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ORIGINAL PAPER

Focus Group in Community Mental Health Research: Need for Adaption

Vesna Zupančič[1] · Majda Pahor[2] · Tina Kogovšek[2]

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Abstract
The article presents an analysis of the use of focus groups in researching community mental health users, starting with the reasons for using them, their implementation in mental health service users' research, and the adaptations of focus group use when researching the experiences of users. Based on personal research experience and a review of scientific publications in the Google Scholar, Web of Science, ProQuest, EBSCOhost, and Scopus databases, 20 articles published between 2010 and 2016 were selected for targeted content analysis. A checklist for reporting on the use of focus groups with community mental health service users, aiming to improve the comparability, verifiability and validity was developed. Adaptations of the implementation of focus groups in relation to participants' characteristics were suggested. Focus groups are not only useful as a scientific research technique, but also for ensuring service users' participation in decision-making in community mental health and evaluating the quality of the mental health system and services .

Keywords Qualitative research · Focus group · Data publication · Community mental health · User perspective · Performance evaluation

Introduction

There is a lack of information as to why researchers use focus groups (FG) in community mental health (CMH) research, how they are implemented among mental health service users, and on any adaptations when using FGs among mental health service users. We aimed to create a profile for presenting FG implementation and potential adaptations, striving for a more productive use of FGs in research on CMH regarding the comparability, verifiability, and validity of findings.

FG as a data collection method has been a part of qualitative research for a century (Onwuegbuzie et al. 2009, 2010; Harding 2013). It is most commonly defined as a data collection technique involving group discussion on a specific subject, carried out in a safe area in the presence of a moderator (Krueger and Casey 2002; Wilkinson 2004; Acocella 2012; Ness et al. 2014). In some cases, the theoretical background of FG use is symbolic interactionism (Goffman 1961), while in others, it is more about focusing on discourse and discussion analysis (Flick 2007; Rapley 2007). Vaughn et al. (1996) present key elements of FG implementation as follows: (1) subject of study (study of a single topic); (2) size and characteristics of the group of participants (homogenous group includes 6–12 members); (3) the moderator and his or her qualifications (ways of encouraging discussion); (4) arguments for FG use (provokes perceptions, emotions, opinions, and ideas of participants about the selected topic); and (5) limitations (does not produce quantitative information; data cannot be generalised).

FG use is mainly justified as a way to gain insight into personal opinions, descriptions, perceptions, thoughts, attitudes, experiences, and service users' view of the subject of research (i.e. concept, idea, service, yet-to-be-addressed issues). This can be done in an economical/cost-effective manner (less time, fewer resources, greater number of participants, and greater validity) (Krueger and Casey 2002;

✉ Vesna Zupančič
vesna.zupancic@guest.arnes.si

Majda Pahor
majda.pahor@zf.uni-lj.si

Tina Kogovšek
tina.kogovsek@fdv.uni-lj.si

[1] Ministry of Health of the Republic of Slovenia, Štefanova 5, Ljubljana, Slovenia

[2] Faculty of Social Sciences, University of Ljubljana, Kardeljeva ploščad 5, 1000 Ljubljana, Slovenia

Onwuegbuzie et al. 2009; Eriksson and Hummelvoll 2012; Then et al. 2014). On the one hand, the power of FGs mainly lies in the focus on the solution to a practical problem and developing potential solutions that would improve the quality and relevance of the research (Adam et al. 2012). On the other hand, FGs are not appropriate when the aim is reaching a consensus, sensitive information is required that cannot normally be discussed in a group setting, the situation is emotionally charged situation, confidentiality cannot be guaranteed (Redmond and Curtis 2009) or results are expected to be generalised (Vaughn et al. 1996). Gorodzeisky (2011) also sees FGs as a means of creating and verifying questionnaires.

In health-related research, the use FGs as research tools began to appear in the 1980s (Wilkinson 1998; Tong et al. 2007). They are becoming the norm in researching experiences of service users. These findings can help build excellence in the health care system and improve service users' experience (Gilburt et al. 2008). Quirk and Lelliott (2001) found that most quantitative research reveals service users' negative experiences of hospital treatment. FG use, on the other hand, shows that service users have both positive and negative experiences with hospital treatment (Gilburt et al. 2008). FGs are also used to identify service users' perceptions of their participation in the research process as a researcher (Moltu et al. 2013). Smith et al. (1995) found that FGs are useful for developing and testing new services, as they enable the identification of factors that service users deem important.

Frank (1995) points out that it is necessary to consider if the FG participants are sick people. These participants are more than just victims of a disease or medical patients; they are 'wounded storytellers'. Barry and Yuill (2012) state that FG implementation issues stem from the very fact that there is a group of people. As in any other social situation where a group of people gathers to discuss a particular subject, some people are louder than others, while some are too fearful or nervous to contribute. It is essential to decide on rules, and the moderator must pay attention that the atmosphere created is relaxed and participatory (Acocella 2012).

Cyr (2016) explains that FGs help collect data at three analysis levels: individual, group, and interaction level, which scientifically justifies the added value of FG use. Miles and Huberman (2003) see the analysis of FG data composed of three concurrent activities: data condensation (encoding, definition of categories and main subjects), selection (data output), and data presentation and verification. Aiming to improve the quality of use and reporting, Tong et al. (2007) created the Consolidated Criteria for Reporting Qualitative studies (COREQ) checklist; it contains 32 items and a question guide on three domains: (1) research team and reflexivity; (2) study design; and (3) data analysis and reporting. It is, however, unknown what the differences are in using FGs with CMH service users according to the existing checklist (Tong et al. 2007).

Use of Focus Groups in Community Health Care Research

Studying CMH has become relevant due to the processes of dehospitalisation and deinstitutionalisation, which have provided the right to choose the treatment location for people with mental health problems. CMH care is implemented by restructuring existing capacities, introducing new CMH programmes, increasing the influence of people with mental health problems in decision-making on the system and the treatment process, and ensuring improved quality of life in a home setting (Flaker 1998; Thornicroft and Tansella 2004; Švab 2011; Videmšek 2013). It is based on empowering people with mental health problems, which helps people and marginalised groups obtain and improve their skills, experience, reputation in interpersonal relationships, and assume socially valued roles (Linhorst 2005).

In the context of studying CMH care, it is vital to assess access to services and defining the level of compatibility between service users' needs and the system or service offer (Penchansky and Thomas 1981). The link between social system macro analysis and the phenomenology of people's mental health problems can be seen in the social role concept. In the context of a social phenomenon at the micro (personal) level, the basis for studying treatment is the interaction between actors in a drama of health and sickness. According to Goffman (1961), this is symbolic interactionism. It starts with an interest in the subjective experience of a mental health disability developing through interaction with other people, which coincides with the theoretical background for FG use. Durkheim's (1964) view, for instance, of what is normal and what is pathological, matches the current view of mental health, which is identified as normal, and mental health problems, which are viewed as pathological. The consequences of Durkheim's functionalist findings, as also viewed by Busfield (2000), are that: (1) the rules defining the normal and pathological differ according to the values of the social group or community, and as a result, the definition of mental health problems is socially and culturally relative; (2) rules are always an element of social control, including rules on what is normal and what is pathological; and (3) rules are essential for the integration and smooth functioning of the community and society. It is reasonable to consider these factors when obtaining data via FG.

Findings by Parsons (1951), Goffman (1961), and Foucault (1977) are particularly useful. Parsons (1951) discusses the typical rights and obligations of sick people; together, this constitutes the entirety of the (socially) expected

behaviour of the sick person, which Parsons terms the role of the patient. Goffman (1961) studies the development of a "mental patient's career", which is a consequence of significant others' response to the person's mental health problem. Foucault (1977) emphasises several times that madness is a social construct and that there is no knowledge that does not include a balance of power. He indicates that generating knowledge tells a great deal about the attitude of people with mental health problems, which is a reason for use and limitation when studying through use of FGs. Mental health disabilities, as temporary or permanent disorders in the functioning of the brain that manifest themselves as a change in behaviour, judgement, or experience of self and one's surroundings, must not be an obstacle for FG use. In accordance with the mental health continuum, it is important to consider that the line between mental health and mental health problems is thin and blurred. People with a diagnosed mental health problem may feel mentally well and even recover in some cases, reaching a high level of wellbeing. Similarly, people without a clinically diagnosed mental health disability may feel mentally unwell (Keyes 2002; Hird 2003; Connell et al. 2012). An important question is where on the mental health continuum the person with a mental health problem is currently, what measures have already been introduced into their everyday life, and what the efficiency of these measures is. When researching by using FGs, it is important that the person and his or her mental health be prioritised, rather than the mental health problem, which is not the only characteristic defining the person with a mental health problem (Frank 1995; Pahor 2007; Connell et al. 2012; Videmšek 2013).

With international research and political imperatives, the importance of the participatory role of mental health service users is becoming apparent in improving the culture, responsiveness, and quality of services they receive (Daremo and Haglund 2008; Goodwin and Happell 2008). Including people with mental health problems in planning services and activities and encouraging joint decision-making are the main principles of contemporary mental health policy (WHO 2012). Bee et al. (2016) carried out a qualitative analysis to gain a deeper understanding of expert positions on the ideology of participants cooperating in the planning of mental health care. They pointed out the discrepancy between international mental health policies (WHO 2012) and the readiness to accept this practice. User movements or on-governmental organizations (NGOs) are striving to overcome these discrepancies. They significantly affect the empowerment and recovery of people with mental health disabilities, the development of community services, and changes in the power relations between service providers and users (Zupančič and Pahor 2016). An indirect possibility to overcome these differences may also be FG use. FGs were used within the research on NGOs working for people with mental health disabilities in 56 local communities in two health regions in Slovenia. Differences were found between service users' views of NGOs' role within the support network for people with mental health disabilities and the mental health care system for local community population according to other stakeholders included in the research: experts, service providers, and administrative entities. The open focus group type was used, in which participants (mental health service users) were free to come and go during the FG process. They did not have to record their presence by signing an attendance list. As a result, they only took part in one segment of the questions. This adaptation to FG use enabled participation for people who could not attend such activities due to their health situation (Zupančič and Pahor 2016).

There is a great deal of evidence that service users are motivated to participate in care planning. Major obstacles are poor information exchange and insufficient opportunities for participatory decision-making (Bee et al. 2016). Neuman (2003) lists the advantages of FGs, including the fact that they generally encourage members of marginalised groups to express their views openly, and that people often feel empowered in FGs. It is possible that FGs may be promoted not only as a scientific research technique but also to help ensure service users' participation in decision-making mechanisms in CMH. Further questions may be raised on the range of necessary adaptations to FG implementation with various user groups—for instance, in a state of acute exacerbation of their mental health problem (Laugharne et al. 2012)—and on the researchers' view of these adaptations in terms of the validity of FG findings.

Purpose, Aim and Research Questions

The purpose of the study was to collect and present information on FG use experiences based on data from CMH service users' research. The study sought to develop a checklist to report on FG implementation and potential adaptations for more productive use of FGs by the target group of participants in terms of the validity, reliability, and comparability of findings. The following research questions were posed:

- What does the ideal checklist for reporting on FG implementation in scientific publications include?
- What is the scientific basis for using FGs to obtain data about the perspective of CMH service users?
- What are the experiences of implementing FGs, and what are the adaptations to the process of obtaining data from the viewpoint of people with mental health problems when conducting research on CMH?

Methods

Methods included a literature review and content analysis of available scientific articles reporting on findings obtained using FGs with CMH care service users. The aim was to identify views regarding the reporting on FG use justification and the adaptations made to the research of CMH service users. The ideal reporting checklist profile was constructed, enabling a more productive use of FGs in terms of the validity, verifiability, and comparability of findings than the one identified in the analysed literature.

Overview Methods

The literature search took place in the Google Scholar, Web of Science, ProQuest, EBSCOhost, and Scopus databases between January and July 2016. The search included relevant keywords, based on the research questions: 'focus group', 'community', 'mental health', 'CMH', 'users of services', 'people with mental health problems'.

Results of the Overview

During the literature review, the inclusion criteria for further in-depth analysis were: (a) relevance of the publication according to the title, topic, or article type; (b) year of publication between 2010 and 2016; (c) publication in English; and (d) accessibility of the full text of the article. After a review of databases and obtained publications, 20 scientific articles were selected in accordance with the review objectives, by combining various keywords. The selected articles included reporting on results of CMH research, whereby the data were obtained via FGs with people with mental health problems as users of services within the CMH support network.

Overview of Quality Assessment and Description of Data Processing

The literature review produced data for critical evaluation of knowledge in the field and represents the basis for further scientific research or evidence-based practical work (Hart 2001; Pahor and Domanjko 2005; Coughlan et al. 2013). The literature review process for preparing a profile for reporting on FG is presented in Fig. 1.

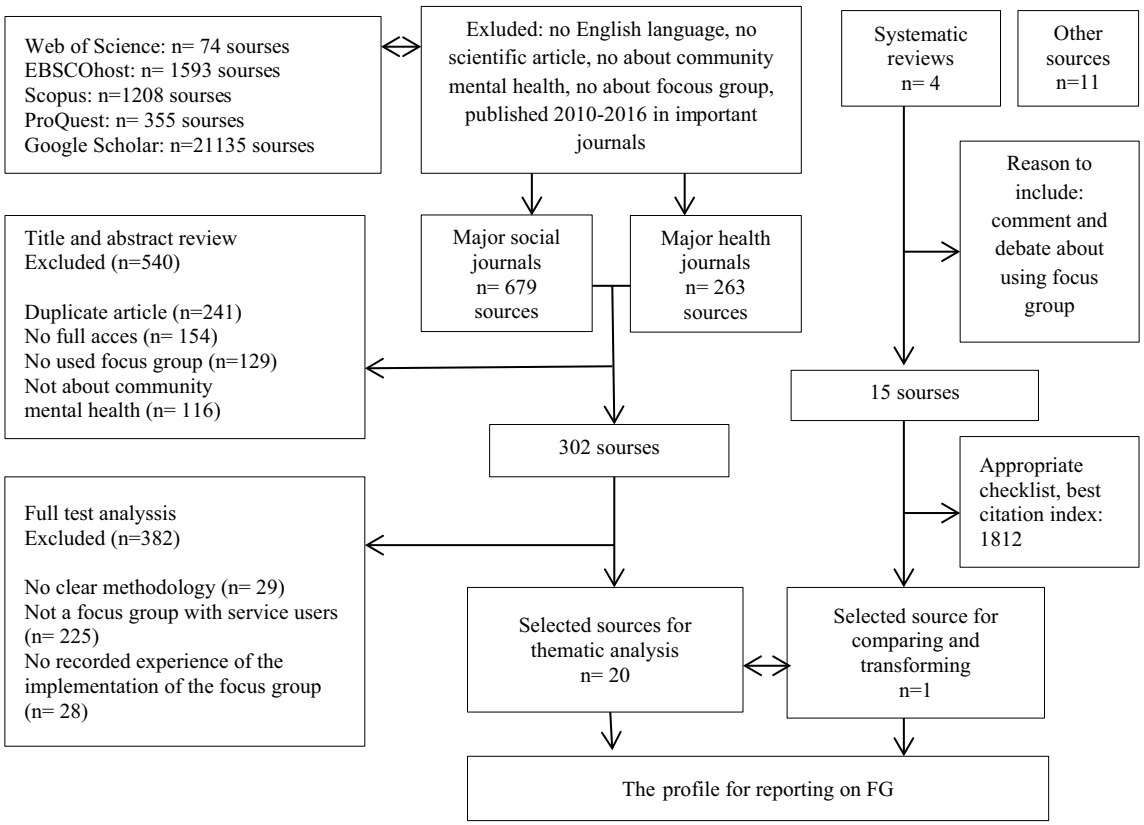

Fig. 1 Literature review process for preparing a profile for reporting on FG

The criteria used for final selection of scientific articles and data processing method are in accordance with a qualitative research process and the research questions. We performed a content analysis (Patton 2002; Polit and Beck 2006; Bengtsson 2016) of the 20 scientific articles on the final list through data processing using codes and categories (open coding), based on which we developed a map of items for reporting on the merits of use, implementation, and adaptations of FGs when researching the experiences of CMH service users. Considering the existing checklist (Tong et al. 2007), the item map was restructured into a checklist for reporting on the use of FGs when researching the experiences of CMH service users.

Results

Based on the content analysis of selected scientific articles, a map of items was developed for reporting on FG implementation when researching the experiences of CMH service users. The map is presented in Table 1.

A synthesis of the analysed presentations of FG use with mental health service users led to selection of 20 items that may form a basis for an ideal profile for presenting FG use. The presentations of the subject of study show that, from the perspective of mental health service users, FGs as a data collection technique are mainly used at the negative end of the mental health continuum. It is possible to insert subjects of study into the positive end of the mental health continuum, such as determining the acceptability of the programme for early detection of mental health problems from the perspective of service users (Lloyd-Evans et al. 2015) and studying the measures for reducing risks of cardiovascular conditions of people with mental health disabilities (Burton et al. 2015).

The authors of the analysed studies carried out between two and nine FGs. The target population was mainly people with mental health disabilities in different life circumstances. The inductive approach was the most common research approach. No all the articles presented justification for FG use. The developed profile shows that FG use is mainly justified by the need to better understand the experiences of people who use CMH services and to evaluate the performance of the mental health care system developed for various service user groups (Mgutshini 2010; Ardila Gymez 2014; Girard et al. 2014; Sweeney et al. 2015; Sandhu et al. 2016). FG use is also justified in the following ways:

(a) By the findings and positive experiences of FG use by other authors (Burton et al. 2015);
(b) By the fact that interaction yields better understanding of the studied phenomenon (Dieleman 2014; Girard et al. 2014);
(c) By emphasising a local narrative and acquiring knowledge from those directly involved (Eriksson and Hummelvoll 2012; Sweeney et al. 2015);
(d) By the exchange and meaningfulness of experiences (Lloyd-Evans et al. 2015; Moltu et al. 2013);
(e) By recording participants' (Panayiotopoulos and Kerfoot 2013); and
(f) By assessing the adequacy of the content (Sandhu et al. 2016).

FGs were generally implemented as part of various research models: participative research model (Graham et al. 2014), pilot study (Sundar et al. 2012), comparative phenomenological study (Mgutshini 2010), and action research and intervention study (FG one of the evaluation methods) (Graham et al. 2014; Lloyd-Evans et al. 2015). There is also a flexible combination of methods (Starnino et al. 2014), use of similar questions for different participant groups for subsequent data triangulation (Proudfoot et al. 2010), and to enable a view from multiple perspectives (Mgutshini 2010; Starnino et al. 2014; Lloyd-Evans et al. 2015).

The number of participants in each FG is not always specified, but it ranges between 3 and 30 participants. Participants were aged range between 16 and 78. Recorded participants' characteristics included their gender, ethnicity, primary medical diagnosis, social status, duration of using the service/contact with the services, profession, social exposure, and referrer. FG characteristics include descriptions of whether it is a permanent group where members know each other, whether it is assembled for the opportunity, and which participant characteristic makes the group homogeneous or heterogeneous. The location of implementation is also presented; it can be known to participants, familiar, nearby, or a public space at a health organisation or local community centre. The most common FG participant sampling methods in the articles were: purposive, convenience, and quota sampling. Contributing factors for mental health service users' participation included: personal acquaintances, introduction through co-workers in community services, public invitation, invitation to participate as part of training/education, prior visit 14 days before implementation, personal explanation of the research and discussion of participation, or prior consultation with a practitioner on user's ability to consent followed by invitation to participate.

When reporting on obtaining consent, authors emphasised either obtaining consent via ethics committees, personal and written consent from participants, or considering international documents on research and codes of ethics. Girard et al. (2014), for instance, refer to international documents and specify that additional consent by an ethics committee was not necessary; they did, however, obtain personal consent from participants. It is evident that another common motivational method for participation is

Table 1 Results of analysis of FG use presentations

Source	Subject of study	Items
Mgutshini (2010)	Experiences of people using mental health services	– Number of FGs – Target population – Justification for use – Number of participants – Characteristics of participants – Characteristics of groups – Implementation location – Sampling – Motivation techniques to encourage participation – Consent for implementation – Implementation process – Circumstances and adaptations – FG duration – Moderator's role/experiences – Process of analysis – Limitations of the research – Advantages of FG use – Use of techniques for extending validity – Goal achievement – Guidelines for further work
Proudfoot et al. (2010)	Attitude of people with mental health problems towards using a programme for monitoring and managing depression, anxiety, or stress on a mobile phone or on the Internet	
Douglas et al. (2011)	Causal link between intensive use of plants with calming effects (*khat*) and the presence of severe mental health problems in people from various vulnerable groups	
Eriksson and Hummelvoll (2012)	Experiences of a risk society by mentally disabled people	
Sundar et al. (2012)	Understanding the meaning and complicated practice of working with people with mental health problems and disabilities who are members of different cultures	
Makdisi et al. (2013)	Understanding the needs of people with acute psychosis	
Moltu et al. (2013)	Experience of own integration into the research process from the viewpoint of people with mental health problems as service users	
Stenfert Kroese et al. (2013)	Gender differences in responses to current services by people with mental health disabilities	
Panayiotopoulos and Kerfoot (2013)	Efficiency and operation of supported employment for people with mental health problems	
Shefer et al. (2013)	Cultural beliefs regarding mental health problems	
Ardila Gymez (2014)	Evaluation of community mental health services	
Dieleman (2014)	Needs of people with mental health disabilities involved with the criminal justice system, according to services	
Girard et al. (2014)	Experiences of cooperation between outreach team members and homeless people with mental health problems	
Graham et al. (2014)	Development of user-generated quality standards for young people with mental health problems	
Starnino et al. (2014)	Evaluating and recognising differences in the spirituality of people with severe mental health problems	
Burton et al. (2015)	Measures for lowering cardiovascular disease risk for people with mental health disabilities	
Lloyd-Evans et al. (2015)	Acceptability of programme for early detection of mental health disabilities	
Sweeney et al. (2015)	Experience of continuous treatment by people with mental health problems	
Sandhu et al. (2016)	Service user experiences of mental health service development	
Zupančič and Pahor (2016)	Differences in understanding the role of non-governmental organisations in the mental health support network by various stakeholders	

payment or reward (e.g., $20, €20, £20) (Douglas et al. 2011; Makdisi et al. 2013; Burton et al. 2015). An additional means of motivating participants to engage and persevere for the duration of the FG is providing snacks, fruit, and coffee (Zupančič and Pahor 2016).

Descriptions of implementation procedures, circumstances, and adaptations were scarce. They included observers taking notes, a translator, a key employee from the organisation, whether the process was non-, partly, or completely structured, and details of the group dynamics.

FG duration was between 45 and 120 min. The description of the moderator included the number of moderators participating in the research, the moderators' level of experience in research and with the population, and their role as promoters of interaction and ensuring that all participants are aware and respond confidently and in an adequate manner. Due to the target groups' characteristics and to achieve the research goals, adaptations were introduced into the FG implementation, particularly regarding the number of participants to ensure participation and into the FG workflow. The profile of adaptations includes the following activities:

(a) Particular attention to motivating participation;
(b) Attention to the use of agreed-upon terminology (e.g., 'believe' is replaced by 'think') (Sandhu et al. 2016);
(c) Addition to the recording of minutes (Graham et al. 2014);
(d) Efforts for detailed knowledge and understanding of content by moderators (Makdisi et al. 2013);
(e) Providing information via interpreter (Douglas et al. 2011); and
(f) Enabling participants to come and go during FG activities (Zupančič and Pahor 2016).

The data analysis process was similar in all studies, i.e. audio recording, literal transcription, content analysis, analysis according to guidelines of specific authors: Krueger and Casey (2002), Patton (2002), Laverty (2003), Smith et al. (2009) and others. Most authors analysed/coded the prepared text with NVivo 9 software.

The developed map of items (see Table 1) was reformatted into a profile for reporting on FG implementation when researching the experiences of CMH service users, and developed by extending the checklist the researchers used as a baseline (Tong et al. 2007). The process of preparing a profile for reporting on FG is presented in Fig. 2.

Two basic items were identified in this research which enriched Tong's checklist. Taking into account all identified items and meaningful aggregation of the profile for reporting on FG, which we named the "new checklist" for reporting on the use of FGs when researching the experiences of CMH service users includes 14 items described in detail below:

1. Subject of study: definition of the core subject of research;
2. Purpose of study: definition of research purpose, objectives, and questions;
3. Research plan: study approach, use, and non/hierarchical combination of methods;

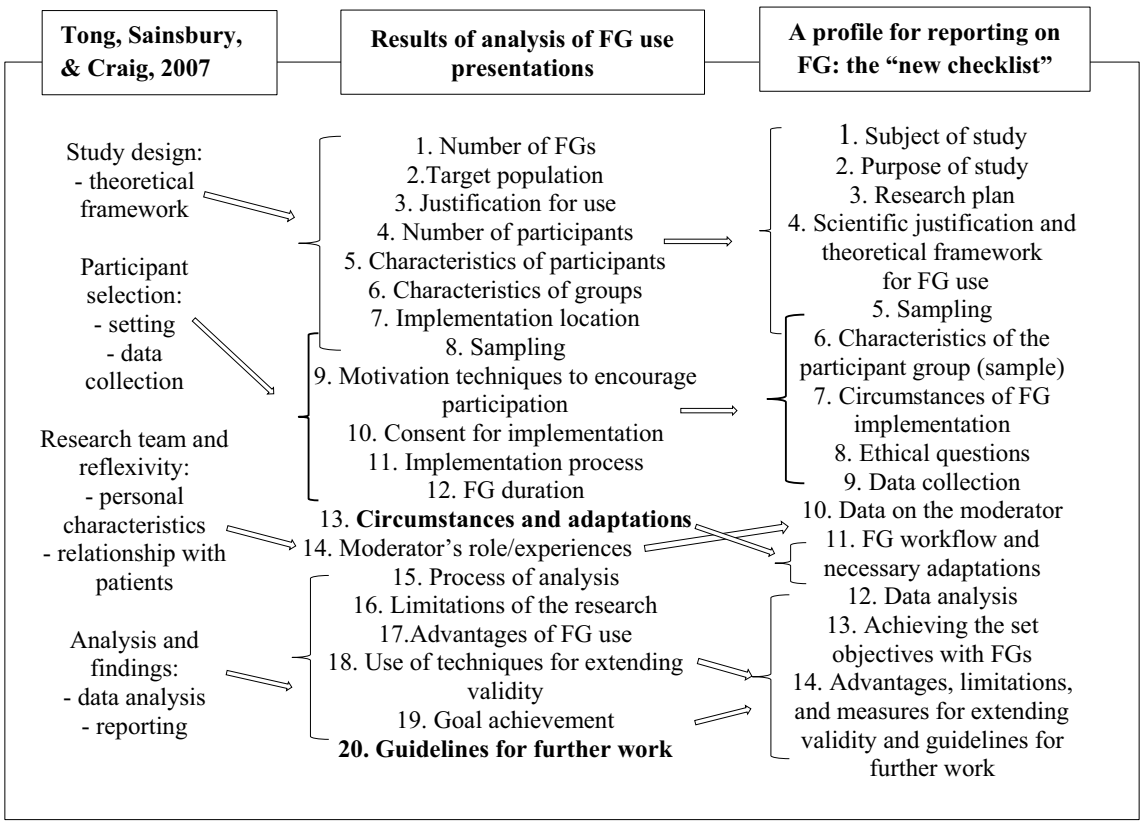

Fig. 2 Process of preparing a profile for reporting on FG

4. Scientific justification and theoretical framework for FG use: reason for the use of the FG method and theoretical clarification; equivalence of using this method in combination with other methods; analytical models, etc.;
5. Sampling: sampling method, sampling approach method, estimated/final sample size, non-participation (how many people rejected inclusion or were eliminated from the sample), sample composition;
6. Characteristics of the participant group (sample): number, demographic characteristics, group continuity; relationships established before the beginning, participants being acquainted with the moderator/interviewer; number of members, characteristics, deviations from the expected pattern;
7. Circumstances of FG implementation: number, FG repetition, location, presence of outside participants (in addition to participants and researchers);
8. Ethical questions: approval of ethical committees (why, yes/no), informed consent, adopted agreements;
9. Data collection: outline of questions (how was it developed/was it pilot tested), re-implementation, audio/video recordings, FG duration, data saturation, records returned for revision;
10. Data on the moderator: not/overlapping the role of moderator and researcher, personal characteristics of the moderator, mandate, profession, gender, experience, moderator's characteristics as described by participants;
11. FG workflow and necessary adaptations: prior agreements, prior written completion of personal data, enabling participation without signing an attendance list, possibility to leave/arrive at any time, interruptions, inclusion of motivational elements;
12. Data analysis: information on number of codes, description of coding, topic development, software used, participant feedback according to the findings;
13. Achieving the set objectives with FGs: presentation of findings, consistency of data and findings, clarity of main topics, clarity of minor topics;
14. Advantages, limitations, measures for extending validity: critical assessment, proposals for extending validity, and guidelines for further work.

Discussion

To answer the research questions, this paper's researchers performed content analysis of 20 selected scientific articles reporting on scientific findings obtained using FGs with CMH care service users. Based on the analysis of selected articles, the researchers deduced that authors do not place enough attention on presenting their use of FGs. The use of the prepared checklist for reporting on the use of FGs to obtain data from the viewpoint of CMH service users' can have a positive impact on the clarity of the scientific findings presented. The experiences of implementing FGs, and the adaptations to the process of obtaining data from the perspective of people with mental health problems when conducting research on CMH reveal the problem of limited access to the issue for the selection of FG participants.

The map of items for presenting FG use, which was developed because of a content analysis of the selected articles, introduces advantages for researchers using and reporting on the use of FGs when collecting data from the perspective of CMH service users. However, when comparing the map with the Tong et al. (2007) checklist, conceptual differences became evident. Tong et al. (2007) focused on both the theoretical and applied levels of FG use and implementation in three domains: research team and reflexivity; study design, and data analysis and reporting.

The checklist suggested here is based on the COREQ Checklist (Tong et al. 2007) and has been remodelled after considering the experience of the present researchers. Researchers of focus group use in CMH health more on the studied topic than on the theoretical bases of FG use. The developed checklist was updated with missing items. The resulting new checklist was created as an added value to the present research, in accordance with previous research and FG presentations.

The new checklist includes 14 items outlined with descriptors. Items are given in order of the research process. The present researchers estimate that the main advantage of such a structure is the checklist transparency, which leads to systematic reporting.

Presentation of scientific findings obtained by using FGs with CMH care service users must include the presentation of the FGs' implementation and its necessary adjustments (checklist point 11). The researchers believe that such a checklist would increase attention to reporting adjustments that have been made in the research process, and subsequently discussing them from the point of view of the validity, verifiability and comparability of findings. Systematic comprehensive reflection of the experience of the FGs can lead to consideration if the data really reflect service users' experiences, or are not perhaps socially acceptable answers.

Scientific Justification for FG Use with Community Mental Health Service Users

Scientific justifications for FG use when obtaining data from the viewpoint of CMH service users is scarce in the selected articles. The descriptions are, however, in accordance with the scientific justification for FG use in methodological articles (Krueger and Casey 2002; Onwuegbuzie et al. 2009; Then et al. 2014). A noteworthy example of a scientific

justification is the article by Makdisi et al. (2013), which describes FG use as the most adequate method because

(a) Its interactive nature helps establish mutual support between members and enables simplification of discussions, adding new perspectives and responses (more information is generated rather via individual interviews with the same number of participants);
(b) It helps investigate sincere attitudes and beliefs (the discussion is usually less formal than in one-to-one interviews); and
(c) It helps reveal the true language the participants use.

There is also an emphasis on the importance of cumulative data collection according to the purpose of the study. In fact, group interactions have the potential to produce new information; the greater the weight of the participants' opinions, the smaller the researcher's impact must be (Moltu et al. 2013).

Ardila Gymez (2014) expresses concern that a vulnerable group may not be able to realistically evaluate a programme they depend on. Busfield (2000), on the other hand, draws attention to the fact that those who work in health care can—as seen in Foucault's (1977) perspective—be called to re-evaluate their understanding of power and power-related repression. Busfield emphasises that a change of view is only possible without resistance to power relationships. In his opinion, Habermas's (1976) view can help develop recommendations for change by encouraging communication between all interested parties. More open communication can provide open interaction between all possible sides, including people with mental health problems. He suggests a combined Foucault and Habermas approach: "all interested parties must work together". The importance of including FGs with service users in CMH research is certainly not only due to scientific justification of the research methodology, but it is also an opportunity for service users to participate in evaluation and decision-making mechanisms within CMH care development.

Adaptations, Limitations, and Opportunities of FG Use with Mental Health Service Users

What are the experiences of FG implementation in CMH research regarding the adaptations necessary to obtain data from people with mental health problems? There is no single answer to this question, as the authors did not provide much information. When comparing generally established FG implementation standards (Vaughn et al. 1996) with the content analysis results of the selected publications, it can be noted that there are various adaptations in FG implementation for this group. Due to the characteristics of the target group, adaptations are introduced, particularly regarding number of participants, sampling, the FG workflow, and ensuring participation. In the research on the role of NGOs within the support network for people with mental health disabilities (Zupančič and Pahor 2016), the sampling phase introduced adaptations in accessing CMH service users through NGOs. In general, however, based on the present researchers' experience, as a viable aspirational ethical stance for the research community (Lahman et al. 2011), this method helped collect more data in terms of a larger number of different participants.

Compared to other research and FG presentations, the open-type FG is another adaptation not yet mentioned; it has proven to be feasible and successful. The profile of adaptations has so far mainly included activities such as focus on motivating to participate, emphasis on use of agreed terminology (Sandhu et al. 2016), addition of recording the minutes (Graham et al. 2014), care for the moderator's accurate knowledge and understanding of context (Makdisi et al. 2013), and informing via interpreter (Douglas et al. 2011) etc.

In most of the articles, it was impossible to differentiate the limitations of FG use from the limitations of the rest of the research. Burton et al. (2015) emphasise that it is essential to take into account the limitations of the research. The highlighted limitations mainly stem from the size and composition of the sample, making it impossible to generalise the results. Starnino et al. (2014), for instance, point out that only motivated participants took part in the research. Girard et al. (2014) mention the issue of the lack of variability in terms of the participants' mental health, as the more or less acute phases provide for different forms and patterns of contact between all participants. It is evident that most issues stem from sampling. Samples primarily include 'non-problematic' service users, which is a significant limitation that must be clearly presented when reporting on FG implementation.

On the one hand, payment as motivation to participate is acceptable, as the target group is, on average, financially deprived. On the other hand, a fundamental principle of working at NGOs is volunteering when taking part or actively collaborating. Rifkin (2003) emphasises that the notion of empowerment grows inside the individual and power cannot be donated; however, it is reasonable to create opportunities for empowerment. Taking part in FGs is one such opportunity for empowerment. Linhorst (2005) differentiates between empowerment through health care planning, choice of accommodation, collaboration in shaping public policy, employment, taking part in research, and active involvement in assistance programmes. In this manner, people with mental health problems improve their individual perceptions of personal control, and thus directly influence their own health (Laverack 2006).

There are disadvantages in conducting this FG, such as:

(a) Not openly talking about one's views and experiences (Graham et al. 2014);
(b) The danger of certain views being silenced (Moltu et al. 2013);
(c) The sensitivity of the research regarding the participatory approach for people with a mental health crisis (Makdisi et al. 2013);
(d) The lack of individual data for comparison or explanation of potential links (Sandhu et al. 2016); and
(e) Frank warning about the difficulty of FG implementation involving the particular group of participants (Graham et al. 2014).

These issues show the need for an experienced moderator with knowledge and understanding of the context to achieve the research objectives. The issue of moderators' experience not only limits the research, but also presents a potential risk for participants when moderators pass from identifying users' needs to the level of encouraging them to relive personal experiences.

Advantages described by authors include a complex research plan that leads to the view of the studied issue from multiple perspectives, thus producing new knowledge (Mgutshini 2010; Starnino et al. 2014; Lloyd-Evans et al. 2015). The final analysis of data collected using different methods is generally based on data triangulation. One of the advantages mentioned is the use of triangulating sources as methods (Sweeney et al. 2015). In any case, it is important to verify whether individual methods are considered (non-)equivalent (Creswell and Clark 2007). Zupančič and Pahor's (2016) analysis of data collected from combining qualitative and quantitative methods showed the differences in the descriptions of NGOs' role within the mental health support network among various stakeholders. The differences are linked to their integration into NGO activities and are apparent in the amount of criticism of NGOs. This can represent an obstacle in the processes of integrating NGO's into the public health support network at the local level.

Guidelines for further work must also be outlined (basis for further research, implementation of findings into practice, impact on policy, theory development). Despite naming several advantages of their research, Makdisi et al. (2013) leave it to the reader to judge the quality of the presented research. In order for the reader to be able to judge the quality of the selected research, the author must report responsibly not only on the research findings, but also in accordance with the newly developed profile for presenting FG use (Makdisi et al. 2013).

Opportunities for Further Research and Limitations of the Study

This study provides further opportunities based on the new checklist developed for reporting on FG use with service users. It represents a substantial scientific basis to promote FG use as a means of enabling and achieving necessary user participation at all levels and in all processes. The study limitations are related to sample selection and crosssectional design, which limit the findings' generalisability to a certain extent. In the future, it is advisable that the overview include researchers' experiences regarding the necessary adaptations for implementing this method with mental health service users according to various risk factors and their combinations, whether the service users are in a CMH setting or undertaking institutional treatment.

Conclusion

There are shortcomings in the reporting on the scientific merits of FG use and adaptations in its implementation while researching the experiences of CMH service users. They point to a need for increased focus on reporting, in order for FG use to become more productive. The profile for presenting FG implementation we developed (the "new check list") shows the possibility of a more productive use of FGs in CMH research in terms of the comparability, verifiability, and validity of findings. FGs are not only useful as a scientific research technique, but also for ensuring service users' participation in decision-making mechanisms in CMH, and evaluating the quality of the mental health system and services.

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Compliance with Ethical Standards

Conflict of interest There are no financial, personal, or academic conflicts of interest.

Ethical Approval Ethical approval for this research was not required. Questions for patients were formulated in such a manner that did not allow an invasion of privacy or recollection of unpleasant events.

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