

Online Resource 5

Patient and Family Perspectives on Accessing and Continuing Behavioral Health Services: A Qualitative Investigation
Community Mental Health Journal

COREQ (Consolidated Criteria for Reporting Qualitative Research) 32-item checklist

Checklist source. Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, 19(6), 349–357. <https://doi.org/10.1093/intqhc/mzm042>

How to read this checklist. Item numbering, item names and guide questions are reproduced verbatim from the published COREQ checklist. The final column gives the location in the revised manuscript and, where the item is answered by a specific statement, quotes that statement verbatim. Page numbers refer to the revised manuscript submitted with this file.

Items reported as not done. Five items (13, 18, 22, 23 and 28) record procedures that were not carried out. COREQ asks whether each item was addressed, not whether it was performed, and these are reported explicitly in the Methods rather than left silent.

Domain 1: Research team and reflexivity

No.	Item	Guide question / description	Page	How and where the item is addressed in the revised manuscript
Personal characteristics				
1	Interviewer / facilitator	Which author/s conducted the interview or focus group?	6	Methods → Research team and reflexivity: “Focus groups were led by a licensed psychologist, with one or two additional team members present to co-lead, assist with logistics, and take notes.” Spanish-language groups were co-facilitated by one of two bilingual consultants (Methods → Procedures, p. 6). Facilitating authors: DM and JM.
2	Credentials	What were the researcher’s credentials? E.g. PhD, MD	6	Methods → Research team and reflexivity: “The team comprised two clinical psychologists, one health services researcher, and three research coordinators, all of whom had prior training and experience in qualitative research.” Degrees of the facilitating authors: DM, PsyD, MPH; JM, PsyD. Degrees of the two primary coders: KS, BA; EB, MPH.
3	Occupation	What was their occupation at the time of the study?	6	Methods → Research team and reflexivity: “The evaluation was carried out by a health services research and evaluation team at an academic medical center under contract to the state Medicaid agency.”
4	Gender	Was the researcher male or female?	7	Methods → Research team and reflexivity: “The evaluation team comprised five women and one man.”
5	Experience and training	What experience or training did the researcher have?	5–6	Methods → Research team and reflexivity: the team were “all of whom had prior training and experience in qualitative research.” Study-specific preparation is described in Measures (p. 5): the family member and caregiver guide was rehearsed in mock sessions in November 2021, and the first member focus groups each closed with a full-team debrief to fine-tune questions and prompts.
Relationship with participants				
6	Relationship established	Was a relationship established prior to study commencement?	6–7	Methods → Research team and reflexivity: “No member of the team had a prior clinical, professional, or personal relationship with any participant, and no member of the team had any role in participants’ eligibility for MassHealth or in their access to behavioral health services.”
7	Participant	What did the participants know	5, 7	Methods → Research team and reflexivity: “Participants were told at the start of each

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	knowledge of the interviewer	about the researcher? E.g. personal goals, reasons for doing the research		session that the purpose of the discussion was to bring their experiences to the attention of MassHealth, and that neither their names nor other identifying information would be shared with MassHealth or with their clinicians.” A fact sheet explaining the study and participants’ rights was sent to every selected participant in advance (Procedures, p. 5).
8	Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? E.g. bias, assumptions, reasons and interests in the research topic	7–8, 21	Methods → Research team and reflexivity reports the team’s characteristics relative to participants: “All six team members self-identified as White and none spoke Spanish. The team therefore did not share the racial or ethnic background or the language of many participants. The Spanish-language sessions depended on the bilingual consultants.” The same subsection reports the practices used to surface and check the team’s influence: note-taking at every session and full-team debriefs after the early focus groups, continuing as a standing meeting item (p. 7). The independent double coding, reconciled against a shared code book to inter-rater reliability above 80 percent, is described in Analysis (p. 8). The bias created by the team’s position is named in Strengths and Limitations (p. 21): participants “were speaking about a program that paid for their care, to researchers working on that program’s behalf, which may have discouraged some criticism.”

Domain 2: Study design

No.	Item	Guide question / description	Page	How and where the item is addressed in the revised manuscript
<i>Theoretical framework</i>				
9	Methodological orientation and theory	What methodological orientation was stated to underpin the study? E.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	7	Methods → Analysis → Coding of transcripts: “We analyzed the transcripts using an inductive thematic analysis following the principles outlined by Patton (2015) for the design, conduct, analysis and reporting of qualitative studies. Codes were derived from the data rather than from a prior conceptual framework, a shared code book was developed and applied by two coders working independently, and intercoder agreement was assessed as a check on the consistency with which codes were applied. Initial code development drew on established grounded theory coding techniques, but the study did not adopt a grounded theory design and we did not seek to generate theory.” The sentence immediately following cites Glaser & Strauss (1967) for the coding technique drawn on at that initial stage.
<i>Participant selection</i>				
10	Sampling	How were participants selected? E.g. purposive, convenience, consecutive, snowball	5–6	Methods → Procedures: “Multiple recruitment strategies were employed to obtain a diverse sample including both purposive and snowball sampling.” Selection into focus groups was by quota: “Members and family members were selected from the registrations using quota sampling to obtain demographic breadth across age, gender, race/ethnicity, and geographic region” (pp. 5–6).
11	Method of approach	How were participants approached? E.g. face-to-face, telephone, mail, email	5	Methods → Procedures: “Recruitment flyers and a registration form (Qualtrics, Provo, UT) were developed in English and Spanish. A website address to the registration was included on all recruitment materials, as well as a quick response (QR) code.” Channels were “distribution of recruitment flyers to relevant listservs, outreach to

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				colleagues working in primary care settings across Massachusetts, and posts on social media”, with snowball distribution by participants and interested clinicians.
12	Sample size	How many participants were in the study?	9	Seventy participants: 45 MassHealth members and 25 family members or caregivers (Table 1, p. 9). Results → Participant characteristics: “Twenty focus groups and five individual interviews were conducted between November 2021 and February 2022.” Fifteen of the 70 participants (21%) took part with Spanish interpretation (Table 2, p. 10).
13	Non-participation	How many people refused to participate or dropped out? What were the reasons for this?	6, 9	Table 1 (p. 9) reports the full recruitment funnel: 174 registrants, 97 invited (56% of registrants), 70 participants (72% of invitees). Reasons were not collected, and this is stated: “Reasons for non-participation were not collected. Registrants who were not selected were not contacted further, and selected participants who did not attend were not followed up” (Procedures, p. 6).
Setting				
14	Setting of data collection	Where was the data collected? E.g. home, clinic, workplace	5–6	Methods → Procedures: “FGs were scheduled for 90 minutes and took place remotely over Zoom.” Participants who were not comfortable using Zoom were sent written instructions in advance, offered assistance from a team member, and could take part by telephone instead (p. 5).
15	Presence of non-participants	Was anyone else present besides the participants and researchers?	6	Methods → Procedures: “FGs were conducted by one lead interviewer from the evaluation team and one or two other team members to co-lead, assist with logistics, and take notes.” Spanish-language groups were co-facilitated by a bilingual consultant who provided consecutive interpretation. No one else was present.
16	Description of sample	What are the important characteristics of the sample? E.g. demographic data, date	3, 9–10	Table 1 (recruitment and participation by respondent type and primary language, p. 9) and Table 2 (current diagnosis, age group, gender, race/ethnicity, geographic location and primary language, pp. 9–10). Data were collected between November 2021 and February 2022 (Setting, p. 3; Results, p. 9).
Data collection				
17	Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	5	Methods → Measures describes the development of both semi-structured guides between July and November 2021, the domains covered, and the Spanish translation process. Pilot testing is reported: “Before data collection began, the family member and caregiver guide was rehearsed in mock sessions in November 2021, and notes from those sessions produced revisions to question wording, question order, and probes in both guides.” The full guides are supplied: “Copies of both guides, in English and in Spanish, are provided as Online Resources 1 to 4.”
18	Repeat interviews	Were repeat interviews carried out? If yes, how many?	6	No. Methods → Procedures: “No participant took part in more than one session.”
19	Audio / visual recording	Did the research use audio or visual recording to collect the data?	6	Audio only. Methods → Procedures: “FGs were audio-recorded with the permission of the participants.”
20	Field notes	Were field notes made during and/or after the interview or focus group?	6–7	Yes. Every session included a team member “to co-lead, assist with logistics, and take notes” (Procedures, p. 6), and Research team and reflexivity states “A team member took notes during every session” (p. 7). Debriefs followed the early focus groups and continued as a standing item in team meetings.

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21	Duration	What was the duration of the interviews or focus group?	6	Methods → Procedures: “FGs were scheduled for 90 minutes and took place remotely over Zoom.” Scheduled duration is reported; actual session durations were not recorded.
22	Data saturation	Was data saturation discussed?	8	Yes, and it is reported as not assessed. Methods → Analysis: “We did not assess data saturation. Recruitment was governed by the evaluation’s fixed data collection window and by quota sampling designed to obtain demographic breadth across age, gender, race/ethnicity, and geographic region, rather than by a judgment that no new information was being contributed. ... We make no claim that the themes reported here exhaust the range of experience among MassHealth members and their families.”
23	Transcripts returned	Were transcripts returned to participants for comment and/or correction?	8	No. Methods → Analysis: “Transcripts were not returned to participants for comment or correction...”

Domain 3: Analysis and findings

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Data analysis				
24	Number of data coders	How many data coders coded the data?	7–8	Four team members produced the initial codes; two served as primary coders throughout. Methods → Analysis: “four evaluation team members reviewed the transcripts independently to create an initial set of codes”, and “Two evaluation team members served as primary coders for all transcripts.” The two coders reconciled independently coded transcripts “until the two coders reached an inter-rater reliability (IRR) level of greater than 80% across select transcripts”, with oversight by the lead evaluator. Primary coders: KS and EB.
25	Description of the coding tree	Did authors provide a description of the coding tree?	7–8	Methods → Analysis describes code book development in full: independent initial coding by four team members, a draft code book, regular team review of excerpts and code applications with iterative addition of codes until the code book was finalised, and a single code book applied to both member and family member transcripts, which were analyzed together. The code book itself is not reproduced in the manuscript: “The final code book is available from the corresponding author on request” (p. 8).
26	Derivation of themes	Were themes identified in advance or derived from the data?	7	Derived from the data. Methods → Analysis: “Codes were derived from the data rather than from a prior conceptual framework...” The manuscript also records the one respect in which the process was not purely open: “This process was guided by a careful review of the interview guide to ensure representation of all relevant themes discussed by participants.”
27	Software	What software, if applicable, was used to manage the data?	7	Methods → Analysis: “Transcripts were quality assurance checked and uploaded into the mixed-methods software, Dedoose (v 9.4), for qualitative analysis.” Registration data were collected in Qualtrics (Procedures, p. 5).
28	Participant checking	Did participants provide feedback on the findings?	8	No. Methods → Analysis: “...and participant feedback on the findings was not sought.”
Reporting				
29	Quotations	Were participant quotations	11–16	Yes, and every quotation is identified. Table 3, “Exemplar Quotations by Sub-theme”

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	presented	presented to illustrate the themes / findings? Was each quotation identified? E.g. participant number		(pp. 11–13), presents one exemplar quotation for each of the sixteen sub-themes, numbered Q1 to Q16 in the order the sub-themes appear in the Results; two further quotations are embedded in the Results narrative, Q17 under sub-theme 1a (p. 13) and Q18 under sub-theme 3d (p. 16). Each quotation carries a respondent-type label and a unique number, for example “(Family member, Q1)” and “(Member, Q11)”.
30	Data and findings consistent	Was there consistency between the data presented and the findings?	8, 11–16	Each sub-theme in the Results (pp. 13–16) is reported as narrative and illustrated by its exemplar quotation in Table 3 (pp. 11–13). Prominence is reported using a fixed vocabulary rather than counts, and the basis for that choice is stated in Analysis (p. 8): “We do not report the number or percentage of participants endorsing each theme... We therefore describe the relative prominence of findings using consistent verbal descriptors, reporting a finding as shared by nearly all, most, many, some, or a few participants, or by one participant, and we make no claim about the prevalence of any experience beyond this sample. We use ‘nearly all’ to mean all but one or two of the participants who spoke to a topic, ‘most’ a clear majority of them, ‘many’ a substantial share short of a majority, ‘some’ a minority larger than a few, ‘a few’ two or three participants, and ‘one participant’ a single voice.”
31	Clarity of major themes	Were major themes clearly presented in the findings?	11–17	Four major themes are named and used consistently in the Abstract, the Results (pp. 13–16), Table 3 (pp. 11–13) and the Discussion (p. 17): Theme 1, Preferences for demographically concordant clinicians; Theme 2, Barriers and facilitators to care navigation; Theme 3, Importance of patient-centered clinician behaviors and strong therapeutic alliance; Theme 4, Benefits and risks of family involvement in treatment engagement.
32	Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	11–16	Each major theme is reported as named sub-themes, sixteen in all, each with its own heading in the Results (pp. 13–16) and its own row in Table 3 (pp. 11–13): 1a, Difficulty finding demographically concordant clinicians, and occasional success; 1b, Directories and referral guides omit clinician demographics; 1c, Limited workforce diversity discourages and delays engagement; 2a, A confusing, discouraging search, with outdated and inaccurate information; 2b, Care pathways are often built for crisis and court-ordered care; 2c, Resources and dedicated pathways that help, including navigators and care coordinators; 2d, System-level facilitators and disruptions: scheduling flexibility, telehealth, coverage lapses, and financial assistance; 2e, Clinician turnover as a system-level disruption; 3a, Demeanor, communication, and “fit” shape engagement in both directions; 3b, Need for clinician patience, especially after trauma; 3c, Preference for experienced clinicians, flexibility, self-disclosure, and genuine engagement; 3d, Harms associated with lengthy, repetitive, impersonal intake assessments; 4a, Families as practical and emotional facilitators; 4b, Involvement seen as necessary for children and adolescents; 4c, Some participants expressed desire that their family members be invited into treatment; 4d, Risks of family involvement: adverse experiences, loss of autonomy, and exclusion. Diverse and divergent cases are reported within the sub-themes, for example the occasional successes alongside the difficulties in 1a, clinician behaviors that shape engagement “in both directions” in 3a,

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				and the contrast between participants who wanted family invited into treatment (4c) and those who chose to exclude family (4d).

Checklist completed against the revised manuscript. Item numbering, item names and guide questions reproduced from Tong, Sainsbury & Craig (2007).