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Co-Designing Psychosocial Disability Inclusion: Public Service Innovation in Community-Based Rehabilitation in Yogyakarta, Indonesia

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Abstract

Despite rights-based mental health reforms, persons with psychosocial disabilities continue to experience stigma and exclusion, exposing gaps in the participatory implementation of Community Based Rehabilitation (CBR). Evidence on co-design as a form of governance innovation within CBR remains limited, particularly in decentralized contexts. This study examines how co-design reshapes service delivery, governance arrangements, and social inclusion in CBR initiatives in Yogyakarta, Indonesia. Using a qualitative case study informed by Participatory Action Research, the study draws on interviews, focus groups, participant observation, and policy analysis involving village governments, NGOs, Self-Help Groups (SHGs), and persons with psychosocial disabilities. The findings show that co-design enabled SHG members to shape livelihood activities, enhance agency and recovery, and participate in local decision-making, while generating governance innovations through village regulations, budget allocations, and cross-sectoral collaboration. These practices were constrained by power asymmetries, stigma, and dependence on NGO facilitation. This study conceptualizes co-design as a politically embedded governance process that reconfigures power and participation, underscoring the need for stronger policy alignment to institutionalize inclusive, community-driven rehabilitation.

Keywords: community-based rehabilitation, co-design, persons with disabilities, social inclusion.

INTRODUCTION

Community-Based Rehabilitation (CBR) has been widely promoted in Indonesia as a key strategy for advancing disability inclusion at the local level, particularly under the country's decentralized governance system. In the Special Region of Yogyakarta (DIY), CBR initiatives are embedded within strong community institutions at the *kalurahan* and *padukuhan* levels, supported by primary health care facilities (*puskesmas*), social services, community mental

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health volunteers (*kader kesehatan jiwa*), and families. In principle, this setting offers a favorable environment for inclusive, community-driven approaches to psychosocial disability rehabilitation.

National and local statistics indicate that disability, including psychosocial disability, represents a substantial and continuing concern in Indonesia. Data from the Long Form of the 2020 Population Census show that the Special Region of Yogyakarta recorded one of the highest disability prevalences in Indonesia at 2.05%, exceeding the national average (Badan Pusat Statistik, 2020). Municipal social service data further indicate that the number of registered persons with disabilities in Yogyakarta City increased from 2,340 in 2022 to 3,099 in 2023, suggesting improved identification and potentially rising service demand (Dinas Sosial DIY, 2024). In terms of mental health conditions, national health survey analyses report that the prevalence of severe mental disorders such as schizophrenia in Yogyakarta is approximately 2.7 per 1,000 population, higher than several other provinces (Minas & Diatri, 2018). Advocacy reports also estimate that thousands of persons with psychosocial disabilities (PwPDs) in Indonesia remain institutionalized or socially confined due to stigma and limited community-based alternatives (Perhimpunan Jiwa Sehat, 2022).

These trends underscore persistent reliance on institutional or facility-based rehabilitation models, which historically emphasized containment, medical treatment, and social protection rather than participation and empowerment. Although Indonesia ratified the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) through Law No. 19/2011 and enacted Law No. 8/2016 on Persons with Disabilities, translating rights-based commitments into community-level inclusion remains uneven (Irwanto et al., 2017). Service delivery for psychosocial disability often continues to operate through top-down programmatic approaches shaped by bureaucratic routines, sectoral fragmentation, and risk-averse institutional cultures (Gooding & Maramis, 2021). Participation mechanisms, when present, are frequently consultative rather than deliberative, limiting the meaningful involvement of persons with psychosocial disabilities in shaping services that affect their lives (Antlöv et al., 2016).

Within this context, CBR has been positioned as an alternative to institutional-based rehabilitation by promoting community participation, social reintegration, and cross-sectoral collaboration. In practice, however, CBR implementation in Yogyakarta continues to face

persistent challenges. Empirical studies indicate that CBR programs remain largely dominated by professionals and government agencies, with persons with psychosocial disabilities positioned primarily as service recipients rather than active contributors to service design and decision-making (Suryani et al., 2020; Trani et al., 2022). Participation mechanisms tend to focus on service compliance and monitoring rather than meaningful involvement, limiting opportunities for persons with psychosocial disabilities to articulate priorities, influence program strategies, or shape evaluation processes. These dynamics risk reproducing stigma and dependency, undermining the transformative aims of community-based mental health services.

Within public administration and governance scholarship, co-design has emerged as a promising approach to address these limitations. Co-design reframes public service delivery by positioning citizens not merely as beneficiaries but as co-creators of public value, emphasizing collaborative problem definition, joint decision-making, and shared responsibility across the service cycle (Bovaird, 2007; Osborne et al., 2016). For complex and sensitive policy domains such as psychosocial disability (where stigma, power asymmetries, and contextual factors strongly shape outcomes) co-design offers a conceptual and practical pathway to reconfigure governance relationships and enhance inclusion.

The relevance of co-design is particularly pronounced in Yogyakarta, where local traditions of *musyawarah* (deliberation) and *gotong royong* (mutual aid) provide culturally embedded foundations for collective action. Yet, despite this apparent alignment, systematic empirical research examining how co-design operates within Community-Based Rehabilitation for psychosocial disability in Indonesia remains limited. Existing studies on CBR and mental health primarily assess service availability, program effectiveness, or stigma reduction, with little attention to how participatory design processes reshape governance arrangements, power relations, and service delivery practices at the community level (Minas & Diatri, 2018; Trani et al., 2022).

Addressing this gap, this study examines co-design as a form of public service innovation within Community-Based Rehabilitation for psychosocial disability in the Special Region of Yogyakarta. The research is guided by two questions: (1) How does co-design reshape CBR governance and service delivery in the Yogyakarta context? and (2) How can co-design foster inclusion and empowerment of persons with psychosocial disabilities within local

communities? By grounding the analysis in local practices, the study highlights how decentralized governance structures, community norms, and participatory innovations intersect in the delivery of mental health services.

This article contributes to the literature in three ways. First, it advances public administration scholarship by empirically situating co-design within Indonesia's decentralized CBR governance, illustrating how public service innovation unfolds at the sub-national level. Second, it contributes to psychosocial disability studies by foregrounding lived experience and agency as central elements of inclusion and empowerment. Third, it offers policy-relevant insights by proposing an integrative framework linking co-design, Community-Based Rehabilitation, and public value creation, with implications for local governments and practitioners seeking to strengthen inclusive mental health governance.

Community- Based Rehabilitation, Co-design, and Social Inclusion

Community-Based Rehabilitation (CBR) has evolved from a welfare-oriented and medically driven intervention into a participatory, community-driven governance model for disability inclusion. Initially framed as a cost-effective alternative to institutional care, CBR is now understood as a multi-sectoral approach that emphasizes participation, empowerment, and shared responsibility among state actors, communities, and persons with disabilities (Cornielje, 2009; WHO, 2010) . The WHO CBR Matrix comprising health, education, livelihood, social participation, and empowerment, reflects this shift by positioning empowerment and social inclusion as central, rather than residual, dimensions of rehabilitation. From a governance perspective, CBR operates as a decentralized and network-based service model, aligning with collaborative and community governance frameworks. However, studies consistently show that CBR implementation often remains service-provider centric, with limited influence of persons with disabilities over decision-making processes, particularly in the domain of psychosocial disability (Kuipers et al., 2019; Trani et al., 2022).

Co-design has emerged in public administration literature as a key mechanism of public service innovation that reconfigures the relationship between citizens and the state. Defined as the active involvement of citizens as partners in the design of public services, co-design moves beyond user-centered approaches toward user-led and shared decision-making models (Bovaird, 2007; Osborne et al., 2016). It is closely linked to collaborative governance,

participatory design, and human-centered governance, emphasizing joint problem definition, iterative learning, and the co-creation of public value (Ansell & Torfing, 2021). Unlike traditional participation, co-design challenges hierarchical authority and redistributes power within service systems. In complex social services such as mental health and disability support, co-design has been shown to enhance service relevance, legitimacy, and inclusion, yet empirical applications within CBR (particularly in low- and middle-income country contexts) remain limited.

Theoretical perspectives on inclusion provide a critical foundation for understanding the role of co-design in disability governance. Social inclusion theory emphasizes participation, recognition, and access to social, economic, and political life, highlighting how institutional arrangements can systematically exclude marginalized groups (Silver, 2015). Complementing this, the Capabilities Approach conceptualizes inclusion in terms of individuals' real freedoms to achieve valued ways of being and doing, underscoring the importance of agency, voice, and choice (Nussbaum, 2006; Sen, 1999). For persons with psychosocial disabilities, inclusion is further shaped by intersectional factors such as stigma, poverty, gender, and local power relations, which often compound exclusion within community and service settings (Beresford, 2016; Goodley, 2017). Within this framework, co-design functions as a transformative mechanism that repositions persons with psychosocial disabilities from passive "beneficiaries" to active "co-creators" of services and governance arrangements, thereby operationalizing inclusion as both a process and an outcome.

RESEARCH METHODS

Research Design and PAR Orientation

This study adopts a qualitative case study design informed by Participatory Action Research (PAR) to examine co-design as a public service innovation within Community-Based Rehabilitation (CBR) for psychosocial disability. PAR is particularly appropriate for this study as it emphasizes collaboration, reflexivity, and the co-production of knowledge between researchers and participants, aligning closely with the principles of co-design and inclusive governance (Cornish et al., 2023; Walker & Suter, 2025). Rather than positioning participants as research subjects, PAR frames them as co-researchers who actively contribute to problem identification, interpretation of findings, and reflection on service practices (House, 2024). This

approach enables an in-depth understanding of how co-design reshapes governance and inclusion within real-world CBR settings.

Research Setting

The research was conducted in three districts of the Special Region of Yogyakarta (DIY), Indonesia, a decentralized governance context with strong village-level institutions (kalurahan), active civil society organizations, and established community-based mental health initiatives. These district were Kulon Progo, Sleman and Gunung Kidul. Yogyakarta was selected as a theoretically relevant case due to its alignment with national disability and mental health policies and its reputation for participatory community development. These characteristics make DIY a suitable site to explore how co-design and PAR operate within local CBR governance.

Participants

Participants were selected through purposive and relational sampling, consistent with PAR principles, to capture diverse perspectives across the CBR governance network. The study involved village government officials, CBR facilitators, non-governmental organizations (notably PRYakkum), self-help groups (SHGs), and persons with psychosocial disabilities and their families. The composition of the 56 informants listed in Table 1 reflects a multi-level stakeholder structure. The inclusion of TPKJM at the provincial and regency levels provide a macro policy perspective on program design. The village government and NGOs representative represent the meso level focusing on the practical implementation of the program. A deliberate emphasis was placed on informal actors, including 15 religious and community figures and 9 SHG, to capture the community centric nature of CBR in Yogyakarta. This composition allows for an analysis of how power and information flow between formal state actors and informal social network that often facilitate inclusion for persons with psychosocial disabilities.

Sampling continued until thematic saturation was achieved, ensuring that the lived experiences of the seven (7) persons with psychosocial disabilities and their six (6) relatives provided a primary basis for interpreting the effectiveness of the governance network. Number of participant sample was chosen based on its representation, snowball sampling,

and the degree of saturation status during data collection. As result, the number of participant is not even for each category due to the scope and depth of data in the respective areas.

Table 1. Research Informants

Category	Group of Participant	Number of Participant
Government	TPKJM at Provincial level (the Social Affairs Agency Health Affairs Agency and Empowerment and)	2
	TPKJM at Regency/City level	6
	Local government at village level	8
Civil Society & NGOs	Organizations of persons with disabilities	4
	Religious leaders and community figures	15
	Self Help Groups	9
PwPDs & Relatives	Persons with psychosocial disabilities (PwPDs)	7
	Family or carer of persons with psychosocial disabilities	6
Total		56

Source: Authors (2025)

Data Collection

Data were collected using participatory and qualitative methods from July to October 2025. Semi-structured interviews were conducted with institutional and community actors to explore governance arrangements, decision-making processes, and experiences of co-design in CBR. Focus group discussions (FGDs) with SHGs and community members were designed as dialogical spaces that encouraged collective reflection rather than one-way data extraction. In addition, participatory observation was conducted during CBR activities, meetings, and co-design sessions, allowing the researcher to observe interactional dynamics, power relations, and forms of inclusion in situ. Consistent with PAR, preliminary insights were periodically shared with participants for validation and reflection.

Data Analysis

Data analysis followed an iterative thematic approach, integrating inductive coding with theoretically informed categories derived from co-design, CBR, and inclusion literature. The analysis was operationalized through these specific frameworks.

1. Co-design participation mapping, this step involved using a thematic exploration on PwPDs participation across four stages which are agenda setting, planning,

implementation, and evaluation. Each instance of participation was inductively coded based on their real practices. The mapping follow the degree of participation by Arnstein (1969).

2. Inclusion impact and challenges, the analysis focused on whether the co-design process resulted in tangible changes in how PwPDs navigated social spaces and influenced local program priorities. In addition, exploration on challenges was executed to capture the practical barrier during co-design implementation.

Analytical rigor was maintained through triangulation across multiple data sources and collective reflection sessions with selected participants to verify the accuracy of the emerging themes.

Ethical Considerations and Reflexivity

Given the involvement of persons with psychosocial disabilities, the study adhered to strict ethical standards. Informed consent was obtained using accessible, non-technical language, and participation was voluntary with the right to withdraw at any stage. Confidentiality and anonymity were ensured through pseudonyms and secure data storage. To minimize potential distress, data collection was conducted in collaboration with trusted local facilitators and community organizations. Reflexivity was integral to the PAR approach, with the researcher continuously examining positionality, power relations, and the ethical implications of knowledge co-production. Ethical approval was obtained from Universitas Negeri Yogyakarta Number T/139.2/UN34.9/PT.01.04/2025 on July 10, 2025.

RESULTS AND DISCUSSION

Results

The frontline actors driving Community-Based Rehabilitation (CBR) activities in the Special Region of Yogyakarta (DIY) are mental health cadres organized within Self-Help Groups (SHGs). These groups play a critical role in mobilizing community-based rehabilitation initiatives, strengthening peer support, and bridging formal service systems with the everyday needs of persons with psychosocial disabilities at the local level.

In the Special Region of Yogyakarta, approximately 20 SHGs are facilitated by PRYakkum, a non-governmental organization focusing on the development and

strengthening of CBR. These SHGs are distributed across three districts: Kulon Progo, Sleman, and Gunung Kidul. Data on PRYakkum-supported SHGs during the period 2017–2024 are presented in Table 2.

Table 2. Self-Help Groups in the Special Region of Yogyakarta

District	Name of SHG/Kalurahan	Number
Kulon Progo (KP)	SHG Temon Kulon, Temon Wetan, Kulur, Kedundang, Kaligintung, Karangsari, Pengasih dan Sendangsari	8
Sleman (S)	SHG Sidoluhur, Sidoagung, Sidomulyo, Sidomoyo, Margomulyo dan Margoluwih	6
Gunung Kidul (GK)	SHG Wonosari, Siraman, Karangrejek, Mulo, Gading dan Ngunut	6
Total		20

Source: Authors (2025)

Self-Help Groups (SHGs) in CBR settings typically comprise persons with psychosocial disabilities as core members, supported by family caregivers, mental health cadres, NGO-based CBR facilitators, and, in selected activities, village-level actors. Persons with psychosocial disabilities actively involve in the SHG to design activities to identify their needs, livelihoods interventions, and community engagement and social inclusion

Co-Design in Identifying Needs and Service Priorities

The findings indicate that persons with psychosocial disabilities were actively involved in the early stages of CBR implementation, particularly in identifying needs and setting service priorities. Through facilitated discussions within Self-Help Groups (SHGs) and village-level meetings, participants articulated personal, social, and economic challenges that were often overlooked in conventional rehabilitation programs. One of persons with disabilities (ODDP) shared her experience in SHG:

> "Participating in the SHG has been extraordinary for me. I learned how to socialize, even though I made many mistakes along the way. With support from the village head, the *kamituwo*, YAKKUM, the cadres, and my family, I gradually improved. Family understanding is crucial, without it, even good medical treatment cannot succeed." (*Interview-Member of SHG, Kulon Progo*).

This account illustrates how SHGs function as inclusive co-design spaces that foster social learning, family engagement, and role transformation, enabling persons with psychosocial disabilities to move from service recipients to active organizational actors within community-

based rehabilitation governance. This participatory needs assessment shifted the focus of CBR from symptom management toward livelihood security, social participation, and dignity.

Co-Designed in Livelihood Activities

The findings show that co-designed livelihood activities within Self-Help Groups (SHGs) contributed to both economic engagement and psychosocial stability among persons with psychosocial disabilities. Participants and facilitators reported that regular, meaningful activities reduced social withdrawal and behavioral distress while increasing daily structure and responsibility. Livelihood initiatives (such as small-scale livestock rearing and agriculture) were developed collaboratively based on individual capacities and local resource availability. As one mental health cadre explained, prior to SHG involvement, some participants experienced emotional instability and inactivity. Following engagement in SHG-based livelihood activities, observable changes occurred in daily routines and productivity:

> "Before the SHG activities, one of the people we support often had emotional outbursts and spent most of his time at home without activities. After being involved in SHG activities, his behavior changed. Now he goes to the fields every morning to collect grass for his livestock, which has grown significantly. The village government has also provided start-up support in the form of goats, and some participants now require additional facilities because their livestock numbers have increased." (*FGD-Mental health cadre in Gunung Kidul)*

This account illustrates how co-designed livelihood interventions functioned as both therapeutic and economic mechanisms. The increase in livestock ownership and subsequent support from the village government indicate growing institutional trust and recognition of persons with psychosocial disabilities as productive community members. Importantly, livelihood outcomes were not limited to income generation but also encompassed improvements in routine, responsibility, and social participation, reinforcing the role of SHGs as key platforms for inclusive community-based rehabilitation.

Community Engagement and Social Inclusion Outcomes

In addition to economic activities, persons with psychosocial disabilities participated in planning and implementing community engagement initiatives. SHGs also facilitated collective planning for recreational and social engagement, which participants and facilitators

associated with improved well-being and motivation. Regular home visits by mental health cadres supported medication adherence, daily routines, and early identification of health concerns, contributing to continuity of care at the community level. Importantly, SHG members increasingly initiated ideas for shared activities, indicating growing agency and collective ownership. As one mental health cadre described, routine monitoring evolved into participant-led initiatives for social participation:

> "Every month I visit their homes to check medication, daily activities, and health conditions. Recently, they began asking, 'When are we going to the beach again? When can we have time to refresh together as an SHG?' We have already reported this plan to the *kamituwo* to seek funding." (*FGD-Mental health cadre*).

This account highlights a shift from compliance-oriented care toward participatory well-being practices. The initiative taken by SHG members to propose collective recreational activities reflects increased confidence, social connectedness, and engagement in co-design processes. Moreover, the involvement of village authorities in fundraising efforts illustrates how SHG-led ideas can be translated into institutional support, reinforcing the role of SHGs as platforms for inclusive and recovery-oriented community-based rehabilitation.

In terms of promoting social inclusion, a person with psychosocial with disabilities as a member of SHG said that she gained benefits of joining SHG:

> "Before joining SHG activities, I had no direction and spent most of my time at home with unstable thoughts. Through these activities, I found my own motivation to recover and return to work. Over time, the community began to see me as healthy again and accepted me back. Having gone through this myself, I understand how important it is for others to regain self-control and re-engage with society. Recovery is not only about medication, but also about developing positive thinking so that one can truly return to the community." (*FGD-SHG member*)

These reflections illustrate social inclusion as a dynamic process of regaining participation, recognition, and acceptance within the community, rather than merely the absence of symptoms. From a Capability Approach perspective, SHG participation expanded individuals' real opportunities to work, form social relationships, and exercise agency, demonstrating that recovery involves strengthening capabilities and choice, not solely clinical treatment.

Governance Innovation through Co-Design

The findings indicate that co-design functioned as a form of governance innovation by reshaping relationships among NGOs, village governments, health centers (*puskesmas*), and social service agencies in the implementation of Community-Based Rehabilitation (CBR). Through facilitated co-design forums, actors engaged in shared problem definition and joint planning, moving beyond sectoral and hierarchical coordination. As one village official explained,

> "CBR activities are discussed together with SHG members, cadres, and NGOs before being included in village plans, not decided by the village office alone. We first assessed what each person with psychosocial disability actually needed. Some required goats, while others, like Mas Rohmat, already had goats and needed a shed instead. This approach helped us identify a key issue: securing budget allocation was crucial, because SHG activities can only run effectively when they are supported funding." (*FGD-SHG facilitator*)"

Similarly, a village staff explained that the village government provided annual budget after knowing the routine activities of SHG.

> "In 2021, we started allocating village funds specifically for SHG activities, including monthly SHG meetings. Budgeting was not easy, as mental health activities were not yet clearly included in existing budget accounts, a concern we repeatedly raised at the *kapanewon* and district levels. Working together with the village secretary, we reviewed general health expenditures and eventually used the *Desa Siaga* health budget line to support SHG activities."*(Interview-Village official)*

This budgeting practice reflects governance innovation by demonstrating how local actors creatively reinterpreted existing fiscal instruments to accommodate psychosocial inclusion within village governance. Rather than waiting for formal sectoral mandates, village officials used co-design processes to integrate SHG needs into the *APBDes*, illustrating adaptive, problem-solving governance that expands public value through locally negotiated institutional change.

Challenges of Promoting Co-Design Activities

Despite its contributions to inclusive governance, the implementation of co-design in Community-Based Rehabilitation (CBR) also encountered several challenges. First, tokenism and unequal power relations remained evident in some co-design forums. While persons with psychosocial disabilities and SHG members were formally invited to participate, decision-making authority often continued to rest with village officials or service providers. This limited

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the extent to which experiential knowledge fully shaped program priorities and reflects the persistence of hierarchical governance norms within participatory settings.

Second, limited awareness and enduring mental health stigma constrained broader community engagement. Misconceptions about psychosocial disabilities affected willingness among some community members and local actors to support SHG activities, particularly in the early stages of implementation. These attitudes sometimes reduced participation in co-design processes and required continuous advocacy and sensitization efforts by NGOs and mental health cadres.

Third, the sustainability of community initiatives emerged as a key concern. Although co-design enabled the mobilization of local resources, SHG activities often remained dependent on NGO facilitation and external funding. Variations in local budget priorities and leadership commitment across villages influenced the continuity of programs, highlighting the need for stronger institutional embedding of co-design mechanisms within local governance structures to ensure long-term sustainability.

Mapping the Depth of Co-Design Participation in CBR Governance

The finding demonstrate the active involvement of PwPDs in various form of CBR implementation. This highlighting the role of PwDPS not only as a passive beneficiaries but as active actors in the program instead. This participation then could be mapped using the degree of participation by Arnstein (1969). The depth of involvement is categorized into three levels, which are informative, consultative, and collaborative, based on the degree of decision making authority exercised by the participants.

The mapping (Table 3) reveals that the agenda setting and planning stages achieved a collaborative level of participation. This evidence from the shift of CBR focus from symptoms management to broader social inclusion and livelihood security. In these stages, persons with psychosocial disabilities acted as co-researchers and co-designers who define their own recovery pathways. In the implementation stage, the participation remained collaborative as SHG members took ownership of daily activities. The agency increased due to the transition from being passive service recipient to a more active organizational actors. For instance, the move from regular home visit by cadres to participant led request for collective social activities illustrates a high degree of collective ownership and social connectedness.

Table 3. The Degree of Participation Mapping

Stage of Co-Design	Degree of Participation	Key Evidence and Operational Activities
Agenda Setting	Collaborative	Participants identified service priorities beyond clinical needs, focusing on livelihoods and social dignity within SHG forums.
Planning	Collaborative	SHG members initiated ideas for social and economic activities which were subsequently integrated into village budget (*APBDes*) allocations.
Implementation	Collaborative	Livelihood initiatives such as livestock rearing and recreational activities were managed directly by SHG members and cadres.
Monitoring and Evaluation	Consultative	While mental health cadres conducted routine monitoring, the process remained focused on clinical compliance, though participant led initiatives for well-being are emerging.

Source: Author (2025)

However, the monitoring and evaluation stage is primary categorized as consultative. While the participant already provide the feedback on their health status, the overall framework was still largely structured around the reporting requirement of health centers (Puskesmas) and village authorities. The persistent challenge of tokenism in certain decision making forums suggests that while the space for participation has expanded, the ultimate authority in some administrative aspects remains hierarchical. This mapping highlights that co-design in Yogyakarta is not a uniform process but a dynamic negotiation of power. The successful institutionalization of SHG initiatives into village funding indicates a move toward sustainable inclusive governance, even as the network continues to navigate the boundaries of formal and informal authority

Discussion

Co-Design and the Expansion of Agency: An Inclusion Impact Assessment

This study demonstrates that co-design within Community-Based Rehabilitation (CBR) in Yogyakarta operates simultaneously as a mechanism for addressing the lived needs of persons with psychosocial disabilities (ODDP), enabling livelihood-oriented SHG activities, and generating local governance innovation. By involving ODDP and SHG members in identifying priorities and designing interventions, co-design shifted rehabilitation from a service-provider–

centric model toward one emphasizing agency, participation, and contextual relevance. This aligns with contemporary interpretations of social inclusion and the Capabilities Approach, which stress the expansion of substantive freedoms, recognition, and collective agency rather than clinical recovery alone (Nussbaum, 2011; Sen, 1999; Slade et al., 2019). Livelihood initiatives such as small-scale agriculture, livestock, and craft production functioned not only as economic strategies but also as social processes that supported recovery, reduced stigma, and facilitated reintegration into community life, consistent with recent participatory mental health and disability research (Burgess et al., 2022; WHO, 2021).

At the governance level, co-design produced institutional effects by reshaping decision-making processes, regulatory instruments, and budgetary practices at the village level. The incorporation of SHG proposals into village development plans and the adaptive use of *APBDes* budget lines illustrate how co-design can generate flexible and context-sensitive governance responses within decentralized systems. These findings resonate with recent scholarship on collaborative governance and co-production, which conceptualizes co-design as a process of public value creation through shared authority and mutual dependence among state and non-state actors (Brandsen et al., 2018; Osborne et al., 2021; Torfing et al., 2021). The participation mapping previously discussed shows that when village officials move beyond consultative roles to collaborative ones, co-design can generate flexible and context sensitive responses. This adaptive governance is crucial for sustaining community based initiatives within decentralized systems.

Power Relations and the Challenges of Durable Inclusion

Despite the positive outcomes, the mapping of participation also highlight the persistent structural barrier. The governance innovations were accompanied by persistent challenges, including unequal power relations, tokenistic participation, and continued reliance on NGO facilitation, limiting the transformative potential of co-design in some settings. Enduring stigma and variable institutional commitment further constrained sustainability, reinforcing critiques that participatory governance may reproduce existing hierarchies when not supported by structural and capacity-building interventions (Brandsen et al., 2018; Cornwall, 2008).

Taken together, the findings suggest that co-design in CBR should be understood not as a technical method but as a politically embedded governance process that reconfigures

institutional roles, redistributes authority, and enables community-level innovation. Sustained institutional support, reflexive power-sharing, and explicit normative commitments to inclusion are therefore essential to move co-design from episodic participation toward durable, locally owned, and inclusive governance for psychosocial disability (Denters & Rose, 2020; Westley et al., 2017).

CONCLUSION

This study shows that co-design within Community-Based Rehabilitation (CBR) in Yogyakarta functions as both a service and governance innovation. Anchored in the everyday practices of Self-Help Groups (SHGs) and the lived experiences of persons with psychosocial disabilities, co-design shifted rehabilitation toward participatory, community-driven approaches that supported social inclusion, capability expansion, and recovery. These SHG spaces emerged as critical sites of transformation, enabling persons with psychosocial disabilities to articulate priorities, shape livelihood activities, and renegotiate their roles within the community. At the governance level, co-design reconfigured institutional relationships by enabling village governments to integrate psychosocial inclusion into local regulatory and budgetary instruments. However, these innovations were uneven and constrained by power asymmetries, stigma, and continued dependence on NGO facilitation, underscoring that co-design operates as a politically embedded process rather than a technical solution. The findings contribute theoretically by framing co-design as institutional reconfiguration and practically by demonstrating how decentralized fiscal and regulatory mechanisms can support inclusive governance. Ultimately, the sustainability of co-design–based CBR depends on the ability of local governments to institutionalize participatory practices, align policy frameworks, and strengthen local capacities to ensure enduring, community-owned inclusion.

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