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Social Determinants and Indigenous Perspectives in Mental Health Legislations: A Comparative Study of England and Pakistan

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Abstract

A diversity in the socioeconomic, cultural, and healthcare landscapes exists between Pakistan and England. Within Pakistan, mental health is speckled with stigma alongside poor mental health infrastructure. On the contrary, despite having a better, advanced, and developed healthcare system in place with relatively less stigma afforded to mental health, England's mental health legislations are not inclusive due to the exclusion of different cultural and indigenous understandings of mental health in the Mental Health Draft Bill (2022) for example. This is a further portrayal of the underrepresentation of alternative understandings of mental health. Despite these disparities, the rationale for adopting a comparative approach is to develop a nuanced understanding of mental health along the lines of the biomedical model and social determinants of mental health by studying the mental health legislative documents of the former colonizer and colonized states. This can further allow one state – Pakistan – to learn from the strengths of the other – England – and in the process help add to the existing broader understanding of mental health.

Introduction

A cursory glance at Pakistan's mental health policymaking through the lens of the biopsychosocial model reveals shortcomings. It has been seen in the Mental Health Ordinance (MHO) 2001 that more space is given to offering a cure and treatment to the mental health issues sustained by the population, without considering the various cultural and indigenous understandings of mental health in the Pakistani context. Hence, the biomedical model of mental health that asserts that the source of mental health problems is organic in nature originating from genetics, biochemistry, neurology, or biology requiring an absolute reliance on psychiatric interventions in the form of medication and drugs (Watters, 2010) forms the bedrock of the mental health policy in Pakistan.

Calls are raised by scholars to retire and abandon the dominant biomedical model of mental health that has been promoted to the status of a fact (Ramon and Williams, 2016) to adopt the alternative models – psychosocial and biopsychosocial – because of the surfacing of doubts pertinent to its utility as the hegemonic paradigm wherein the "central planks of the issues at stake are not taken into account – or denied attention – by that hegemonic paradigm" causing the beginning of the delineation of an alternative perspective (Ramon and Williams, 2016, p. 14). Jenkins (2013) has shown the ineffectiveness of the biomedical model in improving mental health and its adverse consequences. Despite growth in biomedical knowledge, there is a rising burden of mental health problems, with psychopharmaceuticals showing statistically insignificant efficacy over placebos. Additionally, there is increasing stigma towards those with mental health issues, as public perception frames them as a menace with an element of unpredictability due to their perceived genetic and neurochemical imbalances resulting in a poor health outcome. Within the alternative models, the social context is given primacy in interpreting and understanding mental health conditions as the dominant biomedical model has denied attention to the centrality of social context, psychology, and power relationships espoused within mental health systems and the wider social

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context (Ramon and Williams, 2016). Thus, it is generally understood that subjected to the right environmental stressors and conditions any individual can become mentally sick (Scheid and Brown, 2010). This brings attention to the social determinants of mental health as well – factors and structures that encompass the conditions in which individuals are born, grow, live, and age (Compton and Shim, 2015, Shim *et al.*, 2015), such as gender, household income, employment status, educational attainment, social isolation (Allen *et al.*, 2014), family, built environment, and societal stability (Lefley, 2010).

In the following article, the research question "How does Pakistan's mental health legislation compare with England's current mental health legislation?" is answered. Thus, the purpose of this study is to present the case of England's mental health legislations as the follower of the biopsychosocial model that has also integrated the social determinants of mental health – aspects that can be learned by Pakistan. The significance of this study lies in its novelty as such a comparative mental health policy analysis across England and Pakistan has not been done before.

Methodology

Qualitative method was employed to conduct this secondary-based comparative public policy analysis. The exploratory nature of the study was evident in the research question that has provided a rationale for this qualitative research. To answer the research question, the latest mental health documents from Pakistan and England were studied to gauge the latest state policy on mental health and to understand the inclusion or exclusion of alternative theories of mental health that could suggest the state's allegiance to a particular set of ideas (Warner, 2009) beyond the dominant biomedical model. The list of these documents includes Pakistan's Mental Health Ordinance 2001 and the Non-Communicable Diseases & Mental Health National Action Framework 2021-30: Enhancing the Inter-Sectoral Response to Disease Prevention and Control, and reports produced by the various governmental departments of the United Kingdom such as the Department for Education and the Department of Health and Social Care. Official documents released and published by the government of Pakistan and England were chosen because they met qualitative study rigor of authenticity, credibility, soundness, and meaning showcasing their genuineness and actually being what they purported to be (Burnham *et al.,* 2008) while also presenting the evidence with clarity in a comprehensible manner (Scott, 1990). Furthermore, as the documents were part of public records with easy accessibility, it has been declared that their authenticity can be established without difficulty because the records align with the procedures known to have been used by government departments that created them (Burnham *et al.,* 2008).

Documentary analysis formed a crucial research method to evoke meaning and gain a deeper understanding of the construct and research problem under investigation (Bowen, 2013). The mental health documents were studied thoroughly to undertake data reduction wherein parts significant to the research were highlighted. The next step warranted coding of the highlighted data in the documents and establishing categories according to the theoretical framework of social determinants of mental health, the biomedical model and its alternatives guiding this research. For example, it was decided that the category social determinants of mental health would be coded with greenspaces, housing, and loneliness, while the category of treatment was coded with medicine and admission to psychiatric facility. In the last step themes were drawn from the categories and codes to write interpretations that are presented in the next section.

Findings and Discussion

Mental Health Legislation in England: Dynamic and Progressive

Mental health legislation in England is a dynamic narrative, as highlighted in a document authored by Garratt (2023b). This document notably uses the term "mental health" instead of "mental disorders," as seen in the MHO 2001, and employs considerate language such as "older adults" compared to the MHO 2001's indifferent language.

Reforming England's Mental Health Act 1983

England's Mental Health Act 1983 has undergone various reforms in response to evolving understandings of mental health, with new Acts and strategies being implemented to address changing circumstances. The reformation of the Mental Health Act 1983 included an investigation into concerns about outdated processes that no longer align with the modern mental health system. The resulting Mental Health Draft Bill (2022) proposed several significant changes: granting individuals greater autonomy and empowering them to shape their treatment and care decisions, redefining mental disorder, reconsidering the need for frequent detention, and tightening the criteria for detention. The proposition for redefining "mental disorder" under section 1 of the Mental Health Act 1983 was under consideration in the Mental Health Draft Bill (2022) because the 2007 amendment broadened the definition of mental disorder. Accordingly, the term has been defined as "any disorder or disability of the mind," which includes learning disabilities and autism (Bunn and Foster, 2024). The new proposition aimed to prevent the detention of individuals with autism and learning disabilities for treatment unless they have a co-occurring mental health issue, as their treatment under the Mental Health Act has been deemed unsuitable (Garratt, 2023a). Because of the broader definition of mental disorders, individuals from BAME (black, Asian, and minority ethnic) communities had been disproportionately impacted as they were subjected to higher detention rates and faced profound racial inequalities as compared to the White community (Garratt, 2023a; 2023b). In iterating the perspectives and lived experiences of the minority African-Caribbean community in a town of South England, it has been found by McLean and others (McLean *et al.,* 2003) that such inequalities were manifested in the access to mental health services because of social exclusion alongside the experience and expectation of racist mistreatment that has fed into reproducing mental health inequalities. The Joint Committee's proposals for pre-legislative scrutiny of the draft Mental Health Bill (2022), which have been upheld in the 2024 Government Response (Department of Health and Social Care, 2024), aimed to address these sustained inequalities. The proposals included allowing individuals to challenge detention orders and amplifying the voices of those undergoing treatment and care. Additionally, the proposals advocated for a more diverse workforce in healthcare settings to enhance overall cultural competence and the provision of culturally appropriate advocates to either speak on behalf of individuals or encourage them to speak for themselves. These initiatives are missing in the health legislations of Pakistan.

Hence, the positive developments in England, in contrast to Pakistan, offer a model of learning. England acknowledges and addresses shortcomings in mental health provision and service delivery through government-led investigations. These investigations have exposed undignified and inhumane care practices that breach basic human rights, such as the inappropriate detention and care of individuals with learning disabilities and autism, including overuse of restraints and over-medication (Bunn and Foster, 2024; Garratt, 2023b). Such revelations are expected to prompt appropriate government actions, especially considering the UK's commitment as a signatory to the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

Updating Mental Health Legislations with Changing Circumstances

The mental health policy of Pakistan largely screams a pessimistic miasma created by exclusive stagnancy showcasing that the understanding of mental health by the top echelon of the country has not kept up with the changing times that require a multidimensional focus on mental health thereby forsaking the sole focus on the biomedical narrative favorable to the entrenched capitalistic and neoliberal system and take into consideration the diversity of aspects influencing the mental health of a given state. The continued amendments, updates, and additions to the mental health legislation in England is worth learning from by Pakistan, especially given the changing geopolitical conditions within the country and its neighbors that inevitably have had an impact on the mental health of the citizens.

The case in point is the palpable reality of the war on terror within the Pakistani state and its bordering state of Afghanistan that has had a deleterious impact on the mental health of individuals seen through an increased proclivity towards suicide and mental health problems such as PTSD, stress and anxiety disorders, and depression (Khan *et al.*, 2012) that can potentially lead the masses towards anomie (Nizami *et al.,* 2018). This aligns with the understanding that mental health should be included in all policies because it is everyone's concern. Such inclusion can lead to the development of plans that prioritize the mental health of citizens and ensure that proposed policies do not further deteriorate public mental health. This makes a further case of public policies such as employment, housing, education, and neighborhood that cover the many facets of society to include mental health in them because despite not being health policies, they drive the social determinants of mental health (Shim *et al*., 2015).

COVID-19 and Mental Health Legislations of Pakistan and England. In addition to including mental health in all policies, it also becomes crucial that the state puts forward revisions to the mental health legislation to allow it to become a testimony and a reflection of changing external and internal circumstances. It is a pity to note the absence of terrorism – one of the unfortunate realities and potent environmental stressor grappling Pakistan – within Pakistan's mental health policy. Exogenous shocks and external factors, such as the COVID-19 pandemic, have had a significant adverse impact on global mental health. The state-led public health measures, including lockdowns and work-from-home mandates, were introduced to limit the spread of COVID-19 but have also affected mental well-being. However, in Pakistan the MHO 2001, NHV 2016-2025, and NCD & MH 2021-30 have not addressed these impacts, nor have they demonstrated a commitment to rectifying the negative mental health effects of the pandemic. This is particularly concerning given the pandemic's multidimensional impacts—economic, social, physical, environmental, and psychological. On the other hand, England's progressiveness shone through because the English government acknowledged the deterioration of mental health as one of the major repercussions of COVID-19. The research briefing produced (Bunn and Dias, 2021) for the UK's Parliamentary Office of Science and Technology explicated that the individuals who contracted the COVID-19 infection were directly impacted by symptoms of depression, anxiety, and PTSD. Bunn and Dias (2021) also mentioned the indirect effects of the pandemic on the general populace in the form of higher frequency of depression, anxiety, self-harm, suicide, and plummeting wellbeing of the population as loneliness increased by 16% in just one month from February 2021 to March 2021. One study funded by the Mental Health Foundation UK (2020) have identified certain groups -- the BAME community, transgenders, and young adults among others – to be at more risk than others to have their mental health negatively impacted by the pandemic (Lombardo *et al.,* 2023).

England's COVID-19 Mental Health and Recovery Plan

Such studies and statistics have served as a backdrop to the introduction of a pandemic response centered on mental health service provision to meet the needs of individuals of all ages that can move into the post pandemic era (NHS, 2020). This was followed up with a COVID-19 mental health and wellbeing recovery action plan penned down by the Department of Health and Social Care (2021) with an ambitious whole-person and cross-government approach to support individuals with mental health issues for the year 2021-2022. This is because the government has acknowledged that in the aftermath of this unprecedent public health event the worsening of the mental health of individuals is not unusual, though different individuals have experienced this differently with some feeling temporary bouts of anxiety and low mood, many might require social and emotional support, and some may need specialist support. Accordingly, the action plan has been put forward to take an initiative to tackle the factors which play an essential role in molding mental health outcomes for adults and children, while also ensuring that the general population is offered support in taking action to look after their mental wellbeing which

is enabled by expanding and transforming the mental healthcare scene to offer services to those requiring specialist support. Furthermore, the UK government's policy paper (2022) "Build Back Better: Our Plan for Health and Social Care" includes proposals to reform adult social care and health systems through unprecedented investment. This aims to protect individuals and their families from astronomical care costs for specialized care. The policy also provides occupational health funding to frontline healthcare workers during COVID-19, helping them recover from their extraordinary role in aiding the country through the pandemic. This support includes peer-to-peer coaching, counseling, and workplace improvements for healthcare staff. On the contrary, no such initiatives have been seen in the mental health and health policies of Pakistan that acknowledged the duress caused by COVID-19 nor have practical measures taken by the government to address these issues been incorporated into legislation.

Incorporation of Social Determinants in England's Mental Health Legislations

The inclusion of the social determinants in England's mental health is an aspect which should be incorporated in the MHO 2001 because it recognizes the contextual issues rather than promoting a reductionist understanding of mental health that has the prospect to do greater deal of harm (Bracken *et al.*, 2016). The social determinants are the factors that cause mental health to straddle the realm of politics leading to the understanding that mental health is political as the social determinants are under the control of the government. Thus, it has been outrightly stated in the discussion paper produced by the Department of Health and Social Care (2021) that social circumstances – employment opportunities and retention of employment as a stable job is key to upholding good mental health (NHS Long Term Plan, 2019), social care, suitable housing, education, access to greenspaces, cordial social relationships, physical health, getting support through the benefits system, and provision of social care through voluntary and community sector – are equally important to the NHS treatment in helping individuals recover and live well.

Addressing Economic Determinants of Mental Health

The document produced by England's Department of Health and Social Care (2021) addresses the broader determinants of mental health by recognizing the well-established connection between social, economic, and environmental factors and mental health, highlighting how these factors shape individuals' mental well-being. Therefore, acknowledging from the outset that "There is a clear and well-established relationship between financial insecurity and poor mental health" (Department of Health and Social Care, 2021, p. 36) by citing studies showcasing an increase in the levels of anxiety and depression of individuals who experienced loss in income, the government has been able to put forth swift and tangible actions during COVID-19. The examples of such actions include the propagation of the furlough scheme that helped in the payment of wages of more than 11 million jobs across the UK. Furthermore, under the furlough scheme, households could claim and receive incremental benefits following the establishment of the relationship between poor mental health and financial insecurity in the document. Thus, the economic welfare policies announced by the government in the form of creation and protection of jobs, capital investment to support the economy to recover from the impact of the pandemic, and giving debt advice to individuals whose mental health has been impacted for the year 2021 had been influenced by research underscoring that strong welfare policies are a protective factor for mental health as vulnerability to financial and employment insecurity is reduced.

On the other hand, economic initiatives during COVID-19 were not missing in Pakistan – the initiation of the Ehsas Emergency Cash flagship project that was promulgated as a social protection response to protect the most vulnerable in the country (Markhof, 2020) and food subsidies (Hashim, 2021) are cases in point. However, such initiatives were not put into effect as an amelioration to the poor mental health experienced by the population of Pakistan during COVID-19 as has been the case for England.

Suicide Prevention

Support programs launched such as the Coronavirus Job Retention Scheme during the pandemic by England proved to be a crucial part of preventing suicides because financial adversity has the potential to result in individuals being inundated with suicidal thoughts with a great possibility of acting upon them too (Department of Health and Social Care, 2023). Within Pakistan suicide is a hushed topic and suicide attempts were criminalized hitherto (The Express Tribune, 2022) under Section 325 of the Pakistan Penal Code 1860 stipulated that "Whoever attempts to commit suicide and does any act towards the commission of such offence, shall be punished with simple imprisonment for a term which may extend to one year, or with fine, or with both". In 2022, Section 325 of the Pakistan Penal code, a colonial remnant, was repealed by the passing of the Criminal Laws (Amendment) Act, 2022 in the Senate that decriminalized suicide on the basis of the understanding that the act of suicide is a result of depression or other mental illnesses or disorders reasoning that the "issue of suicide ought to be dealt as a disease and should be treated as one". Thus, the incrimination of individuals with imprisonment, a fine, or both has been lifted because "punishment is meant to create deterrence for a healthy person not for a mentally disturbed individual". Before learning from England by promulgating actions that can prevent the incidences of suicide, it is important that Pakistan develops a non-stigmatizing understanding of suicide and the causes behind it through state-led research such that the policies produced are aligned with the culture of Pakistan.

Initiatives for Housing Insecurity

Furthermore, through the acknowledgement of the fact that housing insecurity leads to poor mental health, the document produced by the Department of Health and Social Care (2021) stipulates that 6000 long-term homes were brought by the Ministry of Housing, Communities and Local Government (MHLG) over the period of four years to provide secure accommodation for those sleeping roughly on the streets. This is complemented by all areas within the UK to have a mechanism in place underpinned by the mental health needs assessment to further ensure that every area's mental health services can support rough sleepers. Furthermore, the MHLG has tasked itself with the Rough Sleeping Initiative that delivers several mental health roles such as mental health navigators or outreach workers to support rough sleepers.

England's Commitment to Bringing Individuals to Greenspaces

The positives of greenspaces on mental health have been well-documented in prior research that has demonstrated it to act as a buffer against stress (Barton and Rogerson, 2017) because exposure to greenspaces showcases a significant positive impact by reducing mental health conditions of depression and anxiety. This is augmented by the sanguine view of the Barton and Rogerson (2017) that this finding from the upper-middle and high-income countries can also be beneficial for the lower-middle income countries. This is because the mental health benefit can be reaped in a cheap manner (Nawrath *et al.*, 2021). This can further inform policymaking towards the end of mental health promotion to lead towards positive mental health outcomes through the increase in greenspace exposure (Zhang *et al.*, 2021) as spending time in nature is helpful for improvement in mood and making individuals feel relaxed.

Recognizing the mental health benefits of greenspaces, the English government is committed to increasing opportunities for people of all ages to enjoy national landscapes. Additionally, from 2020 to 2023, the government launched an ambitious project titled 'Preventing and tackling mental ill health through green social prescribing' to support communities disproportionately impacted by COVID-19 by promoting nature-based social prescribing, which involves referring individuals to nature-based activities as a treatment for mental health conditions such as stress, depression, and anxiety. It was a further aim of the project to enhance understanding of the way green social prescribing could address the needs of individuals with mental health problems, and those at risk of developing such conditions to help guide future

policy development as well (Department of Health and Social Care, 2021). Additionally, the NHS through its Long-Term Plan (2019) is playing an extensive role in influencing local communities by working with the government to design the built environment in a way that health and wellbeing are promoted by initiating 'Putting Health into Place' program. Accordingly, town planning has to take into account the incorporation of green spaces and physical activity to boost physical health and mental wellbeing of individuals such that healthier lifestyles are facilitated within an urban setting. Such an inclusion is needed when urbanization has reduced contact and exposure to the natural environment resulting in negative mental health outcomes that allows planned urban greenspace to provide an opportunity to improve mental health (Beemer *et al.*, 2021). The case of Pakistan is a representation of a bleak picture wherein the legislations under study have not mentioned the positives of greenspaces on mental health and the commitment of the state to increase their coverage as a buffer against mental health problems.

Loneliness and Social Isolation

Furthermore, the largely negative repercussions of loneliness and social isolation for psychological well-being and deterioration of mental health have been well-documented (e.g., Rhode *et al*., 2016). It has been observed that the COVID-19 pandemic further plummeted mental health because of strict lockdown policies followed across the globe (e.g., Pancani *et al*., 2021). Within the UK, loneliness had been recognized as a significant public health issue even prior to the pandemic (Groarke *et al*., 2020) that also led to the tackling of the affliction through the establishment of the ministry of loneliness (Pimlott, 2018). Within England, it has been reported that 45% of adults experience some degree of loneliness making the issue social and economic in nature (Díaz, 2021). Research elsewhere reports that 6% of adults "often/always" feel lonely – a result consistently produced for the year prior to the pandemic and for the pandemic year as well because it has been established that within England the pandemic period did not predict loneliness itself as the predictors of loneliness were similar to before the pandemic – young people, women, differently abled, and those not living with a partner (Department for Culture, Media, and Sport, 2022).

Nevertheless, the reality of loneliness cannot be dismissed, especially for older adults (Dahlberg and McKee, 2014) in England who consider it as a normal part of ageing (Victor and Sullivan, 2015). Thus, since the beginning of COVID-19, it has been stipulated by the Department of Health and Social Care (2021) that more than £31.5 million have been made as investments to organizations that support people experiencing loneliness. Such support is extended to individuals through social activities to get them to engage with the community while also perpetuating a national conversation on loneliness to inform the public in aiding themselves and one another in reducing it. Additional practices such as investing in the 'Know Your Neighborhood Fund' has the aim to increase volunteering to reduce chronic loneliness and 'Tackling loneliness with transport fund' to get an understanding into how transport policies can help in reducing the numbers of loneliness penned down by Department of Health and Social Care (2023) in their suicide prevention in England document.

It has been observed that the actions enshrined in the official policy documents to tackle the social determinants of mental health in England have been backed by the results produced by the primary research conducted in the population. Within Pakistan there is a dearth of research conducted to understand the reality on the ground that can help guide the making of apt policies. In that regard, it becomes crucial that Pakistan follows the practice done by the English government to conduct primary research that can provide the governing bodies with the mental health reality and the determinants of mental health to tackle those aspects before they act in conjunction to exacerbate the current situation into becoming an uncontrollable crisis.

Inclusion of Cultural and Indigenous understandings in Mental Health Legislation

A discussion on the meanings of mental health understood by different cultures and indigenous population in the literature review led to an understanding of the superiority of non-technical aspects of care such as connections, meaning, and relationships that stem from the recognition of different ontologies that influence the healing efficacy of individuals. Hence, they become pivotal to aiding in recovering from mental health issues (Bracken *et al*., 2016). Such recognition of the diversity of the meanings of mental health and its conception in different cultures has been missing in both the MHO 2001 and the England's mental health legislations, although the latter has acknowledged in various documents the importance of culturally informed mental health support, especially for the BAME community.

Within Pakistan, the presence of the mental health conceptualizations by vibrant indigenous, cultural, and ethnically diverse communities has not been made part of the MHO 2001. The meaning attributed to mental health by the indigenous communities in Pakistan are similar to the understandings of mental health as other indigenous communities around the world whereby the perceived causes of mental health problems have been understood as a web of biological, psychosocial and environmental factors (Choudhry *et al*., 2018). This is because the etiology of mental illness is encompassed in the supernatural and metaphysical aspects such as forgetting to honor one's ancestors, losing compassion for the wellbeing of another, disconnectedness from the land, the home, and the family, stemming from their understanding of an extended self which is holistically defined in terms of spiritual relationships, collective identity, ritual, community spirit, kinship, and sense of cohesion with an inextricable and inseparable link with the land and nature (Benning, 2013).

The research of Choudhry and colleagues (2018) expressed the emergence of psychological resilience within the indigenous Kalasha community of Pakistan in the face of mental health problems as a result of cultural protective factors in the form of intra-communal bonding, participation in festivals and traditions that bring a sense of fulfillment and meaningfulness, belief in the domains of purity and impurity that causes striving towards chastity and cleanliness and to stay away from the polluting forces and hedonistic pleasures to purify the soul, and the shared value of happiness that causes a persistence in pursuing joy during times of grief. This represents a mixture of the micro, meso, and macro systems, with the latter being the most important in guiding the lives of the Kalasha as they place greater value on their ancestral traditions and communal bonding. Nevertheless, the Kalasha have an array of interventions ranging from the emerging trend of getting *ta'awiz* (amulets) because of the influence from the Muslims settled in close proximity to the Kalash valley, to the traditional spiritual practice of shamanic treatment, herbal treatment, and communal problem sharing and solving along with the development of the understanding in the youth to acquire medical interventions owing to the medical causes of mental health problems.

Nonetheless, a problematic notion is observed in the mental health legislations of both Pakistan and England that the indigenous healing systems have been undermined in favor of the homogenization of psychiatry. This homogenization has emerged in spite of large cultural, social, and linguistic differences present in both states that have culminated in the "deleterious initial, secondary, and tertiary after-shocks within local culture systems, as the diffusion of Western-based knowledge promoted professional elitism and asylum-based responses to distress regardless of context, with over-use of medication and ECT" (electroconvulsive therapy) (Bracken *et al*, 2016, p. 508). This showcases the global fundamental inequality wherein power and wealth are to a great degree in the hands of the West that allow for the perpetuation of a similar narrative through legislation.

At the fundamental level, it is also important for both England and Pakistan to include a profound respect for other traditions by promulgating a comprehensive understanding of mental health at the beginning of the mental health legislation that is grounded in diffidence to allow for the inclusion of all cultural and indigenous aspects to showcase a holistic

understanding that manifests in the desire and readiness to learn from them (Bracken *et al*, 2016). Broadly, it has also been understood that the Pakistani society follows a collectivistic culture that proves to be a significant resource in providing care for those living with mental health conditions owing to the significant familial involvement in decision making (Dey and Mellsop, 2023), but such understandings have also been abstracted from the MHO 2001 that further impose the Western-based medical interventions as part of the solution.

Conclusion

Despite the differences in culture, the mental health policies of England serve as a benchmark for Pakistan to learn from. This is within the backdrop of understandings developed pertaining to the holistic understanding of mental health as beyond mental illness, mental disorders, and medical interventions. This is because there is an incorporation of cultural differences in response to mental health issues and their subsequent treatment in England's mental health legislations in the form of the BAME community. Furthermore, there is a recognition of the entrenched racism faced by the BAME community that thwarts their access to mental healthcare. It has also been recognized that awareness perpetuated through education as stipulated in the mental health legislation of England helps in reducing stigma – another factor worth learning for Pakistan..

Furthermore, it has been understood that social elements impact the mental health of individuals. Therefore, the inclusion and acknowledgment of social determinants within England's mental health legislation serve as a crucial model for Pakistani mental health policy. This recognition, supported by primary research, enables the government to take targeted actions to address these determinants effectively, given that they fall within the realm of governmental control. Nonetheless, England's mental health legislation does not address the indigenous understandings of mental health harkening to the fact that more work needs to be done for England's mental health policy to be well-rounded. However, this qualitative study did help in generating the hypothesis based on the analysis conducted that England's mental health legislation is inclusive, elaborative, and dynamic as compared to Pakistan, which can be tested empirically in subsequent studies.

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