TITLE: Supporting women leaving prison: a participatory health research study of the impact of peer health mentoring

ABSTRACT

Background: During the transition between prison and community people are at greatly increased risk for adverse health outcomes. This article explores the impact of a peer health mentor program that supports women in the first three-days following their release from a provincial correctional facility in British Columbia Canada.

Methods: We used a participatory health research framework to develop a multi-method evaluation of the impact of the Unlocking the Gates Peer Health Mentoring Program (UTG program). Between 2013-2018 women being released from Alouette Correctional Centre for Women were invited to access the UTG program. All clients were invited to participate in evaluating the program. We analyzed survey and interview data using descriptive analysis and content-analysis for quantitative and qualitative data respectively.

Results: Women identified a range of needed supports during the transition from prison to community including access to clothing, social assistance, housing and healthcare. Participants described a mix of experiences of release including excitement, anxiety, hope and a wish for understanding and support. Within 72 hours of release nearly half (47%) of participants accessed a family physician, and 85% accessed at least one community resource. Overall 93% of participants reported that their Peer Health Mentor assisted them in accessing community resources.

Interpretation: This study found that peer health mentorship provides valuable, multifaceted support in helping women to navigate health and social services and to meet their basic needs. Strengthening health supports during the transition from prison to community is critical to promoting the health and wellbeing of women leaving prison.

Introduction

On any given day, about 40,000 adults are imprisoned in Canadian correctional facilities. (1) In Canada, the vast majority of people return to community after weeks rather than years. (1) During the transition between prison and community, people are at greatly increased risk for poor health outcomes, harm and death. (2,3) Many people who experience incarceration have histories of unstable housing, low educational attainment, financial insecurity and childhood abuse or trauma. (4–6) On release people often lack financial resources and adequate housing (7) and are released without supports or tools for this transition. People who experience incarceration have a high burden of health conditions including mental health, substance misuse, as well as acute and chronic physical health conditions. (8,9) Immediately following release people face multiple, competing challenges and priorities which may make it difficult to prioritize their health. (10) Compounding these challenges, people with history of incarceration may experience barriers to accessing healthcare services including discrimination due to their criminal justice involvement. (7,11) Ensuring adequate support during this transition is critical from both health and justice perspectives as medical co-morbidities and poor health are linked with relapse to substance misuse following release (7) and with recidivism. (5)

In this paper, we define peers as people with lived experience of incarceration. Peers trained as health mentors can provide important social and navigational support during this transition. Peers can act as role-models and inspire hope. (12,13) Additionally, peers are uniquely positioned to develop empathetic, non-directive relationships and to support people to trust and engage with services. (12) Among people with substance use disorder there is evidence peer support can increase engagement with treatment, reduce relapse, improve relationships with providers and enhance treatment experience. (13) Peer support is also a fundamental component of trauma-informed care. (14)

During previous community-based participatory health research, (15) women with incarceration experience proposed a peer health mentor program that would support women to achieve their health goals as they

transition from prison to community. The purpose of this article is to explore the impact of a peer health mentor program that supports women in the first three days following release.

Methods

We undertook an evaluation study using a participatory health research (PHR) framework, which engages participants in research processes, thereby creating research that informs or creates social action to improve the quality of people's lives and their communities. (16) Formerly incarcerated women, who proposed, developed and implemented the Unlocking the Gates Peer Health Mentor program (UTG program), also participated in designing and implementing the evaluation by developing the survey tools, applying for Research Ethics Board review, conducting the interviews, assisting with data analysis, interpreting study findings, writing reports and leading other dissemination activities.

Setting

Alouette Correctional Centre for Women (ACCW) is the main provincial custodial centre for women in BC. It is a multi-level security prison located in Maple Ridge. Length of stay averages three months and ranges from a few days to 24 months.

Participants

The only criterion for eligibility for the study was being a client in the UTG program.

Recruitment

Incarcerated women were contacted by personalized letters mailed by the UTG team, or by posters and flyers in ACCW living units. Beginning June 1, 2013, the UTG team wrote an invitation letter to every woman who received a custodial sentence as identified in the Court Services Online, BC Ministry of Attorney General. (https://justice.gov.bc.ca/cso/esearch/criminal/partySearch.do)

Women who wished to participate were invited to either 'call collect' to the UTG program or to approach a specific staff member within ACCW to facilitate referral.

During the first meeting following release, the peer health mentors (PHM) invited women to participate in the evaluation of the program. Responses to survey questions were recorded on paper forms. At the end of the three-day mentorship period, participants were invited to complete the three-day post-release survey, and return it in a stamped, addressed envelope to the UTG office. Following the three-day program, PHMs often kept in contact with participants, providing mentorship via cellphone, Facebook or by word-of-mouth.

Protocol Development

Members of the UTG team (previously-incarcerated women and academics) co-created a multi-method program evaluation framework to evaluate the impact of the UTG program. We report here two components of the evaluation.

1. When released, women met their peer health mentor and completed the ***Release Intake Form*** which included questions such as: "What supports do you need? Number three choices in order of importance."; "What was it like for you to have a peer mentor meet you today as you were released?"; "What are you feeling most hopeful about?"; "Did you have any fears about being released?" In July 2016, a ***demographic factor survey*** was added which included questions about: age, marital status, education, income support, children and incarceration history.
2. The ***three-day post-release survey*** included questions about: current location; resources accessed during the first 72 hours following release, participant's experience with their peer health mentor; a satisfaction scale; a 27-item Q-sort tool, which presented variables as personal statements ("it would make a difference in my life if I had…").

Approval was obtained from the University of British Columbia Behavioural Research Ethics Board (#H11-02961). Amendments were obtained for study modifications which emerged through iterative PHR processes, and for secondary use of data from UTG program telephone interviews.

Analysis

Each participant was given a unique study ID number. Data were deidentified and entered into an Excel spreadsheet. Quantitative data were analyzed using descriptive statistics. Open-ended questions were examined using content analyses (conducted by KM, verified REM, MK, PY).

To check the evaluation findings, women with incarceration experience were invited to review the manuscript through a closed Facebook group. Additionally, four co-authors are women who have experienced incarceration and are also members of the UTG team.

Findings

Participants

Between March 2013 and July 2018 there were 346 program contacts from 340 women (Figure 1). For each contact, a telephone interview was conducted and recorded for UTG program use. Of these contacts, 173 met their PHM mentor; 172 completed the intake interview and signed consent forms. At the end of their three-day mentoring relationship, 105/172 (61%) women completed a three-day post release survey.

During intake interview, 92/172 (53%) participants identified themselves as Indigenous women. In 2016, a demographic survey was added and was completed by later program participants (n=66). Of these 66 women, 65% were aged 31-50, 15% identified as LGBTQ2+, 70% were single, never married, and 51% attained grade 10 or lower as their highest level of education. At the time of intake 24% of women were homeless and 86% were accessing social assistance or disability. Fifty-four (80%) women had children and 46 (70%) had one or more child under age 18. Only five (7%) women were leaving their first time in custody and 54 (90%) were

on probation at the time of intake. Twenty-nine (44%) women were 18 or younger at the time of their first incarceration. The median time served for this most recent incarceration was 45 day (Table 1).

Identified Needs

At the time of the study, women leaving ACCW were returning to communities across the province (Table 2). This made navigating travel home an immediate need for most women. At the time of their telephone interview, 10% of women were unsure where they would go when released.

Women identified their support needs twice, first in the telephone interview during their incarceration and again during the in-person intake interview following their release (Table 3). A majority of women identified clothing and social assistance (welfare) as needs in both interviews. Housing was identified as a need by a majority (52%) of women during the telephone interview and by 37% in the intake interview. An immediate need for healthcare was identified by 15% of women in the telephone interview, and 30% in the intake interview.

During the intake interview, women were asked to identify resources they felt could have helped them before release. Responses were received from 108 women and included: more contact with the community; more telephone; more release planning support; having welfare set up; having safe housing lined up; more connections with Alcohol & Drug (A&D) counsellors; and recovery houses or treatment centres.

To understand more about women's needs and the contexts of their lives, participants were asked to respond to a series of questions adapted from the Difference Game. (17) Women were asked to agree or disagree with statements starting with "it would make a difference in my life if I had…" (Table 4). The most commonly identified factors were: money to buy necessities (87%), someone to talk about the things that worry me (86%), housing (85%), medical care (85%) and a real friend (85%).

Experience of Release

At the intake interview women were asked what they would like people to know about women being released from prison. Illustrative quotes are provided in Table 5. Several women wrote about *greater understanding and the difficulties of release*. Others wanted people to know about the *need for greater support* during transition back to community. Women were also asked to share how they were feeling. Some expressed *excitement, especially related to their families, and that they were happy and hopeful* for a fresh start. Some women expressed *anxiety and fear about the uncertainty of release*. Many women expressed a *mix of emotions*.

Program Evaluation

Within the first 72 hours of release, 85% of participants connected with at least one community resource and nearly half (47%) accessed a family doctor. Among those who did not access a family doctor, 31 (60%) reported that their PHM provided information about how to access a family doctor. A majority of women (63%) required access to income assistance and of these women, 83% reported that their PHM accompanied them to obtain income assistance. Overall 93% of participants reported that their PHM assisted them in accessing community resources and 90% reported that their PHM helped them to achieve the goals they had identified for themselves before release.

The evaluation form invited participant narrative comments. Most wrote about how they saw *importance and value in the support of their peer health mentor*.

> "Peer health mentors are a huge help. They understand what you've been through and how you want to be free of it."

> "I am so grateful to have [PHM] here with me today otherwise I would of probably used"

> "I am happy with everything and very grateful for this program. If it wasn't for your program I would have given up on trying."

Interpretation

To our knowledge, no other study has reported on the importance of peer health mentorship in supporting women transitioning from prison to the community in Canada. This study found that peer health mentorship provided valuable, multifaceted support which helped women to navigate health and social services as well as meet their basic needs. In this study, nearly half (47%) of women accessed a family physician within 72 hours of their release. A recent study in BC found that people are more likely to be refused by a family physician if they disclose a history of incarceration. (11) Additionally, women incarcerated in Ontario identified health literacy and knowledge of services as barriers to accessing healthcare inside prison and in the community. (18) A PHM may be valuable in helping to navigate services and to identify specific services and practitioners who will not discriminate.

Though 4.9% of the Canadian population identify as Indigenous, (19) 53% of participants in this study were Indigenous women. In provincial/territorial facilities, 28% of incarcerated men are Indigenous men, and 43% of incarcerated women are Indigenous women. (1) There is an urgent need to address the systemic criminalization of Indigenous people, and to provide culturally safe and trauma-informed approaches to address the ongoing legacy of the 60's Scoop and the residential school system. (20) Future work in the PHM program will seek to increase ways knowledge and supports may be grounded in Indigenous culture and ways of knowing.

Our study highlighted the critical need for stable housing for those who are leaving prison. Housing is a key determinant of health (21,22), and an essential resource for addressing other needs such as employment and healthcare services. Finding secure housing is also one of the most challenging barriers people face in reentry into community. (23) In this study 80% of participants had children and most had children under age 18. This sobering reality of parenthood among incarcerated women highlights the need for family-based programming and supports, as well as collaboration between ministries responsible for corrections, health and child and family services during incarceration and following release.

The distance to travel home was a huge challenge faced by women leaving prison. In this study, 40% of women were returning to communities outside the region the prison is located in (Lower Mainland/Southwest). The geographical separation of women from their communities is also a barrier to maintaining family connections and relationships throughout incarceration. This separation contravenes international recommendations for smaller, local custodial units for women in the criminal justice system. (24)

When asked what would make a difference in their lives, women most often identified needs related to money, social connection, housing and healthcare. This reflects the disproportionate experience of inadequate social supports and services on the health and wellbeing of people who experience incarceration. In this study, 44% of participants reported that it would make a difference in their life if they had access to birth control. This finding is consistent with research in Ontario which found that 80% of incarcerated women reported an unmet need for contraception before their admission to corrections, and 38% anticipated this as an unmet need after release. (25)

Women evaluated the PHM program at the end of the three days of mentorship. This short window limits the ability to understand the lasting impact of peer mentorship immediately following release. Future research should assess the impact of peer health mentoring in long-term achievement of health goals as well as on supporting women to break the cycle of reincarceration. In the short-term this evaluation shows multi-faceted benefits to having the support of a PHM during the transition from prison. The positive experiences expressed by participants are reflective of the impact of peer support described in other studies. In a USA randomized control trial, people leaving prison who were connected with a transition health team which included a peer mentor had reduced use of Emergency Department (26) compared to another accessible clinic. In British Columbia, the Provincial Health Services Authority (PHSA) which has been responsible for healthcare in provincial correctional facilities since October 2017, is piloting Community Transition Teams which include peers. Although this paper does not report on the content of the telephone calls, program

records indicate that PHM provide practical advice about healthcare and other community resources over the telephone to women in prison, to assist them in addressing their health and social goals related to their pending discharge.

Strengthening health supports during the transition from prison to the community is important in increasing access to primary health and social services and mitigating morbidity, mortality, hospitalization and emergency department use.

References

1. Malakieh J. Adult and youth correctional statistics in Canada, 2016/2017 [Internet]. 2018 [cited 2019 Mar 28]. Available from: https://www150.statcan.gc.ca/n1/pub/85-002-x/2018001/article/54972-eng.htm
2. Groot E, Kouyoumdjian FG, Kiefer L, Madadi P, Gross J, Prevost B, et al. Drug toxicity deaths after release from incarceration in Ontario, 2006-2013: Review of coroner's cases. PLoS One. 2016;11(7).
3. Binswanger IA, Blatchford PJ, Mueller SR, Stern MF. Mortality after prison release: opioid overdose and other causes of death, risk factors, and time trends from 1999 to 2009. Ann Intern Med. 2013;159(9):592–600.
4. Stewart LA, Nolan A, Thompson J, Power J. Social determinants of health among Canadian inmates. Int J Prison Health. 2018;14(1):4–15.
5. Janssen PA, Korchinski M, Desmarais SL, Albert AYK, Condello L-L, Buchanan M, et al. Factors that support successful transition to the community among women leaving prison in British Columbia: a prospective cohort study using participatory action research. C open. 2017;5(3):E717–23.
6. Bodkin C, Pivnick L, Bondy SJ, Ziegler C, Martin RE, Jernigan C, et al. History of Childhood Abuse in Populations Incarcerated in Canada: A Systematic Review and Meta-Analysis. Am J Public Health. 2019;109(3):E1–11.
7. Binswanger IA, Nowels C, Corsi KF, Glanz J, Long J, Booth RE, et al. Return to drug use and overdose after release from prison: a qualitative study of risk and protective factors. Addict Sci Clin Pract. 2012;7(1):3.
8. Kouyoumdjian FG, Schuler A, Matheson FI, Hwang SW. Health status of prisoners in Canada Narrative review. Can Fam Physician. 2016;62(3):215–22.
9. Binswanger IA, Krueger PM, Steiner JF. Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population. J Epidemiol Community Heal. 2009;63(11):912–9.
10. Dong KR, Must A, Tang AM, Beckwith CG, Stopka TJ. Competing priorities that rival health in

adults on probation in Rhode Island: substance use recovery, employment, housing, and food intake. BMC Public Health. 2018;18(1):289–99.

11. Fahmy N, Kouyoumdjian FG, Berkowitz J, Fahmy S, Neves CM, Hwang SW, et al. Access to Primary Care for Persons Recently Released From Prison. Ann Fam Med. 2018 Nov;16(6):549–51.

12. Barrenger SL. Enacting lived experiences: Peer specialists with criminal justice histories. Psychiatr Rehabil J. 2019;42(1):9–16.

13. Reif S, Braude L, Lyman DR, Dougherty RH, Daniels AS, Ghose SS, et al. Peer Recovery Support for Individuals With Substance Use Disorders: Assessing the Evidence. Psychiatr Serv. 2014;65(7):853–61.

14. Chaudhri S, Zweig KC, Hebbar P, Angell S, Vasan A. Trauma-Informed Care: a Strategy to Improve Primary Healthcare Engagement for Persons with Criminal Justice System Involvement. J Gen Intern Med. 2019;34(6):1048–52.

15. Martin RE, Murphy K, Chan R, Ramsden VR. Primary health care: applying the principles within a community-based participatory health research project that began in a Canadian women's prison. Glob Health Promot. 2009;16(4):43–53.

16. Macaulay AC, Commanda LE, Freeman WL, Gibson N, McCabe ML, Robbins CM, et al. Participatory research maximises community and lay involvement. Br Med J. 1999;319(7212):774–8.

17. Grant T, Ernst CC, McAuliff S, Streissguth AP. The difference game: Facilitating change in high-risk clients. Fam Soc. 1997;78(4):429–32.

18. Ahmed R, Angel C, Martel R, Pyne D, Keenan L. Access to healthcare services during incarceration among female inmates. Int J Prison Health. 2016;12(4):204–15.

19. Statistics Canada. Aboriginal peoples in Canada: Key results from the 2016 Census [Internet]. 2017 [cited 2019 May 12]. Available from: https://www150.statcan.gc.ca/n1/daily-quotidien/171025/dq171025a-eng.htm

20. Adelson N. The Embodiment of Inequity: Health Disparities in Aboriginal Canada. Can J Public Heal / Rev Can Sante'e Publique. 2005;96(Suppl 2):S45–61.

21. Guirguis-Younger M, McNeil R, Hwang SW. Homelessness & Health in Canada. Ottawa: Univ. of Ottawa Press; 2014.

22. Lee BA, Tyler KA, Wright JD. The New Homelessness Revisited. Annu Rev Sociol. 2010;36:501–21.

23. Geller A, Curtis MA. A Sort of Homecoming: Incarceration and the housing security of urban men. Soc Sci Res. 2011;40(4):1196–213.

24. Cortson J. The Corston Report: a review of women with particular vulnerabilities in the criminal justice system. [Internet]. London; 2007. Available from: http://www.justice.gov.uk/publications/docs/corston-report-march-2007.pdf

25. Liauw J, Foran J, Dineley B, Costescu D, Kouyoumdjian FG. The Unmet Contraceptive Need of Incarcerated Women in Ontario. J Obstet Gynaecol Canada. 2016;38(9):820–6.

26. Wang EA, Hong CS, Shavit S, Sanders R, Kessell E, Kushel MB. Engaging individuals recently released from prison into primary care: a randomized trial. Am J Public Health. 2012;102(9):e22–9.

Table 1 - Demographic factors of women who participated in a peer health mentoring program for up to 3 days following their release from a provincial correctional centre

Demographic Variable	n (%)
Self-identified Indigenous Identity (n=172)	
Indigenous	**92 (53)**
First Nations	71 (41)
Metis	16 (9)
Inuit	4 (2)
Don't know	1 (1)
Not Indigenous	77 (44)
Don't know	2 (1)
Missing Data	3 (2)
Demographic data (n=66)	
Age	
16-30	19 (29)
31-50	43 (65)
51-70	2 (3)
Missing Data	2 (3)
Sexual Orientation	
Straight/heterosexual	54 (82)
LGBTQ2+	10 (15)
Prefer not to say	2 (3)
Marital Status	
Married	1 (2)
Divorced	2 (3)
Living Common Law	6 (9)
Single, Never Married	46 (70)
Widowed	5 (8)
Separated	6 (9)
Highest Educational Attainment	
Grade 8 or lower	7 (11)
Grade 9-10	27 (41)
Grade 11-13	26 (39)
Some Post-Secondary	12 (18)
Don't Know/Prefer not to say	3 (5)
Homeless at time of intake interview	16 (24)
How do you support yourself? *	
Accessing Social Assistance/Disability at time of intake interview	57 (86)
Wages and salaries	1 (2)
Under the table income	1 (2)

Non-legitimate source of income	1 (2)
Parental support	1 (2)
Other	3 (5)
Don't know	3 (5)
Prefer not to say	1 (2)
Have Children	53 (80)
Children <18 years old	46 (70)

Incarceration History

Age at first conviction	
18 or younger	29 (44)
19-30	23 (35)
31-50	7 (11)
51-70	0
Missing Data	7 (11)
Type of offenses on your record	
Violence	27 (41)
Property	40 (61)
Drugs	22 (33)
Administrative	18 (27)
Time served (most recent incarceration)	
Average	115 days
Median	45 days
Range	0 – 1095 days
First time in custody**	5 (7)
On parole at time of intake	4 (6)
On probation at time of intake	54 (90)
Years incarcerated over your lifetime	
Less than 1 year	20 (30)
1-2 years	20 (30)
2-5 years	16 (24)
5-10 years	6 (9)
10-15 years	2 (3)
15-20 years	2 (3)

* Respondents could select more than one answer. Only one of the women interviewed reported being employed at the time of intake.

**Among the 61 women who reported that it was not their first time in custody, responses of how many times they'd been in custody previously included: Too many to count, lots, many, countless and didn't know. Of those who did report a number of times in provincial custody ranged between 2 – 50+ average of 6.7 and median of 4.5. Seven women reported having been previously incarcerated in a federal facility.

Table 2 – Region in British Columbia that- Where incarcerated women reported to be going after their release from provincial correctional facility during telephone interview with a peer health mentoring program. (n=346)

BC Region	n (%)
Vancouver Island/Coast	49 (14)
Lower Mainland/Southwest	166 (48)
Thompson-Okanagan	76 (22)
Kootenay	2 (1)
Cariboo	7 (2)
North Coast	0 (0)
Nechako	0 (0)
Northeast	1 (0)
Out of province	2 (1)
Unsure*	36 (10)
Answer Missing	7 (2)

*Includes those women reported they were 'unsure' of where they would go and those who reported more than one possible destination

Table 3- Needs most commonly identified by women during telephone interview prior to release from provincial correctional facility and during intake interview after/upon their release.

Need identified*	Telephone Interview (n=346) n (%)	Intake interview (n=161)** n (%)
Clothing	217 (63)	92 (57)
Welfare	209 (61)	112 (70)
Housing	178 (52)	60 (37)
Probation	109 (32)	1 (1)
Drug & Alcohol Counsellor	95 (28)	44 (27)
Outreach Worker***	87 (25)	40 (25)
NA/AA Meeting Times	63 (18)	25 (16)
Healthcare	52 (15)	48 (30)

In this table NA stands for Narcotics Anonymous, and AA stands for Alcoholics Anonymous.
***Other needs identified include access to a dentist, food, a safe ride home or to other transportation, help with court, family services, access to grief counselling,** support to stop shoplifting, treatment programs, mental health services and help with bail supervision.
**** Answer missing for eleven women**
******* Outreach workers are employed by community organizations to support people who are street involved or have unstable housing to meet their needs such as getting healthcare or connecting to housing.

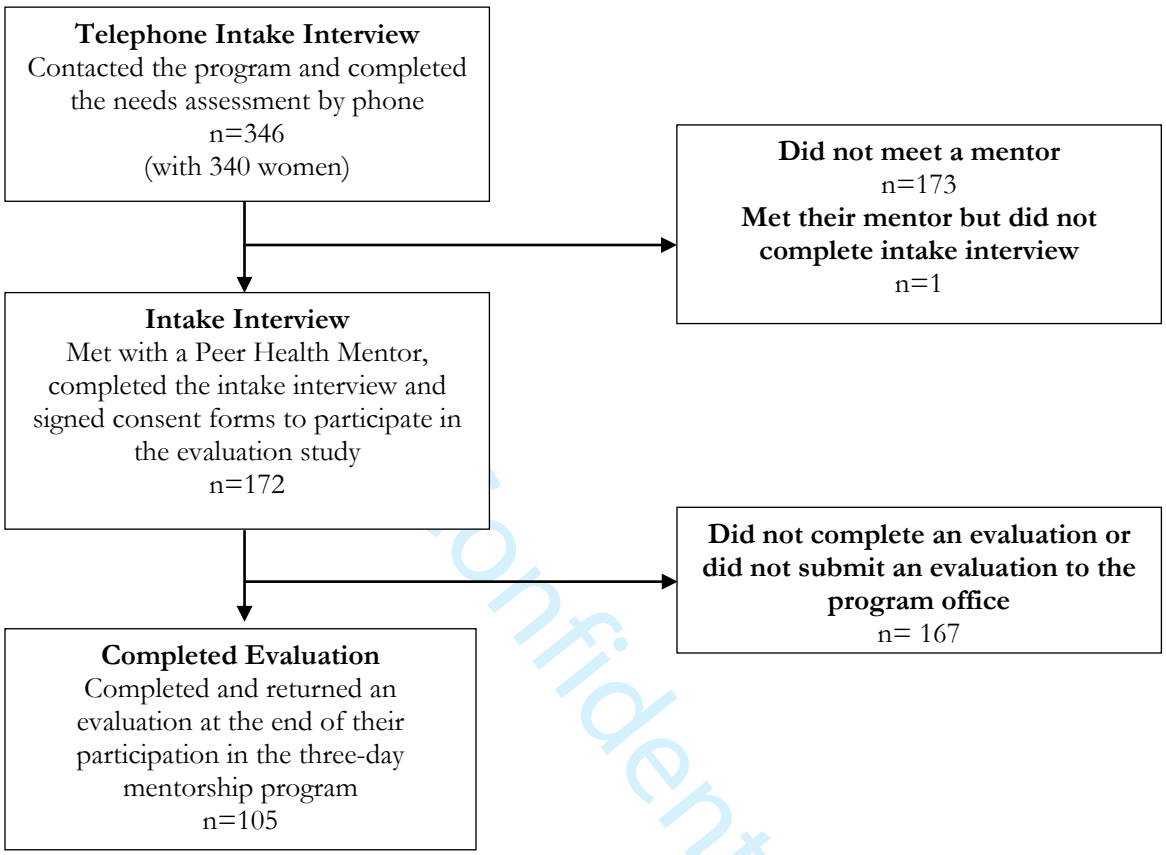
Table 4 -Women who answered 'Yes' to the question "it would make a difference in my life if I had…" during evaluation of a three-day peer health mentoring program (n=105)

"it would make a difference in my life if I had…"	**# (%)**
Money to buy necessities	91 (87)
Someone to talk to about the things that worry me	90 (86)
Housing	89 (85)
Medical care	89 (85)
A real friend	89 (85)
Dependable transportation	84 (80)
Someone to hassle with agencies when I can't	83 (79)
More education	82 (78)
Healthy food to eat	81 (77)
Drug or alcohol treatment	79 (75)
A good job	79 (75)
More control of my life	78 (74)
Personal safety	78 (74)
Enough clothes	77 (73)
Food	76 (72)
Freedom from abuse	72 (69)
Time for fun	71 (68)
Somewhere else to live	67 (64)
A good partner	65 (62)
A dependable relationship	64 (61)
Legal help	63 (60)
Someone to lend me money	63 (60)
A telephone or access to a phone	62 (59)
Help with child custody problem	61 (58)
Time to get enough sleep	58 (55)
Time to be by myself	58 (55)
Birth control	46 (44)

Table 5 - Quotes from narrative comments provided by women participating in a three-day peer health mentoring program during their intake interview.

What would you like people to know that would be helpful for women being released?	
Greater understanding and the difficulties of release	"That we're human and we all make mistakes and addiction is very powerful" "That there is hope for everyone" "That it's overwhelming" "We are struggling so be patient."
Need for greater support	"That we need help not to just throw us into society" "We don't get much support so if someone can help us we would really appreciate it"
Write a little bit about how you're feeling right now	
Excitement, especially related to family; happy and hopeful	"I feel motivated and blessed to have another chance to be successful and a great mother." "I'm happy and glad to have a new start in life." "Like I'm being honoured in my head"
Anxiety and fear about uncertainty	"Overwhelmed, anxious, wanting to use, hopeful and excited" "Having a lot of stress not knowing what to expect" "Scared don't want to go back to the streets"
Mix of emotions	"Full of anxiety, unsure of the future but hopeful" "A little scared but confident I will succeed" "I am between anxiety attacks and feeling happy to have support and someone who is there for me."

Figure 1 - Flow chart of data collected from participants in a three-day mentorship program following release from a women's provincial prison in British Columbia.



Reporting checklist for qualitative study.

Based on the SRQR guidelines.

Instructions to authors

Complete this checklist by entering the page numbers from your manuscript where readers will find each of the items listed below.

Your article may not currently address all the items on the checklist. Please modify your text to include the missing information. If you are certain that an item does not apply, please write "n/a" and provide a short explanation.

Upload your completed checklist as an extra file when you submit to a journal.

In your methods section, say that you used the SRQRreporting guidelines, and cite them as:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. Acad Med. 2014;89(9):1245-1251.

		Reporting Item	Page Number
Title			
	#1	Concise description of the nature and topic of the study identifying the study as qualitative or indicating the approach (e.g. ethnography, grounded theory) or data collection methods (e.g. interview, focus group) is recommended	1
Abstract			
	#2	Summary of the key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results and conclusions	1
Introduction			
Problem formulation	#3	Description and signifcance of the problem / phenomenon studied: review of relevant theory and empirical work; problem statement	2
Purpose or research question	#4	Purpose of the study and specific objectives or questions	2-3

Methods

Qualitative approach and research paradigm	#5	Qualitative approach (e.g. ethnography, grounded theory, case study, phenomenolgy, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g. postpositivist, constructivist / interpretivist) is also recommended; rationale. The rationale should briefly discuss the justification for choosing that theory, approach, method or technique rather than other options available; the assumptions and limitations implicit in those choices and how those choices influence study conclusions and transferability. As appropriate the rationale for several items might be discussed together.	3
Researcher characteristics and reflexivity	#6	Researchers' characteristics that may influence the research, including personal attributes, qualifications / experience, relationship with participants, assumptions and / or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results and / or transferability	3-4
Context	#7	Setting / site and salient contextual factors; rationale	3
Sampling strategy	#8	How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g. sampling saturation); rationale	3-4
Ethical issues pertaining to human subjects	#9	Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	5
Data collection methods	#10	Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources / methods, and modification of procedures in response to evolving study findings; rationale	3-4
Data collection instruments and technologies	#11	Description of instruments (e.g. interview guides, questionnaires) and devices (e.g. audio recorders) used for data collection; if / how the instruments(s) changed over the course of the study	3-4

Units of study	#12	Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	3-4
Data processing	#13	Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymisation / deidentification of excerpts	4-5
Data analysis	#14	Process by which inferences, themes, etc. were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale	5
Techniques to enhance trustworthiness	#15	Techniques to enhance trustworthiness and credibility of data analysis (e.g. member checking, audit trail, triangulation); rationale	5
Results/findings			
Syntheses and interpretation	#16	Main findings (e.g. interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	5-7
Links to empirical data	#17	Evidence (e.g. quotes, field notes, text excerpts, photographs) to substantiate analytic findings	5-7
Discussion			
Intergration with prior work, implications, transferability and contribution(s) to the field	#18	Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application / generalizability; identification of unique contributions(s) to scholarship in a discipline or field	8
Limitations	#19	Trustworthiness and limitations of findings	8
Other			
Conflicts of interest	#20	Potential sources of influence of perceived influence on study conduct and conclusions; how these were managed	n/a
Funding	#21	Sources of funding and other support; role of funders in data collection, interpretation and reporting	n/a