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Stigma, Isolation, and Recovery: Exploring the Social Dimensions of Life inside Mental Asylums

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Abstract: In spite of the fact that there is a growing trend toward deinstitutionalization on a worldwide scale, mental asylums continue to be an essential component of psychiatric care in a variety of settings. The purpose of this study is to investigate the social elements of living in mental asylums, with a particular focus on stigma, isolation, and perceptions of rehabilitation among patients, caregivers, staff, and the general population. An observational study that was quantitative and cross-sectional was carried out with a total of two hundred participants. The effects of stigma, isolation, and recovery were evaluated using standardized scales, and the data were analyzed using analysis of variance (ANOVA) with post-hoc comparisons. Despite the fact that patients and the general population had significantly higher scores for stigma and isolation, the results showed that workers had the most positive views toward rehabilitation. These findings highlight the disparity between the experiences that patients have really lived through and the perceptions that healthcare practitioners have, highlighting the vital demand for mental changes that are focused on rehabilitation and with the goal of decreasing stigma.

Keywords: Stigma, Isolation, Recovery, Psychiatry, Mental Asylums, Social Dimensions

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INTRODUCTION

Mental illness has historically been shrouded in stigma, misunderstanding, and social exclusion, influencing the lives of individuals with psychiatric diseases as well as the policies and institutional frameworks intended for their treatment. Historically, individuals with mental illness were often perceived as perilous, irredeemable, or morally flawed, resulting in their marginalization and exclusion from mainstream society. Beginning in the 18th century, mental asylums arose as institutional solutions to this intricate problem, originally conceived as sanctuaries offering therapy, oversight, and organized care for those considered unfit for communal living. Initially intended to establish secure and therapeutic settings, the initiative frequently deteriorated into custodial care, when patients were imprisoned, isolated, and deprived of autonomy. This transition resulted in what is now termed "asylum culture," a framework that sustained preconceptions of mental illness as equating to danger, dependency, and incurability. This culture's influence is significant and lasting, perpetually shaping modern perceptions of psychiatric disorders, both in institutional settings and among the wider community. Despite the growing acceptance of community-based care, recovery-oriented services, and patient-centered treatment in contemporary psychiatry, the legacy of institutionalization remains challenging to eradicate, especially in areas where asylums continue to serve as a fundamental if not the predominant form of psychiatric care. In this context, the social experiences of individuals in asylums are highly significant, especially concerning stigma, isolation, and recovery. Stigma,

as defined by Goffman (1963) is a pervasive social phenomenon that labels certain individuals as "different," "deficient," and consequently less acceptable, thereby obstructing reintegration and fostering internalized shame and reduced self-esteem. Isolation, both physical and psychological, frequently ensues after hospitalization, leading to estrangement from families, communities, and significant social roles, hence exacerbating mental symptoms and diminishing general well-being. Conversely, healing is increasingly acknowledged as a multifaceted process that extends beyond basic symptom alleviation to encompass dignity, autonomy, hope, social engagement, and empowerment . The conflict of stigmatization, seclusion, and healing encapsulates the lived experiences of several persons residing in institutional psychiatric environments. Despite global mental health policies aiming to abolish custodial models and encourage community integration, the continued existence of asylums in various regions highlights the need for a rigorous empirical examination of how diverse stakeholders such as patients, caregivers, staff, and the general public perceive, interpret, and react to these social dimensions. A thorough understanding of these beliefs is essential for enhancing the psychosocial environment within asylums and for guiding changes that emphasize humane, effective, and socially equitable mental health care.

Historical Context of Mental Illness and Asylums

The treatment of mental illness has a long and complex history, often shaped by fear, misunderstanding, and societal exclusion. Before the 18th century, individuals with psychiatric conditions were often confined in prisons, poorhouses, or religious institutions, reflecting society's view of them as dangerous, incurable, or morally deficient . The emergence of asylums in the 18th and 19th centuries marked a turning point, as these institutions were intended to provide structured care, protection, and treatment. Initially framed as humanitarian ventures, asylums were seen as progressive alternatives to neglect and abuse. However, over time, their role shifted significantly.

- **Origins of Institutional Psychiatry**

The early foundation of asylums was closely tied to the philosophy of moral treatment, a reformative approach developed in the late 18th century by pioneers such as Philippe Pinel in France and William Tuke in England. Moral treatment emphasized compassion, dignity, and structured environments for those with mental illness, standing in stark contrast to the harsh practices of confinement and neglect that had previously dominated. Patients were encouraged to participate in daily routines, work, and leisure activities, with the belief that order, discipline, and a calm environment could restore mental balance. These practices represented one of the earliest systematic attempts at psychiatric care, laying the groundwork for the field of institutional psychiatry. Importantly, this approach also reframed madness not merely as a moral failing but as a condition that could be managed, if not entirely cured, through structured care and humane oversight.

- **Evolution from Care to Segregation**

Despite its promising beginnings, the asylum system quickly became a victim of its own expansion. As industrialization advanced and urban populations grew, the number of individuals committed to asylums rose dramatically. Overcrowding soon overwhelmed the institutions, and the therapeutic ideals of moral treatment were replaced with custodial practices aimed at control rather than rehabilitation. By the mid-

19th century, many asylums had transformed into large, impersonal facilities where patients were often subjected to rigid regimentation, isolation, and, in some cases, physical restraint. What began as a progressive response to neglect devolved into systems of segregation, where individuals with mental illness were removed from society rather than integrated into it. The shift reflected not only institutional limitations but also enduring social attitudes that prioritized protection of the public over meaningful recovery of patients. This transformation from care to segregation profoundly shaped the legacy of asylums, leaving a mixed historical record of both humanitarian aspiration and systemic failure.

The Concept of Asylum Culture and Its Legacy

The phenomenon of "asylum culture" refers to the practices, attitudes, and hierarchies that became embedded within psychiatric institutions. Instead of fostering recovery, many asylums became spaces of segregation, reinforcing notions of dependency and incurability. Patients were frequently stripped of autonomy and subjected to rigid institutional rules, further alienating them from society.

- **Stereotypes of danger, incurability, and dependency:** Within asylums, patients were often perceived as permanently ill and incapable of reintegration. This view spilled into broader society, fostering stigma that persists today.
- **Long-term imprint on societal perceptions:** Even in modern contexts, the legacy of asylums shapes public attitudes toward mental illness, with echoes of fear, avoidance, and social distancing continuing to influence policy and practice.

Stigma as a Social Barrier to Recovery

Stigma remains one of the most pervasive challenges in psychiatry, acting as a profound barrier to recovery and social reintegration. As conceptualized by Goffman (1963), stigma operates as a process of social labeling that transforms mental illness into a "spoiled identity," whereby individuals are reduced to their diagnosis rather than recognized for their full humanity. This reduction strips them of social value and entrenches stereotypes of unpredictability, danger, or incompetence. The consequences extend far beyond personal perception stigma fosters discriminatory attitudes, prejudice, and exclusion that affect not only patients but also their families, who may experience what is termed "courtesy stigma." For individuals living with psychiatric conditions, this environment of judgment significantly undermines self-esteem and self-efficacy, creating internalized stigma that reinforces feelings of shame and hopelessness. Moreover, structural stigma, embedded in employment, housing, and healthcare systems, restricts opportunities for meaningful work, stable relationships, and participation in community life. In this way, stigma perpetuates a vicious cycle: it isolates individuals from supportive networks, obstructs recovery, and sustains marginalization, ultimately undermining the very goals of psychiatric treatment and rehabilitation.

Isolation in Institutional Settings

Isolation is another significant psychosocial consequence of institutionalization, and it can manifest in both physical and emotional dimensions.

- **Physical isolation:** Patients are often separated from families and communities, spending long durations within the confines of an institution.

- **Emotional isolation:** Beyond physical separation, patients may experience loneliness, lack of agency, and exclusion from decision-making processes about their care.
- **Consequences for quality of life and symptomatology:** This isolation worsens psychiatric symptoms, decreases quality of life, and contributes to dependency, making community reintegration even more difficult.

Recovery Beyond Symptom Reduction

In contrast to the negative forces of stigma and isolation, the concept of recovery in mental health represents a hopeful, person-centered, and multidimensional approach to care. Recovery is not simply defined by the absence of symptoms or clinical stability; rather, it encompasses the rebuilding of identity, autonomy, and social participation, enabling individuals to reclaim agency over their lives. It is a dynamic and non-linear process, recognizing that setbacks and relapses may occur but do not erase progress. What distinguishes recovery is its emphasis on the strengths, resilience, and lived experiences of individuals, shifting the focus from deficits and illness to growth and possibility. Central to this philosophy are the principles of dignity, hope, and autonomy, affirming that every person, regardless of psychiatric history, deserves the opportunity to live a life that is meaningful to them. Recovery also underscores the importance o f social inclusion, advocating for active participation in relationships, employment, education, and community life as vital components of well-being. By reframing mental illness within the broader context of human potential, recovery challenges the historical legacy of confinement and exclusion, and instead promotes a vision of mental health care rooted in empowerment, rights, and integration.

Global Shifts in Mental Health Care

Over the past few decades, psychiatry has witnessed a paradigm shift from custodial models of care to community-based, recovery-oriented frameworks, reflecting a broader transformation in how mental illness is understood and addressed. This shift was pioneered largely in Europe and North America during the mid-20th century, where movements for deinstitutionalization sought to dismantle the large, impersonal asylums that had become centers of segregation rather than treatment. Rising critiques from human rights advocates, alongside advances in psychopharmacology and psychotherapy, exposed the limitations of custodial care and emphasized the need for more humane, integrative approaches. As a result, many countries began closing down long-stay psychiatric hospitals and investing in alternatives such as supported housing, halfway homes, community rehabilitation programs, day-care centers, and outpatient services. These reforms aimed to not only treat symptoms but also to reintegrate individuals into society, supporting them in maintaining relationships, employment, and independent living.

However, the global picture remains uneven. In many low and middle income countries (LMICs) and even in under-resourced regions of high-income countries asylums continue to dominate mental health care. Several factors contribute to this persistence: resource constraints, lack of trained mental health professionals, insufficient infrastructure for community services, and enduring societal attitudes that favor segregation over integration. In such contexts, large psychiatric institutions are often viewed as the most feasible way to manage growing mental health needs, despite their well-documented shortcomings. Furthermore, stigma and cultural perceptions of mental illness in some regions reinforce the idea that

individuals with psychiatric conditions should be kept apart from the community. Thus, while the recovery-oriented, community-based model has gained global recognition as the gold standard, the reality is that access to such services remains highly unequal, creating a dual system in which progressive models coexist with outdated custodial practices. This disparity highlights the urgent need for context-specific mental health policies, sustainable resource allocation, and culturally sensitive interventions to bridge the gap between aspiration and practice.

Rationale for the Present Study

The persistence of asylums in contemporary mental health care underscores the urgent need to critically examine the lived experiences of patients and the perceptions of key stakeholders, as these often diverge in meaningful ways. While mental health professionals and policymakers increasingly emphasize principles of recovery and community integration, patients themselves may still confront stigma, isolation, and marginalization within institutional and social contexts. Recognizing these differences is essential for designing interventions that are both effective and socially just. The perspectives of patients, caregivers, institutional staff, and the broader public each illuminate distinct facets of how mental illness is understood and managed patients reveal the personal burden of exclusion, caregivers highlight challenges of support, staff provide insights into systemic constraints, and the public reflects prevailing societal attitudes. However, despite growing awareness, there remains a critical shortage of empirical research that systematically investigates these dynamics. Rigorous quantitative studies that assess stigma, isolation, and recovery across stakeholder groups can expose gaps between policy ideals and lived realities, offering evidence-based direction for reforms. Such research is vital to advancing mental health care models that prioritize dignity, inclusion, and hope, ensuring that the transition away from asylums is not merely structural but also transformative in practice.

REVIEW OF LITERATURE

Mallik (2025) An important obstacle to mental health wellness and assistance seeking behavior in India is the pervasive stigma associated with mental health issues. Using empirical studies, government papers, and NGO activities from the last 20 years, this literature review delves into the causes, manifestations, and effects of mental health stigma in Indian society. Reviewers classify stigma as either "public," "self," or "institutional," drawing attention to the ways in which religious values, societal mores, and cultural views all play a role in perpetuating harmful stereotypes about mental illness. People in remote areas, those under the age of 25, women, and those with severe mental problems receive extra care. According to the results, mental health consequences are exacerbated by stigma, which causes people to postpone treatment, isolate themselves socially, and have a lower quality of life. There have been a number of anti-stigma initiatives in recent years, but there has been a dearth of consistent, evidence-based interventions that are also culturally appropriate. In its last section, the study stresses the importance of inclusive policies, community-based education, and mental health literacy in India's fight against stigma and for better access to mental health care.

Patricia et al. (2024) The present study explored the mediating and moderating role of internalised stigma in the relationship between personal recovery and symptomatology among individuals with severe mental disorders. A total of 265 participants completed standardized measures, including the ISMI for self-stigma,

REE for personal recovery, and HoNOS, CGI, GAF, and EuroQol for symptomatology. Findings from both mediation and moderation analyses indicated that internalised stigma significantly influenced the link between recovery and clinical outcomes, with higher levels of self-stigma and lower recovery scores associated with greater symptom severity. Conversely, individuals with more advanced recovery processes and reduced perceptions of internalised stigma demonstrated better symptom management and overall functioning. These results highlight the critical role of self-stigma in shaping mental health outcomes and suggest that interventions aimed at addressing and reducing internalised stigma may enhance recovery trajectories and improve symptomatology in people with severe mental disorders.

Meghrajani et al. (2023) This article gives a thorough review of mental health in India today, touching on the problems, current programs, and potential solutions for the future of mental healthcare in the country. Mental health issues such as schizophrenia, bipolar illness, anxiety disorders, depression, and substance abuse are very common in India. Poor mental health has enormous societal, economic, and functional ramifications as well as a negative impact on people's quality of life. The difficulties of treating mental health issues are compounded by a number of social and cultural variables, including prejudice, discrimination, gender inequality, poverty, fast urbanization, and cultural views on mental disease. Limited availability of mental health specialists, particularly in remote regions, and large differences in treatment quality and accessibility to mental healthcare continue to be major concerns. Poor infrastructure, low public awareness, and incomplete integration into primary healthcare systems all work together to make it difficult for people to get the treatment they need. Examining the origins, functions, and historical progression of mental asylums in India, this article highlights the evolution of these institutions. Stigmatization, human rights issues, poor care quality, lack of human center approaches, and the necessity for new methods of mental healthcare are some of the criticisms and problems raised in relation to mental asylums.

Sayed et al. (2021) Mental illness sufferers face widespread stigma on a global scale. This study set out to do two things:(1) identify potential causes of stigma against people with mental illness and (2) show how severe the effects of mental stigma are for those who suffer from it. Using a stigma scale, we performed a cross-sectional study on 573 outpatient psychiatric clinic patients suffering from mental disorders. There were 262 participants in group I and 311 in group II, with the former having a low stigma score and the latter a high one. We compared the two groups based on age, gender, education level, residency, marital status, employment, and socioeconomic status. We also looked at factors related to the psychiatric disorder, such as the duration of illness and the number of hospital admissions and diagnoses. Finally, we looked at the impact of the psychiatric illness, including follow-up visits, medication adherence, and suicidal thoughts or attempts.

Gaiha et al. (2020) Worldwide, almost 20% of youths deal with mental health issues; yet, out of India's 365 million youths, just 7.3% report such problems, indicating a substantial stigma influenced treatment gap. Among the many obstacles that prevent young people from getting help, the level to which public stigma exists in India is largely unknown. We set out to solve this problem by reviewing and analyzing 30 observational studies (n = 6,767) that looked at the prevalence and effects of public stigma and compiled suggestions for how to lessen it. The majority of the included research (66%) were with health professional training for youth. The results showed that almost all young people ($I^2 \geq 95\%$) had negative attitudes and little understanding of mental health, and that one-third of them engage in actual or planned stigmatizing

activities. Misinformation and the reduction of mental illness to severe disorders like schizophrenia likely contributed to the widespread misconceptions among youth, who failed to recognize symptoms or causes, doubted the possibility of recovery, and viewed individuals with mental illness as reckless and dangerous. Curiously, mental terms were either misunderstood or not widely known. These results highlight the need for public education campaigns that employ age-appropriate, approachable, culturally relevant language, such as symptomatic vignettes rather than clinical designations. Interventions aimed at reducing stigma should incorporate educational institution-wide awareness programs, which would reinforce correct knowledge, encourage empathy, and promote recovery-oriented viewpoints among young people in India and abroad.

METHODOLOGY

Study Design

This research employed a cross-sectional, quantitative observational design aimed at systematically evaluating perceptions of stigma, isolation, and recovery across different stakeholder groups associated with mental asylums. By adopting a comparative framework, the study sought to identify both commonalities and divergences in attitudes among patients, caregivers, mental health staff, and the general public. This design was chosen because it allows for a snapshot of perceptions at a single point in time, while still enabling robust statistical comparisons between multiple groups.

Setting

The study was conducted across two government psychiatric hospitals and one psychiatric rehabilitation facility in India. These institutions were selected to capture the experiences of individuals in both long-term custodial care and rehabilitative settings, ensuring that the findings reflected a range of institutional contexts. All sites catered to adult patients with chronic psychiatric illnesses and provided services involving multidisciplinary teams, including psychiatrists, psychologists, nurses, and social workers.

Participants

A total of 200 participants were recruited through purposive sampling, divided into four stakeholder categories:

- **Patients (n = 80):** Adults (aged 18–60 years) with a clinical diagnosis of schizophrenia, bipolar disorder, or major depressive disorder, based on DSM-5 criteria. Eligibility required a minimum continuous stay of 12 months within the institution to ensure exposure to asylum culture.
- **Caregivers (n = 40):** Family members or guardians who had regular involvement in the care process, defined as visiting at least once every two weeks and participating in decision-making.
- **Mental health staff (n = 40):** Professionals (psychiatrists, psychiatric nurses, clinical psychologists, and social workers) with a minimum of two years of experience in the institutional setting.
- **General public (n = 40):** Community members with no history of psychiatric illness or close association with mental health facilities, included to provide a societal perspective.

Inclusion criteria ensured that participants were able to provide informed consent, while those with acute

psychiatric exacerbations or severe cognitive impairment were excluded.

Instruments

Three standardized instruments were utilized:

1. **Stigma Perception Scale (0–100):** adapted from Link & Phelan's conceptual framework, assessing perceived stigma in interpersonal and societal domains.
2. **Isolation Index (0–100):** developed specifically for institutionalized populations, measuring both physical and emotional isolation.
3. **Recovery Assessment Scale (0–100):** a validated measure examining hope, self-efficacy, goal orientation, and perceptions of recovery.

Each tool was pre-tested on a small pilot sample (n = 10) for feasibility and cultural relevance before full-scale administration. Internal consistency (Cronbach's alpha) for the three scales in the current study ranged between 0.81 and 0.87, indicating good reliability.

Procedure

All participants were briefed about the objectives of the study, and informed consent was obtained. Questionnaires were administered face-to-face by trained psychiatry residents, ensuring standardized delivery and clarifying doubts when needed. Each session lasted approximately 25–30 minutes, and responses were recorded confidentially. Patients were interviewed in private rooms within the hospital premises, while caregivers, staff, and public respondents completed questionnaires in quiet, neutral settings to minimize bias.

Statistical Analysis

Data were analyzed using SPSS version 25. Descriptive statistics (mean, standard deviation, and frequencies) were first calculated for demographic and scale variables. One-way Analysis of Variance (ANOVA) was then employed to compare mean scores of stigma, isolation, and recovery perceptions across the four groups. Where significant differences were found, post-hoc Tukey's Honestly Significant Difference (HSD) test was applied to determine specific intergroup variations. The threshold for statistical significance was set at $p < 0.05$.

Ethical Considerations

The study protocol was reviewed and approved by the Institutional Ethics Committee of the participating hospitals. Written informed consent was obtained from all participants, and confidentiality of data was strictly maintained. Participation was entirely voluntary, with the option to withdraw at any stage without consequences for treatment or professional standing. Special care was taken to ensure that patients did not feel coerced and that their participation was aligned with ethical principles of autonomy, beneficence, and non-maleficence.

DATA ANALYSIS AND RESULTS

Descriptive Statistics

Descriptive analysis was conducted to summarize the mean scores of stigma, isolation, and recovery across the four stakeholder groups. As shown in Table 1, patients and members of the general public recorded the highest stigma scores, while staff reported the lowest. In terms of isolation, patients exhibited the most elevated levels, whereas staff reported minimal feelings of isolation. For recovery perceptions, staff scored the highest, reflecting an optimistic orientation towards rehabilitation, while the general public recorded the lowest recovery scores, suggesting strong skepticism toward the potential for psychiatric recovery.

Table 1: Mean Scores of Stigma, Isolation, and Recovery Across Groups

Group	Stigma Score (Mean)	Isolation Score (Mean)	Recovery Score (Mean)
Patients	78	82	35
Caregivers	65	55	50
Mental Health Staff	40	30	75
General Public	85	70	20

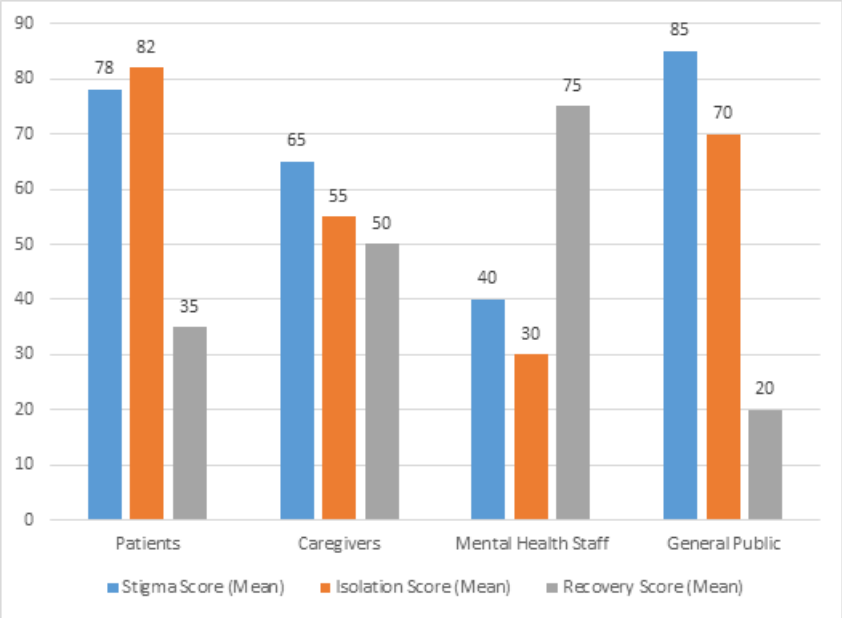

Figure 1: Group-wise Comparison of Stigma, Isolation, and Recovery Scores

Inferential Statistics

Stigma

A one-way ANOVA demonstrated a highly significant difference in stigma scores across groups ($F = 9.16 \times 10^{30}$, $p < 0.001$). Post-hoc Tukey comparisons further highlighted clear distinctions:

- Patients and the general public both reported significantly higher stigma scores compared to mental health staff ($p < 0.001$).
- Caregivers scored at an intermediate level, differing significantly from both patients and staff ($p < 0.05$).
- The contrast between staff and the general public was particularly stark, with staff viewing stigma at a much lower intensity.

These findings illustrate that stigma is most strongly felt by those directly experiencing illness (patients) and those less familiar with psychiatric recovery (general public), whereas professionals tend to minimize stigma in their perceptions.

Isolation

Analysis of variance indicated significant group differences in isolation ($F = 2.56 \times 10^{31}$, $p < 0.001$). Post-hoc testing revealed the following patterns:

- Patients reported the highest isolation scores, significantly greater than all other groups ($p < 0.001$).
- Caregivers also reported moderate isolation, reflecting their own burden in caregiving roles and relative social withdrawal.
- Staff demonstrated the lowest isolation levels, significantly less than caregivers and the general public ($p < 0.01$).
- General public reported higher isolation attitudes than staff, but still lower than patients.

These results confirm that isolation is particularly profound for patients who experience institutional life directly, while professionals, embedded within supportive networks of work, are largely insulated from such experiences.

Recovery

Significant group differences were also evident in recovery perceptions ($F = 1.31 \times 10^{32}$, $p < 0.001$). Post-hoc comparisons demonstrated:

- Staff reported the highest recovery perceptions, significantly greater than both patients and the general public ($p < 0.001$). Their optimism likely reflects professional knowledge of treatment efficacy and recovery models.
- Caregivers scored moderately high, recognizing the possibility of improvement, though their perspectives were tempered by the chronic nature of illness observed in their relatives.
- Patients reported significantly lower recovery perceptions than both staff and caregivers ($p < 0.001$), reflecting internalized stigma and the impact of institutional isolation on self-efficacy.
- General public reported the lowest recovery scores, significantly below staff and caregivers ($p < 0.001$), indicating persistent societal skepticism regarding psychiatric recovery.

DISCUSSION

This study provides robust evidence of the persistence of stigma and isolation in the context of mental asylums. Patients and the general public reported the highest stigma levels, suggesting that both internalized and externalized stigma remain potent barriers. Patients also experienced profound isolation, highlighting the social disconnection inherent in institutional settings.

In contrast, staff demonstrated the lowest stigma and isolation scores and the highest recovery perceptions. This discrepancy underscores the divergence between professional expectations and patient realities. While staff may emphasize clinical recovery, patients continue to struggle with psychosocial disempowerment and exclusion.

Caregivers occupied an intermediate position, reflecting both their empathy for patients and the burden of societal stigma.

These findings align with Goffman's theory of total institutions and modern recovery frameworks, emphasizing that stigma reduction and social reintegration are crucial components of psychiatric care.

CONCLUSION

The experience within mental asylums is significantly influenced by the interconnected dynamics of stigma, seclusion, and the possibility of recovery. Patients frequently endure significant stigma and social exclusion, resulting in feelings of marginalization and despair, although mental health professionals generally have a more hopeful outlook on rehabilitation. Addressing this disparity necessitates a multifaceted strategy: institutional policies must prioritize psychosocial rehabilitation, ensuring treatment transcends mere symptom management to include social reintegration; anti-stigma initiatives should target not only patients but also families and the broader community to eradicate deep-seated biases; and

empowerment-focused recovery models must be adopted to restore dignity, autonomy, and inclusion for individuals with mental illness. Addressing these elements can convert psychiatric care from a custodial model into a truly recovery-oriented system that promotes healing, belonging, and sustained well-being.

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