Reducing attitude toward the stigma of post-restraint individuals with mental illness: A pre-experimental study on FGD-Based mental health education

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Abstract

Background: Stigma refers to socially constructed negative meanings, labels, and stereotypes that lead to fear, social distancing, discrimination, and exclusion toward individuals with mental illness. Stigma toward people with post-restraint mental illness is still high, mainly due to limited mental health literacy within the community and strong cultural beliefs in agricultural communities that view mental illness as a disgrace. Focus group discussions (FGD) facilitate interactive dialogue, collective reflection, and social learning processes, making it more suitable for targeting attitude change and stigma reduction because it addresses both cognitive and social dimensions of stigma.
Purpose: This study aimed to assess the effect of mental health education, conducted through focus group discussions, on reducing community attitudes toward the stigma of Post-Restraint Individuals with Mental Illness.
Methods: This study employed a pre-experimental one-group pre-posttest design, involving 40 respondents who were purposively selected. The intervention consisted of four FGD sessions conducted over one month. The level of stigma was measured using the Community Attitudes Toward the Mentally Ill questionnaire, and data were analyzed using descriptive frequencies and the Wilcoxon Signed-Rank test.
Results: The results showed a decrease in the level of high stigma from 90.0% to 52.5%, and an increase in the level of low stigma from 10.0% to 47.5%. Wilcoxon Signed-Rank test results showed significant differences before and after the intervention (p = 0.000). FGDs allowed participants to reflect on their views, share their experiences, and gain a better understanding of people with mental illness, thus reducing attitude toward the stigma of people with post-restraint mental illness.
Conclusions: Based on these findings, it can be concluded that mental health education through the FGD method is effective in reducing community attitude toward stigma of people with post-restraint mental illness.

Keywords: focus group discussion; mental health education; people with mental illness; post-restraint; stigma

Introduction

Many people with mental illness experience stigma in society (World Health Organization, 2022), including those who have been shackled (Luni et al., 2024). Social stigma experienced by people with mental illness after being restrained has a major impact on their psychological condition and that of their families (Dewi et al., 2019). The high level of stigma can occur due to a lack of knowledge and understanding of mental health illnesses (Fatin et al., 2020). The community can act as social support to help the process of handling and recovering people with mental illness (Pavarini et al., 2021). Communities, especially those in agricultural areas, are often difficult to engage in mental health intervention programs; therefore, special adjustments are needed (King et al., 2023).

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Globally, 970 million people around the world are living with mental illness, and this number is increasing after the COVID-19 pandemic (World Health Organization, 2022). In Indonesia, 315,621 households have a member with psychosis/schizophrenia, with a prevalence of mental illness and depression of 630,827 each (Ministry of Health of the Republic of Indonesia, 2023). The high prevalence of mental illness in Indonesia contributes to stigma, discrimination, and denial of human rights to sufferers, including the practice of restraint which still occurs (Ministry of Health of the Republic of Indonesia, 2023), especially in East Java Province, with 754 cases recorded (Ministry of Health of the Republic of Indonesia, 2019). In Jember District in 2024, there were 3,286 cases of people with mental illness, of which 21 cases were in restraint. Stigma related to mental illness has significant consequences affecting individuals, families, communities, and even societal structures. It is widely associated with increased severity of psychiatric symptoms, lower self-esteem, reduced quality of life, slower recovery, social withdrawal, and reduced employment opportunities (Guerrero et al., 2025). Based on the results of a preliminary study, the working area of the Wuluhan Community Health Center showed the highest prevalence of people with mental health illness, reaching 128 patients, including six cases of post-restraint. A survey conducted among 43 community members in the working area of Wuluhan Community Health Center showed that 35 (81.4%) of them had high stigma toward people with post-restraint mental illness, which was reinforced by cultural background and lack of adequate knowledge.

Efforts to increase community knowledge and reduce stigmatizing attitudes are carried out through health education (Sari & Daryanto, 2021). The form of the educational method has an impact on the accurate and clear delivery of information to the audience. Educational methods include lectures (Suryani, 2020), printed media such as leaflets and posters (Hasanica et al., 2020), films (Putri et al., 2022), audio-visual (Kurniasari et al., 2023; Ruhyandi et al., 2022), and Focus Group Discussion (FGD) (Kansil et al., 2019; Shahwan et al., 2022). Research conducted by Muiswanah et al. (2023) emphasized the importance of knowledge as a source of information to improve the community's positive attitude toward people with mental illness. One method that has proven effective is focus group discussion (FGD), which can significantly increase knowledge through a problem-solving process based on social interaction and exchange of experiences. Diverse opinions encourage participants to think critically during the discussion (Suryani, 2020). Accordingly, this study was conducted to determine the effectiveness of FGD as an educational method in reducing attitude community toward the stigma of people with post-restraint mental illness in the working area of Wuluhan Community Health Center.

Materials and Methods

Study design

The research design used was pre-experimental with a one-group pre-posttest approach. The intervention was conducted in four meetings for one month.

Sample and Setting

The sampling technique used was purposive sampling, with the following inclusion criteria: aged 18 to under 65 years; living near a person with mental illness who had been restrained for at least one year; having completed elementary school or an equivalent level of education; having no family history of mental illness; being able to read and write; and having no verbal communication disorder. The exclusion criteria included: respondents who did not complete the questionnaire, did not attend all intervention sessions, withdrew before signing the informed consent, or died during the data collection process. Based on these criteria, 40 respondents were selected as research samples.

Variable

The dependent variable is community stigma toward people with post-restraint mental illness, and the independent variable is mental health education through the FGD method.

Instruments

Stigma was measured using the Community Attitudes Toward the Mentally Ill (CAMI) questionnaire, which has been translated into Indonesian. CAMI questionnaire consists of four dimensions: authoritarianism, benevolence, social restrictiveness, and community mental health ideology. Of the 40 statement items tested for validity and reliability, 35 items were declared valid with r values ranging from 0.365 to 0.786, exceeding the r table of 0.361 at the 5% significance level. Five items (numbers 5, 17, 18, 26, and 40) were dropped because r count < r table. The questionnaire was also reliable with a Cronbach's Alpha value of 0.728, indicating good internal consistency (Hasrianti, 2023). The retained 35 items still represent all four CAMI dimensions, as each dimension continued to be covered by multiple valid items, and no dimension was eliminated entirely. The internal consistency of each subscale remained within acceptable reliability thresholds, indicating that the construct coverage and conceptual integrity of the CAMI were preserved despite item reduction.

Intervention

The intervention in this study is mental health education through the FGD method, which was implemented based on a protocol. Respondents were divided into groups based on the village of residence to ensure contextual homogeneity and ecological validity of the FGD process. Individuals

Table 1. Characteristics of Respondents (n = 40)

Variable	Median	Min	Max	n (%)
Age (Years)	44.50	38	58	
Gender				
Male				13 (32.5%)
Female				27 (67.5%)
Socioeconomic Status				
Equal to or above minimum wage				3 (7.5%)
Below minimum wage				19 (47.5%)
No income				18 (45.0%)

Table 2. Results of Analysis of Scores Before and After Intervention (n=40)

Variable	Median (Min-Max)
Before Intervention	78.00 (67-101)
After Intervention	87.00 (71-113)

Table 3. Wilcoxon Signed-Rank Statistical Test (n = 40)

Variable	p-value	Rank	
Difference in Stigma Before and After Intervention	0.000	Negative	1
		Positive	39
		Ties	0

Table 4. Differences in Community Stigma by CAMI Aspect

Aspect	Median		
	Pre	Post	Difference (Post-Pre)
Authoritarianism	20.00	13.00	-7.00
Benevolence	16.00	20.47	+4.47
Social Restrictiveness	19.00	20.00	+1.00
Community Mental Health Ideology	22.50	32.00	+9.50

from the same village share similar sociocultural norms, collective experiences, and prior exposure to post-restraint individuals with mental illness, which facilitates open discussion, mutual understanding, and richer interaction. In this study, respondents were divided into five groups of 6-10 people. The intervention was given to respondents gradually in four FGD meetings over one month. Each meeting lasted 30-45 minutes, and each group was facilitated by a facilitator. All facilitators have received a briefing session before data collection, including an orientation to the study objectives, mental health concepts, FGD guiding questions, and facilitation techniques. Regular coordination and debriefing among facilitators were conducted to maintain consistency of the educational intervention across all groups. Before the first FGD session, all respondents were asked to complete a pre-test questionnaire to measure their initial attitudes toward people with mental illness. After all intervention sessions were completed, participants were again asked to complete the same questionnaire as a post-test to assess the effectiveness of the intervention.

The educational materials were systematically organized based on respondents' needs, informed by findings indicating that knowledge level is significantly associated with attitudes toward people with mental illness (Asriani et al., 2020). The materials included an understanding of the causes, treatment, and prevention of mental illness, as individuals with low knowledge levels tend to show negative attitudes toward people with mental illness. Therefore, the materials were developed to cover basic knowledge aspects. Topics discussed at each FGD meeting included: (1) Introduction to Mental Health; (2) Causes of Mental Illness; (3) Prevention of Mental Illness; and (4) Access to Services and Treatment. Stigma-related content was not presented as a separate theoretical topic during the FGD due to methodological

Table 5. Statements with the Most Change per Aspect of CAMI

Aspect	Item statements with	Comparison		Difference
		Pre	Post	
Authoritarianism	Almost anyone can become mentally ill.	2.5% (Disagree)	47.5% (Disagree)	+25% (Disagree)
Benevolence	It is best to avoid anyone with mental problems.	22.5% (Disagree)	45% (Disagree)	+22.5% (Disagree)
Social Restrictiveness	A woman would be a fool to marry a man who has suffered from a mental illness. even if it appears that he is fully recovered.	12.5% (Disagree)	32.5% (Disagree)	+20% (Disagree)
Community Mental Health Ideology	Having mentally ill patients living in residential neighborhoods may be a good therapy. but the risk to residents is too great.	20% (Strongly Agree) 27.5% (Disagree)	0% (Strongly Agree) 47.5% (Disagree)	-20% (Strongly Agree) +20% (Disagree)

considerations. The FGD was designed with a contextual and experiential approach, meaning that stigma was addressed implicitly through discussions of community perceptions, social reactions, exclusion, and acceptance of people with post-restraint mental illness. This approach was chosen to prevent defensive responses from community participants and to encourage reflective dialogue and attitude change. Importantly, stigma was clearly operationalized and measured in the pre–post assessment, ensuring consistency between the intervention and the study outcomes.

Data collection

Data was collected twice, before (pre-test) and after (post-test) the implementation of mental health education intervention through the FGD method. The instrument used was the Indonesian version of the CAMI questionnaire, which has been proven valid and reliable. The questionnaire consists of 35 statements covering four aspects of attitudes toward people with mental illness, namely Authoritarianism, Benevolence, Social Restrictiveness, and Community Mental Health Ideology. Completion was done directly with the assistance of researchers and facilitators to ensure participants' understanding. The results of the pre-test and post-test were analyzed to evaluate changes in attitudes after the intervention.

Data analysis

The analysis included frequency, percentage, median, minimum, and maximum values to describe demographic characteristics and stigma distribution. The Shapiro-Wilk test showed that the data was not normally distributed ($p = 0.024$ pre-test; $p = 0.002$ post-test). Therefore, the Wilcoxon Signed-Rank test was used to assess significant differences in stigma levels before and after the intervention. Data was analyzed using SPSS version 22.

Ethical consideration

This study was approved by the Health Research Ethics Committee (KEPK), Faculty of Nursing, University of Jember, under approval number 014/UN25.1.14/KEPK/2025. Before the pre-test and intervention were conducted, all participants were given a detailed explanation of the objectives, research methods, potential risks, and benefits through in-person information sessions. Participants were assured of the confidentiality and anonymity of their responses in accordance with research ethics principles. Consent for participation was obtained in writing through an informed consent form. All data was stored securely and could only be accessed by the research team to maintain the privacy of the study participants.

Results

Based on the respondents' characteristics, age was not normally distributed ($p = 0.018$) and is therefore presented as a median of 44.50 years. Most of the respondents were female (67.5%). Based on socioeconomic status, most respondents had incomes below the minimum wage (47.5%), while 45.0% had no income (Table 1).

Before the intervention, most of respondents were in the high stigma category. After the intervention, the number of respondents with high stigma decreased significantly while the number of respondents in the low stigma category increased (Figure 1).

The median score before the intervention was closer to the minimum value, indicating a relatively high level of stigma. After the intervention, the median score increased, indicating an improvement in the level of stigma, although still in the low value range (Table 2).

The Wilcoxon Signed-Rank test results showed a significant value of $p = 0.000$ ($p < 0.05$), indicating

a significant difference between the pre-test and post-test scores. A total of 39 respondents experienced a decrease in stigma score (positive rating), one respondent experienced an increase in stigma (negative rating), and no one had a fixed score (Table 3).

There was a change in the median of four aspects in the CAMI questionnaire. Three aspects improved after the intervention, namely benevolence, social restrictiveness, and community mental health ideology, with the highest improvement observed in the community mental health ideology aspect. One aspect, authoritarianism, decreased. The decrease in authoritarianism and the increase in benevolence and community mental health ideology reflected a decrease in stigma, while the increase in social restrictiveness showed an increase in stigma (Table 4).

The most significant change is seen in the authoritarianism aspect, with a 25% increase in disagreement with the statement "Almost anyone can become mentally ill," which shows an understanding that mental illness can be experienced by anyone. On benevolence, disagreement with the statement "It is best to avoid anyone with mental illness" increased by 22.5%, reflecting the growth of empathy toward people with mental illness. On social restrictiveness, disagreement with the statement "A woman would be foolish to marry a man who has suffered from mental illness, even though he seems to be fully recovered" increased by 20%, indicating the beginning of social acceptance in the context of personal relationships. While on community mental health ideology, there was a 20% decrease in "strongly agree" and 20% increase in "disagree" responses to negative statements about the presence of people with mental illness in the neighborhood, reflecting an increase in community acceptance (Table 5).

Discussion

Characteristics of Respondents

Age

The median age of respondents in this study was 44.50 years, which is categorized as middle adulthood (Hurlock, 2012). This is based on data from the Central Bureau of Statistics, which shows a large proportion of Indonesia's population in this group, also reflected in the research area (Center for Statistics, 2023; Centre for Statistics of Jember Regency, 2024). According to Erikson (Rizki, 2022), individuals of this age are at the developmental task of generativity versus stagnation, focusing on productivity, social contribution, and guiding the next generation. At the same time, according to Hurlock (2012) in Rizki (2022), this age is the most stable period experienced by individuals emotionally; so, they can control themselves well. These characteristics also support the effectiveness of FGDs in shaping a more open and accepting attitude toward people with post-restraint mental illness.

Gender

Most of the respondents in this study were female, 27 (67.5%), while 13 (32.5%) were male. This difference can be attributed to the higher number of low-educated women in rural areas (Iqbal et al., 2023) and the high involvement of women in the study area in social activities, especially in the health and family sectors. The dominance of

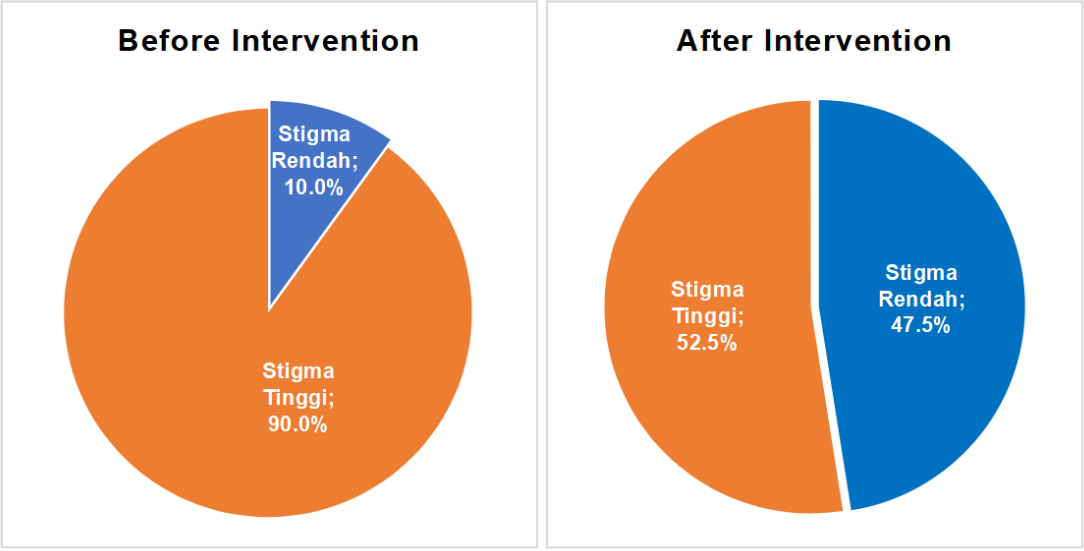

Figure 1. Distribution of Stigma Categories Before and After Intervention (n = 40)

female respondents in this study reflects a rural community group whose education, social roles, and involvement in health issues actively contribute to the dynamics of the discussion on the stigma against people with post-restraint mental illness and are relevant in promoting social change at the community level.

Socioeconomic Status

Based on the research data, 3 respondents (7.5%) had an income equal to or above the minimum wage, 19 people (47.5%) had an income below the minimum wage, and 18 respondents (45.0%) had no income at all. This is based on 2023 data from the Central Bureau of Statistics of Wuluhan District, which shows that the largest proportion of employment is in the agriculture and livestock sector, with a total of 30,087 individuals (Centre for Statistics of Jember Regency, 2024). This sector generally has a low economic status because it depends on uncertain agricultural yields (Amelia et al., 2021). Research by Rusdiadi et al. (2024) also revealed that many farming households experience difficulties in achieving economic welfare. These characteristics reflect the socioeconomic status of the community in the study area, most of whom have incomes below the minimum wage due to the dominance of the agriculture/livestock sector, which has not been able to guarantee economic welfare.

Overview of Community Attitude toward Stigma Before and After Intervention

Overview of Community Attitude toward Stigma Before Intervention

Before the intervention, most respondents (90.0%) had a high attitude toward stigma of people with post-restraint mental illness, and only 10.0% had a low attitude toward stigma, with a median score of 78.00 (67-101). These results indicate that most of the community is highly stigmatized, which may hinder the social acceptance of people with post-restraint mental illness. This high attitude toward stigma is influenced by the community's lack of knowledge and understanding of mental health (Fatin et al., 2020). This is consistent with the characteristics of the respondents, all of whom had low educational attainment, primarily at the elementary school level. This was also reflected in their responses when asked to define "mental health," as many described incorrect characteristics of mental illness and expressed beliefs that mental illness is caused by supernatural factors.

Local culture in agricultural areas also reinforces stigma, particularly the tendency to view mental illness as a sign of weakness (King et al., 2023). In addition, mental health education is still limited to school children, while it has not been conducted in the general community, and many people are unaware that community health center provide mental health services. This ignorance is compounded by concerns about the cost of treatment. According to Goffman's (1964) stigma theory in Ihsan (2024), this condition causes people with mental illness to experience social exclusion. Based on the findings and references, the high level of stigma towards people with post-restraint mental illness before the intervention was caused by low understanding, community culture, and limited access and information on mental health services.

Overview of Community Attitude toward Stigma After Intervention

After the intervention, the proportion of high attitude toward stigma decreased (52.5%), while low attitude toward stigma increased (47.5%), with the median score remaining in the high category, namely 87.00 (71-113). The low median score among all respondents can be attributed to the characteristics of people living in rural areas (rural), who generally have strong cultural values (Saleena, 2022) and the low education level of respondents which makes the process of receiving and understanding information more limited (Akbar et al., 2020). Although health education through FGDs can reduce stigma, a more in-depth strategy is needed to achieve optimal changes in rural communities.

Differences in Community Attitude toward Stigma Before and After Intervention

Differences in Community Attitude toward Stigma Based on Percentage, Median, and Wilcoxon Signed-Rank Test

The difference in community attitude toward stigma of people with post-restraint mental illness can be seen in several ways. First, the percentage of respondents with high attitude toward stigma levels decreased from 90.0% to 52.5%, and the percentage of respondents with low attitude toward stigma increased from 10.0% to 47.5%. Second, the median score increased from 78.00 (67-101) to 87.00 (71-113), indicating a decrease in attitude toward stigma, although it is still in the high category. Third, the Wilcoxon Signed-Rank test showed a significant difference ($p = 0.000$), with 39 respondents experiencing a decrease in stigma, and only one respondent showing an increase.

This result is in line with the research of Muiswanah et al. (2023), which emphasized that increased community knowledge contributed to a more positive attitude change toward people with mental illness, and Wahyudi et al. (2024), indicating that FGD participants experienced increased understanding after participating in group discussions. FGDs have also proven effective in reducing stigma on other health issues, such as PLWHA (Putri et al., 2022). Nola J. Pender's Health Promotion Model supports this, where health behavior change is influenced by awareness, perceived benefits, and social support (Yani & Ibrahim, 2017). Meanwhile, the increase in attitude toward stigma in one respondent may be explained by differences in individual responses

to the information provided. Factors such as age affect how a person absorbs information (Corrigan et al., 2012). Therefore, naturally, a 53-year-old respondent would show a more negative attitude after the intervention. In addition, Seidler et al. (2016) emphasized that traditional gender views, particularly in adult males, can be a barrier to receiving educational messages that emphasize empathy or gentleness in understanding mental conditions. In this study, one male respondent may have perceived the educational material as conflicting with his masculinity values, leading him to reject the information and maintain stigmatizing attitude towards people with post-restraint mental illness.

Differences in Attitude toward Stigma Based on CAMI Aspects

Differences in community attitude toward stigma of people with post-restraint mental illness are also supported by the results of the analysis on each aspect of the CAMI instrument. High scores on the authoritarianism and social restriction aspects reflect high community stigma towards people with mental illness, while high scores on the benevolence and community mental health ideology aspects indicate lower levels of stigma (Zaini et al., 2024). The following is a description of each aspect:

Authoritarianism

The median score after the intervention decreased from 20.00 to 13.00 (a difference of -7.00), indicating a decrease in authoritarian attitudes towards people with post-restraint mental illness. According to Safitri et al. (2022) and Zaini et al. (2024), the low score in this aspect indicates that the community does not consider individuals with mental illness inferior to other members of the community. A significant shift was also seen in the statement item that mental illnesses are only experienced by certain groups; the answer “disagree” increased from 22.5% to 47.5%. This result is in line with Rahayu and Nugraha (2024), which shows low attitude toward stigma in this aspect, because people consider that almost everyone can experience mental illness. This finding is different from the results of Seo and Kim (2010), where education using online media did not significantly change the authoritarian attitude of people with mental illness, indicating that the intervention using the FGD method in this study was more effective in reducing the authoritarian attitude of the community towards people with mental illness. Participants also admitted that they began to see people with post-restraint mental illness more humanely, although there were still concerns about the potential aggressive behavior of people with post-restraint mental illness.

Benevolence

There was an increase in the median from 16.00 to 20.47, with a difference of +4.47. According to Safitri et al. (2022) and Zaini et al. (2024), this high score indicates that the community tends to be humanizing and sympathetic towards people with mental illness. Disagreement with the statement “It is best to avoid anyone with mental illness” increased from 22.5% to 45%. The increase of 22.5% in the “Disagree” category indicates an increase in empathy and openness, which reflects a more supportive and less ostracizing view of people with mental illness. This result is inconsistent with a study by Seo and Kim (2010) , which emphasized that education with online media did not provide significant changes in the benevolence aspect. This comparison suggests that the FGD intervention is more effective in increasing community compassion towards people with mental illness. The results are reinforced by the participants’ responses when they received the materials in the FGD, which showed a positive change in the way they interact with people with mental illness. Participants began to understand the importance of treating people with mental illness humanely, such as inviting conversation and not judging, as a tangible form of increasing empathy and the quality of social interaction.

Social Restrictiveness

There was an increase in the median from 19.00 to 20.00 (difference +1.00). According to Safitri et al. (2022) and Zaini et al.(2024), the tendency of high scores in this aspect indicates that the community still considers people with mental illness as threatening individuals. This result is in line with Seo and Kim’s (2010) study, which found that education did not provide a significant change in social restrictions by the community on people with mental illness. However, there was a change in the item “A woman would be a fool to marry a man who has suffered from a mental illness, even if it appears that he is fully recovered.”, where disagreement increased from 12.5% to 32.5%. This increase reflects the community’s growing acceptance of people with post-restraint mental illness in the context of personal relationships. Another indication can be seen from the existence of the neighborhood security post as a space for social interaction between people with mental illness and the community. After the intervention, respondents also began to be willing to interact, although it is still situational and has not been completely released from the sense of vigilance.

Community Mental Health Ideology

There was a significant increase, with the highest pre-post-test difference compared to other aspects, from 22.50 to 32.00, with a difference of +9.50. Disagreement with the statement “Having mentally ill patients living in residential neighborhoods may be a good therapy, but the risk to residents is too great.” increased from 27.5% to 47.5%, while the “strongly agree” response decreased from 20% to 0%. According to Safitri (2022) and Hasrianti (2023), the high score on this aspect indicates community acceptance of mental health and the services of

people with mental illness in the community. Although the initial score on this aspect was already high, the score increase after the intervention shows that the FGD intervention strengthened this acceptance. This shift shows that the community's concern about people with post-restraint mental illness has been replaced with the belief that support from the social environment plays an important role in the recovery process. According to Jung and Baik (2005) in Seo and Kim (2010), when an individual knows mental health, his/her positive attitude towards mental health ideology in the community tends to be high. Some respondents also recognized the importance of mental health education after participating in the FGD. They considered this activity useful and thought that it should be held more often. However, there were views that imply doubts about the effectiveness of education in rural environments. Some respondents felt that rural communities often find it difficult to receive information through an educational approach, indicating the need for strategies more suited to the local social and cultural context.

Overview of Respondents' Perceptions by FGD Topic

In the first meeting (Introduction to Mental Health), respondents began to understand that mental illness is not limited to extreme behavior, but also includes symptoms such as stress, withdrawal, behavioral changes, or sleep disturbances. Then, the second meeting (Causes of Mental Illness) explained that social, economic, and trauma factors contribute to mental illness, although some respondents still attributed mental illness to a lack of faith or spiritual influence. Furthermore, the third meeting (Prevention of Mental Illness) touched on emotional aspects and personal experiences. Respondents realized the importance of sharing stories, getting social support, and not harboring problems. Lastly, the fourth meeting (Access to Services and Treatment) helped change attitudes from excluding people with mental illness to a greater acceptance of the importance of treatment and the availability of mental health services.

The FGDs provided an opportunity for participants to explore various views, share experiences, and correct negative prejudices, to create a more comprehensive and informed understanding. The topics covered in the discussions, ranging from mental health concepts, causes, prevention to the importance of treatment, provided space for participants to understand the issue from various sides. The role of the FGD facilitator was also important in determining the results of this study. Facilitators who are able to manage group dynamics can create a conducive environment for respondents to express their opinions (Ridlo et al., 2018). In this study, the facilitator was able to direct the discussion effectively and understand the group dynamics, so that the FGD resulted in significant changes in respondents' stigma after the intervention. In addition, the involvement of community leaders in educational initiatives may further support efforts to reduce stigma associated with restraint (Agustina et al., 2025). In this study, community leaders such as the village secretary and dusun (sub-village) head were also involved in encouraging the community to actively participate in regular discussions, as well as creating a sense of security and comfort for the community to participate. This created a conducive atmosphere for the community as FGD respondents reflected on their perceptions and attitudes towards people with post-restraint mental illness, resulting in a more positive shift in attitudes.

Conclusion

Based on the results of the study, before the intervention, most of the respondents showed a high level of stigma towards people with post-restraint mental illness, and some respondents showed low stigma. After the intervention, there was a decrease in high stigma and an increase in low stigma. There is a significant difference between before and after the intervention, indicating that mental health education delivered through the FGD method had an effect on community attitudes toward stigma of people with post-restraint mental illness in the working area of Wuluhan Community Health Center. The community is advised to be more active in seeking correct information about mental health, building empathy, and supporting the social reintegration of people with post-restraint mental illness. Wuluhan Community Health Center is expected to continue providing services to people with post-restraint mental illness to strengthen support for them.

Declaration of Interest

The authors declare that they have no conflict of interest related to this study.

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Data Availability

The data used in this study is available upon request to the corresponding author and are not published openly to maintain participant confidentiality.

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