

Perspectives of people with mental health problems at hot spots: Attitudes and perceptions of safety, crime, and the police

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People who live in places with high levels of crime and disorder are more likely to experience mental illness compared with those who do not live in these types of place (Weisburd et al., 2018; Weisburd & White, 2019). The increased police presence on high crime streets may also increase the likelihood that these individuals will encounter law enforcement. There is a strong body of literature focused on the relationship between neighborhoods and the physical and mental health of residents (e.g. Arcaya et al., 2016; Duncan & Kawachi, 2018; Leventhal & Brooks-Gunn, 2003), but there are very few studies that look at the perceptions of people with mental illness directly, particularly as they relate to the environment of the street on which they live and attitudes toward the police. In turn, existing studies generally look at the most serious mental health problems (e.g. schizophrenia), ignoring more common mental health concerns such as post-traumatic stress disorder (PTSD) and depression. This paper uses self-report data from a large in-person survey of people who live on crime hot spot and non-hot spot streets in order to assess attitudes among a broader group of persons with mental health problems. Furthermore, we examine the interaction between living in crime hot spots and non-hot spots and perceptions of these residents. Our findings in this broader sample confirm earlier studies that identify greater fear and less trust of the police among persons with mental illnesses. At the same time, our findings suggest that fear of crime

and perceptions of police are moderated by living in a crime hot spot.

1 | INTRODUCTION

Scholars have long attempted to understand how neighborhood residents are affected by crime by using residential surveys to capture perceptions of the neighborhood (Wilson-Genderson & Pruchno, 2013). Some studies have found that resident perceptions of crime and safety are influenced by individual characteristics, such as race and socioeconomic status (see Sampson & Raudenbush, 2004), while other research has found that residents' perceptions of crime, disorder, and safety in their neighborhood are related to official crime levels (Quillian & Pager, 2001; Sampson & Raudenbush, 2004).

Research has also found that neighborhood context plays a role in perceptions of police. Specifically, communities that have higher levels of crime tend to have more negative opinions of the police (Haberman, Groff, Ratcliffe, & Sorg, 2016; La Vigne, Fontaine, Dwivedi, & Center, 2017; Weitzer & Tuch, 2005), although perceptions of police can vary even within a community (Schafer, Huebner, & Bynum, 2003; Thurman & Reisig, 1996). A few studies have looked at perceptions of the police by specific populations, including arrestees (White, Mulvey, & Dario, 2016), minorities (Peck, 2015), LGBTQ individuals (Satuluri & Nadal, 2018), and crime victims (Koster, Kuijpers, Kunst, & Van der Leun, 2016). Not surprisingly, overall, these studies have shown that individuals who have negative experiences with the police are less likely to trust them and see them as less procedurally just.

Despite the interest in examining various resident perceptions about crime and about the police, few studies examine perceptions of police by people with mental illness (PMI). Those that do generally focus on individuals with serious mental illnesses such as schizophrenia (Livingston et al., 2014), even though most individuals who have mental health problems and live in the community have disorders such as depression or anxiety. Further, most of this research looks at larger scale geographies, such as communities or census units (e.g. census block groups or tracts), rather than micro-geographies, such as streets. This paucity of research is unfortunate, since people with mental health problems may not only perceive crime, safety, and the police differently (cf. Newman, 1994; Yanos, Felton, Tsemberis, & Frye, 2007), but they are also more likely to live in, and be affected adversely by, the particular environments where these issues are more prevalent (Latkin & Curry, 2003; Ross, 2000; Weisburd et al., 2018; Weisburd & White, 2019).

These observations suggest the value of exploring perceptions of residents with mental health problems regarding their safety, crime, and the police, both in terms of individual factors and in a micro-geographic context. This paper uses self-report data from a large in-person survey of people who live on crime hot spot and non-hot spot streets in order to assess attitudes among a broader group of persons with mental health problems. Furthermore, we examine the interaction between living in crime hot spots and non-hot spots and perceptions of these residents. Our findings not only contribute to understanding how a unique population perceives the street they live on, they also inform us on how police departments can improve their relationships with members of the community, specifically those with mental health problems. Given the current turmoil in community-police relations, gaining a better understanding of perceptions of the police, particularly among those who are at greater likelihood of police contact, can provide insight into how certain groups perceive the police and how the police can use this understanding to develop strategies.

1.1 | Police contact with PMI

The role of a police officer long ago shifted beyond crime and safety concerns. Modern police officers are called upon to address a growing number of community concerns, particularly as the availability of other community

services have declined. This is particularly true for issues of mental health. Police are frequently the first point of contact for PMI (Lamb, Weinberger, & DeCuir, 2002). These encounters frequently occur when a citizen is having a mental health crisis and other citizens call the police to respond. Scholars who have explored the relationship between the police and contacts with PMI have referred to the police in these situations as “gatekeepers” (Lamb et al., 2002), a “major mental health resource” (Teplin, 1983), “frontline responders to mental health emergencies” (Steadman, Deane, Borum, & Morrissey, 2000), and most famously “street-corner psychiatrists” (Teplin & Pruett, 1992).

In 1998 an examination of calls for service in 174 US police departments (that had more than 100,000 citizens) found that approximately 7% of all police contacts involved a person thought to have a mental illness (Deane, Steadman, Borum, Veysey, & Morrissey, 1999). These encounters typically occur when police are called for low-level types of offense or nuisance behaviors such as loitering and panhandling, and not serious criminal offenses (Green, 1997; Teplin, 1984). This means that police are encountering these individuals often, but usually in “low stakes” situations that are not violent in nature. Furthermore, despite the research that has shown that these individuals are more likely to hurt themselves than others (Federal Bureau of Investigation, 2018), police officers may still perceive a potential dangerousness to themselves, particularly if they do not recognize that a person has a mental illness.

Though it is widely acknowledged that police officers are now the primary response to individuals in the community with mental health issues who need help (particularly those having a crisis; see Lamb et al., 2002), most officers are undertrained or lack any training on how to handle encounters with these individuals (Bittner, 1967; Franz & Borum, 2011; Lamb et al., 2002). The lack of training in conjunction with officer concerns for their own safety during these encounters means that individuals with mental illnesses are likely to have a fraught relationship with law enforcement (Borum, Williams Deane, Steadman, & Morrissey, 1998; Patch & Arrigo, 1999; Watson, Swartz, Bohrman, Kriegel, & Draine, 2014). This tension is not ideal for members of this fragile community, as they rely on law enforcement to keep them safe. It also presents challenges for officers who may struggle to perform their jobs without community support and cooperation.

1.2 | Geographic context

Studies have consistently found that crime is highly concentrated on a small proportion of city streets (see Telep Cody & Weisburd, 2018). These findings have been found for crime generally (e.g. see Weisburd, 2015; Weisburd, Hinkle, Famega, & Ready, 2011) and also with specific types of crime such as drug markets (Weisburd & Green, 1995; Weisburd & Mazerolle, 2000), juvenile crime (Weisburd, Morris, & Groff, 2009), gun violence (Braga, Papachristos, & Hureau, 2014), and mental health related calls (White & Goldberg, 2018). Furthermore, a recent study found that individuals who live in violent crime hot spots are more likely to have depression and/or PTSD (Weisburd et al., 2018; see also Weisburd & White, 2019). Because residents who live in crime hot spots are more likely to have mental health problems and come into contact with the police, it is important to examine their perceptions specifically. Haberman et al. (2016) examined perceptions of police by residents who lived in hot spots of crime and found that respondents who were younger and more educated had the least amount of satisfaction with the police, and respondents who perceived more social disorder or were more fearful of crime saw the police as more procedurally unjust. To date, there has been no research that looked at the perceptions of residents with mental illnesses who live on crime hot spot streets.

1.3 | Resident perceptions

The ability of police to carry out their jobs successfully is directly predicated on how they are perceived by the public they are serving. The police rely on the community to call the police to report crimes; if the community does not

respect officers or is afraid of them, they may be less likely to be cooperative, which may affect the effectiveness with which the officers can carry out their job (Tyler, 1990, 1997; Tyler & Huo, 2002). Thus, it is important to examine the personal characteristics of residents, because these attributes and prior experiences may form their current perceptions and behaviors.

While there is a body of research that has examined how police officers view PMI they encounter in the community (Cooper, McLearn, & Zapf, 2004; Wells & Schafer, 2006), there is little research on how PMI view the police (Livingston et al., 2014). It is critical to get both perspectives to ensure that policies are created that make residents feel comfortable and safe with the police, as well as to ensure police can do their jobs successfully and without incident. Research on residents' perceptions of the police may inform policies and programs that not only make sure the police are better prepared for these interactions, but will also divert citizens out of the criminal justice system and into the mental health system. For example, people with depression tend to see their neighborhood in a negative way (Watkins, Martin, & Stern, 2000) and be more sensitive to stressors (such as social disorder). As a result, they may be more likely to evaluate their neighborhood as more problematic (Harkness & Monroe, 2006).

Research that focuses on the perceptions of the police from the perspective of people with mental health issues is limited. The few qualitative studies that have been conducted are with smaller samples, with subjects who were in crisis or had a self-reported diagnosis of severe mental health problems, or with subjects directly recruited from psychiatric wards and intensive support units (Jones & Mason, 2002; Livingston et al., 2014; Watson, Angell, Morabito, & Robinson, 2008). For example, Livingston et al. (2014) used a community-based participatory research (CBPR) protocol to examine perception of the police in Canada. They interviewed 60 individuals who were involved in mental health centers and agencies in Canada who also identified as having a current diagnosis of schizophrenia, schizoaffective disorder, other psychosis, or bipolar disorder and who also had previous contact with the police. Overall, participants reported interactions with police as common, and overall their perceptions of the police were more positive than negative. While this study provides perspectives from PMI, the sample is small and limited to individuals with serious mental illnesses; it does not reflect the experiences of people with more common mental illnesses such as depression and PTSD.

Another small exploratory study was done in Australia with subjects in an acute adult inpatient mental health unit who were involuntarily committed there as a result of police contact. It evaluated perceptions of the police of persons who had contact with a special unit of the police department that involved a co-response with police officers and a mental health professional compared with the perceptions of people who experienced a traditional police response (Furness, Maguire, Brown, & McKenna, 2016). The authors found that those who had interactions with the co-responder teams had high ratings of procedural justice, but both groups had equitable perceptions of coercion. Again, this study is limited by a small sample size and the unique sample type (individuals who were involuntarily committed), and the fact that all respondents' opinions of police coerciveness were colored by the fact that they were involuntarily committed.

The only study done to date of which we are aware that compares the perceptions of the police by PMI with those by the general public is that by Desmarais et al. (2014), which used the 2009 Canadian General Social Survey (GSS); they also examined the role of police contact within the last year. The authors matched individuals who were identified as having a mental illness with those who did not based on sociodemographic factors. The results of the comparison were that, while PMI were more likely to have had contact with police in the previous year, they still generally had favorable opinions of the police, although slightly less favorable than the general population. While this study provided a first look at perceptions of police by PMI, the subjects self-identified as having a mental illness and were not screened or diagnosed as having one, and the comparison between the groups was not based on actual geographic proximity, but based on sociodemographic similarities and whether they lived in small rural areas or large urban areas.

Finally, while there has been a growing body of research that shows the importance of micro-geographic units in the production of crime problems, there is little research on the perceptions of people with mental health problems living in crime hot spots. What we do know about perceptions of crime, safety, and the police has focused on large

geographical units, which are much larger than the streets people live on. An ongoing research program ongoing at George Mason University, on which we rely here, provides the first data we know of on mental health outcomes at this geographic level (Weisburd et al., 2018; Weisburd & White, 2019).

Therefore, this paper addresses two research questions.

1. How do people with mental health problems perceive crime, safety, and the police as compared with those without such problems?
2. Among those with mental health problems, do perceptions vary between residents who live in hot spots of crime compared with those who do not?

2 | METHODS

This paper uses data from a large, longitudinal study carried out in Baltimore, MD (National Institutes of Health grant number 5R01DA032639-03, 2012). The specific data used in the current study come from residential surveys collected on 449 street segments (both block faces on a street between two intersections) between April and December 2017. The sampling of the street segments involved a multistage clustered sampling design beginning with a population of 25,045 street segments. Streets were identified as violent crime hot spots, drug crime hot spots, combined drug/violent crime hot spots, or cool/cold using Baltimore City Police Department calls for service data for 2012. Calls types were categorized as being either violent, drug, or other and then geocoded using a geolocator and shapefile from the Baltimore City Police Department; there was a 97.6% match rate (85% match score and side offset of 20 feet and end offset of 3%).¹ Furthermore, only street segments with 20 or more occupied dwelling units were included, since the study was focused on residential streets, reducing the sample to 4,630 street segments.² All of the street segments in the crime hot spots samples (violent, drug, or combined) were within the top 3% of all city segments for either violent or drug crime calls for service.³ Cold spots were defined (after sampling) as streets with three or fewer crime calls for drug or violent crime, and the remaining non-hot spot streets are defined as cool spots. The final sample of street segments consisted of 47 cold spots, 100 cool spots, 121 drug hot spots, 126 violent hot spots, and 55 combined drug and violent hot spots.⁴

Once the street segment sample was identified, field researchers visited the streets and conducted a census of occupied dwelling units (e.g. apartment buildings, row houses, stand-alone homes) to provide a sampling frame of residential dwelling units. The viable households were then randomized, and the field researchers were given a random sample of them to complete face-to-face surveys with. The first resident the field researcher encountered at the dwelling unit who was at least 21 years old and who had resided on the street for at least 3 months was eligible to participate in the survey. The goal was to collect at least seven surveys from each street. The contact rate during the third wave was 87.9% and the cooperation rate was 58%.⁵ The total final sample was 3,139 surveys from 449 street segments.

¹All administrative calls were removed from the data prior to geocoding the calls for service.

²This criterion was used in order to allow a large enough sampling frame to achieve a goal of 7–10 survey respondents on each street examined.

³The initial threshold for violent and drug crime was 18 drug calls and 19 violence-related calls, respectively (approximately the top 2.5% of segments in the city for each category). Although this was the final threshold for the combined violent and drug crime hot spots, to meet sampling goals for streets that were hot spots of violence or hot spots of drug crime the threshold was reduced to 17 violent calls and 16 drug crime calls respectively (approximately the top 3% of all city street segments in that category). We also required that streets evidence drug or violent crime throughout the year by setting a criterion that calls be spread across at least 6 months. In our sampling frame of residential streets (4,630), 284 were classified as violent crime hot spots, 248 as drug crime hot spots, and 98 as combined drug and violent hot spots, and 4,000 were comparison street segments.

⁴A complete and detailed write up of the methodology for the project is available online (<http://cebcp.org/wp-content/cpwg/NIDA-Methodology>).

⁵The contact rate was calculated by dividing those households with contact by eligible households, and the cooperation rate was calculated by dividing households with a completed survey by households with contact.

2.1 | Measures

2.2 | Mental health measures

The mental health of the respondents was assessed using two symptomology scales that capture symptoms of depression and post-traumatic stress disorder (PTSD). There are a number of reasons why depression and PTSD were selected as measures of mental health in community members. First, individuals with depression are found more widely in the community compared with other people with other types of serious mental illness that may result in in-patient hospitalization (Tannenbaum, Lexchin, Tamblyn, & Romans, 2009). Additionally, the prevalence rate of American adults with depression and PTSD is much higher than the rate for other types of mental illness. The National Institute of Mental Health found that 7.1% of American adults had a major depressive episode in the previous year and 3.6% of US adults had PTSD in the previous year, compared with incidence rates of 2.8% of bipolar disorder and 0.33% to 0.75% of schizophrenia (among non-institutionalized persons) in the previous year (NIMH, 2018). Lastly, these specific scales are often used and well established in identifying individuals with these two disorders, meaning that experts studying mental illness also use them in their own research and these papers would be comparable to studies in the same area (Cameron, Crawford, Lawton, & Reid, 2008).

2.2.1 | Depression

The depression symptomology scale used is the well established and often used PHQ9, which consists of nine items (Kroenke, Spitzer, & Williams, 2001). There is evidence that supports the reliability and validity of the PHQ-9 as a measure of depression for the general public (Kocalevent, Hinz, & Brähler, 2013). The questions ask respondents about their mood and behaviors in the past 30 days, with responses of 0, not at all, 1, several days, 2, more than half of the days, and 3, almost every day. The final score is based on the summation of the scores of the nine questions; score ranges are categorized into levels of depression (minimal depression, score 1–4, mild depression, 5–9, moderate depression, 10–14, moderately severe, 17–19, and severe, 20–27; $\alpha = 0.859$). These cutoffs were created based on the recommendations of the scale itself (Kroenke et al., 2001). Individuals with scores higher than 10 were given the binary outcome as “yes” for depression, as that is the accepted cutoff, though scores of more than 15 typically indicate probable major depression (Kroenke et al., 2001).

2.2.2 | PTSD

Post-traumatic stress disorder (PTSD) was identified using a seven-symptom screening scale developed by Breslau and colleagues and is based on the symptomology presented in the DSM-IV (Breslau, Peterson, Kessler, & Schultz, 1999). In order to be given the screener, respondents were first asked, “At any time in your life, have you experienced a traumatic life event such as abuse, an act of violence, or a serious accident?” and if they answered yes, they were then given the screener. Like the depression screener, the PTSD screener asked questions about behaviors and feelings from the past 30 days; respondents could answer “yes” (1) or “no” (0) to whether or not they had experienced things such as lack of interest in activities or hyperarousal. The “yes” responses indicated a “1” and the scores were then summed to create a score out of 7 ($\alpha = 0.818$); scores of 4 or higher indicated that a person met the screening criteria for probable PTSD as recommended by previous studies (Breslau et al., 1999; Kimerling et al., 2006). Individuals with a score of 4 or higher were given the binary outcome of “yes” for PTSD.

2.2.3 | Perceptions of the police—Legitimacy and procedural justice

Respondents were asked how strongly they agreed (1, strongly disagree, to 4, strongly agree) with 14 statements about the police on their block; these 14 statements were broken into two scales (police legitimacy, $\alpha = 0.539$, and procedural justice, $\alpha = 0.945$). The statements used for each scale are drawn from previous research on procedural justice and police legitimacy (Sunshine & Tyler, 2003; Tyler, 2006; Tyler & Huo, 2002). For example, residents were asked how strongly they agreed with statements such as “in general, police care about problems on your block,” “people’s basic rights are well-protected by the police on your block,” “police officers treat people fairly,” and “the police take time to listen to people on your block.” For each scale, we summed the scores across the items and divided by the number of valid responses to create a mean score for each individual, ranging from 1 to 4. The mean score for procedural justice was 2.60 and that for legitimacy was 2.79. Responses to each item were also re-coded as bivariate for comparisons across the groups, where strongly agree and agree = 1 and strongly disagree and disagree = 0.

2.2.4 | Feelings of safety

The survey asked respondents to report on their feelings of safety about the block they live on; items were rated from strongly disagree (1) to strongly agree (4) ($\alpha = 0.820$). The items were taken from the Crime Displacement and Diffusion Study (Weisburd et al., 2006). The scale items are “It is safe for children to play outside on your block,” “In general, it is safe to walk on your block at night,” “You are afraid of being attacked on your block (reverse coded),” “You are worried that someone will break into your home (reverse coded),” “It is safe for you to go outside alone during the day,” “You are worried about drugs on your block (reverse coded),” and “Most people think your block is becoming more dangerous (reverse coded).” Again, a mean score was created for the scale; the mean score for the entire sample was 2.87. Responses were re-coded as dichotomous, where strongly agree and agree = 1 and strongly disagree and disagree = 0.

2.2.5 | Fear of crime

To assess fear of crime and risk victimization on their street, respondents were asked how worried they were (from very worried (1) to not worried (3)) about the following items: “Someone breaking into your home,” “Somebody threatening to take money or property from you,” “Someone attacking you on your block,” “Somebody breaking into your car [if applicable],” “Someone damaging or vandalizing your property,” and “Somebody sexually assaulting you” ($\alpha = 0.870$) (Weisburd et al., 2011). The mean score for the five-item scale was 1.27. Responses were re-coded as dichotomous, where very worried/somewhat worried = 1 and not worried = 0.

2.3 | Analysis

The purpose of the current study is to assess differences in fear of crime, feelings of safety, and perceptions of the police between people with depression and/or PTSD and those who do not meet criteria for depression or PTSD,⁶ and to compare the responses among those with depression and/or PTSD across different types of crime hot spot, as contrasted with cold and cool spots. For the binary variables (individual survey items) we performed chi-square

⁶We also had questions that identified whether the respondents had ever been diagnosed with schizophrenia or bipolar disorder, though we could not identify when such diagnoses were made. To make sure that our results would remain consistent if these subjects were excluded, we ran Tables 1 and 2 without these subjects. The results vary little from the full sample tables.

tests, and for the mean score outcomes we used *t*-tests to identify significant differences in responses between the sample with depression and/or PTSD and the rest of the sample. To compare responses on the mean scores across the five street segment types, we used one-way analysis of variance (ANOVA).

3 | RESULTS

3.1 | Sample description

Table 1 presents a summary of the sample characteristics of survey participants and compares residents with depression and/or PTSD as identified by our screening assessments ($n = 388$) to those who did not meet our screener criteria ($n = 2,753$).

In both samples, the majority of respondents were black females with a high school diploma or some college experience. The sample of respondents with depression and/or PTSD was slightly younger, with an average age of 43.7, compared with the general sample, which had an average age of 48.2. About half of the sample with depression and/or PTSD were not working at the time of the survey (51.1%), compared with 24.8% of the general sample who reported being unemployed. Disparity between the two groups was also reflected in the difference of yearly household income: over 80% of the sample with depression and/or PTSD made less than \$40,000 compared with less than 70% of the general sample.

3.2 | Comparisons of perceptions between people with mental health problems and general sample

Table 2 presents affirmative responses to each of the items that make up the four scales—feelings of safety, fear of crime, police legitimacy, and procedural justice. In agreement with studies that sampled larger geographic units, respondents who were identified as having depression and/or PTSD have significantly different perceptions on each of the scales, and on most of the individual survey items, compared with respondents who did not have these mental health problems. Respondents with depression and/or PTSD reported feeling less safe, had higher levels of fear of crime, and reported lower levels of police legitimacy and lower levels of procedural justice compared with the sample without mental health problems. For example, in regard to perceptions of crime and fear of crime, 76.8% of the general sample agreed that “In general it is safe to walk on your block at night” compared with 59.9% of the sample with depression and/or PTSD, and when asked whether they had a fear of someone breaking into their home 29.3% of the sample without depression and/or PTSD responded affirmatively compared with 48.4% of the sample with depression and/or PTSD. Some of the items that highlight the differences in opinions of the police include agreement with “In general police officers treat people with respect” (depression/PTSD sample 54.6% versus general sample 70.9%), “The police take time to listen to people on your block” (depression/PTSD sample 51.1% versus general sample 70.6%), and “People’s basic rights are well protected by the police on your block” (depression/PTSD sample 48.2% versus general sample 71.3%).

3.3 | Comparison of perceptions of people with mental health problems by segment type

A one-way ANOVA was performed to compare the differences in responses of only those with depression and/or PTSD by street segment type (hot spots and cool and cold spots). Table 3 presents the results of the

TABLE 1 Sample characteristics^a

	Depression/PTSDn = 388 (12.4%)	No Ddepression/PTSDn = 2753 (87.6%)
Gender***		
Male	32	39.9
Female	68	60.1
Race		
White	17.0	16.9
Black	73.2	75.8
Other	9.8	7.3
Age: M (SD)***	43.7 (14.6)	48.2 (16.7)
Education level**		
Some middle or high school	24.5	16.7
High school diploma	33.6	36.6
Some college	25.3	22.2
Associates degree	4.7	5
Bachelor's degree	6.2	11
Master's degree or professional degree	5.7	8.7
Employment status***		
Full time	24.8	43.2
Part time	11.1	10.8
Not working	51.4	24.8
Retired	7.8	18.2
Other	4.9	2.9
Income***		
Less than \$10,000	40.9	21.9
Between \$10,001 and 25,000	30.4	23.1
Between \$25,001 and 40,000	10.6	22.8
Between \$40,001 and 60,000	9.2	14.9
Between \$60,001 and 80,000	5.3	7.3
Between \$80,001 and 100,000	2.3	3.6
More than \$100,000	1.3	6.4

^aPercent within each sample. The total number of respondents used in this analysis is 3141.

** $p < 0.01$; *** $p < 0.001$.

ANOVA, including the mean and standard deviation of each scale by hot spot. The feelings of safety scale and the procedural justice scale are the only scales that showed significant differences in responses among segment types. Notably, feelings of safety were highest for residents who lived on cold (2.89, SD = 0.50) and cool (2.80, SD = 0.50) streets and lowest on combined (2.54, SD = 0.63) hot spot streets. Procedural justice levels were highest on cold streets (2.67, SD = 0.40) and lowest on cool (2.27, SD = 0.61) and drug (2.27, SD = 0.55) streets.

TABLE 2 Affirmative responses to scales

	No mental illness	Mental illness
	%/mean (SD)	%/mean (SD)
Feelings of safety	2.89 (0.46)***	2.70 (0.55)***
It is safe for children to play outside on your block***	83.3	70.4
In general it is safe to walk on your block at night***	76.8	59.9
It is safe for you to go outside alone during the day***	85.9	73.1
You are afraid of being attacked on your block***	75.4	60.6
You are worried that someone will break into your home	94.6	92.7
You are worried about drugs on your block***	69.2	53
Most people think your block is becoming more dangerous***	71.2	53.2
Fear of crime	1.26 (0.44)***	1.49 (0.57)***
Someone breaking into your home***	29.3	48.4
Somebody threatening to take money or property from you***	17.3	28.3
Someone attacking you on your block***	14.4	29.5
Somebody breaking into your car***	36.2	57.4
Someone damaging or vandalizing your property***	22.3	39.9
Somebody sexually assaulting you***	8.5	17.1
Police legitimacy	2.79 (0.34)***	2.73 (0.38)***
People should obey the law even if it goes against what they think is right***	89.5	81.6
I always try to follow the law even if I think it is wrong	90.8	89.6
Disobeying the law is rarely justified	58.3	58.6
It is difficult to break the law and keep your self-respect***	63.8	54.2
If a person is doing something and a police officer tells them to stop they should stop even if they think what they are doing is legal***	92.8	87.8
The police have too much power***	39.3	25.8
Procedural justice	2.63 (0.51)***	2.34 (0.58)***
In general the police do a good job preventing crime***	63.8	46.6
The police are dishonest***	57.3	41.4
Police officers treat people fairly***	65.2	44.7
The police do a good job controlling drug activity***	52.9	36.9
The police can be trusted to make decisions that are right for your block***	63.5	45.2
In general the police care about problems on your block***	64.1	46.3
The police do a good job enforcing traffic laws***	72.5	57.6
In general police officers treat people with respect***	70.9	54.6
The police take time to listen to people on your block***	70.6	51.1
Police make decisions based on facts and the law and not their own personal opinion***	62.9	44.4
Peoples basic rights are well protected by the police on your block***	71.3	48.2
I am proud of the police on my block***	62.5	40.3
I have confidence that the police can do their job well***	69.6	52.3

To measure the differences between binary outcomes we used a chi square test. To measure the differences of scale outcomes we used t-tests.

*** $p < 0.001$.

TABLE 3 Respondents with mental illness by hot spot type

Segment type					
Cold (n = 22)		Cool (n = 79)	Drug (n = 100)	Violent (n = 134)	Combined (n = 53)
Mean (SD)					
Feelings of safety*	2.89 (0.50)	2.80 (0.50)	2.66 (0.51)	2.70 (0.57)	2.54 (0.63)
Fear of crime	1.49 (0.55)	1.46 (0.49)	1.45 (0.56)	1.46 (0.56)	1.71 (0.72)
Police legitimacy	2.75 (0.33)	2.76 (0.33)	2.66 (0.39)	2.77 (0.42)	2.71 (0.34)
Procedural justice*	2.67 (0.40)	2.27 (0.61)	2.27 (0.55)	2.40 (0.61)	2.31 (0.53)

* $p < 0.05$.

4 | DISCUSSION AND CONCLUSIONS

The goal of this article was to examine the perceptions of crime, safety, and the police among individuals who self-reported mental health problems, particularly depression and/or PTSD, and to compare their perceptions with those of members of their community who did not report similar problems with mental health. A further goal was to see if perceptions varied for the residents with mental health problems if they lived on a street that had high levels of crime. This study is the first that we are aware of that specifically examined the perceptions of police and community safety from the point of view of individuals struggling with depression or PTSD. In agreement with studies conducted on higher geographic units, the findings suggest that people with mental health problems not only are more fearful of crime and their safety, but also perceive the police as less legitimate and less procedurally just, as compared to residents without such mental health problems. Importantly, the level of criminal activity on the respondent's street plays a significant role in perceptions of procedural justice and feelings of safety.

Thus, one key implication of our study is that the specific street on which a person with mental health problems lives is an important factor in predicting residents' perceptions of crime and safety. As noted above, our study is consistent with studies using communities and larger geographies, where people with mental health problems differ in perceptions from those without. At the same time, such perceptions are significantly impacted by the type of street on which people live. Living in a crime hot spot increases fear (presumably because the risk of harm is higher) and decreases evaluations of procedural justice (perhaps because police pursue more aggressive strategies in such places). These results emphasize the importance of taking into account the micro-geographic context in understanding perceptions.

More generally, our findings reinforce the idea that residents with mental health problems have more negative perceptions of the police and therefore may be apprehensive about cooperating with the police and more likely to be at risk for victimization. While these findings confirm results from prior studies, they also provide new information, because we studied more common and less serious mental health issues than those studied earlier. Based on these data, it is clear that differences observed for serious mental health outcomes also apply to a sample focused on depression and PTSD.

These findings have important implications for policy and theory. A first implication is the need for improving relations between the police and PMI, which has increasingly been a focus of scholarship (Steadman et al., 2000; Teplin, 1984; Wood & Watson, 2017). This goal is important not only for its own sake, but also because the police rely on the public's cooperation to do their jobs, including carrying out investigations (Tyler, 1990, 1997; Tyler & Huo, 2002).

To improve the interactions between police and PMI (and thereby hopefully improve police effectiveness), programs have been developed that train officers on how to deal with PMI, and that train mental health care workers as a resource for officers. An example of the former type of program is the Crisis Intervention Team (CIT). CIT has improved police crisis response and training (Teller, Munetz, Gil, & Ritter, 2006; Watson et al., 2008) and is

considered the “gold standard” for police response to mental health crises, given to its ability to affect officers' knowledge, attitudes, and comfort in dealing with PMI (Watson, Compton, & Draine, 2017). Another type of program that may help improve the relationship between police and PMI in the community involves establishing teams of police officers and mental health clinicians that are paired to respond to calls, in what is commonly referred to as a “co-responder model” (Lamb, Shaner, Elliott, DeCuir, & Foltz, 1995; Reuland, 2010). A more recent proactive version of the co-responder model was tested in Baltimore City, where a police officer and mental health professional proactively visited crime hot spots in attempt to connect residents to health (White & Weisburd, 2017). All of these approaches have the potential to enhance police relationships with residents with PMI, heighten feelings of safety, lessen fear of crime, and build trust with the police (see White & Weisburd, 2017). A second, related implication of our research has to do with our findings regarding hot spots. Rosenbaum (2006) argues that living on a hot spot street can cause residents to perceive their neighborhood more negatively and impact feelings of safety within these communities. Our data support Rosenbaum's thesis regarding people with mental health problems. Additionally, previous research has found that living in or near crime hot spots can result in negative mental health outcomes (Weisburd et al., 2018) for residents compared with those who live on cool or cold streets. If residents do not feel safe, they are likely to withdraw from their communities, which can result in a decrease in informal social control and an increase in crime and disorder (Weisburd et al., 2011; Wilson & Kelling, 1982). As social withdrawal has been found to be concurrent with depression in some individuals already (Alfano, Joiner, & Perry, 1994), the additional stress of living in a high crime hot spot may cause individuals to withdraw even further from their neighborhoods and social support systems, potentially leading to negative health effects and worsening of mental health.

One practice that may halt this cycle of negative perceptions affecting behavior and potentially leading to increased criminal activity is to focus on building relationships among neighbors, particularly between those with mental illnesses and those without them. This focus on community building may provide a variety of positive outcomes for all residents on a street (see Gill, Wooditch, & Weisburd, 2017), a form of crime prevention through informal social control but also a form of social support for residents with mental health problems. Future research should expand this line of inquiry in order to further understand the complexities of this dynamic, and how different people interact with their environment and how this effects their mental health and wellbeing.

Though this study takes advantage of a distinct dataset that provides insight into this unique population, we want to note limitations in our study. First, our study is an exploratory descriptive study. We did not seek to control out and identify causal factors in producing perceptions, we simply set out to identify those perceptions in a unique study sample. Second, the definition of “mental illness” in this study is limited to the screening tools available at the time the survey was administered. While these tools are commonly used to identify individuals with mental illnesses, they are meant to screen for depression or PTSD at that point in time; our method did not necessarily capture individuals who have a lifetime prevalence of either problem that is currently dormant. Further, the potential for misdiagnosis was not insignificant, since assessments were not by a trained clinician. Our study was also limited to those persons who, as identified through this method, had depression or PTSD, not other mood or anxiety disorders. It is possible that disorders that affect a person's sense of reality, such as schizophrenia, have a different and more extreme effect on a person's perceptions of their safety and environment.

Overall, this study confirms prior studies that show that mental health status plays a role in how people perceive crime, safety, and the police. At the same time, we were able to replicate the findings of prior studies in a broader sample of people with mental health problems. We also found that living in crime hot spots can have significant impact on perceptions of people with mental health problems. These findings reinforce the importance of police and other community actors paying specific attention to people with mental health problems. They also suggest the key importance of recognize the micro-geographic context in which these problems play out. We should be focusing on not only who the person is, but also where they live, in trying to address these problems. Mental health plays a role in how we perceive the world around us, especially as it relates to our safety. Police departments need to pay particular attention to members of this population to ensure not only that they feel safe where they are living, but also that they are comfortable and willing to work with police officers should the need arise. Understanding how PMI perceive

their communities and those tasked to protect and serve them has major implications for not only police departments but also the quality of life of residents

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