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Rapport de recherche

PROGRAMME ACTIONS CONCERTÉES

Tenir compte des traumatismes en contexte carcéral pour les professionnels qui y travaillent : exploration de l'approche Trauma-informed care (TIC) comme outil d'intervention et de prévention par le biais d'une synthèse des connaissances.

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Part A — The Research Context

Professionals in adult prisons or jails are exposed to routine and extreme potentially traumatic experiences (PTE), such as violence directed towards prison staff or others, and the aversive details of abuse or violence suffered by those in custody [1]. PTE elevate the risk of multiple mental health and well-being consequences including post-traumatic stress disorder (PTSD), suicidality, and physical injury [2]. These impacts on staff mental health and well-being can undermine the quality of services provided, and result in high costs related to leaves of absence, employee turnover, and the litigation of complaints [3, 4]. These consequences can also result in negative mental health and well-being challenges for the families and support networks of those directly impacted [5]. Primary, secondary and tertiary preventative measures are required to mitigate the impacts associated with elevated trauma-exposure inherent in prison-based work. To achieve this, it is important to understand what strategies have been implemented to date and to assess their efficacy.

Research examining PTE exposure among prison staff and related negative consequences demonstrates that both are elevated. James and Todak (2018) [6] investigated PTSD among American prison employees and found a rate equivalent to that of veterans of the Iraq and Afghanistan wars (19%). According to Correctional Service Canada (2015) [7], a cross-section of correctional professionals in Ontario (n=122) disclosed exposure to an average of 27.9 PTE, including witnessing suicides, homicides, and other violent incidents. Only 2% of that sample had not been exposed to such events, 41% of those affected had impacts that interfered with their daily living, 59% required psychiatric medication, and 17% had been diagnosed with PTSD. In contrast, the lifetime prevalence of PTSD in the Canadian general population is 9.2% [8].

In their systematic review, Regehr et al. (2021) [9] confirmed that correctional officers suffered from rates of PTSD, depression, and anxiety many times higher than the general population. PTSD was most strongly associated with physical danger due to the on-the-job violence perpetrated against prison staff, and their resulting injuries. Specifically, “[d]epression and anxiety…[were] most strongly associated with low levels of perceived support from the organization, low job satisfaction, and low-

perceived social valuing of the roles these officers perform" (pp. 237-238). People working in carceral institutions need protective strategies to manage routine potential harms related to PTE. Repetitive trauma exposure at any time in life can result in "significant impairment in personal, family, social, educational, occupational or other important areas of functioning" (para. 1)[10]. Strategies must specifically target validated risk factors for poor outcomes following exposure to PTE because there is a dose-response relationship between trauma exposures, illness and early death [11, 12]. Because the harms encountered by this professional group are organization and system-wide, preventive measures at the organizational level may be effective strategies to reduce the impacts of workplace trauma. These findings are in line with research conducted in health and social services settings that suggest implementing trauma-informed care (TIC) at the organizational level can reduce post-traumatic stress at the individual level [13-15]. An emerging body of research has begun to examine how TIC implementation impacts people working in other human services settings. For example, some studies have explored whether TIC interventions increase trauma-informed attitudes and practices and reduce traumatic stress among professionals working in involuntary contexts [14, 16, 17]. While TIC interventions such as the Correctional Officer Trauma-Responsive Training Project [18] and Trauma Training for Criminal Justice Professionals [19] are being implemented among professionals in adult carceral contexts, their impacts remain unclear.

Prompted by problems in the relationship between work and well-being made clear during the COVID-19 pandemic, the Office of the United States Surgeon General (2022) [20] identified the need for workplaces to go further than responding to problems impacting worker wellbeing, workplaces must become engines of well-being. Driven by this philosophy, a framework was developed in consultation with workers and unions across a wide variety of occupations and sectors and following the recommendations of multiple groups including the National Academy of Medicine and the American Psychological Association, along with U.S. government agencies such as the Department of Veterans Affairs, the Occupational Safety and Health Administration (OSHA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Centers for Disease Control and Prevention (CDC)

National Institutes of Occupational Safety and Health (NIOSH).The U.S. Surgeon General's Framework for Workplace Mental Health and Well-being (2022) [20] describes how workplaces can protect and promote wellness among staff by centering worker voice and equity, and prioritizing five essentials: "protection from harm, connection and community, opportunity for growth, mattering at work, and work-life harmony" (p. 10). This approach articulates how to apply TIC at the organizational level for the benefit of staff. TIC is a relatively novel approach in human services delivery, promoting the integration of trauma-informed knowledge and the implementation of trauma-informed intervention strategies for all stakeholders and at all organizational levels [21]. This approach aims to protect all stakeholders involved in a system from harmful impacts related to PTE. While the implementation of TIC in programs serving prisoners is an active field of study, less appears to have been done to evaluate the effectiveness of TIC on prison staff mental health and well-being. It is therefore necessary to increase understanding of what TIC efforts have been implemented to mitigate risks of harm related to trauma-exposure among carceral professionals; an assessment of whether and if those efforts were effective; and inquire into the experiences and perspectives of the professionals themselves regarding systemic risk factors and TIC organizational responses. With these objectives in mind, this project was developed with two distinct strategies. The first strategy was a systematic literature review and meta-analysis focusing on the implementation of trauma-informed care (TIC) in carceral settings and the impact on staff mental health and well-being. The research questions posed were, "What components of TIC interventions have been implemented within adult prison environments, specifically concerning the mental health and well-being of staff?" Objective 2 was to gain a better understanding of prison staff experiences with TIC, organizational strategies related to workplace wellbeing in the wake of exposure to potentially traumatic experiences, and to invite them to share what was most relevant to them in relation to these subjects.

Part B — Methodology

This project was approved by the Université Laval Human Research Ethics Board (see *Annex 1: Université Laval Research Ethics Board Approval*). Two methods were employed to obtain the data necessary to increase understanding about TIC efforts to protect staff wellbeing in prisons and jails. Our first method was a systematic review and meta-analysis of the literature on the implementation of trauma-informed approaches in prison settings that included efforts to protect staff (see *Annex 2: Research Protocol*). Our title was accepted and registered with The Campbell Collaboration and Cochrane. Cochrane was founded to increase evidence-based understanding of medical practices, and the Campbell Collaboration was formed to serve the same need in non-medical and socials science domains. They have since merged their methods and practices. These organizations are the global standard for systematic reviews and meta-analyses. By registering with these bodies, we gained access to the most rigorous practices and peer review process to ensure the trustworthiness of our findings (see Annex 3: Methodological expectations of Campbell Collaboration intervention reviews: Conduct standards). The systematic review process allowed us to identify all implementations of trauma-informed approaches published in English or French, that have occurred globally in prisons and jails. These studies can be synthesized to create a description of what is known about the implementation of trauma-informed approaches in prison settings towards the wellbeing of staff and will serve to complete multiple future analyses.

Our second method was a survey of prison and jail professionals across Canada. Purposive and snowball sampling were employed to reach these professionals. They were invited to complete a questionnaire that included an assessment of efforts made by their employer to reduce the potential harmful impacts of secondary traumatic stress in the institutions in which they worked. Secondary traumatic stress was defined as the “trauma symptoms caused by indirect exposure to traumatic material, transmitted during the process of helping or wanting to help a traumatized person” p.1 [22]. Moral distress refers to the distress elicited in a professional when they are obligated to work in ways that they deem to be unethical. It was included to capture the presence or absence of institutional

capacity to enable ethical practices that reduce staff distress (see *Annex 4: Sociodemographic Information* and *Annex 5: Measures*). Due to the sensitive nature of this survey, which involved providing feedback about one's employer and expressing work-related distress, no information on the identity of these participants will be collected (see *Annex 6: Questionnaire Invitation* and *Annex 7: Questionnaire Consent Form*). They received the link through targeted search and snowball sampling. They could opt out at any time, in which case all data about that participant was deleted. The measure of moral distress was included to ascertain if they were impeded from doing the work they believed was necessary by institutional factors. Finally, they were given a text box in which they could add any information they deem relevant (see *Annex 8: Final Question*). This content was then analyzed thematically through an Interpretive description approach [23]. Each text was analysed inductively, the resulting descriptive labels were then grouped thematically. The result of this survey offers a window into the lived experiences of prison professionals with trauma-informed approaches, or the lack thereof, and allowed them to let us know more about what they are experiencing at work. These results were described, compared, and contrasted with the results of the literature review, providing guidance for understanding the needs and promoting the well-being of these professionals. The results of these two distinct inquiries serve to enrich multiple evidence bases by describing practices, the strengths of certain approaches and specific needs from a Canadian and Québécois perspective.

Part C — Principal results

Method 1: The documents identified through the protocol are represented in *Annex 9:* Figure 1, PRISMA 2020 Flow Diagram. The breadth of returns was an unexpected result, showing that many international initiatives touch on trauma and carceral environments. The PRISMA flow diagram traces how the references were screened, excluded and included to achieve our final sample of 24 documents. In *Annex 10:* Table 1, Publication by year, results are organized by date of publication demonstrating that TIC has gained ground as a viable approach in carceral environments. The uptake has been international, as shown in *Annex 11:* Figure 2, Geographic locations of carceral TIC interventions. Both North America and two countries in Western Europe are represented. As shown in *Annex 12:* Figure 3, Format and distribution of TIC interventions, four distinct formats of TIC intervention were used: Organizational-level change, Post-incident responses and Services on request, Trainings, Trauma-informed practices. The format most often reported were efforts at the organizational-level, consistent with best practices as outlined by the U.S. Substance Abuse and Mental Health Services Administration [21]. In this approach, practices were changed to conform with a mission or philosophy that addressed trauma-related needs and impacted multiple domains of organizational functioning. The domains named by SAMHSA include: Governance and leadership; Policy; Physical environment; Cross sector collaboration; Screening, assessment, treatment services; Training and workforce development; Progress monitoring and quality assurance; Financing; Evaluation. The papers in this group are: Auty, Liebling [24], Cherniack, Namazi [25], D'Angelo, Gozzoli [26], Hughey [27], Jaegers, Ahmad [28], McClelland, Brandon [29], McManus [30], Penney [31], Vaswani and Paul [32].

With almost the same frequency, post-incident responses and services on request, were represented. This category includes strategies such as: critical incidence stress debriefing, critical incidence response teams, wellness and employee and family assistance programs. While these efforts also implicate multiple organizational domains they are classified separately from the previous group. This is because they are reactive and do not target fundamental changes in the philosophy of the organization. These papers either described the implementation of such approaches: Dignam and

Fagan [33], Guariglia and Smith [34], Tylutki [35]; qualitatively describe experiences of them: Cassiano, Ricciardelli [36], Wohlmuth [37], McKendy, Ricciardelli [38]; or quantitatively evaluate their effectiveness using pre-post measures: Engelmann [39] Ruck, Bowes [40].

The next two categories represent efforts to make change that includes the potential for prevention of traumatization. While more than one domain of organizational functioning might be implicated, they also seek to implement a program or service within an existing organizational structure that is not globally trauma informed. To provide greater detail, this category is divided into two sub-groups. The first sub-group describes or evaluates trainings aimed at increasing awareness and capacity to prevent mental health issues among professionals and/or the incarcerated people they serve: DeHart and Iachini Aidyn [41], Gruner [42], Ricciardelli, Cassiano [43], Johnston, Ricciardelli [44]. The second sub-category will be described as trauma-informed practices. The main foci of these three studies were the implementation of trauma-informed programs (TIP). It is difficult to determine if they are all aimed at both the domains of screening, assessment, and treatment services as well as training and workforce development. Whatever the intention, these TIP appear to benefit both the professionals and the people incarcerated in the prisons where they worked: Hughes and Radcliffe [45], Mercer, Gibson [46], Morgan-Jones [47].

As shown in *Annex 14:* Table 2, Focus of intervention by time-period and geographic location, TIC implementations specifically appear to be increasing over time. This might be related to the complexity of making such a shift in the already complex organizational structures of carceral institutions, i.e., it might take time to build buy-in and capacity to accomplish such a large-scale shift. This also suggests that whole-system change is more desirable than reactive or partial implementations as suggested by TIC theorizing. Although much remains to be analysed within this data set, several notable findings are apparent: In relation to the second category of findings, Post-incident responses and services on request, the efficacy of single session psychological debriefing has been determined to be ineffective or to increased PTSD symptoms over time [48]. Therefore, the critical incident-type responses that we identified in this systematic analysis can be considered ineffective. Indeed, our findings show mixed

results, with anecdotal evidence showing emotional support as helpful [34, 37, 40] and in some cases critical incidence responses may have caused harm [36, 39]. Because the implementation strategies and services were heterogeneous, some of the support efforts may have indeed been helpful. Therefore, following the suggestion of Rose, et al. [48] to screen and treat, or piloting a more recent model of post-incident response are indicated. Seeking an evidence-based reactive response developed in other service domains to adapted and pilot for carceral professionals is indicated. Regarding services on request, EAP approaches also varied widely in their application and the professionals for whom they are intended do not often use them, with some believing that if they did ask for help it would be used against them by their employer [38]. Therefore, they must be reconsidered. Despite the effort on the part of many employers to ensure that these programs are up and running for their staff, the services themselves have not been designed using evidence-based strategies. Further, their availability and quality are not guaranteed by policy [35]. A biproduct of the poor quality and availability of these services is a belief among many professionals that their employers (often the government) simply does not care about them or their wellbeing [38].

Trainings showed mixed results, the dissatisfaction with them often stemmed from difficulty in seeing how the information could be used, and be helpful, in practice [43]. For example, training that was not immediately applicable for corrections officers was not universally helpful, and in some cases contributed to the felt sense of not being important [44]. Indeed, reorienting how correctional officers intervene is challenging in the dangerous and emotionally demanding settings where they work [24]. Successfully retraining staff and management was made difficult by organizational factors such as turnover (including management), complex governance, and confidentiality concerns [25]. None of the implementation efforts appeared able to provided adequate consultation, support, and ongoing training [24, 41], and training alone was inadequate to achieve the necessary culture change [32].

Trauma-informed practices appeared to be very well accepted, especially when both the staff and the incarcerated people were included [45, 46]. Any future TIC initiatives must actively counteract correctional officers' sense of a lack of support, that their safety and wellbeing are not a priority, and

that they are perceived as a low status profession or unimportant to their employers [26]. One such strategy is found in McClelland, et al. [29], where staff were able to choose to work on the special mental health unit. Clinical supervision also appears to have been well received and helpful [47].

Reading the autoethnography of Hughey [27], a current warden at Delaware Department of Correction, demonstrates the value of TIC for protections. She traced her own experiences leading her to a TIC management style. Many of her life experiences represented risks for incarceration and she used them to shape how she led her teams. In Penney [31], a Hawaiian cultural practice was used to anchor a TIC implementation. Focussing on multiple domains within carceral institutions, especially those unrelated to service provision, was essential towards shifting the functioning of the system towards safety for all [24, 30, 42]. D'Angelo, Gozzoli [26] reported that the TIC implementation in their setting reduced overall violence, it is unclear how this was determined. Finally, the two least represented domains and principals were evaluation and cultural, historical, and gender issues. Future implementation of TIC must be adapted to be responsive and accountable to the needs of all stakeholders.

Method 2: As shown in *Annex 15:* Table 3, Prison and jail employees who completed the Moral Distress inventory, 76 prison employees responded to our questionnaire. The sample included prison employees across the West Coast, the Prairies and Central Canada. They worked in institutions with minimum, medium and maximum, super-maximum and multi-level security classifications. Many belonged to equity-deserving groups. The majority of the institutions were federally administrated (including military settings), with some participants working in provincial institutions.

Moral Distress: The average global scores on the MDI was 53.04 out of 168, with a standard deviation of 48.60. As shown in *Annex 16:* Figure 4, Moral Distress Instrument (MDI) scores, this suggests that a majority of participants (58%) experienced no or infrequent and mild moral distress; 11% experienced occasional and mild to moderate moral distress; 24 % experienced routine and moderate to elevated moral distress; and 8% reported frequent and severe moral distress (8%). An analysis of the subscales in the MDI offers more definition to what types of experiences were more or less distressing (see Annexes 17-23, Figures 5 -11). Out of a total subscale score of 24, scores of 0 – 6 indicate no or

infrequent and mild moral distress and scores of 6 – 12 reflect occasional and mild to moderate moral distress. Scores of 12 – 18 indicate routine and moderate to elevated moral distress and scores of 18 – 24 are considered as frequent and severe moral distress, scores in this range reflect important impairments in both perceived ethical practice and wellbeing. These findings suggest that the majority of carceral professionals do not experience a problematic level of moral distress and a small subgroup of the participants were experiencing elevated to severe moral distress across all of the pathways measured.

Organizational efforts to mitigate secondary traumatic stress*:* As shown in *Annex 24: Table 4,* Prison and jail employees who completed the Secondary traumatic stress Organizational Assessment, a smaller sample completed the second measure. These findings reflect the degree to which participants' organizations were promoting resilience-building activities, a sense of safety, trauma-informed organizational policies, trauma-informed leadership practices, trauma-informed organizational practices, and organizational efforts to evaluate and monitor trauma-informed policies and practices. As *Annex 25:* Figure 12, STS-OA Scores shows, the participant ratings on the STS-OA suggest that prison and jail employers do little to try to mitigate the risks associated with secondary-traumatic stress among their employees. The final item on the questionnaire was an open text box with the prompt, "Is there anything that you would like to add?" Participants in central Canada, the prairie provinces, and on the west coast responded. Participants came from both federal and provincial institutions with all security classifications, serving women, men and mixed populations. This subsample is described in *Annex 26: Table 5,* Prison and jail employees who opted to qualitatively share their perspectives.

Annex 27: Table 6, Thematic Structure of Prison and Jail Employee Comments shows the superordinate themes that were used to group the data, and the subthemes describing different aspects of the superordinate themes. The texts, although generally short, were rich with meaning and most addressed multiple themes. All of the data were all critical of employers, both Federal and provincial.

Practices: The vast majority (25/30 participants) described the *practices* at their institutions as inadequate. Front-line staff reported a lack of appropriate follow up after traumatic events and being

generally “undervalued and under-equipped”. One participant explained that “[t]he double standards [for disciplinary measures for management versus staff] are rampant and the cause of a lot of frustration for many…” Staff mental health and wellbeing were described as “disregarded” and “ignored”. Stressors were rarely described as resulting from exposures related to the inmates. “The greatest strain from what I have seen at work on staff’s mental health comes not from inmates but from management.” Several of the texts were emphatic, for example: “The RARE instances, the Organization PRETENDS to ADDRESS STS, IS ALWAYS NEVER FOLLOWED UP WITH, or ACTED UPON. In other words, they PRETEND TO CARE, BUT THEY COMPLETELY DON'T CARE ONE BIT.....!!” One participant demonstrated the overlap between how practices were perceived as both inadequate and incoherent, there was a lack of felt support, poor leadership and policy practices: “They are not interested in fixing the gaping holes in this mental health crisis. Staff are assaulted daily and there are never any changes. They over-scrutinize security responses and that directly leads to staff feeling they have no support in sometimes highly traumatic situations. Staff feel we are damned if we do and damned if we don't. They simply don't care about us. The people who are promoted are without exception some of the most morally and ethically challenged people I've ever met. I would strongly discourage anyone from seeking out a career with this employer. They will destroy new staff. The only thing they care about is money. Staff are treated as if they are expendable.”

Leadership: The second most mentioned theme, as alluded to in the datum directly above, spoke to poor leadership. In this extract, harassment from leadership and peers and the extremely dangerous nature of this work converge. “When we can’t [handle something] we are mocked by our peers for being weak. Our managers threaten us with discipline or yell at us…A […] manager once threatened to send cons to my house to kill me. Then … threatened my family. You can’t do the right thing when managers threaten your life and your families’ lives.” Some participants felt irreparably harmed by their work, “This organization ruins people to the point of no return, and even when we know this is happening it’s too late for us to leave this environment and try to start over somewhere else or another career because we are too far gone. We no longer fit into society and segregate ourselves because no one else

understands what we have seen, what we do, and how we have to conduct ourselves in a backwards world…" One participant explained how the empty efforts to address staff wellbeing dovetailed into practices, policy and a perceived general decline in workforce mental health. "The only thing our organization does is send out emails about [maintaining wellbeing] but their policies, procedures, lack of training and unwillingness to deal with harassment and racism by managers increases the mental health decline in staff nation-wide. If they would follow their own policies and words that they say in their emails they could actually make a difference …" Another explained, "Management has never reached out to our peer counselling teams after critical incidents - it is always an officer who needs help having to look to find it." and, "Management disciplines employees who are involved in traumatic situations but rarely commends them for work well done. Management uses staff who are good at resolving incidents over and over and then complains about what they do while other staff sit back and do nothing so they don't get into trouble."

Fear: In this datum a perception that there is a lack of regard for staff wellbeing and safety, inadequate training, poor quality professional development, and unresponsiveness to staff concerns culminate in a feeling of being unsafe at work. "[This] organization has no regard for staff mental health and personal safety. The bare bones training is provided at the beginning of your career and then a day yearly to meet the standards. When concerns are brought forward they are rarely considered and even more rarely is anything meaningful done to address the concerns. As time progresses staff feel increasingly more unsafe in our work environment". The following text demonstrates the types of frightening situations front-line staff can find themselves in, "I have personally witnessed a [female staff member] secure herself in a closed room, with an inmate, who was previously aggressive with a [different female staff member] in the exact same situation only [a few] hours prior ". As a result of incoherent practices and policies, some staff fear not only for their physical safety but their livelihoods as well, "I have been assaulted by an aggressive inmate in a cell and the only thought I had was how do I gain control of the situation without jeopardizing my livelihood and future career. There [are] absolutely zero repercussions for poor/aggressive inmate behaviour within the institution. Management will actively contradict floor

staff when dealing with incidents when it was management who directed floor staff to act the way they did. I am constantly faced with an internal battle of acting the way management wants, who is in charge of my future career development, and following best safety practices and moral obligations."

Organizational climate: As the previous themes demonstrate, the staff in carceral institutions are exposed to multiple and chronic potentially traumatic experiences. This participant described the workplace climate itself, "Our work environment is toxic, mentally draining, and [there is] harassment in the workplace…incidents [involve] intimidation and hostility. However, a single incident of trauma is sufficient to create a hostile work environment. It often adversely affects the victim's work performance. This…harassment we experience involves unwanted physical, verbal, and gestures of intimidation." Another participant explained how such stressors were normalized by management, "In an environment that is extremely stressful, the service seems to dismiss it as part of the job rather than a traumatic event, or they seem to diagnose and deem it to be psychosomatic. Only on rare occasions does the service reach out to see how people are coping. Oftentimes people are left to deal with things on their own whether it is from physical, emotional or psychological injury due to the nature of being front line staff." This datum shows the overlap between the feeling of being in a toxic environment; poor leadership, policy, and practices; and, the emotion impact on staff. Another participant explained that they had "… a very toxic employer. Mangers who have been deemed guilty of harassing and bullying employees are always left in positions of power (never demoted) and when an employee does the same thing, they are heavily disciplined in comparison, sometimes fired. The double standards are rampant and the cause of a lot of frustration for many union members."

Policy: As will be shown in the data grouped under this theme, several participants describe policies that they perceived as putting them in danger, disallowing them to act in their best interests, and that were incoherent with what they saw as their own goals and those of their employer. For example, "The organization does not and will not care or address issues with psychological wellness and physical safety of its employees. Anything the employer offers is subject to interpretation, conditions, favouritism, or is used against employees". One participant reflected on the questions asked about moral distress

in the questionnaire, and in explaining their thoughts also shared a political analysis. A sense that they were dealing with this frightening and ineffective approach to inmate violence because “the left”, seemed to hold enough power to set the policies that disregarded frontline staff wellbeing. “When the questions were asked [about] if I’m asked to do things at work that aren’t right or made to feel uncomfortable…management scares staff into believing they’re not able to defend ourselves against violent offenders, they always make you feel like you have to be assaulted before you can defend yourself, wait to get hit, and when a violent offender assaults staff or other inmates there is nothing we can do except put them right back on the range because we can’t segregate any more, we have had inmates violently assault other inmates multiple times in a day, We realize the left doesn’t care about CO’s, but how are we supposed to keep other inmates safe from violent inmates if we can’t segregate them?, The province still segregates, even Hospitals with violent patients segregate… if you read the old seg books 85 to 90% of inmates in segregation wanted to be there. You couldn’t drag them out, but no one is talking about that”. This idea that correctional officers were simply not important in policy decisions can also be seen in the following participants reflection reflecting a sense of powerlessness against the misdeeds of their employer, “…[It] is an awful organization that is more concerned about inmate wellbeing than that of its correctional officers. Our morals are continually questioned, and we are asked to overlook issues in favour of inmate demands. Because we cannot sue the organization and the inmates can, we are at a severe disadvantage.”

Resources: Multiple datum in the previous themes have demonstrated a sense of a lack of resources given to, or available to staff. One participant shared how their provincial union developed services to respond to needs among their membership that were ignored by their employer. “[L’employeur] ne s’occupe pas de ses employés en tant qu’organisme, [ici] le syndicat local a créé une fondation pour s’occuper des officier qui soufre de trouble lié à l’alcoolisme, drogue ou choque post traumatisme.” As mentioned above, the efforts made seem empty, “They provide training and resources that are not effective or willing to help us. Stress management is referred to as a "ticky box" by management”. The same participant who described staff being locked in rooms with dangerous inmates and being

assaulted at work explained, “I have been employed in the service for 5 and a half years and have had 2 instances of 4hr training in that time to 'refresh' my personal safety training - of which 2/4 hours is spent discussing agenda and stretching”. A few of the participants reflected how their only resource seemed to be each other, “It seems like anything being done at the site is being driven by line staff, not managers and we don’t have the power to really change. Except be there for each other” and “Staff must look out for each other”.

This project shows that there are effective strategies currently used for many professionals working in prisons and jails; it also reinforces previous research showing that a sub-sample of Canadian correctional officers are suffering important impacts to their well-being as a result of their work. Moral distress specifically, has been shown in this population for the first time. These findings strengthen the conclusion that current practices to prevent or neutralize harms are insufficient. The safety and wellbeing of staff must be reprioritized to be at the forefront of all corrections policy and management efforts, including training and leadership strategies. These findings also confirm that TIC is indicated in prison and jail contexts and shows promise as a global strategy to meet the complex current needs in all of the organizational domains identified by SAMHSA.

Part D — Possible solutions or actions supported by the results of this research

Trauma-informed care with a specific focus on the wellbeing of staff is indicated.

The findings of this systematic review support TIC as an approach to protect overall staff wellbeing. TIC is also an evidence-based approach for incarcerated people and others, including children and youth, making it an attractive option for carceral systems. Safety is shown to be a critical aspect of TIC for all stakeholders. Safety represents the first of the trauma-informed principles named by SAMHSA: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; cultural, historical and gender issues [49]. These findings also warn that incomplete applications of TIC could introduce new or perpetuate old harms. TIC requires a whole systems approach.

Effective current strategies can be retained within a TIC implementation.

Despite the omnipresent needs of people who are incarcerated, and the well-established omnipresent risks posed by working with this population, reactive and on demand services that place the onus on the injured party to seek assistance are frequently the only approach available. There is a place for post-incident responses when the system as a whole is also trauma informed. The following quote from SAMHSA explains what this means:

> A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization. p.9 [49]

However, when reactive and on demand services are the only available remedy for trauma-exposure it can contribute to a lack of trust among correctional officers and a belief that their employer does not prioritize staff safety. Indeed, single session psychological "debriefing" after traumatic events has been shown to be harmful for some and should be immediately stopped. To elaborate, reactive and on demand services are engaged only after the trauma-exposure has already occurred. As such, these services do not impact the systemic conditions that might allow the traumatic experiences to occur in the first place. For example, a staff member who is negatively impacted by responding to an injured

party might reach out to employee and family assistance services to manage post-traumatic stress related reactions. Even if those services are helpful, they will do nothing to reduce the danger of a similar incident in future. This lack of prevention might cause the staff to assume that their wellbeing is not a priority to their employer. To tackle the problem, efforts must target multiple organizational domains: Governance and leadership to propose and implement new strategies to prevent future injury; Policy to articulate standards and responses to problematic situations; Physical environment to either provide alternative spaces that promote wellbeing or renovate existing spaces to prevent danger; Screening, assessment, treatment services to identify and implement clinical strategies to prevent or reduce violence among the incarcerated population; Training and workforce development to train all staff on the new policies and additional treatment strategies; Progress monitoring and quality assurance to consult all stakeholders and obtain ongoing feedback and incorporate new learning; Financing to reallocate budgets for new strategies; Evaluation to assess the efficacy of these changes. Indeed, the studies identified in our review also showed a lack of meaningful inclusion of cultural, historical, and gender issues. The intersections of identity present in staff and incarcerated people present a richness of meaning and experience that can be leveraged to improve the overall environment. As one participant noted, “Étant donné mon orientation sexuelle, la direction n’a pas agi de façon adéquate pour me donner une protection suffisante”. Making space to understand, consider, and address the unique needs of diverse staff members as proposed by TIC might be an effective strategy towards improving overall culture and climate. That said, TIC does not require that all practices be replaced. Only that all practices be coherent with the TIC principles. Therefore, there are many aspects of existing strategies that can be retained, such as:

1. Current critical incident teams can be repurposed to provide peer support using trauma-informed strategies that do not risk retraumatization. Optimizing peer support has shown benefits for healing in the wake of trauma [50].
2. Trauma-informed intervention strategies exist and have been shown to be effective to prevent injury and promote wellbeing when working with trauma-survivors [19, 51-53]. Staff training can therefore be improved by included strategies developed using recent research evidence that

explain how trauma impacts human functioning. This information is helpful towards understanding how to manage behaviour stemming from other mental health issues [42] and the needs of staff working with high trauma exposure. Trauma-informed concrete, role specific, actionable strategies are indicated.

3. There exist many effective practices towards supporting staff, a desire to support staff on the part of management is evident in much of the literature. Current strategies, while helpful for many, are not universally effective and a more comprehensive strategy is indicated. For example, some participants described interactions within their professional teams as traumatic, asserting that dangers posed by working with an incarcerated population were less harmful to them than their "toxic" work environment. These findings are not generalized to all of the participants who responded to our survey, nor reflected in all of the studies returned in our review. TIC principles can be incorporated within current practices towards transforming workplace climate and culture [26, 27, 31].
4. The studies identified in our review showed a lack of ongoing evaluation, suggesting that this might be an area for global improvement. Existing evaluation strategies can be leveraged to include the evaluation of TIC initiatives and be broadened to seek greater stakeholder involvement.

Following an evaluation of current strategies through meaningful stakeholder consultation, gaps in current practices can be identified and TIC strategies codeveloped. All new strategies require systematic planning, site-specific security plans, and comprehensive training prior to, and following, roll-out.

Corrections officer identity

It is recommended that the The U.S. Surgeon General's Framework for Workplace Mental Health and Well-being (2022) [20] be adapted and implemented in Canadian prison and jail systems. This framework describes how workplaces can protect and promote wellness among staff by centering worker voice and equity, and prioritizing five essentials: "protection from harm, connection and community, opportunity for growth, mattering at work, and work-life harmony" (p. 10). These priorities

are in line with the needs identified by our findings. To elaborate, front-line corrections work represents one of the most challenging branches of human services delivery. Correctional officers report to work each day knowing that they are in harm's way. Incarcerated people present many complex needs, some related to their own traumatic experiences. Research is unequivocal about the high rates of traumatization in the histories of incarcerated people [54, 55]. These experiences can have impacted their development and subsequent mental health and functioning. Correctional professionals are, therefore, essential towards creating the day-to-day security required to promote healing and wellbeing among incarcerated trauma survivors. The secure physical and relational environment that staff can provide through "[s]taff-prisoner relationships are the most important feature of trauma-informed custodial care" p.733 [24]. Despite the value of this complex work, some consider their training to be "bare bones", believe that they are not considered as important within society at large, see their safety-related needs at work ignored, and experience being disregarded when they express themselves at work.

Our findings echo the results of the corpus of research examining correctional officer wellbeing. A significant subsample of Canadian correctional staff appears to be in crisis and need immediate remedy. Strategies implemented within carceral systems to address issues facing their staff must be evidence-based, coherent across all organizational domains, and be developed through meaningful stakeholder consultation (staff at all levels, their unions, families, etc.). Strategies to implement TIC must pay special attention to defining and validating the fundamental value of prison staff, creating secure workplace environments, and collaborating with staff to operationalize and align the wellbeing of staff with their organizational missions. Finally, given the pace and interdisciplinarity of discovery inherent in TIC research and theorizing, any teams implementing TIC should be supported researchers specialized in interpersonal trauma.

Limitations

The findings in this report must be considered in light of several limitations in our methods and findings. Despite the promising or positive impacts of TIC, the majority of programs lacked rigorous evaluations

of their efficacy. Much of the work here synthesized occurred internationally and cannot necessarily be generalized to the Canadian context. Given the heterogeneity of the research efforts identified by our systematic review, our understanding of the practices already implemented by various prisons needs to be deepened and broadened by future research efforts with rigorous design. Due to our recruitment effort, our survey data may reflect a response bias for people who are particularly dissatisfied with their current or recent employer. No current or previous employees in the Atlantic or Northern Territories regions were represented, nor were any employees of community or First Nations/Indigenous Institutions.

Part E — New avenues and research questions

Many new questions and opportunities are made visible by this project. They will be thematically organized by organizational domain: 1. *Governance and leadership*: How can large-scale TIC implementation efforts be protected against staff turnover (including among management)? 2. *Policy*: What existing policies are effective in protecting employee wellbeing, what is missing? What policies are perceived as harmful to prison staff and what alternatives would they propose? What standards must employee and family supports respect? 3. *Physical environment*: Which physical environments result in the least amount of work-related injury and why? What types of environments can be created in prisons and jails to support emotion regulation? 4. *Cross sector collaboration*: How can researchers and clinicians be better leveraged to support prison staff to manage the needs and behaviours? What strategies are most successful in managing trauma-related symptoms and behaviours? 5. *Screening, assessment, treatment services*: What evidence-based trauma-informed practices (zootherapy, yoga, EMDR, etc.) can be introduced to benefit incarcerated people and prison staff, how can these practices be maintained over time? 6. *Training and workforce development*: How can staff training and ongoing development be improved from a trauma-informed perspective? What types of support, both on and off the job, are perceived by prison staff to be most effective? What do prison staff want to improve their health and well-being at work? 7. *Progress monitoring and quality assurance*: How can the inclusion of diverse staff perspectives and experiences be improved in ongoing progress monitoring and quality assurance? 8. *Financing*: Are trauma-informed prisons and jails more expensive? How can TIC be leveraged to reduce costs? 9. *Evaluation*: What are the barriers to the implementation and sustainability of TIC in prisons? How well do prisons and jails include the needs and perspectives of their diverse stakeholders? How can research strategies measuring TIC in prisons and jails be standardised to facilitate meta-analysis of the results obtained and improve future research evidence?

Part F — References

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Annex 1: Ethics approval from the Comité d'éthique de la recherche de l'Université Laval

APPROBATION DE L'ÉTHIQUE

Projet de recherche impliquant des êtres humains ou
la consultation de renseignements personnels

Ce projet de recherche a été examiné en conformité avec les
Modalités de gestion de l'éthique de la recherche sur des êtres humains de l'Université Laval,
par le Comité plurifacultaire d'éthique de la recherche

Projet intitulé :	*L'approche tenant compte des traumatismes en contexte d'emprisonnement: un examen de la portée et cadre théorique de synthèse*
Nom du chercheur :	Madame Denise Brend
Numéro d'approbation :	2023-001 / 23-05-2023
Date de décision :	23 mai 2023
Date d'expiration de l'approbation :	1er juin 2024

Après examen des informations et des documents qui lui ont été transmis, le Comité a constaté que ce projet respecte les principes d'éthique de la recherche avec des êtres humains. Il prend acte de la confirmation écrite de la chercheuse à l'effet qu'elle a pris connaissance des mesures de suivi[1] associées à l'émission de l'approbation éthique de son projet et qu'elle accepte de les appliquer. Par conséquent, le Comité approuve ce projet pour un an.

Monique Cardinal, coprésidente
Comité plurifacultaire d'éthique de la recherche

9 juin 2023
Date

[1] Rappel des mesures de suivi au verso

Mesures de suivi associées à l'approbation éthique

Pour le projet intitulé : L'approche tenant compte des traumatismes en contexte d'emprisonnement : un examen de la portée et cadre théorique de synthèse

Numéro de dossier : 2023-001

1. Informer le Comité par écrit et dans les meilleurs délais (indépendamment du calendrier de ses réunions statutaires) des situations suivantes si elles se présentent :
   - de **toute modification au projet,** comme il a été approuvé en ce jour, qui comporterait des changements dans le choix des participants, dans le recrutement, dans la manière d'obtenir leur consentement, de réaliser la collecte des données ou encore, dans les risques ou inconvénients encourus par la participation, et ce, préalablement à l'application de ce changement (modèle de lettre de demande d'amendement disponible sur le site Internet des CÉRUL) ;
   - de **toute modification** qui serait apportée à un **instrument utilisé pour le recrutement** (annonces, affiches, etc.), pour confirmer le **consentement** (formulaire de consentement, feuillet d'information, etc.) ou pour effectuer la **collecte** des données (questionnaire, grille d'entrevue, etc.) en fournissant la nouvelle version du document concerné, où les modifications auront été mises en évidence, préalablement à son utilisation ;
   - de **tout événement imprévu et sérieux** (ex. : détresse psychologique d'un participant, menace proférée à l'égard d'une personne, effets secondaires ou imprévus ou indésirables d'un produit, d'un médicament ou d'un test, etc.) qui surviendrait dans le déroulement d'une activité du présent projet et qui impliquerait un participant, en complétant le formulaire VRR-EI disponible sur le site Internet des CÉRUL ;
   - de l'**interruption prématurée de ce projet de recherche** pour une raison quelconque, qu'il soit financé ou non, y compris en raison de la suspension ou de l'annulation de l'approbation d'un organisme subventionnaire.
2. Tant que le projet ne sera pas terminé, et non seulement le recrutement, présenter annuellement une **demande de renouvellement** de l'approbation, en fournissant un rapport sur le déroulement de la recherche, le nombre de participants recrutés et, le cas échéant, sur les difficultés rencontrées en cours de réalisation, à l'aide du formulaire VRR-107. La demande de renouvellement doit être transmise au Comité dans un délai de 30 jours avant la date de fin de l'approbation, indépendamment du calendrier des réunions statutaires.

Québec, le 17 août 2023

Madame Denise Brend
Pavillon Charles-De Koninck
1030, avenue des Sciences-Humaines, local 5444
Québec (Québec) G1V 0A6

Objet : **Projet de recherche intitulé :** L'approche tenant compte des traumatismes en contexte d'emprisonnement: un examen de la portée et cadre théorique de synthèse **(Numéro de dossier : 2023-001 A-2 / 17-08-2023)**

Madame,

Le Comité plurifacultaire d'éthique de la recherche a pris connaissance de votre demande d'amendement au projet cité en objet et vous remercie pour les précisions et les documents fournis. Il comprend que cet amendement consiste à ajouter une question au questionnaire sur la détresse morale.

Après étude, il considère que cet amendement respecte les principes éthiques de la recherche avec des êtres humains. Par conséquent, le Comité **approuve l'amendement** de ce projet **jusqu'au 1er juin 2024**, comme mentionné lors de l'approbation initiale, **moyennant les mesures complémentaires, décrites ci-après, à appliquer :**

Mesures de suivi associées à l'émission de l'approbation du présent amendement :

- Le Comité vous demande de modifier la configuration de LimeSurvey pour que la mention à l'effet que le questionnaire est anonyme soit retirée du feuillet de consentement. Au besoin, contacter le Centre de services en TI et en pédagogie pour obtenir de l'aide.

- Retourner la version anglaise et française du formulaire de consentement implicite, mentionnant nommément que le projet a été **approuvé par le Comité d'éthique de la recherche de l'Université Laval** et le numéro d'approbation **(2023-001 A-2 / 17-08-2023)**, afin que ces documents soient déposés à votre dossier, à défaut de quoi le projet pourrait sembler ne pas avoir été approuvé par le Comité. Il est à noter qu'aucune autre modification ne peut dorénavant être apportée à ces documents, sauf si le projet doit être modifié en cours de réalisation. Le cas échéant, cette

modification devra faire l'objet d'une demande d'amendement, préalablement à son application.

Au nom du Comité, je vous remercie d'avoir soumis votre demande d'approbation d'amendement à son attention. Je vous souhaite le plus grand succès dans la poursuite de vos travaux de recherche et je vous prie d'accepter, Madame, mes salutations distinguées.

Monique Cardinal, coprésidente
Comité plurifacultaire d'éthique de la recherche

Annex 2: Research protocol

WILEY

CAMPBELL SYSTEMATIC REVIEWS

Trauma-informed care in adult prison occupational contexts

Journal:	*Campbell Systematic Reviews*
Manuscript ID	Draft
Wiley - Manuscript type:	Title Registration Form-Systematic Review
Date Submitted by the Author:	n/a
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Abstract:	

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Trauma-informed care in adult prison occupational contexts

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Citation

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Abstract

Objectives

This is a protocol for a Cochrane Review (prognosis). The objectives are as follows:

This review focuses on the implementation of trauma-informed care (TIC) in carceral settings and the impact on staff mental health and well-being.

There are two objectives:

Objective 1 is to qualitatively synthesize the components of TIC interventions within adult prison environments, specifically concerning the mental health and well-being of staff.

Objective 2 is to evaluate the impact of TIC interventions on adult prison staff mental health and well- being.

Background

The problem, condition or issue

Working in adult prisons results in exposure to routine and extreme potentially traumatic experiences (PTE), such as violence directed towards prison staff or others, and the aversive details of abuse or violence suffered by those in custody [1]. PTE elevate risk of multiple mental health and well-being consequences including post-traumatic stress disorder (PTSD), suicidality, and physical injury [2]. These impacts on mental health and well-being can undermine the quality of services provided, and result in high costs related to leaves of absence, employee turnover, and the litigation of complaints [3][4]. These consequences can also result in negative mental health and well-being challenges for families and support networks [5]. Because the impacts associated with elevated trauma-exposure inherent in prison-based work are severe, primary, secondary and tertiary preventative measures are required. To mitigate the risks associated with trauma exposure, it is important to understand what strategies have been implemented to date and to assess their efficacy.

Research examining PTE exposure among prison staff and related negative consequences are elevated. James and Todak (2018) [6] investigated PTSD among American prison employees and found a rate equivalent to that of veterans of the Iraq and Afghanistan wars (19%). According to Correctional Service Canada (2015) [7], a cross-section of correctional professionals in Ontario (n=122) disclosed exposure to an average of 27.9 PTE, including witnessing suicides, homicides, and other violent incidents. Only 2% of that sample had not been exposed to such events, 41% of those affected had impacts that interfered with their daily living, 59% required psychiatric medication, and 17% had been diagnosed with PTSD. In contrast, the lifetime prevalence of PTSD in the Canadian general population is 9.2% [8]. In their systematic review, Regehr et al. (2021) [9] confirmed that correctional officers suffered from rates of PTSD, depression, and anxiety many times higher than the general population. PTSD was most strongly associated with physical danger due to the on-the-job violenceperpetrated against prison staff, and their resulting injuries. Specifically, “[d]epression and anxiety…[were] most strongly associated with low levels of perceived support from the organization, low job satisfaction, and low-perceived social valuing of the roles these officers perform” (pp. 237-238). These results suggest that preventive measures at the organizational level may be effective strategies to reduce the impacts of workplace trauma. This is in line with research conducted in health and social services settings showing that TIC interventions at the organizational level can reduce post-traumatic stress at the individual level [10, 11, 12].

People working in carceral institutions need protective strategies to manage routine potential harms related to PTE. Repetitive trauma exposure at any time in life can result in “significant impairment in personal, family, social, educational, occupational or other important areas of functioning” (para. 1)[13] . Strategies must specifically target validated risk factors for poor outcomes following exposure to PTE because there is a dose-response relationship between trauma exposures, illness, and early death [14, 15]. Prompted by problems in the relationship between work and well-being made clear during the COVID-19 pandemic, the Office of the Surgeon General (2022) [16] identified the need for workplaces to become engines of well-being. A model was developed in consultation with workers and unions across a wide variety of occupations and sectors and follows the recommendations of multiple groups including the National Academy of Medicine and the American Psychological Association, along with U.S. government agencies such as the Department of Veterans Affairs, the Occupational Safety and Health Administration (OSHA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Centers for Disease Control and Prevention (CDC) National Institutes of Occupational Safety and Health (NIOSH).The U.S. Surgeon General’s Framework for Workplace Mental Health and Well-being (2022) [16] describes how workplaces can protect and promote wellness among staff by centering worker voice and equity, and prioritizing five essentials: "protection from harm, connection and community, opportunity for growth, mattering at work, and work-life harmony" (p. 10). This approach articulates how to apply TIC at the organizational level for the benefit of staff.

TIC is a relatively novel approach in human services delivery, promoting the integration of trauma-informed knowledge and the implementation of trauma-informed intervention strategies at all organizational levels [17]. This approach aims to protect all stakeholders involved in a system from harmful impacts related to PTE. While the implementation of TIC in programs serving prisoners is an active field of study, less appears to have been done to evaluate the effectiveness of TIC on prison staff mental health and well-being. An emerging body of research has begun to examine how TIC implementation impacts people working in other human services settings. For example, some studies have explored whether TIC interventions increase trauma-informed attitudes and practices and reduce traumatic stress among professionals working in involuntary contexts [18, 19, 11]. While TIC interventions such as the Correctional Officer Trauma-Responsive Training Project [20] and Trauma Training for Criminal Justice Professionals [21] are being implemented among professionals in adult carceral contexts, their impacts remain unclear.

The intervention

This review focuses on a) synthesizing the key characteristics of trauma-informed interventions in carceral contexts that include staff, and b) assessing the impact of these interventions on carceral staff mental health and well-being. SAMHSA has articulated a framework for comprehensive TIC that includes a series of assumptions, principles, and domains.

There are four key assumptions that underline trauma-informed approaches: “A program, organization, or system that is trauma-informed: 1. realizes the widespread impact of trauma and understands potential paths for recovery; 2. recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; 3. responds by fully integrating knowledge about trauma into policies, procedures, and practices; 4. seeks to actively resist re-traumatization” (p. 9) [17]. These assumptions are operationalized differently depending on the implementation context.

All stakeholders involved in a program, organization, or system in which TIC is being implemented, such as clients, staff, and/or families, are meant to benefit from the six TIC principles of: 1. safety; 2. trustworthiness and transparency; 3. peer support; 4. collaboration and mutuality; 5. empowerment, voice, and choice; and 6. cultural, historical, and gender issues (p. 10). SAMHSA also identified ten organizational domains in which TIC can be implemented: 1. governance and leadership; 2. policy; 3. physical environment; 4. engagement and involvement; 5. cross sector involvement; 6. screening, assessment, and treatment services; 7. training and workforce development; 8. progress monitoring and quality assurance; 9. financing; and 10. evaluation (p. 12) [22]. (Figure 1)

TIC theorizing is flexible about how many domains to include in implementation, but endorsing all assumptions and principles is necessary. To elaborate, approaches that implement a program solely at the client-level only can be described as trauma-informed or trauma-responsive. For example, a therapy group that selectively applies TIC principles and assumptions to client care without also acknowledging and responding to how trauma-exposure can impact staff, or how organizational practices might impede staff mental health and well-being related to PTE exposure, cannot be considered a comprehensive approach to TIC. Comprehensive TIC “recognizes the signs and symptoms of trauma in all stakeholders involved with a system and responds by fully integrating knowledge about trauma into policies, procedures, and practices” (p. 9) [17].

How the intervention might work

TIC represents a philosophical shift towards practices that promote well-being among all stakeholders in trauma-exposed and exposing systems. This is done by reshaping policies and practices to create trauma-informed organizations and by building a trauma-informed workforce [21]. For example, a trauma-informed organization makes changes to the environment, practices, and policies to actively prevent PTE, including potential triggers for the re-experiencing or exacerbation of traumatic stress symptoms related to previous exposures suffered among clients, staff, and the larger community. Practices and resources are provided to assist in healing people with post-traumatic stress through respectful collaboration amongst all stakeholders. TIC aims to transform systems to promote mental health and well-being while managing extant post-traumatic stress. Strategies specific to staff well-being include workplace violence prevention, secondary traumatic stress prevention, and responses to staff exposure to PTE such as, staff first aid [23], or hybrid approaches aimed at improving the overall culture of the organization. Evidence suggests that organizations that promote resilience- building activities, physical and psychological safety, trauma-relevant policies, collaborative and transparent leadership practices, and routine practices that promote support, will reduce the rates of trauma-related stress among their staff [11].

Outcomes

Oral et al. (2020) [24] conducted a systematic review of the implementation of TIC in US healthcare and related fields. Across the 144 articles that met their inclusion criteria, multiple positive outcomes were identified including improved provider knowledge about trauma, patient satisfaction, medical information recall, improved patient compliance, decreased healthcare costs, and increased referrals to mental health services. One multisystem implementation study that included juvenile justice services saw improvements in client competence, depression symptoms, behavioral problems and caregiver strain reduction [25]. Other services reported reductions in the use of restraints and seclusions among adolescents; reductions in post-traumatic symptoms; drug use severity, and other mental health symptoms; better health outcomes; and. increased competence of primary care providers [24]. Reporting benefits across many domains, the authors drew attention to the increased benefit of multiple services adopting TIC. Hales et al. (2019) [26] implemented TIC in a nonprofit organization providing services for problematic substance use, mental health issues, and homelessness. They used the five guiding values of TIC outlined by Fallot and Harris (2009) to evaluate the program including safety, trustworthiness, choice, collaboration, and empowerment [27]. Implementation of TIC in this setting was associated with “improvements to organizational climate, procedures and practices, staff and client satisfaction, and successful completion of treatment” (p. 537) [26].

Trauma-focused treatments for PTSD have been demonstrated effective symptom reduction [28]. Two reviews investigating treatments for PTSD in correctional settings underlined the need for more to be done to treat this high-needs population [29, 30]. Several trauma-informed interventions in correctional settings have shown promise across gender and among multi-ethnic samples [31, 30, 32]. Malik et al. (2023) [33]conducted the only review investigating trauma-informed interventions in prison settings to use both meta-analytic techniques and to investigate treatment-level factors. The sixteen studies meeting their inclusion criteria “revealed a small but significant overall effect size for trauma-focused interventions in reducing PTSD and other trauma-related symptoms, relative to prison control comparisons” (p. 4). These reviews identified the following challenges: limited trauma-informed treatmentoptions, the need for high quality assessment of outcomes, and the implementation of TIC beyond direct services aimed at symptom reduction.

Overall, current evidence suggests that comprehensive TIC interventions contribute to better outcomes however the impact of TIC interventions on correctional staff remains underexplored. In one exception, Purtle (2018) [34] conducted a systematic review of TIC interventions that included staff trainings. Twelve of the fourteen studiesmeasuring changes in staff knowledge, attitudes, or behaviors identified improvements. Overall, “[t]rauma-informed organizational interventions appear[ed] to have the most meaningful impacts on client outcomes when the intervention include[d] other components (e.g., policy changes) in addition to trauma-informed trainings for staff” (p. 12). None of the included studies investigated outcomes related to staff well-being such as job satisfaction, burnout, or turnover. To better understand the impacts of an organizational change process aimed at improving staff well-being, Sprang et al. (2021) [11] measured secondary traumatic stress and burnout among professionals working in a department of health and human services following implementation of a TIC intervention (n=2345). Their results showed that organizational efforts using a data-driven change approach could reduce perceived levels of distress, and that focusing attention on secondary trauma could improve organizational and individual outcomes (p. 1).

Mechanisms

“A program, organization, or system that is trauma-informed acknowledges the widespread impact of trauma and identifies potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involvedwith the system;and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization” (p. 9) [22]. TIC is grounded in multidisciplinary, empirical evidence that demonstrates the impacts of

traumatization on human development and functioning and the critical importance of prevention. Effective responses include all stakeholders in a program, organization, or system and, ideally are implemented at every level of influence [21].

The United States Office of the Surgeon General (2022) released a *Framework for Workplace Mental Health & Well-Being* informed by the SAMHSA principles and global evidence suggesting that workplaces "can be engines of mental health and well-being" (p. 5) [16]. This TIC model offers a comprehensive understanding of the mechanisms involved in safeguarding the well-being of people in relation to their workplace setting. (Figure 2).

Why it is important to do this review

Understanding how best to implement programs for carceral professional exposed to trauma needs further attention [35]. While there are two reviews examining the harmful impacts of working as front-line prison professionals [36, 9], one review examining TIC in carceral settings [33], and one review that evaluates the efficacy of TIC when implemented at the organizational level [10] none of these reviews explore how the implementation of TIC impacts carceral professional exposed to trauma. The proposed review will provide new insights into whether comprehensive TIC impacts the people working within carceral systems, including attention to mental health and well-being.

Objectives

This review focuses on the implementation of trauma-informed care (TIC) in carceral settings and the impact on staff mental health and well-being.

There are two objectives:

Objective 1 is to qualitatively synthesize the components of TIC interventions within adult prison environments, specifically concerning the mental health and well-being of staff.

Objective 2 is to evaluate the impact of TIC interventions on adult prison staff mental health and well- being.

Methods

Criteria for considering studies for this review

Types of studies

Inclusion criteria:

Study design: Any empirical research with quantitative, qualitative, and/or mixed method study design Language: Studies published in English and French

Geographic location: All countries

Format: Peer-reviewed journal articles and dissertations

Exclusion criteria:

Study design: Theoretical or conceptual papers, commentaries, book reviews, and conference abstracts will be excluded. Systematic reviews and scoping reviews will be excluded, but the team will track the references from relevant reviews to ensure they were included in the screening process

Language: Studies published in languages other than English or French Format: Books or book chapters

Types of participants

Inclusion criteria: Adults working within an adult prison or jail setting

Potential job titles include:

- Correctional officers
- Psychologists
- Social workers
- Pharmacists
- Nurses
- Tradespeople
- Maintenance people
- Food service providers

Types of interventions

While the assumptions, principles, and domains of comprehensive TIC have been identified by the SAMHSA [22, 17] in practice there are multiple approaches to implementation. In fact, one of the principles of TIC is that interventions should be adapted to reflect local contexts and needs.

For Screening on Title and Abstract, included studies will meet the following criteria:

1. Intervention focused on addressing trauma in adult carceral setting

For Screening on Full Text, included studies will meet the following criteria:

1. Intervention focused on addressing trauma in adult carceral setting
2. Intervention includes carceral staff

3. Study evaluates the intervention impact on staff mental health and well-being

Types of outcome measures

It is anticipated that research will include multiple approaches to evaluating the impact of TIC interventions on staff mental health and well-being with attention to the following outcomes: PTSD, depression, and other mental health outcomes, secondary traumatic stress, job satisfaction, burnout, workplace climate, and workplace social support. Relevant quantitative measures are expected to include:

- PTSD Checklist for *DSM*-5 [37]
- Impact of Events Scale [38]
- Measures of secondary traumatic stress:
  - Professional Quality of Life Questionnaire/ Compassion Fatigue Self-Test [39]
  - Secondary traumatic stress scale [40]
  - Moral Distress Scale [41]
  - Job Satisfaction Survey [42]
  - Beck Depression Inventory [43]
  - Burnout Inventory [44]
  - Prison and Social Climate Survey [45]
  - Trauma-Informed Climate Scale [46]
  - Psychological Climate Survey [47]
  - Workplace Social Support [48]
  - Perceived Workplace Social Support [49]

Outcomes describing changes in staff behaviour, values, or performance will be excluded, unless they include items that are related to staff mental health and well-being.

Primary outcomes

Impact of TIC interventions on staff mental health and well-being.

Secondary outcomes

Characterization of TIC implementation, including attention to assumptions, principles, and domains [22], and the five essential components for workplace mental health and well-being [16].

Duration of follow-up

No restrictions on duration of follow-up.

Types of settings

Inclusion criteria: State-funded adult prisons or jails.

Exclusion criteria: Halfway houses, community resources that are not secure, healthcare settings, parole services, political prisons, immigration detention, holding environments for prisoners of conscience, wartime prisons, internment camps, concentration camps.

Search methods for identification of studies

A structured, systematic search was developed by an academic librarian to identify relevant published and unpublished studies. There will be no publication date restriction as the time point of the implementation is not relevant to our study objectives. No restrictions on publication format will be used when running searches in order to avoid missing material that was misentered into the databases. No language restrictions will be used, however only results in English or French will be retained due to team capacity.

Electronic searches

The structured search includes the following electronic databases:

- PsycINFO (Ovid)
- MEDLINE (Ovid)
- Criminal Justice Abstracts (EBSCO)
- CINAHL (EBSCO)
- National Criminal Justice Reference Service Abstracts Database (ProQuest)
- Sociological Abstracts (ProQuest)
- Social Services Abstracts (ProQuest)
- PTSDPubs (ProQuest)
- ProQuest Dissertations & Theses Global (ProQuest)
- Cochrane Library (Wiley)
- Web of Science (www.webofscience.com, in the indexes: SCI-EXPANDED, SSCI, AHCI, CPCI- S, CPCI-SSH, ESCI, BKCI-S, BKCI-SSH)

The search strategy was developed in collaboration with a professional librarian (EG), and it is structured around the relevant elements of the PICO framework. The two concepts of the strategy are "prison" (related to the population of interest: prison staff) and "trauma-informed care" (intervention of interest). The concept for trauma-informed care is divided into three blocks:

Block 1. Prison: prison and its synonyms;

Block 2. Trauma-informed: trauma-informed and its synonyms, and names of specific trauma- informed programs found in preliminary searches or already known to the research team;

Block 3. Trauma: trauma and it synonyms;

Block 4. Care: care and its synonyms (intervention, service, program, etc.).

For each block, we will use a combination of free-text terms and controlled vocabulary. The blocks are combined in the following way:

Block 1 AND (Block 2 OR (Block 3 AND Block 4))

No limit (date, language, study design, etc.) will be applied to the search.

The full search strategy for each database is described in Supplementary material 1.

Searching other resources

Dissertations, theses databases, search trial registers and databases of conference abstracts are included in our overall search strategy. The corrections services websites of the Canadian federal and provincial governments and the United States federal and state governments, the European Parliament website, and Canadian and American Carceral professional union websites will be searched for reports and key researchers to consult for unpublished manuscripts. Reference lists of included studies and relevant systematic reviews identified in the search will be searched. Authors of included studies will be contacted for guidance in finding other resources. Conference proceedings from the International Corrections and Prisons Association for the Advancement of Professional Corrections, the International Society for the Study of Trauma and Dissociation, the International Society for Traumatic Stress Studies, the Correctional Leaders Association, American Correctional Association, National Institute of Corrections, and Just Detention International will be reviewed. Key informants with recent professional experience working in prisons will also be consulted.

The search process in electronic databases and other resources will be documented according to the PRISMA-S Checklist to ensure transparency and replicability.

Data collection and analysis

Description of methods used in primary research

Diverse and heterogenous methods are used in this field of study. Participant samples are expected to include cross-sectional representations of staff members obtained through their participation in the implementation effort. It is also possible that administrative data related to variables of interest such as burnout or turnover might be reported. The nature of the participant samples will likely be focused on specific classes of professionals, such as prison guards, psychologists, or nurses.

Typical research designs for quantitative study are suggested by previous systematic reviews on related topics. In Purtle's *Systematic review of evaluations of trauma-informed organizational interventions that include staff trainings* (2018) [34], the sample included 23 studies with the following designs: Single group pretest/posttest (12), Single group pretest/multiple posttests (6), randomized controlled trials (5), and Multiple group pretest/posttest (1). In *Effectiveness of trauma-informed care interventions at the organizational level: A systematic review* [10] similar findings were reported with the addition of pre-post and multiple retrospective designs. All studies reported post-measures, twelve reported inferential statistics, ten reported the N, nine reported a baseline measure, and slightly over half reported longitudinal data, ≥ 3-years. Fernández and colleagues (2023) reported finding no randomized controlled trials or use of control groups, and only two studies reported effect sizes in their sample (n=15). Based on Cochrane standards, the average score of quality they found was 47.5%.

The need to tailor TIC interventions to local contexts suggests that the generalizability of any study must be tentative. The range of diverse measures and contexts renders meta-analytic techniques impossible in most instances, and there is a lack of consensus on the most robust outcome variables given the ultimate goals of TIC. Measures used can be derived from multiple fields of study and the majority of TIC-specific measures available that can be applied to staff do not include consistent measures of mental health and well-being. Relevant examples that highlight these challenges include the Attitudes Related to Trauma-Informed Care Scale (ARTIC) [50], and the Trauma-System Readiness Tool–Short Form (TSRT-SF) [51]. Frost and Scott (2022) [52] reported that the "literature base was challenging to synthesize owing to a lack of conceptual clarity and methodological issues within the included studies" (p. 56). Current consensus indicates that the existing evidence has made it difficult to evaluate the effectiveness of TIC implementation due to challenges with study design [10, 36, 53].

Selection of studies

For Screening on Title and Abstract, included studies will meet the following criteria:

1. Empirical research of any study design
2. Adult carceral setting
3. Purpose of study is focused on trauma
4. Includes an intervention to address PTE or post-traumatic adaptations

References with no abstract will automatically be reviewed on full text.

For Screening on Full Text, included studies will meet the following criteria:

1. Empirical research of any study design
2. Adult carceral setting
3. Purpose of study is to evaluate trauma-focused intervention
4. Intervention includes carceral staff, and

5. Study evaluates the intervention's impact on staff mental health and well-being

References will be imported into EPPI-Reviewer for screening on title and abstract, and subsequent screening on full text. To ensure consistency in the screening process, the inclusion and exclusion criteria will be pilot tested with a random sample of 150 references. Two research assistants, the principal investigator (PI) and the methods expert (ME) will independently screen each reference and then we will run comparisons to check for agreement. Differences will be discussed in order to come to a common understanding and to refine practical application of the inclusion and exclusion criteria.

Once 85%+ agreement has been established between each reviewer, the database will be divided into groups with two individuals appraising the suitability of each reference on title and abstract. A third individual will resolve any disagreements. Conference abstracts included at this stage will be used to identify subsequent published studies, reports, or other documents meeting the inclusion criteria. Conference abstracts themselves will then be excluded. Full text review will be conducted by the PI and one research assistant, with any disagreements resolved by the ME. Errata will be searched for all included studies using the instructions published in Cochrane Handbook for Systematic Reviews of Interventions Version 6.4 Technical Supplement to Chapter 4: Searching for and selecting studies [54].

Data extraction and management

Data will be independently extracted by one research assistant, and verified by either the PI or ME. The team will use a standardised form developed and refined through a piloting process. All team members involved with data extraction are fluently bilingual in English and French, therefore the data will be preserved in its original language.

PRISMA guidelines for reporting systematic reviews will guide the data extraction process [55]. All information will be tracked on an Excel spreadsheet, including details for each study.

Component 1: Study Characteristics

The following information will be extracted for each study (see Supplementary material 2):

- Type of document (i.e., peer-reviewed journal article, dissertation, government report)
- Study aims/objectives
- Study design
- Sample size
- Study setting (type of institution)
- Geographic location of data collection
- Recruitment methods
- Participant demographics (including gender, age, ethnicity, professional role)
- Purpose of TIC intervention
- Structure of TIC intervention (e.g., new/adapted/standardized)
- Length of TIC intervention (e.g., number of months, weeks and/or hours)
- Format of TIC intervention (e.g., online, in-person)
- Participants of TIC intervention (e.g., prisoners-only/staff-only/prisoners and staff)
- Content of TIC intervention (topics covered)
- Data collection methods and measures
- Reported staff mental health and well-being outcomes
- Limitations
- Conflicts of interest
- Funding source(s)

Component 2: Comprehensive TIC implementation

Information related to SAMHSA's TIC domains, principles, and assumptions will be extracted for each study (see Supplementary material 3). Two reviewers will independently rate how closely the intervention reflects TIC domains, principles, and assumptions using the following rating scale: "not reflected", "minimally reflected", "somewhat reflected", or "strongly reflected" (see Supplementary material 4).

TIC assumptions:

1. Realizes the widespread impact of trauma and understands potential paths for recovery;
2. Recognizes the signs and symptoms of trauma in clients, families,staff, and othersinvolved with the system;
3. Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. Seeks to actively resist re-traumatization

TIC principles:

1. Safety;
2. Trustworthiness and transparency;
3. Peer support;
4. Collaboration and mutuality;
5. Empowerment, voice, and choice; and
6. Cultural, historical, and gender issues

TIC organizational domains:

1. Governance and leadership;
2. Policy;
3. Physical environment;
4. Engagement and involvement;
5. Cross sector involvement;
6. Screening, assessment, and treatment services;
7. Training and workforce development;
8. Progress monitoring and quality assurance;
9. Financing; and
10. Evaluation

Component 3: Staff Mental Health and Well-Being

Information related to staff mental health and well-being outcomes will be extracted for each study (see Supplementary material 5) using a form adapted from the extraction strategy used by Munro et al. (2007) [56] and published in Noyes and Lewin (2011) [57]. Data extraction will first be categorized into the components of the Framework for Workplace Mental Health and Well-being identified by the Office of the Surgeon General (2022) [16]. Outcomes not adhering to this framework will be added iteratively. The components of the framework include the following:

1. Protection from harm - safety
2. Protection from harm - security
3. Connection & community - social support
4. Connection & community - belonging
5. Work-life harmony - autonomy
6. Work-life harmony - flexibility
7. Mattering at work -dignity
8. Mattering at work - meaning
9. Opportunity for growth - learning
10. Opportunity for growth - accomplishment
11. Worker voice
12. Worker equity
13. Other outcome

For quantitative studies, the intervention and outcome sought will be described and, as recommended by Wang et al. (2021) [58], the most detailed outcome data available will be collected and utilised for further analyses of included studies (2×2 tables, means and standard deviations, effect estimates, confidence intervals, test statistics, P values, or individual participant's data).

Assessment of risk of bias in included studies

Two independent reviewers will evaluate the risk of bias in selected studies. As we are including both randomized and quasi-experimental trials, we will use two different tools appropriate for these study designs to identify potential biases. Any conflicts will be resolved by discussion followed by reaching consensus.

Cochrane Risk of Bias 2 (RoB 2) tool: We will use the RoB 2 tool [59] when reviewing a randomized controlled study. This tool is designed for randomized studies and appraises seven domains of bias pertinent to these studies. These include: (1) random sequence generation; (2) allocation concealment; (3) blinding of participants; (4) blinding of outcome assessment; (5) incomplete outcome data; (6) selective reporting; and (7) other biases. Based on these assessments, we will label each study for one of three categories: "low risk", "some concerns", or "high risk".

Risk Of Bias In Non-randomized Studies - of Interventions (ROBINS-I tool): For studies that have employed quasi-experimental designs, we will use ROBINS-I tool [60]. This assesses seven domains of bias that are pertinent to non-randomized studies. The domains are: (1) bias due to confounding, (2) bias in selection of participants into the study, (3) bias in classification of interventions, (4) bias due to deviations from intended interventions, (5) bias due to missing data, (6) bias in measurement of outcomes, and (7) bias in selection of the reported result. We will categorize each study as having a "low", "moderate", "serious", or "critical" risk of bias.

Measures of treatment effect

If it appears to be appropriate to conduct meta-analysis after reviewing the selected studies, we will calculate Hedges' g from means and standard deviations of the continuous outcomes [61]. We will employ Hedges' g to measure the effect size for the outcomes in our review. As we expect to have our outcomes (such as organizational climate and staff well-being) measured through different scales, Hedges' g will be particularly useful for comparing the means between outcomes obtained through different scales. Also, it allows to correct the error occurs due to small sample size studies when calculating Cohen's d [62]. It provides a standardized measure of effect (standardized mean difference), which will allow for the comparison of results across different studies.

Unit of analysis issues

This review will likely include studies with various designs, including those with clustering (individuals randomized/allocated in clusters), crossover designs, and studies with multiple outcome measurement time-points. We will follow the guidance provided in the Cochrane Handbook to address these unit-of- analysis issues [63]. This includes conduction of sensitivity analysis to understand the effects of these studies on the pooled estimate. If studies with cluster randomization did not consider clustering design, we will use intraclass correlation co-efficient (ICC) [64] to approximate the effect. If the ICC is not reported, we will look for

external estimates from similar studies. Sensitivity analysis can also help rectify the carryover effects in studies with cross-over design. For multiple time points, we will capture both short-term and long-term effects and the effects of repeated measures within the same participants.

Criteria for determination of independent findings

Effect size multiplicity, where multiple effect sizes arise from the same or overlapping groups of study participants, will be addressed during meta-analysis. Potential sources of multiplicity include reporting effect sizes for subgroups as well as the full sample, studies with multiple intervention arms or exposure groups, measurement of multiple outcome variables, use of multiple ways of measuring the same construct, measurement at multiple timepoints, and reporting of analyses using different metrics or statistical approaches, all of which potentially violate the assumption of independence and can distort meta-analytic results.

We will take appropriate measures to handle this effect as evident in literature [65]. Measures include but not limited to selecting one effect size per study using a rationale decision rule, for example choosing the total sample over subgroups, the outcome of greatest interest, the longest follow-up timepoint, or the analysis approach considered most valid. However, this will discard potentially useful information. We will carefully examine the database of effect sizes to identify sources and extent of multiplicity based on populations, constructs, measures, timepoints, and analyses. We will take the average of the effect sizes from multiple reports from same study reporting similar outcomes [66]. However, we will remain open to refining decisions during the review process as needed. Clear reporting on multiplicity and the implications of choices made will be critical.

Dealing with missing data

In the event of missing data within the published articles, we will attempt to contact the authors. If the author and the data do not respond, we will report on available data. This limitation will also be captured during our appraisal and ensure the rigorosity of our study.

Assessment of heterogeneity

We will examine effect size heterogeneity using appropriate statistical tests, such as the Q test and/or I2 statistic [67]. Visual inspection of the forest plot will also help us identify the points of heterogeneity. If possible, we will conduct meta-regression to identify the sources of heterogeneity.

Assessment of reporting biases

We will use funnel plot to check for publication bias across included studies [68]. This will help us account for the studies with null results that are not published due to the publication bias.

Data synthesis

We will provide a descriptive summary of the dataset based on the information extracted related to Component 1: Study characteristics, Component 2: Comprehensive TIC implementation, and Component 3: Staff Mental Health and Well-Being. This will provide a clear picture of the types of interventions that have been implemented in adult prison settings, and their impact on carceral staff mental health and well-being.

Continuous variables will be reported using mean with 95% confidence intervals, and categorical will be using count and percentages. To calculate the standardized mean difference (Hedges' g) and 95% confidence interval for each outcome, we will be using random effects meta-analyses. This type of model is based on the assumption that the true intervention impact varies between trials. To calculate the between-study heterogeneity, we will combine the restricted maximum likelihood with inverse variance weighting. We will use STATA version 17.0 for both the meta-analysis and meta-regression.

Subgroup analysis and investigation of heterogeneity

Subgroup or meta-regression analyses will be conducted if appropriate. This will involve identifying potential effect measure modifiers and providing a rationale for each. This could include factors such as location, population demographics, ethnicities, etc.

Sensitivity analysis

To maintain the rigorosity of the analysis, we will conduct a sensitivity analysis of the pooled estimate. This will allow us to explore the effects of study designs on our results and to understand the potential impact of including studies that carry a high risk of bias, particularly in relation to our primary outcomes.

Treatment of qualitative research

Qualitative data will be appraised using the Joanna Briggs Institute Critical Appraisal Checklist for critical and interpretive research recommended Lockwood et al. (2015). [69] (Supplementary material 6).

Summary of findings and assessment of the certainty of the evidence

We do not plan to include Summary of findings and assessment of the certainty of the evidence.

Supplementary materials

[For display in the published PDF only] Supplementary materials are available with the online version of this article: 10.1002/14651858.CA000362.

[For display on the Cochrane Library only] Supplementary materials are published alongside the article and contain additional data and information that support or enhance the article. Supplementary materials may not be subject to the same editorial scrutiny as the content of the article and Cochrane has not copyedited, typeset or proofread these materials. The material in these sections has been supplied by the author(s) for publication under a Licence for Publication and the author(s) are solely responsible for the material. Cochrane accordingly gives no representations or warranties of any kind in relation to, and accepts no liability for any reliance on or use of, such material.

CA000362-SUP-01-searchStrategy.html

Search strategies

Supplementary material 2

CA000362-SUP-02-other.html

Data Extraction Tool: Component 1, Study Characterstics

Supplementary material 3

CA000362-SUP-03-other.html

New Supplementary material, SAMHSA's TIC Domains, Principles, and Assumptions Data

Supplementary material 4

CA000362-SUP-04-other.html

Data Extraction Tool: Component 2, Comprehensive TIC implementation

Supplementary material 5

CA000362-SUP-05-other.html

Data Extraction Tool: Component 3, Staff Mental Health and Well-Being

Supplementary material 6

CA000362-SUP-06-other.html

New Supplementary material, Joanna Briggs Institute Critical Appraisal Checklist for critical and interpretive research

Additional information

Acknowledgements

We gratefully acknowledge Liz Eggins, editor at Campbell Systemic Reviews, who shepherded us through the title registration process and search strategy; Catherine Rossi and Felice Yuen, our co-researchers who were instrumental in securing the funding for the larger project within which this review is embedded.

Contributions of authors

All authors contributed to this protocol at each stage (conception and design, drafting, revision, and final approval of the version of the protocol manuscript for publication). Author roles in the review are as follows:

Denise M. Brend will serve as the lead content expert. Dr. Brend is a professional social worker, registered psychotherapist, and assistant professor in criminology at Université Laval; a co-researcher on the *Canadian Consortium on Child and Youth Trauma;* and, affiliated researcher in the Centre international de criminologie comparée and the *Recherches appliquées et interdisciplinaires sur les violences intimes, familiales et structurelles* research group. Her program of research and clinical work focus on interpersonal and systemic trauma and relationship between staff wellbeing and trauma-informed care in systems of care and control.

Zack Marshall will serve as the systematic review methods lead. Dr. Marshall is an associate professor at the Cumming School of Medicine at the University of Calgary with over ten years' experience in community mental health, including work with people who have been deeply impacted by trauma. Dr. Marshall is Co-Chair and Editor of the Campbell Collaboration Subgroup on Sexual Orientation and Gender Identity. He is also a member of the Sex/Gender Methods Group, a subgroup of the Campbell and Cochrane Equity Methods Group. A dynamic educator, he has had 22 graduate students under his supervision.

Élyse Granger will serve as the Information retrieval lead. She is an academic librarian at Université Laval for the School of Social Work and Criminology and the School of Psychology. She has over 4 years of experience as a health and social sciences librarian. She has participated in several evidence syntheses (systematic reviews, scoping reviews and health technology assessments) with various research teams from Université Laval and the Centre intégré universitaire de santé et de services sociaux (CIUSSS) de la Capitale-Nationale.

Nashit Chowdhury will contribute to the systematic review through his methodological expertise and review coordination experience. He is currently a PhD student at Community Health Sciences, and currently focused on research on health and wellness and community engagement. He has over four years of experience in population and public health research. He works with the diverse immigrant population of Canada to improve their physical and emotional wellbeing and social integration.

Tanvir C Turin will serve as a quantitative analysis lead for this systematic review and meta-analysis. Dr. Turin is an Associate Professor in Department of Family Medicine and Department of Community Health Sciences in the Cumming School of Medicine, University of Calgary. He is also associated with the Newcomer Research Network, O'Brien Institute for Public Health, and Libin Cardiovascular Institute. He leads a community-engaged program of research which addresses disparities faced by socially vulnerable population groups, including racialized/immigrant communities, with a focus on equity, diversity, and inclusion (EDI). His research program is built on transdisciplinary and cross-sectorial efforts where deep and meaningful community engagement is at the core.

Declarations of interest

Zack Marshall is the Co-Chair and Editor for the Campbell Sexual Orientation and Gender Identity Subgroup and so will not be involved in the editorial or formal approval process for this protocol or the subsequent review.

Preliminary timeframe

Planned submission of draft review: January 29, 2024

Plans for Updating this review

Searches will be rerun for all relevant databases within 12 months before publication of the review any studies identified will be incorporated prior to publication. Denise M. Brend, Zack Marshall, and Élyse Granger will update the search prior to publication.

Sources of support

Internal sources

- Université Laval, Canada
  Faculté des sciences sociales

External sources

- Fonds de Recherche du Québec - Société et culture (FRQSC), Canada
  Programme Actions concertées, Programme de recherche sur la santé psychologique au travail, Volet : Synthèse des connaissances, Concours 2022-2023: 2023-0SYS-312951

Registration and protocol

Title Registration Form Approved by Campbell Collaboration Crime and Justice Group (Nov 8, 2022)

Data, code and other materials

See Supplemental material 4. Data Extraction Tool: Component 2, Comprehensive TIC implementation (CA000362-SUP-04-other.html)

See Supplemental material 5. Data Extraction Tool: Component 3, Staff Mental Health and Well-Being (CA000362-SUP-05-other.html)

See Supplemental material 6. New Supplementary material, Joanna Briggs Institute Critical Appraisal Checklist for critical and interpretive research (CA000362-SUP-06-other.html)

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Figures

Figure 1

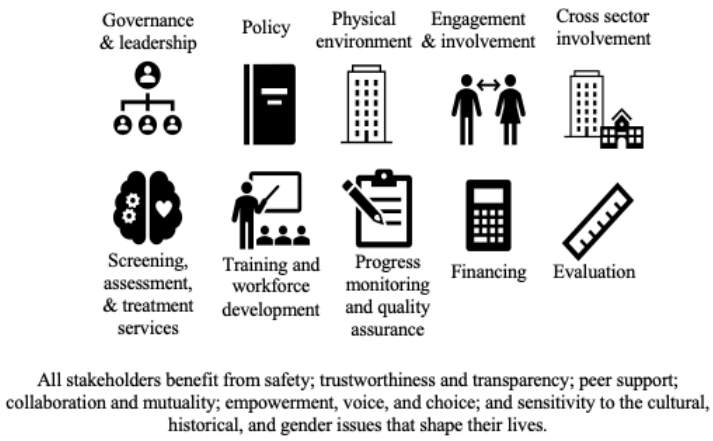
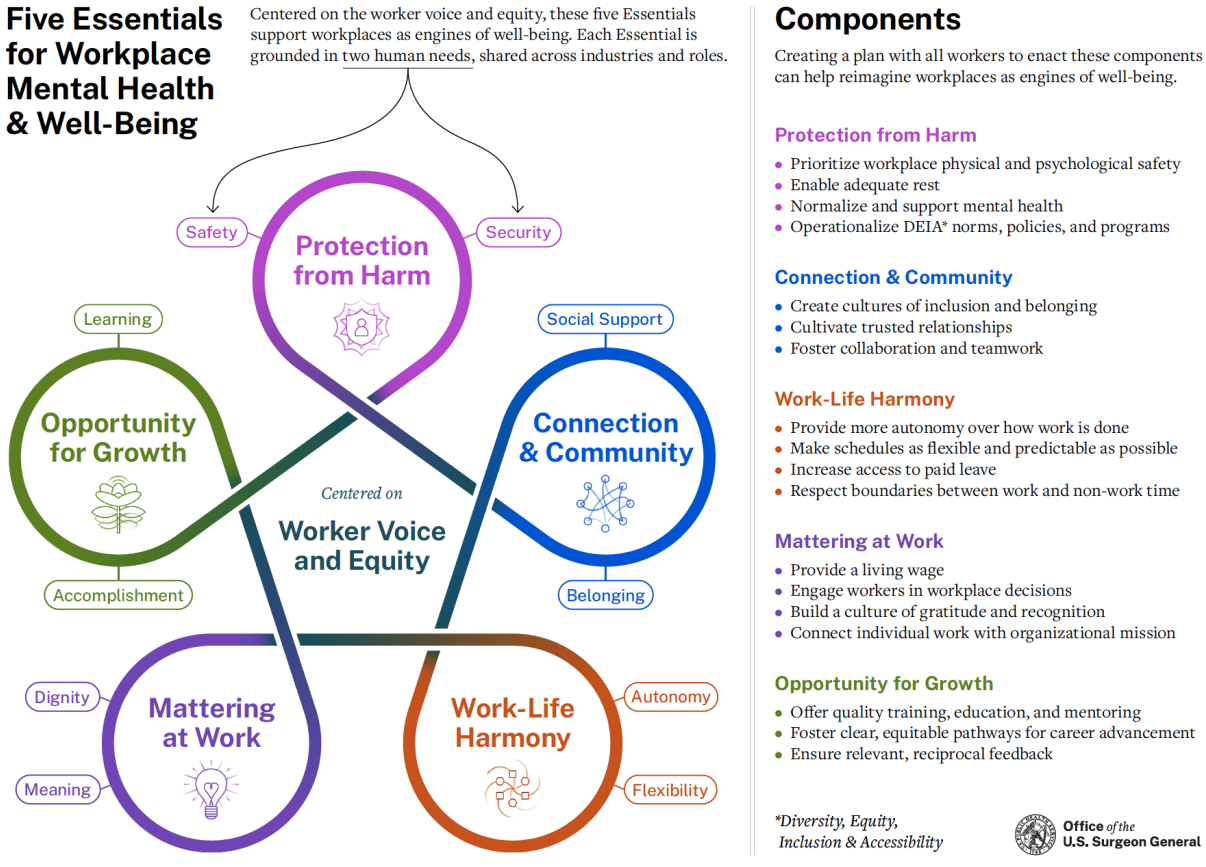


Figure 3, SAMHSA's TIC domains and principles

Figure 2



Office of the Surgeon General. (2022). The US Surgeon General's Framework for Workplace Mental Health & Well-Being.

Annex 3: Methodological expectations of Campbell Collaboration intervention reviews: Conduct standards

Campbell Policies and Guidelines Series No. 3

October 2019

Methodological expectations of Campbell Collaboration intervention reviews: Conduct standards

Colophon

Title	Methodological expectations of Campbell Collaboration intervention reviews: Conduct standards
Authors	The Methods Group of the Campbell Collaboration
DOI	10.4073/cpg.2016.3
No. of pages	23
Last updated	28 October 2019
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ISSN	2535-2458

Acknowledgement	Adaptations on MECIR Version 2.2 Conduct Standards (Chandler, Churchill, Higgins, Lasserson, & Tovey, 2012) October 2019- updated to remove section numbers for Cochrane Handbook since these are out of date with the new Cochrane Handbook published in October 2019

The Campbell Collaboration was founded on the principle that systematic reviews on the effects of interventions will inform and help improve policy and services. Campbell offers editorial and methodological support to review authors throughout the process of producing a systematic review. A number of Campbell's editors, librarians, methodologists and external peer-reviewers contribute.

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Note for authors:

This document provides detailed methodological expectations for the conduct of Campbell Collaboration systematic reviews of ***intervention effects***. It is important to note that some Campbell reviews may not focus on intervention effects, but may synthesize observational research that is policy relevant. For instance, such reviews may examine correlational or descriptive research, diagnostic or test accuracy, or other topics that do not necessarily focus on intervention effects. Although most of the methodological expectations listed below will be appropriate for all review topics (intervention focused or not), some (particularly those related to study design) may not be entirely applicable to non-intervention reviews, and have been noted as such under the 'rationale and elaboration' column.

Status: Mandatory means that a new protocol or review will not be published if this standard is not met. Highly desirable means that this should generally be done but that there are justifiable exceptions. There may be legitimate variation between or within Campbell Coordinating Groups in the relative emphasis placed on compliance with highly desirable standards. The emphasis placed on compliance with highly desirable standards will remain at the discretion of each Campbell Coordinating Group. Optional means this is done at the authors' discretion.

The Campbell Collaboration Policies and Guidelines document and the Cochrane Handbook (2019) may be helpful references for additional details on conduct standards.

Item No.	Status (T = Title, P = Protocol, R = Review)	Item Name	Standard	Rationale and elaboration	Authors note: pages where addressed
C1	Mandatory (T & P)	Formulating review questions	Ensure that the review question and particularly the outcomes of interest, address issues that are important to stakeholders such as consumers, practitioners, policy makers, and others.	Campbell reviews are intended to support practice and policy, not just scientific curiosity. The needs of consumers play a central role in Campbell Reviews and they should play an important role in defining the review question	Page 4 : Why it is important to do this review
C2	Mandatory (T & P)	Pre-defining objectives	Define in advance the objectives of the review, including participants, interventions, comparators, and outcomes.	Objectives give the review focus and must be clear before appropriate eligibility criteria can be developed. If the review will address multiple interventions, clarity is required on how these will be addressed (e.g. summarized separately, combined or explicitly compared).	Page 4
C3	Highly desirable (P)	Considering potential adverse effects	Consider any important potential adverse effects of the intervention(s) and ensure that they are addressed.	It is important that adverse effects are addressed if applicable in order to avoid one-sided summaries of the evidence. In these cases, the review will need to highlight the extent to which potential adverse effects have been evaluated in any included studies. Sometimes data on adverse effects are best obtained from non-randomized studies, or qualitative research studies. This does not mean however that all reviews must include non-randomized studies.	Our Primary outcome (page 5) is the impact of TIC interventions on staff mental health and well-being. These impacts are not pre-conceived as effective or aversive. We have yet to encounter any reported aversive impacts in the literature, if we identify any we will report them as we willreport all other effects identified .
C4	Highly desirable (P)	Considering equity and specific populations	Consider in advance whether issues of equity and relevance of evidence to specific populations are important to the review, and plan for appropriate	Where possible reviews should include explicit descriptions of the effects of the interventions not only on the whole population but also describe their effects upon specific population subgroups and/or	Page 3: TIC is intended to 1. realize the widespread impact of trauma and understands

			methods to address them if they are. Attention should be paid to the relevance of the review question to populations such as low socioeconomic groups, low or middle-income regions, women, children, people with disabilities, and older people.	their ability to reduce inequalities and to promote their use to the community.	potential paths for recovery; 2. recognize the signs and symptoms of trauma in clients, families, staff, and others involved with the system; 3. respond by fully integrating knowledge about trauma into policies, procedures, and practices; 4. seek to actively resist re-traumatization" in relation to " cultural, historical, and gender issues:. This will be appraised in the review.
C5	Mandatory (P)	Pre-defining unambiguous criteria for participants	Define in advance the eligibility criteria for participants in the studies.	Pre-defined, unambiguous eligibility criteria are a fundamental pre-requisite for a systematic review. The criteria for considering types of people included in studies in a review should be sufficiently broad to encompass the likely diversity of studies, but sufficiently narrow to ensure that a meaningful answer can be obtained when studies are considered in aggregate. Considerations when specifying participants include setting, age, identifying personal characteristics, demographic factors, and other factors that differentiate the participants. Any restrictions to study populations must be based on a sound rationale, since it is important that Campbell reviews are widely relevant.	Page 4 and page 5
C6	Highly desirable (P)	Pre-defining a strategy for studies with a subset of eligible participants	Define in advance how to handle studies in which only a subset of the sample is	Sometimes a study includes some 'eligible' participants and some 'ineligible' participants, for example when an age cut-off is used in the review's eligibility	Page 9

			eligible for inclusion in the review.	criteria. In case data from the eligible participants cannot be retrieved, a mechanism for dealing with this situation should be pre-specified.	
C7	Mandatory (P)	Pre-defining unambiguous criteria for interventions and comparators	Define in advance the eligible interventions and the interventions against which these can be compared in the included studies.	Pre-defined, unambiguous eligibility criteria are a fundamental pre-requisite for a systematic review. Specification of comparator interventions requires particular clarity, including the extent to which the experimental interventions are compared with a control or comparison conditions with matched or similar participants. Any restrictions on interventions and comparators, such as regarding delivery, dose, duration, intensity, co-interventions, and features of complex interventions should also be pre-defined and explained.	Page 4 (Criteria for considering studies for this review)
C8	Mandatory (P & R)	Clarifying role of outcomes	Clarify in advance whether outcomes listed under 'Criteria for Inclusion and Exclusion of Studies in the Review' are used as criteria for including studies (rather than as a list of the outcomes of interest within whichever studies are included).	Outcome measures need not always form part of the criteria for including studies in a review. However, some reviews do legitimately restrict eligibility to specific outcomes. For example, the same intervention may be studied in the same population for different purposes (e.g. reading interventions); or a review may address specifically the adverse effects of an intervention used for several conditions. If authors do exclude studies on the basis of outcomes, care should be taken to ascertain that relevant outcomes are not available because they have not been measured rather than simply not reported.	Page 5
C9	Mandatory (P)	Pre-defining study designs	Define in advance the eligibility criteria for study designs in a clear and unambiguous way, with a focus on features of a study's design rather than design labels. For reviews with multiple objectives, specify whether study design inclusion criteria are common across all questions, or identified	Pre-defined, unambiguous eligibility criteria are a fundamental pre-requisite for a systematic review. This is particularly important when non-randomized (e.g., quasi-experimental or observational) studies are considered. Some labels commonly used to define study designs can be ambiguous. For example a "double blind" study may not make it clear who is blind; a "case control" study may be nested within a cohort, or be undertaken in a cross-	Page 4 Any empirical research with quantitative, qualitative, and/or mixed method study design

			separately for each type of question.	sectional manner; or a "prospective" study may have only some features defined or undertaken prospectively.	
C10	Mandatory (P, effectiveness reviews only)	Including randomized trials	Include randomized trials as eligible for inclusion in the review, if they are feasible and available for the interventions, outcomes, and populations of interest.	Randomized trials are the best study design for evaluating the efficacy of many interventions. If they are feasible for evaluating questions that are being addressed by the review, they must be considered eligible for the review. However, appropriate exclusion criteria may be put in place, for example regarding length of follow-up.	All study designs are included
C11	Mandatory (P)	Justifying choice of study designs	Justify the choice of eligible study designs.	The particular study designs included should be justified with regard to appropriateness to the review question and with regard to potential for bias. It might be difficult to address some interventions or some outcomes in randomized trials. Authors should be able to justify why they have chosen either to restrict the review to randomized trials or to include non-randomized studies.	Page 6
C12	Mandatory (P & R)	Including studies regardless of publication status	Include studies irrespective of their publication status, and their electronic availability.	Obtaining and including data from unpublished studies (including grey literature) can reduce the effects of publication bias.	Page 6 "Searching other resources"
C13	Mandatory (R)	Changing eligibility criteria	Justify any changes to eligibility criteria or outcomes studied. In particular, *post hoc* decisions about inclusion or exclusion of studies should keep faith with the objectives of the review rather than with arbitrary rules.	Following pre specified eligibility criteria is a fundamental attribute of a systematic review. However unanticipated issues may arise. Review authors should make sensible *post hoc* decisions about exclusion of studies, and these should be documented in the review, possibly accompanied by sensitivity analyses. Changes to the protocol must not be based on findings of the studies or the synthesis, as this can introduce bias.	Noted
C14	Mandatory (P)	Pre-defining outcomes	Define in advance which outcomes are primary outcomes and which are secondary outcomes.	Pre-definition of outcome reduces the risk of selective outcome reporting. The *primary outcomes* should be as few as possible (ideally no more than three). It is expected that the review should be able to synthesize these outcomes if eligible studies are identified, and that the conclusions of the review will be based in	Page 3 "Outcomes" Page 5 "Types of outcome measures" and "primary outcomes" and

				large part on the effect of the interventions on these outcomes.	"secondary outcomes"
C15	Highly desirable (P)	Choosing outcomes	Keep the total number of outcomes selected for inclusion in the review as small as possible. Choose outcomes that are relevant to stakeholders such as consumers, practitioners, and policy makers. Consider the importance of resource use and cost outcomes.	Campbell reviews are intended to support practice and policy, and should address outcomes that are important to consumers. These should be specified at protocol stage. Where they are available, established sets of core outcomes should be used. Participant-reported outcomes should be included where possible. It is also important to judge whether evidence on resource use and costs might be an important component of decisions to adopt the intervention or alternative management strategies around the world. Large numbers of outcomes, while sometimes necessary, can make reviews unfocused, unmanageable for the user, and prone to selective outcome reporting bias.	Page 5 "primary outcomes" and "secondary outcomes"
C16	Highly desirable (P)	Pre-defining outcome details	Define in advance details of what are acceptable outcome measures (e.g., test scores conditions, characteristics, scales, composite outcomes).	Having decided what outcomes are of interest to the review, authors should clarify acceptable ways in which these outcomes can be measured.	Page 5 "Types of outcome measures"
C17	Highly desirable (P)	Pre-defining choices from multiple outcome measures	Define in advance how outcome measures will be selected at the coding stage when there are several possible measures (e.g. multiple definitions, assessors, or scales) or at the analysis stage if multiple effect sizes are coded per outcome construct.	Pre-specification guards against selective outcome reporting or selective analysis, and allows users to confirm that choices were not overly influenced by the results. A pre-defined hierarchy of outcome measures may be helpful. It may however be difficult to pre- define outcome measures for adverse effects. A rationale should be provided for the choice of all outcome measures (including adverse effects).	Page 8 (Measures of treatment effect)
C18	Highly desirable (P)	Pre-defining time points of interest	Define in advance how differences in the timing of outcome measurement will be handled in the review.	Pre-specification guards against selective outcome reporting or selective analysis, and allows users to confirm that choices were not overly influenced by the results. Authors may consider whether all time frames or only selected time-points will be included in the review. These decisions should be based on outcomes important for	Page 8 (Unit of analysis issues)

				making policy or practice decisions. One strategy to make use of the available data could be to group time- points into pre-specified intervals to represent 'short-term', 'medium-term', and 'long- term' outcomes and to use information on no more than one from each interval from each study for any particular outcome.	
C19	Mandatory (P)	Planning the search	Plan in advance the methods to be used for identifying studies. Design searches to capture as many studies as possible meeting the eligibility criteria, ensuring that relevant time periods and sources are covered and not restricting by language or publication status.	Searches should be motivated directly by the eligibility criteria for the review, and it is important that all types of eligible studies are considered when planning the search. There is a possibility of publication bias and/or language bias (whereby the language of publication is selected in a way that depends on the findings of the study) if searches are restricted by publication status or by language of publication. Removing language restrictions in English-language databases is not a good substitute for searching non-English language journals and databases.	Pages 4 – 6 "Methods" and Supplementary material 1
C20	Mandatory (P)	Planning the assessment of risk of bias/study quality in the included studies	Plan in advance the methods to be used for assessing risk of bias/study quality in included studies, including the tool(s) or codes to be used, how the tool(s) or codes will be implemented, and the criteria used to assign studies to risk of bias or quality categories (at outcome- and/or study-level), for example, low risk, high risk, and unclear risk of bias; low quality or high quality.	Pre-defining the methods and criteria for assessing risk of bias/study quality is important because analysis or interpretation of the review findings may be affected by the judgments made during this process. For randomized trials, the Cochrane risk of bias tool is a recommended option.	Page 8
21	Mandatory (P)	Planning the synthesis of results	Plan in advance the methods to be used to synthesize the results of the included studies, including whether a quantitative synthesis is planned, how heterogeneity will be assessed, choice of effect measure (e.g.,	Pre-defining the synthesis methods, particularly the statistical methods, is important because analysis or interpretation of the review findings may be affected by the judgments made during this process.	Pages 7 – 8 "Data extraction and Management" Page 9 "Data synthesis »

			standardized mean difference, odds ratio, risk ratio), and methods for meta-analysis (e.g. inverse variance or Mantel Haenszel, fixed-effect or random-effects model). If a quantitative synthesis is not planned, or if it is not possible, plan the specific methods to narratively synthesize the results of the included studies.		
C22	Mandatory (P)	Planning moderator analyses	Pre-define potential effect modifiers for moderator analyses (e.g. subgroup analyses or meta-regression analyses) at the protocol stage; restrict these in number; and provide rationale for each.	Pre-specification reduces the risk that large numbers of undirected moderator analyses lead to spurious explanations of heterogeneity	Page 9 (Subgroup analysis and investigation of heterogeneity)
C23	Optional (P)	Planning a 'Summary of findings' table	If a formal 'Summary of findings' table is anticipated, specify which outcomes will be included, and which comparisons and subgroups will be covered (if appropriate).	The 'Summary of findings table' offers a specific approach to summarizing the findings of a systematic review of intervention effects. Its use is not mandatory or recommended in Campbell Reviews of intervention effects but is highly desirable if the review is co-registered with a Cochrane group. Methods for 'Summary of findings' tables should be pre-defined, particularly with regard to choice of outcomes, to guard against selective presentation of results in the review. If included, the table should include the essential outcomes for decision making (typically up to seven), which should generally not include surrogate or interim outcomes. These outcomes should not be chosen on the basis of any anticipated or observed magnitude of effect, or because they are likely to have been addressed in the studies to be reviewed. Outcome-level summary risk of bias judgments made using the Cochrane Risk of Bias tool feed directly into the 'Study limitations' column of a formal 'Summary of findings table'.	Page 9

				Therefore, authors planning a formal 'Summary of findings table' should plan to use the Cochrane Risk of Bias tool in their assessments of risk of bias.	
C24	Mandatory (P)	Planning the search	Refer to "Searching for Studies", the Campbell information retrieval guide, to ensure that all relevant databases have been properly searched.	Searches for studies should be as extensive as possible to reduce the risk of publication bias and to identify as much relevant evidence as possible. There is no minimum set of databases to search, but reviewers should consider consulting with a research retrieval specialist to avoid unnecessary duplication of effort.	Pages 5 -6 "Search methods for identification of studies"
C25	Highly desirable (P)	Searching specialist bibliographic databases	Search appropriate national, regional, and subject specific bibliographic databases.	Searches for studies should be as extensive as possible to reduce the risk of publication bias and to identify as much relevant evidence as possible. Databases relevant to the review topic should be covered (e.g., ERIC for educational interventions, PsycINFO for psychological interventions), and regional databases (e.g. LILACS) should be considered.	Pages 5 -6 "Electronic searches"
C26	Mandatory (if applicable) (P)	Searching for different types of evidence	If the review has specific eligibility criteria around study design to address adverse effects, economic issues, or qualitative research questions, undertake searches to address them.	Sometimes different searches will be conducted for different types of evidence, such as for non-randomized studies for addressing adverse effects, or for economic evaluation studies.	Does not apply to our project as we are including all types of primary research design to a combined single search.
C27	Mandatory (if applicable) (P)	Searching trials registers	When relevant, search trials registers and repositories of results, where relevant to the topic through ClinicalTrials.gov, metaREGISTER, the WHO International Clinical Trials Registry Platform (ICTRP) portal, and other sources as appropriate.	When relevant, searches for studies should be as extensive as possible to reduce the risk of publication bias and to identify as much relevant evidence as possible. Although ClinicalTrials.gov is included as one of the registers within the WHO ICTRP portal, it is recommended that both ClinicalTrials.gov and the ICTRP portal are searched separately due to additional features in ClinicalTrials.gov.	Page 6 "Searching other resources"
C28	Mandatory (P)	Searching for grey literature	Search relevant grey literature sources such as reports/dissertations/theses databases and databases of conference abstracts.	Searches for studies should be as extensive as possible to reduce the risk of publication bias and to identify as much relevant evidence as possible.	Page 6 "Searching other resources"

C29	Mandatory (P)	Searching within other reviews	Search within previous reviews on the same or similar topic.	Searches for studies should be as extensive as possible to reduce the risk of publication bias and to identify as much relevant evidence as possible.	Page 6 “Searching other resources”
C30	Mandatory (P)	Searching reference lists	Check reference lists in included studies and any relevant systematic reviews identified.	Searches for studies should be as extensive as possible to reduce the risk of publication bias and to identify as much relevant evidence as possible.	Page 6 “Searching other resources”
C31	Highly desirable (P)	Searching by contacting relevant individuals and organizations	Contact relevant individuals and organizations for information about unpublished or ongoing studies.	Searches for studies should be as extensive as possible to reduce the risk of publication bias and to identify as much relevant evidence as possible. It is important to identify ongoing studies, so that when a review is later updated these can be assessed for possible inclusion.	Page 6 “Searching other resources”
C32	Mandatory (R)	Structuring search strategies for bibliographic databases	Inform the structure of search strategies in bibliographic databases around the main concepts of the review, using appropriate elements from PICO and study design. In structuring the search, maximize sensitivity whilst striving for reasonable precision. Ensure correct use of the AND and OR operators.	Inappropriate or inadequate search strategies may fail to identify records that are included in bibliographic databases. Expertise may need to be sought, in particular from an Information Retrieval Specialist. The structure of a search strategy should be based on the main concepts being examined in a review. In electronic bibliographic databases, a search strategy to identify studies for a Campbell Review will typically have three sets of terms: 1) terms to search for the population of interest; 2) terms to search for the intervention(s) evaluated; and 3) terms to search for the types of study designs to be included. There are exceptions, however. For instance, for reviews of complex interventions, it may be necessary to search only for the population or the intervention. Within each concept, terms are joined together with the Boolean ‘OR’ operator, and the concepts are combined with the Boolean ‘AND’ operator. The ‘NOT’ operator should be avoided where possible to avoid the danger of inadvertently removing from the search set records that are relevant.	Page 6 “Electronic searches” and Supplementary material 1
C33	Mandatory (R)	Developing search strategies for bibliographic databases	Identify appropriate controlled vocabulary (e.g. MeSH, Emtree, including 'exploded' terms) and free-text terms	Inappropriate or inadequate search strategies may fail to identify records that are included in bibliographic databases. Search strategies need to be	Pages 5 -6 “Search methods for identification of

			(considering, for example, spelling variants, synonyms, acronyms, truncation, and proximity operators), and tailor the search strategy to each specific database.	customized for each database. It is important that MeSH terms are 'exploded' wherever appropriate, in order not to miss relevant articles. The same principle applies to EMTREE when searching EMBASE and also to a number of other databases. The controlled vocabulary search terms are different for each electronic database, and thus search strategies must be tailored to each database. To be as comprehensive as possible, it is necessary to include a wide range of free-text terms for each of the concepts selected. This might include the use of truncation and wildcards. Developing a search strategy is an iterative process in which the terms that are used are modified, based on what has already been retrieved.	studies" " and Supplementary material 1
C34	Highly desirable (R)	Using search filters	Use specially designed and tested search filters where appropriate (such as the Cochrane Highly Sensitive Search Strategies for identifying randomized trials in MEDLINE), but do not use filters in pre- filtered databases (e.g. do not use a randomized trial filter in CENTRAL or a systematic review filter in DARE or PROSPERO).	Search filters should be used with caution. They should be assessed not only for the reliability of their development and reported performance but also for their current accuracy, relevance, and effectiveness given the frequent interface and indexing changes affecting databases.	Does not apply to our project
C35	Mandatory (P & R)	Restricting database searches	Justify the use of any restrictions in the search strategy on publication date, publication format, or language.	Date restrictions in the search should only be used when there are date restrictions in the eligibility criteria for studies. They should be applied only if it is known that relevant studies could only have been reported during a specific time period, for example if the intervention was only available after a certain time point. Searches for updates to reviews might naturally be restricted by date of entry into the database (rather than date of publication) to avoid duplication of effort. Publication format restrictions (e.g. exclusion of letters) should	Page 5 "There will be no publication date restriction as the time point of the implementation is not relevant to our study objectives. No restrictions on publication format will be used when

				generally not be used in Campbell reviews, since any information about an eligible study may be of value.	running searches in order to avoid missing material that was misentered into the databases. No language restrictions will be used, however only results in English or French will be retained due to team capacity.
C36	Mandatory (R)	Documenting the search process	Document the search process in enough detail to ensure that it can be reported correctly in the review/ update. Include the month and year the search began and ended for future replicability.	The search process (including the sources searched, when, by whom, and using what terms) needs to be documented in enough detail throughout the process to ensure that it can be reported correctly in the review, to the extent that all the searches of all the databases are reproducible.	Page 6 "Search methods for identification of studies", last sentence of this section
C37	Highly desirable (R)	Rerunning searches	Rerun or update searches for all relevant databases within 12 months before publication of the review or review update, and screen the results for potentially eligible studies.	The published review should be as up to date as possible. The search should be rerun close to publication, if the initial search date is more than 12 months (preferably 6 months) from the intended publication date, and the results screened for potentially eligible studies. Ideally the studies should be fully incorporated. If not, then the potentially eligible studies will need to be reported, at a minimum as a reference under 'Studies awaiting classification' or 'Ongoing studies'.	Page "10 Plans for Updating this review"
C38	Highly desirable (R)	Incorporating findings from rerun searches	Incorporate fully any studies identified in the rerun or update of the search within 12 months before publication of the review or review update.	The published review should be as up to date as possible. After the rerun of the search, the decision whether to incorporate any new studies fully into the review will need to be balanced against the delay in publication.	Page "10 Plans for Updating this review"
C39	Highly desirable (P & R)	Making inclusion decisions in duplicate	The preferred procedure is for at least two members of the review team to	Duplicating the study selection process reduces both the risk of making mistakes and the possibility that	Page 7 "Once 85%+ agreement has

			independently screen candidate studies and resolve discrepancies by consensus. Where large numbers of studies are involved, samples of the candidate studies might be drawn and rescreened to estimate the reliability of the inclusion decisions.	selection is influenced by a single person's biases. The inclusion decisions should be based on the full texts of potentially eligible studies when possible, usually after an initial screen of titles and abstracts. It is desirable, *but not mandatory*, that two people undertake this initial screening, working independently.	been established between each reviewer, the database will be divided into groups with two individuals appraising the suitability of each reference on title and abstract. A third individual will resolve any disagreements. Full text review will be conducted by the PI and one research assistant, with any disagreements resolved by the mthods expert"
C40	Mandatory (P & R)	Including studies without useable data	Include studies in the review irrespective of whether measured outcome data are reported in a 'usable' way.	Systematic reviews typically should seek to include all relevant participants who have been included in eligible study designs of the relevant interventions and had the outcomes of interest measured. Reviews must not exclude studies solely on the basis of *reporting* of the outcome data, since this may introduce bias due to selective outcome reporting (i.e., that an effect size is not estimable although the outcome was clearly measured). While such studies cannot be included in meta-analyses, the implications of their omission should be considered. Note that studies may legitimately be excluded because outcomes were not *measured*. Furthermore, issues may be different for adverse effects outcomes, since the pool of studies may be much larger and it can be	Usable data is not an inclusion criterion. If it appears to be appropriate to conduct meta-analysis after reviewing the selected studies, we will do so. (Page 9)

				difficult to assess whether such outcomes were measured.	
C41	Mandatory (R)	Documenting decisions about records identified	Document the selection process in sufficient detail to complete a PRISMA flow chart and a table of 'Characteristics of excluded studies'.	A PRISMA flow chart and a table of 'Characteristics of excluded studies' will need to be completed in the final review. Decisions should therefore be documented for all records identified by the search. Numbers of records are sufficient for exclusions based on initial screening of titles and abstracts. Broad categorizations are sufficient for records classed as potentially eligible during an initial screen. Studies listed in the table of 'Characteristics of excluded studies' should be those which a user might reasonably expect to find in the review. At least one explicit reason for their exclusion must be documented. Authors will need to decide for each review when to map records to studies (if multiple records refer to one study). Lists of included and excluded studies must be based on studies rather than records.	Page 7 "Data extraction and management"
C42	Mandatory (R)	Collating multiple reports	Collate multiple reports of the same study, so that each study rather than each report is the unit of interest in the review.	It is wrong to treat multiple reports of the same study as if they are multiple studies. Secondary reports of a study should not be discarded, however, since they may contain valuable information about the design and conduct. Review authors must choose and justify which report to use as a source for study results.	Page 9-10 (Criteria for determination of independent findings)
C43	Mandatory (P & R)	Using data collection forms	Use a data collection form, which has been piloted.	Review authors often have different backgrounds and level of systematic review experience. Using a data collection form ensures some consistency in the process of data extraction, and is helpful if comparing data extracted in duplicate. The original data collection forms should be included in the protocol for the review. If the data collection forms are altered during pilot testing, the final data collection forms should be submitted in an appendix with the final review.	See supplemental materials: 1. Data Extraction Tool: Component 2; Data Extraction Tool: Component 3
C44	Mandatory (R)	Describing studies	Collect characteristics of the included studies in sufficient	Basic characteristics of each study will need to be presented as part of the review, including details of participants,	See supplemental material: 1.

			detail to populate final tables and narrative overview.	interventions and comparators, outcomes and study design.	Data Extraction Tool: Component 1;
C45	Highly desirable (P & R)	Extracting study characteristics and outcome data in duplicate	The preferred procedure is for at least two members of the review team to independently code each study and resolve any discrepancies through discussion and consensus. Where large number of studies makes this procedure too demanding, random samples of the studies can be drawn and recoded by a different team member so that the reliability of the coding can be assessed and reported. The procedures planned for training coders and checking their accuracy before they begin providing data for the review should also be described along with the relevant background of those expected to do the coding.	Duplicating the data extraction process reduces both the risk of making mistakes and the possibility that data selection is influenced by a single person's biases. Dual data extraction is particularly important for outcome data, which feed directly into syntheses of the evidence and hence to conclusions of the review.	Page 7 "Data extraction and management"
C46	Mandatory (P & R)	Making maximal use of data	Collect and utilize the most detailed numerical data that might facilitate similar analyses of included studies. Where 2×2 tables or means and standard deviations are not available, this might include effect estimates (e.g. odds ratios, regression coefficients), confidence intervals, test statistics (e.g. t, F, Z, chi-squared), p-values, or even data for individual participants.	Data entry into most specialized computer software for meta-analysis is easiest when 2×2 tables are reported for dichotomous outcomes or when means and standard deviations are presented for continuous outcomes. Sometimes these statistics are not reported but some manipulations of the reported data can be performed to obtain them. For instance, 2×2 tables can often be derived from sample sizes and percentages, while standard deviations can often be computed using confidence intervals or p-values. Multiple software options are available for conversions.	Page 8
C47	Highly desirable (R)	Examining errata	Examine any relevant retraction statements and errata for information.	Some studies may have been found to be fraudulent or may for other reasons have been retracted since publication. Errata	Page 7

				can reveal important limitations, or even fatal flaws, in included studies. All of these may potentially lead to the exclusion of a study from a review or meta-analysis. Care should be taken to ensure that this information is retrieved in all database searches by downloading the appropriate fields together with the citation data.	
C48	Highly desirable (P & R)	Obtaining unpublished data	Seek key unpublished information that is missing from reports of included studies.	Contacting study authors to obtain or confirm data makes the review more complete, potentially enhancing precision and reducing the impact of reporting biases. Missing information includes details to inform risk of bias/study quality assessments, details of interventions and outcomes, and study results (including breakdowns of results by important subgroups).	Page 9 "Dealing with missing data""
C49	Mandatory (P & R)	Choosing intervention groups in multi-arm studies	If a study is included with more than two intervention arms, include in the review only intervention and control groups that meet the eligibility criteria.	There is no point including irrelevant intervention groups in the review. Authors should however make it clear in the 'Table of characteristics of included studies' that these intervention groups were present in the study.	Page 9
C50	Mandatory (R)	Checking accuracy of numeric data in the review	Compare magnitude and direction of effects reported by studies with how they are presented in the review, taking account of legitimate differences.	This is a reasonably straightforward way for authors to check a number of potential problems, including typographical errors in studies' reports, accuracy of data collection and manipulation, and data entry into a computer software program. For example, the direction of a standardized mean difference may accidentally be wrong in the review. A basic check is to ensure the same qualitative findings (e.g. direction of effect and statistical significance) between the data as presented in the review and the data as available from the original study. Results in forest plots should agree with data in the original report (point estimate and confidence interval) if the same effect measure and statistical model is used.	Page 7
C51	Mandatory (P & R)	Assessing risk of bias/study quality	Assess the risk of bias/study quality for each included study,	Assessing risk of bias/study quality is an important task because it has been shown	Page 8

			regardless of the study design or randomization type.	that risk of bias/study quality can influence estimates of intervention effects. If the review is co-registered and uses randomized controlled trials, then the Cochrane Risk of Bias tool should be used. If not, then one of the many other study quality tools and/or coding schemes for study quality should be utilized and detailed within the protocol prior to implementation. Coding schemes for study quality are often used in addition to (or instead of) risk of bias/study quality tools in order to code specific quality variables relating to each source of bias/ dimension of study quality. Campbell reviews should not use composite scales, indices, or other measures that conflate multiple measures of risk of bias/study quality into a single score (e.g., using an average scale that combines measures of allocation concealment, attrition, and baseline equivalence measures). These composite quality scales can be misleading and should not be used in a Campbell review. Instead, any risk of bias/study quality coding should isolate unique measures of quality (e.g. separate measures for allocation concealment, attrition, spillover, selective outcome reporting, selective analysis reporting, and baseline equivalence).	
C52	Highly desirable (P & R)	Assessing risk of bias /study quality in duplicate	Use (at least) two people working independently to apply a risk of bias/study quality tool or coding scheme to each included study, and define in advance the process for resolving disagreements.	Duplicating risk of bias/study quality assessment/ coding reduces both the risk of making mistakes and the possibility that assessments are influenced by a single person's biases.	Page 8
C53	Highly desirable (R)	Supporting judgments of risk of bias/study quality	If applicable, justify categorical risk of bias/study quality judgments (e.g., high, low, and unclear) with	Providing support for the judgment makes the process transparent.	Page 8: under the heading of: Assessment of risk of bias in included studies.

			information directly from the study.		
C54	Highly desirable (R)	Providing sources of information for risk of bias/study quality assessments	If applicable, collect the source of information for each risk of bias/study quality assessment. Where judgments are based on assumptions made on the basis of information provided outside publicly available documents, this should be stated.	Readers/editors/referees should have the opportunity to see for themselves where supports for judgments have been obtained.	Page 8
C55	Highly desirable (P & R)	Differentiating between performance bias and detection bias	Consider separately the risks of bias due to lack of blinding for (i) participants and study personnel (performance bias), and (ii) outcome assessment (detection bias).	The use of mutually exclusive domains of bias (e.g. selection bias, performance bias, detection bias, attrition bias and reporting bias) provides a more comprehensive framework for considering biases in randomized trials.	Page 8
C56	Only if applicable (R)	If applicable, assessing risk of bias due to lack of blinding for different outcomes	Consider blinding separately for different key outcomes.	The risk of bias due to lack of blinding may be different for different outcomes. When there are multiple outcomes, they should be grouped (e.g. objective versus subjective).	Page 8
C57	Only if applicable (R)	If applicable, assessing completeness of data for different outcomes	Consider the impact of missing data separately for different key outcomes to which an included study contributes data.	When considering risk of bias due to incomplete (missing) outcome data, this often cannot reliably be done for the study as a whole. The risk of bias due to missing outcome data may be different for different outcomes. For example, there may be less drop-out for a three-month outcome than for a six-year outcome. When there are multiple outcomes, they should be grouped (e.g. short term versus long term). Judgments should be attempted about which outcomes are thought to be at high or low risk of bias.	Page 8-9
C58	Only if applicable (R)	If applicable, summarizing risk of bias assessments when using the Cochrane Risk of Bias tool	Summarize the risk of bias for each key outcome for each study.	This reinforces the link between the characteristics of the study design and their possible impact on the results of the study, and is an important pre-requisite for the GRADE approach to assessing the quality of the body of evidence.	Page 8

C59	Highly desirable (R)	Addressing risk of bias/study quality in the synthesis	Address risk of bias/study quality in the synthesis (whether qualitative or quantitative). For example, present analyses stratified according to key risk of bias/study quality items, or conduct a moderator analysis with one or more risk of bias/study quality ratings.	Review authors should consider how study biases affect conclusions. This is useful in determining the strength of conclusions and how future research should be designed and conducted.	Page 9
C60	Highly desirable (R)	Incorporating assessments of risk of bias	If randomized trials have been assessed using one or more tools in addition to the Cochrane 'Risk of bias' tool, use the Cochrane tool as the primary assessment of bias for interpreting results, choosing the primary analysis, and drawing conclusions.	For consistency of approach across Campbell reviews, the Cochrane risk of bias tool should take precedence when two or more tools are used.	We will use RoB 2 tool. (Page 8)
C61	Mandatory (R)	Combining different scales	If studies are combined with different scales, ensure that higher scores for continuous outcomes all have the same meaning for any particular outcome; explain the direction of interpretation; and report when directions were reversed.	Sometimes scales have higher scores that reflect a 'better' outcome and sometimes lower scores reflect 'better' outcome. Meaningless (and misleading) results arise when effect estimates with opposite clinical meanings are combined	Page 8-9
C62	Mandatory (R)	Ensuring meta-analyses are meaningful	Undertake (or display) a meta-analysis only if participants, interventions, comparisons and outcomes are judged to be sufficiently similar to ensure an answer that is meaningful for the review question.	A single mean effect size from a meta-analysis of a very diverse collection of studies can be misleading. Variability in the nature of the treatment, control/comparison condition, sample characteristics, and intervention context, may be related to observed effects and a single mean effect size may misrepresent that diversity. Diversity does not necessarily indicate that a meta-analysis should not be performed. However, authors must be clear about the underlying question that all studies are addressing and	Page 8

				interpret the results appropriately. The determination of whether a meta-analysis is meaningful should be made based on substantive knowledge of the effect sizes being synthesized; it should never be made based on statistical results for heterogeneity assessments.	
C63	Mandatory (P & R)	Assessing statistical heterogeneity	Assess the presence and extent of between-study variation when undertaking a meta-analysis.	The presence of heterogeneity affects the extent to which generalizable conclusions can be formed. It is important to identify heterogeneity in case there is sufficient information to explain it and offer new insights. Authors should recognize that there is much uncertainty in measures such as I-squared and tau-squared when there are few studies. Thus, use of simple thresholds to diagnose heterogeneity should be avoided.	Page 9
C64	Highly desirable (R)	Addressing missing outcome data	Consider the implications of missing outcome data from individual participants (due to losses to follow up or exclusions from analysis).	Incomplete outcome data can introduce bias. In most circumstances, authors should follow the principles of intention to treat analyses as far as possible (this may not be appropriate for adverse effects or if trying to demonstrate equivalence). Imputation methods can be considered (accompanied by, or in the form of, sensitivity analyses).	Page 9
C65	Highly desirable (R)	Addressing skewed data	Consider the possibility and implications of skewed data when analyzing continuous outcomes.	Skewed data are sometimes not usefully summarized by means and standard deviations. While statistical methods are approximately valid for large sample sizes, skewed outcome data can lead to misleading results when studies are small.	Page 9 (Sensitivity analysis)
C66	Mandatory (P & R)	Addressing studies with more than two groups	If multi-arm studies are included, analyze multiple intervention groups in an appropriate way that avoids arbitrary omission of relevant groups and double- counting of participants.	Excluding relevant groups decreases precision and double counting increases precision spuriously; both are inappropriate and unnecessary. Alternative strategies include combining intervention groups, separating comparisons into different forest plots and using multiple treatments meta-analysis.	Page 8-9
C67	Mandatory (P & R)	Comparing subgroups	If subgroup analyses are to be compared, and there are judged to be sufficient studies to do this meaningfully, use a formal	Concluding that there is a difference in effect across subgroups based on differences in the level of statistical significance within subgroups can be very misleading. Two groups may have similar	Page 9

			statistical test to compare them.	treatment effects yet one may be statistically significant and the other not. Any conclusion that the intervention is effective for one group and not for the other should be based on a direct test of the mean difference between the groups (e.g., with meta-analytic analog-to-the-ANOVA or meta-regression).	
C68	Mandatory (P & R)	Interpreting subgroup analyses	If subgroup analyses are conducted, follow the subgroup analysis plan specified in the protocol without undue emphasis on particular findings. If post hoc subgroup analyses are conducted that were not specified in the protocol, the review must clearly state that these analyses are post hoc and exploratory in nature.	Selective reporting, or over-interpretation, of particular subgroups or particular subgroup analyses should be avoided. This is especially a problem when multiple subgroup analyses are performed. This does not preclude the use of sensible and honest post hoc subgroup analyses.	Page 9
C69	Mandatory (R)	Considering statistical heterogeneity when interpreting the results	Take into account any statistical heterogeneity when interpreting the results, particularly when there is variation in the direction of effect.	The presence of heterogeneity affects the extent to which generalizable conclusions can be formed. If a fixed-effect analysis is used, the confidence intervals ignore the extent of heterogeneity. If a random-effects analysis is used, the result pertains to the mean effect across studies. In both cases, the implications of notable heterogeneity should be addressed. It may be possible to understand the reasons for the heterogeneity if there are sufficient studies.	Page 9
C70	Mandatory (P & R)	Addressing non-standard designs	Consider the impact on the analysis of clustering, matching, or other non-standard design features of the included studies.	Cluster-randomized trials, cross-over trials, studies involving measurements on multiple body parts, and other designs need to be addressed specifically, since a naive analysis might underestimate or overestimate the precision of the study. Failure to account for clustering is likely to overestimate the precision of the study - i.e. to give it confidence intervals that are too narrow and a weight that is too large. Failure to account for correlation is likely to underestimate the precision of the study, i.e., to give it confidence intervals	Page 8

				that are too wide and a weight that is too small.	
C71	Highly desirable (P & R)	Conducting sensitivity analysis	Use sensitivity analyses to assess the robustness of results, such as the impact of notable assumptions, imputed data, borderline decisions, and studies at high risk of bias or with poor quality.	It is important to be aware when results are robust, since the strength of the conclusion may be strengthened or weakened.	Page 9
C72	Mandatory (R)	Interpreting results	Interpret a statistically non-significant p-value (e.g. larger than 0.05) as a finding of uncertainty unless confidence intervals are sufficiently narrow to rule out an important magnitude of effect.	Authors commonly mistake a lack of evidence of effect as evidence of a lack of effect.	Page 9
C73	Highly desirable (R)	Investigating reporting biases	Consider the potential impact of reporting biases on the results of the review or the meta-analyses it contains.	There is overwhelming evidence of reporting biases of various types. These can be addressed at various points in the review. A thorough search, and attempts to obtain unpublished results, might minimize the risk. Analyses of the results of included studies, for example using funnel plots or regression tests for funnel plot asymmetry, can sometimes help determine the possible extent of the problem, as can attempts to identify study protocols, which should be a more routine feature of a review.	Page 9
C74	Optional (P & R)	Including a 'Summary of Findings' table	Include a 'Summary of Findings' table according to recommendations described in Chapter 11 of the Cochrane Handbook (version 5 or later). Specifically: ☐ include results for one population group (with few exceptions); ☐ indicate the intervention and the comparison intervention;	For co-registered reviews, a 'Summary of Findings' table is highly desirable. For those reviews, authors should justify why a 'Summary of Findings' table is not included if this is the case.	Page 9

			☐ include seven or fewer patient-important outcomes; ☐ describe the outcomes (e.g. scale, scores, follow-up); ☐ indicate the number of participants and studies for each outcome; ☐ present at least one baseline risk for each dichotomous outcome (e.g. study population or median/medium risk) and baseline scores for continuous outcomes (if appropriate); ☐ summarize the intervention effect (if appropriate); and ☐ include a measure of the quality of the body of evidence.		
C75	Optional (P & R)	Use the GRADE approach to assess the body of evidence	If the review is co-registered with a Cochrane group, it is highly desirable to use the five GRADE considerations (study limitations, consistency of effect, imprecision, indirectness and publication bias) to assess the quality of the body of evidence for each outcome, and to draw conclusions about the quality of evidence within the text of the review. It is mandatory for all reviews to assess the quality of the body of evidence in some narrative or empirical manner; however, it is not	GRADE is the most widely used system for summarizing confidence in effects of the interventions by outcome across studies. It is preferable to use the GRADE tool (as implemented in GRADEprofiler and described in the help system of the software). This should help to ensure that author teams are accessing the same information to inform their judgments. If the GRADE tool is used, the five GRADE considerations should be addressed irrespective of whether the review includes a 'Summary of Findings' table	Page 8 (Assessment of risk of bias in included studies). As mentioned here, we will be using RoB-2 and ROBINS-I tool for assessing bias. We will not be using GRADE tool.

			mandatory that the GRADE approach be used to accomplish that goal.		
C76	Optional (R)	Justifying assessments of the quality of the body of evidence	Justify and document all assessments of the quality of the body of evidence (for example downgrading or upgrading if using the GRADE tool).	By adopting a structured approach, transparency is ensured in showing how interpretations have been formulated and the result is more informative to the reader.	Page 8
C77	Mandatory (R)	Formulating implications for practice	Base conclusions only on findings from the synthesis (quantitative or narrative) of studies included in the review.	The conclusions of the review should convey the essence of the synthesis of included studies, without selective reporting of particular findings on the basis of the result, and without drawing on data that were not systematically compiled and evaluated as part of the review.	
C78	Highly desirable (R)	Avoiding recommendations	Avoid providing recommendations for practice.	Campbell reviews should not attempt to tell people which interventions should or should not be used, since local considerations may be relevant. However, the implications of the findings should be discussed, and decision-making can be helped by laying out different scenarios.	
C79	Highly desirable (R)	Formulating implications for research	Structure the implications for research to address the nature of evidence required, including population intervention comparison, outcome, and type of study.	Anyone wishing to conduct a study in the topic area of the review should be provided with a clear sense of what the remaining uncertainties are. A useful framework for considering implications for research is EPICOT (evidence, population, intervention, comparison, outcome and time stamp).	

References

Chandler J, Churchill R, Higgins J, Lasserson T, Tovey D. Methodological standards for the conduct of new Cochrane Intervention Reviews. Version 2.2. Cochrane: London, 2012.

Higgins JPT, Thomas J, Chandler J, Cumpston M, Li T, Page MJ, Welch VA (editors). Cochrane Handbook for Systematic Reviews of Interventions version 6.0 (updated July 2019). Cochrane, 2019. Available from www.training.cochrane.org/handbook.

The Campbell Collaboration. Campbell systematic reviews: policies and guidelines. Campbell Policies and Guidelines Series No. 1. DOI: 10.4073/cpg.2016.1. Available at: https://onlinelibrary.wiley.com/page/journal/18911803/homepage/author-guidelines

Annex 4: Sociodemographic items

Informations sociodémographiques

Les caractéristiques sociodémographiques des répondants individuels ne seront pas partagées. Ces informations seront présentées sous forme agrégée seulement.

Temps de travail dans le système carcéral :
0-2 ans
2 ans et un jour-5 ans
5 ans et un jour-10 ans
10 ans et un jour-15 ans
15 ans et un jour-25 ans
25 ans et un jour+

Durée de l'emploi actuel ou le plus récent dans le système carcéral :
0-2 ans
2 ans et un jour-5 ans
5 ans et un jour-10 ans
10 ans et un jour-15 ans
15 ans et un jour-25 ans
25 ans et un jour+

Âge
18 à 24
25 à 34
35 à 44
45 à 54
55 à 64 ans
65 ans ou plus

Genre
Homme
Femme
Je ne m'identifie pas comme étant uniquement masculin ou féminin

Appartenez-vous à un groupe religieux ou à un groupe culturel, ou avez-vous une orientation sexuelle qui a été historiquement, continuellement ou systématiquement marginalisée ? Oui Non

Appartenez-vous à un groupe ethnique ou racisé qui a été historiquement, continuellement ou systématiquement marginalisé ? Oui Non

La Loi canadienne sur l'accessibilité définit un handicap comme suit : toute déficience, y compris une déficience physique, mentale, intellectuelle, cognitive, d'apprentissage, de communication ou sensorielle — ou une limitation fonctionnelle — de nature permanente, temporaire ou épisodique, évidente ou non, qui, en interaction avec un obstacle, entrave la pleine et égale participation d'une personne à la société.

Avez-vous un handicap ? Oui Non

Lieu(x) d'emploi (cochez toutes les réponses qui s'appliquent)

Emplacement
Urbain/Suburbain
Rural

La région de l'Atlantique
Le centre du Canada
Les provinces des Prairies
La Côte Ouest
Les Territoires du Nord

Administration
Fédéral (y compris militaire)
Provinciale ou territoriale
Communautaire et Premières Nations

Population desservie
Hommes
Femmes
Hommes et femmes

Classification de sécurité
En détention provisoire
Minimale (y compris les pavillons de ressourcement ou les centres de ressourcement)
Moyenne
Maximale
Super-maximale
Multi-niveaux

Sociodemographic information

Sociodemographic characteristics of individual respondents will not be shared. This information will be presented in aggregate form only.

Amount of time working in the carceral system:
0-2 years
2 years and a day-5 years
5 years and a day-10 years
10 years and a day-15 years
15 years and a day-25 years
25 years and a day+

Amount of time in current or most recent job in the carceral system:
0-2 years
2 years and a day-5 years
5 years and a day-10 years
10 years and a day-15 years
15 years and a day-25 years
25 years and a day+

Age
18 to 24
25 to 34
35 to 44
45 to 54
55 to 64
65 or older

Gender
Male
Female
I do not identify as uniquely male or female

Do you belong to a religious group, cultural group or is your sexual orientation one that has been historically, persistently, or systemically marginalized? Yes No

Do you belong to an ethnic or racialized group that has been historically, persistently, or systemically marginalized? Yes No

The Accessible Canada Act defines a disability as: any impairment, including a physical, mental, intellectual, cognitive, learning, communication or sensory impairment — or a functional limitation — whether permanent, temporary or episodic in nature, or evident or

not, that, in interaction with a barrier, hinders a person's full and equal participation in society. **Do you have a disability ?** Yes No

Place(s) of employment (check all that apply)

Location

Urban/ Suburban
Rural

The Atlantic Provinces
Central Canada
The Prairie Provinces
The West Coast
The Northern Territories

Administration

Federal (including military)
Provincial or territorial
Community and First Nations

Population Served

Men
Women
Mixed

Security classification

Remand
Minimum (including Healing lodges or healing centres)
Medium
Maximum
Multi-level

Annex 5: Mesures

STRESS TRAUMATIQUE SECONDAIRE (STS-EO) - ÉVALUATION ORGANISATIONNELL ECLAIRÉE

Le **Stress traumatique secondaire (STS)** désigne les symptômes de traumatisme causés par l'exposition indirecte à un traumatisme. Ces symptômes résultent du processus visant à aider ou de vouloir aider une personne traumatisée.
La **résilience** est la capacité d'une personne à s'adapter au stress et à l'adversité de manière saine.
L'**organisation,** telle qu'elle est utilisée dans ce contexte, fait référence à l'environnement de travail en cours d'évaluation.
Après avoir lu chaque élément, cochez la case correspondante à l'option appropriée qui indique les performances de l'organisation dans cet indicateur :
1=Pas du tout; 2=Rarement; 3=Quelque peu; 4=Presque; 5=Tout à fait; 0=S/O

DATE:	1	2	3	4	5	0
1. L'ORGANISATION ENCOURAGE LA RÉSILIENCE EN CRÉANT DES ACTIVITÉS QUI AMÉLIORENT LES POINTS SUIVANTS :						
a. Les connaissances de base sur le STS	1	2	3	4	5	0
b. Le suivi de l'impact du STS sur le bien-être professionnel	1	2	3	4	5	0
c. Le maintien d'une focalisation positive envers la mission clé de l'organisation	1	2	3	4	5	0
d. Un sentiment d'espoir (c.-à-d. confiance dans la capacité du client à récupérer, se rétablir et s'épanouir après des traumatismes)	1	2	3	4	5	0
e. Des compétences spécifiques qui améliorent la perception du travailleur de ses compétences professionnelles	1	2	3	4	5	0
f. Un solide soutien par les pairs entre le personnel, les superviseurs et/ou les consultants externs	1	2	3	4	5	0
g. Des stratégies pour répondre aux exigences psychologiques du travail de manière saine	1	2	3	4	5	0
2. DANS QUELLE MESURE L'ORGANISATION FAVORISE-T-ELLE UN SENTIMENT DE SÉCURITÉ ?						
a. L'organisation protège la sécurité physique de son personnel en utilisant des stratégies ou des techniques pour réduire les risques (p. ex. boutons panique, alarmes de sécurité, personnel multiple, etc.)	1	2	3	4	5	0
b. Le personnel de l'organisation est encouragé à ne pas partager, sans raison valable, les détails explicites des évènements traumatiques avec leurs collègues.	1	2	3	4	5	0
c. L'organisation réalise périodiquement une enquête ou crée un forum de sécurité qui évalue les perceptions qu'ont les travailleurs sur leur sécurité psychologique	1	2	3	4	5	0
d. L'organisation réalise périodiquement une enquête ou crée un forum de sécurité qui évalue les perceptions qu'ont les travailleurs sur leur sécurité physique	1	2	3	4	5	0
e. Les dirigeants de l'organisation gèrent correctement les risques et protègent les travailleurs autant que possible contre les clients dangereux et/ou les situations dangereuses	1	2	3	4	5	0
f. L'organisation offre une formation sur la gestion des situations potentiellement dangereuses (clients en colère)	1	2	3	4	5	0
g. L'organisation a défini un protocole d'intervention auprès du personnel en cas d'incidents critiques	1	2	3	4	5	0
3. EN QUOI LES POLITIQUES DE L'ORGANISATION SONT-ELLES BIEN INFORMÉES ?						
a. L'organisation a défini des pratiques qui traitent de la sécurité psychologique du personnel	1	2	3	4	5	0
b. L'organisation a défini des pratiques qui traitent de la sécurité physique du personnel	1	2	3	4	5	0
c. L'organisation a défini des procédures pour promouvoir la résilience de son personnel (ateliers sur l'auto-prise en charge)	1	2	3	4	5	0
d. Le plan stratégique de l'organisation contient des voies d'amélioration de la résilience de son personnel	1	2	3	4	5	0
e. Le plan stratégique de l'organisation contient des voies d'amélioration de la sécurité de son personnel	1	2	3	4	5	0
f. L'organisation dispose d'une politique de gestion des risques pour fournir des interventions à ceux qui signalent des niveaux élevés de STS	1	2	3	4	5	0
4. EN QUOI LES PRATIQUES DES LEADERS SONT-ELLES BIEN INFORMÉES (DG, PDG, DE, direction, etc.) ?						
a. Le leadership encourage activement l'auto-prise en charge	1	2	3	4	5	0
b. Le leadership montre l'exemple de l'auto-prise en charge	1	2	3	4	5	0
c. Le personnel fournit de l'information aux leaders sur les façons dont l'organisation peut améliorer ses politiques et pratiques relatives au STS	1	2	3	4	5	0
d. Les superviseurs favorisent la sécurité et la résilience au STS en s'attaquant systématiquement aux risques et aux signes de STS	1	2	3	4	5	0
e. Les superviseurs gèrent les problèmes relatifs au STS lorsqu'ils réfèrent les personnes souffrant de niveaux élevés de détresse aux professionnels de la santé mentale qualifiés	1	2	3	4	5	0
f. Les superviseurs favorisent la sécurité et la résilience aux STS en assurant une supervision continue, qui comprend la discussion de l'effet du travail sur le travailleur	1	2	3	4	5	0
g. Les superviseurs font la promotion de la sécurité et la résilience au STS en offrant une supervision supplémentaire en cas de risque élevé de STS	1	2	3	4	5	0
h. Les superviseurs favorisent la sécurité et la résilience du STS par une gestion intentionnelle du volume de travail et les répartitions des tâches, en tenant compte du dosage de l'exposition indirecte au traumatisme	1	2	3	4	5	0
i. Le leadership réagit au STS comme un risque professionnel et non comme une faiblesse	1	2	3	4	5	0
5. EN QUOI LES AUTRES PRATIQUES DE ROUTINE DE L'ORGANISATION SONT-ELLES BIEN INFORMÉES ?						
a. L'organisation offre une formation formelle sur les moyens d'améliorer la sécurité psychologique	1	2	3	4	5	0
b. L'organisation offre une formation formelle sur les moyens d'améliorer la sécurité physique	1	2	3	4	5	0
c. L'organisation offre une formation formelle sur les moyens d'améliorer la résilience au STS	1	2	3	4	5	0
d. L'organisation propose des activités (en plus des formations) qui favorisent la résilience au STS	1	2	3	4	5	0
e. L'organisation parle du STS lors de l'orientation des nouveaux employés	1	2	3	4	5	0
f. L'organisation fournit régulièrement un soutien d'équipe et par les pairs à des personnes ayant un niveau élevé d'exposition	1	2	3	4	5	0
g. L'organisation fournit du temps libre aux employés pour assister aux formations axées sur la capacité à créer de la résilience au STS du contrôle	1	2	3	4	5	0
6. EN QUOI L'ORGANISATION ÉVALUE-T-ELLE ET SURVEILLE-T-ELLE SES POLITIQUES ET PRATIQUES ?						
a. L'organisation évalue le niveau du STS au lieu de travail	1	2	3	4	5	0
b. L'organisation surveille régulièrement les tendances de la main-d' œuvre (c.-à-d. désertion, absentéisme) qui pourraient indiquer un manque de sécurité ou une augmentation du STS	1	2	3	4	5	0
c. L'organisation réagit à ce qu'elle apprend par l'évaluation, le suivi et/ou la rétroaction sur les moyens de promouvoir la sécurité et la Resilience	1	2	3	4	5	0
d. L'organisation sollicite régulièrement la rétroaction de la main-d'œuvre sur les tendances psychosociales qui pourraient indiquer une augmentation du STS (c.-à-d. l'augmentation des conflits, l'isolement social)	1	2	3	4	5	0

The Secondary Traumatic Stress Informed Organization Assessment (STSI-OA)

1. The organization promotes resilience-building activities that enhance the following:

	Not at all	Rarely	Somewhat	Mostly	Completely	N/A
a. Basic knowledge about STS	○	○	○	○	○	○
b. Monitoring the impact of STS on professional well-being.	○	○	○	○	○	○
c. Maintaining positive focus on the core mission for which the organization exists	○	○	○	○	○	○
d. A sense of hope (e.g., a belief in a clients' potential for trauma recovery, healing and growth)	○	○	○	○	○	○
e. Specific skills that enhance a worker's sense of professional competency	○	○	○	○	○	○
f. Strong peer support among staff, supervisors and staff and/or outside consultants	○	○	○	○	○	○
g. Healthy coping strategies to deal with the psychological demands of the job	○	○	○	○	○	○

2. To what degree does the organization promote a sense of safety?

	Not at all	Rarely	Somewhat	Mostly	Completely	N/A
a. The organization protects the physical safety of staff using strategies or techniques to reduce risk (e.g. panic buttons, security alarms, multiple staff, etc.)	○	○	○	○	○	○
b. Staff in the organization are encouraged to not share graphic details of trauma stories unnecessarily with co-workers	○	○	○	○	○	○
c. Periodically, the organization conducts a safety survey or forum that assesses worker perceptions of psychological safety	○	○	○	○	○	○
d. Periodically, the organization conducts a safety survey or forum that assesses worker perceptions of physical safety	○	○	○	○	○	○
e. Organizational leaders manage risk appropriately and protect workers as much as possible from dangerous clients and/or situations	○	○	○	○	○	○
f. The organization provides training on how to manage potentially dangerous situations (e.g., angry clients)	○	○	○	○	○	○
g. The organization has a defined protocol for how to respond to staff when critical incidents occur	○	○	○	○	○	○

3. How STS-informed are organizational policies?

	Not at all	Rarely	Somewhat	Mostly	Completely	N/A
a.The organization has defined practices addressing the psychological safety of staff	○	○	○	○	○	○
b. The organization has defined practices addressing the physical safety of staff	○	○	○	○	○	○
c. The organization has defined procedures to promote resilience-building in staff (e.g. self-care workshops)	○	○	○	○	○	○
d. The organization's strategic plan addresses ways to enhance staff resiliency	○	○	○	○	○	○
e. The organization's strategic plan addresses ways to enhance staff safety	○	○	○	○	○	○
f. The organization has a risk management policy in place to provide interventions to those who report high levels of STS	○	○	○	○	○	○

4. How STS-informed are the practices of leaders (executive directors, CEOs, COOs, administration, etc..)?

	Not at all	Rarely	Somewhat	Mostly	Completely	N/A
a. Leadership actively encourages self-care	○	○	○	○	○	○
b. Leadership models good self-care	○	○	○	○	○	○
c. Staff provides input to leaders on ways the organization can improve its policies and practices regarding STS.	○	○	○	○	○	○
d. Supervisors promote safety and resilience to STS by routinely-attending to the risks and signs of STS	○	○	○	○	○	○
e. Supervisors address STS by referring those with high levels of disturbance to trained mental health professionals	○	○	○	○	○	○
f. Supervisors promote safety and resilience to STS by offering consistent supervision that includes discussion of the effect of the work on the worker	○	○	○	○	○	○
g. Supervisors promote safety and resilience to STS by offering additional supervision during times of high risk for STS	○	○	○	○	○	○
h. Supervisors promote safety and resilience to STS by intentionally managing caseloads and case assignments with the dose of indirect trauma exposure in mind	○	○	○	○	○	○
i. Leadership responds to STS as an occupational hazard and not a weakness	○	○	○	○	○	○

5. How STS-informed are other routine organizational practices?

	Not at all	Rarely	Somewhat	Mostly	Completely	N/A
a. The organization provides formal trainings on ways to enhance psychological safety	○	○	○	○	○	○
b. The organization provides formal trainings on ways to enhance physical safety	○	○	○	○	○	○
c. The organization provides formal trainings on enhancing resilience to STS	○	○	○	○	○	○
d. The organization offers activities (besides trainings) that promote resilience to STS	○	○	○	○	○	○
e. The organization discusses STS during new employee orientation	○	○	○	○	○	○
f. The organization has regular opportunities to provide team and peer-support to individuals with high levels of exposure	○	○	○	○	○	○
g. The organization provides release time to allow employees to attend trainings focused on reslience building or STS management	○	○	○	○	○	○

6. How well does the organization evaluate and monitor STS policies and practices?

	Not at all	Rarely	Somewhat	Mostly	Completely	N/A
a. The organization assesses the level of STS in the workplace	○	○	○	○	○	○
b. The organization routinely monitors workforce trends (e.g. attrition, absenteeism) that may signify a lack of safety or an increase in STS	○	○	○	○	○	○
c. The organization responds to what it learns through evaluation, monitoring and/or feedback in ways that promote safety and resilience	○	○	○	○	○	○
d. The organization routinely seeks feedback from the workforce regarding psychosocial trends that may signify an increase in STS (e.g. increased conflict, social isolation)	○	○	○	○	○	○

Maija Mänttäri-van der Kuip

Denise Michelle Brend

Instrument de mesure de la détresse morale

MDI

Novembre 2021

Consignes:

Ce questionnaire est conçu pour mesurer les expériences de détresse morale. Il vous est demandé de répondre à la première partie des sept questions concernant les expériences potentielles que vous avez pu vivre au travail.

Si votre réponse est 0, vous pouvez passer à la question suivante, si votre réponse est un nombre entre 1 et 6, alors répondez à la deuxième partie de la question concernant le malaise potentiel lié à votre expérience.

Question 1.

1.A) Avez-vous été dans l'impossibilité d'effectuer votre travail de la façon dont vous croyez qu'il aurait dû être fait?

0	1	2	3	4	5	6
Jamais (passez à la question 2)	Quelques fois par années ou moins (passez à la Question 1.B)	Une fois mois ou moins (passez à la Question 1.B)	Quelques fois par mois (passez à la Question 1.B)	Une fois par semaine (passez à la Question 1.B)	Quelques fois par semaine (passez à la question 1.B)	Chaque jour (Passez à la Question 1.B)

1.B) Cela vous a-t-il mis mal à l'aise ?

0	1	2	3	4
Non	Oui, mais mon malaise était facilement gérable	Oui, et mon malaise a nécessité des efforts à gérer	Oui, et mon malaise était difficile à gérer	Oui, et j'étais incapable de gérer mon malaise

Question 2.

2.A) Au travail, avez-vous été obligé, été forcé ou avez-vous subi des pressions pour faire quelque chose qui ne semblait pas être la bonne ligne de conduite?

0	1	2	3	4	5	6
Jamais (passez à la question 3)	Quelques fois par années ou moins (passez à la Question 2.B)	Une fois mois ou moins (passez à la Question 2.B)	Quelques fois par mois (passez à la Question 2.B)	Une fois par semaine (passez à la Question 2.B)	Quelques fois par semaine (passez à la question 2.B)	Chaque jour (Passez à la Question 2.B)

2.B) Cela vous a-t-il mis mal à l'aise ?

0	1	2	3	4
Non	Oui, mais mon malaise était facilement gérable	Oui, et mon malaise a nécessité des efforts à gérer	Oui, et mon malaise était difficile à gérer	Oui, et j'étais incapable de gérer mon malaise

Question 3.

3. A) Au travail, avez-vous déjà vécu une situation qui vous demandait d'agir malgré le fait que vous étiez incertain.e de quelle était la bonne ligne de conduite?

0	1	2	3	4	5	6
Jamais (passez à la question 4)	Quelques fois par années ou moins (passez à la Question 3.B)	Une fois mois ou moins (passez à la Question 3.B)	Quelques fois par mois (passez à la Question 3.B)	Une fois par semaine (passez à la Question 3.B)	Quelques fois par semaine (passez à la question 3.B)	Chaque jour (Passez à la Question 3.B)

3. B) Cela vous a-t-il mis mal à l'aise?

0	1	2	3	4
Non	Oui, mais mon malaise était facilement gérable	Oui, et mon malaise a nécessité des efforts à gérer	Oui, et mon malaise était difficile à gérer	Oui, et j'étais incapable de gérer mon malaise

Question 4.

4.A) Au travail, avez-vous déjà été témoin de situations que vous jugiez incorrectes, mais face auxquelles vous vous sentiez impuissant.e d'agir?

0	1	2	3	4	5	6
Jamais (passez à la question 5)	Quelques fois par années ou moins (passez à la Question 4.B)	Une fois mois ou moins (passez à la Question 4.B)	Quelques fois par mois (passez à la Question 4.B)	Une fois par semaine (passez à la Question 4.B)	Quelques fois par semaine (passez à la question 4.B)	Chaque jour (Passez à la Question 4.B)

4.B) Cela vous a-t-il mis mal à l'aise?

0	1	2	3	4
Non	Oui, mais mon malaise était facilement gérable	Oui, et mon malaise a nécessité des efforts à gérer	Oui, et mon malaise était difficile à gérer	Oui, et j'étais incapable de gérer mon malaise

Question 5.

5.A) Avez-vous vécu des situations au travail qui vous forçaient à aller à l'encontre de vos valeurs personnelles ou de vos principes éthiques?

0	1	2	3	4	5	6
Jamais (passez à la question 6)	Quelques fois par années ou moins (passez à la Question 5.B)	Une fois mois ou moins (passez à la Question 5.B)	Quelques fois par mois (passez à la Question 5.B)	Une fois par semaine (passez à la Question 5.B)	Quelques fois par semaine (passez à la question 5.B)	Chaque jour (Passez à la Question 5.B)

5.B) Cela vous a-t-il mis mal à l'aise?

0	1	2	3	4
Non	Oui, mais mon malaise était facilement gérable	Oui, et mon malaise a nécessité des efforts à gérer	Oui, et mon malaise était difficile à gérer	Oui, et j'étais incapable de gérer mon malaise

Question 6.

6.A) Avez-vous vécu des situations qui vous forçaient à aller à l'encontre de vos valeurs personnelles ou de vos principes éthiques?

0	1	2	3	4	5	6
Jamais (passez à la question 7)	Quelques fois par années ou moins (passez à la Question 6.B)	Une fois mois ou moins (passez à la Question 6.B)	Quelques fois par mois (passez à la Question 6.B)	Une fois par semaine (passez à la Question 6.B)	Quelques fois par semaine (passez à la question 6.B)	Chaque jour (Passez à la Question 6.B)

6.B) Cela vous a-t-il mis mal à l'aise?

0	1	2	3	4
Non	Oui, mais mon malaise était facilement gérable	Oui, et mon malaise a nécessité des efforts à gérer	Oui, et mon malaise était difficile à gérer	Oui, et j'étais incapable de gérer mon malaise

Question 7.

7.A) Au travail, avez-vous rencontré des situations dans lesquelles vous saviez la bonne à faire, mais où vous vous sentiez incapable de le faire?

0	1	2	3	4	5	6
Jamais	Quelques fois par années ou moins (passez à la Question 7.B)	Une fois mois ou moins (passez à la Question 7.B)	Quelques fois par mois (passez à la Question 7.B)	Une fois par semaine (passez à la Question 7.B)	Quelques fois par semaine (passez à la question 7.B)	Chaque jour (Passez à la Question 7.B)

7.B) Cela vous a-t-il mis mal à l'aise?

0	1	2	3	4
Non	Oui, mais mon malaise était facilement gérable	Oui, et mon malaise a nécessité des efforts à gérer	Oui, et mon malaise était difficile à gérer	Oui, et j'étais incapable de gérer mon malaise

Maija Mänttäri-van der Kuip

Denise Michelle Brend

Pointage:

- Calculer les indices de la question :
    - Pour chaque item individuel, multipliez les scores des réponses à A et B pour obtenir un indice de chaque item, les scores seront compris entre 0 et 24 (A x B = Indice de l'item).

- Calculer le score total du MDI:
    - Additionnez tous les indices des items pour obtenir un score global allant de 0 à 168 (indice Q1 + indice Q2 + indice Q3 + indice Q4 + indice Q5 + indice Q6 + indice Q7 = le score total du MDI). Interprétation des scores :

Interprétations des résultats:

• Les indices des items

• Le score total du MDI

Moral Distress Instrument
November 2020

Directions:

This questionnaire is designed to measure experiences of moral distress. You are asked to answer the first part of all seven questions concerning potential experiences you may have had at work. If your answer is 0 you can move on to the next question, if your answer is any number between 1 and 6, then answer the second part of the question concerning potential discomfort connected to your experience.

Question 1.

1.A) Have you ever been unable to do your job in the way you believe it should have been done?

0	1	2	3	4	5	6
Never (move to question 2)	A few times a year or less (answer Question 1.B)	Once a month or less (answer Question 1. B)	A few times a month (answer Question 1. B)	Once a week (answer Question 1. B)	A few times a week (answer Question 1. B)	Every day (answer Question 1. B)

1.B) Did this cause you any discomfort?

0	1	2	3	4
No	Yes, but my discomfort was easily manageable	Yes, and my discomfort took effort to manage	Yes, and my discomfort was difficult to manage	Yes, and I was unable to manage my discomfort

Question 2.

2.A) Have you been pressured, obligated, or forced to do something at work that did not seem like the right course of action?

0	1	2	3	4	5	6
Never (move to question 3)	A few times a year or less (answer Question 2.B)	Once a month or less (answer Question 2. B)	A few times a month (answer Question 2. B)	Once a week (answer Question 2. B)	A few times a week (answer Question 2. B)	Every day (answer Question 2. B)

2.B) Did this cause you any discomfort?

0	1	2	3	4
No	Yes, but my discomfort was easily manageable	Yes, and my discomfort took effort to manage	Yes, and my discomfort was difficult to manage	Yes, and I was unable to manage my discomfort

Question 3*.*

3.A) Have you been in a situation at work that required you to act despite being unsure about what the right course of action was?

0	1	2	3	4	5	6
Never (move to question 4)	A few times a year or less (answer Question 3.B)	Once a month or less (answer Question 3. B)	A few times a month (answer Question 3. B)	Once a week (answer Question 3. B)	A few times a week (answer Question 3. B)	Every day (answer Question 3. B)

3.B) Did this cause you any discomfort?

0	1	2	3	4
No	Yes, but my discomfort was easily manageable	Yes, and my discomfort took effort to manage	Yes, and my discomfort was difficult to manage	Yes, and I was unable to manage my discomfort

Question 4.

4.A) Have you witnessed things happening at work that you believed to be wrong but felt powerless to change?

0	1	2	3	4	5	6
Never (move to question 5)	A few times a year or less (answer Question 4.B)	Once a month or less (answer Question 4. B)	A few times a month (answer Question 4. B)	Once a week (answer Question 4. B)	A few times a week (answer Question 4. B)	Every day (answer Question 4. B)

4.B) Did this cause you any discomfort?

0	1	2	3	4
No	Yes, but my discomfort was easily manageable	Yes, and my discomfort took effort to manage	Yes, and my discomfort was difficult to manage	Yes, and I was unable to manage my discomfort

Question 5.

*5.A) Have you encountered situations at work that have caused you to compromise your **professional** values or ethical principles?*

0	1	2	3	4	5	6
Never (move to question 6)	A few times a year or less (answer Question 5.B)	Once a month or less (answer Question 5. B)	A few times a month (answer Question 5. B)	Once a week (answer Question 5. B)	A few times a week (answer Question 5. B)	Every day (answer Question 5. B)

5.B) Did this cause you any discomfort?

0	1	2	3	4
No	Yes, but my discomfort was easily manageable	Yes, and my discomfort took effort to manage	Yes, and my discomfort was difficult to manage	Yes, and I was unable to manage my discomfort

Question 6.

*6.A) Have you encountered situations at work that have caused you to compromise your **personal** values or ethical principles?*

0	1	2	3	4	5	6
Never (move to question 7)	A few times a year or less (answer Question 6.B)	Once a month or less (answer Question 6. B)	A few times a month (answer Question 6. B)	Once a week (answer Question 6. B)	A few times a week (answer Question 6. B)	Every day (answer Question 6. B)

6.B) Did this cause you any discomfort?

0	1	2	3	4
No	Yes, but my discomfort was easily manageable	Yes, and my discomfort took effort to manage	Yes, and my discomfort was difficult to manage	Yes, and I was unable to manage my discomfort

Question 7.

7.A) Have you encountered situations at work in which you knew the right thing to do, but felt you were unable to do it?

0	1	2	3	4	5	6
Never	A few times a year or less (answer Question 7.B)	Once a month or less (answer Question 7. B)	A few times a month (answer Question 7. B)	Once a week (answer Question 7. B)	A few times a week (answer Question 7. B)	Every day (answer Question 7. B)

7.B) Did this cause you any discomfort?

0	1	2	3	4
No	Yes, but my discomfort was easily manageable	Yes, and my discomfort took effort to manage	Yes, and my discomfort was difficult to manage	Yes, and I was unable to manage my discomfort

Scoring:

- Calculating Item Indexes
  - For each individual item, multiply the scores for the answers to A and B for an index of each item, the scores will range from X to XX (A x B = Item Index).
- Calculating the Total Index
  - add all of the item indexes for an overall score ranging from X to X (Q1 index + Q2 index + Q3 Index + Q4 Index + Q5 Index + Q6 Index + Q7 Index= MD Score).

Interpreting the Scores

- Item Indexes
- Total Index

Annex 6: Invitation for the questionnaire

UNIVERSITÉ LAVAL

Centre de services en TI et en pédagogie

Titre du projet : **L'approche tenant compte des traumatismes en contexte d'emprisonnement: un examen de la portée et cadre théorique de synthèse.**

Travaillez-vous dans un milieu carcéral (prison municipale, provinciale ou fédérale), ou avez-vous travaillé dans un tel milieu au cours de la dernière année ? Nous souhaitons savoir comment votre lieu de travail gère l'exposition au stress traumatique et le potentiel de détresse morale lié à des choses que vous avez pu faire au travail.

Notre sondage devrait prendre environ 15 à 30 minutes à remplir, et nous ne recueillons aucune information permettant d'identifier les personnes qui participent à ce projet de recherche.

Si cela vous intéresse, veuillez cliquer sur le lien ci-dessous. Vous serez dirigé vers le site Web sécurisé du sondage, géré par la chercheuse principale, Denise Michelle Brend, PhD, et hébergé sur le serveur institutionnel de l'Université Laval.

Vous y recevrez toutes les informations nécessaires pour prendre une décision éclairée quant à votre participation. Aucune information n'est recueillie sur les personnes qui visitent le site.

Nous vous remercions d'avoir pris le temps de lire cette invitation

Denise M. Brend, PSW, PhD

RÉPONDRE AU QUESTIONNAIRE

Cette recherche est réalisée par Denise Michelle Brend, de l'École de travail social et de criminologie à l'Université Laval (chercheure principale), Catherine Rossi (École de travail social et de criminologie à l'Université Laval) (cochercheure) ; Felice Yuen (Applied Human Sciences, Concordia University) (cochercheur) et Zack Marshall (Community Health Sciences, University of Calgary) (collaborateur).

Ce projet a été approuvé par le Comité d'éthique de la recherche de l'Université Laval : N^{O} d'approbation 2023-001 / 23-05-2023

Copiez-collez ce lien dans la barre d'adresse de votre navigateur si le bouton ne fonctionne pas : https://www.questionnaires.cstip.ulaval.ca/v3/index.php/749437?newtest=Y&lang=fr

UNIVERSITÉ LAVAL

Centre de services en TI et en pédagogie

Project Title: Trauma-informed care in the context of imprisonment: a scoping review and framework synthesis

Are you working in a carceral setting (jail or prison), or were you working in one within the past year? We are interested in how your place of employment managed exposure to secondary traumatic stress and the potential for moral distress related to things that you may have done at work.

Our survey should take about 15-30 minutes to complete, and we are not collecting any identifying information about people who participate in the survey.

If this is of interest to you, please click on the link below. You will be taken to the secure website of the survey, managed by the primary researcher, Denise Michelle Brend, PhD, and housed on the institutional server of the Université Laval.

There you will be given all the information to make an informed decision about whether or not you want to participate. No information is collected about people who visit the site.

Thank you for taking the time to read this invitation.

Denise M. Brend, PSW, PhD

Please follow this link to the questionnaire

This project is being done by Denise Michelle Brend, de l'École de travail social et de criminologie à l'Université Laval (principal researcher), Catherine Rossi (École de travail social et de criminologie à l'Université Laval) (coresearcher) ; Felice Yuen (Applied Human Sciences, Concordia University) (coresearcher) et Zack Marshall (Community Health Sciences, University of Calgary) (collaborator)

Ce projet a été approuvé par le Comité d'éthique de la recherche de l'Université Laval : N^{o} d'approbation 2023-001 / 23-05-2023

Copiez-collez ce lien dans la barre d'adresse de votre navigateur si le bouton ne fonctionne pas :
https://www.questionnaires.cstip.ulaval.ca/v3/index.php/749437?newtest=Y&lang=en

Annex 7: Consent form for the questionnaire

0%

Langue : Français Changer de langue

L’approche tenant compte des traumatismes en contexte d’emprisonnement : un examen de la portée et cadre théorique de synthèse

Titre du projet : L’approche tenant compte des traumatismes en contexte d’emprisonnement : un examen de la portée et cadre théorique de synthèse

Cette recherche est réalisée par Denise Michelle Brend, de l’École de travail social et de criminologie à l’Université Laval (chercheure principale), Catherine Rossi (École de travail social et de criminologie à l’Université Laval) (cochercheure) ; Felice Yuen (Applied Human Sciences, Concordia University) (cochercheur) et Zack Marshall (Community Health Sciences, University of Calgary) (collaborateur).

Contexte du projet : Projet financé par les Fonds de recherche du Québec- Société et culture : Programme Actions concertées, Programme de recherche sur la santé psychologique au travail, Concours 2022-2023

Renseignements sur le projet: L'étude a pour objet l'approche tenant compte des traumatismes en contexte d'emprisonnement. Elle vise à documenter et établir une évaluation critique et une synthèse des connaissances existantes sur les approches tenant compte des traumatismes en contexte d'emprisonnement visant à améliorer le bien-être psychologique des professionnels carcéraux de première ligne. Pour ce faire, nous avons besoin d'entrer en contact avec le plus de participants possibles afin de recueillir des témoignages qui nous aiderons à mieux comprendre la réalité des professionnels œuvrant en contexte carcéral.

Votre Participation : Votre participation à cette recherche, consistera à remplir le présent questionnaire comprenant 101 questions portant sur les difficultés qu'expérimentent les professionnels œuvrant dans le milieu carcéral. Ce questionnaire prendra entre quinze et trente minutes à remplir. Bien que les réponses à chacune des questions soient importantes pour la recherche, vous demeurez libre de choisir de ne pas répondre à l'une ou l'autre d'entre elles ou encore de mettre fin à votre participation à tout moment, sans avoir à vous justifier. Les données obtenues d'un participant qui choisirait de se retirer du projet après avoir soumis son questionnaire ne pourront être détruites.

Confidentialité. Les chercheurs sont tenus d'assurer la confidentialité aux participants. À cet égard, voici les mesures qui seront appliquées dans le cadre de la présente recherche :

Durant la recherche :

- L'ensemble du matériel de la recherche, incluant les données en format numérique seront, pour leur part, conservées sur le serveur sécurisé de l'Université Laval;

Lors de la diffusion des résultats :

- Les résultats seront présentés sous forme globale de sorte que les résultats individuels des participants ne seront jamais communiqués;
- La recherche fera l'objet de publications dans des revues scientifiques et les fiches d'information, et aucun participant ne pourra y être identifié.

Après la fin de la recherche :

- Les données utilisées dans le cadre d'autres recherches soient rendues anonymes sans possibilité absolue d'identifier les participants les ayant fournies.

Remerciement.
Votre collaboration est précieuse pour nous permettre de réaliser cette étude. C'est pourquoi nous tenons à vous remercier pour le temps et l'attention que vous acceptez de consacrer à votre participation.

Attestation du consentement
Le simple retour du questionnaire rempli sera considéré comme l'expression implicite de votre consentement à participer au projet.

Renseignements supplémentaires
Si vous avez des questions sur la recherche ou sur les implications de votre participation veuillez communiquer avec la chercheure responsable, Denise Michelle Brend, à l'adresse courriel denise-michelle.brend@tsc.ulaval.ca (mailto:denise-michelle.brend@tsc.ulaval.ca)

Plaintes ou critiques
Si vous avez des plaintes ou des critiques relatives à votre participation à cette recherche, vous pouvez vous adresser, en toute confidentialité, au bureau de l'Ombudsman de l'Université Laval aux coordonnées suivantes :

Pavillon Alphonse-Desjardins, bureau 3320
2325, rue de l'Université
Université Laval
Québec (Québec) G1V 0A6

Renseignements - Secrétariat : (418) 656-3081
Ligne sans frais : 1-866-323-2271
Courriel : info@ombudsman.ulaval.ca (mailto:info@ombudsman.ulaval.ca)

RESSOURCE D'AIDE
Soutien en santé mentale
https://www.canada.ca/fr/sante-publique/services/services-sante-mentale/sante-mentale-obtenir-aide.html (https://www.canada.ca/fr/sante-publique/services/services-sante-mentale/sante-mentale-obtenir-aide.html)

Approuvé par le Comité d'éthique de la recherche de l'Université Laval (2023-001 A-2 / 17-08-2023)

Suivant

Language: English Change the language

Trauma-informed care in the context of imprisonment: a scoping review and framework synthesis

Project title: Trauma-informed care in the context of imprisonment: a scoping review and framework synthesis

This research is being carried out by Denise Michelle Brend, École de travail social et de criminologie à l'Université Laval (principal researcher), Catherine Rossi (École de travail social et de criminologie à l'Université Laval) (co-researcher) ; Felice Yuen (Applied Human Sciences, Concordia University) (co-researcher) et Zack Marshall (Community Health Sciences, University of Calgary) (collaborator).

Context of the project: This is a research project funded by the Fonds de recherche du Québec- Société et culture : Programme Actions concertées, Programme de recherche sur la santé psychologique au travail, 2022-2023 competition.

Information about the project: Our study aims to document and establish a critical assessment and synthesis of existing knowledge on trauma-informed approaches in the context of imprisonment aimed at improving psychological well-being front-line prison and jail professionals. To do this, we need to get in touch with as many participants as possible in order to collect perspectives to help us better understand the reality of professionals working in prisons.

Participation in research: Participation in this research consists of completing this questionnaire with 101 questions about the difficulties experienced by professionals working in prisons. This questionnaire will take between fifteen to thirty minutes to complete. While the answers to each question are important to the research, you remain free to choose not to answer any of them or to terminate your participation at any time, without having to give any reason. If a participant chooses to withdraw from the study data that has been submitted cannot be destroyed.

Confidentiality: Researchers are required to ensure confidentiality for participants. To do this, the following measures will be applied in this research:

During the research:

- All research material, including data in digital format, will be kept in encrypted files whose access will be stored on the secured server of Université Laval

When disseminating results:

- Results will be presented in aggregate form so that individual participants' results will never be communicated
- The research will be published in scientific journals and fact sheets, and no participants will be identified

After the search is complete:

- Data to be used in other research will be anonymized with absolutely no possibility of identifying the participants who provided it.

Thank-you
Your collaboration is precious to enable us to carry out this study, which is why we would like to thank you for the time and attention that you agree to devote to your participation.

Attestation of consent
The submisson of the completed questionnaire will be considered as an implicit expression of your consent to participate in the project.

Additional Information
If you have any questions about the research or the implications of your participation, please contact the lead researcher, Denise Michelle Brend, at denise-michelle.brend@tsc.ulaval.ca (mailto:denise-michelle.brend@tsc.ulaval.ca)

Complaints or criticisms
Any complaint or criticism related to your participation in this research project may be addressed to the Office of the Ombudsman of Université Laval:

Pavillon Alphonse-Desjardins
2325, rue de l'Université, bureau 3320
Université Laval
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Renseignements - secrétariat : (418) 656-3081
Ligne sans frais : 1 (866) 323-2271
Courriel : info@ombudsman.ulaval.ca (mailto:info@ombudsman.ulaval.ca)

HELP RESSOURCES

Mental health services
https://www.canada.ca/en/public-health/services/mental-health-services/mental-health-get-help.html (https://www.canada.ca/en/public-health/services/mental-health-services/mental-health-get-help.html)

Approved by the Comité d'éthique de la recherche de l'Université Laval (2023-001 A-2 / 17-08-2023)

Annex 8: Final question

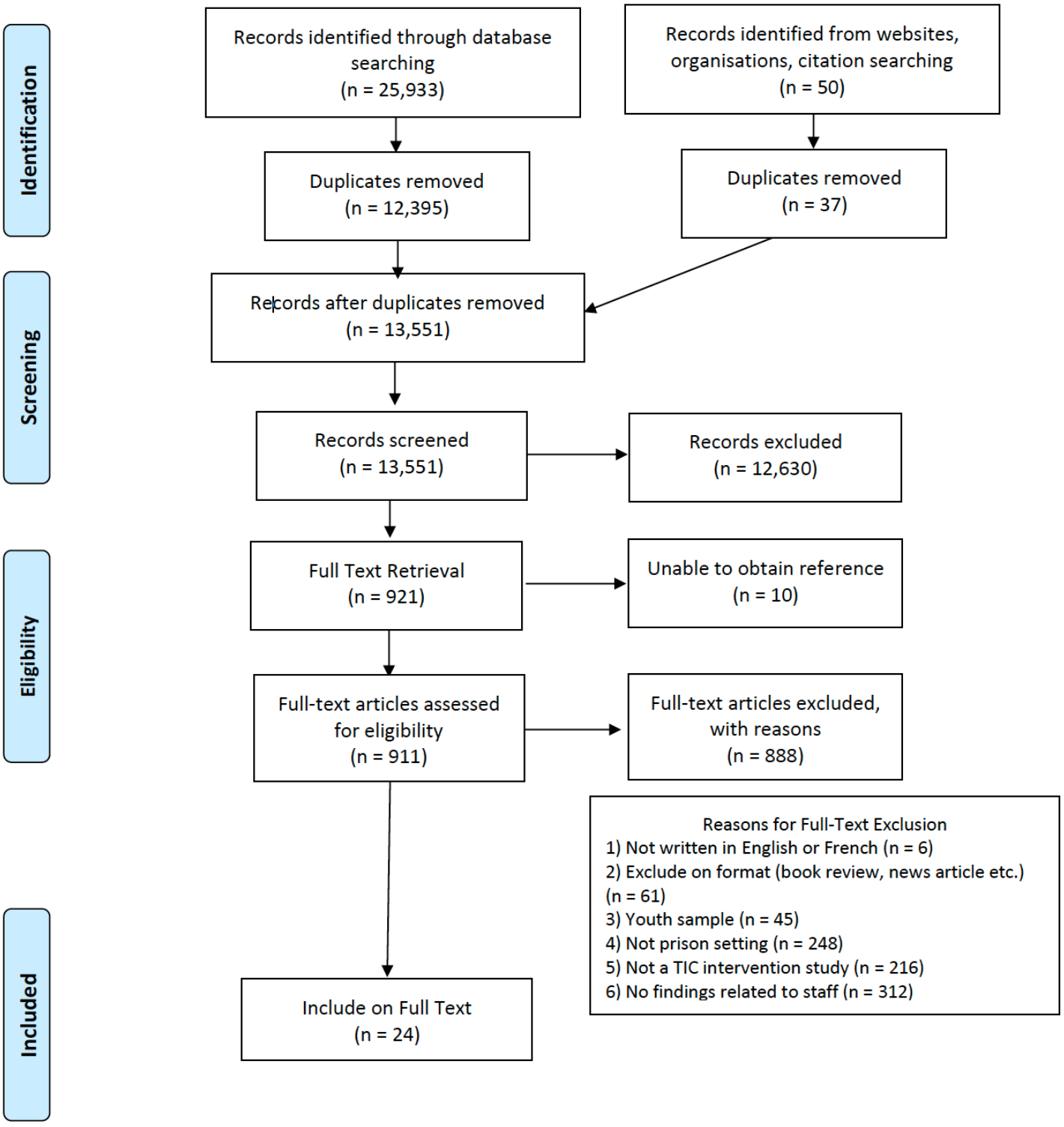
Dernière question du questionnaire

Y a-t-il quelque chose que vous aimeriez ajouter ?

Anglais :

Is there anything you would like to add?

Annex 9: Figure 1, PRISMA 2020 Flow Diagram



Annex 10: Bibliographic references of systematic review findings, n = 24

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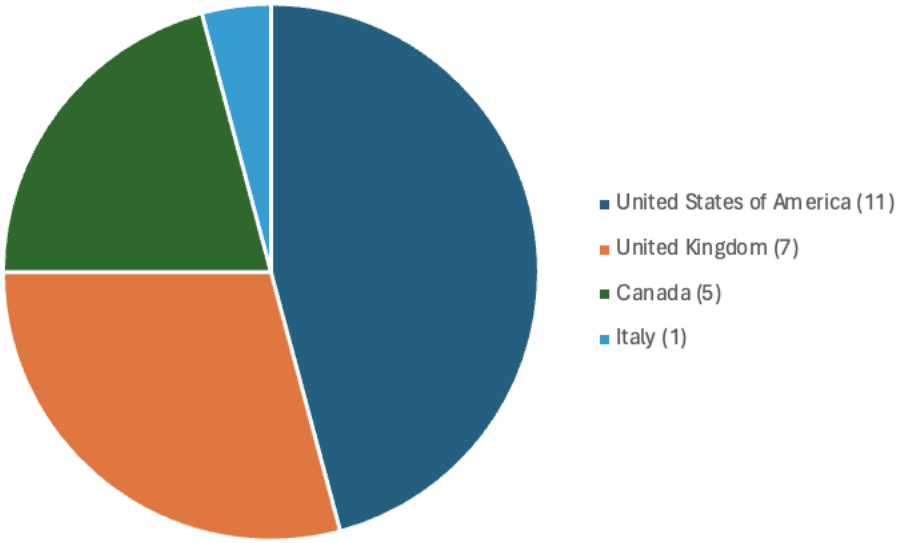
Annex 11: Table 1, Publication by year

Table 1

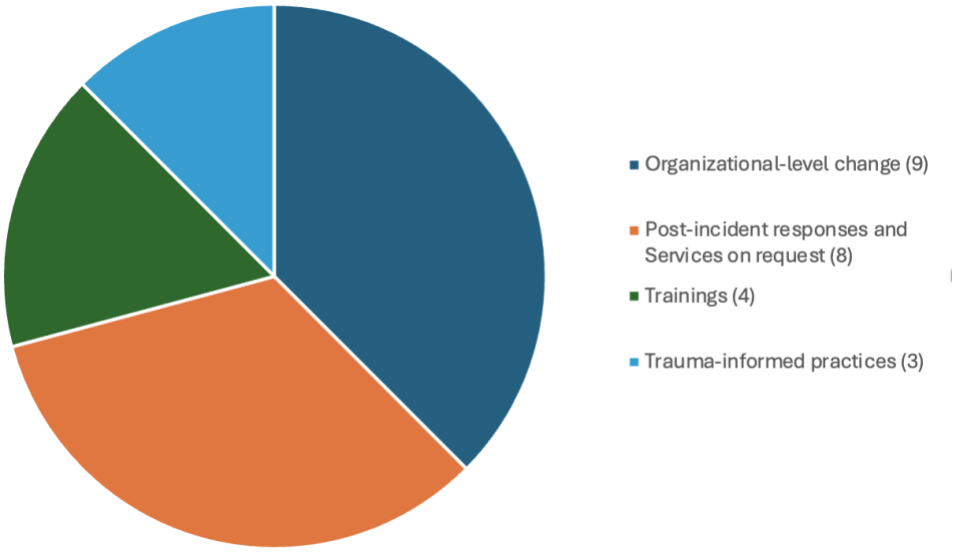
Publication by year, n = 24

Time period	Number of publications	Year by publication
1995-1999	3	1995, 1996, 1997
2000-2004	1	2003
2005-2009	1	2006
2010-2014	3	2010, 2013, 2013
2015-2019	6	2015, 2018, 2019, 2019, 2019, 2019
2020-2024	10	2020, 2021, 2021, 2022, 2023, 2023, 2023, 2023, 2024, 2024

Annex 12: Figure 2, Geographic locations of carceral TIC interventions



Annex 13: Figure 3, Format and distribution of TIC interventions



Annex 14: Table 2, Focus of intervention by time-period and geographic location

Table 2

Focus of intervention by time-period and geographic location, n = 24

Time period	Main focus of intervention		
	Reactive and on demand services	Trauma-informed practices[1]	TIC[2]
1995-2004	USA		
	USA		
	USA[3]		
	Canada		
2005-2014		UK	
			UK
	Canada		
			USA
2015-2024		UK	
			Italy
		USA	
		USA	
		USA	
			UK
			USA
		Canada	
			USA
	Canada		
		Canada	
			UK
			UK
	Canada[4]		
			USA

[1]This category also includes trainings
[2]TIC (trauma-informed care) represents implementations with a vision for whole system change
[3]This implementation also had a training component
[4]This research effort was an analysis of the efficacy and uptake of on demand services

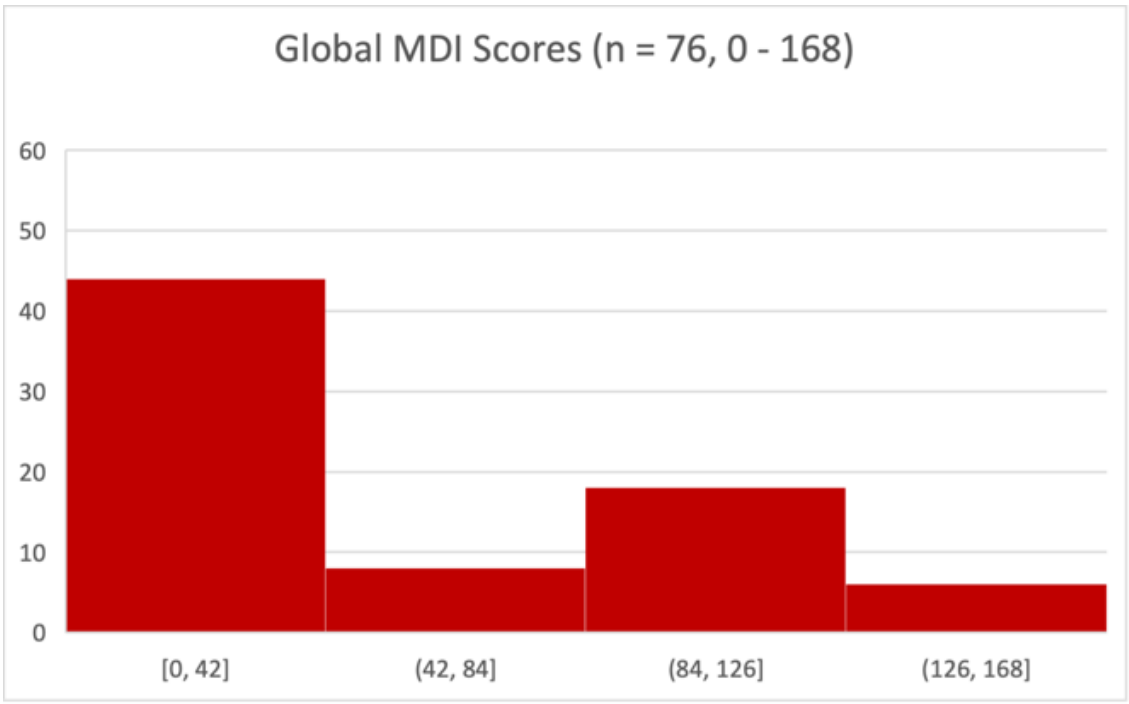
Annex 15: Table 3, Prison and jail employees who completed the Moral Distress inventory

Table 3

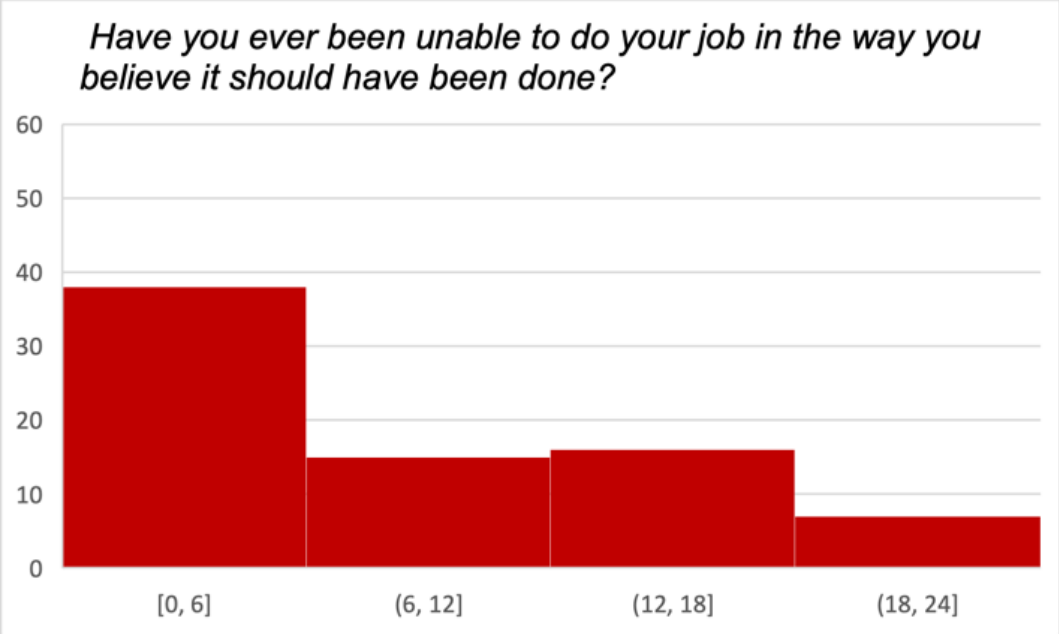
Prison and jail employees who completed the Moral Distress inventory, n = 76

Gender	Number	Percentage
Women	25	33%
Men	51	67%
Length of employment at current or most recent employer		
0 – 2 years	4	5%
2 years plus a day – 5 years	15	20%
5 years plus a day – 10 years	12	16%
10 years plus a day – 15 years	18	24%
15 years plus a day – 25 years	23	30%
25 years plus a day +	4	5%
Belonging to a religious group, cultural group or has a sexual orientation that has been historically, persistently, or systemically marginalized.		8 (11%)
Belonging to an ethnic or racialized group that has been historically, persistently, or systemically marginalized.		14 (18%)
Has a disability as defined by the Accessible Canada Act		18 (24%)

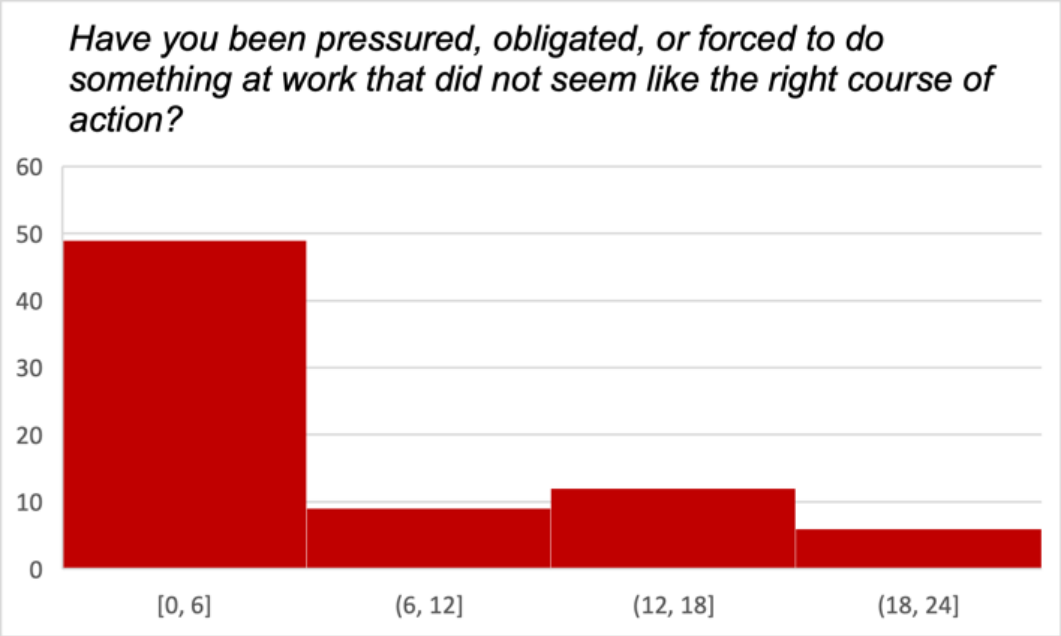
Annex 16: Figure 4, Moral Distress Instrument scores



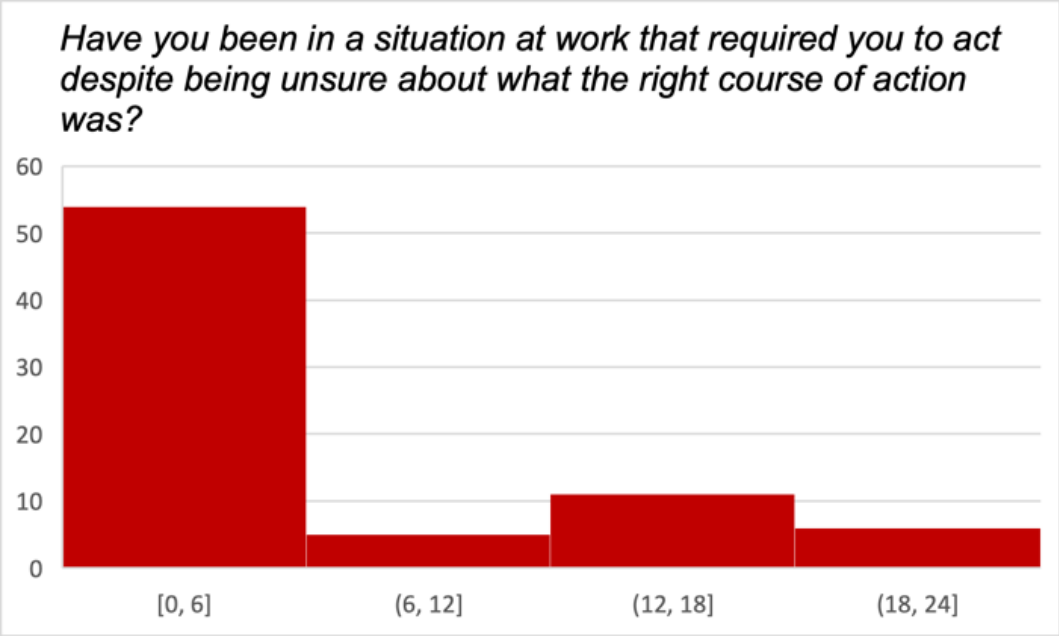
Annex 17: Figure 5, MDI subscale 1



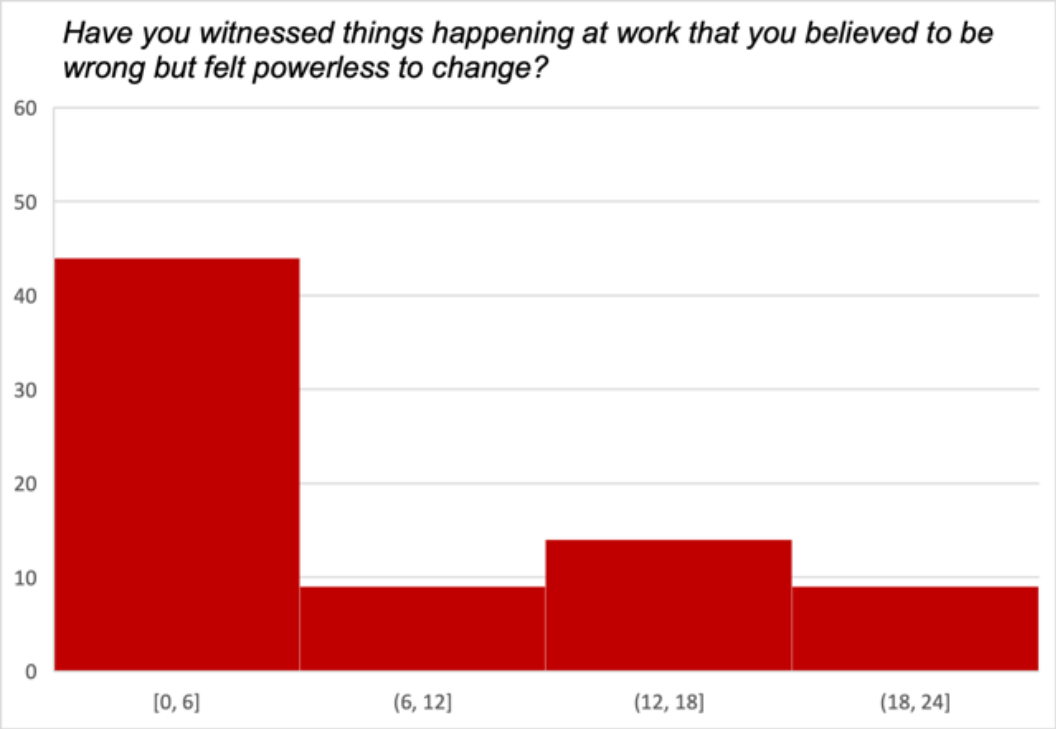
Annex 18: Figure 6, MDI subscale 2



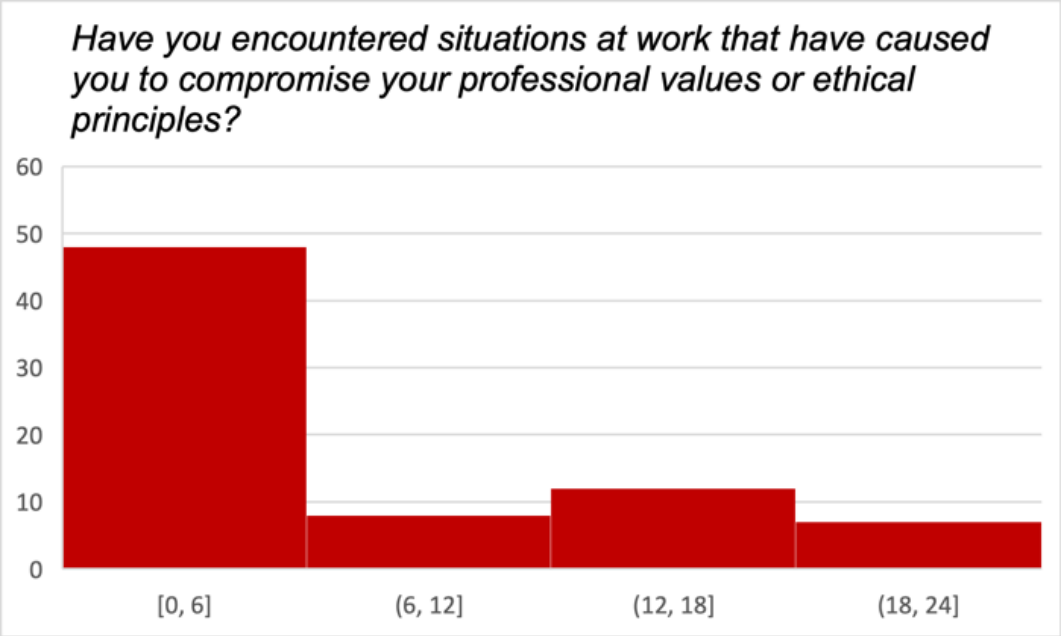
Annex 19: Figure 7, MDI subscale 3



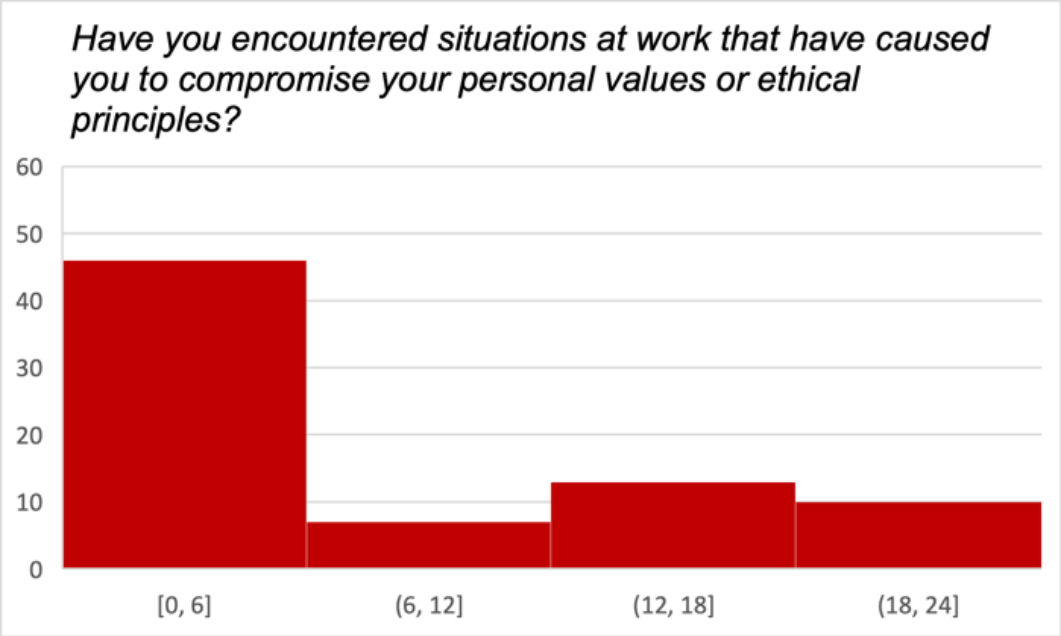
Annex 20: Figure 8, MDI subscale 4



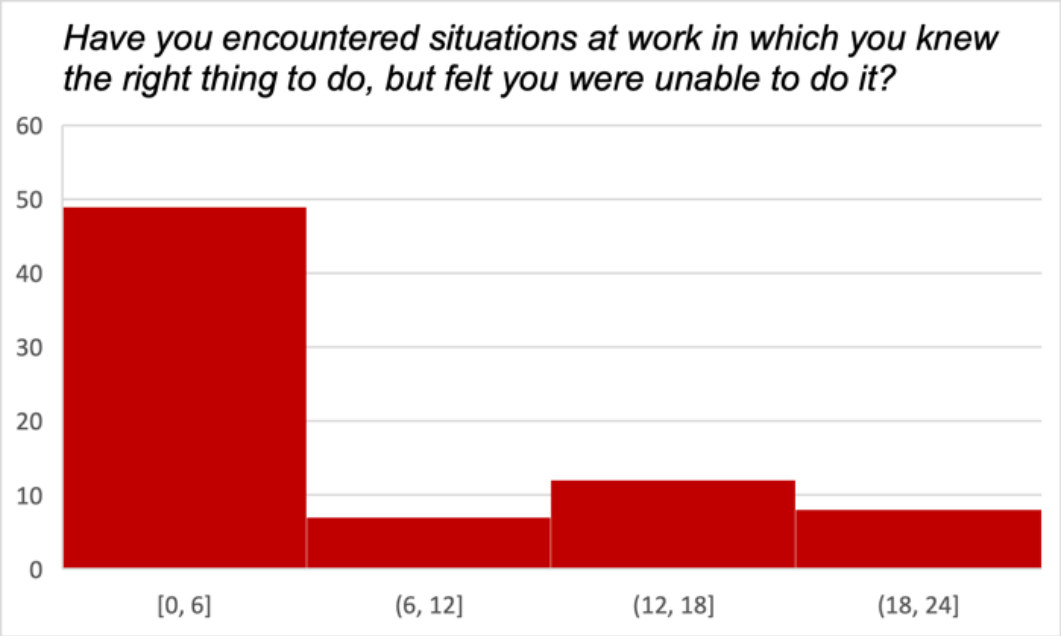
Annex 21: Figure 9, MDI subscale 5



Annex 22: Figure 10, MDI subscale 6



Annex 23: Figure 11, MDI subscale 7



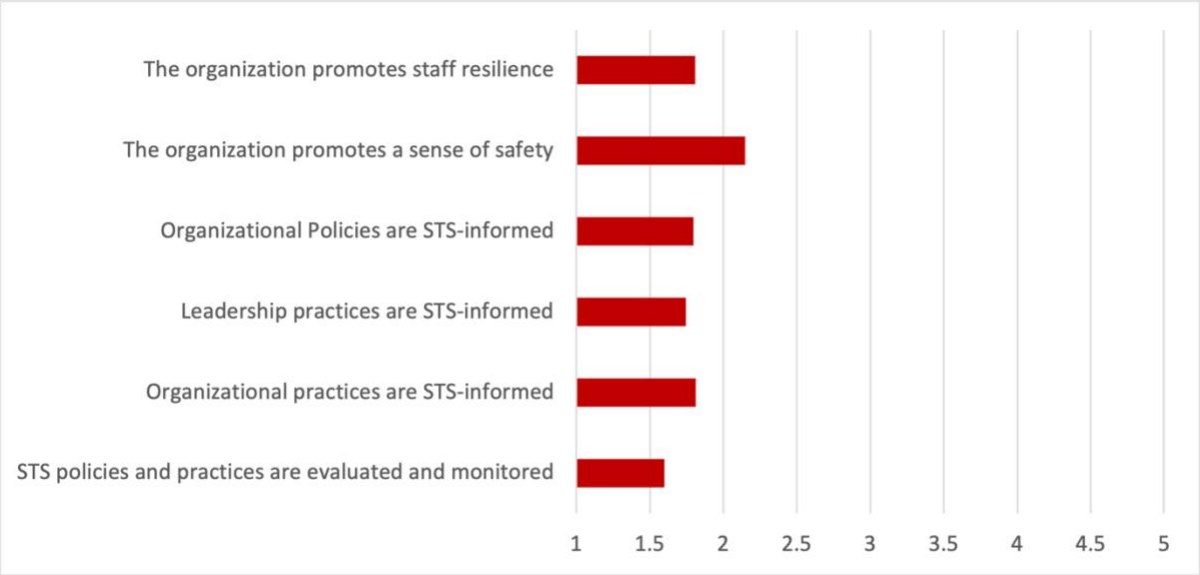
Annex 24: Table 4, Prison and jail employees who completed Secondary traumatic stress Organizational Assessment

Table 4

Prison and jail employees who completed the Secondary traumatic stress Organizational Assessment, n = 63

Gender	Number	Percentage
Women	22	35%
Men	41	65%
Length of employment at current employer		
0 – 2 years	1	2%
2 years plus a day – 5 years	15	24%
5 years plus a day – 10 years	12	19%
10 years plus a day – 15 years	11	17%
15 years plus a day – 25 years	20	32%
25 years plus a day +	4	6%

Annex 25: Figure 12, STS-OA Scores



Annex 26: Table 5, Prison and jail employees who opted to qualitatively share their perspectives

Table 5

Prison and jail employees who opted to qualitatively share their perspectives, n = 30

Gender	*Number*	*Percentage*
Women	11	37%
Men	19	63%
Age		
18 – 24	1	3.3%
25 – 34	3	10.0%
35 - 44	5	16.7%
45 – 54	17	56.7%
55 – 64	4	13.3%
Language Used		
English	28	93%
French	2	7%
Years of experience		
0 – 2 years	1	3.3%
2 years plus a day – 5 years	4	13.3%
5 years plus a day – 10 years	5	16.7%
10 years plus a day – 15 years	5	16.7%
15 years plus a day – 25 years	12	40.0%
25 years plus a day +	3	10.0%
Length of employment at current or most recent employer		
0 – 2 years	1	3.3%
2 years plus a day – 5 years	7	23.3%
5 years plus a day – 10 years	5	16.7%
10 years plus a day – 15 years	4	13.3%
15 years plus a day – 25 years	10	33.3%
25 years plus a day +	3	10.0%
Belonging to a religious group, cultural group or has a sexual orientation that has been historically, persistently, or systemically marginalized.		6 (20%)
Belonging to an ethnic or racialized group that has been historically, persistently, or systemically marginalized.		9 (30%)
Has a disability as defined by the Accessible Canada Act		12 (40%)

Annex 27: Table 6, Thematic Structure of Prison and Jail Employee Comments

Table 6

Thematic Structure of Prison and Jail Employee Comments

Superordinate themes	Subordinate themes
Practices	Practices are inadequate
	Incoherent practices
Leadership	Poor leadership
	Dehumanization, degradation
	Threats
	Taking empty credit
	Unreasonable expectations
	Inmates over staff
Feelings	Feeling unsupported
	Fear
	Powerlessness, being trapped
	Feeling blamed
Organizational climate	Exposure
	Toxic work environment
	Harassment, intimidation, hostility
	Violence
	Peer bullying
Policy	Inadequate policies
	Disagreement or confusion about policy
Resources	Inadequate resources
	Inadequate training
	Staff must look out for each other