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Review essay

Place for being, doing, becoming and belonging: A meta-synthesis exploring the role of place in mental health recovery

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ABSTRACT

Background and aim: The role of place in mental health recovery was investigated by synthesizing qualitative research on this topic.
Methods: Using a meta-ethnographic approach, twelve research papers were selected, their data extracted, coded and synthesized.
Findings: Place for doing, being, becoming and belonging emerged as central mechanisms through which place impacts recovery. Several material, social, natural and temporal characteristics appear to enable or constrain the potential of places to support recovery.
Conclusions: The impact of place on recovery is multi-faceted. The multidimensional interactions between people, place and recovery can inform recovery-oriented practice. Further research is required to uncover the role of place in offering opportunities for active engagement, social connection and community participation.

1. Introduction

This paper explores how people living with mental health issues experience the role of place in their recovery. By summarizing and integrating findings form qualitative studies, this paper aims to contribute to the knowledge about the significance of place in health and wellbeing.

1.1. Recovery; does place matter?

The term 'recovery' is widely used in the mental health field, yet it has divergent origins and meanings that are both multifaceted and contested (Davidson et al., 2005a; Lal, 2010; Whitley and Drake, 2010). From a clinical perspective, recovery is used to refer to cure, that is the remission of symptoms of the mental health conditions and restoration of previous functioning (Davidson et al., 2005a, 2005b; Whitley and Drake, 2010). Understandings of recovery originating from the mental health consumer-survivor movement and the lived experience of people with mental health issues have challenged these traditional clinical notions of recovery based in deficits and pathology (Slade, 2009). Grounded in this lived experience perspective, personal recovery is viewed as a self-directed journey, through which people discover new possibilities and create meaningful and satisfying lives of their choosing that are not defined by mental illness, whether or not symptoms persist (Davidson and Roe, 2007; Slade, 2009). So, while personal recovery may be described as a process of (re-)building a positive identity, a sense of meaning, purpose and hopefulness, determination and responsibility, there is no single path in recovering (Anthony, 1993; Davidson and Roe, 2007; Leamy et al., 2011; Slade, 2009). A further facet of recovery is social recovery, which focuses attention on the interpersonal and community arenas in which people's everyday lives are embedded (Whitley and Drake, 2010).

There is growing recognition that social inclusion, community participation and citizenship are pivotal to social recovery (Mezzina et al., 2006a, 2006b; Tew et al., 2011; Vandekinderen et al., 2012). However, people living with mental health issues experience challenges to social recovery due to persistence of discrimination in housing, employment, social and public arenas (Mezzina et al., 2006b; Thornicroft, 2006). Further, people with mental illness may face barriers in accessing community resources to make meaningful choices and assume socially valued roles that support recovery (Borg and Davidson, 2008; Bradshaw et al., 2007; Duff, 2016; Onken, Craig, Ridgway, Ralph and Cook, 2007; Thornicroft, 2006). Thus, to promote mental health recovery, it is necessary to more closely attend to people's experiences of places for constructing meaningful lives, connections and participation within their communities (Mezzina et al., 2006a; Slade et al., 2014;

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Tew, 2013; Onken et al., 2007).

1.2. What is place?

Places are where people live; develop a sense of meaning, identity and self-efficacy; find community connections and identify opportunities for participation (e.g. Curtis, 2010; Macintyre et al., 2002; Manzo and Perkins, 2006; Paulsen, 2004). Place has typically been difficult to define. Several approaches and terminologies are used to conceptualize place across disciplines (Cummins et al., 2007; Macintyre et al., 2002). Generally, objective and subjective approaches are the main ways of defining place (e.g. Cresswell, 2014; Kearns and Gesler, 1998). From an objective view, place consists of observable physical and social attributes, such as material objects, spaces, and the presence of other people (Castree et al., 2013; Harrison et al., 2016). In comparison, subjective perspectives focus on meanings, experiences and social interactions, viewing place as fluid, dynamic, experiential and relational. As a lived environment, place is interpreted by the individuals and constructed through social interactions, cultural values and shared meanings (Castree et al., 2013; Cresswell, 2014; Cummins et al., 2007). Based on experiencing place over time, it has been observed that people develop meanings, establish daily routines, form emotional ties, and develop a sense of 'insideness' (e.g. Cresswell, 2014; Paulsen, 2004). These experiential aspects of and emotional ties with place are often referred to as 'sense of place' (Beidler and Morrison, 2016; Convery et al., 2014). Social interactions, collective meanings, shared values and cultural beliefs can also transform places into communities (e.g. Cresswell, 2014; Fisher et al., 2002; MacQueen et al., 2001). Landscape is a further way to define place, which has been used metaphorically by health geographers to explain the links between people, places and health. The mechanisms through which place impacts the lives of individuals or populations are theorized as different 'types' of landscapes. Therapeutic landscapes (Gesler, 1993), for example, refer to built and natural places that can have physical, mental or spiritual healing impacts. Yet, as Cresswell (2014) argues, "we do not live in landscapes, we look at them" (p. 18), so that landscapes tend to provide an outsider view rather than a lived, or insider perspective of place. Hence, as a relational, dynamic and experiential context, place is constructed through experiences, actions, interpretations and interactions (Andrews et al., 2014; Cummins et al., 2007).

1.3. Aim

The ways in which people make sense of and interact with place during their recovery have not been systematically studied. Housing type, neighborhood characteristics, location and access to facilities, material objects, natural landscapes and public places have each been individually identified as potentially important factors in recovery (e.g. Brewster, 2014; Duff, 2016; Townley et al., 2009; Yanos, 2007). Furthermore, some evidence suggests a role for place-based interventions focused on supported housing, neighbourhood safety, and the qualities of shared community spaces for promoting mental health (Aubry et al., 2015; Brewster, 2014; Duff, 2016; Pitt, 2014; Whitley and Prince, 2006). However, such interventions generally focus on physical and location-based aspects of place (Thornicroft, 2006; Whitley and Prince, 2006). What is less well understood is how people with mental health issues experience place, connect to the community and develop sense of belonging and attachment through access to personal and community spaces (Milner and Kelly, 2009). This paper aims to contribute to knowledge about people's experiences of place and its impacts on health and wellbeing, by reviewing and synthesizing findings from qualitative studies. It explores experiences of place in recovery as viewed by people living with mental health issues. A better understanding of the role of place in recovery will also broaden our understanding of people's lives and resources for supporting recovery (Sweet et al., 2017), as well as informing the further development of place-based initiatives designed to promote health and wellbeing.

2. Methods

A qualitative meta-synthesis method was used to review and synthesize research about the role of place in recovery as viewed by people experiencing mental health issues. Qualitative meta-synthesis refers to a group of systematic review methods that summarize and conceptually integrate findings from qualitative studies, so as to develop new understandings that can inform policies and evidence-based practices (Barnett-Page and Thomas, 2009; Bondas et al., 2013). Meta-ethnography is one approach which was first developed to combine meanings across ethnographic studies. It emphasizes the development of higher order interpretations or models of the phenomena being explored (Doyle, 2003; Noblit and Hare, 1988). Guided by a meta-ethnographic approach, our review involved the following steps: 1) targeting the relevant studies; 2) reading and appraising the studies; 3) deciding how studies are related; 4) translating and synthesis; and 5) presenting the synthesis and writing up (Bondas et al., 2013; Doyle, 2003).

2.1. Targeting relevant studies: search and selection

We searched three electronic databases (CINAHL, PsycINFO, and MEDLINE), as well as reference lists, citation tracking, key journals and a Google Scholar general search. Search terms on the topic included: *mental disorder$, mental health issue$, mental illness$, psychiatric patient$ or psychiatric disabilit$; environment$, place$, housing$, facility resource$, communit* or material object$; recovery, mental health lived?experience or mental health life?experience.* Terms used to identify qualitative studies were: *qualitative studies, phenomenolog$, grounded theory, interview$, participatory action research, perspective$, ethnograph$, exploratory research, naturalistic inquir$ or multimethod studies.* We limited the search to articles written in English, published in peer-reviewed journals between 2000 and 2016, and included adult participants only (19 years of age and above).

Study selection took place in two phases (Fig. 1). First, through reviewing the abstracts, we selected qualitative research articles whose aims addressed the links between place and recovery. Twenty-one studies were selected through this phase. Second, each of the authors selected studies independently through reviewing full-texts. Since this paper aims to understand how place influences recovery as a lived experience, rather than a clinical outcome, studies were included if they: 1) defined recovery as a subjective process; 2) focused on place from the perspectives of people experiencing mental health issues; and 3) addressed place as a 'normal' environment encountered in daily life, rather than a clinical or treatment setting. As a result, 12 studies were chosen for the meta-synthesis.

2.2. Reading and appraising the studies

We extracted key information from the twelve selected studies (Table 1). Through data extraction, we appraised methodological and interpretive rigor of the studies across 10 areas (congruence, responsiveness to social context, appropriateness, adequacy, transparency, authenticity, coherence, reciprocity, typicality and permeability and researchers' position) (Fossey et al., 2002). Quality assessment seems the most debated phase among meta-synthesis methods with differing views about whether it should be done and how (e.g. Bondas et al., 2013; Gewurtz et al., 2008; Sandelowski, 2012; Walsh and Downe, 2005). In this meta-synthesis, we used the appraisal checklist to enhance our understanding about the strengths and limitations of the studies, but not to include or exclude studies based on their rigor.

2.3. Deciding how studies are related

Determining how the findings of the studies can be compared and