Fear of crime, mobility and mental health in inner-city London, UK

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Abstract

This paper examines the relationship between fear of crime and mental health, and assesses the role interventions may have in helping overcome any negative impact arising from this fear. The data were gathered over a 2-year period in the Gospel Oak neighbourhood of North London using in-depth interviews, focus groups and participant observation. The data are analysed primarily by comparing the impact of fear of crime across sub-groups notably divided by gender, age and mental health status. It was found that fear of crime had a disproportionately negative impact on certain sub-groups, most notably low-income mothers, and to a lesser extent the mentally ill. They experienced what we term “time-space inequalities” as a consequence of fear of crime and other related factors. These inequalities describe variation in the ability to access and utilise different times and spaces within both the immediate and the wider environment. These have negative behavioural and affective consequences that appear to impact on overall mental health. They restrict spatial and temporal movement deterring protective social activity, health-promoting community involvement and use of services. Affective consequences include negative mood and low self-esteem. These inequalities were experienced less in other groups such as mentally healthy men or middle-income women. They appeared to be diminished by interventions that encourage spatial and temporal movement. These include comprehensive local transport, government-issued free travel passes for vulnerable populations and neighbourhood community safety measures such as the installation of CCTV. We suggest that experience of time–space inequalities may be damaging to mental health and that interventions which lessen them may help prevent, ameliorate or shorten episodes of mental illness.

Keywords: Fear of crime; Qualitative; Urban health; Mental health; London; UK

Introduction

Policy interest in how factors particular to urban environments can affect health has recently been revived by governmental and non-governmental organisations alike. The World Health Organisation (1994) has instigated an intervention known as “Healthy Cities” for urban areas where a series of health-promoting initiatives are taken to improve health. In the UK the British Government has introduced a similar intervention known as “Health Action Zones” (Department of Health, 1998). Ongoing government rhetoric acknowledges...
the role social and environmental conditions can play in the aetiology of health outcomes, British Prime Minister Blair recently remarked:

Depression is a particular concern, which costs lives and affects quality of life. We can achieve goals…but only if we tackle the underlying social, economic and environmental conditions as well as specific causes (Dawson & Tylee, 2001).

Though the policy climate may have recently shifted, there has been a long historical tradition in public health research of investigating the role factors specific to urban environments can play in determining health outcomes (Ashton & Seymour, 1998). This tradition may be more prominent in research on physical health, though there is a smaller amount of historical evidence suggesting a relationship with mental health. For example Faris and Dunham (1939) demonstrated an association between urbanicity and schizophrenia in Chicago in an early seminal study. They found a “doughnut effect”, with greater prevalence of schizophrenia downtown than in the outer suburbs. More recent studies have shown that people with schizophrenia still tend to live in socially deprived areas (e.g., Logdberg, Nilsson, Levander, & Levander, 2004). One ever-present issue in these type of studies regards direction of causality; i.e., does living in a deprived area cause mental health problems or does the experience of mental health problems cause suffering individuals to drift to deprived areas? It has been argued that socio-environmental factors prevalent in urban areas, such as fear of crime, directly worsen residents’ mental health (e.g., Freeman, 1984). However, little empirical attention has recently been paid to the relationship between fear of crime and mental health outcomes. One of the few notable exceptions is a British neighbourhood longitudinal case study that found a drop in fear of crime correlated with a drop in rates of anxiety and depression (Halpern, 1995). This drop was ascribed to a comprehensive urban regeneration programme that put an emphasis on community safety. Halpern likened the collective effect of fear of crime that was observed at the beginning of his study to individual phobic/anxiety neuroses in that it immobilises behaviour and stunts affect leading to social withdrawal. In a similar longitudinal study, Dalgard and Tambs (1997) found that improvement in social and physical characteristics of different Oslo neighbourhoods correlated with collective improvement in mental health. More recently Chandola (2001) found that fear of crime in the UK was associated with self-rated health (a variable presumably combining elements of physical and mental health) even after adjustment for notable individual and household-level risk factors.

In light of the paucity of studies, the present paper attempts to explore the relationship between fear of crime and mental health. As this is an under-researched area, we decided to adopt an open-ended qualitative approach by an ethnographic exploration of fear of crime in the neighbourhood of Gospel Oak, London, UK. This allowed us to make an in-depth examination of our field of interest, giving us the opportunity to construct a theory that may be tested by others. Relevant issues raised in both the social psychiatry and criminology literature drove our design and methodology. Despite many points of commonality, these two literatures stand largely unconnected. Thus the present paper not only draws its theoretical basis from these two sources, but also attempts to add to them, aiming to bridge the two in a manner accessible and relevant to both criminology and social psychiatry.

As mentioned, the small amount of social psychiatry literature exploring crime as a risk factor suggests that fear of crime can negatively influence mental health, and that increases in community safety may have a positive influence on mental health. However mechanisms of effect remain unestablished, and it is unknown whether specific sub-groups’ mental health suffers disproportionately. Thus a key aim of the present paper is to explore these two issues. Related to this, we also examine which, if any, interventions, appeared to promote mental health by reducing fear of crime.

With regard to the vast criminology literature, most survey evidence suggests that certain sub-groups in the city, most notably women and older people, experience more fear of crime in the public sphere than others (Lindstrom, Merlo, & Ostergren, 2003; Maxfield, 1987; Yodanis, 2004). However qualitative evidence has suggested that fear of crime in older people (Pain, 1995, 1997a) and women (Gilchrist, Bannister, Ditton, & Farrall, 1998; Stanko & Hobdell, 1993) may have been significantly over-estimated or mis-conceptualised. In a review of the literature, Pain (2001) notes that relations between fear of crime and the social identities of age and gender are exceedingly complex and that there are no easy answers to many questions current in this area of criminology. In light of this uncertainty in the criminology literature, as well as the gap in the literature of social psychiatry, a key aim of the present study is to qualitatively compare the impact of fear of crime among men and women, as well as younger and older adults. This is in line with recent research in public health suggesting that women and older people may be particularly at risk of negative factors associated with neighbourhood context (Ellaway & Macintyre, 2001; Macintyre, Ellaway, & Cummins, 2002).

As a qualitative study, the present paper does not attempt to establish comparable rates of fear of crime in sub-groups. Furthermore, it does not attempt to explain fear of crime. This study is primarily anchored in social
psychiatry. Therefore its most significant aim and novel contribution is its assessment of the impact of fear of crime on mental health, per se and by sub-group. We were primarily interested in participants' cognitive, behavioural and affective response to fear of crime, assessing how this can relate to mental health. In order to explore this point further, we also compare the experience and impact of fear of crime for people with or without mental health problems. It has been remarked that the mentally ill are a social group that have been excluded from fear of crime research, even though they may theoretically be at increased risk (Pain, 2000). Examination of their narratives addresses a further gap in the literature. In addition we aimed to explore in detail how mental health status interacts with age and gender. We were interested in assessing whether certain groups suffered double (or triple) jeopardy as a consequence of their mental health status, age and gender.

Methodology

We conducted a qualitative case study of the Gospel Oak neighbourhood (London, UK) over a 2-year period. The population is approximately 6200, mostly living in Camden Council’s Gospel Oak Housing Estate. Gospel Oak is generally typical of inner-London in terms of unemployment, poverty and crime (Camden Council, 2000, 2001).

Recruitment of Gospel Oak residents

The names of potential participants for the present qualitative study were generated from within an epidemiologically orientated quantitative survey that recruited over 900 residents using random probability sampling methods (see Weich et al., 2002). For the qualitative study, we attempted to recruit an even number of participants with or without a common mental disorder (CMD). CMD is an umbrella term for a heterogeneous range of disorders characterised by anxiety and depressive symptoms that can lead to a breakdown in functioning (Goldberg & Huxley, 1992). CMD caseness was defined as those scoring 16 or over using the Center for Epidemiologic Studies Depression (CES-D) scale, a validated cut-off score indicating likely mental illness (Roberts & Vernon, 1983). Names of all potential participants were randomly generated from within the quantitative survey, according to specific subgroup criteria. For example, CES-D scores of the residents who participated in the original quantitative survey were available to us, so we deliberately oversampled those scoring over 16 so that the CMD group made up 50% of our recruitment list. Similarly, we deliberately sampled an even number of men and women into our recruitment list. The aim was to provide internal comparison groups to assess whether fear of crime differentially affected sub-groups. Fifty-eight letters were sent out in total asking residents to participate, 32 agreed. Eighteen of these were men, half of whom reached CMD caseness. Fourteen were women, half reaching CMD caseness. Taking into account people who had moved, overall response rate was 65%.

Interviews and focus groups

Twenty-six participants took part in in-depth interviews, lasting on average 1h. The remaining six participants took part in one of two focus groups, both lasting 90min. All were conducted/facilitated by the first author. They were recorded onto cassette then transcribed verbatim. We explored a number of issues related to fear of crime, community safety and consequent impact on behaviour and affect. Questions included how residents perceived crime in the area, what this meant to them in their everyday lives, feelings on measures taken to reduce crime, and what kind of impact their assessment had on behaviour. Additionally two local religious leaders and a local doctor each participated in an in-depth interview. We also regularly discussed issues relating to community safety with approximately a dozen key informants. These ranged from senior officials to local activists. We discussed our emerging findings and preliminary conclusions with these informants as a form of respondent validation, an accepted check on rigour in qualitative research (Bloor, 1978; Lincoln & Guba, 1985).

Participant observation

We used the method of participant observation to collect further data about fear of crime in Gospel Oak. This was done in a cyclical and iterative nature through two-way feedback loops with data gathered through interview/focus groups. For example we collected data at some of the locations identified by participants as crime hot-spots to observe real-time social behaviour. Similarly, on discovery of prominent community safety interventions such as CCTV cameras we would ask participants for their thoughts on these measures. This fortified the data, as it allowed for further exploration of claims made by interview/focus-group participants. Data were recorded as a set of field notes. This triangulation of data collected and compared through different methods is another important check on rigour in qualitative research (Mays & Pope, 2000).
**Analysis and presentation of data**

Data from interviews, focus groups and participant observation were coded, categorised and grouped into themes relevant to the research question. These themes included “views on crime in Gospel Oak”, “vulnerable times/spaces for crime” and “impact on behavioural patterns”. Once these data had been generically themed, they were grouped specifically according to our subgroups of theoretical interest. For ease of analysis, these were primarily divided into responses of men/women, CMD/non-CMD and older/younger. However, we also closely analysed the data within and across these divisions. This was done to assess levels of homogeneity of response within sub-groups, as well as to examine interaction effects. These are prominently discussed in the results. All grouped data were compared and contrasted using the method of constant comparative analysis developed by Glaser and Strauss (1967). This relies on constant comparison between sub-groups noting significant differences and using these to generate theory. In the presentation of the results we have used the method recommended by Miles and Huberman (1994). They suggest that once data have been reduced through analysis, selective representative examples that are emblematic of wider data should be given to support arguments, from which conclusions can then be drawn. We obtained ethical approval from the local research ethics committee. All names and other key identifying variables have been changed to protect confidentiality.

**Results**

The vast majority of residents reported that they enjoyed living in Gospel Oak. Nevertheless, the analysis suggested that a minority of people were markedly more negative about the Gospel Oak neighbourhood. The defining factor that appeared to separate this minority from the majority was their attitudes and behaviours associated with fear of crime. This fear appeared to impact on mental health through two primary mechanisms: firstly, it negatively influenced general affect by lowering mood; secondly it restricted these residents’ movement and participation over time and space. Other factors, such as the presence of young children contributed to this restriction of spatial and temporal movement. We have termed these observed phenomena *time–space inequalities*. Our data suggested that the impact of fear of crime on mental health was disproportionately felt by three sub-groups, most notably low-income mothers of young children and to a lesser extent the mentally ill and the elderly. Interaction effects were observed between these variables where being mentally ill and elderly, or being mentally ill and a low-income mother, further increased fear of crime and its associated mental health impact. For ease of comprehension, we have divided the results into four related sections, discussing firstly gender, secondly age and thirdly, mental-health status. Throughout each section, we assess how our principal variable of interest interacts with other variables to establish possible cases of double (or triple) jeopardy. We close the results by discussing which interventions in the Gospel Oak neighbourhood appeared to reduce time-space inequalities and positively impact on mental health.

**Gender, fear of crime and mental health**

Women disproportionately mentioned fear of neighbourhood crime as a factor of concern affecting their everyday lives. They frequently talked about threatening situations or actual incidents which led to psychological stress and behavioural changes. This theme did not emerge from men’s accounts when treated as a group per se. In this sense, our data support the view, discussed in the introduction, that fear of crime has a more powerful impact on women than men. However, we also found a significant degree of heterogeneity in experience and impact of fear of crime among women participants. Low-income mothers of dependent children, especially those with an existing CMD, appeared to be most significantly affected. In contrast other women, though acknowledging fear of crime as a negative aspect of life in the neighbourhood, did not appear to feel so personally afflicted. For example, Nicola is a low-income mother of two with a CMD. She witnessed violence recently, and now stays in more as a result:

> There is a lot of violence! Drunks! Drugs! It’s awful! It does frighten you in the evening and you worry for your children as well. We went out two weeks ago and a big fight broke out, that was a bit awful, the first time in ages I had been out. I don’t think I will bother now.

Throughout the interview Nicola states that she constantly feels “frightened” and “worried” due to fear of “trouble” or “drugs”. She not only worried about her own safety, but also that of her children. Mothers commonly expressed this fear. For example, Sharon is another low-income mother of three dependent children with a CMD who shared Nicola’s concerns. This appeared to limit her temporal and spatial horizons. Twice during the interview she stated “you are stuck!”; to summarise the life of a low-income mother:

> There is so much drugs and trouble round, and then it’s plain, it’s not sort of hiding it or anything…it’s bad, especially when you got little kids. It’s so open they do it on the streets and everything. Every pub you go in around here you can buy whatever you want…every pub around here, you go in there, by
the end of the night there is some sort of punch up, usually too much drugs being done.

Like Nicola, these restrictions appeared to have a negative impact on affect. She gave many examples of negative ongoing events such as vandalism and drugs that appeared to cause her intense worry and stress. This pattern was observed in other low-income mothers, one of whom seemed to sum up the attitude by saying “there is so much trouble... it disturbs your health”. Women without children or with more income seemed less affected by fear of crime. Fear and worry associated with crime appeared to be less prominent because they utilise higher incomes to take appropriate avoidance behaviour and they do not have children to govern and worry about. For example Ruth is in her twenties, without children or a CMD:

I am quite modest, I don’t invite crime. Crime doesn’t really affect me much at all, as I work harder I suppose I go out less at night...I am more likely to jump in a cab because I have more money, now I would probably take the easy option.

Ruth’s comment is emblematic of those of other young, medium-income women without a CMD or children. They do not seem to be particularly perturbed by crime in the neighbourhood, usually owning cars or having enough money for taxis. Also their daily life trajectory leads them to spend large amounts of time outside the neighbourhood. Many worked and socialised in central London, also spending time away on holiday or business. Thus exposure to neighbourhood events is less than more housebound women.

As mentioned, the views of men chimed most closely with those of the middle-income motherless women. The majority did not raise fear of crime as a significant issue, though mentally ill men and some older men, were more negative in their assessment, discussed in more detail later. A discussion in one of the focus groups illustrates how men and women differentially interpret risk and vulnerability:

Patrick: I mean I personally don’t find the surrounding area is that dangerous really, although a lot of people do, I don’t think it is.

Jane: I am just careful, I am not frightened I am careful, I mean the gentleman there [pointing to Patrick] he is a tough guy! If somebody saw you they would say ‘oh Christ! I won’t have him, I will have the lady with the walking stick!’ I mean my son wouldn’t fear, he would run and kill the kids!

To conclude this section we will summarise our main findings regarding gender, fear of crime and mental health. Fear of crime appeared to have a larger impact on women’s lives than men’s. However we found a large degree of heterogeneity among the women interviewed. Those with certain socio-demographic factors, in particular being on a low-income, having children and having a pre-existing mental health problem seemed to experience fear of crime the worst. This had a behavioural and affective impact on mental health. Women with a higher-income utilised their financial resources to avoid perceived risky situations. Though there is an association between fear of crime and CMD status, direction of causality is uncertain; this is explored further in the discussion.

Age, fear of crime and mental health

As mentioned, some question the received wisdom in criminology that older people fear crime more than younger people. We thus compared responses of residents according to their age, dividing participants into those of working and those of retirement age. Key informants stated that they believed crime disproportionately affects the elderly. A religious leader contrasted their own feelings of safety with those of older friends:

...with the vandalism and the kids walking up the streets...some of the older people don’t dare go out at night...I mean I can see some of the mythology surrounding this but they, they can’t walk fast or they can’t walk far...

Other key informants suggested that elderly people restrict their movements after dark due to fear of crime. Our data suggests that this is the case for both elderly men and women. For example Jane is a pensioner with a CMD who adjusts her behaviour:

You have problems but you just have to keep out of problems, you don’t go out if you are my age and disabled on your own at night. You just have to be aware of life in 2001, what it is like!

However Jane did not indicate that this fear of crime had a negative impact on general affect. Throughout, she was generally very positive about Gospel Oak and stated how much she enjoyed living in the area. Mary is another pensioner with a CMD. Again she states how she restricts her movement due to fear of crime:

If I was going to a wedding or a party I would get brought home, I wouldn’t get the bus, at night. I mean I hear footsteps, in the night-time of women, and I think ‘my God what are you doing out at this hour of the night!’ I would be frightened! I wouldn’t do it. No way! It’s too dangerous, every place is dangerous, I wouldn’t go up the park alone, I wouldn’t, because you hear about these things happening and kids and everything, with kids you know, if anything happened to me I wouldn’t be able to run would I? I don’t go in the way of danger. I
keep out the way. Go on the bus, come home when there is plenty of people about.

Older men assessed risk similarly, adjusting their behaviours accordingly. Harry is another pensioner with a CMD. He does not go out at night and states that this leads to constant worry. As with the two participants previously quoted in this section, Harry has a CMD. The data did suggest an interaction between older age and worse mental health status leads to a situation of double jeopardy with regards to impact of fear of crime:

It doesn't help when they get worried indoors, when they cannot go out at night, You definitely can’t go out now you know…I am not easily sort of frightened but it is different now, there is all knives out there now.

We again found that access to a higher income allowed some to overcome the negative effects of fear of crime. Arnold is a middle-income pensioner with no CMD. He uses his income to overcome the relative paralysis induced in others by fear of crime:

I don’t worry about it very much now. At our age we don’t go out at a night-time. My son when he comes down here he always feels all right and he don’t get in sometime ‘til 3am. If we go out late we will normally grab a cab or something.

Arnold remarks, like Jane previously, how less vulnerable people such as his son do not appear to be negatively affected by this fear of crime. This was borne out by the data in general. Younger people (especially men) were far more blasé about crime, rarely restricting their temporal and spatial movement based on fear. This was verified through participant observation we conducted at night-time, when we noticed far fewer older people and women on the streets. In winter this can sometimes mean that some residents feel their movement is restricted from mid-afternoon onwards.

To summarise this section of the results, we note that older people were behaviourally affected by fear of crime in a similar manner as the low-income mothers. However in terms of impact on overall affect, the older people seemed to be more resilient, generally remarking that fear of crime was one negative factor outweighed by many other positive individual and neighbourhood-level factors. With respect to mental health status, we found that older people with a pre-existing CMD appeared to be disproportionately affected by fear of crime. This is similar to the finding in the previous section regarding gender and CMD and is examined in more detail in the next section.

**Mental-health status and fear of crime**

Throughout the previous sections, we have noted that women or older people with mental health problems were more likely to be negatively influenced by fear of crime than others. This was confirmed through further systematic comparison of responses between mentally healthy and mentally ill participants. In answer to the question about the worst thing in the area Fernando, a middle-aged resident with a long-term CMD, states:

The worst thing? The violent people…the fear they are coming around and breaking and burning and hitting. It can happen, you can get mugged…late, late night you have to be careful…it can get really rough, people are scared here because you don’t know who is coming next to the door, people living in fear.

Fernando’s comments match with those of others, as well as data gathered through participant observation, that there is an environmentally driven dichotomy between night and day in Gospel Oak. Steven is another middle-aged man with a long-term mental health problem. He is similarly worried after dark, taking appropriate avoidance behaviour. He also mentions how people have become security-conscious due to fear of crime. Steven describes the defences that are put in place to protect against crime:

I would hate to come into my flat at 12 at night…in the winter I very rarely go out, during the daytime maybe…You got to have the front door, then you got to have this horrible gate and then my neighbour has got these bars over his window. You know you might as well be in Wormwood Scrubs [a nearby prison] or something! When you live in London you have to have these things for security.

Some elderly participants echoed this view, though we found that, when visiting participants in their homes, they were not suspicious of us and we noticed during participant observation that many people actually left their front doors open during the day. Still, other residents with mental health problems expressed similar metaphors of living in a prison. Sharon repeated the phrase “you are stuck!” to indicate her daily existence. Luke, another resident with long-term mental health problems uses similar imagery, this time saying living in the neighbourhood is like living on “an island”. He did not seem particularly perturbed by crime though he stated that it worsens the reputation of the area and deters visitors:

There are pillars and columns on the estate where people can easily hide behind. Some of my friends do not like visiting me around here because the place is sort of known as a rough area.
Overall, Luke was quite positive about the area and participated in a number of local activities. This could be due to a protective interaction effect; his younger age and confidence in his own physical ability. In fact, among the mentally ill participants, women and older people appeared to be primarily affected by fear of crime. Sean is a pensioner with a CMD who stated that he no longer utilises Hampstead Heath due to fear associated with the Heath’s popularity as a homosexual “cruising ground”. This concern was shared by other older people with a CMD:

I used to go to the Heath but I don’t go anymore especially what’s going on there, you know the men. Imagine hearing it! Imagine hearing it in a public pathway! Seeing that laid out especially for them! I mean what is going on there? I don’t know what they are doing them men up there but I am not chancing that!

To summarise this section of the results, our data suggest that people with mental health problems appear to disproportionately suffer from fear of crime. This interacts with age and gender in that women and older people with mental health problems appear to be in double (or triple) jeopardy. A primary mental health impact of fear of crime in this group appeared to be the restriction of movement. Fear of crime also appeared to create, or perpetuate, hyper-vigilance, associated with ongoing worry and generic stress.

Effective interventions

The results suggest that certain segments of the population suffer from what we call time–space inequalities. This is a simple concept describing variation in the ability to access and utilise different times and spaces within the immediate and wider environment. We found that certain vulnerable groups lived in restricted temporal and spatial spheres that appear to negatively affect their mental health. This time–space restriction not only has negative behavioural consequences, but it also appears to negatively influence affect. We thus discuss interventions which appeared to help people overcome time–space inequalities, most notably transport/mobility and urban design.

Mobility and public transport

Higher-income residents used cars and taxis to expand geographical boundaries meaning that little actual time was spent in the neighbourhood by these residents. Fear of local crime appeared to be transcended through use of these luxuries. Some residents used public transport for similar purposes. Many remarked that there was a comprehensive local transport system which positively facilitates access to a variety of other opportunities. This was confirmed during participant observation. Three London Underground stations form a triangle around Gospel Oak. An over-ground railway runs to two nearby stations. Various local bus routes run into central London as well as other residential neighbourhoods.

Many residents remarked that the local transport system allowed them to visit family and friends, access appropriate services and attend community activities. This was especially so for those entitled to a “Freedom Pass”. This is given by government to pensioners and registered disabled enabling them to travel free of charge on public transport in the Greater London area. Pass holders independently praised this as a lifeline that maintains their social and economic involvement in society. Arnold is a mentally healthy pensioner who uses his pass daily:

I use transport all the time and now we have got bus passes so we are out about five times, seven times a week…there is not many places we cannot go. We go right through to Brent Cross if we want to for shopping or down the West End. We can go up that way to Highgate or Archway, up to North London and on the railway we can go to North Woolwich that way, or Richmond and Kew that way.

For Arnold, the transport system and the freedom pass interact to help him preserve his social life and protect his psychological well-being. For residents with a CMD, the pass allows residents to access services, facilities and social support outside the neighbourhood. This appeared to ameliorate some symptoms of CMD and prevent deterioration. Vesna is in her fifties and receives a free pass due to her mental illness. Like other mentally ill residents she uses the pass to access social support and utilise various services outside the neighbourhood. She is explicit about the role she believes this plays in preventing the deterioration of her mental illness:

I go on the bus because I have my bus pass because of my illness. With the free pass you can travel anywhere. You know that is good because if I didn’t have that I would feel isolated and angry because it helps even if you go away for a day. Even if you buy a day pass it is expensive if you are unemployed…

Urban design

During the research, a number of changes occurred to the urban environment of Gospel Oak, mostly as part of urban regeneration programmes (see Camden Council, 1997). Many residents praised certain aspects of this regeneration, particularly those which facilitated the reduction of time–space inequalities. For example, Jane
is a pensioner with a CMD. Like many people, she makes very positive remarks about the urban regeneration and its effect on uplifting mood and encouraging behavioural changes:

The place is cleaner, the children are playing, you see trees coming up and you think ‘oh how wonderful’. I think the area is getting much better. It’s on the up! When I come out now you look and think ‘God isn’t this nice!’ You think they are looking after that and you feel a bit lighter in your heart.

One factor that was regularly singled-out as positive by vulnerable residents was the redesign of an open space known as Lismore Circus. It is an important location as many residents must pass through it to access shopping and community facilities. As part of the urban regeneration, buildings were knocked down and overhead walkways demolished in an attempt to make the Circus safer. Clive, who has a CMD, states that he has noticed behavioural changes during the redesign of Lismore Circus:

I think the old people there in the Circus, they are coming out more, even if they are just to bring their little dogs out, it is right open so they feel safer there, whereas before you don’t know who is going to come out.

Another structural factor which was consistently singled out as positive by vulnerable residents was the redesign of an open space known as Lismore Circus. It is an important location as many residents must pass through it to access shopping and community facilities. As part of the urban regeneration, buildings were knocked down and overhead walkways demolished in an attempt to make the Circus safer. Clive, who has a CMD, states that he has noticed behavioural changes during the redesign of Lismore Circus:

I think the old people there in the Circus, they are coming out more, even if they are just to bring their little dogs out, it is right open so they feel safer there, whereas before you don’t know who is going to come out.

Well you know this wonderful CCTV on Bacton, now it is all finished. Because I had to visit my friend on the 16th floor and they had made it a no-go area. Its fantastic, kids can’t go from the little flats next door to the main block of Bacton because they have cut the little flats off and now they have got a concierge. They got a security gate and I think ‘God this is fabulous why can’t we have one?’

Participant observation generated data that tended to support the theory that changes in urban form were positively influencing the reduction of time-space inequalities. At the end of the research, when many of these measures were complete, we noticed a distinct increase in the amount and variety of people using places such as Lismore Circus, especially in the day. Nevertheless we still found that sunset acted somewhat as a curfew for more vulnerable residents such as women and the elderly.

Discussion

The majority of residents did not interpret the neighbourhood as a specially threatening environment. However certain vulnerable groups appear to make a more negative assessment of levels of threat, adjusting their behaviours accordingly. Our data support the view that fear of crime impacts more severely on older people and women. However our data also caution against essentialist interpretations of fear of crime in older people and women, as we found large degrees of heterogeneity of experience and impact in those groups. Having young children seemed to considerably affect women’s appraisals regarding crime. People with pre-existing mental health problems also appear to be disproportionately affected by fear of crime. Older people and women with mental health problems appeared to be more severely affected by fear of crime, experiencing double (or triple) jeopardy.

The impact of fear of crime

The impact of fear of crime can be divided into impact on affect and impact on behaviour. With regard to affect, we found that the perceived hostility and restrictions concomitant with negative evaluations of crime appeared to lower the mood of some vulnerable residents. Many expressed feelings of fear, worry and general unease associated with crime in Gospel Oak. This replicates findings from other qualitative research in criminology (e.g., Gilchrist et al., 1998; Pain, 1997b).

With regards to impact on behaviour, we found that many vulnerable residents restricted their daily activities in order to lower risk. Many stated that they would not leave their houses at certain times of the day, or would not walk through certain areas perceived as particularly threatening. On various occasions, Stanko (1987, 1990) has written about how women’s routine life is structured by precautionary behaviour taken due to fear of crime. Our results not only support this assertion, but moreover suggest that older people and people with mental health problems build these precautions into life routines.

Our results converge with existing literature from social psychiatry. Halpern (1995) also observed overall negative affective and behavioural outcomes in an urban case study. Brown and Harris (1978) found that lack of social support and low self-esteem/mood were vulnerability factors which may predispose people to depression. As stated fear of crime among some residents lowered mood and led them to restrict their own behaviour, making it difficult to access or form social support networks. Fear of crime may act to deter outsiders from visiting them, again cutting off potential sources of social support. These affective and behavioural limitations may restrict access to activities...
believed to promote mental health such as community or
religious participation (Brown & Prudo, 1981; Camp-
bell, Wood, & Kelly, 1999). These restrictions may also
inhibit the mentally ill from beginning new activities
which may provide the “fresh start experiences” identified by Brown, Adler, and Bifulco (1988) as
preceding recovery from depression.

Our finding that low-income mothers seem to be most
affected by fear of crime could assist the explanation of
other literature in social psychiatry. As mentioned, other
case studies of British neighbourhoods found neighbour-
hood context disproportionately affected women’s
mental health in a negative manner (Ellaway &
Macintyre, 2001). Brown and Harris (1978) found that
the presence of three or more children under 14 years of
age was a direct risk factor for depression among urban
low-income mothers. The traditional explanation for
increased rates of depression among women is usually
given as multiple role strain (Jenkins, 1985; Wilhelm &
Parker, 1989). Our research suggests another process
whereby a constellation of factors specific to low-income
mothers, though partially applicable to women in
general, may also contribute to these epidemiological
variations. Low-income mothers tended to have re-
stricted spatial and temporal movement due to fear of
crime and other factors, reducing the possibility of
accessing social support, work opportunities, or leisure
facilities. Their low income prevents them overcoming
these inequalities through using taxis, private cars or
paying for childcare. They are also generally not eligible
for free public transport passes. Added to this are
mothers’ profound worries that their children will be
exposed to or involved in crime. This led parents to keep
their children inside the house, which in turn appeared
to lead to more intense familial relationships and
increased tension, especially where this was confounded
by overcrowding. Interestingly Lewis et al. (1998) found
that not having access to a car was a risk factor for
neurotic disorder. However, this was treated mainly as a
proxy measurement of material standard of living. Our
data suggest lack of access to a car could in fact be a
main effect in itself, preventing health-promoting
activity.

Direction of causation

Generally speaking, qualitative studies are limited
concerning what they can say about direction of
causation. In this study we are suggesting, rather than
definitively stating, that time–space inequalities may
play a role in the onset and/or maintenance of mental
illness. However, we are aware that it could reasonably
be argued that mental health problems lead to fear of
crime, rather than vice versa. It is known that people
with a CMD may have impaired judgement and see
otherwise neutral areas of life in more negative colours
(Beck, 1967). Thus one explanation of the variation in
Gospel Oak by mental-health status could be that
people with a CMD are simply making an overly
negative appraisal as a consequence of their illness. We
acknowledge that this response bias may be playing a
role. Having said all this, our data paint a complex
picture in this regard. Many participants with a CMD,
most notably younger men, did not fear crime differ-
ently from the mentally healthy. Similarly, many of the
participants with mental health problems were positive
about other aspects of local life, for example public
transport or community spirit. It has been suggested
that fear of crime may be particularly prone to negative
bias, as it becomes the channel by which individuals
unconsciously displace other fears, uncertainties and
insecurities (Hollway & Jefferson, 1997, 2000). Which-
ever, it is undeniable from our data that people with
mental health problems disproportionately feared crime
and that this fear had an important affective and
behavioural impact. This is a significant finding in itself
as it suggests a hitherto unknown social inequality
suffered by people with mental health problems. In a
sense, this finding also diminishes the relevance of
questions regarding direction of causation, making more
relevant questions regarding what can be done, at the
individual or structural level, to diminish fear of crime
and its impact among the mentally ill.

Furthermore, it may be erroneous to conceptualise the
question of whether mental illness leads to fear of crime
or vice versa as one of the either/or variety. Our data
suggest extremely complex non-linear relations between
mental health status, age, gender and fear of crime.
Commentators in recent reviews (e.g., Hale, 1996; Pain,
2001) have also remarked on this complexity regarding
the fear of crime, further stressing the importance of
other significant variables not investigated in the present
study, such as ethnicity. It may be more valuable to
model relations between fear of crime and mental health
as reciprocal rather than linear; i.e., that there is an
ongoing inter-penetration between fear of crime and
mental health with both continuously affecting each
other. As can be seen in the results, many cases from our
data would support such a model. For example, many
mentally ill participants stated that generic fear of crime
inhibited their involvement in mental-health promoting
activity; however they felt encouraged by recent com-
munity safety interventions such as CCTV. In this case,
it could be argued that pathways from mental illness to
fear of crime (e.g., initial paranoia raising fear) and
pathways from fear of crime to mental health (e.g.,
diminished fear due to CCTV improving mood) are both
reciprocally active. This reciprocal conceptualisation
may be especially important if mental health/illness is
modelled as a continuous, rather than a discrete
variable. Fear of crime may make moderate mental
health problems severe, whereas appropriate interventions
may stabilise moderate mental health problems, preventing deterioration and even assisting restitution.

**Conclusion**

One of the key aims of any qualitative study is to assist in the construction of new theory (Glaser & Strauss, 1967). We do this by proposing that fear of crime and other factors create what we term *time–space inequalities*. As previously stated, this is a simple concept describing variation in the ability to access and use different times and spaces within the immediate and wider environment. These inequalities may be produced by a combination of individual characteristics such as age, structural characteristics such as availability of public transport, and social discourse such as the spread of fear associated with local crime. Low-income mothers, older people and people with mental health problems appear to suffer time–space inequalities most acutely. These inequalities appeared to be diminished through availability of comprehensive cheap public transport, changes in urban design and new community safety measures. These measures that opened up time and space and encouraged communal interaction appeared to have a positive impact on the mental health of certain sub-groups. These results partly replicate those from other studies that found that physical and social change in urban environments may help promote mental health (e.g., Dalgard & Tambs, 1997). Reducing time–space inequalities could thus rely on both individual and population interventions. Reducing time–space inequalities may help prevent, ameliorate, stabilise or foreshorten episodes of mental illness, though further research is necessary before definitive conclusions can be made.

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