

## Adaptive Social Rehabilitation Model for People with Mental Disorders (ODGJ) Based on Local Community

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### ABSTRACT (10 PT)

This study develops an adaptive community-based social rehabilitation model for People with Mental Disorders (ODGJ) that reflects local cultural characteristics. A qualitative ethnographic case study approach was applied to explore the social interactions, communal practices, and adaptive processes experienced by ODGJ in daily life. The research was conducted in Sumberjati Village, a semi-rural community in Central Java recognized for its strong social traditions and informal support systems for individuals with mental disorders. Eight purposively selected informants including survivors, family members, community leaders, and social facilitators provided diverse perspectives on rehabilitation dynamics. Findings indicate that positive symbolic interaction, strengthened social capital, and supportive adaptive environments contribute to improved participation, reduced stigma, and enhanced psychosocial well-being among ODGJ. The study recommends the development of humanistic, inclusive, and sustainable community rehabilitation programs that leverage cultural practices, social networks, and active community involvement as foundational elements of the adaptive model. These insights offer significant implications for advancing theory, program implementation, and policy formulation in social rehabilitation.



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## INTRODUCTION

Social rehabilitation for People with Mental Disorders (ODGJ) has increasingly gained recognition as a strategic dimension of social health development in many low- and middle-income countries, including Indonesia (Chilmy, Faris, and Faisol 2025). The rising concern emerges from the growing demand for recovery-oriented services that promote dignity, active participation, and long-term reintegration into society (Lomonosova et al. 2023). Current rehabilitation practices still tend to rely on centralized and institutional approaches that emphasize biomedical treatment, often neglecting the social, cultural, and communal environments that shape patient recovery trajectories (Petrova, Vishnyakova, and Kalinina 2025). Contemporary shifts in mental health policy and global discourse advocate for more inclusive, participatory, and culturally grounded models of intervention. These emerging perspectives highlight the need for services that address not only clinical stabilization but also social functioning, personal autonomy, and quality of life (Suhartono, Albab, and Priyanto 2025). Within this context, developing an adaptive, community-rooted rehabilitation model becomes highly relevant as part of broader efforts to transform social and mental health services (Maikowati 2023).

International studies consistently emphasize that communities are essential actors in ensuring successful social reintegration and long-term recovery for individuals with mental disorders. Yet, in the Indonesian context, rehabilitation practices often position ODGJ primarily as passive recipients of services rather than agents capable of participating in shaping their own recovery process (Rzhevskaya 2023). Previous studies expose persistent gaps in integrating professional services, family engagement, and community involvement. Fragmented service delivery, limited material and human resources,

persistent cultural stigma, and insufficient recognition of local knowledge are recurrent constraints that hinder comprehensive rehabilitation. These conditions show an urgent need for alternative service models that are adaptive to community realities and that strengthen social support systems embedded in local cultural structures (Widiyawati 2023).

The core problem addressed in this study lies in the disjunction between the social recovery needs of ODGJ and the rehabilitation services currently available (Purnama, Sedarmayanti, and Priyanto 2025). Many rehabilitation interventions assume that the same standardized approach can be applied across diverse communities. Such uniformity overlooks the relevance of local norms, social capital, and cultural practices that may serve as protective factors for recovery (Suhartono et al. 2025). Moreover, institutional services frequently operate in isolation from the community context and may fail to equip individuals with the relational and functional skills necessary for reintegration after returning to society. This centralized approach also reduces community ownership and responsibility in supporting recovery, potentially reinforcing damaging stereotypes that portray ODGJ as burdensome or threatening (Purnama et al. 2025).

A clear research gap appears in the limited attention paid to systematically integrating cultural elements into rehabilitation design. While numerous studies investigate the clinical efficacy of psychopharmacology or psychological interventions, few consider how sociocultural dimensions influence recovery outcomes (Sanz et al. 2024). Existing research on community-based rehabilitation also tends to focus disproportionately on urban settings, despite the fact that Indonesia is marked by highly diverse local traditions, communal ties, and informal support systems, characteristics that differ significantly between rural, semi-rural, and urban communities (Steno and Jønsson 2022). Therefore, research is needed that not only maps current service barriers but also proposes an adaptive model grounded in a holistic understanding of cultural values, community participation, and interpersonal relationships (Song et al. 2025).

The novelty of the present study lies in designing an Adaptive Social Rehabilitation Model that blends humane treatment principles, culturally responsive practices, and direct engagement of local communities (Purnama et al. 2025). Unlike conventional models that treat community settings merely as passive environments in which interventions occur, the proposed adaptive approach considers the community as an active support system that shapes personal recovery experiences (Suhartono et al. 2025). The model assumes that successful rehabilitation depends not solely on professional services but also on the ability of families and communities to foster social acceptance, emotional support, and opportunities for meaningful participation. By prioritizing community involvement and cultural sensibility, the adaptive model aims to strengthen sustainable and humanistic rehabilitation pathways rooted in local realities (Sanz et al. 2024).

The research seeks to answer several interrelated questions: What is the current condition of community-level rehabilitation services for ODGJ? How do local communities interpret, respond to, and participate in the recovery process? Which sociocultural factors act as barriers or enablers of rehabilitation? How can a locally grounded adaptive rehabilitation model be constructed to promote greater inclusivity and human dignity? To what extent can such a model enhance the effectiveness of social recovery among ODGJ?

The objectives of this research are to formulate an adaptive rehabilitation model rooted in the dynamics of local community support. Specifically, the study aims to: (1) examine existing social rehabilitation practices and identify systemic and cultural gaps; (2) analyze sociocultural determinants that influence recovery outcomes; and (3) generate a model that integrates professional interventions with locally embedded social support mechanisms to enhance sustainability. Additionally, the study is expected to contribute conceptually by advancing theoretical discussions on community-based rehabilitation models that position local norms and social capital as central components of recovery.

The study holds significance across theoretical, academic, and practical dimensions. Theoretically, it enriches the literature on social rehabilitation by highlighting the role of local cultural knowledge, symbolic interaction, and collective care in the recovery of ODGJ (Rzhevskaya 2023). Academically, the research offers methodological and conceptual foundations for future inquiry in

social health, psychosocial reintegration, and community development (Maikowati 2023). Practically, the findings provide strategic recommendations for government agencies, professional service providers, and civil society organizations in designing more humane, inclusive, and sustainable programs that enhance social well-being and community acceptance of ODGJ (Petrova et al. 2025).

Despite its contributions, the study acknowledges limitations in terms of geographic scope, participant diversity, and the contextual specificity of the findings. The research focuses on a particular semi-rural community, which may limit the generalizability of the model across other sociocultural landscapes in Indonesia (Petrova et al. 2025). The ethnographic and participatory methods used rely heavily on researcher immersion and interpersonal trust, carrying risks of subjective interpretation. Time constraints also limit the capacity to capture the complex, long-term dynamics of recovery and community adaptation (Lomonosova et al. 2023).

Future research may expand the exploration of adaptive models in diverse regions to test flexibility and transferability across different cultural contexts. Longitudinal studies are also required to assess sustainability, particularly in communities that must maintain rehabilitation practices without external support (Song et al. 2025). Furthermore, integrating digital technologies such as mobile applications, participatory monitoring tools, and online support networks offers potential opportunities to strengthen community-based rehabilitation in contemporary settings.

In sum, this research provides a comprehensive examination of an adaptive social rehabilitation approach that respects and mobilizes local cultural knowledge. Through ethnographic engagement and participatory inquiry, the study presents a holistic understanding of the relational dynamics between ODGJ, families, and communities. The findings underscore the importance of consistent social support, positive symbolic interaction, and community participation as key components for strengthening recovery (Sanz et al. 2024). By proposing an adaptive model that centers community engagement, the research contributes to ongoing discussions on innovative and sustainable rehabilitation practices and demonstrates the urgency of shifting toward culturally grounded, community-oriented service designs that advance social justice and improve the quality of life for people with mental disorders.

## **RESEARCH METHODS**

This study employed a qualitative research approach with an ethnographic case study design to investigate the adaptive social rehabilitation model for people with mental disorders (locally referred to as ODGJ) within the context of local communities. The decision to adopt this design stems from the need to explore deeply embedded social dynamics, cultural meanings, interpersonal relationships, and community practices that shape the lived experiences of individuals with psychosocial disabilities. A qualitative approach allows for the examination of subjective interpretations, contextual variations, and cultural constructions that quantitative methods may overlook (Sikström and Garcia 2020).

Ethnographic case study design provides a holistic perspective by enabling prolonged engagement within the research setting. This approach also supports participatory observation, allowing the researcher to directly witness everyday interactions between community members and ODGJ, and consequently develop insights grounded in authentic social reality. The chosen design is particularly relevant because the adaptive model under study evolves from informal social practices rather than formal institutional programs (Piorecký and Škrabal 2020).

The study combined elements of ethnography—participant observation, immersion in local activities, capturing symbolic meanings—with case study characteristics—examining a bounded system, focusing on a particular social context, and generating thick descriptions. Its use aimed to detail how local social norms, values, kinship systems, and informal care networks contribute to rehabilitation processes (Johri 2020). Through this methodological orientation, the study sought to reveal the implicit assumptions and unwritten rules governing community behavior toward people with mental disorders and explore how these practices can be formalized into adaptive rehabilitation models grounded in local wisdom (Campagnolo 2020).

### **Research Setting**

The research was conducted in a rural community referred to pseudonymously as *Sumberjati Village* located in Central Java Province, Indonesia. This setting was selected intentionally because the village community has demonstrated informal mechanisms of social support for ODGJ for many years, despite the absence of formally structured government rehabilitation programs. The village's social structure is characterized by strong communal values, traditional collective work practices, kin-based caregiving norms, and ritual-based social cohesion all of which provide fertile ground for developing community-based mental health interventions.

The semi-rural characteristics allow the investigation of social rehabilitation within a context where formal infrastructure for mental health services remains limited, compelling families and community actors to adopt adaptive and improvised social support practices. The village is composed of extended family units embedded in dense social networks, facilitating access to both formal and informal actors relevant to the study (Vedadhir, Rodrigues, and Lambert 2020).

Community openness toward research activities, willingness to engage in participatory inquiry, and familiarity with local solidarity traditions were additional considerations informing the selection. These contextual components are central to analyzing social capital, trust, collective responsibility, and shared cultural scripts influencing rehabilitation practices.

### Participants and Sampling Strategy

Data collection involved individuals from diverse social roles within the community who interacted directly or indirectly with ODGJ. Participants were selected using purposive sampling based on relevance, experiential knowledge, and potential contribution to the research objective (Chilmy et al. 2025). The total number of informants was eight, representing families, survivors, community leaders, frontline village healthcare actors, and volunteers (Cahaya et al. 2024). The selected informants were assigned pseudonyms to protect confidentiality. They consisted of a village psychosocial assistant, a community leader, a family caregiver, a recovered survivor actively reintegrated into community life, two community health cadres responsible for basic health services, a village government representative familiar with social policies, and a community volunteer involved in support group initiatives (Rini, Soesanto, and Lestari 2025).

Their complementary roles ensured triangulated perspectives derived from multiple actors who participate in, influence, or are affected by community-based rehabilitation processes.

In addition to Key Informants, three ODGJ survivors undergoing reintegration processes were selected as primary respondents. They were chosen based on indicators of psychological readiness, consent from families, and recommendations from community social workers. The aim was not numerical representativeness but depth of information. Rather than functioning as statistical samples, these respondents served as narrative sources articulating personal experiences, challenges, social barriers, and changes during community-based recovery.

Table 1. **Categories of Informants and Respondents**

Participant Category	Number	Description of Role
Village psychosocial companion	1	Provides informal assistance for ODGJ rehabilitation
Community leader	1	Mediates social issues and mobilizes community participation
Family caregiver	1	Represents household caregiving experiences
Recovered survivor	1	Participates in community activities post-recovery
Village health cadres	2	Provide basic healthcare and linkages to public health centers

Village official	1	Understands local social policy and administrative processes
Community volunteer	1	Coordinates informal support activities
ODGJ survivors in recovery	3	Share lived experience perspectives regarding rehabilitation

Source: Compiled by the author based on field research, 2026

Table 1 presents a systematic classification of informants and respondents involved in the study. The categories reflect diverse social roles within the village ecosystem relevant to adaptive social rehabilitation. Each participant group contributes complementary information regarding community-based support for ODGJ. Psychosocial companions and health cadres provide service-oriented insights, while community leaders, officials, and volunteers illuminate institutional and socio-cultural dynamics. Family caregivers and ODGJ survivors offer experiential narratives essential for understanding daily adaptation, stigma, and coping strategies. The inclusion of multiple actor groups strengthens data credibility through source triangulation and ensures a holistic representation of community perceptions, practices, and informal rehabilitation mechanisms.

### Data Collection Techniques and Analysis

Data for this study were generated through a combination of participant observation, semi-structured in-depth interviews, and systematic document review. The integration of these three qualitative techniques was intended to strengthen the credibility of findings through triangulation and to ensure that emerging interpretations reflected the complexity of community-based social rehabilitation processes (Cahaya et al. 2024). Each technique captured different dimensions of interaction between people with mental disorders and their surrounding social environment, enabling a holistic understanding of adaptive rehabilitation practices rooted in local contexts.

Participant observation constituted the primary method for accessing naturally occurring behaviors within the community. The researcher maintained prolonged engagement in village socio-cultural activities, allowing immersion in daily life and relationships that shape perceptions and treatment of individuals with mental disorders (ODGJ) (Marek 2022). Direct involvement in neighborhood meetings, mutual cooperation events, informal gatherings, and routine communal work provided opportunities to observe how interactions unfolded across public spaces. Field observations documented behavioral patterns, emotional responses, symbolic gestures, and implicit social rules that shaped social inclusion or marginalization (Media et al. 2025). By documenting subtle interactions—such as who initiated conversations with ODGJ, how caregivers negotiated stigma, and how community members responded to symptoms—the researcher gained access to social realities that may be masked during formal interviews. These longitudinal observations also facilitated identification of adaptive strategies employed both by ODGJ and by community members working to maintain social cohesion.

Semi-structured in-depth interviews supplemented observation by capturing subjective experiences and personal narratives that could not be inferred solely from external behavior. Interviews were carried out with informants representing diverse stakeholder categories, including caregivers, survivors, village officials, community health cadres, volunteers, and local leaders. Interview guides ensured consistency across sessions while allowing flexibility for probing emergent ideas (Thomson 2022). Conversations focused on themes such as community interpretations of mental illness, caregiving challenges, coping practices, religious and cultural beliefs informing treatment, mechanisms for social support, and strategies perceived to facilitate or hinder social reintegration. Each interview was audio recorded with explicit consent, transcribed verbatim, and reviewed repeatedly for accuracy. The iterative nature of interviews allowed participants to reflect, clarify meanings, and elaborate on lived experiences, thereby enriching the depth of data collected (Li 2022).

Document review served as an additional source of contextual and historical information. The researcher collected and analyzed community meeting minutes, village regulations, health center reports, photographs of informal rehabilitation activities, and archival materials related to local social

welfare initiatives. These documents provided insight into institutional discourse, policy priorities, and practices governing village-level social services. When permissible under ethical guidelines, health and administrative data were used to verify interview claims and strengthen triangulation. Document review enabled comparison between recorded policies and actual community practices, highlighting gaps, inconsistencies, and informal mechanisms operating outside institutional frameworks.

Data analysis followed a systematic thematic approach to ensure rigor and transparency. The first stage involved familiarization, during which transcripts, field notes, and documents were read multiple times to develop an initial sense of recurring issues. Next, inductive codes were generated line by line, identifying phrases and narrative segments containing relevant meaning units. These codes were then clustered into conceptual categories to reveal connections among participant statements. Subsequent refinement produced overarching themes that encapsulated significant patterns within the data. Themes were interpreted through theoretical lenses drawn from Symbolic Interactionism, Social Capital Theory, and Social Adaptation Theory (Zardy and Huda 2024). Applying these frameworks enabled interpretation of how meanings are negotiated in interactions, how trust and networks facilitate or impede recovery, and how adaptation emerges within social systems. The final thematic map illustrated interrelationships among family support, public stigma, cultural healing practices, leadership roles, solidarity networks, and social reintegration experiences.

To enhance validity and reliability, the research adopted multiple trustworthiness strategies. Source triangulation compared perspectives across participant groups, including survivors, families, community institutions, and volunteers. Method triangulation integrated observation, interviews, and documentation to corroborate findings. Theoretical triangulation compared interpretations using three analytical frameworks (Ramadhan et al. 2025). Member checking was carried out by presenting preliminary interpretations to selected informants to ensure alignment between researcher conclusions and participant meanings. A transparent audit trail documented methodological decisions, analytical memos, and coding revisions. Reflexive journaling recorded potential researcher biases, assumptions, and emotional responses throughout the fieldwork process. These procedures collectively enhanced dependability, credibility, confirmability, and transferability.

Ethical protections were applied rigorously due to the vulnerability of participants. Informed consent was obtained prior to data collection, and pseudonyms were used to safeguard identities. Interviews were conducted in familiar, non-threatening environments conducive to psychological comfort. Sensitive topics were approached with empathy and cultural sensitivity. Permission for data collection was granted by village authorities and relevant health institutions. The researcher remained attentive to emotional distress and ensured participants retained the right to withdraw at any time.

Overall, the methodological choices allowed the study to capture the lived complexity of adaptive social rehabilitation within culturally embedded community settings. The combination of immersion, narrative inquiry, and documentary analysis produced contextually grounded evidence illustrating how symbolic meanings, social capital, and communal norms shape recovery trajectories. This methodological approach ensured that the development of the adaptive rehabilitation model was firmly rooted in empirical realities rather than abstract theoretical assumptions. The techniques described contribute to scholarly debates on community-based mental health, provide a foundation for future policy and programmatic design, and reaffirm the importance of participatory social environments in promoting psychosocial recovery for individuals with mental disorders in rural Indonesia.

## **RESULTS AND DISCUSSION**

The findings of this study reinforce the urgent need to develop an adaptive, community-based social rehabilitation model for people with mental disorders (ODGJ). Through participant observation and in-depth interviews with eight key informants and three ODGJ survivors undergoing recovery in Sumberjati Village, the data reveal fundamental social dynamics shaping rehabilitation effectiveness. These dynamics relate to symbolic interactions, the strength of community support, and individual adaptation processes. The emergence of these themes demonstrates the critical role of cultural norms and social relationships in shaping community responses toward ODGJ.

A central finding concerns the relationship between social interaction patterns and psychosocial recovery. The majority of informants reported that participation in communal activities strengthened ODGJ motivation for social engagement. Observations indicated increased confidence and emotional stability among survivors who were regularly involved in collective routines such as neighborhood meetings or shared work activities (gotong royong). Such interactions accelerated reintegration, reduced social withdrawal, and fostered trust between ODGJ and community members. Conversely, instances of stigmatization and discriminatory behavior in some micro-contexts triggered feelings of fear, hesitation, and avoidance among survivors. These unfavorable interactions hindered adaptation, validating Blumer's Symbolic Interactionism that emphasizes how meaning emerges from interpersonal exchanges.

The study also identifies a persistent structural gap between professional services and community-driven support. Although survivors occasionally accessed institutional rehabilitation services, the transition back to community life remained inadequately supported. Many returned home without systematic community follow-up, creating a vacuum of social support that increased the risk of relapse. Informants disclosed that institutional treatment did not adequately prepare families and communities to support the reintegration process. As a result, ODGJ survivors depended heavily on informal care systems that varied widely in quality and continuity. This fragmentation underscores the need to integrate formal and informal sectors in a more coherent rehabilitation model.

The analysis further shows that community social capital constitutes an underutilized resource for strengthening rehabilitation. Interviews with volunteers, health cadres, and village officials indicated spontaneous acts of solidarity, including emotional support, informal supervision, and collective responsibility for ODGJ wellbeing. However, these practices lacked structure and coordination. Social Capital Theory (Putnam) helps interpret this phenomenon: bonding capital within close family networks, bridging capital across neighbor relationships, and linking capital involving village authorities can be mobilized to form a foundation for sustainable community-based rehabilitation. The data suggest that structured facilitation is necessary to activate latent social capital and prevent exclusionary attitudes.

Cultural norms significantly affect rehabilitation experiences. Observations show that ODGJ are often judged based on traditional beliefs regarding mental illness, including perceptions that disorders are related to spiritual imbalance or ancestral disruption. While some respondents expressed empathetic interpretations grounded in religious values, stigma stemming from fears of unpredictability or perceived abnormality persisted. Such ambivalence influences community willingness to involve ODGJ in public spaces. When cultural narratives frame ODGJ as dangerous or shameful, participation decreases; when framed through values of compassion, communal duty, and shared humanity, participation improves. These symbolic meanings are constantly negotiated through social practices.

Individual adaptation emerged as another critical determinant of rehabilitation success. Survivors reported improved coping mechanisms when they experienced stable family support and predictable community routines. Interviews revealed that consistent participation in social activities reduced psychological distress and supported gradual reintegration. This aligns with Grinker's Social Adaptation Theory, emphasizing that adaptive functioning depends not only on individual capacity but also on enabling environmental conditions. Interview data showed that survivors internalized positive identity shifts when treated respectfully and given opportunities to contribute meaningfully to community life.

The research identifies key inhibiting factors: persistent stigma, inconsistent support from extended family networks, limited understanding of mental health within local leadership, and insufficient collaboration between village services and healthcare providers. Informants emphasized that stigma manifests not only verbally but also through subtle gestures of avoidance. Such microaggressions reinforce fear and internalized shame among ODGJ. In addition, the lack of formal mechanisms for coordination between actors results in fragmented support. Health cadres reported challenges related to limited training, inadequate referral systems, and unclear rehabilitation responsibilities.

Supporting factors identified include strong traditions of mutual cooperation, communal gatherings that encourage participation, existing informal caregiving practices, and emerging leadership commitment from village authorities. The existence of periodic social activities provided natural spaces for social reintegration. Furthermore, several key individuals particularly volunteers and the village psychosocial companion played bridging roles that increased community empathy and normalized interactions with ODGJ. Their presence demonstrates the potential for community-driven facilitation of psychosocial recovery.

The study's findings provide empirical justification for constructing an adaptive community-based rehabilitation model composed of three main components: (1) strengthening symbolic interaction through consistent social engagement and stigma reduction practices; (2) activating community social capital through structured involvement of families, volunteers, and village institutions; and (3) supporting individual adaptation by fostering enabling environments grounded in local culture. These elements mutually reinforce one another and produce more resilient rehabilitation outcomes.

The data also demonstrate that informal rehabilitation already operates implicitly in Sumberjati Village. Family and community responses, although inconsistent, reflect culturally embedded forms of social protection. For example, survivors were often included in communal labor even when deemed unstable. Such practices reflect collective responsibility values rooted in local wisdom. However, without structured facilitation, reliance solely on informal practices risks perpetuating discrimination or passive containment rather than constructive engagement.

These findings affirm the relevance of community participation and cultural integration in mental health rehabilitation programs. Institutional services alone cannot meet survivor needs, especially in rural settings. Interventions must leverage local social structures, cultural norms, and routine communal practices that naturally promote social interaction. The findings suggest that rehabilitation programs that ignore cultural and relational dimensions are likely to fail.

**Table 1. Research Findings and Their Implications for the Adaptive Community-Based Rehabilitation Model for ODGJ**

<b>Research Theme</b>	<b>Key Findings</b>	<b>Implications for Adaptive Community-Based Rehabilitation</b>
Social Interaction and Symbolic Meaning	Positive interaction promotes social participation; stigma inhibits adaptation	Programs must strengthen stigma reduction and create structured social contact opportunities
Community Social Capital	Informal support exists but remains uncoordinated	Social capital should be mobilized through structured collaboration and shared responsibility
Individual Adaptation	Supportive environments enhance coping and reintegration	Adaptation requires emotional, cultural, and social support systems
Cultural Norms	Mixed interpretations influence stigma and inclusion	Rehabilitation should integrate local cultural knowledge and belief systems
Service Integration	Weak linkage between institutional and community supports	Policies must ensure seamless continuity of care from institutions to communities

Source: Compiled by the author based on field research, 2026

Table 1 synthesizes major empirical findings derived from participant observation and interviews, organizing them into five thematic dimensions relevant to the development of the Adaptive Community-Based Rehabilitation Model for ODGJ. Each research theme identifies a specific aspect influencing rehabilitation outcomes, followed by key field insights and corresponding implications for model development. The findings demonstrate that positive symbolic interactions, mobilization of social capital, supportive adaptive environments, culturally grounded norms, and integrated service delivery function as critical enabling factors for sustainable rehabilitation. Furthermore, the table

highlights the need for intentional strategies that strengthen collaboration, reduce stigma, and ensure continuity of care across institutional and community settings.

The discussion deepens interpretation of the empirical findings and connects them to the overarching aim of formulating an Adaptive Social Rehabilitation Model for ODGJ grounded in community contexts. The results address the main research problem: concentrated rehabilitation systems insufficiently responsive to local social and cultural realities. Conventional institutional rehabilitation focuses on clinical stabilization but often fails to address the sociocultural mechanisms essential for reintegration into community life. This creates a systematic gap when survivors return home, leaving them vulnerable to relapse due to insufficient social interaction and limited social capital.

The central argument emerging from the findings is that meaningful interaction between survivors and community members forms the foundation of adaptive rehabilitation. Blumer's Symbolic Interactionism provides analytical insight into how community perceptions toward ODGJ evolve through symbolic exchanges. When survivors participate actively in collective activities, they display socially recognizable roles, gradually transforming social meanings attributed to their identities. Conversely, negative symbolic labeling reinforces stigma and exclusion. The findings demonstrate that rehabilitative outcomes depend not only on access to services but fundamentally on the quality of social participation integrated into everyday life.

The observed informal caregiving systems illustrate latent community capacities that could be mobilized strategically. Putnam's Social Capital Theory explains how networks of trust, shared norms, and mutual assistance can facilitate participatory rehabilitation. However, unstructured informal support risks perpetuating stereotypes when caregivers lack knowledge about mental health. Thus, adaptive rehabilitation requires strengthening social capital intentionally through formal community programs and collaborative initiatives. For example, structured peer support groups, stigma-reduction campaigns, and coordinated involvement of village authorities can transform latent social capital into actionable resources.

The study also highlights how local cultural values and practices can serve as restorative mechanisms. Cultural narratives of mutual aid, shared responsibility, and communal belonging strengthen social inclusion. Ritual events and neighborhood gatherings foster supportive environments in which survivors experience informal monitoring, emotional validation, and constructive social expectations. These findings challenge dominant biomedical rehabilitation models that isolate mental illness management from cultural contexts. Instead, effective rehabilitation strategies must integrate cultural meaning-making to enhance individual psychological resilience and community acceptance.

Grinker's Social Adaptation Theory provides a useful interpretive lens for understanding individual coping processes. ODGJ survivors adapt more effectively when environmental stressors are minimized and supportive cues increase. The findings indicate that adaptation is not an internally generated process; rather, it emerges through interaction with enabling environments. Structured opportunities for social participation create predictable routines that enhance emotional stability, strengthen self-worth, and reduce relapse risks. Therefore, adaptive rehabilitation must emphasize environmental structuring that facilitates gradual, sustainable engagement.

This research extends previous findings that rehabilitation services remain overly centralized and insufficiently linked to community realities. The analysis contributes to ongoing scholarly debates concerning community-based mental health approaches. The integration of symbolic interaction, social capital, and adaptive functioning into a single rehabilitation model addresses the shortcomings of prior models that viewed community participation merely as supplemental. Instead, community involvement becomes the core environment for rehabilitation.

The findings respond to the research problem by revealing that stigma operates subtly through symbolic cues, not merely overt discrimination. Avoidance, silence, and body language play essential roles in reinforcing social exclusion. Thus, stigma reduction interventions should target symbolic meanings embedded in community communication practices. Rather than merely providing mental

health education, rehabilitation programs should cultivate positive shared narratives regarding recovery and reintegration.

Consistent with research objectives, the study demonstrates how adaptive rehabilitation requires coordinated multi-actor participation. Village authorities, family caregivers, volunteers, health cadres, and institutional services must form a collective system. This collaboration reflects linking social capital connecting community-level resources to broader institutional infrastructures. The findings underscore the need for policy reform encouraging distributed rehabilitation leadership rather than centralized control.

The identified cultural variability in community perceptions underscores that adaptive rehabilitation models cannot adopt uniform templates. Programs must accommodate cultural heterogeneity, addressing beliefs regarding mental illness origins and healing. This aligns with scholarship advocating for culturally sensitive mental health interventions in rural contexts. Culturally resonant approaches promote stronger acceptance by leveraging existing belief structures rather than imposing external frameworks. Interpreting the findings through the three theoretical lenses allows a holistic understanding:

- Symbolic Interactionism reveals how meanings constructed through interaction shape identity and possibility for social reintegration.
- Social Capital Theory clarifies how networks and relational resources support or constrain rehabilitation.
- Social Adaptation Theory explains behavioral adjustment as a relational process informed by environmental opportunities.

Together, they justify designing rehabilitation interventions centered on relational, cultural, and environmental adaptation.

The results confirm that institutional services alone cannot produce sustainable outcomes. Community-based adaptive rehabilitation leverages local cultural competencies, collective responsibility, and lived proximity. Institutional services, however, remain essential in specialized treatment phases. Thus, the findings advocate multi-layered collaboration in which institutions provide clinical stabilization while communities sustain reintegration processes.

The study contributes practical insights for rehabilitation program design. Rehabilitation initiatives should systematize latent informal practices into structured interventions. Facilitation roles can be delegated to psychosocial companions trained to coordinate volunteers, liaise with health services, and advocate stigma reduction. Developing community-based training modules for caregivers may enhance understanding of adaptive needs and reduce harmful practices grounded in inaccurate beliefs.

Academic implications arise from integrating three theoretical frameworks in analyzing rehabilitation processes. Most community-based mental health literature isolates sociological, psychological, or medical perspectives. By synthesizing symbolic, relational, and adaptive mechanisms within a single explanatory framework, this research contributes conceptual advances for community rehabilitation scholarship.

The findings further support policy recommendations encouraging decentralization of mental health services and investment in community-level initiatives. Such policy directions are consistent with global mental health movement principles advocating respectful, culturally grounded, rights-based approaches. This research provides empirical grounding for these principles within the Indonesian village context.

The study's limitations include the confined geographic scope and focus on a limited set of informants. These limitations constrain generalizability but enhance contextual depth. Future research could examine longitudinal processes of adaptation, comparative community contexts, or

interprofessional collaboration mechanisms. Despite these boundaries, findings illustrate critical lessons relevant for designing culturally situated rehabilitation programs.

In summary, the discussion demonstrates that an Adaptive Social Rehabilitation Model for ODGJ grounded in local community contexts responds directly to identified weaknesses in existing centralized rehabilitation systems. The model promotes positive symbolic interactions, activates community social capital, and supports individual adaptation through culturally resonant environmental structures. Such a model offers a human-centered, sustainable framework capable of confronting stigma, isolation, and reintegration barriers often faced by survivors upon reentry to community life.

## CONCLUSION

This study concludes that a locally grounded Adaptive Social Rehabilitation Model offers a strategic and transformative pathway for improving rehabilitation services for People with Mental Disorders (ODGJ) in Indonesia. The empirical findings demonstrate that prevailing institutional and clinic-centered rehabilitation systems tend to marginalize community involvement, reinforce passive dependency, and weaken sustainable reintegration. By contrast, a community-embedded adaptive rehabilitation approach redistributes responsibility across family, community members, and local institutions, thus generating more inclusive and culturally meaningful processes of psychosocial recovery.

Three interdependent pillars shape the model's effectiveness: positive symbolic interaction, community social capital, and adaptive social environments. First, the research highlights that constructive symbolic interaction between ODGJ survivors and community members fosters dignity, recognition, and social identity repair. Respectful communication, opportunities to express agency, and acknowledgement of personal capabilities mitigate stigma and rebuild personal efficacy. The role of symbolic interpretation is decisive: when the community attributes competence and social value to ODGJ individuals, reintegration becomes attainable. These insights substantiate the central premise of Symbolic Interactionism, which emphasizes the constitutive role of social meaning in shaping actions and identity.

Second, social capital emerges as a core resource that strengthens the resilience of rehabilitation processes. Trust networks, reciprocal obligations, and informal safety nets inherent in local communities provide emotional, instrumental, and relational support that cannot be substituted by institutional services alone. The findings confirm that integrated networks accelerate recovery by enhancing participation opportunities and reinforcing belonging. Yet, the study reveals that social capital remains latent unless intentionally mobilized. Thus, rehabilitation must not be viewed as a purely technical intervention but rather as a collective process that relies on shared values and communal cohesion.

Third, adaptive social environments constitute a necessary condition for sustained adjustment. Consistent with Social Adaptation Theory, the results show that survivors achieve optimal functioning when afforded participatory roles, access to safe spaces, and opportunities to contribute meaningfully. The adaptive environment reduces relapse risks and enhances psychosocial well-being by enabling survivors to regain autonomy, reestablish social ties, and engage in productive activities.

A key contribution of the study is the reaffirmation of cultural relevance in rehabilitation. Local values, customary practices, communal rituals, and shared narratives foster a sense of connection and legitimacy among survivors. When rehabilitation strategies align with local traditions such as collective work, communal gatherings, and shared creative practices ODGJ individuals experience inclusion rather than estrangement. These culturally embedded interventions enhance sustainability by reinforcing existing social structures rather than imposing external programs that communities struggle to internalize.

In theoretical terms, the model advances interdisciplinary integration across sociology, social psychology, and community mental health by demonstrating how symbolic meaning, relational resources, and adaptive contexts jointly influence rehabilitation trajectories. Practically, the study provides actionable guidance for local institutions, community facilitators, and policymakers seeking

to strengthen mental health services in resource-limited settings. Academically, the research expands literature on non-institutional rehabilitation models, particularly in Global South contexts where community solidarity remains a dominant social foundation.

In summary, the Adaptive Social Rehabilitation Model based on local communities addresses systemic weaknesses in centralized rehabilitation services, responds directly to the research questions, and achieves its intended objectives. Implementing this model can foster sustainable psychosocial recovery, enrich collective welfare, and reinforce community cohesion. The study confirms that mental health rehabilitation is not solely a clinical or biomedical process but a relational, cultural, and contextual endeavor requiring collective responsibility. Sustained success hinges on community participation, reinforcement of local social capital, and development of adaptive environments that honor dignity, inclusion, and cultural rootedness.

Recommendations for strengthening and institutionalizing adaptive community-based rehabilitation services for ODGJ. These recommendations target practitioners, policymakers, community leaders, and academic researchers, and aim to ensure sustainability, inclusivity, and long-term effectiveness.

First, rehabilitation programs should systematically integrate local cultural norms, social rituals, and shared practices as integral components of intervention design. Evidence shows that survivors benefit significantly from participation in culturally meaningful collective activities, which foster mutual trust and reduce stigma. Community-based rehabilitation must thus extend beyond clinical treatment toward culturally grounded social reintegration. Program developers should collaborate with local leaders, cultural actors, and community facilitators to co-design interventions that resonate with communal identity.

Second, strengthening community-wide social capital is essential for sustaining rehabilitation gains. Mechanisms that activate interpersonal trust and reciprocity must be institutionalized through community groups, peer support systems, and inter-family cooperation. Practical instruments include establishing community mental health committees, organizing structured peer-support circles, and integrating ODGJ involvement in communal planning forums. These mechanisms formalize roles, enhance accountability, and reinforce social norms that uphold solidarity and inclusion.

Third, the model should prioritize the creation of adaptive environments that enable functional participation by ODGJ. This entails designing safe social spaces, community work opportunities, and inclusive public events that encourage survivors to rebuild social roles. Community infrastructures such as cultural halls, village centers, or social enterprise groups can be transformed into rehabilitative platforms. Interventions must avoid paternalistic approaches and instead empower survivors to contribute meaningfully to shared goals.

Fourth, capacity-building programs for families, social workers, community volunteers, and village authorities are critical. Training modules should address stigma reduction, effective communication strategies, culturally sensitive facilitation, and practical guidance for monitoring psychosocial well-being. Enhancing relational competencies strengthens symbolic interaction and improves the quality of interpersonal encounters. These initiatives help prevent social exclusion, burnout, and dependency within families and caregivers.

Fifth, monitoring and evaluation must be institutionalized to ensure program continuity and adaptive learning. Evaluation should assess progress through qualitative indicators such as community attitudes and relational trust alongside quantitative measures like participation rates and relapse frequency. Results can inform program adjustments and maintain alignment with evolving social and cultural contexts.

Sixth, local governments should adopt supportive regulations, resource allocation policies, and partnerships with health and social institutions to formalize adaptive community-based rehabilitation as a permanent pillar of local social services. Policy frameworks should recognize family and community roles, legitimizing them as co-providers rather than passive beneficiaries. Multi-sector collaboration

between village government, public health centers, social service departments, and civil society organizations is essential for strengthening governance and funding models.

Finally, academic researchers should pursue longitudinal and comparative studies to assess the replicability and long-term impact of adaptive rehabilitation across diverse cultural settings. Future research may examine economic empowerment, relapse prevention, livelihood integration, and digital platforms for community support. Mixed-method and participatory action research designs will help refine intervention components, identify contextual barriers, and enhance theoretical robustness.

Collectively, these recommendations emphasize that effective implementation requires cultural legitimacy, social embeddedness, and shared responsibility. Strengthening positive interaction, mobilizing social capital, and shaping adaptive environments will not only enhance rehabilitation outcomes but also foster community resilience and social cohesion. The adoption of this model is expected to contribute to the development of sustainable, inclusive, and people-centered rehabilitation systems anchored in local community wisdom and collective commitment.

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