not diminish the importance of the factors, which are still key for understanding how evidence informs the mental health policy agenda. Three different sub-levels of macro context were identified: international, national (India) and state (Assam).

7-2.1 International context

Interviewees expressed a range of views about the level of influence of the international context. This range of views was mirrored in the online survey: 40% of respondents agreed, 40% disagreed, and 20% neither agreed nor disagreed that international factors influence the mental health policy agenda in Assam. Whilst international evidence was said to not be particularly useful to inform the setting of the policy agenda in Assam, the international context was seen to more broadly influence how evidence is used in agenda-setting.

7-2.1.1 Extent of international influence

The international media was said to be a key influence and to have the potential to drive changes to the policy agenda, at the national, state, and also district levels. One participant gave the example of Erwadi, where 28 persons with mental illness, who were tied up in chains in a privately run mental home in Erwadi, Tamil Nadu, tragically died in a fire. The media outcry at both international and national levels was said to spark increased policy attention on mental health across the whole country. The establishment of new medical colleges and increased training for mental health professionals was directly attributed to the Erwadi tragedy, and the resultant media attention that it generated:

"One of the incidents which I think it's worth mentioning is Erwadi[…] It became international news, and after that there was a lot of this focus on providing as much as mental healthcare as possible in even district level." (researcher – national, M)

Although, as discussed in Chapter 4, international evidence is seen of limited relevance and applicability to the Assam context to feed into policy directly, there is still recognition of the use of learning across countries more abstractly at a higher level. Such recognition has been enacted in the professional development of some stakeholders. A participant recounted first-hand experience of a study visit to the UK, which they felt was of value to them. However, based on their account it appears that the learning is one-way, rather than a sharing of experiences. Integration of mental health in the wider health and care system was one specific observation made during the field visits. Interestingly, the separation of mental health as distinct from physical health, was separately raised by another participant as a contributing factor the stigma surrounding mental health. The ability of stakeholders to use expert opinion, a type of informal evidence based on personal experience to inform policy was questioned, suggesting it is perceived by researchers to be less valued than formal evidence:

"The fact that we are here [the UK] is one indication that we are prepared to[…] improve the system[…The trip is about] policy, definitely[…] We carry back the experience with us of the system: how functioning, how well it is[… I don't know if at policy level we can impact the system[…] This

exposure [visit to the UK] is basically for that; this training is basically to give us an experience of a system which is seen to be a positive initiative." (researcher – Assam, F)

A range of participants thought the (at the time) rapidly evolving global COVID-19 pandemic would be a major contextual factor in the future, and present challenges compounding the pressure on already-constrained resources. Interestingly, one participant expressed hope that the COVID-19 pandemic may act as a catalyst, that it is important to capitalise upon, for the shift towards online communication methods, important for the sharing of evidence with communities:

"[COVID-19] will definitely have an impact[…] maybe in one way this is an opportunity to have a greater reach of population in that way, so using up a lot of multimedia activities will come in now." (intermediary – Assam, F)

7-2.1.2 Value of international influences

International factors and influence were, however, not always seen as positive with regards to the use of evidence in mental health agenda-setting for Assam. While policies from other countries were seen to influence policies within India, participants also cautioned that policies that are successful in one context may not necessarily be appropriate or effective in another. As a result, some policies introduced at a national level were seen by participants as not being suitable for the Indian context. Instead, they were seen as more suitable for Western, HIC, contexts because they consider input from "experts" and "professionals" rather than from local communities. Thus, this suggests that the evidence used to inform mental health policy does not represent the views and needs of communities, and that this is true even for informal evidence including expert opinion. Human rights were a particular area where significant differences between India and the West in how the issue is framed and understood:

"They have prepared a bid called, act called Mental Health Care Act, okay, so in that Act and the opinion of the mental health professionals, the doctors, most of the opinions that were taken together from the social activities, okay. So, because of that what has happened that they have problems with the policy which is more suitable for European and American, for European countries and America rather than us." (researcher – Assam, M)

7-2.2 National context: India

7-2.2.1 Historical and geographical patterns

Within India, mental health is an area of recent focus, and *"mental health policy is new in the country"* (researcher – Assam, F). Recent advances for mental health policy have also been made in related sectors. For instance, in the education sector, the new national education policy was perceived to have some relevant elements for child mental health. However, despite recent developments in national-level mental health policy, most notably the first national mental health policy of India in 2014 (Government of Government of India, 2014), participants stated that there is still a need for standalone policies for specific issues, including adolescent mental health. Historically mental health has been low on the agenda, and so policy development has only taken place relatively recently:

"Mental health was never a priority area for several years after the independence of the country, and I would say only in the probably the late '80s or early '90s this, some initiatives were started." (researcher – national, M)

The magnitude of the influence of the national and international context, particularly the West, was said to be large both on a broader cultural level, including the arts, as well as for mental health. However, this influence of the national-level was not seen to be reflected in the similar progress of mental health policy across different states within India; participants judged there to be variation in the status of mental health policy, with different states at different stages of policymaking: "*In different states, it is not in the same pace.*" (researcher – Assam, M). Accordingly, the influence of the national-level was seen to differ between states, highlighting the importance of the interaction between the national and state-level contexts. For the State of Assam, it was seen to be geographically and culturally on the periphery of India, and almost distinct from the rest of the country. Interestingly, the attenuated influence of the national context, in comparison to other more central states, was seen to apply to mental health policy, as well as to culture. The separation of Assam from the rest of India was seen to lead to a slower pace of change for the prioritisation of mental health:

"Usually the term goes around that it's [Assam] not the mainland, that is the mainland, and this is the other, like the periphery of the country." (intermediary – Assam, M)

Interestingly, mental health policy reform directly was seen to be delayed in Assam due to its geographic location. The rate of which mental health is raised on the policy agenda at the state-level was observed to directly correlate with the geographical distance from the Centre, the Government of India, based in New Delhi. It was implied that the greater geographical distance weakens the influence of the centre, and the momentum made, regarding mental health. A potential reason could be that due to the different context of Assam, national-level evidence may not have the same impact on agenda-

setting given then the emphasis participants placed on the need for evidence to be contextually relevant. Further research would be needed to confirm this. Nevertheless, progress is perceived to as being made in Assam, albeit at a slower rate than other states. Thus, this suggests that national contextual factors are key, but may be less acute in Assam than in other Indian states, with state-level factors being of greater importance:

"Very soon I'm expecting that they [Assam] will develop some state level policy and some action plans. Already in the centralised government they have done it but in different state it is not happening and there are some regional variations also. So, some states, like southern states like say Tamil and Kerala, that is in the southern part of India, their mental health submissions are very developed, they are already working on it. But in Assam, as it is away from the mainland it is delayed. But I hope that in next few years this coming up." (researcher – Assam, M)

The diversity, in addition to the size, of India was further seen by participants to limit the extent of national-level influences at the state-level. Diversity was manifold, encompassing socio-cultural, economic, political, demographic and geographic factors. Such variation among the different states within India was reported by participants to create difficulties when trying to generalise evidence and policies in different states. Again, this emphasises the need for evidence to be locally relevant (as highlighted in Chapter 4):

"Geographically it's a huge country, it's a big country, and for example your study in Assam might not be replicable or that it won't be for my state in down south, so that's one barrier, where in actually kind of you're having national level project[…]Heterogeneity it is very significant in this, a very diverse kind of country with different cultures and different subcultures, that there are different[…] what is applicable in one place may not be applicable in another place, so there's a lot of modification that is required." (researcher – national, M)

In spite of the heterogeneity among the different states within India, learning across different states of India was said to occur, and more frequently than at an international level as described above. It appeared to be initiated by individuals themselves, in contrast to the more organised international training and exposure visits:

"When we see there is something very positive happening in any parts of India say, of course we have not gone beyond the borders so much. But you know if we feel we are very convinced about it, we usually see that we get ourselves in there and see what the experience of it, whether we can be trained." (researcher – Assam, F)

Although there was recognition of the challenges presented by the diversity among the Indian States, participants often felt that the central government was not doing enough to promote progress for state-level mental health policies. As a result, of the absence of influence from the national-level, other

states in India were reported to have taken their own initiative. This suggests that whilst support from the central government can help raise mental health on the policy agenda at the state-level, it might not be necessary:

"There are some states, or some places where they have launched their own innovative programmes, rather than waiting for too much of government support and all these things. Like, for example, for people who are mentally ill as well as homeless, that are certain centres that are launched, some centres that are focused on women with mental illness." (researcher – national, M)

7-2.2.2 Relationship between the central and state governments

Understanding the role of the state government in setting the mental health policy agenda, and the influence that the central government has is important for understanding the different users of evidence and the ways in which they used evidence. Participants gave different accounts about the nature of the relationship between central and state governments. One participant described the relationship as "*heavily structured"* (researcher – Assam, M). The key role of the central government was the provision of financial resources, which suggests the central government therefore holds the most power. A structured relationship also implies there are established and functioning relationships between policymakers at the state at national levels:

"The Government of India, the central government is just providing the resources, the monetary resources. The manpower and all those things it is all being provided by the Government of Assam, so in that way the state government is also fully involved." (researcher – Assam, M)

Contrastingly, another participant described the relationship between national and state levels as *"very ambiguous"* (policymaker – national, M). The central level was said to be responsible for providing resources and support for the state level to act as a catalyst for action at the state-level. However, a tension was noted between the autonomy of the state and the financial control of the centre. Commitment and sensitivity of both central and state governments, working together proactively, were stressed as being key elements for the implementation of mental health policy:

"*When they want resources they [states] may say "give us the resource", but when they implement it, review the program, the state may say "you are impinging on the state's autonomy". Ok? Now this creates a problem which is going to be very, very difficult to solve[…] For example, if the centre says "I'm going to give you x amount of resources, what, why program?" The resources have to be related back. And the state will have to utilise and give back the utilisation details. And if there are gaps in any one of these things, suppose if I give, let us say some amount of money to a state, and if the state doesn't use it and doesn't ask for refill of the money, the centre will keep quiet, isn't it? So, it is not necessarily defined by the state-centre relationship, it is more defined by how proactive is the centre,*

how proactive is the state, how committed is the state, how committed is the centre, how sensitive both these things are." (policymaker – national, M)

7-2.3 State context: Assam

The importance of the state, and sub-state level was emphasised by participants. The real-world effectiveness of national level policies, when implemented at the state-level, was seen to be low because they did not adequately consider the local state context. As a result, setting a realistic policy agenda appropriate for Assam is important. Hence this suggests better outcomes would be achieved if evidence from the grass-roots level informed mental health policymaking much more strongly:

"The local context is being ignored and somehow the policymakers in this Mental Health Care Act[…] it looks very good, okay, to read is very good and they are doing this thing for the person, that thing for the person, but in reality cannot be done." (researcher – Assam, M)

In Assam, participants concurred that mental health was not currently seen as a policy priority, both by policymakers and by communities: *"I just think it's not a priority. It's as simple as that."* (intermediary – Assam, F). Policymakers were seen to be faced with multiple compelling priorities, including both health and non-health priorities. For communities, one participant raised the complexity of community needs, with some issues being faced by members of a community even if these are not always recognised at large:

"Though some communities may still think "no, it is not a priority". Some people may view family will have to increase their ability to take responsibility. But if families are poor, what is to be done, how that is to be responded to? That is something that we need to understand." (policymakers – national, M)

At the state level, the key contextual factors affecting the use of evidence in setting the mental health policy agenda in Assam were identified as: socio-cultural factors including stigma; geography and infrastructure; the political context.

7-2.3.1 Socio-cultural factors

The state of Assam, located within a large and diverse country, is itself large and emphasised by participants to be *"very diverse"* (researcher – Assam, M). Diversity is exhibited in multiple facets, with multiples tribes[13], languages, culture, and ethnicity. Such diversity is also reflected in, and

[13] The people of Assam fall under one of three distinct groups: hill tribes, plain tribes, and the non-tribal inhabitants of the plains (Indrajit Sharma, 2018). The tribal population is further broken down into the

argued to lead to, diversity in the patterns of mental health across the state. Hence, different groups may have different policy needs and wants, making setting a collective policy agenda for Assam even more challenging:

"There are numerous groups of people whose dialect, language, dresses, everything is different, and according to that their substance abuse pattern is also different." (researcher – Assam, M)

Assam does not yet have a standalone state mental health policy, but the need for one has been identified by key stakeholders (Pathak et al., 2017). Moreover, it was specifically stressed that such a policy needs to be comprehensives across the entire population and *"covers everyone"* (intermediary – Assam, F). Given the diversity in the population, and in the presentation of mental health, this makes such as an aim even more challenging to achieve.

Despite recognition of the vast diversity among the people and communities of Assam, and the importance of ensuring this is represented in setting the policy agenda, simultaneously participants cited the vast diversity as a key challenge in engaging communities in the policymaking process. Different languages and dialects were highlighted as a practical barrier to engaging with different tribes. As well as language, mental health is understood differently, as discussed above under micro-level contextual influences. Tea tribes communities consist of the descendants of slaves brought to Assam by the British East India Company during colonial times as labourers on the plantations of Assam's large tea industry (Hazarika, 2012). Their low socio-economic status has persisted post-Independence and are recognised by the Government of Assam as 'Other Backward Classes'. These tea tribe communities were given as an example, where community engagement efforts require greater effort in part due to being a marginalised group and their lower literacy levels. The additional resources, human and financial, required may lead to further marginalisation of this group. Working with intermediaries who are fluent in both Assamese and the dialect of a particular tribe was therefore said to be particularly important:

"I think there is a lot of barrier and challenges because we have got so many plain tribes as well as hill tribes, right, and each dialect is different. So one of the ways that we have been trying it when we were helping doing life skills programmes, which are the psychosocial interventions in the field, was to do a training of trainers from the local communities, no, who will understand maybe Assamese as well as they also have their own dialect. For example, if you're looking at the Boro language, so maybe we are picking up a trainer who will be, who is a Boro girl or a Boro boy, as well as he also or she also understands Assamese. So, we are delivering that training through them in Assamese but we are also helping them to translate it into their own language." (intermediary – Assam, F)

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administrative categories Scheduled Tribes (STs), Other Backward Classes (OBC), and More Other Backward Classes (MOBCs).

Stigma, arising due to socio-cultural factors, was generally agreed by participants to remain widespread, although decreasing, among the population. However, within the policymaking system, one participant felt that there has been a continuous reduction in stigma due to the provision of increased resources. This view contrasts with the view that individual policymakers, suggesting a distinction between individual and system stigma. In comparison to the rest of India, this reduction in stigma was seen to be occurring at a slower rate. Assam being on the outskirts of India, was said to be behind the slower rate of progress, for mental health awareness and stigma, which is also reflected in the status of mental health policy development:

"It's [mental health] something that is very less talked about I guess, like anything in India, the conversation is about mental health has become mainstream very recently, like because of social media and now movement per se, right. So, in Assam it's a lot less, because everything that's happening in pan India let's say, the magnitude of those particular things is lesser in Assam, or like the north eastern states." (intermediary – Assam, M)

Contextual factors were not always framed by participants as barriers, but also as facilitators to the use of evidence in agenda-setting, particularly by communities. As well as the socio-cultural barriers due to the diversity, participants also stressed that some socio-cultural factors were advantageous. Community engagement, particularly of agrarian communities in rural areas of Assam in the agenda-setting process may be aided by a strong sense of community, thus helping to reflect the needs and wants of communities on the policy agenda:

"The community in Assam is comparatively a little more close knit, than many other parts of India. The 'we' feeling among people is still there. You know, so that is something to capitalise on." (researcher – Assam, F)

7-2.3.2 Geography and infrastructure

A range of participants, including researchers and intermediaries, suggested how mental health was framed as a policy issue by government contributes to the stigma surrounding mental illness. The focus on mental health as a distinct issue from physical health, was said to contribute to stigma surrounding mental health by marking it out as a special case, rather than as a medical illness. A state level policy therefore *"which covers mental health as a health problem rather than a separate entity from health"* (intermediary – Assam, F) was therefore seen as important by stakeholders.

Physical and logistical barriers were also reported due to the large size of Assam, the weak infrastructure and inaccessibility of remote areas, and conflict. Places outside the capital Guwahati were said to require a full day of travelling time, making community engagement difficult and time-consuming. These logistical difficulties were said to interact with and compound the marginalisation

of a lot of these rural communities from the policymaking process. Despite the rise in the use of the internet and social media, access, this increase is not equally shared by all communities in the state. Consequently, this was said to pose difficulties for engaging with rural communities, who are already marginalised and not involved in the agenda-setting process. Furthermore, this lack of engagement may result in the potential loss of valuable evidence from these groups:

"A lot of villages do not have that smartphone or the connectivity is not there, the networks are very poor and so, and since we, so teaching them to use those mediums is sometimes again a barrier. So, you are only having one way of communicating, it's either the face-to-face communication or physically being there with them. So, we are losing out a lot of opportunity of using the multimedia or any kind of online activities because of that." (intermediary – Assam, F)

7-2.3.3 Political context

The political context was reported by participants to affect both researchers and policymakers. For state-level agenda-setting, participants largely emphasised the importance of the political context at the state-level. Nonetheless, the national and, albeit to a lesser extent, international level political context were also reported to be influential. As mentioned previously, the relationship between the central and state governments is an important contextual factor. Political context was said to affect how policymakers, specifically politicians, perceive and receive evidence. This highlights how researchers need to be aware of the political context, even if they aim to be apolitical (see Chapter 5):

"Regarding what are the kinds of data that politicians will be thinking about some may not be amenable to the politicians who are making the policies. So, the researchers need to present the data in a diplomatic way." (researcher – national, M)

In order for evidence to inform policy throughout all stages of the policy cycle and ultimately contribute to tangible improvements, sustained, genuine, political commitment, was said to be needed. Political commitment needed to be demonstrated and backed up by sufficient financial resources:

"Any research evidence that is implemented in the field to the logical end is, depends upon resource, commitment, consistency of that commitment, and conviction. These are very, very important." (policymaker – national, M)

7-3. Meso-level context

This thesis considers meso context to be at an organisational-level. Individuals often framed their policy involvement through their organisation or institute, and therefore understanding the meso-level

context is important. For example, a participant described contributing towards the input for the development of a national suicide strategy. Although only more senior members of the organisation were the formal, named, contributors for the policy, the organisation as a whole was seen to shape the policy input:

"I am not directly involved in any of this policy, but[…] as this is a mental health premier institute in the country[…] many of our faculties and many of these chairs were involved in the direct policy[…] and we kind of helped to formulate it, and they are present at that national level. So,[…] indirectly we help them or help, or to review the, for example that recently we reviewed suicide prevention plan for the country, which was not directly to us, but the same time the senior faculties got it and they asked us to review it and send our comments." (researcher – national, M)

In terms of evidence use, two key contextual factors were identified at the meso-level: influence and leadership, and funding and regulation.

7-3.1 Influence and leadership

Participants felt organisations and institutes needed to demonstrate stronger and more active leadership and advocacy was needed in order raise mental health on the policy agenda. Those holding senior leadership positions within key institutes were perceived to have the necessary power and influence. Interestingly, participants holding such leadership positions commented on the constraints that their leadership positions place on them for advocacy, due to these being governmental institutions and positions and having to be in line with governmental positions. Consequently, this may impair their ability to use evidence in the agenda-setting process. Expert opinion, a type of informal evidence (based on personal experience) may be particularly affected. Thus, there appears to be a difference in the perceptions of the role of actors in positions of power and influence:

"The mental health institutions and the departments, they have to actually push it more because they are in that capacity where they can talk about it more." (intermediary – Assam, F)

Internally, the leadership of institutes were also deemed to need to take responsibility for prioritising policy advocacy, alongside other activities including teaching and service provision. This requires policy advocacy to be given sufficient resources, rather than in being conducted at the expense of individuals:

"At the institutional level, so the institutions have to make some kind of, you know, initiative to take this upon themselves, like saying that our role is there with regards to this policy advocacy also, and we should allow the faculty to spend some of their time, devote some of their time, and that has to be adequately remunerated or compensated" (researcher – national, M)

7-3.2 Funding and regulation

On the other hand, other organisations with a greater ability and freedom to advocate reported difficulty in accessing funding. These organisations were generally newer and smaller organisations and those working at the grassroots level. This is likely to affect their power and ability to proactively engage with setting the mental health policy agenda in Assam, and therefore be a contributing factor for the low policy priority assigned to mental health. The role of these organisations in bridging the gap with communities, was recognised as a particularly resource intense endeavour, and so is particularly likely to be affected by any funding gaps. Moreover, this compounded the human resource issues due to the time demands that funding applications require. One participant recounted the difficulty in accessing funding inhibited their ability to propose potential policy solutions based on their experience on the ground:

"One of our main agendas, our objectives in the long-term is that we'll try to reduce like, increase the affordability of counselling sessions or therapy[…] let's say we have a working [funding] model within our organisation where we[…] subsidise those therapy sessions[…] But then because there's a lot of funding issues and we have a lot of work to put up before we actually access grants, so it's a long way off now, but it's definitely one of our objectives,[…] and that's where[…] advocacy and taking it to the policymakers, that's where it comes then." (intermediary – Assam, M)

Moreover, the lack of tax revenue generated by mental health organisations, including service providers where home practices are common, was said to result in a lack of attention from policymakers due to the overriding importance of the economy. Accordingly, there is little governmental support or regulation for many mental health organisations. Legitimacy was highlighted as an important characteristic of actors (see Actors Chapter), and the lack of a formalised system for organisations may impede their input, and use of evidence, in policymaking. Interestingly, this lack of formal recognition and regulation from the state was said to be a result of a lack of policy. As a consequence, there appears to be a feedback cycle where the lack of a formalised sector, leads to less policy attention, which maintains the lack of formalisation.

"If you become an organised sector which is clearly defined and clearly regulated, then there are a lot of things that fall into place automatically […] So that responsibility I think comes through the recognition by the state and the state has not been able to do that yet because the policy level, at the policy level it doesn't exist right now." (intermediary – Assam, F)

7-4. Micro-level context

The micro context, in this PhD, is considered to concern individuals. In the Actors Chapter, the importance of individual actors was noted. Accordingly, micro-level influences were raised by participants as being crucial. In terms of evidence use, two key contextual factors were identified at the micro-level: motivation, and beliefs, values, and interests.

7-4.1 Motivation

Motivation for the accomplishment of two aims were reported to be important in relation to the use of evidence for setting the mental health policy agenda: first for raising the priority of mental health, and second for strengthening the use of formal research evidence in policymaking.

High levels of motivation were expressed by individuals for raising the priority of mental health and ultimately improving mental health services and outcomes. Participants working in the field stated this was something *"something that we are all very passionate about."* (intermediary – Assam, F). The high levels of motivation may be particularly useful for the use of informal evidence that is based on personal experience for agenda-setting, and in particular expert opinion. Interestingly, rather than being demotivating as might be expected or seen as an increase in workload, the COVID-19 pandemic (section 2.1.1) was framed in a positive light be a participant. COVID-19 seemed to add a further source of motivation to drive further mental health work: rather than be a barrier to impede current progress:

"Any challenge is also an opportunity; that's my way of looking at it." (intermediary – Assam, F)

The demands and barriers stakeholders face are particularly acute in the resource-constrained LMIC context of Assam (see Chapter 5), and higher levels of individual motivation were seen to be needed in order for stakeholders to influence the mental health policy agenda. Even so, due to the resource constraints and other barriers, motivation alone may not sufficient and may not get translated into the participation of stakeholders in policymaking processes. Policymaking was seen as a further task on top of an already stretched workload:

"They need to be actually very committed to [mental health], and especially like in a country like ours[…] Because of the resource gap kind of thing I mentioned, so each one of us, like we do a lot of multitasking kind of thing, so we teach, we do research, we are expected to work at the clinic, and we are expected to do that because of the kind of programmes, and then in addition it's all this policymaking." (researcher – national, M)

However, there were differences in the levels and areas of motivation among different types of stakeholders. The same degree of motivation of those working at the grassroots level was not seen in

nor perceived to be enacted by those in senior leadership roles with power and influence in the policymaking process. Moreover, there was also reported to be a high level of variation in motivation among individuals. Notably, such variation in the level of personal interest towards mental health was also perceived to apply to policymakers. In terms of approaches to strengthen the use of evidence, this presents a barrier as successful approaches likely require individual tailoring, given the high turnover of staff reported (see Chapter 5) which would require sufficient knowledge about the individuals involved. Notwithstanding, it does also encouragingly suggest that there are policymakers with a high level of interest in mental health who can be targeted:

"There's a high unpredictability that I have noticed in my experience with the dealing with policymakers, because, they, some are heavily committed towards one issue and some are indifferent to it. So, there is a huge personal aspect to this whole enterprise." (researcher – national, M)

Differences in the areas of mental health of individual interest were also reported, as well as in the overall level of motivation. Motivation often stemmed from personal experiences and one participant recounted *"I started my organisation from a very personal story actually."* (intermediary – Assam, M) Potentially, this might explain the greater value assigned to informal evidence (as discussed in Chapter 4), which is based on personal experience. Furthermore, motivation also needs to be coupled with awareness about mental health and power in order to for stakeholders to enact their motivation. Again, this power of knowledge and influence appeared to vary among individuals:

"I could because I was privileged and I was aware enough about mental health and its repercussions, I could sense that they are going through some kind of a mental health problem" (intermediary – Assam, M)

Many participants believed greater use of evidence was needed to achieve the goal of raising mental health on the policy agenda. Although, as discussed in Chapter 4, the importance of evidence for mental health policy was widely recognised, researchers and intermediaries felt it an area over which they exerted less influence. For policymakers, motivation to use evidence by itself was seen to not be sufficient. Motivation needs to be sustained and backed-up by sufficient financial resource for evidence to inform all stages of the policymaking cycle:

"Any research evidence that is implemented in the field to the logical end is, depends upon resource, commitment, consistency of that commitment, and conviction. These are very, very important." (policymaker – national, M)

7-4.2 Beliefs, values, and interests

A lack of knowledge and skills specific to mental health agenda-setting were reported by participants. First, there was said to be a low, although increasing, levels of mental health awareness. A lack of

understanding, and therefore also terminology, was said to result in the use of stigmatising vocabulary to described persons with mental illness. A key reason behind this lack of knowledge was said to be a lack of inclusion in the school curriculum. Consequently, mental health knowledge was reported to largely come from word-of-mouth. Encouragingly, there appears to be recent increase in awareness in recent years; the growth of internet and social media use was reported to be a key driver:

"I came to realise the details very much later in my life, like I joined college and then the whole world of internet and the social media and like people started talking about it, and that's when I realised that oh this is a problem and this is like the gravity of the problem is such, right, so in the same way I think in the last two or three years people have been talking a lot, and at least online about like mental health[…] So yeah, the influence is huge." (intermediary – Assam, M)

However, this growth in awareness is not universal, and there is much variation at the individual level. Just as the socio-cultural diversity in Assam was said to pattern mental health epidemiology, such diversity is said to likewise shape the beliefs, values, and interests regarding mental health, including stigma (as mentioned in Chapter 4). Such beliefs, values and interests are important in shaping individual and community priorities and affect how evidence is valued and used for setting the mental health policy agenda. A diversity of beliefs, values and interests regarding mental health was described by participants, and this was patterned along two main demographic characteristics: a rural/urban and a generational divide. Mental health was reported to have recently become a priority for communities in urban parts of Assam. Consequently, awareness campaigns were stated to be largely exclusive to urban areas, thus likely exacerbating the rural-urban divide:

"Only like at the urban level have we actually figured out that mental health is important. It's a very, very urban thing. If you really go to like, even a Tier 2 city or a Tier 2 town, like most people would not think of it as a priority because it is not a priority.[…] So, there is a lot of, I think, campaigns being run for creating awareness but it's happening at a very urban level." (intermediary – Assam, F)

In rural parts of Assam, the beliefs around mental health were reported to centre around traditional beliefs. Due to the lower level of mental health awareness in rural areas, mental health is not viewed as a priority by rural communities. Moreover, there is less evidence on the issue due to a lack of people seeking mental health services making it a hidden problem:

"A lot of like, you know, traditional practices also kind of deal with mental health in a very different way[…] like, you know, you can go to a counsellor to just get advice because, you know, sometimes you just need a third voice. There are songs that we sing […] but most of it is actually just advices from the elders, so they don't really feel like okay there's like something tremendously wrong but then they understand obviously when say for example they see the deterioration of mental health, that they call mad because of lack of vocabulary again or the lack of awareness." (intermediary – Assam, F)

As well as a rural-urban divide, a generational divide was described by participants in relation to the understanding of, and priority assigned to mental health. The older generation, even within the same families and communities was said have a lower awareness of mental health. It is likely that this the awareness raising effects of social media and the internet described above has not benefited this demographic to the same extent from. Thus, the older generation were reported to ascribe a lower priority to mental health than other age groups:

"I can talk about my own grandmother, like my grandmother does not understand the kind of work my mum does, she doesn't understand what my work is entirely." (intermediary – Assam, F)

Despite the rise in mental health awareness, this has not yet manifested in the absence of stigma. Participants frequently recounted the persistence of stigma surrounding mental health in Assam even among younger age groups in urban area, the demographic with the highest awareness. Such prevalence of social stigma suggests that an increase in mental health awareness may not be sufficient in reducing mental health stigma:

"The stigma is so huge that even your best friend would not talk to you because she's probably ashamed, or he's probably not realising what he's going through." (intermediary – Assam, M)

Stigma was said to affect individuals differently depending upon their personal circumstances. For instance, stigma was reported to compound financial barriers to restricting access to mental health care. As well as impeding the production of formal research evidence and informal evidence based on personal experience, potentially, this could be a further barrier to the engagement of service users and communities in agenda-setting processes:

"Imagine a student who's still studying in college, right, so he or she or they doesn't have a job right now, so they do not have the money to sort of fund their own counselling session[…] and now there's a second problem which is the stigma, […]so the primary problem and one of the most common problems that people of my age group face, we are going through a tough problem is they can't talk to their parents, they don't like, either they are ashamed to talk to their parents, or it's other way where they're reluctant to talk to their parents because their parents would not grasp the problem." (intermediary – Assam, M)

Of note, policymakers were also perceived to exhibit stigma. This was said not only to include their own stigma, but to reflect the stigma of the communities in their constituencies. Hence this suggests reducing stigma across society is important for mental health policy agenda-setting, both to influence how evidence is perceived and valued, and also to increase the priority assigned to mental health:

"One of the reasons is their [policymakers] own stigma coming out of it, because there is an inherent conditioning that every person from a particular region goes through it, right, there's a bit of

conditioning, and for[…] they also reflect the sentiment of the community that is a stigma that is reflected by them." (intermediary – Assam, M)

Social skills, and being able to read and respond to social cues, were also identified as important characteristics for stakeholders to be able to use evidence to inform and influence the policy agenda (as mentioned previously in the Actors Chapter). However, these skills were perceived to be underdeveloped across stakeholder groups, leading to a skills gap which one participant described as a *"huge problem"* (intermediary, Assam, F). This prevents stakeholders effectively engaging the policy process. Similarly to mental health knowledge, a key determinant of this skills gap was said to result insufficient inclusion in the formal education system where 'hard' skills are prioritised; both were seen to be needed for the active involvement of stakeholders in the agenda-setting process. Again, this highlights the importance of people and their context in how they use evidence, in addition the evidence per se. A suggestion for developing these skills were greater extracurricular activities, in particular arts-based activities:

"A lot of people they're really smart and they may like do really well in their studies but then they may lack a lot of like social, you know, cues because they were never exposed to any sort of extracurricular." (intermediary – Assam, F)

7-5. Interactions between different contextual factors and levels

Although participants viewed each level of context (micro, meso, and macro) to be important in their own right, participants emphasised the need to understand the context as a whole, including how contextual factors operate together, within and between different levels and sub-levels. Hence, it was reported that different elements of the context, for example political and economic factors which operate at micro, meso, and macro levels, could not be understood in isolation. This highlights the complexity of context and understanding how it affects the use of evidence in setting the mental health policy agenda for Assam:

"*You can't like, cannot take one thing and just look at this one particular aspect of society, right? So if you're looking at let's say political orientations, you're looking at social acceptability of it, you're looking at the economy gains that you can get out of this, only like, I think it's about the structuring of it.*" (intermediary – Assam, F)

Participants explicitly highlighted the importance of the interaction between the state and national levels, particularly the relationship between state governments and the national government, and how they operate together in an intrinsically-interlinked manner. Although not directly specified by participants, it was apparent that many other contextual factors transcended the different context sub-

levels. Stigma was a key example of a factor which was reported to operate within and between all levels of context.

Interactions between the national and state levels of context were also reported to operate in multiple directions. National influences appear to not just operate as top-down on state-level mental health institutions and policymaking, but these relationships are rather multi-directional and multifaceted.

"[The Lokopriya Gopinath Bordoloi Regional Institute of Mental Health] has significant role in changing the mental health scenario as a whole country." (researcher – Assam, M)

Interaction between the different levels of context was seen as important by participants important in shaping mental health as a policy issue in Assam, and in determining how evidence is used in policymaking. For the agenda-setting stage, in particular, the broader mental health context is important as any developments may represent a 'window of opportunity' for evidence to influence policy.

Rather than a dichotomy, some contextual factors were viewed as being simultaneously both potential barriers and facilitators to the use of evidence in policymaking. This was suggested to be due to the way in which they modulate the effect of other contextual influences to shape mental health as a policy issue in Assam. A good illustration offered by one participant is the unfolding of the COVID-19 pandemic. The state context could attenuate the effect of the pandemic on mental health because of prior exposure to traumatic and stressful events. Conversely, the state context could exacerbate the effect of the pandemic and resultant lockdowns given the high sense of community and a lack of tools for people to deal with mental health and wellbeing. The global and state context therefore interacts with the individual environment to shape how mental health is experienced, affecting the needs and demands of communities and therefore the nature of the policy issue of mental health. Therefore, this example additionally highlights how international, state, and individual contextual factors interact:

"*I see it in two ways. One is that, you know, some people may be immune to it [mental illness] because, you know, Assam has faced a lot of these kind of conflicts earlier also[…] ethnic violence or you are looking at flood[…] The other one will be definitely who will not be able to take the stress more[…] our people from India or Assam we are very social people, so one of our biggest need is actually, you know, to meet people, to socialise and which has actually stopped absolutely, yeah? And that is bringing them a lot of fear and uncertainty and hopelessness and so I will also most probably come up with cases where we will see post-traumatic stress disorder, PTSD may come up after some time, anxiety and depression is already coming in. And because again in a lot of households we are in a smaller space and we are, you know, people are getting affected because of lack of personal space."* (intermediary – Assam, F)

7-6. Discussion

The significance of the findings will be discussed in relation to the literature, followed by the resultant implications for theory and practice.

Participants in the current study unanimously stressed the importance of context in how the policy agenda is made, and how evidence informs this process. This supports the literature which also underscores the importance of context in addition to the evidence per se for health policy in LMICs: "Availability of evidence is necessary but not sufficient for developing policies in this area. Wider socio-political contexts in which actors develop policy can facilitate and/or constrain actors' roles and interests as well as policy process" (Etiaba et al., 2015). Moreover, a finding of the present study was the need to consider different aspects and levels of the context together. Weiss et al. (2001) similarity recognise the interaction between the different levels of context, stating that local programs require the support of national and international policy, and national and international policy must be considerate of diverse local contexts. (Weiss et al., 2001) have further argued that the multiple levels of policy context – state, national, and international – act synergistically. The findings of the current study, exploratory in nature, is unable to provide sufficient evidence in support of such as synergy, however this presents an interesting area for further exploration.

7-6.1 International context appears less influential

Contextual factors at the macro-level concerning systems were reported by participants in the present study to be important. This finding concurs with a policy analysis which found that the adoption of mental health policy is highly clustered temporally and spatially, thus suggesting that macro contextual factors are important (Shen, 2014).

The current study noted the importance of the influence of the international press on the policy agenda at national and state levels. This is consistent with previous studies: for example, other scholars have noted the significance of the effect of the media coverage, including the Erwadi fire tragedy, on the development of mental health policy in India (Murthy, 2001; Nizamie & Goyal, 2010). The Erwadi incident highlights how evidence that powerfully demonstrate the importance of mental health as a policy issue is not restricted to formal scientific evidence but can come from informal forms of evidence based upon personal experience, and may also trigger further production of research evidence. Public reaction to the media coverage appears to have pressured government action. However, it remains unclear how much the international media coverage versus the national and sub-national media coverage had in driving the cascade of changes that resulted from the Erwadi tragedy,

and other news items. The exact mechanism is an important avenue for further research as it may affect the most effective medium for researchers can communicate their findings.

However, other international contextual factors were rarely mentioned in participants' accounts. Jat et al. (2013), in one of the few studies that have explored state-level agenda-setting for health in India, reported that in Madhya Pradesh international influences, including international targets and international agencies such as the UN, were a key factor in raising mental health on the policy agenda. Due to the socio-cultural influence of mental health, international influences may be less influential, and suggest why international evidence may be viewed as less relevant.

The application of evidence generated in other country contexts, particularly HICs, was suggested by the current study to have questionable usefulness in term of informing the mental health policy agenda in Assam. This is consistent with Melluish and Burgess's (2019) argument that the field of global mental health can facilitate the inappropriate translation of Western models at the expense of local knowledge. The particular example highlighted by the current study of human rights in relation to mental health, and how this concept differs across contexts and cultures, has been previously reported (Melluish & Burgess, 2019).

Recently the WHO has issued guidance in recognition of the importance of human rights in mental health to persuade and support countries ensure their mental health systems and services meet international human rights standards. Interestingly, the guidance purposefully contains examples picked from a diverse range of global contexts to demonstrate how human rights-based approaches in mental health can be achieved across different contexts. International evidence may therefore still have the potential to usefully inform policymaking, including agenda-setting, in Assam but this may depend on how international evidence is framed for a local audience. Mbachu et al. (2016) argues that actors are heavily informed by the factors in the context of their local reality in evidence-based policymaking. Further research would thus be useful to elucidate whether such types of international evidence are deemed relevant to the Assam context.

Notwithstanding, the findings of the current study suggest that learning can still take place across contexts. Cox and Webb (2015) advocate that when applying learning from Western contexts to LMICs, evidence from the local context needs to be used in addition. However, this learning tends to occur in only one direction, highlighting the power imbalance (Melluish & Burgess, 2019) at the global level. Other scholars have argues that such learning can and should go both ways between HICs and LMICs (McKenzie et al., 2004).

The need for policies to be specifically developed for the local context, rather than being based on those already implement in other, usually Western, countries. Transplantation of HIC mental health policies, or elements of, to LMICs has been previously described by other scholars to be ineffective, with the local context needing to be incorporated into any policies (Zhou et al., 2018). For agenda-

setting, priorities are likely to be different. As discussed in Chapter 6, caution was expressed around seeking to raise mental health to the top of the policy agenda as quickly as possible. A further potential effect highlighted by Zhou et al. (2018) is that if mental health is raised on the policy agenda, the increased attention could lead to resources being spread more thinly over different aspects covered by policy, such as service provision and human resources. Interestingly, donor funding, which is frequently included in frameworks, and by studies in LMICs on health policy more broadly (Dodd et al., 2019), was absent from the participants responses. Potentially this suggests the low priority and subsequent absence of international donors in Assam with regards to mental health despite growing international attention; although there is a lack of data, development assistance for mental health in developing countries is estimated to account for less than 1% of all development assistance for health (Gilbert et al., 2015).

COVID-19 was found by the current study to be seen, on balance, as potential opportunity rather than a challenge, as may have been expected. Subsequent developments after the interviews were conducted tentatively suggest that such optimism may have been well-placed; the Government of Assam has launched a number of mental health programs and initiatives in response to the pandemic (Hazarika et al., 2021; Saha, 2020). Interestingly, this suggests that mental health may also become more of a priority in terms of policy.

7-6.2 Complicated relationship between state and national policy

The importance of, and the tension in, the relationship between central and state levels of government was a key finding of the current study. Within India fragmentation of governance between the centre and states has been previously reported (Roy et al., 2019). In addition, the current study adds that in states on the periphery of India, such as Assam, and likely other North Eastern States, this fragmentation is likely to be greater. Other scholars have also commented on the centre-state relationship with regards to health policy: Jeffery (2021) noted that whilst public health issues can reach the top of the policy agenda of the Government of India, for state governments this is much less likely and can therefore lead to conflict. Stronger evidence may therefore be required in order to demonstrate mental health is a priority policy issue in Assam.

Jeffery (2021) further argues that the relationship between central and state governments are becoming less important for public health policy, in part due to the reduced discretional central funding and the increased commercialisation of the health sector. However, the current study does not support this finding for mental health policy and the relationship between the Governments of India and Assam, where the cooperative relationship was said to be key for mental health policy.

Momentum for mental health, and mental health policy, has been observed in India over recent years (Gautham et al., 2020; Patel & Copeland, 2011), including the recent effects of the COVID-19 pandemic (Dandona & Sagar, 2021). However, diversity within India was also a recurrent finding of the present study, and reported widely in the literature (Peters et al., 2003). Due to the diversity in the development progress of different states in India, Peters et al. (2003) argue that state-level factors should be important for prioritising different health issues. Factors proposed include those relating to the physical, social and political environment. There was a high-level of crossover between the state-level factors identified by the present study, including natural risks and social capital.

The diversity of Assam was reported to be a defining feature of the state, and its diversity of languages and culture is well reported elsewhere (Deka, 2005; Government of Assam). Kattumuri (2015) has argued that for Indian context, the diversity of languages and cultures means that intermediaries are even more important for brokering knowledge to policymakers for conducting fieldwork, analysing evidence and communicating it an understandable manner to policymakers. This is likely to be particularly acute for Assam; Saikia (2020) has argued that due to the "multi-cultural, multi-lingual, multi-racial and multi-religious" nature of the state of Assam has compounded development and social progress challenges. This is in line with a key finding of the current study is that this diversity can lead to challenges in evidence informing the agenda-setting process.

In addition, recent studies have supported the point raised by participants that conflict and religious diversity affect the mental health burden; in states across India, including Assam, marginalized social groups, scheduled castes and Muslims, had worse levels of self-reported mental health than the dominant social group (higher caste Hindus), which differences in socioeconomic status were unable fully explain, especially for Muslims (Gupta & Coffey, 2020). Therefore, suggesting there is a cultural component. Muslims who have historically been the target of violent riots in Assam are reported to have faced 3.5 times higher levels of anxiety and depression that higher caste Hindus (Gupta & Coffey, 2020). This does however contradict accounts of some participants that such populations may be more resilient to mental health issues due to repeated exposure to trauma. It is interesting to note because, similarly to gender, the effect of stigma means that groups with higher burden of mental health are also those most likely to be excluded from policymaking processes. The tensions between certain groups have been suggested to make crafting a single policy 'ask' challenging (Mackenzie, 2014). In addition, such tension may also, as suggested by the findings of the current study, contribute to the sensitive nature of mental health as a policy issue which may affect how evidence is interpreted by policymakers.

In addition, diversity is also present within mental health practices and services. Prior research in Meghalaya, another North-Eastern State in India, found that whilst traditional medicine is commonly used and accepted, but is not recognised and respected by policymakers (Albert et al., 2015). The

current study has reported a similar finding regarding mental health in Assam, and this is suggestive of evidence being used to inform beliefs and decisions regarding mental health differently between stakeholders. Therefore, the recommendation that policymakers and the policy process engage with a wider range of stakeholders, who can bring contribute different types of evidence based upon personal experience such as community narratives, is also argued by the present study to apply to the context of Assam from mental health.

Political considerations were said to be important for determining how evidence can be used to influence policymakers; this is supported by prior studies, and a suggestion is that evidence should be placed in the wider political context (Jenkins, 2013). The broader political context and political priorities has been reported to shape how and to what extent evidence is used, and that framing evidence to align with existing political priories, e.g. economic growth and poverty reduction, can lead to more successful uptake (Liverani et al., 2013). However, consideration of the political context is often missing from health policy and systems research; this has been demonstrated for another LMIC, Ethiopia, (Østebø et al., 2017). Furthermore, inclusion of political context is often limited to positive influences: political will, commitment and leadership (Østebø et al., 2017). Interestingly, participants in the current study tended to stick to the same components of political context.

Social as well as political considerations were shown to be important by the current study, a finding supported by previous research. Value judgements also play an important role in priority setting, and these are influenced by social values that are highly context-dependent (Clark & Weale, 2012), and therefore need to be understood for Assam. As evidence operates alongside, and sometimes in competition with social values, in order to understand the role of evidence, how social values shape the use of evidence is important.

For communities who are likely to be important in the use of evidence for setting the mental health agenda in Assam, although not recent data, a high level of trust by the population of Assam in the government (65%) has been documented, but in parallel with a low level of interest in politics (7%) and of newspaper readership (<10%) (Renata, 2001). These are some of the factors that have been incorporated by other scholars to measure social capital "the power of networking based on a strengthened sense of belonging, trust and reciprocity" (Ogden et al., 2013, p. 1076) (Ogden et al., 2013). The building of social capital is a concept that has been proposed as a way of strengthening health policy advocacy and engaging community voices in the policymaking process to ensure community priorities are reflected in the agenda-setting process (Ogden et al., 2013). A key finding of the present study is that a strong sense of community exists in Assam, but particularly in rural areas; notably, often it is rural communities who are most marginalised and excluded from agenda-setting processes. A high level of social capital in Assam has been previously documented (Renata, 2001). Interestingly, this suggests there is a potential opportunity to engage such communities.

7-6.3 Informal nature of the mental health sector and services

The informal, unorganised, unregulated and nascent nature of the mental health sector in Assam, and the organisations within it, was said to be a key factor affecting organisations, and their capacity to engage with evidence and the agenda-setting process. Lack of funding was an issue for many organisations. Given the value of many service providers and civil society organisations as knowledge brokers, due to the diversity of cultures within Assam, constraints at the organisational-level may therefore reduce the extent to which evidence is used in setting the policy agenda. Moreover, capacity issues may constrain their ability to act as a bridge between policymakers and communities, and facilitating the inclusion of communities in policymaking processes, and therefore a broader range of evidence types including informal evidence which is based upon personal experience. Difficulties with funding are not unique to Assam; funding has been recognised as a major preoccupation of mental health NGOs in India (Patel & Thara, 2003).

Capacity for mental in LMICs is often aimed solely at clinicians; however, it has been argued that the capacity of wider range of individual and organisational actors is important including service users, policymakers, and researchers (Evans-Lacko et al., 2019). For Madhya Pradesh, another Indian state, Kokane et al. (2021) argue that given the importance of local evidence for mental health, building research capacity in LMICs is crucial. For the informal mental health sector in Assam the present study suggests that building organisational capacity is likely to be helpful for strengthening the use of evidence in policymaking.

In other LMIC contests, such informal activity has been reported to mean mental health is absent from formal policymaking processes (see Chapter 6) (Mackenzie, 2014). Therefore, this implies that informal evidence based upon personal experience may be necessary to complement formal research evidence to capture such ‘hidden’ activity. A further consequence of the informal nature of the mental health sector was raised by Hall et al. (2020); in Timor-Leste, an LMIC, people affected by mental illness may not identify as ‘service users’ because of barriers to formal mental health services, including stigma and poverty. In turn this may affect their participation in policy processes. It would be useful to explore whether this applies in Assam.

7-6.4 Diversity of mental health beliefs

A wide range of beliefs and values held by individuals around mental health was a key finding of the current study. Dedication and commitment of different individuals, a key micro-level contextual factor identified by the current study has been previously documented to be a key influence for national level health policymaking in India (Mirzoev et al., 2017). However, the importance of

highly-motivated individuals in terms of driving evidence-informed policy change reported by Mirzoev et al. (2017) was of individuals in leadership positions who were perceived to be 'policy champions'. Conversely, while the current study found that for mental health in Assam individuals from the grassroots levels to middle management level were highly passionate and motivated, this was not always perceived to be the case for individuals in senior leadership positions. Although senior leaders may be constrained by the political environment, stakeholders reported the absence of policy champions for mental health and this may affect the use of evidence to inform the policy agenda.

Social media and the internet were found to be responsible for a large proportion of mental health awareness. Support for this finding has been reported from other contexts, as well as the role that social media can play in reducing stigma (Robinson, Turk, Jilka, & Cella, 2019). Social media has also been shown to simultaneously have potentially have negative effects by amplifying stigma and trivialising mental health (Robinson et al., 2019), a finding which is not reported by the current study.

Concurrently, stigma was a prominent theme in the current study, and patterned the mental health burden in Assam, and thus shaping mental health as a policy issue. Other scholars have previously reported that socio-cultural factors can contribute to the aetiology of mental illness (Levy et al., 2014). Additionally, stigma was also found by the current study to directly affect the policymaking process, and the use of evidence. Other scholars have previously acknowledged stigma to be a key consideration for mental health policymaking, in part due to the resultant lack of attention the issue of mental health receives from policymakers and communities (Jenkins, 2003). Moreover, Mackenzie (2014) argues that a removing stigma in the wider public is as important as eliminating stigma in policymakers, in order to raise mental health on the policy agenda.

Additionally, stigma was shown by the current study to affect the involvement of stakeholders, and their use of evidence, in the policymaking process. This extends prior research in Assam which reported that the lower social status of women in Assam is affected by mental health due to the associated stigma (Choudhury, 2017). The discrediting manner that impeded women from their personal, professional and social aspirations may affect how evidence from this group is seen and valued within policymaking. Stigma further entrenches disadvantage is this group, by their priorities are not adequately taken into account in agenda-setting. Other researchers have, however, argued that stigma is not the factor affecting attitudes and behaviours in relation to mental health. Although women may face higher levels of interacting stigma, and men exhibit higher levels of stigma, men were less forthcoming when talking about mental health (Borooah & Ghosh, 2017). Thus, this may affect their engagement in policymaking processes.

Understanding how stigma operates at multiple-levels, has been argued to be an important component of frameworks in order to mitigate the potential negative effects of stigma in policymaking (Stangl et al., 2019). As mentioned in Chapter 4, stigma may affect how evidence is perceived and used by a

range of stakeholders, including policymakers. The interaction of gender and mental health stigma was discussed in Chapter 5, and how this might potentially affect the role of women in the policymaking process.

Given the recognition of a broader range of stakeholders, as discussed in Chapter 5, understanding the diversity of beliefs, values and interests is important. The generational divide, whereby stigma appears to be lower in younger age groups in Assam, found by the current study, is consistent with the findings of previous studies in Assam (Borooah & Ghosh, 2017). The authors also speculate that this may result in disagreement when bringing stakeholders together. However, although lower than older age groups, high levels of stigma are still exhibited by young people across India (Gaiha et al., 2020). Due to the intersectional nature of mental health stigma as discussed above, the complexity is unsurprising, and suggests further research is needed.

7-6.5 Interconnectedness of the different levels of context

How different levels of context operate together, was identified by the present study as an important influence on the use of evidence in agenda-setting. The synergy of mental health policy at international, national, and local levels have been argued to be important for improving mental health outcomes in India (Weiss et al., 2001). International, national, and state support were reported to be needed to support the local programs to be attentive to the needs of their communities. The current study extends this finding to policymaking, although in the current study participants placed less emphasis on international support and international influence not always viewed in a positive light. This discrepancy between the two studies maybe due to changes that have taken place over the last twenty years, and the shift in importance towards the local, rather than global, levels of context.

The framing of mental health and the economic environment, both highlight the influence of factors at both ends of macro-meso-micro contextual spectrum. How mental health is framed, at the individual level, and the terminology used, was found by the current study to vary with the socio-cultural diversity within Assam. How evidence is framed, and whether it aligns with prevailing social norms and values, and the current political agenda has been argued to determine its uptake and use in policymaking (Liverani et al., 2013).

The importance of availability of financial resources, is a finding of the current study which has been widely reported as a barrier for evidence-to-policy more broadly (Oliver et al., 2014). The economic environment highlights the highly interconnected nature of context: resources are need from national and state levels, however these need to trickle down to communities, including community-based organisations, and members of these communities in order to enable them to use evidence to influence agenda-setting more strongly. It was also cautioned that approaches that seek to increase engagement

with evidence and policy processes need to cognisant of the impact on individuals, and should not add further burden onto a group that faces a high-level of poverty.

7-6.6 Implications for theory and practice

The findings reported in this chapter have implications for both theory and practice.

An implication for theory is that the current study supports the non-hierarchical nature of the macro-meso-micro context, with a combination of factors at all levels being important. This is commensurate with other studies, including a study of the role of evidence in health policy development in India (Mirzoev et al., 2017). However, the current study noted that the international context was perceived to be less influential for the use of evidence in mental health policy in Assam than other macro-contextual factors. This finding may potentially apply to other sub-national contexts but further research is required to explore this.

A further implication for theory is that the present study also supports the finding of previous research highlighting the importance of links between the different levels of context (Mirzoev et al., 2017). The stacked Venn diagram (Figure 26) presented at the beginning of this chapter is used to emphasise that the three levels of context are overlapping and interrelated. In particular, in the initial meta-framework, beliefs, attitudes and values was included under the micro-level context. However, from the analysis it became apparent that stigma, as well as other beliefs, attitudes and values were more appropriately conceptualised as a cross-cutting dimension that linked together other components of the framework.

The dynamic nature of the context, adds to the complexity; the changing global context has been highlighted for public health (McMichael & Beaglehole, 2000), the current study extends this to multiple levels of context for mental health. Similarly, to the dynamic nature of the stakeholder map, any analyses of the context are likely to be time limited due to the changing nature of the context. These were apparent as both gradual changes over time, such as changing attitudes, and as much more rapid changes such as the coronavirus pandemic.

In term of practice, the findings of the current study support the rationale for the current study, that mental health stakeholders in Assam support the need for a standalone state mental health policy. This assumption was based chiefly on the Assam State Report of the National Mental Health Survey 2015-16 (Pathak et al., 2017). The findings of the current study confirm this, and extend this finding to include other actor types, including intermediaries and researchers.

In Chapter 5 it was stated that an implication for practice is that a more equal focus on community-targeted and policymaker-targeted approaches may be beneficial for strengthening the use of evidence

for setting the mental health policy agenda in Assam, rather than a focus on policymaker-targeted approaches. The findings of the present chapter, focusing on context, highlight the practical difficulties associated with this due to the high levels of heterogeneity reported within Assam. The heterogeneity of the mental health context in Assam suggests that a variety of community-targeted approaches to strengthen the use of evidence are likely to be necessary, particularly as the importance of tailored approaches has been highlighted. However, encouragingly, the present study also noted contextual factors were not solely viewed as barriers, but also as opportunities.

7-7. Conclusion

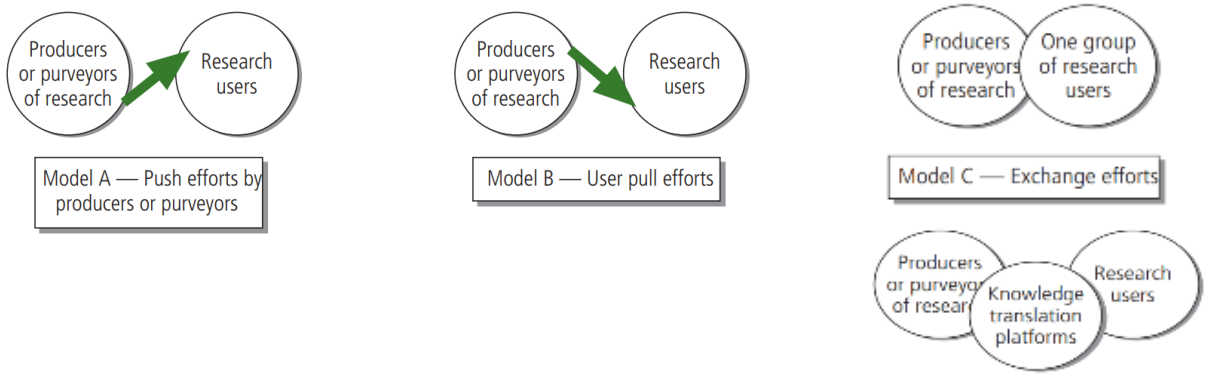
Context was unanimously perceived to be of utmost importance for shaping the use of evidence, and consequently for strengthening evidence use. Understanding context at all levels, including the local context, and the wider context was seen to be important. Moreover, how the different levels of context operate together was seen to be important, particularly so given the complex federal and state division with regards to mental health as well as the socio-cultural component of mental health. For Assam in particular, the heterogeneity within the state poses a further challenge to the genuine, inclusive engagement of communities in the policy process, and community-directed approaches, to strengthen the use of evidence for setting the mental health policy agenda.

CHAPTER 8: RESULTS (Approach) – How approaches can be used to strengthen the use of evidence in agenda-setting

8-1. Introduction

Due to the benefits of using evidence to inform policymaking, researchers have developed various strategies to strengthen the use of evidence. In the field of health policy, the predominant classification of approaches is based upon the direction from which the demand for, and transfer of, evidence occurs. The three main categories of approaches are: (1) 'push' approaches from researchers to users; (2) 'pull' approaches from users (predominantly policymakers) to researchers; and (3) 'exchange' or linkage approaches that connect researchers and users (including through the use of intermediaries and formal processes and platforms) where the transfer of evidence is multi-directional. (Gold, 2009; Lavis et al., 2006). 'Push approaches' focus on the supply side, and 'pull approaches' focus on the demand side of evidence use for policy.

Figure 27. Categories of approaches used in the field of health policy. (Adapted from (Lavis et al., 2006) - CC BY-NC-SA 3.0 IGO).



However, there is a lack of both theoretical work and empirical research on the effectiveness of approaches to strengthen the use of evidence for mental health policy specifically (Williamson et al., 2015). This research gap is of particular significance as Williamson et al. (2015) note that the approaches used to date for mental health policy differ markedly from those used for public health. As observed in Chapter 3, one element of the challenge of conducting research on the effectiveness of approaches is that there is no clear consensus on how to measure the impact of evidence on policy (Cruz Rivera et al., 2017; Newson et al., 2018), and therefore the effectiveness of any approaches.

Such assessments are difficult due to the multiple other influences on policies such as media attention, which make it difficult to isolate and thus attribute any impact.

This chapter will set out: the different types of approaches, as conceptualised by participants according to the target audience and who the approaches are led by; and the role of communication in all approaches. Alongside this, what participants view to be successful approaches will be explored.

8-2. Tailoring approaches for key stakeholder groups

Participants expressed the view that there will always be a need for approaches to strengthen the use of evidence in agenda-setting, and for these to be continually refined. Even if a particular policy is evidence-informed, the continuous nature of policymaking and the ongoing production of evidence means that getting evidence into policy is a continual challenge. This was viewed not just to be the case for India, but for all countries regardless of their level of development:

"The translation of research into policy will forever remain a challenge, both for lower and higher income countries." (policymaker – national, M)

Two categories of approaches according to which group of stakeholders they targeted were emergent from the participant's accounts: (1) policymaker-targeted approaches and (2) local grassroots communities-targeted approaches.

8-2.1 Policymaker-targeted approaches

8-2.1.1 Defining the audience

'Policymaker' is an umbrella category (see Actors Chapter). The effectiveness of different approaches was said by participants to differ according to broad category of policymaker of the intended audience: unelected officials and elected politicians. These different types of policymakers have different evidence preferences and values and therefore how evidence is packaged and presented was reported to be an important consideration of any approach. For instance, research evidence packaged in the form of journal articles, was said to be a less widely accessible format. On the other hand, research evidence packaged specifically in a less technical manner for a non-specialist audience, such as policy briefs, was said to be more suited to unelected officials and thus more likely to have influence. Therefore, clearly defining the audience is important when designing any approaches:

"Often such advocacy is aimed at such civil service officers, what is called in India administrative services officers, and there would be a bit more favouring of the modalities such as policy briefs, PowerPoint presentations, technical reports, and these kind of products, knowledge products let's say if not necessarily products of science, you know, not necessarily peer reviewed publications, but certainly you know, knowledge products. So, there is, there seems to be broadly they will, these kind of knowledge products will probably find more favour." (researcher – national, M)

8-2.1.2 Interactional approaches

A common approach is the passive dissemination of research evidence: a one-way approach focused on the movement of evidence from researchers to policymakers. Particularly as *"policymakers, so often times there are a lot of compulsions for them"* (researcher – national, M), passive efforts were seen as unlikely to be the optimal approach in the face of multiple competing demands for policymakers' attention. Rather, approaches should be interactional which are more engaging, and further facilitate discussion about the research evidence. Although policymakers hold the decision-making power, participants cautioned this conversation should not be limited to researchers and policymakers, but involve other relevant stakeholders including communities:

"Given that we are, you know, sort of privileged in the sense that we have access to this kind of data and knowledge tools, we ought to then create spaces or platforms where others can similarly sort of experience this benefit of this knowledge. So, and what is not advisable for researchers is to have passive dissemination meetings where we are making boring presentations to a bunch of people, you know, because we have the social networks to get the secretary to give a circular requiring all officials to come for some workshop[…] Rather than that approach[…] we need to create spaces where conversations about our research can happen within officials, amongst officials, or between officials and communities, or among policymakers, or among implementors." (researcher – national, M)

8-2.2 Community-targeted approaches

Intriguingly, participants largely focused on approaches that target grassroots communities at the local-level, rather than policymakers. Communities were seen as important users of evidence and able to influence policy decisions. Therefore, approaches to strengthen the use of evidence in agenda-setting, need to equally target communities in addition to policymakers. Some participants even argued that community-targeted approaches were more important than policymaker-targeted approaches.

The online survey added further support to the interview findings that community-targeted approaches are as, or if not more important, that policymaker-targeted approaches. 80% of respondents agreed or strongly agreed that here should be a greater emphasis on approaches that share evidence with communities than on approaches that take evidence directly to policymakers, with the remainder 20% neither agreeing or disagreeing.

Moreover, the use of document analysis to triangulate the interview data lent support to the finding of the need to enable communities, and particularly rural communities, to utilise their potential power on the policy agenda. An online news article of the seminar 'Health condition of women in rural Assam' hosted by the Centre for North East Policy Studies and Research (C-NES), stated that a conclusion of the seminar was the need to empower (rural) communities that need to "play a much more vigorous role in leading the health movement in the state". In particular, rural communities and relevant village committees within these communities, in this case Village Health and Sanitation Committees.

One participant with a prominent role in policymaking, was a strong proponent of the need to target communities with evidence:

"We are also working towards disseminating evidence among the user[…] if that doesn't happen, I'm afraid whatever evidence we generate will not be of any use to influence the lives of people."
(policymaker – national, M)

This participant proposed sharing evidence with users helped to overcome two challenges: users being 'voiceless' and not demanding change. From all of the interviews, several mechanisms by which communities use evidence to influence and inform the policy agenda became apparent. Although communities are key users of evidence, unlike policymakers, they are not decision-makers and therefore the mechanisms by which approaches can work to strengthen the use of evidence differ to those aimed at policymakers. The key mechanisms are to: (1) attract political attention to mental health; (2) facilitate engagement in the policymaking process; and (3) raise awareness and reduce stigma.

8-2.2.1 Attract political attention

One mechanism by which service users use evidence to inform policy was explained by participants to be through securing greater political attention to the issue. This was understood to force policymakers to take action and generate political and systemic commitment.

"There is a gap that exists, which can only be addressed in a very big way if the user demands for it[…] Consumer pro-activism and participation is going to be very, very critical. We know that states have a role to provide services, provide resources, and other agencies have responsibility to implement programs, if the consumer is passive, consumer is non-participating that is likely to

happen, will not happen. That, for me, is the most important insight. So, consumer activism, pro-activism in terms of demanding for services will make the difference." (policymaker – national, M)

8-2.2.2 Facilitate engagement in the policymaking process

Bringing discussions on mental health and the policy agenda into the community was highlighted to be an important need. In order to productively engage in such discussions, communities need access to evidence as well as the skills to use it. Present approaches, according to participants, do have an element of community engagement built in. However, as agreed by both researchers and intermediaries, this is rather limited and needs to constitute a much more substantial aspect of any approach and not a 'tick-box' exercise.

"A lot of community outreach, that happens definitely, I'm not denying it, but it happens I think on a very surface level even now where you've not been able to penetrate into the ground grass root level" (intermediary – Assam, F)

Including communities in the policymaking process was seen as the responsibility of a wider set of stakeholders; policymakers and researchers were also said to have a role in engaging with stakeholders. Doing so would broaden the range of evidence used in policymaking, rather than solely expert opinion which may not be representative of the needs and wants of diverse communities:

"The professionals themselves they may start acting like this, saying that say if I'm in as an expert I'll sit in my room and write something and just send it to the government, than actually going to the ground[…] meeting all stakeholders." (researcher – national, M)

Community-directed approaches may be particularly promising in the context of Assam due to the strong community ties (see Chapter 7):

"Community engagement is something that we can look at as a really like big opportunity to just uplift everyone together because that's the aim, like personally I feel like you cannot uplift yourself if you're not uplifting people around you because where you live is how you are." (intermediary – Assam, F)

However, for community-based approaches in particular, the need to be realistic about the level of success attainable by an approach was stressed by participants. Many potentially useful approaches were identified, but participants cautioned that there was a limit to what any one approach could achieve, and the cost of any approach must also be considered and balanced against the perceived benefits. Therefore, continual efforts are needed, and a single approach is unlikely to be sufficient:

"We know that all people who have had this capacity building process may not take it to the real world, and we are realistic in understanding what we are told, or half will actually do it. And we will have to keep on doing this." (policymaker – national, M)

8-2.2.3 Raise awareness and reduce stigma

Raising awareness of mental health and reducing stigma among communities were said to be crucial components for any approach designed to increasing the political attention given to mental health and facilitating engagement in the policymaking process. Ensuring communities have access to relevant knowledge was seen as key in order to reduce stigma. However, social stigma is reflected by policymakers (see Actors Chapter) and, hence, it will also be beneficial for policymaker-targeted approaches. Stigma was cited as a barrier to evidence use, and why mental health remained low on the political agenda despite evidence demonstrating the magnitude and importance of mental health as a policy issue:

"[A] very important thing is people have to have technical knowledge about the problems, otherwise it's very difficult [to reduce stigma]." (policymaker – national, M)

The online survey, used to credibility check the findings from the interviews, confirmed the importance of awareness-raising. Moreover, the survey highlighted the importance of the approach (awareness-raising) in accordance to the evidence available. As noted in Chapter 4, the online survey confirmed the importance of informal evidence in addition to formal research evidence in informing the mental health policy agenda in Assam. Interestingly, one survey respondent explicitly linked the nature of evidence in the centre of the meta-framework to the approaches to strengthen the use of evidence:

"Mental Health policy should be based on evidence both research and informal. For a low mental health resource state like Assam, scientific research is limited as academic institutions have increased only after 2005. Thus awareness and advocacy is of prime importance." (intermediary – Assam, M)

Awareness and advocacy are interrelated concepts: awareness can be thought of as identifying the needs of a community, and advocacy can be used to generally refer to creating awareness on an issue (Ravichander, 2019). Awareness and advocacy featured highly in the key approaches, direct (e.g. share evidence more widely) and indirect (e.g. reduce stigma), identified by the current study; the online survey adds further support to the inclusion of these approaches in order to strengthen the use of evidence in setting the mental health policy agenda in Assam.

8-3. Key stakeholders to lead approaches

A key determinant of the success of approaches to strengthen the use of evidence in agenda-settings are the stakeholders are involved with the development and delivery, who should be considered in tandem with the intended audience, i.e. policymaker or community. Specifically, similar approaches from different parties may be received differently. Two main ways in which approaches can be developed were identified by participants: researcher-led approaches and intermediary-led approaches.

8-3.1 Researcher-led approaches

Researchers were reported to be key in leading many approaches to strengthen the use of evidence in policy, including expert opinion as well as research. One example given by a participant involved the use of their networks to garner support for some of the definitions of certain aspects of the 2017 National Mental Health Care Act. Notably, this involved using an invitation from the government for public opinion, suggesting that this avenue is not only limited to researchers. Thus, if some of the actors with a high degree of potential influence but limited interest at present (see Chapter 5) became more interested, similar approaches could be utilised. Moreover, establishing a reputation and relationships was a critical first step, which led to invitations for efforts directed towards policymakers:

"We sent emails to people saying that "are you agreeing with this. If you agree please send a mail to the Parliament". There was a standing committee asking for public opinion on the definitions of certain, various aspects of the Mental Health Act[…]and therefore we got an opportunity[…] since it was in the public domain each of us could send in an opinion to the government saying that this is what is needed. So finally, a majority came about, and they took about this. And we became the standing point which, you know, they were consulting us too, "why don't you tell us more about this area". (researcher – Assam, F)

8-3.1.1 Limited effectiveness

However, the effectiveness of approaches led by researchers was stressed to vary by a large extent according to the individual researchers involved. Reasons included their personalities, motivation, as well as their reputation and standing among policymakers. In spite of the engagement in policy processes by some researchers, many recognised a lack of researcher-led approaches. However, this suggests a potential opportunity to strengthen researcher-led approaches:

"There is a huge gap between academia [and policymaking], where we kind of do research and publish and we stop there." (intermediary – Assam, F)

Even when involving individuals highly suited to these activities, researchers also acknowledged that there was a limit to what researcher-led approaches can achieve. The need to be realistic when considering intended outcomes of any approaches was stressed. Moreover, effective approaches were also said to need to change how researchers use, interact with, and share evidence. In tandem, approaches also need to focus on how policymakers and communities engage with evidence through, as the intended audience of, policymaker and community-targeted approaches. Accordingly, researchers were reported to need to consider a broader range of approaches with which they may have limited experience, or which may be outside of their current skillset. This means that researchers need to be introspective when designing any approaches:

"Within research communities itself I think more, things that we can change, we can't, I mean we can't go around in a project setting sort of to create a better culture[…] But what we can change is[...] the kind of things we are more comfortable with, we are comfortable with making PowerPoint presentations, we are not comfortable with having a freewheeling discussion for example among implementors, we are not comfortable, we put too rigid boundaries, we say okay this is what our project was about and we cannot talk too much outside of that boundary. But the boundaries we put are too limited for, often for implementors and they feel not part of." (researcher – national, M)

Interestingly, a researcher cautioned against developing any approaches that over-emphasise the importance of researchers in agenda-setting, and their control of the types of and roles of evidence involved. So, whilst researchers have a key role in sharing evidence and helping to facilitate agenda-setting, they should not try to own the process as this could conflict with the largely unanimous aim of a co-created policy agenda. A truly collaborative process could therefore lead to changes in the way in which evidence is used; the more diverse range of actors involved may value and interpret evidence in different ways. Moreover, evidence-informed agenda-setting may not necessarily equate to research-informed policy, but an agenda that is informed by other types of evidence based upon personal experience:

"Agenda-setting is an exercise that has to be done together with diverse range of people[…] it's very likely that when you co-create things it changes, you know, different people bring their own thinking into it and so it evolves, it changes, and it becomes something else. So this, there needs to be a kind of comfort with that, and I often feel that as researchers we tend to want to control, because often because we have made commitments to donors or to we have made presentations and made our charts and stuff, so we have our own frameworks to, that require us to control and steer things in a certain way and I think that we need to let go." (researcher – national, M)

8- 3.2 Intermediary-led approaches

Due to the limited scope and effectiveness that participants ascribed to researcher-led approaches, approaches led by intermediaries were also seen to be key approaches to strengthening the use of evidence. Two key types of intermediary-led approaches were identified by participants: intermediaries (1) acting as brokers of knowledge; and (2) as links to communities.

8-3.2.1 Knowledge brokers

Intermediaries were identified as important brokers of evidence to policymakers and communities, ensuring that evidence is easily accessible and useable to these groups. Evidence presented by a range of intermediaries - intergovernmental organisations, NGOs, patient support groups – were reported to have a different level of influence, to each other and in comparison to researchers, on policymakers and the agenda. The WHO was given as an example of an intermediary with a lot of influence when present evidence to policymakers:

"If it's the WHO country office for India, which is delivering the evidence, perhaps the best way is even a presentation or a report being made on behalf of the WHO country office, even from a junior member who just walks into the secretary's office, or the minister's office and convinces him that look mental health, this is what you have to do, this is what the WHO considers important, etc. It will be received, it will be received respectfully, it will set some wheels into motion." (researcher – national, M)

8-3.2.2 Links to communities

Determining whether communications were most effective when initiated by intermediaries or researchers was seen to be partly dependent upon on whether the approaches primarily targeted, policymakers or communities. Intermediary-led approaches, as opposed to researcher-led approaches, were seen to be, arguably, more important for community-targeted approaches than policymaker-targeted approaches due to the role of intermediaries as links to communities (see Chapter 5). For intermediary-led approaches, where community-based organisations are the intermediaries, in order to develop effective approaches greater collaboration among intermediaries was stated to be important in ensuring a joined-up approach. This was important for whether such intermediary-led approaches target policymakers or communities.

"A lot of us work in silos and that again, like it's overlapping information[…] today I can go and tell you about gender violence, tomorrow somebody else comes and tells you about mental disorders, another person comes and tells you about learning disabilities, it becomes very, like it's an overwhelming situation at that point, right?[…] But if you actually have that talk beforehand of how

to go about it, we could have like say a centre or say like a group of individuals in the mental health sectors from different fields who actually talk to each other and say "okay fine, I have so-and-so organisation under me, we do this kind of work, we're planning on doing this, do you think it would work with yours?" So, I think that give and take could help us a lot in understanding the situation better and give a lot more information to the policymakers so that the policies are not jarring themselves." (intermediary – Assam, F)

8-3.3 Combined approaches

Researcher-led and intermediary-led approaches are, however, not necessarily mutually exclusive. Intermediaries voiced the need for greater collaboration between researchers when developing approaches, however researchers tended not to bring up the same suggestion themselves:

"Ideally, I should have a conversation with the researcher […] that whole data, that whole mathematics can be portrayed better to the public when it's converted into a story and that story itself cannot be retained by the advocate alone, or me alone that has to be a combined work of the researcher as well as me, or the storyteller." (intermediary – Assam, M)

Policymakers may also be able to play a role in approaches. Methodological triangulation of the interview data supports the need for approaches to strengthen the use of evidence to not solely focus on policymakers as the target audience. As mentioned in the Actors Chapter, two separate reports of attendance from the 2017 'Transforming Food and Nutrition Landscape in Assam' policy seminar disclosed that officials presented key statistics to other stakeholders.[14]

8-4. Communication

Participants discussed the different ways in which evidence can be communicated as part of any approach, including from and to whom, range of media that can be used, and how it can tailored for different audiences.

8-4.1 Direction of communication

Participants felt that the transfer of evidence should not be uni-directional. Genuine multi-directional communication involving listening, as well as disseminating evidence, was seen as key to effective

[14] Although in a different, but related, field, similarly to mental health nutrition falls under the Health and Family Welfare Department of the Government of Assam.

approaches. Researchers specifically were said to need to place more emphasis on listening, as well as the ability to present evidence.

"How do we have then a communication with groups who do not privilege or prioritise knowledge that way we do? So that requires enormous flexibility among the researchers ourselves, it needs for us to be more humble, it needs for us to be more listening, and it needs for us to be able to engage with people who might strike as being too, you know, indifferent, arrogant, etc." (researcher – national, M)

The need for interactive approaches that involve multi-directional communication dialogue among all stakeholder types, as opposed to the conventional one-way dissemination of evidence, was highlighted as being central to any approaches, including both policymaker and community-targeted approaches.

"We need to stop imagining passive exchange of evidence, between one group with another group, we need to talk about dialogue and conversation together with bureaucrats or ministers or officials, etc. So potentially workshops, you know, iterative workshops which together discover, create an agenda is much better than interviews or one-on-one conversations with, you know, very senior authorities. Or maybe both?" (researcher – national, M)

Although an interactive approach with communities being listened to, due to the stigma surrounding mental health, participants reflected that stigma reduction strategies that are more educational are also needed:

"It's that process of getting someone to think differently that often becomes very, very challenging" (intermediary – Assam, F)

8-4.2 Medium of approach

For facilitating more effective engagement of stakeholders with evidence, gaining the interest of people was considered an important first step: *"Once you have curiosity you have the people"* (intermediary – Assam, F). The medium of the approach was reported to be a key determinant in the effectiveness of the approach. Use of multiple concurrent media was proposed to be useful for both evidence dissemination, as well as interactive approaches. In particular, the arts was a medium that participants highlighted to be of potential use. Spoken word poetry and theatre are two forms that participants have considered to have been used successfully for awareness and engagement activities with communities. The responses to the online survey added support to the use of folk theatre in Assam due to their *"great acceptability in the region"* (researcher – Assam, F). An advantage of performance arts is said to be that they evoke reflection from the audience:

"So you go back home thinking, oh, this poem talked about something that I did not observe before[…] these performance arts pieces is to sort of, that made the reader, made the audience ask those questions, which are like those questions about mental health." (intermediary – Assam, M)

Online technology is a new medium of communication that participants stated allow them to disseminate evidence more easily and quickly than relying on print media. Social media, in particular, was highlighted as a vital channel allowing a wide range of people to be reached, especially the younger demographic:

"Because our generation of people are very fast forward, or like fast paced, and like social media and that, so I think it's very important to use that tool of social media to sort of reach out to people." (intermediary – Assam, M)

The online survey provided more nuance to the findings from the interviews. Academic publications are perhaps not as useful as they could for informing agenda-setting in their current guise, which is not tailored for this purpose. Nevertheless their importance was still stressed. It thus appears that there is the potential for academics and academic literature to have a greater impact, and the style in which articles and other outputs are communicated is an area for improvement that has been highlighted.

"Journal articles are very necessary, but to a large extent they remain in the academic level. At times I feel that the whole exercise is done to achieve academic achievement only. Very true for Assam." (intermediary – Assam, M)

8-4.3 Style of communication

As well as the medium, the style or language used was deemed important. For community-targeted approaches, the need to use, and adapt, materials to the language and dialect of the community was seen as vital. Furthermore, a current criticism of researchers by intermediaries is that the terminology used was often too technical or archaic, with a need for simple, clear language to ensure that the message is understandable. The below quote also implies there are unequal power relations whereby social norms suppress certain groups, in this instance junior individuals, from raising issues with researchers who are seen to be in power. Approaches that involve researchers and intermediaries working together need to ensure an environment conducive to the frank and free-spoken input of both parties in order to maximise the benefits of collaborative working:

"I don't know like this maybe controversial thing to say but I think our academics[…] should sort of do away with a lot of jargon that they have[…]so that a layman could understand the research better." (intermediary – Assam, M)

As well as language, how ideas are framed were said to be important. This is to make sure that evidence is relatable to diverse communities in Assam, especially rural village communities and middle-aged residents. It was suggested this can be achieved by using examples, in their dialects, that reflect their lived experience and with which they can identify. By making 'mental illness' less frightening and more relatable and mundane, communities are more likely to become curious about, and engaged with, topics:

"You can't impose, you know, a very foreign language or a very foreign idea on people who have never heard of it, so if you start using jargon, like you'd be "okay, you have depression", they'd be like "no, I'm just feeling sad" because that's what I understand[…] But if I can break through that communication barrier by using their own examples, using their own language and dialects and the way that their lived experiences look like to them, I think that just helps all of us more to get along and it doesn't become the scary thing anymore, it just becomes a different thing, which kind of also then spurs curiosity." (intermediary – Assam, F)

Effective communication was said to be possible. An example provided of a successful initiative was Barefoot Counsellors run by MIND India where a team of women were trained to engage with communities with regards to gender-based violence. However, this tailored communication and advocacy was said to be a *"huge project"* (intermediary – Assam, F) and a very time and resource intensive endeavour. Sufficient time is also required in order to gradually sensitise communities to mental health:

"We try and kind of engage the participants and the audience and gently and subtly." (intermediary – Assam, F)

Although the use of some media types (e.g. social media and the arts) were seen as having the potential to engage some groups better with evidence, they could further marginalise others without access to such technology. Therefore, some participants exercised caution and stressed the need to remain cognisant of not further entrenching already existing inequalities in access to evidence and engagement in the policy process. Without strategies in place, *"the arts otherwise becomes very, very exclusive"* (intermediary – Assam, F).

Participants drew inspiration from approaches in other areas of health. For example, community-targeted approaches were seen to be necessary throughout the policy cycle, and not just agenda-setting, including the implementation of policies and participants saw these process developed better in relation to other health issues:

"The polio policy that they have, and they have like a great like, you know, campaign about it, the Pulse campaign and they got like big actors and all of that to kind of go through to villages, and like

it was a great, well done campaign so that we nearly have, like we slashed the polio statistics." (intermediary – Assam, F).

The effectiveness of approaches that aim to improve the communication of evidence, have not necessarily seen to be successful to date in raising mental health on the policy agenda. Participants often used the prioritisation of mental health as a proxy measure of the extent to which evidence was used to inform the agenda:

"I just think it's not a priority. It's as simple as that. That no matter how many like social media campaigns have come up now or like small NGOs [non-governmental organisation] have come up to talk about mental health, the state has not prioritised mental health as one of its aim." (intermediary – Assam, F)

8-5. Discussion

The significance of the findings will be discussed in relation to the literature, followed by the resultant implications for theory and practice.

8-5.1 Reach of approaches

A key finding of the current study is that approaches to strengthen the role of evidence in mental health agenda-setting in Assam need to focus on communities in addition to policymakers as users of evidence. A refined typology of approaches is therefore proposed. Considerations of relevance for approaches that target different audiences, including communities, are then examined.

8-5.1.1 A typology of approaches to strengthen the role of evidence in agenda-setting

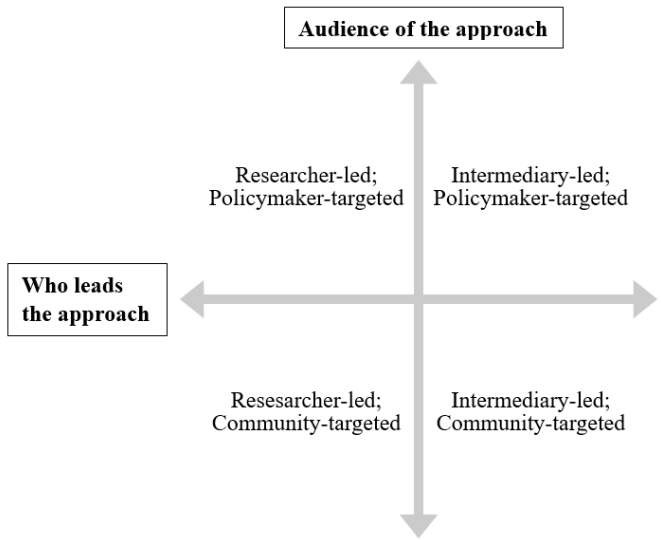
As outlined in earlier in Figure 27, the prevailing categorisation of approaches used to strengthen the use of evidence in health policy is based upon the direction of the demand for, and transfer of, evidence occurs. The three main categories are approaches: (1) 'push' approaches from researchers to users; (2) 'pull' approaches from users (predominantly policymakers) to researchers; and (3) linkage approaches that connect researchers and users (including through the use of intermediaries and formal processes and platforms) where the transfer of evidence is multi-directional (Gold, 2009; Lavis et al., 2006).

Despite representing approaches that focus on both increasing the supply and demand of evidence, all three categories of approaches focus on communicating and promoting the use of evidence to

policymakers. Users of evidence are predominantly considered to be policymakers when categorisations are specifically applied to just policymaking (Gold, 2009). Other users, including patients and healthcare professionals, have been recognised to some extent where the categorisations are to strengthen the use of evidence for 'action' more generally, however the different users of evidence still do not feature in the categorisation (Lavis et al., 2006). The findings of the current study suggest that the categorisations are needed to reflect the different mechanisms by which evidence use is strengthened for different users.

From the analysis, a new categorisation of types of approaches for strengthening the role of evidence in agenda-setting was developed (as shown in Figure 28). Approaches were categorised along two axes according to: the audience (user of evidence) and who the approach is led by. Four types of approaches were included in the categorisation: policymaker-targeted researcher-led; policymaker-targeted intermediary-led; community- targeted researcher-led; community-targeted intermediary-led. These are not mutually exclusive categories. Rather, approaches lie on a continuum; researchers and intermediaries can work together and/or target policymakers and communities. Whilst a greater range of approaches exist, for example policymaker-led approaches, the proposed categorisation includes only those approaches which participants viewed as feasible. It is important to consider local communities alongside policymakers due to their potential role and influence on the agenda-setting process. Therefore, they are key potential users of evidence in the agenda-setting process. According to Kingdon's multiple stream model which explain agenda-setting, when the problem, politics, and policy streams join together, a window of opportunity for an issue to make it into the policy agenda is created. The problem stream, encompasses the policy issues that have received public attention, and thus communities are pivotal to agenda-setting (Kingdon & Stano, 1984).

Figure 28. Categories of approaches for strengthening the role of evidence in agenda-setting.



This categorisation developed by the current study differs and extends the predominant categorisation (Figure 27) used in the field of health policy that focus on the direction by which evidence is transferred by the approach (Gold, 2009; Lavis et al., 2006): The direction by which evidence is transferred is still captured by the categorisation proposed by the current study, however the current study does not assume that the start (who the approach is led by) and end (who the intended audience is) points are the same. Thus, the new categorisation captures and extra level of detail to the conventional categorisations.

Whilst the basis for the prevailing categorisations, the direction by which evidence is transferred, is still captured by the categorisation proposed by the current study, not all types of approaches are retained as they were not deemed to be significant by participants. 'Pull' approaches, where the transfer of evidence is led by users (predominantly policymakers) to researchers were not seen as a significant type of approach by participant and are therefore not included in the updated typology of approaches. As mental health is not currently seen as a priority in Assam, policymakers were not seen to be actively seeking evidence. These, however, may become more relevant in the future if mental health moves higher on the policy agenda in Assam and thus the interest in, and demand for, evidence by policymakers may increase.

Linkage approaches that connect researchers and users (including through the use of intermediaries and formal processes and platforms) were seen as significant by participants, but especially intermediary-led approaches. The current categorisation further disaggregated intermediary-led approaches by those targeting policymakers and those targeting communities. However, for agenda-setting, participants largely felt all approaches should be interactive in order to be effective, with the discussion of evidence being key. Whilst an element of a didactic approach was still considered as important for certain aspects of strengthening the use of evidence, especially with regards to awareness raising and stigma reduction, the current study strongly supports the recommendation for collaborative approaches.

8-5.1.2 Evidence has multiple users for agenda-setting

Previous chapters have highlighted the importance of communities in the agenda-setting process (see Chapter 5). A key finding of the current study is that, where relevant, users need to demand changes to the policy agenda much more strongly and to draw on evidence to make their case. The current study therefore extends the findings of previous research, by recognising that for agenda-setting the 'user' of evidence in policymaking is not only the policymakers themselves but also communities who will ultimately be impacted by the policies made. Communities can bring evidence to the attention of policymakers (see Chapter 6), as well as participating directly in the agenda-setting process. A key finding of the current chapter is that a range of relevant stakeholders agree that the

policy agenda should be co-created and, therefore, that this stage may be one of the most collaborative of the policy cycle, for example more than might be optimal for policy formulation. This highlights how the role of evidence in agenda-setting may be different to the other stages of the policy cycle, and that different approaches that target communities as well as policymakers may be useful.

To effectively target communities as key users of evidence, different approaches to those used with policymakers are needed. For example, community engagement is an essential feature of any community-targeted approach. A systematic review found community engagement in health promotion, research, and policy can lead to improvements in health for disadvantaged populations (Cyril et al., 2015). This was reported to be achieved through a multitude of mechanisms, including genuine power distribution, collaborative partnerships, multi-direction learning, and including community voices in research design. Of interest for the current study is determining what affect community engagement has on the role of evidence. The links between evidence and community engagement has been highlighted using a case study of a project to improve HIV services in South Africa (Colvin et al., 2018). Bringing together a wide range of actors with unconventional forms of health information that are locally relevant, such as testimonials from local service users, was shown to elicit fruitful dialogue and solutions. However, this case study did not look specifically at policymaking and some authors have questioned the extent to which approaches that seek to engage communities in policymaking have resulted in the genuine distribution of power (Head, 2007; Reynolds & Sariola, 2018). The willingness of governments to share power, and the motivation and capacity of communities to participate, are cited as key barriers that need to be overcome (Head, 2007).

8-5.1.3 Inclusivity without exclusivity

Although community-targeted approaches are important, a further finding of the current study is that any approach that involves communities need to be cognisant of, and mitigate, the risk of unintended exclusion of already marginalised groups. Additionally, as discussed in Chapter 5, there is the risk of shifting the burden of solving policy issues onto disadvantaged groups and alleviating the responsibility of those in government. A key finding of this chapter is that some media that use technology and the arts, whilst increasing the engagement of some groups, may systematically exclude others. Digital approaches are being used more widely, both in Assam and in other contexts: a trend which COVID-19 has increased. However, this may bias evidence towards that compatible with technology with which not all demographics are equally comfortable or have access to (Montagni et al., 2019).

Limited research on community engagement has been conducted in Assam. However, a study in the city of Silchar in Assam[15] suggested that, for college students, television has different influences on males and females. Interestingly, for females, watching TV serials were reported to increase social mobility and for females to feel freer to speak in public (Pandey & Das, 2019). This highlights the complexities of the effects of different media.

In order to mitigate some of the issues of the involvement of communities in any approach, other authors have suggested the use of intermediaries may help limit the burden placed resource-constrained individuals and groups (Tebaldi et al., 2017). George et al. (2016) propose that realistic expectations about the roles of communities are needed. Further research is needed to explore what realistic expectations look like in the context of Assam.

8-5.2 Responsibility and ownership of approaches

8-5.2.1 Focusing on adapting evidence not policymakers

To date, research has largely focused on policymakers and how they can make better use of the available evidence. There has been less emphasis on how evidence can be better communicated to meet the needs of policymakers (Meisel et al., 2019). Interestingly, in the current study, participants including researchers emphasised the need for approaches to consider the constraints that policymakers are working under, including multiple policy issues and demands on their time. Therefore, it was recognised by a range of participants that all parties have a role to play in strengthening the role of evidence and not just policymakers. This is despite the limited number of participants from the 'policymaker' category. There is therefore onus on researchers and intermediaries to effectively generate and shape evidence according to the requirements of policymakers and to effectively communicate it, as well as for policymakers to use it. This requires closer partnerships between policymakers, and researchers and intermediaries.

Additionally, top-down mandated imposition of research outcomes have been shown to be ineffective at increasing the use of evidence by policymakers, including at the state level in the US (Purtle et al., 2021). Where policymakers value of evidence, they are more likely to use it. Therefore, approaches should seek to increase policymakers demand for evidence. Although Purtle et al. (2021) focused on policymakers in their study, it appears likely that these findings also apply to other stakeholders and potential users of evidence including communities. Approaches that increase the demand for evidence, when combined with approaches that also reduce barriers relating to the supply of evidence,

[15] The second largest city in Assam.

such as the inclusion of actionable recommendations, are more likely to be most effective and efficient at strengthening the role of evidence in policymaking (Purtle et al., 2021).

8-5.2.2 Role of researchers important but limited

A key finding of the current study is that whilst researchers have an important role in strengthening the use of evidence in agenda-setting, this should be to facilitate the use of evidence by a broad range of groups rather than by using their privileged access to evidence to exert control over how it is used. It has been suggested that acting as ambassadors for local communities is one way for researchers to facilitate the use of evidence for a co-created agenda (Schroth et al., 2020). Issues, and evidence of issues, at the community-level need to be raised higher up at the state-level to influence the policy-agenda. Therefore, Schroth et al. (2020) have proposed that a potential role for researchers is to help shape the abstract potential of local issues into policy solutions in a way policymakers can digest and register as significant. Another role, particularly for research institutions, is that of ambassador at the state and national levels due to their power facilitating dialogue and the sharing of evidence given that local decision-makers may have limited influence outside their community.

Collaborative, bottom-up approaches involving the use of dialogue are reported to be important for the translation of grassroots knowledge and innovation at the community level to that of the organisational level and, ultimately, to the policy level (Narasimhan et al., 2019). To ensure that aims and activities are aligned, it is important to have access to a shared space for stakeholders to meet to reflect and act upon in-depth understanding of local problems utilising both quantitative and narrative evidence (see Chapter 4). Relevantly, this finding was reported from a case study of a non-profit organisation working in the Indian state of Tamil Nadu to deliver mental health services to people living in poverty. Although largely focused on practice, the findings of the present study indicate this also applies to policy processes.

Whilst an element of a didactic approach was still considered important for certain aspects of strengthening the use of evidence, especially with regards to awareness raising and stigma reduction, the current study strongly supports recommendation for collaborative approaches. Collaborative approaches were stressed to enable optimal use of evidence and necessary for effective policies that meet the needs of communities. Moreover, the value of open-ended engagement of communities with evidence has been highlighted by other scholars, from research in South Africa on HIV, due to the freedom for creative solutions to arise (Colvin et al., 2018).

8-5.3 Mechanisms of approaches

8-5.3.1 Multiple components to approaches

A finding of the current study is that approaches which only focus on the communicating evidence between researchers and policymakers is unlikely to be sufficient to strengthen the use of evidence in agenda-setting. Communities are, as identified by the current study, potentially important users and intermediaries of evidence and this needs to be reflected in any approach used. For evidence to inform the agenda-setting process, approaches need to focus not only on better communicating evidence but enabling stakeholders to be able and wanting to use evidence.

Other scholars have started to include approaches with aims other than the communicating of evidence, for instance, increasing the uptake of research evidence for health policy in LMICs, Erismann et al. (2021) propose three approaches that focus on stakeholder involvement: (1) well-informed policymakers seeking evidence; (2) engaging stakeholders throughout the research process; (3) co-creation and equal partnerships. Whilst the first two map to approaches led by policymakers and researchers, respectively, the third represents a fundamentally different approach: enhancing stakeholder engagement. Stakeholder engagement does not directly strengthen the use of evidence in policy. Nonetheless can indirectly contribute to efforts by positively influencing the actors and context involved.

The current study further extends the different types of approaches that can strengthen the use of evidence in agenda-setting. From the analysis three direct and three associated indirect approaches were identified. Table 16 below depicts these approaches, and also conceptualises how indirect approaches can support the direct approaches. Direct approaches specifically impact the use of evidence in agenda-setting and focus on ensuring evidence is communicated to all relevant parties, including communities, for agenda-setting. Indirect approaches, whilst by themselves won't necessarily lead to the strengthening of evidence in agenda-setting, will support the direct approaches to do so. These approaches focus on fostering a conducive environment for the use of evidence.

Table 16. The different focuses of approaches to strengthen the use of evidence in agenda-setting.

	Direct Approach to strengthen the use of evidence in agenda-setting – Aim (and examples)	*Associated Indirect Approach – Aim (and examples)*
1.	**More trusted sharing of evidence** E.g. Innovative approaches to more effectively communicate evidence such as online knowledge platforms	**Strengthen stakeholder relationships** E.g., Networking
Intended influence on evidence use in agenda-setting	Increases the likelihood that evidence which is shared with stakeholders will inform agenda-setting. Who shares the evidence is important, rather than just evidence per se	Enables evidence to be shared more effectively through trusted relationships and used within stronger, collective movements.
2.	**Share evidence more widely**, including with communities E.g. community-targeted approaches and community engagement	**Capacity-building** E.g. skill development workshops
Intended influence on evidence use in agenda-setting	Effective agenda-setting is a collaborative process with a diverse group of people; evidence can facilitate community agency to draw attention to local issues.	Ensure users of evidence have the tools to influence the agenda-setting process.
3.	**Increased stakeholder engagement** (in research and policy) E.g. Community participation in research	**Reduce stigma** (of policymakers and communities) surrounding the policy issue E.g. Awareness raising
Intended influence on evidence use in agenda-setting	In policy: communities can influence the agenda as users of 'evidence'; communities can contribute informal evidence based on personal experience. In research: facilitate research evidence reflecting community priorities and lived experience.	Facilitates community engagement with mental health policy and research; strengthens the use of evidence by stakeholders through evidence-based information and openness to examining one's potential prejudices.

From the analysis, three direct approaches which were seen as important by participants were identified. First, more trust sharing of evidence, that aims to increase the level of trust that stakeholders place in the evidence as well as just awareness of the evidence, increases the likelihood that likelihood that evidence which is shared with stakeholders will inform agenda-setting. Second, sharing evidence more widely increases the range of stakeholders that can use it to inform and influence agenda-setting. Third, increasing stakeholder engagement in research and policy gives stakeholders greater opportunities to shape and use evidence in agenda-setting.

However, it also emerged from the analysis that these direct approaches by themselves may be insufficient and that the effectiveness of these approaches may be improved through the concomitant use of indirect approaches, which were assigned an equal level of importance by participants. Indirect approaches work to strengthen the use of evidence by focusing on the environment in which evidence is used. By reducing stigma, and increasing the awareness of mental health issues, communities can become motivated and interested to engage with the agenda-setting process. Once engaged, communities are important users of evidence in the agenda-setting process and can bring valuable informal evidence based on personal experience into the process that was previously inaccessible to other stakeholders. By building the capacity of communities and strengthening the relationship between communities and the other policy actors (including researchers, policymakers, and intermediaries), enables communities to leverage their influence in the agenda-setting process. Consequently, evidence can be used to ensure community priorities are reflected more strongly in the policy agenda: a need identified by the current study.

The three indirect approaches identified may help all of the direct approaches, for example approaches that seek to reduce the stigma associated with mental health may also help facilitate evidence being shared more widely. However, only the strongest links as inferred from the participants responses are shown in the table. Taken together, these direct and indirect approaches not only seek to increase the use of evidence, but that evidence is used to ensure community priorities inform the agenda much more strongly. To enable this, all these six approaches to some extent include a focus on engaging potentially influential communities.

It should be noted that each individual approach is also complex in nature. For instance, interestingly, negative attitudes to mental health do not necessarily correlate with knowledge and exposure to people with mental health problems (Borooah & Ghosh, 2017). As a result, efforts to reduce stigma are unlikely to be straightforward.

8-5.4 The power of storytelling

Throughout the different approaches, a recurrent theme is the importance of storytelling as a potentially useful means of sharing and communicating evidence. Personal and community narratives were identified in Chapter 4 as an important form of informal evidence for policymaking, especially when used alongside formal research evidence including statistics. Storytelling as a means of sharing evidence has been argued to have strong potential to improve attitudes and behaviour around public health issues (McCall et al., 2019). For mental health in Assam this is particularly important due to lack of awareness and stigma: key reasons why mental health is low on the policy agenda.

A key finding of this chapter is that the way these stories are told is central to determining the story's influence on agenda-setting. There is a limited, although growing, body of research on storytelling as an approach in policy agenda-setting (McCall et al., 2019). In the main it is the grey literature that can provide inspiration as to innovative, interactive and creative storytelling approaches via successful case studies (Davidson, 2017) as well as practical advice. A story which highlights or solves a problem can be effective, and for example visual storytelling can be used to attract media attention and add credibility to evidence on neglected policy areas previously disregarded by policymakers (Davidson, 2017).

Other scholars argue that to enhance the persuasiveness of a story communicating research evidence it should have dramatic structure and timing (Thomson et al., 2007). These desirable features may explain why performance art was proposed by participants in the current study as a potentially useful storytelling medium. However, we must be cautious emphasising this medium due to the small sample size of the present study and discussion of the use of storytelling was largely focused upon community-based approaches. Other research has suggested that storytelling is also an effective approach directed towards policymakers, but that the effectiveness of different stories varies between different individual policymakers (Thomson et al., 2007).

8-5.4.1 Non-traditional media

The emergence of social media as a potential channel for sharing and using evidence was recognised in the current study and by other scholars (Grande et al., 2014). However, at present, there is limited evidence as to how social media might influence health policy (Roland, 2018) and therefore little guidance to draw on. Creating guidance is important because stakeholders, particularly in LMICS, are often unfamiliar with social media, for example as highlighted recently by the COVID-19 pandemic (Mahendradhata & Kalbarczyk, 2021), particularly since there are potentially negative consequences related to social media, such as trolling where people intentionally create conflict.

Other non-traditional media have been used by academics for the purposes of health policy impact in other contexts. For example, in South Africa, another context where stigma is prevalent, a role-play board game was used a creative tool for HIV advocacy to facilitate discussion and empathy among stakeholders of (Tran, 2016). When used alongside a more traditional, complimentary approach, such as a report, non-traditional media can be effective and warrants further research.

8-5.4.2 The process is as important as the outcome

A key finding of the current study is that the development of approaches can also aid strengthening the use of evidence, through researchers and intermediaries working together and developing relationships, as well as through the sharing of evidence. Although partnerships between community organisations and researchers are recognised as valuable, other scholars have recommended that community organisations in India should consider a number of factors before deciding whether or not to partner with researchers (Pratt et al., 2020). These were based on the experience on the involvement of a community organisation representing the indigenous population with a research project on safe motherhood conducted by local researchers. Factors advised to consider include: whether the project aligns with the mission of the community organisation; the extent of participation and joint decision-making; and the understanding of, and commitment to solving, issues faced by the community. These insights may be useful to consider when developing approaches to strengthen the use of evidence for setting the mental health policy agenda as in the current study, several community organisations in Assam expressed an interest in working more closely with researchers.

8-5.4.3 The Storyteller

A finding of the current study is that approaches using multiple media are likely to have value. This is in line with research for other policy areas in different contexts. For example, a common attribute of approaches to strengthen the use of evidence in social policy, at least in the US, is to draw out a simple, accessible, and relevant message from the research that can be communicated via multiple channels and media (Ashcraft et al., 2020). The current study identified a need to present evidence sensitively to policymakers. This has also been reported for child mental health research in the US policymaking context due to the potential for policymakers themselves to exhibit stigma towards mental health (Purtle et al., 2020).

In Chapter 5 it was reported that the format in which evidence is conveyed, including stories, is important. In contexts where there are competing narratives, for example from industry and health advocated such as tobacco control in New Zealand, there is a need for exceptional storytellers to communicate the health message (Thomson et al., 2007). This is very relevant to mental health

policymaking in Assam given that research can sometimes seem to compete with stories rooted in traditional beliefs.

8-5.5 Implications for theory and practice

An implication for theory is that a different categorisation of approaches that seek to strengthen the role of evidence in agenda-setting are likely to be significantly different from those focusing on policymaking in general, or on the other stages of policymaking such as policy formulation. Agenda-setting should have multiple 'users' of evidence, not just policymakers. Consequently, an implication for practice is that the aim of approaches should be to facilitate the use of evidence in co-created agendas with multiple stakeholders. In particular, although policy-targeted approaches are important, approaches also need to be aimed at communities. Approaches also need to have a broader range of aims. For example, as well as communicating evidence, successful approaches will need to include other components such as stakeholder engagement and awareness raising which support the main aim.

Other implications for practice include that, although researchers have an important role, researcher-led approaches may not always be the most effective. Researchers should focus on sharing evidence and facilitating the engagement of other stakeholders in the process, particularly communities and intermediaries, rather than controlling how evidence is used and determining the outcome of the process. This requires a focus on creating an evidence-informed policy dialogue, rather than evidence-informed policy, may be useful and lead to a focus on sharing power among stakeholders. Moreover, whilst the use of evidence cannot be strengthened without sharing evidence with communities, care needs to be taken when working with disadvantaged, communities. Finally, a range of innovative media with potential to communicate stories, including creative and technological media, were identified in the current study. These warrant further exploration to assess their usefulness and to ensure that they do not further exclude marginalised groups.

8-6. Conclusion

Different types of approaches to strengthen the role of evidence in agenda-setting were identified. They could be broken down according to whether they target policymakers or communities, and whether they are led by researchers or intermediaries. Communities, and not only policymakers, were seen as key potential users and brokers of evidence. In order to utilise the potential power held by communities, approaches were also seen to also need to target communities to a greater extent, and these are likely to be different to those that effectively target policymakers. Three key direct approaches were identified: (1) more trusted sharing of evidence; (2) share evidence more widely; and

(3) increased stakeholder engagement. These approaches by themselves are likely to be insufficient without recognising the wider environment in which evidence is used. Therefore, a further three key indirect approaches were identified that will support the direct approaches by providing a conducive environment in which evidence can be used: (1) strengthen stakeholder relationships; (2); capacity-building; and (3) reduce stigma.

Common to all types of approaches were the need for genuine multi-directional communication, that is accessible and relatable to all. Storytelling, using various creative and technological mediums emerged as a potential approach to be considered, although there is the potential for negative unintended consequences and should be used carefully especially there is scant literature about what is known from other contexts. The process of developing stories will itself lead to greater sharing and discussion of evidence among stakeholders, irrespective of the outcome. Key to the success of storytelling, and other approaches, are the individual storytellers and conveyors of evidence.

CHAPTER 9: DISCUSSION - Broadening considerations of evidence and its use in agenda-setting

First, to recap, the key findings from the proceeding results chapters will be summarised. Second, this Chapter will subsequently present a synthesis of these findings. Third, the implications of these findings for theory and practice will then be discussed, along with, fourth, the strengths and limitations of this study. This will enable, fifth, at the end of this Chapter, an assessment of the extent to which the research question has been answered.

As set out in the Introduction Chapter, the research **question** this study aimed to answer was: "*To what extent, and in what ways, does research evidence inform the mental health policy agenda in Assam?"* Hence, the **aim** was to create an in-depth understanding of the extent and ways in which research evidence informs the mental health policy agenda in Assam.

9-1. Summary of Findings

In this thesis, in the absence of an appropriate framework, a meta-framework was developed from a *review of reviews*. This framework drew together the large number of general health evidence-to-policy frameworks, adapting it for mental health agenda-setting in LMICs by using insights about what is known mental health as a policy issue and these contexts. The framework consisted of five components (evidence, actors, process, context, and approach). Additionally, four cross-cutting dimensions were identified: (1) capacity; (2) trust and relationships; (3) power and politics; and (4) beliefs, values, and interests.

In the preceding results chapters, based on each of the five components from the framework, a discussion sub-section encompassing the significance of the findings in relation to the literature was incorporated. These findings are summarised here:

The key findings for *evidence* were the potential role highlighted for informal evidence, such as narratives, alongside other types of evidence, such as formal scientific evidence, to inform agenda-setting. The potential role of informal evidence can be both direct and indirect. An example of a direct role is its use in informing policy decisions and ensuring community priorities inform agenda-setting in Assam much more strongly than at present. It can be used in an indirect way by making the wider policy environment more conducive to the use of evidence - for example, by reducing stigma.

The key findings for *actors* were the importance of considering and sharing evidence with the full range of actors, including communities who have a large amount of potential influence. Mental health stakeholders are divergent, and individuals can be hugely influential. Nonetheless, how actors work together is equally important; collectively institutions and communities, consisting often of individuals with limited voice, can exert much power. Power imbalances are often exacerbated by the tendency to rely on personal networks in the absence of formal networks, and this limits evidence sharing.

The key findings for *process* were that raising mental health on the policy agenda too quickly was cautioned to not necessarily be desirable be the goal, as this can lead to subsequent policy formulation being rushed with less stakeholder engagement and a limited extent and range of evidence used. Sustained, inclusive stakeholder engagement in the process was seen as important for communities to be able to utilise evidence, for evidence from these groups is possible to be incorporated, and for policy agendas to be reflective of community needs.

The key findings for *context* were that multiple levels of context, and how they operate together was seen to be important, particularly so given the complex federal and state roles as well as the socio-cultural component of mental health. Furthermore, stigma was seen to influence how actors trust, interpret and use evidence. For Assam, the heterogeneity within the state poses a further challenge to the genuine, inclusive engagement of communities in the policy process, and community-directed approaches, to strengthen the use of evidence for setting the mental health policy agenda.

The key findings for *approach* were that communities should be targeted to a greater extent, as well as policymakers. Three key direct approaches were identified: (1) more trusted sharing of evidence; (2) share evidence more widely; and (3) increased stakeholder engagement. These approaches by themselves are likely to be insufficient without recognising the wider environment in which evidence is used. Therefore, a further three key supporting indirect approaches were identified: (1) strengthen stakeholder relationships; (2); capacity-building; and (3) reduce stigma. Common to all approaches was the need for genuine, accessible, multi-directional communication. Storytelling emerged as a potential approach; the process of developing stories will itself lead to greater sharing and discussion of evidence among stakeholders, irrespective of the outcome.

9-2. Synthesis of findings

The key findings, as stated above, in relation to each of the five components will now be considered in relation to each other. As emphasised in the conceptual framework developed from the literature review, as well as understanding each individual component (evidence, actors, process, context, and

approach), how the components link together is important in understand the role of evidence in agenda-setting. This approach was supported by the empirical findings of the current study, which found the role of evidence in agenda-setting is complex, and needs to be considered along with actors, process, context and approach. Other scholars in the field of mental health have also begun to note the importance of how the different components operate together through the emergence of the field of mental health ecosystems research, which incorporates understanding evidence-to-policy (Furst et al., 2021).

The analysis of the interviews revealed that all five components were highly interrelated, in particular *evidence*, *actors*, and *approach*. A key finding was that *evidence* from, and used by, a wider range of *actors*, including communities needs to inform the policy agenda in Assam. A range of direct and indirect *approaches* were identified in order to effectively reach these audiences for this broader use of evidence.

The synthesis, however, of the findings developed an understanding of the *nature* of these interrelationships. Other authors have argued the health policy appropriateness of *evidence* depends upon the established *actors* and how they operate, and how contested the policy issue is, and that this is relevant for any *approaches* used to strengthen the role of evidence (Walls et al., 2017). The current study argues that for agenda-setting there is a need to consider stakeholders with potential influence but that are currently not engaged when considering the relevance of evidence. In addition, in order for these approaches to be successful, they also need to be designed with an understanding of the *process* and *context* in which evidence is used, described by other authors as to "balance inputs to assemble the evidence jigsaw" (Oliver & Pearce, 2017).

In order to further develop understanding of the *nature* of the interrelationships between components, the cross-cutting dimensions from the meta-framework were used to guide the synthesis. The meta-framework was developed from a review of the literature, along with insights about what may be learnt for mental health agenda-setting in LMICs from these fields, and consisted of five components (evidence, actors, process, context, and approach). Additionally, four cross-cutting dimensions were identified: (1) capacity; (2) trust and relationships; (3) power and politics; and (4) beliefs, values, and interests.

A plethora of links between the components were identified. The cross-cutting dimensions were helpful to emphasis the finding of the importance of the outer components of the meta-framework (i.e. all those apart from evidence – actors, process, context, and approach), and perhaps more crucially illustrate the ways in which these outer components influence the use of evidence.

Although the cross-cutting dimensions linked all five of the components, they were particularly poignant for *approaches*: all four of the cross-cutting dimensions were apparent in and map onto the *approaches*, direct and indirect, to strengthen the use of evidence in agenda-setting identified from the

analysis (as shown in Table 17). Thus, this highlights the importance of importance of holistic approaches which consider the whole ecosystem, including all components and interrelations. Approaches reflect how it is understood that the ecosystem can be affected, and hence operates.

Table 17. Cross-cutting dimensions and their relevance to approach.

Approach to strengthen the use of evidence	**Cross-cutting dimension**
Capacity-building	*Capacity*
More trusted sharing of evidence & strengthen stakeholder relationships	*Trust and relationships*
Share evidence more widely & increased stakeholder engagement	*Power and politics*
Reduce stigma	*Beliefs, values, and interests*

Each of the cross-cutting dimensions will now be discussed in more detail.

9-2.1 Capacity

Capacity is a broad term that is consequently rarely explicitly, and often loosely, defined, including when used in evidence-to-policy. To help distinguish what is meant by the term, in this thesis it was taken to specify the capacity of whom and at what level, as well as what capacity need is important - tools; skills; staff and infrastructure; and structures, systems and roles (Green & Bennett, 2007). Policy capacity has been argued to be essential for evidence to be used in health policy (Forest et al., 2015).

In the meta-framework developed from the literature review, capacity linked *actors* and *process* together: Actors' capacity is a key determinant of their involvement in the policy process. On the other hand, involvement in the policy process can magnify actors' capacity to engage, such as through increasing their experience and skills. However, the empirical findings research of the current study highlight that capacity is an important component of *approaches*, and identified this as a key indirect approach.

9-2.1.1 Capacity needs for the use of evidence vary among stakeholders

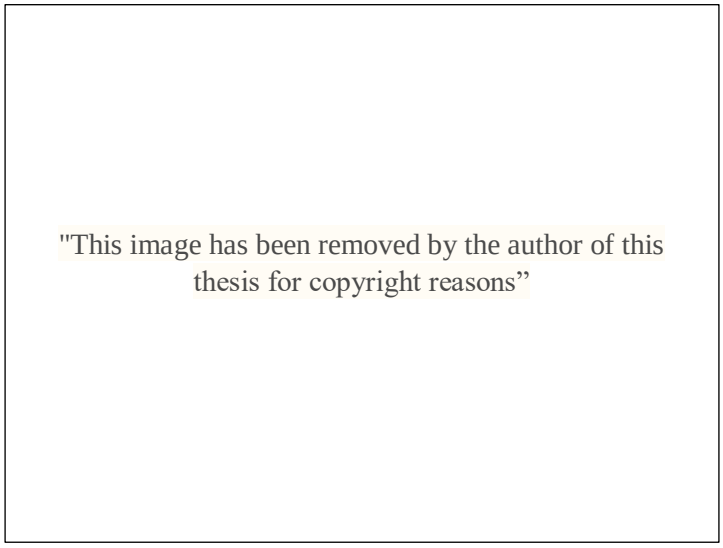
From the analysis, a key finding was that the sustained involvement of a range of *actors*, including communities, in the agenda-setting *process* was said to be crucial for the use of evidence. However, capacity was highlighted in the actors chapter as a key barrier to the engagement of all stakeholders in the process and their use of evidence in agenda-setting *processes*, as well as in *approaches*, despite often high levels of motivation.

Whilst the need for greater capacity for strengthening the use of evidence in policy has been well documented (Oronje et al., 2019), it is important to untangle what is meant by capacity and develop a

more nuanced understanding. In a similar fashion to the range and broadness of definitions found in the literature, it was apparent that in the current study, stakeholder participants used capacity to allude to a range of concepts. In this thesis, capacity was identified as a factor at multiple levels of context; and included both technical skills enabling the engagement and assessment of research evidence, as well as soft skills for the communication of evidence, and resources.

In order to explore capacity in more detail, a conceptual framework (Figure 29) from outside evidence-to-policy was found to offer useful insights. Although not specifically developed for health policy, nor the use of evidence, the Policy Capacity conceptual framework (Wu et al., 2015) offers a useful framework for understanding the different elements of capacity (analytical, operational and political) at different levels (micro, meso, and macro). Analytic capacity refers to technical knowledge and skills; operational capacity includes the co-ordination of efforts and alignment of resources; and political capacity can be considered to be equivalent to policy acumen.

Figure 29. The Policy Capacity Conceptual Framework: A nested model of policy capacity (taken from (Wu et al., 2015))



The Policy Capacity framework also acknowledges the importance of the capacity of a range of actors, not just policymakers. In particular, the framework recognises that the use of evidence involves a range of skills enacted by a range of actors at different levels of context. This is useful for the use of mental health evidence for agenda-setting in Assam, given the finding of the current study of the need for approaches to strengthen the use of evidence to target a wider range of stakeholders.

Moreover, different elements of capacity were emphasised for different stakeholders in the present study. For communities, technical knowledge and skills (analytical) was emphasised, whereas for researchers, who already have a high level of technical knowledge and skills, participants emphasised soft skills (political). For organisations, operational capacity was emphasised. The importance of capacity across the full range of stakeholders has also been recognised by other authors for evidence-

informed health priority-setting in other LMIC contexts, and mobilise their wealth of skills and experience (Li et al., 2017). Given the finding of a high turnover of actors by the current study, it is likely that continual capacity building is needed (Shukla et al., 2014), as well as plans put in place to improve the long-term retention of staff, such as better incentives, and hence reduce the high levels of staff turnover.

9-2.1.2 Capacity building is an important element of approaches

Capacity-building emerged as a key indirect *approach* in this thesis; the need for greater capacity for a full range of actors (not just policymakers) to use evidence to further engage with and use evidence in the agenda-setting process was highlighted. Interestingly, given the findings around the importance of informal evidence in the current study, effective capacity-building has been reported to lead to the greater inclusion of community-based evidence in health planning in Maharashtra, another Indian state, leading to significant positive changes in the health planning process (Shukla et al., 2014).

Due to the range of stakeholders, and their differing capacities, there is thus no single approach to capacity building for evidence-informed priority-setting. A spectrum of activities, rather than discrete approaches, is needed to recognise the roles and skills of all stakeholders, as has been suggested by other authors for LMICs (Li et al., 2017), and recommended by the WHO supported by broader changes, including stronger demands from civil society groups (Green & Bennett, 2007). Nevertheless, soft skills were an aspect of capacity highlighted as important for all stakeholders in Assam by the current study. Other research has highlighted the importance of 'researcher entrepreneurship', the communication and persuasive skills of researchers, as important for *approaches* strengthening the use of evidence in policy processes, including for child health policy in an Indian state, Andhra Pradesh (Sumner & Harpham, 2008).

9-2.1.3 Links to other cross-cutting dimensions

Link to trust and relationships

Interestingly, the current study found that soft skills, an element of capacity, were important in the establishment of trust of between stakeholders, and of evidence, both of which contribute to the trusted sharing of evidence. Other authors have noted that building relationships and trust takes significant capacity (Oliver & Faul, 2018). This is an important part of both policymaker and community-targeted approaches to strengthen the use of evidence.

9-2.2 Trust and relationships

In the meta-framework developed from the literature review, trust and relationships linked *actors* and *approach* together. The empirical findings of the current study strongly support the meta-framework: more trusted sharing of evidence was identified as a key direct approach: and strengthening stakeholder relations was identified as key indirect approach.

The existing literature for evidence-informed policy does recognise the importance of trust and relationships. Largely, although not exclusively, the literature focuses on the relationships between policymakers and researchers (e.g. Campbell et al., 2009). However, the present study emphasises the importance of relationships between a range of stakeholders. Trust has been specifically recognised as important, from the wider public policy literature, both for the relationships between actors as well as more relevantly for the use of evidence within policymaking (Cairney & Wellstead, 2019).

9-2.2.1 Trust of evidence and actors interdependent

In the present study the importance of relationships between stakeholders based on trust featured heavily in participant's responses. The trust placed in evidence was often shaped by the trust placed in the messenger of the evidence. In the literature, a lack of trust between researchers and policymakers with regards to evidence-informed policymaking has been well documented (e.g. Uzochukwu et al., 2016). Unlike previous research, the current study emphasised the importance of trust among a wider range of stakeholders. Moreover, the bi-directionality of this link between actors and approach as displayed in the framework was confirmed and emphasised; both approaches require and can build trust between actors.

This importance of trust among a wide range of stakeholders reflected in the *approaches* identified. More trusted sharing of evidence was identified as a key direct *approach* to strengthening the use of evidence in agenda-setting, and strengthen stakeholder relationships was identified as a key indirect approach, as well as for reducing stigma. These approaches are important for ensuring a range of evidence from different groups and communities is used. In another LMIC context (Burkina Faso), scholars have argued that more hetergoenous networks of actors leads to research evidence being used to a greater extent in polucymaking, due to the increased exposure to new ideas within such networks (Shearer et al., 2018). This findings of this thesis suggest that a more pertinent outcome of such increased exposure to new ideas is the likely increased the use of informal evidence, that which is based on personal experience, arguably to a greater extent.

The inclusivity of relationships and networks important is therefore important; trusted relationships and closed networks that exclude certain stakeholders, whilst may promote the use of certain types of

evidence in policy, can simultaneously constrain the use of evidence, particularly evidence from already excluded groups and thus further exacerbating their lack of inclusion.

Therefore, this thesis supports calls, made outside the field of health policy, but within the broader context of public policy, of the need for approaches to strengthen the use of evidence to consider relationships and networks due to the significant role of networks on the exchange and use of knowledge (Oliver & Faul, 2018; Shearer et al., 2014). Such approaches include identifying existing relationships, as well as creating, maintaining, and using relationships (Oliver & Faul, 2018); networks with a diverse membership are needed for the inclusion of diverse evidence.

9-2.2.2 Trust in the process needed for evidence to then be used in agenda-setting

As well as trust between stakeholders, trust in the evidence generation and policymaking processes appears able to help strengthen the use of evidence in for mental health agenda-setting in Assam. Trust in the process of the generation of evidence was shown in the current study to be important for the trust in the resultant evidence generation. Recently, the importance of trust in evidence generation and knowledge exchange has been recently argued for by other scholars (Cvitanovic et al., 2021). The need for trust in the policymaking process, where evidence is used, was also highlighted by the current study. For stakeholders to engage in policymaking processes, and in any approaches, and therefore be able to use evidence, trust is also needed in policy processes. A lack of trust in policymaking has been shown to be a barrier to the use of research in policymaking in Argentinian health policy (Corluka et al., 2014); the present study extends this finding to informal evidence, that which is based on personal experience.

In Assam, although high levels of trust in the Government of Assam have been reported, simultaneously it has been reported there are low levels of political interest (Renata, 2001). However, this is historical data and must therefore be interpreted with caution. This suggests trust of politicians by stakeholders may not necessarily translate into trust in the process, and that their engagement as stakeholders will be genuine and meaningful. This suggestion is supported by findings from the wider public policy literature where a lack of trust has been reported to lead to disengagement (Institute for Public Policy Research & the John Smith Centre, 2021). In Assam, the constraints on actor's time and resources, as strongly emphasised by participants of the current study, may exacerbate any negative consequences to stakeholder engagement in agenda-setting. This is particularly important given that the involvement of a diverse range of stakeholders in the policymaking process was said to be important for the use of evidence, and increased stakeholder engagement was identified as a key direct approach to strengthening the role of evidence.

9-2.2.3 Links to other cross-cutting dimensions

Link to beliefs, values, and interests

The differences between actors and their backgrounds and beliefs was found by the current study to play an important role in how stakeholders place trust in evidence, other stakeholders, and processes. This finding is supported by another study which argues that how actors form connections is deeply influenced by their beliefs and values (Oliver & Faul, 2018). Given the finding of this thesis of the need for approaches to strengthen the use of evidence for mental health agenda-setting in Assam to target a greater range of stakeholders, this presents a challenge in building trust with a more diverse pool of stakeholders.

Link to politics and power

Political power has been argued to play a key role in relationships (Freudenberg & Tsui, 2014) and in networks (Oliver & Faul, 2018). For the use of evidence specifically, the distribution of power among networks, and which actors are included, is important as it affects the range of evidence accessible to policymakers and stakeholders (Oliver & Faul, 2018). The current study found stakeholders currently relied on personal networks. Interestingly, the formation of formal networks, a demand expressed by several participants, may potentially have negative unintended consequences including the exacerbation, rather than the reduction, of existing power imbalances (Faul, 2016). A lack of trust in the policymaking *process*, discussed above as being important in addition to trust in *evidence*, has also been argued to reflect wider power inequalities in societies (Institute for Public Policy Research & the John Smith Centre, 2021). In order to build trust in the policymaking process, and for this to facilitate a stronger use of evidence, addressing the much greater challenge of reducing societal power imbalances may be required. This lends supports to the indirect approaches proposed by the current study that focus on increasing the engagement of a wider range of stakeholders, including communities.

9-2.3 Politics and power

Power and politics are closely related concepts; politics is sometimes defined as the exercise of power (The Open University, 2014). In the meta-framework developed from the literature review, power and politics linked *process* and *approach* together. Both politics and power have received limited attention by previous health evidence-to-policy research despite growing acknowledgement of their importance. Political factors affecting the use of health evidence in policy are often neglected and little empirical work has been done (Liverani et al., 2013). Likewise, whilst power has been acknowledged as being vital for evidence-informed policymaking (Oliver & Pearce, 2017), power,

however, has not been considered in the development of strategies to support evidence-informed decision-making (Oliver & Pearce, 2017).

The empirical findings of this PhD support the relevance of power and politics for approaches; in the current study sharing evidence more widely, including to communities, emerged as a key direct approach to strengthening the use of evidence by helping reducing power inequalities. In turn this will help engage a wider range of stakeholders in policy processes, enabling then to utilise their power influence.

In order to develop deeper insights on the role of power for evidence-to-policy, two established conceptualisations from the field of development were used. Whilst there is no universal definition of the concept of power, power is often described using Veneklasen's expressions of power: power over; power to; power with; and power within (VeneKlasen et al., 2002). These are often used alongside Gaventa's power cube encompassing the levels (global, national, and local), spaces (closed, invited, and created), and forms (invisible, hidden, and visible) of power, and their interrelationships (Gaventa et al., 2014). These conceptualisations were useful to apply to the current study; power was found to operate in complex and manifold ways.

9-2.3.1 Evidence as power

Understanding how power affects mental health policy agenda-setting in Assam appears to offer useful insights to help facilitate the use of evidence. The findings of the current study suggest that for the prioritisation of issues that reflect community needs, evidence should also be translated to the community, as well as policymakers. Widening access to evidence is therefore likely to facilitate a more equal distribution of power, and enable greater, pro-active, participation of the community in the policymaking process. Ultimately, this may lead to an agenda that is co-produced and reflects the needs and demands of the community. At present communities are recognised of holding a lot of potential power, but are not capitalising upon this.

VeneKlasen et al.'s expressions of power (2002) are of particular interest here, specifically: power to, power with, and power within. Being equipped with evidence, and the skills tools to use such evidence will mean individual community members more capable to act (power to). A wider and more equitable access to evidence will enable communities to collectively act (power with); collective action both within and between stakeholder groups was seen to be key in order to drive change. Recognition of such power is also needed to act and effect real change within their communities through changes to the policy agenda (power within). Recognition of power also appears to be an area for potential improvement in Assam for researcher and intermediaries, as well as communities.

9-2.3.2 Power of stakeholders in agenda-setting

A key finding of this thesis was a need for power to be disturbed more equally across stakeholders, including communities. It has been previously argued by other scholars that the inclusion of stakeholders who are currently rarely heard is needed in order for the generation of research evidence that adequately addresses the policy issue, for agenda-setting in a different LMIC context, maternal health in Timor-Leste (Wild et al., 2015). The current study backs these calls but extends this to the inclusion of these stakeholders in the whole agenda-setting process, in order to facilitate the use of a more diverse evidence for the agenda to adequately address the policy issue.

The spaces and forms of the power cube (Gaventa et al., 2014) were of specific interest to explore here. There were differing views as to the inclusivity of *spaces* of power, some participants saw policymaking as a closed space, whilst others saw it as an invited space that drew in relevant stakeholders. Whilst there was a demand for more formal spaces and platforms which bring together stakeholders, self-created, or claimed spaces by communities were seen as key in order to redress the power imbalance. Importantly for evidence use, this is likely to bring in more diverse, and representative forms of evidence, as well as increasing the extent to which such evidence is used in setting the agenda. Social media was seen as a recent technological advancement that could help enable less powerful actors (communities, and intermediaries) to establish such spaces.

In a similar vein, participants expressed differing views on the *forms* of power to the visibility of formal policymaking processes, i.e. whether agenda-setting take place in open forums. A large amount of power was perceived to be invisible; people may be unaware of their rights and/or ability to speak out. Stigma appeared to be a factor contributing to the lack of visibility of power and the invisibility of power.

9-2.3.3 Links to other cross-cutting dimensions

Link to capacity

Capacity building appears to be a potential way to help create a more equal distribution of power between stakeholders, particularly for communities; the current study identified capacity-building as a key indirect approach to strengthening the use of evidence.

Link to beliefs, values & interests

Beliefs and attitudes can have much power, and when coupled with a lack of awareness can result in stigma (Knaak et al., 2017). Stigma is inherently political, and the political environment has been argued to shape how mental health evidence is viewed (The Lancet, 2019). Power (in the form of

evidence from communities) may help to address stigma; reducing stigma was an indirect approach to strengthening the use of evidence identified by the current study.

9-2.4 Beliefs, values & interests

Beliefs, values, and interests are related, yet subtly distinct concepts; within the field of health systems and policy research values are often defined as the normative beliefs that underlie individual preferences (Whyle & Olivier, 2020). Health systems are conceptualised as social systems, and thus health systems software - including beliefs, values, and interests – are integral to the relatively new and still emerging field of Health Policy and Systems Research (Whyle & Olivier, 2020). Values, in particular, have attracted attention within the literature. But although values are recognised as being integral to health systems, there is much less known about how values shape policymaking (Vélez et al., 2020). It therefore follows that how values influence the use of evidence in policy is also an area that is not yet well understood. An understanding of values has been argued to be of particular importance for LMIC contexts, like Assam, where the 'hardware' is weaker and formal processes and actors are less established (Whyle & Olivier, 2020).

In the meta-framework developed from the literature review, beliefs, values, and interests linked *actors* and *context* together. The context shapes the beliefs, values, and interests of actors that in turn shape how evidence is perceived and used in agenda-setting. In the current study stigma, the negative attitudes associated with mental health, particularly featured and reducing stigma was identified as a key indirect approach. Other authors have recently recognised stigma as a cross-cutting issue for mental health evidence-to-policy (Votruba et al., 2020). A potential explanation for the importance of stigma found in the present study is that, as argued by David (2013), the use of evidence to inform policy is far more likely to face opposition when the policy issue is surrounded in controversy, particularly those related to religion and ethnic politics.

Accordingly, 'The Health Stigma and Discrimination Framework' (Stangl et al., 2019) was applied to gain a deeper and more comprehensive understanding of stigma at multiple socio-ecological levels. The framework includes, although is not limited to: drivers and facilitators; intersecting stigmas; manifestations; and outcomes.

9-2.4.1 Stigma shapes evidence perception and engagement with policy processes

A key finding of this thesis is that stigma is a barrier to evidence-informed policymaking in Assam, leading to low policy priority and ultimately worse outcomes. First, stigma was found to affect how stakeholders engage with evidence at all stages of its use in agenda-setting including evidence

generation as well as how it is perceived and interpreted. Stigma affects all stages, including the generations, interpretation and use of evidence. In line with the diverse context of Assam, particularly socio-culturally, stigma does not, however, manifest uniformly and there is considerable variation in the beliefs, values and interests surrounding mental health between and among stakeholder groups. Such heterogeneity also gives rise to intersecting stigmas, surrounding tribe (including tea tribes), religion, caste, and LGBTQ. This further compounds stigma associated with co-morbidities, including COVID-19.

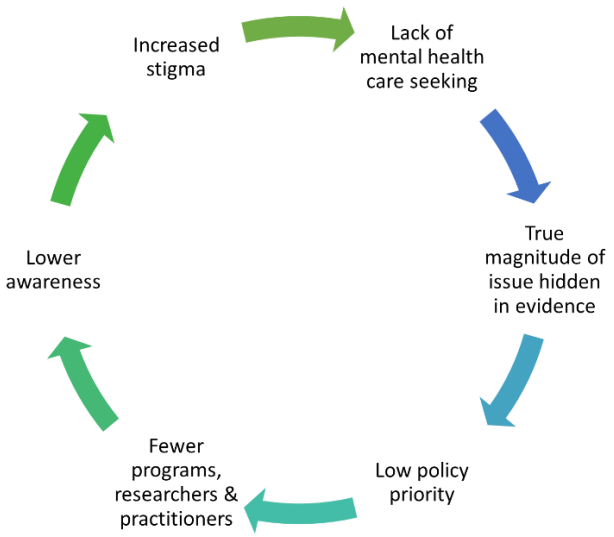
Second, stigma was also found by the current study to manifest as a barrier to stakeholders engaging (with evidence) in the policy process, leading to a lack of public discussions by policymakers and communities. A need for a wide range of stakeholders, including communities, within Assam need to be targeted by approaches to strengthen the use of evidence was identified by the present study, essential to facilitating a co-created policy agenda a need emphasised by participants. In order to engage a more diverse range of stakeholders, stigma must be reduced across all stakeholder groups, including communities. This may be hard to achieve as stigma in the population is reflected and reinforced by policymakers.

Nevertheless, there are encouraging signs of change, and although pervasive stigma appears to be reducing particularly among younger age groups, particularly among the urban youth. Social media was reported to have a key role through awareness-raising by amplifying personal stories and facilitating conversations, as documented by others in the literature (Betton et al., 2015). Social media appears to be a facilitator in that it has the potential to both increase and decrease stigma. Interestingly, there are early indications COVID-19 may be a catalyst for reducing stigma due to the increased issue of and consequent spotlight given to mental health, and this is an area for future research.

9-2.4.2 Stigma acts in a reinforcing cycle for evidence use in agenda-setting

In Chapter 4, the cycle of low policy priority and insufficient evidence was described, and the contribution of stigma was noted. Following the synthesis of the findings, this cycle has been expanded in order to include the role of stigma on the other components of the meta-framework (actors, process, context, and approach). Figure 30 below illustrates the role the stigma plays in how evidence is used to inform the policy agenda.

Figure 30. The cycle of influence of stigma on how evidence is used to inform the policy agenda.



In the framework developed from the literature review, the beliefs, values, and interests cross-cutting dimension, of which stigma forms part of, was conceptualised to act as a bi-directional arrow. However, this may be too simplistic and underplay the role of stigma in the use of evidence for setting the mental health policy agenda in Assam. In order to strengthen the role of evidence, further attention is needed by approaches to weaken the cycle. This reinforces the inclusion by this thesis of stigma reduction as a key indirect approach for increasing the role of evidence. Encouragingly, the current study found that awareness programs have been seen to be successful in reducing stigma, albeit on a small scale. A key recommendation of this thesis is the potential role for informal evidence to capture lived experiences and the use of storytelling to raise awareness in a relatable way to more communities.

9-2.4.3 Links to other cross-cutting dimensions

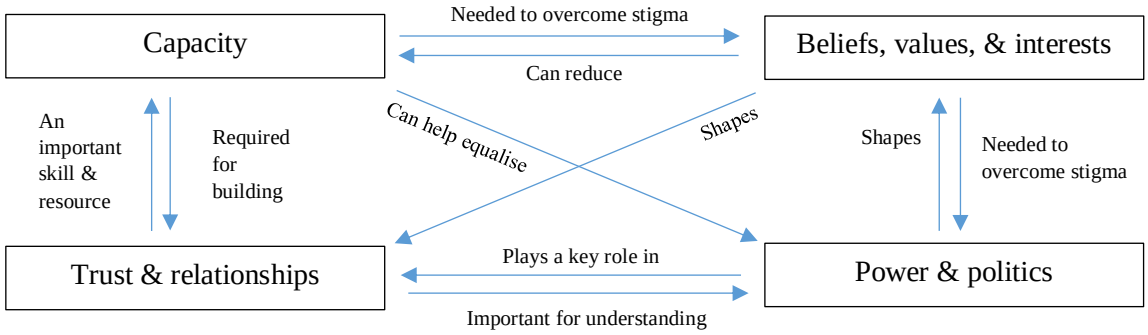
Link to capacity

Significant capacity is needed for effective stigma reduction activities. Whilst current efforts have been seen to be successfully conducted, the extent of these have been limited to date. The challenge is conducting them on a sufficient scale, tailored to a diverse range of people. Thus, due to the socio-cultural diversity in Assam, this will require significant resources including personnel with specialist skills, including language and communication skills. These are not trivial in Assam, a resource-constrained context.

9-2.5 Links between the cross-cutting dimensions

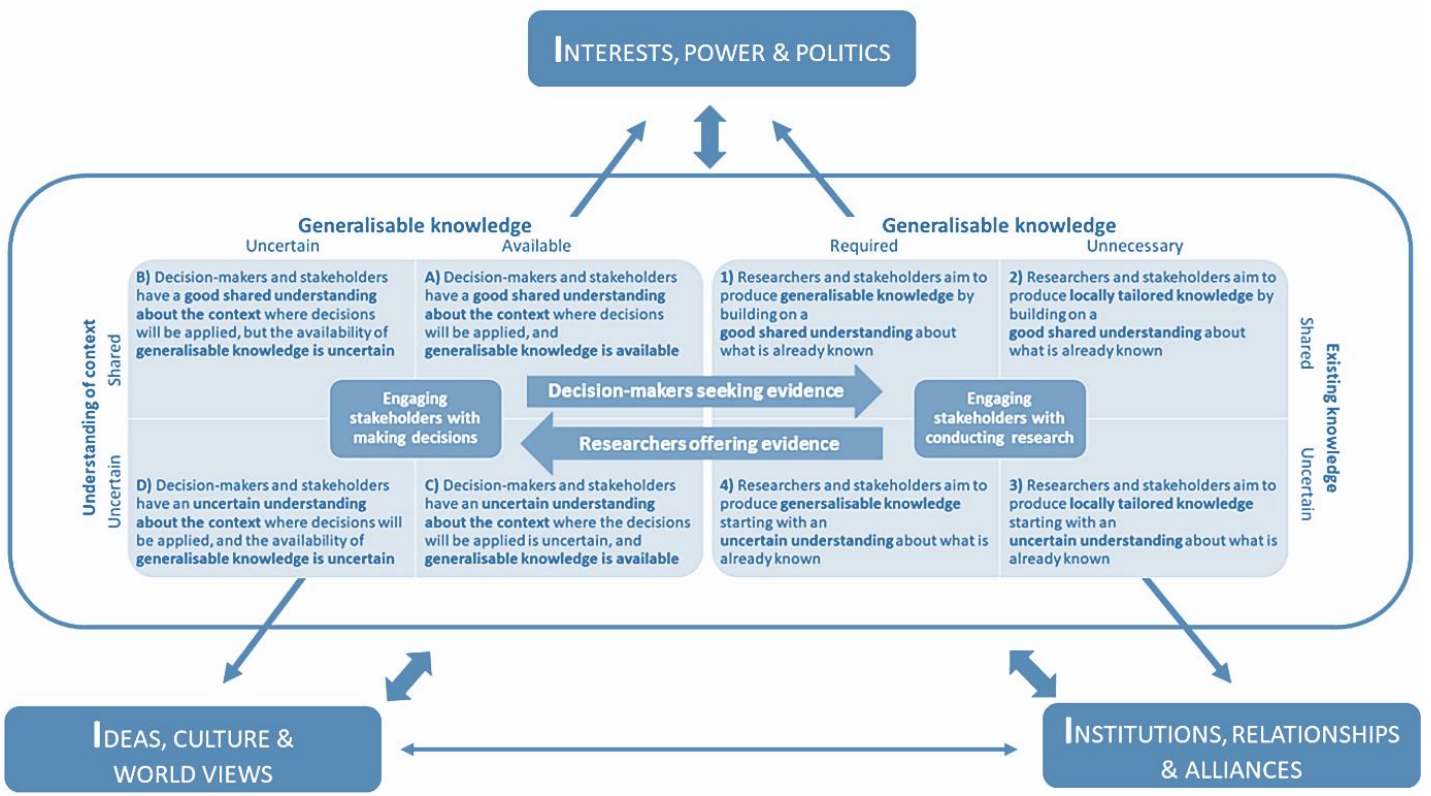
The meta-framework developed from the *review of reviews*, conceptualised the four cross-cutting dimensions (capacity; trust and relationships; power and politics; and beliefs, values, and interests) as stand-alone dimensions that link the different components (evidence, actors, process, context, and approach). From the synthesis of the findings, it became apparent that they cannot be considered in isolation from each other and are highly interconnected. Figure 31 displays the prominent links between the cross-cutting dimensions for the use of evidence for mental health agenda-setting.

Figure 31. Links between the cross-cutting dimensions for the use of evidence in mental health agenda-setting.



For policy in non-health areas, these links between the dimensions, and to evidence, have been recognised by other scholars. A framework, shown in Figure 31, was developed in the international aid and social development sector for engaging stakeholders with decision-making and research, to encourage evidence-informed decisions that appropriate to their context (Oliver, 2018). It links the social, cultural and political environment to the use of evidence for decision-making.

Figure 32. Decisions and Research for Development and Aid Programmes within a Social, Cultural and Political Context (taken from (Oliver, 2018) - CC BY).



All four of the cross-cutting dimensions are represented in, and support, the social, cultural and political environment in the Decisions and Research for Development and Aid Programmes framework (Oliver, 2018). In their conceptualisation, the environment can vary in terms of how the world is understood, the relevant institutions and networks, and the power dynamics. The current study extends this by linking these elements of the environment in more nuanced ways specific for mental health in Assam; for example, capturing the influence of stigma.

9-2.6 The refined conceptual framework

The meta-framework for the role of evidence in agenda-setting for mental health policymaking in LMICs was developed from the *review of reviews* in Chapter 3. Based upon the empirical findings of this PhD, where the meta-framework was applied to the case study of Assam, the framework was refined; the revised conceptual framework for the role of evidence in agenda-setting for mental health policymaking in LMICs is shown in Figure 33.

On the whole, application of the meta-framework, developed from the *review of reviews* in Chapter 3, helped offer useful insights to the case study of Assam and supported the design of the framework. Therefore, multiple elements of the meta-framework are retained in the refined conceptual framework. These include the five inter-related components identified from the review: evidence, actors, process, context, and approach - which altogether determine the role of evidence in mental health agenda-setting. In addition, the framework retains the four key aspects worth noting in relation to 'evidence' in our framework: the nature of available evidence on the topic; perceptions of useful evidence by stakeholders; supply and demand for evidence from stakeholders; and degree of use of evidence in agenda-setting. The framework links these concepts via four cross-cutting dimensions that capture pertinent interrelations between concepts: beliefs, values and interests; capacity; politics and power; and, trust and relationships.

Nevertheless, there were some key findings from the data that the initial framework did not capture. Accordingly, two key revisions to the conceptual are suggested based upon the empirical findings of this PhD study and the synthesis of these findings: (1) approach linked more extensively to the rest of the framework; (2) the interconnection of the four cross-cutting dimensions. The revised conceptual framework is shown in Figure 33.

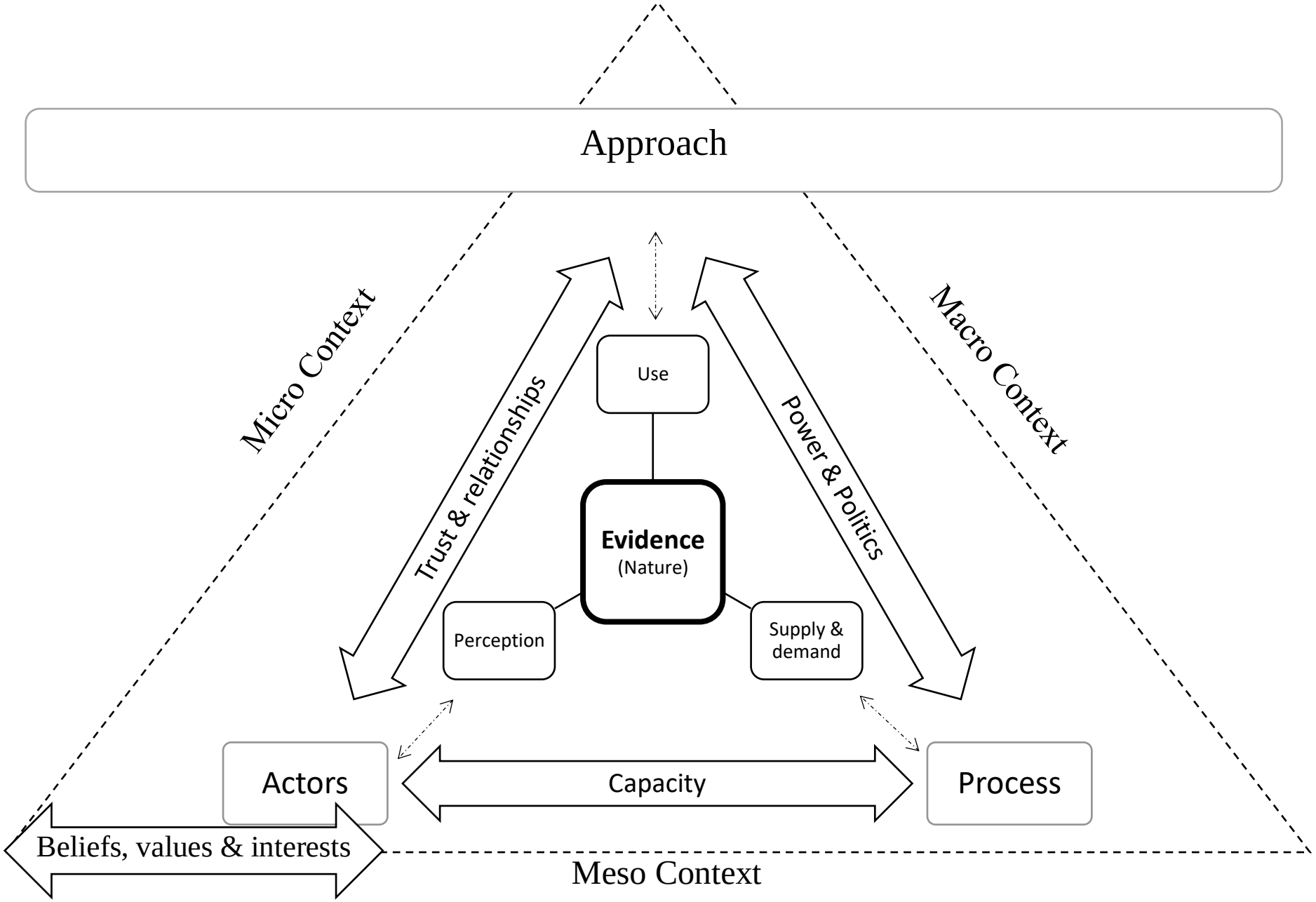
Firstly, approach should be linked to all other components (evidence, actors, process, context and approach) and cross-cutting dimensions (capacity; trust and relationships; power and politics; and beliefs, values, and interests) of the framework; in the initial meta-framework, approach linked *actors* and *process*, via trust and relationships, and power and politics respectively. Whilst the initial framework acknowledged that all components were linked, only the links with were prominent

enough to be displayed. The empirical findings emphasised that approaches can use multiple levers to strengthen the use of evidence, and a range of potential indirect as well as direct approaches were identified (see 9-1.). These included all components and cross-cutting dimensions. In order to reflect the importance of the links between approach across the whole of the framework, in the revised conceptual framework approach is represented as a bar extending across the framework.

Secondly, the four cross-cutting dimensions (capacity; trust and relationships; power and politics; and beliefs, values, and interests) are also interlinked. In the initial meta-framework, the cross-cutting dimensions linked the components (evidence, actors, process, context and approach) together. However, the empirical findings suggested that the cross-cutting dimensions themselves were interlinked. Improvement in one dimension often was facilitated by improvement in another. Most of these links were bi-directional; for example, building trust and relationships requires capacity. Furthermore having a network is an important resource in itself and can open the doors to training opportunities, for example. The two exceptions where the link was largely, and hence conceptualised, as uni-directional, were (1) capacity and power and politics, and (2) beliefs, values, and interests, and trust and relationships.

A supplementary framework, intended for use alongside the main framework, is used to display these interlinks, as this allows them to be covered more detail and with greater clarity than would be possible by adding this detail to the main framework. Furthermore, the interlinks between dimensions are more strongly emphasised in the accompanying text of the framework.

Figure 33. Refined conceptual framework for the role of evidence in agenda-setting for mental health policymaking in LMICs.



9-3. Implications

The conclusions of this PhD give rise to a number of implications for stakeholders in Assam, for both theory and practice. In the discussion sub-sections of the five previous results chapters, implication for theory and practice were given for the use of evidence for mental health agenda-setting in Assam. The main implications are summarised briefly in Table 18 below:

Table 18. A summary of implications for theory and practice.

	Implications for Theory	**Implications for Practice**
Evidence	Conceptualisations of evidence for evidence-to-policy should be widened to incorporate the diversity of stakeholder perspectives on the understanding of evidence.	Approaches to strengthen the use of evidence in policy should integrate informal and formal types of evidence.
Actors	Current conceptual frameworks should be expanded to consider a broader range of relevant stakeholders, and recognise overlapping nature of the roles of actors.	A more equal focus on community-targeted and policymaker-targeted approaches may be beneficial.
Process	Specific frameworks for agenda-setting may offer greater insights than those developed for policymaking in general, due to the differences of the agenda-setting stage to the rest of the policymaking cycle.	It may be more useful for any approaches to strengthen the use of evidence to aim to gradually raise mental health on the policy agenda.
Context	Although the current study supports the non-hierarchical nature of the macro-meso-micro context, with a combination of factors at all levels being important, the international context was perceived to be less influential for mental health policy in Assam.	The heterogeneity of the mental health context in Assam suggests that a variety of community-targeted approaches to strengthen the use of evidence are likely to be necessary, particularly due to highlighted importance of tailored approaches.
Approach	A broader categorisation of approaches to strengthen the role of evidence are likely to be useful for agenda-setting, than for other stages of policymaking, including approaches aimed at multiple 'users' of evidence not just policymakers and approaches led by other stakeholders not just researchers.	Approaches need to have a broader range of aims. For example, as well as communicating evidence, successful approaches will need to include other components such as stakeholder engagement and awareness raising which support the main aim.

Having synthesised the findings, further implications for theory and practice for stakeholders in Assam will now be set out.

9-3.1 Implications for theory

9-3.1.1 Extending the scope of the theorisation of the role of evidence

This thesis extends the scope of theorisation of the role of evidence; presented here is the first framework, to our knowledge, for the use of evidence for mental health agenda-setting in LMICs that does not focus upon formal research evidence. Based on initial findings, the focus of the research question was changed from initially 'research evidence' to 'evidence' more broadly, i.e. both to include formal (based on the scientific method) as well as informal (based on personal experience, such as community narratives) types of evidence. This proved to be important, as a range of approaches to strengthening the use of evidence were identified that would have been missed with a narrower focus on research evidence.

Due to the broader scope, some relevant bodies of work from outside of evidence-to-policy have been identified. In particular, community participation (or engagement) in health programs, systems, and research has been well studied empirically, however remains under-theorised (Abimbola, 2019a; Hoon Chuah et al., 2018). Community participation for mental health in LMICs receiving less attention, as shown by the systematic review by Semrau et al. (2016). Community engagement explicitly for policymaking, and how this can strengthen the role of evidence in policymaking, has received rather less attention in the literature.

This thesis argues that these fields may be useful to combine and draw upon for evidence-to-policy need to be drawn together. It appears plausible this may also be beneficial for evidence-to-policy in other contexts where the issue of interest is low on the policy agenda despite a clear need, and there is a lack of formal research evidence. This body of work could usefully inform community engagement in mental health *policy*. This thesis therefore lends support to the call by other scholars of the need for more developed theorisation of community participation (Abimbola, 2019a), and adds evidence-to-policy as another area where this would make a useful contribution.

Correspondingly, research attention has been given to stakeholder analysis which has been valuable in identifying and characterising what stakeholders are important for mental health in LMICs (Makan et al., 2015). However, in order for this stakeholder analysis to more effectively prioritise stakeholders, the criteria by which this is done needs to be informed by a broader body of work. Work on policy processes has usefully fed into this. However, this thesis argues that rather than focusing on those stakeholders with current interest and/or influence, the focus should instead be on realising the potential power of communities. Again, the work on community participation and engagement provides a useful resource to be drawn on.

9-3.1.2 Illuminating the links between components

In addition, through the identification of four cross-cutting dimensions (capacity; trust and relationships; power and politics; and beliefs, values, and interests), and the link between the dimensions, this thesis helped improve understanding of how the components of the framework are intricately linked together. This helps address a key limitation of current evidence-to-policy theory, that the phenomenon remains a "black box" (Gold, 2009). Evidence-to-policy is complex and multi-faceted, but in order for the use of evidence to be strengthened, this complexity must be embraced and understood.

Given the finding of this thesis, emphasising the importance of other components in addition to evidence itself, and the identification of a range of indirect as well as direct approaches to strengthening the use of evidence that understanding these links becomes more poignant. Other scholars have commented on the important, yet challenging, nature of balancing the evidence "jigsaw", with multiple types of evidence and actors in policy processes (Oliver & Pearce, 2017). The refined framework helps to address these challenges (Oliver & Pearce, 2017).

9-3.1.3 Reflections on the value of theory

General health evidence-to-policy is extensively theorised; however theory has not been specifically developed for the case of mental health agenda-setting in Assam, an LMIC context. As a suitable 'off the shelf' frameworks were not available, a literature review was conducted to see what could be learnt from general health evidence-to-policy frameworks for mental health agenda-setting in LMICs. A meta-framework was developed from a *review of reviews* which drew together the extensive body of theory along with insights about what may be learnt for mental health agenda-setting in LMICs from these fields. Application of the framework in the empirical work of this PhD showed that this framework was of use. Revisions likely to be useful were made based on what was already known about context, and from empirical testing of the framework, helped ensure it was suitable for the context of use.

So, whilst carbon copy applications of general health evidence-to-policy frameworks are unlikely to be the most useful course of action, with sufficient refinement they provide a useful starting point. Refinement for other specific cases, for example different health policy issues and contexts, where suitable 'off the shelf' frameworks also do not exist, using what is already know about these topics are likely to offer useful frameworks which can be refined through further empirical work.

However, this thesis has highlighted that the roles of informal evidence and communities for the use of evidence in mental health agenda-setting processes are missing from current theorisations. These are found to be important in Assam, and likely other similar contexts. A limitation of using an

established “off the shelf” framework has been argued is that it can obscure and take attention away from that which is not encompassed by the framework (Moore & Evans, 2017). The general health evidence-to-policy frameworks were not necessarily wrong, in that what they covered was broadly applicable. However, they missed out important components (communities and informal evidence) and thus placed emphasis to. Caution is therefore required; existing evidence-to-policy frameworks may help appear to be a good fit but could lead to important findings being missed. Whilst this thesis highlights the value of applying existing evidence-to-policy theory to the context of mental health agenda-setting in Assam, it was important to use at least a partly inductive approach to allow the data to speak for itself. Application of a carbon copy of a general health evidence-to-policy framework may have provided insights that addressed the questions but missed the most salient points.

9-3.2 Implications for practice

9-3.2.1 Strengthen the use of evidence in agenda-setting for whom?

The approaches to strengthening the use of evidence in agenda-setting identified by this these may have different aims traditional evidence-to-policy approaches. A finding of this thesis is that evidence, and consequently, evidence-informed agenda-setting can mean many different things to different stakeholders. Given the importance of wide range of mental health stakeholders, and users of evidence for agenda-setting as highlighted by this study, this is particularly significant. Stakeholders, however, agree that a co-created agenda that reflects community priorities and needs is an important success criterion that the use of evidence should seek to achieve. At present some voices may be louder than others, a key barrier to co-creation. Consequently, the success of any approaches to strengthen the use of evidence in agenda-setting need to work to towards this aim, and this requires a range of approaches, encompassing non-traditional approaches, i.e. those which do not solely focus on transferring evidence to policymakers.

It therefore follows that a range of approaches to strengthen the use of evidence are required to reflect the multiples users and uses of a range of evidence; a range of indirect, as well as direct, approaches were identified by this thesis. Approaches need to facilitate a wide range of evidence, both formal and informal evidence, to ensure community priorities and needs are reflected in the policy agenda. This thesis does not argue that informal evidence is more robust, but rather in the absence of formal research evidence, a focus on formal research evidence are of particular use.

Approaches also need to work with a range of stakeholders, including communities. Additionally, these diverse approaches will likely require different skills, the strengths of different stakeholders can be drawn upon. Therefore, there is a need to be cognisant of the relationships and trust between these

stakeholders, varying power and politics at play, different capacities and beliefs, values, and interests. The process of engaging with communities appears as important as the outcome such approaches.

9-3.2.2 Potential transferability of implications

As outlined in Chapter 3, in qualitative research transferability is the consideration of whether findings can be applied to other contexts. Although the scope of this thesis, and the research question it sought to answer, was limited to the use of evidence for mental health agenda-setting in Assam, it is likely that some of the findings and implications may be of use for other policy issues and contexts.

The lack of formal mental health research evidence for across India, and in other LMICs, suggests that the high-level findings of this thesis of the need approaches to strengthen the use of evidence to integrate informal as well as formal evidence may be broadly applicable to mental health in many states across India. This is particularly true for the findings relating to process, given the complicated roles of, and relationships between the centre and state in for mental health policy in India. However, India is an extremely diverse country; this poses questions as to the transferability of the findings, and thus implications, of this thesis to other states within India. This is important given the significance of the interaction of culture and mental health noted in India (Sarkar & Punnoose, 2017). Findings are perhaps more likely to be more applicable to other states in the North East Region of India (Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Tripura and Sikkim). Whilst there is still a large amount of diversity between states in this region (Asian Development Bank, 2021), they have more similarities between them in comparison to states in the rest of India; the geographic proximity was compounded by the 1947 partition of India which practically sealed the region off from the rest of the country. The states in the region are recognised as being under-developed in comparison to the rest of India (PwC, 2014).

Additionally, the high-level findings of this thesis might be transferable to some other policy issues in Assam. In particular, those which are surrounded by stigma and under-researched. Hence these are policy issues where there is consequently a lack of formal research evidence and community engagement.

It therefore appears as though there is likely to be potential value of the findings and implications of this thesis to other contexts and policy issues, however further research is needed to more fully ascertain whether they are appropriate and optimal in other contexts. Moreover, this study supports the finding from Kerala, another Indian state, that stakeholders emphasis the need for locally owned and driven solutions for the use of evidence in priority setting (itad, 2016), in the Assam context. Therefore, whilst there can be learning between contexts, it appears that there may be a limit to the extent of this.

9-3.3 Areas for future research

Although the present study has provided numerous findings that have helped illuminate the role of evidence for mental health agenda-setting in Assam, further research is still needed. This was expected; as a largely exploratory study, an intention of the current study was to identify areas for further research in addition to the findings presented above, rather than necessarily generating conclusive findings.

In the discussion sections of the previous results chapters, a number of areas for future research were mentioned: (1) the effect of gender; and (2) potential approaches to strengthen the use of evidence. These are elaborated below:

Current research on the potential effect of gender on the use of evidence in health policy more broadly is inconclusive. The present study found limited evidence to support gender as a barrier to the use of evidence. However, given the recommendation for community-targeted approaches to strengthen the use of evidence, this may become more pertinent. This may be particularly poignant for rural communities in Assam, where progress on gender is often slower, for example the gender educational gap is higher in rural areas of Assam (World Bank, 2017). Moreover, progress on political representation for women has reversed; the 2021 state elections in Assam saw the lowest proportion of women (5%) elected to the state legislative assembly (Vidhan Sabha) in twenty years (Bharadwaj, 2021). Despite being active at the grassroots level, women are not recognised as leaders or given a place at the table for decision-making (Bharadwaj, 2021).

Second, the exploration of potential approaches represents another avenue for future research. The current study highlights some potential direct and indirect approaches that could be utilised to strengthen the use of evidence in setting the mental health policy agenda in Assam. A number of non-traditional, but innovative approaches were suggested by stakeholders to be potentially useful, such as the use of the arts as a medium. Performance arts, such as theatre, was mentioned particularly frequently as being culturally appropriate for Assam. There has been some emerging work demonstrating the potential of community and arts based approaches, however there has been a lack of robust evaluation of these approaches (Ball, Leach, Bousfield, Smith, & Marjanovic, 2021). Given that success of was approaches found to be highly context-dependent, further research in Assam will be useful. Further research to empirically test the impact of these suggested approaches would be useful. Most of what is known about the impact of approaches to strengthen the use of mental health evidence for policy relates to the implementation stage of the policymaking cycle, rather than agenda-setting (Williamson et al., 2015) and so this is another area where further research would be useful.

In addition, understanding how the role of evidence for mental health agenda-setting in Assam changes over time was identified as a further area for future research. This thesis utilised a cross-

sectional design, however longitudinal research, is likely to be able to provide further useful insights due to the dynamic and unpredictable nature of policymaking, and the changing nature of mental health, reported by the current study in Assam. The importance of context was noted by this PhD study, and supports previous studies (Weyrauch, 2016). The context of evidence-informed priority setting in India is evolving rapidly at the state and national levels (itad, 2016). The present study supported this finding, noting the changing context – for example the growing importance of social media.

Additionally, it is likely that change has been accelerated by the COVID-19 pandemic, the course of which has developed during the time period of this PhD. COVID-19 has shone a light on the role of health evidence for policymaking and this may change the extent, and ways in which, evidence informs the policy agenda in Assam. Subsequent to the data collection phase of this PhD, further insight into the use of evidence by policymakers, and the effect of COVID-19, has been documented (Abbott, 2021). A preliminary study of the utilisation of a telephone counselling set up in response to the pandemic was reported to be sufficient to convince the government to take action, despite back and forth with officials, and set up 'Monon', a state-wide remote mental health service (Hazarika et al., 2021).

Whilst the changes to the policy agenda may be in part due to an increase in the size of the policy issue, i.e. an increase in the mental health burden, the attention given to evidence and the way in which it is perceived may have changed. As a scholar in Assam, Hazarika (2021, p. 615), stated "Hopefully the pandemic will force the government to pay attention [to mental health in Assam]…If it doesn't you have to ask yourself what will.". One way in which this may occur is through the reduction of stigma, both for policymakers and communities, due to the increased awareness of the importance of mental wellbeing due to lockdowns, as also suggested by Dewa (2020).

Communication of evidence is another area that appears to be evolving. A recent study on the use of Twitter as means of communication by the Government of Assam for public health messaging, in particular regarding COVID-19, has shown the importance of the cross-cutting dimensions identified by the current study (capacity; trust and relationships; power and politics; and beliefs, values, and interests) in how communities respond to and engage with evidence (Rohman & Sonowal, 2021). Their study found that how communities engage with health evidence and messaging is dependent upon their socio-cultural backgrounds as well as access to resources. Tailoring messages for communities, sensitive to their values, as well as building shared identity and trust are useful for communication. Although the study centred on the use of Twitter by policymakers to communities, rather than communities to policymakers – a key type of approach identified by the present study, multidirectional communication was highlighted as important (Hazarika, 2021). The acceptance of

evidence shared from policymakers to communities via social media was demonstrated, a further area to explore is the reverse scenario – the acceptance of evidence from communities to policymakers.

9-4. Strengths & limitations

The methods chapter covered the strengths and limitations of the design of this PhD study. Here, the strengths and limitations will now be discussed in relation to the findings of the study.

9-4.1 Strengths

Three key strengths were identified: (1) application of theory to an in-depth case; (2) a more comprehensive consideration of evidence; and (3) use of multimedia to engage more effectively with participant stakeholders.

First, this PhD applied theory to an in-depth case study: mental health policy agenda-setting in Assam. A criticism of many of the existing evidence-to-policy frameworks are they have not been empirically tested, nor is it clear how they have been developed. This study attempted to address both these gaps through the meta-framework developed by the current study, initially developed from a *review of reviews* and therefore made use of existing theory. Insights gained from the subsequent in-depth application of the meta-framework to the case study of mental health agenda-setting in Assam then enabled refinement of the framework, and extra layer of detail, illuminating the ways in which components are linked and so attempts to further make more explicit the "black box" connecting evidence and policy (Gold, 2009) through specifying how the components of the framework are linked together. The greater detail included in this study about the development of an evidence-to-policy framework, and how it has been applied, will help potential users of the framework understand to what extent it may be transferable by knowing where it, and its constituent components have originated from.

This PhD applied existing general health evidence-to-policy theory in-depth, to mental health agenda-setting in Assam. Existing theory was applied through the meta-framework developed from the *review of reviews* which drew together the extensive body of theory along with insights about what may be learnt for mental health agenda-setting in LMICs from these fields. This was in important test of theory; a criticism of existing theory is that it is often untested.

Second, a more comprehensive consideration of evidence was included within the scope of this PhD. Although the initial research question focused on 'research evidence', this was changed to evidence

more broadly when it quickly became apparent that for this context, informal evidence was equally, if not more, more important. In addition to the level of detail that the current study applies theory to a case study, the current study extends the scope of the existing theory and empirical work by considering evidence more broadly rather than just 'research evidence' or 'scientific research' to explicitly include informal evidence such as community narratives. Therefore this thesis extends the works of other scholars of the role of evidence for mental health agenda-setting in LMICs (Votruba et al., 2020). As well as the role of informal evidence being important in its own right, formal and informal evidence are used together to inform the policy agenda and therefore cannot be considered separately. Additionally, a key finding of the present study was the importance of the other components and cross-cutting dimensions in understanding the role of evidence, as well as indirect approaches. Consequently, too narrow a focus on formal evidence may limit any approaches to strength the use of evidence.

Third, multimedia was utilised to more effectively engage with stakeholders, including participants. An animated video used to help communicate the findings (initial and refined) to stakeholders, and as a credibility check was also received positive feedback from participants who found it engaging and novel. Another advantage was its accessibility; for some stakeholders, who had (or felt that they had) less familiarity or involvement with policy processes, but were still highly important. It is also likely that the use of video helped to reduce the time burden of participants, versus the greater time demands of reading written outputs, an important ethical consideration particularly for resource-constrained environment and during the COVID-19 pandemic. It is planned for a further animated video to be made and disseminated to stakeholders with the revised findings.

9-4.2 Limitations

Three key limitations were identified: (1) recruitment of participants; (2) reliance on the perception of participants; and (3) the focus of the research question.

First, the recruitment of participants was challenging and led to the sample not representing the full range of stakeholders as desired. Whilst a range of participants were successful recruited, data from certain participants would have been useful, including from rural communities. All participants were recruited from urban Assam due to practical constraints; including language and geography. This is particularly poignant given the finding of the importance of communities for strengthening the role of evidence. Difficultly was also faced in recruiting policymakers, exacerbated by the pressures placed on them as a result of the COVID-19 pandemic. In addition, there may have also been self-selection by potential participants. Participants who agreed to participate in the study were likely interested in the use of evidence for mental health policy; this may for example explain the high-level of

motivation reported. Stakeholders who have potential influence, but at present are not interested, in mental health are unlikely to have agreed to participate.

Second, the analysis relied upon the perceptions of participants and their recall. Resultantly there is the potential for social desirability bias, the inclination for participants to provide answers they perceive to be more acceptable by others, rather than their honest opinion (Grimm, 2010). For example, what participants may state may be important to them in terms of evidence may not be the preferences that they enact. This may be further exacerbated due to the stigma surrounding mental health. Through the fieldwork and non-participant observation, there were some indications that some participants might have participated in a professional rather than a personal capacity, i.e. stated the lines of their institution, especially around more politically sensitive topics, despite the anonymisation. It is unclear to what extent this would have affected the findings.

Third, the research question focused upon the agenda-setting stage of the policymaking cycle in the state of Assam. Assam was often reported to be distant, in multiple senses, from the mainland of India, and therefore a unique case rather than a representative case for Indian states. In terms of transferability, this may have reduced the wider theoretical contributions of this study.

9-4.3 Reflections

All approaches have strengths and weaknesses, and rather than trying to achieve the unrealistic aim of eliminating all limitations, the aim was to decide on the optimal balance of strengths and limitations.

Determining the scope of the research question was a balance between depth and breadth, as well as ensuring feasibility as a PhD project. Evidence-to-policy is a complex phenomenon, requiring a broad inter-disciplinary approach. Simultaneously, policymaking, mental health and the wider context of Assam are highly complex topics that require intricate understanding. The scope was refined and evolved during the course of the PhD in order to try and optimise the balance. In some ways the scope was widened by including not just formal research evidence but also informal evidence, such as community narratives. Furthermore, the richness of the data from the interviews, whilst fascinating, opened up more interesting avenues of enquiry that made striking a good balance more challenging. The scope was also narrowed during the early stages to include a specific focus on Assam and agenda-setting, both to help ensure the feasibility of the study, and gaps in the literature (for agenda-setting and sub-national-level policymaking). However, it may have led to less of a holistic understanding of evidence use in the policy cycle given the high degree of interrelatedness found.

There is no singular ‘right’ balance; a judgement call is required. The stakeholders for mental stakeholders in Assam (and for this research) were used to help guide the desired balance. Whilst a

higher degree of transferability would have been desirable, it would have been extremely difficult to achieve without reducing the usefulness of the recommendations for the stakeholders in Assam, the main beneficiaries of this research.

9-5. The Research Questions

As stated at outset of this Chapter, the research **question** this study aimed to answer was: "*To what extent, and in what ways, does research evidence inform the mental health policy agenda in Assam?"* Hence, the **aim** was to create an in-depth understanding of the extent and ways in which research evidence informs the mental health policy agenda in Assam. In order to answer the research question, four objectives were set out. Now, the extent to which the four **objectives** and the overarching research questions have been addressed will be discussed.

9-5.1 Refinements of the research question

The scope of the initial research question was limited to agenda-setting, as opposed to policymaking more broadly based upon preliminary research. The findings of the full study, that agenda-setting whilst interrelated is sufficiently distinct from the other stages of the policymaking cycle, support this decision. As expected, due to the interrelatedness of the policy stages it was not possible, nor desired, to completely exclude all other stages. Moreover, this thesis highlighted the complex nature of evidence-to-policy and a broader research question focusing on policymaking would not have been able to be covered in sufficient detail, particularly given the broadening of the scope of the research question in other areas.

Subsequent to the research questions being set out, the scope was expanded in the original research question from 'research evidence' to 'evidence'. During the study, it became apparent that exclusively focusing on research evidence would not, nor generate findings and implications that would be of use to mental health stakeholders in Assam, the primary intended audience beneficiaries of this research.

Broadening the scope to 'evidence' would also incorporate informal evidence based on personal experience, such as community narratives. Informal evidence was found to be equally or, arguably, more important, than formal research evidence for informing the mental health policy agenda in Assam given the lack of the latter. Therefore, the scope of the research question was expanded to include informal evidence: "*To what extent, and in what ways, does evidence inform the mental health policy agenda in Assam?"* It should be noted that this thesis does not make the argument that informal

research is intrinsically more important for agenda-setting than formal research evidence, rather simply given the mental health evidence available in Assam and the lack of formal research evidence.

Refinements to the objectives are discussed below under an assessment of how they have been met.

9-5.2 Assessment of the study objectives

An assessment of how this PhD met each of the four **objectives** set in order to answer the research question is given here:

1) understand current knowledge on key theories and frameworks for evidence-informed health policymaking and explore their application to mental health agenda-setting

A meta-framework was developed from a *review of reviews* which drew together the extensive body of theory along with insights about what may be learnt for mental health agenda-setting in LMICs from these fields. Preliminary research indicated agenda-setting in LMICs was likely to be sufficiently distinct from general health policymaking to warrant a specific focus. Three key recommendations were developed for application to mental health agenda-setting in LMIC. First, for understanding the role of evidence there is a need for a greater recognition of the role of informal evidence (based on personal experience such as expert advice and community narratives). As in LMIC contexts formal evidence for mental health is often less abundant. Second, there is a need for the inclusion of broader range of stakeholders in policy agenda-setting including communities, given the importance of informal evidence based upon personal experience as well as the marginalisation and stigmatisation surrounding those affected by mental health. Third, a greater recognition of power and politics is needed to better understand the role of evidence in agenda-setting specific.

The initial framework consisted of five components (evidence, actors, process, context, and approach). Additionally, four cross-cutting dimensions were identified: (1) capacity; (2) trust and relationships; (3) power and politics; and (4) beliefs, values, and interests. Based upon the empirical application of the framework, two refinements to the framework were made: approach linked more extensively to the rest of the framework; and the interconnection of the four cross-cutting dimensions.

2) undertake a stakeholder analysis for mental health agenda-setting in Assam, and develop an understanding of the key actors and their roles;

A stakeholder map (Figure 22) was produced from the stakeholder analysis which summarised the key stakeholder groups in Assam and their level of influence and interest for mental health policymaking, and agenda-setting in particular. A broader range of stakeholders were identified, in addition to those traditionally viewed as being involved in or influencing policy. Furthermore, the

main categories of stakeholders traditionally used in the field of health policy may not be appropriate for Assam, where there is a large degree of overlap between categories.

Potential influence and interest were also identified as important, as well as current levels; a key finding was the opportunity for communities to play a bigger role, currently of low interest but high potential influence. However, a limitation of the stakeholder map produced is that is has a limited lifespan; the high turnover of staff, and fluctuating interest in mental health means stakeholder maps need to be continually updated to remain useful.

3) identify and analyse the processes and approaches for mental health-related agenda-setting in Assam through an analysis of the literature and through interviews with key stakeholders;

Process and approach formed two of the components of the meta-framework developed by this thesis. The results chapters explored the ways in which evidence was used in agenda-setting, and what factors influenced this. The data analysed came from stakeholder interviews, fieldwork observations, an online survey and document analysis.

The key findings for *process* were that raising mental health on the policy agenda too quickly was cautioned to not necessarily be desirable be the goal, as this can lead to subsequent policy formulation being rushed with less stakeholder engagement and a limited extent and range of evidence used. Sustained, inclusive stakeholder engagement in the process was seen as important so that communities can utilise evidence, that evidence from these groups can be incorporated, and for policy agendas to be reflective of community needs.

The findings of this thesis informed how the term ‘approach’ was used, and a consideration of approaches is given under the fourth objective.

4) identify effective research-policy pathways for mental health agenda-setting in Assam.

This thesis identified approaches to strengthening the use of evidence for mental health policy agenda-setting in Assam, instead of research-policy pathways. ‘Approaches’, rather than ‘pathways’ were used as pathway implies direct routes that link evidence to policy. Strengthening the role of evidence was found by this thesis to be more complex and multifactorial, and the approaches identified by this thesis may not necessarily direct lead to greater evidence use but may help create a more conduce environment.

Three key direct and three key indirect approaches to strengthening the role of evidence were identified in the Approach Chapter. The three key direct approaches were: (1) more trusted sharing of evidence; (2) share evidence more widely; and (3) increased stakeholder engagement. This thesis found that these approaches by themselves are likely to be insufficient without recognising the wider environment in which evidence is used. Therefore, a further three key supporting indirect approaches

were identified: (1) strengthen stakeholder relationships; (2); capacity-building; and (3) reduce stigma.

9-6. Conclusion

Although evidence-to-policy has been extensively studied, the use of evidence for mental health in LMICs has been largely neglected. Previous research has tended to focus on formal research evidence, however, approaches to strengthen the use of evidence in agenda-setting that reflect the available evidence are likely to be more effective. The significance of informal evidence based upon personal experience was highlighted by this thesis, due to the paucity of formal mental health research evidence in Assam. The inclusion of informal evidence within the scope of evidence extends the current body of knowledge; presented here is the first framework, to our knowledge, for the use of evidence for mental health agenda-setting in LMICs that does not focus upon formal research evidence. This framework may be useful for other contexts and health policy issues.

As well as the need to consider evidence more broadly, how evidence interacts with other elements is crucial. Whilst evidence is a critical element for informing the mental health policy agenda-setting in Assam, agenda-setting is complex, and evidence is only one of many elements and cannot be considered in isolation. It therefore follows that for effective approaches to strengthen the use of evidence, creating a conducive environment for the use of the evidence that indirectly strengthen the use of evidence, such as reducing stigma, are needed in addition to direct approaches.

Additionally, it is important to consider whose evidence, and evidence-informed agenda-setting for whom. A wide range of stakeholders and users of evidence were found to be important, not just policymakers. Stakeholders in Assam agreed that a co-created agenda that reflects community priorities and needs is an important success criterion that the use of evidence should seek to achieve. This thesis argues that a greater emphasis on community-targeted approaches to strengthening the use of evidence is needed, in addition to policymaker-targeted approaches. The focus of approaches should not, as sometimes conceptualised, centre on researchers meeting the evidence needs of policymakers better and communicating such research evidence more effectively to policymakers. Rather they should seek to engage a broader range of stakeholders including communities with evidence and agenda-setting. A range of non-traditional, but innovative approaches for strengthening the use of evidence in policymaking were suggested by stakeholders to be potentially useful, including the use of performance arts as a medium. Further research is needed to explore these approaches, and evaluate their effectiveness, in Assam.

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Appendices

Appendix 1. Summary of review included in the literature review.

N	Author (year)	Type of review	Scope of the review	Name of framework (if produced)	Level of confidence
1	Contandriopoulos et al., 2010	(Narrative) Systematic review	Knowledge exchange processes at the organizational and policymaking levels	An integrative model of collective-level knowledge transfer	Low
2	Damschroder et al., 2009	Non-systematic review	Models, theories, and frameworks that facilitate translation of research findings into practice primarily within the healthcare sector	Consolidated Framework for Implementation Research (CFIR)	Moderate
3	Gold, 2009	Non-systematic review	Policy formation and organizational behavior, factors influencing research use, and knowledge transfer and exchange strategies	Factors, processes, and actors that shape pathways between research and its use	Low
4	Graham et al., 2006; Graham et al., 2007	Non-systematic review	Knowledge translation planned action theories, models and frameworks for research to policy and practice	Action categories representing steps of a planned action model; The Knowledge-to-action process framework	Very low
5	Green et al., 2009	Non-systematic review	Diffusion dissemination, and implementation aspects of research translation in public health practice and community change	Utilisation-focused surveillance framework	Low
6	Greenhalgh, et al., 2007; Greenhalgh et al., 2004	Systematic review	How innovations can be spread and sustained in health service delivery and organizations	Conceptual Model for Considering the Determinants of Diffusion, Dissemination, and Implementation of Innovations in Health Service Delivery and Organization	High
7	Moullin et al., 2015	Systematic review	Implementation frameworks of innovations in healthcare	A Generic implementation framework (GIF)	High
8	Votruba et al., 2018	Systematic Review	Theories, frameworks and models to understand and guide action in research evidence and policy interrelationships in mental health and LMIC (a focus on policy agenda-setting was removed due to no results)	A framework for the interrelationship of mental health evidence and policy in low- and middle-income countries	High

N	Author (year)	Type of review	Scope of the review	Name of framework (if produced)	Level of confidence
9	Ward et al., 2009	Non-systematic review	Models that explain all or part of the knowledge transfer process	A framework for transferring knowledge into action	High
10.	Almeida & Báscolo, 2006	(Critical) Non-systematic review	The theoretical literature on the relationship between research results and its use in policy decision-making, formulation and implementation	N/A	Low
11.	Milat & Li, 2017	(Narrative) Non-systematic review	Frameworks for translating research evidence into policy and practice	N/A	High
12.	Mitchell et al., 2010	Non-systematic Review	Theoretical models for translational science in nursing	N/A	High
13.	Mitton et al., 2007	Non-systematic review	The Knowledge, transfer, and exchange literature on health care policy.	N/A	High
14.	Nilsen, 2015	(Narrative) Non-systematic review	Theories, models and frameworks applied in implementation science, including those describing and/or guiding the process of translating research into practice	N/A	Low
15.	Oborn et al., 2013	Non-systematic review	The conceptual landscape around knowledge translation (KT) and how management literature on knowledge and learning theories might inform health services research on KT.	N/A	Moderate
16.	Tabak et al., 2012	(Narrative) Non-systematic review	Models for disseminations and implementation research for health	N/A	Moderate
17.	Wilson et al., 2010	Systematic (scoping) review	Conceptual/organising frameworks relating to research dissemination.	N/A	High
18.	Cruz Rivera et al., 2017	Systematic review	Methodological frameworks used to measure healthcare research impact, including influence on policymaking	Simplified consolidated methodological framework	High
19.	Newson et al., 2018	Non-systematic review	Methods for assessing research impacts on policy and the policy utilisation of health research	Descriptive framework for research impact and research use assessments	Moderate

Appendix 2. Initial interview schedule for semi-structured interviews.

Interview structure	Questions
Introduction	1) Could you tell me a little bit about yourself, including what organisation you currently work for, and what your role is within this organisation? 2) Have you been involved in the mental health policy making process and can you give me any examples? 3) Can you provide me with an example of a policy that you have been involved with?
Evidence	4) To what extent is the mental health policy agenda informed by evidence? 5) How aware are stakeholders of the key evidence on this topic? 6) What are the most important characteristics of evidence for use in agenda-setting, both in terms of the content and how it is presented?
Actors	7) Who are the key actors in mental health agenda-setting? 8) What do you see as your role in agenda-setting and policy-making? 9) What are the barriers to fulfilling this role, and what would help facilitate this? 10) How strong are the relationships between different stakeholders? And how effective are these in relation to evidence-informed agenda-setting? 11) How aligned are the beliefs, values and interests of researchers, policy-makers and intermediaries?
Process	12) What are the characteristics of the agenda-setting process for mental health? 13) How effective are existing agenda-setting processes for mental health? 14) Are there any likely upcoming policy windows?
Context	15) Which key contextual influences facilitate or constrain evidence-informed agenda-setting? 16) Are there any likely upcoming contextual changes, such as elections?
Approach	17) What approaches to strengthen the use of evidence in agenda-setting are currently used, and how effective are these? 18) What factors drive or constrain these approaches? 19) Are there any way in which you think these approaches could be improved?
Concluding questions	20) Are there any documents that you recommend as being relevant for this study? 21) Can you suggest any further potential participants who you suggest that I speak to? 22) Are you aware of any events that you think I should observe? 23) Is there anything else on the role of evidence in mental health agenda-setting that you would like to add that we have not already covered?