

COLLECTIVE CONFINEMENT: HOW PERCEPTIONS OF COLLECTIVE
EFFICACY INFLUENCE FEELINGS OF SAFETY AMONG INDIVIDUALS LIVING
IN RESTRICTED HOUSING UNITS

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Taylor Nicole Hartwell
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Committee:

_____ Director

_____ Department Chairperson

_____ Dean, College of Humanities
and Social Sciences

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Collective Confinement: How Perceptions of Collective Efficacy Influence Feelings of
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A Thesis submitted in partial fulfillment of the requirements for the degree of Master of
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by

Taylor Nicole Hartwell
Bachelor of Science
York College of Pennsylvania, 2017

Thesis Committee Chair: Danielle S. Rudes, Associate Professor
Department of Criminology, Law, & Society

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George Mason University
Fairfax, VA

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List of Abbreviations

RHU	Restricted Housing Unit
PA-DOC	Pennsylvania Department of Corrections
SCI	State Correctional Institute
SA	Superintendent's Assistant
CO(s)	Correctional Officer(s)
DTU	Diversionary Treatment Unit
ACE!	Center for Advancing Correctional Excellence
SMI	Severely Mentally Ill

Abstract

COLLECTIVE CONFINEMENT: HOW PERCEPTIONS OF COLLECTIVE EFFICACY INFLUENCE FEELINGS OF SAFETY AMONG INDIVIDUALS LIVING IN RESTRICTED HOUSING UNITS

Taylor N. Hartwell, B.S.

George Mason University, 2019

Thesis Director: Dr. Danielle S. Rudes

Solitary confinement (i.e., Restricted Housing Unit/RHU) is traditionally defined as a “prison within a prison” (Brown, Cambier, & Agha, 2011). Individuals residing in RHUs experience heightened rules including restricted movement and interaction. It is expected that these heightened restrictions will influence residents’ perceptions of collective efficacy and safety while residing in restricted housing. This research uses survey and semi-structured interview data collected from individuals residing in RHUs to explore perceptions of collective efficacy and safety, and more specifically examine how the presence/absence of collective efficacy influences perceptions of safety while living in RHUs. Implications for this research include extending theoretical concepts regarding collective efficacy and perceptions of safety in carceral environments. Additionally, this work provides insight on the living experiences inside restricted housing units, and practical/policy recommendations for improving prisoner, unit, and institutional safety.

Chapter One: Introduction

The purpose of this research is to examine RHU residents¹' perceptions and understandings of collective efficacy and safety. More specifically, this research explores perceptions of collective efficacy with other RHU residents and staff, perceptions of safety, and how perceptions of collective efficacy influence perceptions of safety among individuals living in RHUs. Previous research pays little attention to perceptions of collective efficacy in prisons or, more specifically, within RHUs. Additionally, while prior work addresses feelings of safety among individuals living in prisons more broadly, little work considers feelings of safety among individuals in solitary confinement units.

As displayed in Table 1, this project is three-fold and consists of a mixed-method approach. The first portion of this research qualitatively examines RHU residents' perceptions and understandings of collective efficacy and safety. In terms of collective efficacy, specifically, (1) How do RHU residents experience *trust* with other residents? (2) Are RHU residents willing to *intervene* during incidents with other residents?, and, (3) Does *social cohesion* exist among RHU residents? Secondly, in terms of perceptions

¹ As many organizations are beginning to push for criminal justice organizations to use first-person humanizing language, I use the term "RHU resident" to describe individuals residing in restricted housing units, and "prisoner" to describe individuals living in prison more generally. For more information, see <http://www.osborneny.org/resources/resources-for-humanizing-language/>.

of safety, specifically, (1) Do residents report *feeling safe* while living in the RHU?; and, (2) Under what conditions do RHU residents report feeling safe and unsafe? The third portion of this research is to quantitatively understand how perceptions of collective efficacy influence feelings of safety while living in RHUs. More specifically, (1) How do RHU residents' perceptions of collective efficacy with other residents influence their perceptions of safety and (2) How do RHU residents' perceptions of collective efficacy with correctional officers (COs) influence perceptions of safety? It is hypothesized that: (1) RHU residents feel safe while living in the RHU due to the sense of collective efficacy with other residents residing in the RHU and (2) A lack of collective efficacy between RHU residents and correctional officers results in residents feeling unsafe while living in the RHU.

Table 1
Research Questions

	Research Question	Method
1	<i>Collective Efficacy</i>	
	How do RHU residents perceive/understand collective efficacy (e.g., social cohesion, trust, willingness to intervene)?	Survey Qualitative Interviews
2	<i>Perceptions of Safety</i>	
	Under what conditions do RHU residents report feeling safe/not feeling safe while living in the RHU?	Survey Qualitative Interviews
3	<i>Collective Efficacy & Perceptions of Safety</i>	
	How do elements of collective efficacy contribute to RHU residents' perception of safety while living in the RHU?	Survey

Chapter Two: Literature Review

Solitary confinement is typically described as “a prison within a prison” (Brown, Cambier, & Agha, 2011). The use of solitary confinement emerged in the United States in the late 1770s based on the principal that individuals who were isolated had time to “repent and rehabilitate” themselves. The use of solitary confinement units increased dramatically since the 1980s (Brown et al, 2011). Today, approximately 80,000 individuals live in solitary confinement (ACLU, 2014). Prisoners are typically placed in solitary confinement for: (1) disciplinary segregation; (2) administrative segregation, or (3) protective custody. Individuals placed in solitary confinement for disciplinary segregation are typically there as a punishment for some type of rule violation. In contrast, individuals placed in solitary confinement for administrative segregation are there because they may pose a larger threat to security and safety of the institution, such as a high-profile gang member. Lastly, individuals placed in solitary confinement for protective custody are typically there for their own safety and are thought to be at risk in general population, such as a high-profile sex offender (Brown et al., 2011; US DOJ, 2016).

Many correctional staff refrain from using the term “solitary confinement” due to the negative connotation and misleading picture associated with the term. The United States Department of Justice (DOJ) notes that segregation units do not always house prisoners in “solitary,” and many institutions engage in the practice of “double-celling” or housing two segregated prisoners together. Thus, the DOJ (2016), as well as the Pennsylvania Department of Corrections (PA-DOC), uses the term Restricted Housing Units (i.e., RHUs) to describe this type of confinement. According to the DOJ, “restrictive housing” involves three basic elements: (1) removal from the general inmate population, whether voluntary or involuntary; (2) placement in a locked room or cell, whether alone or with another inmate, and (3) inability to leave the room or cell for the vast majority of the day, typically 22 hours or more” (DOJ, 2016, p. 3).

Solitary confinement units have heightened levels of restriction and control. Typically, individuals living in restricted housing generally spend at least twenty-three hours in a cell with a mattress, toilet, and sink, exiting their cell for approximately one hour per day, usually for recreation (i.e., yard) or to shower. While in restricted housing, prisoners have little human contact or interaction and suffer other deprivations including limited or no natural light, limited reading materials, limited/no television, radios, or other property (ACLU, 2014). When RHU residents come out of their cells, they are handcuffed and may be shackled at the waist and ankles (Brown et al., 2011). Face-to-face contact is largely severed in RHUs with meal trays being delivered through a slot in the cell door, visits with staff conducted at the cell door, and family visits limited or taken

away and conducted through a window with a telephone. However, in some cases, prisoners in RHUs may be double-celled due to overcrowding (Browne et al., 2011).

Research consistently demonstrates placement in restricted housing has detrimental and harmful health effects. Harmful psychological effects of restricted housing include negative attitudes and affect, insomnia, anxiety, panic, withdrawal, hypersensitivity, ruminations, cognitive dysfunction, hallucinations, loss of control, irritability, aggression, rage, paranoia, hopelessness, lethargy, depression, a sense imminent emotional breakdown, self-mutilation, and suicidal ideation and behavior (see Haney, 2003). In his research, Haney (2003) found alarming prevalence rates, including symptoms of anxiety and nervousness experienced by 90% of the individuals living in the RHUs that he examined; including headaches, lethargy, chronic tiredness, trouble sleeping, feelings of an imminent emotional breakdown, ruminations, irrational anger, oversensitivity to stimuli, confused thought process, and social withdrawal experienced by over 80% of the individuals living in the RHUs he examined. While much research considers the effects of solitary confinement, little work considers collective efficacy and perceptions of safety in these units.

Collective Efficacy

Collective efficacy is a “place” theory traditionally defined as, “The neighborhood’s ability to maintain order in public spaces, such as streets, sidewalks, and parks” (Bernard, Snipes & Gerould, 2010). Collective efficacy consists of, “social cohesion among neighbors combined with their willingness to intervene on behalf of the common good” (Sampson, Raudenbush & Earls, 1997). One caveat regarding this theory

suggests that mutual trust among neighbors must be present for social cohesion and a willingness to intervene to exist. This theory suggests that neighborhoods with high levels of collective efficacy (i.e., high levels of social cohesion, willingness to intervene, and mutual trust) are associated with lower levels of crime. Conversely, areas with high crime associate with low levels of collective efficacy (Sampson et al., 1997; Sampson & Raudenbush, 1999; Morenoff, Sampson & Raudenbush, 2001; Schrek, McGloin & Kirk, 2009). There is evidence suggesting these findings are consistent across locations including internationally, such as Stockholm (Sampson & Wikstrom, 2008), Los Angeles (Burchfield & Silver, 2013), Tianjin, China (Zhang, Messner, & Liu, 2007), and Brisbane, Australia (Mazerolle, Wickes, & McBroom, 2010).

Various disciplines consider collective efficacy beyond criminology. Collective efficacy originated in psychology, and was defined as, “Perceived collective efficacy will influence what people choose to do as a group, how much effort they put into it, and their staying power when group efforts fail to produce results” (Bandura, 1982, p. 143). However, additional multi-disciplinary scholars examine collective efficacy research within health sciences, schools, among adolescents, parenting, and intimate partner violence. Specifically, previous research demonstrates that the existence of collective efficacy is effective in combatting premature mortality, cardiovascular disease mortality, and obesity (Cohen, Inagami & Finch, 2003); bullying in schools (Gendron, Williams & Guerra, 2011); risky sexual behavior among adolescents (Browning, Burrington, Leventhal & Brooks-Gunn, 2008), substance abuse (Erickson, Harrison, Cook, Cousineau, Adlaf, 2012), early sexual initiation (Browning et al., 2005), heightening self-

control (Gibson, Sullivan, Jones & Piquero, 2010), and in combatting intimate partner violence (Browning, 2002; Wright & Benson, 2011).

Although collective efficacy is typically considered in neighborhood settings, Cuhna (2008) argues that prisons in Portugal are extensions of communities and neighborhoods due to the imprisonment of a prisoners' family members, friends, and neighbors, and combines living, working, and leisure spaces, that together forms a symbolic neighborhood. Cuhna (2008) also suggests that prisons no longer involve strangers living together in a space, and that life inside and outside of prison become intertwined, as relationships do not end in prison, but continue to develop. Furthermore, Draus and Lempert (2013) finds that when developing a therapy group through an inside-out program, group members exhibit a shared sense of purpose, and began to trust each other and became more cohesive as a unit. Additionally, Malkin (2016) finds collective efficacy exists in female prisons and that high collective efficacy is possible when correctional authorities are clear about their expectations and standards. Furthermore, Malkin (2016) argues that when respect is present, the likelihood of collective efficacy increases. Similarly, Jiang and Winfree (2009) find that female prisoners have higher social support in prison than males, which reduces rule violations, and are more likely to participate in groups or clubs, which increases social support. Unfortunately, previous research has not extensively considered collective efficacy in prison settings and more specifically, has not considered collective efficacy within RHUs.

Perceptions of Safety

According to the Eighth Amendment of the United States, individuals housed within the department of corrections maintain the right to safety. In *Ruiz v. Estelle* (1980), the United States District Court ruled against the Texas DOC for failing “to furnish minimal safeguards for the personal safety of the inmates” (*Ruiz v. Estelle*, 1980, p.1288). Furthermore, in *Farmer v. Brennan* (1994), the United States Supreme Court upheld rulings that under the Eighth Amendment that prisons must “take reasonable measures to guarantee the safety of inmates,” and that “a prison official’s duty under the Eighth Amendment to ensure reasonable safety” (*Farmer v. Brennan*, 1994, p. 844).

Research considering prisoners’ perceptions of safety is limited (Wolff & Shi, 2009a). Despite prisons being dangerous and violent places, prisoners report feeling generally safe while living there. This dynamic is described as the “safety paradox” (Wolff & Shi, 2009a). In their work, Wolff and Shi (2009a) examined feelings of safety among 7,221 adult male prisoners living in general population by distributing surveys and questionnaires with topics such as quality of life in prison and feelings of safety. These scholars find victimization experiences reduced feelings of safety, with specific victimization experiences such as sexual victimization, having a stronger impact on feelings of safety. Further, these scholars find that those experiencing victimization more recently are the most unlikely to report feeling safe (Wolff & Shi, 2009a).

Wolff and Shi (2009b) also examine individual characteristics, including vulnerability, prior victimization, and psychological disorders and their influence on feelings of safety in prison. These scholars conclude that prisoners with longer sentences

feel safer because they are more adjusted to the prison culture and environment. However, prisoners suffering psychological disorders, such as anxiety, depression, or post-traumatic stress disorder feel more unsafe than individuals without these disorders. Wolff and Shi (2011) also consider the differences between male and female prisoners' feelings of safety. These scholars find that male and female prisoners who experienced victimization felt more unsafe than non-victimized prisoners and that more than two-thirds of prisoners who report being sexually assaulted reported feeling unsafe. However, consistent with the safety paradox, these scholars find that most prisoners felt safe while living in prison.

Chapter Three: Methods

Selected Institutions, Correspondence & Access²

The PA-DOC houses over 47,000 men and women in 24 state correctional institutions throughout the state and employs over 16,000 individuals (PA-DOC, 2018). The PA-DOC consists of three regions: western region, central region, and eastern region. No institutions in the eastern region are included in this study. The selected institutions exclusively house male prisoners, and are all D-Code institutions, meaning that they can house severely mentally ill prisoners. The institutions varied in security level. Three of the institutions have been in operation for over twenty years, while one institution has been in operation for less than ten years.

Prior to data collection, the Principal Investigator (Rudes) contacted the Superintendent's Assistant (SA) at each institution to coordinate the data collection trips (e.g., dates and times). This also allowed the project manager to describe the purpose of the research, the data collection process, the number of RHU residents that the research team planned to interview, and answer any questions or concerns regarding the project. In addition, a project flyer was provided to the SA for distribution to RHU residents and staff.

² This thesis is part of a larger team project. For additional information on methods, see additional works by Dr. Danielle Rudes and Shannon Magnuson.

The plan was to schedule data collection trips throughout the summer. However, the PA-DOC initiated a lock down amongst all prisons in the state, which temporarily postponed our research and delayed our final data collection trip until December. The research team traveled to each institution one time for four consecutive days for a total of four visits or sixteen days of data collection, totaling approximately forty hours in each institution. In total, our team spent 1,017 hours in the field collecting data.

Upon arrival at the institution, our team (usually consisting of six to ten researchers) entered the institution and checked-in with the COs. On the first day of the data collection trip, a small meeting was held with the SA and at least one member of the executive team (e.g., Superintendent, Deputy Superintendents, Major of the Guard, and Major of Unit Management) for introductions, to discuss the project, and to answer any questions or concerns.

Procedure

After meeting with the executive team, the research team was escorted to the RHU. The RHU building consists of four housing pods, three traditional RHUs, and a Diversionary Treatment Unit (DTU), which is a specialized restricted housing unit that houses individuals with severe mental illnesses. After the research team was escorted to the RHU, a member of the research team introduced the other team members and explained the research project and informed consent. The research team then began study recruitment and invited all RHU residents to participate in the research study. Research team members paired together, and a staff member accompanied them to each housing pod and each residents' cell. Upon arriving at each cell door, the researchers introduced

themselves, and one researcher explained the research and informed consent (see Appendix A) and answered any questions that the resident had regarding the research and/or their participation. If they agreed to participate in the research, their name, institution number, and cell room number were written down on a piece of paper and the researcher provided them with a recruitment flyer (see Appendix B) and survey (see Appendix C). After recruitment was complete, the research team developed a list of interested participants and worked with staff to have them escorted from their cells to a location for an interview. While the staff members knew which residents agreed to participate in the research, interviews took place in a secure location where confidentiality was assured, typically, the RHU non-contact visitation rooms. This location allowed the research team to access staff members, but also ensured the confidentiality of the interview.

Interviews lasted roughly 45 to 60 minutes and addressed a variety of topics. Topics relevant to this research included: (1) relationships with other residents and staff in the RHU; and, (2) perceptions of safety while living in the RHU (see Appendix D and E). The interviews were not electronically recorded as electronic devices are not permitted within the institution. Researchers took notes during the interview and added depth and detail to the notes in a private location within the institution upon completion of the interview. This is a common interviewing strategy that allows the interviewer to build rapport and maintain natural eye contact throughout the interview (Tracy, 2019). When the data collection trip was completed, researchers transcribed interview notes into typed Microsoft Word documents for qualitative analysis.

Interviews concluded at 4:00 PM when there were no available staff available to move individuals from their cells to the interview location. The remaining time at the institution allowed the research team to observe the unit and speak with staff.

Research Team Training

This research was a portion of two larger ongoing collaborative research projects lead by Dr. Danielle Rudes at George Mason University's Center for Advancing Correctional Excellence (ACE!), *Together Alone: Organizational Change and Perceptions of Punishment, Risk & Health for those Living and Working in Solitary Confinement*, and *Changing the Hole Mind: Living and Working in Solitary Confinement During Reform* with the Pennsylvania Department of Corrections. Dr. Rudes assembled a team of faculty, graduate, and undergraduate researchers to tackle this research endeavor. Notably, each undergraduate held a position in Dr. Rudes' Undergraduate Research Lab, was paired with one another, and developed their own research project to embark on throughout the summer as they accompanied the research team to data collection trips. As part of this position, undergraduate researchers worked closely with graduate students to learn qualitative research methods and interviewing skills. Prior to the data collection trips, the research team met to discuss each researchers' research and interview questions to create consistency throughout data collection (Hartwell, Rudes & Magnuson, 2019).

Surveys and Interviews

The survey used for this research (see Appendix C) comes from a previous collaborative research effort initiated by Drs. Brandy Blasko and Danielle Rudes at ACE! in collaboration with the PA-DOC. The survey instrument was developed by Dr. Brandy Blasko and encompasses measures from the Prison Environment Inventory (Wright,

1985), Prison Social Climate Survey (Saylor, Gilman & Camp, 1996), English Measurement of Quality of Prison Life (Liebling & Arnold, 2004), and the Working Alliance Inventory (Horvath & Greenburg, 1989). Prior to data collection for the larger project, a research instrument was developed, vetted, and piloted with randomly selected individuals living in five Pennsylvania prisons. Prior to the pilot study, Dr. Blasko hosted a focus at each prison with six prisoners to discuss the survey items, specifically trying to determine if items had confusing wording and if the item captured what the research was trying to measure. The final measures were used in the pilot study. Over a ten-month period, a five-person research team conducted surveys and interviews with prisoners. This pilot study allowed for adjustments to the survey instrument. Throughout the pilot study, minor adjustments were made to the wording of questions, and the measures were proved to be effective. The final survey instrument for this project was eleven pages and took approximately 20 to 30 minutes to complete (Blasko & Rudes, 2014). The survey instrument used for the current research does not include all survey items. Instead, items from specific sections (e.g., demographics, relationships, community, safety, etc.) were selected for the survey since these were related to the research questions. The condensed survey instrument took approximately ten minutes to complete.

Interviews used a semi-structured interview guide, which allowed for informal, conversational style useful for rapport building and greater depth and data yield but guided the interviewer through the relevant topic areas. Specific to this project, three interview questions (see Appendix E) were developed to get additional detail that could not be captured from the survey items. Interviews lasted approximately 45 to 60 minutes.

Additionally, because this research consisted of an undergraduate research team and was part of two larger projects, the interview protocol included research questions from each team's research project.

Analysis Strategy

When the data collection trip was complete, the interview notes were transcribed from handwritten notes into typed documents for qualitative analysis. After completing the transcription, the typed interview notes were linked to ATLAS.ti, a qualitative data management software program. This research followed a semi-grounded approach to data analysis with interview question themes guiding initial coding. Once completed, an open-coding inductive strategy that involved a line-by-line technique was employed to produce a broad set of new themes and details as they emerged organically (Charmaz, 2005). This approach allowed for informed continued data collection in subsequent institutions (Glaser & Strauss, 1967). In addition, survey data was entered into Microsoft Excel and then linked to SPSS, a quantitative data management software program for analysis.

Sample

Within each RHU, there are typically four housing pods. Each institution visited had a DTU, which is a specialty RHU that houses severely mentally ill (SMI) prisoners. A traditional RHU pod can hold approximately one hundred residents, and the DTU can house fifty residents. Every resident in the RHU was sampled and had the opportunity to participate in the study. However, residents were excluded if: (1) they did not have the mental capacity to provide informed consent; (2) they were currently detoxing from a substance; (3) they did not speak English; or, (4) they were self-harming or behaving violently toward staff.

While participation was difficult to predict, based on the research teams' previous research endeavor inside RHUs, it was anticipated that approximately 75% of the residents living in the RHU would agree to participate in an interview and survey. There were 548 residents living in RHUs across the four institutions. 135 residents were unable to participate for reasons such as not being in their cell during recruitment, leaving 413 residents eligible to be surveyed and interviewed. 42 residents refused to participate in the research, and 368 residents agreed, with an agreement rate of 90%. In total, 177 residents were interviewed, a completion rate of 43%. 376 surveys were distributed to residents living in the RHUs, and 304 completed surveys were collected, a response rate of 81% (see Table 2).

Table 2
Research Totals

	I-1	I-2	I-3	I-4	Study Total
Resident Surveys	63	100	76	66	305
Resident Interviews	27	37	50	60	177
Total Hours in Institution	277	192	294.5	253.5	1,017

As shown in Table 3, the average age of interviewed residents was 31 years old, with the youngest interviewed resident being 19 years old, and the oldest resident being 73 years old. The average age of surveyed residents was 33 years old, with the youngest resident being 18 years old and the oldest being 73 years old. 58% ($N=102$) of the interviewed residents were Black, 31% ($N=54$) were White, and 12% ($N=21$) were Hispanic. Approximately 58% ($N=175$) of the surveyed residents were Black, 33% ($N=100$) were White, and 9% ($N=28$) were Hispanic. 75% ($N=132$) of the interviewed residents resided in the RHU while 25% ($N=45$) resided in the DTU. Approximately 79% ($N=241$) of the surveyed residents resided in the RHU and roughly 20% in the DTU. 70% ($N=124$) of the residents had DC status, while 30% ($N=53$) had AC status. The average time spent in prison was approximately nine and a half years and the average reported time spent in the RHU was approximately 67 days. The average time spent in prison was just under three and a half years, with the shortest period being three days and the longest being 47 years. Despite the 90-day maximum sentence to the RHU, the average reported

time spent in the RHU was approximately 140 days, with the shortest stay being one day, and the highest reported stay being 11 years.

Table 3
Demographics

Variables	Interview Participants (N=177)	Survey Participants (N=304)
Age	31	33
Race		
Black	102	175
White	54	100
Hispanic	21	28
Status		
AC	124	-
DC	53	-
Time in Prison (months)	116.10	-
Time in SCI (months)	35.79	36.29
Time in RHU (days)	67.41	93.76
Previous Institutions		
Yes	145	260
No	11	42
Institution		
SCI-1	27	63
SCI-2	37	100
SCI-3	57	76
SCI-4	59	65
Unit		
RHU	132	241
DTU	45	62

Chapter Four: Results

Perceptions of Collective Efficacy in the RHU

Resident Perceptions of Collective Efficacy with Other Residents. To assess perceptions of collective efficacy among RHU residents, residents were asked to indicate their level of agreement (*1=strongly disagree to 4=strongly agree*) with the following questions: (1) “The inmates in this RHU are a close-knit group”; (2) “Inmates in this RHU generally get along with each other;” (3) “The inmates in this RHU share the same values;” (4) “The inmates in this RHU are willing to help each other,” and (5) “The other inmates in this RHU can be trusted.”

Generally, RHU residents disagreed that they were a close-knit group ($M=2.00$, $SD=.81$). 54% of the surveyed residents indicated that they either strongly disagreed or disagreed that residents in the RHU get along ($M=2.39$, $SD=.74$). Additionally, the majority (82%) of residents indicated that residents in the RHU do not share the same values ($M=1.86$, $SD=.74$). These three variables were combined to create a social cohesion sum variable, which was included in the first multiple linear regression model. Further, nearly half of the surveyed residents indicated that they agreed or strongly agreed that residents in the RHU are willing to help each other ($M=2.00$, $SD=.84$). Finally, most surveyed residents indicated that other RHU residents could not be trusted

($M=1.88$, $SD=.70$). Overall, these findings indicate that RHU residents do not feel close to or trust one another, or share the same values, but are willing to help each other.

During interviews, residents were asked to describe their relationships with other RHU residents. Most interviewed residents (58%) described having positive relationships with other RHU residents, whereas 23% described negative relationships with other residents. Seven percent of interviewed residents described relationships that were like a “brotherhood” or “family-like.” One resident notes, “*My relationship with other inmates is like a brotherhood,*” and another described, “*Some of these dudes are like family. I’m a gang member. I’m a known gang member. We help each other. Some of these dudes have life and are more kindhearted and caring than people I’ve met on the streets. A lot of people do fucked up things to each other, but a lot of people help each other.*” Seven residents described conditions of relationships with other residents on the unit, which involved a foundation of respect and trust. For example, one resident described, “*There are maybe five or six inmates I trust and would consider them good friends,*” and another resident described “*Respect is reciprocated. I help people when they need help and just don’t cause or make problems.*”

Additionally, when asked about their relationships with other RHU residents, six percent of the interviewed residents described helping other residents on the unit. To illustrate, one resident described, “*My relationship with the other inmates is fine. I can talk to my cellie about personal stuff. If you need any help, the other inmates will help you out.*” Three residents described helping other residents out by giving them supplies. For example, when asked about his relationships with RHU residents, one resident

described *“I talk to my neighbors. I try to be of assistance, if someone needs paper. The COs won’t give it. We have to learn how to fish it. If I notice someone isn’t eating or pacing in their cell, I’ll ask them what’s wrong.”* Another resident described a resident helping him to read and write, *“I got one guy – nice and cool. Helps me read and he writes it down for me,”* and another described helping other residents with law work.

On the contrary, residents also described conditions in which they did not have relationships with other RHU residents. Four percent of the interviewed residents described not having relationships with other residents because of arguments or “gang war.” For example, when asked about his relationships with other RHU residents, one resident described, *“It’s here or there. One or two people, I talk to. It’s not easy. We have to shout through our vents. Or yell through the door. The other inmates are constantly yelling at the door. It’s lots of arguing for no reason. They just argue.”* Another resident described, *“I don’t have a good relationship with the other inmates, either. It’s a gang war. It’s person against person.”* Lastly, residents described not trusting each other as a reason for avoiding relationships with other RHU residents. One resident mentioned, *“I don’t trust inmates. I don’t trust nobody. The things you experience on the streets. They aren’t in your shoes. They don’t understand.”*

RHU Perceptions of Collective Efficacy with Correctional Officers. To assess perceptions of collective efficacy with correctional officers on the unit, RHU residents were asked to indicate their level of agreement (1=*strongly disagree* to 4=*strongly agree*) with the following questions: (1) “The COs in this RHU get along with inmates;”

(2) “The COs in this RHU share the same values as me;” (3) “The COs in this RHU are willing to help inmates;” and, (4) “I trust the COs in this RHU.”

Most residents disagreed that COs in the RHU get along with residents ($M=1.97$, $SD=.78$). Almost all residents (90%) indicated that they disagreed or strongly disagreed that COs in the RHU shared the same values as residents ($M=1.60$, $SD=.66$). These two variables were combined to create a social cohesion sum variable which was included in the second multiple regression model. Additionally, only 25% of residents indicated that they agreed or strongly agreed that COs in the RHU were willing to help residents ($M=1.95$, $SD=.80$). Finally, 50% of residents strongly disagreed that they trusted the COs in the RHU ($M=1.60$, $SD=.70$). These findings indicate that RHU residents do not trust, feel that they get along, or share the same values with COs, and that COs are unwilling to help residents.

During interviews, residents were asked to indicate if they trusted the COs, and to share a story that made them trust or not trust the COs. The data were coded to understand: (1) Under what conditions does trust exist with COs? and, (2) Under what conditions is trust broken with COs? As displayed in Table 4, there were 62 instances where interviewees discussed conditions of trust and 144 instances where interviewees described conditions of no trust among RHU residents and COs.

Table 4
Conditions of CO Trust in the RHU

Conditions of Trust		Conditions of No Trust	
Category	Percent	Category	Percent
Good Job Intentions	29%	Bad Job Intentions	29%
Respect Residents	21%	Not Respectful	19%
Help Residents	18%	Revenge/Retaliation	10%
Low Use of Force	7%	Lack of Care	8%
Care	5%	Inconsistent	8%
Maintain	5%	Does Not Maintain	6%
Confidentiality		Confidentiality	
Follow-Up/Keep	5%	Not Fair	6%
Word			
Listen	3%	“Cops and Robbers”	6%
Fair	3%	Use of Force	5%
Morality	3%	“Stir the Pot”	2%
Honest	2%	Does Not Help	1%
		Residents	
<i>N=62</i>		<i>N=144</i>	

Most notably, 29% of the conditions of trust involved residents perceiving the officer to have good job intentions, such as “doing their job,” “not messing with food or property,” and providing the resident with supplies and “rights.” This is demonstrated in the following interview excerpt:

Interviewer: You said there are one or two COs you do trust – how are they different?

RHU Resident: The way they carry themselves, they’re helpful, they’re sympathetic, they’re not aggressive, they try to help you get stuff like pens or toothpaste. There are a lot of COs that do shit they’re not supposed to, like bring extra trays. I don’t want them to break rules for me, I just don’t want them to treat me like a scumbag.

However, 29% of the conditions of no trust involved perceptions of bad job intentions, such as “not doing their job,” “losing” property, choosing other officers over residents, or “being burned”. Residents use the term “burned” to describe them not receiving something from an officer that they believe they are entitled to. To illustrate, this is demonstrated in the following interview excerpt:

Interviewer: Do you trust the guards?

RHU Resident: No, absolutely not.

Interviewer: How come?

RHU Resident: Number one, they're cops at the end of the day. I'm a criminal, a convict. It's the natural order. But not only that, they have given me reason time and again not to trust them.

Interviewer: Can you tell me about a time?

RHU Resident: Just last night I got an extra 15 days for refusing a cellie, and I cussed out a cop. I said yes, but that he had to give me an extra tray. I took a cellie and he burned me.

Feeling respected was also important for residents to trust COs. Some of the conditions involved trusting officers if they respected residents (21%). For example, one resident indicated during an interview when asked if he trusted the COs, “*No. The officers in the morning are the only ones that are decent. They give you respect. They're not assholes.*” On the contrary, 19% of the conditions indicated that they did not trust the COs because they were not respectful. For instance, when asked if he trusted the COs,

one resident responded, *“Can’t trust them. Some are okay, but overall they are sneaky. They do not respect the inmates.”*

Residents also reported trusting officers if they were fair (3%) and demonstrated morality (3%). To illustrate, when asked if he trusted officers, one resident responded, *“Yeah. I’ve got a decent relationship with a few. I’m straight up. I wouldn’t say all... some are mean-spirited. Some treat you fairly and have a conscious.”* Six percent of interviewed residents indicated that they didn’t trust officers who they perceived as unfair. One resident mentioned, *“If you take a position of a correctional officer, you shouldn’t turn into an oppressional officer. You should treat people fair.”*

Seventeen percent of the conditions involved trusting officers when they helped residents. When asked why he trusts COs, one resident replied, *“It’s an instinct once you get to know them. Like CO [redacted], he’s been to my door like 60 times. He knows me and my problem and he’s always helping me. He checks on me every round. This morning he asked me if I had seen psych yet.”* Only two of the interviewed residents indicated that they did not trust officers if they did not help residents. For example, when asked if he trusted officers, one resident said, *“None at all. No trust because of the things I’ve seen and heard. I’ve watched someone commit suicide because an officer said he would get help and never did.”*

Perceptions of care were also a condition of trust. Five percent of conditions involved trusting officers if they perceived that the officer cared about them. For example, one resident described, *“I’ve been in this RHU five times. When things like suicide happen, things will tighten for a few days and then go back to normal. For*

example, the officers will actually give psych to people that request it and answer to inmate call buttons. There are about five out of ten guys that generally give a fuck, but the majority don't." On the contrary, eight percent of the conditions of no trust referenced perceptions of officers not caring about residents. One resident indicated, *"They don't care about you. They only care about your paycheck. If I were to fall over in front of medical, they would take twenty minutes to come and check on me."*

Use of force was an important condition of trust. There were four instances where residents indicated that they trusted COs if they didn't frequently use force. For example, one resident indicated, *"They will actually talk to you. They won't hit you with spray."* Five percent of the instances involved residents indicating that they did not trust officers due to use of force incidents. For example, one resident indicated, *"While I was here, I saw a guy getting tackled for really no reason. That had an effect on me. I shouldn't have to be subjected to that and it made me look at guards differently. They might do the same thing to me... That really impacted if I could respect and trust them, and how I feel about my safety here."*

Maintaining confidentiality was another condition of CO trust. Five percent of the instances involved residents indicating that they trusted officers if they maintained their confidentiality. When asked what makes him trust certain officers, one resident described, *"They don't go telling people what you said to them. They ask you how you're feeling and really try to help you."* Furthermore, six percent of instances involved residents describing that they did not trust officers because they did not maintain confidentiality. For example, when asked if he trusted COs, one resident indicated that he

did not and explained, *“There were sometimes where I confided in them and they used that information against me.”*

Additionally, five percent of the instances involved residents reporting trusting officers if they followed-up or kept their word. For example, one resident described, *“If I had questions that I needed answers to, I could call him, and he’d get the answers for me.”* Three percent of the instances involved residents indicating that they trusted an officer if they listened to the resident. One resident described, *“They actually listen and don’t just say yeah, yeah, yeah, and then never come back.”* Lastly, one resident indicated that he trusted officers if they were honest. When asked what makes him trust an officer, he responded, *“They don’t lie, and they don’t disrespect me. If I need something, they tell me, ‘If I can, I will, but I need to check it out.’”*

In addition to perceptions of negative job intentions and lack of respect, ten percent of the instances involved residents indicating that they did not trust officers if they perceived them as revengeful, such as making threats or “messaging” with residents. For example, one resident described, *“I don’t trust the COs. I check my food every time I get it. Some food hurts my stomach... I don’t know if they’re doing stuff to my food.”* Inconsistency was another condition of no CO trust, with eight percent of the instances involving a resident reporting that they did not trust officers because they were inconsistent. To illustrate, one resident indicated, *“I don’t trust any COs. You could be cool one day and not the next. Some of them are okay, but you can’t trust them. I live here, but they ‘got a job to do.’ They could be friendly to you; then have a bad day and now they’re not friendly.”* In addition, six percent of interviewed residents indicated they

did not trust officers because of a “cops and robbers” or an “us vs. them” attitude. For example, when asked why he did not trust the COs, one resident responded, “*Because it’s us against them. There are some COs that can be fair and then there’s COs that abuse their power.*” Lastly, residents described not trusting officers because they “stir the pot,” perceive COs to be petty, or cause trouble and start fights among residents. For example, one resident described, “*The inmates argue every day over what programs to watch on the TV. Everyone wants to watch something different. The COs use the TV as a tool to keep us from communicating with each other... The guards like hearing us fight.*”

Perceptions of Safety

To assess perceptions of safety while living in the RHU, residents were asked about their perceptions of safety both during surveys and interviews. In the surveys, residents were asked to indicate their level of agreement (*1=strongly disagree to 4=strongly agree*) to the following question: “I feel safe in this RHU.” Overall, residents tended to disagree with this statement ($M=1.89$, $SD=.96$). Nearly half (43%) of the residents indicated that they strongly disagreed with this statement, whereas only five percent of residents reported that they strongly agreed that they felt safe.

During interviews, when asked about feelings of safety, 60% of residents told interviewers that they did not feel safe while living in the RHU. Residents were asked to specify why they did or did not feel safe living in the RHU. Based on previous research that considers resident perceptions of safety, it was expected that residents would cite reasons, such as victimization experiences, the prison environment, or being locked down

and restricted. Instead, as displayed below in Table 5, many residents cited correctional officers and residents as the reason they did or did not feel safe while living in the RHU.

Table 5
Conditions of Safety in the RHU

Category	Percent
COs	24% (n=29)
No	79%
Yes	21%
Residents	11% (n=10)
No	40%
Yes	60%
COs & Residents	15% (n=18)
No	44%
Yes	28%
No (COs); Yes (Residents)	11%
Yes (COs); No (Residents)	17%
Increased Security	19% (n=23)
<i>Locked Down</i>	60% (n=9)
No	13%
Yes	40%
Neutral	7%
<i>Restraints</i>	33% (n=5)
No	20%
Yes	13%
<i>Personal Responsibility</i>	7% (n=9)
Yes	100%
Victimization Experience	6% (n=7)
No	100%
Environment	2% (n=3)
No	100%
No Reason Listed	11% (n=14)
Misc.*	12% (n=15)

N=111

Abbreviation: COs=Correctional Officers

**Consists of a combination of categories*

Approximately one-quarter of the interviewed residents cited correctional officers as their reason for feeling safe or not feeling safe in the RHU. Seventy-nine percent of those residents indicated they did not feel safe because of the COs. Many residents indicated that they did not feel safe due to the COs behavior. For example, one resident said, *“You could accidentally step on the COs shoe on the way to the shower and they could rough you up cause they’re having a bad day.”* Residents also expressed being unable to defend themselves in the RHU. To illustrate, one resident said, *“The cops [referring to COs] can whoop my ass for no reason. I’m in cuffs and can’t defend myself. I don’t feel safe knowing they can just pull me out of my cell and do what they did to me.”* Only 3% of interviewed residents indicated that they felt safe because of the COs. One resident mentioned that he felt safe because he trusted the COs, *“I trust the COs, some are stand up guys that want to help you and won’t mess with your food or mail. A good number of guys want to be assholes. They know they have control over you. For the most part, they make me feel safe.”*

Eleven percent of the interviewed residents expressed that other residents made them feel safe or unsafe in the RHU. Forty percent of those residents indicated that they did not feel safe living in the RHU because of other residents. One resident referenced a previous assault as his reason why he did not feel safe around other residents in the RHU, *“A little while ago, an inmate at another prison stabbed a CO in the neck and killed him over a towel – a fucking towel. You never know what these guys are capable of. You even have gang members fighting their own kind. You can’t trust no inmate. The same dude*

that you trust is the same person that will stab you. I've been stabbed in the stomach and head." However, 60% of residents indicated that they did feel safe in the RHU because of other residents. One resident described his cellie and that he feels safe because of him, *"Sometimes I feel safe – depends on my cellie. For the first time ever, I have a cellie. I get along with him, we have good rapport. We got along right away. I trust him fully. I feel safer with him here. If something were to happen to him and I was around, there would be a real big problem. We would battle for each other."*

Fifteen percent of interviewed residents described both residents and COs as the reason they did or did not feel safe in the RHU. For example, the following resident discussed feeling safe around COs but not around other residents, *"They [COs] do their job when they believe a situation will happen. They actually figure out what's going on. They let it play out. I don't feel safe around inmates. Some around only to manipulate,"* whereas another resident described feeling safe around residents but not COs, *"The COs don't really care about us. We mean nothing to them. No COs have ever been abusive though. I do feel physically safe around inmates though, most are friendly towards you."*

Nineteen percent of the interviewees described increased security as their reason for feeling safe or not feeling safe in the RHU. Specifically, residents referenced being locked down, having restraints, or a personal responsibility for their own safety. Sixty percent of those residents indicated that they felt safe because they were locked down, meaning that they could avoid physical contact, or stay in their cell. One resident explained, *"Down here, there isn't any physical contact allowed, so I feel safe. There isn't a chance for physical altercation."* Another resident explained, *"I feel safe because I*

don't have to interact with people, unless I choose to interact." Only one resident expressed not feeling safe due to being locked down, *"I feel safer in GP [i.e., general population] because the COs can't do you dirty if you're locked in. I've never been maced in GP. I wasn't locked in there. I wasn't dependent on them."* Thirty-three percent of the interviewed residents also referenced being restrained as a reason for their feelings for safety. While only one resident expressed feeling safe because other residents were handcuffed, four residents indicated that they did not feel safe because they were restrained. One resident discussed his inability to defend himself when handcuffed, *"You never want to be in a position where you can't defend yourself, and here, you're handcuffed every time you leave the cell. It's hard to feel safe when you're cuffed."* Seven percent of the interviewed residents reported feeling safe and discussed feeling personally responsible for their own safety. These responses included, *"I feel safe because I can protect myself," "I feel safe. I know me. I can take care of myself,"* and *"I feel safe because of me. It boils down to who you surround yourself with. I walk with myself."*

Six percent of interviewed residents referenced past victimization or traumatic experiences that they experienced as reasons why they did not feel safe. For example, one resident discussed being victimized by another resident, *"It's not safe. Maybe at one point, but never again. I get anxiety attacks and the staff knows. It was traumatizing. I don't trust other inmates based on what happened. I couldn't do anything – he crushed me."* Another resident discussed a time when a suicide occurred, *"A guy just killed himself in here a few weeks ago. He was asking for help, but no one helps us. When we see that, it messes with us... makes us feel unsafe."*

Three of the interviewed residents cited the environment as the reason that they did not feel safe, suggesting that they did not feel safe generally because they were in prison. For example, one resident said, *“This is a violent environment, not really safe. Anything can happen. I’m around all criminals. Some don’t care about other people.”* Another resident described, *“It’s prison. You can never really let your guard down. Some of the people in here will do anything to get to the hole, so you have to be careful.”*

Eleven percent of interviewed residents did not specify a reason they did or did not feel safe living in the RHU. Lastly, 12% of residents specified a combination of reasons why they did not feel safe. For example, one resident indicated that he did not feel safe because of his mentality and due to being locked down, *“Physically, I feel safe in here, but mentally, no. We don’t have much contact with staff or inmates, so I’m not afraid of getting hurt, but I’m worried about my mental health. It’s tough in here.”*

The Influence of Collective Efficacy on Perceptions of Safety

Two multiple linear regression models investigate how perceptions of collective efficacy influence feelings of safety among RHU residents. The first model examining perceptions of collective efficacy with other residents and the influence on perceptions of safety and the second model examining perceptions of collective efficacy with correctional officers and the influence on perceptions of safety. Descriptive statistics for all key study variables are provided in Table 6.

Table 6
Mean and Standard Deviations for Study Variables

Variables	Mean	Standard Deviation
Perceptions of Safety	1.89	.96
Perceptions of Collective Efficacy with RHU Residents		
Close-knit group	2.00	.81
Get along	2.39	.74
Shared values	1.86	.74
Willingness to help	2.00	.84
Mutual trust	1.88	.70
Perceptions of Collective Efficacy with Correctional Officers		
Get along with residents	1.97	.78
Shared values with residents	1.60	.66
Willingness to help residents	1.95	.80
Trust correctional officers	1.60	.70
Controls		
Age	33.48	10.33
Race	-	-
Time in Prison (months)	40.14	53.14
Time in RHU (days)	139.58	360.29
Institution	-	-
Unit	-	-

Assumptions were tested by running diagnostic tests for multicollinearity, and examining normal probability plots of residuals and scatterplots between dependent and independent variables to test for linearity, scatterplots of residuals by predicted residuals to test for heteroscedasticity, and a histogram of standardized residuals to test for normality. The diagnostic tests indicate that no multicollinearity exists among the independent variables (see Table 9 in Appendix H), and that there are no violations of homoscedasticity (see Figure 7 in Appendix G) or linearity (see Figure 5 in Appendix G) in the model. Figure 6 (see Appendix G) reveals that RHU resident responses to

perceptions of safety are slightly positively skewed with most residents indicating that they either disagreed or strongly disagreed that they felt safe in the RHU, slightly violating the normality assumption. Since this data is relatively normal, it is not problematic for the analysis. However, as previously discussed, scatterplots reveal that potential outliers exist in the time in prison and time in RHU variables. Before running the regression, these variables were temporarily excluded, and the scatterplots were recreated. However, since there was no significant change in the scatterplots, the cases were included in the analysis. In addition, prior to running the multiple linear regression analyses, correlations between independent variables in the model were examined (see Table 10 in Appendix I).

The Influence of Collective Efficacy with RHU Residents on Perceptions of Safety. A multiple linear regression examines the relationship between perceptions of safety (i.e., dependent variable) and social cohesion, willingness to help, and mutual trust (i.e., independent variables) among RHU residents. This model is statistically significant when compared to the baseline model with intercept only ($F(12,236)=2.170, p=.014$). The R^2 value in this model is .099, suggesting that together, these variables explain approximately 10% of the variance in perceptions of safety. Table 7 displays the results of the multiple linear regression model, including the unstandardized regression coefficients (b), standardized regression coefficients (β), the intercept, and the standard error (SE) for each variable.

Table 7
RHU Resident Perceptions of Collective Efficacy with Other Residents Regressed on Feelings of Safety

Variables	<i>b</i>	β	SE
Intercept	1.689	-	.339
Perceptions of Collective Efficacy with RHU Residents			
Social cohesion sum	-.028	-.050	.044
Willingness to help residents	.012	.010	.087
Mutual trust	.059	.045	.092
Controls			
Age	-.002	-.018	.006
Race (W) †	.528*	.270	.128
Race (H) †	.232	.070	.213
Time in Prison (months)	-.001	-.033	.001
Time in RHU (days)	-9.39E-5	-.038	.000
Unit (DTU) ††	.083	.035	.151
Institution (SCI1) †††	.001	.000	.172
Institution (SCI3) †††	.256	.121	.155
Institution (SCI4) †††	.211	.091	.169
Total Variance Explained	9.8%		

* $p < .05$

$N = 304$

Abbreviation: SE=standard error

† dummy coded; reference group=Black

†† dummy coded; reference group=RHU

††† dummy coded; reference group=SCI2

In terms of individual relationships between the independent variables and perceptions of safety, the only variable that significantly predicted safety was being White ($t=4.137, p=.000$). This finding suggests that White residents have a safety score that is .528 points higher than Black residents. Overall, these results demonstrate that these variables, collectively, are statistically significant in predicting feelings of safety.

The Influence of Collective Efficacy with Correctional Officers on

Perceptions of Safety. An additional multiple linear regression was performed to examine the relationship between feelings of safety and social cohesion, willingness to intervene, and mutual trust with correctional officers in the RHU. This model is statistically significant when compared to the baseline model with intercept only ($F(12,234)=9.251, p=.000$). The R^2 value in this model is .322, indicating that the variables in the model collectively explain approximately 32% of the variance in responses to the safety survey question. Table 8 presents the results of the model, including the unstandardized regression coefficients (b), standardized regression coefficients (β), the intercept, and the standard error (SE) for each variable.

Table 8
RHU Resident Perceptions of Collective Efficacy with Correctional Officers Regressed on Feelings of Safety

Variables	b	β	SE
Intercept	.520*	-	.235
Perceptions of Collective Efficacy with Correctional Officers			
Social cohesion sum	.170*	.229	.053
Willingness to help RHU residents	.190*	.161	.079
Mutual trust	.315*	.228	.095
Controls			
Age	-.007	-.080	.005
Race (W) †	.255*	.128	.116
Race (H) †	.228	.069	.186
Time in Prison (months)	.000	-.024	.001
Time in RHU (days)	.000	-.042	.000
Unit (DTU) ††	.085	.036	.133
Institution (SCI1) †††	-.051	-.022	.143
Institution (SCI3) †††	.163	.074	.138
Institution (SCI4) †††	.046	.019	.149

Total Variance Explained 32.2%

* $p < .05$

$N = 304$

Abbreviation: $SE =$ standard error

† dummy coded; reference group = Black

†† dummy coded; reference group = RHU

††† dummy coded; reference group = SCI2

When examining the individual relationships between the independent variables and perceptions of safety, consistent with the previous model, being White was significantly associated with feeling safer ($t = 2.197$). In fact, White residents have a safety score that is .255 points higher than Blacks, indicating that White residents feel safer than Black residents. In addition, social cohesion with COs ($t = 3.228, p = .001$), CO willingness to help residents ($t = 2.396, p = .017$), and trusting COs ($t = 3.322, p = .001$) were significant in predicting safety. As social cohesion, CO willingness to help residents, and trust increase, RHU residents' perceptions of safety also increase. More specifically, for each additional one-level increase in social cohesion, safety scores increased by .17 points. Additionally, for each additional one-level increase in CO willingness to help residents, safety scores increase by .190 points. Finally, for each additional one-level increase in trust, safety scores increase by .315.

Chapter Five: Discussion

Collective Efficacy in Carceral Spaces

Analysis of survey data from this research demonstrate that residents do not feel close to other residents, trust other residents, or share the same values as other RHU residents, but report that they are willing to help other residents in the RHU. However, during interviews, many residents described having positive relationships with one another. While some residents reported avoiding relationships with residents on the unit, several others described relationships that resembled a “brotherhood” or that were “family-like,” and some residents described helping other residents on the unit. Survey data also demonstrate that residents do not trust COs, feel close, or share the same values as the COs on the unit. During interviews, most residents indicated that they did not trust the COs in the unit. Residents reported trusting officers based on perceptions of the officer’s job intentions. Specifically, residents reported trusting officers when they perceived as officer to have positive job intentions (e.g., “doing their job,” “not messing with food or property,” etc.). On the contrary, residents reported not trusting officers when they perceived the officer to have negative job intentions (e.g., “not doing their job,” “burning” residents, etc.).

Safety in Carceral Spaces

Survey data demonstrate that nearly half of the residents in this sample indicate that they strongly disagree that they feel safe living in the RHU. Additionally, during interviews, almost 60% of the residents told interviewers that they did not feel safe while living in the RHU. Based on previous research that considers feelings of safety, it was hypothesized that residents would cite reasons, such as victimization experiences, the prison environment, or being locked down and restricted as their reasons for their safety. However, many residents cited correctional officers and other residents as the reason they did or did not feel safe in the RHU. In addition, residents also discussed an increased level of security. Some residents reported feeling safe due to being locked down and confined, whereas others reported feeling unsafe because of restraints. Interestingly, a few residents discussed this idea of having a personal responsibility for their safety as in they are responsible for their safety and protection.

Collective Efficacy & Safety in Carceral Spaces

Two multiple linear regression models investigate how perceptions of collective efficacy influence perceptions of safety among RHU residents. The first regression analysis demonstrates that the variables in the model, collectively, are significant in predicting safety. However, the collective efficacy variables were not significant. When examining the individual relationships between the independent variables and perceptions of safety, being White was significantly associated with feeling safer. The second regression analysis demonstrates that together, when controlling for individual and institutional characteristics, perceptions of collective efficacy with correctional officers in the RHU is significant in predicting safety. Consistent with the previous model, being

White was associated with feeling significantly safer. However, in addition, social cohesion, willingness to help residents, and mutual trust were also significant in predicting safety.

It was expected that: (1) residents feel safe while living in the RHU due to a sense of collective efficacy with other residents residing in the RHU and (2) a lack of collective efficacy with COs results in residents feeling unsafe. The results of this research partially confirm the first hypothesis. Although the model is statistically significant in explaining perceptions of safety, more than 90% of the variance in safety responses is not explained by resident perceptions of collective efficacy, indicating that this model does not include key predictors of safety. The second hypothesis was not confirmed. In fact, the analysis suggests that perceptions of collective efficacy with COs more strongly predict perceptions of safety in the RHU than perceptions of collective efficacy among residents in the RHU. In other words, when residents perceive there to be social cohesion with COs, trust COs, and perceive that COs are willing to help them, residents are more likely to report feeling safe. This analysis also reveals that residents who are White feel safer than Blacks and Hispanics while living in the RHU.

Theoretical Implications

Collective efficacy theory is traditionally defined as, “The neighborhood’s ability to maintain order in public spaces, such as streets, sidewalks, and parks” (Bernard et al., 2010), and consists of, “social cohesion among neighbors combined with their willingness to intervene on behalf of the common good” (Sampson et al., 1997). While collective efficacy is traditionally considered in neighborhood settings, the current

research expands upon previous work on collective efficacy theory by considering it in carceral spaces. To the researcher's knowledge, this is the first research endeavor that considers collective efficacy in RHUs.

The results from this research suggest that RHU residents are willing to intervene, despite a lack of mutual trust and social cohesion. These findings refute conclusions from previous research that suggests that mutual trust among neighbors must be present for social cohesion and a willingness to intervene to exist (Sampson et al., 1997). Given the results from this research, collective efficacy may operate differently in carceral spaces. RHUs are highly structured and punitive environments where face-to-face contact with other residents is limited. Additionally, on any given day, residents are moving in and out of the RHU. Given that residents do not have the opportunity for face-to-face contact coupled with residents frequently moving in and out of the RHU, while some residents may get along and share the same values, it is possible that the residents residing there do not have the opportunity to become a socially cohesive group. However, despite the limitations of face-to-face contact, RHU residents find nontraditional methods of communication, such as talking through the vents or cracks in their cell doors, or passing notes and letters using string to other cells.

Furthermore, while little work considers trust in prisons, Liebling and Arnold (2012) found that prisoners were less likely to trust other prisoners when they perceived the relationships to be convenient rather than genuine. Due to the relatively short stays of the majority of individuals living in RHUs, it is possible that the characteristics that Liebling and Arnold (2012) described are exacerbated in the RHU, making it incredibly

difficult for residents to form trust with other residents. Lastly, measuring residents' willingness to intervene is difficult in this environment because residents are physically unable to intervene in incidents when they are locked down in their cell. However, this work demonstrates that residents may intervene in non-physical ways in the RHU. This might involve talking with other residents in the RHU through the cell doors and vents to attempt to deescalate an upset resident, to avoid CO cell extractions, or intervening when residents on the unit are engaging in verbal disagreements.

Collective efficacy theory suggests that neighborhoods with high levels of collective efficacy are associated with lower levels of crime and vice versa (Sampson et al., 1997; Sampson & Raudenbush, 1999; Morenoff et al., 2001; Schrek et al., 2009). While collective efficacy upholds order in public spaces, it should be noted that there are not public spaces in RHUs for residents to freely access and operate within. Therefore, crime cannot occur in public spaces and may need to be conceptualized differently. Individuals in the RHU may engage in "crime" (e.g., destruction of property), however, given the design of the RHU, other residents may not know when residents on the unit are engaging in some types of "crime" because they are in the privacy of their own cell. Therefore, residents may only intervene when an incident may affect the entirety of the unit, and they may intervene before that incident occurs. For example, if a cell extraction were to take place and mace was used, it is possible that other residents may be exposed to the chemical, or perhaps an incident occurs and the officers may not have the manpower to offer shower, yard, or recreation. Ultimately, these conclusions reinforce the importance of mixed-methods research. Quantitatively, the results from this work

demonstrate that collective efficacy is associated with increased feelings of safety.

However, qualitative interview data suggest that the variables that are used to measure collective efficacy cannot be directly applied to carceral settings and need to be explored in future research studies.

In addition to expanding collective efficacy theory, this work also expands research that considers safety in prisons. While previous research has considered feelings of safety in prisons, mostly in general population settings, to the researcher's knowledge, this is the first research endeavor to consider perceptions of safety among individuals residing in solitary confinement.

Previous work on perceptions of safety in prison demonstrates that despite prisons being dangerous and violent, prisoners report feeling safe while living there. This is also known as the safety paradox (Wolff & Shi, 2009a). The current work suggests this may not apply to RHUs. Forty-three percent of surveyed residents and 60% of interviewed residents in this sample indicated that they did not feel safe living in the RHU. Previous research suggests that feelings of safety are influenced by previous victimization experiences (Wolff & Shi, 2009a). Although residents were not directly asked about victimization experiences, only 6% cited a past victimization experience as responsible for their feelings of unsafety. It is possible that few residents described victimization experiences because many living in the RHU reside there alone and therefore do not need to worry about experiencing victimization by other residents during their stay.

In addition, contrary to previous literature that suggests that safety is influenced by the prison environment and victimization experiences, this research adds to that

literature and suggests that perceptions of safety in the RHU, in addition to the environment and victimization experiences, may be influenced by a variety of other factors, including the presence and/or absence of COs and residents, increased security, such as being locked down and/or restrained, or feeling that staying safe is their personal responsibility.

Previous work in disciplines beyond criminology considers the impacts of feeling unsafe. For example, feeling unsafe while living in urban environments was correlated with lower mental health (Guite, Clark & Ackrill, 2006). Additionally, research demonstrates that students who feel unsafe in school have more absences and lower test scores (Lacoe, 2016). Lastly, when individuals residing in inpatient psychiatric units feel unsafe, they are more likely to try to escape (Muir-Cochrane, Oster, Grotto, Gerace & Jones, 2013). Previous work highlights the psychological impacts of being placed in solitary confinement. These psychological impacts include, but are not limited to, negative attitudes and affect, insomnia, anxiety, panic, withdrawal, hypersensitivity, cognitive dysfunction, hallucinations (Haney, 2003). It is possible that the psychological impacts of solitary confinement coupled with feeling unsafe has detrimental short- and long-term impacts that may influence an individual's mental health and overall wellbeing.

Practical Implications

This research provides insight on the conditions of trust in RHUs, specifically under what conditions trust exists and when it is broken with COs. This research has implications for institutional safety. Previous research suggests that trust leads to

legitimacy and is an important characteristic of legitimacy (Franke, Bierie, & Mackenzie, 2010). Legitimacy is traditionally defined as “a quality possessed by an authority, a law, or an institution that leads others to feel obligated to obey its decisions and directives” (Tyler, 2003, p. 208). Given that trust leads to legitimacy, if residents do not trust officers in the RHU, it is possible that they may not perceive the officers as legitimate and are less likely to obey their rules and orders, potentially causing danger to other residents, unit officers and institutional safety. For residents to build trust with unit officers, COs could engage in trust-building approaches, such as exhibiting consistency, giving residents supplies they need or are entitled to, following-up and keeping their word, and avoiding the use of unnecessary force when applicable. By engaging in these trust-building approaches, officers may be perceived as more legitimate and therefore enhance personal, unit, and institutional safety.

The current work provides insight on perceptions of safety among individuals living in RHUs. The findings from this research suggest that COs may not result in residents experiencing heightened feelings of safety. Instead, some residents reported feeling personally responsible for their safety. According to the Eighth Amendment, it is a “prison official’s duty... to ensure reasonable safety” (*Framer v. Brennan*, 1994). During interviews, many residents described not feeling safe due to COs’ physical and verbal behavior, being unable to defend themselves and some described experiencing or witnessing mistreatment. Institutions may consider implementing additional methods or protocols to monitor COs’ behavior, such as ensuring that all spaces in the unit have cameras with audio. In addition, implementing a more effective grievance system may

afford prisoners safety by allowing them to have a voice and witness a CO face repercussions for inappropriate behavior.

Limitations

Having a research team this large yielded a wealth of data. However, a few limitations are notable. Each of the undergraduates, graduate students, and faculty members developed their own interview questions based on their research project. As a result, there were a variety of topics of interest and a lengthy interview protocol. Due to time constraints, it was sometimes impossible to ask the residents all the questions on the protocol or delve into their responses. Additionally, the interviews followed a semi-structured interview guide and did not include the entire interview question. Instead, it included a shorter version of the question to prompt the researcher if they needed guidance during the interviewer. It is possible that some researchers were unable to remember the exact wording of the question or what exactly the researcher was interested in.

Additionally, a notable limitation of the survey data is that the survey did not capture many individual characteristics. For example, prisoners may be placed in RHUs for administrative (e.g., if a prisoner is transgender), protective (e.g., if a prisoner committed a high-profile crime or is a sex offender), or for disciplinary reasons (e.g., if a prisoner assaulted another prisoner or staff, or had contraband) (Browne, et al., 2011). Regretfully, the survey did not ask residents to indicate their RHU status. This is disadvantageous because it is possible that RHU status may influence perceptions of safety and whether they maintain relationships, or trust residents or correctional staff.

Additionally, residents who are in the RHU for protection may report feeling safer because they are in a locked cell away from other residents. Further, individuals residing in RHUs in Pennsylvania also have the potential to be double-celled. The survey did not ask residents to indicate whether they had a cellmate. It is possible that having a cellmate could result in residents feeling safe or unsafe. Additionally, in Pennsylvania, residents are not to be placed in the RHU for more than 90 days. However, if residents are in the RHU for protective or administrative reasons, it is likely that time period will be extended. Additionally, if residents are placed in the RHU for a particularly heinous crime such as murdering another prisoner or correctional officer while in prison, they may be placed in the RHU indefinitely. Also, no information is known about the crimes that residents committed to get a prison sentence and to be placed in the RHU. While this information may have been useful to provide context to the outliers in the time in RHU variable, it is also possible that these may influence feelings of safety while living in the RHU.

Furthermore, a collective efficacy scale was incorporated into the survey. However, collective efficacy in this research was used to understand perceptions of community within the RHU, rather than to examine if collective efficacy reduces crime. Additionally, no previous research indicates that collective efficacy is a perfect measure of community or that it increases feelings of safety. In addition, it is possible that collective efficacy and community may never develop in the RHU, due to the highly secured and punitive structure, limited face-to-face contact, the typical 90-day sentence to the RHU, and residents being processed in and out of the RHU every day.

Implications for Future Research

Solitary confinement research is relatively limited. Due to the highly structured and punitive design of RHUs, they offer an incredibly interesting space to explore collective efficacy and community. Future research should seek to understand collective efficacy and community in these spaces, specifically how collective efficacy and community form given the structure of the RHU, and how collective efficacy and community sustains with residents frequently entering and leaving the RHU. Relevant to collective efficacy, despite residents indicating that they are not close and do not trust each other, they admit they are willing to help one another if in need. Future research should consider what drives a willingness to intervene in these restricted environments. Specifically, future research might seek to address the following questions: (1) What drives collective efficacy in prisons?; (2) What makes a resident trust another resident in the RHU?; (3) Under what conditions do residents intervene in incidents with other residents in the RHU?, and (4) Does collective efficacy decrease “crime” in prisons (e.g., violence, misconducts)?

RHUs and solitary confinement also offer an interesting space to explore safety. In Pennsylvania residents can be in RHUs for a variety of reasons, including disciplinary reasons, or for institutional or personal safety, which may influence their perceptions of safety. Additionally, although some residents have a cellmate, many reside alone. It might be expected that being alone in a confined space may afford additional safety. Specifically, future research might seek to address the following questions: (1) Does living alone or with another resident influence RHU residents’ perceptions of safety?; (2)

What about prisoners/COs in general population and RHUs drives or inhibits perceptions of safety?; (3) How does a resident's RHU status (e.g., AC/DC) impact their feelings of safety?, and, (4) What are the short-term and long-term impacts (e.g., behavioral, physical, psychological) of not feeling safe while living in prison/RHUs?

Chapter Six: Conclusion

While research is beginning to consider solitary confinement and RHUs, previous research has not thoroughly examined perceptions of collective efficacy and safety among individuals living in RHUs. This research demonstrates that RHU residents do not feel close to other residents, trust other residents, or share the same values as other RHU residents, but report that they are willing to help other residents in the RHU.

Additionally, this research demonstrates that RHU residents do not trust COs, feel close, or share the same values as the COs on the unit. During interviews, most residents indicated that they did not trust the COs in the unit. Two multiple linear regression model was employed to investigate how perceptions of collective efficacy influence perceptions of safety among RHU residents. The results demonstrate that when social cohesion, willingness to help, and mutual trust are present with COs, residents report feeling safer.

Further, this research demonstrates that the majority of RHU residents do not feel safe, largely due to COs and other residents in the RHU. In addition, residents also discussed an increased level of security. Some residents reported feeling safe due to being locked down and confined, whereas others reported feeling unsafe because of restraints. A few residents discussed this idea of having a personal responsibility for their safety as in they are responsible for their safety and protection.

This research provides qualitative insights about resident perceptions of collective efficacy among other residents and COs, and perceptions of safety while living in RHUs and demonstrates that a sense of collective efficacy with COs influences residents' perceptions of safety. While additional research is necessary to better understand safety, collective efficacy, community, relationships, and social processes in RHUs, this research encourages a continued focus on understanding safety, relationships, and the dynamics that exist among residents and COs in RHUs. Future research should specifically examine how the absence of relational and community factors, such as social cohesion, willingness to help, and mutual trust affect perceptions of safety.

Appendix A: Consent Form

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Change the Hole Mind: Perceptions of Conditions, Placement and Change for those Living and Working in Solitary Confinement

Principal Investigator: Danielle Rudes, PhD

What is the nature and purpose of this study?

The purpose of this research project is to understand what it is like to live in restricted housing units within prisons undergoing policy changes regarding its use. This project focuses on themes of health, conditions of confinement, support and changes. We will compare your responses with inmates at other prisons in Pennsylvania.

If you agree to participate, you will be asked to complete a survey and participate in an interview.

Why am I being invited to participate in this research study?

You invited to participate in this research because you are incarcerated within the Pennsylvania Department of Corrections and are currently living in a restricted housing unit.

Who is doing the study?

This research is being conducted by Associate Professor Dr. Danielle Rudes from George Mason University.

Where will the study take place?

Research activities will take place at the prison where you are incarcerated.

What will happen in the study and what will I be asked to do?

You will be asked to complete a survey and participate in an interview about your perceptions of your unit's environment, conditions and support. If you choose to participate, the survey will take approximately 10 minutes and the interview will take approximately 35 to 45 minutes.

What are the possible risks and discomforts?

The risks to you as research participant in this study are minimal. The potential risks from participation may involve discomfort or inconvenience.

If at any time you feel uncomfortable, you may choose to end the survey or interview. It is expected that inconvenience will be minimal; however the time commitment may vary, and you may feel this will inconvenience your day. If you do, you can stop the interview at any time or not complete the survey.

If you are upset as a result of this study you should contact your prison psychology department. Your participation is completely voluntary. You may decide at any time not to participate or to terminate your participation. Your decision not to participate will not have negative consequences in terms of your status within the prison. The superintendent of the prison has agreed to be part of this study and to allow inmates to participate with their consent.

How will I benefit from participating in this study?

You will not receive any financial compensation for your participation in this research and there is no direct benefit to participants. At the end of the study, all prisons will be provided with a summary of the research findings. By participating in this research, you may help inmates in a similar position to yours in the future. You also may find this research interesting.

What information will be collected about me and who will have access to that information?

As part of this research, you are asked to complete a survey and participate in an interview. Your responses in the survey and interview will remain confidential unless you tell us that you want to hurt yourself or someone else. If you tell the researchers that you want to hurt yourself or someone else, the researchers must report this to the licensed psychologist on staff. Nothing will be shared with other inmates or prison staff that could link responses or information to you. The prison staff may know who participated in the study but the data collected during the interview will not be shared with them. A password-protected computer will store interview data. We will record demographic information about you (race, age, length of time in prison/solitary, etc.) but we will assign this information a unique identifying number and will keep it in a separate file within a

password protected computer. Only the Principal Investigator and their research staff will have access to the data.

All documents and information pertaining to the research study will be kept confidential, unless required by applicable federal, state, or local laws and regulations to be disclosed. It is also possible that the agencies approving this research will want to do an audit—that is, check to see that the study was done properly. If they do an audit, records and data generated by the study may be reviewed by George Mason University and its agents and/or governmental agencies to assure proper conduct of the study and compliance with regulations. The results of this study may be published, but only aggregate data will be published. You will not be identified by name and no information will be released that can be attributed to any individual.

What will happen if I choose not to participate or decide to withdraw from the study?

Your participation in this research is entirely voluntary. Even after you state you understand and verbally consent to participation, you may change your mind and withdraw from the study at any time. Your decision not to participate or to stop participating will not have any negative effect on your future interactions with the investigators or with George Mason University. Your decision will have no effect on your current or future status with the Pennsylvania Department of Corrections, including parole decisions.

What if I have questions or want to provide additional information?

Before you decide whether to take part in this study, please ask any questions that come to mind. Later, if you have questions about any aspect of the research, you can contact Dr. Danielle Rudes. If you would like to provide any additional information that was not covered in interview, you may correspond with us by phone or mail at any time. Please be aware that the information you share with us via phone or mail can and will be used in our study unless you specify that you do not want us to use this information. We welcome any questions about our study and any additions to our research.

Danielle Rudes, Ph.D.
George Mason University
4087 University Drive, Suite 4100
Fairfax, VA 22030

(703) 993-6021

If you have any questions about your rights as a research subject, you may contact the Institutional Review Board at George Mason University by telephone at 703-993-4121 or by regular mail at:

Institutional Review Board (IRB) Office
George Mason University
4400 University Drive, MS 4C6
Fairfax VA 22030.

If you have read this form and all of your questions have been answered by the research staff, please verbally let the researchers know if you agree to participate in this study or not.

Appendix B: Recruitment Flyer



CENTER FOR ADVANCING CORRECTIONAL EXCELLENCE at GEORGE MASON UNIVERSITY

In coordination with PA-DOC's Secretary Wetzel, researchers from George Mason University are interested in understanding more about non-general population housing units and what they look like day-to-day. The PA-DOC is interested in trying to make positive changes for both inmates and staff, and to do this, George Mason researchers will be observing various units and interviewing both inmates and staff.

Their goal is not to interfere with your unit, but to learn from inmates and staff about how it operates. Your participation in the research is completely voluntary and the information you provide will not be shared with prison officials.

Although researchers often study inmates and sometimes correctional staff, no research currently examines how non-general housing units work in practice and how living and/or working on these units impacts both inmates and staff. Your participation and voice in this research is really important.

If you have any questions now or after the researchers' visit, you may contact the person in charge of this research:

Danielle Rudes, Ph.D.
George Mason University
4087 University Drive, Suite 4100
Fairfax, VA 22030
(703) 993-6021



Appendix C: Survey

We appreciate you taking time to complete this questionnaire. Below are a series of questions, please fill in or circle the answer that best meets how you feel about each statement. Please ensure that your handwriting is legible.

Demographics

How long have you lived in this jail?	Years:	Months:	Days:		
How long have you lived in this unit?	Years:	Months:	Days:		
Have you lived in any other Pennsylvania prisons before this one (circle)?	Yes	No	If yes, which ones:		
On average, how many hours do you talk to prison staff each day (circle)?	8+ hours	6-7 hours	4-5 hours	2-3 hours	1 hour or less
In a few sentences, how would you describe this unit?					

Relationships

*Please circle **ONE** answer that best represents how much you agree or disagree with each statement.*

I respect the COs in this RHU.	Strongly Agree	Agree	Disagree	Strongly Disagree
I trust the COs in this RHU.	Strongly Agree	Agree	Disagree	Strongly Disagree

I trust some COs in this RHU, but not all COs.	Strongly Agree	Agree	Disagree	Strongly Disagree
Some COs are easier to deal with than others.	Strongly Agree	Agree	Disagree	Strongly Disagree
The COs in this RHU are fair.	Strongly Agree	Agree	Disagree	Strongly Disagree
The COs in this RHU treat me with respect.	Strongly Agree	Agree	Disagree	Strongly Disagree
Some of the COs in this RHU do not treat me with respect.	Strongly Agree	Agree	Disagree	Strongly Disagree
Some of the COs who work in this RHU are not fair.	Strongly Agree	Agree	Disagree	Strongly Disagree
COs in this RHU care about my well-being.	Strongly Agree	Agree	Disagree	Strongly Disagree
The COs in this RHU give me the opportunity to express my views before making a decision about me.	Strongly Agree	Agree	Disagree	Strongly Disagree

Community

*Please circle **ONE** answer that best represents how much you agree or disagree with each statement.*

The inmates in this RHU are a close-knit group.	Strongly Agree	Agree	Disagree	Strongly Disagree
The inmates in this RHU are willing to help each other.	Strongly Agree	Agree	Disagree	Strongly Disagree
Inmates in this RHU generally don't get along with each other.	Strongly Agree	Agree	Disagree	Strongly Disagree
The inmates in this RHU do not share the same values.	Strongly Agree	Agree	Disagree	Strongly Disagree
The other inmates in this RHU can be trusted.	Strongly Agree	Agree	Disagree	Strongly Disagree
The COs in this RHU are a close-knit group.	Strongly Agree	Agree	Disagree	Strongly Disagree

The COs in this RHU are willing to help inmates.	Strongly Agree	Agree	Disagree	Strongly Disagree
COs in this RHU generally don't get along with inmates.	Strongly Agree	Agree	Disagree	Strongly Disagree
The COs in this RHU do not share the same values as me.	Strongly Agree	Agree	Disagree	Strongly Disagree

Improvements

Please circle ONE answer that best represents how much you agree or disagree with each statement.

The environment in this prison needs improvement.	Strongly Agree	Agree	Disagree	Strongly Disagree
The culture in this prison needs improvement.	Strongly Agree	Agree	Disagree	Strongly Disagree
The relationships between COs and inmates could use improvement.	Strongly Agree	Agree	Disagree	Strongly Disagree

Environment

Please circle ONE answer that best represents how much you believe each statement is a problem in your unit.

How much of a problem is excessive use of force by staff in this RHU?	A big problem	Somewhat of a problem	Not a problem
How much of a problem is lack of trust between inmates and staff in this RHU?	A big problem	Somewhat of a problem	Not a problem

Disciplinary Action

Please circle ONE answer that best represents how much you agree or disagree with each statement.

Disciplinary action is taken against staff in response to incidents of staff violence against inmates.	Strongly Agree	Agree	Disagree	Strongly Disagree
When disciplinary action is taken against the staff member in response to incidents of violence against inmates, the action is not enough.	Strongly Agree	Agree	Disagree	Strongly Disagree

Your Safety

I feel safe in this prison	Strongly Agree	Agree	Disagree	Strongly Disagree
I feel safe in this RHU.	Strongly Agree	Agree	Disagree	Strongly Disagree

In a few sentences, please describe why you feel safe or unsafe in this RHU:

Appendix D: Interview Coversheet

**PARTICIPANT (I) INTERVIEW
FOCAL AREAS & QUESTIONS**

Please use this form for each of your interviews. Once you return to campus, please enter the data from this form into the data management spreadsheet.

INMATE NAME: _____

INMATE STUDY ID NUMBER: _____

DATE: _____

Demographics

State Correctional Institution (circle one): **MUN**

Participant's Unit (circle one): **RHU** **DTU**

Status (circle one): **AC** **DC**

(approx.) Length of Time in DOC: _____ Converted to months:

(approx.) Length of Time in this SCI: _____ Converted to months:

Other SCIs participant lived in (list):

(approx.) Length of Time in RHU/DTU: _____ Converted to days:

Other RHU/DTUs participant lived in (list):

Participant's Race (circle one): **Black** **White** **Hispanic** **Other**

Participant's Age (in years) _____

Appendix E: Interview Protocol

FULL INMATE INTERVIEW QUESTIONS

Relationships & Safety

Do you trust the COs? Why/why not? Can you tell me a story about why or why you do not trust the COs in this unit?

What are your relationships like with other inmates living in this unit?

What about the **COs** makes you feel safe/unsafe while living in this unit? What about the inmates makes you feel safe/unsafe?

Appendix F: Scatterplots of Independent and Dependent Variables (cont.)

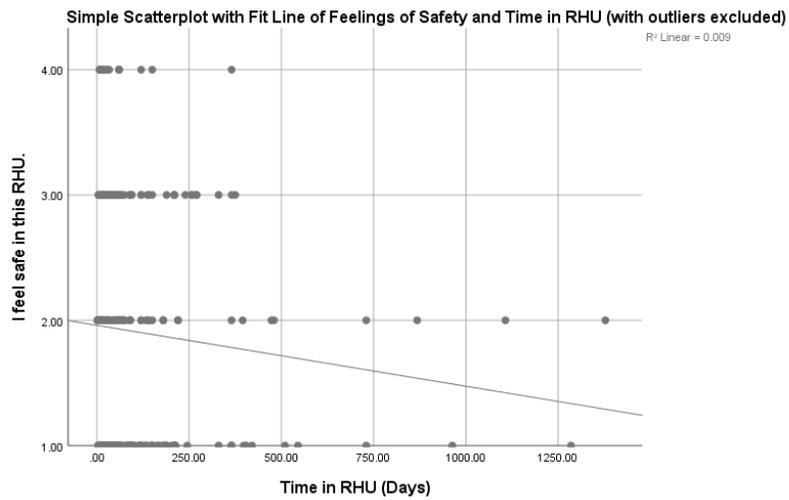


Figure 2. Simple Scatterplot with Fit Line of Feelings of Safety and Time in RHU (with outliers excluded). This scatterplot resembles a similar relationship when the outliers are excluded, with feelings of safety decreasing as time in the RHU increases. Although these outliers alter the regression line, since they do not change the direction of the relationship, these cases are included in the analysis.

Appendix F: Scatterplots of Independent and Dependent Variables (cont.)

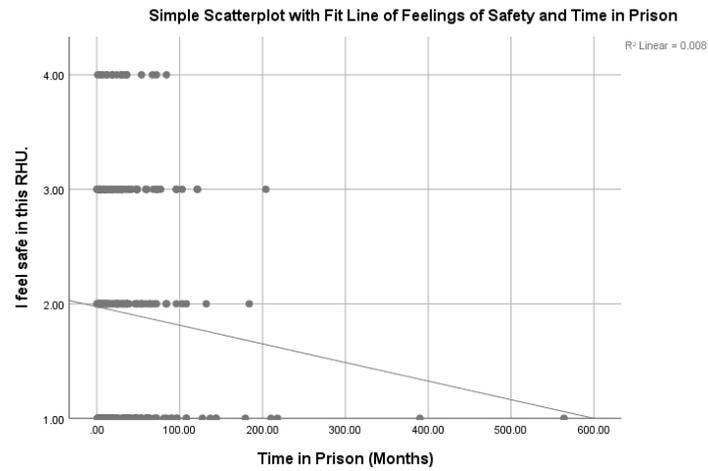


Figure 3. Simple Scatterplot with Fit Line of Feelings of Safety and Time in Prison. This scatterplot demonstrates that as time in prison increases, feelings of safety while living in the RHU decreases. It is possible that this relationship is driven by two outliers. One resident reported living in the RHU for close to 47 years, and another reported living in the RHU for approximately 32 years.

Appendix F: Scatterplots of Independent and Dependent Variables (cont.)

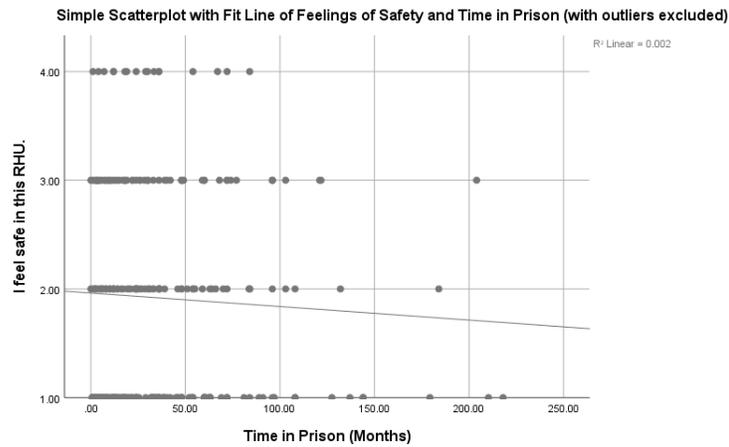


Figure 4. Simple Scatterplot with Fit Line of Feelings of Safety and Time in Prison (with outliers excluded). This scatterplot resembles a similar relationship when the outliers are excluded; as time in prison increases, feelings of safety while living in the RHU decreases. Although these outliers do shift the slope of the regression line, but do not change the direction of the relationship, the cases are included in the analysis.

Appendix G: Tests of Multiple Linear Regression Assumptions

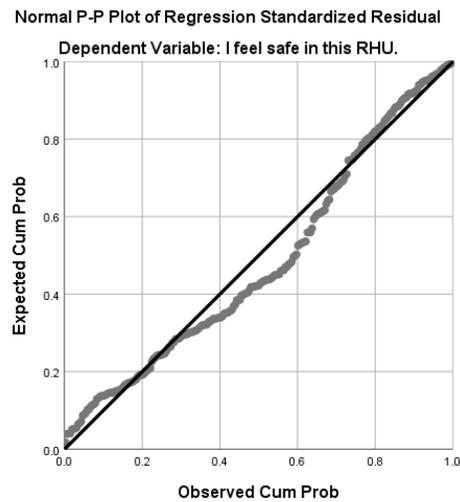


Figure 5. Probability Plot of Standardized Residuals. This probability plot of standardized residuals demonstrates that a linear relationship exists among the dependent and independent variables in this data set, meeting the linearity assumption of the multiple linear regression.

Appendix G: Tests of Multiple Linear Regression Assumptions (cont.)

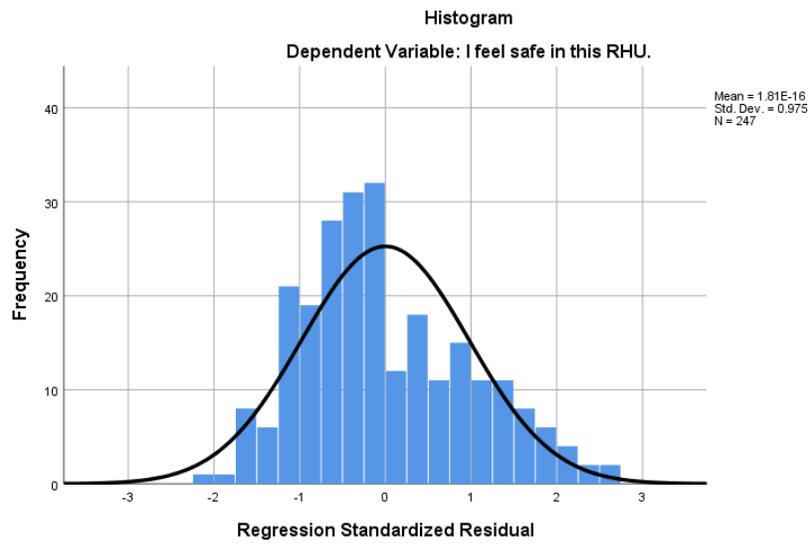


Figure 6. Histogram of Standardized Residuals. This histogram of standardized residuals is to test the normality assumption. It is evident that the distribution is slightly positively skewed. However, since these residuals largely conform to the normal distribution, the normality assumption is not violated for this analysis.

Appendix G. Tests of Multiple Linear Regression Assumptions (cont.)

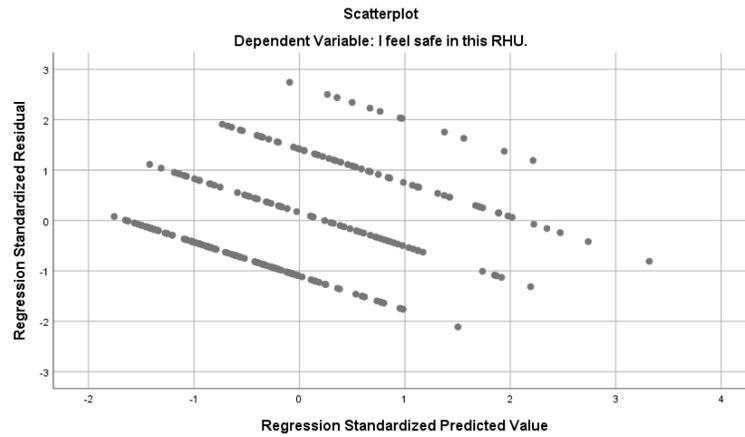


Figure 7. Scatterplot of Standardized Predicted Values and Residuals. To test for heteroskedasticity, a scatterplot of standardized residuals and predicted values was created. This scatterplot demonstrates that heteroskedasticity is not a problem in this analysis, indicating that no violations of homoscedasticity are present in the model.

Appendix H. Tests of Multiple Linear Regression Assumptions

Table 9
Multicollinearity Diagnostics

Variable	Tolerance	Variance Inflation Factor (VIF)
Model 1. RHU Resident Perceptions of Collective Efficacy with Other Residents Regressed on Feelings of Safety		
Social Cohesion	.608	1.644
Willingness to Help	.607	1.620
Mutual Trust	.770	1.298
Age	.856	1.168
Race (W)	.891	1.122
Race (H)	.905	1.105
Time in Prison	.843	1.186
Time in Restricted Housing	.815	1.227
Unit (DTU)	.949	1.054
Institution (SCI1)	.743	1.347
Institution (SCI3)	.715	1.398
Institution (SCI4)	.717	1.394
Model 2. RHU Resident Perceptions of Collective Efficacy with Correctional Officers Regressed on Feelings of Safety		
Social Cohesion	.578	1.729
Willingness to Help	.639	1.564
Mutual Trust	.614	1.629
Age	.844	1.184
Race (W)	.851	1.174
Race (H)	.909	1.100
Time in Prison	.939	1.194
Time in Restricted Housing	.824	1.213
Unit (DTU)	.936	1.068
Institution (SCI1)	.753	1.328
Institution (SCI3)	.737	1.357
Institution (SCI4)	.721	1.387

‡sum variable

† dummy coded; reference group=black
†† dummy coded; reference group=RHU
††† dummy coded; reference group=SCI2

Appendix I. Correlations Among Independent Variables

Table 10
Correlations Among Independent Variables

	Get Along†	Close- knit Group†	Share Values†	Social Cohesion ‡†	Help†	Trust†	Get Along‡†	Share Values‡†	Social Cohesion ‡††	Help‡†	Trust‡†	Safety†
Get Along†	1											
Close-knit Group†	.247**	1										
Share Values†	.325**	.187**	1									
Social Cohesion‡†	.729**	.699*	.698**	1								
Help†	.317**	.570**	.276**	.550**	1							
Trust†	.217**	.312**	.295**	.409**	.340**	1						
Get Along‡†	0.025	0.061	0.114	0.092	0.022	0.04	1					
Share Values‡†	-0.033	-0.029	.245**	0.089	0.006	0.122*	.461**	1				
Social Cohesion‡††	-0.002	0.029	.204**	0.111	0.024	0.103	.880**	.828**	1			
Help‡†	0.001	.173**	0.067	0.108	.196**	0.079	.512**	0.341**	.503**	1		
Trust‡†	-0.014	0.049	0.076	0.05	0.063	.133*	.445*	.426**	.508**	.518**	1	
Safety‡†	0.006	-0.014	0.045	0.022	0.015	0.067	.456**	.342**	.461**	.442**	.409**	1

‡ sum variable

† among prisoners

‡† among prisoners and COs

*correlation is significant at the .05 level

*correlation is significant at the .01 level

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Biography

Taylor N. Hartwell received her Bachelor of Science in Criminal Justice and Psychology from York College of Pennsylvania in May of 2017. She is currently enrolled in George Mason University's Criminology, Law & Society doctoral program, and intends to graduate in May of 2022.