PROMOTING INNOVATION IN HOMELESSNESS AND MENTAL HEALTH SERVICE DESIGN: AN ADAPTATION OF THE TRAJECTORY TOUCHPOINT TECHNIQUE

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ABSTRACT

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Across much of service research, there has been increasing attention granted to consumer wellbeing as a key outcome of value cocreation, with the potential to extend far beyond the duration of a service experience. Such meaningful long-term change is denoted by the concept of transformative value, developed within the wellbeing-oriented field of transformative service research (TSR). Researchers within TSR have drawn attention to the importance of both service design and broader service networks. Conversely, important gaps remain regarding integration of resources across multilevel domains, including the role of customer networks and how transformative value creation relates to therapeutic resource availability. Furthermore, there remains a shortage of TSR on meso-level factors shaping vulnerability emergence and alleviation, understanding of which appears necessary to address the research priority of serving marginalised consumers.

The aim of this thesis is to investigate the constituents of transformative service in a context of multiple marginalisation. This is explored via the construct of transformative value in the experience (T-VALEX), synthesising and building upon extant concepts of transformative value and value in the experience (VALEX). Research consists of a case study within a charitable organisation, collecting qualitative data from three residential services targeting marginalised clients. Main stages of data collection comprise unstructured interviews and application of the adapted Trajectory Touchpoint Technique (TTT), a service design methodology using rich pictures to elicit consumer narratives.

Client narratives deliver qualitative insight into the cocreation of T-VALEX, highlighting key elements and processes across multilevel domains. Therapeutic resource integration is situated with this context, with novel findings regarding availability of these resources within servicescapes, across networks, and in relation to transformative wellbeing outcomes. Accounts of vulnerability emergence and alleviation illustrate the impacts of meso-level forces, which appear largely interrelated with processes of T-VALEX creation in contexts of marginalisation. Observations and explicit participant feedback regarding the utility of the adapted TTT are also presented and discussed, assessing the effectiveness of this technique within the research context.

Findings contribute towards understanding of TSR and transformative service design in a number of ways. The construct of T-VALEX is conceptualised as embedded in a multilevel value configuration space with facilitators emerging and interacting across the different levels, enhancing understanding of how and when value creation produces profound and holistic change. An extended conceptualisation of therapeutic resources is developed and also linked to T-VALEX creation. Additional frameworks are proposed regarding vulnerability emergence and alleviation, addressing the underexplored potential for meso-level forces to mediate the relationship between marginalised group membership and actual vulnerability perceptions. Methodological contributions arise out of insights into narrative elicitation and service design techniques, while contributions to practice include specific opportunities for innovation alongside broader implications for practitioners.

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Chapter One: Introduction

1.1 Background to Research

Over recent years, the field of service research has undergone a paradigm shift, due in large part to increasing interest in (and recognition of) the central role of customers in shaping processes and outcomes of value creation (Bova, 2018; Chathoth et al., 2013; Chathoth et al., 2016; Kontzer, 2016; McColl-Kennedy et al., 2012; Roy et al., 2020; Yi and Gong, 2013). This has occurred against the backdrop of the growing popularity and evolution of service-dominant logic (SDL), which frames value as uniquely and phenomenologically determined by a beneficiary, through processes of cocreation expanding beyond a customer/provider dyad to incorporate service networks and institutional arrangements (Grönroos and Voima, 2012; Lusch et al., 2010; Lush, Vargo, and O'Brien, 2007; Vargo and Akaka, 2008; Vargo and Lusch, 2004, 2008, 2014). However, some critics have asserted that much of SDL does not do enough to incorporate customers' individual networks and internal processes into interpretations of value creation (Grönroos, Strandvik, and Heinonen, 2015; Heinonen and Strandvik, 2020), influencing the conceptualisation of value in the experience (VALEX; Helkkula, Kelleher, and Pihlström, 2012)

Despite disagreements on what exactly value entails, the achievement/improvement of consumer wellbeing in some form is now widely accepted as a key outcome of value creation (Ballantyne and Varey, 2008; Grönroos, 2008; Seppänen, Huiskonen, Koivuniemi, and Kappinen, 2017; Vargo and Lusch, 2004, 2016). Consumer wellbeing is at the heart of transformative service research (TSR; Anderson et al., 2013), which seeks to explicitly centre the enhancement of wellbeing through innovation and improvement in service (Anderson and Ostrom, 2015; Anderson et al., 2013; Berry and Bendapudi, 2007). Developed within TSR, the concept of transformative value denotes a specific form of value creation, involving 'positive disruption' and resulting in meaningful long-term change (Blocker and Barrios, 2015, p.5). This research is built around the synthesis of and elaboration upon this and the aforementioned concept of VALEX, exploring the construct of transformative value in the experience (T-VALEX).

Over recent years, there has been increasing interest in how concepts of transformation and transformative value may be conceptualised and promoted in contexts of disadvantage and deprivation, including for those consumers classed as marginalised and/or vulnerable (Corus

and Saatcioglu, 2015; Davey, Johns, and Blackwell, 2023; Finsterwalder et al., 2020; Gallan and Helkkula, 2022; Johns and Davey, 2019; Ozanne and Fischer, 2012). Marginalisation is defined as the position of individuals, groups, or populations outside of mainstream society (Cheraghi-Sohi et al., 2020; NHS Wales, no date; Schiffer and Schatz, 2008). There is significant evidence to suggest a marginalised status is associated with poorer healthcare outcomes, attributed to various factors including barriers to communication; gaps and inclusivity issues in service design; and systematic exclusion from participation in policymaking (Aldridge et al., 2017; Cheraghi-Sohi et al., 2020; NHS Wales, no date).

Broadly speaking, the concept of vulnerability pertains to 'the quality or state of being exposed to the possibility of being attacked or harmed, either physically or emotionally' (Clark and Peto, 2018). Consumer vulnerability specifically has been defined in relation to difficulties accessing and/or processing resources in a consumption setting, compromising one's inability to realise maximum value from a product or service encounter (Baker, Gentry, and Rittenburg, 2005; Rosenbaum, Seger-Guttman, and Giraldo, 2017; Shi et al., 2017; Smith and Cooper-Martin, 1997; Visconti, 2016). While there has been extensive debate surrounding the conceptualisation of consumer vulnerability, key elements of which will be explored in the literature review (see Chapter 2), for the purpose of this research, vulnerability is defined as a transient state sometimes arising in relation to the relatively static trait of marginalisation. This thesis thus adopts Riedel et al.'s (2021, pp.120-121) definition of 'consumers experiencing vulnerability', which '*refers to unique and subjective experiences where characteristics such as states, conditions and/or external factors lead to a consumer experiencing a sense of powerlessness in consumption settings*'.

The importance of TSR in contexts of consumer marginalisation and vulnerability has received increasing attention within the literature, as related issues of access, inclusion, and integration have been linked to negative wellbeing outcomes (Anderson et al., 2013; Mick et al., 2012; Rittenburg, 2005; Rosenbaum et al. 2017; Russell-Bennett et al., 2020). The importance of customer wellbeing as a service outcome has also proved increasingly influential within the discipline of service design. Service design is a creative, human-centred, and multidisciplinary approach for service innovation (Yu and Sangiorgi, 2018), which involves 'understanding customers and service providers, their context, and social practices, and translating this understanding into the development of evidence and service systems interaction' (Teixeira, Patrício, and Tuunanen, 2018, p.373). The use of service design to benefit vulnerable consumers has been identified as a key service research priority

(Fisk et al., 2015; Ostrom et al., 2015), while synergies between service design and TSR have been highlighted and expanded upon through the concept of transformative design (e.g. Bate and Robert, 2007a; Buchanan, 2004; Junginger, 2008; Junginger and Sangiorgi, 2009; Thackara et al., 2007).

Two specific groups who have frequently been defined as marginalised are those with mental health issues (Brennan et al., 2017; Hill and Sharma, 2020; WHO, 2010) and those experiencing or at risk of homelessness (Banerjee and Bhattacharya, 2020; Curry et al., 2017; Dobson, 2019). Despite large-scale attempts to increase access to psychological therapies over the past decade, mental health services have retained low rates of successful penetration overall and especially in the case of homeless populations, who are significantly more likely to encounter insurmountable barriers to service access and engagement (Ali et al., 2017; Gavine, 2013; Hewett et al., 2012). The importance of transformative change specifically is highlighted by concerns regarding institutionalisation (i.e. service users becoming passive, dependent, and unable to function outside of an institutional context) in homeless shelters and other institutions such as prisons (Huber et al., 2020; Khan, 2010), and by high rates of recidivism associated with formerly incarcerated populations living in supported housing (Metraux, Roman, and Cho, 2007).

Furthermore, mental health service evaluation tools and techniques continue to be dominated by restrictive quantitative measures and a focus on clinical care dimensions (Gill, White, and Cameron, 2011; Newman et al., 2015; Smallwood, 2011; Staniszewska et al., 2019). These have provided minimal insights into the processes underlying the creation of value, which are best captured through interpretive and phenomenological methodologies (Helkkula, Kelleher, and Pihlström, 2012; Langdridge, 2007). For example, thematic interviews with actors across a service ecosystem have been credited with both elucidating past and present processes of value cocreation and promoting future collaboration and cocreation (Ketonen-Oksi, 2018), while others have highlighted the need for and potential impact of case study research exploring the processes by which value emerges (Bluhm, 2011; Verleye, 2019).

In contrast to the history of (at least mainstream) mental health service research, this research seeks to adopt an innovative approach to service design and evaluation through the use of the Trajectory Touchpoint Technique (TTT; Sudbury-Riley and Hunter-Jones, 2017; Sudbury-Riley et al., 2020).

1.2 Overview of the TTT

The Trajectory Touchpoint Technique is a systematic methodology for exploring the lived experiences of customers, which employs a rich picture methodology to elicit full service experience narratives (Sudbury-Riley et al., 2020). The TTT is administered through presenting customers with a series of cards, each representing a different stage of the service experience and featuring a set of images/words depicting key elements (touchpoints). Originally developed in the context of hospice care, the TTT proved highly effective in uncovering opportunities for innovation in this context and has already been successfully adapted for use in related and unrelated services, including most recently in a housing and mental health service context (Spence, 2021; Sudbury-Riley et al., 2020). Furthermore, use of the TTT can help overcome common barriers to discussing potentially distressing topics, including in contexts of service planning as well as service evaluation (Lewin et al., 2020).

This approach is in stark opposition to mainstream tools for mental health service evaluation, within which quantitative measures of mental wellbeing and service experiences are employed and used to claim 'objectivity' of measurement (e.g. Sweeney and Soutar, 2001). Such tools are designed to emulate the positivist, 'outcome-oriented' approach of the natural sciences (Cook and Reichardt, 1979, p.10). While these techniques are not without their merits, there are important limitations and drawbacks inherent to applying (or attempting to apply) the 'natural scientific' method in this context (Sokal, 2015). The notion that only 'countable' evidence is viable is problematic here, discounting the large proportion of human experience which cannot be 'objectively' measured whilst also failing to acknowledge that numbers assigned to (for example) mental wellbeing or service quality perceptions are all ultimately 'imbued with human subjectivity' (Dalal, 2018, p.2, p.142).

Furthermore, research suggests that value creation is best captured through interpretive and phenomenological methodologies, which have the capacity for uncovering forms and elements of value in the experience that would be inaccessible to the 'natural attitude' (i.e. one's typical everyday way of seeing the world, which is unquestioning of underlying assumptions and biases, etc.) (Helkkula, Kelleher, and Pihlström, 2012; Husserl, 1900/1970; Langdridge, 2007; Langdridge, 2008). The phenomenological paradigm is underpinned by a belief that each individual's subjectively experienced 'reality' is no less real than 'an objectively defined and measured reality' (Fetterman, 2010, p.5), and is therefore well-suited for exploring the meanings ascribed by different individuals to different situations (Bloor and

Wood, 2006). Rather than confining participants to a limited set of predefined response options, the TTT is designed to elicit narrative descriptions which do not strive to isolate certain service aspects but rather situate these within lifeworld contexts (Stroh, 2000).

1.3 Research Setting

This research consists of a case study within a Welsh charitable organisation, henceforth referred to as 'Organisation X'. Based in South Wales, Organisation X strives to enable social inclusion through providing a variety of services for disengaged and marginalised citizens, with a focus on homelessness and housing insecurity. To these ends, it offers both services geared towards those considered at high risk of homelessness, defined in public health literature as secondary interventions, and services tailored towards those already experiencing homelessness, defined as tertiary interventions (Burt, Pearson, and Montgomery, 2005; Culhane, Metraux, and Byrne, 2011; Shinn, Baumohl, and Hopper, 2001).

This research focuses specifically on three of Organisation X's residential services, in which housing is provided in conjunction with mental health and practical support. Two of the three services covered by this research (Services 1 and 2) can be categorised as tertiary, providing housing and support to people who are currently homeless and/or have histories of homelessness. The other (Service 3) is a secondary intervention, targeting a group that is considered to be at high risk of homelessness due to severe mental health issues (Rogers et al., 2020).

Service 1 is a direct access rapid rehousing project, combining aspects of traditional direct access hostels with a rapid rehousing approach. Direct access hostels are intended to provide easily accessible accommodation, often accepting direct approaches from homeless people themselves (rather than specific agencies) and offering services to those with low, medium, and high support needs (Shelter, 2021). Stays in these hostels are typically limited to a relatively short period; however, the rapid rehousing approach prioritises helping people into permanent accommodation (Crisis, 2018). Thus, in addition to providing short-term accommodation, Service 1 also seeks to support individuals in identifying and accessing longer-term housing solutions, some of which are provided by Organisation X. This service is open to anybody aged 18 or over who is either homeless or at risk of becoming homeless.

The other two services consist of longer-term supported accommodation, respectively geared towards those with severe addiction (Service 2) and mental health issues (Service 3). Service 2 is technically limited to those aged 45 and over (though interviews with service providers revealed there is a degree of flexibility about this) and is for those with complex, long-term substance use issues, who are either homeless at the point of referral or have a history of homelessness. Service 3 is specifically for care-managed individuals who are living with or recovering from mental health difficulties, having previously been hospitalised for mental health issues.

1.4 Aims and Research Questions

In light of the aforementioned factors,

> *this research aims to explore the constituents of transformative service in a context of multiple marginalisation, integrating principles from TSR and service design.*

Research objectives towards this end are as follows:

Objective 1: To identify and evaluate research examining service design within the context of transformation, healthcare and homelessness

Objective 2: To critically analyse extant research on value creation and transformative change in contexts of marginalisation and vulnerability, specifically exploring the potential for transformative value and VALEX to be usefully synthesised and elaborated upon in the construct of T-VALEX.

Objective 3: To deliver qualitative insight into the cocreation of value in a residential homelessness and mental health service context, identifying facilitators and prohibitors of transformative value creation from the perspective of service users.

Objective 4: To identify opportunities for innovation within the case study organisation, with potential implications for the broader sector(s) of homelessness and mental health services.

In accordance with these objectives and with the findings of the literature review, four research questions have been identified:

RQ1. What are the key elements and processes underlying the cocreation of T-VALEX across multilevel domains?

RQ2. How is T-VALEX creation influenced by therapeutic resources and servicescapes, extending beyond the customer/provider dyad?

RQ3. How can meso-level forces help to minimise and alleviate vulnerability perceptions throughout a full service experience, particularly for multiply marginalised consumers?

RQ4. How (if at all) can a service design methodology, the Trajectory Touchpoint Technique, be effectively adapted for the context of integrated housing and mental health services?

1.5 Justification for the Research

This research is justified on multiple grounds, including (1) the potential to explore and build upon the relationship between transformative value and VALEX; (2) the need for more research into temporal aspects of TSR and vulnerability; (3) the importance of homelessness and mental health sectors; and (4) anticipated contributions to practice. These reasons will now be justified.

1.5.1 Research gap in synthesising concepts

While naturally aligned in some senses, concepts of transformative value and VALEX differ significantly in key aspects of their focus, with the former denoting the potential for long-term change while the latter is more concerned with how value emerges in the context of users' ecosystems and everyday life practices (Blocker and Barrios, 2015; Heinonen et al., 2010). Both of these concepts thus have important contributions to make regarding value creation in contexts of vulnerability, in which the generation of meaningful long-term change *and* the acknowledgement and incorporation of lifeworld factors are both highly relevant (Corus and Saatcioglu, 2015; Mick et al., 2012).

Despite its inbuilt focus on wellbeing, TSR has historically been criticised for adopting a narrow view of relevant outcomes, focusing predominantly on those conventionally deemed to have managerial relevance (Anderson et al., 2013; Rosenbaum et al., 2011). Another common criticism of TSR stems from an alleged tendency to focus on the customer/provider dyad, failing to acknowledge the impact of broader ecosystem and lifeworld factors (e.g.

Rosenbaum and Wong, 2015; Sanchez Barrios et al., 2015; Van Dolen and Weinberg, 2017; Yunhsin et al., 2017; Zayer et al., 2015). Conversely, transformative value is conceptualised as a more radical alternative to this version of TSR, seeking to promote equitable and inclusive services and adopting the service-dominant concept of value-in-use, shaped by and within institutional arrangements and service ecosystems (Blocker and Barrios, 2015; Corus and Saatcioglu, 2015; Rendtorff, 2009; Vargo and Lusch, 2008). The understanding of institutions and ecosystems is recognised as central to an organisation's role in promoting transformative change, generating awareness of their own role in reproducing (and potentially transforming) social structures (Emirbayer and Mische, 1998; Ozanne and Anderson, 2010).

However, SDL itself is also associated with certain limitations, with some critics asserting that this is excessively focused on the management of visible customer/provider interactions and the provider perspective, despite ostensibly accepting the centrality of the beneficiary (Ellway and Dean, 2016; Grönroos and Gummerus, 2014; Heinonen and Strandvik, 2015). This has been attributed in part to the lack of a sufficiently strong phenomenological characterisation and analysis of value (Edvardsson, Tronvoll, and Gruber, 2010; Helkkula, Kelleher, and Pihlström, 2012). In contrast, VALEX is grounded in an interpretive approach to value formation, building on the service-dominant concept of 'value-in-context' to explicate the wide range of individual factors impacting customers' experiences of value (Helkkula, Kelleher, and Pihlström, 2012; Meyer and Schwager, 2007; Seraj, 2012; Vargo, 2008).

However, this approach does not acknowledge the significance of interactions with economic and social entities (Zeithaml et al., 2020), and is thus in itself insufficient for the generation of social change (Blocker and Barrios, 2015; Emirbayer and Mische, 1998). By focusing on T-VALEX, this research aims to overcome the limitations associated with both approaches, with an explicit focus on the active role of customers, the transformative potential of a service experience, and the broader individual and institutional influences beyond a customer-provider dyad.

1.5.2 TSR, temporality, and vulnerability

Leading on from the conceptualisation and exploration of T-VALEX, this research also strives to provide further insights into the hitherto underexplored temporal aspect of TSR, specifically within the priority research area of consumer vulnerability (Fisk et al., 2015;

Ostrom et al., 2015; Russell-Bennett et al., 2020). While wellbeing has long been recognised as a multidimensional construct (Guyader et al., 2019; McColl-Kennedy, Hogan, Witell, and Synder, 2017; Pham et al., 2019), in practice TSR has largely focused on wellbeing as a whole, operating under the implicit assumption that all dimensions are equally valuable and failing to distinguish between long- and short-term influences (Kuppelwieser and Finsterwalder, 2016; Russell-Bennett et al., 2020).

Further research into the temporal dimensions of TSR is necessary and important for a number of reasons. Broadly speaking, measurements of wellbeing are typically categorised as either hedonic or eudaimonic, with the former referring to happiness in a given moment while the latter denotes overall quality of life and realisation of individual potential (Ryan and Deci, 2001; Ryff, 2018). Thus, while hedonic happiness is important and indeed a primary outcome of many services, it is impacts on eudaimonic wellbeing that are most pertinent to consider in exploring the transformational potential of service, and indeed that are captured by the concept of transformative value (Bauer, McAdams, and Pals, 2008; Blocker and Barrios, 2015; Taiminen, Taiminen, and Munnukka, 2020).

Moreover, it may be at times that hedonic wellbeing outcomes are not solely ineffective but counterproductive in pursuing transformational outcomes. Wellbeing trade-offs occur when consumers encounter a dilemma in which one dimension of wellbeing must be sacrificed for another, for example reducing financial wellbeing to improve physical wellbeing (Hill et al., 2013; Kelly et al., 2005; Russell-Bennett et al., 2020). In the case of transformational change, there is strong evidence that this is often associated with periods of discomfort, in which instance consumers ultimately must sacrifice a degree of short-term hedonic wellbeing for the sake of longer-term eudaimonic wellbeing (or transformative value creation) (Nguyen, 2023).

Taken together, the use of the TTT and the exploration of T-VALEX provide a comprehensive view of how value is created and how wellbeing is impacted over time, distinguishing between habitual value/hedonic wellbeing and transformative value/eudaimonic wellbeing. The incorporation of VALEX further serves to ensure that these processes are situated within the full lifeworld context of the consumer, their networks and internal processes, thus generating a richer understanding of the processes facilitating transformation (Helkkula, Kelleher, and Pihlström, 2012; Jaakkola et al., 2015; Tynan, McKechnie, and Hartley, 2014).

1.5.3 Importance of the mental health and homelessness sectors

Mental health issues are an incredibly prominent concern on both a national and a global scale. The most recent national survey revealed that around one in six adults (17%) surveyed in England met the criteria for a common mental disorder (CMD) (McManus, Bebbington, Jenkins, and Brugha, 2016). While these statistics are somewhat outdated, the record 4.6 million referrals received by mental health services in 2022 (British Medical Association, 2024) suggests that the situation has only worsened in the intervening years. The World Health Organisation has reported that around one in eight people in the world currently live with a diagnosable mental disorder, identifying this as the leading cause of years lived with disability (YLDs) and a major source of economic and social harm (WHO, 2022). Depressive disorders specifically have been identified as the third greatest cause of death and disability across the UK (Vos et al., 2020). Mental distress can also be life-threatening, with research suggesting that between 80 and 90% of those who attempt suicide have diagnosable mental health conditions (Arsenault-Lapierre, Kim, and Turecki, 2016; Cho et al., 2016) and severe mental health issues associated with a 10-25-year reduction in life expectancy (WHO, 2010). The personal cost of mental health issues is evident, often affecting the abilities of individuals 'to sustain relationships, work, or just get through the day' (Mental Health Foundation, 2015, p.1).

Mental health issues have long been debated as both a cause and consequence of homelessness (Amore and Howden-Chapman, 2012; DoH, 2010; Folsom et al., 2005; Fox et al., 2016; Gavine, 2013; Hewett et al., 2012; Homeless Link, 2010; Kleinman, 2009; Maguire et al., 2009; Rees, 2009; Rogers et al., 2020; Shelter, 2006). A 2017 review by the Local Government Association reported that 45% of homeless people surveyed had a diagnosed mental health problem, highlighting the prevalence of psychological and substance use issues as both causes and consequences of homelessness (Leng, 2017). Both overall mortality and suicide rates specifically are significantly higher for homeless groups than for the general population, with suicide rates specifically increasing by 30% between 2018 and 2019 (ONS, 2020).

Recent years have overseen significant efforts to address a nation-wide 'epidemic' of mental illness, most notably with the 2008 introduction of the Improving Access to Psychological Therapies (IAPT) scheme aimed at making psychological therapies widely available to those in need (Clark et al., 2009). Nonetheless, mental health services remain overstretched, with

long waiting times, a lack of specialist services in some regions, and low overall rates of successful penetration into the 'ill' population (British Medical Association, 2023; Chen and Cardinal, 2021; Royal College of Psychiatrists, 2022). Furthermore, a reported relapse rate of approximately 50% (Ali et al., 2017) is indicative of a shortage of transformative value creation, suggesting that even those who have an initially positive mental health service experience (i.e. experiencing hedonic wellbeing) often do not undergo an experience which meaningfully changes their life in the long term (i.e. contributes towards eudaimonic wellbeing) (Anderson and Ostrom, 2015; Blocker and Barrios, 2015; Russell-Bennett et al., 2020).

Despite being among those in the greatest need, evidence suggests that homeless groups are especially likely to encounter barriers to accessing mainstream mental health services such as IAPT, including lack of information, lack of access to referrals, and service provider prejudice (Blood et al., 2007; Caldwell and Jorm, 2001; DoH, 2010; Gavine, 2013; Hewett et al., 2012; St Mungo's, 2016). IAPT has also been criticised for failing to engage with those most in need due to prohibitive entry requirements, such as refusing to treat those with comorbid mental health and substance use issues unless they are 'clean' (i.e. no longer consuming addictive substances) (Miller, 2018; NHS Confederation, 2012; Ramesh, 2012).

In order to address issues of access and engagement, integrated care has been identified as a priority by major housing charities and by the UK government itself (e.g. Crisis, 2013; Public Health England, 2019; St Mungo's, 2016). Across most of Europe and North America, housing provision for the homeless and mentally ill has historically been dependent upon the completion of a series of steps, operating under a 'treatment first' philosophy which asserts that independent living should be an option only after reaching a certain level of psychiatric stability and/or sobriety (Crisis, 2010; Johnsen and Teixera, 2010; Tsemberis, 2010). This is sometimes referred to as a 'staircase' model, with an individual's housing becoming increasingly 'normal' as they progress through treatment (Crisis, 2010, p.3). Since the early 2010s, however, there has been a gradual shift across Europe and in the UK specifically towards a 'Housing First' model, first trialed in New York in the 1990s, in which accommodation is provided unconditionally and other (mental health, substance abuse, and other) services are delivered directly to this accommodation (Bretherton and Pleace, 2015; Housing First Europe Hub, 2016; Tsemberis, 2010; Turning Point Scotland, 2010).

In Wales specifically, the Housing (Wales) Act (2014) placed a duty upon local authorities to provide support to all those at risk of and experiencing homelessness, seeking to provide the foundations for greater partnership working across housing, mental health, and physical health service providers. Despite this substantial shift to a more universal model (Mackie, 2014b), a review of the Act's effectiveness between 2016 and 2018 found that many of the same issues persisted, with bureaucracy, silo working, and insufficient resources for complex needs identified among the factors limiting the effectiveness of the Act (Rogers et al., 2020). Furthermore, despite the now widespread popularity of the general principles of Housing First, there remains dramatic variation in how these interventions are implemented and a lack of clarity and consensus on what makes them successful (Benston, 2015; Dickson-Gomez et al., 2017; Newman and Goldman, 2009).

Additionally, both homelessness and mental health services across the UK have been placed under intense strain in recent years. The number of people seeking treatment for mental health issues has grown significantly and consistently (BMA, 2023), with percentages in Wales specifically increasing year on year since surveys began in 2003 (Rogers et al., 2020). At the same time, many services have suffered from limited resources due to widespread budget cuts since the 2010 onset of austerity politics (Centre for Welfare Reform, 2016; Stuckler et al., 2017; United Nations, 2016). The COVID-19 pandemic and subsequent lockdowns, beginning in March 2020, were also associated both with increased demand for mental health services and with resource and staffing shortages across mental health and homelessness services (BMA, 2023; Johnson et al., 2020; Mohammed et al., 2020; Schneider et al., 2022). Pandemic-related staffing issues are especially concerning in settings already associated with high rates of staff burnout and turnover, as has been reported to be the case for both IAPT services (Johnson, Corker, and O'Connor, 2020; Westwood et al., 2017) and much of the homelessness sector (Rogers, George, and Roberts, 2020; Voronov et al., 2023).

This is therefore a key moment for research which promotes innovation, within services themselves and in the kinds of evidence that are considered viable, and which explores the creation of transformative value in this context, enhancing understanding of how meaningful change can be facilitated in the context of two mutually reinforcing vulnerabilities.

1.5.4 Usefulness of potential applications

In addition to advancing the theory surrounding value and vulnerability in contexts of homelessness and mental health, this research provides practical recommendations, seeking to contribute positively towards developments in this field. This is particularly true of South Wales, where this study is based, but also of mental health service delivery and service delivery to homeless populations more broadly. These research findings will contribute towards a growing body of evidence on integrated housing and mental health service provision, differing from the majority of measures of success through a focus on ongoing processes over clear-cut outcomes. In Wales specifically, the evaluation of a nongovernmental, not-for-profit organisation is intended to build upon existing research on statutory Welsh homelessness services in the context of the Housing (Wales) Act 2014, seeking to influence bodies such as the Welsh Health Board and social policymakers.

In addition to evaluating individual services, this study will also encompass broader service ecosystems, thus providing insights into the ways in which connections and interactions between different services may be enhanced in order to better facilitate value co-creation as well as the instances in which this is already occurring. Moreover, this research also has implications for other services and service networks seeking to engage more effectively with homeless and other marginalised citizens. Finally, it is hoped that this adaptation of the TTT will have further practical applications beyond this study and beyond this region, providing a technique for mental health service evaluation which can be widely applied and used to uncover practical opportunities for innovation in a multitude of contexts.

1.6 Original Contributions to Knowledge

This research makes multiple theoretical contributions, related to the integration of concepts to promote transformative service design; the conceptualisation of value; the utility of the TTT itself; and the effective implementation of both services and evaluation techniques in contexts of extreme disadvantage. These are briefly summarised below, following which specific implications for practice are outlined.

1.6.1 Novel application and synthesisation of concepts and theories

This research strives to integrate and employ influential and interrelated service research concepts, drawing primarily upon TSR and service design literatures, within the largely unexplored (for service researchers) terrain of mental health and homelessness research. It is the intention of this research to avert the pitfalls sometimes associated with rigid adherence to one or another perspective, in particular those that arise as a consequence of insufficient attention to the customer perspective and goals (e.g. Anderson et al., 2013; Helkkula, Kelleher, and Pihlström, 2012). By explicitly focusing on the cocreation of T-VALEX, this research is actively centred on the customer role and on a definition of value that is both sufficiently broad to encompass service ecosystems and lifeworld contexts (Helkkula, Kelleher, and Pihlström, 2012) and sufficiently narrow to exclude routine forms of value creation unlikely to meaningfully impact upon the well-being of highly disadvantaged, multiply marginalised consumers (Blocker and Barrios, 2015).

1.6.2 Insights into the cocreation of value

The TTT offers a new methodology for the evaluation of homelessness and mental health services, which is innovative not only in its exact content but also in its underlying assumptions. Specifically, the TTT is designed to facilitate insights into the co-creation of value, in a way which the ceaseless disputes between proponents of different approaches have largely failed to do. Rather than striving to either attack or defend a particular model in its entirety, the application of the adapted TTT is intended to evoke granular descriptions of a full service experience, facilitating the pinpointing of both instances of and untapped opportunities for value creation.

It is the intention of this research to go beyond the narrow definitions of viable evidence, suitable participants, and concepts of neatly defined and prepackaged service elements which have proliferated and stifled mental health service research. In the place of this approach is a fundamentally customer-centred methodology and mindset, rooted in SDL and TSR, striving for a processual understanding of value creation which is both affected by and impacts upon broader service ecosystems and lifeworld contexts.

1.6.3 Building on TTT evidence base

The effectiveness of the TTT has been demonstrated extensively in the context of hospices and palliative care organisations. Single applications of adapted versions of the TTT have also been effectively applied within one related (a hospital medical/surgical unit) and one unrelated service (a veterinary practice) (Sudbury-Riley and Hunter-Jones, 2017; Sudbury-Riley et al., 2020). Having already demonstrated a degree of versatility and adaptability, the question remains of to what extent the TTT can be effectively utilised for client experience research in other areas, within healthcare and beyond. An extensive body of empirical research within a wide range of contexts is necessary in order to establish the circumstances under which the TTT can and should be applied, and to test the creators' hypothesis that the TTT can be 'easily adapted for use in a wide range of services where client experience is paramount' (Sudbury-Riley et al., 2020, p.40). While still remaining within the broad field of health services, mental healthcare poses unique challenges for design and evaluation, while the integration of this with housing services adds further complexity to processes of value cocreation and innovation.

1.6.4 Implications for practice

This research is not only intended to advance the theory surrounding mental health services and transformative value co-creation, but also to directly contribute towards practical developments. Specifically, research findings will contribute towards a growing body of evidence on the effectiveness of accommodation-based interventions for homeless people with mental health/substance use issues, differing from the majority of measures of success through a focus on ongoing processes over clear-cut outcomes. Moreover, this research also has implications for other services and service networks seeking to engage more effectively with homeless and other marginalised citizens. Finally, it is hoped that this adaptation of the TTT will have further practical applications beyond this study and beyond this specific context, providing a technique for accommodation-based service evaluation which can be widely applied and used to uncover practical opportunities for innovation.

1.7 Overview of Methodology

Figure 1.1 provides an overview of the data collection methods employed in this research.

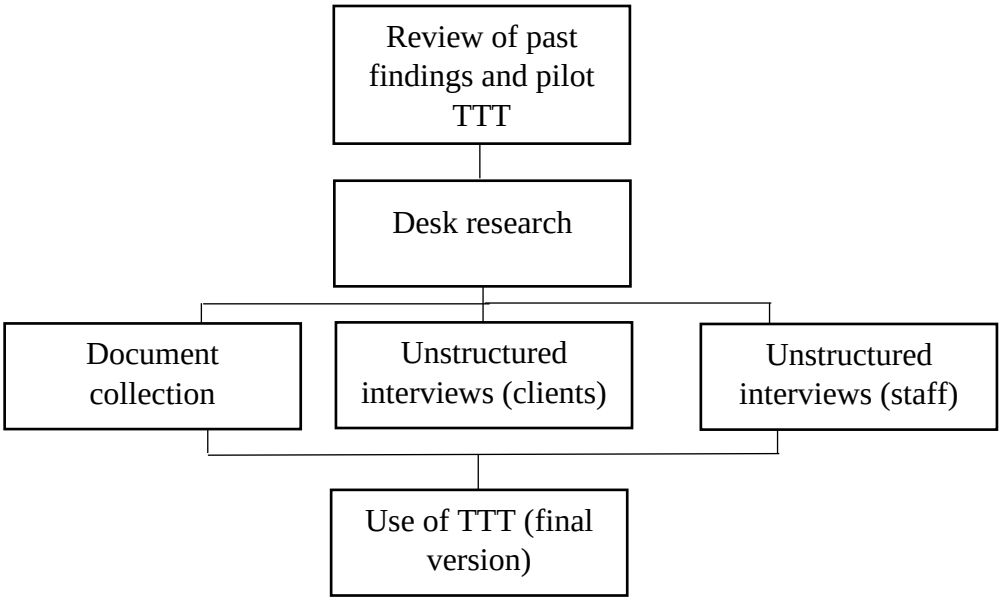


Figure 1.1: Data collection methods

As shown in Figure 1.1, data collection consisted of four main stages:

In *Stage 1*, a draft version of the adapted TTT was developed drawing on the literature review, methodology, and findings of an earlier related study (Spence, 2021), which centred on another Organisation X service providing tenancy and mental health support. The literature review for this study encompassed a combination of service research, mental health and homelessness literature, and mental health and homelessness policy documents, all of which were also pertinent to this thesis. An initial adaptation of the TTT for the context of housing and mental health services was applied in the tenancy support service context (see Chapter 3, Section 3.4.3 for an overview of different adaptations). Initial planning for the thesis methodology was shaped in part by the stages and touchpoints selected here, in addition to the responses these generated.

Having established that the primary focus of the research was going to be on models of integrated residential support, *Stage 2* consisted of extensive and focused desk research, delving into the current state of service delivery in this area. The directions of this literature review were also shaped in part by difficulties encountered in the earlier study, for example

investigating existing research into effective communication tools in a context of vulnerability and/or cognitive impairment (Spence, 2021).

In *Stage 3* key documents were retrieved from across Organisation X's residential services, providing insights into the key dimensions of service delivery in this context. During the same period, unstructured interviews were conducted with management (n=2), frontline staff (n=3), and service users (n=5) within the relevant services. This allowed for insights both into the formal operation and structure of the services, as perceived by staff, and the subjective perceptions and emotions that were the most influential and memorable for customers themselves.

Finally, in *Stage 4*, narrative accounts were accrued from Organisation X residential service users (n=20) using the finalised adapted TTT (see Section 3.4.3, Figures 3.1-3.8). Conversations were conducted over the phone and using video software (Microsoft Teams). These consisted of going through the cards one at a time, asking participants to comment on as many or as few of the pictured touchpoints as they considered relevant and also providing opportunities for identifying and elaborating upon any additional touchpoints.

1.8 Outline of Thesis

This thesis is divided into six chapters. Chapter One has placed the research in context, summarising the relevant concepts and background, providing a brief overview of the technique used, and identifying the key aims and research questions shaping the research. The research was justified on multiple theoretical and practical grounds, leading onto a brief overview of the key methodological stages including two main stages of primary data collection.

Chapter Two is dedicated to reviewing the relevant literature. This begins with an exploration of customer value research as a whole, leading into a more in-depth account of the central concept of T-VALEX and associated literature streams. A discussion of TSR follows, explicating key contributions and objectives underpinning the field. Specific TSR addressing the research context (i.e. healthcare and homelessness) is reviewed before moving on to consider relevant literature on consumer vulnerability and (multiple) marginalisation. Service design is explored in a similar manner to TSR, highlighting key influences, elements, and debates within the field. Subsequent sections discuss service design in the thesis context, beginning with codesign and vulnerable consumer engagement before moving on to

applications in healthcare, homelessness, and integrated models of housing and mental health support. Finally, literature on therapeutic servicescapes is summarised and discussed, exploring the relevance of this concept to transformative service contexts.

Chapter Three consists of a detailed description and evaluation of the methodology. The phenomenological approach at the heart of the research is first explained and justified. Each of the different stages of research and methods employed are discussed in detail, as are the processes of thematic data analysis. In Chapters Four and Five, findings from each of the different Organisation X services included are described and compared. Evidence on the effectiveness of the adapted TTT is also explored.

Lastly, Chapter Six summarises the study's managerial and theoretical implications, pertaining both to service research and to mental health and homeless service delivery. Key contributions relating to each of the research questions are summarised and areas for further research are proposed.

1.9 Chapter Summary

This chapter has placed the research in context, explicating its purpose and intentions. Central concepts were identified as value cocreation, TSR, consumer marginalisation and vulnerability, and service design. Adopting a lens of transformative service design, the research focus and methodology were explained in terms of the need for in-depth insights into customer experience and customer value perceptions, highlighting the insufficiency of popular tools and techniques. The primary data collection technique adopted in this study, the TTT, was briefly described and justified in the subsequent section. The overall objective of the research was then identified and broken down into four concrete research questions. Key justifications for the research related to gaps in service literature, in particular the effective synthesisation of concepts; to the importance of providing effective services for those experiencing mental ill health and homelessness; and to the anticipated contributions to practice in this area. Original contributions to knowledge were summarised, encompassing three distinct theoretical contributions and contributions to practice.

The process of data collection and the various methods employed were then briefly recounted, with four stages consisting of: reviewing the findings and literature review of an earlier study (Spence, 2021), in order to develop a first draft of the adapted TTT; extensive desk research; document collection and interviews further informing the development of the

TTT; and collection of narratives using the finalised TTT. Finally, an outline of the full thesis was provided, briefly summarising each of the six chapters.

Chapter Two: Literature Review

2.1 Introduction to Chapter

The previous chapter provided a brief overview of the theoretical background to this study, encompassing relevant branches of service, mental health, and homelessness research, situating this within the UK context. The research aim and objectives, questions, justification, and contribution to knowledge were all explicated, followed by a brief overview of the methodological stages. This chapter will consist of a comprehensive review of the relevant literature, encompassing key concepts and fields of research. Firstly, the concept of customer value is discussed, summarising relevant debates and developments (Section 2.2). The specific value construct at the heart of this research, T-VALEX, is then explicated in relation to past research on transformative value and VALEX, and more broadly within social constructionist and interpretive research streams (Section 2.3).

In order to provide theoretical context and understanding of the various strands of TSR, the next section (2.4) is structured around the conceptualisation of TSR, exploring the contributions of transformative consumer research (TCR); services and social marketing; commercial friendships and third place attachments; and culminating in a description of the conceptualisation and development of TSR. Subsequently, the relevance and prior applications of TSR to the research context are discussed (Section 2.5), first looking broadly at healthcare, then specifically at mental health services, and then at homelessness. This section highlights the importance of TSR addressing these areas, discusses existing applications and how these can be built upon, and identifies significant gaps in the literature which this research strives to redress.

This leads on to an overview of consumer vulnerability, with a particular focus on contexts of healthcare (Section 2.6), before moving on to consider research on intersecting vulnerabilities and multiple marginalisation (Section 2.7). The focus then shifts to service design thinking and tools as valuable resources in pursuing transformative outcomes, beginning with an overview of the background and conceptualisation of service design (Section 2.8) encompassing influences within and outside of service research. The particular value and challenges of applying codesign in work with vulnerable consumers is addressed, drawing attention to frameworks and proposals for vulnerable consumer engagement (Section 2.9).

The following section considers the synergies between service design and TSR, identifying extant research on transformative service design and areas for further development (Section 2.10). The following two sections consist of a discussion of service design in the thesis context. This begins with an overview of applications of service design and codesign across various sectors of healthcare, culminating in a summary of codesign projects within mental health services and directions for moving forward (Section 2.11). Section 2.12 summarises pertains to homeless service design and integrated residential models of support, summarising key developments and research findings and proposing areas for future research. Finally, the concept of therapeutic servicescapes is discussed in relation to TSR and implications for transformative service design, again highlighting areas in need of further exploration (Section 2.13).

2.2 Customer Value: An Overview of Debates and Developments

While the term 'customer value' has been used to denote a variety of meanings (Smith and Colgate, 2007; Woodall, 2003), this research will focus on the most prevalent meaning of value *for* the customer, also referred to as customer perceived value (Chang and Dibb, 2012; Helkkula and Kelleher, 2010; Hsin Chang and Wang, 2011). First gaining traction in the 1980s (Dodds and Monroe, 1985; Zeithaml, 1988), in the decades since customer value research has proliferated across management, marketing, and organisational disciplines, underpinned by a now globally widespread assumption that all meaningful marketing activity must necessarily be directed towards the creation of customer value (e.g. Leroi-Werelds, 2019; Zeithaml et al., 2020). This section will set the scene for discussion of value creation in contexts of vulnerability, providing a broader overview of the history and current state of customer value research.

Earlier conceptualisations of customer value treated this primarily as a pre-consumption phenomenon, assumed to be created by a provider during product/service development and then transferred to a customer in exchange for a cost (value-in-exchange) (Anderson, Narus, and Narayandas, 1999; Prahalad and Ramaswamy, 2004). Zeithaml's (1988, p.8) seminal paper defined customer value as 'the consumer's overall assessment of the utility of a product based on the perceptions of what is received and what is given', triggering a stream of research underpinned by 'get-versus-give' (i.e. cost-benefit) calculations (e.g. Gale and Wood, 1994; Ruiz et al., 2008). However, while these early contributions remain influential,

it is now widely accepted that value perceptions can be formed not only during consumption but also at pre- and post-consumption stages (Dodds, 1991; Parasuraman and Grewal, 2000; Patterson and Spreng, 1997). Furthermore, customer value has increasingly been understood as a multidimensional construct, with emotional and social as well as cognitive and rational components (Boksberger and Melsen, 2011; Holbrook and Corfman, 1985; Holbrook, 1999, 2006; Mattson, 1991; Plewa et al., 2015; Zeithaml et al., 2020).

However, while complexity and multidimensionality are now widely accepted as features of customer value, key differences in underlying assumptions regarding epistemology, ontology, and methodology persist (Boksberger and Melsen, 2011; Gallarza, Gil-Saura, and Holbrook, 2011; Zeithaml et al., 2020). Zeithaml et al. (2020) identify three primary research streams and associated paradigms in relation to customer value, classified as positivist, interpretive, and social constructionist. This research will draw primarily on the latter two. The positivist approach is focused primarily on value-as-outcome, producing predominantly quantitative research seeking to uncover causal relationships (Becker and Jaakkola, 2020; Brodie, Löbler, and Fehrer, 2019; Burrell and Morgan, 2017; Crotty, 1998). Conversely, interpretive and social constructionist approaches are more concerned with the experience or construction of value, lending themselves towards interpretive and phenomenological methodologies (Helkkula and Kelleher, 2010; Langdridge, 2007).

Also highly pertinent here is the concept of value cocreation and the varied nature and extent of customer engagement in this process, understanding of which has been shaped in large part by the influence of SDL (Vargo and Lusch, 2004). SDL depicts value creation as a socially constructed, multi-actor process (Elg et al., 2012; Maglio et al., 2009; Ranjan and Read, 2016), occurring ‘at the intersection of activities among providers, consumers, or any other possible actors’ (Ketonen-Oksi, 2018, p.2). This therefore challenges the goods-dominant view of organisations as the sole creators of value, encouraging an understanding of customers as active agents and cocreators and acknowledging the collaborative roles of multiple stakeholders (Grönroos and Voima, 2012; Prahalad and Ramaswamy, 2004; Sheth and Uslay, 2007; Vargo and Lusch, 2004b; Vargo and Lusch, 2008).

Furthermore, SDL not only acknowledges but prioritises the customers’ role in and perspective on value creation. According to Vargo and Lusch (2008), value is uniquely and phenomenologically determined by a beneficiary and service effectiveness is fundamentally contingent upon customer orientation, suggesting that techniques for service design and

evaluation must take the role of the customer into account (Edvardsson, Tronvoll, and Gruber, 2011; Helkkula, Kelleher, and Pihlström, 2012). Moreover, while goods-dominant logic centres passive and tangible factors of production, or 'operand resources', SDL focuses on intangible, 'operant resources', such as individuals' skills and knowledge (Constantin and Lusch, 1994; McColl-Kennedy et al., 2012; Vargo and Lusch, 2008). Customers thus play a fundamental role in shaping the processes and outcomes of value creation, with their roles and those of providers becoming increasingly blurred as collaboration and cocreation have become the norm (Im and Qu, 2017; Roy, Balaji, Soutar, and Jiang, 2020).

The service dominant focus on customer engagement in value cocreation has generated research on the subject of value cocreation behaviours (VCCB). These are defined as 'a series of activities customers undertake during service exchanges to achieve desired outcomes' (Roy, Balaji, Soutar, and Jiang, 2020, p.355). VCCB include direct and indirect interactions and engagement with a service provider, but also occur within and are shaped by broader service networks and cultural, historical, and social contexts (Grönroos and Gummerus, 2014; McColl-Kennedy et al., 2012; Vargo and Lusch, 2004, 2008, 2016). Within the broad category of VCCB, Yi and Gong (2013) propose two dimensions of 'customer participation behaviour' (e.g. information seeking and sharing, responsible behaviour, personal interaction) and 'customer citizenship behaviour' (e.g. feedback, advocacy, helping), with the former often being expected and required while the latter comprises extra-role behaviours with the potential to provide extraordinary value (Choi and Kim, 2013; Roy et al., 2020).

Further to enhancing service-specific outcomes, value cocreation has increasingly been explored as a source of broader benefits to wellbeing (Lusch and Vargo, 2014; Sharma et al., 2017; Zeithaml et al., 2020), aligning with the fundamental purpose of TSR (Anderson and Ostrom, 2015; Anderson et al., 2013). In accordance with this alignment, value cocreation in transformative service contexts has repeatedly been identified as a priority area within service research (Anderson and Ostrom, 2015; Kuppelwieser and Finsterwalder, 2016; Mende and Van Doorn, 2015; Torkzadeh, Zolfagharian, and Iyer, 2021). Moreover, there is evidence of a relationship between active customer participation and wellbeing outcomes (Hau, Tram Anh, and Thuy, 2017; McColl-Kennedy et al., 2017; Ng, Sweeney, and Plewa, 2019; Roy et al., 2020), with calls for further research expanding on cocreative roles and how these can be leveraged within TSR (Hau and Thuy, 2015; McColl-Kennedy et al., 2012; Torkzadeh, Zolfagharian, and Iyer, 2021).

In addition to measuring apparent changes in wellbeing, there is also a need for research uncovering the specific factors and processes underlying the transformational impact of a given service experience. Towards these ends, it is necessary to go beyond a basic understanding of value cocreation in itself, to drawing distinctions between different forms of value and their relationships to wellbeing outcomes and transformative change (Giraldo, Garcia-Tello, and Rayburn, 2020; Mulder et al., 2015; Parsons et al., 2021; Previte and Robertson, 2019). The conceptualisation of transformative value (Blocker and Barrios, 2015) has been influential on subsequent explorations of value cocreation within TSR, promoting a focus on longer-term and eudaimonic wellbeing outcomes (Bieler et al., 2021; Dean and Indrianti, 2020; Gallan and Helkkula, 2022; Johns and Davey, 2019; Mulcahy, Zainuddin, and Russell-Bennett, 2021; Parsons et al., 2021; Previte and Robertson, 2019).

At the same time, a comprehensive analysis of value cocreation processes and outcomes must also extend beyond service contexts into customers' broader lifeworld contexts, for example incorporating the roles of secondary consumers and the perspectives of prospective consumers (Helkkula et al., 2012). This is the focus of the concept of value in the experience (VALEX), defined as 'an individual service customer's lived experiences of value that extend beyond the current context of service use…[to] include past and future experiences and service customers' broader lifeworld contexts' (Helkkula, Kelleher, and Pihlström, 2012, p.58). The concept of transformative value in the experience (T-VALEX) was proposed in an attempt to synthesise and elaborate upon the constructs of transformative value and VALEX, combining a focus on transformative change with a holistic view of customer experience (Spence, 2021). The key features and theoretical underpinnings of all three of these constructs will be further explored in the following section.

2.3 Transformative Value in the Experience

According to Zeithaml et al.'s (2020) analysis, transformative value is a subcategory shaped by a social constructionist understanding of value creation, whereas value in the experience can be situated within the interpretivist paradigm. A brief overview of similarities and differences between these paradigms is provided in Figure 2.1.

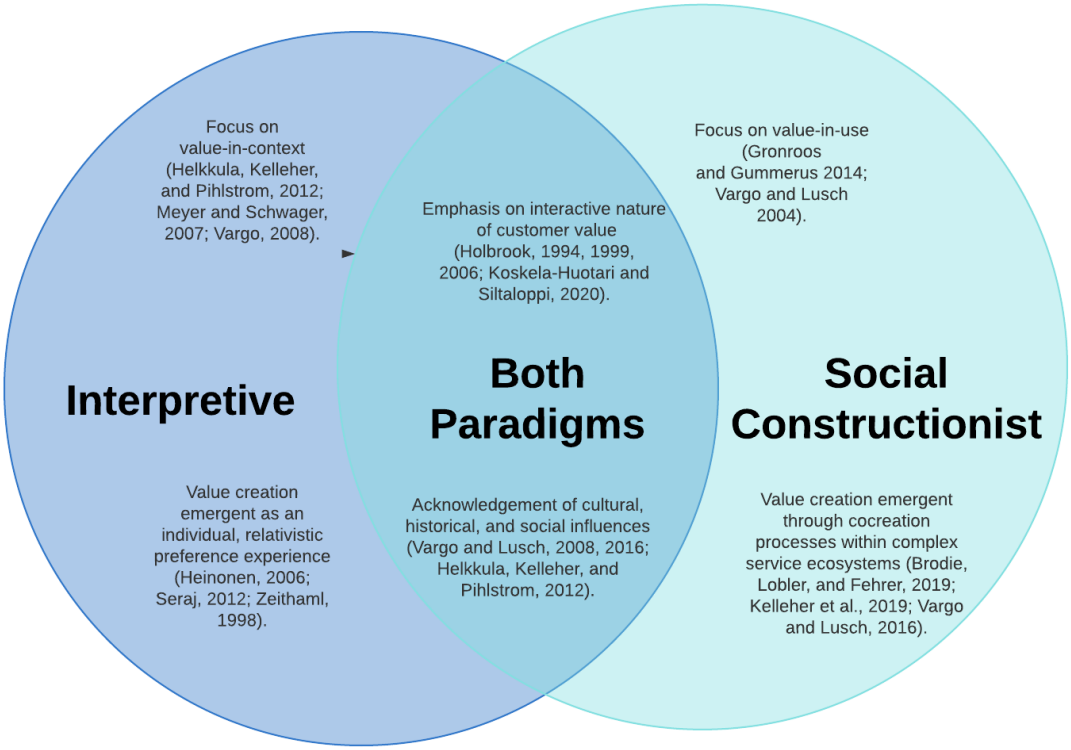


Figure 2.1: Overview of interpretive and social constructionist paradigms (adapted from Zeithaml et al., 2020).

As highlighted in Figure 2.1, concepts of both value-in-use and value-in-context are important here. Value-in-use denotes ‘a customer’s outcome, purpose, or objective that is achieved through service’ (Macdonald et al., 2011, p.671), presupposing that the customer is in a cocreating role and assuming a more nuanced stance than the goods-dominant concept of value-in-exchange (defined in Section 2.2) (Lusch, 2007; Vargo and Lusch, 2004; Zainuddin and Gordon, 2020; Zeithaml, 1988). While value-in-exchange pertains to value embedded in a good or service, which is created by organisations in advance, proponents of value-in-use adopt a more process-orientated approach, asserting that value is realised during an experience (Grönroos, 2011; Grönroos and Gummerus, 2014; Sandström et al., 2008; Vargo and Lusch, 2004). Furthermore, it is understood that organisations cannot unilaterally create value but can merely offer a customer value proposition (CVP), defined as ‘a strategic tool that is used by a company to communicate how it aims to provide value to customers’ (Payne, Frow, and Eggert, 2017, p.467). Consequently, while providers may play some role in cocreation, it is the customer who uniquely and phenomenologically determines value through the application of operant resources (Vargo and Lusch, 2004, 2008; Vargo, 2008).

The development of the concept of transformative value has been described as one manifestation of the shift from a dyadic to a systemic perspective within value-in-use research, consistent with more recent contributions to SDL emphasising how customers and value creation processes are embedded in social and economic (eco)systems (Akaka and Vargo, 2015; Chandler and Vargo, 2011; Brodie, Löbler, and Fehrer, 2019; Figueiredo and Scaraboto, 2016; Zeithaml et al., 2020). Specifically, Blocker and Barrios (2015) embed transformative value in a value configuration space spanning the three levels of social structures (Giddens, 1984); service design and service practices; and human agents. Moreover, while habitual value creation serves to maintain order and reinforce the status quo, transformative value creation is associated with increased agency in contexts of vulnerability and resource restriction, including specifically '*chimerical agency*' fuelling 'movement toward' a desirable reality (Blocker and Barrios, 2015, p.280). This systemic form of value-in-use thus has key contributions to make in terms of understanding how consumer vulnerability is created, reinforced, and mitigated in different institutional contexts.

However, Vargo (2008) argues that the concept of value-in-use remains under the influence of goods-dominant logic in its emphasis on customer *use* of *firm output* (tangible and intangible products), asserting that these are not the only processes and resources in need of consideration in researching customer participation in coproduction. Consequently, he proposes the concept of value-in-context, with context defined as 'a set of *unique actors with unique reciprocal links among them*' (Chandler and Vargo, 2011, p.40). Value-in-context is grounded in a multilevel (macro, meso, and micro) conceptualisation, acknowledging that actors' broader contexts influence their abilities to engage in resource integration and also indirectly affect other actors (Araujo and Easton, 2005; Chandler and Vargo, 2011; Kjellberg and Helgesson, 2006; Kogut, 2000; Uzzi, 1997; White, 2002). This thus expands the potential boundaries of innovation, opening up opportunities for new types of offerings, actors, and activities (Chandler and Vargo, 2011; Koskela-Huotari et al., 2016; Lusch and Nambisan, 2015; Windahl and Wetter, 2018).

Furthermore, unlike the majority of value-based constructs (Helkkula et al., 2012; Zeithaml et al., 2006), value-in-context is also applicable to the perspectives of noncustomers and prospective customers, emphasising that it is possible to experience value without direct experience of a service or service provider (Helkkula, Kelleher, and Pihlström, 2012; Meyer and Schwager, 2007; Vargo, 2008). This concept therefore has important contributions to make in terms of exploring value creation throughout the entirety of a customer experience,

which begins when an individual first needs (rather than first accesses) a service and extends beyond the end of service use (Sudbury-Riley et al., 2020; Zomerdijk and Voss, 2010).

Both transformative value and VALEX are thus essentially focused on the 'bigger picture' of value creation but centre their attention on different elements of this: institutional in the case of the former, and intrapersonal in the case of the latter (Blocker and Barrios, 2015; Blocker et al., 2011; Flint, Larsson, and Gammelgaard, 2008; Helkkula, Kelleher, and Pihlström, 2012; Zeithaml et al., 2020). An initial attempt at applying the concept of T-VALEX found that this proved highly appropriate and effective in a context of vulnerability, identifying key features such as the relationship between connecting with customers' broader lifeworld contexts and the experience of a 'turning point' at which transformative value creation began (Spence, 2021). This thesis seeks to further build on the concept of T-VALEX, specifically within the context of integrated housing and mental health support.

2.4 Background and Conceptualisation of TSR

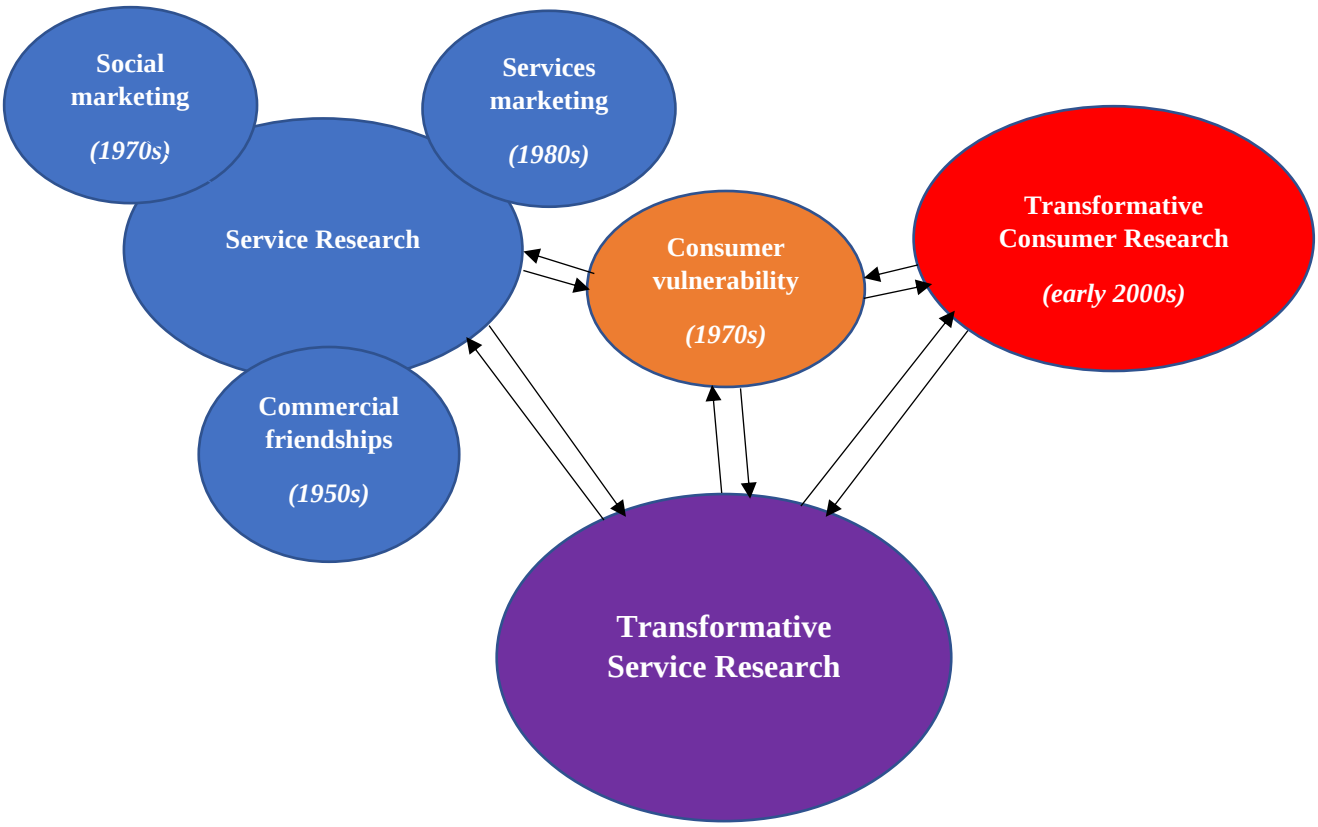


Figure 2.2: Summary of key influences on TSR

In terms of conceptual development, TSR is located at the intersection between service research and transformative consumer research (TCR) (Anderson et al., 2013). More broadly, this field draws on a range of service- and wellbeing-related disciplines and subdisciplines, specified in Figure 2.1. In addition to helping to shape TSR more broadly, these disciplines all have important contributions to make specifically to the subject of value creation in contexts of vulnerability. Having already provided an overview of consumer vulnerability, the impacts of TCR and service research in shaping TSR will now be discussed, before moving on to the unique contributions of TSR itself.

2.4.1 Transformative Consumer Research

The interest of consumer research in individual, societal, and environmental wellbeing has fluctuated over time, ebbing and flowing in accordance with broader socioeconomic trends. Growing out of the Association for Consumer Research (ACR), transformative consumer research (TCR) is defined broadly as 'academic, theory-based research that examines individual and group-level problems and opportunities related to consumption, with the goal of improving consumer wellbeing' (Ozanne et al., 2015, p.1). The six core commitments of TCR (Mick et al., 2012) are explicated in the table below:

Core Commitments	Description
To improve wellbeing.	Addressing issues and opportunities associated with various dimensions of wellbeing, at individual and collective levels (McGregor and Goldsmith, 1998; Mick, 2006).
To emanate from ACR and encourage paradigm diversity.	Honouring a long tradition within ACR of fostering diverse research traditions, welcoming researchers from all backgrounds/perspectives, and appreciating the viability of different paradigms for different types of research (Anderson, 1986; Ozanne and Fischer, 2012).
To employ rigorous theory and methods.	Promoting meticulous application of theory and methods, embracing rigor alongside relevance rather than viewing it as a trade-off between the two (Lehmann, 2003).
To highlight sociocultural and situational contexts.	Keeping consumers' lifeworld contexts in clear focus and working on issues consumers consider to be of the greatest relevance.
To partner with consumers and their caretakers.	Embracing a new role for consumer researchers as advocates for, and close partners with, consumers/caretakers (Andreasen, Goldberg, and Sirgy, 2012).
To disseminate findings to relevant stakeholders.	Sharing insights with consumers, policymakers, etc., and treating effective communication of findings as a key priority from the outset of a project.

Table 2.1: An overview of the core commitments of TCR (adapted from Mick et al., 2012, pp.6-8).

The concept of TCR arose in the early 2000s, at a time when the combined effects of financial crises and increased awareness of the negative (environmental and personal) effects of some forms of consumption had generated numerous calls for research on consumption, ethics, and wellbeing (Bazerman, 2001; Csikszentmihalyi, 2000). Against this backdrop, TCR was heralded as a means to apply marketing tools and techniques to 'real [consumer] problems', in marked contrast to the traditional role of marketing as a discipline of maximising profits through influencing consumer behaviour (Mick, 2006, p.1).

At its core, TCR addresses the age-old question of 'what is the good life?', acknowledging the importance of consumption habits and opportunities and the broad range of purposes consumption can serve: 'from nourishment, empowerment, and renewal, to gluttony, disenfranchisement, and destruction' (Mick et al., 2012, p.2). At a global level, the most impoverished individuals have been characterised as 'base of pyramid' (BoP) consumers,

whose daily lives are characterised by inadequate service systems and limited access to basic service. Originally developed to describe underprivileged citizens in emerging economies, the term has since been used effectively in regard to citizens in 'developed' economies falling below the level of consumption adequacy, exploring everyday challenges and relevant institutional arrangements in order to generate innovate means for improved wellbeing (Baron et al., 2018).

The two main problems of consumption have been identified as overconsumption and underconsumption (Sheth, Sethia, and Srinivas, 2011), both of which can pose critical challenges to the wellbeing of individuals, societies, and the environment (Csikszentmihalyi, 2000; Ozanne et al., 2011). Issues of overconsumption relate to unhealthy intake of and/or dependence on both legal goods (e.g. "junk food") and banned goods (e.g. illicit drugs) (Grover et al., 2011; Scarpaci, Sovacool, and Ballantyne, 2016). While consumers at the BoP are primarily associated with issues of underconsumption, such as insufficient food or housing, consumer vulnerability can also arise in association with issues of overconsumption, such as alcohol or drug addiction (Ozanne et al., 2011). These two types of issues may also coexist within a single individual, as is the case for the disproportionately high numbers of homeless individuals with some form of substance use issues (Department for Communities and Local Government, 2012; Leng, 2017).

TCR has made some important contributions towards understandings of consumer vulnerability and of the creation of value in this context. As experiences of poverty have been conceptualised in increasingly holistic ways, going beyond simple metrics and/or income levels (Blocker et al., 2013; Chakravarti, 2006), some researchers have highlighted the benefits of addressing this from a consumption perspective. According to this view, consumption is understood as the exchange of energy (e.g. money) for objects or services satisfying human needs/wants and improving quality of life (Csikszentmihalyi, 2000). Vulnerability is therefore associated with consumer restraints, restraints on exchange opportunities which arise for example from a lack of income or insufficient access to essential products (Hill, 2002). Vulnerable consumer engagement has thus been defined as 'the level of replenishment of depleted cognitive, emotional, behavioral and social resources invested by vulnerable individuals with scant operant resources' (Fletcher-Brown et al., 2021, p.2).

Furthermore, some transformative consumer researchers have highlighted that lived experiences of vulnerability cannot be understood in full without exploring how these are shaped, perpetuated, or contested in everyday interactions and relationships. On this subject, Blocker et al. (2013) highlighted two focal concepts of felt deprivation and power. Felt deprivation was defined here as '*the beliefs, emotions, and experiences that arise when individuals see themselves as unable to fulfil the consumption needs of a minimally decent life*' (Blocker et al., 2013, p.1197), underlying all of which are power relations with the potential to thwart or facilitate goal pursuit (Baker, Gentry, and Rittenburg, 2005). Some have also highlighted a natural alignment between TCR and the foundations of intersectionality, with the concept being employed by some TCR scholars to describe the combined effects of multiple resource deficits (Mick et al., 2012).

Overall, it appears essential that consumption issues are addressed not in silos but in relation to individuals' full lifeworld contexts and, when appropriate, to each other. Within TCR, some have argued for the necessity of transdisciplinary teams to fully explore the transformative potential of a consumption-related experience (Crockett et al., 2013) whilst others have highlighted the crucial role of interpersonal networks of consumers in improving wellbeing and creating effective policy interventions (Blocker et al., 2013). The impact of this broader, more holistic perspective is also identifiable across much of TSR, particularly in the concept of a transformative service network as the central entity through which value is created (Black and Gallan, 2015).

The fields of TCR and TSR are united by a shared drive to generate knowledge for the advancement of individual and societal wellbeing (Corus and Saatcioglu, 2015), ultimately seeking to enhance 'consumer welfare and quality of life for all beings affected by consumption across the world' (Russell-Bennett et al., 2019, p.2). However, TCR has historically provided little research attention to the potential for services to impact on consumer wellbeing, leaving a crucial research gap TSR strove to fill (Anderson et al., 2013). Furthermore, while TCR's proponents have long called for the dissemination of research results outside of academia (Mick, 2006), these have rarely been effectively articulated into organisational practices and public policy, with transformative consumer researchers typically working in small, unidisciplinary groups and sharing their findings solely through peer-reviewed journals within this discipline (Mick et al., 2012; Ozanne et al., 2011). In contrast, TSR has the inbuilt advantage of often occurring 'in the trenches' with customers and providers (Anderson and Ostrom, 2015, p.247), producing opportunities and structures

for dissemination in the forms of active service users, organisations, and networks (Anderson and Ostrom, 2015; Ostrom et al., 2010).

2.4.2 Service Marketing and Social Marketing

Service(s) marketing and social marketing are two fields of research which evolved largely independently from one another, but which have both been credited with impacting upon the development of TSR (Baron, Warnaby, and Hunter-Jones, 2014; Previte and Robertson, 2019; Russell-Bennett et al., 2019). While TSR first emerged out of a growing interest in consumer-related goals within broader service marketing research and adopted several key service marketing concepts (Baron, Warnaby, and Hunter-Jones, 2014; Berry and Bendapudi, 2007), it is also fundamentally aligned with social marketing in its aims to promote wellbeing and facilitate social change (Previte and Robertson, 2019). This section will consist of a brief summary of each of these fields, their influences on TSR, and the specific implications for this research.

As a field of study, service marketing encompasses the marketing of anything that is not a physical product, spanning all domains of marketing from consumer behaviour to business-to-business (B2B) relationships (Berry and Parasuraman, 1993; Furrer and Sollberger, 2007). From the early days, in efforts to ensure the widest reach and greatest retention possible, service marketers dedicated extensive and ongoing attention to a small set of metrics believed to represent current and predict future service success (Brown, Fisk, and Bitner, 1994). Of the greatest relevance to this research are the concepts of service encounters or experiences (Czepiel, 1990; Solomon et al., 1985) and the services marketing mix, particularly the service-specific components of people, physical evidence, and process management (Afridi, 2009).

Research on service encounters operates on the assumption ‘that customer perceptions of service encounters are important elements of customer satisfaction, perceptions of quality, and long-term loyalty’ (Brown et al., 1994, p.34). The service encounter concept is broadly divisible into the three categories of customer evaluations of individual service encounters (Bitner, 1990; Czepiel, 1990), customer involvement in service production and delivery (Kelley, Donnelly, and Skinner, 1990; Larsson and Bowen, 1989), and the role of the physical environment (Bitner, 1992; Hui and Bateson, 1991). Each of these elements is

significant in determining the relationship between service and wellbeing (Solomon et al., 1985), and thus in meeting the fundamental goals of TSR (Anderson et al., 2013).

The aforementioned aspects of the services marketing mix are similarly informative in exploring the impact of service on wellbeing. Also referred to as the physical environment or the servicescape (Bitner, 1992), the category of physical evidence encompasses all tangible items in an environment, including both the interior and exterior of a building in which a service is delivered (Magrath, 1986; Zeithaml, Bitner, and Gremler, 2010). The category of 'people' includes interactions with all representatives of a given firm and the broader impact of others (customers and employees) in a service environment, captured in the concept of a social servicescape (Tombs and McColl-Kennedy, 2003). Finally, process management necessitates the balancing of service demand with service supply, through uncovering and utilising methods 'to handle peak loads and optimize different customer needs with varied expertise levels within the service company' (Magrath, 1986, p.48).

TSR evolved out of service marketing and adopts a novel approach towards the purpose of marketing, treating consumer and societal wellbeing as the most important fundamental aim and outcome of services and service research (Anderson et al., 2013; Baron, Warnaby, and Hunter-Jones, 2014). Social marketing is another school of the marketing discipline concerned with employing marketing principles towards the improvement of individual and communal welfare (Kuppelwieser and Finsterwalder, 2016). More specifically, social marketing strives to influence target audiences to behave in ways that improve their personal and societal welfare, promoting social objectives such as family planning and safe driving (Andreasen, 2003; Kotler and Zaltman, 1971). Despite lacking influence in early services marketing literature, social marketing has been credited with impacting the development of both TSR and TCR (Baron et al., 2014), reflecting and advancing the growing interest of researchers in expanding service thinking beyond a commercial context (Gordon, Zainuddin, and Magee, 2016).

While TSR has typically focused more on the wellbeing of the individual (Mende and Van Doorn, 2015; Rosenbaum and Wong, 2012; Russell-Bennett et al., 2019), social marketers adopt a network-based multilevel approach to societal problems (Brychkov and Domegan, 2017; Domegan et al., 2017). Across service research, it has increasingly been acknowledged that individual wellbeing does not exist within a vacuum and that consumer vulnerability, for example, emerges and exercises influence within broader service ecosystem and lifeworld

contexts (Azzari, Mitchell, and Dadzie, 2021; Johns and Davey, 2021). TSR thus stands to further benefit from the insights of social marketing, both in exploring individual wellbeing and in broadening the scope of research to include network and systems approaches (Black and Gallan, 2015; Finsterwalder et al., 2017).

TSR has also been described as bridging the gap between service marketing and social marketing, adopting key elements of both whilst also overcoming some identified limitations. Similar to consumer vulnerability research, social marketing scholarship has predominantly centred on promoting change at either the macro or the microlevel, whereas service marketing has been proposed as a meso-level approach for understanding how service exchange affects wellbeing outcomes and behaviour change (Previte and Robertson, 2019; Russell-Bennett, Wood, and Previte, 2013). Conversely, service marketing has been criticised for insufficient attention to the promotion of wellbeing and the avoidance of harm (Berry and Bendapudi, 2007; Stoeckl and Luedicke, 2015). TSR thus provides an opportunity for meso-level research which is geared towards social change (Previte and Robertson, 2019). The importance of such research is highlighted by longstanding evidence of the particular significance of meso-level factors (i.e. service providers and service environments) in contexts of vulnerability, a brief overview of which will be given in the subsequent section.

2.4.3 Commercial Friendships and Third Place Attachments

The first reference to TSR was made by Rosenbaum et al. (2007), whose study on ‘third place’ attachments drew heavily upon extant research on loneliness (Forman and Sriram, 1991; Goodwin, 1997; Kang and Ridgway, 1996; Weiss, 1973) and commercial friendships, defined as customer-provider relationships characterised by such positive interactions and emotions as accommodation, affection, and self-disclosure (Albrecht and Adelman, 1984; Price and Arnould, 1999; Stone, 1954). Third places are defined here as ‘core settings of informal life’ outside of the home and the workplace, which host informal, regular, and voluntary meetings of individuals who enjoy each other’s company (Oldenburg, 1999, p.15). Third place attachments are therefore those established between consumers and a service organisation and/or organisational representative(s) (Albrecht and Adelman, 1984; Rosenbaum et al., 2007).

While third place relationships were traditionally understood to be amongst the weakest of ties (Granovetter, 1983), there has been substantial evidence to suggest that consumers

frequently do rely upon service workers for support, generated by both marketing researchers (Rosenbaum et al., 2007; Rosenbaum, 2006) and others in the social sciences (Albrecht and Adelman, 1984; Cowen, 1982). Furthermore, there has long been evidence that the fostering of community and/or one-on-one connection within service contexts is typically most influential for the most vulnerable members of society, such as minority groups and the elderly, who are more likely to suffer social support deficits (Forman and Sriram, 1991; Goodwin, 1997; Kang and Ridgway, 1996; Rosenbaum, 2005; Rosenbaum, 2006; Stone, 1954).

Rosenbaum et al. (2007) expanded upon the mechanisms underlying commercial friendships in vulnerability contexts, finding a significant correlation between the experience of socially supportive destructive events (e.g. bereavement, divorce, illness) and the extent of personal reliance upon a service organisation and the people met there. Socially supportive destructive events are associated with social support deficits, pertaining to the three broad categories of companionship (i.e. friendship, fun, relaxation), emotional support (i.e. close, personal bonds and opportunities for intimate disclosures), and instrumental support (i.e. practical assistance) (Helgeson, 2003; Rook, 1984). Attempts to promote wellbeing through service should thus consider each of these forms of social support. Social support deficits are also associated with greater place attachment (Baker and Brocato, 2006; Rosenbaum et al., 2007), highlighting the potential for service establishments to consciously alter their servicescapes to appeal to those in need of a sense of community (Kozinets, 2002).

2.4.4 Conceptualisation and Development of TSR

In light of aforementioned evidence regarding the importance of commercial attachments in contexts of social support deficits, Rosenbaum et al. (2007, p.55) advocated for the development of a ‘transformative service research paradigm’, grounded in exploration of person-place relationships and geared towards understanding ‘how service establishments, intangible exchanges, and humanistic and social elements within servicescapes promote consumer welfare’. This basic premise was expanded upon by Anderson et al. (2013), who identified the illustrative wellbeing outcomes of access, decreasing disparity, happiness, health, and literacy. These concepts pertain to two broad concepts of customer wellbeing: hedonic wellbeing, or happiness in a given moment, and eudaimonic wellbeing, defined as

overall quality of life and realisation of individual potential (Ryff, 2018; Ryan and Deci, 2001).

Service effectiveness is thus commonly evaluated based on the changes (or lack thereof) in wellbeing prior and subsequent to a given service experience. These outcomes are applicable at individual, collective, and ecosystem levels (Anderson et al., 2013). Explorations of transformative value at the ecosystem level have resulted in the emergent construct of a transformative service network, defined as a collaborative system of multiple entities working in unity towards cocreation of value (Black and Gallan, 2015). At the centre of this value-cocreating system is a core service, a customer-provider interaction addressing a certain need, around which dynamic interactions between the core service and service network elements occur. Consistent with the social constructionist emphasis on complex service ecosystems (Zeithaml et al., 2020), Black and Gallan (2015) describe how value cocreation can be promoted or constrained by properties of the service network, highlighting the impact of structural and relational factors on healthcare outcomes (see Section 2.5.1 for further details).

In addition to the importance of structural properties and relationships formed across these service networks, Black and Gallan (2015, p.832) refer to the role of service users' social support networks, defined as 'a system of (human) resources surrounding a patient that provides structure and offers assistance (companionship, emotional support, etc.)'. The importance of personal networks and resources is further explored by Hepi et al. (2017), drawing on Engeström's (2015) conceptualisation of activity systems comprising such factors as an actor's intended outcome, instruments (resources), rules, community, and contributions. Focusing on the context of (potentially) transformative social service relationships, Hepi et al. explore service cocreation and wellbeing outcomes in terms of interactions between social worker and client activity systems, emphasising how clients' wider set of relationships can enable and enhance transformative value cocreation but equally how insufficient 'fit' between systems can prohibit engagement with marginalised populations. Consequently, it has been argued that TSR conducted in a service ecosystems context must also incorporate clients' personal networks or activity systems (Finsterwalder et al., 2017), naturally aligning with the focus of VALEX on micro-level processes and relationships (Helkkula, Kelleher, and Pihlström, 2012).

While TSR has been conducted in a wide range of settings, health and social care have been identified amongst the key transformative service contexts, in which core offerings have

profound repercussions on individual wellbeing (Mende and Van Doorn, 2015; Torkzadeh, Zolfagharian, and Iyer, 2021). Such services can be characterised as transformative by design (Rosenbaum et al., 2011) or inherently transformative (Anderson et al., 2013), though the extent of actual transformative value cocreation hinges on factors such as service design and consumer participation (Previte and Robertson, 2019; Sweeney, Danaher, and McColl-Kennedy, 2015). In accordance with the research context of integrated residential services, the following section will discuss applications of TSR across healthcare and homelessness service settings, summarising key findings and identifying areas for development.

2.5 TSR, Mental Health, and Homelessness

2.5.1 TSR and Healthcare

At a global level, healthcare services are amongst the largest and, it has been argued, most important service sectors, contributing substantially towards financial and societal wellbeing and constituting a 'crucial' and 'fertile' field for service research (Berry and Bendapudi, 2007; Hamed, El-Bassiouny, and Ternes, 2017). Researchers have specifically highlighted the 'transformative potential' (Anderson et al., 2013, p.1207) of healthcare services, with access and uptake potentially meaning the difference between life and death and almost always meaningfully affecting an individual's daily and long-term quality of life (Berry and Bendapudi, 2007; Danaher and Gallan, 2016; Davis, Mohan, and Rayburn, 2017). At the same time, healthcare interactions frequently involve confusing, disjointed, and scary processes (Danaher and Gallan, 2016) and a lack of control and familiarity that can produce feelings of inferiority and powerlessness (Berry et al., 2015.

Healthcare can thus be defined as a high emotion service, naturally inclined to elicit strong emotional responses from consumers (Berry et al., 2022; Berry, Davis, and Wilmet, 2015), making it a highly relevant area in terms of both the promotion of wellbeing and the avoidance of harm. Danaher and Gallan (2016) highlight multiple opportunities for untapping the 'transformative potential' of healthcare, including defining 'health' and 'value' from different perspectives, developing transformative healthcare service organisations, and developing transformative servicescapes. These authors also identify a need for further research into mental health service design and delivery, advocating for (among other things)

in-depth investigations of vulnerability, of factors driving nonadherence, and of what they term ‘unproductive patient behaviours and value destruction’ (p.3).

Since the turn of the century, across much of the Western world, there have been important shifts in the ways in which healthcare services are conceptualised and delivered, with ‘patients’ increasingly viewed as consumers (Brinkmann, 2018) and active co-creators of experience rather than as passive recipients (Danaher and Gallan, 2016). Underpinning practical changes to service design and delivery has been a widespread ideological shift towards a more patient-centred approach, defined as ‘a way of providing care that strives to increase the quality of interaction between service and consumer entities by placing consumers…at the center of decisions that affect their wellbeing’ (Anderson, Nasr, and Rayburn, 2018, p.99). In addition to the inherently transformative potential of healthcare, the patient-centred approach in particular is naturally amenable to the goals of TSR (Anderson et al., 2013), opening up countless opportunities for research and innovation in this sphere.

In some key ways, the growing influence of the patient-centred approach has been facilitated by technological advancements and the democratisation of information access, providing an ever-increasing number of consumers with the tools they need to stay informed and active in their own healthcare (Frow, McColl-Kennedy, and Payne, 2016). Already on an upward trajectory (Topol, 2019), the prevalence and importance of digital health resources increased dramatically in the context and aftermath of the COVID-19 pandemic and subsequent lockdowns (British Medical Association, 2020; Hutchings, 2020; NHS England, 2020), with policymakers seeking to make public health information and telehealth services more accessible than ever before (Department of Health and Social Care, 2020; NHS England, 2020).

Digital health interventions have been associated with a raft of benefits, including greater accessibility, efficiency, and enhanced opportunities for personalisation (Murray et al., 2016). Conversely, as digital forms of engagement become an increasingly prevalent norm, lacking the (operand and/or operant) resources to engage with these effectively has been described by some as a source of long-term vulnerability, with Gallan and Helkkula (2022) specifically calling for transformative value propositions (TVPs) to address the digital divide. In addition to access issues, there is a risk of patient care becoming excessively task-oriented, diminishing practitioners’ abilities to respond therapeutically to patients (Anderson, Nasr, and Rayburn, 2018). Evidence indicates that capitalising on the transformative potential of digital

health services and resources necessitates both addressing access issues and ensuring consumers' wants and needs are taken into account, ensuring human interfaces are not being replaced in contexts in which consumers specifically desire human interaction (Beatson, Lee, and Coote, 2007; Kiely, Beamish, and Armistead, 2004). It is therefore important for research to assess ways in which digital mediums influence the effectiveness of healthcare service delivery, particularly considering the context of the COVID-19 pandemic and the extent to which changes enforced during lockdown should be sustained.

Further to the abovementioned findings, there has been some research into adoption of technology-enabled transformative services within the specific context of mental healthcare, indicating that adoption decisions were driven largely by the extent to which services were perceived as instrumental to client goals (Schuster, Drennan, and Lings, 2015). Despite such applications of TSR to mental health service contexts, these are typically treated as fundamentally indistinguishable from physical health services, failing to acknowledge key differences such as centrality of the therapeutic relationship (Luborsky, 1976; van Os et al., 2019) and difficulties defining and measuring service quality (Kilbourne, Keyser, and Pincus, 2010). Furthermore, transformative value creation is in many ways analogous to the notion of mental health recovery, pertaining to individual empowerment and meaningful improvement in psychosocial spheres (Kelly, Lamont, and Brunero, 2010). There is therefore a significant gap to be filled by research synthesising concepts from mental health research and TSR.

Though not explicitly relating value cocreation to recovery, the work of Gopaldas et al. (2021) and Gopaldas, Siebert, and Ertimur (2022) generated multiple valuable insights regarding transformation in mental health services. Based on research conducted within dyadic mental health services, the concept of a transformative service conversation is defined as a customer/provider interaction involving the combination of questions asked to inspire new ways of being and evaluative listening to affirm customers' ideas (Gopaldas et al., 2021). This provides insight into how transformative value propositions can be offered by providers within therapeutic conversations, while T-VALEX is only realised when a customer 'imagines new possibilities, determines which of those possibilities are viable and actualizes those possibilities' (Gopaldas et al., 2021, p.996).

The power of transformative service conversations is attributed to their role in producing microtransformations, which over time can create 'positive, significant, lasting changes in consumers' self-understandings, outlooks on life and overall well-being' (Gopaldas, Siebert,

and Ertimur, 2022, p.649). This conceptualisation contributes towards understanding of the microprocesses involved in recovery (van Weeghel et al., 2019), enabling greater understanding of how this may occur in practice. In addition to provider and customer actions, the facilitation of transformative service conversations has been explored in relation to servicescape design (Gopaldas et al., 2022), key elements and implications of which will be discussed in the broader context of transformative service design (see Section 2.10).

Conversely, the focus on core provider/customer interactions may limit both the depth and generalisability of this account. Grounded in a definition of mental health services as 'dyadic services to improve people's psychological well-being via conversation with a trained provider' (Gopaldas et al., 2021, p.991), it is questionable to what extent the findings and implications described are applicable to contexts of integrated care and other mental health services which are less centred on the client/provider dyad, such as self-help groups and peer-to-peer support. Additionally, and arguably more importantly, this conceptualisation of transformation in mental health services omits the impacts of broader connections. This is at odds with calls to explore value cocreation at a network level, understanding of which has been described as key to the advancement of TSR (Anderson et al., 2013; Black and Gallan, 2015; Gallan and Helkkula, 2022; Krisjanous et al., 2023; Previte and Robertson, 2019) and in the specific context of healthcare (McColl-Kennedy et al., 2017; Virlée, Hammedi, and van Riel, 2020).

Proposing the concept of a health service delivery network, Tax, McCutcheon and Wilkinson (2013) describe how multiple distinct organisations can nonetheless provide a connected service from the customer perspective, highlighting the importance of interagency collaboration and of seeking opportunities to affect external touchpoints (e.g. through partnering with other firms and stakeholders). Black and Gallan's (2015) discussion of transformative health service networks additionally identifies specific structural properties influencing value cocreation, for example reporting a curvilinear relationship between network size (i.e. number of connections) and capacity for transformative value cocreation and suggesting that network density (i.e. high levels of interconnectedness) can facilitate resource integration even in contexts of otherwise unmanageable complexity. Thus, while it may be true that transformative service conversations are a core offering of mental health services as a whole (Gopaldas, Siebert, and Ertimur, 2022), focusing solely on these dyadic interactions provides only a partial understanding of transformative processes and outcomes,

omitting systemic factors affecting resource integration (Virlée, Hammedi, and van Riel, 2020).

Black and Gallan (2015) additionally highlight the need for mutualistic relationships, characterised by a balance between service user and provider control. Mutual and reciprocal activities are widely recognised as crucial to value cocreation (Storbacka et al., 2016; Vargo, 2009), though there has been substantial debate regarding how appropriate this is in vulnerable consumption contexts (Johns and Davey, 2019). It is often suggested that consumers experiencing vulnerability by definition lack the resources or resource integration capabilities to realise optimal levels of CX, meaning that they may require additional support and/or adopt different roles to mainstream consumers (Battistella-Lima, Veludo-de-Oliveira, and Barki, 2020). Johns and Davey (2019) argue that vulnerable consumers often require third party mediation to successfully engage in transformative value cocreation, proposing the concept of a transformative service mediator (TSM) who facilitates resource integration via apomediation (representing consumer interests) and/or intermediation (facilitating provider resources) (Storbacka et al., 2016). Whether these different forms of mediation ultimately facilitate or detract from consumer agency remains to be determined (Davey, Johns, and Blackwell, 2023).

Consistent with the framing of value cocreation within broader lifeworld contexts (Helkkula, Kelleher, and Pihlström, 2012), personal networks are also incorporated into the transformative service network model, with Black and Gallan (2015) referring to ‘a social support network, or a system of (human) resources surrounding a patient that provides structure and offers assistance (companionship, emotional support, etc.)’. Drawing on interviews with lung transplant patients and other stakeholders in their service delivery networks, Virlée, Hammedi, and van Riel (2020) identify social support from nonprofessional networks as the most important systemic factor affecting value cocreation, exerting a greater influence than geophysical proximity or service system connectivity. The importance of both service and personal networks is reinforced by evidence from addiction and mental health research, highlighting the importance of social support (Soundy et al., 2015; van Weeghel et al., 2019; Wood and Alsawy, 2018) and the need to transform service delivery systems to promote recovery (Chamberlin, 2005; Laudet and White, 2010).

Consequently, there is a need for further research adopting a holistic view of transformative value creation in mental health and addiction services, particularly within complex service

ecosystem contexts. While the transformative service network model (Black and Gallan, 2015) offers valuable guidance on how to go about this, there are certain areas of interest which are omitted or granted little attention within this framework. Specifically, while patients' individual social support networks are acknowledged, there is a lack of in-depth exploration regarding how resources from these networks may be integrated into transformative value creation. Moreover, the quality of the core service is conceptualised primarily in terms of the provider/patient relationship, omitting the impact of other relational and restorative resources (Rosenbaum et al., 2020) within a given servicescape (see Section 2.13). This study seeks to address identified gaps through exploring T-VALEX creation across multilevel domains (RQ1), including through devoting attention to how clients conceptualise and connect to broader support networks.

2.5.2 TSR and Homelessness

The potentially transformative effects of service and service research have received particular attention in relation to socially marginalised consumers, defined as those positioned outside of mainstream society (Cheraghi-Sohi et al., 2020) who often encounter major barriers to service access and engagement (Anderson et al., 2013; Corus and Saatcioglu, 2015; Dean and Indrianti, 2020). Consequently, some transformative service researchers have highlighted the need for research exploring how members of marginalised groups can overcome extant barriers and engage effectively with services, including ways in which they may build capacity and 'find their stability' (Davey, Johns, and Blackwell, 2023, p.831) and how services may recognise and capitalise on 'hidden' pools of marginalised consumer resources (Finsterwalder et al., 2021, p.257).

In exploring inclusion of marginalised groups, those experiencing or at risk of homelessness have frequently been identified as key subjects of service and social policy research (Banerjee and Bhattacharya, 2020; Corus and Saatcioglu, 2015; Curry et al., 2017; Dobson, 2019). Conversely, the (transformative) service experiences of homeless and formerly homeless individuals remain understudied on the whole, despite extant research highlighting the need for change to inadequate service delivery systems currently serving (or failing to serve) these populations (Blocker and Barrios, 2015; Boenigk et al., 2021; Hill, 2002; Santos and Laczniak, 2009).

Furthermore, individuals experiencing homelessness are far more likely than average to experience social support deficits, increasing their susceptibility to loneliness but potentially also enhancing the potential for commercial friendships and third place attachments to have a transformative impact on their lives. However, effective application of the concept of third places to homeless individuals necessitates adaptation and adjustment of the original construct, which was explicitly centred on middle-class consumers and grounded in an assumption that people could move freely between and throughout first, second, and third places (Littman, 2021; Oldenburg and Brissett, 1982). In contrast, homeless and other disadvantaged groups are often unable to access varied physical spaces and can encounter numerous barriers to regular use of intended third spaces (e.g. community centres), including experiences of hostility and feeling unwelcome as well as physical and practical limitations (Hickman, 2013; Reitzes et al., 2015). In recognition of these limitations, Littman (2021) proposes the concept of 'collapsed places', including within them multiple subplaces which incorporate aspects of first, second, and third places and encompass both meso- and micro-level systems.

Transformative value creation has also been described as especially important for the most disadvantaged members of society, for whom this may signify not only an improvement in wellbeing but the difference between security and insecurity or even, in the most extreme cases, life and death (Blocker and Barrios, 2015; Mick, 2012). Indeed, it was in the setting of a service tailored towards people experiencing homelessness that the concept of transformative value was first devised (Blocker and Barrios, 2015), and a small but not insignificant body of later research has attempted to further elaborate upon this construct in this context. The potential for transformative service interventions (TSIs) to promote integration for refugees was highlighted by Boenigk et al. (2021), who identified three key phases of awareness (setting goals and seeking information), alignment (gaining skills and understanding through participation), and access (transitioning from TSIs into regular services). It may thus be worthwhile to explore the extent to the same phases apply to contexts of homelessness and other sources of marginalisation.

Conversely, homeless and other multiply disadvantaged people are frequently entangled in a complex web of services and systems, making it often difficult to ascribe transformative change to any specific intervention or relationship (Making Every Adult Matter, 2020). In accordance with the concept of T-VALEX (see Section 2.3), this complexity means that any research seeking to analyse transformative change must not simply address individual

services in isolation but rather encompass entire service ecosystems and personal networks (Blocker and Barrios, 2015; Helkkula, Kelleher, and Pihlström, 2012). Although focused primarily on the core service of Organisation X, this research does not seek to minimise or overlook the impact of broader service ecosystems, instead striving to understand the creation of T-VALEX from an interactive and processual perspective.

Moreover, homeless individuals have been discussed within the category of impoverished consumers, who are often excluded but who stand to benefit greatly from TSR. Such impoverished communities often face significant barriers to transformative service experiences, including issues with 'access to services, marginalisation during service experiences, lack of service literacy, and discrimination embedded in service designs' (Fisk et al., 2016, p.48). Additionally, where opportunities and resources conducive to transformation do exist for homeless and other impoverished populations, these are often overlooked, as these individuals are assumed to be powerless or even entirely beyond help (Chase and Walker, 2013; Fisk et al., 2016).

Addressing the barriers to transformative value creation necessitates a deep understanding of how these negative influences arise and operate. At the same time, in order to avoid also falling foul of harmful and simplistic assumptions, researchers have also highlighted the importance of acknowledging and analysing the creativity of those with least resources in consuming and developing personally beneficial service experiences (Anderson et al., 2013; Rosa, Geiger-Oneto, and Fajardo, 2012), with experiences of individual agency identified as key to long-term change including for homeless people specifically (Centre for Homelessness Impact, 2020). Through employing the concept of T-VALEX and its creation across multilevel domains (RQ1), this research adopts an expansive view of consumer resources and resource integration activities. Specific attention is also devoted to how clients draw on therapeutic resources beyond a focal provider servicescape (RQ2), emphasising consumer roles in co-construction and co-curation (see Section 2.13).

As touched upon in the previous chapter (see Section 1.1), barriers to value cocreation can arise when consumers experience vulnerability, here defined as a sense of powerlessness induced by individual and/or external factors (Baker, Gentry, and Rittenburg, 2005; Riedel et al., 2021). The likelihood of such vulnerability perceptions is increased for socially marginalised consumers, who often encounter both microlevel resource deprivation and meso/macrolevel discrimination (Corus and Saatcioglu, 2015). Having either prior or ongoing

experience of homelessness, mental health issues, and/or addiction, the subjects of this research all belonged to multiple marginalised groups at the point of entering Organisation X services. The following section will therefore cover social marginalisation and consumer vulnerability, discussing different ways in which these concepts have been applied and their relevance to the research context.

2.6 Consumer Vulnerability and Healthcare

Vulnerability is broadly defined as 'the quality or state of being exposed to the possibility of being attacked or harmed, either physically or emotionally' (Clark and Peto, 2018). In a consumption context, this risk pertains to an individual's likelihood of being unable to access and/or engage effectively with a market, product, or service. Consumer vulnerability thus occurs 'when control is not in an individual's hands, creating a dependence on external factors (e.g. marketers) to create fairness in the marketplace' (Baker, Gentry, and Rittenburg, 2005, p.134). This state of apparent powerlessness places affected individuals and groups at risk of failing to obtain maximum utility, or realise maximum value, from service encounters and other marketplace interactions (Baker, Gentry, and Rittenburg, 2005; Rosenbaum, Seger-Guttman, and Giraldo, 2017; Shi et al., 2017; Smith and Cooper-Martin, 1997; Visconti, 2016), and is consequently associated with likely reductions in wellbeing (Anderson et al., 2013; Beudaert, Gorge, and Herbert, 2017; Chase and Walker, 2015; Rosenbaum et al., 2011).

The concept of consumer vulnerability first arose in the late 1990s (Brenkert, 1998; Smith and Cooper-Martin, 1997). Analyses and typologies of consumer vulnerability have proliferated in recent years, with growing interest in the concept spanning consumer and service research (Dunnett, Hamilton, and Piacentini, 2016; Hill and Sharma, 2020; Rosenbaum, Seger-Guttman, and Giraldo, 2017). The table below outlines some key contributions to classifications of vulnerability across various fields.

AUTHORS	SETTING	CONTRIBUTIONS TO CONSUMER VULNERABILITY LITERATURE
Smith and Cooper-Martin (1997).	Marketing research, specifically target marketing.	Defined vulnerable consumers as those who are more susceptible to economic, physical, or psychological harm, resulting from individual characteristics and/or group membership (e.g. cognitive abilities, education, ethnicity).
Brenkert (1998).	Marketing research.	Distinguished vulnerability from related concepts of 'disadvantage' (unequal in obtaining various goods/services) and 'susceptibility' (ability to be affected, especially easily). Identified vulnerability as arising from individual, provider, and/or system characteristics.
Spiers (2000).	Healthcare, specifically nursing.	Summarised emic and etic approaches to consumer vulnerability. Argued for a differentiation between being at risk and the actual experience of vulnerability.
Aday (2002).	Vulnerability to disease and injuries in the USA.	Identified key population groups most vulnerable to disease and injury (e.g. alcohol and substance abusers, chronically and mentally ill, high-risk infants).
Nicholson (2002).	Clinical research.	Argued that every research subject should be treated as vulnerable unless proven otherwise on an individual basis.
Baker, Gentry, and Rittenburg (2005).	Drawing out key themes from previous consumer and marketing literature.	Advanced a context-specific and multi-dimensional definition, arguing that vulnerability is a condition rather than a permanent state and contesting the assumption that all members of a certain group are inherently vulnerable.
Commuri and Ekici (2008).	Macro-marketing.	Proposed an integrative view of consumer vulnerability as a sum of two components: a class-based, systemic component and a state-based, transient component.
Grabovschi, Loignon, and Fortin (2013).	Healthcare research.	Reviewed literature and confirmed hypothesis of a direct correlation between coexisting vulnerability factors and healthcare disparities.
Hill and Sharma (2020).	Considering consumer vulnerability across a broad range of contexts.	Propose key vulnerability antecedents (limited access to resources and restricted control); forms (global and situational); and methods of identification (experience and observation).
Rötzmeier-Keuper (2020)	Considering consumer vulnerability across a broad range of contexts.	Distinguished between actual experiences, generalised potentials, and manifestations of vulnerability.

Table 2.2: Overview of consumer vulnerability definitions and classifications.

Throughout this literature, a prominent point of debate has been whether vulnerability is best conceptualised as class-based or state-based (Baker et al., 2005; Commuri and Ekici, 2008), or emic or etic (Aday, 2002; Spiers, 2000). Class-based, or emic, definitions of vulnerability depict this as a lifelong condition affecting certain groups (Commuri and Ekici, 2008; Shultz and Holbrook, 2009), whereas the state-based/etic approach views vulnerability as a transient, experiential phenomenon, resulting from external factors and potentially affecting all consumers at some point (Baker et al., 2005; Canhoto and Dibb, 2016; Ford, Trott, and Simms, 2016; Garrett and Toumanoff, 2010; Hill and Sharma, 2020). Relatedly, assessments of vulnerability can be situational or global, with the former referring to a certain context while the latter encompasses a 'collection of selves' existing across diverse consumption environments (Hill and Sharma, 2020, p.562).

It is widely accepted that the emergence of consumer vulnerability is made more likely by a variety of factors, broadly characterised as individual characteristics (e.g. chronic diseases, disabilities), individual states (e.g. addictive consumptions, economic poverty), and external influences (e.g. disrespectful social representations, access and distribution issues). However, while these factors are associated with an increased likelihood of vulnerability (Alexander, Pillay, and Smith, 2018; Baker and Mason, 2012; Baker et al., 2005; Edwards et al., 2018; Fletcher-Brown et al., 2021; Ford, Trott, and Simms, 2016; Rötzmeier-Keuper, 2020; Visconti, 2016), the presence of a predisposition (or predispositions) is in itself insufficient to induce perceptions of vulnerability, which have been attributed specifically to the feeling of a loss of control (Smith and Cooper-Martin, 1997; Wünderlich et al., 2020). Additionally, vulnerability is not a static category, with some experiencing these perceptions only for a limited period and/or in a specific context (Baker et al., 2005; Canhoto and Dibb, 2016; Cheung and McColl-Kennedy, 2019; Ford, Trott, and Simms, 2016).

In attempts to reconcile the apparent contradictions between emic and etic approaches to vulnerability, some have attempted to define two distinct categories of vulnerable people: those who are vulnerable due to circumstances, environment, or structural influences and those who are individually, innately, and uniquely vulnerable (Aldridge, 2014; Larkin, 2009; Tileagă, Popoviciu, and Aldridge, 2022). However, the notion of innate vulnerability has also been criticised for accepting the inevitability of the status quo and failing to hold commercial and institutional powers to account, with Hill and Sharma (2020) for example asserting that consumer vulnerability results not solely from possession (or lack) of a certain characteristic relative to others, but from the infliction of harm by marketers or individuals. The notion that

vulnerability exists not within individuals but in societies is shared by proponents of the social model of disability, which is grounded in a distinction between the concept of impairment (i.e. actual physical characteristics or their absence) and disability (i.e. societally imposed restrictions faced by those with certain impairments) (Anastasiou and Kauffman, 2013). Thus, the onus is placed not on individuals but on institutions and societies to adopt more inclusive design practices.

Furthermore, both the concept of innate vulnerability in itself and the ways in which those so labelled are treated have been described as paternalistic and patronising, contributing towards a lack of personal agency and control which may cause or exacerbate perceptions of vulnerability. While assignation of a label of 'vulnerability' may increase an individual's likelihood of receiving help, for example accessing social support (McColl, Pickworth, and Raymond, 2006; Titchkosky, 2007), associations with weakness, fragility, and passivity mean that those considered vulnerable are rarely allowed to participate in decision making or exercise autonomy in regard to their own lives (Burghardt, 2013; Roulstone, Thomas, and Balderston, 2011). Vulnerable consumers have often been assumed unable to make mature or rational decisions (Burghardt, 2013; Chaplin and John, 2010; Hill and Sharma, 2020), legitimising the removal of personal choice and diminishing individuals' 'rights to independent living and full judicial rights' (Roulstone, Thomas, and Balderston, 2011, p.352).

The relationship between health service experiences and consumer vulnerability is one informative representation of the complexity of vulnerability perceptions and their determinants, which is highly relevant to the context of this study. On the one hand, health services are used at some point by almost all of the population, with service users of all characteristics and circumstances typically experiencing a lack of control and user/provider power imbalances, stemming from informational asymmetries and from users' dependence on providers to improve or restore their health (Abma, 2019; Bowl, 1996; Jadad and Gagliardi, 1998; O'Shea, Boaz, and Chambers, 2019). These imbalances take on additional dimensions in the context of mental health services, due to the stigmatisation of mental health issues and the legal capacities of professionals to make decisions about service users (including forced treatment and institutionalisation) against their will (Ning, 2010; Stuart, 2016; Tindall et al., 2021).

However, while all users of health services experience a degree of (state-based) vulnerability, the extent and ramifications of this are influenced by various (class-based) characteristics and circumstances of individual service users. These include biophysical determinants of vulnerability such as disability, race/ethnicity, addiction, and cognitive deficiencies (Baker et al., 2005), many of which are associated both with increased need for health services and with greater difficulties in accessing and engaging with them. These difficulties may relate to practical and financial limitations, but also to pertinent knowledge and skills (Borg, et al., 2019). In addition to the importance of general literacy (i.e. abilities to read, write, and solve problems in everyday life) (Ishikawa and Yano, 2008), there are three other literacy-based constructs which are pertinent to consider here: health literacy, mental health literacy, and digital health literacy.

Health literacy (HL) has been identified as a specific, health-related source of vulnerability, defined by the World Health Organisation (WHO) as cognitive and social skills 'which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health' (Nutbeam and Kickbusch, 1998, p.357). Low HL has been identified as a key form of vulnerability within healthcare services (Ilgün, Turac, and Orak, 2015; Nutbeam, 2008), associated with restricted service user agency and greater reliance on professional expertise (Anderson et al., 2013; Baker, 2006; Diviani et al., 2016; Sharma, Conduit, and Hill, 2017; Yin et al., 2012). While a degree of dependence on professional knowledge is inevitable in a healthcare context, consumer agency has frequently been described as key to resource integration and value cocreation in services and service ecosystems (Davey and Grönroos, 2019; Grönroos, 2008; Lusch and Vargo, 2014). Furthermore, low HL is associated with poorer and slower treatment outcomes (Pounders and Mason, 2018), supporting the broader argument that limited processing abilities can prevent consumers from realising optimal levels of value (Wünderlich et al., 2020).

Mental health literacy and digital health literacy are two subcategories of health vulnerability, both of which are correlated with general health literacy and with general vulnerability (Choukou et al., 2022; Teixeira et al., 2022; Virlée, van Riel, and Hammedi, 2020). Mental health literacy refers to beliefs and knowledge regarding mental health conditions. This has been evidenced to influence service access and engagement (Field, Honikman, and Abrahams, 2020; Gulliver, Griffiths, and Christensen, 2010; Tay, Tay, and Klainin-Yobas, 2018), with low mental health literacy also identified as a possible predictor of vulnerability

to suicide (Kaneko and Motohashi, 2007). Digital health literacy pertains to the ability to seek, access, understand, and apply health information from electronic sources (Honeyman et al., 2020; Rochwerg et al., 2020). Further to HL issues, there is healthcare research to suggest marginalised and minoritised populations are also more likely to lack knowledge of and/or trust in the medical system, compromising the ability to navigate broader health service systems (Jandorf et al., 2005; Salem, Kwon, and Ames, 2018).

Efforts to address the operant resource deficits of medically underserved, designated-vulnerable populations, seeking to improve rates of health service access and engagement, can take a wide variety of forms. In seeking to mitigate the compounding influence of low HL on vulnerability, some programmes have targeted vulnerable groups in order to build on their knowledge and skills (Tinder Foundation, 2016), essentially aiming to help these individuals build up operant resources which can be leveraged for value cocreation during future service use. Other initiatives have focused instead on increasing the accessibility and effectiveness of services for those with low HL, for example minimising demands on users by increasing the actionability and simplicity of health messages (Beaunoyer et al., 2017). Regarding aforementioned barriers to engagement with broader medical systems, there is some evidence of the benefits of a ‘health buddy’ or ‘patient navigator’ system underpinned by the premise that an individual is assigned to each service user to offer one-on-one service system navigation support (Jandorf et al., 2005), the potential value of which has also been highlighted by homeless service providers specifically (Salem, Kwon, and Ames, 2018).

Vulnerability is also closely related to experiences of stigmatisation and discrimination (Peñaloza, 1995). Stigmatisation occurs when a person possesses (or is perceived to possess) a socially undesirable attribute or characteristic (Goffman, 1963; Vázquez et al., 2021), while discrimination is defined as the distinguishing and/or prejudicial treatment of an individual based on their actual or perceived membership of a stigmatised group (Skosireva et al., 2014). The experience of discriminatory treatment has been identified a risk factor for poor mental and physical health outcomes, both increasing the likelihood of suffering from various conditions and creating major barriers to health service access and engagement (Krieger, 2000; Rivenbark and Ichou, 2020; Temple et al., 2021; Williams et al., 2019).

Furthermore, in addition to broader lifestyle and societal factors making stigmatised groups less likely to seek help, discriminatory behaviours of providers themselves and discrimination embedded in processes and structures can create and exacerbate inequalities and

vulnerabilities (Baker et al., 2005; Crockett et al., 2019; Hill and Stamey, 1990; Johns et al., 2017; Johns and Davey, 2021). Experiences of discrimination are also associated with delayed help-seeking and poorer engagement with services after initial access, for example in accessing government social welfare programmes and mental health services (Henderson, Evans-Lacko, and Thornicroft, 2013; Jarrett, 1996). Discrimination and stigma can create something of a vicious circle, wherein the cause of discriminatory treatment is exacerbated by the treatment received.

In healthcare specifically, discrimination and stigma play a key role in contributing towards underdiagnosis, mistreatment, and poor treatment outcomes, even under conditions of equal access to medical care (Nestel, 2012; Skosireva et al., 2014; Stuart and Arboleda-Flórez, 2012; Stuart, 2012). Stigma has long been recognised as a potential cause or exacerbator of vulnerability for those with mental health issues (Stuart and Arboleda-Flórez, 2012; Stuart, 2016). For example, people with mental health issues often encounter restrictions to service access, which have been demonstrated to often have a negative effect on their self-perception and thus their overall mental wellbeing (Sharma, Conduit, and Hill, 2017). Addressing discrimination and stigma is thus an important step in minimising the emergence and exacerbation of vulnerabilities.

This research centres on the experiences of marginalised and especially multiplicatively marginalised individuals, including their perceptions of vulnerability emergence and alleviation. For these purposes, a marginalised identity is defined as an enduring trait, while the actual experience of vulnerability is conceptualised as a transient (but sometimes recurring) state. Vulnerability perceptions may arise for any individual at any time, but the likelihood of their emergence is increased by a combination of individual factors (i.e. sources of marginalisation) and external influences, such as service contexts characterised by low levels of information and control.

Experiences of discrimination can be especially damaging for those possessing (or perceived to possess) multiple stigmatised characteristics, who experience intersecting vulnerabilities and can encounter what has been defined as intersectional discrimination (Conner and Rosen, 2008; Skosireva et al., 2014; Vázquez et al., 2021). This is highly pertinent within the research context, given the focus on multiplicatively marginalised individuals (Corus and Saatcioglu, 2015) and their perceptions of vulnerability emergence and alleviation. The following section will provide a brief overview of the concept of intersectionality and its

application to vulnerability, before turning specifically to the example of multiple exclusion homelessness and the subcategory of those experiencing both homelessness and mental health and/or substance use issues.

2.7 Intersecting Vulnerabilities and Multiple Marginalisation

Rooted in early Black feminist thought (Crenshaw, 1991), intersectionality is a paradigm for understanding how multiple social identity categories coexist and interact with one another to shape individual experiences of oppression and privilege, going beyond an additive approach which assumes that the (dis)advantages afforded by membership of these categories are simply 'summed together' (Corus et al., 2016; Davis, 2008; Gopaldas and Fischer, 2012; Hancock, 2007; Purdie-Vaughns and Eibach, 2008). Instead, intersectionality researchers propose a 'mutually constitutive model', within which disadvantages are experienced holistically and with interlinked and overlapping manifestations (Crenshaw, 1991). Historically focused on specific social identity markers (e.g. class, gender, race), more recent definitions of intersectionality have often adopted a broader focus, incorporating the influence of 'social practices, institutional arrangements, and cultural ideologies' (Davis, 2008, p.68). This more nuanced approach to identity and privilege is comparable to that advanced by critics of the concept of innate vulnerability, with increasing emphasis on the fact that identities are context- and time-specific and that failure to recognise this can result in overly simplistic, deterministic, and fatalistic conclusions (Nash, 2008; Steinfield et al., 2019; Viswanathan et al., 2012).

The concept of intersectionality has also been directly applied to vulnerability research. An approach of intracategorical intersectionality, exploring the impact of interconnected social identity axes within the same overarching social group (McCall, 2005), has been proposed in order to avoid adopting an essentialist approach to studying marginalised populations (Corus and Saatcioglu, 2015; Ozanne and Fischer, 2012). Intersecting vulnerabilities exist when individuals are exposed to one or more (class-based and/or state-based) sources of vulnerability, such as membership of multiple marginalised social groups, and are understood to create hardships that are far greater than the sum of each factor (Corus et al., 2016; Vázquez et al., 2021). At the same time, the impact of exposure to a certain source of vulnerability may be mitigated by possession of certain privileges and/or access to valuable resources (Gopaldas, 2013; Steinfield et al., 2019). An understanding of intersecting

vulnerabilities, how they interact, and the factors that serve to mitigate their impact is thus important, both in appreciating the depth of experience of the multiply vulnerable and in considering how to ameliorate and overcome the impact of vulnerabilities.

Extended experiences of multiple, intersecting vulnerabilities can produce what have been called ‘chronically-traumatised consumers’, who face multiple ongoing, intersectional traumas inhibiting transition out of a vulnerable state (Azzari, Mitchell, and Dadzie, 2021). Furthermore, the effects of these traumas are compounded by experiences of intersectional discrimination and policy invisibility. Intersectional discrimination makes people less likely to be considered worthy of help and more likely to be cut off from both public services and personal support networks, due to being perceived as dangerous and/or responsible for their situations (Skosireva et al., 2014; Vázquez et al., 2021). In addition to facing active discrimination and rejection, people experiencing multiple disadvantages are often simply overlooked as policies and services are geared towards one form/source of vulnerability in isolation, resulting in a state of policy invisibility in which an individual or group is left outside the field of benefit or protection (Corus et al., 2016; Purdie-Vaughns and Eibach, 2008). Consequently, it is not uncommon that those in the greatest need of support are prohibited from accessing this and/or receive a poorer standard of care after access, again potentially resulting in a vicious circle effect.

People experiencing homelessness often experience multiple intersecting vulnerabilities, including extreme poverty, lack of support networks, and physical and mental health problems (Vázquez, Panadero, and Zúñiga, 2017; Vázquez et al., 2019; Vázquez et al., 2021). Furthermore, homelessness is often attributed to personal failings, being both a stigmatising social identity itself and associated with other stigmatised identities (Hopper, 2019; Vázquez et al., 2021). Collectively, these factors often result in a state of social exclusion, in which homeless people are excluded from multiple social domains and ‘separated from much that comprises the normal “round” of living and working within that society’ (Philo et al., 2000, p.751).

The concept of social exclusion is particularly pertinent for those experiencing multiple exclusion homelessness (MEH), defined as a combination of an experience of homelessness (rough sleeping, insecure accommodation, or squatting) with at least one indicator of deep social exclusion (e.g. chronic mental health issues, an institutional background, or problematic substance use) (Bowpitt et al., 2011; Bramley et al., 2015; Brown et al., 2012;

Cornes et al., 2011; Fitzpatrick, Bramley, and Johnsen, 2013). There is a clear association between homeless and mental health issues within the MEH literature (Pattison and McCarthy, 2022). In a seminal article exploring pathways into MEH across seven UK cities, Fitzpatrick et al. (2013) identified five clusters of experience within the MEH population, with approximately 25% of those studied falling into the cluster of 'mental health and homelessness' and 85% of those in four of the clusters described as 'very anxious or depressed'.

Despite this well-documented association, understanding of experiences of discrimination and vulnerability faced by homeless people with mental health and/or substance use issues remain poorly understood, with homelessness research typically only briefly covering mental health and mental health research rarely gathering information on housing status (Pattison and McCarthy, 2022; Skosireva et al., 2014; Wen, Hudak, and Hwang, 2007). Furthermore, the majority of extant research on homelessness and mental health is quantitative, with few in-depth, processual accounts of how homeless people with mental health issues experience vulnerability, discrimination, and services (Fitzpatrick et al., 2011, 2013). There is thus a need for more in-depth research on the experiences of this population, ultimately striving to contribute towards holistic policies and services addressing multiple forms and experiences of exclusion (Pattison and McCarthy, 2022).

Conversely, multiply marginalised people can find support and navigate consumption environments in unconventional ways, for example through 'shadow communities' of street homeless people watching out for each other (Hill and Stamey, 1990) and self-supportive kinship networks often established and referred to as 'street families' by homeless young people (Smith, 2008, p.756). When access is possible, digital spaces can also serve an important function, enabling geographically dispersed people to come together and build coping strategies (Kaufman-Scarborough, 2019; Rötzmeier-Keuper, 2020). While practical resources are obviously important, research has found that their value is often largely dependent on the existence of positive, facilitating relationships (Davey and Grönroos, 2019; DeGregori, 2019). The building and maintenance of positive relationships with service providers specifically has also been found to be especially important in contexts of consumer vulnerability (Amine and Gatfaoui, 2019; Rötzmeier-Keuper, 2020).

Developing understanding of how providers can build and maintain positive relationships with consumers dealing with intersecting vulnerabilities necessitates research at the meso-

level, encompassing organisational infrastructure and services and uncovering opportunities for value cocreation (Blocker et al., 2013; Fletcher-Brown et al., 2020; Rötzmeier-Keuper, 2020). To date, however, consumer vulnerability literature has predominantly fallen into one of two distinct categories (Rötzmeier-Keuper, 2020), either adopting a class-based perspective to explore the macroenvironment (i.e. governments and institutions) (e.g. Smith and Cooper-Martin, 1997) or adopting a state-based perspective to analyse the microenvironment (i.e. individuals) (Baker et al., 2005).

Similarly, intersectionality research has typically focused either on individuals' interconnected identity categories (microlevel analysis) (Gopaldas, 2013) or on legislation and policy-level dynamics (macrolevel analysis) (Crenshaw, 1991; Hankivsky et al., 2010), downplaying the impact of organisations (Dill and Kohlman, 2012). This is in spite of evidence of the potential of the meso-level environment to transform the health and wellbeing of vulnerable consumers (seemingly to a greater extent than the macrolevel) and of the role of organisational practices in creating, maintaining, and challenging discrimination and oppression (Fletcher-Brown et al., 2020; Steinfield et al., 2019). Consequently, there is a need for further meso-level research on the subject of intersecting vulnerabilities in general (Corus and Saatcioglu, 2015; Rötzmeier-Keuper, 2020), and of homelessness and mental health specifically.

Investigation of the relationship between consumer vulnerability and service has been identified as a research priority within transformative service research (TSR) (Anderson and Ostrom, 2015). TSR is a field of service research which is fundamentally about the use of services to generate 'uplifting changes and improvements in the wellbeing of consumer entities' (Anderson et al., 2013, p.1204), including consumers, employees, communities, and ecosystems. Transformative service researchers have emphasised the need to better understand the relationship between vulnerability and service outcomes such as wellbeing (Anderson and Ostrom, 2015), including within the specific context of healthcare service use (Virlée, van Riel, and Hammedi, 2020), and highlighted the particular importance of transformative outcomes for marginalised and vulnerable groups (Blocker and Barrios, 2015). This thesis will therefore adopt a transformative service lens, beginning with an overview of the background and conceptualisation of this field before going on to explore TSR in the research context.

2.8 Background and Conceptualisation of Service Design

Business researchers have historically devoted extensive attention to product design, with a tradition of high-quality work in industrial engineering, marketing, and technology (Ostrom et al., 2010). However, only comparatively recently has service design begun to be acknowledged and explored as a field in its own right, with unique characteristics and potential. Engaging in service design has been defined as the 'activity of planning and organising people, infrastructure, communication, and material components of a service in order to improve its quality and the interaction between service providers and customers' (Andreassen et al., 2016, p.22).

As scholars have increasingly highlighted the need for innovation research to adopt a focus on experience (Prahalad and Ramaswamy, 2003; Vargo and Lusch, 2004), there has been growing interest in the utility of design methods to embrace 'an approach that emphasizes experience as something lived and felt' (Windahl and Wetter-Edman, 2018, p.675), with researchers and service firms alike investing in these methods (Bason, 2017; Clatworthy, 2011; Mager, 2009). Furthermore, the relational and temporal nature of service has led some to argue that the end-result cannot be designed as such, as this is by definition co-constructed through service user engagement and associated processes of value creation (Bate and Robert, 2007; Garud, Jain, and Tuertscher, 2008; Kimbell and Seidel, 2008; Meroni and Sangiorgi, 2011). On this basis, Kimbell (2011, p.45) proposes eschewing the term 'service design' in favour of 'designing *for* services'. This distinction is grounded in the belief that the most one can do is construct 'a platform for action with which diverse actors will engage over time' *(ibid)*, related to the understanding that organisations cannot engage in unilateral value creation but merely offer CVPs (Vargo and Lusch, 2004; Zainuddin and Gordon, 2020).

This section will delve into some of the key influences underlying service design and its different manifestations, beginning within service research and then moving on to consider the roles and relevance of external influences, before providing an overview of the concepts, developments, and debates within the field which are of greatest relevance to this thesis.

2.8.1 Service Research Influences

The field of service design has been strongly influenced by service research, and in particular by several specific subfields. Firstly, service research as a whole has shaped the way in which

the very concept of service is typically understood by service researchers and practitioners, commonly adopting the SDL definition of service as the application of one entity's competences to benefit another (Vargo and Lusch, 2008) and the associated concept of CVP (Frow et al., 2014) in framing opportunities for resource integration, value cocreation, and technological innovation (Edvardsson and Olsson, 1996; Patrício, Fisk, and e Cunha, 2008; Patrício et al., 2011; Zomerdijk and Voss, 2010). Also of great significance here are the specific contributions of the management-orientated fields of marketing and operations management (Kimbell, 2011; Sangiorgi et al., 2019), which will be explicated and discussed below.

Tying in with the aforementioned focus of service design on user experience, it is a central premise of services marketing research that different components of service quality should be examined as a whole, with the alternative of examining aspects in isolation risking confounding understanding of user decision-making and thus producing strategies which overemphasise and/or underplay different variables (Cronin et al., 2000; Wani, Malhotra, and Clark, 2021). The emergence in marketing of a customer-centric philosophy is reflected in the widespread focus on the enhancement of customer experience (CX) and on the crucial roles of customers within service delivery systems, both of which have helped to shape the holistic, experiential focus of much of recent service design research (Crosier and Handford, 2012; Zomerdijk and Voss, 2010). Service design practice and research employing a marketing approach is thus centred around the service concept, i.e. what a service provides for its users, both in terms of what is intended and what is actually realised (Goldstein et al., 2002; Roth and Menor, 2003; Wani, Malhotra, and Clark, 2021).

The main contributions of operations management research to service design have been a focus on service operations, which consist of a combination of 'back office' operations occurring without a customer and 'front office' operations occurring in direct contact with a customer (Joly et al., 2019), and on the design of service delivery systems (Edvardsson and Olsson, 1996; Kimbell, 2011). While marketing literature advocates for a broad, holistic view of customer experience, operations management research has long highlighted the benefits of a narrower focus, such as improved efficiency and reduced costs (Clark and Huckman, 2012; Wani, Malhotra, and Clark, 2021). However, in healthcare specifically, services described as 'focused factories' have historically been highly criticised within health services and policy circles (Kumar, 2010), suggesting that the benefits observed in other fields may not translate

into this context or may be outweighed by negative impacts and perceptions (Wani, Malhotra, and Clark, 2021).

In acknowledgement of the fact that service design and research are grounded in cross-functional efforts of marketing and operations management, there have been some attempts to bridge the gaps between these two perspectives, highlighting the combined effects of marketing tactics and operational decisions (Pullman and Thompson, 2003; Verma, Thompson, and Louviere, 1999). The concept of service experience management was developed in an attempt to promote more widespread integration of customer experience with the operations management focus on service operations/processes, highlighting the importance of both in determining processes of service design, adaptation, and (where applicable) termination (Kwortnik and Thompson, 2009). Integration of marketing and operations perspectives has additionally been tied to the development of service concepts (Kimbell, 2011), which will be further explored in relation to key concepts in contemporary service design research (see Section 2.8.4).

However, even attempts to bring these two branches of service research together are not necessarily accommodating of the impact of external factors such as interaction design and information systems research. On the contrary, different contributions and approaches remain largely dispersed across fields (Joly et al., 2019), hampering opportunities for innovation and for the general advancement of the field. Thus, in an attempt to provide and promote a sufficiently expansive understanding of service design, the subsequent section will define and discuss key influences outside of the field of service research.

2.8.2 External Influences

Interaction design is a design-orientated field of technology centred on designing pleasing and useful technological artefacts and understanding engagement between humans and technologies (Sangiorgi et al., 2019). Compared to other, management/service-driven approaches, the interaction design perspective is comparatively less structured, more emphatic, and more focused on frontstage interaction and the ways in which service interfaces embody service offerings (Teixeira et al., 2017). Interaction design has made important contributions towards addressing technological issues in service design, directly through the creation of interactive artefacts which are used to perform service and indirectly through demonstration/exploration of appropriate methodologies and techniques (Holmlid,

2007). Methodologically, interaction design favours user-centred and participatory approaches (Holmlid, 2009), encouraging empathic engagement with service users to facilitate the transformation of tacit knowledge into sources of innovation (Joly et al., 2017).

The information systems approach is in many ways similar to that of interaction design, also promoting user-centred approaches but with a more specifically systemic focus (Joly et al., 2017). An information system is defined as 'a set of interrelated components that collect, manipulate, store, and disseminate the data and information and provide a feedback mechanism to meet an objective' (Stair and Reynolds, 2010, p.4) In relation to service design, information systems concepts and tools can facilitate the visible representation of different system or value constellation dimensions, supporting process innovation and redesign (Trischler and Charles, 2019). This is most pertinent to the roles of supportive technologies enabling changes 'in terms of new technological solutions (e.g. web service), new service delivery processes (e.g. people-to-machine; machine-machine) and new interfaces (e.g. virtual interfaces)' (Joly et al., 2017, p.389).

2.8.3 Conceptualisation and Development of Service Design

Shostack (1982, 1984) was amongst the first to explicitly discuss the concept of service design, using this to argue in favour of the use of service blueprints (i.e. diagrammatic representations of key components and relationships underlying the functioning of a service). She argued that the tendency to focus on frontline staff members' competencies and behaviours distracted from the underlying cause of service failures: the lack of a systematic, holistic method for design and control, the inclination of service managers to manage 'the pieces rather than the whole' (Shostack, 1984, p.139), and the resultant vulnerability and slow reactivity of the majority of organisations.

Since Shostack's early writings, there has been a steadily growing interest in service design across both practice (e.g. healthcare, high-tech) and research (e.g. organisational behaviour, service innovation) (Anderson, Nasr, and Rayburn, 2018; Junginger and Sangiorgi, 2009; Ostrom et al., 2010). Key components within service design include the servicescape (i.e. environment), service operations management (e.g. procedures, processes), and social factors (e.g. attitudes, culture) (Anderson, Nasr, and Rayburn, 2018; Bitner, 1992; Goldstein et al., 2002; Teixeira et al., 2017).

In spite of these identified key factors, there remains a lack of consensus regarding what constitutes effective application of 'designerly' approaches to service innovation (Sangiorgi et al., 2019, p.157). Several key areas of contention can often be traced back to underlying epistemological commitments to either positivism or constructivism (Dorst and Dijkhuis, 1995). The positivist approach draws strongly upon theories of technical systems, treating design as a rational problem-solving process (e.g. Simon, 1992), whereas a constructivist lens emphasises the individuality of each design problem, understood as a 'universe of one' (Dorst and Dijkhuis, 1995, p.263). While this makes generalisation of rules and insights less straightforward, according to Schön (1992, p.4), it is in this 'reflective conversation with the situation' that the true essence of design practice lies.

This divergence in guiding philosophical principles has had important real-world consequences, pertaining for example to the extent to which service design projects are standardised and deterministic (Holmlid, 2007). Drawing on Simon's (1988) discussion of artificial (as opposed to natural) sciences, Pandza and Thorpe (2010) identify three distinct definitions which have been employed in this context: deterministic, path-dependent, and path-creating or radical engineering design. While all have valuable contributions to make, this research adopts the definition of path-creating design, emphasising continuous evolution and experiential learning over determinism and standardisation. All three approaches are outlined and discussed below:

1) *Deterministic design*

Deterministic design centres the agency of the expert designer, whose decisions are assumed to predictably determine the nature and behaviour of artefacts and who are thus well equipped for the production of optimal design solutions. Design decisions of this kind are made on the basis of prescriptive knowledge, following the basic format of 'to achieve outcome Y in a situation X, a design-based action Z *might* help' (Pandza and Thorpe, 2010, p.173). Prescriptive knowledge is very commonly applied within engineering design, which is defined as the creation of new products, processes, and systems for the purpose of manipulating the human environment (Pitt, 2000, cited in Pandza and Thorpe, 2010).

2) Path-dependent design

This approach builds from the recognition that designers are not the sole determinants of an artefact's development, emphasising the process of evolution through adaptation and repetition and drawing on such theories as Darwinian selectionism and Lamarckian habitual repetition. The contributions of human agency and prescriptive knowledge are therefore challenged, if not completely undermined (David, 2001; Garud, Kumaraswamy, and Karnøe, 2010). Studies of evolutionary design dynamics centre on path-dependent design, subverting 'the inherent assumption that design arises from the divine talent of the artist-designer or the undisputed professional competency of the engineering designer' (Pandza and Thorpe, 2010, p.180) and highlighting the importance of incremental improvements based on experiential learning (Cogdell, 2003; Langrish, 2004; Van Nierop, Blankendaal, and Overbeeke, 1997).

3) Path-creating/radical engineering design

Diverging from the relative simplicity of the two aforementioned approaches, path-creating or radical engineering design does not attribute artefact development to a singular cause of either developer agency or socioenvironmental influences. Instead, design is conceptualised as the pursuit of unpredictable novelty, a form of scientific discovery rather than practical engineering. This approach explores the dynamics of evolutionary design, within which products and services develop through incremental improvements based on experiential, trial-and-error learning (Cogdell, 2003; Langrish, 2004; Van Nierop, Blankendaal, and Overbeeke, 1997). However, while the agency of the individual designer is minimised somewhat compared to deterministic design, human agency as a whole is not, with individual and collective agencies contributing towards the emergence of novel ideas, knowledge trajectories, and technologies (Garud and Karnøe, 2001; Garud, Kumaraswamy, and Karnøe, 2010).

These different approaches to design are not only relevant in comparing different design practices being carried out concurrently, but also in how beliefs and norms regarding service design and effectiveness have shifted over time. The deterministic approach is naturally more conducive towards standardisation of elements and processes, the principle of which has long been associated with significant economic and other benefits in product design (Blind and Mangelsdorf, 2012; Whitelock, 1987). There are also strong traditions of standardisation in certain service sectors, such as financial services and libraries, and standardisation in service

industries as a whole has increased overall in recent decades (de Vries and Van Delden, 2011; de Vries and Wiegmann, 2017).

The notion of a non-subjective, quantifiable blueprint for service design, as both feasible and desirable, was pivotal to Shostack's (1984) argument for a more systematic approach to service, providing managers with a consistent context for process control. The pursuit of coherence and consistency remains a powerful impetus for many service designers and researchers, some of whom describe this as necessary to prevent services from descending 'into a chaotic blend of people, techniques, and outcomes' (Anderson, Nasr, and Rayburn, 2018, p.101). However, in recent years this approach to service design has met some opposition, with some arguing that the unique nature of services (in comparison to products) makes determinism and standardisation fundamentally inappropriate (Kimbell, 2011; Zeithaml, Parasuraman, and Berry, 1985). In healthcare services specifically, there is evidence to suggest that standardised provision is often unreflective of consumers' actual (physical and emotional) needs and wants, disrupting the caregiver-patient relationship and frequently resulting in service failures (Anderson, Nasr, and Rayburn, 2018).

Rather than an aggregated static process, service design is increasingly understood as an evolving, iterative, and personalised process (Rust and Huang, 2014), acknowledging the fundamental nature of services as complex and relational entities that cannot be fully predesigned or predetermined (Sangiorgi, 2011). Thus, while it was originally asserted that service developers should, at the design stage, consider and plan for every prospective customer/provider interaction (Shostack, 1984), more recent interpretations have built from the acknowledgement that this is often not feasible and may not even be desirable. Lee (2004), for example, advocates for the promotion of an overall service culture as opposed to a standardised strategy, thus reducing the risk of overly scripted service exchanges detracting from the authenticity of human interaction.

Therefore, over time the purview of service design has drastically expanded, transforming into an approach which is fundamentally creative, iterative, and human-centred (Kimbell, 2011; Rust and Huang, 2014; Teixeira, Patrício, and Tuunanen, 2018). In order to effectively design a service, designers require insight not only into customers' expressed desires and needs but also into their likely behaviours in envisioned service experiences (Bitner et al., 2008; Kurtmollaiev and Pedersen, 2022), which may be influenced by a multitude of possibly unanticipated factors. While it may not be feasible to plan for every conceivable

circumstance, the need to account for a plethora of possibilities underlines the importance of both early prototypes and ongoing feedback mechanisms, ensuring that consumer input is elicited and applied at every stage (Yu and Sangiorgi, 2018).

2.8.4 Key Concepts and Approaches in Contemporary Service Design

In accordance with the evolution of service design research and methodologies, this study focuses on application, extension, and evaluation of several specific constructs and approaches. Firstly, the service concept is of interest particularly in relation to differences between intended and realised forms, i.e. comparing what a service intends to provide for its users with the reality of customer experience (Roth and Menor, 2003; Wani, Malhotra, and Clark, 2021). The service concept has been defined as the combination of an organisation's strategic intent with the service strategy (i.e. market position and type of customer relationship) and how this is implemented (i.e. design of the service delivery system) (Goldstein et al., 2002).

While an intended service concept represents a provider's plan, or 'cognitive logic' regarding what a service will provide, this is inaccessible to consumers, who solely observe realised concepts as experienced during service encounters (Wani, Malhotra, and Clark, 2021, p.213). The service encounter denotes the actual interaction between a customer and a service, experiential aspects of which are often prioritised (Voss, Roth, and Chase, 2008). There has been substantial attention devoted towards how service encounters are shaped by service delivery system design (Roth and Menor, 2003), including such elements as 'facilities, layout, technology, human resources, complementary service offerings, and communication mechanisms' (Wani, Malhotra, and Clark, 2021, p.210). Service encounters and related concepts of CX management, servicescapes, and service delivery system design have been identified as key to understanding how organisations can design services (Kimbell, 2011), resulting in a plethora of specific strategies and approaches.

2.9 Codesign and Vulnerable Consumer Engagement

One critical way in which the tensions between service and traditional design have been addressed is in the movement away from designing *for* towards designing *with* customers (Kimbell, 2011; Matthing, Sandén, and Edvardsson, 2004). Customers have been widely recognised as a key source of innovation within service industries (Greer and Lei, 2012;

Magnusson, 2003; Taghizadeh et al., 2018), tying in with the importance of customer experience as a predictor of customer satisfaction and organisational performance (De Keyser et al., 2020; Lee, 2018; Ostrom et al., 2021).

Furthermore, there is evidence to suggest that innovation is more often generated through interaction with users and tacit knowledge than through explicit research and development (R&D) activities (Sangiorgi, 2011). This evidence suggests that, rather than devoting extensive resources to R&D, efforts may be more fruitfully directed towards facilitating user involvement in determining the goals and shaping the development of service design projects. Such an approach has been termed human-centred/customer-centred design, within which customer needs are placed at the heart of service development (Anderson, Nasr, and Rayburn, 2018; Danaher and Gallan, 2016). Human-centred designers adopt an 'outside-in' approach, working with communities in order to best understand how consumers experience a service and encouraging participation of all stakeholders in envisioning alternative service models/systems (Dietrich et al., 2017, p.666; Holmlid, 2007; Holmlid and Evenson, 2008).

Alternative models founded on cocreation and collaboration have received substantial attention, promoting the distribution of resources and user participation in the 'design and delivery of services, working with professionals and front-line staff to devise effective solutions' (Cottam and Leadbeater, 2004, p.22; Sangiorgi, 2011). The increasing popularity of such models has been observed among many service designers, with the design focus shifting away from a more traditional, narrower view of problem solving towards the promotion of human-centred innovation through engagement of citizens and communities (Sangiorgi, 2011; Wetter-Edman, Vink, and Blomkvist, 2017). Human-centred innovation is generated through the application of user research methods to elicit insights into (un)successful interactions and relationships from a user perspective, which can provide a base for organisational redesign and service experience enhancement (Yu and Sangiorgi, 2018).

The engagement of service users as codesigners, or 'expert[s] of their experiences' (Sanders and Stappers, 2008, p.12), is one popular way of eliciting user input into a project's goals and strategies, within which customers are encouraged to identify the ways in which their needs and desires can best be met (Trischler and Charles, 2019). Further investigation into and development of participatory approaches has been identified as a priority by researchers affiliated with service research centres and networks across the world, with a particular focus

on the need to involve vulnerable consumers in processes of codesign (Dietrich et al., 2017; Ostrom et al., 2015). Developing services and service ecosystems to better meet the needs of those experiencing vulnerability and/or marginalisation has been identified as a key service research priority (Field et al., 2021; Ostrom et al., 2015; Ostrom et al., 2021), with service design posited as an essential tool for helping the service research community go beyond merely studying the BoP to devising new services that overcome systemic deficiencies and improve the lives of those most in need (Reynoso, Valdés, and Cabrera, 2015).

However, important distinctions have also been drawn between different forms of user engagement. Popular approaches to codesign have been criticised for failing to fully exploit the opportunities contained within the view of customers as cocreators, suggesting that firms should consider not only how customer input can drive innovation but also how they can innovate with regard to different forms of customer input (Ostrom et al., 2010). Additionally, responsiveness to customer needs and desires is important not only in the early stages of service design but throughout the entirety of this process. For example, advocating for codesign in working with young people with mental health issues, Hagen et al. (2012) proposed the three key principles of ensuring users are active participants throughout the entire design process; that they participate in idea generation as well as providing feedback on existing concepts; and that proposed interventions are continually evaluated from a user perspective.

Interpretations of vulnerable consumers vary. Definitions supported by authors such as Baker et al. (2005) suggest they may be marginalised by society and may consequently experience a sense of powerlessness which may reduce their willingness to participate in codesign. They are likely to encounter greater difficulties defining their goals and preferences, whilst also possessing fewer resources to achieve these (Dietrich et al., 2017). Thus, while the practice of user involvement in service design and innovation is gaining increasing acceptance (Hoyer et al. 2010; Gemser and Perks, 2015), the most likely contributors to such activities are typically not vulnerable consumers but rather those with the greatest capabilities and willingness to participate (Hoyer et al., 2010; Piller and Walcher, 2006; von Hippel, 2001).

Furthermore, while innovation and new service development literatures have provided some generic frameworks for active user involvement, these are primarily focused on business-to-business customers and innovative users, failing to account for the unique characteristics and potential difficulties of vulnerable consumers (Hoyer et al., 2010). In response to this

oversight, Dietrich et al. (2017) propose a six-step framework for the involvement of vulnerable consumers in codesign, counterposing these against the actions comprising conventional codesign (see Table 2.3):

Design Stage	Conventional User Involvement	Vulnerable User Involvement
Resourcing	'Outsource' resourcing to users through the provision of generic innovation tools.	Expert-led resourcing and provision of topic-specific design tools.
Planning	Direct communication between experts and users – e.g. online.	Communication via intermediaries – e.g. governmental bodies, schools, and other service providers.
Recruiting	Users self-select and are driven by specific motivations.	Users are recruited through intermediaries and may require incentivisation.
Sensitisation	Users are already knowledgeable about the topic and are sensitised through challenges and competitions.	Users are introduced to the topic and need to develop trust with facilitator(s).
Facilitation	A user-driven process, with experts participating only as consultants.	An expert-guided process, with experts participating as facilitators and making use of stepwise user empowerment.
Evaluation	Focus on feasibility, originality, and user value.	Focus on consumer wellbeing, social change, and transformation.

Table 2.3: Framework for involvement of vulnerable consumers (Dietrich et al., 2017).

Encouraging typically marginalised or vulnerable consumers to share their 'voice' is thus associated with unique rewards, but can also be very challenging (Chakravarti, 2006). Beyond the crucial first step of getting consumers involved in design projects, issues have also arisen regarding power imbalances and role definition (Moll et al., 2020; Osei-Frimpong et al., 2020). While participatory design approaches theoretically embrace alternative forms of expertise and distributed power and resources (Cottam and Leadbeater, 2004; Sanders and Stappers, 2008), in practice evidence of genuine shifts in power relations is often scant (Bate and Robert, 2007; Donetto et al., 2015). Meaningful power shifts seem less likely to occur in all contexts of actual or potential vulnerability, in which (as shown in Table 2.3) 'experts' are still largely leading the process and in healthcare specifically, in which all users are in some sense vulnerable and in which the role of the expert decision-maker is especially well-defined (Donetto et al., 2015).

Overall, while the fields of service design and TSR are both well suited to addressing the needs of vulnerable populations, there is a pressing need for further research exploring transformative design in contexts of marginalisation, encompassing effective strategies and methodologies for marginalised/vulnerable consumer engagement (RQ4) and how services can be designed to minimise and alleviate vulnerability perceptions (RQ3).

2.10 Transformative Service Design

Increasingly, the effective design of services is viewed not as an end in itself but rather as an engine for wider societal transformation, contributing towards redesigning public services and developing communities to promote collaboration, equitability, and sustainability (Alkire et al., 2020; Kimbell, 2011; Kurtmollaiev and Pedersen, 2022; Trischler and Charles, 2019). The synergies between service design and TSR have also been explicitly emphasised by several researchers (Anderson and Ostrom, 2015; Baron et al., 2018), with Anderson, Nasr, and Rayburn (2018, p.100) asserting that 'the ability of a service to achieve TSR's illustrative wellbeing outcomes…is dependent on how well the service is designed'. Consequently, these authors argue that the tools and mindset of service design are essential for ensuring that transformative potential is built into service development and innovation, making customer experiences not only 'transformative by nature' but also 'transformative by design' (p.110). Beyond this, it has also been suggested that service users' experiences of participation may in themselves serve as a means for transformation (Sanders and Stappers, 2008; Wetter-Edman, Vink, and Blomkvist, 2017), with truly transformative service design necessitating the engagement and participation of multiple actors in a community (Alkire et al., 2020).

There are multiple ways in which service design as a field is contended to be naturally conducive towards transformation at macro-, micro-, and meso-levels, and thus to be a valuable frame of reference when conducting TSR. Included amongst these is the much-cited capacity of service design to adopt a transdisciplinary approach, overcoming traditional boundaries in order to promote transformational processes and enhance wellbeing (Anderson, Nasr, and Rayburn, 2018; Ostrom et al., 2010). Service design and TSR are also compatible in terms of their future focus: TSR strives not only to understand problems but also to identify community/organisational strengths and develop strategies accordingly, while service design is focused on delivering courses of action for transforming existing situations into preferred futures (Anderson, Nasr, and Rayburn, 2018; Patrício et al., 2020).

In order to design for transformational change, it is necessary first to establish what this change would look like and the relevant qualities and parameters for consideration. In the context of organisational change, this has been defined by some as the difference between ‘first-order’ and ‘second-order’ changes, with the former denoting changes in an existing system while the latter encompasses qualitative changes to the core processes, culture, mission, and underlying paradigm of a system (Levy, 1986). While such distinctions can be highly informative in an organisational context, multiple issues arise in attempting to translate these categories to the context of service user experience, within which the concept of a ‘transformative’ experience is inherently subjective, difficult to define, and, consequently, difficult to design for. In assessing the effectiveness of a project or service in producing transformative change, is also essential to distinguish between and compare ‘intended’ and ‘realised’ service concepts, with the former signifying the intentions of the service designer while service users only come into direct contact with the latter (Goldstein et al., 2002; Roth and Menor, 2003; Wani, Malhotra, and Clark, 2021).

Advocating for a view of design as a means towards transformative (economic and/or social ends), in the mid-2000s, the Design Council UK proposed the concept of ‘transformation design’ (Burns et al., 2006). In transformation design projects, applications of design thinking and techniques are understood as ‘a way of organizing the process of enabling solutions for radical change’ (Coulson et al., 2018, p.817). Key elements of transformation design projects include codesign and collaboration between diverse actors, spanning across disciplines and between organisations (Burns et al., 2006; Sangiorgi, 2011). Within public services specifically, design strategies seeking to promote transformation can either address this from the ‘inside out’, working within organisations, or from the ‘outside in’, working with communities and various external stakeholders (Sangiorgi, 2015, p.332). This thesis will focus primarily on the former approach, while also highlighting the importance of research bridging the two (Sangiorgi, 2011), and will specifically address applications of transformation design within (mental) health, homelessness, and integrated service models.

2.11 Service Design in Healthcare

There have been significant attempts to apply service design strategies to healthcare and, to a lesser extent, to mental healthcare specifically. In the past two decades especially, design methods and principles have increasingly been recognised as valuable assets in strategies for

healthcare innovation, highlighting the relationship between environmental effects and healing (Arneill and Delvin, 2002; Brown, 2008; Irwin, 2002). The information systems approach to design has also proven effective within certain sectors, with Health Information Systems (HIS) and Electronic Health Records (EHR) associated with improved performance in a variety of critical functions, including data acquisition, analysis, and presentation (Wiederhold and Shortliffe, 2006). Furthermore, the holistic, human-centred, and participatory approach associated with service design has been found to facilitate the successful development and implementation of EHRs, positioning these within the context of a broader service system in order to enable value cocreation with users (Teixeira, Pinho, and Patrício, 2019).

Key design principles have been effectively applied to the field of healthcare, with Lee et al. (2011) for example mapping out the servicescape of an outpatient healthcare facility. Furthermore, tying in with the TSR agenda, the creation of transformative servicescapes for health and wellbeing has been identified as a priority for health service research (Danaher and Gallan, 2016). Anderson, Nasr, and Rayburn (2018) build upon this premise, arguing that the development of transformative health services necessitates a complete redesigning of the industry from a service design perspective. In order for this to occur, they argue, it is essential that healthcare services foster more collaborative relationships and greater consumer engagement, which is achievable only if consumers are at the centre of design projects.

Moreover, the concept of customer-centred design is analogous with a burgeoning movement in favour of customer-centred healthcare, which promotes incorporating insights from the best guest service companies in the design of care environments (Fottler et al., 2000; Lee, 2004). According to this view, the centring of the consumer consists of more than simply meeting their immediate medical needs, with the purview of the provider expanding to include the environmental and interpersonal aspects of a service experience. This has been accompanied by a linguistic shift, away from the traditional denotation of ‘patients’ and towards the alternatives of ‘clients’, ‘consumers’, or ‘customers’ (Brinkmann, 2018). The basic rationale underpinning this movement is that healthcare is not so uniquely challenging that it cannot learn from other service organisations (Lee, 2004) and that healthcare should be structured in accordance with the insights and desires of consumers (beyond basic medical needs).

There is a strong case to be made for the argument that health services should, where possible, make good use of user input and participation, with evidence to suggest that consumer engagement is critical to the success of complex, long-term service experiences in general and in healthcare specifically (Anderson, Nasr, and Rayburn, 2018; Gallan et al., 2013; Hausman, 2004; McColl-Kennedy et al., 2012; Spanjol et al., 2015). Consumer engagement is positively associated specifically with functional service quality perceptions and service process satisfaction (Chan, Yim, and Lam, 2010; Gallan et al., 2013; Hausman, 2004). Furthermore, there is evidence that involvement in the design and delivery of one's own healthcare can increase feelings of empowerment, satisfaction, and subjective wellbeing (SWB), including for populations classed as vulnerable or disadvantaged (Carlini et al., 2024; Safran, 2003).

Additionally, consumers are the only people to experience the entirety of a health problem or other issue/need underlying service use (Elg et al., 2011, 2012), meaning that any attempt to conceptualise a service experience that does not draw directly from user experience will be inherently incomplete. There have been some notable attempts in healthcare to map full-service experiences from a consumer perspective, for example in Irwin's (2002) 'patient journey framework', which drew directly on the work of design firm IDEO. There is also evidence of the positive effects of customer participation in healthcare on satisfaction and quality perceptions, with relevant actions including engaging in shared decision making, providing input/suggestions, and sharing information (Gallan et al., 2013).

In spite of the aforementioned evidence, and of increased international recognition of the importance of active consumer participation in mental healthcare specifically (Lammers and Happell, 2003; WHO, 2010), mental health service users in particular have typically been very rarely treated as cocreators, with highly restrictive eligibility being applied in those cases in which consumers have been included as research participants (Elg et al., 2012; Lammers and Happell, 2003, Newman et al., 2015). Furthermore, when user input has been sought, this has typically been almost exclusively through restrictive quantitative measures, focusing solely on the clinical dimensions of a service experience (Newman et al., 2015). Over the past few years, however, there have been some notable efforts to redress this historical limitation in mental health service research, seeking to employ and to explore the constituents of effective codesign. Key examples of these research endeavours, their aims, and pertinent findings are summarised in Table 2.4 (below).

Authors	Aims	Theoretical Contributions	Implications for Practice
Komashie and Clarkson (2018).	To contribute towards codesigning a diagrammatic language for describing mental health service delivery systems.	Identified key system components: Conditions, Data/Information, External Agencies, Family/Friends, Goals, Interventions, Person/Group Resources, Processes, and Staff/Carers. Need for further research into inclusion of emotions in diagrammatic representations.	Contributed towards a more accessible systems description approach, to be applied within mental health services and potentially related domains.
Warwick et al. (2018).	To analyse the impact of the codesign process on the wellbeing of stakeholders involved in mental health service design.	Identified similar factors affecting the wellbeing of co-designers and users, highlighting synergies between codesign and mental health research.	Identifies potential pressure points in design process and proposes mitigation strategies, drawing on insights from mental health sector (e.g. commonality of experience, facilitation). Promotes expansion of designer role to include explicit management of co-designer wellbeing.
Cole (2019).	To explore how young people story the experiences and meaning of participation in delivery and design of NHS mental health services.	Identified prominent storylines (e.g. repositioning from patient to person) and strategies of resisting dominant narratives re: 'patient' subjectivity and young people. Survivor discourse identified as key to resistance/construction of alternative subjectivity.	Highlighted areas for development to encourage and enhance benefits of participation, e.g. increased opportunities for dialogue and alliances with professionals. Evidenced benefits of youth participation (e.g. re: mutual aid, sense of belonging) used to argue for greater involvement at service and policy levels.
Mulvale et al. (2019).	To explore perceptions re: three elicitation techniques employed in experience-based codesign (EBCD): codesigning visual 'prototype' solutions, creating and viewing trigger videos, and creating experience maps.	Developed conceptual framework re: building mutual understanding and innovation during EBCD process – interplay of elicitation techniques and processes. Three core processes: building common perspectives, building innovation, and building mutual understanding.	Highlighted need for a 'safe space' to facilitate essential elements of elicitation: building trust, creating common vision, finding voice, and sharing perspectives.
Scholz et al. (2019).	To analyse how the rhetoric of 'representation' was used re: consumer engagement in mental health services, and how this was used to (dis)empower consumers.	Identified layered meanings and understandings re: rhetoric of 'representation' in consumer leadership. Specific empowering (e.g. opportunities for minoritised groups) and disempowering (e.g. lack of clarity for consumers and managers) factors.	Need for comprehensive training to ensure service providers are clear re: expectations of consumer leaders. Advocated shift in focus, from holding consumer leaders to account (to individually represent all others) to holding organisations to account (to ensure a range of consumers are represented).
Sangiorgi et al. (2019).	To identify key issues of contention and strategies for overcoming these in mental health service design.	General areas of contention: culture clashes, meaningful participation, organisational constraints, power dynamics, and systems approaches.	Specific organisational constraints: diagnostic categories, eligibility criteria, focus on acute crises. Also need to consider impacts on participants, e.g. of sharing traumatic lived experience.

Guinaudie et al. (2020).	To describe how shared decision making (SDM) strategies have been applied in a youth mental health project, identifying challenges and recommendations.	Extended SDM beyond customer/provider dyad to multiple other domains – e.g. capacity building, network governance, service design. Challenges to SDM: power dynamics, project pace, time constraints, and tokenism.	Identified specific strategies for fostering dialogue and partnerships among stakeholders (e.g. youth, carers/family members, clinicians, policymakers, researchers). Insights into processes, challenges, and solutions can be applied to other (mental) healthcare settings.
Peck et al. (2020).	To describe the participatory creation of a web-based digital resource to structure discussion about recovery in early psychosis.	Developed framework of recovery processes relevant to young people experiencing psychosis. Framework themes: *Connections*, *Life*, *My Identity*, *My Journey*, *Mental Health*, and *Self-Care*.	Utilised innovative approach to creating peer resources grounded in lived experience. Framework themes used to shape module development – may also be applicable in related contexts.
Colleran et al. (2021).	To explore how service design can be used to increase the likelihood of young people seeking and effectively accessing mental health support.	Incorporation of contextual factors, specifically service design and provision, into model of young people's help-seeking behaviours. Demonstrated impact of service design and location (suitability of processes and structures) on likelihood of access.	Developed 12 specific options for improving access, generated by young people and approved by practitioners – e.g. need to make servicescapes more familiar and welcoming.
Mulvale et al. (2021).	To explore how to prepare and empower youth with mental health issues to effectively participate in experience-based codesign (EBCD) and what the role of the research team is in this.	Major themes for coproduction presented in four quadrants: supporting managers, preparing participants, building affinity, and fostering sensitivity. Groups traditionally holding structural power often feel vulnerable during codesign sessions, whereas traditionally repressed can feel empowered. Codesign/coproduction as a microcosm through which to challenge entrenchment of interests.	Developed heuristic tools (COMPASS, MAPS): unified framework to complement existing EBCD and quality improvement toolkits. Demonstrated need for research team to balance adaptive/responsive approach to promoting opportunities to reform; transparency with participants re: risks; and remaining cognisant of managers' goals.
O'Brien, Fossey, and Palmer (2021).	To identify research using codesign methods with culturally and linguistically diverse (CALD) communities in mental health services and identify methodological considerations for working with these populations.	Identify key methodological considerations, e.g. need to consider existing explanatory models re: codesign, community, and mental health. Highlight need for further research into transferability of codesign tools with CALD communities.	Provides information re: importance of the quality of relationship between a researcher and the CALD community.
Tindall et al. (2021).	To experientially describe how a codesign team was effectively developed and used to design a new acute mental health inpatient unit.	Develop a framework for codesign in the form of an iterative cycle: four stages of evaluate, scope, plan, and implement. Insights re: vulnerability: importance of all parties acknowledging this at an early stage, potential for time	Lessons from real-life experience of codesign team, including impacts of power imbalances and experiences of trauma – may enhance future codesigned projects.

		constraints to exacerbate power differentials.	

Table 2.4: Overview of recent research contributions to codesign in mental health services.

At the same time, evidence of the importance of the built environment in promoting good mental health (Evans, 2003) in conjunction with evidence of the importance of supportive physical materials in other mental and physical health services (Vink et al., 2019) suggest that physical features should not be disregarded. A significant attempt to address the role of physical amenities and characteristics in addiction services has been carried out in the development and utilisation of the Physical and Architectural Characteristics Inventory (Timko, 1996), a tool designed to access the role of features in adding convenience, recreation, and support. This has been used to highlight the importance of physical amenities in community and hospital-based substance abuse programmes, with greater amenities associated with more involvement in community activities and higher rates of programme completion.

As previously discussed in relation to third place attachments, the physical environment of a service may be especially crucial for multiply disadvantaged groups such as those experiencing homelessness in conjunction with mental health issues, who are often reliant upon one space to serve multiple meso- and micro-level functions (Littman, 2021). At the same time, these individuals are among the most likely to encounter social and structural barriers to full participation in services and in coproduction activities (Grabovschi, Loignon, and Fortin, 2013; Mulvale et al., 2021), with exclusion from participation or even tokenistic involvement often unintentionally reinforcing power divides (Davies, Gray, and Webb, 2014; Iedema et al., 2010).

2.12 Homeless Service Design and Integrated Models of Support

Despite many similarities, there is also a fundamental difference between the roles of (especially residential) services for homeless groups and those of mainstream mental health services: namely, the fact that housed people also have access to traditional ‘first places’ (i.e. their own homes) and are also far more likely to frequent conventional second and third places (i.e. places of work and leisure) (Littman, 2021; Oldenburg and Brissett, 1982). As previously discussed, people experiencing homelessness more often rely on one place to fulfill multiple (meso- and micro-level) functions and to provide multiple forms of social

support (Littman, 2021; Rosenbaum et al., 2007). Equally, these individuals often have complex, integrating needs and little access to the mainstream marketplace, necessitating well-functioning health and social service ecosystems (Letaifa and Reynoso, 2015; van Everdingen et al., 2023; Pierce, 2024). In recognition of these factors, homeless service design must accommodate for diverse practical and emotional functions and facilitate collaboration across individual and service networks.

In an effort to capture the complexity of services providing housing for the 'hard-to-house' (specifically, homeless people with HIV/AIDS diagnoses) in Canada, Lawrence and Dover (2015, p.390) identify three distinct roles of places as complicating, containing, and mediating. In a complicating role, places are incorporated as 'practical objects', which can introduce unexpected complexity to a situation and/or public perceptions. For example, the use of churches as overnight accommodation for homeless people has been credited with shifting the boundaries of 'us' to include this typically socially excluded group, potentially helping to reshape public understanding of roles and responsibilities. Containing consists of establishing and maintaining boundaries around certain institutions/programmes, for example the geographic area within which a programme is enacted, while mediating places connect institutional work to targeted institutions. However, these role definitions were drawn primarily from interviews with organisational staff and volunteers, failing to explore how these were perceived by service users or by the broader community.

In addition to design efforts targeting individual services/organisations in isolation, practitioners and researchers have also repeatedly emphasised the importance of collaboration between different organisations towards shared goals, helping for example to avoid confusion, misunderstanding, and wasted resources (Centre for Homelessness Impact, 2020; Gunner et al., 2019). Continuity of care has been described as essential for people experiencing homelessness but can also be highly challenging in this context, given homeless people's often complex and everchanging life circumstances and logistical barriers to consistent engagement with many key services (e.g. GP surgeries) (Jego et al., 2016). The integration of different services and introduction of standardised registration procedures have been proposed as partial solutions to these issues, for example enabling clinicians to access past medical records and make contact with secondary services (Zeitler et al., 2020). Conversely, while the importance of collaboration and communication are widely accepted, there has been substantial debate between those who advocate for highly consolidated and standardised systems of health and social service integration and proponents of more

adaptive, loosely coupled delivery systems, networks, and organisations (Fisher and Elnitsky, 2012; Nichols and Doberstein, 2016).

In addition to service ecosystems and networks, personal relational networks are also important in facilitating positive engagement with services. The importance of building opportunities for community and connection into homeless service design is underlined by the importance not only of social connectedness but of the nature and strength of social relationships in affecting the likelihood of positive and transformative change (Gasior, Forchuk, and Regan, 2018; MacKean and Abbott-Chapman, 2012). While community and social connectedness have been tied to a raft of benefits for homeless service users (Centre for Homelessness Impact, 2020; Kirkpatrick and Byrne, 2011), unsupportive relationships can have the opposite effect, perpetuating cycles of unhealthy behaviours and discouraging engagement with potentially transformative services (Gasior, Forchuk, and Regan, 2018; Hughes et al., 2010).

Despite various forms of housing and mental health support having existed for several decades, there remains no standardised model for housing homeless people with mental health issues, with ongoing variation stemming from a combination of financial constraints, philosophical disagreements, and ambiguity in official guidelines (Benston, 2015; Newman and Goldman, 2009; Tabol, Drebing, and Rosenheck, 2010). For example, while promoting client choice in housing options and service plans is widely recognised as key in providing supported housing to those with serious mental illness, there is a lack of clarity and consistency regarding what ‘shared decision making’ means in practice (Tabol, Drebing, and Rosenheck, 2010) and thus the extent to which agency and autonomy are promoted.

A typology recently developed by the Centre for Homelessness Impact (2020) offers an informative overview of accommodation-based approaches, based on the behavioural conditions, the level of support, and the type of housing offered. This typology is summarised in Table 2.5 (below).

	Level of Support	Conditionality
Basic/Conditional	Short-term accommodation meeting basic human needs (e.g. food, shelter) – no additional services or support.	Dependent on meeting conditions such as punctuality or sobriety.
Basic/Unconditional	Short-term accommodation meeting basic human needs (e.g. food, shelter) – no additional services or support.	Not dependent on meeting conditions such as punctuality or sobriety.
Housing Only/Conditional	Long-term accommodation with no additional services or support.	Dependent on meeting behavioural expectations (e.g. entering paid employment within six months).
Housing Only/Unconditional	Long-term accommodation with no additional services or support.	Not dependent on meeting behavioural expectations.
Moderate Support/Conditional	Long-term accommodation with some general additional support – not specific to individual, personal needs.	Dependent on meeting behavioural expectations, e.g. abstaining from alcohol and/or drugs.
Moderate Support/Unconditional	Long-term accommodation with some general additional support – not specific to individual, personal needs.	Not dependent on meeting behavioural expectations.
High Support/Conditional	Long-term accommodation provided alongside assertive, individualised interventions and services.	Dependent on meeting behavioural expectations, e.g. abstaining from alcohol and/or drugs.
High Support/Unconditional	Long-term accommodation provided alongside assertive, individualised interventions and services.	Not dependent on meeting behavioural expectations.

Table 2.5: Typology of interventions (adapted from Centre for Homelessness Impact, 2020).

Until relatively recently, the majority of integrated residential services followed continuum of care (CoC) or 'transitional' housing models, which would typically be classified as either Moderate Support/Conditional or High Support/Conditional under the above typology (Benston, 2015; Centre for Homelessness Impact, 2020). In these models, users do not immediately enter into accommodation-based services but instead begin by accessing drop-in

centres and outreach programmes, before progressing through multiple different forms of congregate living involving varying levels of support (Gulcur, 2003). However, these models have been gradually overtaken by permanent supportive housing, loosely defined as subsidised housing coupled with supportive services. Like CoC and transitional housing, support in these programmes ranges from moderate to high; however, unlike these alternatives, long-term accommodation is provided at the earliest possible opportunity and with no behavioural conditions (Moderate Support/Unconditional and High Support/Unconditional) (Benston, 2015).

There is now fairly broad consensus on the value of long-term, unconditional accommodation integrated with (moderate to high) supportive services for homeless and especially chronically homeless individuals, with the use of restrictive conditions widely criticised by homeless service providers and those with lived experience of homelessness (Benston, 2015; Tsemberis, 1999). There exists substantial evidence tying use of these services to positive behavioural and medical health outcomes, in addition to which cost studies suggest this approach may be cost-neutral or even cost-effective due to reductions for example in use of hospitals or the criminal justice system (Baxter et al., 2019; National Academies of Sciences, Engineering, and Medicine, 2018). Overall, High/Unconditional support appears to generally produce the best outcomes in terms of both health and housing stability. While most other categories of intervention also appear to have some positive impact (when compared to no intervention), there is some evidence to suggest that Basic/Unconditional interventions may be actively detrimental to health and housing stability (Baxter et al., 2019; Benston, 2015; Centre for Homelessness Impact, 2020).

In considering the value of integrated residential models in promoting positive mental health outcomes, it is important to acknowledge the effects not only of integrated mental health services themselves but also of other factors, such as the physical environment and opportunities for community and connection. Such long-term servicescape encounters necessitate a holistic approach to customer experience, exploring how transformative capabilities might emerge in relation to different dimensions and the significance of social interaction (Sheng, Siguaw, and Simpson, 2016). In addition to the impact of the physical environment, community participation and social support provided by group membership have been linked to greater ease of transition and adaptation to new environments (MacKean and Abbott-Chapman, 2012), which is especially influential in the case of supported accommodation.

Overall, there is a need for further research which details 'the specific therapeutic benefits of supported housing beyond having a roof overhead' (Benston, 2015, p.812), addressing both the factors and processes shaping positive outcomes and the (transformative or otherwise) ways in which these manifest (Benston, 2015; Carnemolla and Skinner, 2021; Centre for Homelessness Impact, 2020). Researchers and practitioners have also highlighted the need for further analysis of preventative efforts tailored towards people at risk of homelessness, such as those with serious mental illnesses (Culhane, Metraux, and Byrne, 2011) and of ongoing processes of evaluation and monitoring in which service users are consistently and meaningfully involved (Making Every Adult Matter, 2020).

2.13 Therapeutic and Transformative Servicescapes

One informative way to explore potential therapeutic benefits of supported housing may be via the concept of a therapeutic servicescape, which is characterised by 'restorative environmental conditions and meaningful relational interactions' (Rosenbaum et al., 2020, p.7). Within a marketing context, exploration of the therapeutic properties of servicescapes has drawn heavily from health geography and environmental psychology, in particular from attention restoration theory (ART; Kaplan, 1995) and the concept of a therapeutic landscape (Gesler, 1992). This subsection will first offer a brief summary of each of these theories and their relevance to a transformative service context, before moving on to discuss key outputs and limitations of therapeutic servicescape research.

Within the domain of environmental psychology, Kaplan (1995) proposed ART as a means of understanding how natural settings can help alleviate negative wellbeing states, specifically those such as burnout which are associated with directed attention fatigue (i.e. reduced capacity to focus on effort-requiring tasks). Restorative natural environments were conceptualised in terms of four key properties, defined as being-away, coherence, fascination, and scope. According to ART, for a setting to possess abovementioned healing potential, it must provide a sense of escaping from one's daily concerns (being-away); be clearly organised to enable visitor understanding and goal pursuit (coherence); include elements which effortlessly hold attention (fascination); and provide enough engaging stimuli (scope) to take up 'a substantial portion of the available room in one's head' (Kaplan, 1995, p.173). The potential for such environments to redress attention fatigue is pertinent to transformative

services, with states of fatigue being linked to poorer mental wellbeing (Rosenbaum et al., 2020) and reduced customer cocreation effort (My-Quyen, Hau, and Thuy, 2020).

The healing potential of certain environments has been further explored through the concept of a 'therapeutic landscape', defined as a setting in which 'physical and built environments, social conditions, and human perceptions combine to produce an atmosphere which is conducive to healing' (Gesler, 1996, p.6). Later work expanded this concept to adopt a broader understanding of wellbeing promotion, encompassing maintenance and prevention as well as recovery from illness (Williams, 2002). While ART traditionally focuses on the physical environment, therapeutic landscapes are described as comprising both physical and social stimuli (Gesler, 1992; Williams, 2002), analogous to original (Bitner, 1992) and social (Tombs and McColl-Kennedy, 2002) servicescape dimensions. Furthermore, it has been recognised that realisation of therapeutic benefits requires active consumer participation (Conradson, 2005), otherwise known as engagement in VCCB (Roy et al., 2020). Thus, exploration of the relationship between therapeutic resources/servicescapes and T-VALEX creation (RQ2) must address both availability of resources and the extent to which clients engage constructively with these. Barriers to value cocreation may additionally be understood in relation to ART, for example if a servicescape's lack of coherence prevents clients understanding how best to access and integrate resources.

Within service research, growing interest in the potential for (service) environments to promote recovery and wellbeing has resulted in notable adaptations and applications of the servicescape model. Rosenbaum's (2009) account of restorative servicescapes was the first to bring ART to a marketing context, identifying the four aforementioned types of restorative stimuli (being-away, coherence, compatibility, fascination) in a commercial (video arcade) setting and providing evidence that these aided recovery from attention fatigue. The restorative servicescape model has since been applied to a range of commercial and nonprofit settings, building an evidence base for the role of restorative stimuli in shaping customer wellbeing, place attachment, and behavioural intention (Korpela et al., 2001; Mody, Suess, and Dogru, 2020; Purani and Kumar, 2018). Conversely, as in both the original servicescape model (Bitner, 1992) and the original context of the ART model (Kaplan, 1995), these applications have focused largely on the restorative potential of physical stimuli, with little attention to relational resources or active customer participation.

Compared to the constraints of the restorative model, discussion of therapeutic servicescapes typically adopts a broader and more holistic view, devoting greater attention to interactions and relationships with others in the service environment. Insights from research on therapeutic landscapes have been highly influential here, with Rosenbaum et al. (2020, p.2) integrating therapeutic landscapes and restorative servicescapes to encompass a 'confluence of certain physical and social elements'. Building on prior work conceptualising the role of place in marketing (Rosenbaum et al., 2017), the therapeutic servicescape is conceptualised as a service environment comprising a 'pool' (Rosenbaum et al., 2020, p.3) of relational, restorative, and social support resources, which together constitute therapeutic resources (Leino et al., 2022). Of central importance here is the assertion that places are more than just physical locales and offer more than just tangible resources, with more complex resource acquisition being important to wellbeing outcomes and levels of place attachment (Leino et al., 2022; Rosenbaum et al., 2017, 2020). Thus, these three categories of resources are especially important to consider within transformative service contexts, arguably even moreso when these environments serve a (temporary or permanent) homelike role (Leino et al., 2022).

While restorative resources pertain to physical properties and their adherence to the four dimensions of ART (Kaplan, 1995), relational and social support resources are received from other consumers and/or employees (Rosenbaum et al., 2017). Relational resources are defined in relation to economic (e.g. discounts), psychological (e.g. reduced anxiety), and social (e.g. recognition) benefits customers can receive from (especially long-term) exchanges and relationships with service firm employees (Cowen, 1982; Gwinner et al., 1998). Such benefits are often not readily available to all but are more likely where commercial friendships (Albrecht and Adelman, 1984; Price and Arnould, 1999; Stone, 1954) have been established, as in the practice of 'service sweethearting' (Brady, Voorhees, and Brusco, 2012, p.81) where additional resources (e.g. advice, discounts) are offered to favoured customers. Relational resources can also be accrued through customer-to-customer interactions including engagement in social networks and sharing communities (Rosenbaum et al., 2017). Such service user communities may be especially influential in the research context, given the evidenced importance of social connectedness for homeless populations (Centre for Homelessness Impact, 2020; Kirkpatrick and Byrne, 2011).

Also arising out of engagement with others in the servicescape, social support resources are sometimes classified as a distinct category (Leino et al., 2022; Rosenbaum et al., 2017) and

other times as a subcategory of relational resources (Rosenbaum et al., 2020). For the sake of simplicity and adherence with Rosenbaum et al.'s (2020) therapeutic servicescape model, this thesis will generally include social support within the broader category of relational resources but will first provide a specific definition and overview of social support resources. These encompass the four types of social support identified by Sherbourne and Stewart (1993), namely affectionate support; companionship and positive social interaction; emotional or informational support; and instrumental or tangible support. Described by Rosenbaum et al. (2017, p.284) as the 'glue that solidifies place attachment', social support resources are key to understanding how therapeutic servicescapes shape behavioural intentions and wellbeing outcomes, including how these relate to T-VALEX creation (RQ2). These should also be explored in relation to social support deficits, expanding on understanding of how more severe deficits can lead to greater place attachment (Baker and Brocato, 2006; Rosenbaum et al., 2007).

Therapeutic servicescapes and resources have frequently been tied to transformational outcomes, though most research has in practice adopted a fairly short-term perspective. For example, Rosenbaum et al. (2020) propose that customers may receive transformative health-related benefits from time spent in therapeutic environments, while Higgins and Hamilton (2019) discuss how sociospatial features promote emotional transformation and revitalisation. Furthermore, as alluded to in the context of TSR in mental healthcare (see Section 2.5.1), servicescape design has been linked to the facilitation of transformative service conversations (Gopaldas et al., 2022) in which providers help to inspire new ways of being through a combination of questions asked and evaluative listening (Gopaldas et al., 2021). Drawing on interviews with clients and providers in dyadic mental health services (counselling, psychotherapy, and coaching), Gopaldas et al. (2022) identify two servicescape design strategies of service sequestration and service serialisation, which they argue facilitate client microtransformations via specific psychological mechanisms. Firstly, service sequestration consists of spatial design strategies constructing the sense of a 'safe space' (Gopaldas et al., 2022, p.653) in which clients can express themselves freely, cultivating a sense of psychological safety or protection from judgement (Newman et al., 2017; Rogers, 1954). Secondly, service serialisation involves temporal design tactics enabling the development of rituals pre-, post-, and during the actual service encounter, building clients' psychological readiness to engage with difficult aspects of their lives (Kruglanski et al., 2014).

While Gopaldas et al. (2022) do not explicitly incorporate elements of ART (Kaplan, 1995), application of this lens reveals natural alignment between the proposed strategies and restorative environmental characteristics. Specifically, service sequestration can be related to the sense of being-away, in the sense of feeling that a (service) environment is meaningfully detached from one's everyday life and associated demands (Rosenbaum et al., 2020), in this context producing a reassuring sense that 'what happens in session stays in session' (Gopaldas et al., 2022, p.653) through such spatial design features as opaque walls and the use of a white noise machine. Furthermore, service serialisation can be understood in relation to coherence, providing clients with greater understanding of the servicescape and capacity for goal pursuit (Rosenbaum et al., 2020) via tangible features (e.g. visible clock) and associated rituals and routines (e.g. routinisation of appointment times, provider signalling when an encounter is nearing the end). Environmental characteristics of being-away and coherence can thus be tied to the specific mechanisms of psychological safety and psychological readiness, potentially offering further understanding of how and why these characteristics can have therapeutic effects.

Conversely, there are some notable differences between traditional ART characteristics (Kaplan, 1995) and the servicescape design strategies proposed by Gopaldas et al. (2022), highlighting possible limitations of Rosenbaum et al.'s (2020) therapeutic servicescape model and areas for further research. While being-away is traditionally associated with complete (temporary) escape from one's concerns (Friman et al., 2020; Pasini et al., 2014), sequestration of mental health service encounters actually enabled clients to openly confront difficult feelings and experiences, protected from the expectations and judgements of 'normal' life (Gopaldas et al., 2022). There is thus scope to compare these two forms of being-away (i.e. generating relief vs. promoting introspection) in relation to T-VALEX creation, including one's ability to move from an everyday life orientation based on past experience towards an evaluative present and a projective future (Blocker and Barrios, 2015). Other ART characteristics should be similarly assessed, for example exploring if the restorative properties of fascinating and attention-holding stimuli (Ogunmokun and Ikhide, 2022; Pasini et al., 2014; Rosenbaum et al., 2020) translate into microtransformations (Gopaldas et al., 2021) and T-VALEX creation.

Overall, discussion of the role of servicescape design in facilitating microtransformations (Gopaldas et al., 2022) offers important insights pertaining to mental health service design, illustrating the relationship between environmental features, psychological mechanisms, and

transformative outcomes. In conjunction with research on therapeutic and restorative servicescapes (Ogunmokun and Ikhide, 2021; Rosenbaum and Massiah, 2011; Rosenbaum et al., 2020; Rosenbaum, 2009), these findings highlight the need for more explicit, in-depth exploration of the relevance and manifestation of ART characteristics (Kaplan, 1995) across different transformative service contexts. At the same time, there is also a need for further research into the broader applicability of service sequestration and serialisation in both dyadic (Gopaldas et al., 2022) and nondyadic services, potentially investigating how these or other servicescape design strategies may facilitate transformative conversations outside of the core provider/customer dyad.

The relationship between therapeutic resource availability and transformative outcomes has been explored in the context of nursing homes, analogous to supported accommodation in the sense that these bridge the gap between home environments and (transformative) servicescapes (Leino et al., 2022). Therapeutic resources and place attachment may take on special significance in such homelike servicescape contexts, with implications for the construction of 'home' and potential first place attachments in the absence of conventional home environments (Littman, 2021). Leino et al. (2022, p.2856) focus specifically on the notion of 'feeling at home', which they use as 'a heuristic evaluation tool for whether transformative outcomes are being generated'. Additional insights were offered into the most important therapeutic resources in this context, particularly highlighting the need for coherence in everyday routines to create feelings of belonging and compatibility. Relational and other restorative resources were accessed mainly through day trips and recreational activities, facilitating joyful and meaningful moments.

In addition to linking transformative outcomes to therapeutic resources (RQ2), Leino et al. (2022) also provide some insights into wellbeing promotion in contexts of vulnerability, addressing the underexplored TSR outcome of relieving vulnerable consumer suffering (Cheung and McColl-Kennedy, 2019; Nasr and Fisk, 2019). Notably, wellbeing benefits tied to feeling at home include increased feelings of autonomy and security (Leino et al., 2022), both of which have been identified as important to transformative outcomes in contexts of potential vulnerability (Blocker and Barrios, 2015; Sharma, Conduit, and Hill, 2017). Thus, making consumers feel at home may be one way in which organisations can minimise or alleviate vulnerability perceptions, with potential implications for those facing multiple sources of marginalisation (RQ3).

Conversely, further research on nursing home servicescapes has highlighted how autonomy enhancement and security promotion can exist in tension with each other, with Sandberg et al. (2022) asserting that trade-offs between the two are often needed in contexts of care and vulnerability. As previously highlighted regarding criticism of the innate vulnerability construct, limiting consumer decision-making due to (alleged) vulnerability has been criticised as paternalistic (Burghardt, 2013; Roulstone, Thomas, and Balderston, 2011), while opportunities for autonomy have been linked to enhanced wellbeing and reduced vulnerability in healthcare (Mele et al., 2022) and homelessness (Phipps et al., 2021) contexts. The role of therapeutic servicescapes in promoting autonomy is also suggested by the emphasis on coherence and scope, which are respectively linked to active goal pursuit and unrestricted movement throughout a service environment (Rosenbaum et al., 2020).

However, challenges arise when enhanced autonomy risks undermining security through compromising the safety of a service environment (Sandberg et al., 2022). In addition to the emphasis on security within TSR (Blocker and Barrios, 2015; Rosenbaum, Sweeney, and Massiah, 2014), safety elements have recently been acknowledged as key to servicescapes in general (Siguaw, Mai, and Wagner, 2019) and may be especially important in contexts where psychological safety is key to enable transformative processes (Gopaldas et al., 2022). Sandberg et al. (2022, p.11) argue that nursing home residents by definition 'have a deficit in handling their lives', suggesting that the purpose of the servicescape is in part to counter threats to physical and psychological safety even when this necessitates restricted client autonomy. A similar argument has been applied to a mental health service context, with Harnett and Greaney (2008, p.6) endorsing 'protective responsibility' and shared decision-making over absolute autonomy for patients in states of vulnerability. Further research is required to establish how homelike servicescapes can be designed to provide an appropriate balance between autonomy and security, including how these values are promoted by specific therapeutic resources and the effects on T-VALEX creation (RQ2) and vulnerability perceptions (RQ3).

Moreover, there is scope for exploration of how other wellbeing trade-offs can arise in therapeutic servicescapes and how these influence T-VALEX creation, for example if short-term hedonic wellbeing is sacrificed for long-term eudaimonic outcomes (Nguyen, 2023). Responding to broader calls for more TSR to explicitly address different forms of wellbeing (Kuppelwieser and Finsterwalder, 2016; Russell-Bennett et al., 2020), more in-depth exploration of therapeutic servicescapes and transformative outcomes necessitates

distinguishing and interrogating the relationship between short-term amelioration and long-term transformation (Kaley, Hatton, and Milligan, 2019). Such a distinction is drawn in Kaley et al.'s (2019) account of a therapeutic care farm landscape, with some therapeutic experiences (defined as ameliorating) providing temporary refuge and relief while others (defined as transformative) produced longer-term health and wellbeing benefits. Building on this, discussion of the relationship between therapeutic resources and T-VALEX (RQ2) will explore how these processes differ from and influence one another, including if there are circumstances under which tradeoffs occur between the two.

Relatedly, while the association between therapeutic servicescapes and place attachment is widely assumed to be positive (Korpela et al., 2001; Leino et al., 2022; Mody, Suess, and Dogru, 2020; Purani and Kumar, 2018; Rosenbaum et al., 2020), this may be more complex when servicescapes are both homelike and temporary, potentially limiting the relevance of nursing home servicescape research (Leino et al., 2022; Sandberg et al., 2022) to an integrated residential housing context. While nursing home residents are typically expected to stay for the remainder of their lives and only become more dependent over time, supported accommodation services are often bound by time restrictions (Centre for Homelessness Impact, 2020) and frequently strive for clients to become more independent and require less support (Gulcur, 2003). This may complicate the extent to which place attachment results in intended, transformative outcomes, for example if high levels of attachment preclude moving on due to encouraging clients to stay in the service environment for as long as possible (Rosenbaum et al., 2020).

Thus, the benefits of therapeutic servicescapes as typically defined (Rosenbaum et al., 2020) may hinge upon aspects of the intended service concept (Roth and Menor, 2003; Wani, Malhotra, and Clark, 2021), including whether this actually seeks to produce transformative (rather than ameliorative) outcomes (Kaley, Hatton, and Milligan, 2019) and intended behavioural outcomes in relation to place attachment. In addition to these meso-level influences, the extent to which individual customers value and benefit from different (therapeutic) resources may be influenced by microlevel factors, including individual states and traits as well as service use trajectories and motivations (Leino et al., 2022; Rosenbaum et al., 2020; Sandberg et al., 2022). Such factors may shape the trade-offs which clients are willing to make, with evidence on nursing home servicescapes indicating that those who had come from hospital valued autonomy more than those who came straight from their own homes (Sandberg et al., 2022).

Valuable insights may be accrued through exploring how service trajectories and broader personal histories shape the importance of different relational and restorative resources, highlighting the need to capture broader lifeworld contexts in both methodologies (Sudbury-Riley et al., 2020) and constructs of value (Helkkula, Kelleher, and Pihlström, 2012). In exploring wellbeing trade-offs in therapeutic servicescapes, Sandberg et al. (2022) highlight the need for further research both at the microlevel of individual customer experience and in relation to broader service ecosystems. Additionally, recent research on transformative health services has highlighted the importance of client agency and participation in servicescape co-curation, including drawing on microlevel resources and social support networks (Krisjanous et al., 2023). Therefore, there is a need for further research which does not explore therapeutic servicescapes in isolation but in relation to customer roles and broader network factors, including ways in which these may constrain or enable T-VALEX creation (RQ2).

Advancing multilevel understanding of therapeutic and transformative processes may be achieved in part by integrating and expanding upon therapeutic servicescape (Rosenbaum et al., 2020) and transformative service network (Black and Gallan, 2015) models, considering for example how therapeutic resources may be accessed via broader networks (as opposed to solely the focal provider servicescape) and how restorative qualities (Kaplan, 1995; Rosenbaum, 2009) relate to structural network properties (Black and Gallan, 2015). To address these points and further elucidate the relationship between therapeutic and transformative processes, this study will explore how T-VALEX is influenced by therapeutic resources (RQ2) drawn from personal and service networks in addition to the focal provider (i.e. Organisation X) servicescape, with attention to the proposed distinction between ameliorative and transformative effects (Kaley, Hatton, and Milligan, 2019).

2.14 Chapter Summary

This chapter has delved into the relevant literature across fields of TSR, service design, servicescapes, and mental health and homelessness research. Central concepts of customer value and consumer vulnerability were defined and positioned within the research context, exploring the relationship between the two and elucidating upon the central construct of T-VALEX. The foundations and tenets of TSR and service design respectively were elucidated and synergies between the two were highlighted, focusing on the integrative concepts of transformative design and therapeutic and transformative servicescapes.

Specific research gaps in need of addressing were also identified across the main bodies of literature. In TSR, for example, findings demonstrated a shortage of meso-level research on vulnerability (RQ3) and minimal application of TSR concepts to mental health services. Additionally, studies and evaluations of integrated homelessness and mental health services specifically typically fail to look in-depth at the specific factors and processes producing positive personal transformation. Calls for further research in this area related both to tertiary and secondary, or preventative, interventions.

Having established the current state of the field, the key concepts to be applied, and areas in need of further development, the following chapter will provide a detailed account of the specific methodology applied in this study.

Chapter Three: Methodology

3.1 Introduction

This chapter provides an in-depth account of the methodology used in this study. This begins with an overview of the philosophical foundations of the research (Section 3.2) and their applicability to the subject matter, discussing the interpretivist paradigm and the application of social constructionism to service research. The following section goes more in-depth into researching populations defined as vulnerable or at high risk of experiencing vulnerability (Section 3.3), identifying related difficulties and explicating the importance of this research before delving into attempts to 'give voice' in health and homelessness research specifically. The research design is then explained and justified (Section 3.4) in terms of the selection of the research tool, the Trajectory Touchpoint Technique (TTT); the organisational setting; and the two main stages of data collection. Data analysis efforts are described, and example images included (Section 3.5), with two phases of template analysis conducted in accordance with the two main stages of data collection. Finally, primary ethical considerations are discussed (Section 3.6) and a chapter summary provided (Section 3.7).

3.2 Philosophical Foundations

3.2.1 The Interpretivist Paradigm

This research can be broadly situated within the interpretive paradigm, as it seeks fundamentally to understand social phenomena through the eyes of a particular group of people, exploring how they assign meaning to experience and engage in processes of sensemaking (Antwi and Hamza, 2015). At its core, interpretivism priorities richness and depth over definite and universally applicable laws, approaching truth and knowledge not as objective facts of life but rather as socially constructed phenomena filtered through individual interpretations and interpersonal interactions (Angen, 2000). Accordingly, the aims of the study diverge from positivist norms across much of health and social research, striving not to establish generalisable causal relationships between variables but rather to uncover emic perspectives on subjective and intersubjective phenomena (Glaser and Strauss, 2017; Hassard, 1990; Strauss and Corbin, 1990).

The decision to undertake research from this standpoint is underpinned by two key considerations, one of which is fundamentally values-based and the other of which is more pragmatic. The first of these is the belief that quantitative data, despite its significant merits, is of limited value in truly understanding the nature of human experience. From this conviction comes a strong sense that rich, qualitative data representing service user perspectives is essential for gaining genuine insights into the constituents and processes underpinning value cocreation, elucidating what does and doesn't work for the clients studied while also shedding light on how and why this is. While precise quantitative approaches can be highly valuable for purposes of control and prediction, particularly within the natural sciences, they are of limited utility in understanding complex inner 'lifeworlds' and the implicit norms and understandings shaping social realities (Glaser and Strauss, 2017; Guba and Lincoln, 1994; Strauss and Corbin, 1990). Such insights can be especially important for client groups whose voices are often, or have traditionally been, marginalised, as is the case for those with experiences of homelessness and/or addiction and mental health issues (Papoulias, 2018; Phillips and Kuyini, 2018).

The second, more practical justification pertains to the existing body of research and its limitations (Benston, 2015; Carnemolla and Skinner, 2021; Centre for Homelessness Impact, 2020). Quantitative methodologies have come to dominate most of health and social care policy across the UK, with an increasingly prevalent focus on prioritising 'what works' essentially translating into prioritising what produces the best statistical outcomes (Giddings and Grant, 2007). In integrated residential services specifically, the subject of benefits and key components beyond the obvious advantage of shelter has been underexplored to date. An in-depth understanding of potential benefits, their facilitators, and their prohibitors can be achieved only through thorough explorations of experience which are not contextually stripped in the manner of quantitative research, decreasing theoretical rigour but crucially increasing the applicability of findings to real-world scenarios (Cialdini, 2009; Guba and Lincoln, 1994). Exploratory, qualitative methodologies are therefore necessary to provide clients with the opportunity to raise whatever topics are important to them, regardless of whether these would have been anticipated by practitioners and/or theorists.

As discussed in the previous chapter (2.6), the interpretivist paradigm is also specifically well-suited to exploring processes of value cocreation (Helkkula and Kelleher, 2010; Langdridge, 2007). This is especially true where value creation is conceptualised as an emergent individual preference experience incorporating manifold past and present

influences (Holbrook, 1999, 2006; Koskela-Huotari and Siltaloppi, 2020; Vargo and Lusch, 2008, 2016), i.e. value-in-context (Vargo, 2008) or value in the experience (VALEX; Helkkula, Kelleher, and Pihlström, 2012). Fundamental to the concept of VALEX is the argument that customers make sense of value creation using subjective inner thoughts, necessitating interpretive research methods to explore these in depth (Helkkula, Kelleher, and Pihlström, 2012; Zeithaml et al., 2020).

In summary, this research adopts an interpretivist epistemological stance, treating the grounds of knowledge (Burrell and Morgan, 2019) as embedded within participants' subjective experiences and acknowledging that meaning is also mediated through researcher perceptions (Antwi and Hamza, 2015). Rather than seeking a 'single, universal, and quantifiable' truth or state of being, interpretive methodologies aim to explore complex and constant processes of becoming (Zainuddin and Gordon, 2020, p.357). Closely linked with this understanding of truth is a definition of reality as existing in multiple subjective and intersubjective forms, local and specific in nature but with elements shared among large collectives and even across cultures (Guba and Lincoln, 1994). This constructionist view treats reality as the product of complex and interlinking social processes, which cannot effectively be studied in artificial and/or fragmented forms (Antwi and Hamza, 2015). The following section will provide further information on social constructionism, how it has been applied within service research to date, and how it is applicable to this research topic specifically.

3.2.2 Social Constructionism and Service Research

Social constructionist research can largely be traced to the interpretive and dialogical paradigms of social science, sharing the interpretive focus on knowledge acquirement through discourse and creation of meaning (Schwandt, 2000) and the dialogical interest in the processes by which individuals explain the world in which they live (Berger and Luckmann, 2016; Edvardsson, Tronvoll, and Gruber, 2011). Constructionism thus approaches social realities in terms of 'how actors on a societal, group and individual level create, realize, and reproduce' social situations, structures, and roles (Edvardsson, Tronvoll, and Gruber, 2011, p.329). Social constructionists adopt a mutualist view, meaning that individual cognitive representations are considered within the context of broader organisational and societal structures (Hackley, 1998; Still and Good, 1992; Benford and Hunt, 1992; Burr, 2015).

Social constructionism therefore provides a lens for exploring the ways in which organisational, institutional, and social forces impact the development of meanings and roles, with the potential to both enable and/or constrain different individuals and social groups (Benford and Hunt, 1992; Bradbury, 2020; Burr, 2015). While this research is centred on individual perceptions and processes of sensemaking, it is crucial to recognise that these do not occur in a vacuum but rather that experiences and problems are 'manufactured in a social, cultural, and political context…over a long period of time' (Monk, 1997, p.26). This is particularly relevant when researching or working with underprivileged populations, where it is key to acknowledge that personal struggles are often not rooted in individual failings so much as in broader social and political contexts (Held, 2006; Liedtka, 1996).

A social constructionist view of marketing was proposed by Hackley (2001, p.53), who stated that this 'respecifies inner mental processes as interactional practices, thus setting the consumption of marketing within a more complex psychological and cultural landscape and…frames research from the point of view of those who experience marketing [consumers] rather than from the a priori precepts of consultants [suppliers]'. The service-dominant view is largely consistent with this, conceptualising marketing as a 'social and economic practice' in a permanent state of flux (Pels et al., 2009, p.328). Furthermore, Bradbury (2020) argues that the combination of constructionism with participatory approaches to social research implies transformative work, necessitating essentially inhabiting another's mindset, displaying empathy towards them, and actively working towards desired futures. This is important for service research in general but especially for TSR, which is explicitly intended to contribute towards reshaping institutional arrangements, service ecosystems, and socioeconomic structures (Arnould, Price, and Malshe, 2006; Blocker and Barrios, 2015; Zeithaml et al., 2020).

One pertinent philosophical stance premised on a form of constructionism is that of an ethic of care, which eschews universal moral principles in favour of prioritising caring relationships and attending to real-world contexts and needs (Gilligan, 1982; Held, 2006). While this concept has reached certain areas of organisational research, such as business ethics and stakeholder theory (Burton and Dunn, 1996, 2005; Wicks, Gilbert, and Freeman, 1994), the majority of studies have historically been grounded in an 'ethic of judgement', assuming the existence of external, universal truth which can be effectively uncovered through appropriately rigorous research methods (Gilligan, 1982; Jacques, 1992). Although typically well-intentioned, this approach can serve to maintain the status quo to the possible

detriment of the marginalised, guided by an ontology of actuality which imposes strict limits on how personal histories are conceptualised and how present/future selves are envisioned and enacted (Gilligan, 1982).

In contrast, when applied in conducive organisational contexts, an ethic of care has the potential to promote an 'ontology of possibility', emphasising the socially constructed nature of both past and present and conceptualising reality in terms of manifold possible futures (Lawrence and Maitlis, 2012, p.649). This ties in with the potential for services and service research to facilitate transformation at different levels, with transformative value creation necessitating individuals and/or communities moving away from an everyday life orientation based on past experience towards an evaluative present and a projective future (Blocker and Barrios, 2015; Emirbayer and Mische, 1998).

More broadly, it has been argued that all value created in services should be understood as value-in-social-context, with construction processes ongoing prior to, during, and after service exchange/use (Edvardsson, Tronvoll, and Gruber, 2011; Peñaloza and Venkatesh, 2006). Implications of a social constructionist approach to value cocreation were discussed in more detail in the previous chapter (see Section 2.3).

SDL is essentially compatible with this viewpoint, as it treats marketing as a fundamentally social and economic process and all social and economic actors as resource integrators (Pels et al., 2009; Vargo and Lusch, 2008). In spite of this natural alignment, however, proponents of SDL have been criticised for often failing to fully explore the social implications of this model, for example not initially giving explicit reference to networks and relations despite the clear connections to these concepts (Gummesson, 2008; Pels et al., 2009).

While Vargo and Lusch (2008) asserted that interactions and networks were attended to implicitly, Edvardsson et al. (2011) argued that directly applying key concepts from social constructionist theories to SDL could be beneficial in expanding understanding of value cocreation processes. These key concepts are summarised as 'social structures and systems, positions and roles, social interactions, and the reproduction of social structures' (*ibid.*, p.330). Social structures are defined here as empirically unobservable resources and rules that influence social activities (Giddens, 1984), which are present in service exchange as in other aspects of everyday social life. Social systems are comparable to service systems, frequently referenced in SDL literature, defined as a 'value co-production configuration of people, technology, other internal and external service systems, and shared information' (Spohrer et

al., 2007, p.72). Positions and roles are created and reinforced through service exchange and accompanying social interactions, with all actors in a given service system being 'conditioned' by a variety of technological, economic, political, and social influences underpinning every interaction (Pels et al., 2009).

Overall, the lens of social constructionism appears to be highly valuable for service research which seeks to honour and expand upon the premises of SDL. This viewpoint and associated constructs can also be especially valuable in research working towards transformative goals, tying in with the concept of transformative value as one manifestation of the social constructionist paradigm in customer value research (Zeithaml et al., 2020). While the positivist 'ontology of actuality' (Lawrence and Maitlis, 2012, p.653) can serve to uphold societal norms, a constructionist approach facilitates moving beyond the status quo to challenge structures maintaining stigma, discrimination, and inequality, making this naturally well-suited to TSR centred on marginalised and potentially vulnerable populations. Further considerations around researching vulnerable populations in general, and those with experiences of homelessness and/or mental health issues specifically, will be addressed in the subsequent section.

3.3 Researching Vulnerable Populations

3.3.1 Difficulties Encountered and Justification for Recruitment

Researching populations who are defined as highly and/or multiply vulnerable raises a plethora of issues, both ethical and pragmatic. While identifying and serving the needs of these populations has repeatedly been identified as a priority across research and policy alike, in practice they are often excluded from or denied full participation in research (Aldridge, 2014). There are various reasons for this. The most vulnerable groups often exist on the margins of society and can therefore be very 'hard to reach', sometimes to the point of requiring a 'case by case' approach to recruitment which can be ethically challenging and time-consuming (Aldridge, 2014; Goodley and Moore, 2000). Furthermore, by definition, the most vulnerable people are considered at greater risk of harm than average in many situations, potentially complicating adherence to the fundamental ethical principle of doing no harm (Boxall and Ralph, 2009; Lincoln and Guba, 1989). The necessity for prospective participants to provide fully informed consent prior to partaking in research can also be an area of confusion and contention, as it has been argued that certain vulnerable groups (e.g.

those with severe learning disabilities) struggle with, or are even incapable of, grasping the full meaning of the research process/purpose and thus of genuinely consenting (Boxall and Ralph, 2011; Griffiths, 2014).

Additionally, high levels of dependency of vulnerable individuals on certain organisations or services can be problematic when these are the research sites, as service users may feel compelled to participate out of a sense of obligation or even fear of the removal of support (Baker, Gentry, and Rittenberg, 2005; Griffiths, 2014; Rosenbaum, Seger-Guttman, and Giraldo, 2017). While there are certainly legitimate concerns here, the view of vulnerable groups as unable to make decisions for themselves can also be reflective (and reinforcing) of a widespread association between vulnerability and perceived passivity or powerlessness. This dictates that vulnerable people have high needs but are not trusted to act in (or even know) their own best interests, facilitating their exclusion from decision-making and self-autonomous activities (Burghardt, 2013).

Despite aforementioned difficulties and complications, this research has opted to focus on a group experiencing multiple intersecting vulnerabilities: those at risk of homelessness *and* with mental health and/or addiction issues. By centring the perspectives and priorities of these people, the aim is not at all to disregard ethics but rather to acknowledge the ethical obligation to hear and serve the traditionally marginalised segments of society. This entails adopting a broader view of protection from harm which encompasses the harmful implications of exclusion (McVilly and Dalton, 2006; Ramcharan et al., 2004). This is especially pertinent here given the long history of people experiencing multiple disadvantages, and this population specifically, being overlooked and thus subject to policy invisibility (Corus et al., 2016; Purdie-Vaughns and Eibach, 2008).

Having decided to research this population, further ethical issues arise, regarding how to minimise the risks identified above while also employing accessible, inclusive, and effective research methods (Boxall and Ralph, 2009). As previously referenced, constructionist and interpretivist enquiries are naturally well-suited to ‘giving voice’ to vulnerable participants, allowing for in-depth explorations of participants’ individual perceptions and processes of sensemaking, and furthermore giving space for reconstruction of narratives and roles (Aldridge, 2014; Hamilton et al., 2014). Moreover, unlike the positivist approach which treats ethics as external to the process of enquiry, ethical considerations are intrinsic to the

constructionist paradigm, with participant values being built into the purpose and nature of enquiry rather than overridden by those of the enquirer (Guba and Lincoln, 1994).

In spite of these advantages, qualitative, interpretive methodologies are often taken less seriously and/or considered too high-risk for researching vulnerable populations. For example, there is evidence of a reluctance of ethics committees to approve qualitative research with vulnerable groups in UK health research, and policymakers and practitioners have often been more cautious in responding to evidence based on less conventional, more participatory approaches (Hannigan and Allen, 2003; Walker et al., 2009). This is particularly due to the constraints imposed by legal and organisational requirements. Adherence to strict ethical procedures and requirements is formally treated as of utmost importance in researching vulnerable groups, with regulations seeking to protect people (Aldridge, 2014) but also accused of excluding those in greatest need and prioritising bureaucracy over actual clients' needs and desires (Boxall and Ralph, 2009).

It was therefore key for this research to balance the need for accessibility and flexibility with the importance of abiding by ethical requirements and avoiding all forms of coercion and harm (for further details of specific ethical considerations, see Section 3.7). In addition to being more generally well-suited to the exploratory aims of this study, the qualitative methods employed were also selected on the grounds of their being appropriate for involving vulnerable participants in research, providing a degree of adaptability and sensitivity that would not often be present in conventional service evaluation techniques (e.g. online surveys, questionnaires) (Aldridge, 2014; Goodley and Moore, 2000). In recognition of the traditional underrepresentation of highly vulnerable people in research and policy, this study sought to contribute towards the broader aim of bringing 'previously unheard voices into scholarly and associated professional conversations' (Thomson, 2008, p.3). The following section will address the concept of 'giving voice' and how this has been applied across healthcare and homelessness research.

3.3.2 'Giving Voice' in Health and Homelessness Research

As this research centres on bringing typically marginalised voices into research and policy conversations, a fundamental question was how best to access and share these perspectives. The concept of giving voice is most associated with collaborative and participatory methods, which seek to promote inclusion and 'walk the talk' in terms of bringing about genuinely

meaningful change (Aldridge, 2007, 2012, 2014; Goodley and Moore, 2000; Hamilton et al., 2014). This section will consider some of the manifold ways of 'giving voice' and how these have been applied in (mental) health and homelessness research.

Commonly underpinning the relationship between vulnerability and participation are individual and collective narratives, which can be chronological or constructed around certain themes or concepts (Aldridge, 2014; Gummesson, 2003). Allowing marginalised and vulnerable groups the space to (re)define and share their own narratives can result in novel processes of sensemaking and the development of transformative representations, sometimes helping to positively reshape how people view themselves and/or how they are viewed by others (Hackley, 1998; Hamilton et al., 2014). This can be powerful for those who are accustomed to having their own experiences and perceptions denied and having external definitions and 'knowledge claims' imposed upon them, as is frequently the case for homeless people and those classified as mentally ill (Beresford and Boxall, 2013, p.71).

At the same time, it is also important to consider the issues that can arise with narrative research techniques. The imposition of researcher interpretation on first-person narratives, involving 'overwriting, grouping, and renaming experiences' is at risk of suppressing the voice(s) it claims to elevate, particularly when this is done without these individuals' knowledge and consent (Russo, 2016, p.221). In order for narrative elicitation to be genuinely liberatory, participants must be enabled to define the boundaries of the conversation and identify what is important to them, taking an exploratory approach rather than seeking to fit accounts into predefined categories, and at times 'unsettling previously unquestioned research practices and understandings' (Christensen and Prout, 2002, p.482).

Furthermore, to reach the most marginalised people, it is crucial to ensure that narrative elicitation techniques are widely accessible, not excluding people on the basis of (for example) abstract reasoning or reading comprehension skills (Booth, 2018). The research population in this study often have low health literacy and can also struggle with communication more broadly, for example due to cognitive impairments associated with long-term substance use and mental health issues (Sharma, Conduit, and Hill, 2017). While it has been common to exclude people from participation on these grounds, evidence indicates that communication and comprehension issues do not preclude a desire to participate in service design, and the proclivity for highly and multiply vulnerable people to be overlooked and underserved by services suggests a profound need for further insights into their

perspectives (Corus et al., 2016; Purdie-Vaughns and Eibach, 2008; Sharma, Conduit, and Hill, 2017).

The use of visual methods can be beneficial for those who struggle with written and/or verbal communication, requiring different kinds of contributions and sensory skills (Aldridge, 2014; Papoulias, 2017). Visual participatory approaches can also be revelatory of dimensions of people's experiences and engagement with services that would not be accessed through more traditional methods (e.g. surveys and semi-structured interviews), tapping into 'the kind of tacit knowledge or felt engagement that constitute our immersion in daily habits and routines' (Papoulias, 2018, p.173). Allowing participants to take or select the photos that best represent them can also be a way of socially marginalised groups asserting control over their narratives, providing genuine insight into their living conditions and perspectives (Padgett, 2021) and thus potentially contributing towards transformative representations.

Narrative approaches have also been applied specifically in homelessness and mental health research. A range of qualitative studies have sought to explore homeless/formerly homeless people's subjective experiences and personal narratives across various stages of life and service use, including experiences of life on the streets, shelters and different types of housing, and health and social services (Kirkpatrick and Byrne, 2009; Tischler, Rademeyer, and Vostanis, 2007). Narrative accounts have also played an important role in certain fields of mental health research, with survivor narratives treated as one valuable way of '*giving a voice*' (Russo, 2016, p.220) to otherwise silenced psychiatric patients (Bassman, 2001; Ridgway, 2001). Interlinked experiences of homelessness, mental health, and substance use issues have also been subject to narrative analysis, for example specifically exploring psychiatric survivors' long-term experiences of (acquiring, retaining, and losing) housing and using data from multiple interviews to construct narratives of the experiences of those diagnosed with severe mental illness in a permanent housing programme (Kirkpatrick and Byrne, 2011).

This research has demonstrated the value of narratives in exploring the experiences and needs of this population, providing some valuable insights which would likely have been inaccessible through more conventional research methods. At the same time, however, there are important limitations of narrative research and areas for further development. Despite their proclaimed emancipatory aims, psychiatric survivor narratives are often retrieved (e.g. from online sources) without the knowledge or consent of the authors, and even more

regularly are subjected to alternative interpretations of meaning than those given by the authors themselves (Russo, 2016). This often results from an assumption that research which prioritises ‘conveying as faithfully as possible the person’s account’ (Casey and Long, 2003, p.95) is fundamentally less valuable than that which seeks to offer a dissonant interpretation.

Furthermore, there has been little research actually exploring different trajectories of recovery for homeless people with mental health and/or substance abuse issues and the specific factors of supported housing that facilitate (or impede) progress along these, meaning that ‘a better understanding of the timing, sequence and context for changes in complex trajectories of recovery…is still needed’ (Patterson et al., 2013, p.6). Combined with the aforementioned importance of accessibility and inclusivity, this highlights an untapped need for research which explores service user experiences in full, in the context of broader life narratives, without the imposition of preconceived categories or exclusionary participation requirements. This leads on to the adaptation and utilisation of the TTT.

3.4 Research Design

3.4.1 Selection of the TTT

The TTT was selected as an appropriate tool for eliciting detailed narrative accounts of participants’ experiences (Sudbury-Riley et al., 2020). This was chosen from a broad range of possible candidates, with over 160 different service design tools and techniques identified across disciplines (Alves and Nunes, 2013) and a diverse body of narrative-based methodologies (Gregory, 2010). It was important for the chosen methodology to combine the structure and formality of customer journey mapping (detailed below) with the participatory, client-led nature of less formal narrative elicitation techniques. The use of interviewing techniques to elicit participant narratives can take a multitude of forms, for example eliciting narrative accounts of critical events for an individual or community (Reighart and Loadman, 1984; Webster and Mertova, 2007). Building on critical events and narrative analysis, Helkkula, Kelleher, and Pihlström (2012) proposed the use of an experience-based narrative inquiry (EBNIT) technique in exploring consumer experiences of VALEX creation. EBNIT provides consumers with the opportunity to spontaneously reflect on real and imagined value experiences, co-constructing meaning with an interviewer. Participants are encouraged to recount experiences in a conventional narrative form, including character, spatial, and temporal aspects.

Despite the merits of this and similar narrative interviewing techniques, these were ultimately ruled out in light of the decision to utilise a visual methodology, resulting from the aforementioned benefits of these in general and in the context of health and homelessness specifically. Still focusing on elicitation of rich narrative accounts, a number of visual methodologies were considered for this purpose. The use of participatory visual methods discussed above had clear advantages in terms of generating more and richer data and granting participants licence to identify areas of interest and steer the overall direction of the conversation (Boxall and Ralph, 2009). While methodologies such as reflexive photo elicitation can be highly informative, these are often also incredibly demanding, in terms of ethical considerations, equipment purchased and shared, and processes of analysis (Meo, 2010). This also typically lacks a clear structure, tying in with a tendency for more participatory techniques to be lacking in formality (Alves and Nunes, 2013).

This research also sought to focus specifically on opportunities for innovation in service delivery and design, while utilising accessible visual methods and not detracting from or overly simplifying the rich narratives of participants' lives. The use of visualisations is prevalent in service design, manifesting in a diverse range of techniques and tools (Kimbell, 2009; Segelström and Holmlid, 2011). Identifying the most appropriate technique for the research purpose required considering a range of relevant criteria, related to compatibility with the lenses of SDL and TSR. The selected technique had to encompass a service experience in full, from a consumer perspective; to be well-suited to representing the coproduction of T-VALEX; and to depict service as centred on consumers and relationships (Anderson et al., 2013; Helkkula, Kelleher, and Pihlström, 2012; Segelström and Holmlid, 2011; Sudbury-Riley et al., 2020; Vargo and Lusch, 2004).

One popular way of visualising intangible service systems is through service blueprinting (Shostack, 1982), in which services are diagrammatically represented in terms of the five key components of physical evidence, customers' actions, supporting activities, frontstage (visible) employee activities, and backstage (invisible) employee activities (Bitner, Ostrom, and Morgan, 2008). However, service blueprinting typically does not prioritise the customer perspective, focusing more on the underlying infrastructure and organisation of a service (Følstad and Kvale, 2018). This is also somewhat incompatible with SDL and TSR, proving weak in representing coproduction, customer orientation, and relationship-centricity and very weak in representing value-in-use (Segelström and Holmlid, 2011).

Two visualisation techniques which perform better on these fronts are storyboarding and customer journey mapping (CJM). Storyboarding involves the compilation of a series of images in a narrative sequence, representing either an actual or hypothetical service experience and including information about actions and interactions, locations, and personalities (Greenberg et al., 2012; Segelström and Holmlid, 2011). Evaluating the compatibility of various service design visualisation methods with central tenets of SDL, Segelström and Holmlid (2011) found that storyboarding was well-suited to representing consumer-orientated services and the coproduction of value-in-use, but less so to depicting the importance of relationships between service recipients and employees.

CJM therefore proved better suited to the research purpose than either service blueprinting or storyboarding, being naturally compatible with all tenets of SDL and focusing comprehensively and exclusively on the customer experience (Følstad and Kvale, 2018; Segelström and Holmlid, 2011; Zomerdijk and Voss, 2010). As briefly described in Chapter 2, CJM is grounded in the conceptualisation of a full service experience as a customer journey, characterised by different touchpoints (i.e. clusters of experiential elements) and encompassing cognitive, emotional, sensory, social, and spiritual responses (Berry, Carbone, and Haeckel, 2002). This naturally ties in with narrative techniques, having been described as ‘an engaging story’ about a service experience and ‘a walk in the customer’s shoes’ (Følstad and Kvale, 2018, p.197). CJM also differs from the majority of service research in going beyond core service experiences, beginning with understanding how and why a journey begins and ending with potentially long-lasting effects of a service experience (Stickdorn and Schneider, 2012). Customer journey maps therefore typically include at least three stages of preservice, service, and post-service periods (Følstad and Kvale, 2018).

CJM was therefore clearly a valuable methodology to consider and to build upon in this study. However, conventional CJM also risks an overly prescriptive mapping process, which fails to grant consumers the opportunity to determine which elements of the service should be classified as touchpoints and the levels of importance which should be assigned to each featured touchpoint (Glushko, 2013; Rosenbaum, Otalora, and Ramirez, 2017; Shaw and Ivens, 2002). The Trajectory Touchpoint Technique (TTT) is a methodology which draws on CJM and service blueprinting but is also more specifically tailored to eliciting in-depth personal narrative accounts. The elicitation of narratives is intended to capture the ‘complexity and emotionality’ (Sudbury-Riley et al., 2020, p.14) of customer experience, while also retaining focus on key elements of service such as physical and social

servicescapes and service ecosystems (Canfield and Basso, 2017; Rosenbaum and Smallwood, 2011).

Originally developed for the purpose of hospice care evaluation, the TTT is designed to elicit detailed customer experience narratives, structured around a set of identified service stages/elements and associated touchpoints (Sudbury-Riley et al., 2020). A rich pictures methodology is employed, serving to capture and elucidate influences that could otherwise have remained hidden in a context of multiple complex forces and interactions (Cristancho et al., 2015). This is administered through presenting customers with a series of cards, each representing a different stage of a service experience and featuring a set of related images.

Use of the TTT proved highly effective in identifying opportunities for innovation in the original context of palliative care and in later applications within related (i.e. hospital) and unrelated (i.e. veterinary) services, raising the question of to what extent this could be usefully applied in other contexts (Sudbury-Riley et al., 2020). Following a successful earlier study within an integrated tenancy support and mental health service (Spence, 2021), it was determined that this technique also had the potential to be informative within the context of integrated homelessness and mental health services. The following sections will provide further details of the research setting and how the TTT was applied here.

3.4.2 Organisational Setting

This research was centred on a specific case organisation, referred to as Organisation X. The transformation of personal meaning-making into higher-level change is a pervasive challenge for interpretive researchers, which can be especially difficult in working closely with small numbers of marginalised or socially excluded people (Aldridge, 2014). In order to effectively address difficult social issues, researchers are obligated to strive to provide clear directions for policy and practice, and where possible to ensure that research findings are put to positive and productive use in their organisational or societal context (Oliver and Cairney, 2019). In identifying possible research partners, it is therefore crucial to ensure that these will be receptive to the research process and outcomes, and furthermore that they are in a position to enact genuine positive change on the basis of these outcomes. This necessitates the consideration of a multitude of relevant factors, including the size of an organisation and the potential for researchers to pitch desired benefits beyond enhancing scientific knowledge (Gneezy, 2017).

At the point of planning for the thesis, a strong working relationship had already been established with the Organisation X CEO and other key actors across the organisation, with the same research team having worked on a related study within their tenancy support service (Spence, 2021). The success of the earlier research collaboration contributed towards the subsequent decision to maintain a focus on evaluating integrated housing and mental health support, the importance of which was underscored by the findings of an in-depth literature review. The initial intention to conduct a comparative analysis of multiple services across the private, public, and voluntary sectors was complicated by practical considerations, particularly following the onset of the COVID-19 pandemic and successive lockdowns. This made establishing new connections more challenging, as both marginalised people and the organisations serving them were typically hit hard and naturally prioritising survival over involvement in research and service evaluation/improvement (Kirby, 2020).

At the same time, the University mandated switch to virtual data collection methods also opened up new avenues of possibility, removing barriers associated with travel as in-person conversations were no longer an option. It was because of this that the line of communication with Organisation X was reopened, and it was established that the aims of this study coincided with the organisation's aims to evaluate and improve upon their residential services. These aims pertained specifically to three distinct services (referred to within this thesis as Service 1, Service 2, and Service 3), all of which provided housing in conjunction with (varying levels of) emotional and practical support. Further to the overview provided in Chapter One (Section 1.3), the below table summarises each of these services in terms of their key characteristics and the nature of service users targeted.

Service	Service Category	Intervention Type	Admission Criteria	Official Remit
1	Direct access rapid rehousing project	Tertiary: targeting those experiencing/with histories of homelessness	Aged 18+; experiencing or at immediate risk of homelessness.	Two years
2	Supported housing (potentially permanent)	Tertiary: targeting those experiencing/with histories of homelessness	Aged 45+; ongoing experiences/personal histories of homelessness; long-term substance use issues.	No time limit
3	Supported housing (temporary)	Secondary: targeting population at high risk of homelessness	Aged 18+; care-managed individuals previously hospitalised for mental health issues	Three years

Table 3.1: Overview of Organisation X residential services

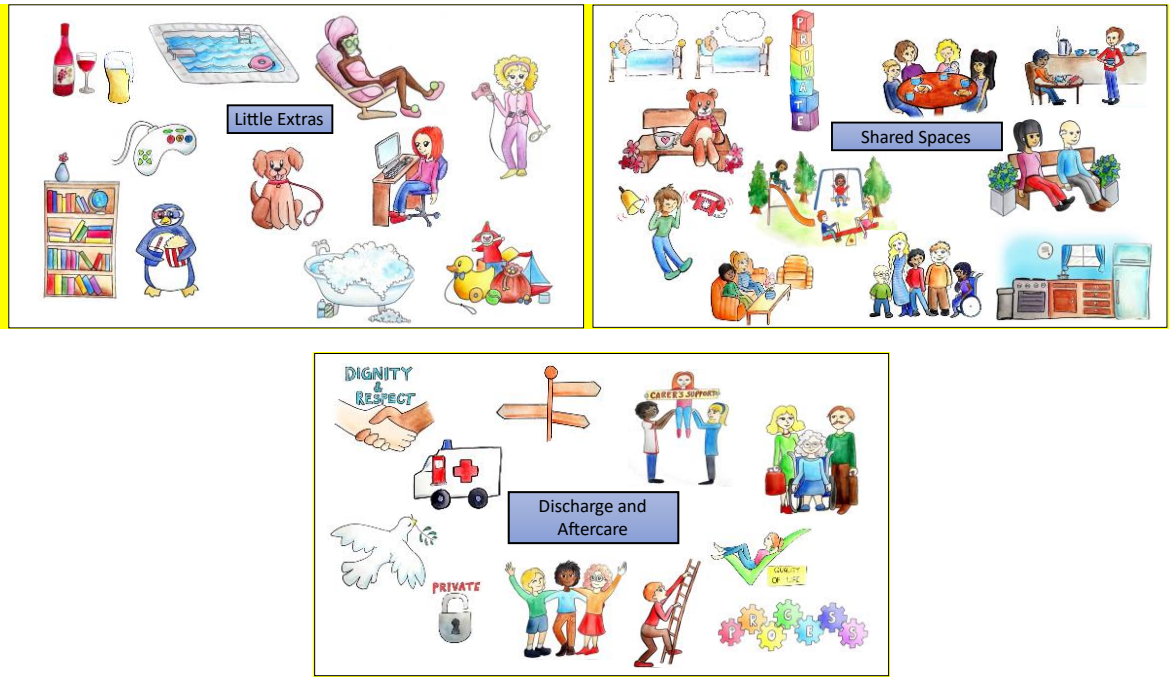
Furthermore, management were understanding of and enthusiastic about further use and development of the TTT within their services. Thus, as with the previous study (Spence, 2021), Organisation X management embraced the research process, as this was understood to be assisting them in their broader effort to establish a coherent evidence base regarding service effectiveness, to improve on their performance and potentially to contribute towards securing greater funding in future. The enthusiasm of management played a key role in overcoming obstacles encountered throughout the data collection process, which included the effects of COVID-19 and high turnover rates for frontline employees.

Consequently, this research sought first to further develop and refine the adapted TTT, then to apply this to collect data from users of Organisation X's residential services. It was the intention of the first stage of this study to produce a version of the TTT that is sufficiently generalisable to be effectively used to evaluate each of these services and to also be

potentially applicable to other, similar organisations. In terms of benefits for the organisation, this was intended to assist in developing a more effective service intervention, increasing engagement by the people using the service, the efficiency of the service, and its cost-effectiveness from the perspectives of commissioners. It is also hoped that the data gathered in this project will ultimately help to influence regulators (e.g. the Care Standards Inspectorate), social policy makers (e.g. the Welsh government), and the Welsh Health Board.

3.4.3 The Adapted TTT: Final Version

Development of the final version of the adapted TTT drew on a multitude of influences, including both the original technique (Sudbury-Riley et al., 2020) and the version created and employed in the tenancy support service study (Spence, 2021), here referred to as the pilot version. For reference, the original seven TTT cards are presented below (Figures 3.1-3.7).



Figures 3.1-3.7: Original TTT cards (Sudbury-Riley et al., 2020)

The basic structure of the original TTT, from pre- to post-service experience, was loosely applied to both the pilot and final versions of the adapted TTT, though with some important adjustments. The final adapted TTT cards are presented below (Figures 3.8-3.15), followed by an overview of all three versions in Table 3.2.

Figures 3.8-3.15: Final adapted TTT cards

	Original TTT	**Pilot Adapted TTT**	**Final Adapted TTT**
Servicescape	*Facilities* (nonsocial dimensions) and *Shared Spaces* (social dimensions).	*Relationship with Service Provider* (primarily social dimensions).	*Facilities and Shared Spaces* (social and nonsocial dimensions).
Service Experience Stages	*Pre-Arrival*, *Arrival*, *Clinical Care and Support*, *The Little Extras*, and *Final Processes and Aftercare*.	*Beginning the Journey to Organisation X*, *First Meeting*, and *End of Service and Follow-Up*.	*Pre-Arrival*, *Arrival*, *Assessment and Goal Setting*, *Practical and Emotional Support*, and *Moving On*.
Sites of T-VALEX Creation	N/A	*Building Skills and Resources* and *Connecting to Broader Support Network*.	*Building Skills and Resources* and *Connecting to Broader Support Network*.

Table 3.2: Overview of different versions of the TTT

As demonstrated in Table 3.2, these three versions of the TTT differed somewhat in their approaches to the different aspects of the servicescape. There are multiple reasons for this variation. While the original TTT covered social and nonsocial dimensions of the servicescape separately, the relevance of the physical servicescape was significantly reduced in the context of the tenancy support service study (Spence, 2021) which was based within service users' own homes. This also greatly diminished the significance of interactions with other service users, which were anticipated to be unlikely and were not mentioned in any of the narratives elicited here. In contrast, the provision of some form of housing was a central component of the three services included in the main study. The decision to combine 'Facilities' and 'Shared Spaces' was made for primarily practical reasons, specifically the realisation that both sets of touchpoints would easily fit on one card and the desire to avoid an excessive number of cards that could increase the risk of participant fatigue (having already surpassed the original TTT by one and the pilot adapted TTT by two).

Both adaptations of the TTT remained relatively faithful to the original, building upon the traditional division of preservice, service, and post-service elements of the customer experience (Følstad and Kvale, 2018; Stickdorn and Schneider, 2010). The preservice period was originally captured by the stage of 'Pre-Arrival', which had to be adjusted slightly for the purpose of the tenancy support service study (again due to the service being based in service users' own homes) but was directly applicable to the main study. In the original TTT, the service period was broken down into multiple stages, beginning with initial encounters and impressions ('Arrival') and then moving on to cover the core ('Clinical Care and Support') and augmented ('The Little Extras') aspects of the service.

The pilot adapted TTT differed from the original in including 'First Meeting', analogous to 'Arrival'. This resulted from a degree of uncertainty about core service aspects (outwith specific sites of T-VALEX creation) prior to data collection, which was inevitable in light of this being the first attempt to apply the TTT to a context of housing and mental health services and particularly as time restrictions meant these cards were developed primarily on the basis of a literature review alone (as opposed to interviews with actual service users and/or providers). Conversely, the final adapted TTT included the additional stages of 'Assessment and Goal Setting' and 'Practical and Emotional Support'. The identification of these stages and their associated touchpoints was informed by the findings of the earlier tenancy support service study (Spence, 2021), a more extensive literature review and

document analysis, and (most importantly) by unstructured interviews with clients and providers in these specific services.

Finally, both the pilot and the final adapted TTT are set apart from the original by the inclusion of cards specifically focused on T-VALEX creation: 'Building Skills and Resources' and 'Connecting to Broader Support Network'. These have been categorised not only to emphasise the centrality of T-VALEX to this research but also, crucially, in recognition of the fact that these elements span an entire service experience, from pre- to post-service. Though evidence of T-VALEX creation could and did arise throughout all stages and sections, these two cards were designed to elicit deeper insights through a specific focus on areas of transformation and how service experiences influenced and interacted with broader lifeworld contexts.

3.4.4 Primary Data Collection: Stage One

The first stage of data collection for the main study consisted of unstructured interviews and concurrent document analysis. Interviews at this stage were carried out with a combination of clients and staff from across the three services. In an attempt to minimise the risk of harm resulting from participation, client recruitment was preceded by an initial vetting process, with employees asked to specify if they believed any of their clients were not in a position to complete the interview (e.g. if they were currently hospitalised or in a state of extreme distress). This stage was completed by the service providers, with outcomes applying to participation in both stages of the study. Clients were not involved in this preliminary stage.

Following this vetting process, recruitment for Stage One began. A selection of physical information sheets and consent forms (Appendices 2-5) were sent out to Organisation X head office to be distributed to clients and staff alike. Frontline employees (FLEs) were enlisted to mention the study to a sample of their clients, aiming to identify roughly five who were willing to participate in unstructured interviews and providing potential participants with the relevant information sheet and consent form. Each consent form came with a prepaid envelope addressed to the university, so that those who chose to participate could return the form at no expense. They were also given the opportunity to receive and return these forms via email. Interested clients retained copies of the documents and were encouraged to take a few days to think over if they wished to participate, and to contact myself if they had any concerns or questions. Those who did choose to participate were asked to post or email the

form and contact myself to share their contact details and arrange a date and time for an interview, using a freephone number redirecting to my personal phone.

At the point of recruitment, Organisation X staff at the relevant services had already been made aware of the study, as their assistance was key to recruiting and coordinating interviews with client participants. Having established that they were all comfortable with being involved in the study to this extent, a brief description of the staff interviews and their purpose (Appendix 1) was emailed by the researchers to the Organisation X CEO, who then distributed this to the staff (via work email addresses). My university email address was provided as a point of contact for anybody who was interested in taking part and/or had any questions. Those who were interested were emailed copies of the consent form (Appendix 5) and participant information sheet (Appendix 2). Having virtually returned the consent forms, prospective participants were then emailed to enquire about their preferred medium (Microsoft Teams, Zoom, or phone) and a convenient date and time for the interview to take place.

This resulted in a total of nine participants at this stage, consisting of –

- Clients (n=5) –
    - Service 1 (n=2).
    - Service 2 (n=2).
    - Service 3 (n=1).
- Frontline employees (FLEs) (n=2) –
    - Service 2 (n=1).
    - Service 3 (n=1).
- Management (n=2): based across services.

Unstructured interviews were conducted over the phone, Microsoft Teams, and Zoom due to COVID-19 restrictions, with or without video in accordance with participant preference. The majority of interviews were conducted one-on-one but one client (C1, Service 3) and one FLE (S3, Service 3) were interviewed together as the client felt more comfortable in their support worker's presence. This resulted in a slightly different dynamic, which largely proved conducive to eliciting rich data.

In keeping with the procedure for developing the original TTT (Sudbury-Riley et al., 2020), interviews did not follow any specific protocol but rather consisted of general discussion about what participants considered to be the most important elements of the service(s). The specific focus differed slightly between staff and client interviews, with the former centred more on the formal aspects of service delivery and structure and the latter more on clients' individual memories. This allowed for insights into both the technical operation of the services and the influence of subjective perceptions and emotions.

3.4.5 Primary Data Collection: Stage Two

Recruitment for Stage Two followed the same basic protocol but focusing solely on recruiting clients and on a larger scale than in the initial stage. Organisation X FLEs mentioned the study to all of their clients (excluding those who had previously been ruled out by the initial vetting process) and provided those who were interested with a consent form (again coming with a prepaid envelope) and information sheet (Appendix 4) to look over. A set of the adapted TTT cards were also included alongside the consent form and information sheet, allowing customers to look over these in advance and thus get a better sense of what the interviews would consist of, with interested clients retaining copies of the TTT cards as well as the consent form and information sheet. Again, clients who decided to participate were asked to sign and post the form and to contact myself via phone to arrange a date and time for an interview. Clients who did not have personal phones and/or felt uncomfortable reaching out themselves were also given the option to have staff members get in touch on their behalf.

Conversations using the TTT were conducted with a total of 20 participants from across the three services. As the combined capacity across all services was 38, interviewees comprised approximately 53% of all service users. The decision to aim for 20 participants in total was additionally informed by prior applications of the TTT indicating that this is around the point at which saturation is typically reached (Sudbury-Jones et al., 2020), which also proved true in this instance. This consisted of 10 Service 1 clients (out of a total of 13), six Service 2 clients (out of 18), and four Service 3 clients (out of seven). While the initial intention was to recruit a representative sample in terms of distribution across the three services, it proved impossible to do so whilst also reaching the overall total of 20, as there were proportionately fewer Service 2 clients interested in participation than in the other two services.

Participants were 70% male, with an average age of 44. A full breakdown of Stage Two participants, in terms of service and basic demographic information, is provided in Table 3.3.

Number	**Service**	**Age**	**Gender**
Client 1 (C1)	Service 1	33	M
Client 2 (C2)	Service 2	63	F
Client 3 (C3)	Service 2	57	M
Client 4 (C4)	Service 2	58	F
Client 5 (C5)	Service 1	45	M
Client 6 (C6)	Service 1	37	M
Client 7 (C7)	Service 2	54	M
Client 8 (C8)	Service 3	31	F
Client 9 (C9)	Service 3	38	M
Client 10 (C10)	Service 2	41	M
Client 11 (C11)	Service 1	53	F
Client 12 (C12)	Service 1	40	M
Client 13 (C13)	Service 1	34	F
Client 14 (C14)	Service 2	50	M
Client 15 (C15)	Service 3	41	M
Client 16 (C16)	Service 3	57	F
Client 17 (C17)	Service 1	36	M
Client 18 (C18)	Service 1	45	M
Client 19 (C19)	Service 1	41	M
Client 20 (C20)	Service 1	25	M

Table 3.3: Sample

Conversations began with checking that participants had the TTT cards to hand, asking if they had any questions, and enquiring as to if they understood how conversations with the TTT worked or would like to receive a quick explanation before getting started. Although all participants had previously read the information sheet, the majority did ask for the precise nature of the study to be reiterated at this stage, allowing for any confusion or

misunderstandings to be addressed and ensuring that clients fully understood what was expected of them before beginning the process of data collection.

Before starting to go through the cards, clients were first asked to say a bit about themselves. Besides asking for basic information such as their age and how long they had been in the service in question, exactly what this meant was left open to participant interpretation, ensuring that they did not feel pressured to divulge anything they were uncomfortable with and also giving them the opportunity to share what they considered to be the most important aspects of their identities. The majority of the conversation consisted of going through the TTT cards, asking participants to talk through their entire service experiences, referencing as many of the images as they felt were relevant and also raising any unpictured topics/experiences they associated with the subject of the card. As conversations were participant-led, these varied dramatically in duration, ranging from 10 minutes to an hour and 42 minutes.

3.5 Data Analysis

Throughout both main stages of data collection, all interviews were audio recorded and transcribed verbatim. Though laborious, personally engaging in the process of transcription was also beneficial in familiarising the researcher with the data, facilitating the close reading and interpretative skills necessary for analysis (Bird, 2005; Lapadat and Lindsay, 1999). Transcripts were then read through multiple times and coded in accordance with the research questions and emergent themes, employing a form of template analysis (King and Brooks, 2017). The following two subsections will provide further details of these analyses and how they developed over time.

3.5.1 Stage One Analysis

Having scoped out some potential areas of interest, analysis of main study data followed a somewhat more structured approach. It was the intention here to incorporate the findings of prior research (Spence, 2021), the literature review, and (as the study progressed) earlier stages of main study analysis, while still retaining a sense of flexibility and openness to new themes emergent in the data. In light of these requirements, a form of template analysis was selected as the most appropriate analytical strategy. Template analysis is similar to Braun and Clarke's (2006) approach to thematic coding in that it is inherently flexible and also focused

on developing a hierarchical coding structure, in which broad themes are subdivided into multiple levels of more specific themes (Brooks et al., 2015).

However, there are some key differences, primarily relating to the stage at which the coding structure is developed. While traditional thematic analysis involves defining and organising themes only after all data has been coded, in template analysis a preliminary template of hierarchical themes is developed partway through coding, after which this is applied and refined in analysis of remaining data. Unlike more theoretically laden analytical approaches, such as grounded theory (Glaser and Strauss, 2017) and interpretative phenomenological analysis (IPA; e.g. Eatough and Smith, 2017), template analysis is adaptable to a range of epistemological and theoretical contexts (Brooks et al., 2015). In this case, working within an interpretative paradigm, analysis followed what has been described as a 'contextual constructionist' (Madill, Jordan, and Shirley, 2000, p.9) approach, generally relying more on inductive analysis but including some tentative a priori themes on the basis of the literature review and prior research (Spence, 2021).

An initial template for evidence and facilitators of T-VALEX creation (Appendix 7) was created after coding the first four Stage One transcripts, focusing specifically on what client and staff accounts indicated were likely facilitators of T-VALEX in the research context. This was used to structure coding for the remainder of Stage One data and initial coding for Stage Two. At this stage, facilitators were broadly categorised as environmental factors (e.g. cleanliness), practical factors (e.g. cooking and eating), and relational factors (e.g. broader network – subcategories of family/friends and phone contact). Four cross-category or higher-level themes were also identified: accessibility of support, achievements and skills, feeling at home, and crisis management. Coding at this stage therefore focused on the three aforementioned dimensions of service and how overriding themes and subthemes manifested in each of these. Two examples of coding, of a staff interview and a client interview respectively, are provided below.

Facilitator Categories

Environmental

Practical

Relational

Overriding/cross-category theme

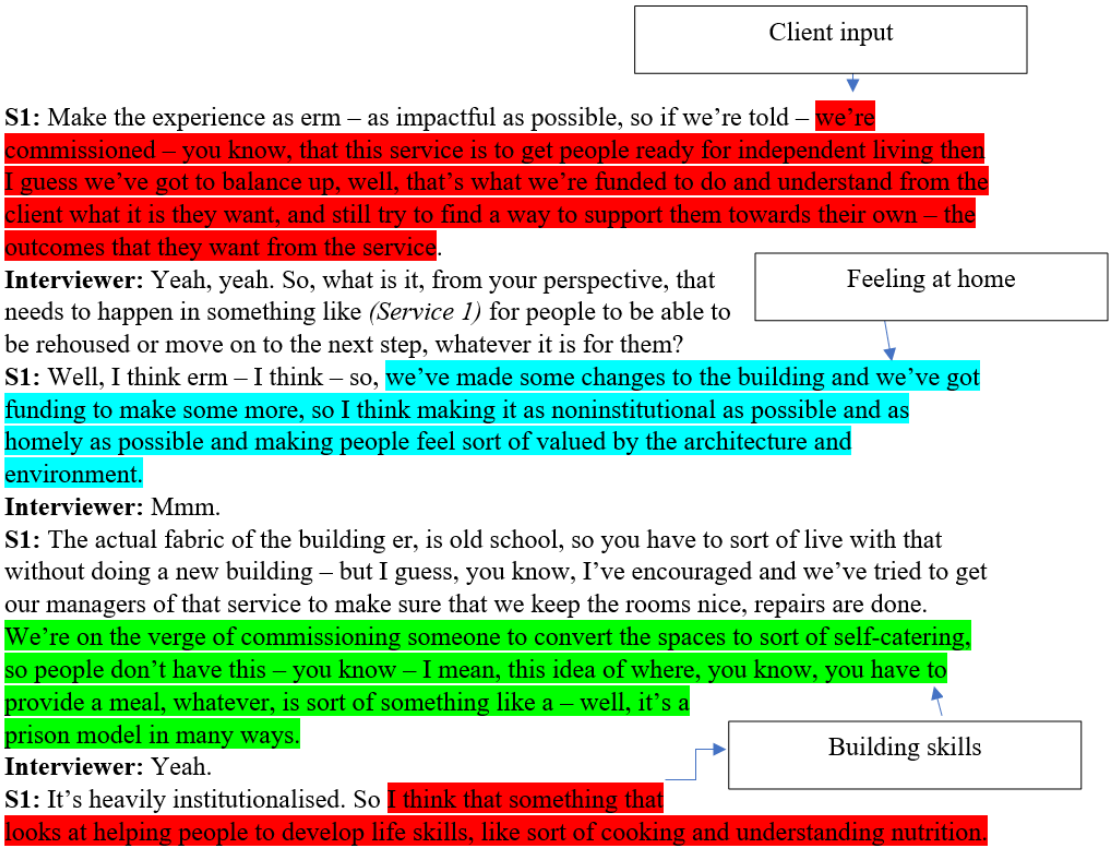


Figure 3.9: Fragment of coded Stage One staff transcript

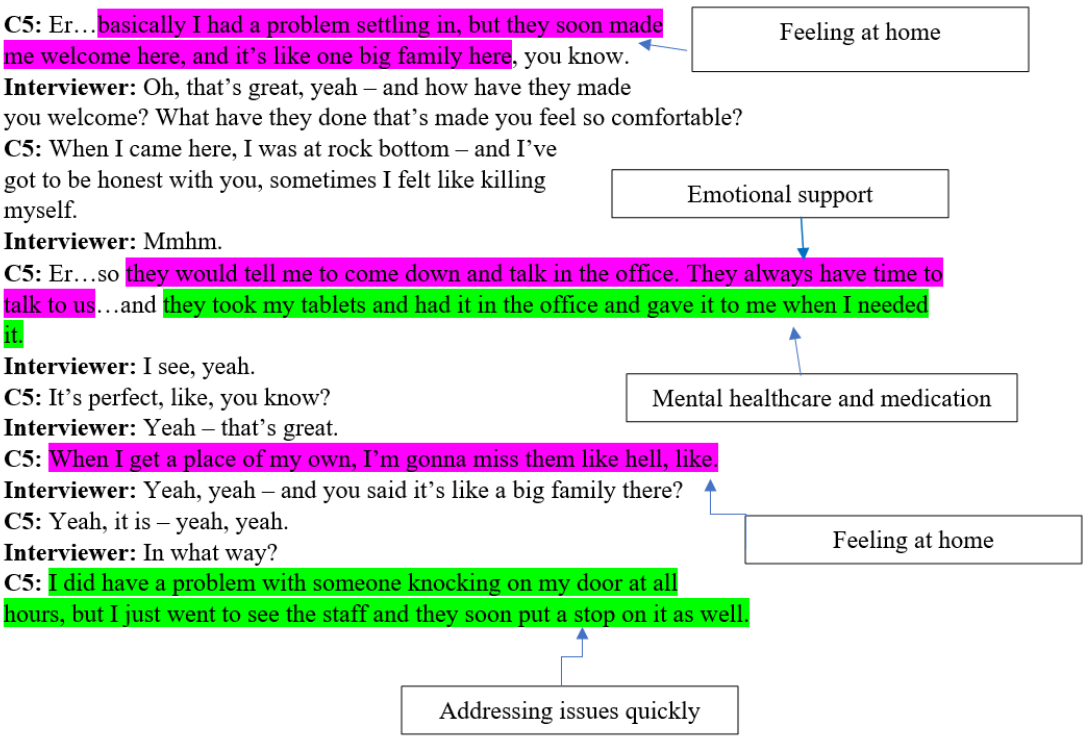


Figure 3.10: Fragment of coded Stage One client transcript

3.5.2 Stage Two Analysis

Coding for Stage Two initially utilised the Stage One template (Appendix 7), seeking environmental, practical, relational, and overriding themes and also identifying novel and recurring subthemes. As the process of analysis progressed, more specific themes and subthemes became apparent, elucidating more about facilitators, processes, and prohibitors of T-VALEX creation. A preliminary Stage Two template (Appendix 8), elaborating on key aspects of the Stage One template and tailoring analysis more directly to the research questions, was developed following coding of the first five out of 20 transcripts. This included more specific facilitators of value creation, all of which were categorised as one or more of the three original overriding facilitative themes (e.g. active participation: practical and relational). An example of facilitator coding using the final five concepts and various subthemes is provided below.

Facilitator Categories

Active participation

Community

Connectedness

Individualisation

Responsiveness

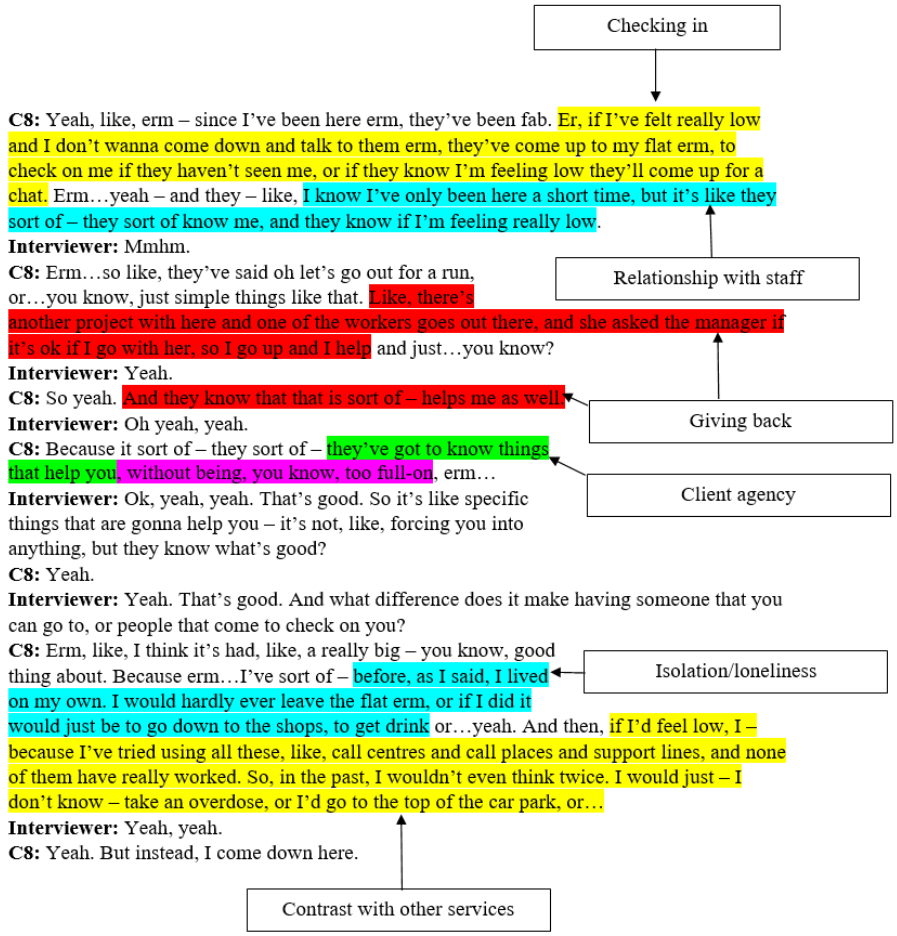


Figure 3.11: Fragment of coded Stage Two transcript

Apparent prohibitors of T-VALEX creation were also identified and connections drawn between these, facilitatory concepts, and subthemes, generating a complex web of interrelated phenomena. Later versions of the template also included higher-level analysis in identifying opportunities for innovation, centred on recurrent subthemes and bringing together the promotion of facilitators and the mitigation of prohibitors (see Appendix 9 for the final Stage

Two template). Figure 3.12 depicts an example of a proposed opportunity for innovation, the subthemes it relates to, and the facilitators and prohibitors of value cocreation addressed.

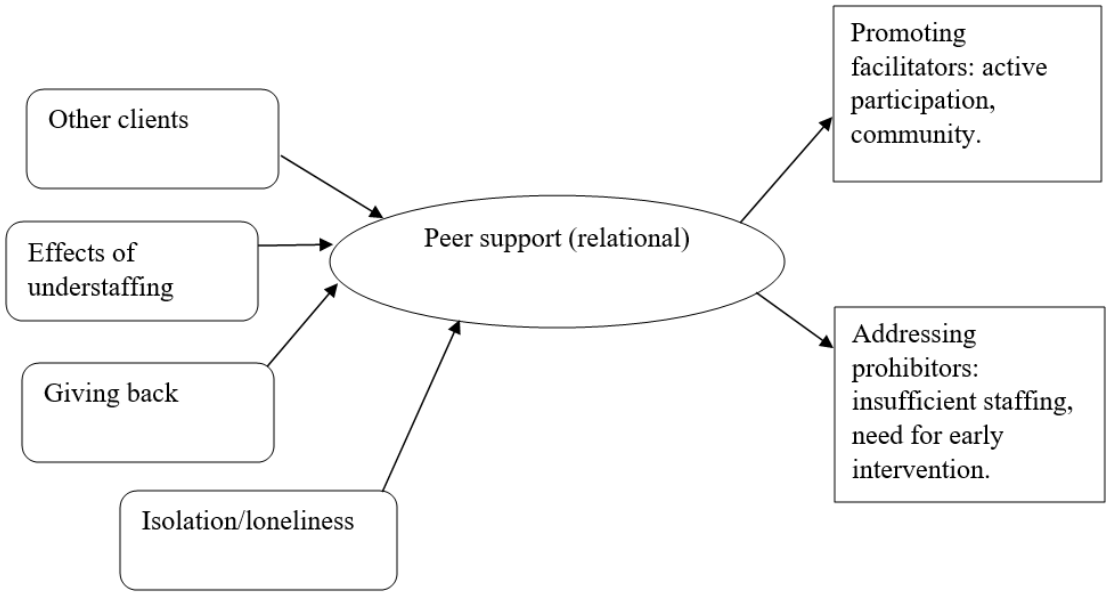


Figure 3.12: Diagram showing an example opportunity for innovation and its relationship to themes identified in the text

3.6 Ethical Considerations

Upholding high ethical standards is important across all research, and even moreso in working with vulnerable populations who are typically understood to be at greater risk of coming to harm as a result of the methods employed. The recognition of susceptibility to harm has resulted in a widespread reluctance to include more vulnerable groups in research, with researchers seeking to avoid the more time-consuming ethical procedures and regulations associated with these populations and/or to bypass the risk of exacerbating existing vulnerabilities through research protocols (Aldridge, 2014).

However, to choose simply to avoid research with vulnerable populations is to overlook the ethical implications of exclusion (Aldridge, 2014; McVilly and Dalton, 2006; Ramcharan et al., 2004). As previously stated, certain exclusion criteria were applied in recruiting for this study, as it was judged that recruiting those in an active state of crisis would pose unethical and unjustifiable risks. Besides this initial vetting process, the recruitment and research processes were intended to be accessible to all who wished to participate, while also seeking to ensure clients were able to give fully informed consent, that they did not feel under any

pressure to take part, and that they were aware of their rights to withdraw or take a break from the study at any stage. If case of any literacy issues, support workers were asked to offer either to read out the consent form and information sheet in full and/or to help clients with any specific words or passages they did not understand. The nature of the study and the TTT was also reiterated at the beginning of every interview in an attempt to compensate for any memory issues and/or misunderstandings.

The entirely voluntary nature of participation was repeatedly emphasised throughout the recruitment process: in direct communication with staff, in staff communication with clients, and in the consent forms and participant information sheets provided. It was also important to ensure that clients did not see the request as coming from Organisation X directly as, particularly if they were not receiving a lot of support elsewhere, it was anticipated that they may feel a sense of obligation to the organisation (Rötzmeier-Keuper et al., 2020). Participant information sheets emphasised that decisions regarding participation would not in any way affect the service they were receiving, and this point was similarly emphasised in conversations with staff members who may consider participating themselves and/or would be responsible for sharing information with clients. It was also made clear to participants in the participant information sheets and consent forms that they are free to withdraw right up two weeks after their interview has taken place, at which point their data would have been transcribed and anonymised.

While ethical considerations are built into constructionist and interpretivist research (Guba and Lincoln, 1994), at the same time, the close personal interactions associated with these methodologies can lead to the creation or exacerbation of vulnerability ‘as knower and known exchange roles, barter trust, and reconstruct identities’ (Lincoln and Guba, 1989, p.232). The focus of this research was specifically on service experiences, and it was not intended that participants should feel under any pressure to divulge aspects of their personal life histories. However, participants were encouraged to freely discuss these experiences as situated within their broader lifeworld contexts, which (given the nature of the research population) typically included more adverse and traumatic life events than the average person. This made it likely if not inevitable that distressing and potentially traumatic topics and experiences would arise. Discussion of mental health and associated service experiences can also provoke feelings of anxiety, discomfort, and embarrassment.

Multiple measures were taken to mitigate the risk of participant discomfort and distress. Firstly, the potentially sensitive content of the interview was communicated to prospective participants, and it was stressed that they did not have to disclose anything that made them uncomfortable and could terminate the interview at any point. Secondly, the use of the adapted TTT, rather than a conventional interview format, further helped to ensure that participants did not feel pressured to disclose anything they are uncomfortable with, enabling them to guide the conversation in accordance with the topics they wished to focus on (Sudbury-Riley et al., 2020). To account for the possibility that upsetting topics may nevertheless arise, a distress protocol was created, adapted from Haigh and Witham (2013), which set out an appropriate course of action to be taken in the case that a participant appeared distressed (Appendix 6). In practice, it was never necessary to go beyond the first stage of this (Response and Review), with a couple of participants appearing momentarily distressed but opting to continue with the interview. Nonetheless, it was important to have this in place to ensure that participants had a clear 'way out' of the conversation and to orchestrate any necessary follow-up.

Audio files were destroyed following transcription and transcripts were pseudonymised in order to ensure the greatest possible level of anonymity of data, in accordance with recommendations for the avoidance of psychological harm (Bryman, 2008). Other potentially identifiable details have also been pseudonymised or removed from the transcripts, including the actual names of Organisation X and the three residential services and the names of other individuals and organisations. All participants quoted are referred to by assigned participant numbers and services (e.g. Participant 1, Service 1). Anonymised data is stored in line with University ethical requirements and accessible only to those named in the ethical approval documentation in order to protect the participants.

3.7 Chapter Summary

This chapter has sought to clearly set out both the actual methodology applied in this study and the underlying rationale. This began with explicating the philosophical underpinning of the research and its applicability to the research context (Section 3.2), before moving on to look at specific methodologies and methodological debates relevant to the research population and other populations classified as vulnerable or at high risk of vulnerability (Section 3.3). The origins of the TTT were then described, leading onto an account of the

development and nature of the final adapted TTT and the two main stages of data collection (Section 3.4). The final two sections related to data analysis (Section 3.5) and ethical considerations (Section 3.6). The next two chapters will address the outcomes of the methodology, first exploring Stage One findings in relation to Research Questions 1 and 4 (Chapter 4) and then Stage Two findings in relation to Research Questions 1, 2, 3 and 4 (Chapter 5).

Chapter Four: Stage One Findings and Discussion

4.1 Introduction

The first of two chapters summarising the output of data collection and analysis, this chapter follows on from the preceding description and justification of methodology, sharing findings from Stage One of data collection. As detailed in the previous chapter, this consisted of unstructured interviews with clients and staff across all three services, including two members of Organisation X management. The primary purpose of Stage One data collection was to inform development of the main research instrument (i.e. adaptation of the TTT). Thus, findings discussed here pertain primarily to RQ4: *'How (if at all) can a service design methodology, the Trajectory Touchpoint Technique, be effectively adapted for the context of integrated housing and mental health services?'* Findings are presented in the same order as the final adapted TTT (see Section 3.4.3, Figures 3.1-3.8), beginning with the preservice (Section 4.2.1) and ending with the post-service (Section 4.2.6) stage.

While addressing RQ4 was the main focus of Stage One interviews, these also produced some preliminary insights into possible facilitators of T-VALEX creation in the research context. Consequently, this chapter includes a section (Section 4.3) pertaining to RQ1: *What are the key elements and processes underlying the cocreation of T-VALEX across multilevel domains?*

These findings are drawn from interviews with a total of nine individuals: five clients, two members of Organisation X management, and two Organisation X employees. Within the text, all participants will be referred to by an assigned number (e.g. Client 1). For all but the management staff (who are referred to respectively as Management 1 and Management 2), this number will be accompanied by a reference to the service in which they are based as either a client or a member of staff (e.g. Employee 1, Service 3). While these pseudonyms will be referenced in full where entire quotes are provided, where certain words or phrases are referenced mid-paragraph, they will be attributed to the relevant participant in a shortened version of the abovementioned pseudonyms (examples below).

Full Pseudonym	Abbreviated Pseudonym
Client 1, Service 1	C1, S1
Employee 1, Service 3	E1, S3
Management 1	M1

Table 4.1: Examples of full and abbreviated participant pseudonyms used in text

4.2 Main Influences Across Key Stages and Multilevel Domains

The primary purpose of Stage One data collection was to identify the most important stages and touchpoints within integrated housing and mental health services, informing the attempted adaptation of the TTT for this context (RQ4) and producing preliminary insights into key factors affecting T-VALEX creation (RQ1). A visual summary of key findings is presented in the below diagram (Figure 4.1), which depicts key stages and touchpoints within the core service context whilst also highlighting influences and interactions across individual and service ecosystem domains.

Figure 4.1: Mapping of Organisation X incorporating interactions with individual lifeworlds and broader service ecosystems

4.2.1 Pre-Service Stage: Pre-Arrival

As in the original TTT (Sudbury-Riley et al., 2020), the preservice period was captured by one card, entitled *Pre-Arrival*. While this was not appropriate in the tenancy support service context, in which the majority of the core service experience occurred in service users' own homes (Spence, 2021), for the three main study services it was quickly established that the Arrival stage occurred when service users physically moved into the service premises. In Stage 1 of data collection, unstructured interviews with clients and staff across the three services illuminated some of the typical pathways and processes characterising the prearrival period. Approved routes in and the degree of flexibility in these varied across the different services, with all generally requiring some kind of referral from a third party.

Clients were typically introduced to Service 1 after presenting to other agencies, at which point they were either already experiencing some form of homelessness or anticipating this in the near future. By far the most commonly mentioned of these was one specific frontline rough sleeper intervention service, referred to here as '*[frontline intervention agency]*'; the local authority (LA) and other agencies were also mentioned as fulfilling this role on occasions. One member of Organisation X management described how prospective service users came to actually enter into Service 1 after making contact with one of the aforementioned agencies:

> *'When a room becomes available in [Service 1] …the team will make contact with those agencies and find out who…is waiting, really, and those individuals who are waiting – they may be in emergency accommodation, either with ourselves or with another provider'* (Management 2).

Despite being designated a 'direct access' project (Shelter, 2021), interviewed staff suggested that it was not actually feasible for prospective service users to simply *'turn up at the door'* (M2) of Service 1, and all Service 1 clients across both stages described coming to the service through other agencies and actors. For example, a member of management explained that it was not simply a 'first come, first served' situation and that Organisation X itself did not bear primary responsibility for determining who was and was not accepted into Service 1:

> *'[Local council] would have a big picture, of the many…50, 100, 200 presentations of people they've got, they'll be saying right, you're a family so you can get this, you're a single person, so you can go here'* (Management 1).

Prospective clients themselves appeared to have minimal control over where they ended up, rendering many behaviours and interactions traditionally associated with the prepurchase/preservice period irrelevant in this context (Hoyer, 1984; Lemon and Verhoef, 2016; Pieters, Baumgartner, and Allen, 1995). While clients recognised that they were in need of support, being in or at high risk of entering highly precarious living situations, they were often not clear on what exactly this would look like or where it would come from, particularly if this marked their first entry into the homelessness service system:

> *'I was a right shambles, you know. I didn't know where to turn'* (Client 5, Service 1).

There were substantial similarities between the referral processes for Service 1 and Service 2, with the local council's housing network playing a key role in both. Unlike in Service 1, however, prospective Service 2 clients were typically already in the system, moving from one residential service to another. Clients generally came from shorter-term and less independent accommodation, such as hostels. This system fell somewhere between traditional continuum of care/transitional housing and Housing First models, with clients progressing through multiple forms of congregate living with varying levels of support (Gulcur, 2003; Schumacher et al., 2003; Sosin, Bruni, and Reidy, 1996) but with no behavioural conditions or specific treatment requirements at any stage (Benston, 2015; Corinth, 2017; Gilmer et al., 2014; Tsemberis, 2010). Moreover, narratives accrued in the subsequent stage revealed that this was not always a linear process, with evidence of circularity and multiple directions of travel to be discussed in the following chapter.

One common route into Service 2 was being referred from Service 1, as was the case for both of the current Service 2 clients interviewed during Stage 1 of data collection. Despite this shared experience, the process and underlying rationale of the move were described in quite different terms by the two service users, with Client 2 highlighting their progress towards greater independence whereas Client 3 associated moving into another residential service (rather than their own accommodation) with an ongoing need for support:

> *'I've moved into my own property because I gave up drinking and drugs and I wanted to be more independent and spend more time with my kids'* (Client 2, Service 2).
>
> *'I was down at [Service 1] and they could see I couldn't look out for myself, and…I came here'* (Client 3, Service 2)

Client choice appeared to play a more significant role in entering into this service, including active consideration of their own long-term needs and objectives. While clients could not remain in Service 1 or similar services indefinitely, they could at least exercise some control over the duration of their stay and whether they moved on to entirely independent or supported accommodation. There is thus a degree of overlap between the pre-service stage of Service 2 and the post-service stage of Service 1, potentially making it more difficult to explore one service experience in isolation.

Service 3 was described as having *'the most regulated of the pathways'* (M2), with service users coming directly from psychiatric hospitals under the direction and ongoing support of an active multidisciplinary team of mental health professionals. Rather than going to multiple agencies and/or the local council, in the case of a vacancy, Service 3 management would go directly to this *'panel'*, who would then send through *'applications of [their] clients'* (E1, S3) to be assessed for suitability by the service manager. This was also associated with a longer transition period, with prospective service users typically coming to stay for periods of gradually increasing durations before moving in permanently, while for those in the other two services, *'it's move in and you're there – you're living there now'* (M2).

Prospective Service 3 clients were therefore able to experience a trial period to determine if the service was right for them, something which is fairly rare in the context of service (as opposed to product) use (Hightower et al., 2002; Pizzam and Tasci, 2019; Wakefield and Blodgett, 1994). These clients therefore appeared to exercise significantly greater agency than those in Service 1 or even Service 2, not only being informed about the nature of the project but also having an opportunity to experience this prior to fully entering into the service.

In the context of the Organisation X tenancy support service, the preservice stage of activity was identified as a key area for innovation, with prospective service users' lack of knowledge about the tenancy support service and Organisation X as an organisation often contributing

towards feelings of reluctance and scepticism (Spence, 2021). While participants in this study could find the waiting period and associated requirements of them to be *'annoying'* (C17, S1), this did not appear to be so significant in discouraging engagement with the organisation as in the former instance, perhaps because of their more immediately desperate situations meaning they did not perceive themselves as having the option to completely disengage. Implications of this for T-VALEX creation and opportunities for innovation will be discussed in Chapter Six.

4.2.2 Early Stages: Arrival and Assessment and Goal Setting

Arrival was another stage of the service experience that was drawn directly from the original TTT (Sudbury-Riley et al., 2020). The contents of this card were again informed by emergent themes in Stage One interviews. One such theme related to how clients were helped to settle in and overcome any initial apprehension about the services, including feelings of inferiority and powerlessness associated with a lack of control and familiarity (Adams et al., 2016; Berry et al., 2015; Tallandini and Scalembra, 2006). Clients were immediately made to feel welcome and were offered enhanced emotional and practical support within the first few weeks, having been assigned a specific support worker at the outset:

> *'I know it's quite hard for some people to kind of settle in, but we would support them quite a lot in the first few weeks to settle in. They'd have a support worker assigned to them, and…we would provide emotional and practical support'* (Employee 2, Service 2).

Consistent with research on common factors impacting mental health service effectiveness, these efforts often served to raise client expectations and inspire engagement with the service (Rutherford et al., 2014; Wampold, 2015). Organisation X would also often work with other agencies to provide a *'wraparound service'* (E2, S2), reinforcing the importance of collaboration and continuity of care across service networks (Begun et al., 2018; Miller, 2011; NHS Primary Care and Community Services, 2010; Zeitler et al., 2020).

Effective interventions at the beginning of the service experience involved a combination of practical steps, providing safety and security, and the assurance that emotional support was readily available when needed, for example taking control of medication (both to ensure this was administered when appropriate and to prevent overdoses) and assuring clients that they

would *'always have time to talk'* (C5, S1). Some staff also described the more practical side of asking prospective tenants to go through licencing agreements, tenant responsibilities, etc., though no interviewed clients identified this as being important to their personal service experiences.

Assessment and goal setting was a theme that emerged in the tenancy support service context as occurring predominantly within a first meeting (Spence, 2021). Conversely, in the main study context this was found to occur some time after arrival and to comprise a stage of its own. Clients and staff both described how initial support meetings were arranged after clients had already begun to settle into a service and had been assigned individual support workers. These meetings were described as having a future focus, with one client for example primarily recalling *'the question of how would you like to be in six months' time'* (C1, S3). The intention to work towards creating preferred futures out of existing strengths and circumstances is consistent with the goals of transformative service design (Anderson, Nasr, and Rayburn, 2018). However, client histories were also incorporated in the form of *'previous and historical needs assessment[s]'* (E1, S3), acknowledging the ongoing impact of past experiences and broader lifeworld contexts (Blocker et al., 2011; Flint, 2006; Helkkula, Kelleher, and Pihlström, 2012).

While staff provided a pre-established set of themes for consideration, clients were described as having significant input into the specific goals that they wished to work towards, establishing their own unique 'trajectories of recovery' (Patterson et al., 2013, p.6). Unlike in the prearrival period, client choice appeared at least hypothetically embedded in this stage, reinforcing the importance of service user agency for resource integration and value cocreation (Centre for Homelessness Impact, 2020; Davey and Grönroos, 2019; Grönroos, 2008; Lusch and Vargo, 2014):

> *'[We would] arrange a meeting with them for their first support session, and then from that support session we'd look at their needs assessment, the goals, maybe the things they want to work towards. So again, maybe they want help with alcohol and drugs, so we'd look at maybe doing a referral to…one of the supporting er, agencies that are in the community. And then we'd look at the goals, and from that we would bring out the support plan'* (Employee 2, Service 2).

Furthermore, clients were not inescapably bound to their initial support plan. This was instead treated as a *'live document'* (E2, S2) to be altered as new goals arose. Thus, rather than being entirely predetermined by service providers/designers, service experiences were were shaped in part by client input and could take on new, perhaps unexpected dimensions and directions as the service experience unfolded. This may be understood as analogous to path-creating design where the 'artefact' in question is an individual's plan for personal and practical development, rejecting standardisation and determinism in favour of continuous evolution and experiential, trial-and-error learning (Cogdell, 2003; French, 1994; Frenken and Nuvolari, 2004; Langrish, 2004; Van Nierop, Blankendaal, and Overbeeke, 1997).

Themes described as coming up in the assessment process included skill-building, e.g. *'budgeting…or meal plan[ning]'* (E1, S3), and mental health support, e.g. regarding *'medication'* (C1, S3). Consistent with a client-centred approach (Anderson, Nasr, and Rayburn, 2018; Fottler et al., 2000; Frow, McColl-Kennedy, and Payne, 2016; Lee, 2004), decisions made at this stage helped to shape the specific, tailored nature of the core service aspects, described below. Assessment and goal setting was not, however, mentioned in the context of Service 1. The extent to which this influenced T-VALEX creation will be explored in relation to Stage Two findings (see Chapter 5).

4.2.3 Core Service Aspects: Practical and Emotional Support

Similar to *Clinical Care and Support* in the original TTT (Sudbury-Riley et al., 2020), *Practical and Emotional Support* soon emerged as the core service offering provided by frontline Organisation X staff across the three residential services. As previously highlighted in relation to the early stages of the service experience, each client in Services 2 and 3 had an assigned support worker, who took on primary responsibility for providing *'often quite intensive support'* (Employee 2, Service 2). This central one-on-one relationship was not present in Service 1, providing an opportunity for comparison in terms of how (if at all) this influences T-VALEX creation, and for evaluating the importance of one-on-one transformative service conversations in dyadic relationships (Gopaldas et al., 2021) against that of collaborative networks (Black and Gallan, 2015).

While staff accounts highlighted the importance of specifically assigned support workers, clients at this stage focused more on the traits they perceived as common to all or most Organisation X staff, including an open-door policy and a supportive attitude:

> *'They say any time you're feeling like that come down, and ever since I have, and the staff at (Service 1) are never too busy'* (Client 5, Service 1).
>
> *'You've just got to knock on the door and say you're not feeling very well, and they'll come out, talk to me for a half hour or an hour, and I settle down then'* (Client 1, Service 3).

In terms of practical support, financial assistance was a key theme, with staff assisting clients for example with claiming benefits and paying bills:

> *'We would help them er, with the housing benefit forms and send them in so that's all sorted…explain about the service charges…and then we'd look at what benefits they are on, if those are working ok. If they're not on benefits, we'd help them to apply for them, like set up a Universal Credit journal, er, maybe fill out an ESA[1] form, a PIP[2] form, look at PIP for them as well'* (Employee 2, Service 2).
>
> *'A lot of our tenants…are in receivership, so they'd be allocated somebody who will allocate money, and their money will go into receivership and their bills will be paid'* (Employee 1, Service 3).

Physical aid could be particularly important for clients in Service 2, who were in the highest age range and also most likely to have health issues associated with long-term substance use:

> *'Because I've got arthritis, I can't walk properly. I'm in a lot of pain a lot of the time, so they go to the shops for me'* (Client 2, Service 2).
>
> *'[We] support them around their use of alcohol and drugs and any of the physical illnesses that they've had from their lifestyle'* (Employee 2, Service 2).

Such support may be purely habitual or may make up one component of a gradual build-up of small changes ultimately manifesting in transformative value creation (Blocker and Barrios, 2015). Evidence in both directions will be discussed in the subsequent chapter when

[1] Employment Support Allowance: available to this who are unable to work due to disability or illness but are not entitled to Statutory Sick Pay.
[2] Personal Independence Payment: available to those with long-term physical and/or mental health conditions impeding the ability to complete everyday tasks.

presenting data on the apparent extent and constituents of transformative value creation. For those nearing the end of their time in a given service, practical support could also include assistance in working towards their housing goals, incorporating future visualisation and potentially helping to shape a more projective orientation (Blocker and Barrios, 2015; Emirbayer and Mische, 1998). This was pertinent especially for Service 1, which was intended to serve more as a transitional stage than as a longer-term housing solution:

> *'[Staff work on] building relationships with landlords, encouraging clients to erm, be really clear about which areas they'd like to live in. But also make it into more of an aspirational experience as well, so…they have, like, a "my perfect gaffe" kind of street where they can visualise and explain what's important to them'* (Management 2).

While the majority of Stage One participants solely focused on face-to-face support, a couple also described virtual (specifically telephone) support as helpful for both practical and emotional purposes. One member of staff identified the value of virtual communication for promoting efficiency as a lesson learned from the COVID-19 pandemic and lockdowns:

> *'I think that what we've learned from the pandemic is actually, some clients are pretty happy with a service that's by text or something…like er, they want something from a support worker, they put it on WhatsApp and get it instantly, without leaving the house'* (Management 1).

The association between increased use of digital resources and greater efficiency is well-documented (e.g. Murray et al., 2016); conversely, heavy reliance on digital technologies can be associated with a lack of human contact and therapeutic input to the detriment of consumer wellbeing (e.g. Beatson, Lee, and Coote, 2007; Galarza-Winton et al., 2013). This was not an issue which came through here, although the general impact of the COVID-19 lockdown and associated lack of face-to-face interaction will be discussed in the subsequent chapter.

Management 1 also referred to a specific telephone support service that Organisation X had partnered with, expressing pleasure at the fact that there had been *'quite a lot of referrals'*. This same service was identified as a key source of support by Client 2 (Service 2), who also

described phone calls from friends as similarly beneficial in providing assurance that *'somebody's there at the end of the line'*.

Findings from Stage One also provided some initial insights into the importance of peer support, which was to become a far more prevalent theme later in data collection. For example, Client 5 (Service 1) described clients and staff as *'like one big family'* and describing how she specifically took on the role of a *'Mother Hen'* looking out for the others. This appeared in some ways akin to the notion of a 'street family' established by homeless young people living on the streets (Smith, 2008), who were found to often take on the specific roles of parents or siblings supporting others. The role of quasi-family units within services will be further elucidated and discussed in Chapter Five, as more Stage Two participants utilised this analogy.

However, the majority of participants in this stage discussed in-service support as coming primarily from Organisation X staff. Some also referred specifically to limited social interaction between clients:

> *'To be honest, they hardly mix with each other anyway'* (Management 2, Service 2).
>
> *'I don't have much contact with other people. I find it hard to make friends and stuff'* (Client 4, Service 1).

4.2.4 Servicescape Dimensions: Facilities and Shared Spaces

The card for *Facilities and Shared Spaces* was developed on the basis of both social and non-social dimensions of the servicescapes, which came to light during Stage One interviews. This combined two cards from the original TTT (*Facilities*, which covered non-social servicescape dimensions, and *Shared Spaces*, which covered social dimensions) into one. This decision was made for pragmatic reasons, because the two naturally seemed to be discussed alongside each other and because it was desirable to mitigate the risk of participant fatigue by avoiding an excessive number of cards to go through (e.g. Ashley, 2020). It would also have been difficult to clearly distinguish between personal and shared spaces in a way that would resonate across all three services, as in Service 1 personal space was limited to a bedroom whereas in Services 2 and 3 clients had entire flats to themselves.

There was some variation in clients' preferences regarding their personal space, with the level of environmental satisfaction depending in part on the fit between the servicescape and their individual lifestyles (e.g. Demoulin and Willems, 2019; Lugosi et al., 2022). For example, clients demonstrated some variation in their size preferences, with one describing how they would actually prefer a smaller room as they would find this more manageable:

> *'I have enough space – personally, I'd rather have less. Because it's less to manage to tidy up…it does get overwhelming'* (Client 4, Service 1).

Conversely, another participant described how they had benefitted from moving from a smaller to a larger flat within the same service, due to being able to host visitors:

> *'I can invite people in for coffee and stuff now, where I couldn't before'* (Client 2, Service 2).

In terms of the specifics of personal space and what was deemed important here, key areas that arose were cleanliness, decoration, and specific facilities and equipment. This related to overall surroundings, with Management 1 for example highlighting the perceived importance of *'[making] people feel that just because you're homeless you don't have to live in an unpleasant or rundown building'*. The role of staff could also be important in managing day-to-day matters of organisation and appearance, with Client 4 (Service 1) describing how staff helped them to *'keep [their] room tidy and [to] keep on top of things'*.

At the same time, taking responsibility for the cleanliness of their own surroundings and communal areas could provide clients with a sense of purpose and satisfaction. This appeared to facilitate the development of positive self-narratives associated with recovery and transformative value creation (e.g. Blocker and Barrios, 2015; Leamy et al., 2011):

> *'I look forward to getting up in the morning now, you know?…I clean up even though it doesn't need cleaning – you know, I do my washing'* (Client 2, Service 2).

> *'I help them – like, with sweeping around or washing around – that's the kind of person I am'* (Client 5, Service 1).

Staff also described the importance of creating, or helping clients to create, a *'homely'* (Management 1) environment, which made them feel comfortable and in control as well as meeting their essential needs. This was achieved using a combination of operand and operant resources (e.g. McColl-Kennedy et al., 2012; Vargo and Lusch, 2008), with staff directly influencing the physical characteristics of service buildings and using their skills and knowledge to help clients set up their new homes:

> *'We've made some changes to the building, and we've got funding to make some more, so I think making it as noninstitutional as possible…and making people feel sort of valued by the architecture and environment'* (Management 1).

> *'We would give that intensive support to them, to try and set them up and get them furniture from other charities and stuff'* (Employee 2, Service 2).

Servicescape design was thus recognised as a significant factor in setting clients up for satisfaction and helping them to meet their (transformative) goals (e.g. Bitner, 1992; Danaher and Gallan, 2016). Descriptions of specific facilities/equipment within personal spaces were limited, though one client did describe a recent enhancement:

> *'They tried upgrading the property. Like, we've got TVs in our rooms, and they've got internet here'* (Client 4, Service 1).

Those in Service 1 shared a *'kitchen area'*, within which two meals a day were provided and they were also free to *'go in and have tea and coffee'* (C4, S1) whenever they chose outside of mealtimes. Clients in Services 2 and 3 had their own kitchen facilities and were responsible for providing their own meals. Some of these clients described the value of time spent cooking and baking, as will be discussed in the subsequent section; however, specific facilities were not explicitly mentioned at this stage.

While this was not immediately apparent from client interviews at this stage, one member of Organisation X management suggested he believed that the Service 1 model was in some way damaging to their mission, and expressed a desire to move closer towards the model of Services 2 and 3 This related to concerns about clients becoming institutionalised and being unable to fend for themselves on leaving the service, as has been documented regarding some

government institutions (e.g. prisons, children's homes) and also some homeless shelters (Huber et al., 2020; Khan, 2010):

> *'We're on the verge of commissioning someone to convert the spaces to sort of self-catering, so people don't have this – you know – I mean, this idea of where, you know, you have to provide a meal, whatever, is sort of something like a – well, it's a prison model in many ways'* (Management 1).

Shared gardens were also identified as beneficial by clients in Services 2 and 3. These could serve as therapeutic servicescapes (Rosenbaum et al., 2020), providing space for quiet personal reflection as well as for socialising both with other clients and with friends and family members outside of the service:

> *'I'll go in the garden in my dressing gown and sit out there with a cup of tea'* (Client 1, Service 3).

> *'If the sun's shining, because we've got a big garden, me and er, [close friend referred to as 'sister], we sun-worship most of the day – so we get…you know, nut burnt'* (Client 2, Service 2).

Engagement with outdoor space could also play an important role in building and utilising skills, which will be discussed below in relation to sites of T-VALEX creation.

4.2.5 Sites of T-VALEX Creation: Building Skills and Resources and Connecting to Broader Support Network

The themes of *Building Skills and Resources* and *Connecting to Broader Support Network* were not present in the original TTT but were carried forward from prior research with Organisation X (Spence, 2021) in line with the focus on T-VALEX creation. Stage One interviews confirmed that these elements were also present across the three main study services and that these were considered significant by those interviewed, though their role in transformative value creation specifically was not explored in-depth until Stage Two.

The skills and inner resources that clients developed and put to use during their time within the three services can broadly be characterised as essential (for independent or semi-

independent living) and additional, though the line between these is often fluid and debateable. Common threads across both of these broad areas were *'confidence building'* (Employee 1, Service 3) and becoming *'more independent'* (Client 2, Service 2), through a combination of observing, learning, and putting knowledge into action. The stated ideology of the company emphasised the importance of trusting clients and granting them the space to put their own abilities and knowledge into use, as opposed to staff taking on the role of the expert practitioner. This appeared very much in line with the mental health recovery framework, positioning the client as the expert regarding their own needs and the practitioner role as that of a facilitator (Johns and Davey, 2021; Simon, 1994):

> *'The kind of ideology about the client is [that they are] their own best expert and they have strengths and resources'* (Management 1).

Both Management 1 and Employee 1 (Service 3) referred to the importance of helping clients to develop *'life skills'*. These were summarised by Employee 1 as *'things like cooking, health and safety issues, [and] all that sort of thing with shopping and budgeting'*. Specific examples included *'looking at a budget plan'* (E2, S2) or *'budgeting for shopping once a week – or a meal plan'* (E1, S3). While the ability to plan and prepare meals was obviously important for meeting clients' fundamental needs, cooking and baking were also valued as hobbies, which clients in Services 2 and 3 were able to build on often after extended periods without access to their own cooking facilities. This could be a specific area of transformative change in terms of clients' abilities and self-confidence (Fu, Tanyatanaboon, and Lehto, 2015; Onken et al., 2007), as observed by one member of staff:

> *'When I first came here, [Client 1] was very nervous about cooking, but now she can whip up a cake in no time'* (Employee 1, Service 3).

Other practical and creative pursuits were also identified as important for wellbeing and personal development, for example involving music and gardening:

> *'I've asked about learning to play the guitar – have guitar lessons'* (Client 2, Service 2).

> *'Say for [Client 1], she wanted to do some gardening and learn about gardening, and in the last year she did a lot'* (Employee 1, Service 3).

Connecting to Broader Support Network emerged as a similarly prominent theme in integrated residential services as in the tenancy support service context (Spence, 2021). This encompassed working closely with organisations, professionals, and individuals already in clients' lives, as well as assisting clients in building and strengthening new connections. The pre-existing network appeared particularly pertinent in the context of Service 3. As previously mentioned, each new client carried forward the same *'multidisciplinary team'* (Management 2, management) that had worked with them during their time in hospital, including community psychiatric nurses (CPNs), care managers, and psychiatrists. In addition to mental health professionals, pre-existing networks could also include other parties such as *'criminal justice worker[s]'* (E1, S3), who would be involved in team meetings setting goals and coordinating support as and when appropriate.

The extent to which these served as transformative service networks, with different actors working collaboratively and effectively towards the coproduction of value (Black and Gallan, 2015; Normann and Ramirez, 1993), was not entirely apparent at this stage; however, it was clear that the involvement of external agents could fulfill important functions going beyond the capacity of Organisation X. For example, one member of staff described the value of CPNs' legal powers from their perspective:

> *'So we work with a CPN, because they've got more power than we have, because of the Mental Health Act as well…So we, as their support workers, will work alongside them with our managers'* (Employee 1, Service 3).

Also included in these teams were psychiatrists, who were described as meeting with clients for *'six-monthly…mental health reviews'* (E1, S3). The CPN or their Organisation X keyworker would typically also attend these meetings, though clients were given the option to have one-on-ones with only their psychiatrist present if preferred. This could help to mitigate the potential complicating effects of clients' complex needs and embeddedness in complex service systems (Making Every Adult Matter, 2020), providing a clear pathway for Service 3 staff to follow when issues outside of their jurisdiction arose:

> *'Maybe (C1) might say that she didn't like the medication that she's on because it's making her tired…but then, from that then we'd have a referral with her psychiatrist, so she can have an appointment with her psychiatrist and can discuss that with her psychiatrist. So anything that's actually discussed in the tenancy support meeting will be actioned'* (Employee 1, Service 3).

Due to their less controlled and more varied pathways, it was less common for clients in Services 1 and 2 to enter the service with such clearly defined support teams. This was particularly the case for Service 1 clients. Nevertheless, management staff did refer to the possibility of these clients already being *'linked up with services'* (M2) such as addiction treatment and homelessness support, which could be integrated into the Organisation X service experience:

> *'If there are other professionals in the person's life, it may be appropriate for them to visit them at the hostel'* (Management 1).

Consistent with a service-dominant understanding of value cocreation, staff also described their roles in bringing in relevant parties and attempting to build strong, multi-actor teams around individual clients (Elg et al., 2012; Maglio et al., 2009; Ketonen-Oksi, 2018; Ranjan and Read, 2016; Vargo and Lusch, 2004). This was particularly emphasised by staff in relation to Service 2, being a long-term project (unlike Service 1) in which new clients did not necessarily come in with strong pre-existing support teams (unlike Service 3). Consequently, after spending significant time in the service, clients were expected to be in a similar position to those entering into Service 3 in terms of their individual networks:

> '*Some of them will have been in the project for a long period of time, so they'll have those established erm, support networks and interventions from stakeholders and be more settled in that regard. So similar to [Service 3], but predominantly more to do with er, maybe treatment support, rather than mental health support'* (Management 2).

Multi-actor teams in Service 2 included drug and alcohol services, legal professionals (e.g. probation officers), and various physical and mental health services and professionals:

> *'We've got good relationships with people in the community, like the local CPN, the mental health nurse, and er, we would – if they wanted to see her, we would arrange an appointment with her as well – and we've got good links with the homeless nurse, who would come and see people. If we ring her to check on them, she would'* (Employee 2, Service 2).

Across the three services, but particularly Services 2 and 3, Organisation X staff played a key role in registering clients with *'dentists [and] doctors'* (E2, S2), in signposting them to other relevant services, and in actively bringing these into the Organisation X service in question. Particularly pertinent here were specific mental health and addiction services working with Organisation X to deliver support:

> *'I was really heartened by the fact that there's been quite a lot of referrals [to telephone mental health service]…So this is something clients want, to have these kinds of referrals, and when we had [counsellor] on the staff team, he got a lot of referrals too. So it's clearly something that, as part of the package, is useful…to the clients we see'* (Management 1).

> *'We've had a drugs and alcohol service – we have good links with them, so we signpost some of our clients to them and we have an engagement officer who comes here and will see people here as well. So we try and bring in a lot of the service – like, probation will come. We've got the drugs and alcohol probation part, so they come and see their clients as well'* (Employee 2, Service 2).

Staff were sometimes able to subvert long waiting lists by testifying to clients' *'particular needs'* (support worker of C2, S2), enabling them to access valuable services in a significantly shorter time period than would otherwise have been possible. In doing so, they fulfilled an apomediary role, representing clients' needs or helping them represent their needs to others across broader service networks (Eysenbach, 2008; Johns and Davey, 2019). Participants also described how staff would offer practical support with appointments, including helping them to keep on top of their commitments, providing reminders, and offering physical accompaniment when possible:

> *'If I have appointments, they keep me up to date with my appointments, tell me what time I've gotta go'* (Client 2, Service 2).
>
> *'Normally a member of staff will call me and remind me about a notification or something – they'll prompt me…Because I've got terrible memory problems'* (Client 4, Service 1).
>
> *'[We support them with] appointments, maybe, er, go and see consultants and things'* (Employee 2, Service 2).

Staff across the three services could directly liaise with organisations and professionals on clients' behalf, something which was highlighted as valuable at this stage particularly in relation to financial matters:

> *'Any problems – like, I'm on Universal Credit. Any problems with it and if I don't feel up to it, the staff go along to them and speak to them for me, with my permission'* (Client 5, Service 1).

A few participants also highlighted the importance of facilitating and maintaining clients' existing personal support networks, which are often damaged or depleted for consumers experiencing chronic vulnerability (Skosireva et al., 2014; Thornicroft et al., 2007; Vázquez et al., 2021):

> *'[Client 1] has got two sons – and again, with the project, she's allowed – she was allowed to have her son that passed away to sleep over occasionally. That's allowed as well, so we encourage erm, sort of relationships with family to continue and make sure that [Client 1] does have her family around'* (Employee 1, Service 3).
>
> *'Looking at the other things, like their relationships maybe with their family and how to er, support them to maintain those'* (Employee 2, Service 2).

Extended personal networks including strong, positive relationships have been identified as important for long-term transformative change (Begun et al., 2018; Gasior, Forchuk, and Regan, 2018; MacKean and Abbott-Chapman, 2012). Conversely, social relationships could also play a role in perpetuating cycles of unhealthy behaviour (Hughes et al., 2010), with one

participant describing how her pre-existing friendship network had been damaging to her sobriety and wellbeing:

> *'I feel like I'm being pushed out – I'm an outsider. It was just like, when you're drinking and that, you're all mates, you're all drinking, you're all having a chat – but if you don't drink, you don't feel, like, the same atmosphere. They're getting drunk, they're falling over, they're arguing…you know, or – you know, not making much sense – and I stood back, and I thought to myself no. You know, I don't wanna be like that – I want out. I need to get out'* (Client 2, Service 2).

Though not an intended focus of the study, the impact of the COVID-19 pandemic came up repeatedly throughout Stage One interviews, and particularly in relation to connecting to broader support networks. At the time that these interviews took place, various regulations remained in place in Wales (Morgan, Watkins, and James, 2023). Clients were still having substantially fewer external appointments and there was dramatically increased reliance on online services, such as *'My GP Online'* (E2, S2). There were also ongoing restrictions on meeting socially with those outside of your household, which had a particularly prohibitive impact on clients in Service 1:

> *'I don't think we've been able to accommodate people's visitors in the pandemic, because I think it just – we just can't work with the regulations'* (Management 1).

> *'Nobody's allowed in the hostel because of COVID at the moment'* (Client 5, Service 1).

Restrictions in the other two services were somewhat less stringent at the time of interviewing, due to clients living in their own flats and therefore able to isolate from each other. While previously there had been no visitors allowed at all, at this point clients were given the option of establishing a 'bubble', described by one employee:

> *'Now they're allowed to nominate one person…within a bubble, who can come and see people. I think that's the biggest thing for a lot of our clients is loneliness, so it has been good that they're allowed to have that one person's support – and now, with things that have changed recently, they're allowed to swap that person if there's ten*

> *days between not seeing them – they can swap it for somebody else'* (Employee 2, Service 2).

The value of this was also highlighted by one client, who recalled how she had been profoundly negatively affected by isolation from her children in particular:

> *'We weren't allowed to see people – I wasn't allowed to see my son and my daughter, and you know, er, it just ground me down so much that I was quite happy to give up, because I was fed up of everything'* (Client 2, Service 2).

Such comments demonstrate the important role that interpersonal connections can play in motivating and shaping processes of personal transformation (e.g. Laudet and White, 2010). At the same time, the abovementioned employee suggested that the option to establish a 'bubble' was not taken up by the majority of clients:

> *'Truth be told, I suppose a lot of our clients wouldn't have a lot of, like, family or friends – it's a minority of people who have kind of chosen somebody in a bubble to come and see them'* (Employee 2, Service 2).

The impact of COVID-19 therefore appeared to be felt across broader service and social networks, though the extent to which this negatively impacted on clients was seemingly contingent on a) how readily they adapted to the shift to virtual service delivery and b) how dependent they were on face-to-face contact to promote wellbeing. The effects of COVID-19 and associated restrictions on T-VALEX creation specifically will be considered in the following chapter.

The aforementioned discussions of skill-building and connecting to broader support networks appeared to confirm that these were important aspects of the customer experience across the three services in question, as in the tenancy support service from which data was previously collected (Spence, 2021). Comments from staff in particular further suggested that it was the intention of these efforts to promote transformative change with influence spreading across all aspects of clients' lifeworlds, a process which is captured in this study by the construct of T-VALEX. However, the extent to which this was successful and these (or other) aspects of the customer experience were actually associated with T-VALEX creation could not be

gauged from Stage One findings alone. This will be touched upon later in this chapter in a discussion of initial impressions of T-VALEX facilitators (4.3) and explored in greater depth in relation to Stage Two.

4.2.6 Post-Service Stage: Moving On

The post-service stage differed most significantly from the contexts of both the original TTT and the pilot version. While final cards of the original TTT and the pilot adapted TTT both denoted a clear and specific post-service stage, the last card of the final adapted TTT pertained somewhat ambiguously to *Moving On*. This was due to the findings of Stage One interviews, from which it transpired that there was not always a clear endpoint at which the 'actual service' experience transitioned into post-service engagement (Rosenbaum, Otalora, and Ramírez, 2016, p.2).

There were two main ways in which the final stage specifically differed from prior applications of the TTT. Firstly, participant remarks often transcended the specific service experience in question, encompassing interactions with multiple providers and other actors and tying in with broader life narratives. This meant that moving on from a specific service was not necessarily viewed as an ending so much as the next step on a far longer path. Secondly, not all participants left or planned to leave Organisation X altogether, with clients often moving across buildings or services and some even remaining within one residence indefinitely.

Of the three services included in the study, Service 1 appeared to have by far the greatest focus on clients' moving on as a key aim of the service, seeking *'to reduce the length of stay as much as possible and…focus on what the specific obstacles are'* (E2, S2). However, the aim here was not simply to get clients out of the service quickly but to ensure that they were moving on to longer-term, more independent accommodation:

> *'We…encourage people to access long-term settled accommodation, rather than moving through a staircase model'* (Management 2).
>
> *'They're gonna put me into…another supported living accommodation'* (Client 4, Service 1).

As discussed in Chapter 1, the 'staircase model' referred to here is one in which homeless people with mental health and/or substance use issues move through a series of progressively more 'normal' housing options as they work towards psychiatric stability and/or sobriety, with independent living the final stage and accessible only after demonstrating substantial evidence of 'housing readiness' (Crisis, 2010). However, in the staircase model, whether and when clients move on from/through services is decided not by clients themselves but by providers, in accordance with their having met certain (treatment and/or sobriety) criteria (Crisis, 2010; Johnsen and Teixera, 2010; Tsemberis, 2010).

The Organisation X approach was thus more closely aligned with a Housing First model in the sense that service access was not contingent upon treatment completed or behaviours evidenced (e.g. Housing First Europe Hub, 2016; Tsemberis, 2010). However, movement between services was common and typically related to clients seeking increasing independence over time. For example, clients in Service 1 with substance use issues were sometimes given the option of moving on to Service 2, in which increased independence extended to making their own choices about alcohol consumption:

> *'[Service 1] is a dry hostel. [Service 2] is a – you could describe it as a wet project. Because the individuals have tenancies, we wouldn't really get involved in prescribing what they can and can't do in terms of their drinking alcohol'* (Management 2).

Clients in Service 2 were able to live there for *'as long as they wish[ed]'* (Management 2), which in some cases meant for the rest of their lives or as long as they were able to stay relatively independent. While there was no expectation for them to move on, there were various options available for those who did want or need to:

> *'Some individuals do choose to move into general lease accommodation, so that's where they'll be offered a flat by the council or by a housing association or someone else in the community, and they'll decide they're going to take that opportunity because they no longer need the support. Some will have to move into a more care type service, because their physical health and support needs are becoming really care needs'* (Management 2).

> *'We've had real success stories where somebody's gone into detox – has stopped*

> *drinking for over a year, and then they felt that they wanted to move on from the project and…we've er, got links with [local council] – so, through [council services], they've moved on to independent living'* (Employee 2, Service 2).

In addition to moving between different Organisation X services, it was also possible for clients to move on to external accommodation without fully exiting the service. This had been the case for Client 2, who had moved from Service 1 to an *'independent living flat'* in Service 2 and then on to her own tenancy but remained under their care, now receiving only *'hands-off, light-touch support'* (C2 support worker, S2).

Service 3 fell between Services 1 and 2 in the sense that clients were often expected to stay for several years but generally not for life. Instead, this served more as a long-term transitional stage between hospitalisation and independent accommodation:

> *'This is a moving on project, it's not a permanent project. It's…a project that's designed to…support the client to move on into their own accommodation'* (Employee 1, Service 3).

While the official remit of Service 3 was for a maximum of three years, from conversations with clients and staff it quickly became apparent that this was not enforced. The one Service 3 client interviewed at this stage, Client 1, had already been in the project for *'six years'* and did not express any immediate interest in moving on. Staff described an inbuilt flexibility, and a prioritisation of client choice and wellbeing over strict adherence to rules:

> *'One individual has never left – he's been [in Service 3] ten years, and the consensus is that he won't be able to transition any further. This is as independent living a scheme as he's going to be able to manage'* (Management 2).

> *'Our remit is – they say is three years, but we've got tenants who have been here eight – and…I mean, we don't force people out. If they're not ready, they're not ready, you know?'* (Employee 1, Service 3).

Some key justifications for clients remaining within the service beyond the allotted three years were captured in a brief back-and-forth between Employee 1 and Client 1:

> ***Employee 1:*** *Some have left and gone through other circumstances – behavioural, that sort of stuff, you know – erm, or they've had a serious mental dip, that sort of thing. And sometimes they're just not ready to move on yet, so…yeah.*
> ***Client 1:*** *And some of us like it here. (laughs)*
> ***Employee 1:*** *(laughs) And I mean, that's good – people love staying here.*

When a client was ready to move on from Service 3, this would be negotiated and organised via the same multi-actor team and associated pathway as had shaped their service trajectory from hospital onwards:

> *'When they are ready for move on [from Service 3] erm, then again it's within the [pathway] and…the decision is made via the multidisciplinary team and consultation with a tenant'* (Management 2, management).

Within all three services, moving on was often a gradual process, with an official follow-up period bridging the gap between service and post-service engagement. According to staff interviewed, Service 1 were committed to providing *'three months of post-support'* (M2), Service 2 to *'about six weeks'* (E2, S2), and Service 3 to *'up to eight weeks or 11 weeks'* (E1, S1). This included convening with new support workers and other professionals and services to ensure that they had all relevant information:

> *'We'd have meetings then with the support workers there, so we'd hand over –we'd do a written handover report er, to the new support worker as well, erm, and the CPN then would have all of the care plans and risk assessments and all the filing systems'* (Employee 1, Service 3).

> *'I suppose it's a bit like when they first come in – so it's about getting them settled in, making sure their housing benefit has been sorted, er, address – making sure the address has been changed and anything else that crops up'* (Employee 2, Service 2).

After the post-support period for Service 2 was over, clients were referred to *'floating…tenancy support'*, with the idea being that the end of Service 2 support should

naturally overlap with this (E2, S2). This could be provided by Organisation X or by any other suitable local service.

Given the aforementioned complexities associated with moving on, it became apparent that this card would need to encompass a broad range of experiences. While the final card of the TTT is typically used exclusively to prompt discussion of the end of the service experience, findings from Stage One interviews indicated that a greater degree of flexibility was needed in this instance. It was therefore decided that clients would be encouraged to talk about any (past, present, or future) experiences of moving out of and/or between Organisation X services, to ensure that this did not exclude those with no plans to completely exit the service/organisation and that the diversity in service processes and structures was captured fully.

4.3 Initial Insights Into T-VALEX Creation

As discussed above, Stage One interviews provided valuable understanding of (what clients and staff considered to be) key touchpoints across the different stages of the customer experience. Not only were these essential for the development of the TTT and selection of appropriate images, but they were also informative in providing some initial insights into the likely facilitators of T-VALEX creation in the research context. Key factors highlighted as important by Stage One participants were broadly characterised as environmental, practical, and relational. Four cross-category themes were also identified and considered to be of particular interest in investigating the creation of T-VALEX: accessibility of support, achievements and skills, crisis management, and feeling at home.

This section will present findings pertaining to these cross-category themes and potential facilitators, exploring how environmental, practical, and relational elements of these manifested across the different services.

4.3.1 Accessibility of Support

The accessibility of practical and emotional support was widely considered by clients interviewed in Stage One to be an important aspect of their experience. It appeared that this could play a significant role in helping to mitigate initial apprehension or concerns, tying back in with the theme of early raised expectations setting the stage for later transformative

change (Rutherford et al., 2014; Wampold, 2015). For example, one participant described how staff helped them to overcome their initial difficulties settling in:

> *'They would tell me to come down and talk in the office. They always have time to talk to us'* (Client 5, Service 1).

From a practical perspective, this involved certain staffing arrangements to ensure that clients always had somebody to turn to:

> *'It's full-time support – there are staff here full-time'* (Client 4, Service 1).
>
> *'There's two staff on each shift. They're eight til eight shifts, more or less – eight til eight in the morning shift and eight til eight evening shift – so there's always somebody'* (Employee 1, Service 3).

Clients valued the relational and emotional implications of this availability, appreciating the fact that staff were *'always there'* (Client 5, Service 1) to talk to them and ease their anxieties:

> *'If I'm worried or get anxious – because I worry a lot – I've got a member of staff here to talk to'* (Client 4, Service 1).
>
> *'It's nice to know that there is somebody there'* (Client 1, Service 3).

This appeared to have a potentially transformative impact in terms of enabling clients to handle the requirements of everyday life:

> *'Without the staff, I don't think I could be on my own properly…I used to, years and years ago, but I've lost confidence and stuff now – with managing and budgeting money'* (Client 4, Service 1).

The accessibility of support can thus be viewed as a transformative element, enabling clients to meet their most fundamental needs and thus dramatically changing (or potentially even saving) their lives (e.g. Blocker and Barrios, 2015; Mick, 2012). However, some members of

staff appeared to view this constant availability in more of a negative, or at least potentially problematic, light, particularly when it came to the more hands-on approach of Service 1.

Concerns stemmed from both practical difficulties and matters of principle, highlighting a possible clash between the agency and empowerment Organisation X strove to promote (i.e. the intended service concept; Roth and Menor, 2003) and the realities of service use (i.e. realised service concept; Roth and Menor, 2003):

> *'Hostels have one major, er, headache for the manager before you've done any work, and that is that you have to have the rota covered, because it's a 24-hour service and you have to have two people on at all times'* (Management 1).

> *'[Service 1 is] a 24-hour staffed project, so…it's at risk of institutionalising somebody'* (Management 2).

Despite the focus on accessibility of support, some client accounts suggested that staff availability had actually declined in recent times, due to the overlapping influences of COVID-19 and staffing issues. The COVID-19 pandemic was identified as a potential cause of some members of staff *'just sit[ting] in their office'* (C5, S1) rather than opening themselves up to engagement with clients, and as a barrier to connecting with broader support networks due to *'stop[ping] people from meeting up'* (C2, S2). Client 2 and her support worker also acknowledged the broader impact of a recent drop in staff:

> *'I'm not having a go at the staff. I'm just saying you know, sometimes…you know, it's not – no fault of their own, but it is hard for them to deal with everybody at the same time, you know?'* (Client 2, Service 2).

> *'We don't have enough staff members – it's spread very thin'* (Client 2 support worker, Service 2).

Accessibility of support could also relate to connecting to broader support networks, which may be especially important in the context of limited staffing within the organisation itself. Management described connection with relevant external services as *'one of the key areas that need to be overcome for them to be able to sustain independent living'*, stating that one responsibility of Organisation X was *'to try and encourage those other stakeholders to fulfill*

their obligations' (M1). This again highlights the potential for staff to serve as apomediaries, transforming service outcomes through encouraging other agents to provide much-needed support (Johns and Davey, 2019).

One client also described the usefulness of external mental health support in direct reference to barriers to support within Organisation X itself:

> *'I find it really good to talk to [counsellor] and you know…no offence to the staff, but at the moment some of the idiots that they've got over in the houses…they're playing up and you know, they're keeping the staff on their toes, and you can't really expect them to drop everything and come and see you – and especially if you've got stuff on your mind…it's nice to be able to talk to somebody else about it'* (Client 2, Service 2).

Broader support networks were important in providing practical assistance. Organisation X were often described as taking on a role consistent with that of the core service provider in a transformative service network (Black and Gallan, 2015), for example placing clients in *'receivership'* so that an external party was responsible for allocating their money and they had *'nothing to worry about'* (C1, S3). This is consistent with the notion of a transformative service network. In addition to directly referring clients to other services, Organisation X staff could help to make these more accessible by providing physical accompaniment and/or acting as a mediator between clients and services/professionals (Johns and Davey, 2019, 2021). In terms of relationality, it appeared that the presence and emotional support of staff could help clients to overcome barriers to effective engagement with other services:

> *'Because obviously, with what happened to me…I know if I went to Women's Aid – personally, if I tell people what's happened to me, I know I'll be a bit of a mess, so I hope one of the staff will come with me'* (Client 5, Service 1).

Support could also come from clients' personal networks, maintenance of which may be facilitated or prohibited by the physical environment and facilities. Though not applicable to all, the ability to host visitors could be crucial for some clients' wellbeing, with service environments also accommodating for secondary customers (Fletcher-Brown et al., 2021; Rötzmeier-Keuper, 2020). One participant described this as a key advantage of having moved to a new, more spacious property (within the same service), tying in with her broader values and priorities:

> *'This move now…means I can get to see my family whenever I want to see them, and they can visit me…Because I'm very family-orientated'* (Client 2, Service 2).

Particularly in the context of the COVID pandemic, accessibility of support did not always necessitate physical proximity, as clients and staff also highlighted the potential benefits of access to virtual communications and assistance. This had both environmental components, pertaining to the availability of necessary facilities in private and shared spaces (e.g. computers, WiFi), and practical components, involving skill-building in terms of digital proficiency (Tinder Foundation, 2016). Access to digital support was associated with the mitigation of isolation, thus helping to compensate for social support deficits and promote consumer welfare (e.g. Rosenbaum et al., 2007):

> *'I like to go on Facebook and talk to friends, and Messenger and talk to people… So now – that would help me, if I got a laptop and I can FaceTime people, which will also help…and you know, I won't feel so isolated away from people then. I'll still be able to speak to people and have more contact with people'* (Client 2, Service 2).

While clients interviewed at this stage were not able to comment on accessibility of support in the post-service period, staff suggested that it was important for guidance and assistance to remain at hand as people transitioned from one residence to another. This included ensuring that new support systems overlapped with the old:

> *'It was just to make sure that they were settled in their new flats, so I visited for a couple of weeks, back and forth, but we then started to withdraw, and the new support worker took over'* (Employee 1, Service 3).

The topic of accessibility of support was a common theme, with the one exception of the preservice stage, with discussions noting some environmental but primarily practical and relational elements. This was widely credited with helping clients to settle in and enhancing the value of the core service offering (practical and emotional support). In keeping with T-VALEX, the impact of accessibility extended into broader personal and service networks (Blocker and Barrios, 2015; Helkkula, Kelleher, and Pihlström, 2012), both in terms of staff availability to accompany and assist clients in engaging with others and in providing an alternative source of support when service staff were unavailable.

There were three areas in which findings on this subject provided insights into possible prohibitors of T-VALEX creation. Two of these are closely related and consistent with one another, pertaining to the respective influences of COVID-19 and staffing issues on accessibility of support both within and outwith Organisation X. The third, however, provides an alternative and somewhat contradictory perspective. This came specifically and solely from the accounts of the two managers interviewed, who expressed a concern that the constant availability of staff to offer advice and assistance could actually have negative long-term effects by promoting dependency and institutionalisation (Burghardt, 2013; Huber et al., 2020; Khan, 2010; Roulstone, Thomas, and Balderston, 2011). To what extent, if at all, this is borne out in client accounts will be addressed in subsequent chapters, along with a broader consideration of balancing interdependencies with promoting independence.

4.3.2 Achievements and Skills

As previously found within the Organisation X tenancy support service (Spence, 2021), Stage One findings provided an early indication that *Building Skills and Resources* was a key site of T-VALEX creation within the three residential services studied. Achievements and skills discussed here were not only practical but also relational and could be facilitated by aspects of the physical environment. As previously mentioned, these were often discussed in terms of promoting increased independence over time, highlighting the potentially transformative impact of both essential and additional life skills (Fu, Tanyatanaboon, and Lehto, 2015). These skill-building efforts appeared to compensate for some of the challenges associated with vulnerability, pertaining to insufficient resources or resource integration capacities (Anderson et al., 2013; Borg, Boulet, and Bragge, 2019; Virlée, van Riel, and Hammedi, 2020).

From first entering into a service, staff emphasised how they believed clients should be playing a leading role in setting their own goals and intentions, also making the most of their extant capabilities. The client role could thus be described as that of a co-designer, drawing on their lived experiences and personal priorities to carve out a path forward (Sanders and Stappers, 2008; Steen et al., 2011):

> *'The tenant has a lot of input into their support plan goals or the goals that they want to achieve'* (Employee 1, Service 3).

This focus on personal priorities was also mentioned by some clients. For example, Client 1 (Service 3) described tenancy support meetings in which she was asked about her goals going forward, relating to immediate needs (e.g. medication adjustments) and to longer-term plans and intentions (e.g. to *'be moved on'*). At the same time, management recognised the value of taking a more proactive approach in certain areas in order to help clients to develop certain skills and knowledge, putting staff's operant resources to use for example in handling financial matters (Constantin and Lusch, 1994; McColl-Kennedy et al., 2012; Vargo and Lusch, 2008):

> *'Where staff have got expertise in things like that, I think that's genuinely valuable to clients…they need to understand the system, see where the client is, and it is a problem-solving, skill-based initiative – so I think where we do stuff like that, that's great'* (Management 1).

While environmental aspects were not mentioned a great deal in relation to this topic specifically, one exception was the value of outdoor space, specifically the communal gardens of Services 2 and 3. As well as providing spaces for relaxing and socialising, these provided opportunities for learning and utilising new skills and working towards concrete, observable achievements, as individuals and/or a group:

> *'We actually got a salad out of [growing vegetables]. We had a lovely potato salad…and of course all the tenants were really proud because they grew it themselves. So [they had] that sense of achievement as well'* (Employee 1, Service 3).

For those with substance use issues, abstaining from alcohol and/or drugs was a major achievement, which could also serve as a gateway to unlocking further opportunities for skill development and personal fulfilment. Sobriety could thus be conceptualised as both an outcome and a precursor to transformative change:

> *'They might be able to get me some voluntary work…if I sort my head out and I can get off, like, using the drugs'* (Client 4, Service 2).

The idea of sobriety being motivated (at least in part) by promised access to desirable outcomes, particularly greater independence, is associated with the treatment-first approach

to integrated housing and addiction treatment (Crisis, 2010; Johnsen and Teixeira, 2010; Tsemberis, 2010). The association between being 'clean' and being capable of independent living is not generally disputed and was clear in multiple participants' accounts, in one client's case enabling her to move on to a new property that was more aligned with her personal priorities, cutting ties with networks of drug users and devoting greater attention to family and personal development (see 4.2.1).

The key point of controversy pertains to mandating sobriety as a prerequisite for service access, which some have suggested results in neglecting those in greatest need (e.g. Miller, 2018; NHS Confederation, 2012; Ramesh, 2012). While findings suggested that the lack of mandated sobriety did not discourage many clients from pursuing and reaping the benefits of this, the reported persistence of substance abuse within some of the services could have detrimental effects on some of those seeking to change (e.g. Hughes et al., 2010), as will later be discussed in relation to peer support and social influences.

Overall, achievements and skills emerged as a central theme at this stage and, as anticipated, appeared likely to be an important factor in the cocreation of T-VALEX. While the majority of these insights were captured in the card of *Building Skills and Resources,* this theme was also prevalent throughout other areas , particularly *Assessment and Goal Setting,* and appeared to play a significant role in determining if and how clients were able to move on.

Building on the theme of independence vs. interdependence, staff emphasised the centrality of client input, granting them individual agency and control (Anderson, Nasr, and Rayburn, 2018; Safran, 2003; Sangiorgi et al., 2019), whilst also acknowledging the value of staff expertise for helping clients to navigate broader service systems and replenish depleted resources (Fletcher-Brown et al., 2021; Johns and Davey, 2019, 2021). This potential tension was not explicitly recognised by clients at this stage. The relationship between client input and staff expertise will be discussed in relation to Stage Two findings, exploring if both can be considered facilitators of T-VALEX creation and if there is an optimal balance between the two.

4.3.3 Conflict and Crisis Management

One aspect of CX that was relatively novel, in relation to previous applications of the TTT, was the perceived importance of averting and mitigating both individual and interpersonal issues. From the perspective of staff, this was a consideration that was present from the

moment a client entered into a service, setting out rules and regulations which they were obliged to follow for the duration of their residency:

> *'As a landlord, we have to be really clear with regards to what er, erm, the obligations are of the residents, and that's to make sure that they don't bring any illegal substances into the premises, they don't use any substances in the premises, and they don't…sell, buy, or deal substances in the premises'* (Management 2).

> *'We have got a drugs policy, and they all have a copy of that when they sign their tenancy or licence agreement – they've signed up and they've signed the drugs policy'* (Employee 2, Service 2).

In Services 1 and 2, these considerations were also incorporated into the process of assessment and goal setting, seeking to protect clients and minimise the risk of harm:

> *'If an individual is engaged in harmful behaviours, erm, such as misusing substances or er, other kind of behaviours, we would look to map those out really, into a risk assessment to keep them safe. But also there may be other considerations in terms of risk that we would need to flag erm, while working with that individual, for stakeholders and staff'* (Management 2).

> *'We'd go through kind of risks. We'd ask them are there any risks that we need to be aware of and then they would inform us if there are risks'* (Employee 2, Service 2).

Such risk assessments were not mentioned in relation to Service 3, perhaps because of the continuity of care element meaning that this information was already held by clients' ongoing support teams and could easily be passed on to Organisation X staff (NHS Primary Care and Community Services, 2010; Zeitler et al., 2020). Clients across all three services did not directly mention the risk assessment process, but did describe how staff acted to reduce the likelihood of harm, with one stating she believed that this had fundamentally changed and ultimately saved her life:

> *'If I'm too depressed in my bedroom and they know, like before when they took my tablets off me, they'll come and check on me every quarter of an hour, to see I've not done anything to try and kill myself…Because if it wasn't like that, anyone could just kill themselves'* (Client 5, Service 1).

Related to the previously discussed subject of accessibility of support, clients appeared to value staff responsiveness all the more in addressing their personal and interpersonal issues prior to reaching a crisis point, for example providing *'extra support'* during *'mental dips'* (E1, S3) and managing the social servicescape to address sources of negative affect (Tombs and McColl-Kennedy, 2003):

> *'I had this one girl that came up every day and knocked on my door every day at two o'clock – knocked on everybody's door upstairs at two o'clock – and er, I mentioned it to the new manager, and he's been here for a week, and he's just stopped it completely…Brilliant, like. He's only been here a week'* (Client 5, Service 1).

In addition to seeking to mitigate the potential for clients to do harm to themselves, staff also recognised a responsibility to help protect clients from being harmed by others, both within and outside of the projects. This pertained to different aspects of vulnerability (e.g. Commuri and Ekici, 2008; Smith and Cooper-Martin, 1997), including to exploitation *'by their peers, a relative, or somebody else'* (M1) and to indirect harm resulting from environmental factors, for example being exposed to others' drug use:

> *'We've had issues with people injecting and unfortunately, because they've been injecting maybe in the kitchen…[or in] a communal lounge…we've had to act on that, because it's a massive risk to others'* (Employee 2, Service 2).

In keeping with this, one client recalled the detrimental impact of being surrounded by substance use whilst trying to recover and move forward:

> *'You know, we all said oh yeah, we're gonna move, and none of us have had the bottle to do it…we're all comfortable around each other drinking and taking drugs, so…you know, you don't really want to move then. But now I'm not doing it. I don't want to be around people like that'* (Client 2, Service 2).

While drug use was (in accordance with legal requirements) prohibited across all three services, only Service 1 disallowed alcohol consumption. This was notable for Service 2, in which clients by definition had addiction issues. Under conventional models of housing support, such individuals would typically have to demonstrate and maintain complete

sobriety (Crisis, 2010; Johnsen and Teixera, 2010; Tsemberis, 2010), with the permittance of alcohol being recognised as an unusual feature of Service 2:

> *'I think what's unique about this project is that people are allowed to drink'* (Employee 2, Service 2).

More broadly, Organisation X were said to take a *'harm reduction approach'*, seeking to offer support rather than simply *'looking to evict or sanction an individual'* (M2) on the basis of their substance use behaviours. In accordance with the Housing First model of unconditional support, clients were not made to stop drinking and/or using drugs (Bretherton and Pleace, 2015; Housing First Europe Hub, 2016; Tsemberis, 2010; Turning Point Scotland, 2010). Instead, Organisation X and especially Service 2 sought to *'support people to manage [their substance use]'*, where appropriate *'signpost[ing] them to agencies that have got more expertise in that area'* (E2, S2). Conversely, despite the focus on client self-determination where possible, there were occasions where staff deemed it necessary to step in and actively stop clients from acting in a way believed to be harmful to themselves and/or others:

> *'You have to put that er, more libertarian view to one side and become somewhat interventionist, because we've got to protect people's health and wellbeing and observe our health and safety'* (Management 1).

In cases where illegal substances were confiscated, staff emphasised that eviction was not considered their first or a desirable option, suggesting that this would come only after attempts to offer intensified support. Connection to broader support networks was again highly relevant here, with staff looking at *'bring[ing] in other services'* (E2, S2) to provide more specialised substance use treatment and support. Where formal warnings of eviction were issued, engagement with alcohol and drugs support services was a typical condition of remaining within Organisation X. Furthermore, these connections could be drawn on in the last resort scenario of eviction:

> *'There are times where we've had to evict somebody, but it's mostly around risks to others…We've still – I suppose still kind of worked with other services to make sure they're going somewhere, you know?'* (Employee 2, Service 2).

Overall, staff appeared to believe that the nature of conflict and crisis management was an important aspect of the Organisation X approach, particularly in relation to substance use in Service 2. While this did not come up as often in client interviews, some did highlight the value of staff proactivity and responsiveness in averting or mitigating issues, potentially transforming their service experiences and/or even their lives. Clients' perceptions of Organisation X's roles in conflict and crisis management will be further explored in the subsequent chapter, looking specifically at how this relates to key themes of connectedness and responsiveness.

4.3.4 Feeling at Home

Unlike in the tenancy support service study (Spence, 2021), where the service was delivered primarily within clients' own homes, the main study services actually constituted clients' homes, typically temporarily but often for a period of several years. This was reflected in how clients talked about the services, in terms of both the servicescape and their relationships with other clients and staff. The importance of making clients feel comfortable and settled through environmental touchpoints and practical support was also acknowledged by staff, including management:

> *'It's really important that we always keep in mind to start that that's the person's home'* (Management 1).

Participant accounts alluded to the roles of the staff and other clients in helping new clients to feel at home from arrival onwards. As previously discussed, it was at this stage that clients were assigned specific points of contact within and, if appropriate, outside of Organisation X. Maintaining regular communication was also considered to be valuable for the adjustment period:

> *'We would…[let] them settle in for a few days, have that contact with them nearly every day, and arrange – get them a support worker, arrange a meeting with them for their first support session, and then from that support session we'd look at their needs assessment, the goals, maybe the things they want to work towards'* (Employee 2, Service 2).

Clients and staff both referred to difficulties settling in and how these were mitigated, with client accounts typically focusing more on the relational side while staff also mentioned the roles of practical support and connections to broader support networks:

> *'I had a problem settling in, but they soon made me welcome here, and it's like one big family here, you know'* (Client 5, Service 1).
>
> *'We would provide emotional and practical support, and we would also work with maybe partner agencies to get them to have a wraparound service'* (Employee 2, Service 2).

The perception of service clients and staff as forming *'one big family'* (C5, S1) was shared by a few clients at this stage. Just as 'actual' family members can offer transformative contributions in contexts of vulnerability (Battistella-Lima, Veludo-de-Oliveira, and Barki, 2020), the development of quasi-families was associated with positive transformation and with a greater sense of identity and purpose. This could also include assignation of specific familial roles, which could be indicative both of dependency on others and of how others depended on them:

> *'[The staff are] like my parents'* (Client 3, Service 2).
>
> *'By them helping me, I try and help the others. They call me Mother Hen'* (Client 5, Service 1).

In addition to the power of specific relationships and associated support, participants suggested that the extent to which clients were made to feel at home was in part of a product of their broader environments, comprising social as well as physical components (de Salles Canfield and Basso, 2017; Parker and Heapy, 2006; Rosenbaum and Smallwood, 2011). A potential tension between feeling at home and the organisation's role in client protection arose in relation to rules. Although Organisation X staff expressed an intention to avoid creating an oppressively rule-based environment in any of the three services, this was nevertheless identified as a major downside of Service 1 by one client at this stage,

suggesting a degree of difference between intended and realised service concepts (Roth and Menor, 2003; Wani, Malhotra, and Clark, 2021):

> *'I think the kind of environments that erm, gives people the best chance is not one that feels like it's bound by heaps and heaps of rules and institutional behaviours'* (Management 1).

> *'There were too many rules for me. I've been in care all my life, and all I've had is rules thrown at me and – I can't do the rules'* (Client 2, Service 2).

Furthermore, one comment of the above manager suggested that he also believed feeling at home to be less of a feature of Service 1 than of the other two projects:

> *'I think…the clients in (Service 2) and the (Service 3) will feel more of a sense of this being their own home and feeling, er, more settled'* (Management 1).

In spite of this, some clients in Service 1 did express a strong sense of feeling at home, which did appear to be positively associated with a transformation in their lives and perspectives. This was especially the case for Client 5 (Service 1). In addition to the above comments on settling in and familial style relationships, this participant also described a reluctance to move on quickly and a desire to maintain communication with the service after she did, suggesting a strong sense of place attachment (e.g. Baker and Brocato, 2006; Rosenbaum et al., 2007):

> *'When it comes to me moving on, I'll miss this place. I'll probably come back and visit the staff'* (Client 5, Service 1).

Feeling at home was therefore emergent as an overarching cross-category theme and a possible facilitator of T-VALEX creation. This will be explored in the subsequent chapter in relation to experiences of active participation, community, and individualisation.

4.4 Chapter Summary

This chapter presented findings from Stage One unstructured interviews with clients and staff across the three Organisation X residential services. The primary purpose of this part of the data collection activity was to inform development of the research instrument to be used in

the main study i.e. adapting the TTT to the study context. Consequently, the focus of this chapter has been upon exploring RQ4: *'How (if at all) can a service design methodology, the Trajectory Touchpoint Technique, be effectively adapted for the context of integrated housing and mental health services?'* The full-service experience, pre, during and post has been considered with data emerging helping to inform the development of the template analysis utilised in the analysis of Stage Two data. Preliminary findings pertaining to RQ1 (*'What are the key elements and processes underlying the cocreation of T-VALEX across multilevel domains?'*) have also been discussed. The next chapter, Chapter Five, picks up the main data collection activity, Stage Two, and seeks to address the four research questions underpinning this thesis.

Chapter Five: Stage Two Findings and Discussion

5.1 Introduction

This chapter pertains to the findings of Stage Two data collection, i.e. narrative elicitation using the adapted TTT. In presenting and discussing these findings, all four research questions are addressed (restated below):

RQ1. What are the key elements and processes underlying the cocreation of T-VALEX across multilevel domains?

RQ2. How is T-VALEX creation influenced by therapeutic resources and servicescapes, extending beyond the customer/provider dyad?

RQ3. How can meso-level forces help to minimise and alleviate vulnerability perceptions throughout a full service experience, particularly for multiply marginalised consumers?

RQ4. How (if at all) can a service design methodology, the Trajectory Touchpoint Technique, be effectively adapted for the context of integrated housing and mental health services?

In response to RQ1, evidence of transformative value creation specifically is first detailed, exploring the concept of a turning point and its applicability here and also looking at instances in which little or no transformative value creation appears to have occurred (Section 5.2). Specific elements and processes associated with transformation in the focal provider domain are then identified and discussed in relation to the role of Organisation X, in both facilitating (Section 5.3) and prohibiting (Section 5.4) T-VALEX creation. The following two sections focus specifically on the influence of therapeutic resources and servicescapes (RQ2), first identifying relational and restorative resources in the focal provider servicescape (Section 5.5) before moving on to consider resources accessed via clients' broader lifeworlds (Section 5.6.1) and across service ecosystems (Section 5.6.2). Findings regarding the relationship between T-VALEX creation, place attachment, and behavioural intentions are subsequently summarised (Section 5.7), shedding further light on therapeutic and transformative processes and outcomes.

The potential for meso-level forces to minimise and alleviate vulnerability perceptions (RQ3) is discussed within each of the aforementioned subsections, in relation to processes of T-VALEX creation and identified therapeutic resources. Finally, findings are used to assess the

utility of the TTT in the research context (RQ4) and identify areas for development, discussing the role of the adapted TTT in narrative elicitation (Section 5.81), inferences based on explicit participant feedback (Section 5.8.2), and issues encountered during data collection (5.8.3).

Findings at this stage are based on interviews with 20 clients from across the three services researched: 10 in Service 1, six in Service 2, and four in Service 3. (For a full breakdown of participants in terms of service and basic demographic information, see Chapter 3, Section 3.4.5). As in the previous chapter, clients are referred to by an assigned number, followed by the service they were in at the time of interview. As some clients had been in multiple services, this will also be specified where appropriate (e.g. Client 3, Service 2 (formerly Service 1).

5.2 Evidence of Transformation

The first stage in exploring key constituents and processes underlying T-VALEX cocreation was to establish if this transformative process had in fact occurred (Blocker and Barrios, 2015; Dean and Indrianti, 2020; Parsons et al., 2021). Following on from the earlier tenancy support service study (Spence, 2021), the concept of a turning point marking the onset of transformative value creation was also of interest here. Thus, before looking at the causes and mitigators of transformation, this section will first set out some key evidence pertaining to transformation, turning points, and the lack thereof for particular clients and circumstances. Findings are discussed in relation to extant literature on transformative value and VALEX, including TSR and value cocreation literature more broadly, with implications for the conceptualisation and creation of T-VALEX fully explicated in Chapter Six (Section 6.2).

Without being asked, many clients credited Organisation X services with profoundly changing their lives, describing dramatic eudaimonic wellbeing increases associated with transformative value creation (Bauer, McAdams, and Pals, 2008; Blocker and Barrios, 2015; Taiminen, Taiminen, and Munnukka, 2020). Furthermore, processes of value cocreation often involved the construction of global meanings, with profound changes to how participants viewed themselves and their place in the world (Blocker and Barrios, 2015; Fu, Tanyatanaboon, and Lehto, 2015; Park, 2010). Transformational processes ascribed to Organisation X included giving clients *'a purpose'* (C9, S3), making them feel like *'a different person'* (C4, S2), and *'giving [them their] life back'* (C11, S1).

Such profound instances of transformation were associated with acute suffering in the preservice period, highlighting the particular significance of transformative value creation in contexts of vulnerability and disadvantage (Blocker and Barrios, 2015; Mick, 2012). Some explicitly stated that they believed moving into the properties may have saved their lives, for example:

> *'Before I moved in here, I was…either being taken down off the top of a car park or I'd taken an overdose at least once a week. Since I've been here, I've done it once'* (Client 8, Service 3).

> *'If I didn't have the facilities here and the resources that they offer…I'd be dead…they've changed my life, basically'* (Client 1, Service 1).

While these were not identifiable in all accounts, several clients' narratives included specific perceived turning points, at which perspective transformation occurred and after which transformative value creation began (Bellaert et al., 2022; Blocker and Barrios, 2015; Mezirow, 1978a). The notion of a specific turning point sheds light on the underexplored temporal dimension of TSR (Anderson and Ostrom, 2015), identifying when and how value creation becomes transformative. This also contributes directly towards mental health and addiction literature, within which the concept of a recovery turning point has been widely used and heavily debated (e.g. Bellaert et al., 2022; Jordan, 2020; Kerr, Deane, and Crowe, 2020).

Turning points in the tenancy support service study were widely associated with the earliest of the core service stages, most commonly occurring within first meetings between clients and staff (Spence, 2021). Similarly, some participants in this study situated turning points within the Arrival stage of their Organisation X service experience, highlighting the impact of first impressions on expectations and the narrative (re)framing of experience (Kerr, Deane, and Crowe, 2020; Rutherford et al., 2014; Spanjol et al., 2015; Wampold, 2015; Weisman and Nathanson, 1985):

> *'I didn't expect it, because I'd never been to these places before, so I didn't know. When I came here, they welcomed me right away. They introduced everybody and asked what do I need'* (Client 10, Service 2).

Initial fears and reluctance could also be allayed through the (re)configuration of broader support networks, facilitating transformative value creation in third-party spheres (Johns and Davey, 2019, 2021):

> *'They did amazing things with me. Because, when I came here, I was terrified, so they helped me loads and they rang the GP when I came here – I had a GP, but I'd never do it, and they deal with it for me'* (Client 10, Service 2).

However, there was significantly more variation here than in the tenancy support service study (Spence, 2021), both in the stage at which turning points occurred and in whether they occurred at all. Some of this variation may be attributed to individual differences spanning personal histories, service trajectories, and the nature and extent of consumer vulnerabilities (Bellaert et al., 2022; Helkkula, Kelleher, and Pihlström, 2012; Wünderlich et al., 2020). For example, those who actively chose to enter Organisation X services in pursuit of higher-order goals (Kokins, Straujuma, and Lapina, 2021) could experience turning points prior to any real engagement with service actors, as the decision to engage signified orientation towards and initiation of recovery (Bellaert et al., 2022; Best et al., 2016; Mezirow, 1978a):

> *'I'd been in hospital quite a long time…Coming down here was a big step'* (Client 9, Service 3).

Conversely, participant accounts suggested that turning points could also occur somewhat later in the service experience than in the tenancy support service context (Spence, 2021). This is perhaps unsurprising given the importance of relationship-building to transformative value creation (Blocker and Barrios, 2015) and the complexity of these social servicescapes, including countless interactions and influences outside of a dyadic client/provider relationship. Consequently, it could take longer to build trust and rapport with staff and/or other service users, delaying the pursuit and provision of appropriate (emotional and instrumental) support:

> *'It takes me a while to open up, erm…to people, and trust people. That's my biggest thing – because I've trusted people in the past and…They've sort of damaged that trust in some way…My trust is a big issue – and, like, I tell the staff here most things, but then at the same time I can feel myself still holding back on some things'* (Client 8, Service 3).

Moreover, the majority of participants in this study suffered from severe mental health and/or addiction issues, the impact of which continued to be felt even after meeting their most salient physical and interpersonal needs (Barnes et al., 2020; Nasr and Fisk, 2018; Rosenbaum et al., 2007). Where acute vulnerability alleviation was more of a gradual process, perceived turning points could occur further down the line, when incremental progress culminated in a moment of perspective transformation (Fu, Tanyatanaboon, and Lehto, 2015).

These later-stage turning points may not be marked by direct interaction with a service or services, but rather by a personal achievement representing progress and self-mastery (Kerr, Deane, and Crowe, 2020). For example, one participant described a major milestone related to their sobriety that could easily be dismissed as insignificant by an outside observer, relating to cooking and eating:

> *'The first time I cooked a meal in many months was the other night, and it was absolutely lovely… I've only just started back to eating again, due to the alcoholism and the er, drug abuse'* (Client 14, Service 2).

Transformative value creation was evidenced across all three services. However, there were a few clients in Service 1 whose accounts indicated that this had not occurred for them, and in fact that they believed being in the service was prohibiting them from moving forward with their lives. In the most extreme instance of this, one client expressed an urgent need to get away from what he perceived as a highly institutional and unfriendly environment:

> *'I can't stay here. Like, when I stay here, like, I am in a detention – I am in a prison'* (Client 20, Service 1).

This client was not the only participant to compare Service 1 to a prison; parallels were also drawn by a member of Organisation X management (see section 2.4.4) and, in a more positive sense, by a client with a history of incarceration (Client 12 – discussed below). For Client 20 specifically, this association stemmed from a combination of isolation and a lack of control over his housing trajectory, exacerbating preexisting vulnerabilities through prohibiting the development of both community and independence (Begun et al., 2018; Gerull, 2023; Kaufman, 2022):

> *'I like to talk with different cultures, different people...But not like this place – no one talks to each other'* (Client 20, Service 1).

> *'When I spoke to a housing officer, she said well, you are single, you are healthy, you are – ok, doesn't matter I am healthy, I am single – I need a house. I need to work. You know, I swear to God, sometimes I feel so embarrassed when I go to job centre and she ask me why are you not working? I don't know – I don't know what to say, you know?'* (Client 20, Service 1).

Another client similarly described being desperate to find somewhere new to live, in this case specifically due to aspects of the social servicescape. Most significantly, noise disruptions were keeping him up at night and causing him to miss college classes, compromising his long-term goals (Pizam and Tasci, 2019):

> *'If I find another place better than this hostel, okay, of course – yes, I need to go and travel, like, to school – but I just – I need a quiet place, you know?'* (Client 19, Service 1).

The third example in this category was not so overwhelmingly negative, as this participant did have several positive things to say about the service and described multiple areas in which value cocreation had taken place. Nevertheless, the extent to which positive long-term change could occur was impeded by restrictions on her freedom and control, reinforcing the need for transformative interventions to promote consumer agency (Centre for Homelessness Impact, 2020; Dean and Indrianti, 2020):

> *'My aim to move on is to get my own property – not shared, and just…you know, try and live a normal life. I know I am living a normal life, but I don't know, it's just – living in somewhere like here is not…you want your own space. I know I've got my own space in my room, but it's not the same'* (Client 13, Service 1).

In addition to a general desire to have her own space and live 'a normal life', this participant also described specific things that she missed during her time within Service 1, such as *'having [her] kids over and cooking for them'*. In conjunction with having one's *'own space'*, such activities were associated with a sense of achievement and with feeling at home,

reinforcing the relevance of these themes to understanding T-VALEX creation (see Section 4.3). The potential for service design to overcome or reduce such barriers will be addressed in subsequent sections, first identifying specific prohibitors of T-VALEX creation (Section 5.4) and, in the following chapter, proposing specific opportunities for innovation (Section 6.4.1). At the same time, there are limitations inherent in residing in a hostel/rapid rehousing project (Crisis, 2018; Shelter, 2021), potentially precluding transformative value creation when these conflict with individual goals, priorities, and/or trajectories (Guillemot, Dyen, and Tamaro, 2022; Johns and Davey, 2019).

Client 18 was similarly largely positive about Service 1, but a lack or insufficiency of transformative value creation in his case was alluded to by his reported recidivism since first entering into the service (Soyer, 2014):

> *'I've been here, like, about three times now…I've always ended up back in prison'* (Client 18, Service 1).

While it is widely acknowledged that recovery is not linear, such instances of recidivism do appear at odds with virtuous trajectories and thus with transformative value creation (Blocker and Barrios, 2015; Fu, Tanyatanaboon, and Lehto, 2015). This also represented a different type of 'moving on' than was portrayed in Stage 1 interviews, capturing a complex service experience characterised by alternating progression towards and regression away from higher-order goals (Hamilton and Price, 2019; Kokins, Straujuma, and Lapina, 2021). The capacity to advance beyond this stage may be compromised by processes of institutionalisation (Huber et al., 2020; Khan, 2010), as was directly suggested by another client with a history of incarceration:

> *'So you're, like, in a routine and you do, like, get a bit institutionalised – do you know what I mean? That's what happens…and then, when you come out then a lot of men can't cope on their own, in a flat on their own. It's as simple as that – could end up dead, do you know what I mean – or – or evicted, you know, for missing bills, etcetera'* (Client 12, Service 1).

In identifying the challenges faced by those re-entering society after time in prison (and potentially similarly institutional settings), this participant provided a clear picture of how incarceration came to be seen as almost desirable, as he was accustomed to the environment

and experienced greater vulnerability on the outside (Clemmer, 1958; Ganapathy, 2018; Rosenbaum et al., 2007):

> *'In prison, like, you know what I mean – you think of it as rough, but…I'm a big boy, I can handle myself, do you know what I mean, so it doesn't fucking bother me…[and] it's like you've got the support there as well'* (Client 12, Service 1)

While management staff highlighted concerns about the environment of Service 1 promoting institutionalisation, both Client 18 and Client 12 emphasised the dangers of being left without necessary support, in terms of increasing the likelihood of recidivism (Metraux, Roman, and Cho, 2007; Soyer, 2014) and potentially putting lives at risk:

> *'Before I had my last sentence, I had a council flat…[and] I stayed clean for three years, like, just on my prescriptions, and, like, I started going out with this other girl and I ended up back into crack, cocaine addiction…[and] started committing crime and all that – and I ended up back in prison for, like, another four years'* (Client 18, Service 1).

> *'If you put me in a flat at the minute, I'd be dead within a couple of weeks, do you know what I mean? I'm pretty sure'* (Client 12, Service 1)

Service 1 could thus be positioned as an appropriate midpoint between the extremes of incarceration and independent living, possessing some of the perceived advantages of the prison environment without many of the negative aspects and facilitating gradual (re)adjustment to 'normal' life (Ganapathy, 2018; Metraux, Roman, and Cho, 2007). The ongoing provision of external structure and routine was particularly valued, offering a much-needed sense of stability and security (Guillemot, Dyen, and Tamaro, 2022; Kelly, Lamont, and Brunero, 2010):

> *'It's something we all need. When you don't have routine, it's chaotic and…chaotic, as we all know, is not good, is it?'* (Client 12, Service 1).

Thus, for Client 12, the more restrictive and regulated environment of Service 1 actually appeared to discourage recidivism and promote transformative value creation, mitigating against the risk factors of social exclusion and material deprivation (Baldry et al., 2006;

Khan, 2010; Kurbin and Stewart, 2006). Despite having been recalled to prison twice, Client 12 displayed evidence of a gradual but fundamental shift in his overall outlook and trajectory (Blocker and Barrios, 2015; Fu, Tanyatanaboon, and Lehto, 2015), suggesting that the conditions of Service 1 facilitated post-incarceration transformation (Maruna and Farrall, 2004). This participant's description of his intention to soon move on to Service 2 was indicative of significantly increased independence and capacity for personal control, but also of an ongoing need for accessible and responsive support (Burt et al., 2004; Corporation for Supportive Housing, 1996; Metraux, Roman, and Cho, 2007):

> *'It's similar to here, but you've got your freedom. It's not always on top – you're allowed visits, etcetera – you know, like, you're not allowed that here. You just get on with your own shit really – but it's not like being out completely on a flat of your own, because there no-one comes to check on – whereas these do once or twice a week come to check on you'* (Client 12, Service 1).

Nevertheless, Client 18 did continue to reoffend while receiving the support of Service 1, suggesting an inability to break away from dominant and destructive behavioural patterns (Blocker and Barrios, 2015; Emirbayer and Mische, 1998; Ganapathy, 2018). This may be partially attributable to service failings. For example, insufficient efforts to build on skills and self-efficacy may leave clients unable to move on and perpetuate their views of themselves as 'revolving-door prisoners' (Ganapathy, 2018, p.164), who are inherently helpless and/or beyond help (Graffam and Hardcastle, 2007; Khan, 2010). This again ties in with the general issue of obstacles to skill development and use, which will be further discussed later in this chapter (see Section 5.4.3) but may be especially damaging for those with histories of incarceration struggling to break away from the prison system (Graffam and Hardcastle, 2007; Scott, 2004; Soyer, 2014).

Transformative value creation could also be prohibited or delayed by a lack of intrinsic motivation to change, a factor which is largely outside of provider control (Edvardsson et al., 2014; McIntosh and McKeganey, 2000). This motivation may be increased by age and experience, including instances of recidivism or relapse helping clients to recognise what they wanted and what was at stake (Kerr, Deane, and Crowe, 2020; Patterson et al., 2013). Despite his history of reoffending, at the time of our conversation Client 18 evidenced reappraisal of his old perspective and a projective future orientation (Blocker and Barrios,

2015; Emirbayer and Mische, 1998; Mezirow, 1978a), suggesting that he could be in the earlier stages of transformative value creation:

> *'I didn't really care back then as much as I do now, like…I don't wanna lose my room here, because I don't wanna be living on the streets – and I wanna try and sort my head and sort my life out'* (Client 18, Service 1).

Profoundly negative experiences could thus contribute towards a desire for transformation (Bellaert et al., 2022; Kerr, Deane, and Crowe, 2020). Whether or not this came to fruition appeared heavily dependent on support received in the aftermath, in terms of shaping everyday quality of life and expectations for the future. Though it has long been documented that incarceration is often viewed as preferable to life on the streets, causing some to seek arrest in order to access basic amenities (e.g. Khan, 2010), these findings suggested that meeting essential physical needs may be insufficient if individuals believe that their other (e.g. social support) needs would be better met in a prison setting (Rosenbaum et al., 2007). This came through in Client 12's account of life in Service 1 during the COVID-19 lockdowns, within which period he described the service environment as *'worse than prison'* and recalled actively planning to reoffend:

> *'I was planning for myself to go back into prison, because it was – we would come in here and we were basically told go straight to your bedroom and just stay in'* (Client 12, Service 1).

The final participant in this category was not a long-term resident at any of the projects but had been staying in the Service 1 emergency bed *'back and forth'* (C17, S1) for the past month at the time of interview. Client 17 had nothing negative to say about the technical quality of the service and described instances of habitual value creation (Blocker and Barrios, 2015; Purcărea, Gheorghe, and Petrescu, 2013), for example providing a *'hot meal'* and helping him to *'get hold of a doctor's [surgery]'*. However, there was no evidence of transformative value creation specifically, with his overall perspective and situation in life seemingly remaining unchanged and his focus remaining on day-to-day survival rather than long-term planning (Blocker and Barrios, 2015; Emirbayer and Mische, 1998; Fu, Tanyatanaboon, and Lehto, 2015).

Multiple possible contributors to the lack of transformative value creation were raised throughout the course of the interview. Unlike most other participants, Client 17 appeared

fairly ambivalent towards Service 1 employees, suggesting that he had not had a lot of contact with staff and expressing some uncertainty about who (if anyone) was supposed to be supporting him:

> *'They're ok…I don't know who my [support] worker is or whether I've got a worker, because I'm in the emergency bed'* (Client 17, Service 1).

Though not on bad terms with any members of staff, Client 17's account suggested that he had not established any form of relational attachment or commercial friendship and felt no strong connection to either the service environment or its representatives (Albrecht and Adelman, 1984; Rosenbaum et al., 2006, 2007). These weak ties may additionally have restricted the capacity of staff to provide individualised and responsive support, factors which are key to customer-centred care (Fottler et al., 2000; Lee, 2004) and which were identified as key facilitators of T-VALEX creation in this context (see sections 5.3.4 and 5.3.5). The emergency bed service appeared well-suited to meeting immediate physical needs but did not offer holistic value propositions or seek to tailor service delivery to broader goals (Blocker and Barrios, 2015; Fottler et al., 2000; Kokins, Straujuma, and Lapina, 2021). Moreover, the short-term nature of service provision did not provide the stability needed to focus on long-term eudaimonic outcomes (Nasr and Fisk, 2018):

> *'Because I'm only in the emergency bed, I haven't, like, actually spoke to them about anything like [building skills and resources]…I'm just trying to focus on getting myself a place to live at the moment, you know?'* (Client 17, Service 1).

While impressions of the emergency bed were based solely on individual client narratives, as this was not identified as important by any of the staff interviewed in Stage 1, from Client 17's account it appeared that the full range of activities and entertainment on offer to long-term clients were not available to emergency bed residents. He stated that he had not *'managed to see…exactly what [Organisation X] can offer'* and did not appear even implicitly aware of the broader values and purpose of the organisation (Arvidsson, 2011; Lee, 2004). This manifested in a lack of attention to skill development and limited opportunities for building community or communitas (Blocker and Barrios, 2015; Kozinets, 2002), resulting in a service experience which was largely characterised by inactivity and isolation:

> *'I've just been sitting in my room…it's pretty boring around here'* (Client 17, Service 1).

In summary, there was substantial evidence of T-VALEX creation across the three services. As in the tenancy support service context (Spence, 2021), these were often marked (in clients' accounts) by the sense of a turning point; however, these turning points did not always occur within the initial stages of the service experience and were often less clear cut than those previously identified. Furthermore, not all clients interviewed described transformative value creation. Of the 20 Stage Two participants, there were four who indicated that this had not or may not have occurred, all of whom were in Service 1 and one of whom was in the Service 1 emergency bed.

Multiple possible causes were identified for the apparent lack of transformative value creation in these cases, including the institutional environment (Huber et al., 2020; Khan, 2010), negative aspects of the social servicescape (Tombs and McColl-Kennedy, 2003), perceived lack of agency (Centre for Homelessness Impact, 2020; Dean and Indrianti, 2020), and (in the case of the emergency bed client) a lack of consistent and comprehensive support (Blocker and Barrios, 2015). The following two sections will look more in-depth at specific facilitators and prohibitors of T-VALEX creation.

5.3 T-VALEX Facilitators in the Focal Provider Domain

Findings highlighted a variety of factors contributing towards and detracting from transformative positive change throughout a full service experience. The most significant factors according to clients' accounts can be summarised in five key concepts: active participation, community, connectedness, individualisation, and responsiveness. While these factors took on varied forms and levels of significance, findings suggested that all needed to be present in at least one domain (individual, focal provider, or service ecosystem) for T-VALEX creation to occur. Table 5.1 summarises key ways in which the five facilitators were promoted or prohibited by the focal service provider, distinguishing between factors specific to this domain and those also affected by broader ecosystem and/or individual lifeworld contexts.

	Focal Provider Domain Only	Focal Provider and Other Domain(s)
Active Participation	• Ability to exercise control over (therapeutic) servicescape. • Service rules and regulations (potentially limiting agency).	• Responsibility for others (individual, focal provider). • Opportunities for skill building and application (focal provider, service ecosystem). • Peer support (focal provider, service ecosystem).
Community	• (In)consistency of staff. • Relationships: familial-style relationships and roles. • Service design: physical and social cues re: 'feeling welcome'.	• Connections rooted in shared experiences (all domains). • Integration of family members into service community (individual, focal provider). • Opportunities for peer support (focal provider, service ecosystem).
Connectedness	N/A	• Integration with preexisting networks (all domains). • Crisis management procedures (focal provider, service ecosystem). • Smooth transition between services (focal provider, service ecosystem).
Individualisation	• Service practices tailored to client goals.	• Alignment between timelines (all domains). • Individual variation re: social support deficits and needs (individual, focal provider).
Responsiveness	• Availability of (all-hours) support. • Crisis and conflict management. • Culture of care and respect. • Perceived staff attributes (e.g. approachable, friendly). • Safety and security procedures.	• Flexibility (individual, focal provider). • Proximity to peers (individual, focal provider). • Risk assessment (individual, focal provider). • Ease of re-entry (focal provider, service ecosystem). • Practical support (focal provider, service ecosystem). • Regular check-ins (focal provider, service ecosystem).

Table 5.1: Summary of T-VALEX facilitators and associated factors in the focal provider domain

Each of the five facilitators is discussed in more detail below, also building on preliminary ideas proposed on the basis of Stage One findings (Chapter Four, Section 4.3).

5.3.1 Active Participation

It appeared essential for clients to be actively engaged in value cocreation behaviours (VCCB) associated with wellbeing promotion and vulnerability alleviation (Roy et al., 2020; Yi and Gong, 2013). At the same time, the acute state of vulnerability in which most entered the services meant that they were often initially ill-equipped to engage meaningfully in customer participation behaviour (Anderson et al., 2013; Yi and Gong, 2013). Organisation X staff thus played an important role not only directly assisting with resource integration but helping clients to develop their own resource integration capabilities (Virlée, van Riel, and Hammedi, 2020). This related to developing specific competencies and capabilities, as well as more generally to aiding clients with confidence building:

> *'I'm able to pay my own bills – I go to the shop, and I pay my bills, and I come out with a big smile thinking I did that on my own'* (Client 4, Service 2).

> *'They've helped me out – building up confidence, going places and stuff on my own where I wouldn't have before'* (Client 1, Service 1)

Clients also engaged in customer citizenship behaviour in the form of helping others in similar or worse circumstances, which could help to provide a sense of *'purpose'* (C9, S3) associated with customer delight and transformative value creation (Barnes et al., 2020; Parsons et al., 2021). There was a sense of mutuality and reciprocity here, with participants recognising that they were doing good for others whilst also improving their personal sense of wellbeing (Held, 2005; Lawrence and Maitlis, 2012):

> *'Like, there's another project with here and one of the workers goes out there, and she asked the manager if it's ok if I go with her, so I go up and I help…and they know that that…helps me as well'* (Client 8, Service 3).

Additionally, physical and social servicescapes could facilitate positive engagement with the outdoors, which benefitted mental health through providing a sense of both pride and personal wellbeing (Jackson et al., 2020; Rosenbaum et al., 2020). Involvement in gardening and decoration of outdoor areas could provide clients with a sense of *'achievement'* (C8, S3) and serve as a worthwhile distraction from unhealthy coping mechanisms:

> *'I like gardening. It's – you know, when you plant something and you look after it, when it grows, you think oh, I'm proud of that – because I've done it myself'* (Client 9, Service 1).

> *'When I'd do [gardening activities], it took my mind off drinking or, you know, everything else'* (Client 8, Service 3).

> *'[Plants] help a lot with the mental side of things…Look after them and they'll reward you'* (Client 2, Service 2).

Active involvement in shaping their own environments could also contribute towards clients feeling at home in a service, making servicescapes feel more *'homely'* (C4, S2) and like *'their own space'* (C3, S2). Particularly in Services 2 and 3, where clients had full flats of their own rather than solely rooms, the importance of personal space could extend far beyond simple shelter or even comfort, being viewed as a physical representation of clients' narrative identities and progress along personal trajectories (Kerr, Deane, and Crowe, 2020; Sandberg et al., 2021). Client-led decoration and maintenance efforts were thus highly valued, enabling people to *'take pride'* (C8, S3) in both processes and outcomes. Ostensibly minor developments could take on special significance when related to higher-order goals and values (Kokins, Straujuma, and Lapina, 2021; Sandberg et al., 2021):

> *'Little things like that – little goals – that's my little goal, is just to make it more like a home, more like it's my – a real life, a proper life'* (Client 4, Service 2).

As already touched upon in the previous chapter (Section 4.2.4), the ability to reach and maintain desired levels of cleanliness and decoration depended upon clients having an appropriate amount of space for their needs, which was neither restrictive nor overwhelming. This could make a big difference in terms of place attachment (e.g. Baker and Brocato, 2006; Rosenbaum et al., 2007), as in the case of one client who described how she came to feel at home in Service 3 only after moving into a larger property:

> *'I didn't sort of do [the old flat] up. I didn't hang any pictures, I didn't…you know, I didn't do it that nice. Well, I really couldn't, to be honest. (laughs) But it was just always a mess – always cluttered. So, like, when I moved here, I've actually done it up nice and it's not cluttered, it's not messy…you know, it's really tidy. So…you know, I feel home'* (Client 8, Service 3).

On the flip side, insufficient active participation (from clients' own perspectives) could be associated with reduced value creation and negative effects on wellbeing. One client who was previously identified as one of those for whom transformative value creation did not appear to have taken place (see section 5.2), described a desire to move on to her own accommodation as motivated in part by the accompanying responsibilities, which she believed would be *'better for [her] mental health'* (C13, S1). The capacity to exercise control over everyday tasks may be associated with a sense of individual empowerment conducive to recovery (Bovaird, 2007; Dunston et al., 2009; HSE, 2017), highlighting the value of active customer engagement in defining and creating wellbeing (Dean and Indrianti, 2020; McColl-Kennedy et al., 2017b; Sweeney et al., 2015).

Overall, the role of active participation in facilitating T-VALEX creation was associated with several key factors: the specific guidance of staff, the general environment of Organisation X services enabling clients to feel more confident and capable, and the capacity to exercise control over their environment (individual living space and shared outdoor space). This was, however, less applicable to clients in Service 1 than in the other two services, raising issues which will again be addressed in subsequent sections.

5.3.2 Community

Concepts of community, family, and home were highly prevalent across client narratives. As already came through in Stage 1 interviews (see section 4.3.4), expectation formation and initial value creation were heavily influenced by physical and social servicescape cues, specifically by the extent to which these helped clients to 'feel at home' in the early core service stages (de Salles Canfield and Basso, 2017; Parker and Heapy, 2006; Rosenbaum and Smallwood, 2011). On entering a service environment, first impressions and expectations for engagement developed largely on the basis of initial sensory reactions (Holbrook and Hirschman, 1982; Pizam and Tasci, 2019), for better or for worse:

> *'Just the atmosphere was so different, and welcoming, and, like, lovely. I think I sort of felt safe here'* (Client 8, Service 3).

> *'I just came to the front door, and I thought ooh, this is a bit dreary!'* (Client 16, Service 3).

To an even greater extent than in Stage One interviews, family metaphors were prevalent across narratives. While previous research on community and quasi-family units amongst homeless populations has primarily focused on street homeless populations (e.g. Hill and Stamey, 1990; Smith, 2008), participant accounts in this study highlighted the potential for these to emerge within services and to encompass members of staff:

> *'I class every member of staff here as my family and everybody who lives here as my family'* (Client 11, Service 1).
>
> *'It's like a little bit of a family…Because we all, like, look out for one another here'* (Client 12, Service 1).

This sense of found family could aid clients in overcoming any initial apprehension, anxiety, and/or shame associated with moving into one of the services:

> *'At the age of 50 – or 53… you don't think you're ever gonna end up in a place like this. But I have, and…you know, it's just like one big family here'* (Client 11, Service 1).
>
> *'It was a bit daunting at first, but it became like one big family'* (Client 2, Service 2).

Identification with quasi-families could be associated with certain dependencies but also with a sense of moral responsibility towards others, identified as a defining characteristic of a service community (Muñiz and O'Guinn, 2001) and as conducive to transformative value creation (Blocker and Barrios, 2015). The balance struck between caring for others in the community and being cared for varied across individuals and, in some instances, over a time. In a few cases, this was described in terms of specific familial roles, with two (female) clients positioning themselves as parental figures and one (male) client adopting the role of a dependent:

> *'I'm the matriarch of the building'* (Client 2, Service 2).
>
> *'They call me Mother Hen here. Number one, because I'm the oldest, but number two, I'm – I'm so caring'* (Client 11, Service 1).

> *'In a certain way, they've become like my mum and dad basically, some of the staff here'* (Client 1, Service 1)

Staff could also help to facilitate positive engagement with service and other communities through a sort of tough love approach, which seemed to be appreciated by those who described it. This included emphasising responsibility towards others, promoting a sense of purpose transcending individual-level concerns (Blocker and Barrios, 2015; Deegan, 1988; Kelly, Lamont, and Brunero, 2010). For example, one participant described how her support worker encouraged her to be there for another client, who had been through a recent trauma:

> *'[Support worker] said to me, [name], I'm not being funny, but you need to be there to get [other client] through it – don't think about yourself. And that hit home then. Although it would seem cruel words, I shouldn't think of what happens to me – [client] needs me now and I am the closest one to her, and I need to be her support to get her through what I've been through'* (Client 11, Service 1).

The value of adopting a more forceful approach was highlighted by one client, who explained how his engagement with another service had been cut short due to them not making the effort to keep in touch and him not having the wherewithal to take initiative:

> *'I've not heard any more about it – and, like, with me, because I'm chaotic with my drugs and stuff, if somebody's not on to me, it doesn't get fucking done, do you know what I mean?'* (Client 12, Service 1).

Building relationships and community across meso-level spheres thus directly contributed towards T-VALEX creation, generating meaningful change to client wellbeing and everyday life practices (Blocker and Barrios, 2015; Heinonen et al., 2010). Value creation also unfolded within and influenced preexisting personal networks (Helkkula, Kelleher, and Pihlström, 2012; Llewellyn, Verity, and Wallace, 2020). While some clients treated the service experience as an opportunity to build new and unconventional models of support, others were more focused on preserving or restoring key relationships in their lives, valuing family cohesiveness and the ability to provide for children and other dependents (Ellickson, 1990; Sarvis, 2017).

The value of community support could also extend to clients' family members, suggesting that secondary customers can benefit from strong peer-to-peer (as well as provider/user) relationships (Amine and Gatfoui, 2019; Fletcher-Brown et al., 2020; Lam and Bianchi, 2019; Leino, 2017; Rötzmeier-Keuper, 2020):

> *'Some of them are very supportive to me and my family…by looking after me and my family. You know, whether it be financially or erm, or some of the other elements – you know, [looking after] my granddaughter'* (Client 14, Service 2).

Overall, community proved a key factor for alleviating vulnerability and promoting wellbeing, with transformative CX characterised by successful efforts to build, strengthen, and/or integrate micro- and meso-level connections. While staff involvement was crucial, feeling comfortable with and supported by others in the service could also make a dramatic difference in terms of how clients felt about their service experiences and their ability to progress towards a desired future (Abney et al., 2017; Blocker and Barrios, 2015). This ties in with the potential for peer support to be better utilised throughout the customer experience, which will be further explored in subsequent sections.

5.3.3 Individualisation

While increased independence was a common goal and outcome, some clients entered Organisation X services with a high level of independence which they strove to maintain, while others envisioned preferred futures including ongoing dependence on service actors. Thus, despite the emergence of common themes, findings highlighted the dangers of overreliance on standardised elements and processes, which required adaptation to each individual's circumstances, needs, and resources (Anderson, Nasr, and Rayburn, 2018; Brown and Wyatt, 2015; Brown, 2008; Fisk, 2015; Rust and Huang, 2014). Individualisation therefore emerged a central facilitator of T-VALEX creation.

Consistent with the ideology underpinning patient-centred care (Anderson, Nasr, and Rayburn, 2018), participants' accounts highlighted the benefits of individualised service provision, with set practices and procedures being adapted in accordance with clients' personal insights and desires. This was emphasised particularly in relation to the first and final stages of engagement with Organisation X, reducing the risk of misalignment between service and customer timelines (van Weeghel et al., 2019). Rather than suggesting one

universal framework for a transformative service experience, narratives highlighted the value of allowing clients consistent input into the structure of their own service trajectories, beginning with whether or not they wished to undertake this specific one:

> *'They gave me a choice – either to stay where I am, or come here, like I did…and asked, like, what are my goals'* (Client 3, Service 2).

After arriving at a service, it was also up to clients to determine the amount and type of help that was appropriate for them. This began with questions asked very early on to establish what a client hoped to get out of the service and the kind of support they required, encouraging an evaluative-projective orientation but leaving it open to individuals to determine their own 'virtuous trajectories' (Blocker and Barrios, 2015; Emirbayer and Mische, 1998):

> *'They introduced everybody and asked what do I need'* (Client 10, Service 2).

As previously mentioned, there was also a great deal of individual variation in the perceived optimal balance between independence and interdependence, with some clients preferring to be largely self-sufficient while others felt reassured by the ability to access support across all areas:

> *'I'm sort of totally…self-reliant, self-independent, independent, but the staff are there for any of the tenants, residents, to sort of go to and say look, can I have this letter or this or that'* (Client 15, Service 3).

> *'They would do anything, practically'* (Client 10, Service 2).

While some have suggested that highly vulnerable groups cannot always know and express what is best for them (Dean and Indrianti, 2020; Nakata and Weidner, 2012), for the most part these clients felt strongly about their own needs and desires, with T-VALEX creation contingent upon these being taken seriously and embedded into service processes (Anderson, Nasr, and Rayburn, 2018; Breidbach, Antons, and Salge, 2016; Danaher and Gallan, 2016; Steen et al., 2011). The need for flexibility to account for individual variation is consistent with a constructivist and human-centred approach to service design (Dorst and Dijkhuis,

1995; Schön, 1983), highlighting the limitations of a standardised approach (Anderson, Nasr, and Rayburn, 2018; Brown and Wyatt, 2015; Fisk, 2015; Galarza-Winton et al., 2013; Kimbell, 2011; Lee and Chen, 2009; Zeithaml, Parasuraman, and Berry, 1985). For example, vulnerability perceptions could arise in response to feeling forced into situations of dependency, as previously discussed in relation to Service 1 rules and regulations (see Section 4.3.4) but also at times in the context of apparent 'progress' towards independent living, where this led to overlooked support needs and/or exacerbated isolation (Hughes et al., 2010; Lee et al., 1999; Rötzmeier-Keuper, 2020).

Regardless of which direction their choices took, engagement through active decision making was associated with the replenishment of behavioural resources, empowering clients to take control over their own trajectories and timelines (Anderson, Nasr, and Rayburn, 2018; Fletcher-Brown et al., 2020; Saffran, 2003; Sangiorgi et al., 2019). This was apparent in how participants described processes of goal setting and goal pursuit, which generated an often-newfound sense of personal agency (Burghardt, 2013; Chaplin and John, 2010; Hill and Sharma, 2020; Roulstone, Thomas, and Balderston, 2011):

> *'I sort of say, like…where I wanna go, what I wanna do'* (Client 8, Service 3)

> *'They did do a care plan and that with me, and everything I do now is, like…what I wanna do. It's not, like, what everyone else wants me to do'* (Client 9, Service 3).

Individualisation also proved highly important in the context of moving on. Rather than relying on provider-imposed definitions, it was important to participants that they were able to define 'housing readiness' (Crisis, 2010) for themselves and to continue to move at their own pace (van Weeghel et al., 2019), with several expressing concerns about being moved into (or forced to find) properties of their own before they were ready. These possibilities were associated with anticipated value destruction (Danaher and Gallan, 2016), threatening their wellbeing or even their lives:

> *'At least there is a little bit of support [in supported living project], whereas you get a flat of your own, no-one fucking visits, and – do you know what I mean? The next time someone visits, it might be fucking two months, do you know what I mean – and the only reason they're alerting police is cause they can smell from the fucking letterbox, do you know what I mean?'* (Client 12, Service 1)

Client accounts were indicative of significant variation in terms of (actual and preferred) service duration, stages, and endpoint. Staff were praised for working to clients' personal timescales, assuring them that they would not be forced to move on before they felt ready (van Weeghel et al., 2019). This entailed taking things one step at a time, rather than overwhelming people by forcing them to think about next steps when they were still trying to adjust to their current circumstances and work on personal development in the areas important to them:

> *'I'm just getting used to being, you know, in a flat…with me, I need reassurance that it's not gonna happen quick and they're not gonna chuck me out in the deep end'* (Client 9, Service 3).

> *'They all agree that it's something for the future – right now, I just need to focus on…me and myself for the minute'* (Client 6, Service 1)

For some clients in Services 2 and 3, the ability to make the decision not to move on at all was also valued. Similar to evidence of the capacity for consumers living in poverty to 'feel well-off' (Dean and Indrianti, 2020, p.678), not all participants aspired to normative standards of adult living, with several feeling that all of their wellbeing needs were met by Organisation X and the unconventional support structure they had established (Dean and Indrianti, 2020; Ellickson, 1990; Littman, 2021). While for some moving into their own property was an overarching higher-order goal (Kokins, Straujuma, and Lapina, 2021), others valued the ability to maintain their current living situation indefinitely, reflecting high levels of attachment to the service environment (Littman, 2021; Rosenbaum et al., 2007):

> *'I think now this is the last stop…I'm gonna try and make this my home now'* (Client 4, Service 2).

In summary, the adaptation of Organisation X service practices to individual circumstances and goals proved key to T-VALEX creation, particularly during the early and end stages of the service experience. It was clear that transformation meant different things to different people, with some striving for total independence while others felt at home and fulfilled remaining within the service environment. A 'one size fits all' approach, though perhaps more convenient and resource-efficient (Flynn, Schroeder, and Sakakibara, 1995; Trajković

and Milošević, 2018), therefore appeared inappropriate for this context. In addition to emerging as a facilitator of value creation in its own right, individualisation was also necessary to devote appropriate resources to each of the other four facilitators, the practical and theoretical implications of which will be discussed in the following chapter.

5.3.4 Responsiveness

Building on the theme of accessibility of support identified in Stage 1 interviews (see section 4.3.1), clients frequently stressed how important it was that staff were responsive to them, their needs, and their issues. In the focal provider context, impressions of responsiveness developed due to a combination of formal service practices and perceived availability of relational resources (Blocker and Barrios, 2015; Rosenbaum et al., 2020). Soon after arrival, clients were informed of Organisation X policies regarding staff availability, potentially helping to raise expectations for their unfolding service experiences (Rutherford et al., 2014; Wampold, 2015):

> *'They just told me we'll have er, 24-hour er, care and support. If you need to speak to anyone in the middle of the night…you can phone downstairs, or you come down'* (Client 16, Service 1).

Furthermore, where clients had experienced other residential services these were often unfavourably compared to Organisation X in terms of the level of care and attention provided. The emergence of T-VALEX in these instances may be understood in terms of the expectancy-disconfirmation framework typically applied to understand customer delight (Oliver, Rust, and Varki, 1997; Zou, Yim, and Chan, 2022), additionally demonstrating the potential for processes of value creation to be shaped by past service experiences (Helkkula, Kelleher, and Pihlström, 2012):

> *'The other hostel was always busy…But [here] they always try and make the time, and they'll phone me if they don't hear from me. They phone me every day or message every day and check – check in to see if I'm alright, if I need anything'* (Client 4, Service 2)

> *'I've been in [other organisation's hostels], and they don't do anything like that…in the night, you can't talk to anyone'* (Client 16, Service 3).

Others similarly described how help was always *'only a phone call away'* (C16, S1) and how staff were always willing to *'guide [them] in any way they can'* (C1, S1), further demonstrating flexibility in the nature and timing of support. This contributed towards a hospitable service environment characterised by fluid and adaptable service processes, which have been associated with greater transformational capacities than a more fixed and rigid system (Boenigk et al., 2020; Kuppelwieser and Finsterwalder, 2016).

While official policies and procedures were important, the potentially transformative effect of responsiveness also hinged on clients viewing staff support as a genuinely valuable resource. This could be encouraged through initial interactions and observations, for example if staff were seen to be *'really approachable'* (C9, S1), and developed over time as repeated positive engagements led to strengthening of relational ties. Reliable access to staff support could have a transformative effect on client wellbeing and behaviour, including in their most emotionally vulnerable moments:

> *'[In the past] I would just lock myself away and be depressed and self-harm myself, or try and kill myself, but all the staff here – you can go down or ring down and just ask them come up or you come down to the office, and they listen to you and give you advice and the support that you need'* (Client 11, Service 1)

Thus, the ability to confide in caring, responsive, and well-informed individuals could play a fundamental role in helping clients to deal with potential mental health crises, fulfilling a crucial harm reduction function (Benston, 2015; Cox, Hayter, and Ruane, 2010; Laudet and White, 2010). More broadly, as demonstrated in the context of the COVID-19 pandemic, the always-important role of client/employee interactions in generating customer delight proved especially important for promoting eudaimonic wellbeing in a context of personal crisis (Barnes et al., 2020). This was also apparent in how some clients described the impact of staff more proactively reaching out to them, with regular check-ins contributing towards enhanced feelings of belonging and self-esteem (Barnes et al., 2020; Fiske, 2008):

> *'If I've felt really low and I don't wanna come down and talk to them…they've come up to my flat erm, to check on me if they haven't seen me, or if they know I'm feeling low they'll come up for a chat'* (Client 8, Service 3)

> *'They always check on me, so they care about me'* (Client 10, Service 2).

Responsiveness to distress thus extended beyond clients' actual words or observable behaviours, as it could be equally important for staff to pick up on more subtle cues including absences and omissions. Being alert to these signals necessitated a person-centred approach to care and support (Anderson, Nasr, and Rayburn, 2018; Breidbach, Antons, and Salge, 2016; Danaher and Gallan, 2016), within which staff were knowledgeable not only about the general issues they were dealing with but also about clients' specific circumstances and characteristics (Azzari and Mitchell, 2021; Fu, Tanyatanaboon, and Lehto, 2015; Jordan, 2020).

The ultimate outcome of this attentiveness was that clients felt heard and understood, promoting confidence in staff and increasing the likelihood of honest self-disclosure. This could be crucial in their most vulnerable moments, offering comfort and protection whilst still respecting client autonomy (Burghardt, 2013; Liegghio, 2013; Roulstone, Thomas, and Balderston, 2011):

> *'Because they're taking the time, and it's not like – because before I've rung someone and said look, I'm just done, I don't want to live anymore, I'm just done – and it's automatically been oh, let's phone the police, even though I'm not saying I'm gonna do something'* (Client 8, Service 3).

> *'I don't feel like I wanna lock myself away so much now. I feel like I've got somebody to talk to and somebody that'll understand and that will listen'* (Client 11, Service 1).

> *'If I'm down, I'll tell them. If anything happens to me, I'll tell them. They're very wise'* (Client 10, Service 2).

In Services 2 and 3, responsiveness was described especially in relation to clients' personally assigned support workers, with whom they typically built the strongest emotional relationship (Mulder et al., 2015; Parsons et al., 2021) and who took on primary responsibility for meeting their needs:

> *'When I have these ideas in my head, I get up – I won't sleep and then I have horrible thoughts in my head. I get up and I knock on the door – knock on the staff door, and my support worker then, [name] – he works nights anyway, but he helps me then to get things into perspective, you know?'* (Client 16, Service 3).

At the same time, responsiveness and attentiveness to client needs were commonly ascribed to service personnel as a whole, suggesting that this was embedded in organisational culture and associated service practices (Blocker and Barrios, 2015; Lee, 2004):

> *'All the staff is lovely here. They all support you – you know, if you've got a problem, you've just got to go down and they'll be up'* (Client 11, Service 1).

> *'In [service building], they always try and make the time, and they'll phone me if they don't hear from me. They phone me every day, or message me every day, and check – check in to see if I'm alright, if I need anything'* (Client 4, Service 2).

Additionally, individualisation and flexibility could be highly important in working towards the development of life skills conducive to T-VALEX creation and vulnerability alleviation (Anderson et al., 2013; Borg, Boulet, and Bragge, 2019; Fu, Tanyatanaboon, and Lehto, 2015; Virlée, van Riel, and Hammedi, 2020). This included the willingness of staff to fit in around clients' often chaotic lifestyles and fluctuating states of wellbeing (Deegan, 1988; van Weeghel et al., 2019), embracing spontaneity where appropriate:

> *'I could book in, you know, er, a support session sort of thing to do things…but I like the sort of spontaneous ones, because then I haven't got time to be like oh, I don't wanna do that now'* (Client 8, Service 3).

Mutual responsiveness was also a key feature of the strongest peer-to-peer relationships, including checking in with each other and at times raising the alarm that the other was in crisis:

> *'[Client] comes in my room to see if I'm ok. I check on her – like, before, she tried to take an overdose and she had to go to hospital to be sorted out'* (Client 11, Service 1).

The responsiveness of Organisation X staff could also extend to periods when people were not actually living within their services, providing a possible source of comfort and stability during periods of recidivism and relapse (Deegan, 1988; Laudet and White, 2010; van

Weeghel et al., 2019). One participant for example described how easy it was to re-enter their services after a period away:

> *'I spoke to…one of the members of staff [and they] assured me that they'd take me back on when I came out [of prison]'* (Client 14, Service 2).

Responsiveness also applied to practical everyday issues. For example, staff were described as quick to notice and offer assistance if clients were struggling with home maintenance. This could be beneficial for meeting both physical and psychological needs, alleviating felt deprivation (Blocker et al., 2013) and enabling clients to maintain a standard of living conducive to personal transformation (see section 5.3.1):

> *'If I have, like, low mood or with my foot now, I haven't been able to, like, tidy up or – like, my dishes – I haven't done my dishes – staff will come up and see how I am, and they'll help'* (Client 8, Service 3).

> *'If I need help, I ask the staff, see – if I need help keeping my flat clean, or…cooking'* (Client 9, Service 3).

As previously discussed in relation to Stage One findings, responsiveness and accessibility of support could mean different things in the context of the COVID-19 pandemic, with government regulations limiting and sometimes entirely prohibiting face-to-face interactions (Morgan, Watkins, and James, 2023). Conversely, even in these circumstances staff made the effort to maintain strong and stable relationships characterised by regular contact (Barnes et al., 2020; Fiske, 2008), be this in person and/or over the phone. These points of interaction could be a small but significant source of hope in a context of struggle and isolation (Deegan, 1988; van Weeghel et al., 2019):

> *'I had COVID here as well and we had to self-isolate in our room, and that was very difficult for me because I suffer depression…but they still came and checked on me, like, you know? But (support worker) is an absolute star, I tell you what – she's one of the ones especially that brightens my day up'* (Client 11, Service 1).

In summary, it appeared that responsiveness was key to everyday emotional and practical

support, including regular check-ins, making clients feel heard and understood, and responding to individual needs as and when they arose. This contributed towards T-VALEX creation facilitating progress towards transformative goals and alleviating impacts of vulnerability and instances of regression.

5.4 T-VALEX Prohibitors in the Focal Provider Domain

In addition to the restrictive influence of general insufficiencies in one or more of the abovementioned facilitators, findings elucidated a number of specific factors precluding or limiting T-VALEX creation in this context. These functioned through reducing or counteracting potentially transformative elements and processes, and in some cases through active value destruction.

Main prohibitive influences are summarised as the effects of understaffing; limited access to early intervention and peer support; obstacles to skill development and use; and negative aspects of the physical servicescape. Evidence pertaining to each of these is summarised below, while potential remedies in the form of opportunities for innovation are presented in the subsequent chapter (Section 6.7.1).

Factor Prohibiting T-VALEX Creation	**Related T-VALEX Facilitators**
Effects of understaffing.	Community, connectedness, responsiveness.
Limited access to early intervention and peer support.	Active participation, community.
Obstacles to skill development and use.	Active participation, individualisation.
Negative aspects of physical servicescape.	Active participation, community.

Table 5.2: Overview of T-VALEX prohibitors and related facilitators

5.4.1 Effects of Understaffing

While clients' sentiments towards staff were overwhelmingly positive, some effects of understaffing were felt throughout core service aspects and (potentially) transformational elements of the service experience. In particular, staff shortages constrained T-VALEX

creation through reducing service actors' capacity for responsiveness and limiting opportunities for community building. Some clients described how staff numbers had decreased over the time that they had been within the services, resulting in reduced capacity for all-hours emotional support:

> *'There's not enough staff here like before. When I was first here, they were up until half past five in the morning. Now I have to go over there to have a chat'* (Client 7, Service 2).

Understaffing could limit opportunities for social interaction and community building (Begun et al., 2018; Rosenbaum et al., 2007; Rötzmeier-Keuper, 2020), resulting in reduced group activities outside of service buildings:

> *'They just haven't got the staff. It's sad. Before, we used to go to the cinema and stuff like that. We used to go constantly. But now we – we don't go nowhere'* (Client 7, Service 2).

Some clients described how staff numbers had decreased over the time that they had been within the services, resulting in reduced capacity for all-hours emotional support:

> *'There's not enough staff here like before. When I was first here, they were up until half past five in the morning. Now I have to go over there to have a chat'* (Client 7, Service 2).

In addition to compromising the responsiveness of staff within Organisation X, understaffing could also detract from connectedness as staff were less often available to accompany clients to outside activities and appointments, and thus to adopt an apomediary role (Johns and Davey, 2019; Storbacka et al., 2016):

> *'I think there's only four staff in the office, and there's eight of us here, so things overlap. If one of the staff has got to go somewhere with one of the other residents, then one of us gets cancelled out'* (Client 2, Service 2).

Furthermore, understaffing led to increased reliance on agency staff, who were perceived by some clients as hostile, uncaring, and/or ill-equipped for addressing their issues. Contrasting with the strong therapeutic relationships (Luborsky, 1976; van Os et al., 2019) many described with Organisation X support workers, there was an apparent lack of relationship building between clients and agency staff, who some described as appearing incompetent and/or disinterested:

> *'Every time they come in, I'm trying to buzz to come in and they're like, who are you…and they're thinking I'm coming in to…burgle the place…what's your name and what room are you in, you know, they follow me up to my room. Like, I've lived here for two years – but they don't know me, do you know what I mean?'* (Client 12, Service 1).

> *'The agencies, they don't really give a shit, do they? They just come in, get money, and [do] bugger all'* (Client 9, Service 3).

Consequently, clients often lacked trust in these individuals to meet their expectations and needs (Gallagher et al., 2010; Gwinner, Gremler, and Bitner, 1998). In the cases of the two participants quoted above, their perception of agency staff as lacking the care and requisite knowledge for the job resulted in a reluctance to disclose their issues, potentially hindering processes of recovery and growth (Llewellyn, Verity, and Wallace, 2020; van Weeghel et al., 2019):

> *'I don't wanna tell anyone – if I'm having a bad day and I tell them why, they say oh, I've never heard of that before. I'm like, oh alright, well, what the hell are you doing in the service?'* (Client 9, Service 3).

> *'So how they're meant to support me and help me, I don't know – so that's a load of shit, you know what I mean?'* (Client 12, Service 1).

Another client stated that they believed agency staff were *'all [doing] their best'*, but that permanent staff were nevertheless a superior source of support:

> *'The ones that actually work here – I suppose because they've been doing it longer, they know how to support people more'* (Client 11, Service 1).

This same client referred to a specific instance during the COVID-19 pandemic in which security staff had been called in to take on the role of support workers, which she had found to be uncomfortable and inappropriate. The discomfort felt around this appeared to stem partially from the discrepancy between her existing perception of the service and associations generated by the presence of these staff, which could make this appear less of a healing community and more of a punitive, institutional environment (Ajeen et al., 2022; Rosenbaum et al., 2020):

> *'I just thought to myself, like – one of them was 19 and I thought to myself, what's going on here, you know? Like, if there'd been trouble here – like, it's never been really bad trouble here, and they're sending security guards in to be a support'* (Client 11, Service 1).

Understaffing within the focal provider could also have knock-on effects on client experiences across broader service ecosystems through undermining the power of connectedness, as staff were less often available to accompany clients to outside activities and appointments and thus to adopt an apomediary role (Johns and Davey, 2019; Storbacka et al., 2016):

> *'I think there's only four staff in the office, and there's eight of us here, so things overlap. If one of the staff has got to go somewhere with one of the other residents, then one of us gets cancelled out'* (Client 2, Service 2).

In summary, issues of understaffing proved potentially prohibitive of T-VALEX creation through multiple mechanisms, threatening both the emergence of specific facilitators and the overall impression of a therapeutic servicescape (Rosenbaum et al., 2020). Specifically, this reduced staff capacity for responsiveness and opportunities to build community with other residents whilst also compromising some of the benefits of connectedness to broader service ecosystems. Furthermore, the associated reliance upon agency staff seemed in some cases to result in an unappealing social servicescape discouraging approach behaviours, with negative implications for clients' affective and cognitive responses (Mehrabian and Russell, 1974).

While reducing understaffing itself is outside of the remit of this study (and inevitably heavily influenced by macrolevel factors), meso-level interventions can play an important

role in mitigating against these negative outcomes. Specific strategies are proposed and discussed in the subsequent chapter (Section 6.7.1.1).

5.4.2 Limited Opportunities for Peer Support and Early Intervention

Although community was a prominent theme across client narratives (see section 5.3.2), analysis also revealed multiple instances in which T-VALEX creation was inhibited by a lack of appropriate social support at key touchpoints, sometimes resulting in escalation or exacerbation of (mental health and other) issues (Laudet and White, 2010; Monson and Thurley, 2011; Rosenbaum et al., 2007). Consistent with the importance of community dynamics for promoting or prohibiting transformation (Blocker and Barrios, 2015; Tsiotsou and Diehl, 2022), isolation emerged as an enduring issue for some of those previously identified as not appearing to experience T-VALEX creation (see section 5.2): Clients 17, 19, and 20 (all Service 1). Client 20 described the environment of Service 1 as *'[making] you feel lonely'*, contrasting this with his earlier experience of staying in a house with other asylum seekers:

> *'When I was [an] asylum [seeker], I would stay in a house – we were six people. We are everyone different culture and every day we are talking – you know, I like to talk with people. But not like this place – no one talks to each other, you know?'* (Client 20, Service 1).

Clients who felt isolated or excluded within the service often expressed unmet desires for community and connection, detrimentally affecting their overall sense of eudaimonic wellbeing (Begun et al., 2018; Blocker and Barrios, 2015; Gasior, Forchuk, and Regan, 2018; MacKean and Abbott-Chapman, 2012; Ryff, 1989):

> *'I haven't got friends now…I'm alone a lot of the time, so I'm trying to find things, and maybe go out and find a group where I can find some new friends that don't drink and don't take drugs'* (Client 4, Service 2).

> *'I am a sociable person. I like to talk with people…different cultures, different people, you know?'* (Client 20, Service 1).

Opportunities for social support could be restricted by limited use of shared spaces, some reasons for which may pertain to unappealing aspects of the physical servicescape (see section 5.4.4). This was also inevitably influenced by the COVID-19 pandemic. The timing of data collection suggested that service-specific limitations on mixing remained in place for some period of time after legal regulations were lifted (Morgan, Watkins, and James, 2023), though it was unclear if this was a deliberate decision of the part of management or merely a delayed response to the fast-changing situation:

> *'Because [of] COVID and stuff, they scrapped [the TV room] and said no…But we were all complaining because we weren't allowed to mix – we were all told to go up to our rooms'* (Client 12, Service 1).

> *'There is a communal room – but obviously, due to COVID, that's mainly the staff room now…so at the moment we haven't really done much, you know, together, sort of thing'* (Client 8, Service 3).

Moreover, even those who described the overall service experience as transformative and espoused the benefits of community often noted times at which they had experienced social support deficits in at least one domain, resulting in practical and/or emotional difficulties (Hegelson, 2003; Rook, 1984; Rosenbaum et al., 2007). Such deficits could also make it more difficult to break away from personal relationships recognised as having a detrimental impact on wellbeing, such as social networks built on and maintaining heavy substance use (Hughes et al., 2010; Patterson et al., 2013):

> *'I think I was afraid that, if I came over, that I would lose all my friends and all my contacts, and – and that I would just be alone…and, in a way, it has happened, but – but it's happened for a good reason, because they're not the right people for me'* (Client 4, Service 2).

Despite the daunting and difficult nature of the transition, this participant ultimately believed that the cutting of social ties had *'happened for a good reason'*, as they were *'not the right people for [her]'* (C4, S2). This may thus be understood as a transformative wellbeing trade-off, with Client 4 framing this socially supportive destructive event as a necessary sacrifice

within a virtuous trajectory (Blocker and Barrios, 2015). Nevertheless, the lack of companionship outside of these predominantly negative social ties was associated with *'doubt'* (C4, S2) about the decision to move, slowing down processes of transition and adaptation (Lee et al., 1999; MacKean and Abbott-Chapman, 2012; Rötzmeier-Keuper, 2020).

Client 4 was one of several participants for whom the potential for T-VALEX creation appeared to have been diminished at times by social influences, particularly networks of drug users both within and outside of the services. For example, another participant described how his initial optimism about Service 1 was blighted by the realisation that he was surrounded by the same kinds of people within the service as he had been outside of it, thwarting the potential for a perceived turning point to occur at this stage (Bellaert et al., 2022; Mezirow, 1978a):

> *'I thought it was awesome. I felt like it was the best thing that had ever happened to me…but when I got down to the nitty gritty and actually realised who my neighbours was…[they were] the same kinds of people…as when – just before I went in. There were users in there'* (Client 6, Service 1).

Feeling surrounded by alcohol and drug consumption could be incredibly challenging for those in recovery, impeding processes of identity transformation and a projective future orientation through providing constant reminders of the past and opportunities for relapse. Compounded in some cases by weak and unsupportive relationships (Hughes et al., 2020), these influences could make it incredibly difficult for clients to find hope and envision an alternative life for themselves (Dean and Indrianti, 2020; Deegan, 1988):

> *'It's hard – hearing them ordering or hearing them off it, or…it makes me wanna be like that, you know?'* (Client 6, Service 1).

> *'When I was in [other service building], it seemed like the walls were closing in, and I was getting darker and going to a darker and darker place – and it wasn't the place for me anymore, because all my friends all drink or take drugs…and that's not really my friends, to be honest. They're just acquaintances'* (Client 4, Service 2).

This could also invoke negative emotional reactions in those who were not personally

struggling with addiction, but who felt uncomfortable and out of place in a social servicescape seemingly dominated by substance use (Pizam and Tasci, 2019). This could disincentivise clients from engaging with the service community and even lead to a sense of place detachment if they wished to distance themselves from this environment (Begun et al., 2018; Gasior, Forchuk, and Regan, 2018; MacLean and Abbott-Chapman, 2012; Warnaby and Medway, 2013), reinforcing social support deficits and associated vulnerability (Goodwin, 1997; Rosenbaum, 2005; Rosenbaum et al., 2007):

> *'I prefer it just me and [client]…[because] the other people here – everyone takes drugs, like'* (Client 11, Service 1).

> *'This area – for someone they don't take drugs, they don't smoke, they don't drink, I think is not a good place – is not a good area'* (Client 20, Service 1).

The case for greater peer support across Organisation X residential services is supported not only by several participants identifying a need for greater help and connection, but also by multiple clients espousing the (actual or anticipated) benefits of supporting others, consistent with prior evidence of the wellbeing benefits of such extra-role behaviours (Roy et al., 2020). A few in Service 3 were already 'giving back' in some way through either helping out in other Organisation X services or engaging in voluntary work elsewhere:

> *'There's another project with here and one of the workers goes out there, and she asked the manager if it's ok if I go with her, so I go up and I help'* (Client 8, Service 3).

> *'Basically, [in charity shop] we raise money…to feed the homeless, let them see a doctor if they need a doctor, erm…clothing, er, sleeping bags, tents. Stuff like that, really – and er, we don't make any money ourselves, but the money we do make goes to (homelessness charity)'* (Client 9, Service 3).

> *'I've been working with erm, across the road there's a (charity) – just across the road there – I was working there for a while'* (Client 16, Service 3).

Two of these three clients spoke in very positive terms about their work, illustrating how mutual and reciprocal activities contributed towards value (specifically T-VALEX) creation (Storbacka et al., 2016):

'They know that [helping out at other Organisation X service]…helps me as well' (Client 8, Service 3).

'I like going [to charity shop], because when we make money, I feel better for it – because all the money, see, goes to (homelessness charity), which feeds, like, the homeless, and people who can't – who have a flat, but they haven't got enough money to live on' (Client 9, Service 3).

While Client 16 had been forced to cut her voluntary work short due to a personal tragedy, she described a desire to help others in a different way, directly referring to involvement in befriending services (though not in Organisation X specifically). Enlisting some clients to provide companionship and support to others may serve a dual purpose in terms of vulnerability alleviation and T-VALEX promotion, addressing social support deficits of the beneficiary whilst also providing a sense of purpose conducive to eudaimonic wellbeing (Blocker and Barrios, 2015; Kelly, Lamont, and Brunero, 2010; Leamy et al., 2011; Rosenbaum et al., 2007; Ryff, 2017):

'I want to…work, like, befriending…an old lady or old man and keep them company and things like that – that's what I would like to do. That'd be nice. I'd get satisfaction out of that' (Client 16, Service 3).

Some other participants also suggested that they would like to be doing more for others in need, often specifically those who had faced similar issues and situations to themselves. These assertions indicated that the ability to draw on one's personal, often highly traumatic experiences for others' benefit may be conducive to developing a meaningful and evaluative self-narrative (Blocker and Barrios, 2015; Kelly, Lamont, and Brunero, 2010; Leamy et al., 2011), also providing opportunities for community built on shared experience without perpetuating unhealthy behaviours (Hughes et al., 2010; Laudet and White, 2010; Monson and Thurley, 2011):

'I'd like to do something like…maybe phoning sorts of people like myself that's gone through this and say well, look, you know, here is my backstory…[which is] a very sad story' (Client 4, Service 2).

'I wanna work, like, with people with mental health and alcohol issues' (Client 8, Service 3).

The ability to guide and assist others through incredibly challenging periods could facilitate assignation of meaning and value to otherwise horrific life experiences, with participants' desire to provide the support they wished they had received serving as a powerful impetus for action. For example, Client 4 (Service 2) expressed a desire to talk to others and ensure that they *'[didn't] feel alone'*, having *'never had anybody'* during the most difficult times of her life. Again, this was associated with anticipated transformative value creation in the form of eudaimonic wellbeing outcomes on both sides of the exchange (Blocker and Barrios, 2015; Parsons et al., 2021):

> *'We'll be helping each other, because I'll feel that I'm doing some good, which will make me feel better – but it'll help them to understand that they're not alone in the world'* (Client 4, Service 2).

Overall, it appeared that processes of T-VALEX creation were constrained by insufficient opportunities for appropriate peer support, in some instances blocking transformative outcomes entirely and in others preventing these from reaching their full potential. In the latter case, this pertains both to augmenting benefits for an individual client and to the capacity for individual-level transformation to have a knock-on effect on others, potentially enhancing collective wellbeing of a (service) community (Anderson et al., 2013; Dean and Indrianti, 2020; Fisk et al., 2016; Previte and Robertson, 2019; Rosenbaum, 2017). Client isolation also appeared to increase the risk of clients reaching a point of crisis as neither personal nor service networks responded to early signs of distress (Black and Gallan, 2015; Löbler, 2013). These findings thus reinforce the importance of community (see section 5.3.2) and highlight the existence of untapped consumer social resources (Arnould, Price, and Malshe, 2006; Baron and Warnaby, 2011). This is also consistent with evidence regarding other obstacles to operant resource development and utilisation, discussed in the subsequent section.

5.4.3 Obstacles to Skill Development and Use

Restrictions to agency were commonly identified as a shortcoming of Service 1, in some cases exacerbating vulnerability perceptions as clients felt a lack of control over their everyday lives (Johns and Davey, 2021; Smith and Cooper-Martin, 1997). These effects

could additionally extend to secondary consumers, for example constraining participants' interactions with their children (Amine and Gatfaoui, 2019; Fletcher-Brown et al., 2021; Lam and Bianchi, 2019; Leino, 2017; Rötzmeier-Keuper, 2020):

> *'I don't make my own decisions there'* (Client 3, Service 2 (formerly Service 1)).

> *'I think I'll cope better with my own place than being in a place like this…Because obviously I've got to manage my own bills, etcetera, and that's gonna keep me occupied – and obviously I've gotta, you know, do my own food shopping and…obviously when I have the kids over, I can arrange better things to do with the children'* (Client 13, Service 1).

Potentially transformative opportunities to build and utilise life skills hinged upon the nature of service processes and sometimes on the availability of specific facilities and equipment, either within the focal provider servicescape or at an accessible external touchpoint (Black and Gallan, 2015; Fu, Tanyatanaboon, and Lehto, 2015; Tax, McCutcheon, and Wilkinson, 2013). This was particularly true of food preparation abilities and responsibilities, which were frequently identified as conducive to transformative wellbeing outcomes. Opportunities to develop and utilise these skills not only generated short-term wellbeing but were tied to higher-order goal pursuit and future planning, effecting meaningful change in attitudes and abilities (Blocker and Barrios, 2015; Fu, Tanyatanaboon, and Lehto, 2015). For example, one participant described how being signposted to a cooking course at a local college had helped him to become *'a lot more confident'* (C15, S3), while another valued the ability to cook one's own meals in Service 3 as a way to develop *'skills for when you move on'* (C9, S3).

However, such opportunities rarely arose in Service 1, with restrictions imposed by the physical servicescape (the existence of only one communal kitchen) and established service processes (the scheduling and preparation of main meals only by staff). The detrimental impact of this setup in some cases related to food preparation as an essential life skill, but also as a potential source of identity and connection (Chen et al., 2020; Muñiz and O'Guinn, 2001). Female clients in particular often associated cooking and eating with providing for their families, which could create emotional difficulties both for those who lacked the necessary physical facilities and who felt unmotivated outside of a traditional family setting:

> *'I like to bake – I usually bake the kids' birthday cakes and stuff…Obviously since I've left the home, I haven't been able to do it as much – but that's one thing I miss'* (Client 13, Service 1).

> *'I find it hard to cook just for one, when you're so used to cooking for a family'* (Client 2, Service 2).

Potential barriers to agency and operant resource integration arose in part out of unavoidable trade-offs between autonomy and security, with provider efforts to protect clients from harm at times increasing feelings of powerlessness and thus perceptions of vulnerability (Baker, Gentry, and Rittenburg, 2005; Burghardt, 2013; Hill and Sharma, 2020). On the theme of food, one participant, who had previously had a career as a cook, described how the rules at Service 1 had made it especially difficult to prepare food independently here:

> *'Because they found some er, knives up in my room, like, in (Service 1), and they weren't happy. Because…I was a cook and I was doing my veg and what have you to put it in the microwave downstairs when the kitchen was shut…[but] they didn't like us having sharp instruments in our rooms'* (Client 3, Service 2 (formerly Service 1).

Another client expressed complex feelings about having their medication taken away and administered by the staff at Service 3, lamenting the loss of control whilst acknowledging the safeguarding benefits (Sandberg et al., 2022; Smith and Cooper-Martin, 1997; Wünderlich et al., 2020):

> *'[Before coming to Service 3] I was, you know, administering my own meds…Like, I always found that as one thing that…I had control over…But then, at the same time, I'd not take my meds or I'd take them all in one go, whereas obviously here I can't do that'* (Client 8, Service 3).

It therefore appeared important to maximise areas where clients were able to experience freedom and exert genuine control, without compromising the crucial role of Organisation X in safeguarding (previously discussed in relation to conflict and crisis management – see section 4.3.3). Specific recommendations regarding skill development and utilisation are provided in the following chapter (section 6.4.3.3). Whether clients opted to engage in skill-

building and other potentially beneficial activities appeared partially contingent upon the attractiveness and cleanliness of the service environment (Bitner, 1992; Demoulin and Willems, 2019; Lugosi et al., 2022), for example the state of shared spaces for cooking and eating and the suitability of outdoor spaces for gardening activities. Evidence specifically regarding the need for innovation in the physical servicescape is provided in the following section.

Findings further indicated that engaging some clients in cleaning and decoration may serve a dual purpose, with both processes and outcomes enhancing eudaimonic wellbeing (Ryff, 2017). Participants often described feeling pride in having worked to improve their environments, contrasting with feelings of shame and embarrassment associated with unsightly living conditions:

> *'[Decorating and gardening] sort of took my mind off – like, when I'd do that, it took my mind off drinking or, you know, everything else'* (Client 8, Service 3).

> *'[I want to be able to] welcome family and friends, and be able to say come in, and not be ashamed – it doesn't look like a bomb's hit it'* (Client 4, Service 2).

5.4.4 Negative Aspects of the Physical Servicescape

Clients generally praised the cleanliness and appearance of the facilities; however, there were a few areas that some believed were in need of greater attention. Negative comments typically related to shared spaces rather than individual rooms or flats. Outdoor areas in particular were sometimes described as messy and so difficult or unappealing to spend time in, detracting from the potential for these to serve as therapeutic servicescapes (Rosenbaum et al., 2020):

> *'All we had [in Service 1] is a little back garden, and that was full of bike parts and all that'* (Client 3, Service 2 (formerly Service 1)).

> *'It needs a bit of a clean-up, it does…we've got problems with erm, seagulls, and we've got a bin problem here as well'* (Client 14, Service 2).

When it came to Service 2 specifically, one of the abovementioned participants expressed hostility towards other clients who he believed were to blame for the state of the garden, while the other suggested he felt its unpleasant state was presently unavoidable:

> *'There's a bin out there for them to put rubbish in, but no, they'd rather put it on the floor, and there's me like an idiot picking their rubbish up and putting it in the bin out there. That's what the bin's for'* (Client 3, Service 2).

> *'There's just loads of rubbish all over the back garden…it's very untidy, but as I said, it's not anyone's fault – you know, we've either got the seagulls or the rats'* (Client 14, Service 2).

Regardless of assigning blame, outdoor spaces in bad condition were perceived as inaccessible and/or undesirable for client use, preventing some from engaging in gardening or other outdoor activities and thus from accessing associated mental health benefits (Jackson et al., 2020; Rosenbaum et al., 2020). Other areas could be unappealing simply because of a lack of decoration or personalisation, making clients less likely to develop a sense of place attachment conducive to community development (Baker and Brocato, 2006; Kozinets, 2002; Rosenbaum et al., 2007):

> *'[The living room] is a bit bare at the moment…a couple of pictures or something, you know, could be put up and all that, a bookshelf maybe, or a plant'* (Client 14, Service 2).

The quality of the physical servicescape is thus bidirectionally related to the extent of active participation and community. While shortcomings may limit clients' capacity for VCCB, improvements in this area have the potential to trigger a virtuous cycle, with physical enhancements increasing clients' sense of place attachment and consequent motivation to invest time and effort in their environment (Roy et al., 2020; Warnaby and Medway. 2013).

Overall, findings suggested that the physical servicescape had the potential to either promote or prohibit T-VALEX creation via multiple specific facilitators, with shortcomings in this area discouraging client participation and limiting wellbeing outcomes (Hamed, El-Bassiouny, and Ternès, 2019; Krisjanous et al., 2023). While connectedness is minimally

affected by the identified prohibitors, enhanced connectedness may pose a potential or partial solution to some of the issues caused.

5.5 Key Elements of the Therapeutic Servicescape

5.5.1 Relational Resources

In terms of relational resources, findings shed light on the formation and maintenance of (client/staff and peer-to-peer) social relationships and resultant psychological, social, and (arguably) economic benefits. Early on in the service experience, staff behaviours and relationship-building efforts could play an important role in meeting clients' basic interpersonal needs, producing immediate psychological benefits:

> *'I was a bit nervous, but when I talked to them, all the staff were friendly, so I was really happy'* (Client 10, Service 2).

> *'When I first arrived, [support worker] interviewed me – and [support worker] is an absolute star. I can't praise her enough. And…I was really upset, but she made me feel comfortable and at home'* (Client 11, Service 1).

Connections formed with other clients could play a similar role in promoting a sense of belonging, identified as a core social need underpinning human motivation (Fiske, 2006):

> *'I did get to know them within a short space of time. Within I mean, like, less than a week – and I become quite close with one in particular, and er…it was good when I arrived. I liked it. I felt…part of something again'* (Client 12, Service 1).

Processes of relationship formation, strengthening, and maintenance may also be viewed as alleviating vulnerability through reducing the impact of social support deficits (Nasr and Fisk, 2018; Rosenbaum et al., 2007). Clients could help their peers to access social benefits through the provision of emotional and instrumental support (Hegelson, 2003; Rook, 1984). Despite the presence of interdependencies between clients, instrumental peer support could actually enable some to become more independent over time, aiding the development of relevant knowledge and skills (i.e. operant resources) and/or facilitating access to tangible

(operand) resources (Constantin and Lusch, 1994; McColl-Kennedy et al., 2012; Vargo and Lusch, 2008). For example, one participant recalled how one of her neighbours had helped her out by getting her a walker. This enabled her to work on becoming more mobile, with the end-goal of being able to travel into town alone:

> *'It's got two wheels in the front and two wheels in the back, and you've got handlebars like you would have on a pushbike. [Client name] got that for me for 20 pound…I've been walking around the car park, up and down there and I'm getting more confident'* (Client 16, Service 3).

In contrast to the short-lived interactions and relationships characterising many service settings (Harris et al., 2000; Lucia-Palacios et al., 2018; Rosenbaum et al., 2020), the full benefits of relational resources were typically realised only after sustained engagement with the same individuals. Perhaps due in part to past experiences of socially supportive destructive events and/or discrimination, a degree of trust- and rapport-building was required for clients to believe they could trust in and rely on staff:

> *'I've had the same worker all the way through, so…that is good – because I'm not very good at opening up'* (Client 2, Service 2).

> *'I'm quite good at putting on, like, a mask sort of thing, but then recently, you know, I've had days where I have just broken down…and then, you know, I've said things to them. And yeah – it's just them taking the time erm, you know? And then that's when I'm starting to build the trust'* (Client 8, Service 3).

Psychological benefits arose out of clients' engagement in VCCB (Roy et al., 2020; Yi and Gong, 2013), which was often made possible by their relationships with staff. Promoting the T-VALEX facilitator of active participation, Organisation X staff could play an important role not only directly assisting with resource integration but helping clients to enhance their own resource integration capabilities. This included developing specific competencies and capabilities, as well as more generally aiding clients with confidence building:

> *'I'm able to pay my own bills – I go to the shop, and I pay my bills, and I come out with a big smile thinking I did that on my own'* (Client 4, Service 2).

> *'They've helped me out – building up confidence, going places and stuff on my own where I wouldn't have before'* (Client 1, Service 1)

Strong provider/user relationships were associated with client openness to wellbeing trade-offs (e.g. Russell-Bennett et al., 2020), as they trusted staff to have their best interests at heart. As previously evidenced, transformative value creation often necessitated sacrificing short-term hedonic wellbeing for the benefit of longer-term eudaimonic outcomes (Nguyen, 2023). In engaging with the local community more broadly, clients lacking in confidence or motivation could be spurred on by staff pressure to *'get out and about'* (C16, S3), initially experiencing some difficulties and discomfort but ultimately building on valued meso-level support networks (Black and Gallan, 2015; Normann and Ramirez, 1993; Tax et al., 2013):

> *'I'm the type of person that just the thought of going somewhere like [organisation offering skill-building courses] is like no. And that's where they've sort of been…I dunno, like – you know, "come on, you can do this, you need this one", and…yeah, so they've sort of been pushing me towards it. I'm like, I'm not going'* (Client 8, Service 3).

> *'They give me a bit of moral support to get me up off my backside to go to my appointments, and me not forgetting them'* (Client 14, Service 2).

Peer-to-peer relationships were associated with additional psychological and social benefits, going significantly beyond those discussed in previous explorations of therapeutic servicescapes (Leino et al., 2022; Rosenbaum et al., 2020) but consistent with some documented benefits of user involvement in mental health service delivery (Chamberlin, 2005; Monson and Thurley, 2011). These could be particularly valuable for instances in which clients did not feel up to confiding in Organisation X or other professionals for fear of judgement or misunderstanding. In these circumstances, participants espoused the benefits of support from people with similar life experience:

> *'Sometimes you don't feel like talking to the staff…sometimes it's just nice to have a little friend here'* (Client 11, Service 1).

> *'There's good people here as well – we all come from the same walk of life, you know what I mean? We're all in the same boat'* (Client 5, Service 1).

Where they emerged, positive peer-to-peer relationships were underpinned by a form of shared consciousness inaccessible to staff, with understanding grounded in common experience (Blocker and Barrios, 2015; Muñiz and O'Guinn, 2001). Outside of direct provider influence, clients collaborated to build trust and engage in value cocreation, establishing mutually supportive relationships of equals (Berry et al., 2022; Llewellyn, Verity, and Wallace, 2020):

> *'[Client name] listens to you, and you know it's going no further than him, do you know what I mean? What – what I say – same as him. If he speaks to me, it goes no further – it stays there, you know what I mean? It's nobody else's business'* (Client 12, Service 1).

Notably, characteristics of balance and reciprocity identified as key for core services in transformative service networks (Black and Gallan, 2015) arose as important in several clients' accounts of the helping relationships (Rogers, 1959) they had formed with others in the same or related services. Active participation and community emerged out of opportunities to engage in customer citizenship behaviour (Yi and Gong, 2013) through helping others, particularly those with shared life experiences. T-VALEX creation occurred within these interactions and in later moments of introspection, as some experienced a newfound sense of *'purpose'* (C9, S3) and meaning affecting their sense of identity (Blocker and Barrios, 2015).

Some explicitly highlighted the importance of mutuality and reciprocity to their community participation, recognising that they were doing good for others whilst also improving their personal sense of wellbeing (Held, 2005; Lawrence and Maitlis, 2012):

> *'Like, there's another project with here and one of the workers goes out there, and she asked the manager if it's ok if I go with her, so I go up and I help…and they know that that…helps me as well'* (Client 8, Service 3).

Familial-style relationships could have transformative effects on wellbeing through meeting some of clients' core emotional needs (Blocker and Barrios, 2015; Fiske, 2008; van Weeghel et al., 2019), helping them to feel *'loved'* (C11, S1), valued, and supported. Feelings of moral responsibility towards others also manifested in customer citizenship behaviour in the form of

practical and emotional peer support, benefitting both the provider and the recipient (Blocker and Barrios, 2015; Choi and Kim, 2013; Roy et al., 2020). One-on-one guidance and support may be especially important for those without preexisting ties to the service community or the local community more broadly, helping these individuals to navigate new environments whilst also providing companionship (Helgeson, 2003; Jandorf et al., 2005; Salem, Kwon, and Ames, 2018). For example, one participant described how he had helped a new client to settle in and overcome his initial difficulties, ultimately leading to the development of a strong friendship between the two:

> *'He come here, and he didn't know anybody, because he's from away, like, so I got in contact with him and talked to him and all that, and me and him became good friends as well now, see. Because he didn't talk to anybody and all that, and he didn't like to go to the shops by himself, so I took him down the shops and everything. I taught him how to do the washing'* (Client 3, Service 2).

The same participant also described looking out for another neighbour of his, through offering emotional and instrumental support (Helgeson, 2003; Rook, 1984):

> *'There is my neighbour, [name]. I make sure she's alright and everything, and I go to the shop and everything for her…and every time I cook something for myself, I always give something to her as well'* (Client 3, Service 2).

Relational resources were also associated with economic benefits, though not in such a direct sense as is typically understood (Rosenbaum et al., 2020).

> *'Some of them are very loyal. I had bullying issues, where I was bullied for money and stuff, and I've had people come with me to the bank and actually stand up to people and say look, he doesn't owe you this money, why are you doing this to him? You know, support like that has helped'* (Client 1, Service 1).

There were also important ways in which client/staff and peer-to-peer relationships coincided and complemented one another. For example, having the guidance and assistance of staff could be beneficial for a client trying to look out for their neighbour(s). This may help to alleviate secondary vulnerability associated with proximity to someone in crisis or distress,

leaving the helping client better able to cope and to support others (Fletcher-Brown et al., 2021; Leino, 2017):

> *'If I'm worried about [client], they say to come into the office, like. So I do – and I feel like that's a good support, because as well as them supporting me, if I'm concerned and worried about somebody else, I can go and see them'* (Client 11, Service 1).

In addition to a widespread sense of feeling settled and comfortable where they were (particularly within Services 2 and 3), some clients further expressed a desire to remain connected to the service and/or specific individuals after moving on, demonstrating a projective future orientation and sustained sense of moral responsibility (Blocker and Barrios, 2015; Muñiz and O'Guinn, 2001). Perhaps the most extreme instance of this was actually a participant from Service 1, who stated that she would like to move in with another client in order to *'be there for [them] all the rest of [her] life'* (C11, S1) and maintain the familial-style relationship they had established. In such instances, service relationships were viewed not only as conducive to positive outcomes but as an end in themselves, filling important gaps in clients' lives and support systems (Vázquez et al., 2021; Viswanathan et al., 2012):

> *'I wouldn't mind moving in with (client). Because the simple fact is, I think she needs me as much as I need her, and to me she's like – like, I got – because she's younger than me obviously, she's like – I class her as a daughter to me. She's a similar age as my daughter, so I'm trying to be that – she ain't got a mother, and I'm trying to be that motherly figure to her as well'* (Client 11, Service 1).

5.5.2 Restorative Resources

Restorative resources emerged as similarly important in the research context and in the facilitation of T-VALEX creation. While in many ways consistent with the findings of Rosenbaum et al. (2020), key differences emerged, with not all components of attention restoration theory (ART; Kaplan, 1995) appearing fully compatible with participants' accounts. Consequently, two main adaptations are made to the therapeutic servicescape model proposed by Rosenbaum et al. (2020), replacing 'Fascination' with 'Opportunities for Immersion' and 'Being-Away' with 'Breaking Away'. The other two components

('Coherence' and 'Scope') have been retained, though with slight alterations to their meaning explicated below.

5.5.2.1 Coherence

For Organisation X clients, perceptions of servicescape coherence were often associated with the ability to shape one's own living environment, contributing towards a greater sense of personal understanding and facilitating goal pursuit (Rosenbaum et al., 2020). Thus, this element appeared not to lend itself to standardised or deterministic design, seeming more compatible with the constructivist view of each design problem (i.e. each client's residence) as a 'universe of one' (Dorst and Dijkhuis, 1995, p.263). Furthermore, coherence appeared bidirectionally related to active participation, the initial emergence of which in this context had less to do with servicescape design and more to do with service practices and regulations.

Servicescape coherence also influenced the perceived accessibility of relational resources, highlighting the importance of welcoming cues (Baker et al., 2007; Pizam and Tasci, 2019; Rosenbaum, 2005) for encouraging clients to make use of available support. Support seeking could be discouraged by a lack of clear signals. Conversely, identification and resolution of specific issues in the social servicescape was aided by the aforementioned culture of responsiveness, as clients' concerns were frequently heard and typically actioned:

> *'They're supposed to keep their door open all night, like, for the office, and there was one [member of agency staff] that was closing the door. And if I had a problem and the door's closed, I wouldn't go in to them…so I spoke to [manager] and [support worker], and they sorted it out. Whatever the problem, [manager] always tells me come into the office'* (Client 11, Service 1).

Moreover, coherence and the facilitation of goal pursuit took on new, potentially transformative meanings here compared to the original context of commercial retail environments (Rosenbaum et al., 2020). Building on Leino et al.'s (2022) study on nursing home servicescapes, findings demonstrated the role of coherence in creating a sense of belonging, making servicescapes feel more *'homely'* (C4, S2) and like *'[clients'] own space'* (C3, S2). Rather than solely facilitating achievement of relatively minor objectives (e.g. locating required items in a shop), servicescapes played a literal and symbolic role in clients'

pursuit of higher-order goals and identity projects. Participants described the importance of being able to *'take pride'* (C8, S3) in their environments, cultivation of which could both be a goal in itself and an emblem of a rewritten personal narrative:

> *'Little things like that – little goals – that's my little goal, is just to make it more like a home, more like it's my – a real life, a proper life'* (Client 4, Service 2).

5.5.2.2 Scope

As already touched upon in the previous chapter (section 4.2.4), the ability to reach and maintain desired levels of cleanliness and decoration depended upon clients having an appropriate amount of space for their needs, which was neither restrictive nor overwhelming. This could make a big difference in terms of place attachment (e.g. Baker and Brocato, 2006; Rosenbaum et al., 2007), as in the case of one client who described how she came to feel at home in Service 3 only after moving into a larger property:

> *'I didn't sort of do [the old flat] up. I didn't hang any pictures, I didn't…you know, I didn't do it that nice. Well, I really couldn't, to be honest. (laughs) But it was just always a mess – always cluttered. So, like, when I moved here, I've actually done it up nice and it's not cluttered, it's not messy…you know, it's really tidy. So…you know, I feel home'* (Client 8, Service 3).

5.5.2.3 Breaking Away

The fourth category of restorative resources discussed here diverges from the conditions proposed in ART (Kaplan, 1995) and subsequent applications of these to measure environmental restorativeness (Pasini et al., 2014; Rosenbaum et al., 2020), supplanting the traditional 'being-away' with the distinct but related concept of 'breaking away'. While being-away grants short-term respite from everyday concerns and demands (Friman et al., 2018; Pasini et al., 2014; Rosenbaum et al., 2020), participant narratives suggested that this was not entirely applicable to the Organisation X context, as services were designed not to provide a temporary escape from normal life but rather to facilitate client progression towards a 'new normal'.

Consistent with an evaluative-projective orientation to life (Blocker and Barrios, 2015; Emirbayer and Mische, 1998), the restorative potential of the servicescape was contingent in part upon how this compared both to clients' past experiences and to envisioned, preferred ways of living. Breaking away encompassed escape or relief from both external and internal threats to wellbeing, contributing towards perceptions of safety and security conducive to feeling at home (Leino et al., 2022) and reduced likelihood of vulnerability perceptions (Sandberg et al., 2022). In the case of potential harm at the hands of others (within or outside of the service), a sense of security was facilitated by access to simple but essential tools for privacy and protection, such as locks and alarms:

> *'If they came here, obviously they'd press the panic bell and phone the police and that'* (Client 18, Service 1).

> *'It feels safe as well, and staff will protect you, like, if there's something that's kicking off, you can go to them, or go to your room – which is behind er, locks so, you know, they can't get into your room'* (Client 1, Service 1).

5.5.2.4 Opportunities for Immersion

Opportunities for immersion were often central to the promotion of active participation. This included the roles of physical and social servicescapes in facilitating positive engagement with the outdoors, which benefitted mental health through providing a sense of both pride and personal wellbeing (Amin, Wahid, and Ismail, 2016; Jackson et al., 2020; Rosenbaum et al., 2020). Involvement in gardening and decoration of outdoor areas could provide clients with a sense of *'achievement'* (C8, S3) and serve as a worthwhile distraction from unhealthy coping mechanisms:

> *'I like gardening. It's – you know, when you plant something and you look after it, when it grows, you think oh, I'm proud of that – because I've done it myself'* (Client 9, Service 1).

> *'When I'd do [gardening activities], it took my mind off drinking or, you know, everything else'* (Client 8, Service 3).

> *'[Plants] help a lot with the mental side of things…Look after them and they'll reward you'* (Client 2, Service 2).

5.6 Contextualising Transformation: Impact of Individual Lifeworlds and Broader Service Ecosystems

While this study was focusing specifically on Organisation X, client narratives revealed how deeply embedded their experiences of these services were within a broader network of services and organisations. Consistent with findings in the tenancy support service context (Spence, 2021) and Stage One interviews (see Section 4.2.5) regarding the importance of connecting to broader support networks, T-VALEX creation emerged as a complex, multi-actor process, often requiring cooperation across a range of public and third sector services.

Table 5.3 summarises how availability of the five aforementioned T-VALEX facilitators was affected by factors in individual and service ecosystem domains. Subsequent subsections will expand upon specific ways in which T-VALEX creation was affected by broader contextual influences, focusing first on individual lifeworlds (Section 5.6.1) and then on service ecosystems (Section 5.6.2).

	Individual Domain Only	**Service Ecosystem Domain Only**	**Both Domains**
Active Participation	• Preexisting skills and knowledge. • Responsibility for others.	• Opportunities for skill building and application.	N/A
Community	• Integration of family members into service community. • Personal attributes and role suitability. • Support needs and capacity/desire to offer support.	• Mediating actors: staff as trusted companions/advisors. • Opportunities for peer support.	• Connections rooted in shared experiences.
Connectedness	N/A	• Crisis management procedures. • Compensating for focal provider limitations (e.g. understaffing). • Mediation compensating for service/system-level barriers (personal difficulties, discrimination). • Smooth transition between services.	• Integration with preexisting networks.
Individualisation	• Capacity and desire for independence. • Impact of past experiences and traumas. • Individual variation re: social support deficits and needs. • Personal priorities and responsibilities.	• Centring client choice re: service engagement.	• Alignment between timelines.
Responsiveness	• Flexibility. • Proximity to peers. • Risk assessment.	• Practical support. • Regular check-ins. • Ease of re-entry.	N/A

Table 5.3: Summary of T-VALEX facilitators and associated factors within individual and service ecosystem domains

5.6.1 Impact of Broader Lifeworld Contexts on T-VALEX Creation

Value creation unfolded within and influenced clients' broader lifeworld contexts and preexisting personal networks (Helkkula, Kelleher, and Pihlström, 2012), from which they could also draw resources related to any of the abovementioned five facilitators (summarised in Table 5.3). The nature and strength of these networks could affect both the extent to which clients relied upon Organisation X to provide certain resources and the relative importance assigned to the different facilitators, further demonstrating the importance of individualisation in how and to what extent other facilitators are promoted in addition to being a T-VALEX facilitator in its own right.

For example, the extent to which clients valued being (or working towards becoming) largely independent in managing their daily lives and environments varied in relation to individual abilities and past experiences, with some appearing to value security over autonomy (Sandberg et al., 2022) and relating this preference to their personal backgrounds:

> *'The security in this place is a big bonus…'I'd never been alone before, so…it's pretty frightening, the thought of having my own flat or house away from here'* (Client 2, Service 2).

> *'When you come out [of prison] then a lot of men can't cope on their own, in a flat on their own. It's a simple as that – could end up dead, do you know what I mean – or evicted, you know, for missing bills, etcetera. So…I do like it here…Because everybody in life needs routine'* (Client 12, Service 1).

Different participants also assigned different meanings and levels of value to community. Some of this variation came down to personality attributes such as level of extroversion vs. introversion, with some clients simply desiring less interaction with others as a rule:

> *'I think I've always sort of been a keep myself to myself person'* (Client 8, Service 3).

Furthermore, while some clients treated the service experience as an opportunity to build new and unconventional models of support, others were more focused on preserving or restoring key relationships in their lives, valuing family cohesiveness and the ability to provide for children and other dependents (Ellickson, 1990). In the latter case, the key function of Organisation X in promoting community pertained to integration of family members into the

service community, also relating to connectedness with preexisting personal support networks. For those with close family members, service design and practices had the potential to strengthen, maintain, or weaken relationships through providing or prohibiting opportunities for interaction (Teixeira et al., 2012). The desire to live a normal or *'proper'* (C4, S2) life again arose here. This could be represented by the ability to host family and take pride in one's home, including during special occasions:

> *'I want to…maybe have my kids come and see me for the first time in my own house. It'll be the first time – and that would be so nice, to have my first Christmas in my own place, with my family around me. That'll be fantastic – because I've always had to go out and see my son or my daughter. Because I didn't want to be in a hostel, because I knew that it would make me depressed, and I didn't want to be in there on my own at Christmastime and stuff like that'* (Client 4, Service 2).

The importance of responsiveness also hinged partially on the accessibility and strength of personal networks, with some describing severe social support deficits (Rosenbaum et al., 2007) which the service had either succeeded or failed to address, while others suggested these needs were being effectively met elsewhere:

> *'My emotional and practical support comes more from outsiders – do you know – friends, family'* (Client 12, Service 1).

> *'I got plenty of choices. A network of family, friends'* (Client 15, Service 3).

5.6.2 Impact of Service Ecosystem Characteristics on T-VALEX Creation

Of all the identified T-VALEX facilitators, connectedness was the most clearly and consistently related to service ecosystem characteristics. Conceptually, this may be viewed as bridging the gap between the concept of density as applied to a transformative service network (Black and Gallan, 2015) and the apomediary capacities of a transformative service mediator (TSM; Johns and Davey, 2019). From the outset of engagement with Organisation X, the capacity for value cocreation often appeared contingent upon interconnection between related entities, otherwise defined as density in a service network (Black and Gallan, 2015; Uchino, 2004):

> *'I had a good team…a support worker and a CPN – you know, they would phone me and see how I'm doing'* (Client 9, Service 3).

The facilitator of connectedness can thus be understood partially in relation to structural properties of a transformative service network (Black and Gallan, 2015). Conversely, an additional dimension emerged pertaining to the extent to which apomediary functions were embedded in the practices of the core service provider, i.e. Organisation X in this instance. In addition to providing relevant contacts and information, staff directly engaged with third-party touchpoints on clients' behalf, organising appointments and managing the relevant correspondence. Connectedness also proved important during the final stages of engagement with Organisation X, reinforcing the need for continuity of care (Begun et al., 2018; Miller, 2011; NHS Primary Care and Community Services, 2010; Zeitler et al., 2020) persisting throughout and beyond an individual service experience.

Confidence in the capacity of Organisation X to manage these processes could be important even for those who were not yet at this stage, helping to maintain a sense of momentum and avoid feeling trapped in one's current circumstances:

> *'Say for example now, one day I woke up and thought I'm fed up of this, I wanna move out, I wanna flat, I wanna job and all the rest, you know – they could probably get all the links and whatnot and get me on that path, that road'* (Client 15, Service 3).

The structural properties and overall coherence of the service ecosystem additionally proved important for promoting individualisation. While the concept of coherence is traditionally applied to individual servicescapes (Rosenbaum et al., 2020), it proved similarly important for clients embedded in complex ecosystems to understand how these were structured and, crucially, how they could be utilised to address needs and pursue goals. Moreover, while strong ties between different actors proved beneficial (Black and Gallan, 2015), it also appeared important that the broader service ecosystem facilitated flexibility and individual variation in levels and types of engagement. Structure and coherence influenced the extent to which client choice was centred and personal timelines were honoured, including the capacity to circumvent normative social structures (Blocker and Barrios, 2015).

Connectedness could help to mitigate against some potential prohibitors of T-VALEX creation in the focal provider sphere, such as the negative effects of understaffing. The availability of T-VALEX facilitators in other services at times appeared to compensate for a deficit or reduction in the Organisation X context, particularly in the case of responsiveness. As Organisation X suffered reduced capacity to offer relational resources (Rosenbaum et al., 2020) such as regular check-ins and all-hours emotional support, these shortcomings could to some extent be overcome through delegation to related services, with clients describing similar benefits arising out of these connections:

> *'[Counsellor] phones me – I think it's once a week, and it's nice – it's like having a friend, you know? Another friend on the end of the phone who rings you up just to say hi, and it's really nice to know that I've got somebody else to talk to. And that makes a lot of difference, knowing that you've got support'* (Client 4, Service 2).
>
> *'If I had another episode – the mental health nurse is always there to talk to you'* (Client 11, Service 1).

Similarly, broader service ecosystems could counteract restorative resource deficits limiting the therapeutic potential of the focal provider servicescape (Rosenbaum et al., 2020). This included drawing on Organisation X's connections for assistance with the creation and maintenance of coherent and immersive shared spaces, offsetting negative aspects of the physical environment and indirectly promoting facilitators of active participation and community:

> *'We had a group of kids come down and do the gardening for us and…they did a lovely job'* (Client 14, Service 2).

In addition to exerting influence via specific T-VALEX facilitators and prohibitors, the apomediary role adopted by Organisation X staff could also help to compensate for constraints to resource integration capacities, as associated with TSMs operating in a context of consumer vulnerability (Johns and Davey, 2019). These included microlevel limitations related to membership of marginalised groups (European Network for Social Inclusion; NHS Wales), with literacy and memory issues for example associated with learning disabilities and extended substance abuse:

> *'[They've been involved with] arranging appointments for me – because I'm terrible at it. I'm actually going to my appointments now…I got a terrible memory, I have'* (Client 14, Service 2).

Equally, staff acting as apomediaries between clients and other, particularly health, professionals was discussed as a way to mitigate the effects of (what clients perceived as) dismissive attitudes towards them (Johns and Davey, 2019; Storbacka et al., 2016). Participant accounts indicated that discrimination and stigma were prevalent throughout broader service systems, posing a threat to consumer wellbeing and goal pursuit (Baker et al., 2005; Crockett et al., 2013; Hamilton, 2014; Hill and Stamey, 1990; Jarrett, 1996; Johns et al., 2017; Johns and Davey, 2021). Conversely, the mediation of external service processes could have a transformative effect, as staff drew on their credibility and insider knowledge to advocate for clients in need (Eysenbach, 2008; Johns and Davey, 2019):

> *'A lot of the time I need the staff to talk to the doctors and help me, because they don't get what I'm trying to tell them – or they just don't listen…[Organisation X staff] have got more clout than I have'* (Client 4, Service 2).

> *'[Psychiatrist] never listens to me'* (Client 8, Service 3).

Dense service ecosystems were additionally associated with harm reduction at times of acute vulnerability, for example ensuring that clients in active mental health crises could access timely and appropriate support:

> *'I stubbed cigarettes out on myself and then took an overdose and that – the mental health moved in quicker then and stepped my medication up and everything'* (Client 11, Service 1).

While traditional economic benefits such as access to discounts (Gwinner, Gremler, and Bitner, 1998) are clearly not relevant here, it is pertinent to consider how relational resources may influence the alleviation of economic poverty, a common contributor towards experiences of consumer vulnerability (Blocker et al., 2013; Hill, 2002). As Organisation X were not directly responsible for allocating or controlling financial resources, their role in promoting financial wellbeing stemmed from their connectedness to social services and other

organisations, particularly the existence of clear and well-trodden pathways between services and the willingness of Organisation X staff to adopt additional apomediary roles.

Contributing towards the literature on autonomy-security trade-offs (Sandberg et al., 2021), there was evidence that some clients actively appreciated imposition of restrictions on their financial agency in the form of *'receivership[s]'* (C16, S3). Seemingly paradoxically, these could be associated with achievements and skills conducive to transformative outcomes (Blocker et al., 2013; Dean and Indrianti, 2020; Fisk et al., 2016; Fu, Tanyatanaboon, and Lehto, 2015), facilitating a degree of active participation:

> *'My money's in the care of social services, er…with social services and I got, like, my own bank card and so on. So yeah, I'm budgeting well and stuff and…I feel confident and respected'* (Client 15, Service 3).

Connectedness in the sense of network properties and apomediary functions was therefore a key theme throughout and beyond engagement with Organisation X, facilitating value creation in the core service delivery and in transitional phases. This confirmed expectations regarding the importance of connecting to broader support networks for T-VALEX creation, with staff acting as mediators to facilitate transformative value creation at external touchpoints (Johns and Davey, 2019; Spence, 2021).

5.7 T-VALEX Creation, Place Attachment, and Behavioural Intentions

Variation in described levels of place attachment was captured in a place attachment scale (Figure 5.1), with five levels ranging from General Fixed Attachment (Level 1) to Active Rejection of Place (Level 5). The top three levels of the scale were associated with the potential for T-VALEX creation to occur, though in actuality whether this necessitated solely purpose-specific (Level 3) or more general attachment (Levels 1 and 2) appeared partially contingent upon the extent of social support deficits (Rosenbaum et al., 2007) in the individual customer domain. These different levels and types of attachment may also be understood in relation to Oldenburg and Brissett's (1982) triadic conception of place and later extensions and adaptations, with Level 1 attachment indicating that participants viewed the service as their 'first place' (i.e. home) while Levels 2 and 3 were more consistent with a third or collapsed place attachment (Littman et al., 2021; Rosenbaum et al., 2007). In

particular, this responds to calls for further research on how socially marginalised communities build meaning in unconventional place contexts, impacts on mental health and wellbeing, and how individuals' histories of homelessness influence their construction of place (Burns, 2015; Burns et al., 2020; Littman et al., 2021).

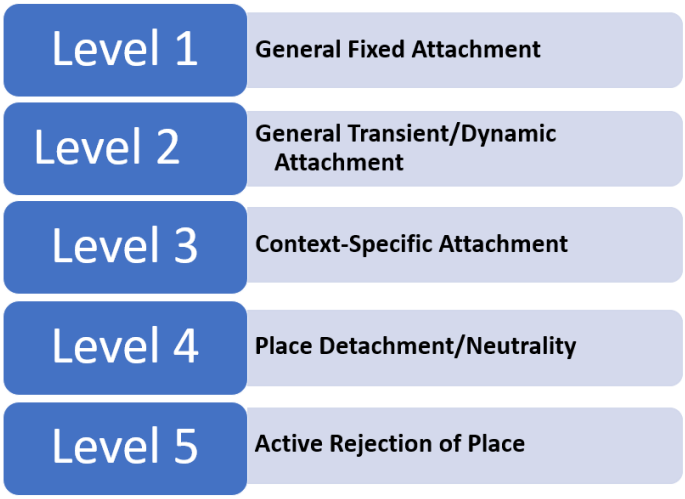


Figure 5.1: Place attachment scale

While the strength of this attachment varied significantly, the existence of a 'positive, target-specific connection' (Brocato, Baker, and Voorhees, 2014, p.201) proved significant, tapping into the fundamental human need for belonging (Relph, 1976) and reflecting the role of place in personal identity (Lomas, Ayodeji, and Brown, 2021; Preece, 2020). Feelings of detachment from and/or hostility towards the service environment were associated with a chronic sense of powerlessness and recurrent perceptions of vulnerability, constricting the potential for T-VALEX creation (see Section 5.2).

Conversely, in the research context, the drive to extend one's stay in a given service was neither inherently nor exclusively tied to desired (i.e. transformative) service outcomes. While in Service 2 clients were allowed and often expected to stay for the remainder of their lives, analogous to nursing homes in bridging the concepts of home and transformative servicescape (Leino et al., 2022), Service 1 and (to a lesser extent) Service 3 were conceptualised as transitional stages, with the end goal of service users moving on to greater independence.

Further to elucidating the complex role of place attachment in T-VALEX creation, findings highlighted the context-dependent nature of what constitutes positive (or, more specifically,

transformative) behavioural intention. While it appeared the upper half of the place attachment scale (Levels 1-3) must be reached for T-VALEX creation to begin, the extent to which this resulted in actual transformative wellbeing outcomes hinged on a combination of the intended service concept and clients' access to relational resources in the individual domain (see Figure 6.2). Narratives revealed a total of four significant behavioural intentions, with only one of these being inherently indicative of sustained T-VALEX creation, one of T-VALEX prohibition or destruction, and the other two bearing the potential to signify either transformative or counter-transformative outcomes. The below table summarises these intentions, associated levels of place attachment, and other conditions affecting the (counter)transformative nature of outcomes.

Behavioural Intention	**Place Attachment Level(s)**	**Conditions for Transformative Outcomes**	**Conditions for Counter-Transformative Outcomes**
Remaining in service on long-term/indefinite basis	Level 1	• Level 1 place attachment. • Meso-level relational resources outweighing microlevel social support deficits. • Intended outcome: co-constructing 'home'.	• Microlevel social support deficits outweighing meso-level relational resources. • Intended outcome: stepping stone to 'home'.
'Full' moving on (terminating or suspending service relationship)	Levels 2-5	• Level 3 or above place attachment. • Availability of microlevel relational resources. • Intended outcome: stepping stone to 'home'.	• Below Level 3 place attachment. • Lack of microlevel relational resources (i.e. severe social support deficits).
'Partial' moving on (maintaining and redefining service relationship)	Level 2	• Level 3 or above place attachment. • Associated with T-VALEX regardless of service concept and relational resource availability.	N/A
Active destruction or disengagement from value creation (e.g. recidivism, relapse)	Levels 4-5	N/A	• Below Level 3 place attachment. • More commonly associated with 'stepping stone' service concept. • May be exacerbated by social support deficits.

Table 5.4: Summary of emergent behavioural intentions in relation to place attachment and T-VALEX creation

Furthermore, the concept of behavioural intention encompassed a broad range of possible outcomes, extending beyond how long clients wished to remain within a given service. Most notably, place attachment appeared to influence positive behavioural intention in the sense of clients wishing to 'give back' to Organisation X, sometimes financially but more often through providing practical and emotional support to other clients. Such instances highlighted the potential for transformative benefits to extend beyond the focal customer/provider dyad, having knock-on effects on others across and beyond the service community, building on extant literature on TSR and collective wellbeing (Anderson et al., 2013; Dean and Indrianti, 2020; Fisk et al., 2016; Previte and Robertson, 2019; Rosenbaum, 2017). Other relevant behavioural intentions besides extended engagement and disengagement included moving on to pursue higher-level transformative goals (having reached certain personal milestones); continuously adapting the Organisation X/client relationship to be consistent with transformational processes and stages; and (on the more negative side) escaping current circumstances regardless of longer-term wellbeing implications (e.g. through (re)offending or accepting any offered pathway out of one's current living situation).

The potential for stronger place attachment to be prohibitive of T-VALEX creation may be attributed to a mismatch between the intended service concept, i.e. the 'cognitive logic about what a service will do for customers' (Wani, Malhotra, and Clark, 2021, p.213), and the actual service concept that is 'perceived in the mind of the customer' (Roth and Menor, 2003, p.150). Where intended service outcomes pertained to co-constructing a long-term home in the service environment, as in prior research (Leino et al., 2022), first place attachment proved conducive towards transformative wellbeing outcomes. Conversely, where providers intended for services to be a 'stepping stone' towards greater independence, first place attachment could be detrimental, detracting from a projective future orientation (Blocker and Barrios, 2015; Emirbayer and Mische, 1998) if clients could not or preferred not to envision life after service use.

This could increase the likelihood of clients either remaining in a service beyond the point that it was beneficial or, given externally imposed limitations on service duration, being forced to leave without the resources or resource integration capacities for ongoing T-VALEX creation.

5.8 Utility of the Adapted TTT

5.8.1 Role in Narrative Elicitation

The process of narrative elicitation followed using the adapted TTT appeared to be largely successful, with participant-led conversations producing rich, in-depth accounts of full service experiences and evidence of transformative representations (Boevink, 2007; Christensen and Prout, 2002; Hamilton et al., 2014; Harre, 1998; Shimrat, 1998; Wetherell, 1996). The broad structure of the narrative accounts determined through the literature review and earlier data collection seemed resonant in most cases, although (as anticipated) not all participants felt that *Moving On* was relevant to them at the time or potentially ever. Client accounts did, however, provide some insights into the kinds of actions taken and assistance received at the time of moving on from or between services, but this was more often discussed in the present or future than in the past tense:

> *'They said there's a property going [at another service], so…all going well, I might take that one…I'm gonna have a chat with (staff member) tomorrow and go from there'* (Client 14, Service 2)

> *'Obviously I'm sticking with (Service 3) for now obviously, as such – but you know, when I get the new CPN as such and so on, and get…a meds review…[we will] crack on from then and just go with things, you know?'* (Client 15, Service 3).

More frequently than eliciting discussion of past experiences, *Moving On* could serve as a springboard for clients delving into their personal hopes and priorities for the future. While this diverged somewhat from the intended purpose of the cards, it was nonetheless valuable in providing insights into participants' goals and support needs, demonstrating the potential utility of the TTT for service planning as well as service evaluation (Lewin et al., 2020). A particularly common theme here was wishing to see or spend more time with family:

> *'My goal then is to, like, have my own flat, get to see my kids again hopefully, erm, and…try and stay away from certain people and drugs, and just stay on a prescription and - and that's it'* (Client 18, Service 1).

> *'I've spoke to the manager and…he mentioned – 'cause obviously people moving on from here, they tend to go into shared housing, but I've said, you know, I wouldn't*

> *like to go into shared housing because of the fact I wouldn't be able to have my kids over'* (Client 13, Service 1).
>
> *'I want to have [grandchild] come and stay with me, you know?'* (Client 16, Service 3)

Responses to this card also provided insights into the circumstances in which clients had no desire to move on, which often related to self-preservation and the decision to prioritise security over autonomy (Sandberg et al., 2022):

> *'I don't really wanna leave, because there's – it's easier here for me because there's staff and stuff, you know what I mean? I feel that, in a flat on my own, I'd be fucking dead within weeks, do you know what I mean?'* (Client 12, Service 1).
>
> *'I don't think living out there on my own would be very good for me. The security in this place is a big bonus'* (Client 2, Service 2).

Moving On could also be used to prompt discussion or elaboration on movement between services, encompassing *'going…back'* (C15, S3) in the case of a relapse as well as moving on to a higher level of independence (e.g. from Service 1 to Service 2). However, use of this card was associated with some difficulties. As the topic of moving on commonly arose organically earlier in conversations, it was sometimes necessary to acknowledge when presenting the card that the participant had already discussed this and/or that this would not be relevant for them, in order to avoid the appearance of not having listened or of forcing them to repeat themselves. This was particularly true of interviews with Clients 19 and 20 (both Service 1), who had already spoken at length about their difficulties moving on from the service. Attempts were made to acknowledge this in introducing the topic of moving on:

> *'The last thing, I guess, is about moving on. So that's difficult, because you're sort of waiting to hear about a house'* (Interviewer to Client 19, Service 1).
>
> *'So, [the card is] about…moving on from the service or moving between different services. Obviously, that's something you're trying to do, but I guess at the moment you're waiting to hear back from people'* (Interviewer to Client 20, Service 1)

Despite such efforts to acknowledge what had previously been discussed, the introduction of the *Moving On* card could at times shut down conversation if clients felt that they had already addressed the topic or that it was irrelevant to them. For example, when asked about if they had any plans for moving on, Client 7 (Service 2) simply responded *'no'*; similarly, when asked if they had anything to say about their moving process, Client 6 (Service 1) responded *'no, I haven't done it yet'*. As previously touched upon, there was also a risk of participants feeling that they were not being listened to or were being asked to repeat themselves, which may have been especially problematic given the tendency for such individuals' voices to be dismissed or overwritten (Beresford and Boxall, 2013; Hennigan, 2017; Liegghio, 2013; Russo, 2016; Thomson, 2008):

> *'We've done 'Moving On', because I talked about – I wanted to move on, and I said I'm gonna stay here…I've covered it all'* (Client 3, Service 2)

There were also a few instances in which other cards and/or the structure as a whole did not fit so well. There were two Service 1 clients, previously mentioned in relation to transformative value creation and institutionalisation (see Section 5.2), whose time at the service had been interrupted by two or more prison stays: Client 12 and Client 18. I will return to Client 12 when on the topic of clients for whom the TTT cards proved largely unnecessary, who provided rich narrative accounts with minimal prompting. For Client 18, however, the TTT proved a useful tool, but could not be followed as straightforwardly as for those who had been within Organisation X continuously. While the participant naturally started off talking about his current service experience, after establishing that there had been multiple separate occasions, subsequent questions were asked so as to account for this, for example:

> *'[Arrival is] about when you first got there, but I guess for you there's sort of been a few times? So maybe if you could talk about, like, the different times – the first time you came here and then the more recent time and how that was'* (Interviewer).

Follow-up questions were then used to prompt the participant to move on from talking about one experience to another:

> *'And then – the most recent time so, like, 13 months ago – do you remember when you first arrived there, what that was like then?'* (Interviewer).

Through accounting for the broken nature of customer engagement, the interview process was able to largely run smoothly, and Client 18 provided detailed insights into both his most recent and previous stays. Conversely, the need to repeatedly divert the focus from one instance to another could disrupt the narrative flow (Jovchelovitch and Bauer, 2000). While in-between periods (during which the participant was either in prison or in other accommodation, e.g. B&Bs) were discussed to an extent, a more authentic and comprehensive narrative may have emerged out of encouraging him to give an entirely chronological account of the period since the first time he found out about Organisation X. This could also have involved going through (some or all) TTT cards multiple times, though participant fatigue would be a significant concern here (Forchuk et al., 2006; Kirkpatrick and Byrne, 2011). The implications of interrupted storytelling for future applications of the TTT will be explored in Chapter Six.

At the other end of the spectrum, one participant cut the interview short after only two cards (*Pre-Arrival* and *Arrival*) due to only having been in the service for a short period of time (six weeks at time of interview):

> *'[The other cards] won't apply to me. I've told you everything I can about the place'* (Client 5, Service 1).

Though encouraged to look at the other cards to see if anything appeared relevant, Client 5 was emphatic that nothing beyond *Arrival* was applicable to his experience. Client 17, who was staying in the Service 1 emergency bed, gave a similar explanation for the sparse nature of some of his responses:

> *'Because I'm only in the emergency bed…I haven't managed to see, like, exactly what they can offer and that'* (Client 17, Service 1).

While this participant did have some things to say on the core service offering (*Practical and Emotional Support*), on the servicescape (*Facilities and Shared Spaces*) and on initial plans and processes related to *Moving On* (in this case seeking a permanent residency), he did not

have anything to say on the subjects of *Assessment and Goal Setting* or on key sites of T-VALEX creation (*Building Skills and Resources* and *Connecting to Broader Support Network*). Client 17 was also similar to Client 18 in lacking a clear-cut continuous narrative, having previously been to the emergency bed *'some time last year'* prior to a spell in prison and then going *'back and forth'* between here and other temporary accommodation over the past month. Such experiences highlighted the need for a research methodology which allows for uninterrupted storytelling capturing complex and nonlinear trajectories, the likes of which were not fully anticipated in the planning stages of this study.

Even for those easily able to follow the narrative structure, the importance of the specific themes and images varied. Some participants required minimal prompting to speak freely about their experiences to and through Organisation X, with the TTT cards being consulted only occasionally and/or fairly far into the interview. The most extreme example of this was Client 12 (Service 1), who naturally transitioned from initial introductions (his response to the question *'could you tell me a bit about yourself?'*) into a detailed account of his life story, how this led him to Service 1, and his experience within the service. Not wishing to disrupt the flow of his narrative by forcing him to switch focus to the cards, I allowed this to organically unfold, asking occasional follow-up questions and waiting for a natural pause in the conversation before returning to the TTT.

Nevertheless, when the TTT cards were eventually consulted, these were useful for eliciting further insights into specific aspects of the service experience. This was especially the case when it came to more negative aspects of the service experience and possible areas for innovation. When speaking freely about the service in the context of his broader life story, Client 12 focused almost exclusively on the positive, emphasising how the staff had helped him and how he believed *'[he would] be dead if it wasn't for [Service 1]'*. In contrast, when asked explicitly to talk about specific themes, gaps and issues within the service began to arise. For example, the topic of assessment and goal setting led Client 12 to reflect on the limited follow-up on his identified goals (i.e. reducing drug use), asserting that staff had *'tried a little bit'* to support him towards this goal but that this had gotten *'a lot worse'* in recent times due to the impacts of understaffing and reliance on agency staff.

The cards also prompted Client 12 to talk more about broader lifeworld influences and service ecosystems. The subject of practical and emotional support led him to describe how his *'support [came] more from outsiders'*, denoting family and friends, including a close

friend also based in Service 1 at the time. On a less positive note, *Connecting to Broader Support Network* triggered an account of how the local crisis team had failed to follow through on their promise to help him claim for Personal Independence Payment (PIP), leaving him close to destitution on a very limited income:

> *'You can't clothe yourself or anything. I know on benefits you're not meant to be living the life of riley, but just to be able to clothe yourself'* (Client 12, Service 1).

The TTT cards therefore proved beneficial in helping Client 12 to provide a more nuanced picture of his experience with Service 1, that was not wholly positive despite being a dramatic improvement over his other recent life experiences. Conversely, it was the general themes of the cards, as opposed to specific images, that appeared to trigger these insights and recollections. This was true of the majority of participants for the majority of cards, with most choosing to speak broadly about a theme and rarely referring to an image directly, though the purpose and relevance of these was generally unquestioned (exceptions will be discussed in the following two sections). Having said this, images could serve as valuable memory prompts (Collier, 1957; Harper, 1986; Hebbelthwaite and Curley, 2015) for when participants got stuck on what to talk about, as in the below example which led on to a discussion about food provision in Service 1:

> *'I can't think of anything at the minute. I'm just looking – 'Facilities and Shared Spaces' – I'm just looking at the pictures, to see if…obviously we have meals together…That's at a set time, so between five and six, and you can go there any time between then – and breakfast is served in the morning, between eight and nine'* (Client 1, Service 1).

Images could also have metaphorical resonance for some participants, with one appearing to see herself in a visual representation of progress:

> *'The picture of…a body or whoever climbing a ladder, to me seems that it's showing someone that is a climbing a ladder and getting better, accepting their illness and moving on'* (Client 16, Service 3).

Overall, the themes provided by the TTT proved at least somewhat helpful in all cases, but

adhering rigidly to the TTT structure was not always appropriate, because of variations both in the nature of narratives and in how participants personally wished to structure and share their narratives. Images played a secondary role and were often not explicitly referenced or obviously drawn upon but could be beneficial in their intended roles as aide-memoirs provoking further discussion of a theme, triggering literal memories and metaphorical associations. The next section will explore what participants thought of the TTT process, based on comments elicited as conversations drew to a close.

5.8.2 Explicit Feedback

In judging the utility of the adapted TTT, it is also important to take into account explicit feedback on the cards and the interview structure. This was provided by participants after going through all cards and as our exchange was drawing to a close, at which point I asked them about how they had found the interview process. The majority of responses were positive, with the process of going through the cards described for example as *'brilliant'* (C15, S3; C16, S3), *'great'* (C13, S1), and *'really nice'* (C1, S1).

The process was also generally viewed as reassuringly simple and *'straightforward'* (C2, S2), helping participants to overcome any initial concerns which may stem from being unused to having their voices heard (Aldridge, 2016; Hamilton et al., 2014):

> *'I was a bit nervous at first, but no – easier than I thought'* (Client 13, Service 1).

Some participants further described feeling comfortable to talk about whatever they wanted, while equally not being pressured into disclosing anything they did not want to:

> *'I know I can talk about anything'* (Client 10, Service 2).
>
> *'I mean, you haven't really asked me, like, any sort of obtrusive or too personal questions, you know?'* (Client 15, Service 3).

Some responses were more ambivalent, suggesting that participants did not feel strongly one way or another about the interview process:

> *'[It was] alright. Different. Not too bad'* (Client 8, Service 3).

Of all participants interviewed, there was one who gave explicitly negative feedback on the TTT, though a couple of others also encountered issues with the process (see 5.5.3). This participant suggested he felt patronised by the format, describing it as *'childish'* and *'like being back in school'* (C3, S2):

> *'Looking at pictures and all that, and I'm thinking what the hell are they talking about?...I thought yeah, I know all these – I've done these all in school and all that'* (Client 3, Service 2).

At the same time, his comments on how he would prefer the conversation to be structured indicated that he was not against the use of images in principle, but would like to have played an active role in the creation of these:

> *'We could do sketches, send them back to you, and you think…what you think of…it's like I do them myself, and I do tidy drawings – but if we were allowed to do sketches, ok, and send them back to you, then you can go through the sketches and get the remarks out of them'* (Client 3, Service 2).

The implications of participant feedback for the usability of the adapted TTT and opportunities for future research will be considered in Chapter Six. The final section of this chapter will look at issues encountered in administering the technique, returning to Client 3 as well as a couple of other clients who expressed confusion and/or encountered difficulties during the process.

5.8.3 Issues Encountered

Besides aforementioned instances in which not all cards were applicable to all participants, administration of the TTT was largely straightforward, with most participants quickly seeming to grasp the purpose of the conversation and the role of the cards in this context. There were, however, a few exceptions to this rule, potentially related to individual variation in the prominence of visual processing (Childers, Houston, and Heckler, 1985) and/or to paternalistic or other negative associations generated by the process (Burghardt, 2013; Gerull, 2023; Melia and Melia, 1989).

Client 3, previously identified as the one client to give explicitly negative feedback on the TTT, was one of these exceptions. While images were intended to trigger memories and thus bring up discussion points, for this participant they could actually seem to shut down conversation, due to him wishing to stress that he understood the images and did not require any assistance:

> *'On this card…I'm quite happy with everything. I've got my choices and everything, and my care plan and whatever'* (Client 3, Service 2).

In spite of this, Client 3 provided a generally detailed account, but suggested that he would have preferred to be presented with the themes in isolation than alongside the cartoon images (despite assurances that he did not have to refer to any of these). Alternatively, he stated he would have liked to be more active in image generation (specific comments detailed in previous section), thus shaping the conversation to an even greater extent than was possible here (Collier, 1957; Harper, 1986; Hebbelthwaite and Curley, 2015). Relatedly, Client 6 spoke on most of the themes but expressed confusion about the purpose of the images after being asked to consult the final card:

> *'I'm just looking at images and – what am I meant to be taking from these images?'* (Client 6, Service 1).

When their intended role as memory prompts was restated, Client 6 responded similarly to Client 3, emphasising that he understood all of the images rather than relating them to his experience:

> *'I'll take all the images then…I'll take them all in, I understand them'* (Client 6, Service 1).

The third participant in this category attributed difficulties primarily to his own memory problems, but was also initially unsure about the nature and purpose of the conversation:

> *'Are you gonna be asking me questions, is all? Or do you just want me to talk about my experiences at the project – is that what you want me to talk about? Or about the staff – is that what you want me to talk about, what I want for the future, or…?'* (Client 14, Service 2).

Despite reassurances that he had provided interesting and useful information, Client 14 expressed regret about his contributions, saying that he wished he *'could give [us] something more'*. At the end of the conversation, he appeared dissatisfied with how this had gone, but again focused on his own perceived shortcomings rather than any aspect of the TTT cards or process but potentially highlighting a limitation in terms of the accessibility of the technique (Booth, 1996; Sudbury-Riley et al., 2020):

> *'I've had better interviews…[because of] my er, lack of memory'* (Client 14, Service 2).

Issues encountered thus related primarily to confusion around the purpose of the TTT cards and images, which in a couple of cases persisted despite multiple attempts to explain this, and in one instance to a participant's own memory issues. All of these clients did in fact provide fairly detailed accounts of their service experiences, but either reacted negatively to the TTT cards themselves or appeared to believe that they had provided insufficient responses. The implications of these difficulties for future adaptations/applications of the TTT and related research will be explored in the following chapter.

5.9 Chapter Summary

This chapter has explored the findings of Stage Two data collection, drawing from narratives elicited using the adapted TTT. Findings provided strong evidence of transformative value creation in most cases, but also highlighted a few instances in which this did not occur or occurred only to a very limited extent (Section 5.2). Overarching facilitators of T-VALEX were identified as active participation, community, connectedness, individualisation, and responsiveness. These were discussed firstly in relation to the focal provider domain (Section 5.3). Four key prohibitors in the focal provider domain (the effects of understaffing; limited access to early intervention and peer support; obstacles to skill development/use; and negative aspects of the servicescape) were explored, with explicit links drawn to aforementioned facilitators (Section 5.4).

The following section focused on key elements of the therapeutic servicescape, covering relational (Section 5.5.1) and restorative (Section 5.5.2) resources, before moving on to situate these within the context of broader lifeworld contexts (Section 5.6.1) and service

ecosystems (Section 5.6.2). Implications regarding the relationship between T-VALEX creation, place attachment, and behavioural intention were subsequently summarised (Section 5.7).

Finally, the utility of the adapted TTT was explored in terms of its role in narrative elicitation, explicit feedback on the cards, and issues encountered (Section 5.8). The following chapter will situate findings discussed throughout Chapters 4 and 5 within the context of extant literature and policy debates, directly applying these to the research aim, objectives and research questions.

Chapter Six: Discussion and Conclusion

6.1 Introduction

This thesis sought to address the topic of promoting transformative change within integrated homelessness and mental health services. Specifically, the research aim was *to explore the constituents of (in)effective homelessness and mental health service in a residential context, through the integration of principles from service design and TSR*. In this final chapter, I posit contributions, limitations, and areas for future research, drawing on evidence presented in the previous two chapters to address study objectives and the four guiding research questions:

RQ1. What are the key elements and processes underlying the cocreation of T-VALEX across multilevel domains?

RQ2. How is T-VALEX creation influenced by therapeutic resources and servicescapes, extending beyond the customer/provider dyad?

RQ3. How can meso-level forces help to minimise and alleviate vulnerability perceptions throughout a full service experience, particularly for multiply marginalised consumers?

RQ4. How (if at all) can a service design methodology, the Trajectory Touchpoint Technique, be effectively adapted for the context of integrated housing and mental health services?

The implications of the research are explicated, beginning with contributions to theory related to each of the RQs. RQ1 is firstly addressed (Section 6.2), proposing a multilevel value configuration space (Figure 6.3) and summarising findings regarding key facilitators across domains. Attention is then turned to the role of therapeutic resources extending beyond the customer/provider dyad (RQ2), with novel frameworks for therapeutic networks, homes-servicescapes, and service ecosystems shaping T-VALEX creation (Section 6.3). The third theoretical contribution pertains to RQ3, applying a lens of consumer vulnerability to the service experience (Section 6.4), proposing a framework for understanding the transition from acute vulnerability to personal transformation (Figure 6.6) and identifying key phases of vulnerability alleviation associated with transformative trajectories (Figure 6.7). Section 6.5

summarises the theoretical contributions set out in Sections 6.2-6.4 and how these have extended upon extant literature.

The focus then shifts to the effectiveness of the adapted TTT for uncovering opportunities for innovation (RQ4), highlighting the methodological contributions of the research in terms of the demonstrated advantages of this technique and areas for further development (Section 6.6). Specific opportunities for innovation are subsequently identified on the basis of the identified facilitators and prohibitors of T-VALEX creation (Section 6.7.1), pertaining to the preparation of agency staff, peer support and early intervention, opportunities for skill development and utilisation, and innovation in the physical servicescape. This leads on to a broader discussion of implications for practitioners across related service sectors (Section 6.7.2), pertaining both to individual service practices and regulations and to service ecosystems, pathways, and partnerships.

Limitations of the research are identified in relation to the nature of the sample and related restrictions on data collection, many of which stemmed from the COVID-19 pandemic context (Section 6.8.1). Finally, avenues for further research are proposed (Section 6.8.2), involving demographic comparisons, longitudinal research opportunities, more participatory methods, and efforts to access and engage with more 'hard-to-reach' populations.

6.2 Cocreation of T-VALEX Across Multilevel Domains

RQ1. What are the key elements and processes underlying the cocreation of T-VALEX across multilevel domains?

This thesis sought to clearly define the concept of T-VALEX and to identify facilitators and prohibitors across multilevel domains (RQ1). Having already critically analysed extant research on value creation and transformative change (Objective 2), including an overview of key synergies and differences between concepts of transformative value and VALEX (see Section 2.3), this section draws from qualitative insights provided in the previous two chapters to summarise facilitators and prohibitors of T-VALEX creation (Objective 3). Firstly, T-VALEX is conceptualised as being embedded in a multilevel value configuration space, spanning multiple spheres of influence and activity (see Figure 6.1).

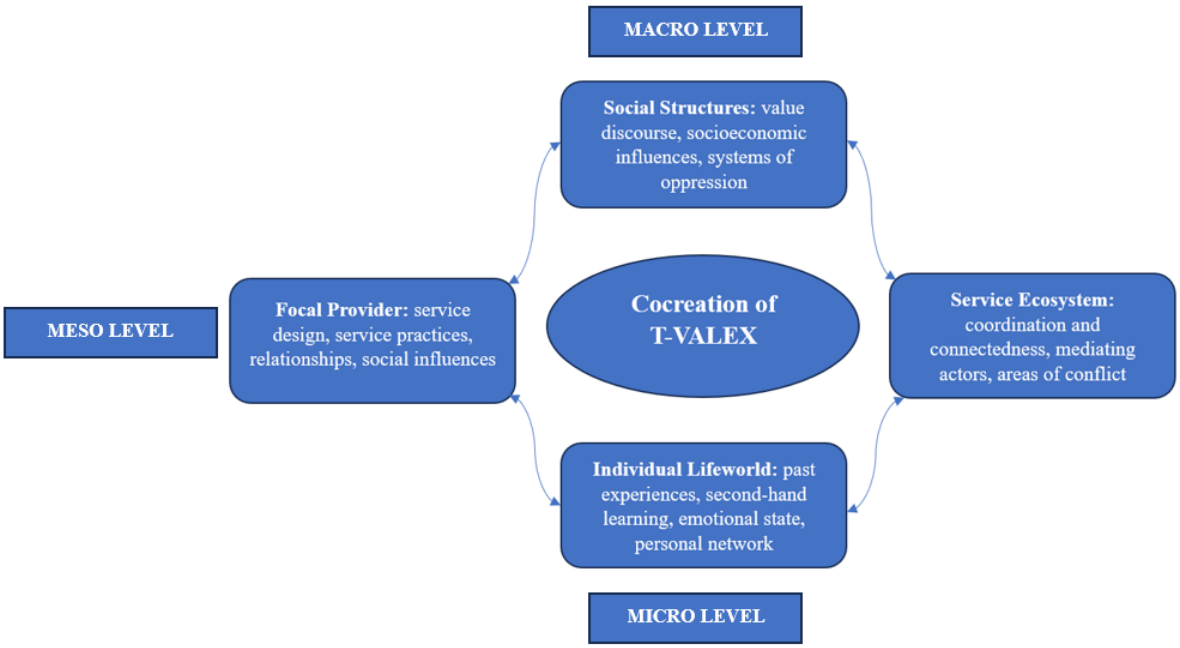


Figure 6.1: Representation of T-VALEX configuration space

The above diagram (Figure 6.1) depicts key influences on T-VALEX creation (or the lack thereof) across macro, meso, and micro levels. This embeds and builds upon aspects of the transformative value configuration space developed by Blocker and Barrios (2015), which incorporates the three levels of social structures (Giddens, 1984), service design and service practices, and human agents. Without undermining the importance of each of these elements, this research responds to calls for greater attention to both actor and systems contexts in TSR (Black and Gallan, 2015; Finsterwalder et al., 2017; Hepi et al., 2017). Consistent with VALEX (Helkkula, Kelleher, and Pihlström, 2012), it is argued that more holistic understanding can be reached through incorporating broader lifeworld contexts, helping to capture how value creation evolves within consumer networks and relationships (Cova and Salle, 2008; Grönroos and Gummerus, 2014). Additionally, the focus on individual service design and practices risks underplaying the importance of broader network factors, such as service ecosystem design (Gallan and Helkkula, 2022) and the potentially transformative role of mediation (Johns and Davey, 2019).

The proposed T-VALEX configuration space (Figure 6.1) thus takes an expanded view of both the micro and the meso level, drawing on prior research and discussion, the insights of the tenancy support service study (Spence, 2021), and novel findings presented in the

previous two chapters. At the micro level, key contributions of the VALEX construct (Helkkula, Kelleher, and Pihlström, 2012) include the impact of past experiences, with both service and nonservice interactions found to play an important role in shaping expectations and engagement; the narratives of others, for example through word of mouth; and customers' emotional states on entering into a service. Preexisting personal networks are highlighted as another key microlevel influence, with the potential to promote or prohibit T-VALEX creation and to affect the importance of meso-level support systems.

At the meso level, this framework identifies two distinct but interrelated categories of the focal provider and the broader service ecosystem (Figure 6.1). In the individual provider context, key elements of service design and service practices are drawn directly from Blocker and Barrios (2015), shaping the presentation and realisation of transformative value propositions. These include organisational provision of therapeutic servicescapes and resources, the nature and influence of which will be discussed in the subsequent section (Section 6.3). Findings additionally highlighted the importance of relationships within the focal provider sphere, including peer-to-peer as well as client/provider engagement. Finally, social influences denote less direct ways in which clients are affected by those within or adjacent to the service environment, for example through observing others model either healthy or unhealthy behaviours.

While these elements may be experienced across multiple services and providers, the importance of broader service ecosystems to T-VALEX creation went beyond merely an extension of the focal provider sphere. Findings provided insights into how ecosystem characteristics helped to shape T-VALEX creation (see Section 5.5.2), specifically illustrating the importance of network density (Black and Gallan, 2015) and the related ability of Organisation X staff to fulfill apomediary functions (Johns and Davey, 2019). Network density and apomediary capacities are both captured in the concept of connectedness, identified as one of the key facilitators of T-VALEX creation (see Section 5.6, Table 5.3). On the flip side, while clashes between different service actors were not apparent in these research findings (perhaps partially due to the focus on client perspectives), connectedness and thus T-VALEX creation may be limited by areas of conflict, as evidenced in healthcare contexts and especially in more complex service networks (Black and Gallan, 2015).

Despite the research focus on microlevel perspectives (Objective 3) and meso-level opportunities for innovation (Objective 4), it would be remiss to disregard the importance of

the macrolevel domain in shaping and constricting opportunities for value cocreation. In addition to value discourse, defined as shared cultural meanings about 'what is valuable' and associated social practices (Blocker and Barrios, 2015, p.267), this framework (Figure 6.1) draws specific attention to socioeconomic influences and systems of oppression. In doing so, this seeks to highlight how macrolevel factors (e.g. legislation and policy-level dynamics) interact with microlevel identity categories and resources to promote or constrain T-VALEX creation. While in-depth exploration of macrolevel forces was outside the remit of this study, the proposed framework situates meso- and micro-level processes within this crucial context. Future research addressing macrolevel effects on T-VALEX should critically consider how social structures facilitate value cocreation for some citizens while constraining others, applying this lens to experiences of marginalisation (Cheraghi-Sohi et al., 2020; NHS Wales, no date; Schiffer and Schatz, 2008) and policy invisibility (Corus et al., 2016; Purdie-Vaughns and Eibach, 2008).

The proposed framework (Figure 6.1) thus responds to calls for transformative service researchers to acknowledge how all consumers and providers are embedded in the combined forces of the three system levels (Fisk et al., 2016). As macrolevel forces were not a key focus of this research, and as clients largely shared the same macroenvironment and occupied (or had occupied) similar positions of socioeconomic deprivation, the main focus here is on the interplay between meso-level and microlevel forces, in the former case distinguishing between the focal provider and service ecosystem domains. Analysis of client narratives revealed five key facilitators of T-VALEX: active participation, community, connectedness, individualisation, and responsiveness. Facilitators emerged in different ways and to different extents across meso- and micro-level domains, with contributing factors (see Chapter 5, Tables 5.1 and 5.3) summarised in the respective levels of the value configuration space (Figure 6.1).

Findings suggested that all five aforementioned facilitators needed to be overwhelmingly present in at least one domain for T-VALEX creation to occur, with substantial deficits in one or more of these seeming to preclude transformative wellbeing outcomes. Conversely, there was significant variation in the importance assigned to each facilitator in each sphere, which often appeared partially determined by resource availability in other domains. For example, building on evidence regarding commercial friendships and social support deficits (Baker and Brocato, 2006; Kozinets, 2002; Rosenbaum et al., 2007), meso-level practices, relationships, and networks proved especially important for those experiencing both socioeconomic

disadvantage (macrolevel resource deprivation) and limited or destructive personal networks (microlevel resource deprivation). Equally, not all clients required or desired community in the focal provider sphere, with some accessing sufficient relational and social support resources (Leino et al., 2022) elsewhere. As this relates directly to RQ2, the relationship between T-VALEX facilitators and therapeutic resources will be further explored in the following section.

Of all T-VALEX facilitators, individualisation emerged as the most consistently highly valued at the meso level of the value configuration space (see Figure 6.1). The importance of flexibility and fluidity was reinforced within (transformative) service systems (Boenigk et al., 2020; Kuppelwieser and Finsterwalder, 2016) and servicescapes (Krisjanous et al., 2023), and was additionally demonstrated in relation to T-VALEX facilitators and temporal design strategies (i.e. pacing and duration of the service experience). Moreover, insights into temporal design suggest a key difference between typical dyadic mental health services and integrated residential services, as adaptability (captured within the concept of responsiveness) proved more important than service serialisation (Gopaldas et al., 2022) for promoting transformative interactions. These findings highlight the value of path-creating design (Pandza and Thorpe, 2010) and how this can manifest at different levels.

In summary, this study has addressed RQ1 and provided valuable insights into value cocreation and transformation (Objective 3), producing an overview of key elements and processes associated with T-VALEX creation in the form of a multilevel value configuration space (Figure 6.1). Specific facilitators of T-VALEX common across meso- and micro-level domains have been identified as active participation, community, connectedness, individualisation, and responsiveness. Key contributions pertain not only to the importance of these facilitators but to the interplay between different domains and the implausibility of transformative service standardisation. The following section addresses the relationship between T-VALEX creation and therapeutic resource integration (RQ2), depicted in therapeutic service network (Figure 6.2) and homes-servicescape (Figure 6.3) models.

6.3 T-VALEX Creation and Therapeutic Resources

RQ2. How is T-VALEX creation influenced by therapeutic resources and servicescapes, extending beyond the customer/provider dyad?

6.3.1 Situating T-VALEX Creation in Therapeutic Service Networks

Expanding upon the multilevel value constellation outlined in the previous section (Figure 6.1), research findings provided insights into the emergence of T-VALEX within complex service and personal networks, also situating therapeutic resources and servicescapes within this context. Crucially, exploration of therapeutic resources and processes extended beyond that directly offered by the focal provider (Organisation X), for example applying this analysis to peer-to-peer relationships as well as the consumer/provider dyad and to service ecosystems as well as focal service environments. Key contributions pertain to integration of and expansion upon therapeutic servicescape (Rosenbaum et al., 2020) and transformative service network (Black and Gallan, 2015) models, exploring how T-VALEX creation is influenced by therapeutic resource availability and integration at different levels.

Exploring the role of therapeutic (i.e. relational and restorative) resources in generating T-VALEX creation was identified as important in light of research highlighting the potential for therapeutic servicescapes to produce transformative wellbeing benefits (Higgins and Hamilton, 2019; Rosenbaum et al., 2020), including specifically within homelike service environments (Leino et al., 2022). Therapeutic servicescapes have been discussed in terms of the restorative and transformative potential of tangible environmental and sociospatial features, the strength and length of service relationships, and the accessibility of different forms of social support (Higgins and Hamilton, 2019; Leino et al., 2022; Rosenbaum and Smallwood, 2011; Rosenbaum et al., 2020). Conversely, research has rarely distinguished between short-term (ameliorative) and long-term (transformative) outcomes (Kaley, Hatton, and Milligan, 2019), despite evidence of (short- vs. long-term) wellbeing trade-offs in transformative service contexts (Nguyen, 2023; Russell-Bennett et al., 2020). There has also been little exploration of how servicescape features interact with customer roles and broader network factors, including if and how therapeutic resources are accessed outside of the focal provider context (Davey et al., 2021; Krisjanous et al., 2023).

In the previous chapter, key findings were shared regarding the availability and transformative potential of therapeutic resources in the Organisation X servicescape (see

Section 5.5); the impact of microlevel relational resources and deficits (see Section 5.6.1); and how T-VALEX was shaped by service ecosystems in terms of relational, restorative, and structural characteristics (see Section 5.6.2). On the basis of these findings, the therapeutic service network model depicted below (Figure 6.2) illustrates how T-VALEX creation is influenced by therapeutic resources across individual, focal provider, and service ecosystem domains. This additionally extends the literature on the three-way relationship between therapeutic resources, place attachment, and future behavioural intention (Krisjanous et al., 2023; Leino et al., 2022; Rosenbaum and Smallwood, 2011; Rosenbaum et al., 2020; Sheng, Siguaw, and Simpson, 2016), proposing two key mechanisms by which therapeutic resources exert influence on service-related intentions: via promotion of place attachment and facilitation of T-VALEX creation. Establishing the extent to which therapeutic resources have been successfully integrated in transformative value creation necessitates disentanglement of these processes and their effects.

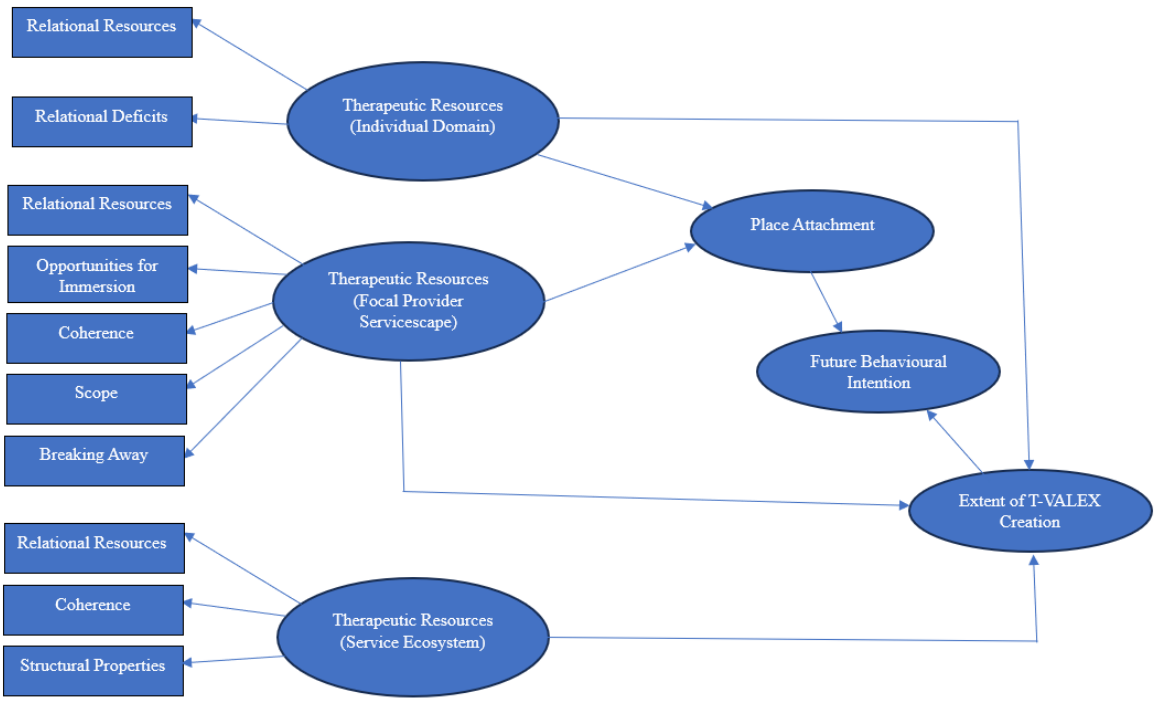


Figure 6.2: T-VALEX creation as a product of therapeutic networks

The following two subsections will focus in on different elements of the therapeutic service network model. Firstly, the adaptation of Rosenbaum et al.'s (2020) therapeutic servicescape

construct is further detailed through mapping of key elements and relationships in a therapeutic homes-servicescape (Figure 6.3), delineating and deconstructing ameliorative vs. transformative pathways (Kaley, Hatton, and Milligan, 2019). Secondly, the multilevel conceptualisation of therapeutic resources and their influences is extended through presentation of a framework for understanding the role of service ecosystems in promoting or constraining T-VALEX creation (Figure 6.4).

6.3.2 Therapeutic Homes-Servicescapes: Characterising Resources and Pathways

In representing the role of therapeutic servicescapes in T-VALEX creation, the therapeutic service network model (Figure 6.2) identifies four restorative resources emergent in client accounts of transformation (Section 5.5): Opportunities for Immersion, Coherence, Scope, and Breaking Away. This represents an adaptation of Rosenbaum et al.'s (2020) therapeutic servicescape model and the ART model characteristics (Kaplan, 1995) on which it is partially based, replacing Being-Away with Breaking Away and Fascination with Opportunities for Immersion. Importantly, this is not intended as a replacement of Rosenbaum et al.'s (2020) model but rather as an additional piece of the puzzle, identifying additional elements proposed to be necessary for therapeutic benefits to translate into T-VALEX creation. In the case of Breaking Away, transformative servicescape design encompassed not only temporary respite from concerns (Friman et al., 2018; Pasini et al., 2014) but presentation of pathways to reshape the conditions of everyday life. Similarly, while clients valued attention-holding or 'fascinating' aspects of the servicescape (Ogunmokun and Ikhide, 2022; Pasini et al., 2014; Rosenbaum et al., 2020), T-VALEX creation occurred only when these translated into Opportunities for Immersion including co-curation of environmental resources (Krisjanous et al., 2023).

Furthermore, there is no intention to suggest that the therapeutic servicescape associated with T-VALEX creation (Figure 6.2) is inherently superior or should be emulated by all services concerned with customer wellbeing. It is instead proposed that therapeutic goals should be broken down into ameliorative and transformative subcategories, as has already been proposed by some in the field of health geography (Kaley, Hatton, and Milligan, 2019), and that servicescapes should be designed accordingly. The original model appears highly well-suited to promoting processes of amelioration, befitting the aims of most hospitality/retail and even some health and social care services (Leino et al., 2022; Ogunmokun and Ikhide, 2022;

Rosenbaum et al., 2020). Conversely, where customer and/or service goals pertain to longer-term transformation, aforementioned adaptations increase the likelihood of therapeutic processes resulting in T-VALEX creation.

Additionally, findings indicated that therapeutic resources were in themselves necessary but not sufficient for T-VALEX creation, with transformative benefits also contingent upon the nature of service practices and the extent to which both practices and resources promoted overarching T-VALEX facilitators (i.e. active participation, community, connectedness, individualisation, and responsiveness). Building on Leino et al.'s (2022) discussion of homelike servicescapes, bridging the concepts of 'home' and services with transformative aspirations, a model has been developed depicting key elements and relationships in therapeutic homes-servicescapes (Figure 6.3). This illustrates the processes by which T-VALEX creation emerged and exerted influence in the focal provider sphere (RQ1), demonstrating the role of therapeutic resources (RQ2) in helping to shape ameliorative and/or transformative outcomes.

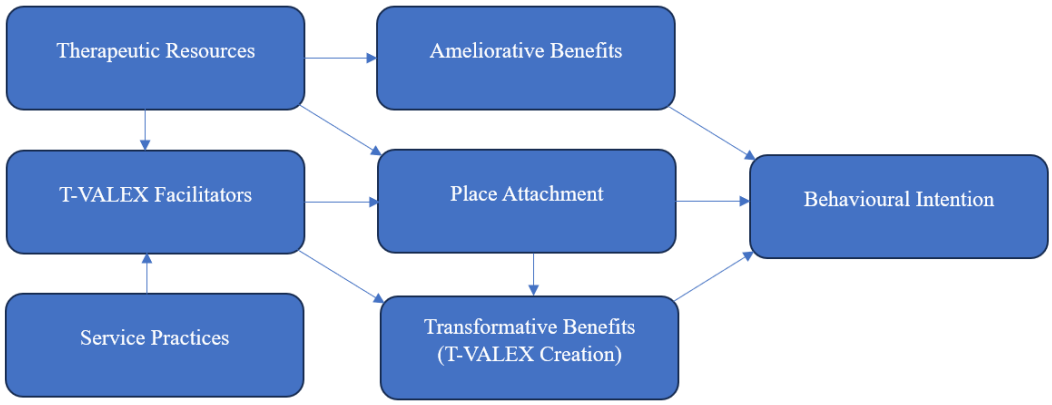


Figure 6.3: Mapping key elements and relationships in the therapeutic homes-servicescape

On the basis of the above mapping, it can be deduced that those in therapeutic homes-servicescapes access wellbeing benefits via one of three trajectories: ameliorative, transformative, or combined. The ameliorative pathway corresponds to the role of therapeutic servicescapes as typically understood in contexts of retail (Rosenbaum et al., 2020) and hospitality (Ogunmokun and Ikhide, 2022), in which customers experience temporary benefits whilst in a service environment characterised by 'restorative environmental conditions and meaningful relational interactions' (Rosenbaum et al., 2020, p.7). Moreover, this pathway can be observed in some accounts of therapeutic healthcare experiences, where

these involve providing a temporary site of respite (Kaley, Hatton, and Milligan, 2019) and arguably also where service use is inescapable (Leino et al., 2022).

Further contributions pertain to the role of place attachment in mediating the relationship between therapeutic resources and transformative outcomes. Consistent with prior research, relational and restorative resources were associated with greater place attachment, while both ameliorative benefits and place attachment influenced future behavioural intention (Brocato et al., 2015; Leino et al., 2022; Ogunmokun and Ikhide, 2022; Ramkissoon et al., 2012; Rosenbaum et al., 2020). Figure 6.3 illustrates how the degree of attachment was influenced by the availability of T-VALEX facilitators in the (physical and social) servicescape, yet a certain level of place attachment had to be established before the actual process of T-VALEX creation could begin. However, the relationship between place attachment and transformative outcomes proved complex and multifaceted, as will be elucidated upon in the following subsection.

6.3.3 A Multilevel Conceptualisation of Therapeutic Resources

Findings provide valuable insights into how therapeutic resources are accessed and integrated outside of the focal provider domain, with the therapeutic service network model (Figure 6.2) illustrating the effects of relational resources across different micro- and meso-level spheres. Building upon the conceptualisation of place as 'a repository of resources' (Rosenbaum et al., 2017, p.281), which may be designed and managed to promote (transformative) value outcomes (Krisjanous et al., 2023; Losada-Otalora and Siqueira, 2020; Rosenbaum et al., 2022), this thesis adopts a more expansive definition of the 'pool' (Rosenbaum et al., 2020, p.3) of available resources, incorporating those drawn from individual lifeworlds and across personal and service networks. In doing so, this responds to calls for further research on the role of customer resources in producing transformative outcomes (Davey et al., 2021; Krisjanous et al., 2023; Ostrom et al., 2021), how servicescapes can facilitate social support/relationships (Rosenbaum et al., 2020), and wellbeing creation in the context of collaborative networks (Black and Gallan, 2015; Ostrom et al., 2021).

Findings thus reinforced the association between social support deficits and greater place attachment (Baker and Brocato, 2006; Rosenbaum et al., 2007), whilst additionally illustrating how microlevel relational resources can be integrated into therapeutic servicescapes (RQ2) and processes of T-VALEX creation (RQ1). This extended to the role of

servicescapes in facilitating positive relationships, providing opportunities for 'rich social interaction' (Rosenbaum et al., 2020, p.7) and access to potentially therapeutic social support (Blocker and Barrios, 2015; Rosenbaum et al., 2017). Specifically, the social dimension of the therapeutic servicescape is extended to include the capacity of the environment to accommodate and integrate members of clients' personal networks, who may come together to form a network of care (Krisjanous et al., 2023).

Furthermore, findings indicate that, in complex service ecosystem contexts, T-VALEX creation is influenced by the availability of relational resources across broader service networks in addition to within the focal provider servicescape. Services operating in such circumstances may promote transformation not only through direct offerings but through facilitating client access to other providers. In the service network model (Figure 6.2), influences on the therapeutic potential of broader service ecosystems are depicted as relational resource availability, coherence, and structural properties consistent with Black and Gallan's (2015) transformative service network model. The below diagram (Figure 6.4) illustrates a process by which connections and interactions in the broader service ecosystem influence the extent of T-VALEX creation during a focal service experience.

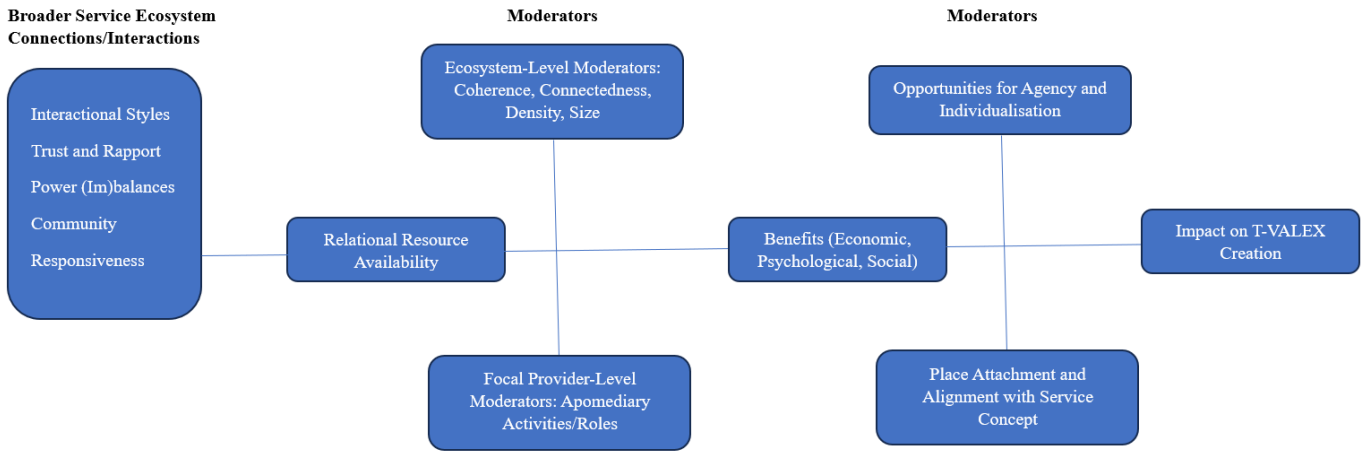


Figure 6.4: Framework for understanding the role of broader service ecosystems in promoting or constraining T-VALEX creation

The proposed framework (Figure 6.4) integrates aspects of the therapeutic servicescape (Rosenbaum et al., 2020), the transformative service network (Black and Gallan, 2015), and the novel insights generated in this study. The importance of interactional styles and power

(im)balances, primarily discussed in the context of the core service interaction (Black and Gallan, 2015), is extended to apply to broader connections and interactions across a service ecosystem. Resource availability is further linked to the building of trust and rapport, which could shape a client's willingness to rely on a given actor as 'an exchange partner with whom one has confidence' (Moorman, Deshpande, and Zaltman, 1993, p.315), and to the T-VALEX facilitators of Community and Responsiveness. On the former point, broader ecosystems could enable access to valuable peer support. On the latter, successful relational resource integration was widely associated with perceptions of exchange partners as accessible and reliable.

This framework extends understanding of the association between relational resources and certain (economic, psychological, and social) benefits (Gwinner et al., 1998; Rosenbaum et al., 2020) through capturing and characterising relational resources in the broader service ecosystem; explicating how resources and benefits relate to transformative outcomes; and identifying moderators influencing both initial benefits received and whether these translate into T-VALEX creation. Moderating forces at the level of the service ecosystem are characterised as coherence (Rosenbaum et al., 2020), i.e. the extent to which clients understand and can navigate networks to pursue their goals; and structural network properties of density and size (Black and Gallan, 2015), while at the level of the focal provider these pertained to engagement in apomediary activities (Johns and Davey, 2019). Taken together, these moderators constitute the T-VALEX facilitator of Connectedness, defined in terms of a combination of structural and interactional qualities.

Finally, the ultimate impact of this process on T-VALEX creation is moderated by the capacity for client agency (i.e. Active Participation and Individualisation) and by an individual's level of place attachment in relation to the intended service concept (Roth and Menor, 2003; Wani, Malhotra, and Clark, 2021). The complex relationship between place attachment and T-VALEX creation (see Section 5.7 for a detailed summary of relevant findings) also complicates the role of therapeutic resources within the homes-servicescape, with the potential for increased resource availability to constrain T-VALEX creation through increasing place attachment (Korpela et al., 2001; Mody, Suess, and Dogru, 2020; Purani and Kumar, 2018; Rosenbaum et al., 2020) to the detriment of future-oriented thought and action (Blocker and Barrios, 2015). Thus, insofar as therapeutic resources influence T-VALEX via increased attachment, optimal resource availability depends upon service intentions for

clients' construction of place (Littman et al., 2021), in addition to whether a servicescape seeks to promote transformative (not solely ameliorative) outcomes.

Relatedly, intentions to engage in approach behaviours (Bitner, 1992; Mehrabian and Russell, 1974) associated with therapeutic effects (Rosenbaum et al., 2020) are not always indicative of, or conducive towards, T-VALEX creation. On the contrary, the most straightforward intentions in terms of approach (i.e. remaining in the service for as long as possible) and avoidance (i.e. terminating the service relationship) behaviours both have the potential to either sustain or constrain processes of transformation. Therefore, behavioural intention should not be treated as a standalone proxy for the extent of T-VALEX creation, but rather assessed in relation to place attachment, intended service concept, and multilevel therapeutic resource availability (see Section 5.7, Table 5.4).

In summary, this research has explored the role of therapeutic resources in T-VALEX creation (RQ2), identifying multiple mechanisms of influence at meso- and micro-levels. While therapeutic and transformative properties are often treated as interchangeable within servicescape research, these findings reinforce the importance of distinguishing between benefits that are experienced solely within a service environment and those that translate into long-term effects on health and wellbeing (Kaley, Hatton, and Milligan, 2019; Willis, 2009). A one-size-fits-all approach to therapeutic (homes-)servicescapes is rejected, highlighting the importance of service design which aligns with specific aspects of the intended service concept (i.e. if intended outcomes are ameliorative/transformative and the intended construction of place). This additionally contributes towards understanding of the underexplored temporal dimension of TSR (see Section 1.5.2), including the potential occurrence of wellbeing trade-offs (Russell-Bennett et al., 2020) between different types of therapeutic benefits.

6.4 Meso-Level Influences on Vulnerability Emergence and Alleviation

RQ3. How can meso-level forces help to minimise and alleviate vulnerability perceptions throughout a full service experience, particularly for multiply marginalised consumers?

6.4.1 Emergence and Alleviation of Vulnerability Perceptions

There is widespread recognition of the need for TSR in contexts of consumer vulnerability, in which achieving transformative outcomes is often more challenging (Boenigk et al., 2021;

Johns and Davey, 2019; Rötzmeier-Keuper, 2020) yet potentially more influential and worthwhile (Blocker and Barrios, 2015). Consumers belonging to one or more marginalised groups, including homeless populations and those with chronic addiction and/or other mental health issues (Cherrier, 2017; Lewis et al., 2023; Luchenski et al., 2018; Vigo, 2016; Visconti, 2016), are frequently classed as either inherently vulnerable (Commuri and Ekici, 2008; Visconti, 2016) or at higher risk of vulnerability perceptions (Baker et al., 2005; Hill and Sharma, 2020; Rötzmeier-Keuper, 2020). Despite calls for TSR to serve such disadvantaged and stigmatised communities (Anderson et al., 2013; Fisk et al., 2015; Reynoso, Valdés, and Cabrera, 2015), to date there has been limited research on the impact of service design and other meso-level factors on vulnerability perceptions (Fletcher-Brown et al., 2021; Rötzmeier-Keuper, 2020; Wünderlich et al., 2020), leaving untapped opportunities for insight which this study sought to exploit.

In this study, multiply marginalised consumers' narratives of service use and (transformative) value cocreation shed light on the emergence and alleviation of vulnerability perceptions, crucially including the impact of factors within the focal provider servicescapes and broader service ecosystems. Consequently, these contribute significantly towards understanding the potential role of meso-level forces in minimising and alleviating vulnerability perceptions for those with marginalised characteristics. On the basis of these findings, a framework (Figure 6.5) is proposed for understanding how vulnerability emerges and can be alleviated by meso-level factors, operating through two key mechanisms of autonomy and security promotion.

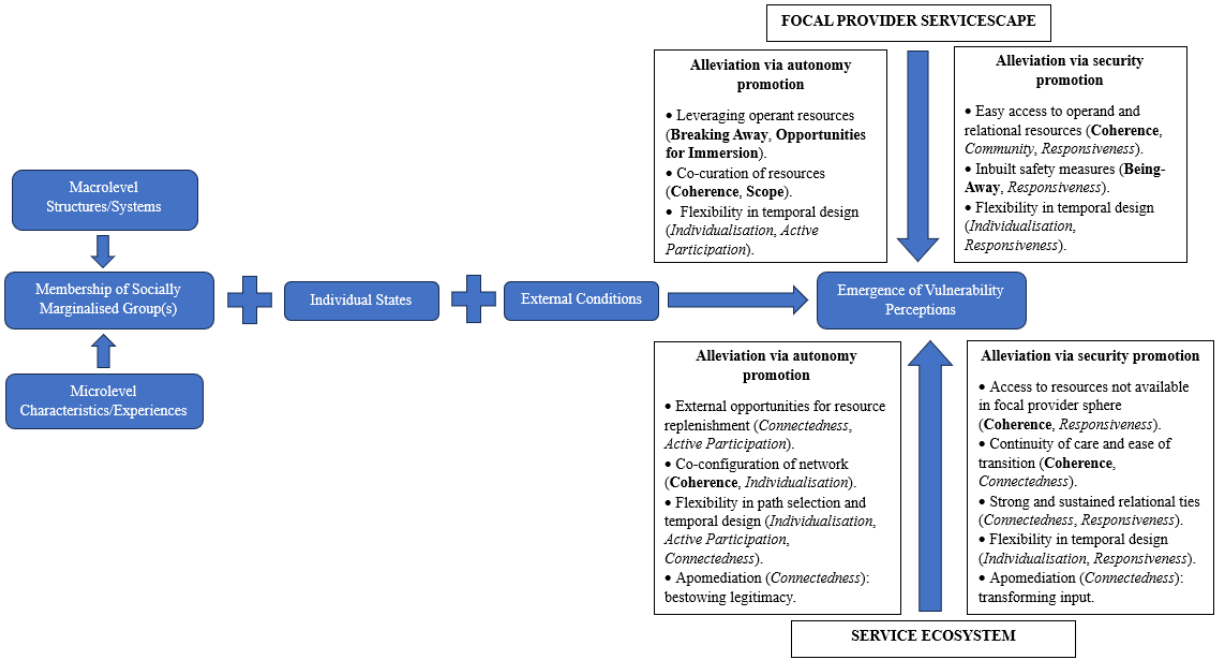


Figure 6.5: Framework for vulnerability emergence and alleviatory meso-level factors

The above framework (Figure 6.5) depicts four main pathways for vulnerability mitigation and alleviation at the meso level, via promoting either autonomy or security in either the focal provider servicescape or the service ecosystem. Alleviatory factors are additionally linked to specific T-VALEX facilitators (italicised) and/or restorative resources (in bold), situating the four pathways within broader contexts of multilevel value creation (RQ1) and therapeutic processes (RQ2). Identification of these pathways contributes towards understanding of the role of services in vulnerability alleviation, demonstrating how specific frameworks and practices may be applied to mitigate vulnerability by design (Rötzmeier-Keuper, 2020). The framework additionally addresses calls for further research on service ecosystems in TSR (Gallan and Helkkula, 2022; Previte and Robertson, 2019), including how these might be reshaped to better support consumers experiencing vulnerability (Johns and Davey, 2019).

Expanding upon Wünderlich et al.'s (2020) research on the alleviatory functions of channel design, novel insights regarding the focal provider sphere encompass physical, social, and temporal dimensions of servicescape design. Channel design strategies may additionally be reinterpreted through the lens of this framework, for example relating flexibility through multiple paths to autonomy and guidance through constrained paths to security. Such associations would have important implications for channel design at different stages and in

relation to different forms of vulnerability (see Section 6.4.2), informing the management of core value trade-offs in potentially transformative servicescapes (Sandberg et al., 2022).

Building on prior discussion of the role of therapeutic resources in T-VALEX creation (see Section 6.3), other key contributions pertain to how counter-vulnerability measures can be embedded in therapeutic servicescape design and network configuration. Efforts to strike an appropriate balance between autonomy and security promotion (Sandberg et al., 2022) may draw elements from each of the different pathways (Figure 6.5), prioritising areas of overlap such as flexibility in temporal design. Additionally, different pathways could be prioritised at different stages based on the prevalence of key vulnerability antecedents (Hill and Sharma, 2020), for example emphasising autonomy in response to restricted control and security in contexts of resource deprivation.

Furthermore, findings provided insights into the interrelated nature of vulnerability alleviation and value cocreation processes. Referring back to the proposed distinction between different types of therapeutic service (see Section 6.3.2), there was evidence of points of overlap between autonomy-based pathways and transformative trajectories (e.g. regarding co-curation and restorative resources), suggesting such factors can serve a dual purpose in alleviating vulnerability while facilitating T-VALEX creation. The role of vulnerability alleviation throughout transformative trajectories will be further explored in the subsequent subsection.

6.4.2 Key Stages of Vulnerability Alleviation in Transformative Trajectories

Building on the above overview of meso-level forces which appeared to mitigate against and ameliorate the effects of vulnerability perceptions (see Figure 6.5), further contributions pertain to the stages of the service experience at which vulnerability perceptions were most likely to occur (Wünderlich et al., 2020) and the alleviation strategies which proved most influential at these different points. Identified stages and strategies are additionally linked to different stages of T-VALEX creation, illustrating how resource replenishment and apomediation served dual interrelated functions of counteracting vulnerability sources and promoting transformational outcomes. Focusing specifically on transformative trajectories, key instances of vulnerability alleviation and mitigation throughout a full service experience are captured in the below framework (Figure 6.6), which in totality represents the process of transition from acute vulnerability and suffering to personal transformation.

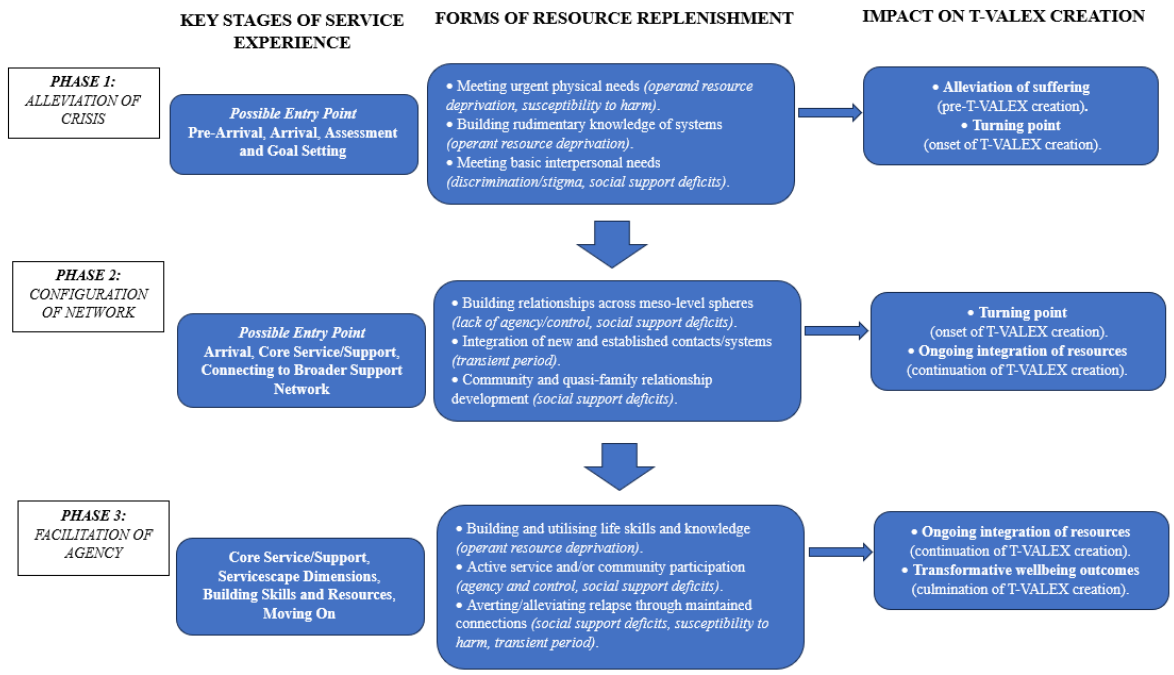


Figure 6.6: Key phases of vulnerability alleviation and minimisation throughout transformative trajectories

The transformative trajectory from experiencing acute vulnerability perceptions to transformative wellbeing outcomes is broken down into three key and overlapping phases, entailing different forms of resource replenishment at the meso level. These phases consist of the alleviation of crises caused by extreme resource deprivation, (re)configuration of support networks, and the facilitation of client agency to pursue desired (transformative) outcomes. Within each phase, specific meso-level processes are identified and tied to the alleviation of pertinent dimensions of vulnerability perceptions (italicised, in brackets). Phases are additionally linked to particular stages of the service experience and subprocesses within T-VALEX creation.

Building on prior TSR in contexts of vulnerability, the alleviatory role of meso-level forces in transformative trajectories can be ascribed to two key mechanisms: providing opportunities for replenishment of resources in the focal provider sphere (Fletcher-Brown et al., 2020) and mediating client interactions with other services, compensating for limited resources or resource integration capabilities (Johns and Davey, 2019). In addition to identifying points at which vulnerability perceptions frequently arose (Wünderlich et al., 2020) and meso-level factors counteracting these (Fletcher-Brown et al., 2021; Rötzmeier-Keuper, 2020), findings highlighted the existence of multiple potential entry points (see Figure 6.6), suggesting that

optimal strategy selection during early service use was influenced by whether clients were actively experiencing extended states of vulnerability (Phase 1) or simply at high risk of vulnerability perceptions (Phase 2) on entering the service. Specific implications for promoting innovation and enhancing T-VALEX creation, for example via peer support mechanisms, will be detailed within the discussion of implications for practice (Section 6.7).

6.5 Summary of Theoretical Contributions

Overall, this thesis makes three main theoretical contributions, corresponding to each of the first three research questions (RQs 1-3). Firstly, findings provide valuable insights into the elements and processes underlying T-VALEX cocreation across multilevel domains (RQ1), identifying five key facilitators of active participation, community, connectedness, individualisation, and responsiveness. In the focal provider context, individualisation emerged as the most consistently influential factor, with the importance assigned to all other facilitators appearing partially contingent on resource availability in other domains. Findings thus provide support for the adoption of a path-creating approach (Pandza and Thorpe, 2020) to servicescape and service system design, contributing towards debates around the possibility and desirability of (transformative) service standardisation (Boenigk, 2020; Krisjanous et al., 2023; Kuppelwieser and Finsterwalder, 2016).

Facilitators are conceptualised as emergent across micro and meso levels of a proposed multilevel T-VALEX configuration space (Figure 6.1), expanding upon the work of Blocker and Barrios (2015) and situating transformative value creation in the full context of everyday lived experience (Helkkula, Kelleher, and Pihlström, 2012). This includes the identification of multiple microlevel influences, addressing calls to explore how value creation evolves within consumer lifeworlds and relationships (Cova and Salle, 2008; Grönroos and Gummerus, 2014; Helkkula, Kelleher, and Pihlström, 2012). Extension of the meso level is also significant, building on extant TSR regarding service ecosystems (Gallan and Helkkula, 2022) and networks (Black and Gallan, 2015) through relating structural and interactional properties to T-VALEX facilitators.

The second main contribution pertains to the conceptualisation of T-VALEX creation as a product of therapeutic networks, drawing from and extending on concepts of therapeutic servicescapes (Rosenbaum et al., 2020) and transformative service networks (Black and Gallan, 2015). The proposed model (Figure 6.2) illustrates how relational and restorative

resources can be accessed across multiple domains, extending Rosenbaum et al.'s (2020, p.3) definition of the 'pool' of available resources feeding into therapeutic processes and outcomes. Additionally, two adaptations are made to the conceptualisation of restorative environmental properties (Kaplan, 1995; Rosenbaum et al., 2020), replacing Being-Away with Breaking Away and Fascination with Opportunities for Immersion. This builds upon understanding of the distinction between ameliorative and transformative service trajectories (Kaley, Hatton, and Milligan, 2019), suggesting that different therapeutic resource combinations are associated with different pathways and potentially with the occurrence of trade-offs between short-term and long-term wellbeing (Russell-Bennett et al., 2020).

Further sub-contributions pertained to different elements of the service network. Building on Leino et al.'s (2022) discussion of homelike transformative servicescapes, the therapeutic homes-servicescape model depicted in Figure 6.3 illustrates how therapeutic resources interact with focal service practices to affect T-VALEX creation. This complicates understanding of the significance of place attachment and behavioural intention within therapeutic servicescapes (e.g. Rosenbaum et al., 2020), highlighting the need to distinguish between ameliorative and/or transformative outcomes. Figure 6.4 situates these processes within a broader context, demonstrating how T-VALEX creation is influenced by therapeutic resource availability in service ecosystems. Key moderators are identified including crucial roles of client agency and alignment between place attachment and service concept (Roth and Menor, 2003; Wani, Malhotra, and Clark, 2021), illustrating the need for transformative servicescape design to facilitate co-curation (Krisjanous et al., 2023) and promote envisioned construction of place (Littman et al., 2021).

Finally, this research contributes towards understanding of how meso-level factors influence vulnerability perceptions, identifying strategies for minimisation and alleviation across different stages of the (multiply marginalised) customer experience (RQ3). Four distinct alleviatory pathways are proposed (Figure 6.5), responding to calls to design for vulnerability mitigation at both the individual service (Rötzmeier-Keuper, 2020; Wünderlich et al., 2020) and broader service ecosystem (Johns and Davey, 2019) levels. This additionally builds on extant research highlighting the coexistent but sometimes conflicting roles of autonomy and security promotion in contexts of actual or potential vulnerability (Blocker and Barrios, 2015; Sandberg et al., 2022; Sharma, Conduit, and Hill, 2017). By relating proposed strategies to one of these two mechanisms, the alleviatory framework offers guidance into managing balance and potential trade-offs (Sandberg et al., 2022), with implications for how different

resource configurations may be tailored to address different vulnerability antecedents (Hill and Sharma, 2020; Rosenbaum et al., 2020).

Furthermore, vulnerability mitigation strategies were explicitly tied to effects on T-VALEX creation, firstly through relating different mitigation strategies to specific facilitators (Figure 6.5) and subsequently through focusing specifically on the role of vulnerability alleviation in transformative service trajectories (Figure 6.6). Findings extend upon extant literature on vulnerability in transformative service contexts, mapping prevalent forms of vulnerability perceptions (Wünderlich et al., 2020) and meso-level mitigating roles (Fletcher-Brown et al., 2021; Rötzmeier-Keuper, 2020) across the different stages. Moreover, these mitigation strategies proved important for promoting transformation in contexts of marginalisation, with potentially transformative forms of resource replenishment (e.g. Fletcher-Brown et al., 2020; Johns and Davey, 2019) exerting influence through interrelated processes of vulnerability alleviation and T-VALEX creation.

In summary, this study addressed RQs 1 to 3 through the theoretical contributions outlined above. Key outputs included the development of a multilevel T-VALEX configuration space and identification of facilitators across domains (RQ1); an extended conceptualisation of therapeutic resources in relation to T-VALEX creation (RQ2); and explication of meso-level strategies and pathways to alleviate effects of vulnerability on (marginalised) consumer experience (RQ3). In the following section, attention will turn to the methodological contributions of this work, interrogating the extent to which the TTT can be effectively adapted for the research context (RQ4) and discussing broader implications for the elicitation of (transformative) CX narratives.

6.6 Methodological Contributions

RQ4. How (if at all) can a service design methodology, the Trajectory Touchpoint Technique, be effectively adapted for the context of integrated housing and mental health services?

By detailing the process and outputs of this adaptation and application of the TTT (Sudbury-Riley et al., 2020), this thesis has demonstrated the potential for such a methodology to effectively capture CX and value cocreation within integrated housing and mental health services. In addition to helping to build the evidence base for the TTT, research outputs provide insights into the potential for service design tools and techniques to promote meaningful consumer engagement and uncover opportunities for innovation. This subsection

will provide an overview of key contributions regarding the elicitation of valuable CX narratives as these pertain to homelessness and mental health service research and to TSR more broadly, highlighting the particular significance to consumers embedded in complex service networks and/or experiencing nonlinear trajectories, before moving on to address vulnerability emergence and alleviation in the research process.

Further to setting the stage for the main process of narrative elicitation, Stage One data collection led to the production of specific outputs which may be applied in different contexts and/or inform the development of related methodologies. These outputs consist of the final adapted TTT cards (see Section 3.4.3, Figures 3.1-3.8) and the mapping of key influences across (pre-, core, and post-) service stages and multilevel domains (see Section 4.2, Figure 4.1). Returning to the typology of integrated interventions detailed in Section 2.12 (Table 2.5; see Centre for Homelessness Impact, 2020), the methodology proved sufficiently versatile to capture service experiences of varied durations involving different levels of support. Thus, future research seeking to evaluate and compare different models may either make direct use of the adapted TTT cards or use these and/or the overview of service stages (Figure 4.1) as a starting point and guide for developing a more tailored methodology.

Furthermore, insights from development and administration of the adapted TTT highlighted the need for a narrative methodology which captures service experiences lacking a clearcut endpoint or continuing until the end of a client's life. While the original TTT explored post-service dimensions of palliative care from caregivers' perspectives (Sudbury-Riley et al., 2020), the particular focus of this study was on clients' perceptions of T-VALEX creation (RQ1, RQ2) and vulnerability (RQ3) across full service experiences, some of which included a post-service stage in the traditional sense and others of which did not (see Section 5.7 for findings regarding intended service outcomes and construction of place). It was thus important for the methodology used to elicit accounts both of physically moving on from services and of how 'moving on' was conceptualised in a context of indefinite service use, a flexibility of function which was facilitated by replacing the post-service stage typically employed in the TTT with the broader theme of 'Moving On'. An unanticipated but positive outcome was the extent to which this also prompted discussion of participants' future hopes and priorities, reinforcing the potential effectiveness of the TTT for service planning as well as service evaluation (Lewin et al., 2020).

Furthermore, observations regarding the role of the adapted TTT in narrative elicitation (Section 5.8.1) and explicit feedback received from Stage Two participants (Section 5.8.2) present implications for how service design methodologies capture nonlinearity in client progression through services and service stages. The importance of accounting for diverse patterns of movement and instances of circularity proved significantly greater in this instance than in the context of palliative care in which the original TTT was developed and first applied (Sudbury-Riley et al., 2020), consistent with evidence of the high relapse rate associated with mental health issues (Ali et al., 2017) and high rates of recidivism for formerly incarcerated populations living in supported housing (Metraux, Roman, and Cho, 2007). While flexibility in administration of the technique (described in Section 5.8.1) enabled discussion of multiple encounters within a single stage, this could risk disrupting participants' narrative flow if they felt compelled to follow a structure incongruent with their lived experience and personal sensemaking (Jovchelovitch and Bauer, 2000). Future applications of this and related techniques may be designed to more effectively capture variation and regression in client trajectories, specific recommendations for which will be proposed in Section 6.8.2.

Evidence of the potential for the adapted TTT to generate rich client narratives and uncover areas for innovation in the research context presents opportunities to adopt a novel and more holistic approach to mental health service evaluation, diverging from the traditional focus on limited quantitative measures and clinical care dimensions (Gill, White, and Cameron, 2011; Newman et al., 2015; Smallwood, 2011; Staniszewska et al., 2019). Relatedly, this addresses calls in both homelessness and mental health service research for the development of forms of evaluation and monitoring in which service users can be consistently and meaningfully involved (Making Every Adult Matter, 2020; Ocloo et al., 2021; Phillips and Kuyini, 2018), providing an avenue for effective client participation and proposing ways to enhance the accessibility and influence of this process. More broadly, the adapted TTT is tailored specifically to capturing experiences of T-VALEX creation, including cards specific to key sites of T-VALEX creation (*Building Skills and Resources* and *Connecting to Broader Support Network*) in addition to service experience stages and servicescape dimensions (see Section 3.4.3, Table 3.2 for an overview of different versions of the TTT). The inclusion of these cards may prove similarly beneficial for eliciting narratives of other services which are transformative by design (Rosenbaum et al., 2011), including diverse health and social care

settings, helping to distinguish between different forms of value creation (Blocker and Barrios, 2015) and different types of therapeutic effects (Kaley, Hatton, and Milligan, 2019).

6.7 Implications for Practice

6.7.1 Specific Opportunities for Innovation

Client narratives elicited using the adapted TTT provided valuable insights into processes of T-VALEX creation and how these were influenced by multilevel interactions and (therapeutic) resources. On the basis of these findings, specific opportunities for innovation are proposed to promote identified facilitators (see Section 5.3) and mitigate against identified prohibitors (see Section 5.4) of transformative wellbeing outcomes, seeking to provide valuable guidance to Organisation X and related services.

6.7.1.1 Preparation of Agency Staff

Insufficient staffing was identified as a likely prohibitor of T-VALEX creation (see Section 5.4.1), which appeared to detract from staff responsiveness, opportunities for community building, and apomediary capacities (Johns and Davey, 2019) associated with connectedness. An additional dimension of this was the resultant reliance of Organisation X services upon agency staff who were widely perceived as ill-equipped for their roles, resulting in negative effects on the social servicescape and a reduction in approach behaviours (Mehrabian and Russell, 1974) linked to active help seeking. Findings thus have multiple implications in terms of agency staff training and preparation, some of which come under the remit of the focal provider (Organisation X) and others of which pertain to broader service ecosystems.

Pursuing innovation in this area may begin with reviewing agency staff training to assess the extent to which this is comprehensive and consistent, equipping all to offer both interpersonal reassurance and practical assistance. While much of agency staff training is likely outside of the focal provider's control, it may be possible to exert some control over these touchpoints through partnerships with external organisations, as previously described in the context of health service delivery networks (Tax, McCutcheon and Wilkinson, 2013). More selective recruitment processes may also be beneficial in identifying those whose abilities and experiences align with key aspects of the intended service concept (Roth and Menor, 2003),

such as a culture of care and respect, and who display attributes associated with perceptions of community and responsiveness (see Section 5.3, Table 5.1). Such considerations may be conducive towards promoting and maintaining the intended service culture (Lee, 2004), accounting for the implausibility of fully standardised interactions (Sangiorgi, 2004) but going beyond simply requiring base level practical knowledge or skills.

In practice, however, the capacity for selectivity is limited as reliance upon agency staff results from persistent issues of understaffing. High staff turnover was a prevalent issue in the research context, not only coming through strongly in the data but also impacting upon the process of data collection. This is characteristic of much of the homelessness sector (Rogers, George, and Roberts, 2020; Voronov et al., 2023), with preexisting sectoral issues being exacerbated by the COVID-19 pandemic context (Schneider et al., 2022). In resulting contexts of reliance on agency staff with little control over recruitment and training, homelessness service providers may indirectly promote staff members' involvement in T-VALEX creation through ensuring they receive comprehensive informational resources at the outset of employment. Specifically, the capacity to deliver individualised and responsive care may be enabled through fairly simply, low-resource solutions such as the provision of client information sheets, including basic information (e.g. name, date of birth) and a brief summary of relevant history and/or support needs. The negative impacts of understaffing may also be mitigated by embracing untapped opportunities for peer support and early intervention, which are explored in detail below.

6.7.1.2 Peer Support and Early Intervention

Limited access to early intervention and peer support was identified as a notable prohibitor of T-VALEX creation (see Section 5.4, Table 5.2), constraining the development of potentially transformative relationships (i.e. community) and practices (i.e. active participation). Such support deficits and delays were associated with increased likelihood of vulnerability perceptions, the maintenance of unhealthy relationships and/or behaviours, and place detachment or active rejection of place (see Section 5.7, Figure 5.1). At the same time, where strong informal peer support mechanisms did exist, these were associated with mutually beneficial processes generating eudaimonic wellbeing outcomes on both sides of the exchange (Blocker and Barrios, 2015; Parsons et al., 2021). Multiple clients additionally expressed a desire for more active engagement in customer citizenship behaviours such as

advocacy and helping (Choi and Kim, 2013; Roy et al., 2020). Taken together, these findings suggest there are untapped opportunities for peer support, which could also play a key role in facilitating early intervention and thus reducing the likelihood of clients reaching crisis point.

Strategies to promote peer support and early intervention may be developed for different stages of the service experience, drawing on findings regarding the different phases of vulnerability minimisation and alleviation in transformative trajectories (see Section 6.4.2, Figure 6.6) to identify points at which social support resources are most needed and when to prioritise specific forms of social support (Helgeson, 2003; Rook, 1984). Key functions of peer support may be determined in relation to different forms of resource deprivation constraining T-VALEX creation and increasing the likelihood of vulnerability perceptions. For example, in the earliest stages of the CX (see Figure 6.6: Phase 1), instrumental peer support in the form of guidance on service system operations may prove highly beneficial in helping new clients to build operant resources and thus engage effectively in processes of value cocreation, while simultaneously building rapport conducive towards other forms of social support. Peer support mechanisms should be embedded in the configuration of client networks (Figure 6.6: Phase 2), providing additional avenues for clients to access relational resources (Rosenbaum et al., 2020) and crucially to disclose distress and receive emotional support (Helgeson, 2003; Rook, 1984) prior to reaching crisis point.

Models of peer support may draw inspiration from prior research on the value of ‘buddy’ systems in homeless service provision and other health and social care services, with more experienced clients adopting supportive roles analogous to ‘patient navigators’ (Jandorf et al., 2005; Salem, Kwon, and Ames, 2018) advising and assisting others as they move through the same services and systems. Clients acting as navigators should be empowered to take on some of the apomediary roles associated with transformative service mediators, crucially including serving as ‘a trustworthy ally…who guides consumers to information and services of high quality’ (Johns and Davey, 2019, p.9).

Given the importance of early intervention and harm reduction (Benston, 2015; Cox, Hayter, and Ruane, 2010; Laudet and White, 2010), it is also important to ensure that peer support programmes include inbuilt safeguarding mechanisms. Provided client interest and resources are sufficient, this should be underpinned by training a subset of clients to recognise and respond to signs of severe distress and suicidal ideation, potentially partnering with suicide

prevention charities and/or utilising their existing training resources (Every Life Matters, 2023; Zero Suicide Alliance, 2022).

6.7.1.3 Opportunities for Skill Development and Utilisation

Opportunities for skill building were found to influence T-VALEX creation primarily through promoting active participation, with individualisation also proving particularly important here. This included adapting service practices to meet different clients' wellbeing needs, for example regarding autonomy and security (Sandberg et al., 2022), and embedding flexibility in routines to account for unpredictable lifestyles and wellbeing states (Deegan, 1988; van Weeghel et al., 2019). At the same time, there were multiple points at which obstacles to skill development or utilisation arose, reducing clients' capacities for agency and thus constraining processes of T-VALEX creation (see Section 6.3.3, Figure 6.4). Given that perceptions of powerlessness are also associated with vulnerability perceptions (Riedel et al., 2021), minimisation of these obstacles is key for multiply marginalised consumers to receive full benefits from potentially transformative trajectories.

Specific opportunities for skill development and use may draw from the resources of both the focal service provider and the broader service ecosystem and may be tailored to different stages of the service experience based on the specific factors prohibiting T-VALEX creation and/or contributing towards vulnerability perceptions. For example, the ease of transitional periods (i.e. moving to a more independent form of living, for example from Service 1 to Service 2) may be increased through providing the option of attending classes in certain 'life skills' (e.g. budgeting, cooking) prior to physically moving on, with Organisation X either providing these themselves or signposting to other organisations (e.g. local colleges and community centres). Efforts may also target the use of facilities and shared spaces during the core service experience, particularly within Service 1. For example, the risk of meal provision promoting dependency and institutionalisation (Huber et al., 2020; Khan, 2010) may be mitigated by including interested clients alongside staff on the rota for cooking meals, as well as potentially organising peer-led group cooking and/or baking evenings.

Such skill-building initiatives could be mutually beneficial, providing group leaders with a sense of purpose and achievement whilst helping others to build on skills and knowledge required for more independent living. In addition to promoting active participation, these

events would also likely provide opportunities for informal peer support and community-building, potentially even facilitating the formation of quasi-family units (Begun et al., 2018; Gasior, Forchuk, and Regan, 2018; Smith, 2008). Conversely, community development frequently depends upon physical as well as social servicescapes (Kozinets, 2002; Sheng, Simpson, and Siguaw, 2017; Singleton and Losekoot, 2020), and in this case could be impeded by issues with shared spaces discussed in the previous chapter (Section 5.4.4). Specific recommendations for enhancing the physical environment are provided below.

6.7.1.4 Innovation in Physical Servicescape

While many aspects of the physical servicescape were praised, there were some significant criticisms, pertaining particularly to shared spaces. Some of these spaces were in poor condition in terms of being unclean and/or physically inaccessible, while others were unappealing simply because of a lack of decoration or personalisation. Findings further indicated that engaging some clients in cleaning and decoration may serve a dual purpose, helping to foster personal pride and environmental ownership whilst also making these spaces generally more appealing and encouraging social interaction.

In light of these findings, it is proposed that involving clients in the decoration of shared indoor areas may help to foster feelings of psychological ownership and place attachment, facilitating the transformative cocreation of wellbeing. Targeted outdoor clean-up efforts could be similarly beneficial, involving clients themselves and/or connecting with other community-based organisations and services. Connections to other services may also provide access to outdoor space when this is not available or accessible in the focal service context, for example establishing partnerships with local public gardens to grant access to potentially therapeutic servicescapes in exchange for client contributions.

6.7.2 Broader Implications for Practitioners

In addition to specific opportunities for innovation described above, findings also had broader implications for transformative design across homelessness, mental health, and related service sectors. In particular, this research sought to shed light on the processes generating and maintaining transformative change in contexts of multiple marginalisation, detailing specific benefits and limitations of the residential services in question (Benston, 2015;

Carnemolla and Skinner, 2021; Centre for Homelessness Impact, 2020). Findings overwhelmingly pointed towards the advantages of unconditional services over enforcement of treatment or sobriety criteria, as transformative outcomes proved largely contingent upon clients' abilities to set their own timelines and define their own recovery trajectories.

Findings additionally contributed towards debates regarding the appropriate level of autonomy for clients in unconditional residential services (Benston, 2015; Tabol, Drebing, and Rosenheck, 2010). In terms of the identified facilitators of T-VALEX, autonomy may be broken down into the two dimensions of individualisation and active participation. Individualisation signified the ability of clients to play a leading role in determining their own goals and influencing related service practices, including the nature and extent of their participation behaviour (Cho and Kim, 2013; Roy et al., 2020; Yi and Gong, 2013). Autonomy in the sense of individualisation proved important across all services and stages, with service practices and intended outcomes needing to be tailored to the client in order to achieve any level of transformative change (see Section 6.2). This included following clients' lead in terms of the appropriate level of active participation, being aware of instances in which maximising participation may actually conflict with their goals, abilities and/or needs.

Participant accounts revealed multiple ways to exert influence over external touchpoints (Becker and Jaakkola, 2020), helping to counter common barriers to mainstream housing and mental health services (Gavine, 2013; Rogers et al., 2020; St Mungo's, 2016). Through accompanying clients and directly liaising with others on their behalf, individually assigned support workers in particular could help to bridge the gap between needs and support, compensating for individual difficulties with resource integration and for others' discriminatory and exclusionary practices. Furthermore, the nature of connection to broader support networks varied across the three services, allowing for comparisons to be drawn between consolidated and standardised systems (as were in place for Service 3) and more adaptive, loosely coupled networks (as were in place for Services 1 and 2).

The comparative advantages of Service 3 highlighted the importance of strong pathways, or gateways (Mackie, 2014b; Rogers et al., 2020), for clients moving between different services. Specific benefits of these strengthened pathways included consistency in clients' personal support networks and effective interagency protocols, which together lessened the difficulty of transitional periods and reduced the likelihood of clients slipping through gaps in the system. At the same time, adaptability and flexibility were also important for developing

personalised pathways and networks. Overall, findings provide support for system-level protocols which are highly consolidated but adaptive, enhancing coordination and efficiency whilst also leaving space for variation based on individual goals, abilities, and support needs.

The identification of specific facilitators and prohibitors of transformative outcomes, via T-VALEX creation, may be highly informative for mental health services and others seeking to promote eudaimonic wellbeing, particularly in a context of low success and/or high relapse rates (Ali et al., 2017; Anderson and Ostrom, 2015; Blocker and Barrios 2015; Russell-Bennett et al., 2020). Recommendations pertain both to seeking to reduce the risk of relapse and to building this possibility into service and system design, acknowledging that this is often an inevitable part of recovery (Deegan, 1988). Instances of relapse were associated with misalignment between service and client timelines, and in some cases with insufficient opportunities for active participation and/or community engagement. Practical ways to factor in episodes of deterioration include prioritising smooth transitions between and ease of return to services, thus reducing diversions from goal pursuit/virtuous trajectories, and keeping channels of communication open even after a formal service period ends.

6.8 Research Limitations and Opportunities for Further Research

6.8.1 Research Limitations

As described above, this thesis makes multiple important contributions. These include proposing novel frameworks for understanding value creation, therapeutic and transformative processes and resources, and the role of meso-level forces in reducing vulnerability perceptions. Additionally, research outputs demonstrate the utility of a novel methodological approach and are used to offer specific implications for practice. Nevertheless, it is important to acknowledge the limitations of this research. All data was collected from one organisation in South Wales, UK, precluding comparison of findings across different local, cultural, and legislative contexts (Hackley, 2001; O'Brien, Fossey, and Palmer, 2021).

Furthermore, while the age range included was fairly broad (25-63), this excluded formerly homeless youth and over 70s, both of whom may encounter specific forms of vulnerability and discrimination (Centre for Homelessness Impact, 2020; Vázquez et al., 2021). The one participant who may still be classified as a 'young person' (Client 20, age 25 – see

FEANTSA, 2020 for a definition of homeless youth) described an overwhelmingly negative experience of Service 1 which contrasted with the majority impression. This may stem in part from different goals and priorities which are more prevalent amongst young people, including a particularly strong relationship between experiences of competence and wellbeing (Brueckner, Green, and Saggers, 2011; Krabbenborg et al., 2017). It is also important to acknowledge that Participants 19 and 20 were refugees, a fact which inevitably had a profound influence on their experiences (Couch, 2011; Flatau et al., 2015).

Additionally, all data was retrieved from 2020 to 2022, a limited time window which is particularly notable given the impact of the COVID-19 pandemic and successive lockdowns from March 2020. This had important implications in terms of both possibilities for data collection and the generalisability of findings. On the former point, ethical approval during the height of the pandemic was contingent upon all data being collected virtually, precluding original plans to engage in face-to-face conversations and observation. The pandemic was also associated with recruitment difficulties as many relevant organisations lacked the staff and resources for research engagement (Kirby, 2020), contributing towards the decision to focus on a single organisation. Furthermore, most participants' experiences were profoundly influenced by the pandemic, providing a fascinating snapshot of this time period but potentially reducing the broader applicability of findings.

While application of the adapted TTT largely produced rich and in-depth narratives, in a few instances the quality of data may have been compromised by participants' difficulties with and/or negative perceptions of the methodology. Though unavoidable in the pandemic context, the fact that all conversations were conducted virtually (in most cases without video) may have reduced the overall quality of interactions and thus the level of detail provided, for example due to the lack of nonverbal cues (Irvine, Drew, and Sainsbury, 2013). Finally, the collection of one-off narratives at a singular point in time may provide a limited perspective compared to longitudinal research (Bryman, 2008; Forchuk et al., 2006; Guba, 1981; Kirkpatrick and Byrne, 2011). Many of these limitations were inevitable within the thesis context but may be addressed in future research, specific avenues for which are proposed below.

6.8.2 Avenues for Future Research

6.8.2.1 Demographic Comparisons

Future studies may provide novel insights through comparing the experiences of different groups within the broad research population, exploring how different demographic characteristics affect CX and thus the effectiveness of accommodation-based interventions (Centre for Homelessness Impact, 2020). For example, age-related factors may influence not only the constituents of T-VALEX creation but the overall nature of CX (Canham et al., 2022; Centre for Homelessness Impact, 2020; Krabbenborg et al., 2017). While this research captured a range of life experiences at different stages of adulthood, as previously acknowledged, this did not touch on the experiences of (formerly) homeless young people (under age 25) or of those over 70, which may meaningfully differ from the more middle-aged majority of study participants (see Section 3.4.5, Table 3.3).

Concepts of 'moving on' and transitional periods are particularly pertinent here. For example, homeless young adults often move directly from children's homes into hostels or onto the streets, with potential implications for the risk of institutionalisation (Tyler and Schmitz, 2013), whereas older people are less likely to have an independent future and may require integrated end-of-life care (Canham et al., 2022; Webb et al., 2020). Age has also been linked to the nature and extent of stigma facing homeless populations (Vázquez et al., 2021), likely influencing the manifestation and alleviation of vulnerability at different touchpoints. Research with these groups could thus be highly informative for testing and refining the proposed models, potentially helping providers to offer more tailored support and to strengthen connections with other relevant services.

Other demographic comparisons may be similarly beneficial, for example exploring if and how different traits influence the importance of different facilitators and resources and identifying any necessary adaptations to models of CX, service delivery, and peer support. The ways in which vulnerabilities are experienced, alleviated, and tie in with T-VALEX creation may vary particularly for those also belonging to other stigmatised groups, such as ethnic minorities, immigrants, and members of the LGBTQ+ community (Fraser et al., 2019; Hill et al., 2022; Kaur et al., 2021; Milburn et al., 2006; Olivet, Dones, and Richard, 2019; Vázquez et al., 2021).

Limited demographic data was collected in this study, with participants not being asked for any specific information besides age and gender. However, the majority of participants appeared to be White British, with the exception of two Asian immigrants whose experiences did differ significantly from the majority (see Section 5.2). Participants were predominantly male, though female clients were better represented than is often the case in homelessness research (e.g. Benston, 2015). Nevertheless, greater attention to homeless women's accounts and if/how these differ from their male counterparts may elucidate how value creation emerges against a backdrop of gendered experiences and expectations, including specific vulnerabilities, power imbalances, and traumas (Gordon et al., 2019; Lewinson et al., 2014; Phipps et al., 2021).

6.8.2.2 Longitudinal Research Opportunities

Operating outside of the time and resource constraints of the PhD, future research may adopt a longitudinal design in order to delve deeper into temporal aspects of wellbeing, T-VALEX, and vulnerability emergence/alleviation. This may involve scheduling multiple conversations with the same participants at different points in time, employing a broader range of qualitative data collection methods, and/or adopting a mixed methods approach. The collection of multiple narratives at different stages may be used to develop a more comprehensive and holistic understanding of CX including affective and cognitive responses, capturing these while they are still felt rather than relying upon hindsight, and exploring how extended experiences are framed and reframed over time. Where applicable, this should include collection of narratives after clients have fully left the service(s), providing greater insights into longer-term (transformative) outcomes.

Additional qualitative methods which may be employed in longitudinal studies include direct participant observation, providing richer contextual understandings and lending greater credibility to the research findings (Bryman, 2008; Guba, 1981; Tuunanen and Peffers, 2018). This may include observation of one-on-one staff/client meetings, social events, and interactions with broader service ecosystems (Kirkpatrick and Byrne, 2011). This is particularly pertinent given that observation proved an important role in developing the original TTT (Sudbury-Riley et al., 2020) and was originally planned to contribute towards production of the adapted technique but proved impossible in the COVID-19 pandemic context.

Future adaptations of this version of the TTT may thus benefit from a period of observation complementing direct participant consultation, gathering data and seeking to build participant trust prior to narrative elicitation. Observation and other ethnographic methods may additionally be employed at later stages of the research process, facilitating the comparison of different types of data (Barely, 1990; Glaser and Strauss, 1967). Such a longitudinal, multimethod study may further benefit from quantitative data collection, seeking to validate observed associations with a larger sample whilst still centring individual voices and narratives.

6.8.2.3 Creating More Participatory Methods

In addition to the aforementioned benefits of employing a broader variety of methods over a longer period of time, building more active participation into all stages of future studies could improve both participants' experiences and the quality of data collected. As was suggested by one participant (see Section 5.8.2), this may involve providing participants with the opportunity to create or select their own images in advance of narrative elicitation, resulting in multiple individualised versions of the TTT cards. While processes of adapting and administering the TTT were already designed to centre clients' perspectives on key touchpoints and stages, the ability to physically select representative images has been linked to participants' capacity to 'drive' conversations and projects (Collier, 1957; Harper, 1986; Hebbelthwaite and Curley, 2015), enhancing their narrative control and reducing the risk of researcher bias distorting client perspectives.

There are multiple possible ways of going about this, dependent upon participant and researcher capacities. At the most time and resource-intensive end of the spectrum, all participants may be asked to produce their own cartoon images (or, if they are unable/unwilling to draw, to select these from Google Images or equivalent) for each of the TTT cards, stages and suggested touchpoints for which would already be established based on other forms of data collection. Alternatively or additionally (if only a subset of participants are involved in active creation of images to be used more widely), participants may be invited to look through and select images and/or full cards that apply to their service experience prior to the TTT conversation.

Such individualised adjustments should allow for diverse and complex CX to be represented, while also avoiding repetition and redundancy. Depending on the complexity of an

individual's experience, multiple sets of cards could be combined to represent multiple instances of service use subsumed within the whole, which may then each be explored separately in a chronological sequence of narrative conversations. At the least, if images are still developed by researchers on the basis of semistructured interviews and other qualitative data collection, clients could be consulted on these prior to their use. Ideally this would involve both a form of member checking with those providing data at this stage, seeking to ensure authenticity of representation (Kornbluh, 2015; Lincoln and Guba, 1986), and testing how images are received by a subset of the broader research population in an effort to identify likely areas of confusion or contention.

6.8.2.4 Including the Excluded

Given that a key aim of this research was accessing and sharing marginalised voices, future enquiries may shift attention to those who were excluded by participation and/or service criteria. In particular, it could be informative to elicit narratives and other qualitative data from those in the target population for supported housing who are currently either homeless or residing in institutional settings, such as psychiatric hospitals and prisons. This should include both those who have never accessed residential services and those who have left or been evicted. While a few participants did describe experiences in the latter category, all were by definition in services at the time of data collection, omitting the perspectives of individuals who faced insurmountable barriers to access or re-entry.

Investigations of this nature have the potential to meaningfully build on the thesis contributions, in terms of both theory and practice. Experiences of hospitals and prisons may be compared to those of residential services, for example looking more in depth at processes of institutionalisation. Understanding of value creation, including T-VALEX facilitation and mitigation, would also be enhanced through directly engaging with noncustomers, former customers, and prospective customers, reflecting the capacity for value to emerge even in the absence of direct service user/provider interactions (Helkkula, Kelleher, and Pihlström, 2012; Meyer and Schwager, 2007; Vargo, 2008).

From a practical perspective, such research could provide novel insights into areas of policy invisibility and untapped service needs (Corus et al., 2016; McCarthy, 2020; Purdie-Vaughns and Eibach, 2008). At the same time, recruitment from an even more socially marginalised population raises further ethical and logistical challenges (Aldridge, 2014; Goodley and

Moore, 2000; Rötzmeier-Keuper, 2020), with currently homeless individuals in particular facing many barriers to participation. In the absence of a core service providing (relative) stability, it is especially important that research procedures account for individual lived realities and provide appropriate support throughout (Sakamoto et al., 2008). This may include compensating participants not only for their time but also for food and travel expenses, ensuring that all essential needs are taken care of and freeing up energy usually dedicated to survival (Norman and Pauly, 2013).

6.9 Concluding Remarks

This thesis explored the constituents of (in)effective integrated homelessness and mental health services in a residential setting, taking a holistic view of service experiences to understand processes of transformative change and pinpoint opportunities for innovation. Specifically, the research process sought to elaborate upon existing understandings of value cocreation through the nascent concept of T-VALEX, explored in relation to multilevel processes and (therapeutic) resources; to investigate the roles of meso-level forces in vulnerability minimisation and alleviation; and to adapt, apply, and evaluate a systematic narrative methodology, the TTT, in this context. Adopting an interpretivist epistemological stance, participants' individual experiences and perceptions were placed front and centre, generating rich insights into complex trajectories including interlinked experiences of vulnerability and value cocreation.

Processes and facilitators underpinning value cocreation were identified and explored, focusing specifically on instances of profound and holistic change captured by the T-VALEX construct and situating therapeutic resources and servicescapes within this context. This study further addressed meso-level gaps pertaining to consumer vulnerability and marginalisation, whilst also extending the focus beyond a customer/provider dyad to integrate broader service networks as well as microlevel forces. Practical contributions pertained not only to integrated residential services specifically but also to other potentially transformative services and service networks, raising a plethora of opportunities for future research.

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APPENDICES

Appendix 1: Call for Participants – Stage 1 (Staff)

Call for Participants: [Organisation X] Staff Interviews

What is the purpose of these interviews?

You should already have been made aware that a sample of [Organisation X] clients will be interviewed by a researcher at the University of Liverpool, investigating what is already working well in [Organisation X]'s residential services and any opportunities for innovation. Before carrying out these main interviews with clients, we are also hoping to interview a small number of [Organisation X] staff.

It is the purpose of staff interviews to get a better sense of the nature and structure of [Organisation X]'s residential services. This will be helpful in developing the technique used to interview clients in the main study, which is a visual tool called the Trajectory Touchpoint Technique. We are very happy to send over more information and examples of the technique if this would be helpful for you.

What will these interviews consist of?

Interviews will be unstructured, simply consisting of discussions of the structure of [Organisation X]'s residential services and what you consider to be the most important elements.

How do you get involved?

If you are interested in participating and/or would like any further information, **please contact Chloe.Spence@liverpool.ac.uk**. You will be emailed a consent form and an information sheet giving more details of the study and can then decide if you wish to participate.

However, **you are under no obligation to participate**, and this will not affect your work with [Organisation X] in any way.

Appendix 2: Participant Information Sheet – Stage 1 (Staff)

Project Title: *Promoting Innovation in Homelessness and Mental Health Service Design: An Adaptation of the Trajectory Touchpoint Technique.*

Lay Title: *Promoting Innovation in Homelessness and Mental Health Service Design.*

Version: 1
Date: 02/12/2020

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand.

Please also feel free to discuss this with your friends, relatives, and anybody else if you wish. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to. If you do choose to participate, please email the completed consent form to Chloe.Spence@liverpool.ac.uk.

Thank you for reading this.

What is the purpose of the study?

The aim of the study is to gain insight into the quality and nature of service users' experiences at [Organisation X] residential services. It is the purpose of interviews at this stage to get a sense of the most important aspects and stages of [Organisation X]'s services from service users' and staff perspectives, helping us to develop an interviewing technique which will be used in later interviews with other service users.

It is the overall purpose of the study to explore what makes residential services like [Organisation X]'s effective and if/how these can be improved. Overall findings will contribute towards a PhD based at the University of Liverpool, on the subject of homelessness and mental health services. Findings will also be shared with [Organisation X] in a service evaluation report, identifying aspects of the service that are working well and any areas for improvement.

Why have I been chosen to take part?

You have been contacted because you are a member of staff involved in some way in [Organisation X]'s residential services.

Do I have to take part?

You do not have to participate in this study, and this will not affect your work with [Organisation X] in any way. If you decide to take part, you are still free to withdraw without giving a reason, at any time up to two weeks after an interview has taken place.

What will happen if I take part?

You will be invited to take part in an interview conducted by a researcher at the University of Liverpool. These interviews can be carried out either on the phone or using your preferred video software. Interviews will be digitally recorded and are expected to last roughly 30 minutes.

Interviews will be unstructured, meaning that, rather than following a set list of questions, you will be in control of where the discussion goes. It is not the intention of these interviews to look in any detail at specific issues faced by clients of the service, but rather to discuss the general structure and key elements of the service.

How will my data be used?

The University processes personal data as part of its research and teaching activities in accordance with the lawful basis of 'public task', and in accordance with the University's purpose of "advancing education, learning and research for the public benefit".

Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. Professor Pippa Hunter-Jones acts as the Data Processor for this study, and any queries relating to the handling of your personal data can be sent to phj@liverpool.ac.uk.

Confidentiality

The confidentiality of all information provided will be protected and won't be released without consent unless required by law. Confidentiality will only be broken if you disclose information suggesting that you are at direct risk of harming yourself or others, in which case we may need to contact the relevant authorities. In this case, the interview would be stopped and you would be informed about the issue.

Further information on how your data will be used can be found in the table below:

How will my data be collected?	Audio Interviews.
How will my data be stored?	On the University of Liverpool M Drive, a location on the university computer system, which will be password-protected and accessed only by the project researchers.
How long will my data be stored for?	Audio data will be stored only until the interview has been written up, and so should be deleted around two weeks after interviews are completed. Data in the form of anonymised interview transcripts will be stored in the University of Liverpool Archive for ten years.
What measures are in place to protect the security and confidentiality of my data?	The interviews are anonymised and stored under password. All names and personal details will be changed. Information provided will not be released without consent unless required by law (i.e. if information is disclosed which raises serious concerns about your own or others' safety).
Will my data be anonymised?	Yes.
How will my data be used?	PhD, service evaluation report, conference presentation(s), journal publication(s).
Who will have access to my data?	Only the named investigators (PI, CO-I's and Student Investigator) will have direct access to your data. Fully anonymised transcript data will be accessible to other authorised university researchers for ten years following the study, after which point it will be destroyed entirely.
Will my data be archived for use in other research projects in the future?	Yes. However, this will only be the fully anonymised data from your transcript. No identifiable information will be shared outside of this specific study and, as explained below, audio data will be deleted immediately after transcription.
How will my data be destroyed?	Audio data will be deleted (from University M Drive entirely) after interviews are written up. Interview transcript data will be removed from the university Archive and permanently deleted after ten years.

Expenses

It is not expected that there will be any costs associated with taking part in the project, as participants do not need to travel anywhere and should not have to pay anything for receiving the call. However, if there are any expenses you think you might incur, please bring this to the attention of Professor Pippa Hunter-Jones (e: phj@liverpool.ac.uk) and she will explore this further for you.

Are there any benefits in taking part?

In the long term, it is hoped that this data may help to influence regulators, social policy makers, and the Welsh Health Board, potentially contributing towards securing funding for [Organisation X] or related projects. However, there are no direct personal benefits to taking part in this research, and your decision about taking part will not affect your work with [Organisation X] in any way.

Are there any risks in taking part?

Although this study is designed to focus on the structure and key elements of the service, rather than on specific cases, it is possible during the interview that potentially distressing subjects could arise in relation to upsetting client contacts. However, you are under no obligation to share anything that you do not want to, and you are also free to end the interview or take a break at any point and for any reason.

What will happen to the results of the study?

Findings will be published in a PhD thesis completed in September 2022, a summary report for [Organisation X], and potentially in an academic journal and conference papers at some point in the future. If you would like to be a sent a copy of the summary report, please indicate this in your consent form.

What will happen if I want to stop taking part?

You are free to withdraw from the study, without providing an explanation, at any point prior to the anonymisation of data. Your data will be anonymised two weeks after your interview.

If you do decide after being interviewed that you'd like to withdraw your information, please contact Chloe.Spence@liverpool.ac.uk as soon as possible and, assuming this is before data anonymisation, I will remove your data immediately and without asking any questions.

What if I am unhappy or there is a problem?

If you are unhappy, or if there is a problem, please feel free to let us know by contacting Professor Pippa Hunter-Jones (e: phj@liverpool.ac.uk) and we will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact the Research Ethics and Integrity Office at ethics@liv.ac.uk. When contacting the

Research Ethics and Integrity Office, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

The University strives to maintain the highest standards of rigour in the processing of your data. However, if you have any concerns about the way in which the University processes your personal data, it is important that you are aware of your right to lodge a complaint with the Information Commissioner's Office by calling 0303 123 1113.

Who can I contact if I have any further questions?

Principal Investigator: **Professor Pippa Hunter-Jones**
Address: University of Liverpool Management School, Chatham Street, Liverpool, L69 7ZH
Email Address: phj@liverpool.ac.uk

Student Investigator: **Chloë Spence**
Email Address: Chloe.Spence@liverpool.ac.uk

Appendix 3: Participant Information Sheet – Stage 1 (Clients)

Participant Information Sheet: Stage 1 (Clients)

Project Title: *Promoting Innovation in Homelessness and Mental Health Service Design: An Adaptation of the Trajectory Touchpoint Technique.*

Lay Title: *Promoting Innovation in Homelessness and Mental Health Service Design.*

Version: 1
Date: 02/12/2020

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand.

Please also feel free to discuss this with your friends, relatives, and anybody else if you wish. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to. If you do choose to participate, after posting the consent form in the envelope provided, please call 08000902482 to arrange a date for your interview.

Thank you for reading this.

What is the purpose of the study?

The aim of the study is to gain insight into the quality and nature of service users' experiences at [Organisation X] residential services. It is the purpose of interviews at this stage to get a sense of the most important aspects and stages of [Organisation X]'s services from service users' and staff perspectives, helping us to develop an interviewing technique which will be used in later interviews with other service users.

It is the overall purpose of the study to explore what makes residential services like [Organisation X]'s effective and if/how these can be improved. Overall findings will contribute towards a PhD based at the University of Liverpool, on the subject of homelessness and mental health services. Findings will also be shared with [Organisation X] in a service evaluation report, identifying aspects of the service that are working well and any areas for improvement

Why have I been chosen to take part?

You have been contacted because you are either a current or former service user within [Organisation X]'s residential services.

Do I have to take part?

You do not have to participate in this study, and this will not affect your relationship with [Organisation X] and any service you receive from them in any way. If you decide to take part, you are still free to withdraw without giving a reason, at any time up to two weeks after an interview has taken place.

What will happen if I take part?

You will be invited to take part in a telephone interview conducted by a researcher at the University of Liverpool. Interviews will be digitally recorded and are expected to last roughly 30 minutes.

Interviews will be unstructured, meaning that, rather than following a set list of questions, you will be in control of where the discussion goes. This will center around what you consider to be the most important memories and feelings associated with your time with [Organisation X]. Findings from this part of the study will be used in developing a version of a service evaluation technique called the Trajectory Touchpoint Technique, which will be used in a later stage of the study.

How will my data be used?

The University processes personal data as part of its research and teaching activities in accordance with the lawful basis of 'public task', and in accordance with the University's purpose of "advancing education, learning and research for the public benefit".

Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. Professor Pippa Hunter-Jones acts as the Data Processor for this study, and any queries relating to the handling of your personal data can be sent to phj@liverpool.ac.uk.

Confidentiality

The confidentiality of all information provided will be protected and won't be released without consent unless required by law. Confidentiality will only be broken if you disclose information suggesting that you are at direct risk of harming yourself or others, in which case we may need to contact the relevant authorities. In this case, the interview would be stopped and you would be informed about the issue.

Further information on how your data will be used can be found in the table below:

How will my data be collected?	Audio Interviews.
How will my data be stored?	On the University of Liverpool M Drive, a location on the university computer system, which will be password-protected and accessed only by the project researchers.
How long will my data be stored for?	Audio data will be stored only until the interview has been written up, and so should be deleted around two weeks after interviews are completed. Data in the form of anonymised interview transcripts will be stored in the University of Liverpool Archive for ten years.
What measures are in place to protect the security and confidentiality of my data?	The interviews are anonymised and stored under password. All names and personal details will be changed. Information provided will not be released without consent unless required by law (i.e. if information is disclosed which raises serious concerns about your own or others' safety).
Will my data be anonymised?	Yes
How will my data be used?	PhD, service evaluation report, conference presentation(s), and journal publication(s)
Who will have access to my data?	Only the named investigators (PI, CO-I's and Student Investigator) will have direct access to your data. Fully anonymised transcript data will be accessible to other authorised university researchers for ten years following the study, after which point it will be destroyed entirely.
Will my data be archived for use in other research projects in the future?	Yes. However, this will only be the fully anonymised data from your transcript. No identifiable information will be shared outside of this specific study and, as explained below, audio data will be deleted immediately after transcription.
How will my data be destroyed?	Audio data will be deleted (from University M Drive entirely) after interviews are written up. Interview transcript data will be removed from the university Archive and permanently deleted after ten years.

Expenses

It is not expected that there will be any costs associated with taking part in the project, as participants do not need to travel anywhere and should not have to pay anything for receiving the call. However, if there are any expenses you think you might incur, please bring this to the attention of Professor Pippa Hunter-Jones (e: phj@liverpool.ac.uk) and she will explore this further for you.

Are there any benefits in taking part?

In the long term, it is hoped that this data may help to influence regulators, social policy makers, and the Welsh Health Board, potentially contributing towards securing funding for [Organisation X] or related projects. However, there are no direct personal benefits to taking part in this research, and your decision about taking part will not affect any service you receive from [Organisation X] in any way.

Are there any risks in taking part?

Although this study is designed to focus on your service experience, rather than any personal details about your life, it is possible in the course of the interview that sensitive and potentially distressing subjects could arise. However, you are under no obligation to share anything that you do not want to, and you are also free to end the interview or take a break at any point and for any reason.

Please do contact your [Organisation X] support worker, your GP, or any other mental health service provider if you experience ongoing distress related to our conversation.

If you need to talk to someone in the hours or days after the interview, you can call [Organisation X] at 01792 646071. Your support worker will be aware that the interview has taken place and will be happy to talk to you about any distress or discomfort this has caused.

What will happen to the results of the study?

Findings will be published in a PhD thesis completed in September 2022, a summary report for [Organisation X], and potentially in an academic journal and conference papers at some point in the future. If you would like to be a sent a copy of the summary report, please indicate this in your consent form.

What will happen if I want to stop taking part?

You are free to withdraw from the study, without providing an explanation, at any point prior to the anonymisation of data. Your data will be anonymised two weeks after your interview.

If you do decide after being interviewed that you'd like to withdraw your information, please contact Chloe.Spence@liverpool.ac.uk as soon as possible and, assuming this is before data anonymisation, I will remove your data immediately and without asking any questions. If you

do not have access to email yourself, you can contact your support worker and ask them to get in touch on your behalf.

What if I am unhappy or there is a problem?

If you are unhappy, or if there is a problem, please feel free to let us know by contacting Professor Pippa Hunter-Jones (e: phj@liverpool.ac.uk) and we will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact the Research Ethics and Integrity Office at ethics@liv.ac.uk. When contacting the Research Ethics and Integrity Office, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

The University strives to maintain the highest standards of rigour in the processing of your data. However, if you have any concerns about the way in which the University processes your personal data, it is important that you are aware of your right to lodge a complaint with the Information Commissioner's Office by calling 0303 123 1113.

Who can I contact if I have any further questions?

Principal Investigator: **Professor Pippa Hunter-Jones**
Address: University of Liverpool Management School, Chatham Street, Liverpool, L69 7ZH
Email Address: phj@liverpool.ac.uk

Student Investigator: **Chloë Spence**
Email Address: Chloe.Spence@liverpool.ac.uk

Seeking support after an interview

If taking part in this study raises any concerns or issues, I would suggest contacting either Let's Keep Talking, your GP or mental health provider, or any of the helplines given below:

Suicide Prevention and General Support

Samaritans:

Call: 116 123
Email: jo@samaritans.org.

Samaritans provide a 24-hour freephone service for anybody in distress or despair.

Addiction

Drinkline

Call: 0300 123 1110

Opening hours: Monday-Friday: 9am-8pm, Saturday-Sunday: 11am-4pm

A confidential and free helpline for anybody concerned about their alcohol use or somebody else's.

Dan

Call: 0808 808 2234
Text: 81066

A confidential and free helpline for anybody wanting further help or information re: alcohol or drugs. Open all hours.

GamCare

Call: 0808 802 0133

Free advice, counselling, and information for prevention and treatment of problem gambling. Open all hours.

Emotional Text Support

Shout

Text: 85258

Offer free support for anybody in crisis and struggling to cope. Open all hours.

Homelessness and Housing

Shelter Cymru

Call: 08000 495 495

Opening hours: Monday-Friday, 9:30am-4pm.

Offer free advice on debt and housing issues.

Mental Health

Mind Cymru

Call: 0300 123 3393
Email: info@mind.org.uk
Text: 86463

Opening hours: Monday-Friday, 9am-6pm.

Advice, information and support about mental health issues, including self-harm.

Appendix 4: Participant Information Sheet – Stage 2 (Clients)

Participant Information Sheet: Stage 2 (Clients)

Project Title: *Promoting Innovation in Homelessness and Mental Health Service Design: An Adaptation of the Trajectory Touchpoint Technique.*

Lay Title: *Promoting Innovation in Homelessness and Mental Health Service Design.*

Version: 1
Date: 02/12/2020

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand.

Please also feel free to discuss this with your friends, relatives, and anybody else if you wish. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to. If you do choose to participate, after posting the consent form in the envelope provided, please call 08000902482 to arrange a date for your interview.

Thank you for reading this.

What is the purpose of the study?

The aim of the study is to gain insight into the quality and nature of service users' experiences within [Organisation X]'s residential services. This project will also be a first attempt at using a new version of the Trajectory Touchpoint Technique (explained below) in evaluating residential homelessness and mental health services.

It is the overall purpose of the study to explore what makes residential services like [Organisation X]'s effective and if/how these can be improved. Overall findings will contribute towards a PhD based at the University of Liverpool, on the subject of homelessness and mental health services. Findings will also be shared with [Organisation X] in a service evaluation report, identifying aspects of the service that are working well and any areas for improvement.

Why have I been chosen to take part?

You have been contacted because you are either a current or former service user at one of [Organisation X]'s residential services.

Do I have to take part?

You do not have to participate in this study, and this will not affect your relationship with [Organisation X] and any service you receive from them in any way. If you decide to take part, you are still free to withdraw without giving a reason, at any time up to two weeks after an interview has taken place.

What will happen if I take part?

You will be invited to take part in a telephone interview conducted by a researcher at the University of Liverpool. Interviews will be digitally recorded and are expected to last roughly 30 minutes-1 hour.

Interviews will be conducted using a tool called the Trajectory Touchpoint Technique. This means that, rather than being asked specific questions, you will be shown a set of cards including images related to different aspects of your experiences and asked to talk freely about these themes. As interviews are being conducted over the phone, the cards have been included along with this information sheet and the consent form. If you do choose to take part, the interview will consist of the researcher going through each of these cards with you, asking you to talk about any of the images that you think are relevant to your personal experience.

How will my data be used?

The University processes personal data as part of its research and teaching activities in accordance with the lawful basis of 'public task', and in accordance with the University's purpose of "advancing education, learning and research for the public benefit".

Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. Professor Pippa Hunter-Jones acts as the Data Processor for this study, and any queries relating to the handling of your personal data can be sent to phj@liverpool.ac.uk.

Confidentiality

The confidentiality of all information provided will be protected and won't be released without consent unless required by law. Confidentiality will only be broken if you disclose information suggesting that you are at direct risk of harming yourself or others, in which case we may need to contact the relevant authorities. In this case, the interview would be stopped and you would be informed about the issue.

Further information on how your data will be used can be found in the table below:

How will my data be collected?	Audio Interviews.
How will my data be stored?	On the University of Liverpool M Drive, a location on the university computer system, which will be password-protected and accessed only by the project researchers.
How long will my data be stored for?	Audio data will be stored only until the interview has been written up, and so should be deleted around two weeks after interviews are completed. Data in the form of anonymised interview transcripts will be stored in the University of Liverpool Archive for ten years.
What measures are in place to protect the security and confidentiality of my data?	The interviews are anonymised and stored under password. All names and personal details will be changed. Information provided will not be released without consent unless required by law (i.e. if information is disclosed which raises serious concerns about your own or others' safety).
Will my data be anonymised?	Yes
How will my data be used?	PhD, service evaluation report, conference presentation(s), and journal publication(s).
Who will have access to my data?	Only the named investigators (PI, CO-I's and Student Investigator) will have direct access to your data. Fully anonymised transcript data will be accessible to other authorised university researchers for ten years following the study, after which point it will be destroyed entirely.
Will my data be archived for use in other research projects in the future?	Yes. However, this will only be the fully anonymised data from your transcript. No identifiable information will be shared outside of this specific study and, as explained below, audio data will be deleted immediately after transcription
How will my data be destroyed?	Audio data will be deleted (from University M Drive entirely) after interviews are written up. Interview

	transcript data will be removed from the university Archive and permanently deleted after ten years.

Expenses

It is not expected that there will be any costs associated with taking part in the project, as participants do not need to travel anywhere and should not have to pay anything for receiving the call. However, if there are any expenses you think you might incur, please bring this to the attention of Professor Pippa Hunter-Jones (e: phj@liverpool.ac.uk) and she will explore this further for you.

Are there any benefits in taking part?

In the long term, it is hoped that this data may help to influence regulators, social policy makers, and the Welsh Health Board, potentially contributing towards securing funding for [Organisation X] or related projects. However, there are no direct personal benefits to taking part in this research, and your decision about taking part will not affect any service you receive from [Organisation X] in any way.

Are there any risks in taking part?

Although this study is designed to focus on your service experience, rather than any personal details about your life, it is possible in the course of the interview that sensitive and potentially distressing subjects could arise. However, you are under no obligation to share anything that you do not want to, and you are also free to end the interview or take a break at any point and for any reason.

If you need to talk to someone in the hours or days after the interview, you can call [Organisation X] at 01792 646071. Your support worker will be aware that the interview has taken place and will be happy to talk to you about any distress or discomfort this has caused. **A list of relevant helplines has also been included at the end of this document.**

What will happen to the results of the study?

Findings will be published in a PhD thesis completed in September 2022, a summary report for [Organisation X], and potentially in an academic journal and conference papers at some point in the future. If you would like to be a sent a copy of the summary report, please indicate this in your consent form.

What will happen if I want to stop taking part?

You are free to withdraw from the study, without providing an explanation, at any point prior to the anonymisation of data. Your data will be anonymised two weeks after your interview.

If you do decide after being interviewed that you'd like to withdraw your information, please contact Chloe.Spence@liverpool.ac.uk as soon as possible and, assuming this is before data anonymisation, I will remove your data immediately and without asking any questions.

What if I am unhappy or there is a problem?

If you are unhappy, or if there is a problem, please feel free to let us know by contacting Professor Pippa Hunter-Jones (e: phj@liverpool.ac.uk) and we will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact the Research Ethics and Integrity Office at ethics@liv.ac.uk. When contacting the Research Ethics and Integrity Office, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

The University strives to maintain the highest standards of rigour in the processing of your data. However, if you have any concerns about the way in which the University processes your personal data, it is important that you are aware of your right to lodge a complaint with the Information Commissioner's Office by calling 0303 123 1113.

Who can I contact if I have any further questions?

Principal Investigator: **Professor Pippa Hunter-Jones**
Address: University of Liverpool Management School, Chatham Street, Liverpool, L69 7ZH
Email Address: phj@liverpool.ac.uk

Student Investigator: **Chloë Spence**
Email Address: Chloe.Spence@liverpool.ac.uk

Seeking support after an interview

If taking part in this study raises any concerns or issues, I would suggest contacting either Let's Keep Talking, your GP or mental health provider, or any of the helplines given below:

Suicide Prevention and General Support

Samaritans:

Call: 116 123
Email: jo@samaritans.org.

Samaritans provide a 24-hour freephone service for anybody in distress or despair.

Addiction

Drinkline

Call: 0300 123 1110

Opening hours: Monday-Friday: 9am-8pm, Saturday-Sunday: 11am-4pm

A confidential and free helpline for anybody concerned about their alcohol use or somebody else's.

Dan

Call: 0808 808 2234
Text: 81066

A confidential and free helpline for anybody wanting further help or information re: alcohol or drugs. Open all hours.

GamCare

Call: 0808 802 0133

Free advice, counselling, and information for prevention and treatment of problem gambling. Open all hours.

Emotional Text Support

Shout

Text: 85258

Offer free support for anybody in crisis and struggling to cope. Open all hours.

Homelessness and Housing

Shelter Cymru

Call: 08000 495 495

Opening hours: Monday-Friday, 9:30am-4pm.

Offer free advice on debt and housing issues.

Mental Health

Mind Cymru

Call: 0300 123 3393
Email: info@mind.org.uk
Text: 86463

Opening hours: Monday-Friday, 9am-6pm.

Advice, information and support about mental health issues, including self-harm.

Appendix 5: Participant Consent Form

Consent Form: Clients (Stage 2)

Title of the research project: Promoting Innovation in Homelessness and Mental Health Service Design.

Name of researcher(s): Chloë Spence, Professor Pippa Hunter-Jones, Dr Lynn Sudbury-Riley, Jim Bird-Waddington, and Steve Flatt.

Please initial box

1. I confirm that I have read and have understood the information sheet dated 02/12/2020 for the above study. ☐

2. I understand that my participation is voluntary and that I am free to stop taking part and can withdraw from the study at any time without giving any reason and without my rights being affected. In addition, I understand that I am free to decline to answer any particular question or questions. ☐

3. I understand that I can ask for access to the information I provide, and I can request the destruction of that information if I wish at any time prior to anonymisation. I understand that following anonymisation, two weeks after interview, I will no longer be able to request access to or withdrawal of the information I provide. ☐

4. *Audio recordings:* I understand and agree that my participation will be audio recorded and I am aware of and consent to your use of these recordings for ☐

the following purposes: PhD, service evaluation paper, academic journal articles, and conference papers.

5. *Legal requirements:* I understand that the confidentiality of the information I provide will be safeguarded and won't be released without my consent unless required by law. I understand that if I disclose information which raises considerations over the safety of myself or the public, the researcher may be legally required to disclose my confidential information to the relevant authorities. ☐

6. *Storage of documents:* I understand that the information I provide will be held securely and in line with data protection requirements at the University of Liverpool until it is fully anonymised and then deposited in the Archive for ten years for sharing and use by other authorised researchers. ☐

7. The study findings will be published as a report; please indicate whether you would like to receive a copy. ☐

8. I agree to take part in the above study. ☐

_____ _____ _____

Participant name Date Signature

_____ _____ _____

Name of person taking consent Date Signature

Principal Investigator

Dr. Pippa Hunter-Jones

University of Liverpool Management School

Chatham Street

Liverpool L69 7ZH

T: 0151 795 3018

phj@liverpool.ac.uk

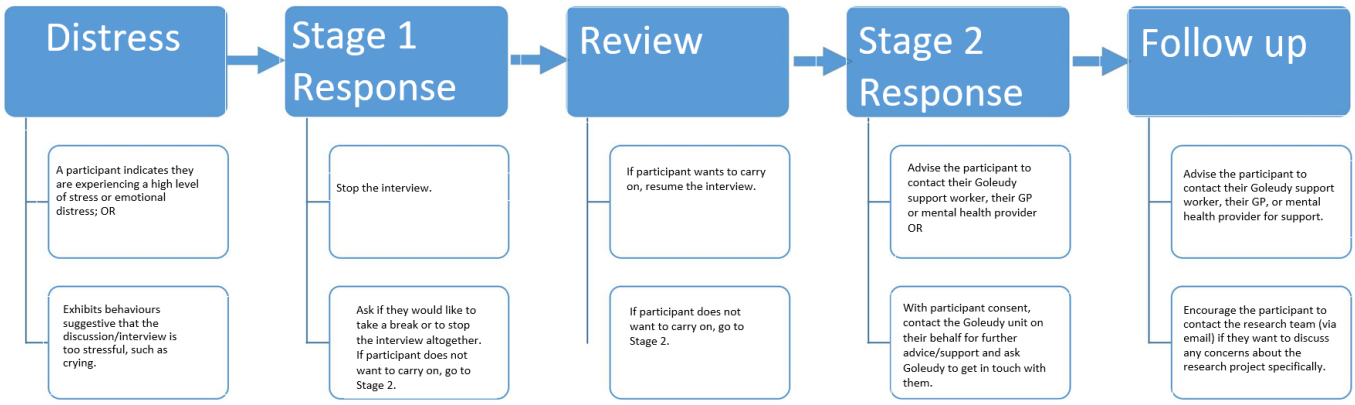
Student Investigator

Chloë Spence

Chloe.Spence@liverpool.ac.uk

Appendix 6: Distress Protocol

Protocol for managing distress in Organisation X client interviews (adapted from Haigh and Witham, 2013)



Appendix 7: Stage One Template

Italicised: a priori themes

Evidence of Transformative Value Creation

1. ***Eudaimonic outcomes***
2. ***Evaluative-projective orientations***
3. ***Global meanings***
4. ***Virtuous trajectories***

Facilitators of Transformative Value in the Experience

1. ***Environmental factors***
   - 1.1 *Facilities*
   - 1.2 *Shared spaces*
   - 1.3 Cleanliness
   - 1.4 Having own space
   - 1.5 Safety and security

2. ***Practical factors***
   - 2.1 *Practical assistance*
   - 2.2 *Delivery/integration of mental healthcare and medication*
   - 2.3 Cooking and eating
   - 2.4 Routine

3. ***Relational factors***
   - *3.1 Broader network*
     - 3.1.1 Family and friends
     - 3.1.2 Maintaining existing connections
     - 3.1.3 Phone contact
   - *3.2 Relationship with staff*
     - *3.2.1 Emotional support*
     - 3.2.2 Feeling listened to
     - 3.2.3 Tough love
   - 3.3 Familial relationship
     - 3.3.1 With staff
     - 3.3.2 With other clients

4. **Integrative themes**
   - 4.1 Accessibility of support
     - 4.1.1 Checking in
     - 4.1.2 Building trust
     - 4.1.3 Connecting to broader networks

Appendix 8: Stage Two Preliminary Template

Italicised: a priori themes

Evidence of Transformative Value Creation

1. ***Eudaimonic outcomes***
2. ***Evaluative-projective orientations***
3. ***Global meanings***
4. ***Virtuous trajectories***
5. ***Evidence of habitual value creation***
6. ***Evidence of (transformative) value destruction***
7. **Contrast with other services**

Facilitators of T-VALEX Creation

1. **Active participation (practical, relational)**
   - *1.1 Achievements and skills*
   - 1.2 Independence
     - 1.2.1 Cooking and eating
   - 1.3 Giving back

2. **Community (relational)**
   - 2.1 Familial relationships
     - 2.1.1 Peer support
     - *2.1.2 Relationship with staff*
     - 2.1.3 Giving back
   - *2.2 Broader network*
     - 2.2.1 Family and friends
     - 2.2.2 Other services

3. **Connectedness (practical)**
   - *3.1 Broader network*
     - 3.1.1 Family and friends
     - 3.1.2 Other services

4. **Individualisation (environmental and practical)**
   - 4.1 Capacity for client agency
   - 4.2 Alignment between timelines

5. **Responsiveness (practical and relational)**
   - *5.1 Relationship with staff*
   - 5.2 Accessibility of support
     - 5.2.1 Checking in
     - 5.2.2 Feeling listened to

5.3 Conflict and crisis management

Prohibitors of T-VALEX Creation

1. **Effects of understaffing**
   - 1.1 Community
     - 1.1.1 Agency staff
     - 1.1.2 Relationship with staff
   - 1.2 Connectedness
     - 1.2.1 Broader network
   - 1.3 Responsiveness
     - 1.3.1 Checking in
     - 1.3.2 Relationship with staff

2. **Need for early intervention and peer support**
   - 2.1 Active participation
     - 2.1.1 Giving back
   - 2.2 Community
     - 2.2.1 Isolation/loneliness

3. **Obstacles to skill development/use**
   - 3.1 Active participation
     - 3.1.1 Achievements and skills
       - 3.1.1.1 Cooking and eating
       - 3.1.1.2 Independence
   - 3.2 Individualisation
     - 3.2.1 Independence
     - 3.2.2 Practical assistance

4. **Physical appearance**
   - 4.1 Active participation
     - 4.1.1 Achievements and skills
     - 4.1.2 Independence
   - 4.2 Community
     - 4.2.1 Feeling at home

Therapeutic Resources

1. ***Therapeutic servicescape***
   - 1.1 *Relational resources*
     - 1.1.1 Staff availability
     - 1.1.2 Other clients
   - 1.2 *Restorative resources*
     - 1.2.1 *Coherence*

1.2.2 *Scope*
1.2.3 *Fascination*
1.2.4 *Being-away*
1.3 *Place attachment*
1.3.1 Evidence of place attachment
1.3.2 Evidence of place detachment/neutrality
1.4 *Behavioural intention*
1.4.1 Approach behaviours
1.4.2 Avoidance behaviours

2. ***Broader lifeworlds***
2.1 Microlevel influences on resource integration
2.2 Relational resource availability in personal networks

3. Service ecosystems
3.1 *Density*
3.2 Structural properties
3.3 Relational resource availability

Vulnerability Perceptions

1. Potential vulnerability determinants
1.1 Class-based determinants
1.2 State-based determinants

2. Vulnerability manifestations
2.1 Difficulties accessing resources
2.2 Difficulties processing resources

3. Evidence of vulnerability alleviation/mitigation
3.1 Accessing resources
3.2 Processing resources

Appendix 9: Stage Two Final Template

Italicised: a priori themes

Evidence of Transformative Value Creation

8. Eudaimonic outcomes
9. Evaluative-projective orientations
10. Global meanings
11. Virtuous trajectories
12. Evidence of habitual value creation
13. Evidence of (transformative) value destruction

Facilitators of T-VALEX Creation

6. Active participation (practical, relational)
6.1 Achievements and skills
6.1.1 Opportunities for skill/resource building
6.1.2 Opportunities for skill application/resource integration
6.2 Customer citizenship behaviour
6.3 Independence
6.3.1 Cooking and eating
6.3.2 Control over servicescape

7. Community (relational)
7.1 Physical environmental cues
7.2 Familial relationships
7.2.1 Peer support
7.2.2 Relationship with staff
7.2.3 Giving back
7.3 Broader network
7.3.1 Family and friends
7.3.2 Other services

8. Connectedness (practical)
8.1 Transition between services
8.2 Broader network
8.2.1 Family and friends
8.2.2 Other services
8.2.3 Role in crisis management

9. Individualisation (environmental and practical)
9.1 Control over goal setting and pursuit
9.1.1 Feeling listened to
9.1.2 Promoting independence

9.1.3 Alignment between timelines
9.2 Practical assistance
9.2.1 Degree of assistance
9.2.2 Nature of assistance

10. Responsiveness (practical and relational)
10.1 Relationship with staff
10.1.1 Individual support workers
10.1.2 Other service staff and broader culture
10.2 Accessibility of support
10.2.1 Checking in
10.2.2 Feeling listened to
10.2.3 Flexibility in temporal design
10.3 Peer support
10.4 Conflict and crisis management

Prohibitors of T-VALEX Creation

5. Effects of understaffing
5.1 Community
5.1.1 Agency staff
5.1.2 Relationship with staff
5.2 Connectedness
5.2.1 Broader network
5.3 Responsiveness
5.3.1 Checking in
5.3.2 Relationship with staff

6. Limited access to early intervention and peer support
6.1 Active participation
6.1.1 Giving back
6.1.2 Peer support
6.2 Community
6.2.1 Giving back
6.2.2 Peer support

7. Obstacles to skill development/use
7.1 Active participation
7.1.1 Achievements and skills
7.1.1.1 Cooking and eating
7.1.1.2 Independence
7.2 Individualisation
7.2.1 Independence
7.2.2 Practical assistance

8. Negative aspects of physical servicescape
- 8.1 Active participation
  - 8.1.1 Achievements and skills
  - 8.1.2 Independence
- 8.2 Community
  - 8.2.1 Feeling at home

9. Evidence of untapped resources (opportunities for innovation)
- 9.1 Environmental
  - 9.1.1 Developing therapeutic shared spaces
- 9.2 Practical
  - 9.2.1 Building participation into service processes
- 9.3 Relational
  - 9.3.1 Enhancing opportunities for peer support
    - 9.3.1.1 Isolation/loneliness
    - 9.3.1.2 Desire to give back

Therapeutic Resources

4. Therapeutic servicescape
- 4.1 *Relational resources*
  - 4.1.1 Staff availability
  - 4.1.2 Other clients
- 4.2 *Restorative resources*
  - 4.2.1 *Coherence*
  - 4.2.2 *Scope*
  - 4.2.3 *Fascination*
  - 4.2.4 Opportunities for immersion
  - 4.2.5 *Being-away*
  - 4.2.6 Breaking away
- 4.3 *Place attachment*
  - 4.3.1 General fixed attachment
  - 4.3.2 General transient/dynamic
  - 4.3.3 Context-specific
  - 4.3.4 Place detachment/neutrality
  - 4.3.5 Active rejection of place
- 4.4 *Behavioural intention*
  - 4.4.1 Indefinite/long-term continuation of service relationship
  - 4.4.2 Terminating/suspending service relationship
  - 4.4.3 Maintaining and redefining service relationship
  - 4.4.4 Active destruction/disengagement from value creation

5. Broader lifeworlds
- 5.1 Interaction with relational resources
- 5.2 Interaction with restorative resources

5.3 Relational resource availability in personal networks

6. Service ecosystems

6.1 *Density*
6.2 Continuity of care
6.3 Coherence
6.4 Structural properties
6.5 Relational resource availability

Vulnerability Perceptions

4. Potential vulnerability determinants

4.1 Discrimination/stigma
4.2 Operand resource deprivation
4.3 Operant resource deprivation
4.4 Social support deficits
4.5 Factors increasing susceptibility to harm
4.6 Factors limiting agency/control
4.7 Experiences of transience

5. Vulnerability manifestations

5.1 Difficulties accessing resources
5.2 Difficulties processing resources

6. Evidence of vulnerability alleviation/mitigation

6.1 Promoting autonomy
6.2 Promoting security