Design of

Kampoeng Pulih:
Community-based Approach for Psychosocial Rehabilitation Center

To Destigmatize Mental Health Disorder in Yogyakarta

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Final Architectural Design Studio
International Undergraduate Program

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Abstract

This architectural project titled **“Kampoeng Pulih: Community-based Approach for Psychosocial Rehabilitation Center To Destigmatize Mental Health Disorder in Yogyakarta”** proposes a community-based mental health rehabilitation center located in Desa Petir, Gunungkidul, Yogyakarta, designed to destigmatize mental health disorders and support reintegration through a village-oriented care model. The project responds to the increasing need for alternative treatment spaces that move away from the institutional rigidity of conventional psychiatric hospitals (RSJ) by embracing inclusivity, therapeutic landscapes, and **localized socio-cultural integration**.

The site is organized into **three core zones**, Zone A (for severe cases), Zone B (for moderate to mild cases), and Zone C (public and administrative hub), each informed by **psychiatric diagnostic frameworks** such as PPDGJ III, ICD-10, and DSM-5's GAF scale. The spatial configuration leverages the natural topography of the hilly site, using contours as soft barriers to separate zones while maintaining inclusivity and openness through accessible ramps, transitional gardens, and seamless pathways.

Zone A, located at the highest point of the site, provides a secure yet **non-institutional living environment** for severe cases. Roster facades replace barred windows to ensure safety while maximizing light and ventilation. Passive supervision is embedded through spatial planning, monitored pathways, and discreet staff presence. Zone B adopts a single-story domestic layout that mirrors surrounding village houses, creating a sense of familiarity and safety. Meanwhile, Zone C serves as the **public interface**, featuring an enclosed therapeutic courtyard, **shared community spaces**, and open seating areas that **encourage interaction between villagers and patients.**

Rejecting high fences and rigid boundaries, the center **integrates with its surroundings** through terraced gardens, community pathways, and open interfaces allowing mutual exchange and reducing stigma. This project reframes mental health care as a communal responsibility and architectural space as an agent of healing, dignity, and reintegration, ultimately advocating for a more humane and context-sensitive approach to psychiatric rehabilitation in rural Indonesia.

Abstrak

Proyek arsitektur berjudul **“Kampoeng Pulih: Pusat Rehabilitasi Psikososial dengan Pendekatan Berbasis Komunitas Guna Menghilangkan Stigma Gangguan Kesehatan Mental di Yogyakarta”** ini mengusulkan sebuah pusat rehabilitasi kesehatan mental berbasis komunitas yang berlokasi di Desa Petir, Gunungkidul, Yogyakarta. Proyek ini dirancang untuk mengurangi stigma terhadap gangguan kesehatan mental serta mendukung proses reintegrasi melalui model perawatan yang berakar pada kehidupan desa. Pendekatan ini menjawab kebutuhan akan ruang penyembuhan alternatif yang tidak kaku dan tidak terinstitusional seperti RSJ konvensional, dengan mengutamakan **inklusivitas, lanskap terapeutik, dan integrasi sosial-budaya lokal.**

Tapak dibagi menjadi **tiga zona utama**—Zona A (untuk kasus berat), Zona B (kasus sedang hingga ringan), dan Zona C (area publik dan administratif)—yang masing-masing dirumuskan berdasarkan **kerangka diagnostik** seperti PPDGJ III, ICD-10, dan skala GAF dari DSM-5. Konfigurasi ruang memanfaatkan topografi perbukitan di lokasi, menggunakan kontur sebagai pembatas alamiah untuk memisahkan zona, sekaligus menjaga keterhubungan melalui ramp yang aksesibel, taman transisi, dan jalur sirkulasi yang menyatu.

Zona A berada di titik tertinggi tapak dan menyediakan lingkungan tinggal yang **aman namun tetap terasa non-institusional** bagi pasien dengan kondisi berat. Penggunaan fasad roster menggantikan teralis untuk memastikan keamanan tanpa mengorbankan cahaya dan ventilasi. Sistem supervisi pasif diterapkan melalui penataan ruang, jalur terpantau, dan keberadaan staf yang tidak mengintimidasi. Zona B menggunakan tipologi bangunan satu lantai yang menyerupai rumah-rumah desa sekitar sehingga terasa akrab dan menenangkan bagi pasien. Sementara itu, Zona C berfungsi sebagai **ruang antarmuka publik**, dengan taman terapeutik tertutup, **ruang komunal bersama**, dan area duduk terbuka yang mendorong **interaksi antara warga desa dan pasien**.

Alih-alih menggunakan pagar tinggi dan batas kaku, pusat rehabilitasi ini **menyatu dengan lingkungan melalui taman bertingkat, jalur yang terhubung** dengan desa, dan area publik terbuka yang memungkinkan **pertukaran sosial dan mengurangi stigma.** Proyek ini melihat perawatan kesehatan mental sebagai tanggung jawab bersama, dan memposisikan ruang arsitektur sebagai agen penyembuhan, martabat, dan reintegrasi—sebuah pendekatan yang lebih manusiawi dan peka konteks terhadap rehabilitasi psikiatri di wilayah pedesaan Indonesia.

Authenticity Sheet

Final Architectural Design Studio entitled:

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Final Architecture Design Studio Book Quality:

Adequate*) **Effective*)** **Excellent*)**

Therefore,
It Is Recommended / Not Recommended (*)
To ~~serve as a reference~~ for the final design studio project (*)
Circle one

Yogyakarta, 4 December 2025

Supervisor

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Statement of Authenticity

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State that all parts of this thesis work/final projects entitled:

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Yogyakarta, 4 December 2025

Aisyah Baswedan

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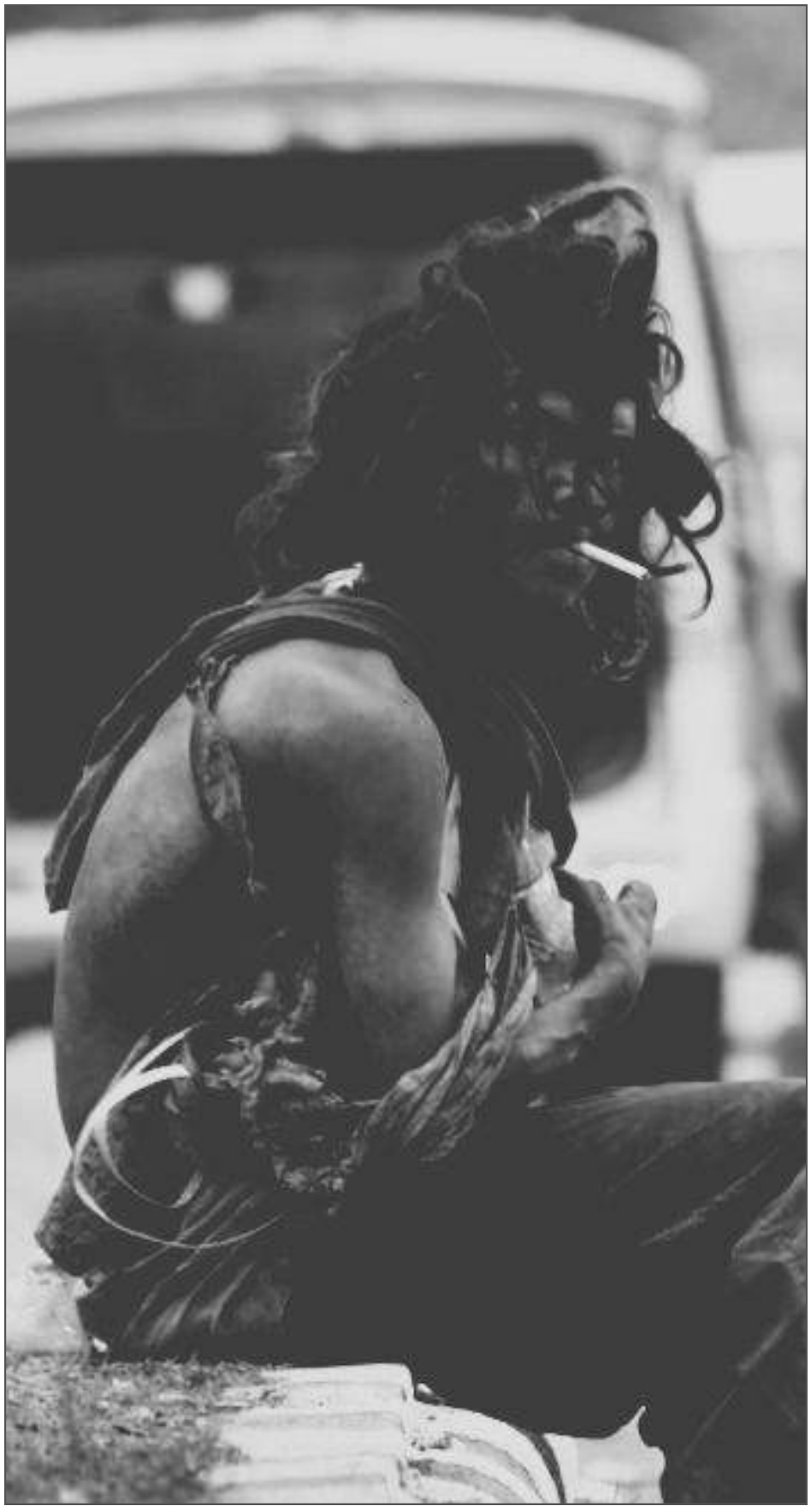
1 Introduction


KAMPOENG PULIH



Background

1.1 Mental Health Issues in Yogyakarta

Mental health disorders are a significant issue in Indonesia. According to the 2018 Basic Health Research by the Ministry of Health, around 19 million Indonesians experience mental health problems, meaning that 1 in 10 people in Indonesia is affected (Ministry of Health of the Republic of Indonesia, 2018). Among all provinces, the Special Region of Yogyakarta (DIY) has one of the highest numbers of mental health cases. DIY ranks second in Indonesia, with a prevalence of 10 per thousand, meaning that for every 1,000 residents, 10 people experience mental health disorders (Dinkes DIY, 2018).

In DIY, Kulon Progo Regency has the highest number of cases. The Ministry of Health reports that 12.1% of the population in Kulon Progo experiences mental health disorders, and 19.36 per thousand (or around 19 in 1,000 people) suffer from severe mental disorders such as depression (Dinkes DIY, 2018). Meanwhile, in Yogyakarta City, the Health Office recorded a mental disorder prevalence of 0.78%, affecting at least 3,239 residents. Among them, 1,285 individuals have been diagnosed with severe mental disorders (ODGJ).

1.2 Why Mental Health Patients and Their Guardian Reluctant to Seek Treatment?

THE FACTORS

1. Social Stigma Towards the Disorder and Facilities
2. Limited Access to Mental Health Services
3. Cultural and Religious Beliefs
4. Economic Barriers

Figure. Movie: Girl, Interrupted (1999)

Figure. Movie: Bedlam (1946)

Figure. Movie: Shutter Island (2010)

The buildings takes place in remote island, far from civilizations.

1.3 Stigma Around Mental Health and Its Facilities

Mental health facilities have long been **subjected to stigma, shaping their location, infrastructure, and societal perception.** Historically, psychiatric hospitals were often placed in isolated areas, creating the idea that individuals with mental illness should be kept away from society (Thornicroft et al., 2007). This segregation has **contributed to the public's misunderstanding of mental health disorders**, creating fear and **discrimination** against those seeking psychiatric care. As a result, many people hesitate to seek treatment due to the shame associated with being admitted to such facilities (Corrigan & Watson, 2002).

Efforts to fight the stigma surrounding mental health facilities involve making changes toward community-based mental health care and integrating psychiatric services into general healthcare settings. Countries like Italy successfully deinstitutionalized psychiatric hospitals in 1978 through the Basaglia Law, replacing them with community-based mental health services (de Girolamo et al., 2011). In Indonesia, however, psychiatric hospitals are still the main form of treatment, with only 40% of Indonesia's 514 districts having community mental health services (Riskesdas, 2018). Raising public awareness, providing proper education on mental health, and improving the conditions of psychiatric institutions can help change perceptions and encourage more people to seek the help they need.

Country	Presence of psychiatric hospitals	Location of psychiatric hospitals	Specific location of psychiatric wards in general hospitals	Stigma influence	Stigmatizing terms
India	Yes	Large cities	Yes	Significant	"Mental," "Psycho," "Pagal"
Indonesia	Yes	Countryside	Yes	Significant	"Crazy"
Iran	Yes	Countryside	Yes	Significant	"Timarestan," "Divaneh," "Ravani"
Italy	No, closed in 1978	-	Yes	Previously high, now lower although present	"Manicomio" (asylum), "Ospedale dei pazzi o dei matti" (hospital of the fools), "Madhouse"
Lebanon	Yes	Formerly isolated, now central	No	Significant	"Majnoun," "Akhwat"
Malaysia	Yes, integrated	Within city hospitals	Yes	Significant	"Tanjung Rambutan"
Nigeria	Yes	Large Cities	Yes	Significant but improving	"Yaba left"
Thailand	Yes	Large Cities	Yes	Variable	None
Tunisia	Yes	City centers	No	Previously high, now low	Famous stigmatizing terms
UK	Yes	Variable	Yes	Variable	"Asylum"

Table 1. Presence and location of psychiatric facilities and stigma

Country	Benefits of remote locations	Destigmatization programs	Medical integration	Employment views	Deinstitutionalization
India	No benefits	Training of primary care physicians and health care professionals	Can help reduce stigma	Mixed based on hospital	Supported
Indonesia	Dignity and privacy of patients	Expansion of Liaison-Consultant Psychiatry	Can help reduce stigma	Positive employment views	Supported
Iran	No benefits	Mental health education for health care workers and the public	Experience shows benefits	Mixed attitude	Supported but challenges remain
Italy	Not applicable	Considered (e.g., Establishment of youth-friendly hubs)	Experience shows it reduces stigma	Lingering stigma remains	Strongly supported
Lebanon	No benefits	Conducted by major hospitals and educational institutions, as well as non-governmental organizations	Helps reduce stigma	No employment effect	Supported
Malaysia	No benefits	No sustained anti-stigma program	No effect	No stigma effect	Supported
Nigeria	Reduced cost, easy access	Awareness programs	Helps reduce stigma	Mixed attitude	Supported but with caution regarding practicability, models, etc.
Thailand	Some benefits	Community-based psychiatric care (Village health volunteer training)	Helps reduce stigma	Mixed attitude	Caution adapting western models
Tunisia	Remoteness from the noise and the pollution	National programs, hospital closure advocated	Did not reduce stigma	No employment effect	Strongly supported
UK	None described	"Choose psychiatry" campaign	Potentially positive	Possible stigma effect	Not a priority currently

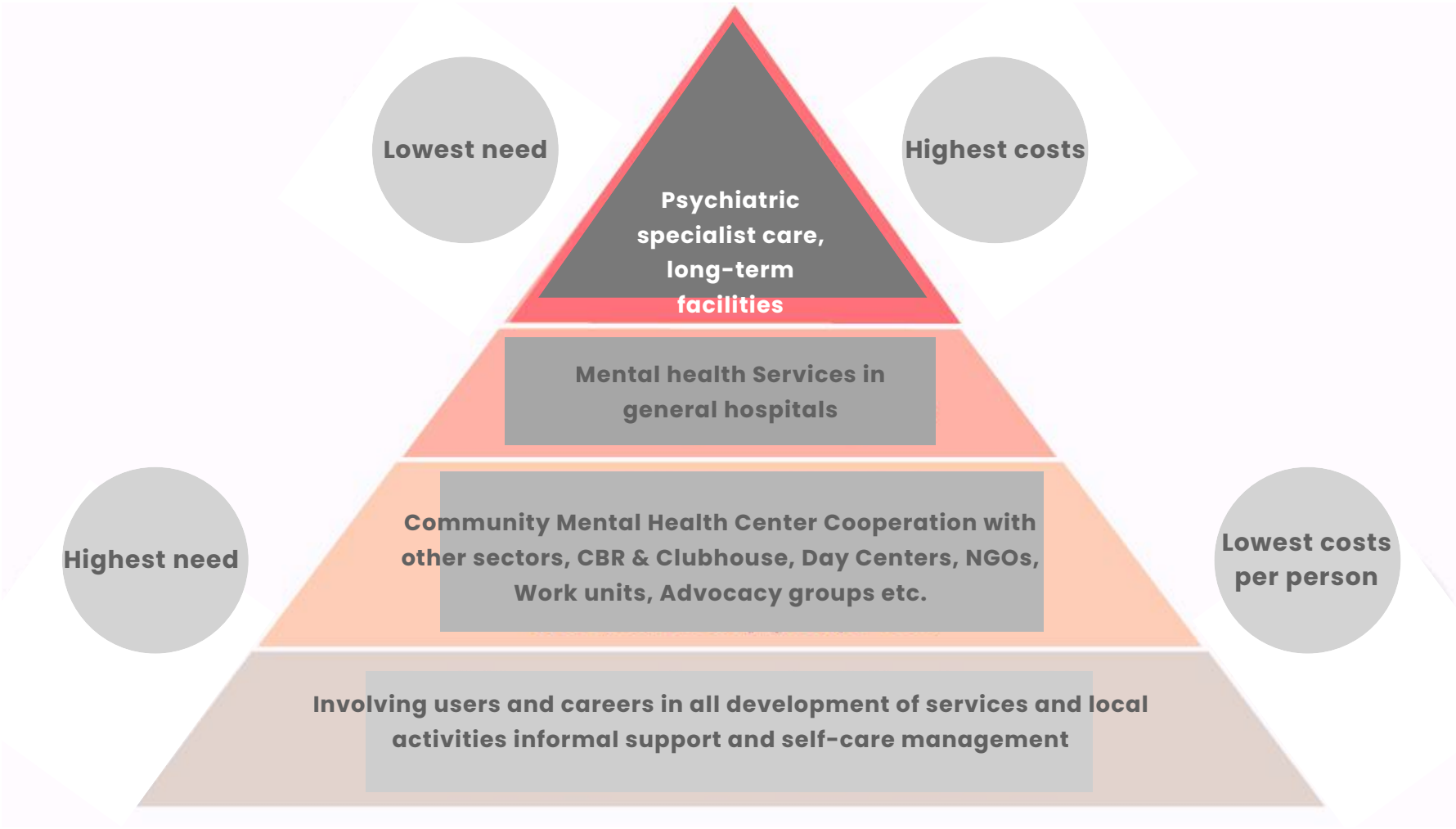
Table 2. Programs, integration, and views on psychiatric care

The article "Impact of stigma on the placement of mental health facilities: insights from early career psychiatrists worldwide" examines how stigma influences the location and perception of psychiatric hospitals across various countries. In Indonesia, psychiatric hospitals are often situated in rural areas, reflecting societal stigma that leads to the isolation of individuals with mental health disorders. This rural placement can prevent accessibility for urban populations and continue to cause negative perceptions on mental health care.

1.4 Why is it Important to Have Rehabilitation Center

THE URGENCY

The World Health Organization (WHO) emphasizes that rehabilitation is an essential component of universal health coverage, alongside health promotion, disease prevention, treatment, and palliative care. Rehabilitation enables individuals to be as independent as possible in daily activities and facilitates participation in education, work, and meaningful life roles, such as family care. In the context of Yogyakarta's high prevalence of mental health disorders, establishing dedicated rehabilitation centers is important to provide comprehensive care and support for affected individuals, thereby enhancing their quality of life and promoting community well-being.



Source: WHO 2003 (Revised 2007), applied by E. Hanninen and E. Mielonen 2012

Figure. kompas.com/Interaksi Masyarakat Desa (2021)

1.2.1 The Positive Impact of Social Culture in the Village on Mental Health

Mental health is an important aspect of individual and community well-being, especially in facing the challenges of modern life that often trigger stress and psychological distress. One factor that contributes to mental health is a supportive social environment, where individuals feel accepted, valued, and have a strong support network. The social culture in the village, which is characterized by close interaction between residents, mutual cooperation, and involvement in communal activities, has long been a natural mechanism in maintaining the psychological balance of the community.

The study about The Function of Slametan in Supporting Community Mental Health by Bayu Adiputro shows that social culture in the village, as reflected in the slametan tradition, has a positive impact on mental health by strengthening social ties, increasing a sense of solidarity, and providing emotional support for community members. In a broader context, these findings are relevant to various studies on the importance of social capital and community involvement in maintaining mental health. Close social interactions in the village environment create a sense of belonging and emotional security, which can help individuals cope with stress and prevent social isolation, two major factors that contribute to mental disorders such as depression and anxiety. In addition, the mutual cooperation and togetherness aspects of the village social culture also support collective coping mechanisms, where individuals can share emotional burdens and find solutions together in facing life's challenges. Thus, this study underlines that maintaining and adapting a strong social culture in communities, both in rural and urban areas, can be an effective strategy in improving the mental well-being of the community as a whole.

While this study highlights slametan as an example of a social culture that has a positive impact on mental health, it is important to understand that similar benefits do not necessarily come from this tradition alone. Each community has its own unique way of building social connections and creating a supportive environment for its members. Social culture in villages can appear in various forms, such as mutual cooperation activities, social gatherings, night patrols, community meetings, or simply gathering at a stall to chat. All of these activities contribute to the creation of a sense of togetherness, provide emotional support, and strengthen social networks that can help individuals cope with psychological stress.

Figure. tempo.co/9 Hal yang Bikin Nglanggeran Yogyakarta Menjadi Desa Wisata Terbaik UNWTO 2021 (2021)

1.2.2 Friendly Village for People with Mental Health Disorders In Yogyakarta

Mental health is a serious issue in Indonesia, especially in rural areas where stigma and lack of healthcare access make it difficult for people with mental disorders to get proper support. In some villages, individuals with severe mental conditions are often restrained (pasung) or isolated due to misunderstanding and fear. However, Desa Petir, a village in Gunung Kidul, Yogyakarta, has taken a different approach by building a supportive and inclusive community for people with mental disorders.

In 2020, Desa Petir had a population of 3,824, with 30 individuals identified as having mental disorders (Orang Dengan Gangguan Jiwa or ODGJ). To improve their well-being, the village declared itself an "Kalurahan Ramah Jiwa" (Mental Health-Friendly Village) in 2015. This declaration makes a strong commitment to ending prejudice and making sure that ODGJ people get respect and dignity. Unlike in many other places where mental health patients are restrained or neglected, Desa Petir makes sure that no ODGJ residents are subjected to pasung or social isolation. Instead, the village encourages them to participate in daily life and receive the care they need.

Another effort made by Desa Petir in the mental health program is the creation of the Forum Komunikasi Lentera Jiwa on May 9, 2017. This forum acts as a support network for ODGJ individuals and their families. Through regular meetings, discussions, and awareness programs, the forum helps families understand mental health better and provide proper care for their loved ones. The forum is strongly supported by Lurah (Village Head) and the Forum Chairman Pratama Windarta, who actively promote mental health education and inclusion. Their leadership has helped bring medical access, therapy sessions, and community awareness programs to Desa Petir, reducing stigma and encouraging more people to be involved in mental health advocacy. Desa Petir proves that a community-based approach can be effective in helping people with mental disorders live better lives.

Kalurahan Petir
Kapanewon Rongkop
Kabupaten Gunungkidul

Profil Kalurahan | Pemerintahan | Lembaga

Beranda | Berita | Agenda | Produk Hukum | Laporan | Informasi Pelayanan | Opo Opo Dho

PENGUKUHAN FORUM KOMUNIKASI LENTERA JIWA

BBC NEWS INDONESIA

Berita | Indonesia | Dunia | Viral | Liputan Mendalam | Majalah

Desa di Gunung Kidul yang 'memanusiakan penderita gangguan jiwa'

suarajogja.id

NEWS

Menengok Desa Petir, Kampung yang Memanusiakan Orang dengan Gangguan Jiwa

Galih Priatmojo

Rabu, 02 September 2020 | 10:45 WIB

Salah satu Orang dengan Gangguan Jiwa yang hidup berdampingan dengan warga di Desa Petir, Gunungkidul, Rabu (2/9/2020). [Kontributor / Julianto]

1.2.3 Types of Mental Health Disorders in Indonesia

PPDGJ III (Pedoman Penggolongan dan Diagnosis Gangguan Jiwa di Indonesia)

PPDGJ III is the third edition of Indonesia's official guidelines for the classification and diagnosis of mental disorders, published in 1993 by the Indonesian Ministry of Health. This edition aligns closely with international standards, particularly the **ICD-10** (International Classification of Diseases, 10th Revision) developed by the World Health Organization (WHO) in 1992. PPDGJ III adopts the alphanumeric coding system from **Chapter V (F00–F99) of ICD-10**, which is dedicated to mental and behavioural disorders.

PPDGJ III uses **a hierarchical classification system**, organizing disorders into diagnostic blocks, which reflect shared clinical and etiological characteristics. Within each block, specific disorders are categorized and described using structured diagnostic guidelines, mirroring ICD-10's format.

The ICD-10 Chapter V outlines mental and behavioural disorders, structured into blocks:
F00–F09: Organic Mental Disorders
F10–F19: Disorders Due to Psychoactive Substance Use
F20–F29: Schizophrenia, Schizotypal, and Delusional Disorders
F30–F39: Mood (Affective) Disorders
F40–F48: Anxiety, Dissociative, Stress-related, Somatoform Disorders
F50–F59: Behavioral Syndromes Associated with Physiological Disturbances
F60–F69: Personality and Behavioral Disorders in Adults
F70–F79: Intellectual Disabilities (formerly called mental retardation)
F80–F89: Developmental Disorders
F90–F98: Behavioral and Emotional Disorders with Onset in Childhood and Adolescence

DSM-5 and the Multi-Axial System

The DSM-5, published by the American Psychiatric Association (APA) in 2013, represents the most recent and globally influential psychiatric classification system. The DSM-IV multi-axial framework widely studied and used for comprehensive evaluations in various settings, including mental health rehabilitation centers.

The multi-axial diagnostic system (from DSM-IV) includes Axis I-V. And the focus is in Axis V which is **Global Assessment of Functioning (GAF)** – a scale (0–100) used to rate the overall psychological, social, and occupational functioning of an individual. It ranges from:
100-91: No symptoms, functioning at maximum, no intractable problems.
90-81: Minimal symptoms, functioning well, moderately mild, no more than ordinary daily problems.
80-71: Transient and manageable symptoms, mild disability in social, work, school, etc.
70-61: Some mild and persistent symptoms, mild disability in functioning, generally good.
60-51: Moderate symptoms, moderate disability.
50-41: Severe symptoms, severe disability.
40-31: Some disability in contact with reality and communication, severe disability in some functions.
30-21: Severe disability in communication and judgment, unable to function in almost all areas.
20-11: Danger of self/others harm, very severe disability in communication and self-care.
10-01: As above => persistent and more serious.
0: information is inadequate.

1.2.4 Community-based Approach in Architectural Design

Community-based design is a collaborative approach that involves the active participation of the community in the design process. The goal is to create spaces and products that meet the unique needs of the community and improve their quality of life.

Collaboration & Engagement:
The design process should actively involve community members, stakeholders, and designers to ensure that the final product reflects the real needs and values of the people it serves.

Inclusivity & Accessibility:
Spaces should be welcoming and usable by everyone—regardless of age, ability, or background. This helps foster a sense of belonging and ownership within the community.

Core Principles

Sustainability & Resilience:
Designs should be environmentally conscious and adaptable over time to meet changing community needs and conditions.

Contextual Identity:
Each design should reflect the cultural, historical, and social context of its location, helping reinforce local identity and pride.

THE MATTERS

Community-based design helps:

- Create more relevant and meaningful spaces.
- Promote social integration and community pride.
- Deliver long-term value by aligning design with real human behavior and local challenges.

1.2.5 Community-based Method in Health Facilities

Community-based healthcare involves engaging community members directly in the health decision-making process. This approach ensures that health services are tailored to the specific needs, cultural contexts, and priorities of the community. Such engagement not only enhances the relevance and effectiveness of health interventions but also promotes a sense of ownership and responsibility among community members.

The World Health Organization (WHO) underscores the importance of this approach, stating that primary health care should be a "whole-of-society" endeavor, focusing on people's needs throughout the health continuum from promotion and prevention to treatment and rehabilitation

Benefits of Community-Based Methods:

- **Enhanced Relevance:** By involving community members, health interventions are more likely to address actual needs and be culturally appropriate.
- **Increased Accessibility:** Community-based approaches often bring services closer to where people live and work, reducing barriers to access.
- **Empowerment:** Engaging communities fosters empowerment, enabling individuals to take charge of their health and advocate for necessary resources.
- **Sustainability:** Programs developed with community input are more likely to be sustainable, as they build local capacity and ownership.

Challenges and Considerations:

While community-based methods offer numerous advantages, they also present challenges:

- **Resource Limitations:** Implementing community-based programs requires adequate resources, including trained personnel and funding.
- **Capacity Building:** Communities may need support to develop the skills and structures necessary for effective participation.
- **Maintaining Engagement:** Sustaining community involvement over time can be challenging, especially if immediate results are not evident.

Figure. Interior View of Health Station’s Waiting Area

1.2.6 Psychosocial Rehabilitation Center

Psychosocial rehabilitation centers play a crucial role in supporting individuals with mental health disorders, particularly those with severe and persistent conditions. According to the World Health Organization (WHO, 2022), psychosocial rehabilitation is a process that facilitates opportunities for individuals with mental disorders to achieve optimal levels of functioning in the community. This approach goes beyond symptom management, focusing on enhancing social skills, vocational capabilities, and overall quality of life (WHO, 2022).

These centers provide a structured, supportive environment where individuals can receive therapeutic interventions, develop life skills, and rebuild social networks. Services typically include individual and group therapy, vocational training, recreational activities, and family support programs (Anthony, 1993).

Community-Based Approach in Psychosocial Rehabilitation

A key aspect of psychosocial rehabilitation centers is their alignment with the community-based model. Instead of isolating individuals in institutional settings, these centers operate within communities to ensure continuous interaction with the social environment.

Community-based psychosocial rehabilitation emphasizes:

- Integration with Local Services: Collaborating with primary healthcare, social services, and community organizations to provide comprehensive support.
- Person-Centered Care: Tailoring rehabilitation plans to individual strengths, goals, and preferences, fostering autonomy and empowerment.
- Family and Community Involvement: Engaging family members and the broader community in the rehabilitation process to reduce stigma and promote inclusion.

Benefits and Impact:

- Improved Functional Outcomes: Individuals show better social functioning, employment rates, and independent living skills when rehabilitation is community-based.
- Reduced Hospitalization Rates: By providing ongoing support and crisis intervention, these centers help reduce relapses and the need for hospitalization.
- Enhanced Quality of Life: Community-based settings promote a sense of belonging and purpose, crucial for mental health recovery.

Figure. Interior View of Emergency Room

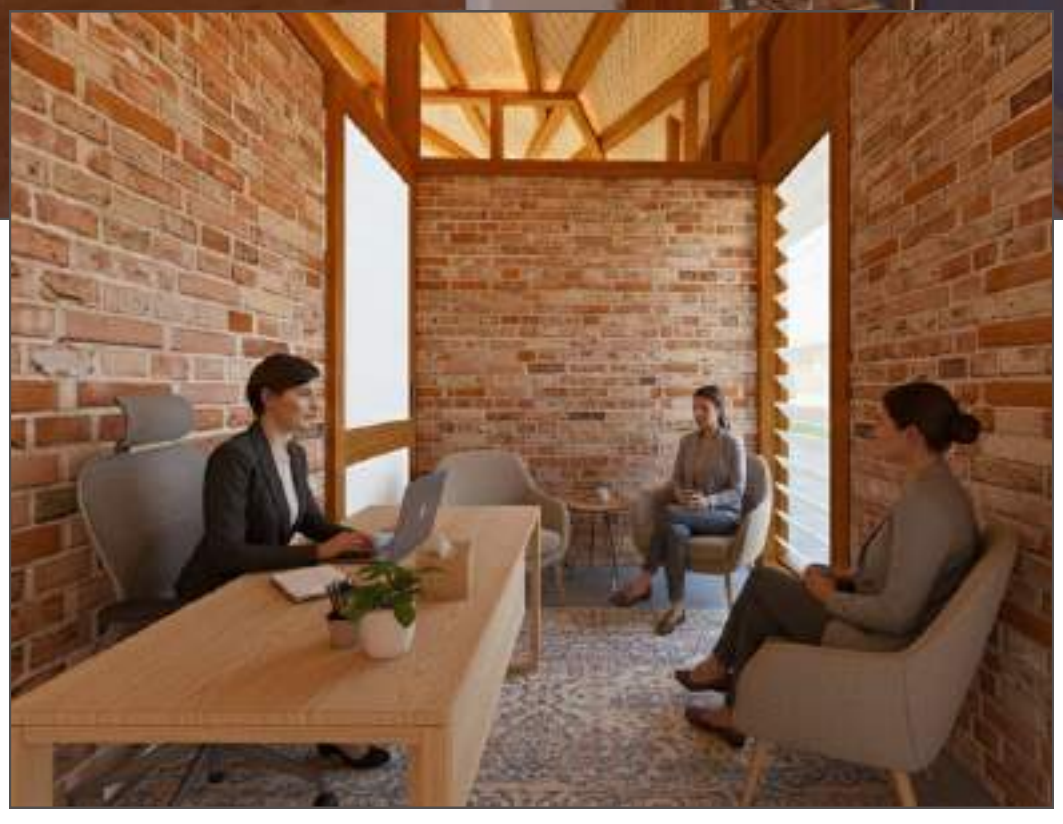


Figure. Interior View of Consultation Room

1.2.7 Village-based Planning

Village-based planning is a participatory approach in public health systems that places village communities as the main actors in identifying needs, planning, and monitoring health services. This approach aims to ensure that health interventions are in accordance with the local context, culture, and priorities of the local community.

According to study by Theodori (2023), community-based planning allows communities to identify the most pressing health problems and design solutions that are appropriate to the resources available. This strengthens local capacity and improves the sustainability of health programs.

Implementation in Health Systems:

- **Formation of Village Facilitator Team:** This team is tasked with facilitating the planning process and ensuring active participation from all levels of the community.
- **Training and Capacity Building:** Team members and the community are provided with training to improve their understanding of health issues and effective planning methods.
- **Identification of Health Problems:** Through group discussions and surveys, the community identifies the major health problems they face.
- **Formulation of Action Plan:** Based on the identified problems, the community collaboratively designs an action plan that includes intervention strategies, resources needed, and indicators of success.

Challenges and Mitigation Strategies:

- **Resource Constraints:** Lack of funds and trained personnel can hamper the planning and implementation process.
- **Varying Levels of Participation:** Not all community members may have the interest or ability to be actively involved in the planning process.
- **Coordination among Stakeholders:** Bringing together different parties with different interests can be complex.

Figure. Bird-eye View of the Site

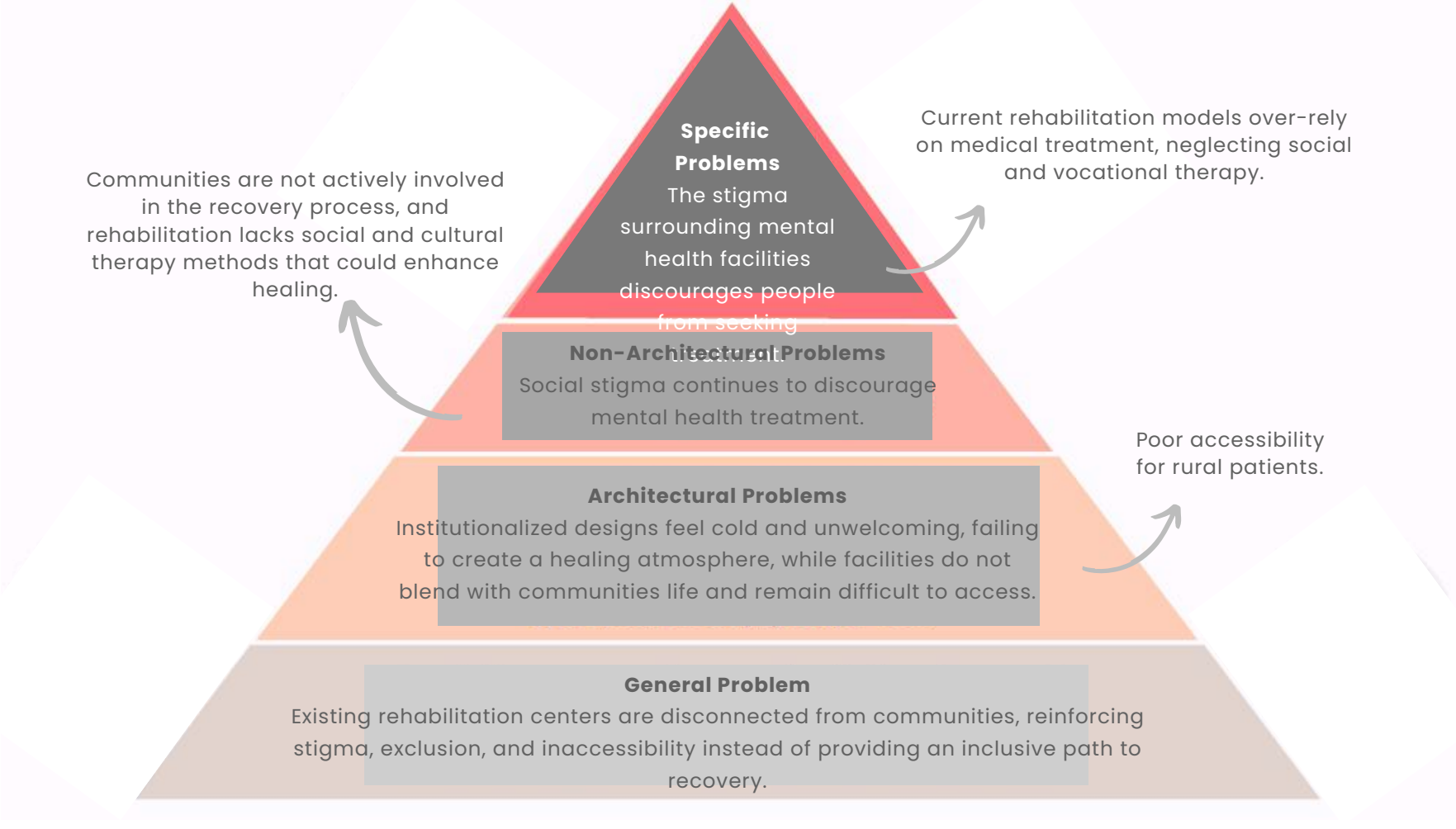
Problematique

1.3.1 Problem Statement

Mental health rehabilitation in Indonesia remains isolated and stigmatized, making treatment inaccessible and socially unaccepted. A community-based approach can integrate rehabilitation with villages daily life, help creating community support and holistic healing.

1.3.2 Design Goals

Kampoeng Pulih aims to create a community-based healing space that integrates with local village culture, creating social acceptance, ensures accessibility for rural communities, and incorporates holistic therapies such as farming and crafts. By engaging the local community in support and recovery, this rehabilitation center will redefine mental health care as inclusive, dignified, and community-driven.



1.3.3 Design Question

Main Design Question
How can architecture facilitate psychosocial rehabilitation in a rural village context in a way that destigmatizes mental illness?

Key Sub-questions
- How can community integration be spatially facilitated?
- How can local identity and nature be utilized to support psychosocial healing?
- How can flexibility in spatial use respond to varied stages of recovery?
- How to design spaces for different levels of mental disorder severity without enforcing segregation?

Methodology

a. Contextual Mapping
Site analysis of Desa Petir: topography, vegetation, settlement patterns, social structure.

b. User-Centered Design
Participatory inputs from former mental health patients, psychologist, families, RT/RW leaders, village caregivers.

c. Zoning by Diagnosis & Function
- Spatial layout based on F30–F48 disorder types (based on PPDGJ III).
- Progression from therapeutic isolation → semi-open spaces → social/public interaction.

d. Typological Integration
Study and adapt local houses, joglo, and pendopo for functional reuse.

Design Hypothesis

If a rehabilitation center for people with mental disorders is designed using community-oriented, psychosocial, and village-based principles, then it will not only **support recovery more effectivel**y but also **reduce stigma, foster social reintegration**, and empower both patients and the community.

a. Supporting Assumptions

- Community involvement reduces stigma.
- Nature and familiarity in spatial design reduce anxiety and promote healing.
- Gradual spatial exposure matches the psychosocial recovery curve.

b. Expected Outcomes

- Improved patient recovery and reintegration rate.
- Positive village perception of mental illness.
- A replicable alternative design model for rural mental health care.

Excellency, Originality, and Novelty

a. Excellency
- Integrates psychosocial therapy, community-based care, and local architecture.
- Responds to both medical and cultural-social needs of ODGJ in a rural context.

b. Originality
- Moves beyond the institutional model by embedding recovery within village life and landscape.
- Uses kampung typology to reframe what a mental health facility can look and feel like.

c. Novelty
- Introduces a "healing pathway" model: a spatial sequence from isolation to reintegration, linked to recovery phases (severe → mild).
- Incorporates local economic activities (e.g. farming, art workshops) into rehabilitation program.
- Adopts a co-living model with community participation as active therapy.

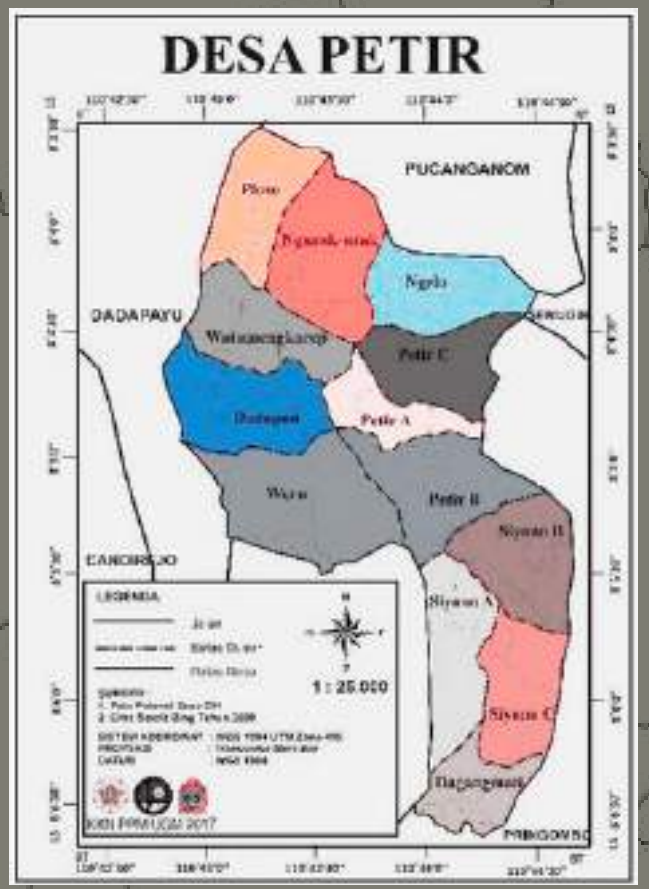
2 Problem & Studies

Design Problem Study

2.1 Site Analysis

Kabupaten Gunungkidul, Yogyakarta

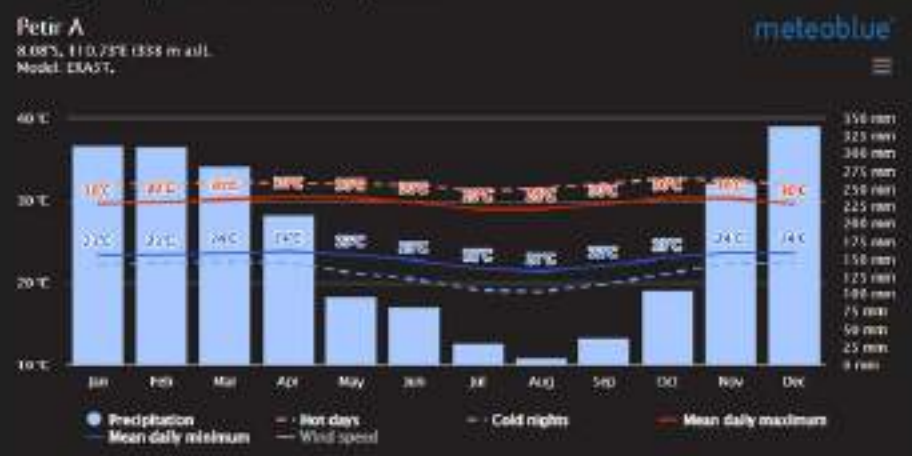
Kecamatan Rongkop, Gunungkidul



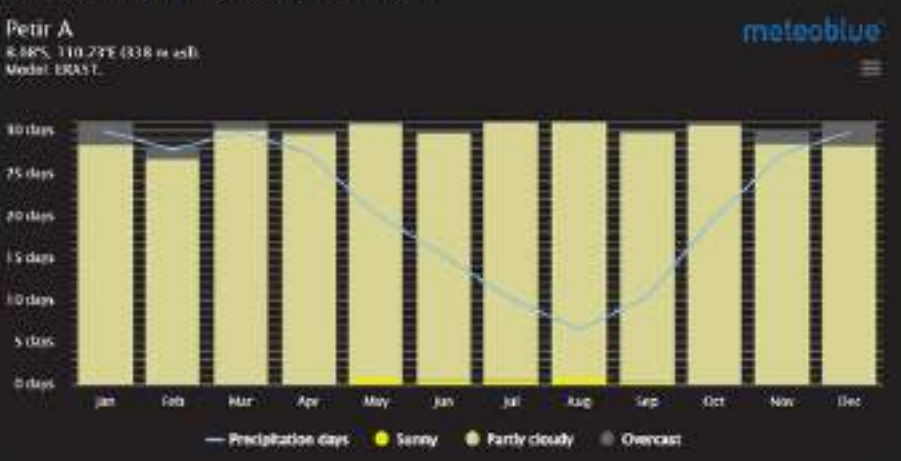
Petir Village, which is a Cultural Pioneer Village, surrounded by mountains and is located on a stretch of land with an area of 1,025,537 m2. The large Petir area is inhabited by a population of 3,824 people. The area is located at an altitude of between 0 - 800 meters above sea level. The land in Petir Village has varying degrees of slope. The average rainfall is 1,382 mm with an average number of rainy days of 120 days. Wet months are 4-6 months, while dry months range from 6-7 months. The rainy season begins in October - November and in April - May there is a dry season every year. The peak rainfall is reached in December - February. The average daily air temperature ranges from 27.7oC, the minimum temperature is 23.2oC, and the maximum temperature is 32.4oC.

> ***Desa Petir is a big region with 13 divided area. Each area have distance around 10 minutes from each other, and they have their own municipality, residential area, and village hall.***

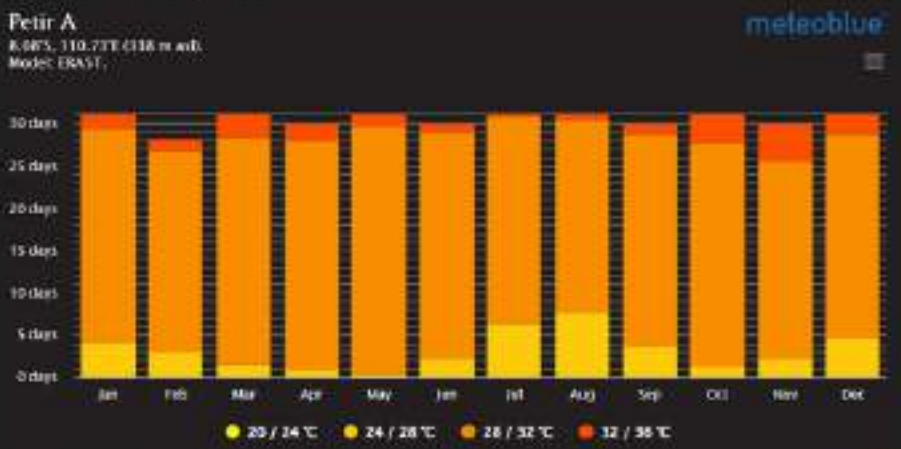
Average temperatures and precipitation



Cloudy, sunny, and precipitation days

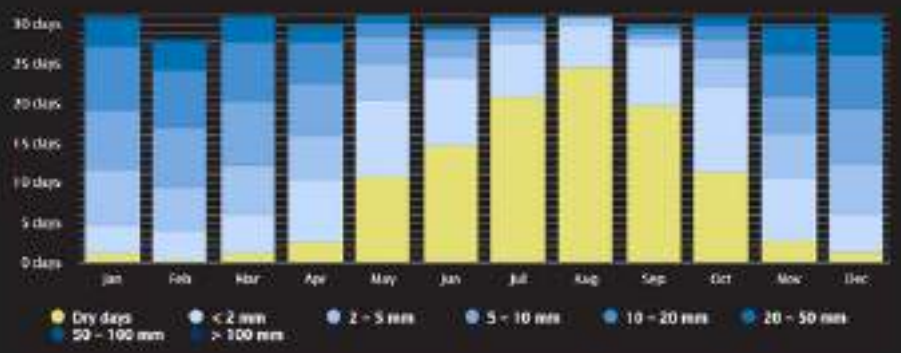


Maximum temperatures

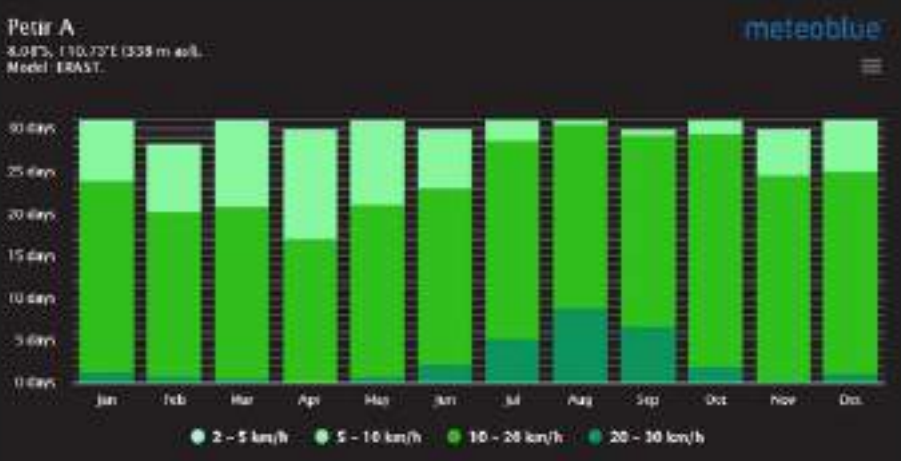


The maximum temperature diagram for Petir A displays how many days per month reach certain temperatures. Dubai, one of the hottest cities on earth, has almost none days below 40°C in July. You can also see the cold winters in Moscow with a few days that do not even reach -10°C as daily maximum.

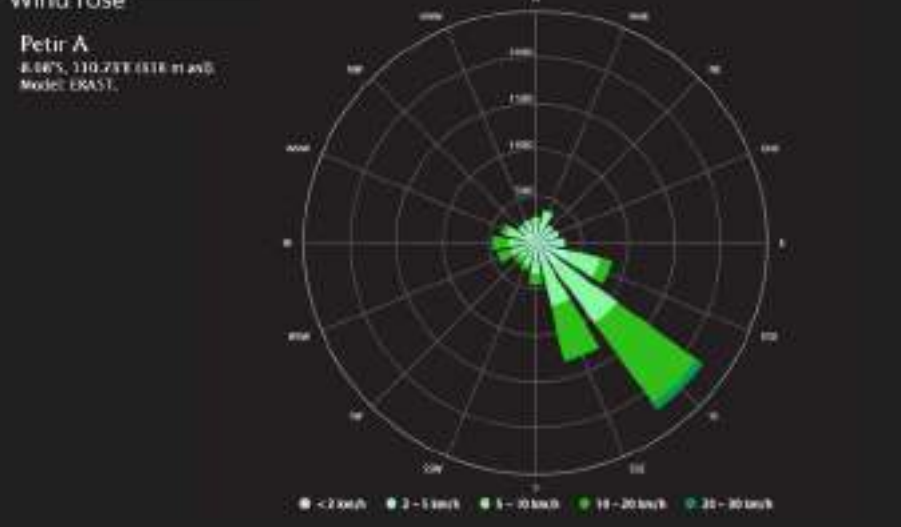
Precipitation amounts



Wind speed



Wind rose



2.2 Site Survey & Analysis

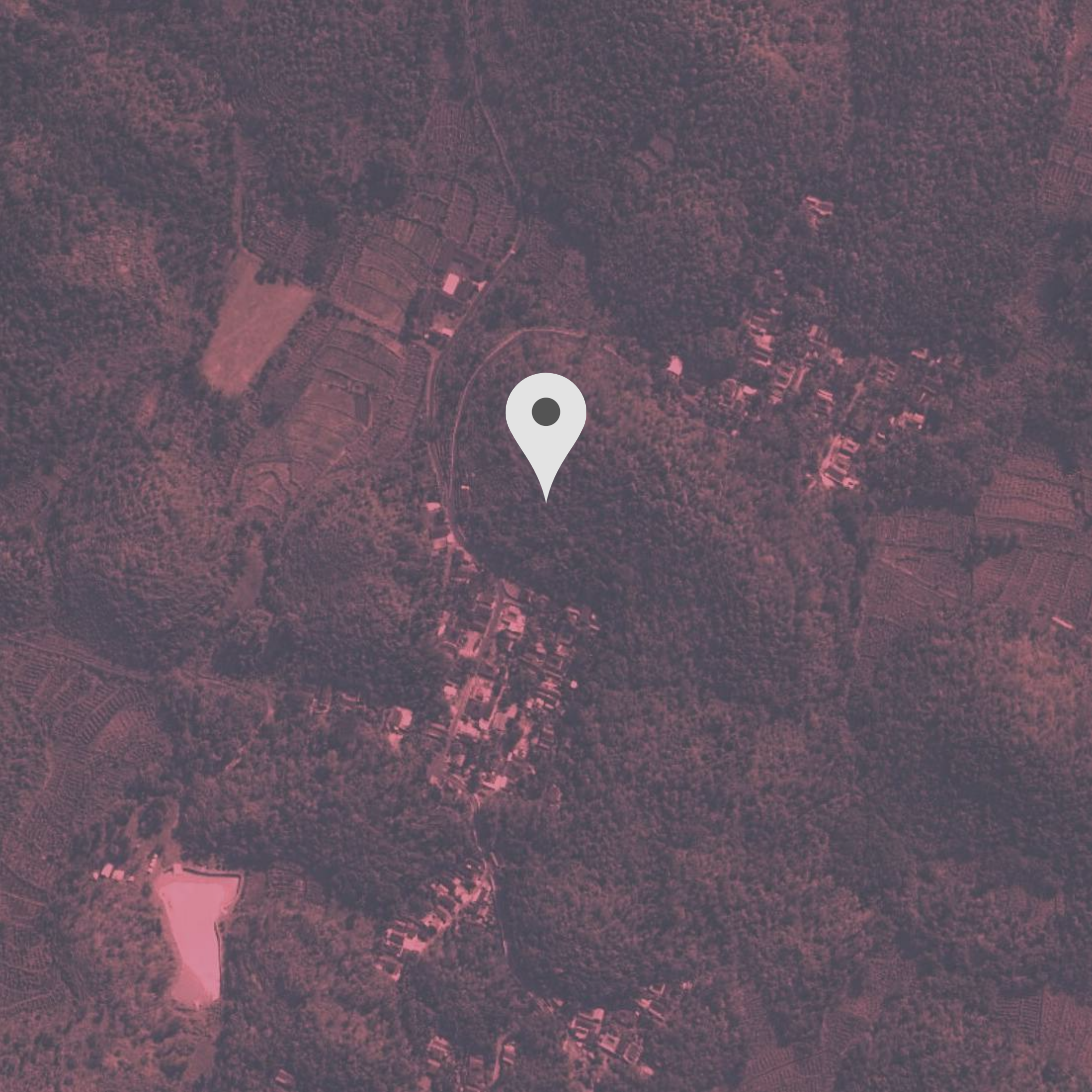
Desa Petir A, Kecamatan Rongkop, Kabupaten Gunungkidul, Daerah Istimewa Yogyakarta

WHY DESA PETIR A?

Initially, the plan was to establish the rehabilitation residential area in Desa Petir A. After conducting a site visit and interviewing local residents, it was discovered that the majority of people with mental health disorders (ODGJ) in the region reside in **Desa Petir Ploso**, approximately a 10-minute ride from Desa Petir A. Unfortunately, the accessibility and infrastructure in Desa Petir Ploso remain significantly **underdeveloped**, lacking proper asphalt roads, which poses a major challenge for transportation and future development.

In contrast, Desa Petir A offers the most **well-developed road access** in the surrounding Gunung Kidul area, including other parts of Desa Petir. The presence of asphalt roads makes it easier to reach the site, ensuring **better mobility for residents, caregivers, and visitors.** The village currently has around **28 families**, with agriculture being the primary livelihood. Over time, the number of families residing in the village has declined, as many younger generations choose to live elsewhere and only return after retirement. This trend has led to **the presence of 3–5 abandoned houses**, primarily due to the passing of their owners or relocation to urban areas.

Despite the fact that most ODGJ patients live in Desa Petir Ploso, the community in Desa Petir A is aware of their presence and **does not hold negative perceptions or stigmas against them**. Instead, they view them as regular members of society and express a willingness to support them. This inclusive mindset, combined with better infrastructure, makes Desa Petir A a more viable and strategic location for the rehabilitation residence. The site offers accessibility, safety, and a supportive community, all of which are essential elements in creating an environment that promotes the well-being and reintegration of individuals with mental health disorders.



Ricefield

District Administration

Housing Zone

Site Location

Figure. Village Meeting hall
Source: Author, 2025

Village hall complex integrated with sub-district office

Figure. Main Street View
Source: Author, 2025

Has a road width of 5-6 meters. Some houses have fences but many do not have fences, just open land

Figure. Site Location View
Source: Author, 2025

The site location has a slightly sloping land contour, 1 meter thick compared to the village road. It also has thick vegetation throughout the site area.

Figure. Site Contour
Source: Cadmapper, 2025

General Topography:
Desa Petir is characterized by a hilly landscape, with a series of valleys and elevated ridges shaping the area's natural form. This terrain contributes to a dynamic and multi-level environment, offering both challenges and opportunities in architectural planning.

Site-Specific Contour:
The site itself is located on a prominent hill, marked by five distinct contour layers with each layer rising approximately 10 meters from the previous one. This indicates:

- A total height difference of approximately 50 meters across the site.
- The site has the potential for terraced design or split-level structures, where buildings step with the landscape rather than altering it drastically.
- The higher elevation offers strategic views of the surroundings, potentially framing vistas of the village below or natural features like valleys and rivers.
- Challenges may include accessibility, drainage management, and soil stability, especially in steeper sections.

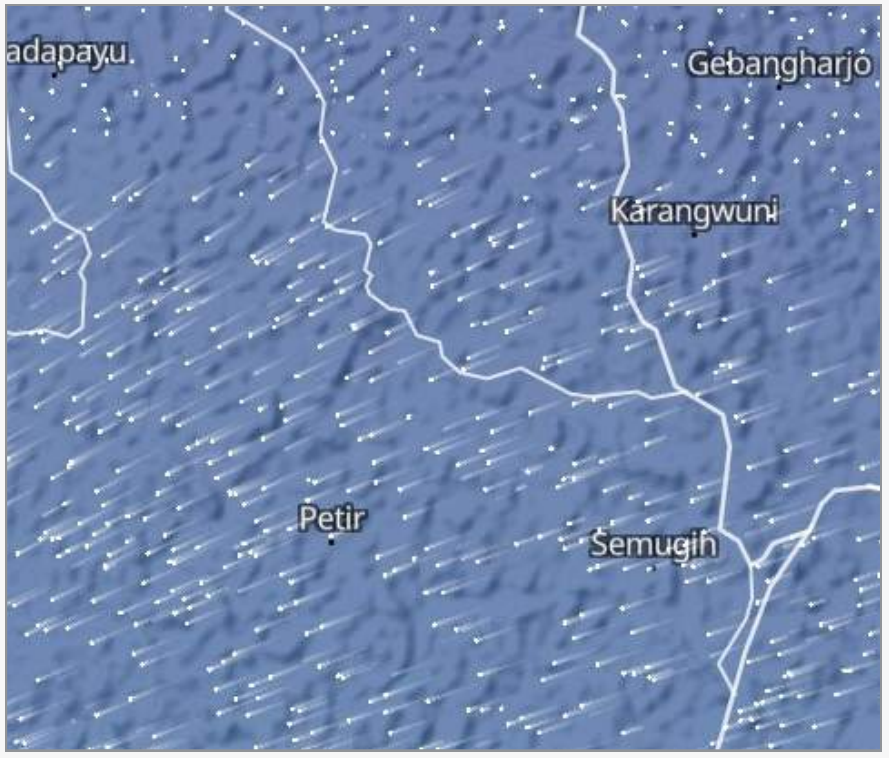
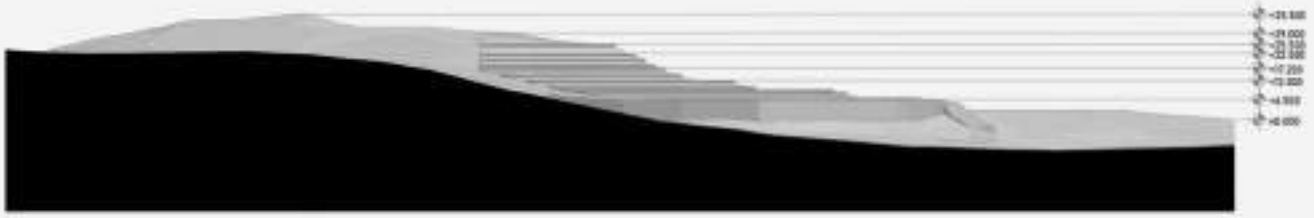


Figure. Site Wind Direction
Source: Meteoblue, 2025

Wind Analysis:
The dominant wind direction for Desa Petir comes from the east-northeast (ENE), which means winds typically approach from the 67.5° quadrant. This brings several considerations:

- The ENE wind is likely to occur most frequently, affecting how natural ventilation is planned in your design.
- In this tropical or sub-tropical region, the wind pattern is influenced by monsoonal systems, so seasonal variations might shift wind intensities or directions.

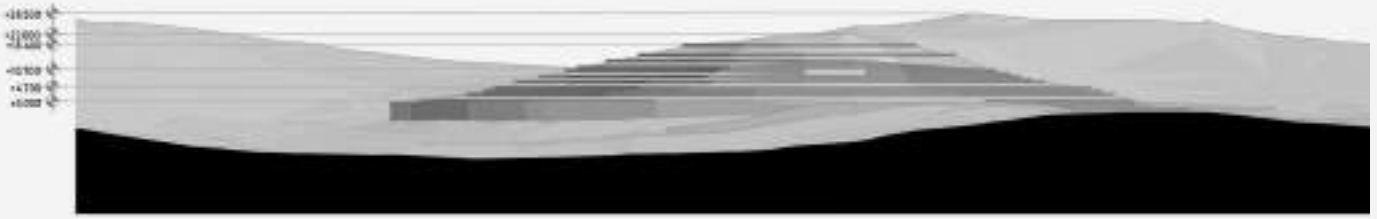
Site Contour



NORTH ELEVATION

EAST ELEVATION

SOUTH ELEVATION



WEST ELEVATION

2.3 Study of Village Characteristic

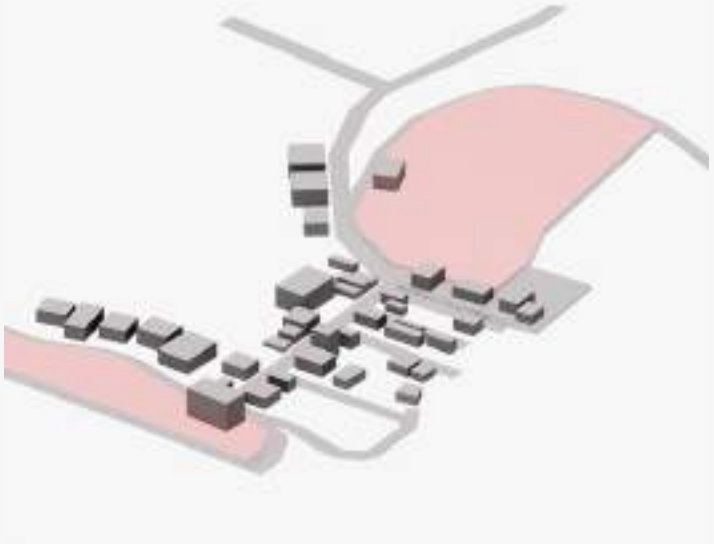
Desa Petir, located in Rongkop District, Gunungkidul Regency, Special Region of Yogyakarta, is a village with a strong agrarian character and a well-preserved local culture. The lives of its people are greatly influenced by the hilly geographical conditions and limited natural resources, especially the availability of water. However, the residents of Petir Village demonstrate resilience and independence through a simple lifestyle that focuses on agriculture, plantations, and home production. The economic activities carried out by the community are not only the backbone of their livelihood, but also reflect the spirit of mutual cooperation and local wisdom that can be an important basis in developing village-based design. Knowledge of the activities and character of this community is very relevant in designing spaces that are inclusive, participatory, and in accordance with the socio-cultural context.

- **Occupation:** Desa Petir has characteristics as an agricultural village, where most of the population works as farmers and gardeners. Data shows that around 40.66% or 1,565 people of the total population of Petir Village work in the agricultural and plantation sectors. The main commodities cultivated include peanuts, cassava, and various other horticultural crops.

- **Community:** The Women Farmers Group (KWT) "Ngudi Rejeki" in Petir Village is active in gardening and farming activities. With around 20 members, they routinely plant various types of plants and prepare nurseries. This activity not only supports local food security but also empowers women in the agricultural sector. The KWT's activities receive support from the Field Agricultural Extension Officer (PPL) and the village government.

- **Micro Industry:** Petir Village has around 30 UMKM actors who produce various processed foods such as tempeh, chips, and traditional cakes. This activity is an alternative source of income, especially for housewives. Products such as cassava chips and other processed products are produced using local raw materials and then marketed through social media and local markets.

- **Potential:** Petir Village has the potential for nature and culture-based tourism, such as the Mbah Jobeh Petilasan pilgrimage tour and the Teras Petir Educational Tourism Park. Routine socio-cultural activities include the rasulan traditional ceremony and karawitan arts. In addition, this village is known as a village that is friendly to People with Mental Disorders (ODGJ), with the **Lentera Jiwa Communication Forum** which is active in supporting and humanizing ODGJ in society.



OCCUPATION

FARMER + PEANUT + CASSAVA

COMMUNITY

WOMEN EMPOWERMENT + COMMUNITY + FOOD SECURITY

MICRO INDUSTRY

PRODUCTION + LOCAL SNACKS + LOCAL MARKET

POTENTIAL

ARTS + CULTURE + FORUM

2.4 Village Typology Study

Desa Petir, shows a blend of traditional Javanese architectural forms and modern developments. This study examines the prevalent building typologies in the village, focusing on their architectural characteristics, cultural significance, and adaptations to contemporary needs.

1. Traditional Javanese Architectural Forms
The architectural landscape of Desa Petir is deeply rooted in traditional Javanese designs, characterized by specific roof structures and spatial layouts.

- Joglo: This is the most prestigious traditional house form, typically reserved for nobility or community leaders. It features a distinctive trapezoidal roof supported by four central pillars (saka guru), symbolizing authority and social status. The Joglo structure is often used for communal gatherings and ceremonies.

- Limasan: Recognized by its pyramidal roof with four sloping sides, the Limasan is commonly found among middle-class families. Its design allows for efficient air circulation, making it suitable for the tropical climate.

- Kampung House: This typology represents the most common residential structure among villagers. It features a simple gable roof and is constructed using locally sourced materials like bamboo and timber.

Figure. Joglo house spatial organization
Source: Indonesian Heritage vol. Architecture, 1999

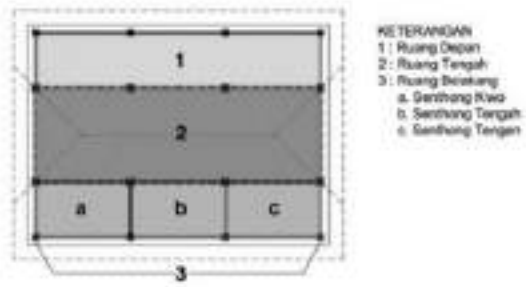


Figure. Limasan house floor plan
Source: Arsitektur Rumah Tradisional Jawa Yogya - Disbud 2022

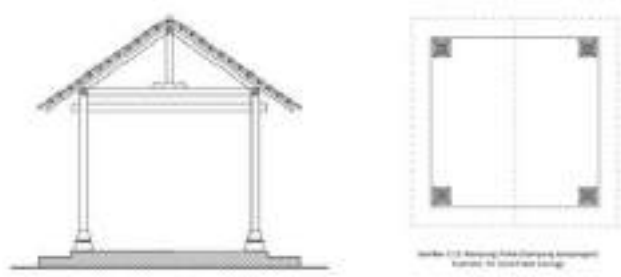


Figure. Example of typical Kampung-shaped house
Source: Arsitektur Rumah Tradisional Jawa Yogya - Disbud 2022

Figure. Desa Petir A Village hall
Source: Author, 2025

Joglo House shaped. Used for village youth organization (Karang Taruna) annual meeting and events.

Figure. Abandoned Houses around the villages
Source: Author, 2025

Has some distinctive element of the typical Joglo house.

Figure. Abandoned Houses around the villages
Source: Author, 2025

Most of the houses around the village have the shape of traditional javanese houses and use wood and red brick materials.

2.5 Study of Building Typology

Building Typology

Mental health rehabilitation centers vary in structure and services, tailored to meet the diverse needs of individuals with mental health disorders. Understanding these types is crucial for developing effective rehabilitation strategies.

Types of Mental Health Rehabilitation Centers:

- Psychiatric Hospitals: These facilities provide acute, short-term care for individuals experiencing severe mental health crises. They offer intensive medical and psychiatric intervention to stabilize patients.
- Residential Treatment Centers: Offering long-term care, these centers combine therapy, psychiatric support, and daily living activities. They are suitable for individuals requiring structured environments to manage their conditions.
- Community-Based Rehabilitation Centers: Focused on integrating individuals into their communities, these centers provide support and rehabilitative services to help patients develop skills for increased independence.
- Outpatient Treatment Programs: These programs offer therapy and support services without requiring patients to reside at the facility, suitable for those needing less intensive care.

Standards for Mental Health Rehabilitation Facilities:

To ensure quality care, various standards have been established:

- Certification and Compliance: Facilities must follow the regulations set by health authorities to maintain certification and funding eligibility.
- Service Delivery Standards: Guidelines outline the necessary services and care levels, emphasizing effective and efficient organization.
- Community Integration: Standards encourage facilities to focus on patient-centered care, aiding individuals in achieving greater independence and community involvement.

Chosen Rehabilitation Center Model:

For this project, a Community-Based Rehabilitation Center has been selected. This model emphasizes integrating individuals with mental health disorders into their communities, providing intensive support and rehabilitative services designed to assist persons with mental disorders in developing skills to become self-sufficient and capable of increasing levels of independence and functioning. This approach aligns with the project's goals of promoting community integration and enhancing the quality of life for individuals with mental health disorders.

Rehabilitation Center Typology Study

Based on study of the **Design Strategy of Rehabilitation Space** for Patients with Cognitive Disorders by Weicong Li, designing rehabilitation centers with specific environmental considerations can significantly enhance patient outcomes. Key design strategies include:

- Single Rooms: Providing private rooms can reduce medical errors and patient stress, improve sleep quality, enhance privacy and convenience, facilitate better communication, and increase overall satisfaction.
- Natural Light: Incorporating ample natural light into patient areas has been shown to reduce pain perception, alleviate negative emotions, and decrease stress levels.
- Natural Scenery: Access to views of nature can diminish pain sensations, lower stress, and boost patient satisfaction.
- Noise Reduction: Minimizing noise levels contributes to reduced patient stress, improved sleep quality, and a decrease in medical errors.
- Rational Layout: Implementing a logical and intuitive facility layout can prevent patients from getting lost and enhance healthcare efficiency.

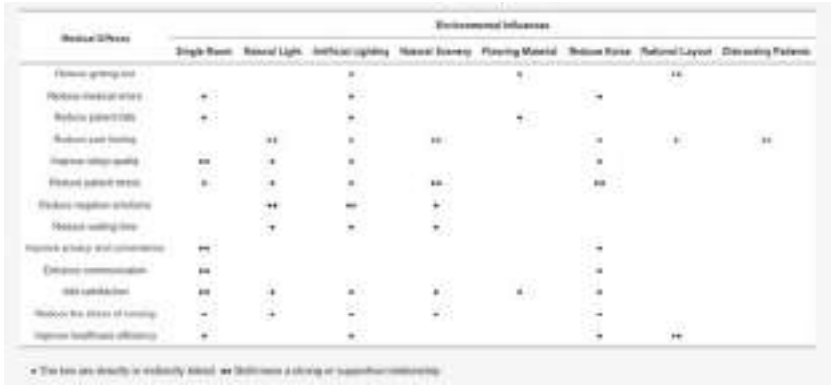


Table. Environmental factors affecting the quality of rehabilitation

The non-centripetal layout is divided into matrix and radial layouts. The matrix layout includes single-corridor and multi-corridor designs. Single-corridor layouts should be avoided because their long, narrow hallways increase walking distances for patients and doctors. In contrast, the multi-corridor layout is more efficient, despite having corridors that are 65% longer than a single corridor; its overall walking distance is only 1.24 times greater.

A compound layout builds on the single-corridor design by forming shapes like “king,” “field,” or “well,” improving visual accessibility, spatial connectivity, and walking efficiency. This design helps shorten walking distances, save time, and enhance convenience in healthcare environments.

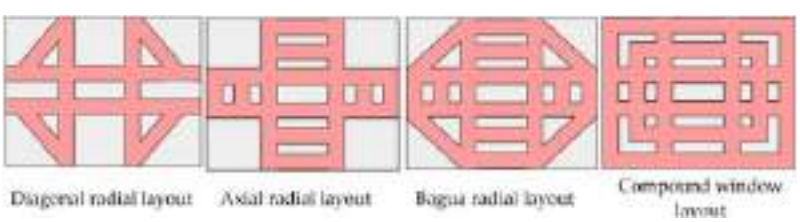


Figure. Radial layout space model

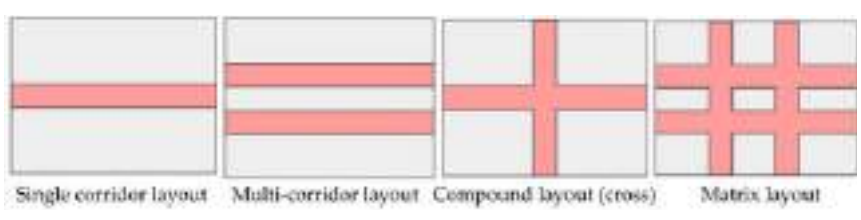


Figure. Matrix layout space model

Interview

Interviewee: Yustisi Kartika Putri, S.Psi., M.Psi., Psikolog
Date of Interview: April 23rd 2025
Interview Method: Offline Meeting
Role in Consultation: Mental health specialist providing insight on rehabilitation needs, patient behavior, and design implications.

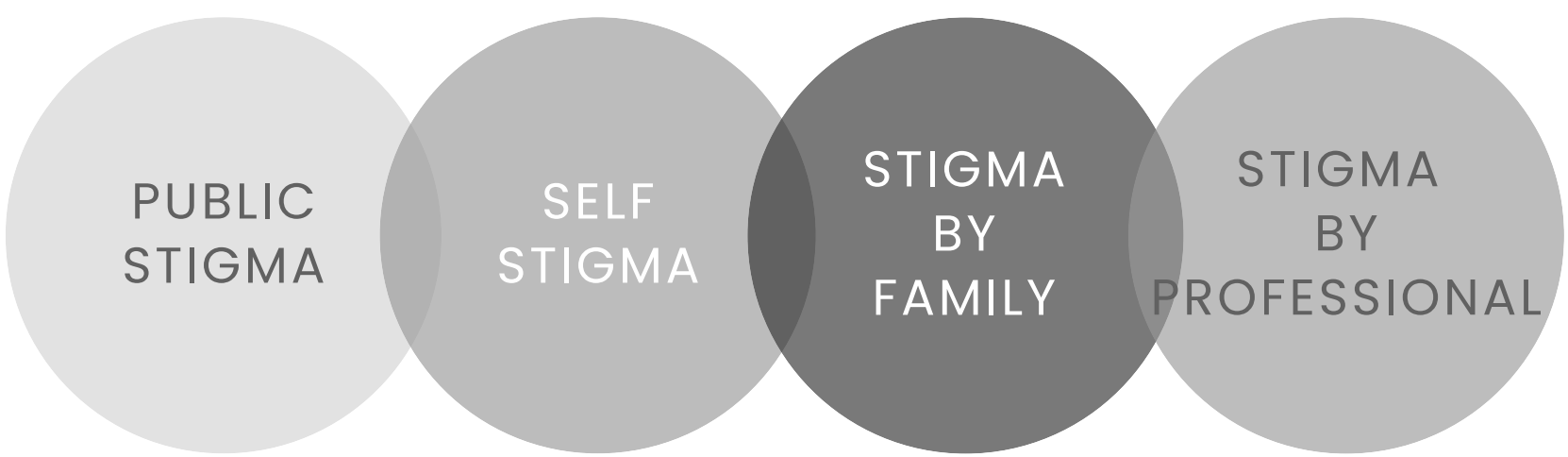
Key Points from the Interview

1. **General Perspective on Mental Health Rehabilitation**
   - Rehabilitation must focus not only on medical treatment but also on building daily routines, independence, and social skills.
   - Community involvement plays an essential role in reducing stigma and supporting long-term recovery.
2. **Needs of Patients Based on Severity**
   - Severe Cases: Require close supervision, controlled access, and structured activities. Spaces must prioritize safety without feeling restrictive.
   - Moderate Cases: Need semi-supervised environments, opportunities for productive tasks, and spaces that support emotional regulation.
   - Mild Cases: Benefit from open interaction with the community, flexible activity spaces, and environments that promote autonomy.
3. **Behavioral Considerations for Spatial Design**
   - Patients may experience sensory sensitivity, therefore, spaces should avoid overstimulation (noise, clutter, bright lights).
   - Clear circulation, predictable layouts, and visual openness help reduce anxiety and confusion.
   - Transitional spaces (verandas, gardens, shaded pathways) are crucial for grounding and calming.
4. **Spatial Programming Recommendations**
   - Provide gradual transitions between secure zones and community areas.
   - Include multi-sensory therapeutic spaces, such as gardens, craft areas, and quiet rooms.
   - Ensure staff supervision points are discreet but effective.
5. **Community-Based Approach Insight**
   - Integration with the village can significantly reduce stigma.
   - Activities like gardening, workshops, and small-scale agro-based programs encourage interaction between patients and residents.
   - Community participation must be voluntary, culturally sensitive, and supported by local leaders.
6. **Safety + Dignity Balance**
   - Avoid the appearance of a typical psychiatric hospital (RSJ).
   - Maintain patient dignity through warm materials, domestic-scale buildings, and non-institutional layouts.
7. **Design Implications Highlighted by the Psychologist**
   - Spaces must adapt to the fluctuating emotional state of users.
   - Architecture should empower patients through independence—clear signage, accessible paths, and choice-driven spaces.
   - Outdoor environments play an important therapeutic role, especially for stress reduction and grounding.

2.6 Study of Mental Health Stigma

THE TYPES

Stigma towards mental health is a significant barrier in the treatment of mental disorders. This stigma can be categorized into:



- **Public Stigma:** Negative attitudes of society towards individuals with mental disorders.
- **Self-Stigma:** Negative perception of oneself due to the mental disorder experienced.
- **Stigma by Family:** Shame or rejection from family towards members with mental disorders.
- **Stigma by Professional:** Discrimination from health workers towards patients with mental disorders.

> A study by Pinfold et al. (2003) showed that interventions based on direct social contact with individuals experiencing mental disorders were effective in reducing public stigma.

2.7 Study of Design Approach

The community-based design approach places the community at the center of the design process, prioritizing active participation, collaboration, and social sustainability. According to Sanoff (2000), community-based design not only aims to produce physical spaces that meet needs, but also to create a sense of ownership and empowerment for its users. In the context of health facilities, this approach combines local wisdom, culture, and the social structure of the local community.

Community-based design is essentially:

- A participatory process, in which the community is involved from the stage of identifying needs, formulating concepts, to implementing the design.
- An empathetic process, which listens to the aspirations and specific needs of the community, including vulnerable groups such as people with disabilities and people with mental disorders (ODGJ).
- A collaborative process, involving architects, planners, community leaders, and other stakeholders in realizing inclusive and sustainable spaces.

Key Elements of a Community-Driven Design Approach:

- **Social Mapping and Community Participation:** Using methods such as Focus Group Discussions (FGDs), in-depth interviews, and surveys to understand social dynamics, space needs, and community issues.
- **Context-Responsive Design:** Utilizing local potential, both in terms of materials, construction technology, and spatial patterns that reflect local culture.
- **Sustainable and Adaptive Scenarios:** Designing spaces that are able to adapt to social and environmental changes, and encourage long-term sustainability.

2.8 Study of Precedent

Precedent 1: Aro Village Project, Nigeria

The Aro Village Project in Nigeria, pioneered by Dr. Thomas Lambo, presents a model of psychiatric care that integrates the built environment with social structures to enhance mental health treatment. The project shifts from the conventional asylum-based design and instead utilized an adaptive architectural strategy that merged healthcare facilities with a village setting.

Approach in the project:

1. Decentralized Patient Housing:
   a. Instead of confining patients within hospital walls, they were housed within the existing village. This approach destigmatized mental illness by embedding patients into everyday community life.
   b. Patients stayed with host families, reinforcing a sense of normalcy and reducing the institutionalized atmosphere.
2. Community-Based Infrastructure:
   a. Existing village homes were adapted to accommodate patients, demonstrating a sustainable use of resources.
   b. Essential hospital functions, such as consultation and therapy spaces, were positioned near the village rather than in an isolated institution.
   c. A 24/7 nursing station was established within the village, ensuring immediate healthcare access.
3. Flexible and Incremental Expansion:
   a. The system evolved organically, with rent payments from patients contributing to infrastructure improvements (e.g., electricity and plumbing systems in the village).
   b. The expansion of patient capacity was achieved through renovations funded by microloans rather than large-scale new construction.
4. Integration of Traditional Healing Spaces:
   a. Collaborations between medical practitioners and local healers took place in designated spaces, recognizing the cultural context of mental health treatment.
   b. Communal gathering areas were established for group therapy and social reintegration activities.

Precedent 2: Residences for the Execution of Security Measures (REMS), Italy

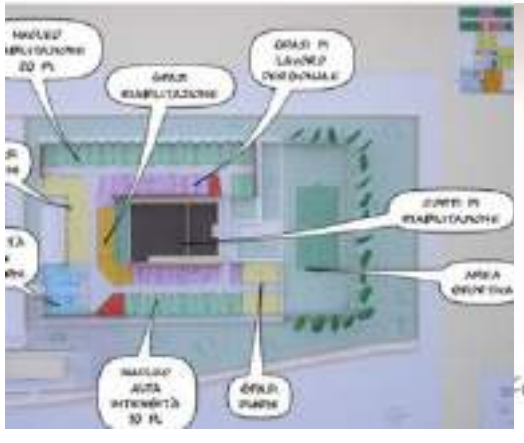
Italy has changed how it treats people with mental disorders, moving away from old psychiatric hospitals (OPG) to more humane facilities called REMS (Residences for the Execution of Security Measures). This shift started after reports in 2011 exposed terrible conditions in OPGs, leading to their closure under Laws 9/2012 and 81/2014. REMS were created to focus on treatment rather than just keeping people locked up, ensuring that even psychiatric patients who have committed crimes get proper care.

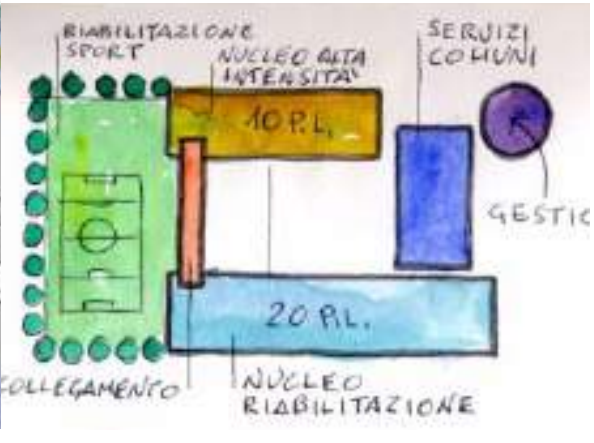
However, REMS are meant to be temporary, not permanent homes. Overcrowding is a problem, partly because too many people are sent there before their cases are finalized. Experts suggest creating more specialized facilities, such as psychiatric units in prisons for short-term stays and health residences for patients with lower risks. There's also a push to invest more in community-based mental health care to reduce the need for institutionalization.

Unlike the old prison-like OPGs, REMS are designed to feel more like homes. Rooms are similar to small apartments, with large windows instead of bars. The buildings include shared spaces for social activities, education, and therapy. Security is handled by healthcare staff rather than guards, with discreet barriers and 24-hour monitoring.

Italy is now taking inspiration from Northern European mental health centers, which focus on small, home-like environments. Future improvements could include making REMS units smaller for better personal care and adding green spaces like healing gardens

Currently, there are no models of new similar structures in Italy to refer to. The REMS in Reggio Emilia will be the first to be built, others are still in the planning stage. From an architectural point of view, they are **small two-story buildings**, since they host a **maximum of 30 patients**, characterized by **3 functional macro-spaces: one for residences, one for care and recovery activities and one for administration.** All these environments are generally organized planimetrically through a **central courtyard system** that also allows for outdoor activities.



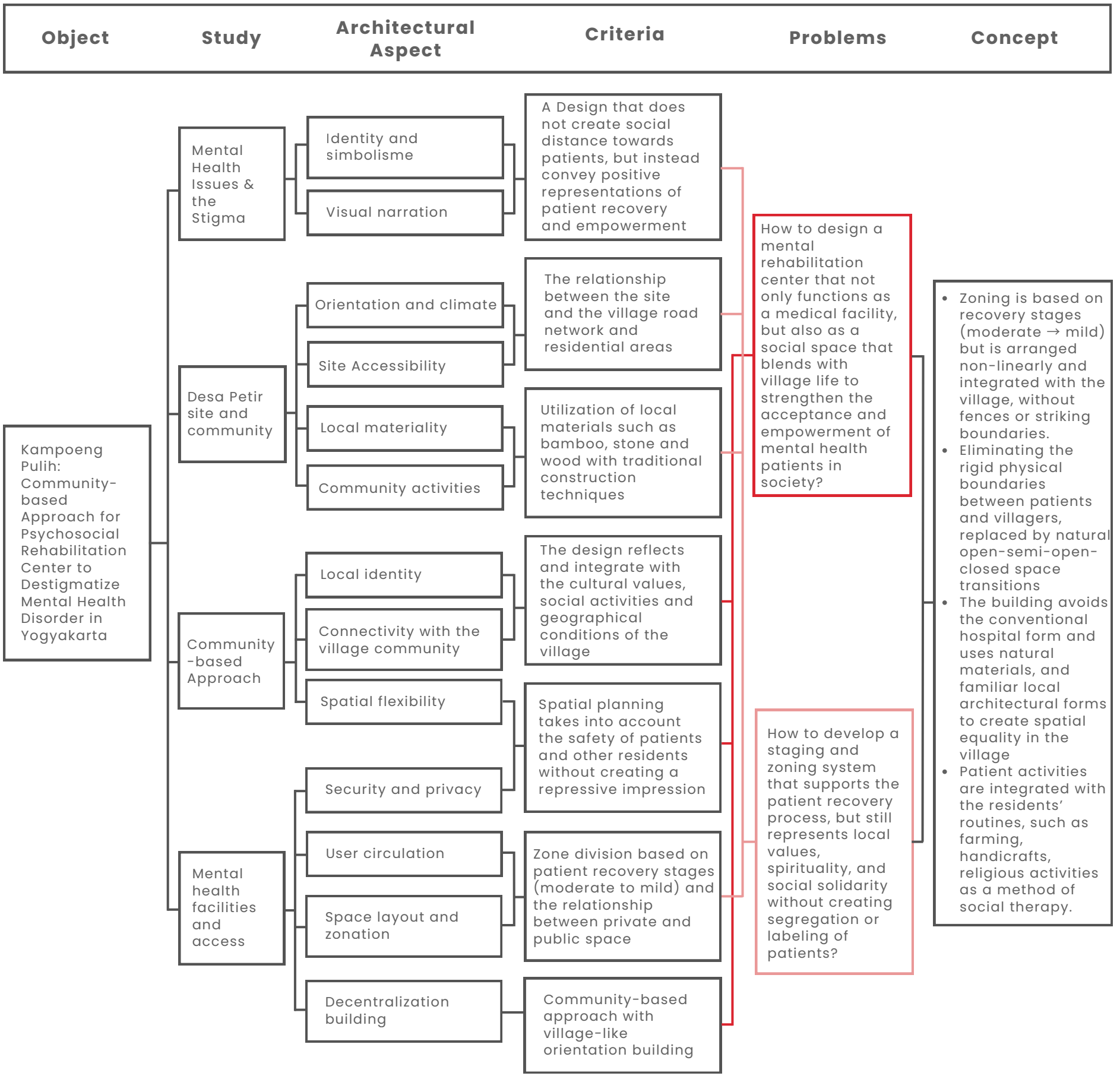


Precedent 3: RSJ Dr. Soeroyo, Magelang

Architectural Analysis of RSJ Dr. Soeroyo Magelang – Bangsal P3

No.	Space	Issues Identified	Recommended Design Solutions	Pictures
1	Floor Plan Bangsal	The layout is elongated, the nurses' room is not strategic, some rooms are difficult to supervise directly.	Reorganization of room positions so that nurses can monitor the entire ward from one point; spaces are made interconnected but remain safe and efficient for patient and staff circulation.	
2	Living Room (Terrace)	Wet when it rains, slippery floor, distant nurse supervision.	Anti-slip and quick-drying floor, add low walls (0.6 m), shorten the distance with the nurse.	
3	Dining Room	Dark at night, excessive interaction between patients, potentially dangerous furniture.	Add artificial lighting, design non-isolating doors, plastic furniture is not sharp, furniture is tidied up when not in use.	
4	Quiet Patient Bedroom	Potential escape via windows/ceilings, high spaces, minimal night lighting, difficulty for nurses to supervise.	Permanent bed, cool wall color (dark color above 3 m), bright & even lighting, locked windows, strategic nurse position.	
5	Noisy Patient Bedroom	Potential for suicide, aggressive, slippery floors, minimal supervision.	Windows without bars or with tight bars, calming colors, safe ceilings, urinals on the edge with a slope to the floor, improved nurse positions.	
6	Medical Room (Nurse/Doctor)	Potential for attacks, medical devices can be misused, supervision from the doctor's office is limited.	Closed & strong cabinets, emergency alarms, surveillance windows, plastic furniture without sharp corners, shaded wall colors.	
7	Patient Bathroom/Toilet	Potential to escape via the ceiling, dirty, slipping, very minimal supervision.	High/strong ceilings, strong or no trellises, sloping & non-slippery floors, overhead lighting not easily accessible.	
8	Warehouse and Support Space	Risk of escape through the ceiling, easily accessible to the patient.	Doors are always locked and unobtrusive, ceilings are strong, bouvenlights are safe.	

2.9 Problem Mapping



3 Design Problem Solving

3.1 Design Concept

Spatial Zoning Concept

ZONE A - Severe Patients

Dormitory-style layout, inspired by psychiatric ward typologies. Focuses on containment, safety, and controlled therapeutic care.
Goal: High-security environment for patients and community safety.

ZONE B - Moderate & Mild Patients

Clustered housing units in a village-like arrangement. Each house accommodates several patients with more independence.
Goal: Semi-autonomous healing through peer interaction and domestic rhythm.

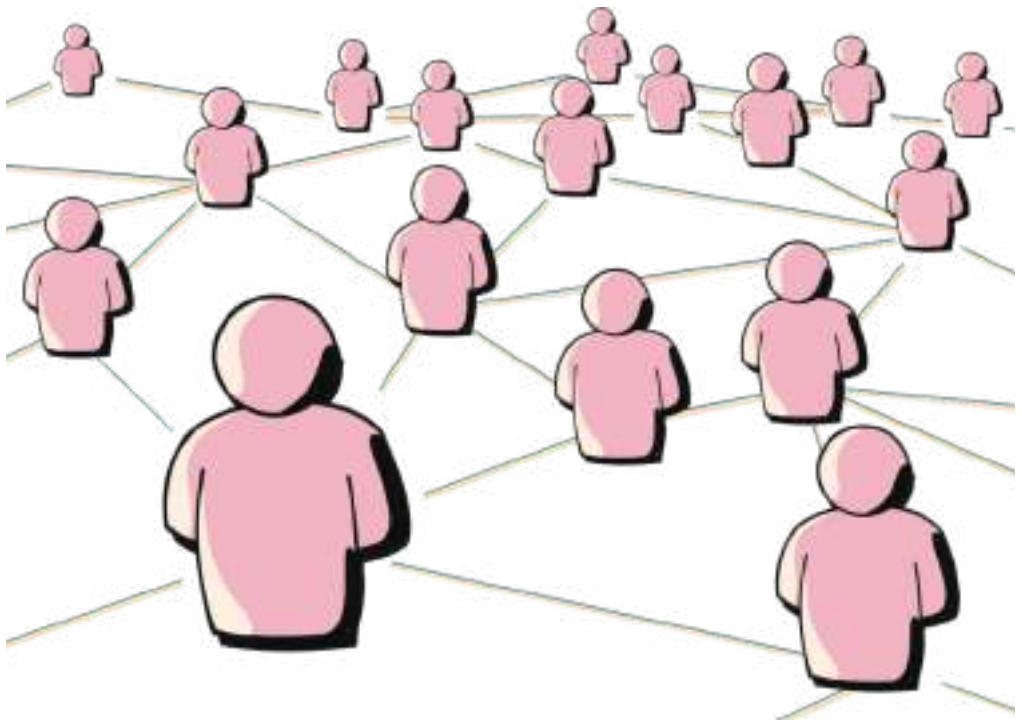
ZONE C - Communal Area

Open, inclusive spaces shared by villagers and patients. It includes public programs to foster social inclusion and destigmatization.
Goal: Re-integration into society and reducing stigma through joint activities.

The design begin through a layered approach, starting with public or communal areas positioned along the main access routes, encouraging interaction and promoting a sense of openness.

These spaces seamlessly transition into semi-private zones, where a blend of programmed and flexible functions accommodate both structured activities and spontaneous social engagement.

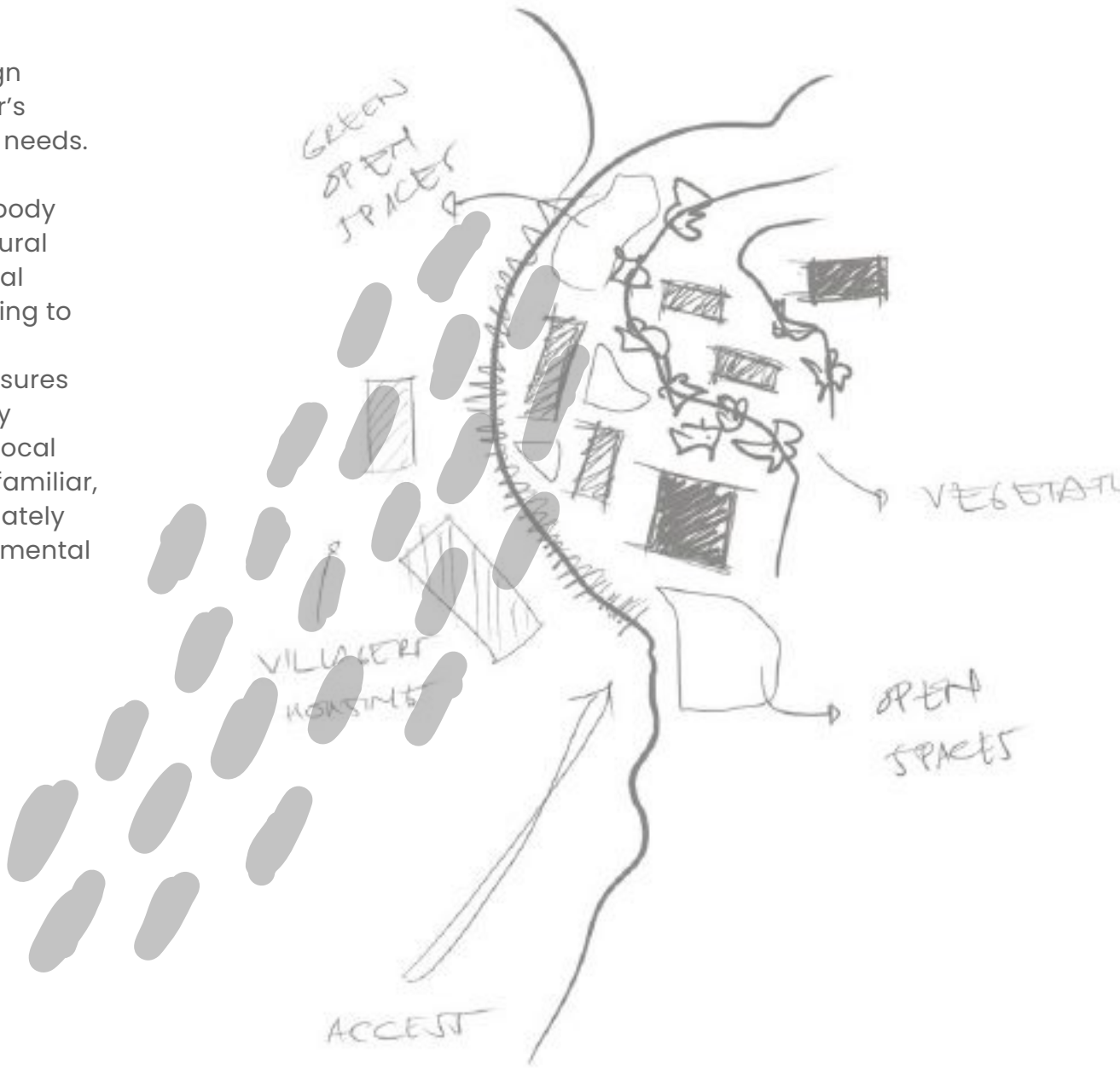
Finally, the most private or restricted zones are strategically placed at the periphery or higher levels, offering calmness, security, and introspection. This zoning strategy not only optimizes spatial flow and user experience but also aligns with the environmental and cultural narratives of the site, integrating natural elements, cross-ventilation, and site boundaries.



3.2 Design Approach Parameter

This table articulates the transformation of community-based principles into architectural strategies for the rehabilitation center in Desa Petir. Rooted in a commitment to destigmatize mental health disorders and promote social reintegration, the design process integrates non-architectural principles, such as fostering transparency, inclusivity, and respect for cultural context. Each principle, inspired by social and psychological considerations, is systematically translated into a design approach that responds to the center's functional, environmental, and social needs.

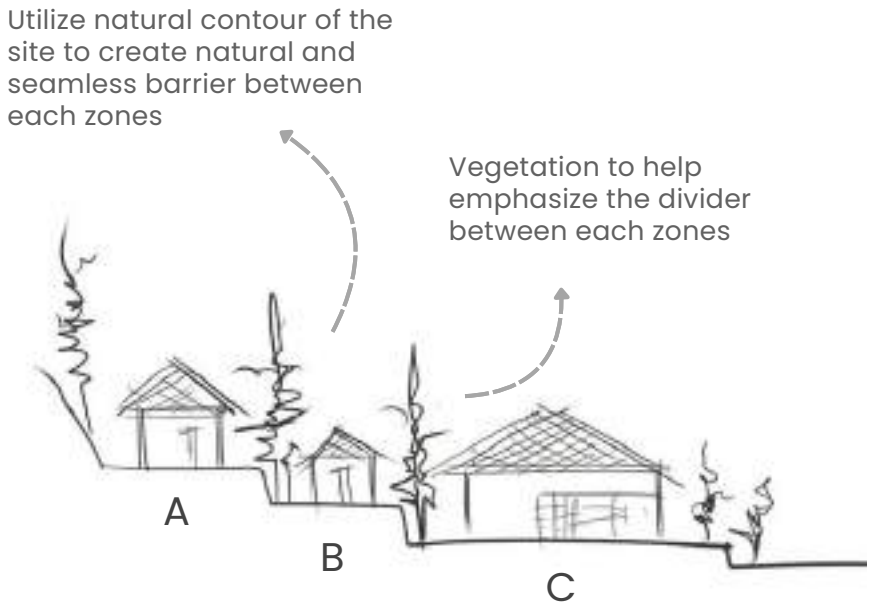
The final architectural responses embody these community values, utilizing natural land contours, vernacular architectural elements, and inclusive spatial planning to create a humane and supportive environment. This layered process ensures that the design is not only functionally effective but also resonates with the local community, creating a space that is familiar, secure, and open to interaction, ultimately reducing the stigma associated with mental health care.



Design Principle (Non- Architectural)	Design Approach	Design Response (Architectural)	Concept Generated
Gradual reintegration of patients through recovery stages with community involvement	Organize zones based on recovery (severe, moderate, mild), using natural transitions	Use land contours and landscape elements (terraces, gardens, ramps) to define zones subtly	Zone Planning (Inter-Zone Barriers)
Promote transparency, openness, and destigmatization through interaction with surrounding village	Encourage porous boundaries and seamless connections between village and site	Replace fences with natural elements (hedges, trees); create visible, open boundaries	Open Interface with Village
Encourage regular social interaction between villagers and patients	Design communal spaces at site- village interfaces for natural interaction	Create seating terraces and open platforms using site contours and natural materials	Social Nodes (Open Spaces)
Build a sense of shared ownership and participation in communal life	Create open, transparent structures accessible to both patients and villagers	Design semi-open buildings with low walls, wide openings, partial enclosures	Semi-Open Community Building
Reflect cultural familiarity and involve local communities in design	Use domestic-scale, familiar forms, materials, and colors	Create single-storey, locally- inspired structures with warm, textured finishes	Building Typology & Materials
Respect local architectural traditions and minimize institutional appearance	Use familiar roof forms that prevent negative symbolism (e.g., climbability, isolation)	Employ vernacular or sloped roof styles with minimal climbable surfaces	Roof Design
Create a safe, dignified, and socially supportive environment	Integrate natural ventilation and openness with safety and privacy	Use courtyard layouts instead of bars, to maintain airflow and security	Innovative openings (rosters blocks/louvre), Dormitory Design (Court & Openings)
Ensure safety and supervision through subtle monitoring	Place supervision points with clear sightlines and natural access routes	Position observation office on elevated contour; design walkways for easy staff access and visual monitoring	Design Supervision Office on High Contour

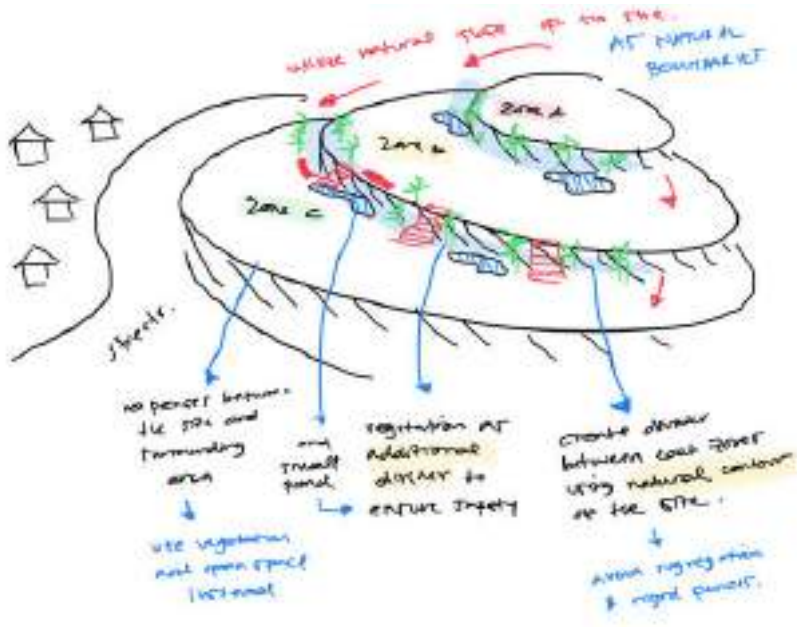
3.3 Sketch and Visualization based on Parameter

Zone Planning: Inter-Zone Barrier



Barrier as Soft Edge: Instead of harsh physical barriers, use the natural rise of the land as a gradual transition between zones. Paths, ramps, and landscape design should follow these contours, creating a seamless and intuitive flow for users.

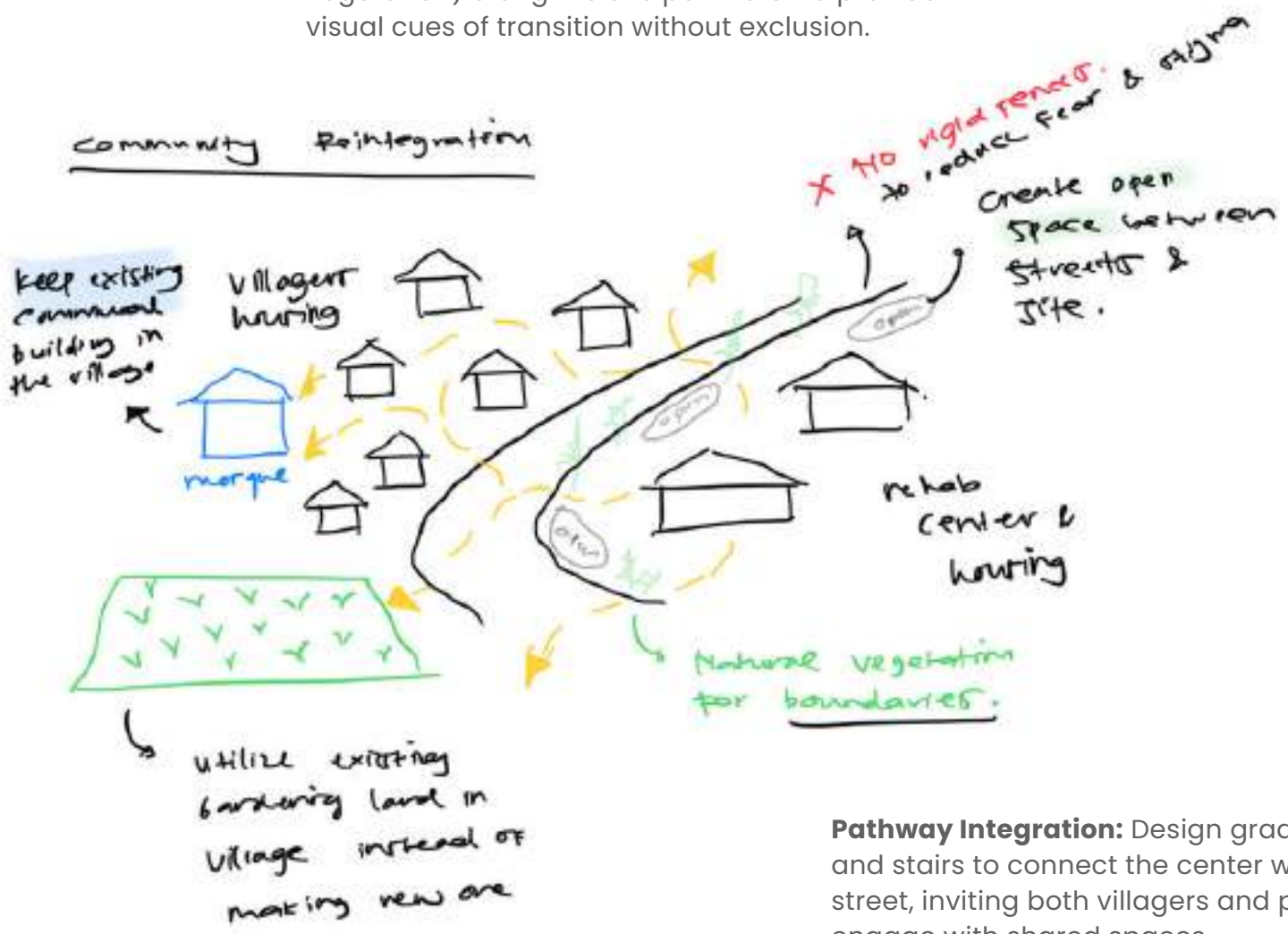
Use of Natural Contours: Utilizing the site's natural terrain, which includes slopes and elevation differences, to define the three zones—Zone A (severe), Zone B (moderate/mild), and Zone C (public/community).



> **Outcome:** Natural contours create seamless transitions between patient severity zones, offering privacy and security without the need for walls or fences. This layered approach helps patients move between spaces comfortably while reinforcing progressive healing stages.

Open Interface with Village

No Rigid Fences: Avoid enclosing the site with walls or fences. Instead, use natural elements (e.g., vegetation) along the site perimeter to provide visual cues of transition without exclusion.

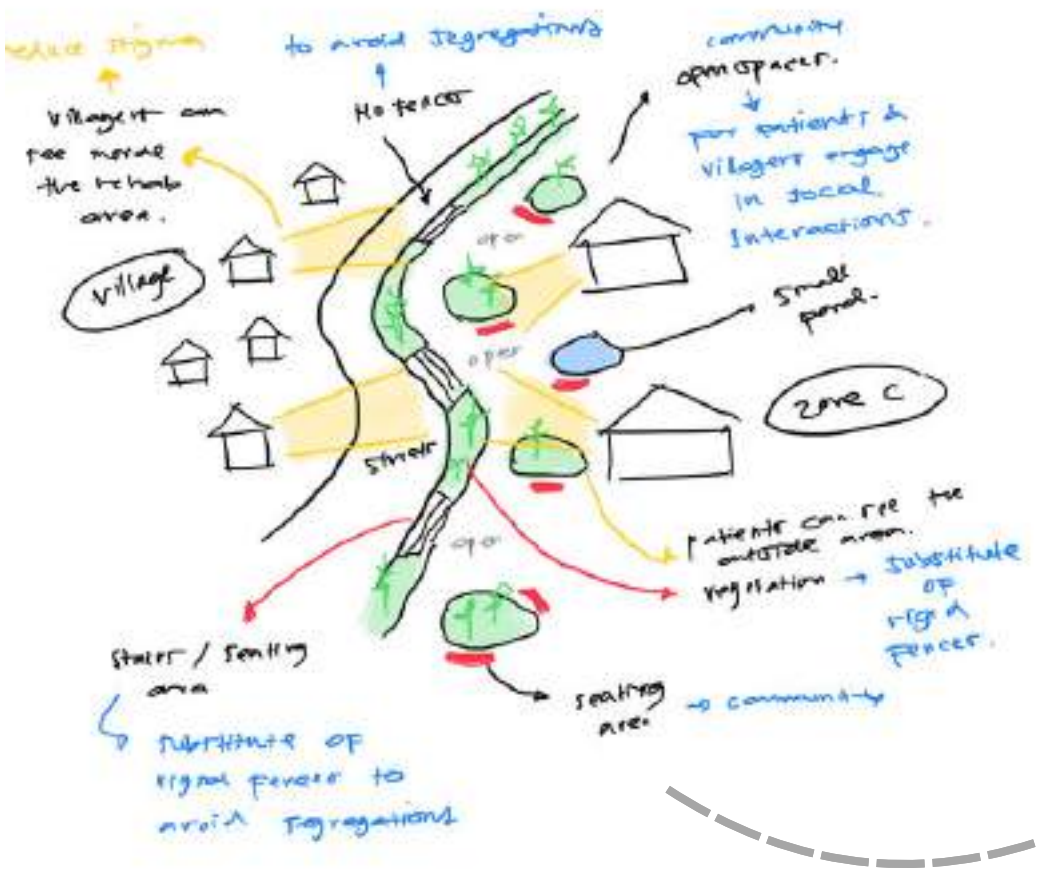


Pathway Integration: Design gradual pathways and stairs to connect the center with the village street, inviting both villagers and patients to engage with shared spaces.

> **Outcome:** Without the rigid fences and the use of natural dividers creating a sense of openness and inclusion, blurring the line between the rehabilitation center and the village. Villagers perceive the facility as a **neighbor** rather than a hidden institution, reducing stigma and enhancing community support.

Social Nodes: Open Space for Interaction

Place social interaction spaces at the site's edge facing the village street, where the site elevation naturally creates a platform-like setting.



Alternative 1

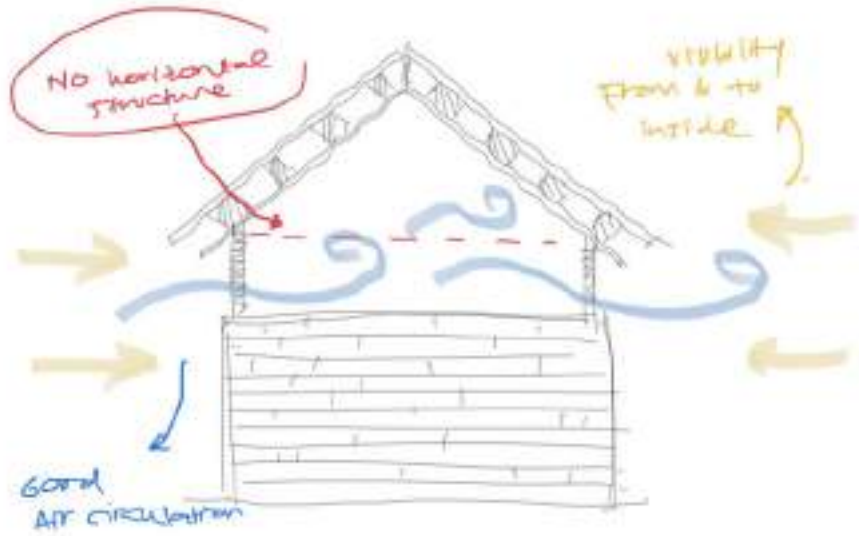
Alternative 2

These nodes serve as "thresholds of interaction," where patients and villagers can meet informally, reducing stigma and promoting inclusion.

Outcome: The stair-like seating area and gathering nodes become welcoming social hubs, encouraging informal interactions between patients and villagers. This creates everyday opportunities for social connection, helping patients regain confidence and destigmatizing mental illness within the community.

Semi-Open Community Building

Visibility and Connectivity: Design the community buildings with semi-open walls or open breezeways, to visually connect interior activities with the village.



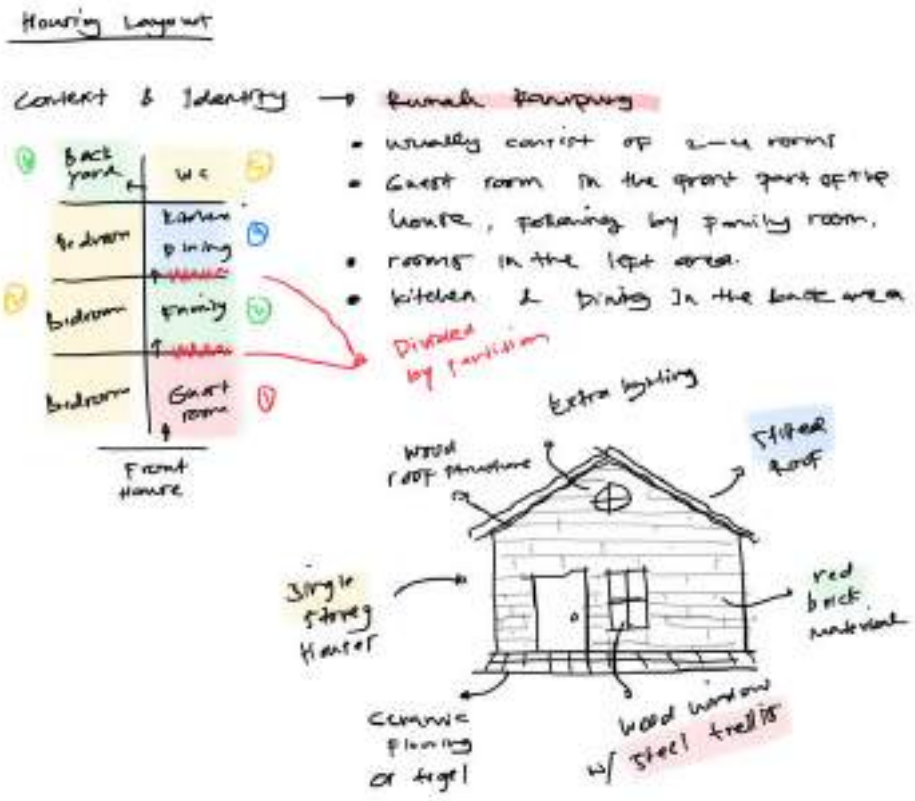
Use local materials (bamboo, brick, wood) and natural finishes to create a familiar, approachable appearance.

Low Wall Height: Keep walls low (waist or chest height) to allow sightlines while maintaining partial enclosure.

Spatial Flow: Organize indoor and outdoor community spaces (workshops, meeting areas) with open verandas that blend into courtyards and gardens.

> **Outcome:** The semi-open design offers visibility of daily life, reinforcing a sense of transparency and dignity. Patients feel part of the community rather than hidden away, and villagers can witness and support the rehabilitation process, building mutual understanding and trust.

Building Typology and Materials



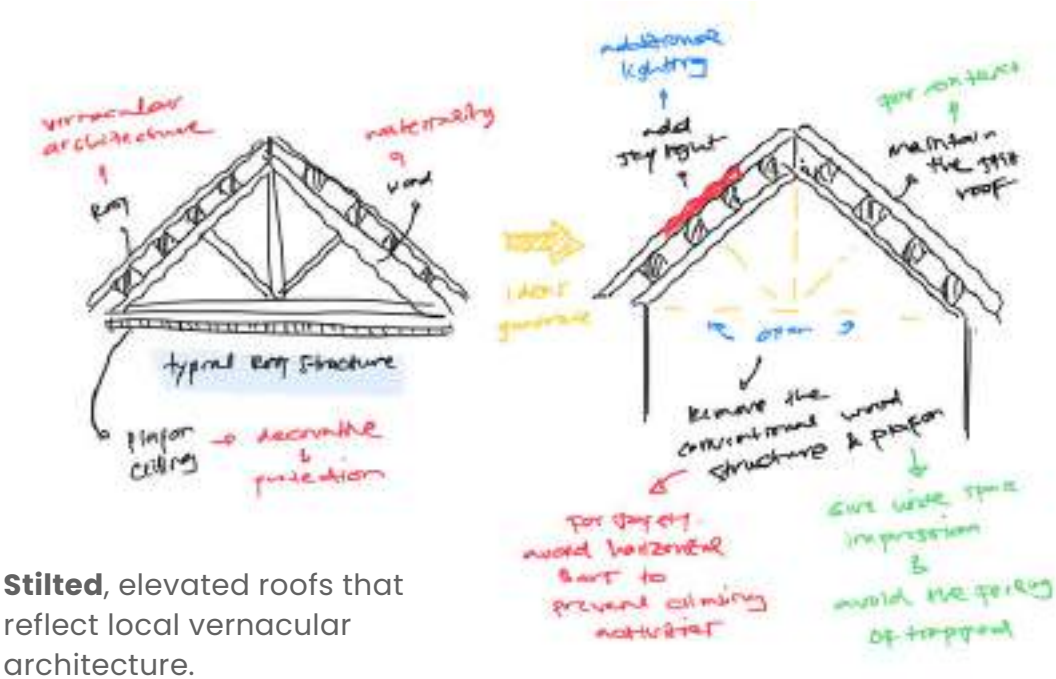
Single-Storey Structures: Maintain a domestic scale that mirrors the surrounding village housing, using pitched roofs and human-scale proportions.

> **Outcome:** Single-storey, domestic-scale buildings with colorful, textured finishes reflect the local village character, providing patients with a familiar and comforting environment.

Roof Design

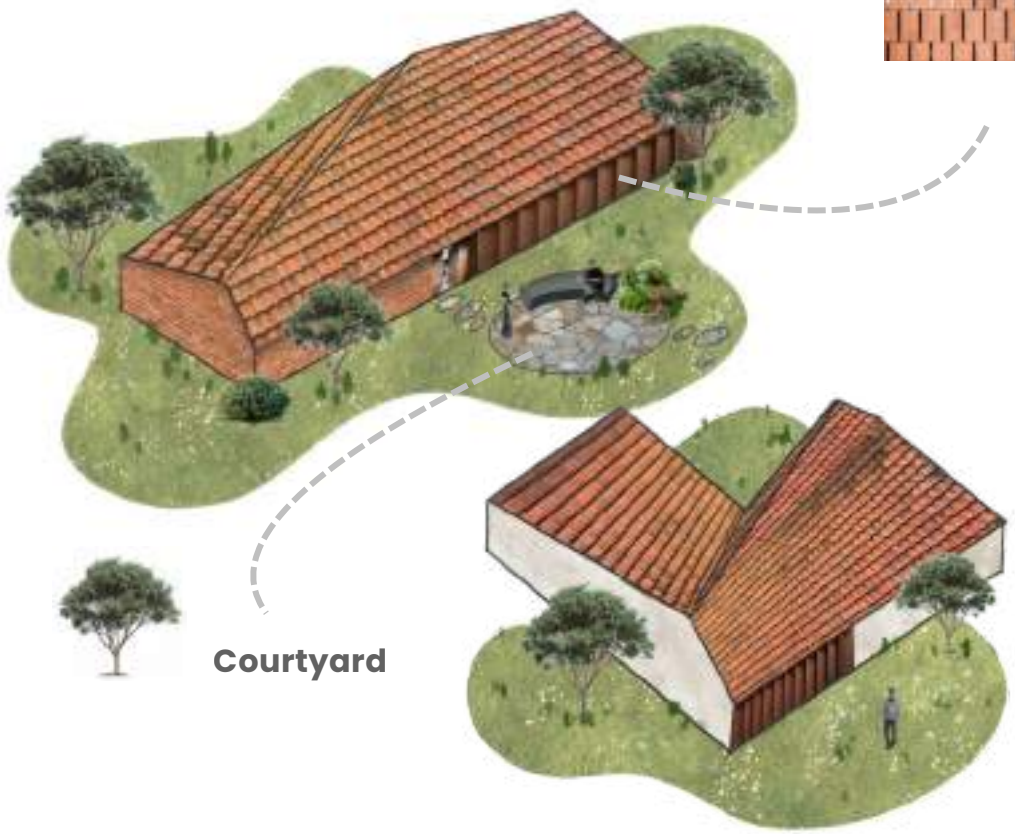
Minimize Climbability: Avoid exposed horizontal structures or accessible flat roofs that might encourage climbing or risky behavior.

> **Outcome:** The vernacular, elevated, and sloped roof designs not only blend with the village context but also minimize climbability, ensuring patient safety.



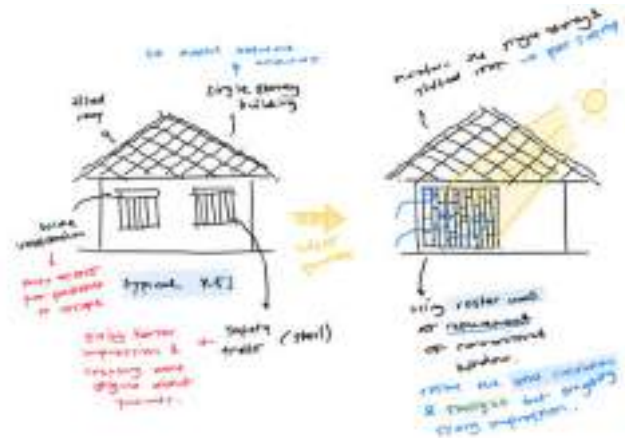
Stilted, elevated roofs that reflect local vernacular architecture.

Dormitory Building Design



Courtyard

Replace barred windows with **ventilation blocks (roster)** and high wall openings that ensure cross-ventilation and natural light while preventing escape.



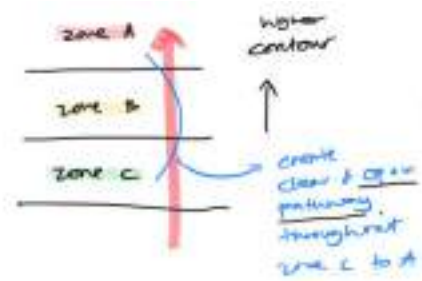
Courtyard System: Arrange dorm rooms around a secure central courtyard, creating a micro-community within the zone and allowing supervised outdoor space for residents.

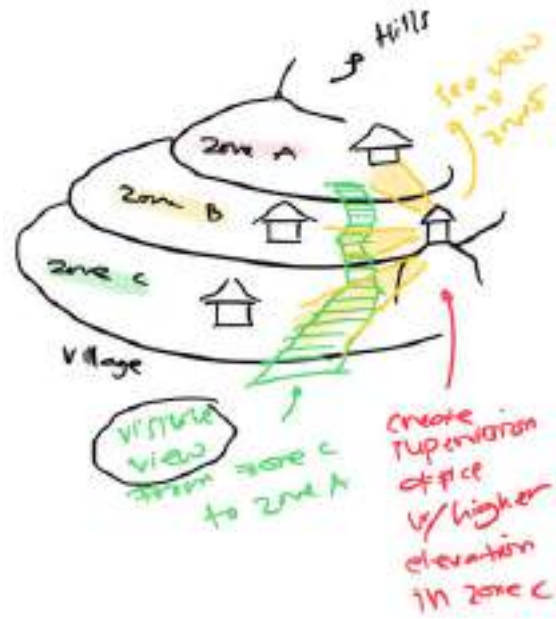
Material and Finishes: Incorporate natural textures, warm colors, and smooth wall finishes to avoid the clinical feel of institutional spaces.

> **Outcome:** The courtyard system fosters a sense of community and supervision within the dorms, while innovative window designs (roster and ventilation systems) ensure natural light, airflow, and security without feeling like a prison. Patients experience a safe, dignified living environment that supports their recovery.

Supervision Pathway Zone C to A

Visual Connection: Design the walkway from Zone C to Zone A as a gently sloping path or ramp, maintaining clear sightlines. The path should be unobstructed, incorporating elements like open railings or natural terracing to enable easy visual monitoring of Zone A.





Strategic Placement: Position a supervision office (staff station or observation post) at the highest contour point of Zone C, overlooking Zone A. This allows for a natural vantage point without needing intrusive infrastructure.

> **Outcome:** The placement of the supervision office at a higher contour in Zone C overlooking Zone A enables natural supervision without intrusive barriers, enhancing patient safety while maintaining openness. The visual connection through the walkpath allows staff to monitor Zone A discreetly, reducing the need for physical separations.

3.4 User & Activity Flow Analysis

Based on User

The user and activity flow analysis of the rehabilitation center is designed to reflect a staged therapeutic process while maintaining strong community integration. The site is divided into **three primary zones**: Zone A (Dorm), Zone B (Housing), and Zone C (Communal), each corresponding to different stages of patient rehabilitation from intensive care to reintegration.

1. **Resident Patients**
- Referred patients from RS JIH. **Paid access** to the rehabilitation center.
- Placement: Based on GAF, placed in Dorm (Zone A) or Housing (Zone B).
- Activities:
  - Receive therapy (individual or isolated depending on condition).
  - Attend counseling and observation sessions.
  - Participate in community therapy when appropriate.
- Progression: Transition from isolation to communal engagement as condition improves.
- Daily Flow: Move between Zones A, B, and C for therapy and communal activities.

2. **Local Patients (Non-residents)**
- Residents of Desa Petir who diagnosed with mental health disorder. **Free access** to the rehabilitation center.
- Activities:
  - Engage in weekly counseling and therapy sessions.
- Zone Use: Primarily use Zone C for community-based therapy and consultation.
- Return Home: Do not stay overnight; leave after therapy sessions.

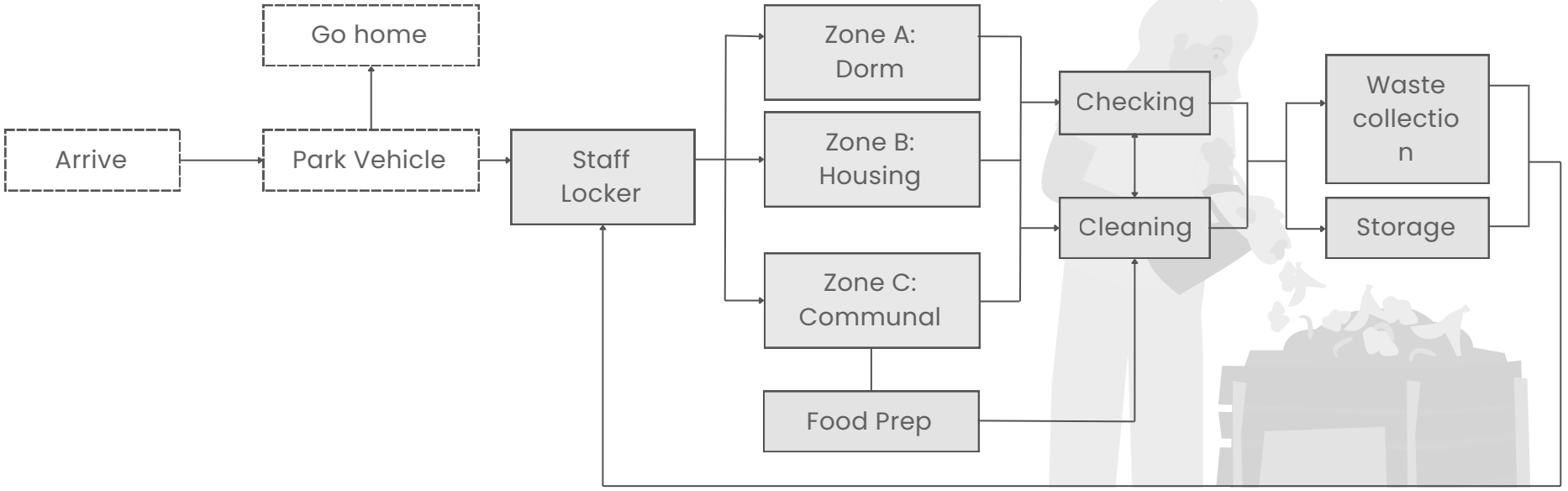
3.**Healthcare Workers**
- Activities:
  - Conduct patient counseling, monitoring, and therapy.
  - Oversee cleaning, food prep, and waste collection.
- Work Zones: Operate across all zones.
- Flow: Maintain operational oversight, ensure therapy processes, and engage with both resident and local patients.

4. **Management & Administrative Staff**
- Activities:
  - Handle patient data, placement records, and administrative work.
  - Supervise overall facility operation and logistics.
- Zones: Mostly located in Zone C with connections to Zones A and B for coordination.

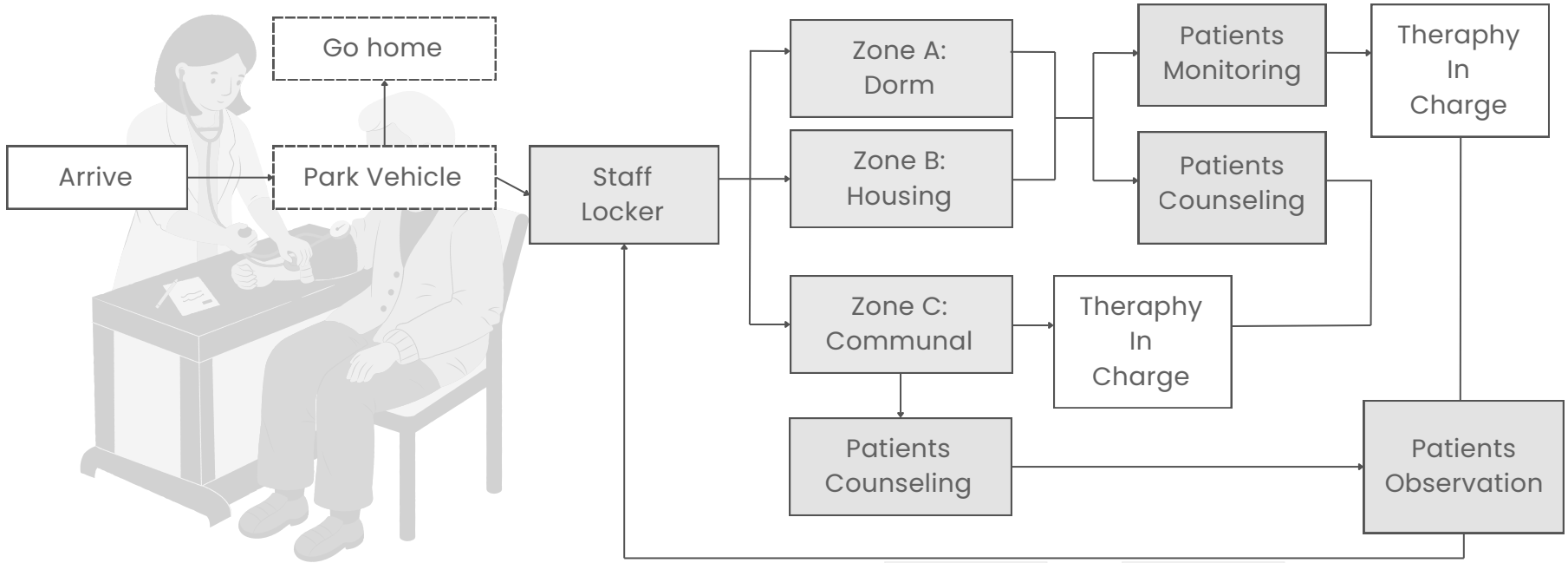
5. **Local Villagers & Visitors**
- Activities:
  - Participate in community kitchen, workshops, and communal hall events.
  - Access mental health consultation services if needed.
  - Receive information and guidance at the lobby/information center.
- Interaction: Engage with patients during communal activities, fostering social reintegration.


Syawalan Halalbihalal

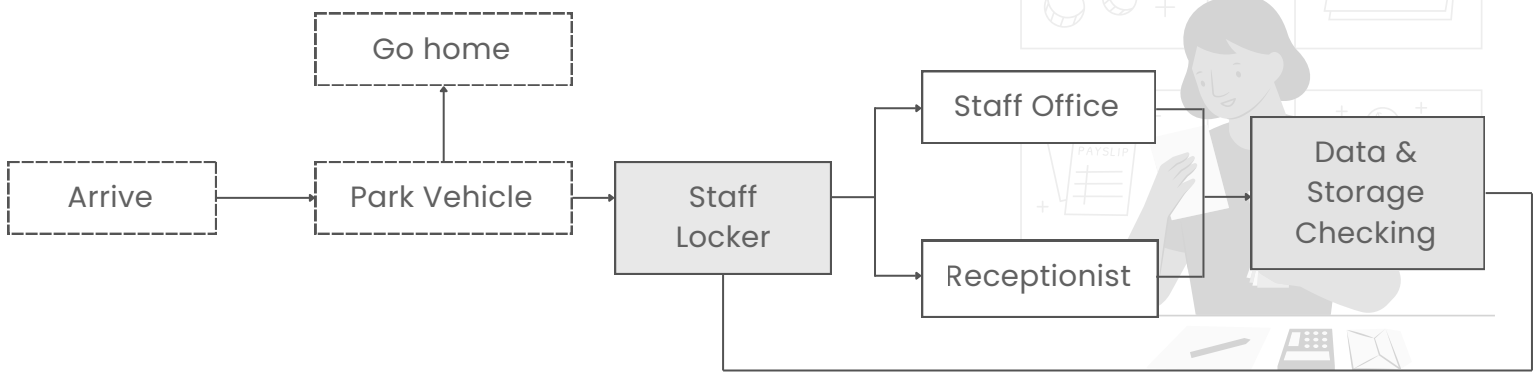
Staff



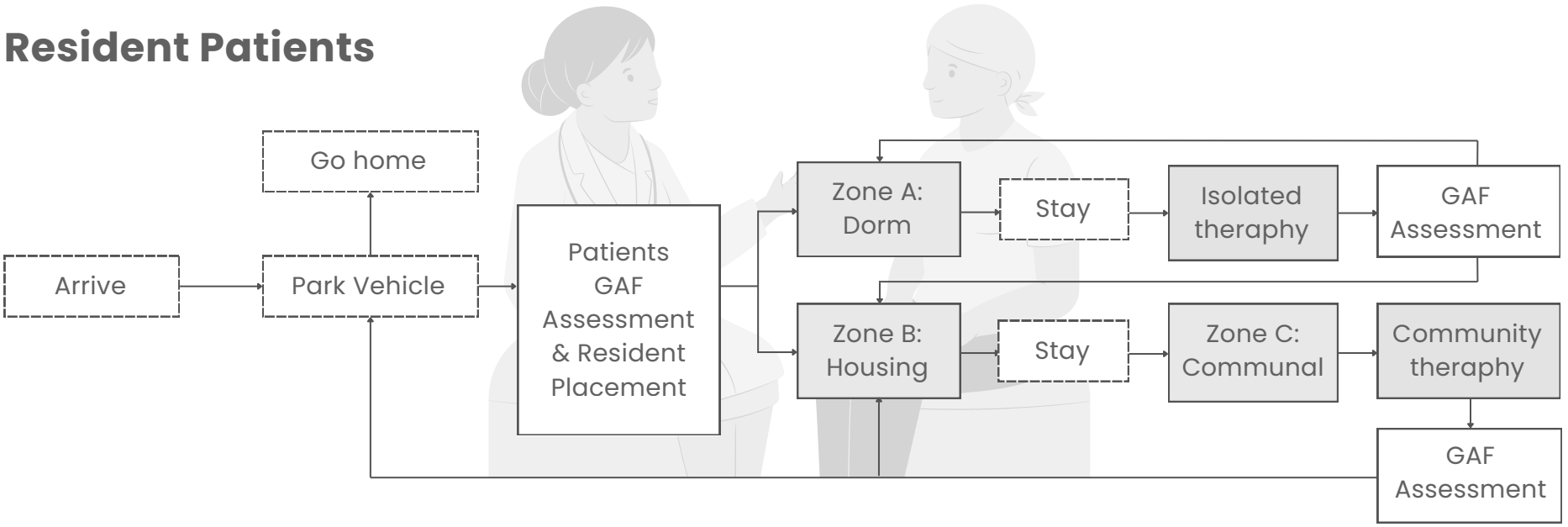
Health Worker



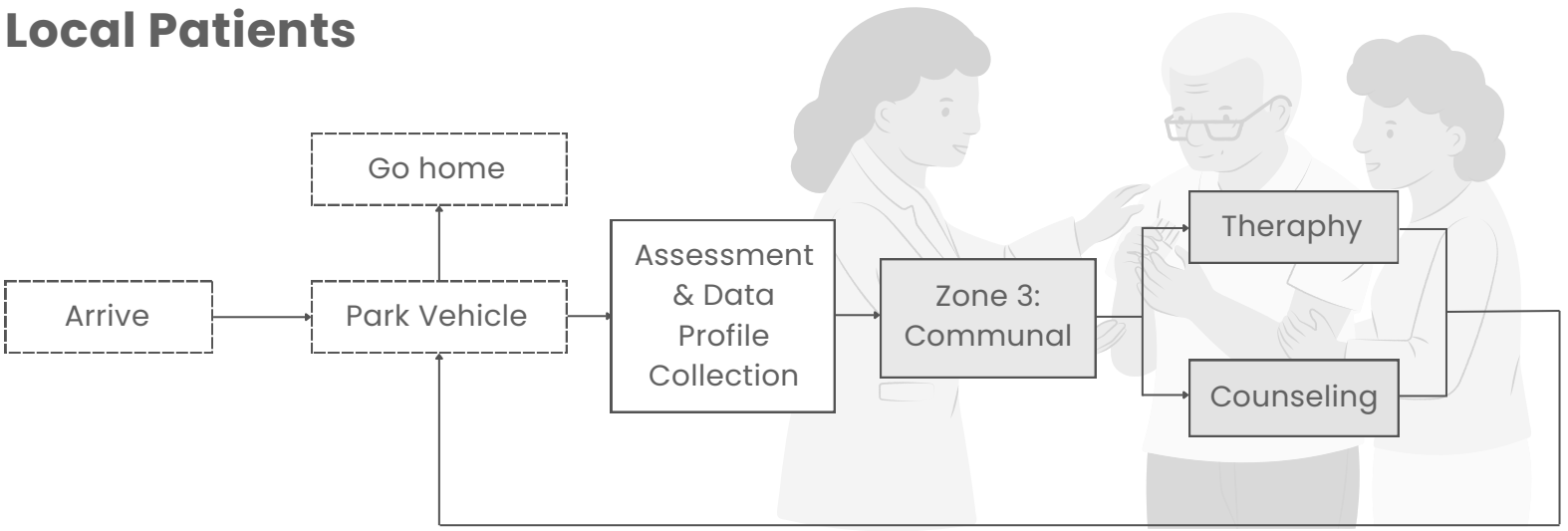
Management



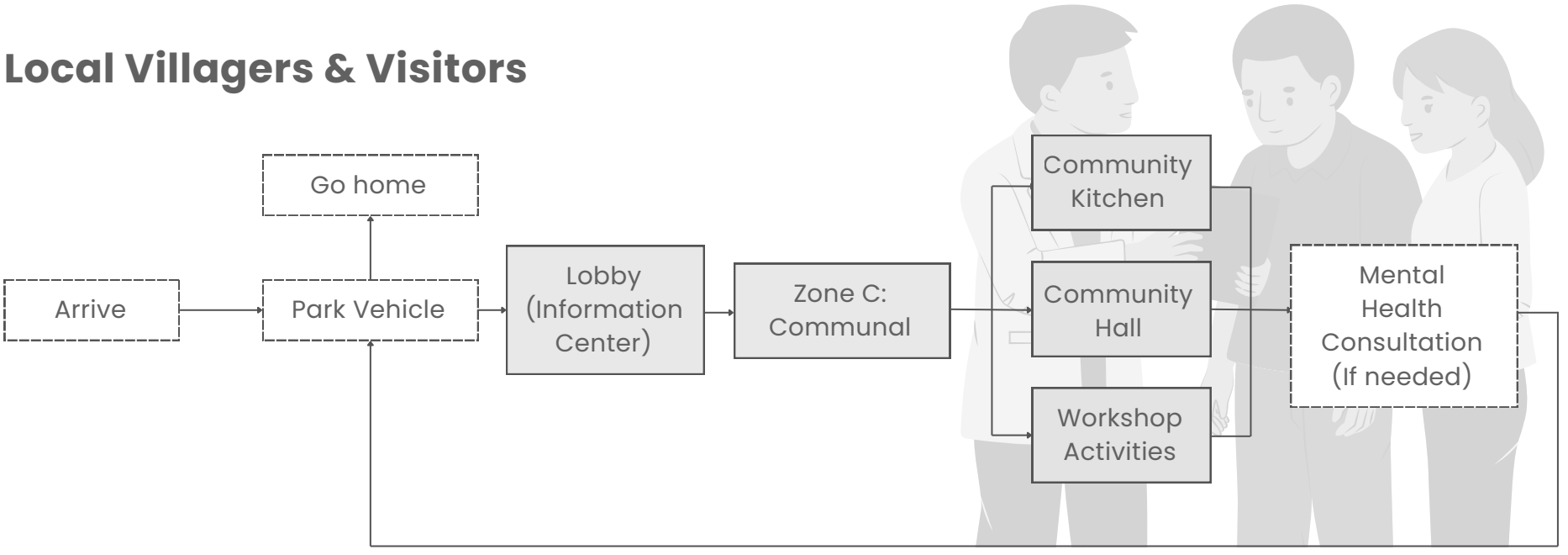
Resident Patients



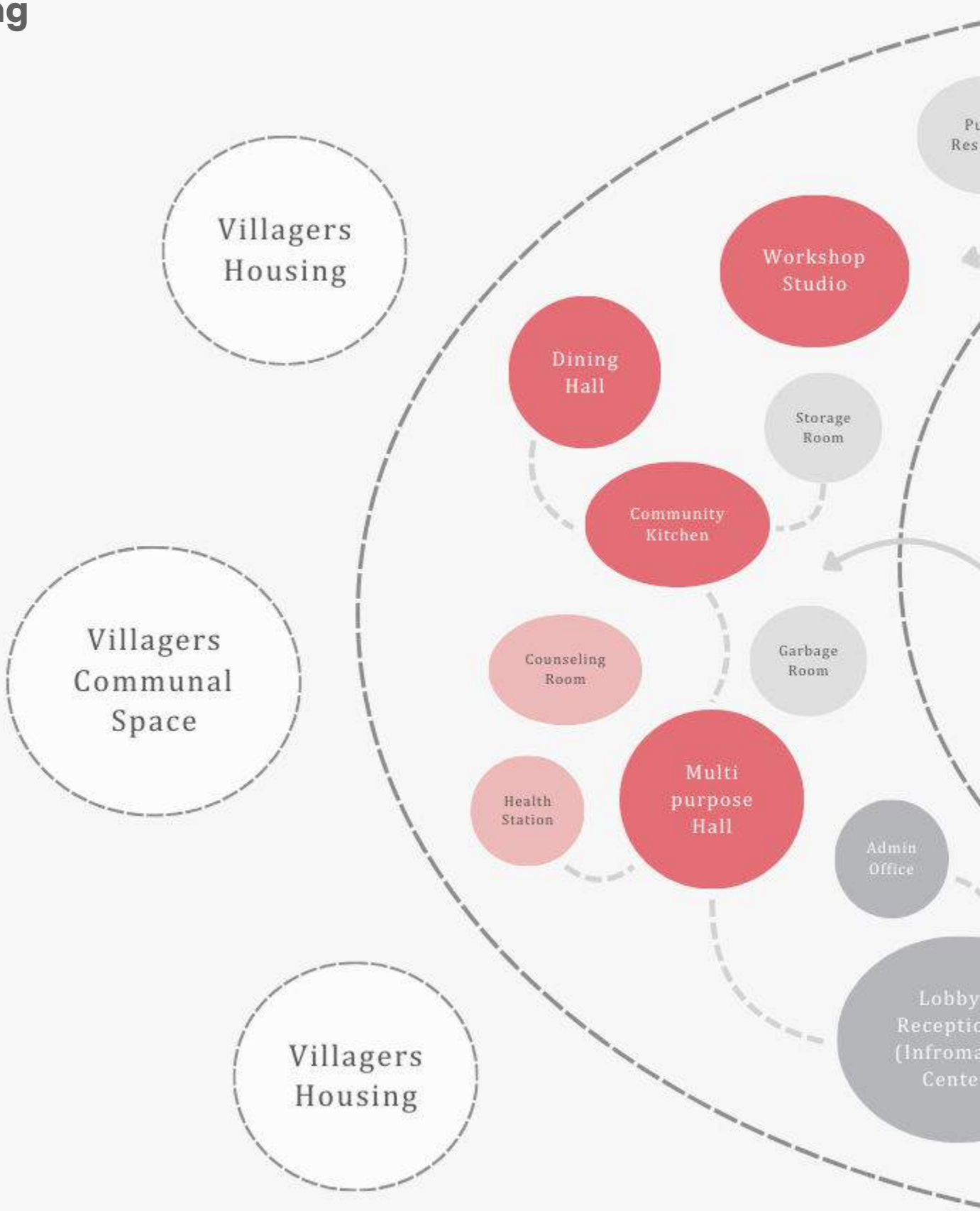
Local Patients

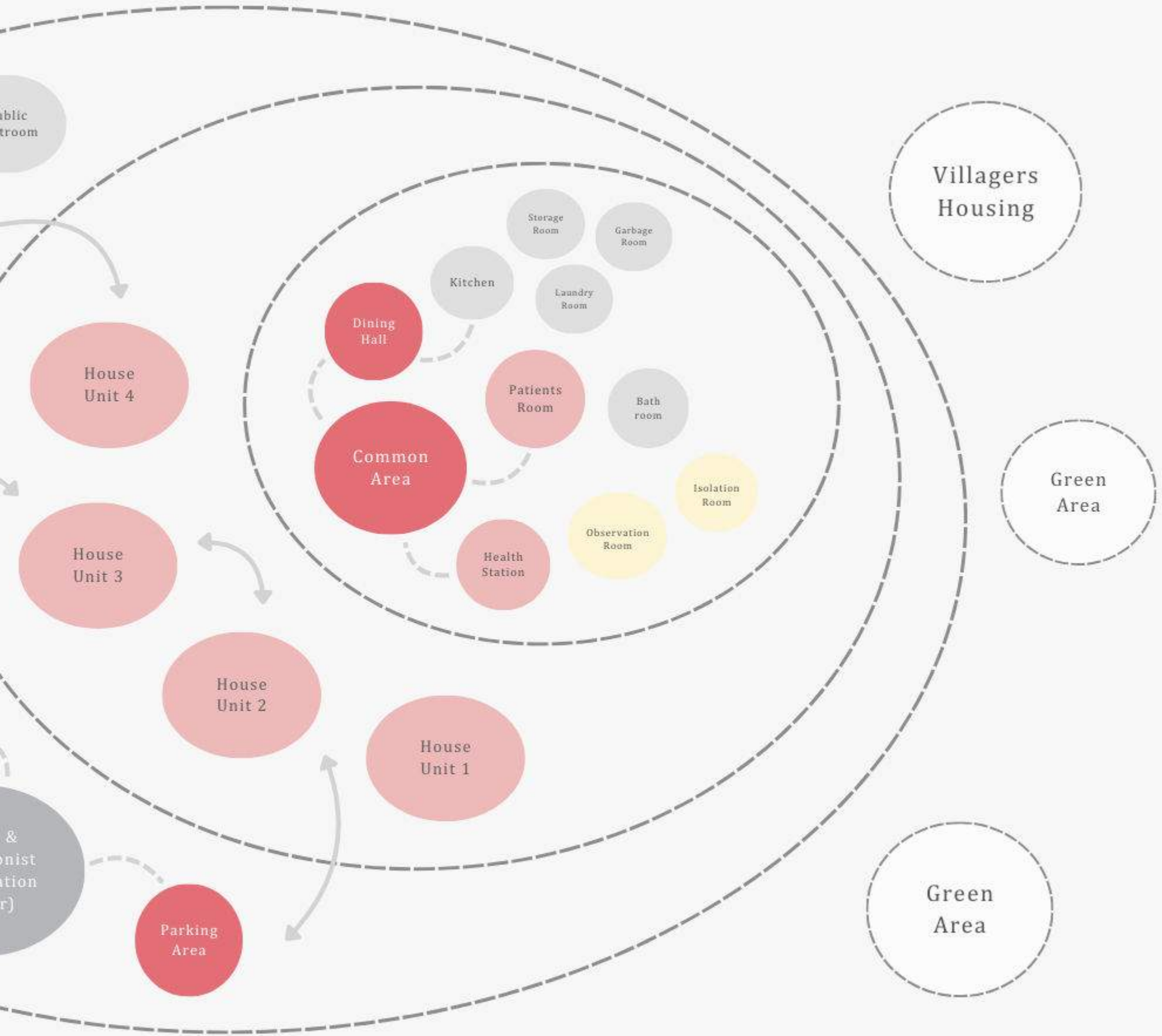


Local Villagers & Visitors



3.5 Spatial Programming

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3.6 Spatial Characteristic

Zone A – Severe Patients (Dorm/Ward Typology)

Room	Function	Spatial Characteristics
Patient Bedroom	Private sleeping/resting for severe patients	Enclosed, minimal visual stimuli, cross-ventilated, private furniture
Observation Room	Staff monitoring patients	Semi-private, close to bedrooms, equipped for emergency observation
Isolation Room	Isolation for acute episodes	Sound-insulated, padded walls, emergency button
Common Room	Shared relaxing & interaction	Calm, daylight access, cozy furniture, indirect lighting
Bathroom	Shared hygiene	Non-slip flooring, good drainage, natural ventilation
Health Station	Medical check-up & treatment	Semi-private, sterile but accessible
Dining Area	Eating area for patients	Comfortable seating, access to natural light
Laundry Room	Staff laundry processing	Cleanable surfaces, machine sound dampening
Kitchen	Food prep (staff only)	Ventilated, safety zoning
Storage Room	Supplies storage	Organized, enclosed
Garbage Room	Waste collection	Enclosed, ventilated

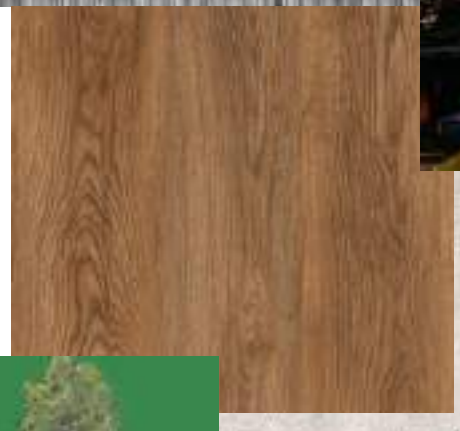
Zone B – Moderate & Mild Patients (Housing Complex)

Room	Function	Spatial Characteristics
Housing Unit	Residential unit (4 patients/unit)	Home-like, semi-private, 25 sqm/unit, communal feel, daylight and views encouraged
Bathroom	Shared in the unit	Integrated, compact, easy to clean
Kitchen	Shared in the unit	Small-scale, encourages independence, natural light
Common Room	Social space in the unit	Domestic atmosphere, cozy layout, visual access to outside

Zone C – Communal Village Interaction Zone

Room	Function	Spatial Characteristics
Lobby/Reception	Welcome area for visitors & new patients	Open, warm ambience, welcoming signage, info center
Admin Office	Administrative tasks	Quiet, secure, accessible to staff only
Staff Locker Room	For staff to store personal belonging	Private, secure, accessible to staff only
Staff Restroom	For Staff	Universal design, hygiene-focused layout
Multipurpose Hall	Community events, education	Large, flexible, stage and AV ready, well ventilated
Community Kitchen	Joint cooking with villagers	Semi-open, familiar layout, encourages bonding
Dining Hall	Shared eating space	Long communal tables, casual setting
Gardening Area	Healing and therapy through gardening	Outdoor, raised beds, shaded, therapeutic vegetation
Workshop Studio	Joint creative activities (open house)	Tables, tools, natural materials, supports craft
Counseling Room	Private mental health consultations	Soft lighting, acoustic insulation, calming tones
Health Station	Light medical service area	Clean, semi-private, near reception
Storage Room	Community or event equipment storage	Organized and accessible
Garbage Room	Waste management	Ventilated, separated from communal routes
Public Restroom	For visitors	Universal design, hygiene-focused layout
Parking Area	For visitors and staff	Accessible, shaded if possible, seperate from activity zones

Moodboard



3.7 Design Exploration

Zoning and Contour Modification

The site features four naturally elevated contour zones, each with a 10-meter difference in height. To enhance accessibility and site integration, the **elevation gaps are reduced to 3 meters**, and the design utilizes only three of the four zones, which will be called **Zone A, B, and C**. This adjustment allows for a more human-scale and interconnected spatial arrangement while respecting the site's natural topography. Also creating seamless separation between each zones to prevent segregation.

Grid System

A grid system is inspired by the site **following the 21-degree orientation of the Desa Petir main road**, ensuring contextual alignment with the local circulation pattern. This grid also draws inspiration from RSJ Soeroyo's spatial organization, particularly its **cross-shaped (plus-shaped) layout** that improves the **ease of movement for users** across different spaces.

Block Formation and Spatial Integration

Building blocks are inserted inside the grid based on the spatial and programmatic needs, with each communal function assigned a separate structure. **These blocks are strategically positioned along the contours, using the natural terrain to subtly separate zones.** This approach create seamless transitions between the rehabilitation center and the surrounding village, preventing rigid boundaries and encouraging social integration.

3.8 Design Alternative

selected

Alternative 1

Alternative 1 uses a more open and scattered layout, placing buildings across all three elevation zones. This creates many pathways and makes it easy for people to move between the rehab center and the village. It encourages openness and interaction, but **may lack clear boundaries and the distance between each zone is too close**, which are important for users safety and privacy. The lower area also has **limited space for parking**, which could cause problems for accessibility and service delivery.

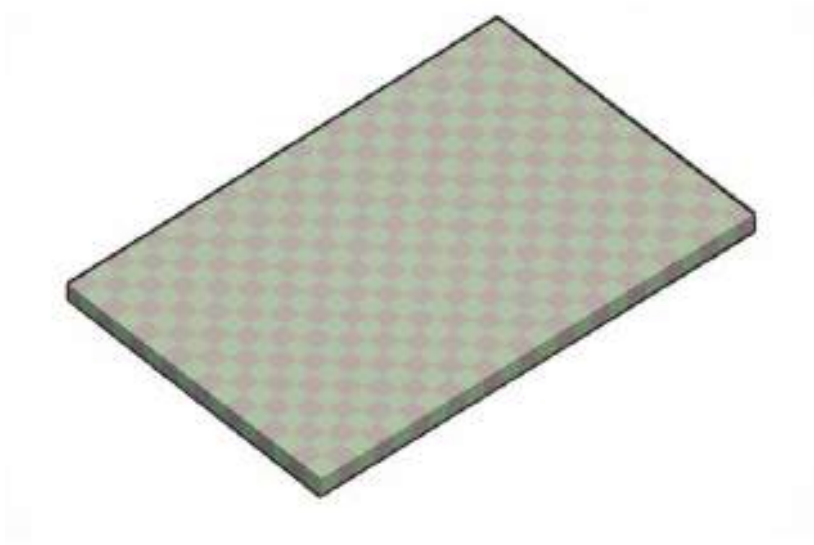
Alternative 2

Alternative 2 offers a balanced layout, with building clusters arranged along the site's contours in a clear, organized way. It follows the natural slope and connects well with the village, while still giving enough privacy for users. While **slightly more enclosed** than Alternative 1, this version strategically maintains key entry points and visual openness to the village. The circulation is easy to follow, making it user-friendly and calming.

Alternative 3

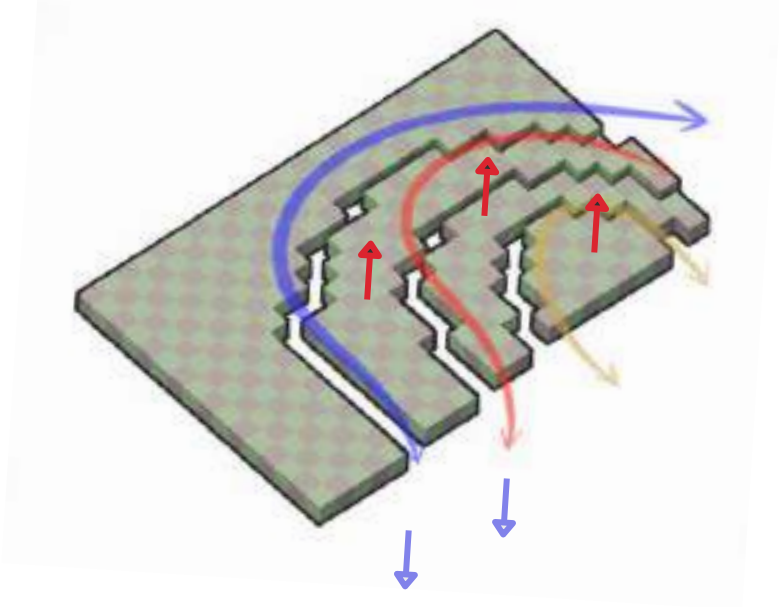
Alternative 3 has a compact layout, with most buildings in the central zone. This creates a more enclosed and quiet environment, which is good for users needing more privacy. However, it reduces the connection with the village and makes movement more limited. In Zone A, **the buildings are placed too far from each other and lack a proper courtyard arrangement**, which weakens the sense of community and interaction that this area is meant to support.

3.9 Design Transformation



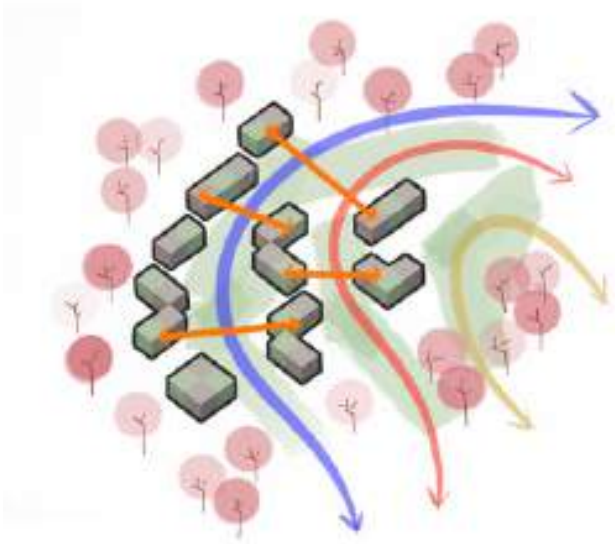
Creating Blocks from the Grid

The transformation begins by forming building blocks based on the grid that was generated to align with the site and village road orientation. This grid provides a structured yet flexible base that supports efficient spatial planning and circulation.



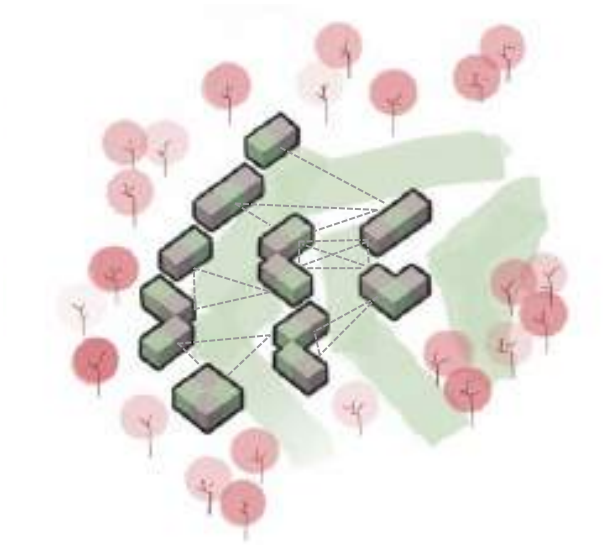
Removing Blocks and Elevating Masses

The blocks located along the contours dividing the zones are removed, and selected blocks are elevated. This move creates a dynamic massing composition, emphasizing transitions between zones through terracing while embracing the site's natural topography.



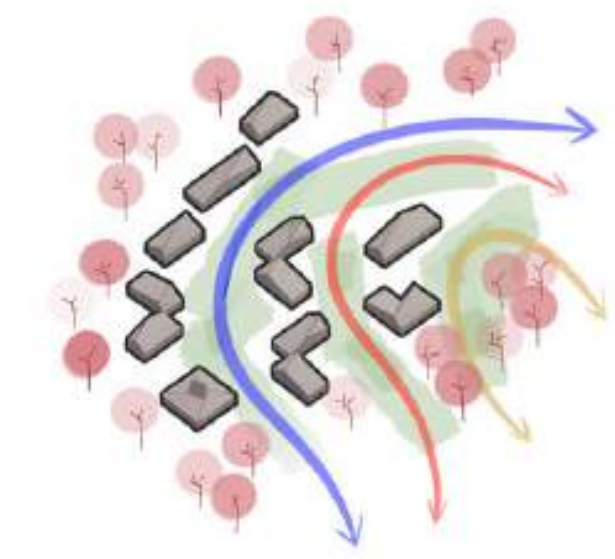
Selecting Layout

All unnecessary blocks are removed, keeping only those that align with the layout chosen in the preferred design alternative. This creates more open space between buildings, allowing shared and communal areas to breathe, while also ensuring clarity and purpose in spatial arrangements.



Visual and Spatial Connections

The remaining blocks are positioned to define in-between spaces that allow visual connections and movement between functions. This layout promotes interaction while maintaining boundaries, helping to avoid feelings of segregation and supporting a harmonious environment.



Visual Continuity

To tie the architecture with its local context, the tops of the blocks are trimmed to form pitched roof-like structures. This gesture reflects the surrounding village buildings, creating a sense of unity and **visual continuity between the new development building and the existing community.**

3.10 Room Programming

Zone A – Severe Patients (Dorm/Ward Typology)

No	Space	User	Qty	Zone	Quality of Space	Furniture	Area (sqm)	Area/User	Users	Total (sqm)	Plus 30% Circulation	Source
1	Patient Bedroom	Patients	16	A	Private	Single bed, Table, Cabinet	6	6	16	96	125	Data Architect
2	Observation Room	Staff	2	A	Semi-private	Desk, Chairs, Medical Station	8	-	-	16	20.8	Permenkes RI No. 24 (2016)
3	Isolation Room	Patients	2	A	Private	Padded walls, Toilet, Emergency button	7	-	2	14	18.2	WHO
4	Common Room	Patients	1	A	Shared	Sofa, TV, Reading corner	20	-	-	20	26	WHO
5	Bathroom	Patients	4	A	Shared	Toilet, Shower, Basin	6	2	16	32	42	Permenkes RI No. 24 (2016)
6	Nurse Station	Staff	1	A	Private	Desk, Medical storage	9	-	-	9	11.7	WHO
7	Dining Area	Patients	1	A	Shared	Tables, Benches	18	-	15	18	23.4	Hospital Ward Guide
8	Laundry Room	Staff	1	A	Service	Machines, Sinks, Tables	10	-	-	10	13	Data Architect
9	Kitchen	Staff	1	A	Service	Stove, Sink, Prep Tables	12	-	-	12	15.6	WHO
10	Storage Room	Staff	1	A	Utility	Storage Shelves	6	-	-	6	7.8	Data Architect
11	Garbage Room	Staff	1	A	Utility	Trash bins	4	-	-	4	5.2	WHO

Zone B – Moderate & Mild Patients (Housing Complex)

No	Space	User	Qty	Zone	Quality of Space	Furniture	Area (sqm)	Area/User	Users	Total (sqm)	Plus 30% Circulation	Source
12	Housing Unit	Patients	4	B	Semi-private	Beds, Chairs, Cabinets (4 pax/unit)	25	6.25	16	100	130	WHO
13	Bathroom	Patients	4	B	Shared in Unit	Toilet, Shower, Basin	4	-	-	20	26	Data Architect
14	Kitchen	Patients	4	B	Shared in Unit	Counter, Sink, Stove	6	-	-	30	39	WHO
15	Common Room	Patients	4	B	Shared in Unit	Sofa, TV, Reading corner	6	-	-	30	39	Urban Village Studies

User Capacity

Workers
Support Staff
- 3 maintenance workers
- 2 security officers

Health Workers
- 1 psychiatrist
- 4 psychologists
- 1 general doctor
- 8 nurses (4 in Zone A, 4 in Zones B & C)
- 1 art therapist

Management
- 2 admin officers
- 1 manager

Total Workers: 18 worker

Users
Zone A
- 8 female patients
- 8 male patients

Zone B
- 4 female patients
- 4 male patients

Local ODGJ (community-based program)
- 30 people

Local Villagers
- 88 people (37 households)

Total Users:
- 54 patients
- 88 villagers

Zone C – Communal Village Interaction Zone

No	Space	User	Qty	Zone	Quality of Space	Furniture	Area (sqm)	Area/User	Users	Total (sqm)	Plus 30% Circulation	Source
16	Lobby/Reception	Visitors & New Patients	1	C	Public	Reception Desk, Sofas, Info Board	20	-	-	20	26	Data Architect
17	Admin Office	Admin Staff	1	C	Private	Desks, Computers, Filing Cabinets	25	-	3–4	25	32.5	WHO
18	Staff Locker Room	Staff	1	C	Private	Lockers, Bench, Mirror	10	-	5-6	10	13	WHO
19	Staff Restroom	Staff	1	C	Private	Toilet, Washbasin	4	-	-	4	5.2	Data Architect
20	Multipurpose Hall	Patients, Visitors, & Villagers	1	C	Public	Stage, Chairs, AV System	60	-	-	60	78	Data Architect
21	Community Kitchen	Staff, Patients, & Villagers	1	C	Semi-private	Stove, Sink, Counter, Tables	20	-	-	20	26	Social Architecture Guide
22	Dining Hall	Staff & Patients	1	C	Shared	Tables, Chairs, Buffet Area	40	-	-	40	52	WHO
23	Gardening Area	Patients & Villagers	1	C	Outdoor	Raised Beds, Tools, Shade Roof	40	-	-	40	52	Permenkes RI No. 24 (2016)
24	Workshop Studio	Patients, Visitors, & Villagers	1	C	Public	Tables, Chairs, Tools	30	2	15	39	50.7	WHO
25	Counseling Room	Psychologists	2	C	Private	Desk, Chairs, Soft Lighting	9	4.5	2	18	23.4	DSM-5 Design Practice
26	Health Station	Medical Staff	1	C	Semi-private	Check-up station, Storage	9	-	-	9	11.7	WHO
27	Storage Room	Staff	1	C	Utility	Storage Shelves	6	-	-	6	7.8	Data Architect
28	Garbage Room	Staff	1	C	Utility	Trash bins	4	-	-	4	5.2	WHO
29	Public Restroom	Visitors & Villagers	2	C	Public	Toilet, Washbasin, Cubicles	12	6	-	12	15.6	Public Health Guidelines
30	Parking Area	Visitors, Staff	1	C	Outdoor	Motorcycle/Car Park (5 car, 10 motor)	60	-	-	60	78	Permen PU No. 14 (2022)

3.11 Client

Partnership Model

The center will establish a **strategic partnership (mitra kerja)** with **Rumah Sakit JIH** (Jogja International Hospital), where patients who need further rehabilitation after hospital treatment especially those not yet ready to return home can be referred (rujukan) to stay in this facility.

- **Referral System:** After initial treatment or stabilization at JIH, patients may be referred for psychosocial rehabilitation if they need further psychosocial rehabilitation treatment.
- **Funding Model:** Operational costs will be co-supported by RS JIH and its associated foundation (Yayasan Badan Wakaf UII).
- **Paid Services:** The inpatient/residential (stay-in) program is designed as a premium, paid service, targeting the upper-middle-class segment who seek continued care in a private, human-centered setting.

Funding

RS JIH was established by the **Yayasan Badan Wakaf Universitas Islam Indonesia** (YBW UII) and is managed by **PT Unisia Medika Farma**. YBW UII oversees various business units, including hospitals, pharmacies, and educational institutions.

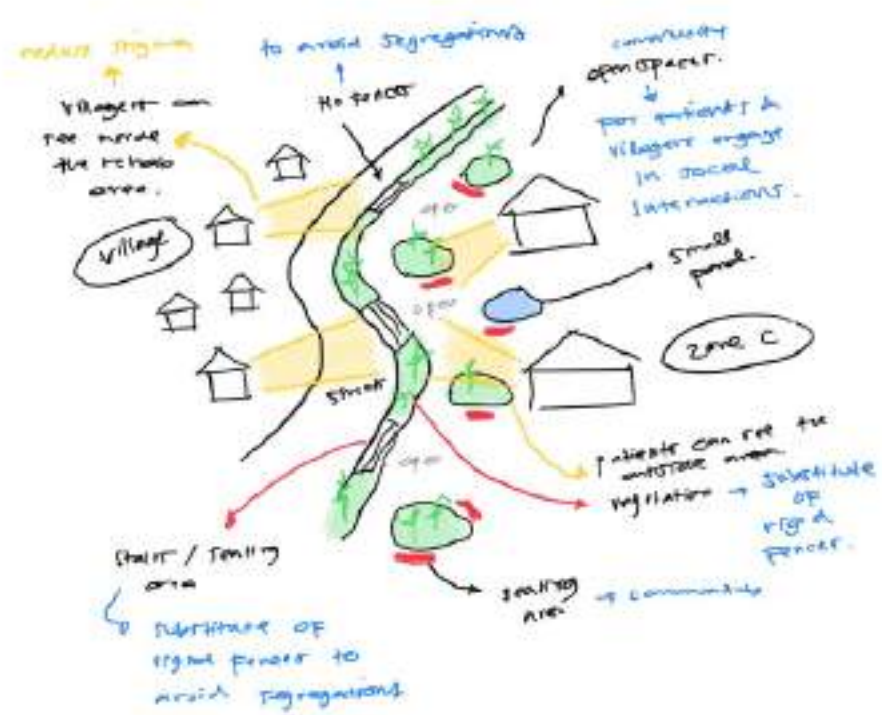
Public Inclusion Program

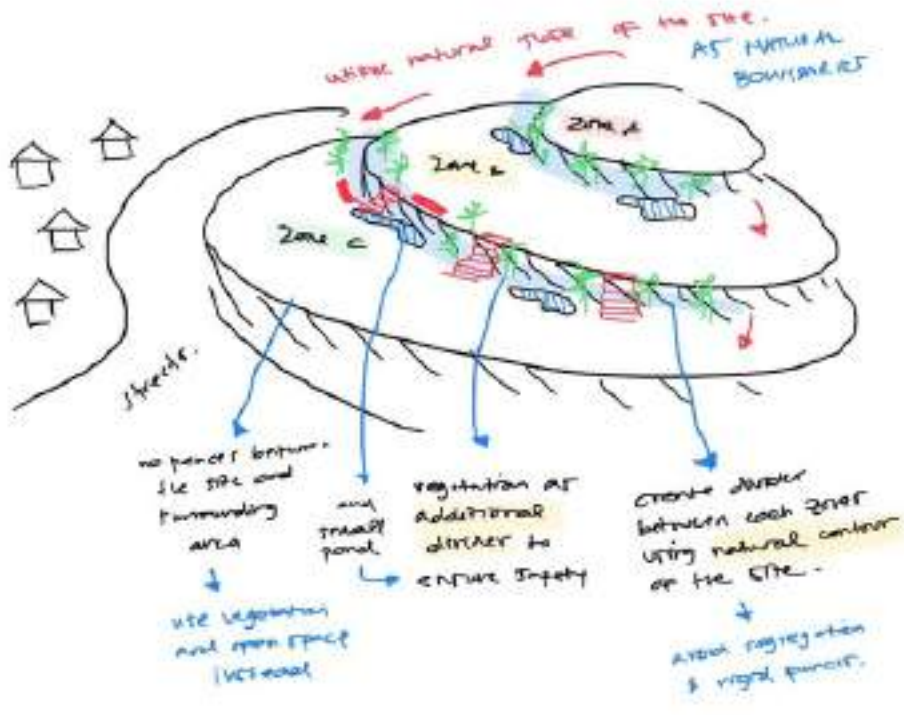
Aside from the residential program, the center will also open for non-residential patients through weekly community-based programs:

- **Free psychosocial rehabilitation activities** will be open to:
  - Local Mental Health Patients (residents of Desa Petir)
  - Individuals from other parts of Yogyakarta seeking support
  - Villagers and community members who want to engage and learn
- **Activities** may include:
  - Group counseling or peer support
  - Occupational therapy (e.g., gardening, sewing, art crafts)
  - Art or spiritual workshops
  - Physical well-being programs (e.g., walking in the fields, morning sun exposure)

4 Schematic Design

4.1 Design Solution





Open Interface with Village

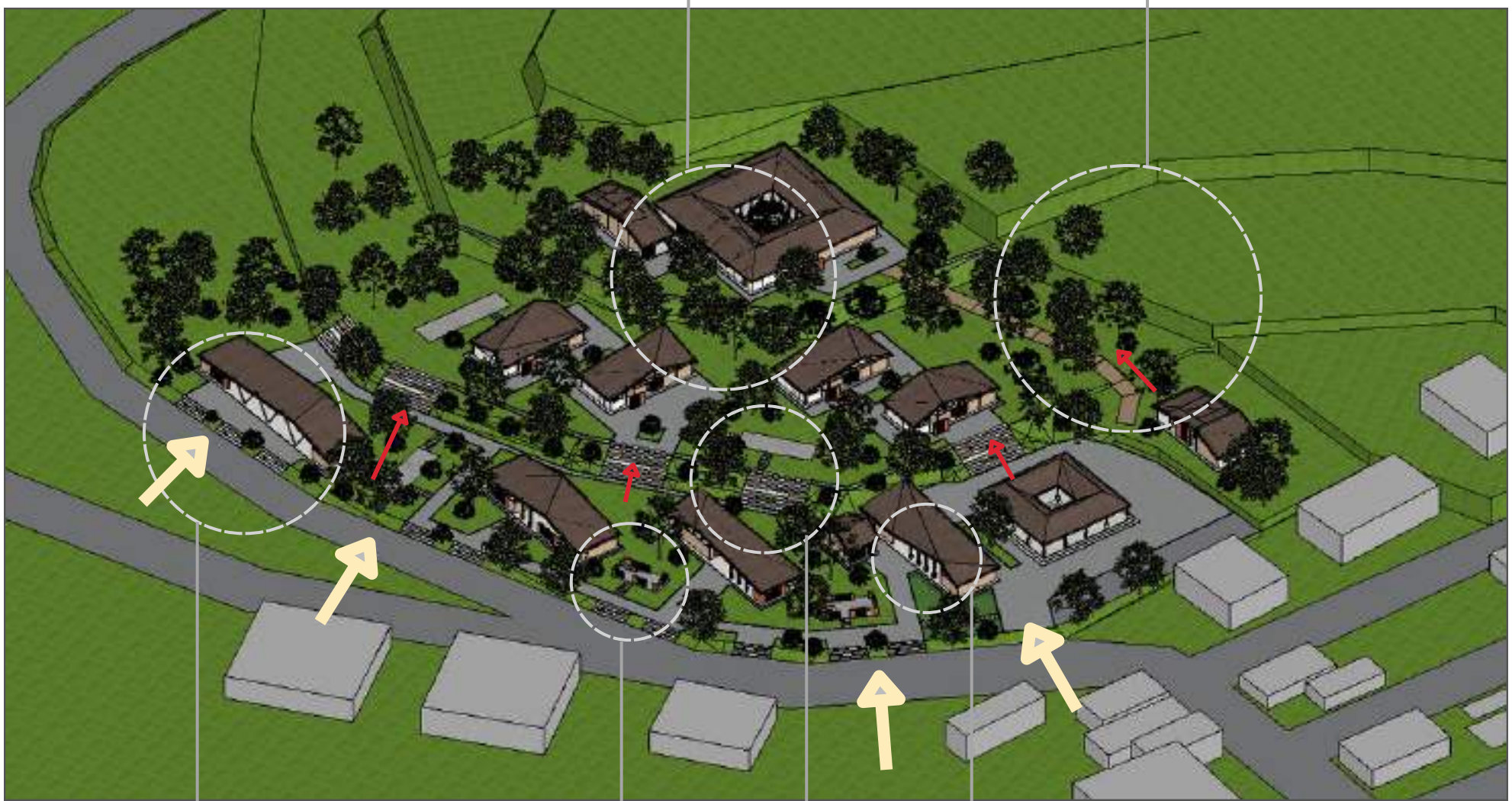
1. No Physical Barrier: Allow open access to community, reinforcing transparency and reducing stigma.
2. Soft Thresholds:
Transition from public to semi-public via stepped gardens and stairs.
3. Define edges using low vegetation beds or elevation changes.
4. Community Access Routes: Clearly visible and direct path from village to lobby/clinic area.

Inter-Zone Barriers: Slope Integration + Gardens

1. Use Topography as Natural Zoning: Utilize contours between Zone A–B–C as gentle dividers.
2. Green Transition Zones: Pathways bordered with buffer gardens: Shrubs or small trees to offer visual screening and privacy.

Natural Barriers: Using natural element such as vegetation to create seamless divider between each zones

Natural Barriers: Using natural contour of the site to create seamless divider between the main site and its surrounding village



Open Interface with Village:
No rigid fences

Social Nodes: Open Space for interaction between villagers and patients

Semi-open Community Building: semi open walls to connect interior activities with the village (visibility)

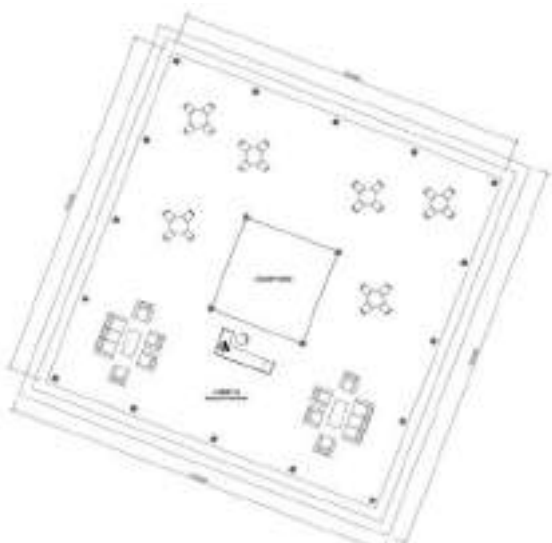
4.2 Site Plan

ASGHGSGHDSAHGDGHS

Figure. Exterior View to the East Side from Front Gate of the complex

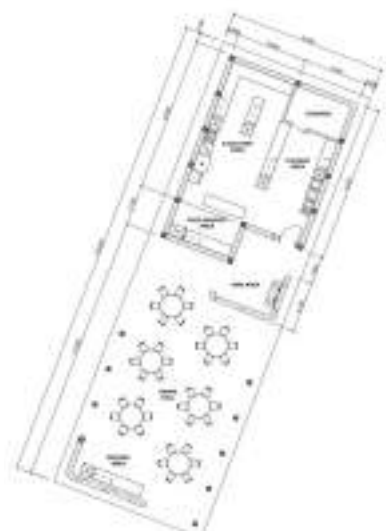
Figure. Exterior View of Site from the East Side

Zone C: Communal Area

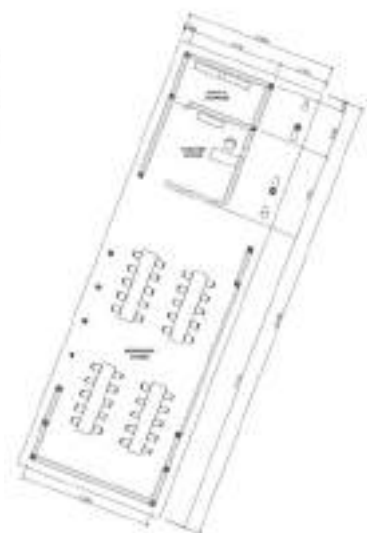


Lobby & Receptionist Area

Administration Office



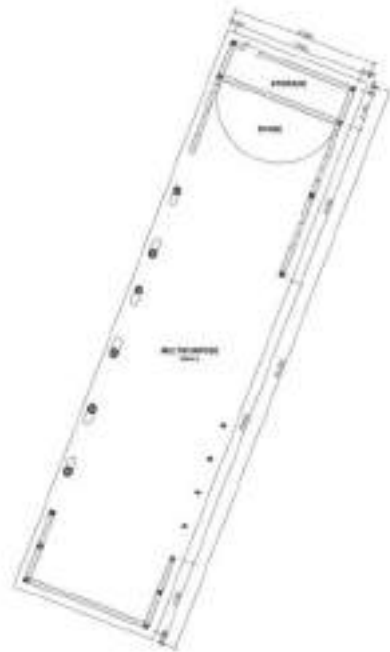
Community Kitchen
& Dining Hall



Workshop Studio

Staff Office &
Security Room

Community Health
Station



Multipurpose Hall

Figure. Interior View of Workshop Studio

Figure. Interior View of Multipurpose Hall

Zone B: Housing Unit

Figure. Exterior View of Housing Unit with outdoor communal space

Housing Unit Floor Plan

Figure. Exterior View of Housing Unit

Zone A: Dormitory

Dormitory Health Station

Figure. View of Walkpath to Zone A Dormitory Building

Dormitory

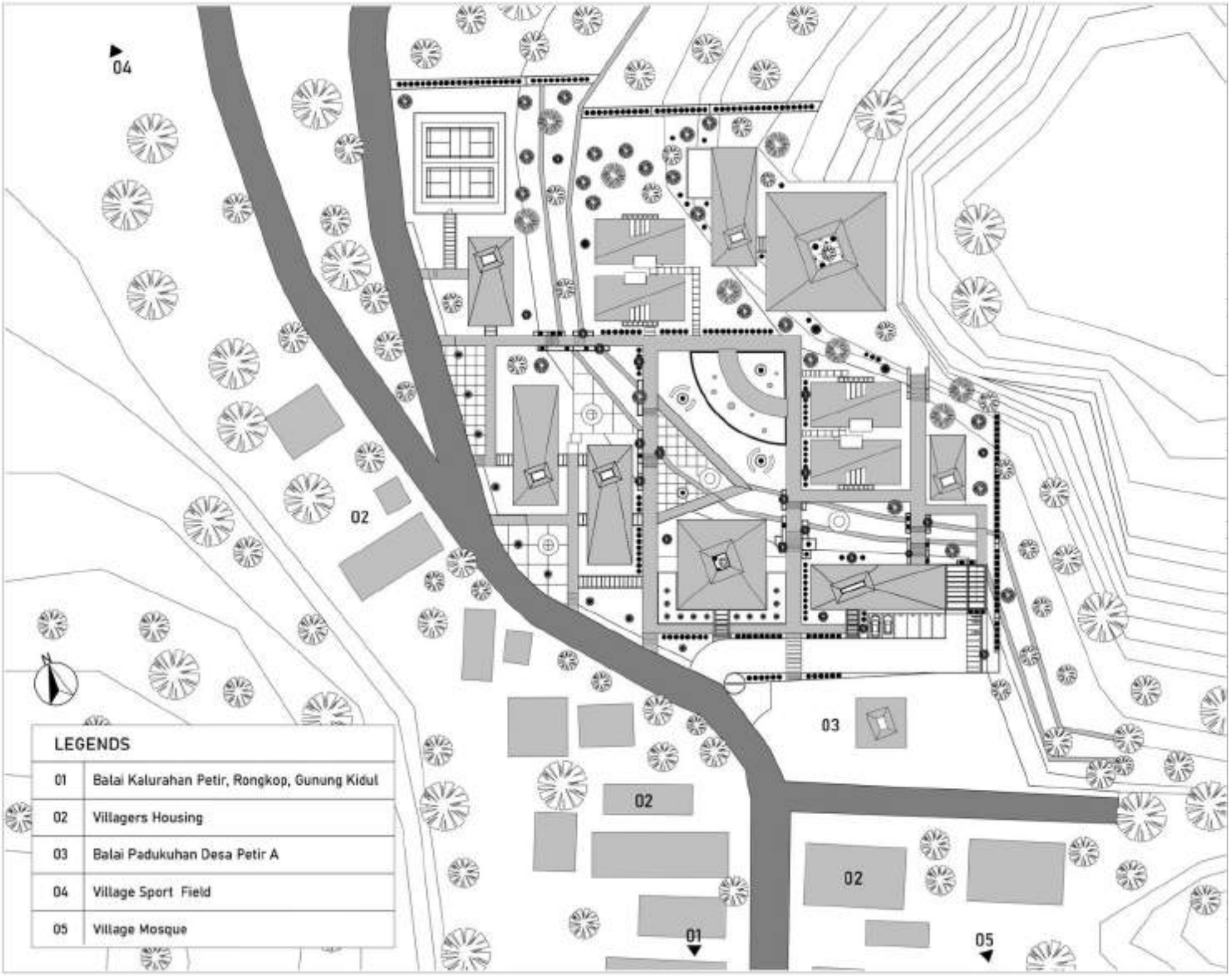
Figure. Interior View of Dormitory Courtyard

Design Proof

5 Design Development

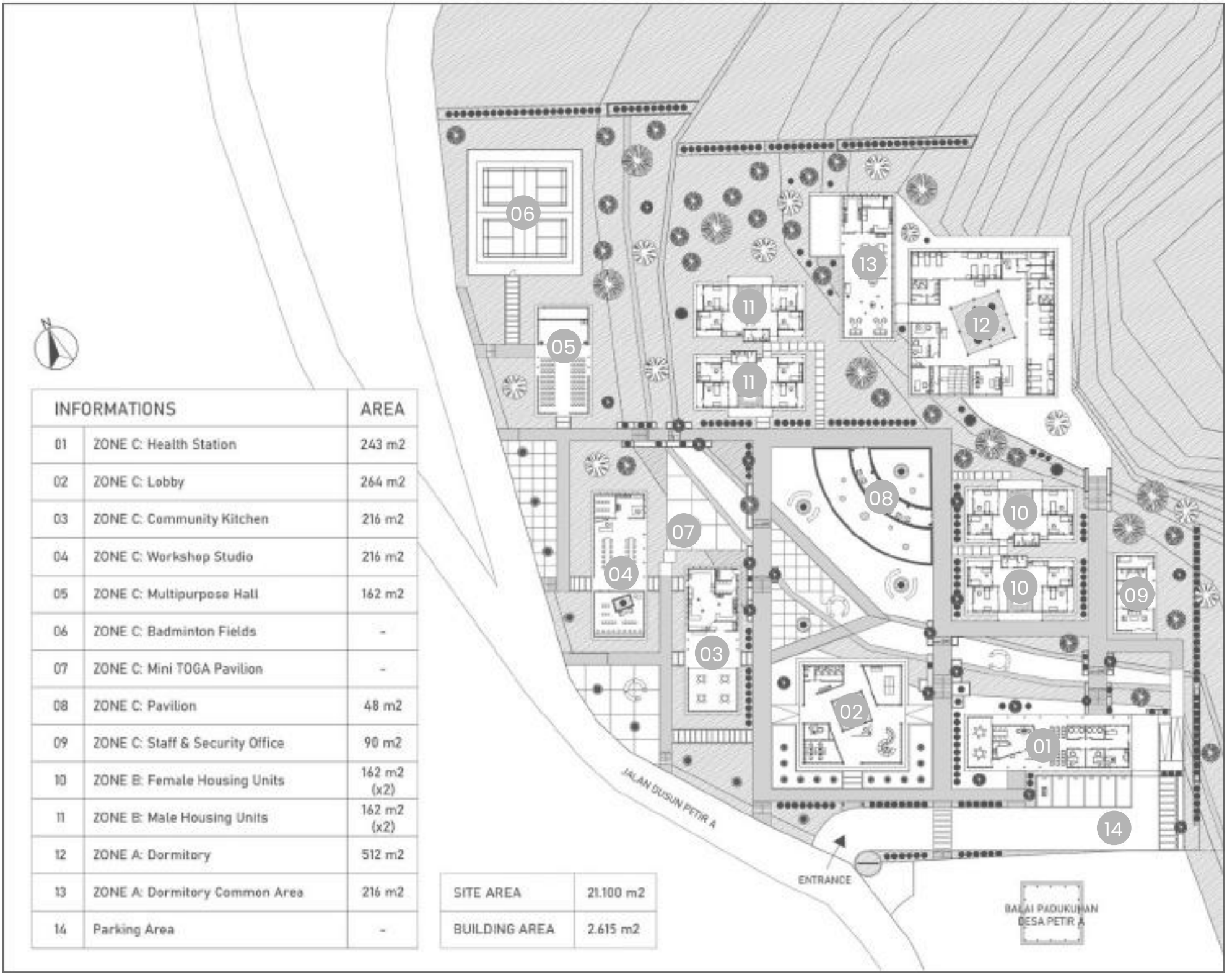
Design Result

5.1 Situation Plan



The zoning system of the rehabilitation center is designed to reflect the gradual process of mental health recovery, where architecture becomes an active tool in shaping behavior, comfort, and community integration. The site is organized into three primary therapeutic zones which is Zone A, Zone B, and Zone C. Each representing a different level of patient independence, supervision, and social engagement. This staged arrangement not only supports clinical decisions but also translates them into spatial experiences that guide patients toward reintegration.

5.2 Site Plan



INFORMATIONS		AREA
01	ZONE C: Health Station	243 m2
02	ZONE C: Lobby	264 m2
03	ZONE C: Community Kitchen	216 m2
04	ZONE C: Workshop Studio	216 m2
05	ZONE C: Multipurpose Hall	162 m2
06	ZONE C: Badminton Fields	-
07	ZONE C: Mini TOGA Pavilion	-
08	ZONE C: Pavilion	48 m2
09	ZONE C: Staff & Security Office	90 m2
10	ZONE B: Female Housing Units	162 m2 (x2)
11	ZONE B: Male Housing Units	162 m2 (x2)
12	ZONE A: Dormitory	512 m2
13	ZONE A: Dormitory Common Area	216 m2
14	Parking Area	-

SITE AREA	21.100 m2
BUILDING AREA	2.615 m2

All zones converge around a central spine and a series of landscaped social nodes that connect the rehabilitation center with the villagers, reinforcing its community-based approach. This zoning system ensures that every spatial progression—from enclosed to open, from supervised to self-directed—mirrors the psychological progression of healing, making the built environment a living framework for recovery, dignity, and reintegration.

5.3 Elevation

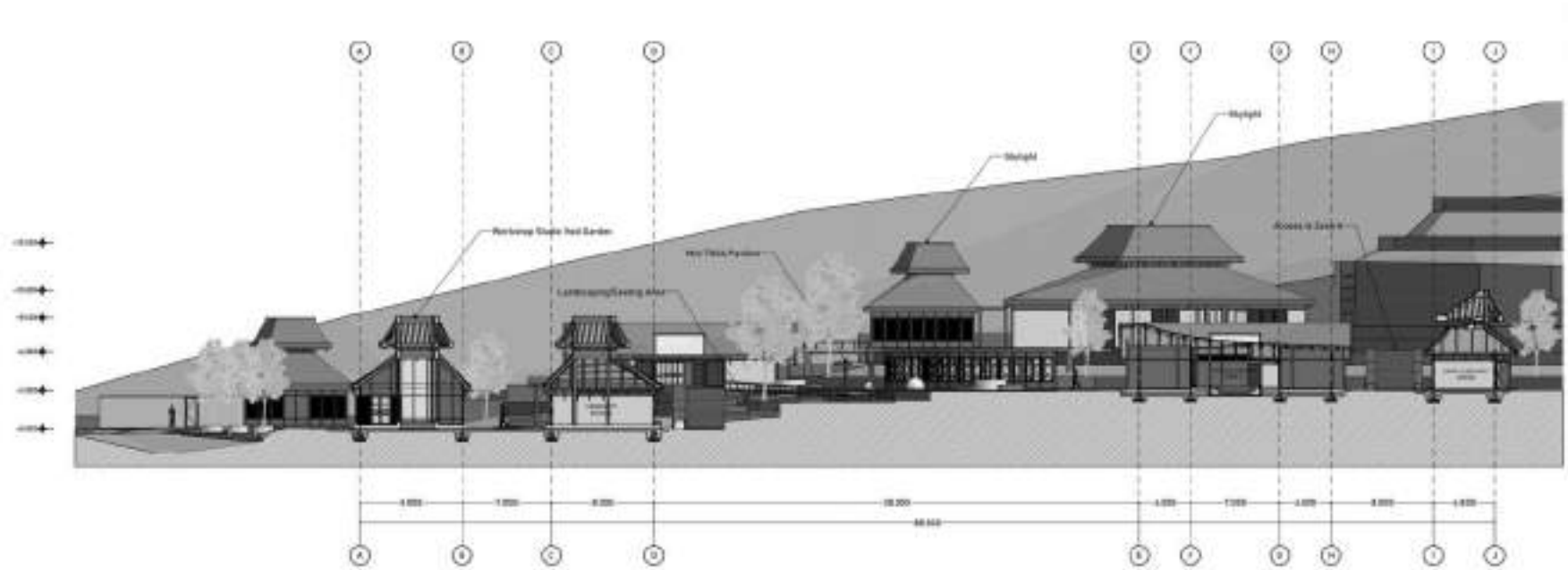
North Elevation
1:300

East Elevation
1:300

South Elevation
1:300

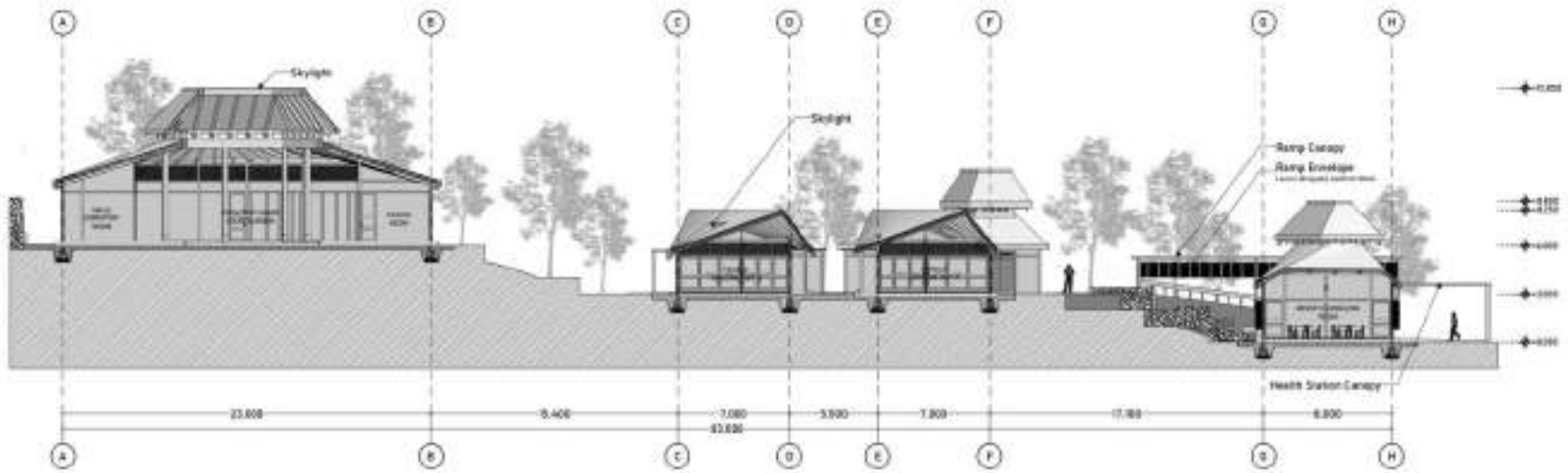
West Elevation
1:300

5.4 Section



Site Section 02

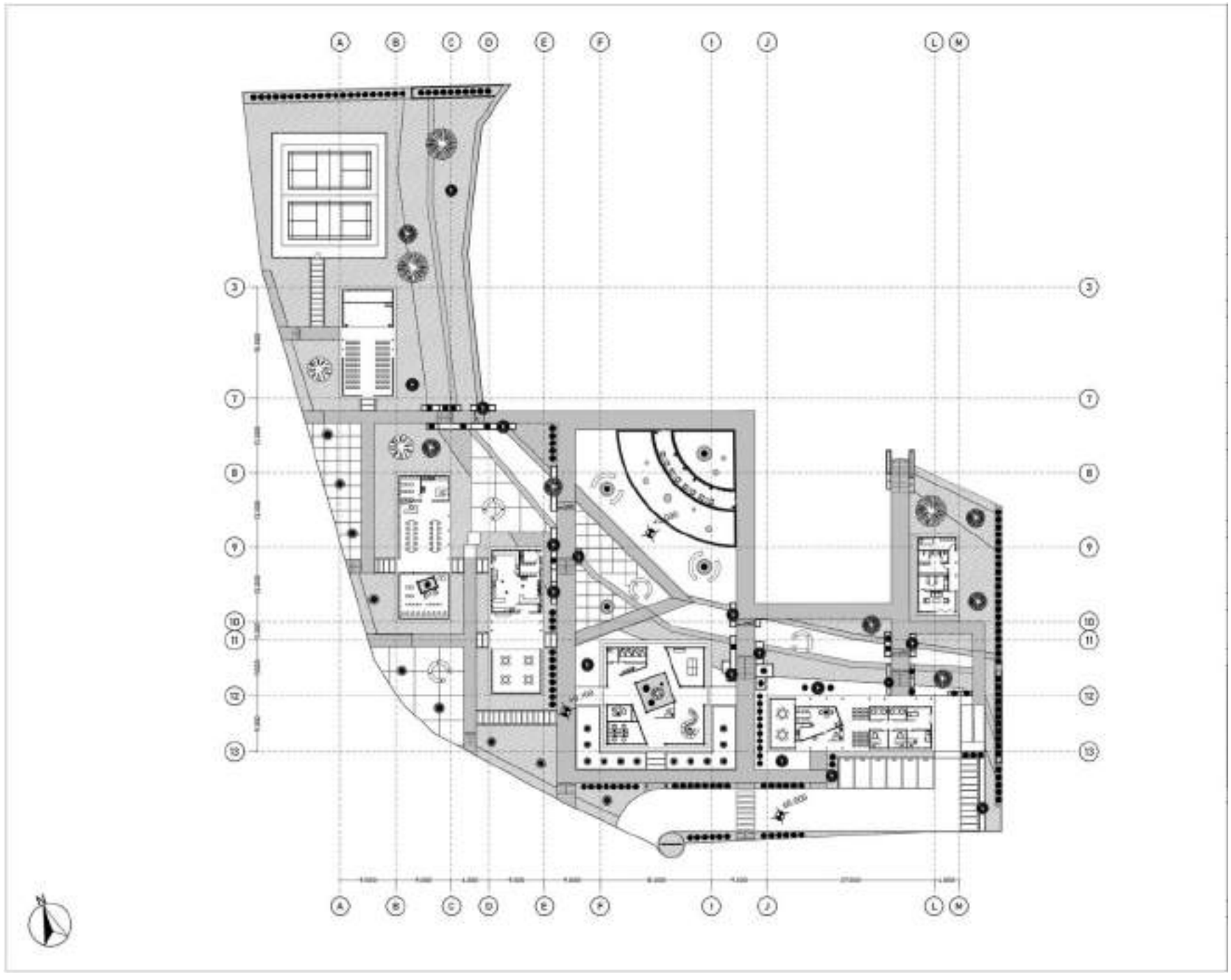
1:250



Site Section 01

1:200

5.5.1 Zone C: Site Plan

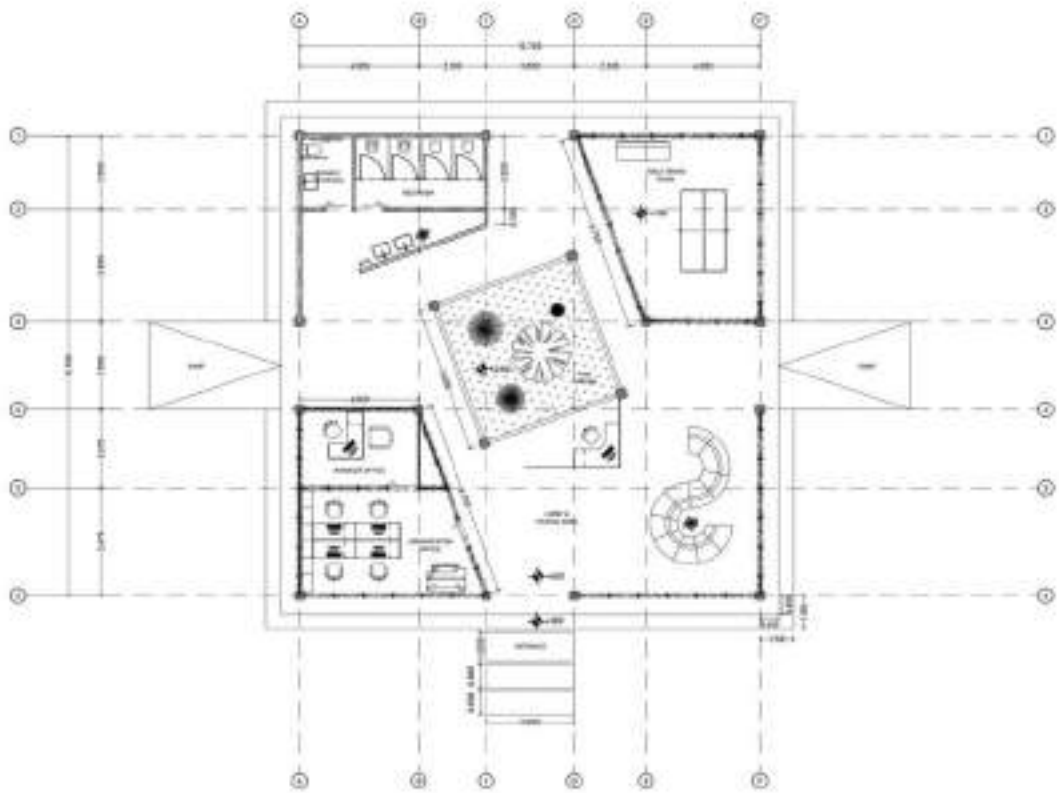


Zone C represents the final stage of the rehabilitation journey, composed of semi-independent living spaces and communal facilities that bring patients closer to village life. Here, architecture opens itself through wider pathways, shared outdoor nodes, and a central pavilion for gathering and relaxation. The boundary between patients and the surrounding community becomes intentionally porous, supported by shared facilities such as the health station, community kitchen, multipurpose hall, and landscaped gardens that host collective activities.

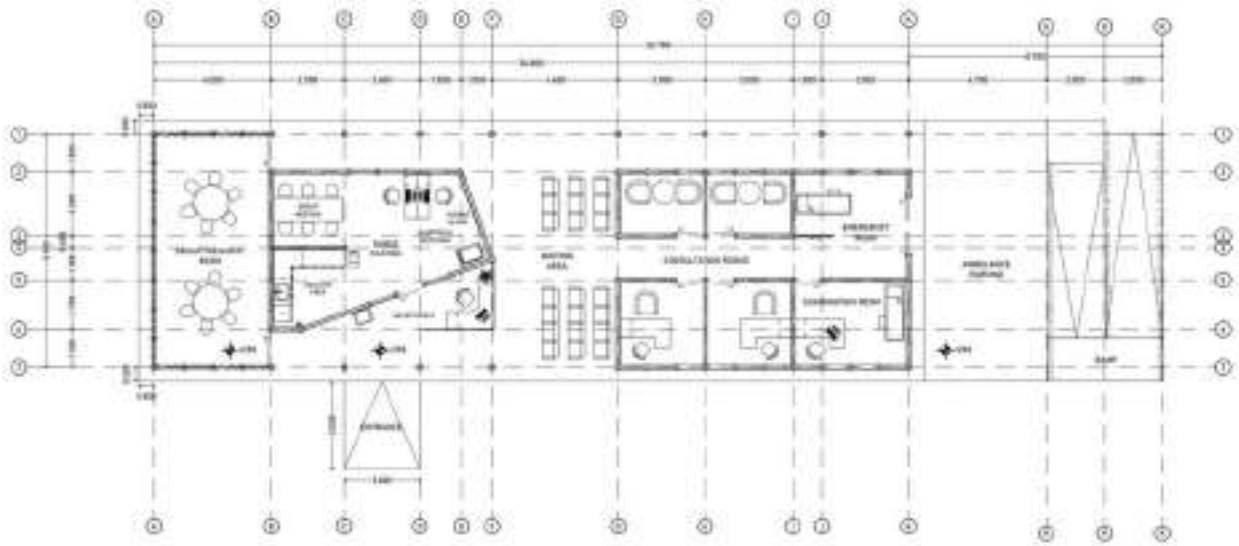
5.5.2 Zone C: Lobby & Health Station Floor Plan

The **lobby** serves as the main welcoming space for both patients and visitors, functioning as **a central meeting point** where families can connect with their loved ones in a comfortable and supervised environment. It includes an information center that provides guidance about the facility's programs and services, along with an administration office for handling registration, inquiries, and daily management tasks. Public restrooms are also available for visitors.

The **health station** functions as the main medical center for **both patients and local villagers**. It includes four mental health consultation rooms, one examination room for physical and psychological assessments, and an emergency room for urgent cases. A nurse station is placed at the center to monitor activities and manage patient flow. Villagers can also access **general healthcare services** here, using the calm and shaded waiting area. The building also provides a group counseling room used for therapy sessions, peer discussions, and mental health education.



Lobby Floor Plan
1:100



Health Station Floor Plan
1:100

The lobby welcomes patients and families with a calming first impression, starting with a shallow fish pond at the entrance that adds freshness, soft movement, and natural sound to reduce anxiety and ease the transition into the rehab environment. Inside, the lobby functions as a shared meeting point with clear access to the information center, administration office, and public restrooms, making navigation easy for all visitors.

Figure. Interior View of the Lobby and Waiting Area

At the center of the space, a small garden or inner court void brings natural light and greenery into the interior, creating a calming environment and enhancing the overall sense of openness and well-being.

To support light recreational activity, the lobby features a table tennis area that encourages casual social interaction and helps create a relaxed atmosphere.

The health station serves as the central medical hub of the rehabilitation center, designed to support both mental health services and general healthcare for the local villagers.

Figure. Exterior View of Health Station with Parking Space

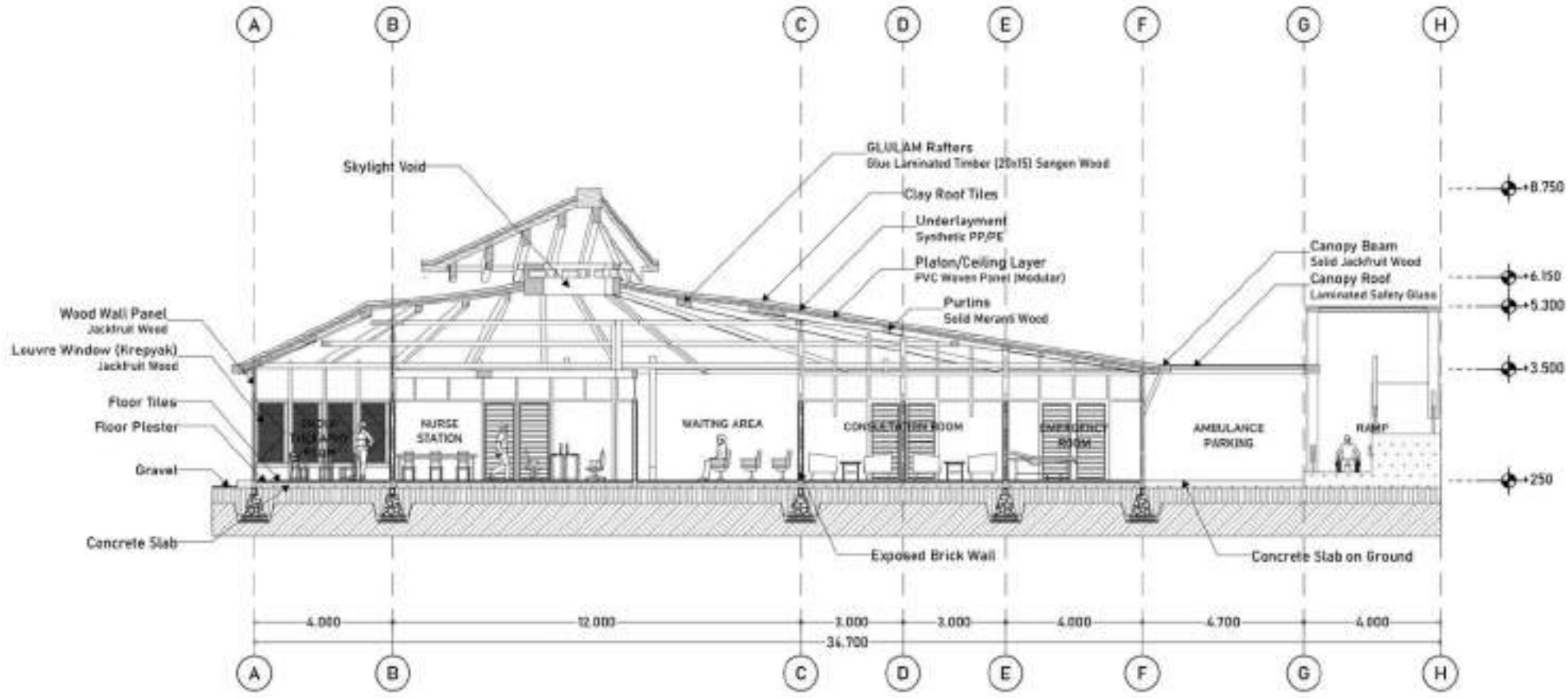
General Health Station & Emergency Room: The facility doubles as a primary healthcare point for villagers. The emergency room provides immediate care for urgent cases, ensuring quick response before referral to larger hospitals if needed.

Waiting Area: A shaded, ventilated waiting space that accommodates both patients and villagers.

Figure. Interior View of Health Station's Emergency Room

Figure. Interior View of Health Station consist of Administration Desk & Waiting Area

5.5.3 Health Station Section



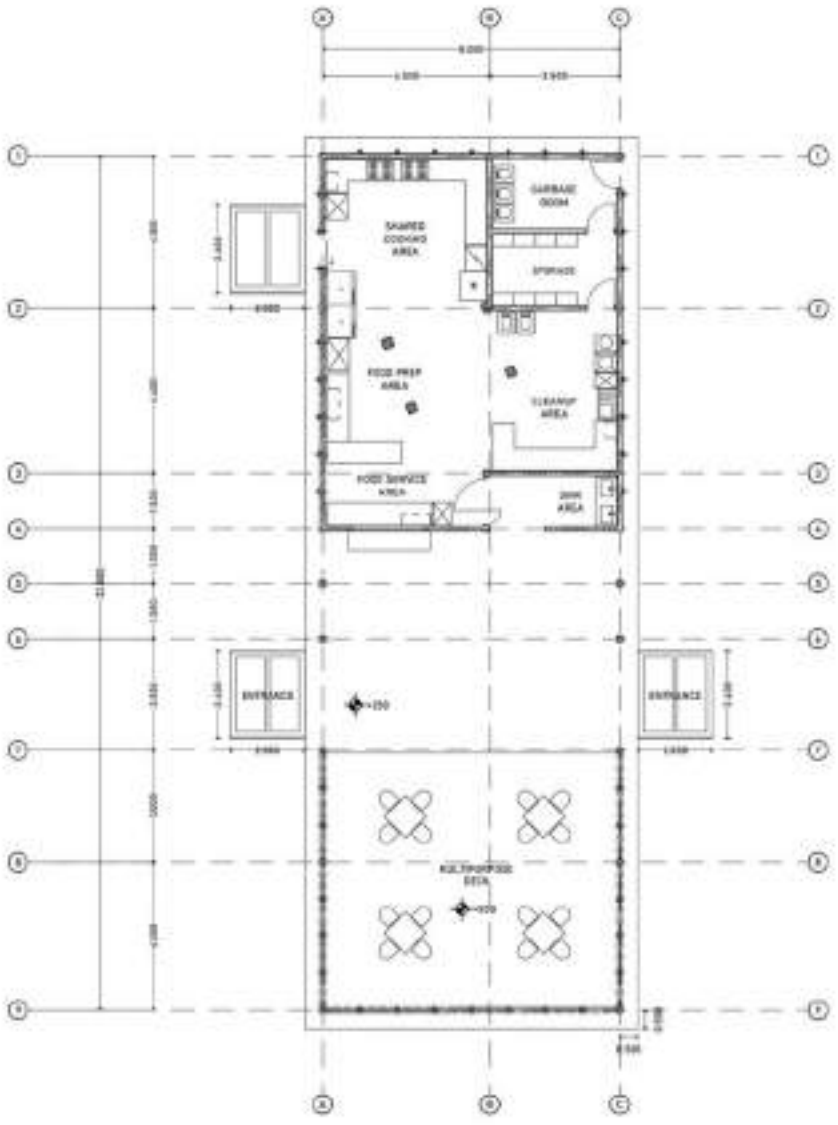
Section 03: Health Station

1:100

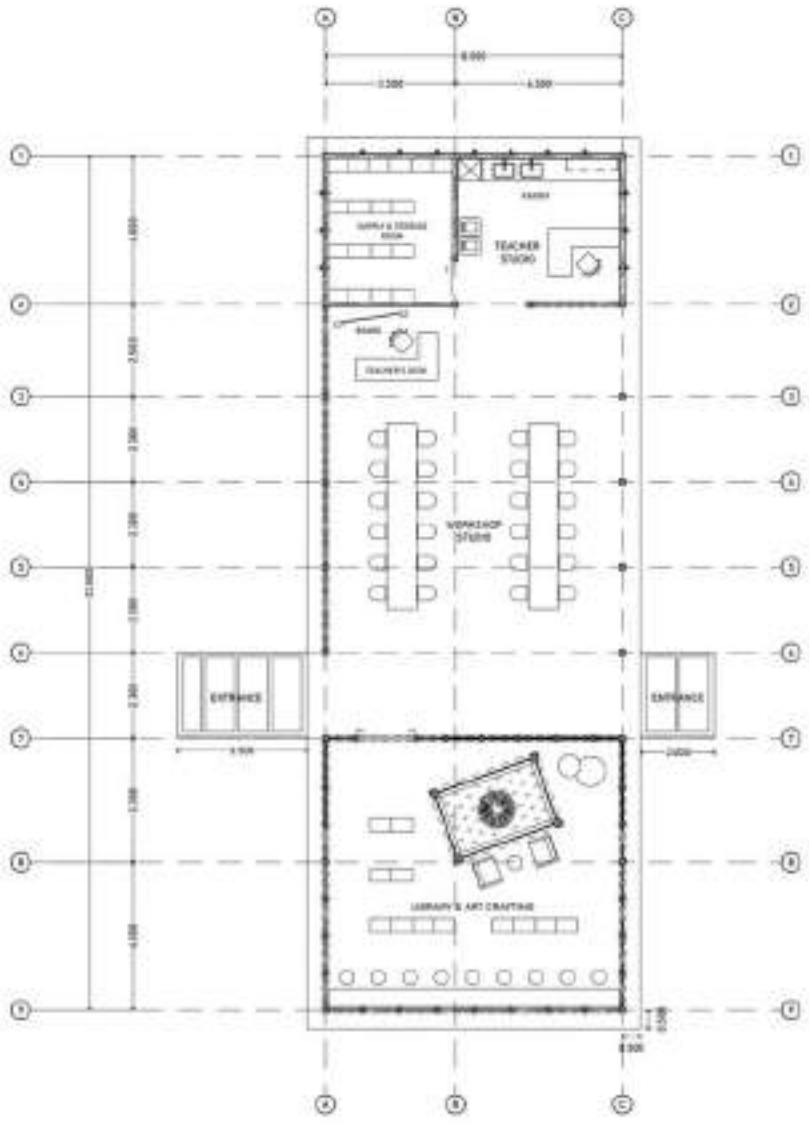
This section illustrates a health-station building designed with a clear functional layout and a strong response to the tropical context. The structure sits on a concrete slab with layered floor finishes for comfort and durability. The nurse station, waiting area, and consulting room are arranged linearly, allowing easy circulation and clear supervision. A central skylight void brings natural light into the waiting area, reducing dependence on artificial lighting and creating a brighter, more welcoming atmosphere. Louvre windows and exposed brick walls enhance cross-ventilation, improving indoor air quality for patients and staff. On the exterior, an extended canopy supported by solid jackfruit wood beams provides shaded ambulance parking and protects visitors from rain. The inclusion of an accessible ramp ensures universal access to the facility.

5.5.4 Zone C: Community Kitchen & Workshop Studio Floor Plan

The community kitchen combines a modern cooking area with a multipurpose deck for traditional community activities, allowing patients and villagers to cook, work, and interact in familiar daily routines. Next to it, the workshop studio provides a calm space for painting, weaving, and other crafts, supported by a small reading corner for individual focus. Together, these spaces encourage social interaction, cultural connection, and creative healing for the patients.



Community Kitchen Floor Plan
1:100



Workshop Studio Floor Plan
1:100

Adjacent to it, a multipurpose deck accommodates traditional food-preparation activities such as making traditional home-made snacks, allowing communal work to unfold in a familiar cultural setting. By engaging patients in these collective routines, the kitchen becomes a bridge between the rehabilitation center and the village, helping patients gradually reintegrate through everyday social and cultural practices.

The community kitchen is designed as a shared culinary hub that strengthens interaction between patients and local villagers. Equipped with a modern kitchen, the space supports daily cooking needs as well as larger community events.

Figure. Exterior View of Health Station with Parking Space

The workshop studio provides a calm, creative environment for therapeutic art activities. The space accommodates painting, weaving, and hands-on crafting, offering patients opportunities for self-expression and emotional healing.

Figure. Exterior View of Health Station with Parking Space

Figure. Exterior View of Health Station with Parking Space

A dedicated reading and corner library area provides a quieter zone for individual reflection, sketching, or researching craft ideas. Large openings bring in natural light, creating a warm and comfortable atmosphere that helps reduce stress and encourages longer, more focused engagement.

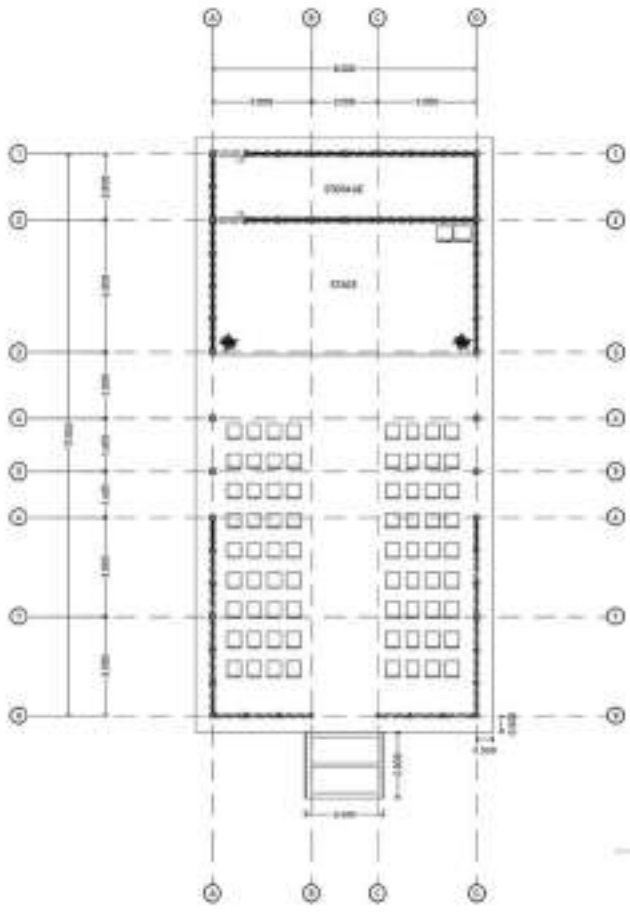
Figure. Exterior View of Pavilion in the Inner court Garden

The landscape design in the central part of the site, strategically placed between Zone B and Zone C functions not only as a circulation buffer but also as a social connector. These landscaped pockets act as informal meeting points where villagers, patients, and staff can interact naturally. Seating edges, shaded areas, and soft groundcover create comfortable micro-environments that encourage social engagement and help support the community-based rehabilitation approach.

Figure. Exterior View of Security & Staff Office

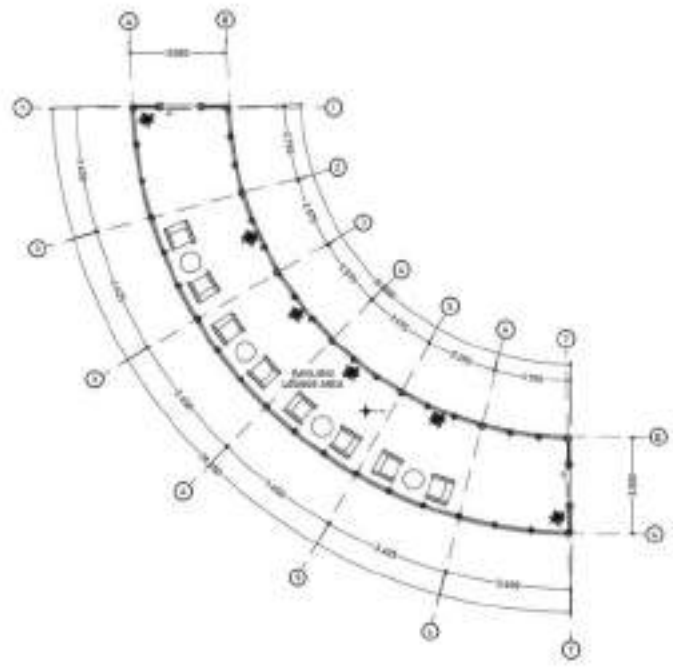
5.5.5 Zone C: Hall, Staff Office, & Pavilion Floor Plan

Zone C brings together the center's public, cultural, and operational functions. The multipurpose hall acts as a flexible venue for community events, performances, religious gatherings, and meetings, helping connect the rehabilitation center with village life. Nearby, the staff and security office provides essential support with workspaces, monitoring areas, a pantry, lockers, showers, and a small rest area for night-shift staff. The pavilion complements these spaces as an open, shaded area for informal activities and small daily programs.



Multipurpose Hall Floor Plan
1:120

Staff & Security Office Floor Plan
1:120



Pavilion Floor Plan
1:120

The multipurpose hall is a flexible communal space used for cultural performances such as jatilan, music events, and art showcases. It also hosts religious activities like prayer gatherings and ceramah, as well as community meetings, workshops, and public events.

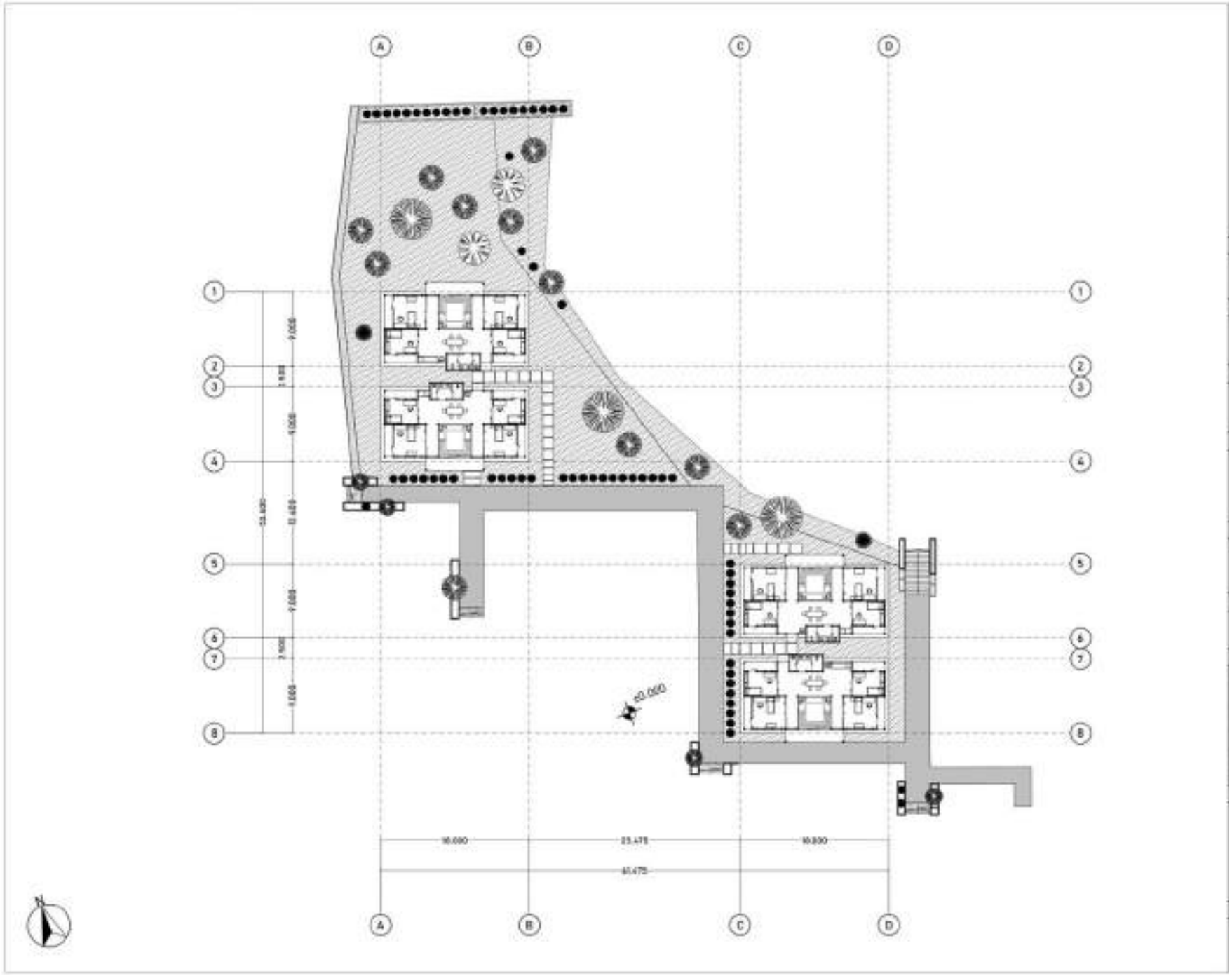
Figure. Interior View of Multipurpose Hall

The hall supports both therapeutic activities and village involvement, strengthening the connection between patients and the wider community.

Figure. Interior View of Multipurpose Hall

The pavilion provides an open, shaded structure for informal gatherings, daily communal programs, and light outdoor activities, acting as a transitional buffer between structured indoor events and the surrounding landscape.

5.6.1 Zone B: Site Plan



Zone B serves as the transitional living area for patients who have progressed in their recovery, offering a balance between privacy, independence, and controlled social interaction. The zone consists of four housing units, two for female residents and two for male residents, with the female units positioned closer to the staff and security office for added oversight and comfort.

Figure. Exterior View of
Male Housing Unit

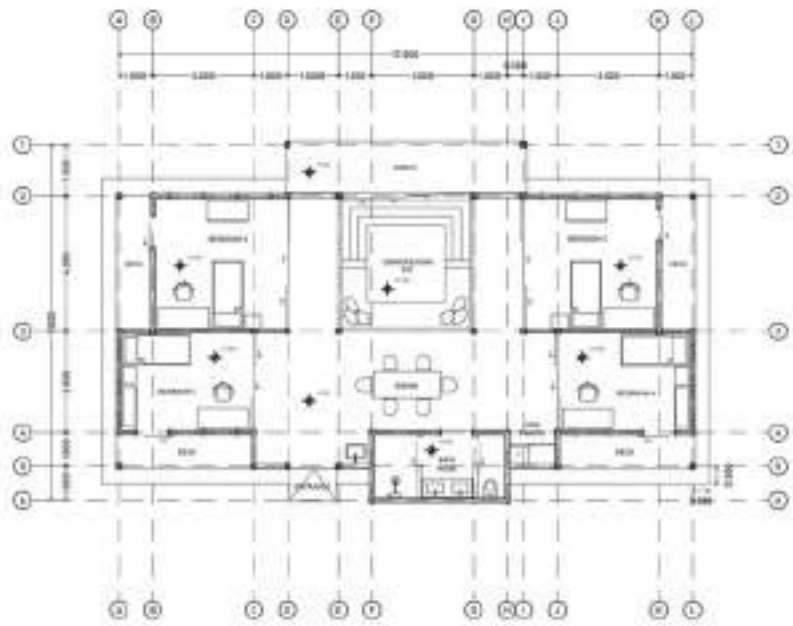
Figure. Exterior View of Female Housing Unit

Each unit is designed with generous openings and natural ventilation, creating bright, breathable living environments. Every bedroom is connected to a small private deck, allowing residents to enjoy personal outdoor space while remaining visually connected to the surroundings.

Figure. Exterior View of Male Housing Unit

5.6.2 Zone B: Floor Plan

Female Housing Unit A Floor Plan
1:100



Female Housing Unit B Floor Plan
1:100

Male Housing Unit A Floor Plan
1:100

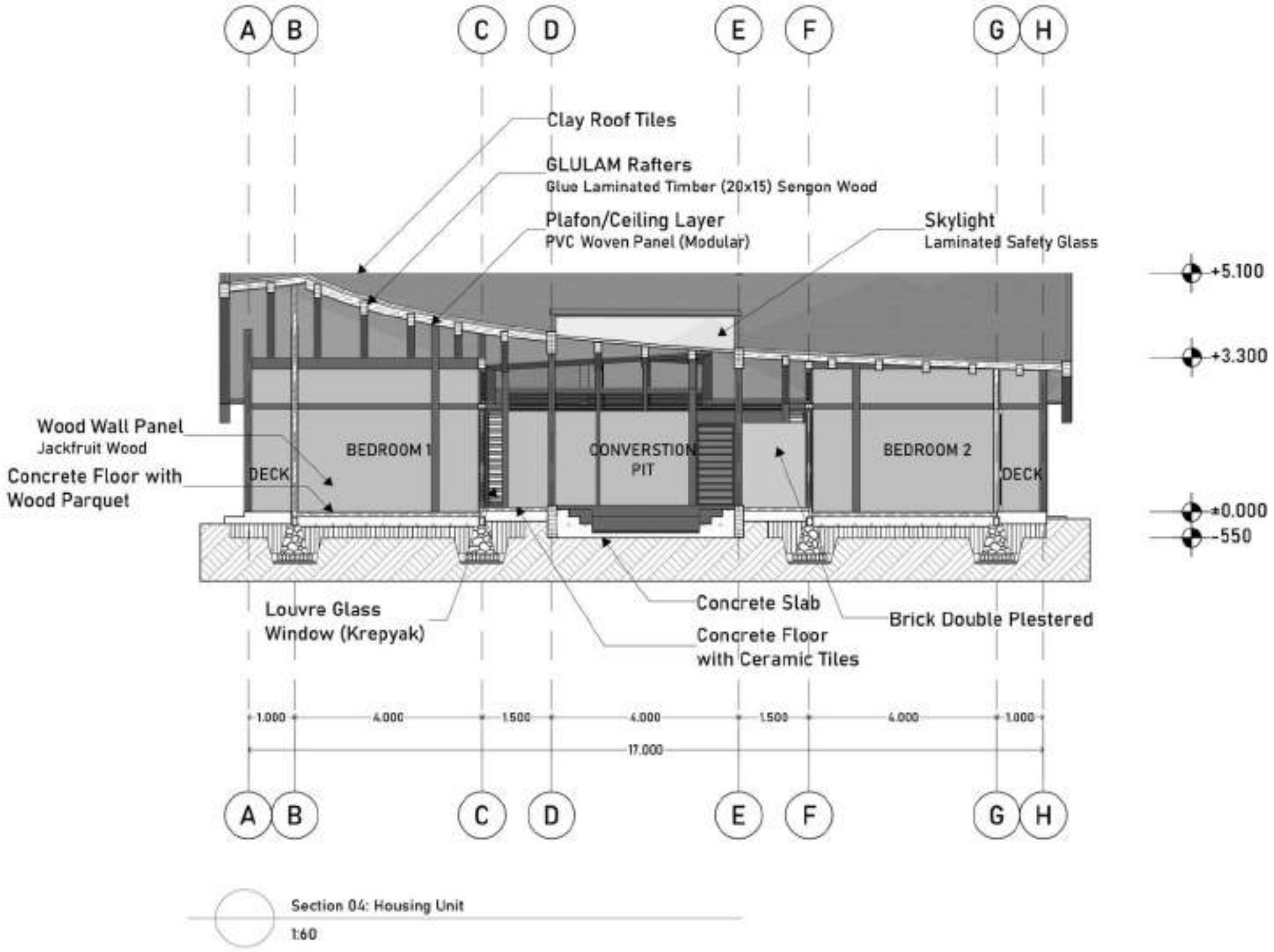
Male Housing Unit B Floor Plan
1:100

Figure. Interior View of Female Housing Unit

Shared facilities, such as the conversation pit, encourage casual interaction and help build social confidence among patients. The overall design aims to gently reintroduce social routines by fostering interaction not only between patients but also with visiting villagers, supporting the center's community-based healing approach.

Figure. Interior View of Female Housing Unit

5.6.3 Housing Unit Section

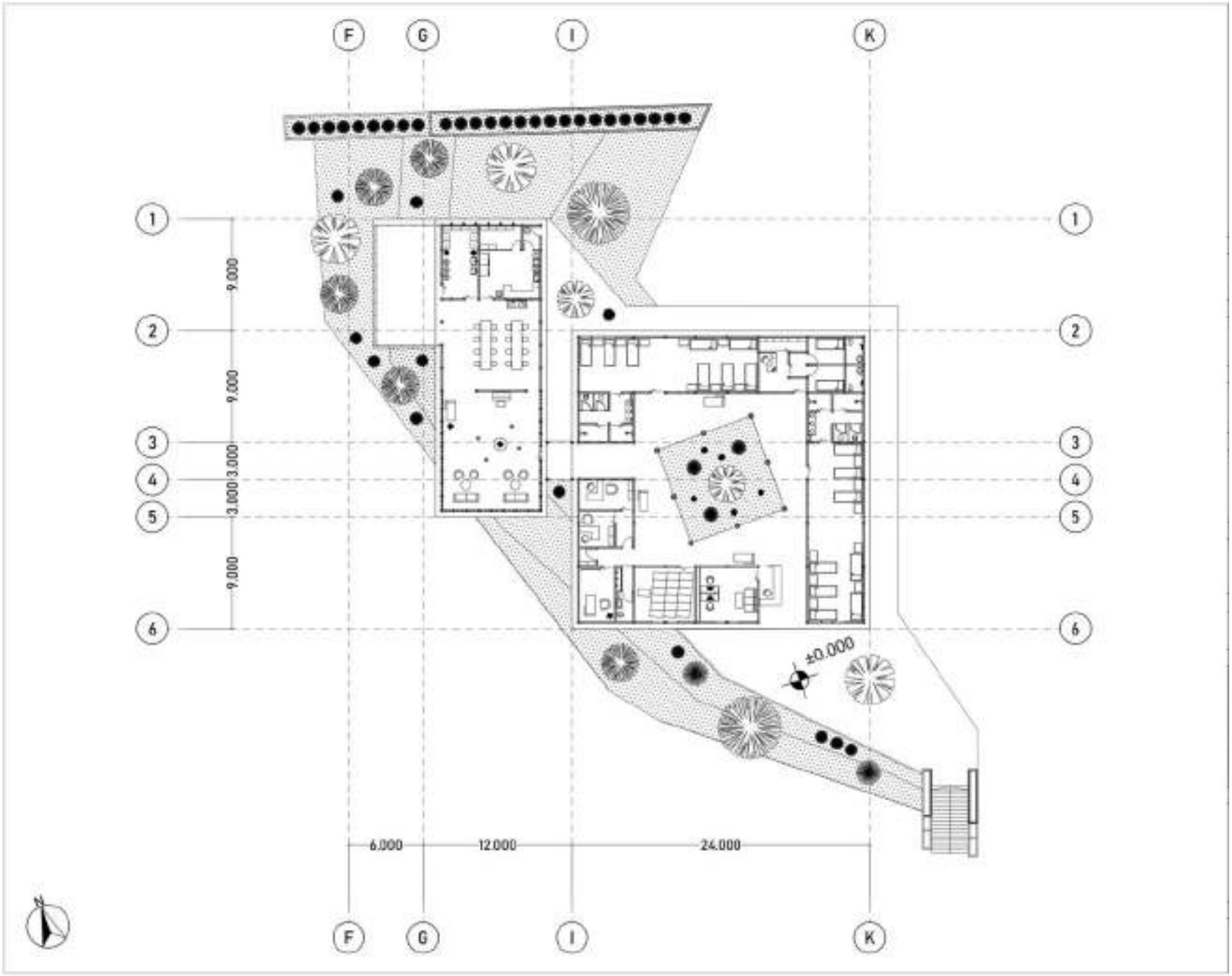


Section 04: Housing Unit

1:60

Figure. Dining Area View of Female Housing Unit

5.7.1 Zone A: Site Plan

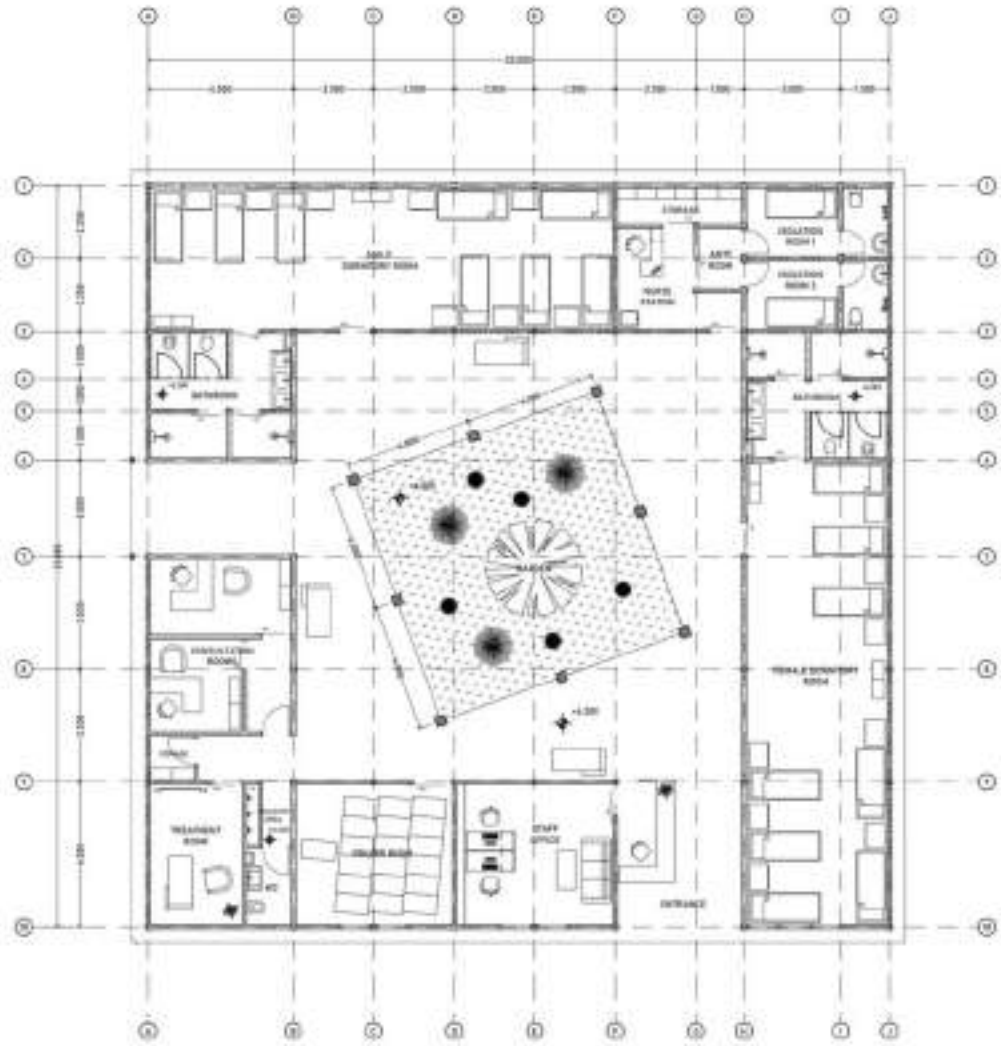


Zone A serves as the primary care area for patients with severe mental health conditions, designed to provide a safe, controlled, yet non-institutional environment. This zone accommodates 16 patients (8 female and 8 male) who require closer supervision, stabilization, and initial treatment before progressing to lighter rehabilitation stages. The spatial arrangement prioritizes passive monitoring, with staff circulation routes, clear sightlines, and a small entrance lobby that functions as a supervision point.

Figure. Common Area of Dormitory Building

5.7.2 Zone A: Floor Plan

Dormitory Common Area Floor Plan
1:100



Dormitory Floor Plan
1:100

Zone A functions as the most controlled and protected area of the rehabilitation center, dedicated to patients in the earliest stages of recovery who require close supervision. It consists of two main buildings. The first is the primary dormitory and the second building is the dormitory common area, designed to support routine-building and communal activities.

At the entrance, a small lobby acts as a controlled transition space where staff can easily monitor patient movement in and out of the dormitory area.

Figure. Interior View of Dormitory Entrance

At the core of the building is an inner courtyard garden, which brings natural light and fresh air deep into the interior spaces. This garden void creates a visual connection to nature, softens the atmosphere of a secured facility, and provides passive therapeutic benefits by offering residents a peaceful, green focal point. The surrounding circulation is arranged around this courtyard, allowing staff to maintain clear sightlines while ensuring patients feel connected to an open, breathable environment.

Figure. View of Dormitory's Inner Courtyard Garden

The main dormitory accommodates separate male and female rooms, each housing eight occupants with shared bathrooms inside. Because patients in this zone cannot leave the area, a small mushola is provided to support their daily worship needs within the secure environment. This building also includes a nurse station for continuous monitoring, two isolation rooms for special cases, two consultation rooms, one therapy room, and a staff office to support daily operations and patient care.

Figure. Interior View of Female Dormitory Room

Figure. Exterior View of Common Area Patio serves as Laundry Area

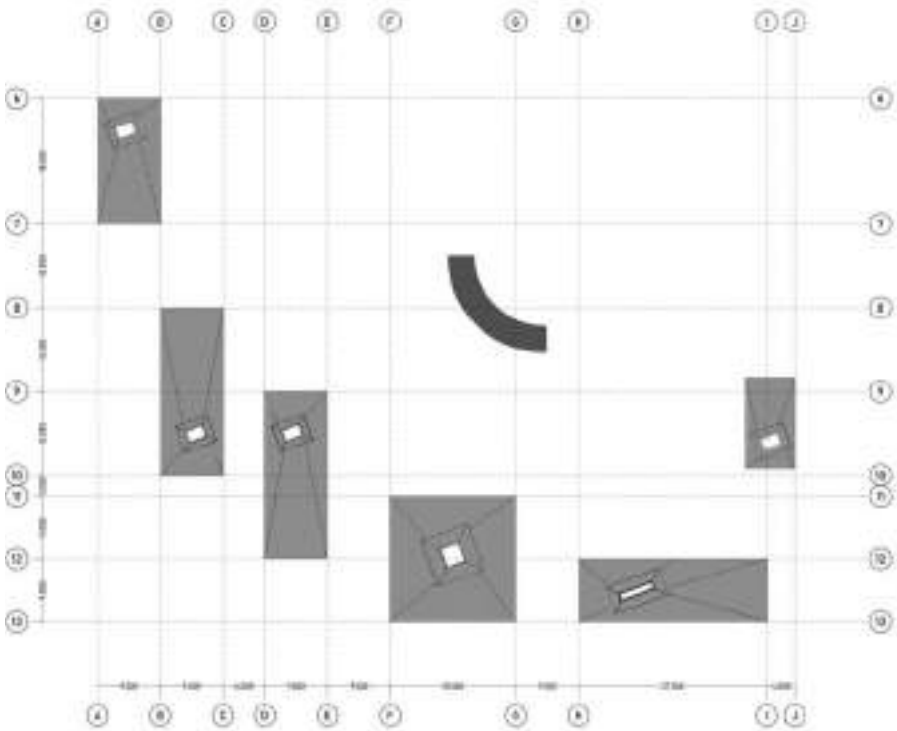
The dormitory common area, designed to support routine-building and communal activities. It includes a shared lounge for patients, a dining room, a staff kitchen for meal preparation, and a laundry room.

Figure. Exterior View of Zone A

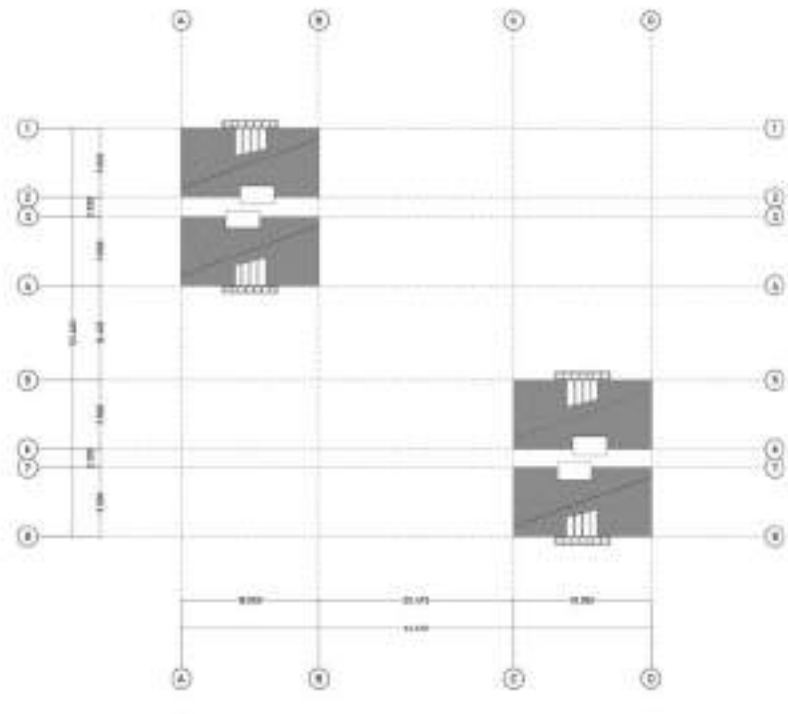
Figure. Interior View of Common Area

Laundry activities are intentionally designed to be done together on scheduled days, helping patients slowly build daily habits while encourage interaction sometimes even involving villagers during supervised sessions.

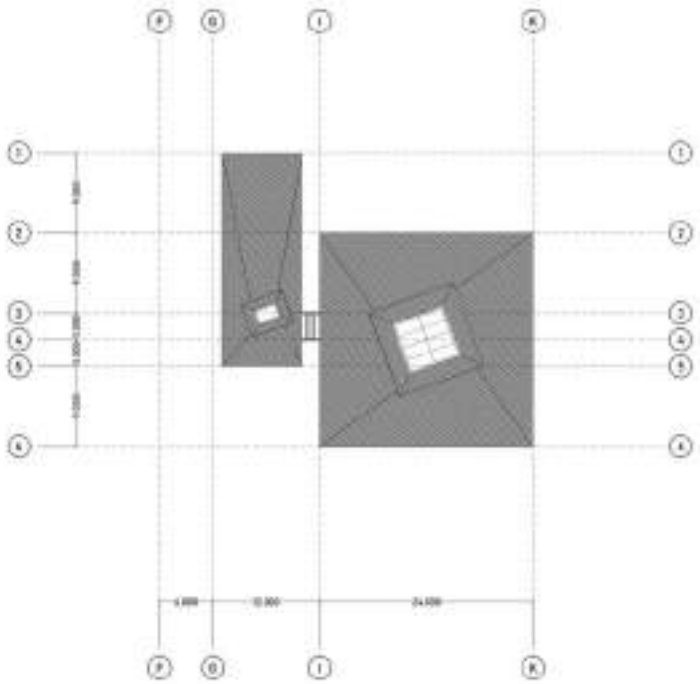
5.8.1 Zone C: Roof Plan



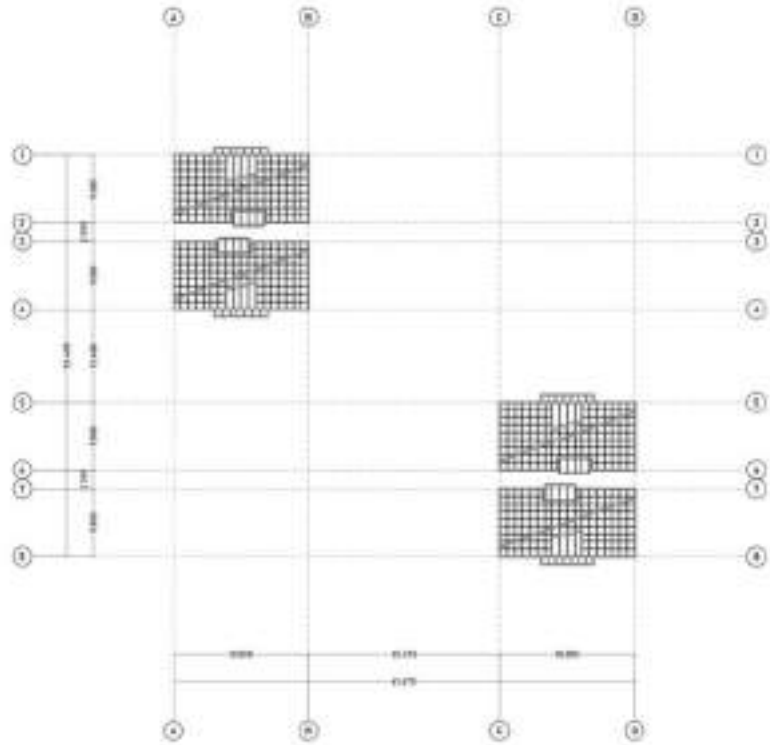
5.8.2 Zone B: Roof Plan



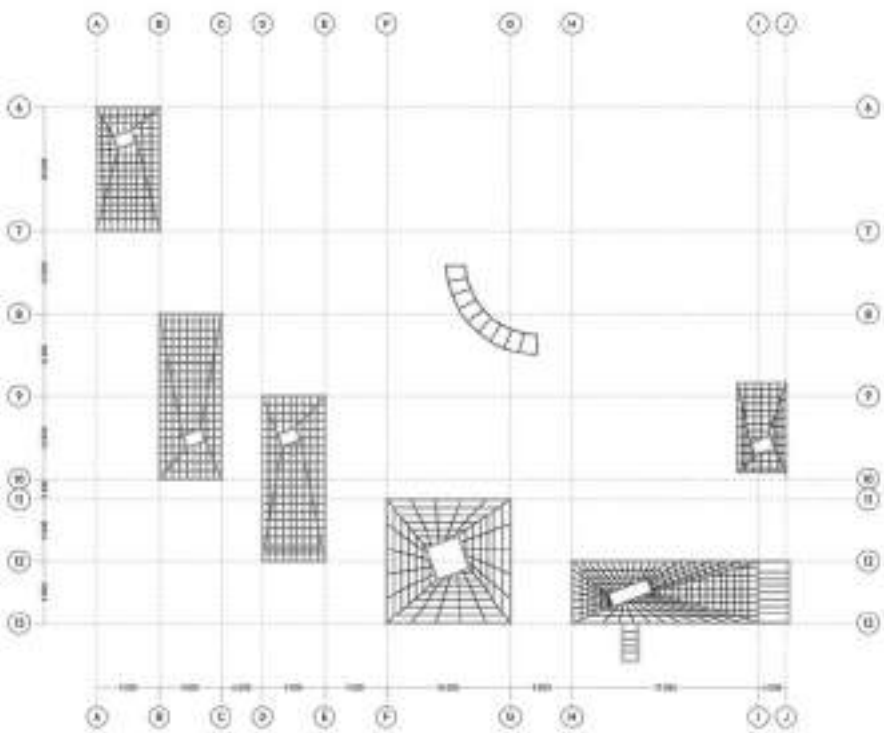
5.8.3 Zone A: Roof Plan



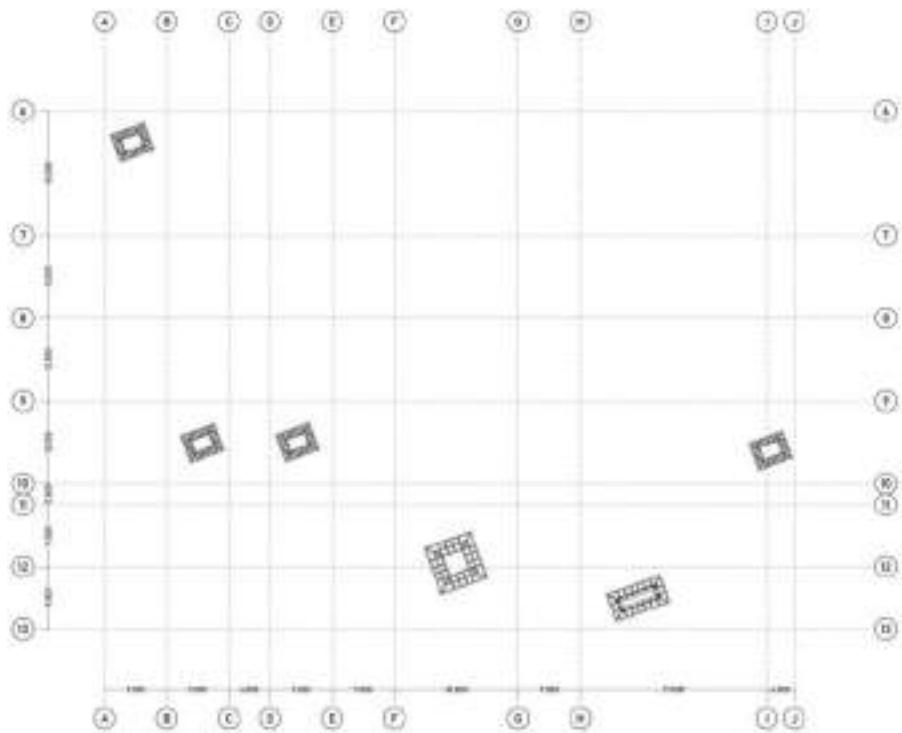
5.8.4 Zone B: Roof Structure Plan



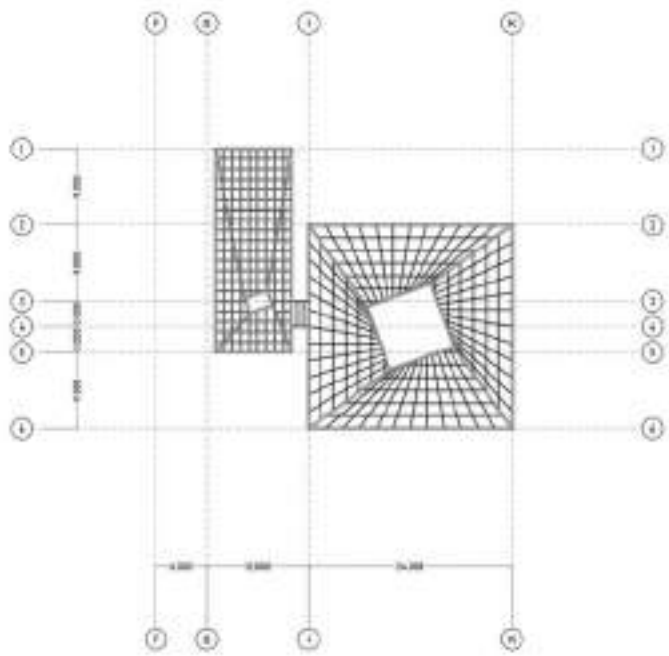
5.8.5 Zone C: Roof Structure Plan Ground Floor



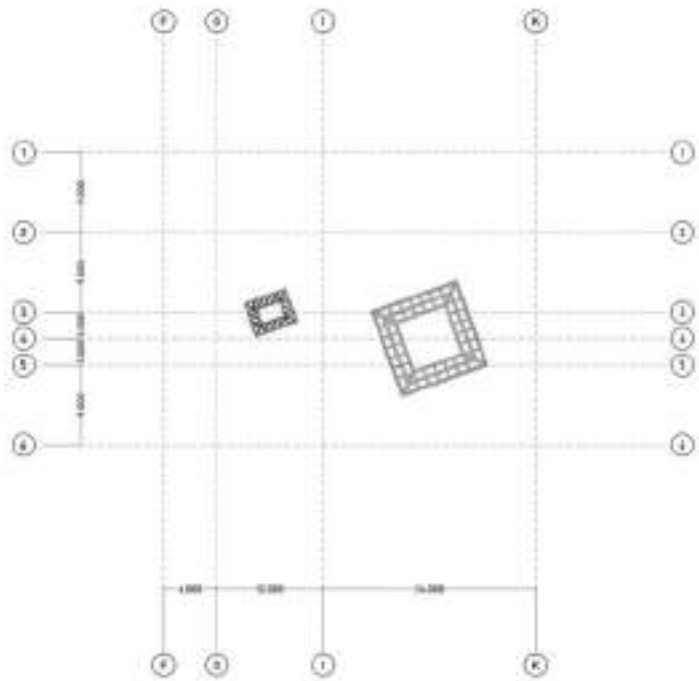
5.8.6 Zone C: Roof Structure Plan 1st Floor



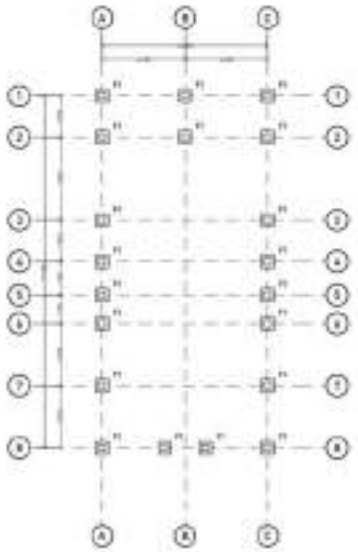
5.8.7 Zone A: Roof Structure Plan Ground Floor



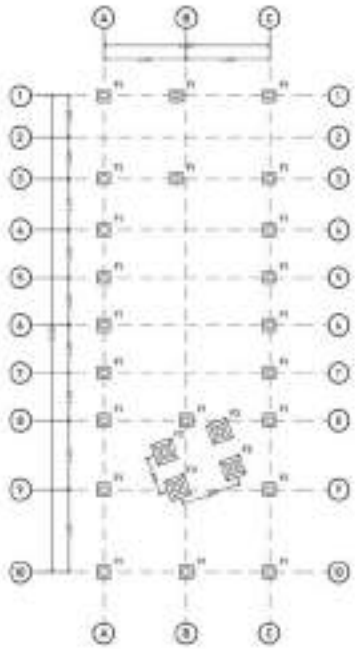
5.8.8 Zone A: Roof Structure Plan 1st Floor



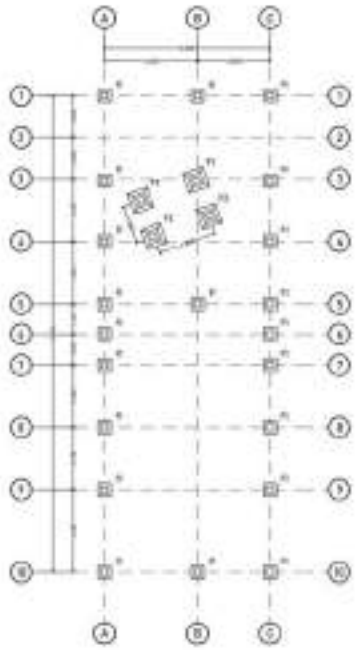
5.9.1 Zone C: Foundation Plan



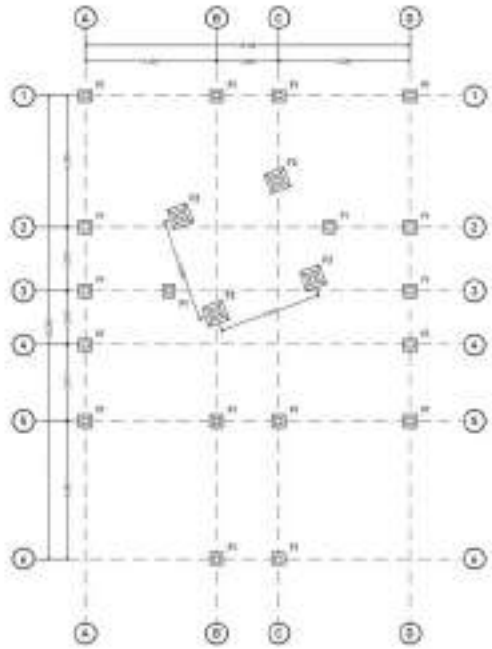
Multipurpese Hall Foundation Plan
1:200



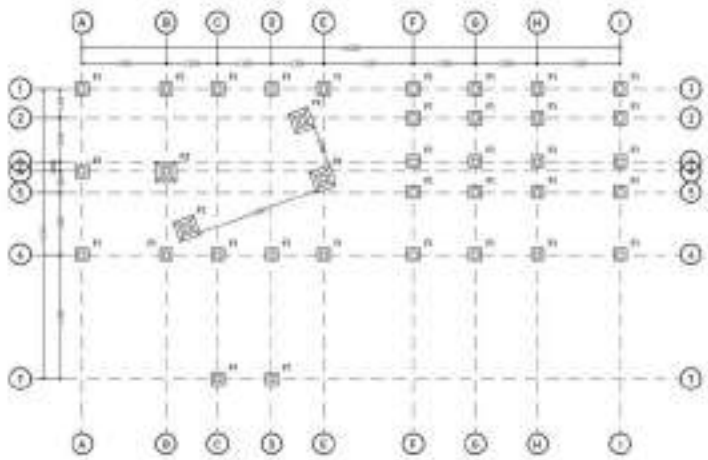
Workshop Studio Foundation Plan
1:200



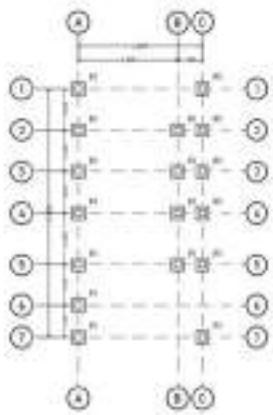
Community Kitchen Foundation Plan
1:200



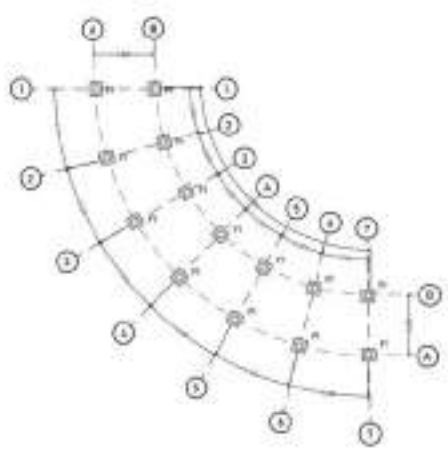
Lobby Foundation Plan
1:200



Health Station Foundation Plan
1:200



Staff & Security Office Foundation Plan
1:200

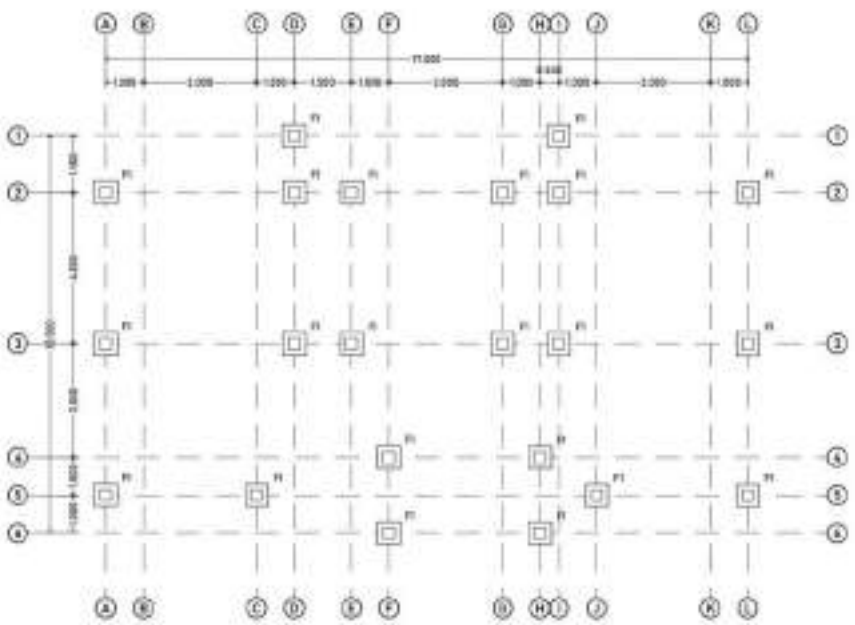


Multipurpose Hall Foundation Plan
1:200

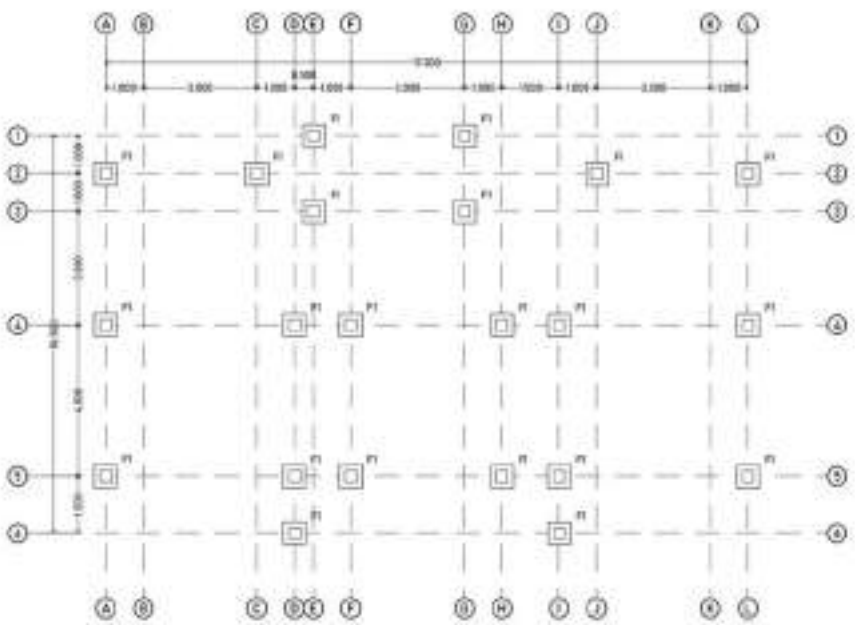
LEGEND

F1	RIVER STONE FOUNDATION (60x60)
F2	FOOTPLATE FOUNDATION (80x80)

5.9.2 Zone B: Foundation Plan



Female/Male Housing Unit B Foundation Plan
1:100



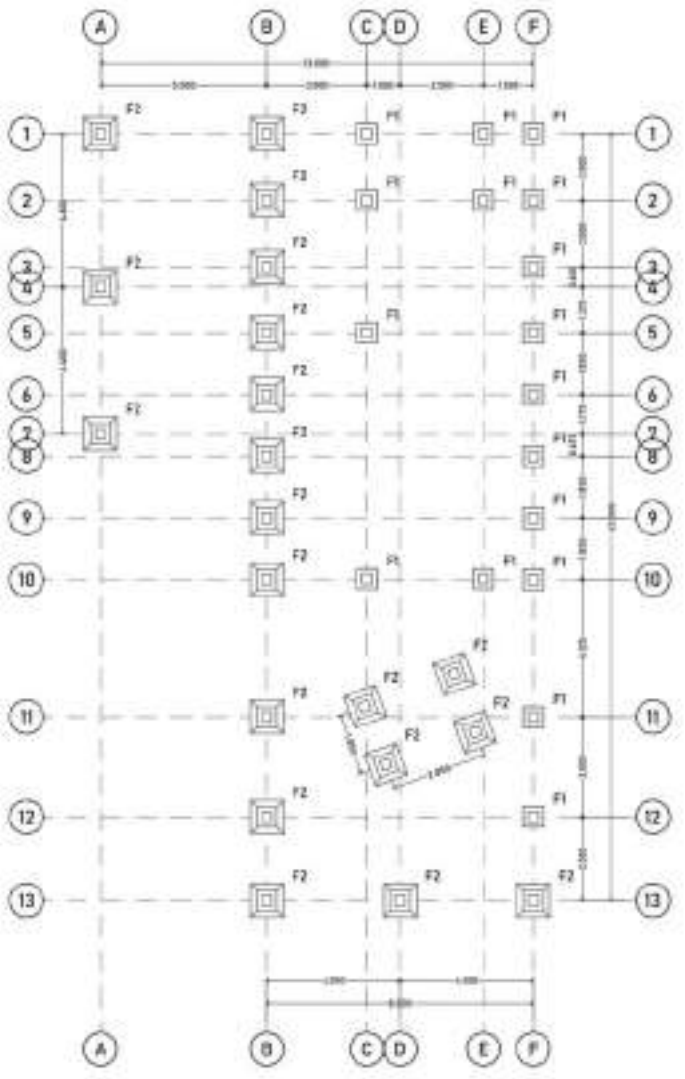
Female/Male Housing Unit A Foundation Plan
1:100

LEGEND

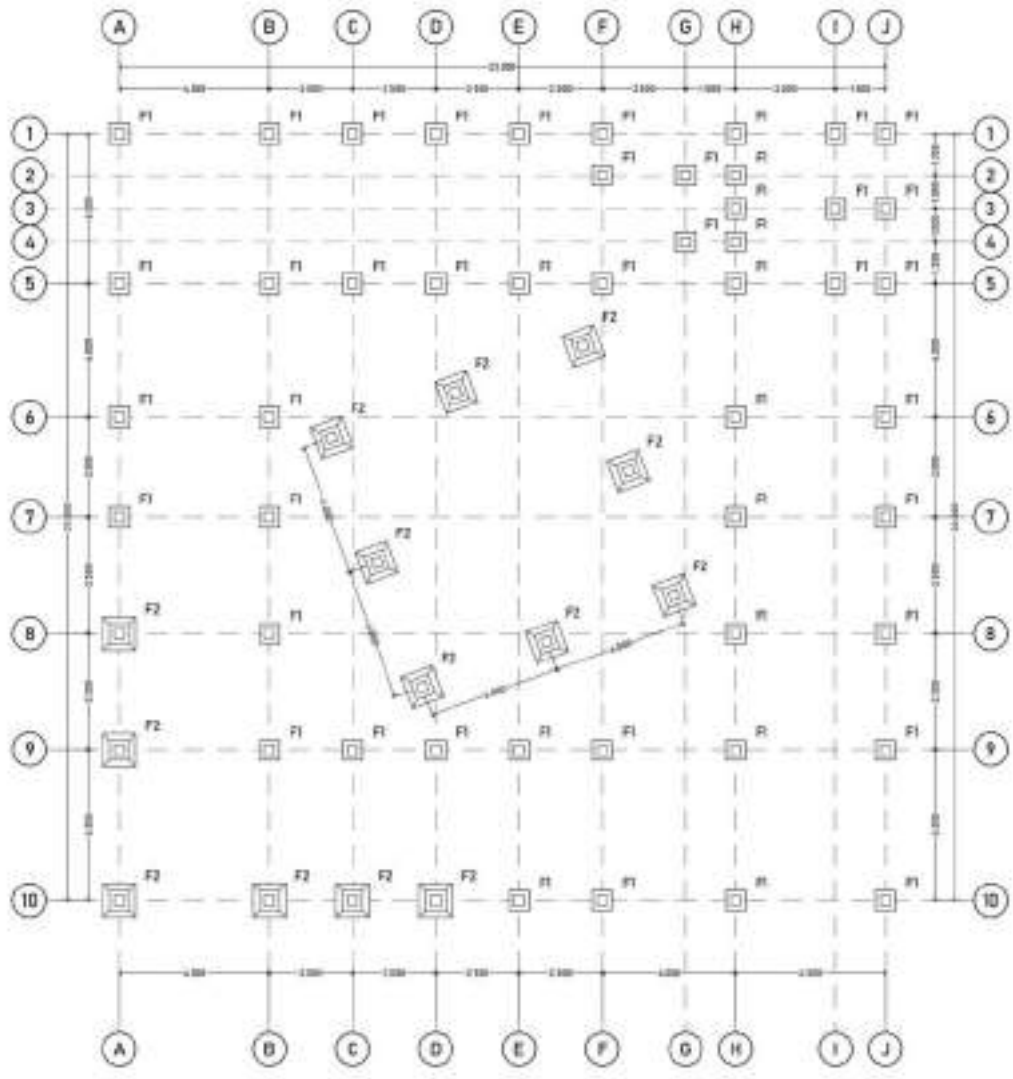
F1	RIVER STONE FOUNDATION (60x60)

The foundation plan for Zone B's housing units uses riverstone foundations, chosen for their durability, good drainage, and alignment with local building practices. Since the housing units are single-storey, this type of foundation provides stable support while remaining simple and efficient to build. Using riverstone also helps the buildings blend naturally with the village context.

5.9.3 Zone A: Foundation Plan



Dormitory Common Area Foundation Plan
1:120



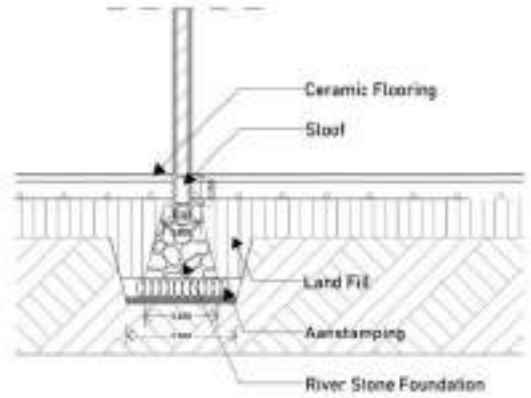
Dormitory Foundation Plan
1:120

LEGEND

F1	RIVER STONE FOUNDATION (60x60)
F2	FOOTPLATE FOUNDATION (80x80)

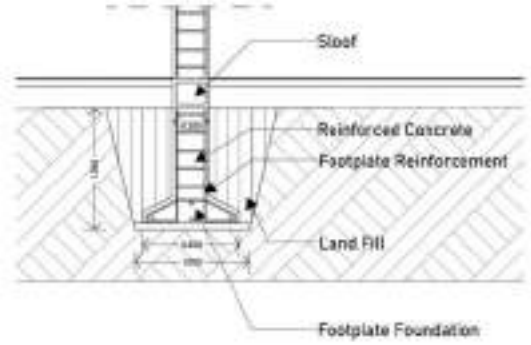
5.9.4 Foundation Detailed

Most of the buildings use a riverstone foundation, which provides stable support, good drainage, and matches the local construction context. However, in areas where the structural load is heavier, specifically at the main columns that support the wide-span and higher roof structure, a footplate foundation is used instead. This type of foundation offers a larger bearing area and stronger load distribution, ensuring the roof structure remains stable and secure.

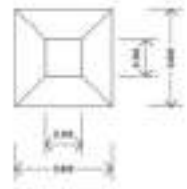


Foundation 01 Detailed Section
1:25

Foundation 01 Detailed Floor Plan
1:25



Foundation 02 Detailed Section
1:25



Foundation 02 Detailed Floor Plan
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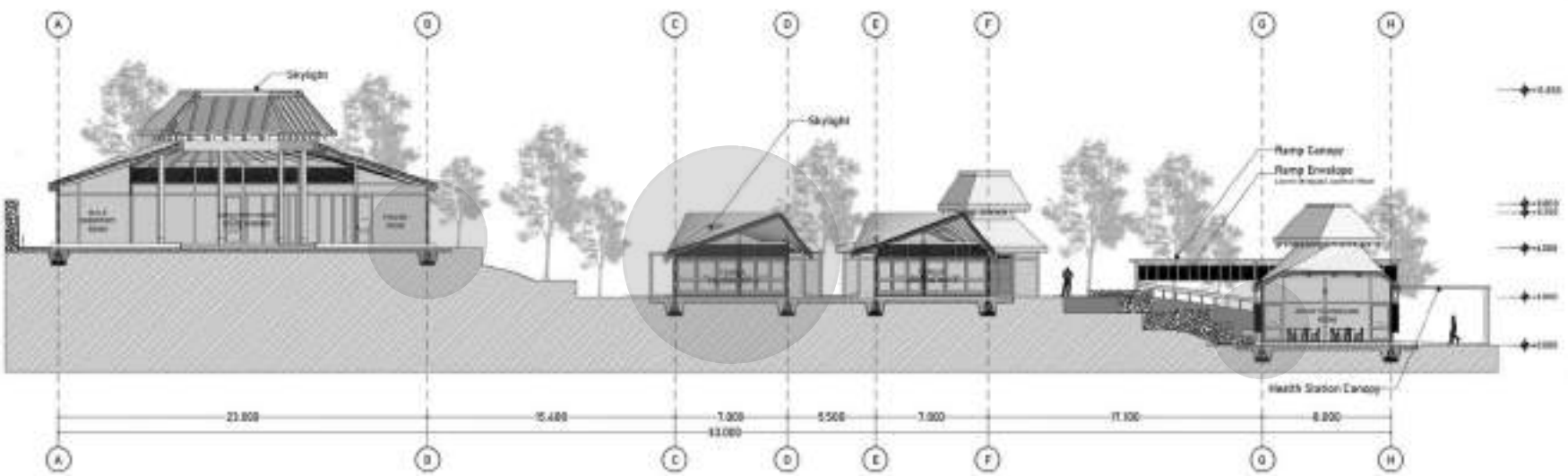
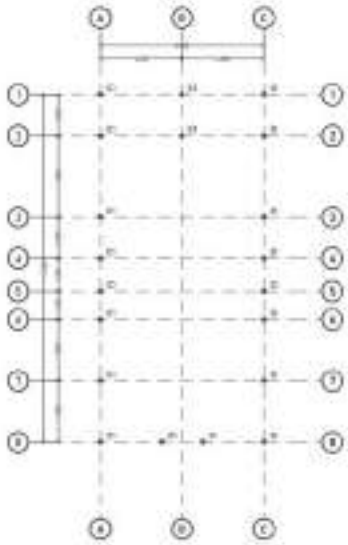
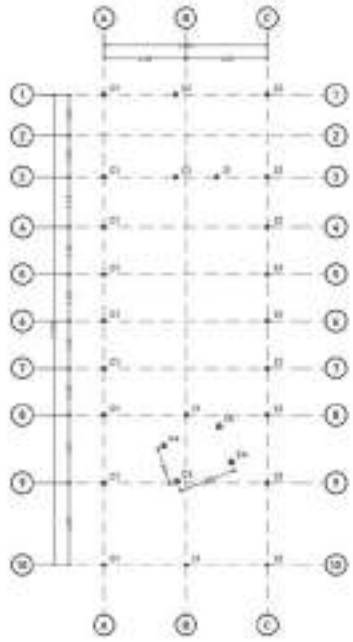


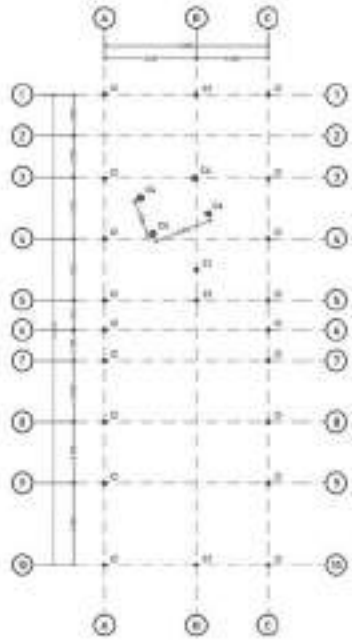
5.9.5 Zone C: Column Plan



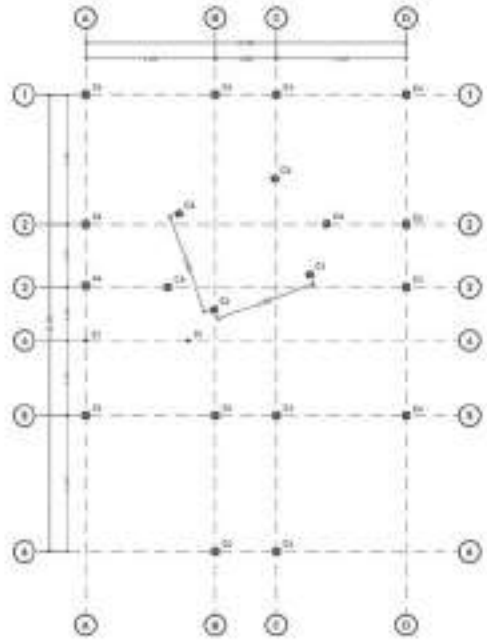
Multipurpose Hall Column Plan
1:200



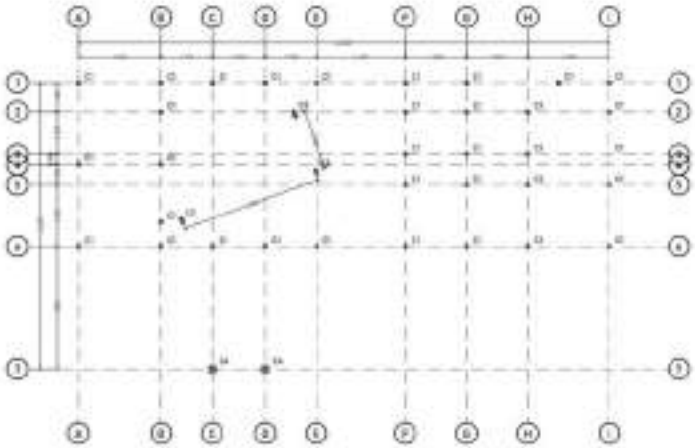
Workshop Studio Column Plan
1:200



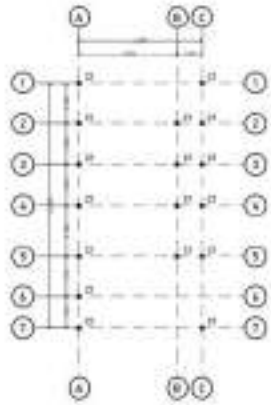
Community Kitchen Column Plan
1:200



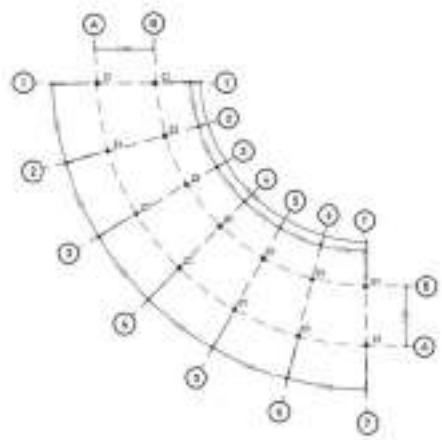
Lobby Column Plan
1:200



Health Station Column Plan
1:200



Staff & Security Office Column Plan
1:200

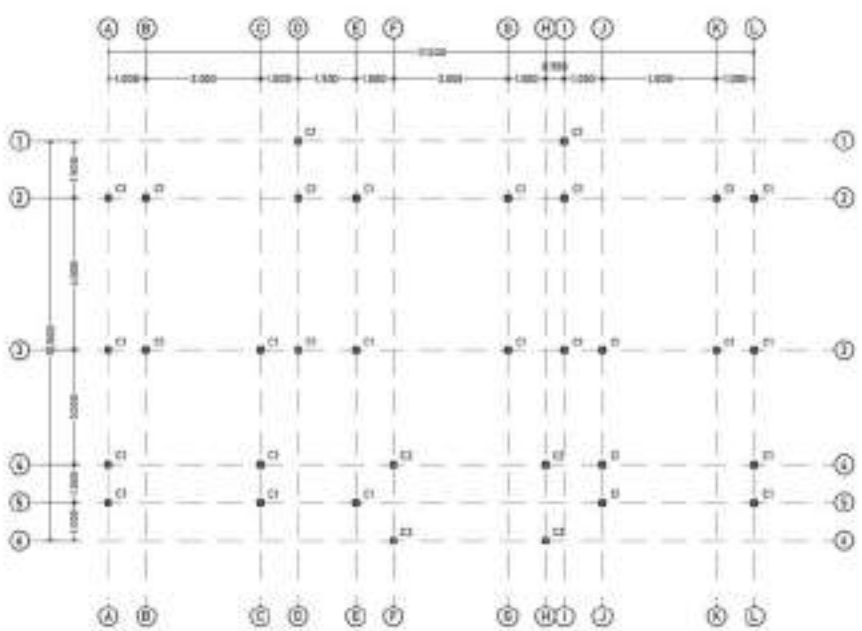


Multipurpose Hall Column Plan
1:200

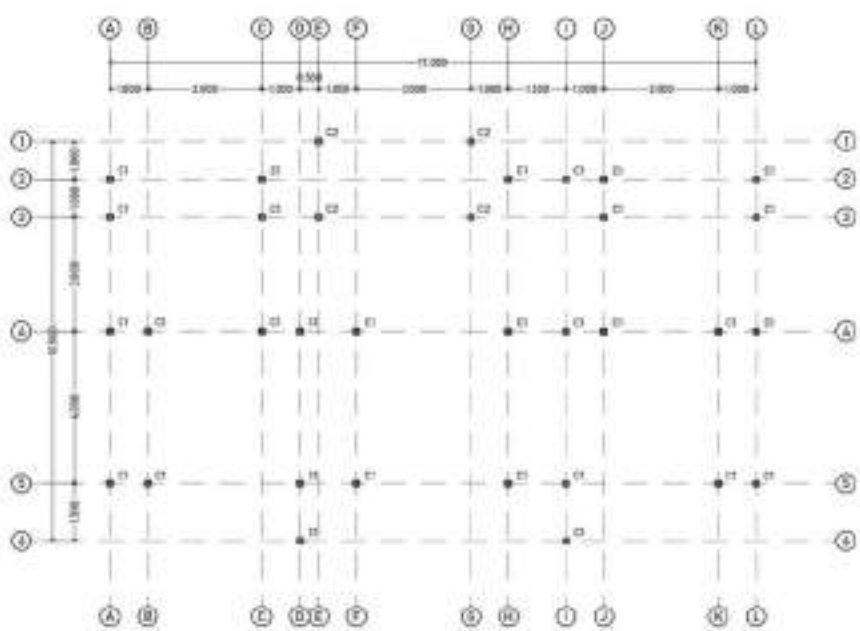
LEGEND

C1	SOLID WOOD COLUMN (15x15)
C2	CONCRETE COLUMN (15x15)
C3	SOLID WOOD COLUMN (15x30)
C4	SOLID WOOD COLUMN (30x30)

5.9.6 Zone B: Column Plan



Female/Male Housing Unit B Column Plan
1:100

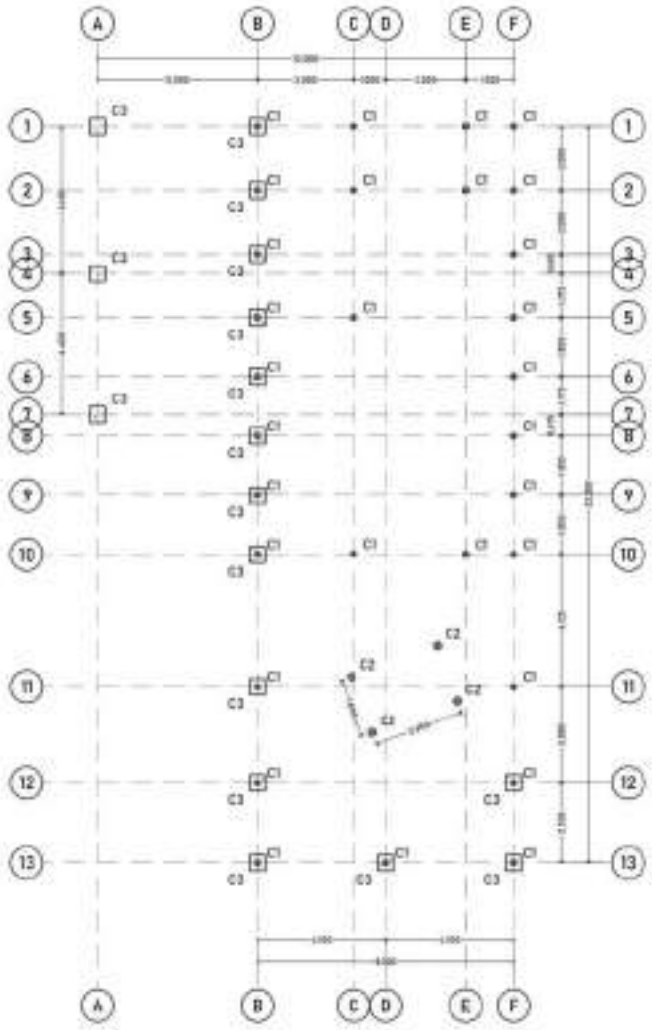


Female/Male Housing Unit A Column Plan
1:100

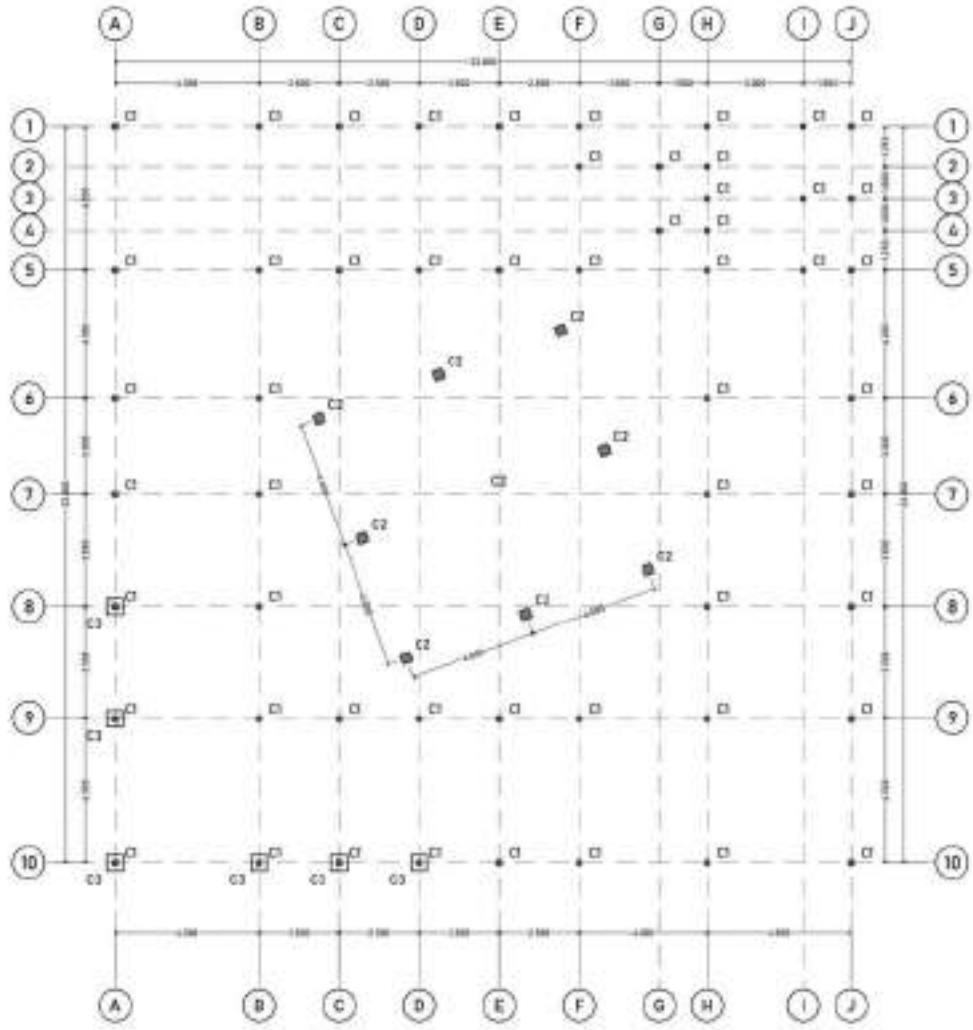
LEGEND

C1	SOLID WOOD COLUMN (15x15)
C2	CONCRETE COLUMN (15x15)

5.9.7 Zone A: Column Plan



Dormitory Common Area Column Plan
1:120

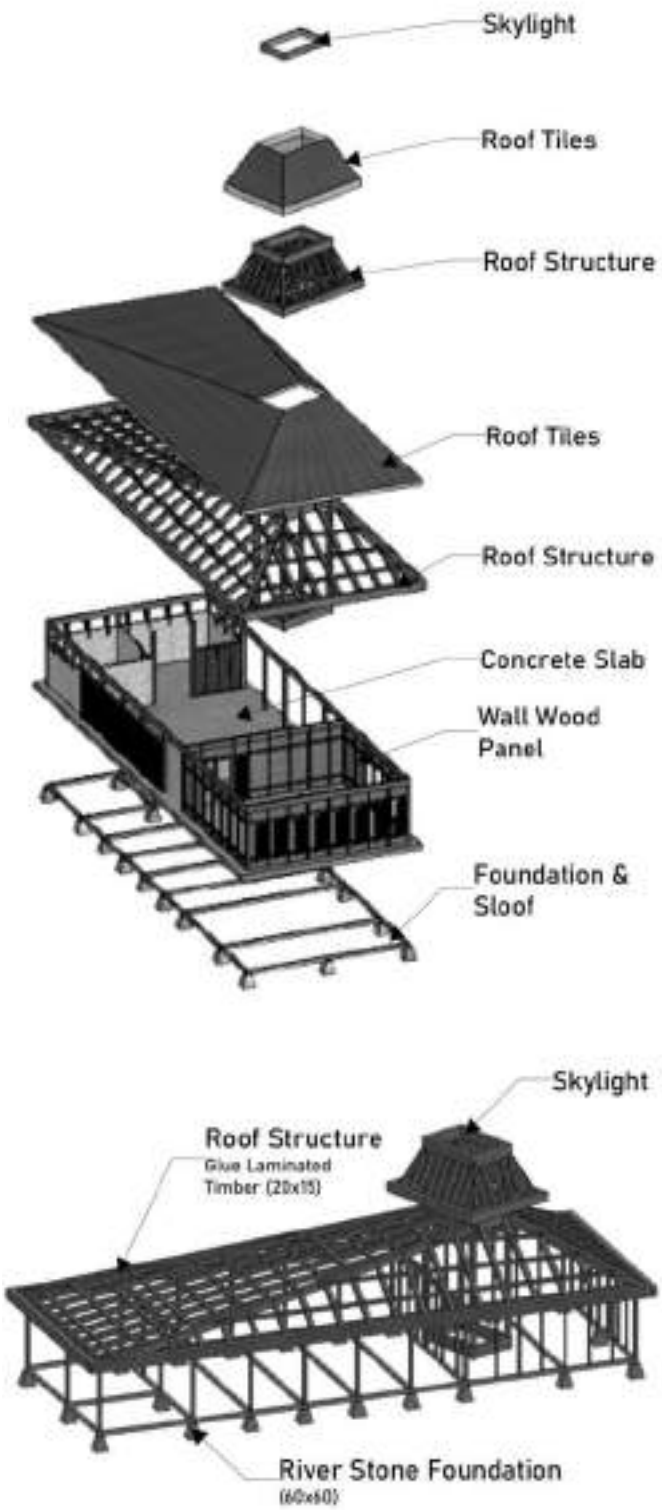


Dormitory Column Plan
1:120

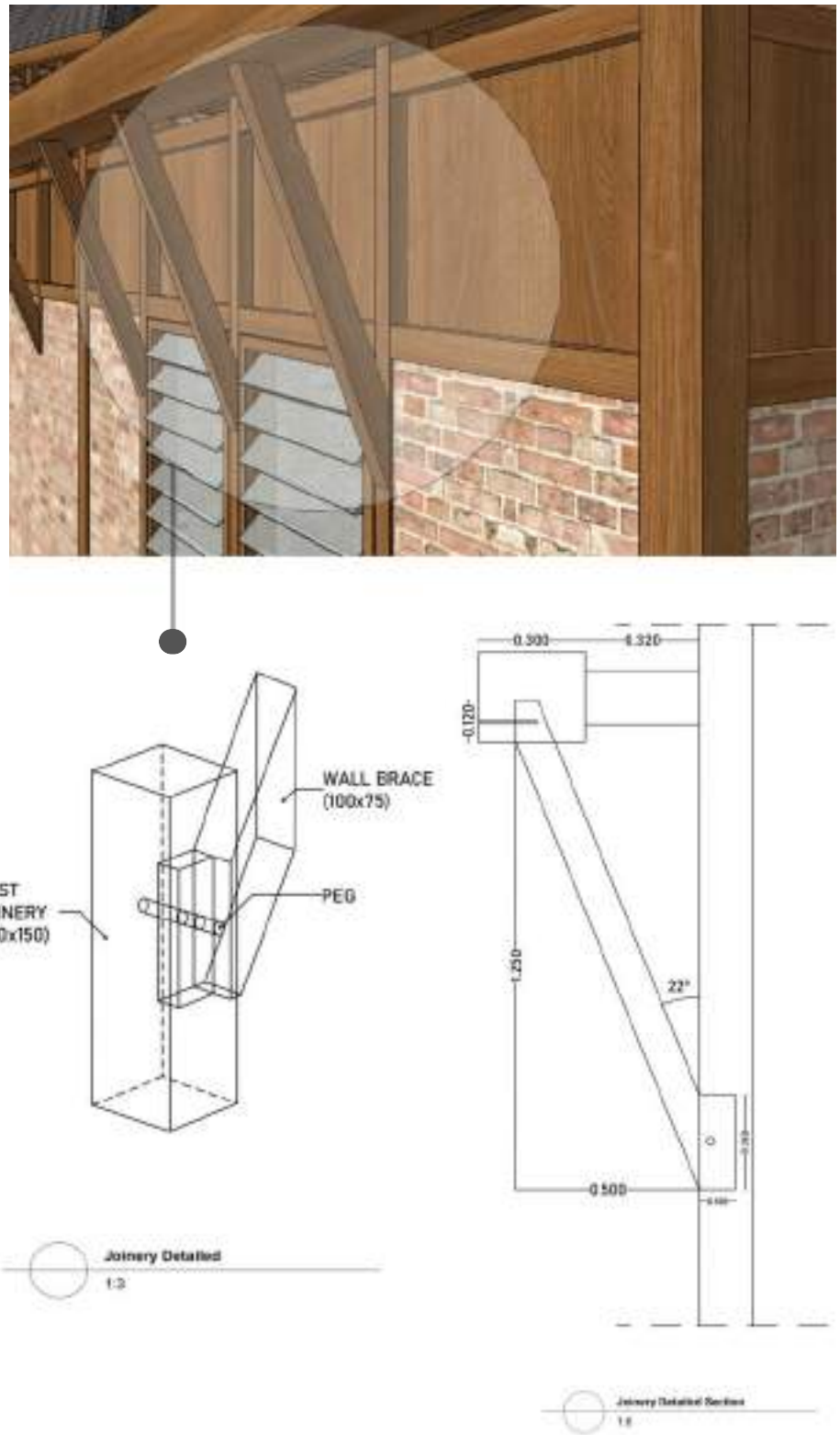
LEGEND

C1	SOLID WOOD COLUMN (15x15)
C2	SOLID WOOD COLUMN (30x30)
C3	CONCRETE COLUMN (50x50)

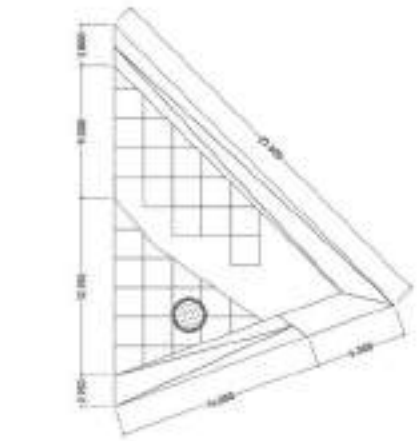
5.10.1 Building Axonometry & Exploded



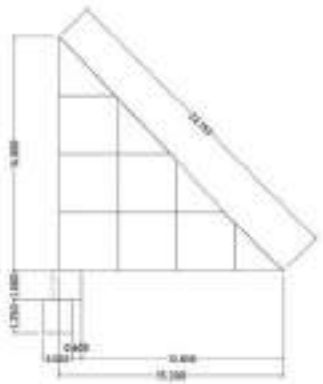
5.10.2 Joinery Detailed



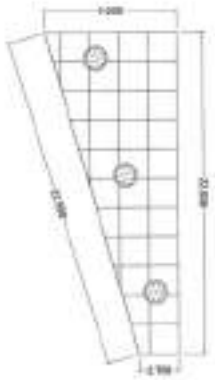
5.10.3 Landscaping Detailed



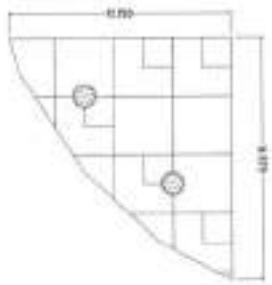
Landscaping 01 Plan
1:200



Landscaping 02 Plan
1:200



Landscaping 03 Plan
1:200



Landscaping 04 Plan
1:200

Landscaping 01 Elevation
1:200

Landscaping 02 Elevation
1:200

Landscaping 03 Elevation
1:200

Landscaping 04 Elevation
1:200

Landscaping 01 Axonometry
1:200

Landscaping 02 Axonometry
1:200

Landscaping 03 Axonometry
1:200

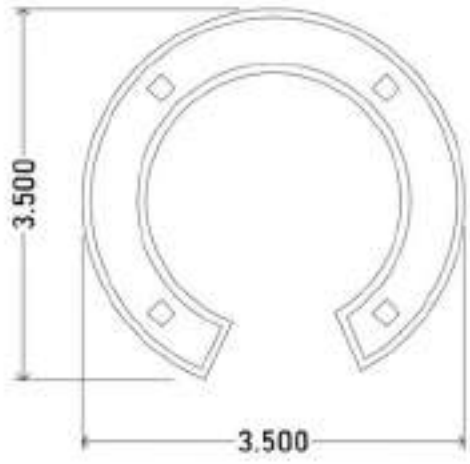
Landscaping 04 Axonometry
1:200

The landscaping is designed as a series of social nodes placed strategically throughout the site to support interaction, transition, and daily community activity. Two of these nodes are located at the outer edges of the site, acting as gentle transitional spaces between the rehabilitation center and the surrounding village. These areas help patients gradually reconnect with the community while providing villagers with a welcoming entry point into the facility. The other two nodes are positioned in the central part of the site, serving as shared outdoor gathering spaces for patients, staff, and visitors. Each node integrates seating, shade, and soft landscaping to create comfortable spots for resting, casual conversations, or small activities. Together, these landscaped nodes form a network of informal social spaces that encourage movement, social engagement, and a sense of openness across the rehabilitation center.

5.10.4 Mini TOGA Garden Detailed

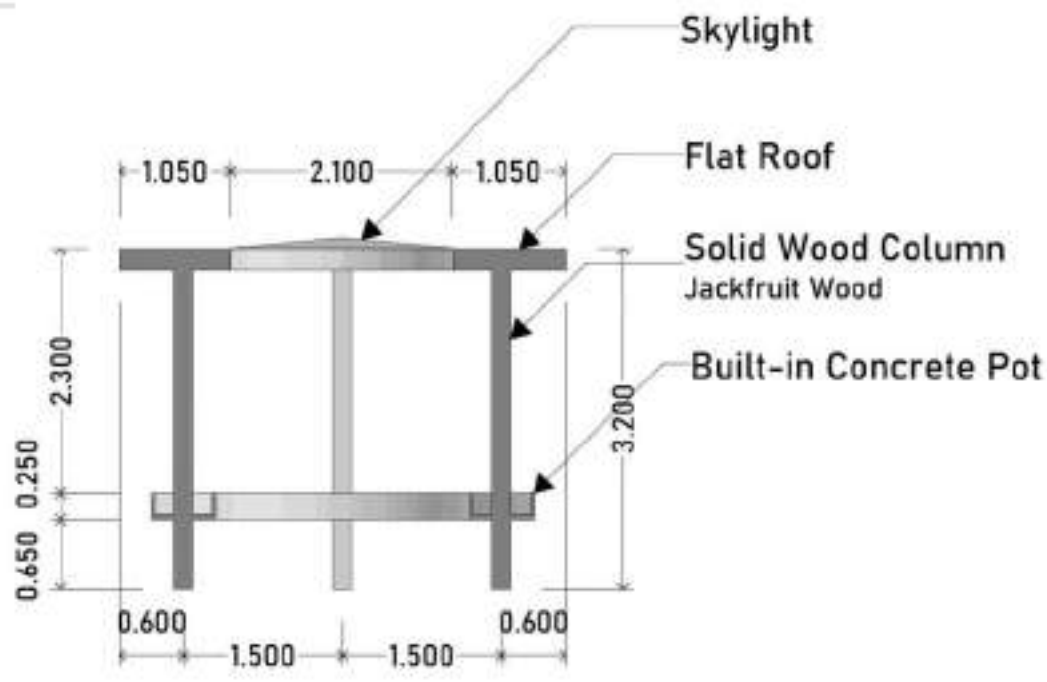
Mini TOGA Garden Pavilion Axonometry

1:40



Mini TOGA Garden Pavilion Plan

1:40

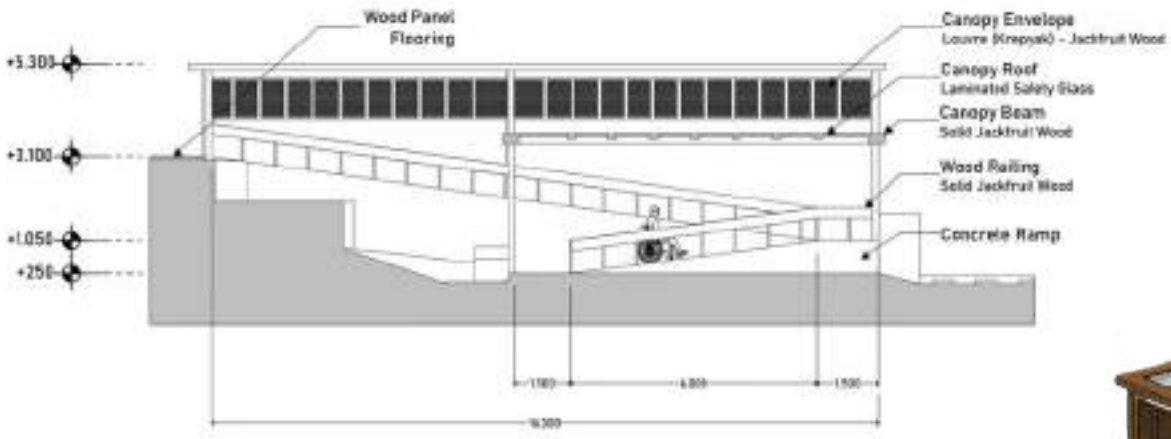


Mini TOGA Garden Pavilion Section

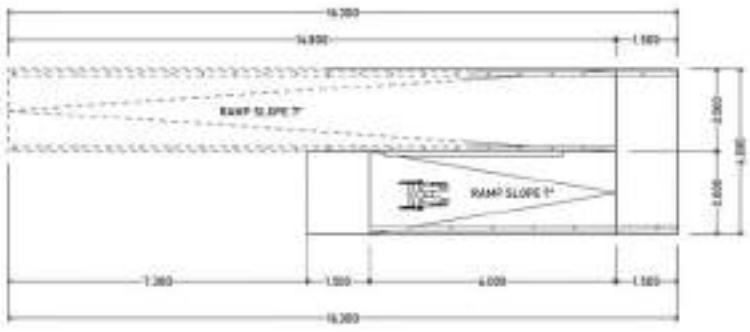
1:40

The mini TOGA (Tanaman Obat Keluarga) pavilion serves as a small outdoor facility dedicated to growing traditional medicinal plants, offering both therapeutic and educational value for patients and visitors. As an accessible garden space, it allows patients to engage in light activities such as planting, watering, and learning about herbal remedies commonly used in village life. The pavilion provides shade and seating, making it a comfortable place for informal gatherings, discussions, or quiet reflection.

5.10.5 Ramp Detailed



Ramp 01 Detailed Section
1:100



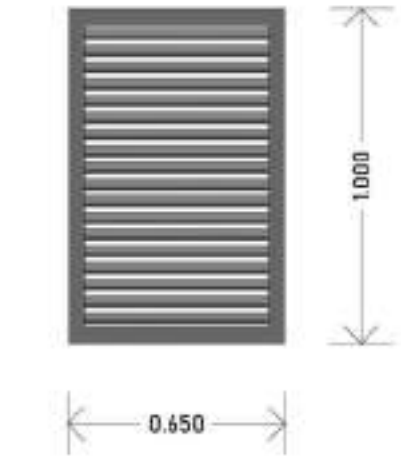
Ramp 01 Detailed Floor Plan
1:100

Ramp 01 Axonometry
1:100

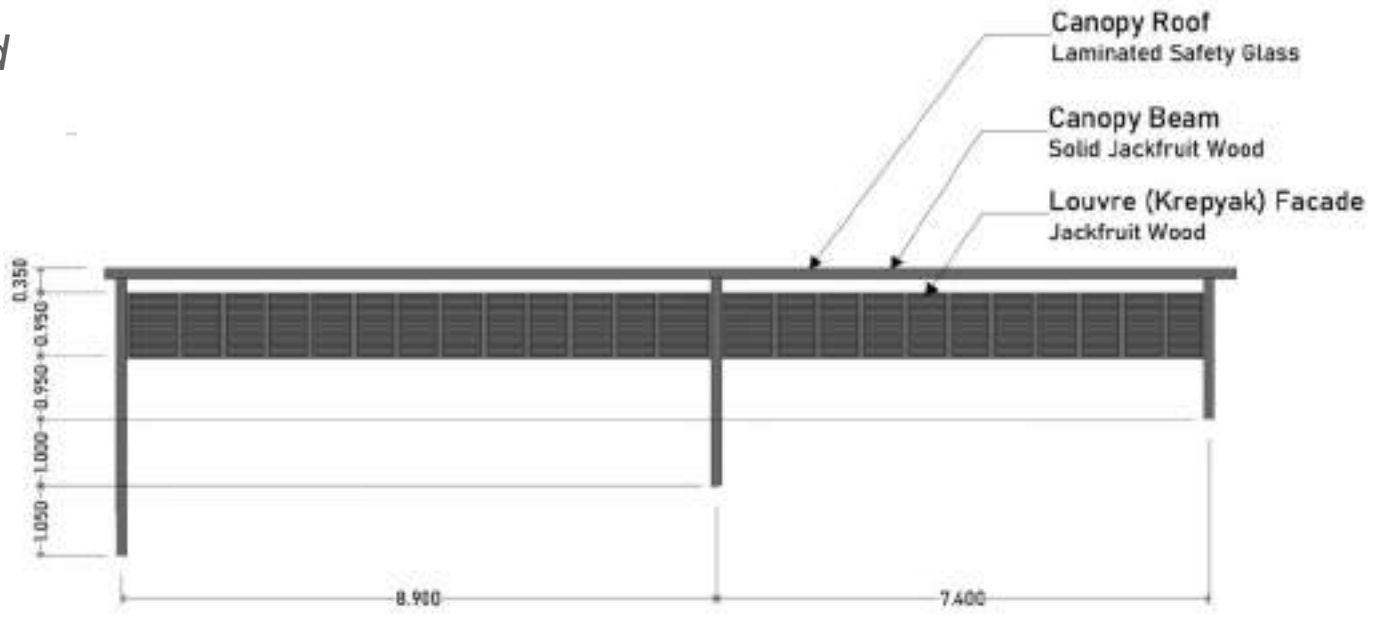
The ramp beside the health station is designed to provide safe and accessible circulation, especially for patients arriving through the ambulance parking area. With a gentle 7-degree slope, it ensures comfortable movement for wheelchairs, stretchers, and individuals with limited mobility. Positioned directly next to the health station, the ramp supports smooth transitions from emergency access into the main treatment spaces.

Figure. Exterior View of Health Station with Parking Space

5.10.6 Envelope Detailed

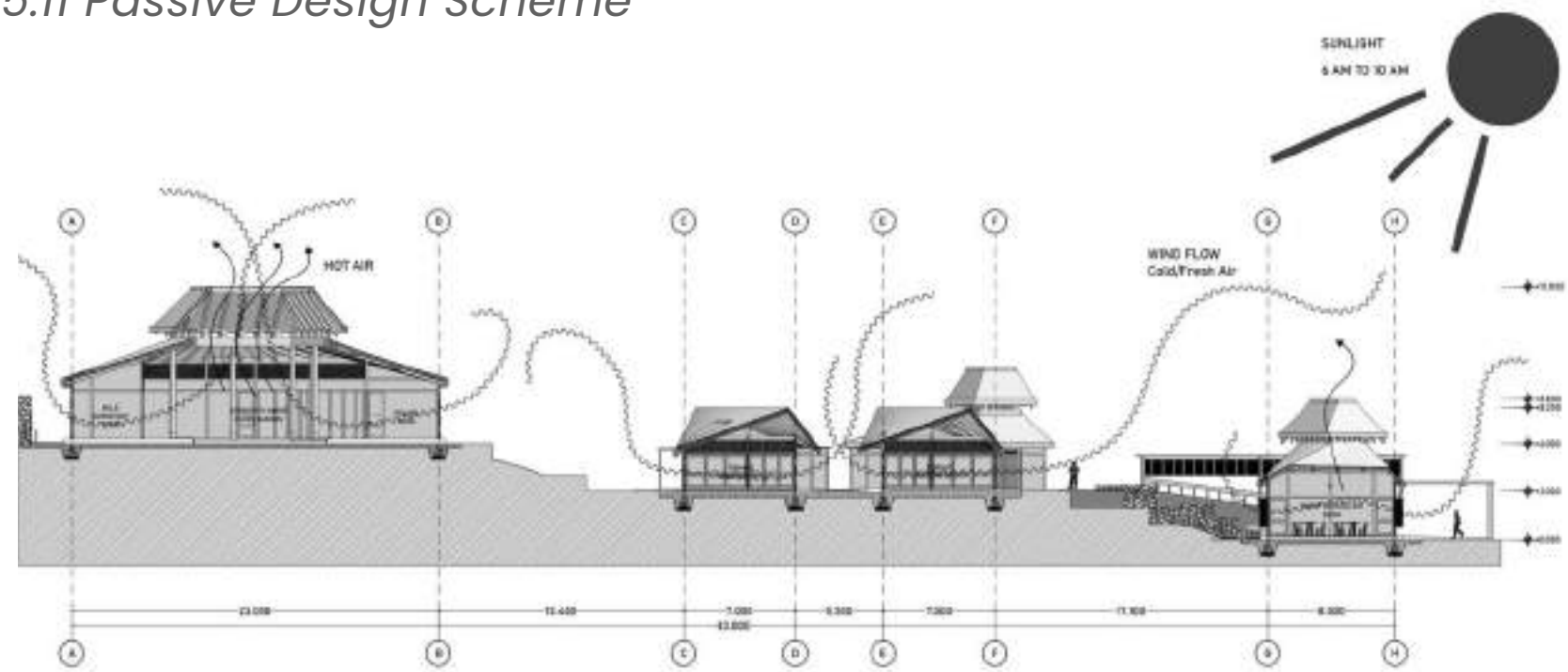


Envelope Detailed Elevation
1:10

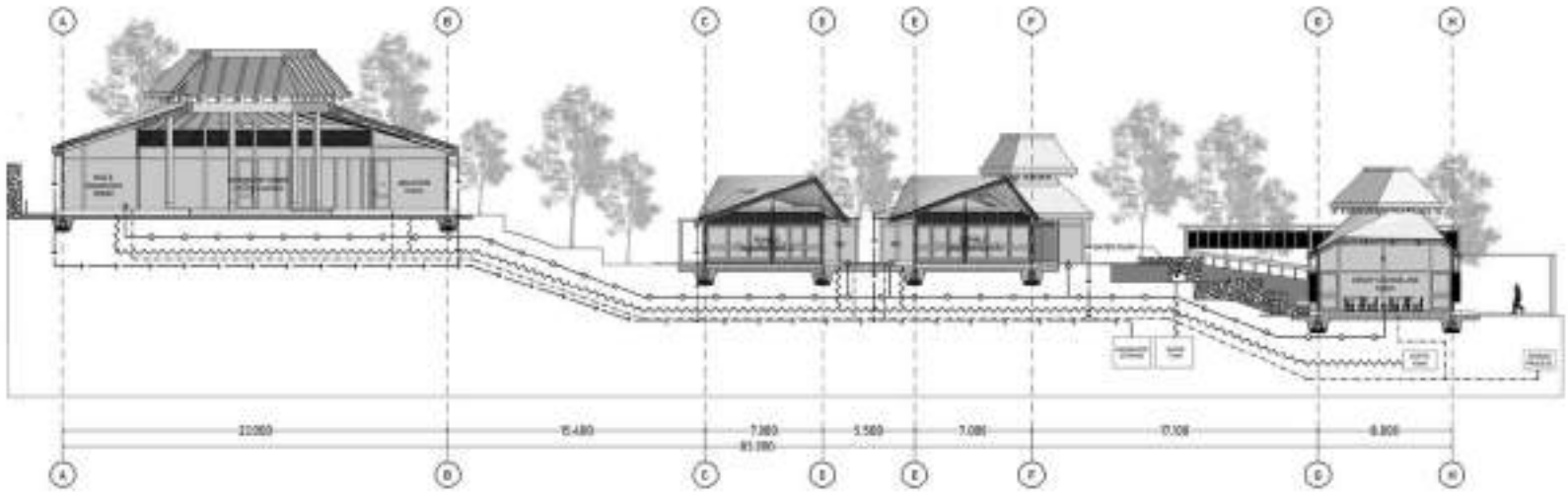


Building Envelope Elevation
1:50

5.11 Passive Design Scheme

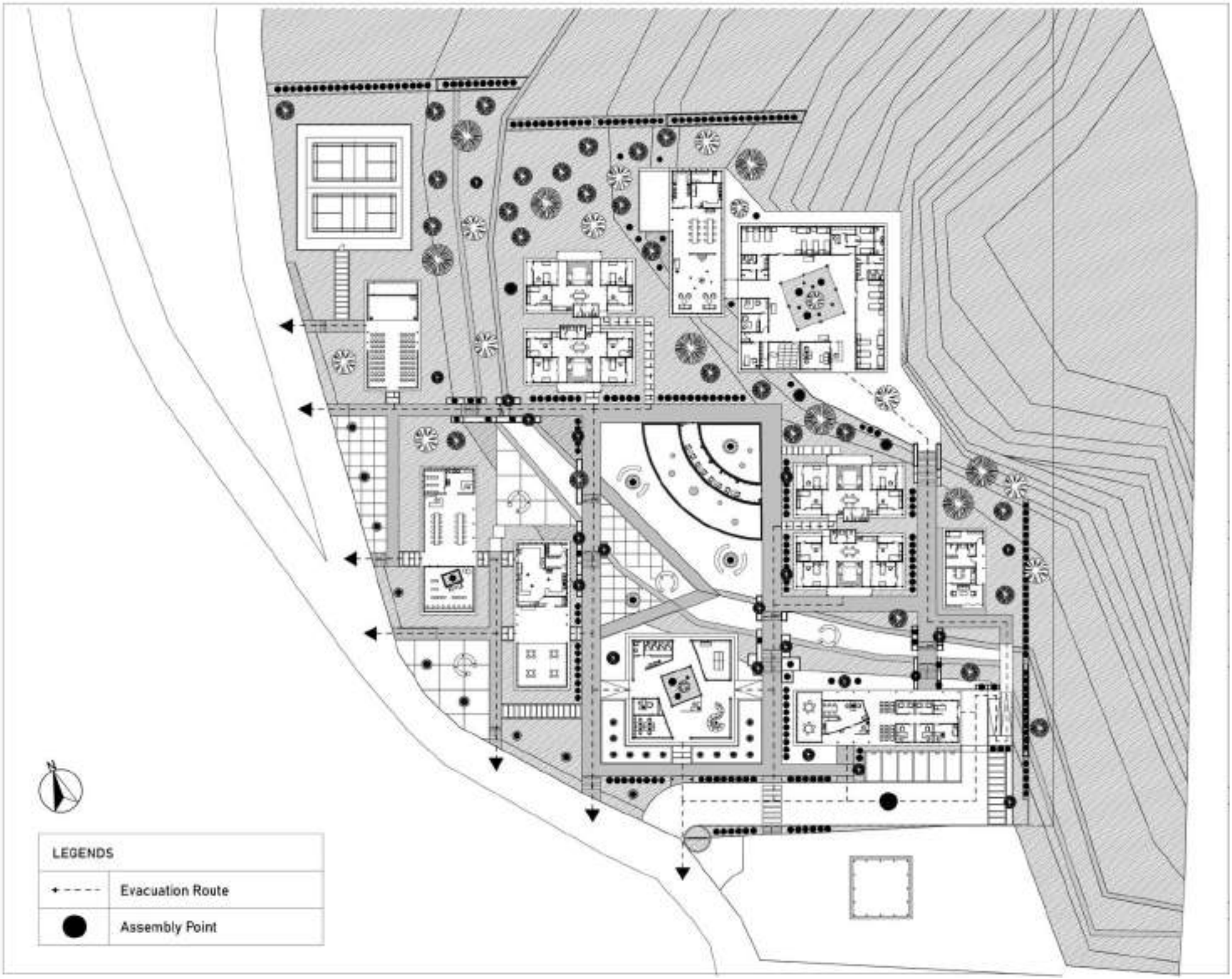


5.12 Water Infrastructure Scheme

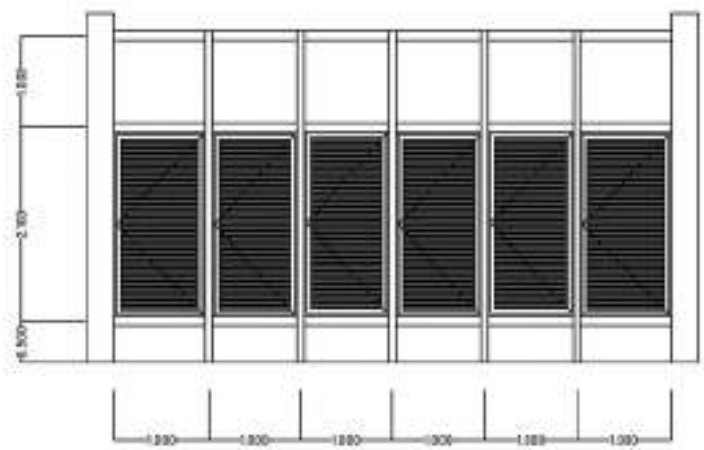


LEGENDS	
——o——o——	Clean Water Scheme
- - - - - -	Gray Water Scheme
~~	Black Water Scheme
——→——→—	Rain Water Collections Scheme

5.13 Emergency Evacuation Scheme

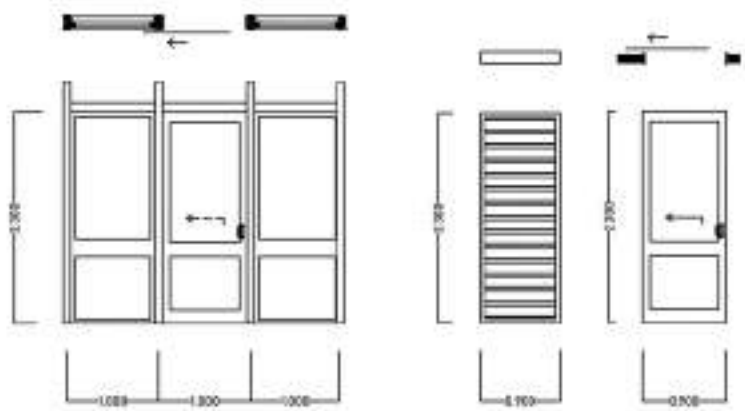


5.14 Detailed Door & Window



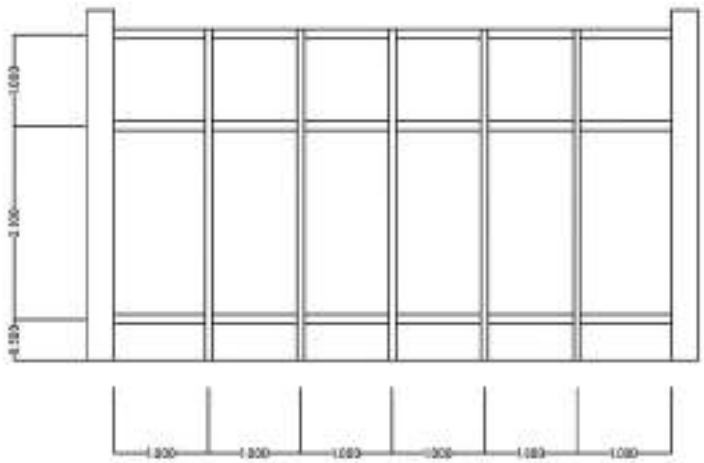
Wall Wood Panel & Louvre Detailed Elevation

1:50



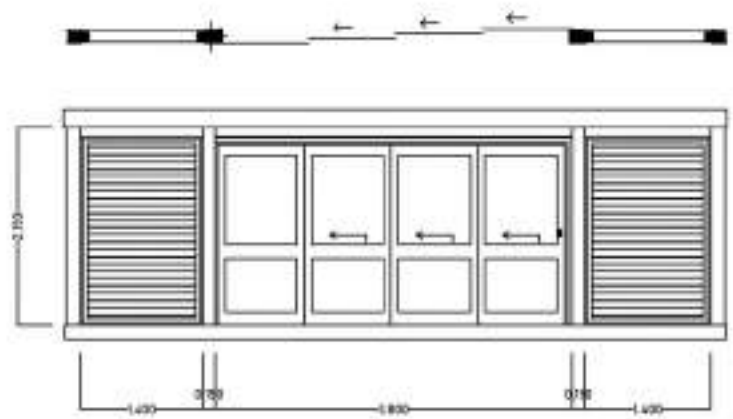
Door & Window Detailed Plan & Elevation

1:50



Wall Wood Panel Detailed Elevation

1:50



Door & Window Detailed Plan & Elevation

1:50

6 Reflection & Evaluations

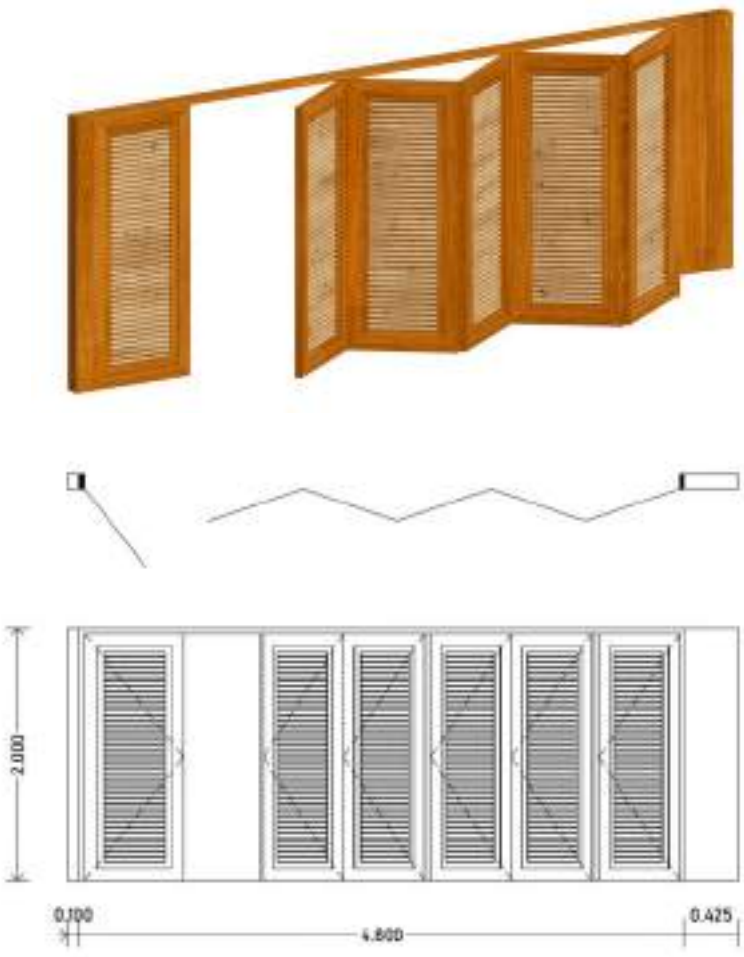
Evaluations

It is necessary to separate the laundry drying areas for male and female due to privacy reason.

1st Examiner: Dr.-Ing. Putu Ayu Pramanasari A., S.T., M.A.

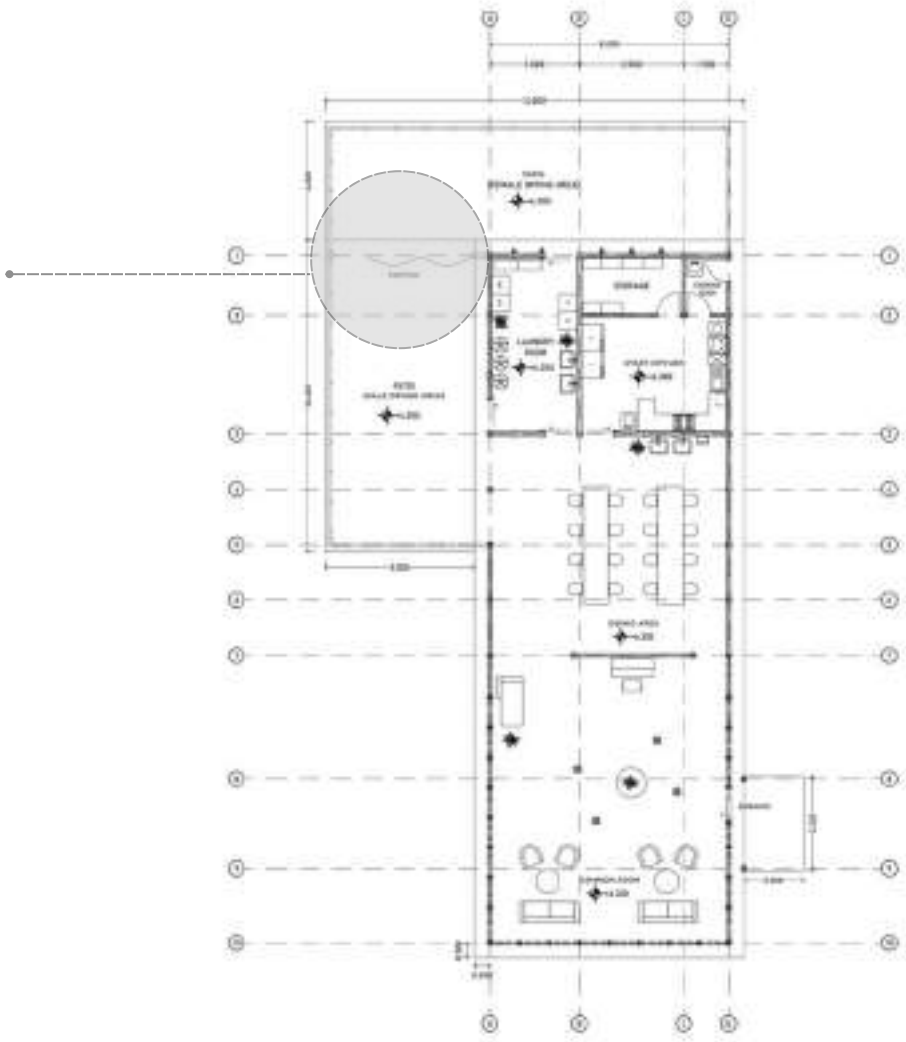
The notes highlighted the need to separate the male and female laundry drying areas to maintain privacy. This issue has already been resolved by **adding a new patio** on the upper side of the existing one, effectively **creating two distinct drying zones**. A **louvered partition**, designed to open and close as needed, now divides the areas to ensure visual privacy. Additionally, the female drying area has been given direct access through the laundry room, further strengthening the privacy and functionality of the layout.

Detailed Partition



Wall Wood Panel & Louvre Detailed Elevation
1:50

Revised Floor Plan



Dormitory Common Area Floor Plan
1:100

Figure. View of Female Drying Area

A newly added upper patio forms the **dedicated female drying area**, directly accessible from the laundry room for convenience and privacy. The space is enclosed with adjustable **louver partitions**, allowing light and airflow while preventing visibility from the male area. This quiet, sheltered corner ensures that women can dry their clothes comfortably without exposure to the public or the male area.

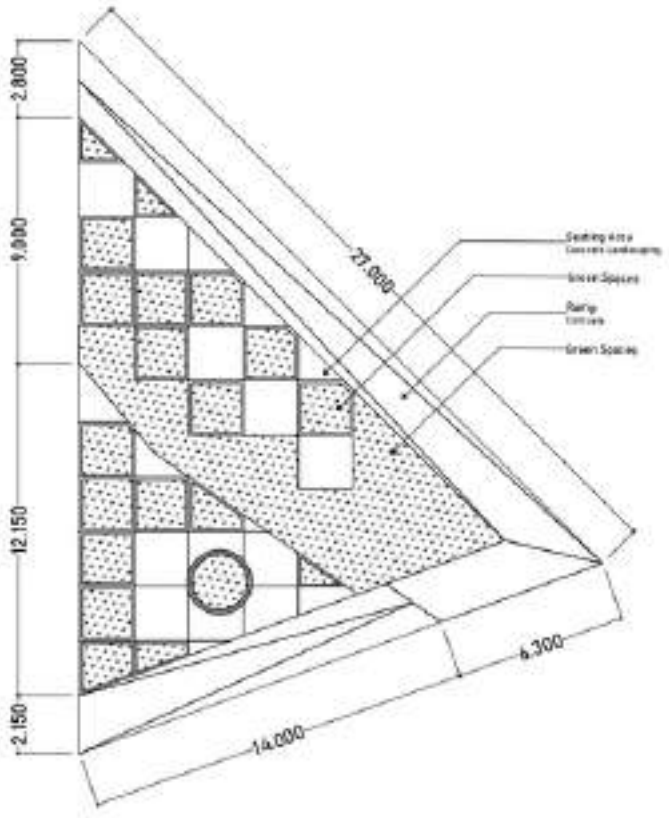
Figure. View of Male Drying Area

The existing patio now functions as the **male drying area**, positioned on the opposite side of the new louver partition. The open, airy setting maintains natural ventilation while the partition provides full visual separation from the female zone. This layout keeps the drying activity organized and **respectful of privacy needs between both groups.**

Design has evolved more maturely. However, there are some deficiencies, especially in managing nature as part of design strategies and stated in as one of the design problem.

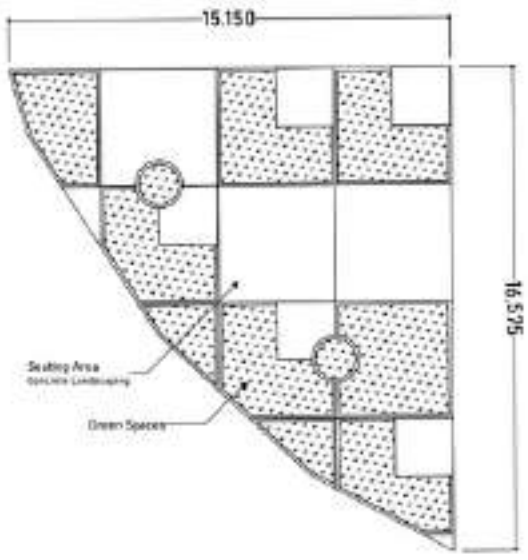
2nd Examiner: Prof. Dr.-Ing. Ir. Ar. Ilya Fadjar Maharika, MA., IAI.

1.The landscaping and social node area feel dominated by concrete and lack natural green elements.



Landscaping 01 Plan

1:200



Landscaping 04 Plan

1:200

In response to this notes, the landscaping has been revised to introduce more natural elements and reduce the dominance of concrete. Several **concrete block** areas have been **replaced with green spaces**, including grass surfaces and added vegetation to create a softer, more natural environment. However, some portions of the concrete blocks are intentionally retained because they serve an important function as **seating areas** and gathering points. Some grass blocks also replaced by natural grass to create more natural element to the space. This approach maintains usability while significantly improving the overall natural quality of the social nodes, making the space more comfortable and contextually integrated.

Figure. View of Landscaping 04

The redesigned social node replaces wide concrete paving with soft green grass and layered vegetation, creating a more natural and calming environment. Some concrete blocks are intentionally preserved to retain their function as seating and gathering spots.

Figure. View of Landscaping 01

2.Why didn't you fully utilize the natural slope of the land contour?

The decision to not fully follow the natural slope was based on the need to create flatter, **more habitable spaces that support accessibility and functional use**. The existing terrain is quite steep, and building directly on it would result in uneven floor levels and circulation challenges, especially for programs that require stability and controlled environments. To address this, the design uses a cantilever retaining wall system connected to a slab foundation. This system is structurally reliable for holding back significant soil loads, with the backfill weight helping stabilize the wall against overturning and sliding. By implementing this approach, the design achieves safe, level platforms while maintaining structural integrity, making the reasoning both logical and appropriate for the project's requirements.

Figure. Retaining walls technical guidance (2014)

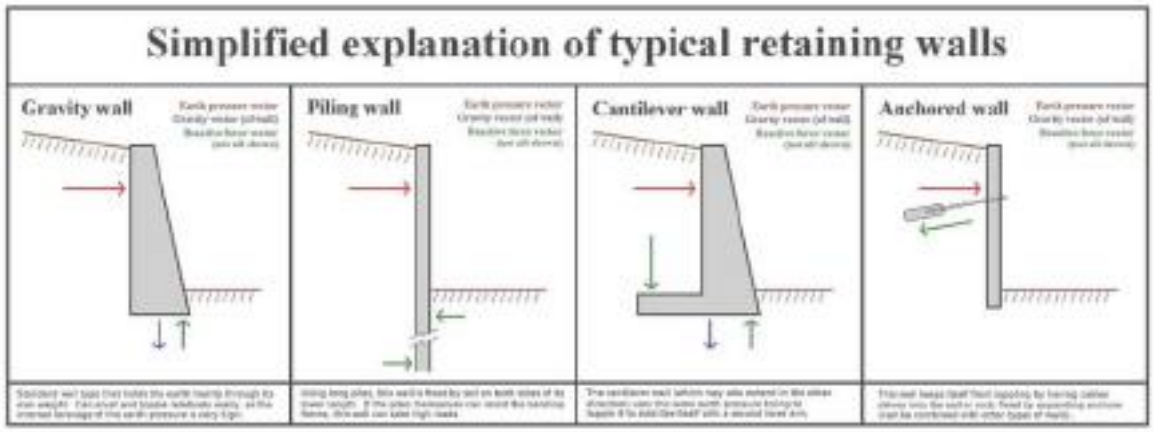
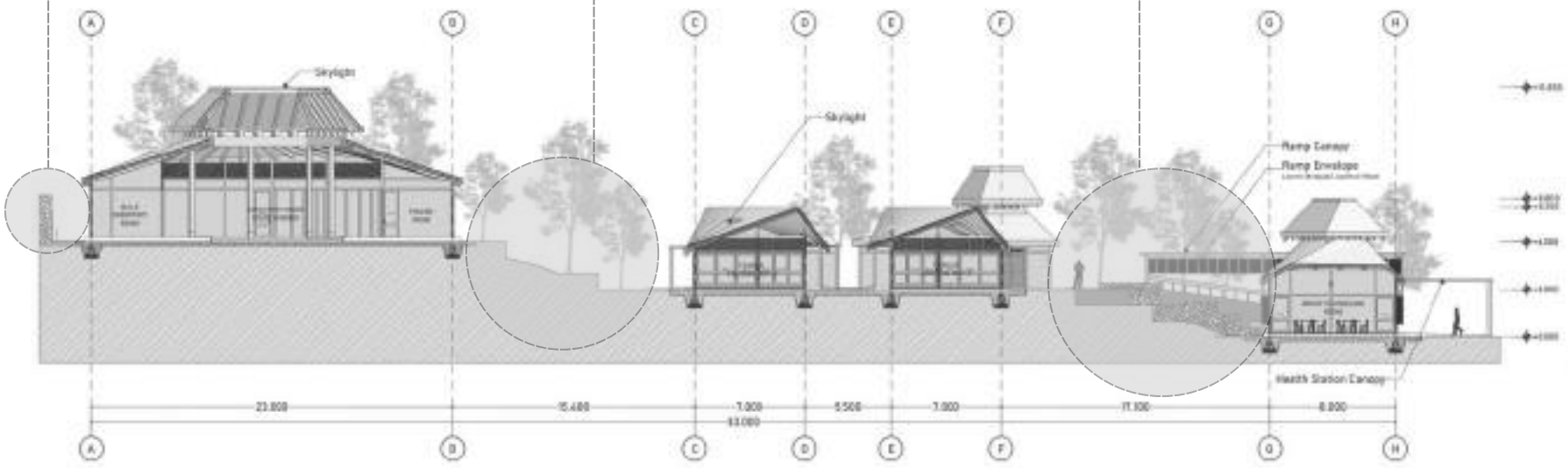


Figure. Render of retaining wall



Section

SADA Response

Notes from 1st Examiner: Dr.-Ing. Putu Ayu Pramanasari A., S.T., M.A.

Stage	Assessment Criteria	Examiner Notes	SADA Response	Revised Part
Design Brief	Form & Space (Abstraction and early concepts expressed artistically, innovatively, creatively)	Create a clinic integrated with the community, create the connectivity of the clinic to the houses in the village.	The design fully integrates the clinic within the village context by creating walkable community paths and placed the building in the front part of the area, to create spatial connections that reflect daily village life. This ensures seamless interaction between the clinic and nearby houses.	Pg. 52
	Cultural & Behavioral Approach	Explore the local community approach in treating the patients and use it in your design.	Local community practices have been incorporated into the healing process through shared spaces, communal activities, and programmatic integration with village routines. These elements reinforce the culturally grounded rehabilitation model.	Pg. 59
Design Comprehensive	Form & Space	A good design, well thought out for all users, maximizing the site potentials.	The design maximizes site potentials by responding to contours, preserving natural features, and ensuring user comfort through intuitive circulation and program zoning. User needs across all groups are accommodated.	Pg. 145-149
	Descriptive Evaluation	The landscape design must help maintain the safety of users and be part of the therapy for patients.	The landscape has been developed with safety-oriented features such as clear visibility, barrier-free access, and disabled ramps. Therapeutic planting, shaded nodes, and gardens activities reinforce healing through daily outdoor interaction.	
Design Development	Descriptive Evaluation	The student needs to separate the drying rooms between male and female.	The drying rooms have been revised, with male and female areas now fully separated to ensure privacy, cultural appropriateness, and operational clarity.	Pg. 157

Notes from 2nd Examiner: Prof. Dr.-Ing. Ir. Ar. Ilya Fadjar Maharika, MA., IAI.

Stage	Assessment Criteria	Examiner Notes	SADA Response	Revised Part
Design Brief	Form & Space (Artistic, innovative, creative abstraction)	The brief is interesting as it tries to reconcile the contradiction between asylum-type and community-based treatment. However, she needs deeper understanding of the site context.	A deeper site study has been completed, including environmental analysis, community mapping, and observation of existing social patterns. This strengthened the project's contextual grounding.	Pg. 50
	Cultural & Behavioral Approach	This community-based treatment is good but must be combined with the hospital/clinic component as an integral design proposal.	Clinical facilities have been integrated as a core part of the program, ensuring professional care supports the community-based system. The design balances medical functions with social and cultural engagement.	Pg. 67
Design Comprehensive	Form & Space	The design already shows the intended function, purpose, and context.	The design continues to reflect the intended therapeutic purpose and fits naturally within its rural context, with coherent zoning and a clear spatial narrative.	Pg. 105-112
	Descriptive Evaluation	1. Show constructability in detail. 2. Show site engineering in detail.	Constructability has been demonstrated through detailed structural drawings, foundation specifications, roofing systems, and material joints. Site engineering including contour treatment and retaining systems has been fully illustrated.	
Design Development	Descriptive Evaluation	The design has matured, but lacks management of nature as part of the design strategy.	Nature-based strategies have been strengthened by redesigning the social nodes and landscaping from predominantly concrete surfaces into greener, softer environments. More vegetation, shaded areas, and permeable natural materials have been introduced to enhance comfort, ecological performance, and therapeutic value.	Pg. 159

Reflection

Throughout the development of **Kampoeng Pulih**, the author realized that not every design challenge requires a modern or highly technical solution. Working within Desa Petir revealed that many answers already exist within the rhythms of the village itself which its **social habits, communal values, and long-standing relationship with nature & culture**. The author learned that healing environments do not always need advanced technologies or institutional aesthetics. They often benefit more from simplicity, familiarity, and cultural grounding.

This project became an exploration of **how traditional spaces, local materials, and natural landscapes can function as therapeutic elements.** Village courtyards, shaded verandas, and communal gardens proved capable of supporting psychosocial recovery in ways that rigid hospital typologies cannot. By embracing these local patterns, the author discovered that architecture can reduce stigma not through grand gestures, but through the quiet reinforcement of belonging.

Kampoeng Pulih allowed the author to reassess assumptions about what “progress” in design means. The process highlighted that **innovation can emerge from reinterpreting tradition, strengthening community bonds**, and letting the natural environment take an active role in care. For the author, the project reaffirmed that meaningful architecture grows from empathy, context, and the wisdom already present in place.

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Bismillaahirrahmaanirrahiim

Assalamualaikum Wr. Wb.

Dengan ini, menerangkan Bahwa:

Nama	: Aisyah Baswedan
Nomor Mahasiswa	: 21512053
Pembimbing	: Arif Budi Sholihah, S.T., M.Sc., Ph.D
Fakultas / Prodi	: Teknik Sipil dan Perencanaan/ Arsitektur
Judul Karya Ilmiah	: Kampoeng Pulih: Community-based Approach for Psychosocial Rehabilitation Center to Destigmatize Mental Health Disorders in Indonesia

Karya ilmiah yang bersangkutan di atas telah melalui proses cek plagiasi menggunakan **Turnitin** dengan hasil kemiripan (*similarity*) sebesar **11 (Sebelas) %.**

Demikian Surat Keterangan ini dibuat untuk dapat dipergunakan sebagaimana mestinya.

Wassalamualaikum Wr. Wb.

Yogyakarta, 11/18/2025
Direktur

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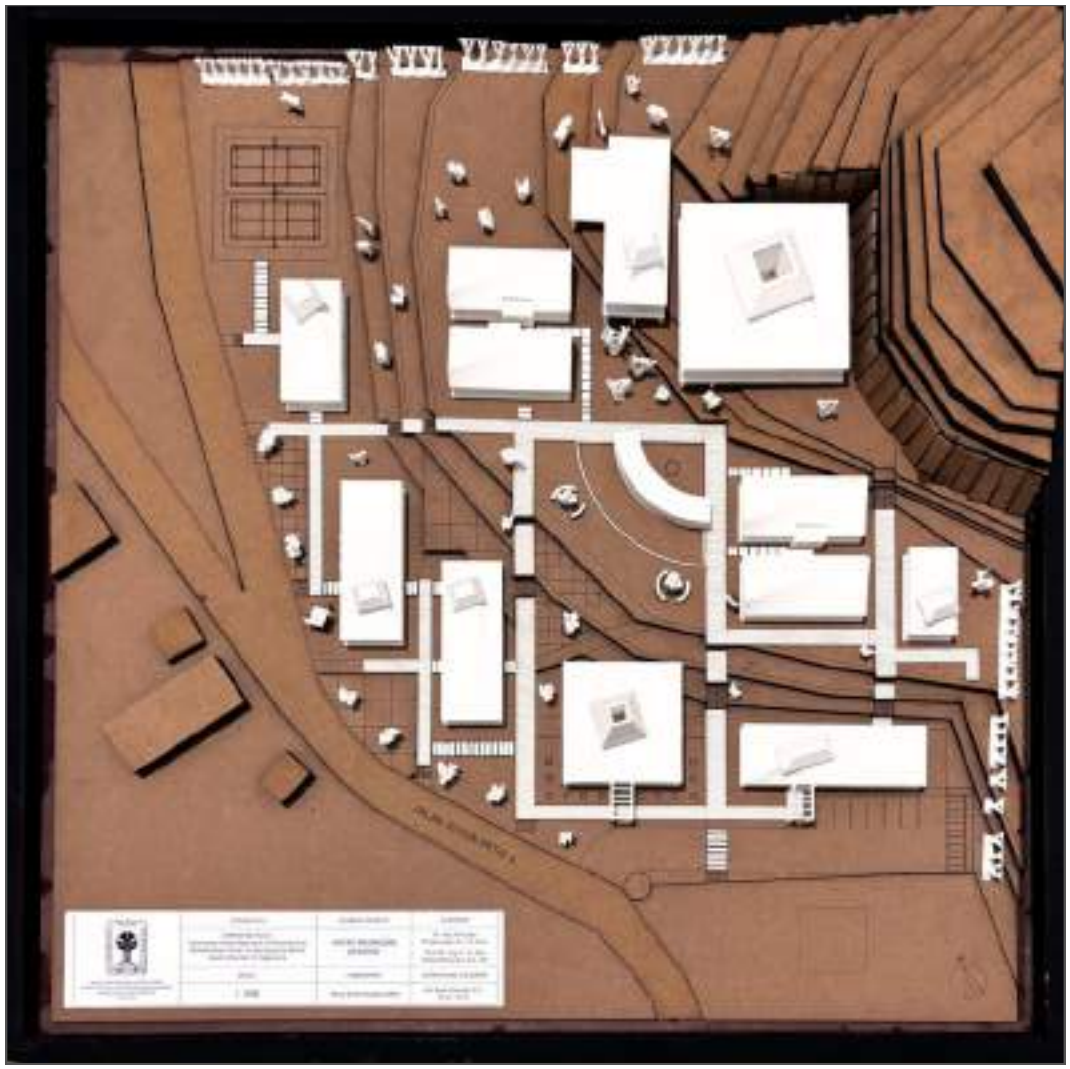
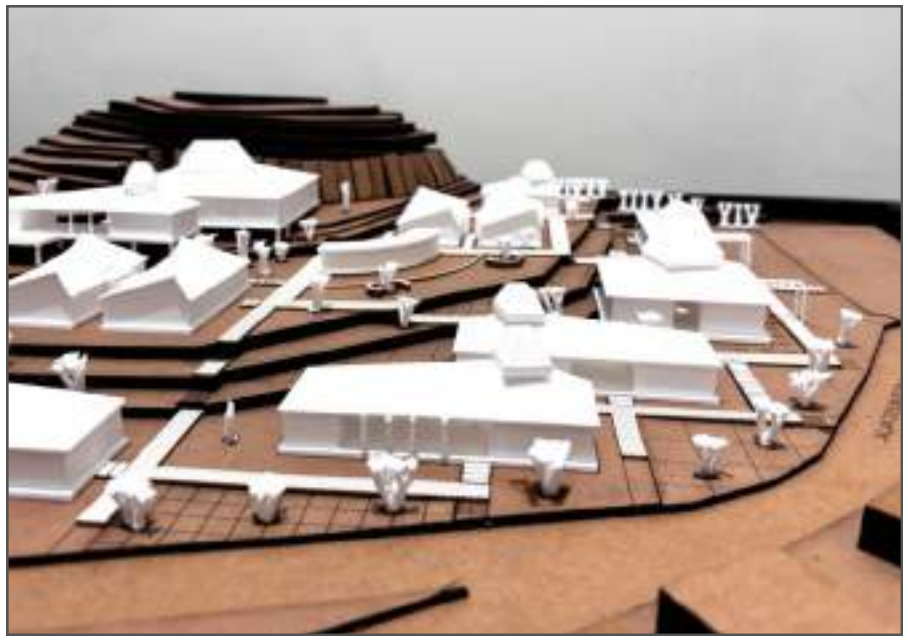
Muhammad Jamil, SIP.

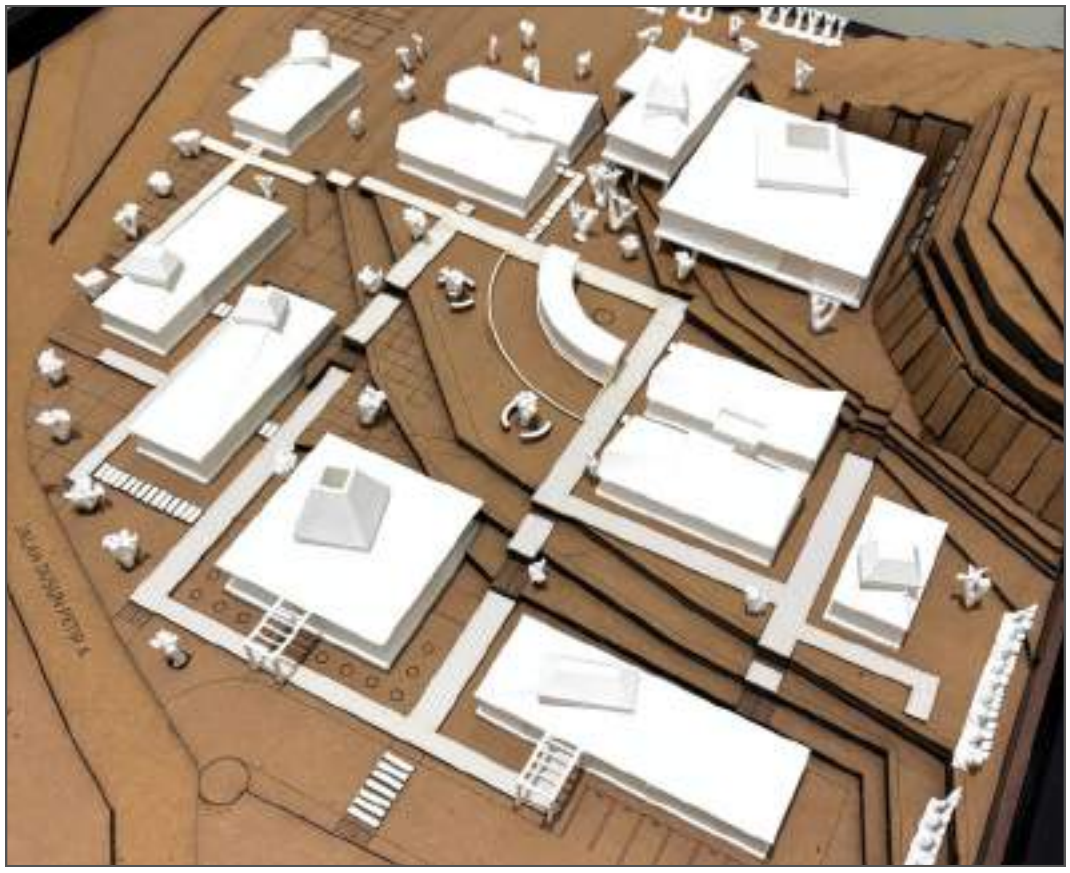
Architectural Presentation Board

APREB

Technical Drawing





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