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'Chugging along, plugging in and out of it': Understanding a place-based approach for community-based support of mental health recovery

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ABSTRACT

Community-based Mental Health (MH) organisations in the United Kingdom (UK) are facing challenges for sustaining in-person service delivery. Without empirical evidence that demonstrates the value of a place-based approach for MH recovery, and the types of resources needed to build nurturing spaces for peer support, community-based MH organisations will struggle to maintain their physical spaces. We present empirical insights from a case study involving interviews with 20 students accessing peer support services at the Recovery College Collective, a community-based MH organisation located in the North East of England. The interview study aims to evidence how a place-based approach can afford MH recovery. We draw from discourses on place-making and interpret our interview findings through an established framework that highlights four mechanisms through which place impacts recovery: place for *doing*, *being*, *becoming* and *belonging*. We use this framework to structure our findings and highlight key qualities of place for establishing and maintaining MH recovery. Our contribution is two-fold: we address a gap in the literature by providing empirical understandings of how place influences MH recovery, whilst extending previous research by considering the role that place plays in community-based organisations. This is timely because of the challenges faced in securing in-person service delivery post-pandemic, and a shift towards remote service provision models. We highlight key implications: (i) Accessing a physical place dedicated to MH support is vital for people who do not have anywhere else to go and are socially isolated due to their health conditions; (ii) Connecting through peer-to-peer interaction is an integral part of the recovery process, and learning from people with lived experience can inform a place-based approach that best suit their needs; and (iii) Recognising the value of place for MH support, and the resources needed for peer support delivery in the community, will help secure places that our research participants described as lifesaving.

1. Introduction

Community-based Mental Health (MH) organisations such as charities are essential for supporting people's recovery and overall wellbeing. Critical to their success is the provision of opportunities for people to come together locally and be supported through activities and social interaction with peers in a place where they can feel safe. However, there are several challenges for community-based MH organisations to sustain their physical places and programme of activities, which prevent them from ensuring the long-term recovery of their community members (Larrieta et al., 2023). Challenges such as scarce budget and short-term funding prevent organisations from securing financial resources for their spaces (ibid.). The digitisation of MH services (Ding et al., 2023) further requires organisations to evidence the added value of in-person service delivery, to justify the required funding. Despite the digitisation of service provision, research following the COVID-19 pandemic demonstrates the need for a blended approach where access to place and in-person services are still considered essential for supporting MH recovery (Branley-Bell and Murphy-Morgan, 2023; Lavis, 2022; Zangani et al., 2022). Indeed, the value of place for supporting MH recovery has been investigated in different community contexts (Aubry et al., 2015; Duff, 2012; Yates et al., 2012) but literature on the role that

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place plays in MH recovery remains limited (Doroud et al., 2018); more empirical understanding on people's 'real experiences' is needed (Duff, 2016) to inform place-based approaches for nurturing MH recovery. Without this empirical evidence (which is often required by funders), service providers will struggle to secure, or continue to maintain, valuable places which are key to supporting users' mental wellbeing.

In this context, we present insights from an interview study with students accessing in-person peer support services provided by a community-based charitable MH organisation in Newcastle upon Tyne, the Recovery College Collective (ReCoCo). Here we use 'students' instead of service users to define individuals with lived experience of mental distress who have enrolled at the recovery college. ReCoCo is a peer-led, peer-delivered education and support service (more details in section 1.1); in the context of this research, it provides a lens through which to reflect upon the therapeutic value of place for community-based support of people with MH issues or diagnoses. In doing so we aim to provide deeper, contextual understandings on how MH recovery can be afforded by a place-based approach and evidence what resources are needed for fostering welcoming and nurturing places. Our contribution is two-fold: first, we add to existing MH research on place in housing (e.g. Aubry et al., 2015), public places (e.g. Duff, 2012) and natural environments (e.g. Yates et al., 2012) by considering the role that place plays for organisations that deliver peer support in the community. Second, we provide empirical insights to evidence the value of place for supporting MH recovery post-COVID-19, in an era where funding for in-person service delivery is scarce (Larrieta et al., 2023) and where the digitalisation of MH support has been accelerated by the pandemic (Li et al., 2022; Zangani et al., 2022). We specifically address the lack of empirical research on how *places* foster community participation and social connections critical for MH recovery (Doroud et al., 2018; Duff, 2016; Pitt, 2014; Whitley and Drake, 2010). We draw from discourses on place-making and recovery: first, we use a framework devised by Doroud and colleagues (Doroud et al., 2018) as a lens to interpret our interview findings and explicate the affordance of place for community support using four mechanisms: place for *doing*, *being*, *becoming* and *belonging*. Secondly, we highlight different types of 'enabling resources' (Duff, 2012) to show how place can provide the social, affective, and material resources that support the everyday work of recovery in a peer support community.

We start by introducing our case study to help the reader envisage ReCoCo as a place for community peer support. Next, we review the background literature on the role of place in MH recovery. Following this, we present our methodology before discussing key findings and implications.

1.1. Setting the scene: ReCoCo

ReCoCo is a UK community-based charitable organisation supporting people who experience MH difficulties and/or people who have endured and survived distress caused by trauma. This can include childhood trauma associated with poverty, neglect, abuse, loss, or parental substance/alcohol abuse, and trauma experienced due to marginalisation, prejudice, or discrimination. ReCoCo is based in the North East of England, a region with some of the highest levels of poor mental health, health inequality and social deprivation in the UK (Corris et al., 2020).

ReCoCo presents itself as a "peer-led and peer-delivered recovery college". Their approach is informed by the recovery college model where emphasis is placed on people's talents and strengths, with opportunities for learning new skills and regaining a sense of control over one's life (NHSb, 2023). The college currently supports over 2000 students, providing a variety of free creative, educational, and peer-led activities (i.e. classes, drop-by sessions) open to anyone in the region who finds them useful for their recovery. To gain access to the college, people begin by enrolling as students, and complete a wellbeing and risk assessment at a one-to-one meeting with a peer support worker or member of staff. The assessment further involves filling in the 'Empower Flower' (Fig. 1), a person-centred self-reporting tool developed by ReCoCo for monitoring different dimensions of wellbeing including people's sense of self-worth, purpose, and connection in life. Following their enrolment, students are guided towards classes or drop-by sessions that are relevant to their self-reported personal experiences and interests.

Following the COVID-19 pandemic and the cost-of-living crisis, there has been a significant increase in demand for MH support across both voluntary and statutory sectors (O'Shea, 2021; BBC, 2022, Bynner et al., 2022). MH services provided by NHS England have experienced a significant increase in waiting times, which has pushed people to the door of voluntary organisations like ReCoCo (BBC, 2022; Murphy-Morgan and Branley-Bell, 2022). Moving forward, both statutory and voluntary sectors are expected to work together to maximise capacity and provide integrated care services (Taylor, 2022). There is growing strategic interest within UK Government to promote a place-based approach to health (Couper et al., 2023) that supports person-centred care; further exacerbating the need for improved service integration to address environmental, economic and social determinants, beyond treatment alone (Davie, 2022). However, there are challenges for both statutory and voluntary sectors to work together. This includes a lack of recognition of community-based organisations' work on the ground (Bynner et al., 2022), and cultural tensions between community-driven, charitable organisations like ReCoCo and statutory organisations (i.e. NHS) whose work is informed by a more corporate and clinical model (Faulkner, 2021). These tensions are partly grounded in organisations' differing understandings and definitions of recovery. We expand on this in section 2.1, but, first, we describe the physical space of our partnering organisation ReCoCo to provide a sense of place. Figs. 2 and 3 aim to convey a sense of place experienced when visiting ReCoCo, and we include a vignette written from notes captured by first author Claisse during her fieldwork.

ReCoCo is located in a large five-storey building and as I enter the place, I am warmly welcomed by a volunteer at the reception desk and asked to sign in [I learned later the importance of monitoring students and volunteers coming in for funding purposes]. The place is always changing and buzzing with new activities and initiatives that are driven by students: I can see that the space downstairs has been set up as a recording studio and a darkroom for photography production. Before making my way upstairs, I check the whiteboard and see that the drop-by for the Creative Wellness session is on today on the fourth floor. The session takes place in the corner of a bright open-plan space surrounded by large glass windows, which overlook the city and riverside. Tables are displayed together with a wealth of craft materials near the windows so there is plenty of natural light. Artworks made by students from the previous week are displayed on the windowsill as a mini pop-up exhibition. One-third of the space is made of wooden floor so students can get messy with their Art. On the other side of the room, there are little clusters of comfortable colourful chairs and sofas used for the Drop-By, an informal facilitated session for students to get to know each other and learn more about ReCoCo. Other parts of the space include classroom-style rooms, used to deliver courses, and smaller rooms for more private conversations. This Wednesday afternoon, I attend the Mindfulness and Self-care drop-by sessions one floor down, in what was described to me as 'the Mindfulness Corner'. The space there has more of an exotic and eclectic feel: Fairy lights and large colourful rainbow fabrics cover the ceiling; mandala patterns and natural materials cover parts of the walls; a Buddha statue thrones on an altar, which features symbolic and sensory objects such as stones and beads (see Fig. 3).

2. The role of place for mental health support and lifelong recovery

2.1. Defining recovery from a community perspective

MH recovery is often described in the literature from two different

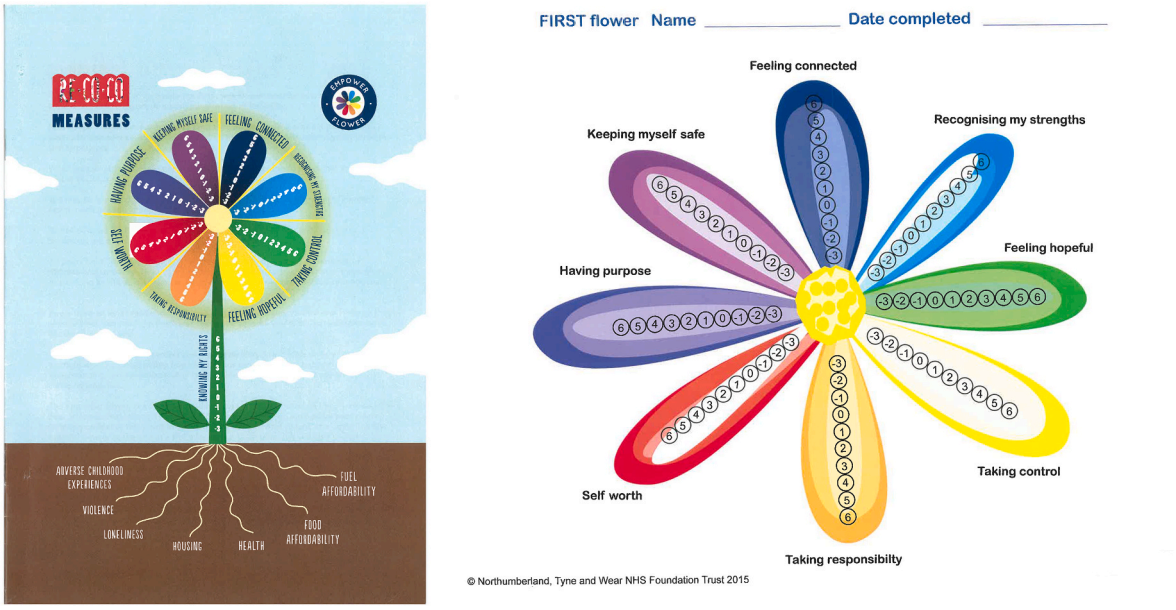

Fig. 1. The Empower Flower: a person-centred self-reporting tool that is iteratively developed by ReCoCo.

Fig. 2. Building entrance and a student in a creative session making a collage in a bright open-plan space.

Fig. 3. The mindfulness corner and details of the altar.

perspectives: one informed by clinical practice and aligned to a biomedical approach, and one that draws from lived experience and community-driven initiatives. Biomedical definitions of recovery tend to be associated with the notion of a cure or treating the causes of an illness by focusing on symptom relief or removal (Slade, 2009; Whitley and Drake, 2010; Yates et al., 2012). In our work, we move away from biomedical models acknowledging this as a limited understanding of recovery which may misrepresent people's lived experiences (Anthony, 1993; Doroud et al., 2018; Slade, 2009). Instead, we align with a more community-driven model, which depicts recovery as a lifelong process, 'a journey of healing and transformation' (Whitley and Drake, 2010, p1248), and as a self-directed journey (Doroud et al., 2018). We view recovery as non-linear and dynamic process, with no end point and which moves towards the reconstruction of a life (Ellison et al., 2018; Yates et al., 2012). Indeed, recovery can be described as a process of becoming well (Duff, 2016) and 'a way of living a satisfying, hopeful,

and contributing life even with limitations caused by illness' (Anthony, 1993 p. 527); further acknowledging that people can recover despite the mental illness not being cured. In this case, health and wellbeing can be understood as more than the absence of disease wherein place like ReCoCo plays a role in 'creating health' by providing the conditions for people to be healthy in their communities (Crisp, 2020).

New perspectives on MH recovery have also recognised the value for a more person-centred care approach to support the individual as a whole person, beyond clinical care aspects and in the context of their broader life activities (Ellison et al., 2018; Whitley and Drake, 2010). However, the recovery journey can be quite chaotic, and researchers have developed conceptual models to identify key processes and stages for recovery. An example is the CHIME framework, which highlights five recovery processes (Leamy et al., 2011): Connectedness; Hope and optimism about the future; Identity; Meaning in life; and Empowerment. This resonates with the multi-dimensional approach to recovery where Whitley and Drake (2010) identify different factors, healers, and measurable outcomes for each recovery dimension. For instance, peers are considered as 'healers' for *social recovery* whilst obtaining and maintaining employment can be beneficial for *functional recovery*. Both models imply that recovery is a multi-faceted process (Doroud et al., 2018), which needs to be considered in its wider socio-environmental context (Leamy et al., 2011).

ReCoCo shares a community-driven definition of recovery. This has informed their person-centred approach whereby students are not discharged (i.e. after a number of sessions) but can freely access the place over the long-term based on their personal needs. This contrasts with the more clinical approach to recovery in the NHS where support is prescribed to people for a particular issue or ailment and for a limited number of sessions before they are discharged as 'cured' or 'treated'. Different definitions of recovery between stakeholders can create tensions, making collaboration difficult. In our study reported herein, we take on the research challenge of developing an 'evidence base' to encourage clinical MH services to more closely align with the perspective of recovery as 'a unique and individual experience rather than something the MH system does to a person' (Leamy et al., 2011, p451).

2.2. The role of peers in mental health recovery

We conceptualise peer support as a two-way process, for giving and receiving support and by which the individuals draw from their lived experiences to support each other, for making sense of their conditions whilst giving them a greater understanding of who they are or can be, which in turn can aid recovery or self-management (Faulkner and Kalathil, 2012; NHSa, 2023). Peer support for MH has a long history, which can be traced back to the late 1700s. Since the 1990s, it has become a more formalised approach used to complement institutional care (Davidson and Guy, 2012), with more people with experience of MH recovery being hired as Peer Support Workers (PSWs) (Ding et al., 2023)) and therefore becoming an integral part of future service delivery (Gilbert, 2022; Kane et al., 2023). In the UK, peer support for MH recovery is integrated into service delivery as follows: peer supporters may be working or volunteering in community-based organisations as part of a peer-led programme or they may be employed in clinical health settings (i.e. in a hospital or clinic) to provide intrapersonal and social care service (ibid.). With time, PSW roles are becoming increasingly formalised and deployed at scale with the risk of being inimical to peer support.

PSWs play a critical role for people with MH issues or diagnoses who are more likely to experience isolation and exclusion from community life (Duff, 2012; Yates et al., 2012). A peer is defined as an equal, someone with whom one can relate because of shared similarities and lived experiences (Shalaby et al., 2020). In this context, 'support' can be defined as 'the kind of deeply felt empathy, encouragement, and assistance that people with shared experiences can offer one another within a reciprocal relationship' (Darby Penney, 2018, p1). Therefore, PSWs can help foster empathy, mutuality and a reciprocal relationship between service users and providers (Kane et al., 2023; Shalaby et al., 2020). The value of peer support and this sense of reciprocity has been widely recognised (Lawton-Smith, 2013). For instance, embedding PSWs in mental healthcare is cost-effective (Together, 2017) because it can decrease admission and rehospitalisation rates (Shalaby et al., 2020). Benefits for service users include an improvement in social inclusion, self-confidence and resilience whilst addressing MH stigma through providing non-judgmental support (Kane et al., 2023; Shalaby et al., 2020).

The integration of PSWs in MH settings is arguably transforming UK service provision towards more trauma-informed, democratised, and humanised care based on mutuality, shared power, and respect. For PSWs, transitioning from service users to service providers can feel empowering and they are playing a critical role in closing the gap between people with lived experiences and clinical healthcare providers (Shalaby et al., 2020). However, numerous challenges have been reported in the literature for implementing PSWs as part of service delivery for MH recovery. These include concerns around a lack of training and support, and the emotional labour attached to their role, making it difficult to maintain personal boundaries in their work (Kane et al., 2023). PSWs often engage in 'infrastructural' work for making peer support safe and effective but this work is rarely seen or acknowledged (Ding et al., 2023). More work is required to ensure that adequate training and safeguards are in place, and openly shared. Crucially, the introduction and integration of PSWs within clinical settings often overlooks and/or dismisses the role of place as an important factor in the recovery journey and in creating a positive and risk-free environment for PSWs and other peers. More research is needed to investigate how the views of people with lived experiences of MH recovery can inform the design of safe, inclusive peer support environments that can nurture the growth and strength of those using the place and associated resources.

2.3. Defining place and its potential for mental health support

We define place as 'a lived environment constructed by people, through interactions, shared experiences and connections' (Doroud et al., 2018). We are particularly interested in how people develop a 'sense of place' (Convery et al., 2014) and 'insideness' (Cresswell, 2014), through being in a particular environment. Our understanding has been informed by a literature review and the concept of 'atmospheres of recovery' (Duff, 2016), which focuses on more embodied aspects of recovery and how different atmospheres may prime bodies to act in certain ways. An example is how cafes and libraries afford 'atmospheres of sociality' (ibid.), whereby seat arrangements can provide spaces to pause and rest, further priming people to some kind of social disposition. We find the concept of *atmospheres* helpful in understanding the qualities of places more fully, in terms of assemblages of both human and non-human factors and where the focus is on 'tracing more of the social, affective, ethical and material becomings of recovery' (Duff, 2016, p62). In relation to this, Duff (2012) previously described three classes of 'enabling resources': social, affective, and material, which were found critical for the everyday work of recovery. Examples may include peer-to-peer connections (social resources) afforded by community settings; place attachment and community belonging (affective resources) afforded by social inclusion, and affordable items or objects (material resources) that support people in carrying out recovery-oriented activities such as craft. The success of a place-based approach for MH recovery is largely dependent on these resources and if they can be maintained over time (ibid.). In our study, we build on such work to explore how social, material, and affective resources can be mobilised for place-based initiatives and community MH support.

Also relevant is research by Doroud et al. (2018), which provides a framework for studying how people make sense of and interact with place during their recovery. The framework highlights four interrelated mechanisms through which place impacts MH support and recovery:

being, *doing*, *becoming* and *belonging*. Through these mechanisms, we can see how place can afford key characteristics of the recovery journey such as safety, agency, hope and social connection. For instance, *place for being* can influence recovery by providing a sense of security and stability; *place for doing* can promote a sense of agency in day-to-day activities; *place for becoming* can foster hope and finally, *place for belonging* can encourage social connection and community participation (Doroud et al., 2018). We build on this work by using the framework to study the role of place in a peer support community context, therefore broadening the scope of previous research on place and MH recovery in other contexts e.g. housing or public places (Aubry et al., 2015; Duff, 2012).

Finally, design-oriented research has evidenced the impact of the built environment on MH and wider wellbeing (Turnbull, 2021). Good design and planning can foster healthy living (Crisp, 2020), and the UK is moving towards more collaborative and integrated ways of working between different sectors for creating healthier places (Turnbull, 2021). There are also many examples ranging from people in their homes to various communities who have designed environments that provide the conditions for 'creating health'. Crisp (2020) argues that there is a lot to learn from these 'health creators' to inform the future of healthcare service delivery. Here we may highlight the importance of community participation and more bottom-up approaches for developing place-based interventions (Crisp, 2020; Turnbull, 2021). We contribute to this agenda by investigating how community-based organisations can act as 'health creators' through a peer support environment. In our work, we address a need to develop more contextual understandings of how people with MH conditions experience community spaces and how through social interaction with other peers, community-based MH organisations may offer opportunities for healing and healthy living more broadly (Crisp, 2020; Doroud et al., 2018).

3. Study design

The overarching aim of our study was to provide empirical insights of how people with MH conditions experience place for peer support and evidence the value of community-based MH organisations in a post-pandemic context where funding is scarce with services moving to online and remote delivery of MH support.

3.1. Methods

Although clearly introduced as a researcher interested in MH and peer support, first author Claisse initially started at ReCoCo by volunteering once a week. This initial period allowed Claisse to become acquainted with the space and service's offerings, and to establish a relationship with the staff and students (in the absence of any data collection or recording). Following this initial acclimatisation period, a study protocol was co-developed with the college's Co-Directors for Claisse to conduct fieldwork for a period of six months. During this time, she was able to gain first-hand experience by attending courses with other students, helping the facilitation of drop-by sessions (i.e. Creative Wellness) and taking part in social events (i.e. College's Christmas party). Her fieldwork informed a series of short, filmed interviews with 20 students to capture their experiences of attending the college. The interviews were organised over two days in a quiet corner space at the college and followed by a screening session (Fig. 4). Most of the participants were familiar with Claisse who conducted the fieldwork and led the interviews. The study was approved by Newcastle University Research Ethics Committee.

3.2. Participant recruitment

We used a mixed sampling strategy for recruiting participants with different profiles and experiences; for example, students who recently joined the college as well as some who had been attending for a longer time, and students living with a broad range of MH conditions. ReCoCo's staff members identified potential participants and verbally introduced the study to them. Those students who expressed an interest in taking part, were sent a participant information sheet to read in their own time without obligation. Some participants were also recruited on the day of the interviews; for example, students who were curious approached us to ask more information about the interview set-up. Participants gave their consent for the interview to be video-recorded and to be contacted for follow-up stages including the development of a short film for further dissemination. Methodological discussion of these outputs is beyond the scope of this paper, but we have reported on it elsewhere[1].

Eight women and 12 men took part in the interviews with an age range of 20–65+ years old (Table 1). All bar one of our participants identified as White English and the majority self-described as heterosexual or straight. Three self-identified as bisexual and one as gay or lesbian. Participants self-reported a broad range of MH conditions including Bipolar Disorder, Schizophrenia, Borderline Personality Disorder and Post-Traumatic Stress Disorder; many lived with multiple comorbid conditions.

3.3. Data collection and analysis

This study was composed of two interlinked components: fieldwork and semi-structured interviews. The fieldwork formally commenced six months before developing the interviews. After each session, Claisse captured notes about her experience of *being* at the college. Those notes were typed into a Word Document and stored on the university server as research data.

Data collection for the interviews was facilitated as follows: On the day of the interview, participants were taken through the consent process by second author second author Durrant, before being invited to go behind a folded screen, which provided some intimacy and sit in a cosy armchair in front of Claisse who led the interviews. The camera was placed behind Claisse and another colleague supported us with filming. The interview was structured with four main questions to capture both participants' personal stories of MH and their experience of attending the college:

(i) Please introduce yourself (as much as you're happy to share), and tell us: why did you come to ReCoCo today?
(ii) Take a minute and reflect back to us: how does visiting the college make you feel?
(iii) Do you have a favourite thing about this place (e.g. a particular place or spot you like)? Please describe it or show it to us;
(iv) ReCoCo's mission is about helping students find their inner gift or talents. Please could you tell us about yours and how the college has supported you so far?

The interview was designed to be short in time with questions framed to focus on positive aspects (i.e. describing their favourite thing about the place and sharing about their inner gift or talents) to minimise the oversharing of sensitive information and triggering of trauma. Despite the positive orientation of the questions, participants were free to talk about any aspect of their experience and were able to withdraw their contributions if they changed their mind after the interview. Overall, each interview lasted for up to 10 minutes and all participants received a £10 voucher to thank them for their time and contributions.

The interviews were video-recorded and anonymised transcripts of the audio recordings were produced by a trusted company approved by our University. The fieldwork notes were summarised and used to inform the analysis of the transcripts, which were coded using an inductive and reflexive approach to Thematic Analysis (Clarke and Braun, 2021). For the purpose of this paper, we report on a follow-up

[1] See Centre for Digital Citizens blog post: 'Research co-production with ReCoCo to understand community-based support for wellbeing'.

Fig. 4. Interview set up (left); interview clips (middle), and screening of interview clips with participants for feedback and reflection (right).

Table 1
Participant demographic table with fictional names.

Fictional names	Age range	Gender	Ethnicity	Sexual identity	Attending College since	Attendance frequency
Elizabeth	24–34	Female	White/English	Heterosexual, straight	2016	Twice a week or more
Jenny	55–64	Female	White/English	Heterosexual, straight	2021	Twice a week or more
Rob	35–44	Male	White/English	Bisexual	Sep 2018	Once a week
Patrick	55–64	Male	White/English	Heterosexual, straight	2017	Twice a week or more
Lily	24–34	Female	White/English	Heterosexual, straight	Oct 2021	[left blank]
George	45–54	Male	White/English	Heterosexual, straight	2018	Once a week
Jacob	55–64	Male	White/English	Heterosexual, straight	Jan 2022	Twice a week or more
Oliver	24–34	Male	White/English	Heterosexual, straight	2018	Every couple of weeks
Edith	35–44	Female	White/English	Heterosexual, straight	[left blank]	Twice a week or more
Jane	24–34	Female	White/English	Bisexual	Jan 2022	Once a week
Ethan	45–54	Male	White/English	Heterosexual, straight	2018	Every couple of weeks
Debra	35–44	Female	White/English	Gay or Lesbian	5 years+	When off work
Barry	45–54	Male	White/English	Heterosexual, straight	Since it's been open	Twice a week or more
Thomas	45–54	Male	White/English	[left blank]	[left blank]	Once a week
Joseph	65 and over	Male	White/English	Prefer not to say	8 years	One a month or less
Stella	45–54	Female	White & Black African	Heterosexual, straight	8 years	Twice a week or more
Will	55–64	Male	White/English	Heterosexual, straight	2016	Twice a week or more
Michael	35–44	Male	White/English	[left blank]	2018	Twice a week or more
Daniel	35–44	Male	White/English/Filipino	Heterosexual, straight	[left blank]	Twice a week or more
Mia	Under 24	Female	White/English	Bisexual	Feb 2022	Twice a week or more

step of our analysis where we took a more deductive approach to explore the role of place in MH recovery. We used Doroud et al., (2018) as the main analytical lens for reviewing our preliminary themes and dataset. In this process, Claisse coded instances of *becoming*, *doing*, *belonging* and *being* (Doroud et al., 2018); these form the main overarching themes within the data. However, it was also noted how these instances were afforded by the social, material, and affective aspects of place drawing from Duff's (2016) concept of enabling resources. The overall analysis process was supported by roundtables with the research team. Thematic insights and anonymised transcripts were also shared with staff at ReCoCo for feedback.

4. Findings and discussion

We present our findings according to the four mechanisms of place (place for *being*, *doing*, *becoming* and *belonging*). The subsections (i.e. sense of security) represent the associated characteristics highlighted in the framework through which place impacts recovery (Fig. 5).

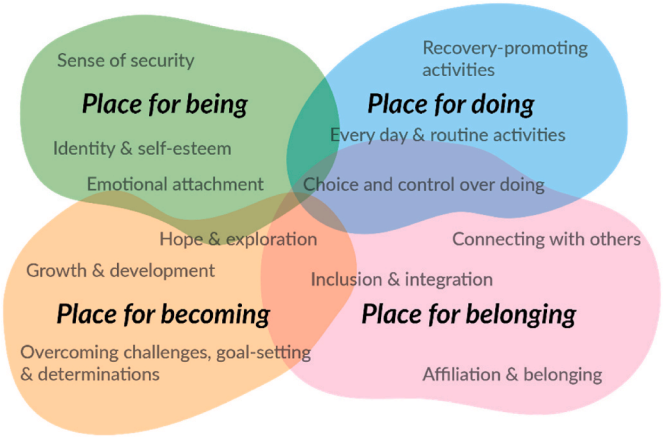

Fig. 5. Four dimensions of place adapted from Doroud et al. (2018) framework by first author Claisse. It highlights the four mechanisms and associated characteristics.

4.1. Place for being

4.1.1. Sense of security

Students described ReCoCo as a safe place: For instance, Oliver commended the college for creating 'such an incredibly welcoming safe space' whilst Ethan observed '[it] will always be my safe space'. Students also recalled times when they entered the building feeling stressed and left feeling calm and grateful, 'I have this lovely sense of peace [when leaving the building]' (Edith). They described how the 'almost zen-like' (Rob) environment with its 'rainbowy colours' (Mia) afforded a sense of calm and peace. Indeed, the peaceful quality of the place felt reassuring for new students like Mia who recalled her experience of completing the enrolment process: 'It felt really calming and just really down to earth, you know'. She described this in contrast with her

experience of other services where communications felt more intense and were either online or via a phone call; 'so just having it face-to-face with a person, who has been there before as well, was really nice'.

The place was described as a 'non-judgmental environment' (George), associated with a sense of safety: 'It's non-judgemental and you can feel very comfortable from the moment you walk into ReCoCo to the moment you leave' (Jacob). This was new for some students who felt understood and able to talk freely with peers: 'I can talk about it [mental health] and people do understand 'cause they have similar experiences themselves and I always – I never feel judged here and I have at other places' (Edith); 'it's like-minded people, they don't judge you. And it doesn't sound a lot but that is a lot, it really is' (Jenny). Students talked about that shared understanding where people don't have to explain everything because peers just know straight away, 'they tick the same boxes as me' (Joseph); Mia talked about that 'understanding nod' that people would get from peers as walking inside the building, 'so everyone just gives you, like, kindness and empathy, like, straightaway'.

4.1.2. Identity and self-esteem

When coming to the college, students talked about experiencing an identity shift; feeling no longer perceived as a person defined by their mental illness: '[when] you walk in here, I'm no longer my diagnosis. It's, kind of, irrelevant. My diagnosis wasn't relevant here' (Debra); 'We're all more than whatever our diagnosis […] we all have worth, and this place helps people find that' (Patrick).

Students also described the place as authentic: 'it's not fake. It's so real, you know' (George). They appreciated coming to the college (ReCoCo) because there was no expectation and no need to perform: 'You can just sit in the corner and say nothing and it wouldn't matter. You wouldn't be judged for that. It would just be accepted' (Debra). Ethan also commented that 'you can just be yourself… if you're depressed you don't need to perform, you can just, sort of, slump in and sit in the corner if you want and just have a cup of tea and do nothing if you don't want to do anything'. Indeed, students felt like the college was a really good place for being themselves particularly 'when having a bad day' 'because people will understand, and they'll be supportive' (Lily); 'You say things what's on your mind and they [peers] don't bat an eyelid' (Jenny). They compared ReCoCo to other physical places, where they described not 'fitting in' (Stella, Barry); 'in the "normal" world [where] you're not supposed to be depressed' (Ethan); 'where people out there, like family and stuff, didn't understand us, didn't get us, whereas coming here, it's a sense of-it's a feeling of acceptance for me' (Stella); 'somewhere to be accepted for who I am' (George).

4.1.3. Emotional attachment

Students demonstrated some levels of attachment to the place. They were grateful for it because it provided them with a supportive place: 'I love ReCoCo, I can't praise it enough' (Jenny); 'I love the place, you know. It's, it's absolute gold' (Rob); 'I love the place… it is an environment where there's a lot of support' (Patrick). Mia further explained how the building was a supportive place for her mental health:

> *What [coming to the college] did was made me, kind of, legitimise what I was going through […] as soon as I stepped in the door I was like, "I'm in a big building that is just for my mental health, erm, and it's for my mental health."*

The place was described as unique for its 'sense of community' 'like a proper community hub' (Debra), which Patrick described as 'ReCoCo's magic'. Indeed, students like Debra who went back into full-time employment would keep coming back when possible:

> *I'm just gonna stick my head in and say hi, …I've left here and moved on to something better that I never would have achieved without this place. So being able to come back and say, "Look, I'm alright, this is great, it's going great, it's going well and it's going well because of everything that I learnt here."*

Debra concluded that there should be more places like this: 'the world would be a much better place for having more ReCoCo, that's for sure'.

4.1.4. Place for being: summary discussion

Place for being influences recovery by providing a sense of security and stability (Doroud et al., 2018). In our case, students highlighted the peaceful qualities of the place and it being a non-judgmental environment, which was found to help cultivate what Duff called 'atmospheres of recovery' (2016). Students also described being in a place that felt *authentic* because they could be themselves (i.e. they could just slump in and sit in the corner if they felt depressed), and this contrasted with the outside or 'normal' world where places that are institutionalised or too restrictive were found unhelpful for recovery (Doroud et al., 2018). In addition, being in a place where one could be accepted and perceived as a whole person, beyond a medical diagnosis, was important for regaining a sense of self-worth. Indeed, places for peer support like ReCoCo favour 'collectivist understandings of identity', which in turn help rebuild a positive sense of identity (Leamy et al., 2011) – one that moves away from being defined by a mental illness (Doroud et al., 2018). Finally, students appreciated being in a place that was dedicated to their mental health, which helped them acknowledge and legitimise what they were going through.

They also demonstrated some attachment to the college for its sense of community, safety and social inclusion. These characteristics relate to what Duff called 'enabling resources' and more specifically 'affective resources' (2012), which are key for facilitating recovery.

4.2. Place for doing

4.2.1. Everyday and routine activities

Students talked about how coming to the college helped them re-establish a routine: it gave them a sense of purpose whilst supporting their daily routine, which was good for their mental health. For example, Jenny said 'It gives you a purpose to get up, get dressed, knowing that you're gonna see friends…'. Lily said how coming in gave students 'something to look forward to and a bit of a little routine to be in'. This felt critical for students who were once unemployed or living in isolated situations due to their mental health conditions. As a result, 'getting out of the house' (George) and having a place to come to was highly appreciated as demonstrated with Elizabeth and Oliver who were both discharged from various health services; 'I had nowhere else to go because I've literally been binned off by services' (Elizabeth); [Coming to the college] gave me somewhere to go once or twice a week. It gave my week a bit of structure and, er, it helped out a lot, yeah' (Oliver). This was also reflected by younger students (Jane, Mia) who reported not having much to do every day whilst being off ill or unemployed. Jane who was on a break from her studies due to mental health difficulties observed: 'because I have places like this, and places like my church, it no longer means that I'm just inside staring at the ceiling. I have a place to come to'. Mia who was unemployed at the time described that she did not have anything to do each day whilst job searching and like Jane, she valued having a place in town she could come to.

Coming to the college provided a sense of achievement but there were also challenges for people to come in and establish a new routine. Students could feel unwell or anxious coming in as with Patrick who recalled his experience of coming to ReCoCo for the first time four years ago:

> *Well, when I first came in, I was quite anxious, because previously I was a psychiatric nurse and, though I tried to help lots of people, the one person I couldn't really help was myself. So I, I felt a lot of shame and guilt working in the, the mental field but struggling myself with my own mental health. So, coming in was really difficult.*

Students also talked about the difficulties of picking up a routine post-pandemic, and highlighted the role of staff members in terms of

checking in with students who were seemingly out of a routine. For instance, if students were not attending the college for a while, staff would give them a call to check in, using information provided at the enrolment. In such instances, a personable approach to follow-up by staff seemed to show care and compassion for the students, to support their continuing engagement.

4.2.2. Recovery-promoting activities

The college offers a rich programme of recovery-oriented courses and activities such as craft and music therapy, which reportedly help students feel better about themselves. For instance, Lily who described often taking part in music therapy and singing drop-by sessions observed:

> *Music and singing is, like, one of my wellness tools. I really like music and it makes us feel happy. I can't sing for toffee but it's not about how you sing, it's about the feeling behind when you're singing – it's important.*

Students also talked about the opportunities to develop their own course and teaching others things they were passionate about. Examples of this included: Stella who said that she was able to use her sewing skills to run a sewing course at the college, 'it's very rewarding to have something, an object there in front of you and say, "Wow, I've made that"'; Barry explained how he was encouraged by staff to set up his own Drug and Alcohol peer support group, which gave him a sense of purpose and pride, 'because I need to support other people and put in place what wasn't there for me in the past', and Daniel who was able to use the space at the college to host his own peer support group for people who experience Psychosis. These students were given the opportunity to progress to volunteer roles and later, they were offered a paid position as facilitators. In this case, the space was configured to suit their needs with material resources playing an important role in scaffolding their recovery-promoting activities.

4.2.3. Choice and control over doing

At the college, students appreciated *doing* things in 'non-prescribed' ways (Rob) and 'at their own speed' (Will). This contrasted with previous experiences in institutionalised and clinical care structures where people were forced to do activities, which did not work for them. This pointed to a lack of choice and control, which contrasted with experiences at the college. Indeed, Rob observed that it was not like a 'mainstream college' with 'a set curriculum' and explained how he was able to bring his own materials to work on his own craft projects, which he enjoys doing. There was also no pressure for students to engage in any activities as highlighted by Elizabeth:

> *Today, I am facilitating Creative Wellness upstairs where people come and it's from 10:00 to 12:00 and you can either just sit and chat and have a cuppa if you want or you can join in colouring in, painting, whatever. There's a lot of tools and materials for people to use.*

Activities on offer were also varied to suit different people as described by Barry:

> *There's (sic.) courses happening in the rooms here next door and courses aren't for everybody. But then you've got stuff like the drop-by where people can just come and relax, have a cup of tea and have a chat with somebody. And then if you're creative, there's a bit of art or a bit of music.*

Mia further described a sense of openness and flexibility of the place in terms of catering for people's needs overtime:

> *Having a place that's open – and is just, kind of, chugging along and you can, erm, plug into it and then plug out of it and plug into it, like, is really, really important. So yeah, more things like ReCoCo.*

4.2.4. Place for doing: summary discussion

Place for doing helps people re-establish a daily routine, which can positively influence recovery (Doroud et al., 2018). Daily routine is a key component for MH recovery, something that was acutely demonstrated when many found themselves struggling with the loss of routine during the COVID-19 lockdowns (Branley-Bell and Talbot, 2020). In our case, coming to the college helped students re-engage with life outside of their home, which had a significant impact on their lives. Our insights align with previous work that shows how people living with MH conditions are more likely to live socially isolated (Duff, 2012; Mind, 2020; Yates et al., 2012; Whitley and Drake, 2010) and this has gained new significance since the COVID-19 pandemic (O'Shea, 2021). Indeed, barriers for accessing place were also reported (i.e. anxiety), which illuminated the complexity of living with a MH condition. In this case, staff and volunteers played an important role for scaffolding engagement, and providing a place that is as inviting as possible. Their level of care can be described in terms of proactive care (Ding et al., 2023) whereby staff or others in the peer support community do not wait for people to seek help but actively check in via social cues and asking or listening to people. Here we refer to the concept of 'enabling resources' and more specifically, affective resources (Duff, 2012) to consider how proactive care may facilitate emotional ties with the place and in turn enable long-term engagement with the service, which leads to better health outcomes (Ding et al., 2023). Long-term engagement is critical if MH recovery is to be understood as a lifelong journey. In our case, students were enrolled for life enabling them to 'chug along' and 'plug into and out of' the college when needed. In the case of a prolonged absence, they would be required to re-enrol but this opportunity for lifelong engagement was appreciated and contrasted with their experiences in medical settings echoing previous research that highlighted the more rigid and illness-centred approach of medical institutionalised places (Yates et al., 2012).

Place for doing also promotes a sense of agency, which is an important aspect of MH recovery (Doroud et al., 2018; Yates et al., 2012; Whitley and Drake, 2010). At the college, students described a range of recovery-oriented activities being on offer, which they could choose from and engage in at their own pace. Indeed, they valued taking part in activities in 'non-prescribed' ways and pursuing hobbies, which led them to teach peers things they liked doing (i.e. sewing, Stella). They felt empowered through making choices, which had a potential impact on their recovery as it helped them feel more in control of their lives (Whitley and Drake, 2010). Fostering feelings of control is an important factor in aiding MH recovery (Branley-Bell and Talbot, 2021). In addition, they developed skills and passion using the college's material resources (i.e. craft materials, musical instruments, educational resources) – things that they could not access or afford otherwise. They were also able to use the space at the college to deliver their own wellbeing activities or organise their own groups. Here we use the concept of material resources (Duff, 2012) to highlight the material affordances that a local community setting like ReCoCo makes possible' for encouraging holistic wellbeing.

4.3. Place for becoming

4.3.1. Hope and exploration

Being in a place with peers sparked hope because each student was able to recognise that they were not the only person suffering, and that recovery was possible (Oliver, Joseph). For Barry, it is about that shared experience and the connection: 'if you run a self-harm group and you see somebody that's got scars and has managed to overcome it, you can kinda connect with that person'. He further explained the power of peer-to-peer connection, which gives people 'that hope that this normal person has turned his life around so they can turn their life around'. Hope was elicited by peer-to-peer interaction; by witnessing peers' progress: 'You see people when they come at the start of their journeys and you can see them grow in confidence and start to come out of their shells and do more and it is such an amazing thing to see'. For Debra, it was others at the college who showed her that there was hope:

'[This place] sparks that hope, like, you come in the door a really broken woman […] I didn't think my world was ever gonna get any better than that. Erm, and coming here, the staff, the students, the facilitators, erm, they all showed me that actually hope is, there is hope. Erm, when you find that spark of hope, er, it just starts as a little, little fire, a little flame and then before you know it, it's, it's a full-on raging fire.

Once Debra regained hope, she explained how the college gave her all the skills she needed to explore her life from a different perspective 'through things like Mindfulness, WRAP (Wellness Recovery Action Plan), DBT (Dialectical Behavioural Therapy) and all the other-Reducing the Rage, all the other wonderful courses that they do here, like, Woodland Wellbeing, all those amazing things, erm, gave me the opportunity to learn the skills and actually it sparked hope'.

4.3.2. Overcoming challenges, goal-setting and determination

A majority of students recalled having to overcome significant challenges when first coming to the college: 'I came here at a very dark point in my life' (Edith), 'I was at the bottom of a deep, dark hole' (Debra). Indeed, Edith had lost her job and purpose in life and Rob joined ReCoCo after 'a pretty traumatic experience', which left his self-esteem 'pretty low'. For them, the college helped them 'cope and move from the difficult situation to a better place' (Jacob) where they could regain hope and establish new goals for their life. Determination was fuelled by new possibilities and directions that students would have never envisioned: 'I never envisaged that I would be employed by the NHS full-time, doing what I'm doing now' (Debra). Indeed, four of them (Edith, Debra, Rob, Joseph) described their experience in terms of being lifesaving.

When I first walked through the doors... I was a broken woman and there's no other way to describe it. I wasn't the same person then as I am now. Erm, ReCoCo saved me, like, saved me from myself. (Debra)

4.3.3. Growth and development

All students talked about their experiences at the college in relation to growth and personal development. Two of them used the verb "blossom": 'They've watch me grow, they've helped us grow as well, they've blossomed us' (Elizabeth); 'I feel like I've blossomed coming here, almost like a butterfly that's come out of a cocoon and spread its wings and you see that with your peers here as well' (Edith). Patrick described how he 'grew within the courses' that the college offers, and Lily explained that her confidence grew a lot through attending the college's drop-by for creative writing. These experiences of growth were associated with feelings of pride, achievement, and self-worth, through which people were able to recognise their unique talents and develop personal interests.

Growth was also scaffolded by the peer-led approach whereby the college encourages students to progress by becoming volunteers, and, where possible, to become paid members of staff. Over half of our sample were now either volunteering or working at the college and commented on the value of being able to progress at their own pace; Barry observed: 'I've kinda progressed my way up'; Debra explained that she was trained to become a facilitator and took on a little bit more responsibility, which she appreciated; Edith who just got a job at the college explained how she slowly regained confidence in herself: '[it] restored my faith in workplaces and helped give me back the confidence that I lost when I was ill'. Debra explained that she was now ready 'to jump into actual full-time work again'. For others, it took more time: Stella who had been at the college for over seven years commented that she was 'still on a journey', aspiring in the future to work in hospital settings to support people with MH issues.

Giving people time and material resources like musical instruments but also training packages were critical for supporting growth and students appreciated these resources particularly in these uncertain times as one student observed:

I will just say that, I don't really know how its funded or anything like that, but, like, it's really good, good in this era, era of cuts to public services that it's available for- to be used, yeah (Oliver).

4.3.4. Place for becoming: summary discussion

Place for becoming fosters a sense of hope and individual growth (Doroud et al., 2018). In our case, relating to peers, witnessing others' progress, and knowing that people were not alone 'sparked hope', which is found to support 'existential recovery' (Whitley and Drake, 2010). Indeed, hope and optimism about the future are two critical processes of recovery (Leamy et al., 2011) and our empirical insights showed how these processes can lead to growth: students became more confident and over time, they were able to find self-worth through recognising their unique talents and pursuing meaningful activities. Students also described their experience of growth at the college in terms of 'blossoming'. Part of this was scaffolded by the college's peer-led programme whereby students were encouraged to progress their way up from students to volunteers, and eventually to paid members of staff. This included 'infrastructural work' in terms of training and fostering people to become active participants rather than passive recipients of care (Ding et al., 2023). One student (Debra) even shared that she was offered a job in the NHS, therefore 'outgrowing' the place (Doroud et al., 2018) and showing how places like the college may support 'functional recovery' (Whitley and Drake, 2010) whereby people can regain self-esteem and confidence through re-engaging with work and succeeding in employment.

4.4. Place for belonging

4.4.1. Connecting with others, inclusion and integration

The college offers meaningful activities and a place for social connections, which are nurtured through shared values (i.e. compassion, kindness). Students talked about how they connected with others, got to know them and made friends through attending courses and drop-by sessions in the building, in person. Indeed, George described how interacting with 'real people' and doing the courses had a better outcome for him than doing years of psychotherapy. Students also talked about building lifelong friendships, which went beyond an association with their MH diagnosis: for example, Patrick talked about building 'friendships that go beyond whatever, you know, your mental health issue might be' and George observed how people will get to know each other pretty quickly through the courses and how 'after, like, a couple of hours in the room with somebody you might have a new best friend for life and it's just a lovely feeling'.

Students described what made a 'friendly atmosphere' (Jacob): for example, Lily appreciated that people would get to know how she liked her coffee, 'It's, like, just shows that people are really interested in you'; Joseph appreciated 'people's friendly words', 'that counts for a lot'; and Mia talked about people's positive voices or how she would get 'a flood of positive voices' by coming to ReCoCo. Patrick described the college as 'an environment where there's a lot of support, love and a word we don't often hear, care'. Care and mutual support were indeed important: 'I'm always available if somebody wants to have a chat and, and I'll say, "Yeah, I know. I know where you're coming from, with, with, er, mental health issues"' (Joseph). Rob reflected on how this level of care makes the place 'so compassionate', and further expanded on what he termed as 'the ReCoCo Effect': 'As soon as I walk in the door, you know, and I see all my friends, all the friendly faces, you know, it lifts my mood'. Joseph also commented: 'As soon as I approach the building, I know there's somebody I'm gonna say hello to that knows me'.

4.4.2. Affiliation and belonging

Place for belonging is also where one can meaningfully contribute to the community (Doroud et al., 2018). Students talked about contributions in terms of *giving back* to the place. Indeed, the process of giving

and receiving is central to peer support, and this was illustrated by Jacob and Will who came to the college 'to see what I could give and what I could learn. And I'm doing both' (Jacob); '[the college] it's been a really important place for me, really, er, to give and to receive' (Will). Patrick also observed:

> *I suppose is that every person who comes here has got something to give. And whether that's just a simple smile to somebody else or a listening ear or helping people develop the place further, like, by doing things like this.*

Students explained how they gave back to the place through volunteering: 'I've trained to facilitate mindfulness, so there, there are opportunities to, you know, do, do more and volunteer, you know, give something back I guess' (Michael). Debra who used to volunteer said that passing on the knowledge to peers was her way of 'paying it forward': 'I was taking the things that I'd learnt as a student and being taught how to help other students with the same things that I knew had helped me'.

4.4.3. Place for belonging: summary discussion

Place for belonging encourages social connection and community participation (Doroud et al., 2018). Indeed, connectedness through peer support is part of the recovery process (Leamy et al., 2011) with peers acting as social healers for recovery (Whitley and Drake, 2010). Here we also connect with the concept of 'enabling resources' and more specifically 'social resources', which is highlighted as the most important resource for promoting recovery from mental illness (Duff, 2012). Regaining a sense of social integration is central to the process of recovery and Yates et al. (2012) introduced the term 'replacement community' to explain how people may heal feelings of loss and rejection by joining and feeling part of a new group or community. In our study, students valued social interaction with peers; they talked about forming new connections and friendships from the moment they entered the building. This was facilitated through what Duff called 'atmospheres of sociality' (Duff, 2016) where one can feel acknowledged and included through compassion and friendliness (i.e. visual cues like that 'understanding nod', Mia). Another important aspect of place derived from our insights is the two-way process and the importance for people to give something back to their peer community. Students described different ways of giving back, which increased their sense of membership and belonging.

5. Implications, limitations and future work

Our findings show the unique contribution that place for peer support can provide in establishing and maintaining MH recovery. Whilst remote support is rapidly increasing and brings with it benefits around potential reach, cost savings, increased capacity, and ease of access; it is important that we recognise that it should not be considered a replacement for in-person place-based support. Both approaches bring their nuanced benefits and challenges (Ding et al., 2023). Likewise, people are different and what works for one will not necessarily work for another. Our study participants described place for peer support in the community as 'lifesaving' therefore we must continue to maintain place-based approaches and see remote services as a complement, not a replacement (Murphy-Morgan and Branley-Bell, 2022). A broad-stroke 'one-size-fits all' approach to transitioning from physical to remote services is unlikely to be successful, and indeed could be catastrophically detrimental to many individuals experiencing MH issues.

Place is an often-overlooked commodity, potentially dismissed by some as simply a shell or vehicle through which to deliver a service. However, as we have demonstrated, place is much more than that – it is a lived environment constructed by the people within it, and through interactions, shared experiences and shared emotions with others. The participants in our study talked about how ReCoCo as a physical place provided somewhere to re-discover themselves, to connect meaningfully with others, to feel less alone and to feel accepted and understood. The space also allowed to regain a feeling of control over their lives and played a role in helping them rebuild a daily routine. There is a vast body of literature spanning decades that supports all of these as important factors in promoting and maintaining MH recovery. What has been missing from the literature, is empirical evidence explaining why – for many individuals –these factors can be explicitly and fundamentally tied to a physical space (Doroud et al., 2018; Duff, 2016). Our study helps to promote recognition of the value of place for MH recovery.

Community-based MH organisations are uniquely positioned to respond to emerging needs with practical and emotional support (Bynner et al., 2022). Our findings demonstrate how through flexibility and openness the college welcome students to 'chug along' and 'plug into and out of' the place when needed. This is critical for MH recovery as a non-linear and lifelong journey (Ellison et al., 2018; Whitley and Drake, 2010) but such an approach requires significant resources to accommodate people's long-term needs. Therefore, we call for more recognition of the value of place-based MH support, and the factors (i.e. resources) that underpin and build a welcoming space that is conducive to effective peer support. We highlight the need for further empirical research in this area, and in particular further investigation around how service providers can measure and/or demonstrate the value of physical place to potential funders who may overlook the nuanced benefits that place can offer. Whilst it is encouraging to see increased integration of peer support workers within the NHS (Gilbert, 2022; Kane et al., 2023), it is also important that existing peer-led community-based MH support organisations are recognised for the value they can bring that may be difficult to emulate within public health settings (Bynner et al., 2022).

Finally, we acknowledge the limitations of this study. First, we have engaged with one peer support community organisation and therefore we highlight an opportunity for engaging with other organisations from the voluntary sector to deepen the understanding about the role of place for community-based MH interventions. Second, we were able to interview 20 students but we recognise that our sample was limited in terms of people's demographics (i.e. cultural background and ethnicity) and also, by focusing on people who were already 'in the building' and part of the community. Therefore, we encourage future research with other groups who may not yet be part of a peer support community to investigate what challenges people might face in terms of access and inclusivity. Finally, we focused on evidencing the value of place-based approach to provide peer support to people with MH issues or diagnoses. In this case, we acknowledge the short length of the interview and the positive framing of the questions, which may have limited discussion of potential barriers and challenges with the service. We are also aware that by choosing to video record our interviews, some students may not have felt comfortable to take part. However, this method was successful for capturing people's feelings and lived experience, and for supporting sense making and dissemination to both participants and a wider group of stakeholders. Sense making and reflexivity were facilitated through our collective analysis with researchers in our team who have expertise within Design, Psychology and healthcare research, and through using the framework by Doroud et al. (2018). In this way, we were able to co-create an analytical space for critical reflexivity and taking subjectivities into account. Further to this, we acknowledge how the charity's co-directors' involvement in the study may have shaped data collection and dissemination but by working closely with our partnering organisation, we were able to co-develop a research agenda that incorporated their knowledge and priorities, reflecting best practice for community engagement in health research (NIHR, 2022). This study has informed follow-up research engagements at the college including co-creation workshops with different groups. Insights from this follow-up work will be reported in a future publication.

6. Conclusion

Our findings demonstrate the role of place in the context of community MH support and recovery. We contribute to discourses in Social

Science and Health research by providing empirical insights from interviews with students about their experience of attending a recovery college in the North East of England – a region that experiences higher health and social inequalities than other regions in the UK. This research is timely as community-based MH organisations have faced challenges for securing in-person service delivery with many peer support services shifting to online platforms post-pandemic. With our work, we evidence the value of place, and the critical role community-based organisations play in MH recovery. We contribute to existing literature with a case study on place-based approach in a peer support context and draw from previous work to explicate the affordance of place for community support. More specially, we show how place for peer support impacts recovery through different dimensions of place i.e. *being*, *doing*, *becoming* and *belonging* (Doroud et al., 2018). We also highlight different types of 'enabling resources' (Duff, 2012) that are needed to foster welcoming and nurturing places for MH recovery. Finally, we draw out key implications, which we summarise as followed: (i) Accessing a building dedicated to MH support is vital for people who do not have anywhere else to go and are socially isolated due to their health conditions; (ii) Connecting through peer-to-peer interaction is an integral part of the recovery process and learning from people with lived experience can inform a place-based approach that best suit their needs, and (iii) Recognising the value of place for MH support and the resources needed for peer support delivery in the community will help secure places that our research participants described as lifesaving.

We have acknowledged the limitations of this co-produced case study, which informed the analysis and further study designs. In future research, we see an opportunity to consider how those insights may be transferred to health psychology service provision, to be more aligned with the complex needs of service users and the concept of recovery as a lifelong journey.

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CRediT authorship contribution statement

Caroline Claisse: Writing – review & editing, Writing – original draft, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Abigail C. Durrant:** Writing – review & editing, Supervision, Methodology, Investigation, Funding acquisition, Formal analysis, Conceptualization. **Dawn Branley-Bell:** Writing – review & editing, Formal analysis. **Elizabeth Sillence:** Writing – review & editing, Methodology, Formal analysis. **Angela Glascott:** Writing – review & editing, Resources, Conceptualization. **Alisdair Cameron:** Writing – review & editing, Resources, Conceptualization.

Declaration of competing interest

None.

Data availability

The authors do not have permission to share data.

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