'An Evaluation of Tenancy Support and Mental Health Service Experience Using the Trajectory Touchpoint Technique'

MRes Dissertation, (Unpublished), University of Liverpool

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Acknowledgements

I would like to thank my supervisors, Pippa Hunter-Jones, Lynn Sudbury-Riley, and Steve Flatt, for their invaluable ongoing guidance and support, and for providing helpful and insightful feedback and advice throughout the entire dissertation process.

Thank you also to my participants, for sparing their time and being so willing to share their personal feelings and experiences for the purpose of this research. Thank you to the employees of Company X, for going out of their way to help with recruiting participants and arranging interviews in addition to their many everyday responsibilities.

Finally, I am grateful as ever to my family and friends for their constant love and support, especially to my Mum for willingly proofreading all 20,000 words, and to all for putting up with me sometimes not leaving my laptop for days on end. I appreciate you all very much.

Abstract

This study is designed to serve as an evaluation of a particular mental health service, here referred to as Company X, and also to act as a pilot study in evaluating an adapted version of the Trajectory Touchpoint Technique (TTT). The TTT is a technique for service evaluation, which employs a rich pictures methodology in order to elicit customer journey narratives. This study employed an adapted version of the TTT to evaluate Company X, a service providing tenancy and mental health support, through interviews with current and former Company X customers.

The service evaluation focuses on exploring processes of value co-creation, opportunities for innovation, and the impact of the psychotherapeutic methodology of solution-focused practice (SFP), which has been applied in different degrees to different treatment groups within the service. The methodological evaluation indicates that this is a promising technique for mental health service evaluation, whilst also highlighting some areas for further consideration relating to participant misunderstanding and memory issues. Findings are discussed in reference to mental health literature and service literature, with proposals for further research and plans for the ongoing development of the adapted TTT.

Chapter One: Introduction

1.1 Background to Research

The accurate evaluation of a service can be a difficult task to accomplish, not least in such a fraught and contentious context as that of mental health services in the 21st century (e.g. Eberhart, Cerully, Shearer, Berry, Burnam, and Ebener, 2017; Tansella and Thornicroft, 2012). A new and promising approach to exploring the customer journey is offered by the Trajectory Touchpoint Technique (TTT) (Sudbury-Riley and Hunter-Jones, 2017). Originally developed for the purpose of hospice care evaluation, the TTT employs a rich pictures methodology to elicit detailed customer experience narratives. This study is designed to investigate the efficacy and suitability of the TTT in the context of mental health service evaluation, whilst simultaneously producing a service evaluation for the organisation of Company X's tenancy support division. This will additionally serve as a pilot study for a forthcoming PhD, focused on the development and implementation of a version of the TTT for mental health service evaluation.

Traditional views of marketing and value creation have predominantly depicted organisations as value creators, with customers as passive consumers (Grönroos and Voima, 2012; Vargo and Lusch, 2004b). Over recent decades, however, there has been a shift towards a service-dominant logic (SDL), advancing the notions that value is created *with* (as opposed to *for*) a customer (e.g. Prahalad and Ramaswamy, 2004; Vargo and Lusch, 2004, 2008) and that service innovations are dependent upon the co-creation of value by multiple actors within a service ecosystem (Vargo, Wieland, and Akaka, 2015). This more expansive and customer-centred approach to service evaluation is reflected in the development of multiple design and evaluation tools, such as service blueprinting (Ostrom and Morgan, 2008) and customer journey mapping (CJM) (Rosenbaum et al., 2017), which have served both as an inspiration for the TTT and as a reference point for limitations to be overcome (e.g. Rosenbaum, Otalora, and Ramírez, 2017).

Having been proven effective in highlighting opportunities for innovation within hospice care (Sudbury-Riley and Hunter-Jones, 2017), the question arises of to what extent and in which way(s) this new tool may also be used to design and evaluate other areas of healthcare. Despite increased recognition of the importance of active customer participation (e.g. Lammers and Happell, 2003; Nambisan and Nambisan, 2009) and a heavy reliance upon

patient satisfaction measures, there remains a dearth of research and tools advancing an in-depth understanding of customers' perceptions (Gill, White and Cameron, 2011). Mental health is an especially pertinent area here, with damning findings regarding the efficacy of mental health service delivery in England (e.g. Dunn, McKenna, and Murray, 2016) and one UK-wide study identifying this as the only area of healthcare in which customer feedback is predominantly negative (Healthwatch, 2018).

While the primary focus of the TTT is on service delivery, rather than specific psychotherapeutic approaches, a better understanding of what constitutes an effective mental health service may be further advanced by considering the impact (or lack thereof) of applying different psychotherapeutic methodologies. One such psychotherapeutic approach is solution-focused practice (SFP), central to which is a focus on exploring the construction of solutions as opposed to the history and archaeology of a problem (Berg and Miller, 1992; de Shazer and Dolan, 2012; Kim, 2008). SFP also appears compatible with SDL, as a collaborative and goal-orientated approach within which change is co-constructed by a customer and a practitioner.

1.2 Research Problem and Research Objectives

This study is thus designed to address two distinct, though interrelated, research problems. Firstly, this study is intended to provide a service evaluation for a specific unit of a particular organisation, appraising service quality as perceived by customers and investigating the elements which make such a service (in)effective. Secondly, through conducting this evaluation, the study addresses the question of whether an adapted version of the TTT can be effectively utilised within the context of mental health services.

The overall aim of this research is therefore to investigate the elements constituting both an effective mental health service and an effective mental health service evaluation tool, with the end product serving as a crucial first step towards the development of an effective technique for service evaluation and innovation. Towards this aim, two objectives have been identified:

1. To evaluate the quality of services at Company X, considering how the introduction of SFP has (or has not) influenced this and identifying significant factors (positively and/or negatively) impacting upon a mental health service experience.

2. To test and refine an adapted version of the TTT within the context of mental health service user experiences, specifically in relation to Company X tenancy support.

1.3 Background to Company

Company X is a charitable organisation based in South Wales, with the aim of enabling social inclusion through a variety of services for disengaged and marginalised citizens. This study focuses specifically on Company X's Swansea-based tenancy support service, which provides one-on-one practical and emotional support to individuals at risk of losing their tenancies. Customers are provided with advice and assistance on a broad range of issues, including (for example) education and relationships as well as housing, budgeting, and debt.

Mental health issues are also prevalent amongst this population and are commonly addressed during a service experience. While all Company X employees have long been trained in providing general mental health support, since early 2019 Company X have been exploring the impact of introducing a structured psychotherapeutic methodology, specifically investigating how different ways of incorporating SFP might affect the experiences and engagement of customers. Company X's customers have therefore been divided into three distinct groups: those receiving simple pragmatic support, simple pragmatic support enhanced by SFP, and structured one-to-one SFP sessions in addition to pragmatic support.

1.4 Overview of Methodology

The research process began with the development of an initial adapted version of the TTT, with reference to the original TTT, service literature, and mental health literature and policy documents. After securing ethical approval, participants were recruited from the Company X customer population, with the aim of recruiting a roughly equal number from each of the three service groups. All interested customers were provided with a set of the adapted TTT cards to consult during interviews, which were conducted over the phone. All interviews were audio recorded and transcribed verbatim.

1.5 Outline of Chapters

This work is divided into five chapters: Introduction, Literature Review, Methodology, Findings and Discussion, and Implications and Conclusions. The Introduction chapter has set the scene, justified the research, and provided overviews of the organisation in question and of the methodological approach adopted. The Literature Review attempts to establish a cogent summary of the relevant research, exploring in detail service literature and mental health literature. The Methodology chapter describes the inception and evolution of the adapted TTT, explicating the different influences and underlying reasoning, and recounts processes of data collection and thematic data analysis.

The Findings and Discussion chapter is divided into two main sections, which relate respectively to the service evaluation and the methodology evaluation. Findings from both evaluations are described and discussed with reference to the relevant literature. Lastly, the final chapter summarises the study's managerial and theoretical implications, acknowledging limitations and proposing areas for future research within and beyond the forthcoming PhD.

1.6 Conclusion

In summary, this study is designed to serve as the first step towards a meaningful contribution to the fields of both mental health and service research. Findings from this research will also directly inform the direction of the aforementioned PhD, with the adapted TTT continuing to be tested and refined across the next three years. In the shorter term, it is hoped that this research will in itself provide valuable insights into the constituents of an effective mental health service. Ideally, this will prove informative not only for Company X and their commissioners but also for others striving to better understand the failures of much of mental healthcare, and, most importantly, what a more effective mental health system might look like.

Chapter Two: Literature Review

The previous chapter provided a brief overview of the theoretical background to this study, before explicating the specifics in terms of research problem and objectives, company background, and the key stages of the research process. It is the purpose of this chapter to go in far greater depth into the relevant literature, bringing together various strands of service and mental health literature and identifying significant points of overlap and gaps for investigation.

This chapter begins with a consideration of SDL and the related concept of value in the experience (2.1), before moving on to the notion of transformative service research (TSR) and transformative value creation (2.2). Concepts of design thinking (2.3) and customer-centred healthcare (2.4) are considered as potential avenues for the improvement of mental health service delivery, before looking specifically at evidence on the determinants of quality and value creation in this area (2.5). An overview of SFP and current evidence on its effectiveness sets the scene for the application of this in different degrees to the different treatment groups of Company X (2.6). Finally, four research questions emerge from the literature review, three of which pertain to the evaluation of Company X and one of which pertains to the evaluation of the adapted TTT (2.7).

2.1 Service-Dominant Logic and Value in the Experience

At the heart of the SDL approach is the notion of value co-creation, in which a customer is an active agent (Prahalad and Ramaswamy, 2004), contrasting sharply with the traditional, goods-dominant view of organisations as the sole creators of value and customers as passive consumers (Grönroos and Voima, 2012; Vargo and Lusch, 2004b). While goods-dominant logic centres passive and tangible factors of production, or 'operand resources', the primary focus of SDL is on 'operant resources', such as individuals' skills and knowledge, which are intangible and which act upon operand resources (Constantin and Lusch, 1994; McColl-Kennedy et al., 2012; Vargo and Lusch, 2008). Thus, according to the logic of SDL, the only truly effective services are fundamentally customer orientated (Vargo and Lusch, 2008), also suggesting that the only effective techniques for service evaluation must take the role of the customer into account.

The SDL approach also emphasises the unique and phenomenological determination of value by a beneficiary (Vargo and Lusch, 2008), calling for a strong phenomenological characterisation and analysis of value (Edvardsson, Tronvoll, and Gruber, 2010; Helkkula, Kelleher, and Pihlström, 2012). This is absent in traditional definitions of value, which have largely excluded or minimised the role of customers as creators. Definitions such as customer-perceived value and value-in-use have conventionally operated on the assumption that service organisations and customers perform different and predefined roles, with the former pre-determining sources of value in a service offering and delivery while the latter's role is limited to the submissive purchase and utilisation of a given service (Heinonen et al., 2010; Kelleher and Peppard, 2011; Sandström et al., 2008; Shah et al., 2006).

This traditional view situates 'value drivers' as embedded within goods and services during product development (Blocker and Barrios, 2015), prescribing a narrow timeframe and a limited category of agents within which value creation can be optimised and observed. 'Customer value' is thus objectified and reduced, to that which can simply be produced and processed by a service for consumption by a customer (Helkkula, Kelleher, and Pihlström, 2012). Consequently, the manager or service researcher adopting this approach is inclined to focus all of their attention on the activities of an organisation, with customers' own actions and efforts being more or less disregarded (Clulow, Barry, and Gerstman, 2007).

In opposition to this narrow perspective, the synthesis of different experiences and interactions, the utilisation of resources, and the influence of social networks have all been receiving increased attention as significant factors impacting upon customer experiences of value (Blocker and Barrios, 2015; Holbrook, 1999; Vargo and Lusch, 2008). Increasing attention has been dedicated towards across-time biological and social processes of valuing and devaluing, accounting for such influences as history, anticipated creation of value, and continuous sense-making (Blocker et al., 2011; Flint, Larsson, and Gammelgaard, 2008; Helkkula, Kelleher, and Pihlström, 2012).

Such a broader conceptualisation is offered in the concept of value in the experience, 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). Built into this conception of value is the recognition that a customer's experience of value may be influenced not only by characteristics of the actual service experience but also by such factors

as past experiences of the same or similar services, friends' stories and recommendations, and even the kind of day that the customer has had. This concept is closely related to that of SDL, with a shared focus on beneficiaries' determination of value (Helkkula, Kelleher, and Pihlström, 2012) and on value as located within an experience, rather than an object, of consumption (Frow and Payne, 2007).

2.2 Transformative Service Research and Transformative Value

Also pertinent to this research is the concept of transformative value, stemming from the broader area of transformative service research (TSR). TSR is a category of research that is dedicated to the utilisation of services for improving lives: of citizens and consumers, individuals and communities, present and future (Anderson et al., 2013). The fundamental drive and focus of TSR pertains to an investigation of the relationship between service and well-being, with the explicit intention of promoting the latter through improvements to the former (Anderson and Ostrom, 2015). Metrics applied to these ends include indicators of financial, mental, physical, and social well-being (Anderson and Ostrom, 2015; Anderson et al., 2013; Rosenbaum et al., 2011). Over recent years, the need for TSR to be taken seriously and treated as a research priority has been highlighted repeatedly (e.g. Anderson and Ostrom, 2015; Ostrom et al., 2010; Ostrom et al., 2015).

Originally exploring customer well-being primarily as a managerially relevant outcome (Rosenbaum et al., 2011), the aims of TSR have since expanded in line with a more holistic and customer-centred perspective, striving to bring about 'uplifting changes' that positively impact upon customers within broader service ecosystems, communities, and lifeworld contexts (Anderson and Ostrom, 2015, p.243). The emergence of the concept of transformative value is one manifestation of this expanded view. While the majority of value creation is habitual, serving to maintain order and stability in everyday life, transformative value is associated with positive disruption, altering the conditions and perspectives of people and social phenomena. Understanding and creating the conditions for transformative value creation is therefore essential for generating 'uplifting change for greater well-being', among individuals and collectives (Blocker and Barrios, 2015, p.5).

There is substantial overlap between the concepts of TSR and SDL, and much of the most recent TSR research has explicitly drawn on SDL's central axioms, particularly with regards to value co-creation and resource integration (Baron et al., 2018; Blocker and Barrios, 2015;

Mirabito and Berry, 2015; Skålén, Aal, and Edvardsson, 2015; Sweeney, Danaher, and McColl-Kennedy, 2015). However, despite a widespread interest in customers' role in value creation, only a few studies (e.g. Guo et al., 2013; Yim, Chan, and Lam, 2012) have actively addressed the impact of co-production on well-being. In light of this, Anderson and Ostrom (2015) argue that there is still much to be gained through an exploration of the nature of co-creation activities and the relationship between these activities and customer well-being.

Additionally, the majority of TSR continues to focus exclusively or primarily on managerially relevant outcomes, such as future behavioural intentions and loyalty, at the expense of exploring how service design and delivery can enhance consumer, societal, or even global well-being (Anderson et al., 2013; Mick, 2006; Rosenbaum, 2015; Rosenbaum et al., 2011). This approach is directly at odds with the SDL focus on co-creation (Vargo and Lusch, 2008), and also seems to undermine the potential for TSR to challenge the status quo.

However, alternative voices have proposed a more radical potential for TSR, as a tool for uncovering knowledge that promotes equitable service for the well-being of all individuals and communities (Corus and Saatcioglu, 2015). TSR and transformative value have also been described as especially important in a context of 'vulnerability', in which the individuals or communities in question are disadvantaged and potentially disempowered by factors such as poverty and discrimination (Mick et al., 2012). These are sometimes referred to as base of pyramid (BoP) consumers, who fall below the level of 'consumption adequacy' (Baron et al., 2018, p.137). This is directly relevant to Company X, as an organisation focused on enabling social inclusion for disengaged and marginalised citizens.

2.3 Well-being and Design

The discipline of service design has also informed the development of this study and of the original TTT. Across recent years, creative and intuitive design culture has increasingly been understood as central to innovation, emergent as a reaction against the predominance of an economic mindset within service research (Maffei, Mager, and Sangiorgi, 2005). The concept of using design for improving service outcomes and enhancing (customer, employee, and community) well-being has gained increasing traction, with the underlying premise that design thinking can be effectively employed for enhancing service development and delivery (Lee, 2011). and that this is central to service innovation and improvement (e.g. Storey and Larbig, 2018).

The application of design thinking to service innovation comprises a systematic examination of services from a design perspective and the utilisation of design concepts, methods, and techniques, in order that identified patterns and needs may be transformed into possible service futures (Sudbury-Riley and Hunter-Jones, 2017). Design has been described as at the heart of service innovation (Storey and Larbig, 2018), uncovering hitherto untapped opportunities for value creation and experience optimisation (Foglieni, Villari, and Maffei, 2018; Patrìcio, Gustafsson, and Fisk, 2018). The 'how and what' of service design has frequently played an important role within operations management research, bringing together customer experience and service outcomes, and taking into consideration such characteristics as customer wait time (Bitran, Ferrer, and Oliveira, 2008; Safizadeh, Field, and Ritzman, 2003), the duration of an interaction (Mills and Morris, 1986; Schmenner, 2004), and the degree of process control (Haywood-Farmer, 1988; Zomerdijk and de Vries, 2007).

However, a narrow approach to service design bears the risk of paying excessive attention to a customer-provider dyad and specifically to the role of the provider in producing a positive experience for the customer, both dismissing broader service ecosystem and lifeworld contexts and relegating the customer to a passive role wholly incompatible with SDL and TSR (Maull, Geraldi, and Johnston, 2012). A more expansive approach acknowledges the multiple levels at which service design and innovation can occur (Patrício et al., 2011) and promotes a more holistic understanding of a service system (Berry, Carbone, and Haeckel, 2002; Patrício et al., 2011). This approach necessitates tools and techniques for service experience exploration that incorporate both design thinking in a specific service context and the broader service ecosystem and lifeworld contexts within which services and individuals operate. It is this dual focus which the TTT strives to accomplish.

2.4 Customer-Centred Healthcare

The concept of customer-centred healthcare is also relevant here. Within healthcare services research, there has been a movement among practitioners and researchers advocating for the application of insight from guest service industries, with care environments designed to intentionally incorporate elements from the best guest service companies (Fottler et al., 2000; Lee, 2004). While care organisations and researchers have traditionally focused almost exclusively on meeting patients' clear medical needs, over the past few decades there has

been a general shift towards a more expansive view, incorporating environmental and interpersonal elements of a health service experience.

This shift in focus has been accompanied by a linguistic shift, with increasing numbers of healthcare researchers and practitioners eschewing the traditional denotation of ‘patients’ in favour of ‘clients’, ‘consumers’, or ‘customers’ (e.g. Brinkmann, 2018). The term ‘customer’ is particularly relevant here, as this is clearly advanced by the application of SDL and the use of such concepts as the ‘customer journey’ in the context of healthcare. This approach implies an equivalence (at least in some significant aspects) between the health service user and other service customers. According to this view, healthcare should not be viewed as a distinct and uniquely challenging field so much as one example of a wealth of service fields and organisations, being both in constant competition with very different kinds of service organisations and well-positioned to benefit from their insights (e.g. Lee, 2004).

As a consequence of this shift in thought, service design methods and principles have increasingly been interpreted and incorporated as a strategy for care innovation (Brown, 2008; Mager, 2009). This is apparent in the emergence of multiple design research projects exploring the relationship between a healing process and environmental effects (e.g. Arneill and Delvin, 2002). For example, Irwin’s (2002) ‘patient journey framework’ identifies typical questions that are likely to arise in an individual’s mind throughout the different stages of their hospital visit, inspired by the work of design firm IDEO. Specific care providers have also implemented a service design practice in attempts to enhance the experiences of both customers and employees (Brown, 2008).

A design thinking approach to evaluating a service includes consideration of the environment within which a service is experienced, defined as a servicescape (Bitner, 1992). Lee (2011) divides characteristics of the healthcare servicescape into the two primary categories of ambient conditions and serviceability, both of which he finds are correlated with approach behaviour, perceived quality of care, and satisfaction with a facility. Ambient conditions include acoustics, cleanliness, and olfaction (Bitner, 1992; Sheng, Simpson, and Siguaw, 2017; Stern et al., 2003), evoking enjoyment at an ‘aesthetic level’ (Desmet and Hekkert, 2007, p.33).

Serviceability features include elements of the physical environment, such as the comfortability of furniture and ease of wayfinding within a facility, but also interpersonal components, such as privacy protection and the conduciveness of communication with staff

(Lee, 2011). Survey data indicates that the attitudes and behaviours of employees within a healthcare organisation significantly influence service users' perceptions of service quality and overall satisfaction (Weisman and Nathanson, 1985), with first impressions and even pre-service impressions of an organisation's staff appearing to meaningfully impact upon the likelihood that service users will a) describe their experience in positive terms and b) feel inclined to recommend the service in question to others.

Despite the growing prevalence of the 'patients as customers' approach, which has influenced certain aspects of health service delivery since at least the 1970s (e.g. Lazare, Eisenthal, and Wasserman, 1975), many medical practitioners remain resistant to the use of 'customer', 'client', or any other phrase with economic implications (e.g. Andreasen, 1995; Torrey, 2011). The assumption that customers are sovereign judges of their needs, the unquestioning satisfaction of which is the role of the commodity producer/service provider has been highlighted as problematic by some, who stress the importance of medical practitioner expert knowledge taking precedence over service users' (potentially misguided) beliefs and desires (Kotler, Burton, and Deans, 2013).

Some also view as callous what they perceive to the 'reduction to money' of care relationships, arguing that this fails to acknowledge how the degree of reliance of a medical service user upon a medical practitioner exceeds that of the average service professional (Krugman, 2011; Torpie, 2014). Similarly, the concept of 'customer service' has been described as inappropriate for the 'therapeutic relationship' at the heart of a clinician/service user relationship, which focuses on 'care for an individual' rather than 'service to a customer'. According to this interpretation, customer service is commonly reliant upon a 'detached, but polite' attitude, with superficiality superseding genuine connection and 'familiar, scripted catchphrases' in the place of meaningful communication (Torpie, 2014, p.6).

However, in protesting a shallow understanding of care relationships, it may be countered that such critics have failed to recognise the depth inherent to positive service relationships. While there can be a risk of service exchanges becoming overly scripted, Lee (2004) posits an alternative approach based around the adoption and promotion of an overriding mindset and culture, as opposed to a 'one size fits all'-style strategy. Furthermore, it can be argued that to reduce the concept of patient-as-customer to a solely, or predominantly, economic model is to seriously misinterpret what it is that the best customer service industries do. For

example, Fottler and colleagues (2000) argue that care services have much to learn from retail companies, which go beyond the fulfilment of the primary economic transaction to also meet customer expectations for 'an environment that anticipates and fulfils their other basic desires for comfort, convenience, safety, entertainment, and information' (p.92).

It may appear crass at first glance, but in comparing the dissatisfaction of a hospital patient with inadequate interpersonal interactions with that of a 'diner at a five-star French restaurant with aloof waiters' (Irwin, 2002, p.8), Irwin and others adopting this line of thinking do not seek to imply that a hospital stay and a meal at an expensive restaurant are comparable in their importance and potential impact upon the individual's broader life and longer-term well-being. Rather, the comparison rests upon the belief that humans share basic needs and desires (e.g. Jimenez, Pohlmeyer, and Desmet, 2015), which are not solely physical but also social and psychological, and that the best, most appreciated services surpass their primary function to also anticipate and meet these.

Ultimately, whether or not medical practitioners should refer to their service users as customers within everyday lingo remains a subject for debate and may come down to the personal preference of the practitioner and/or the service user. It would certainly appear that the term 'customer' has negative connotations for some individuals in some contexts, but, though important to take on board, this does not detract from the valuable contributions that the customer service industry has to make to the field of healthcare. It is this line of thinking that has induced some to encourage doctors to 'continue to call [service users] patients, but treat them like customers' (Bain, 1999, p.1). Regardless, the customer concept is well suited for the purpose of this research, and more broadly for exploring untapped opportunities for value co-creation and innovation in healthcare.

2.5 Mental Healthcare: Determinants of Quality and Value Creation

The need for effective mental healthcare services and systems has received increased attention in the UK across recent years, with the introduction of the Improving Access to Psychological Therapies (IAPT) service in 2008 intended to address what has been described as an 'epidemic' of mental illness. Despite the investment in this project, however, evidence suggests that levels of effective service delivery remain troublingly low, with one recent survey identifying mental health as the only area of healthcare in which UK public feedback was predominantly negative (Healthwatch, 2018). With regards to IAPT specifically, NHS

data shows a successful penetration into the ‘sick’ population of only around 2.5%, in addition to a reported relapse rate of approximately 50% in those who undergo initially ‘successful’ interventions (Ali et al., 2017).

Such findings seem to suggest an ongoing need for a greater understanding of the constituents of an effective mental health service, and, crucially, the identification of opportunities for innovation in this field. The abundance of research and debate already in existence on the merits of different psychotherapeutic treatment approaches is yet to reach any definitive conclusions, with meta-analyses typically revealing the same (small) effects across different approaches (e.g. Cuijpers et al., 2010; Cuijpers et al., 2016; Steenkamp et al., 2015). These findings appear to suggest that the named treatment approach applied is not the sole, or even the primary, determinant of the quality of a mental health service experience, and also perhaps that all of these approaches could be doing better without necessarily altering any of their central practices and premises.

The lack of universal differences in results across approaches implies that there are significant other factors, distinct from the differentiating characteristics of approaches, impacting upon the effectiveness of mental health services and thus warranting further attention. Some attempts have already been made to explicate and explore such features, with the well-known ‘common factors’ debate within the field of psychology comprising discussion and investigation of the ‘non-specific relational and ritual elements in an encounter between patient and clinician’ (van Os et al., 2019, p.390).

The argument for ‘common factors’ essentially asserts that there are certain elements inherent to an effective mental health service, the presence or absence of which is the primary factor in determining whether a mental health service is effective regardless of the technical approach. These factors include a practitioner’s ability to raise customer expectations and inspire engagement (Rutherford et al., 2014; Wampold, 2015), to offer an explanatory model (van Os et al., 2019), and to come across as ‘relationally warm’ (Kaptchuk et al., 2010, p.91). This is supported by evidence showing that outcome differences between active treatments and placebos are typically only minor and are reduced even further by structural equivalence between the two (Baskin et al., 2003).

The ‘common factors’ debate makes some progress in acknowledging the impact of factors distinct from treatment approaches, thus broadening the conversation about effective mental health services and avoiding unquestioning, potentially dogmatic adherence to the tenets of a

specific approach. However, the factors identified are overwhelmingly focused on the qualities and abilities of the service provider. Little attention is given to either the co-creating role of the customer or the impact of service design features external to an individual practitioner, missing opportunities for the application of SDL and/or service design thinking to a mental health context.

On the former point, as within general health services and service literature more broadly, the topic of co-creation has received increased attention specifically within the arena of mental healthcare. The combination of a widespread consensus of dissatisfaction with the state of mental health services and increasing acknowledgement of the co-creation of value have resulted in significant movements for increased customer involvement in service delivery and design, with many highlighting the unique perspectives and contributions customers can bring (e.g. Lammers and Happell, 2003).

This also ties in with the concept of 'empowerment', which is ubiquitous throughout mental health literature and policy documents (e.g. Newman et al., 2015; WHO, 2010), and which also appears consistent with the shift in healthcare away from the passive 'patient' concept and towards the more active, collaborative role of a 'customer' or 'client' (e.g. Sainsbury Centre for Mental Health, 2008; WHO, 2010). Increased attention has also been paid to service ecosystems over recent years, with UK policymakers and researchers promoting the concepts of care continuity and joint working across sectors (e.g. Healthwatch, 2018; House of Commons, 2018).

In spite of these developments, however, the specifics of what such concepts as empowerment and effective collaboration mean, and how these can be translated into effective mental health service design, remain largely unexplored (Newman et al., 2015). Consequently, there remains an unfilled need for mental health service design and evaluation tools encompassing the relational and ritual elements of a service experience, the active customer role, and service ecosystems, whilst also continuing to explore if and how different psychotherapeutic methodologies meaningfully impact upon perceptions of service quality and service outcomes.

2.6 Solution-Focused Practice: An Overview

Solution-focused practice (SFP) is a psychotherapeutic methodology which has received relatively little mainstream attention, and which differs in some fundamental respects from

the majority of psychological approaches. While almost all other approaches to change follow 'problem-leading-to-solution' sequences, manifesting in in-depth explorations of the history and archaeology of a given issue, within SFP conversations between clients and practitioners are driven entirely by the co-construction of solutions, leading to an overriding focus on the present and the future as opposed to any in-depth exploration of the past (e.g. de Shazer et al., 2012).

Initially developed for the purpose of family therapy (de Shazer, 1982), a solution-focused approach has gone on to exert influence not only within different therapeutic contexts but also within diverse fields such as business, education, and social policy (de Shazer et al., 2012). Also termed solution-focused brief therapy (SFBT), SFP was designed as a 'minimalist' or 'reductionist' approach, striving to help as many people as quickly and effectively as possible (Lipchik, 2014). This was pursued through centring of what the approach's founders empirically observed to be the leading generators of change, all of which ultimately came down to a client's focus on positive possibilities and on what was already 'working' in their lives (de Shazer, 1985; de Shazer et al., 2012; Lipchik, 2014).

An overriding emphasis on solution building and co-construction has been translated into specific techniques which are characteristic of SF therapy and coaching. These include the miracle question, which asks clients to envision a reality in which an 'overnight miracle' occurs and solves their problem(s) (Berg and Dolan, 2001, p.7); scaling questions, which ask participants to rate on a scale from one to ten how close they are to this 'miracle' scenario, as well as the number at which they would be satisfied (de Shazer et al., 2012); and exception questions, which ask clients to identify times at which a problem is absent, less intense, or dealt with satisfactorily (de Shazer, 1985; Lee, 1997).

The majority of research to date indicates that SFP is at least as effective as popular treatment approaches, such as cognitive behavioural therapy (CBT) (MacDonald, 2017). There is also some evidence to suggest that SFP can achieve the same quality of outcomes as other treatment approaches within a shorter time period (e.g. Lambert et al., 1998). Reviewing adult referrals at a clinical psychology service, Rothwell (2005) found that SFP clients were seen for an average of two sessions whereas CBT clients were seen for an average of five, with no significant difference in therapist-rated outcomes. If such findings are indicative of a broader pattern, as was the original intention of SFBT, it follows that a broader application of SFP may hold the potential to mitigate the effects of the current overburdening of mental

health services, allowing for greater numbers of people to receive effective psychotherapeutic help within shorter periods of time.

Furthermore, there is significant overlap between the central tenets of SFP and those of SDL, making it a particularly interesting approach to consider in the context of the co-creation of value in the experience. Just as SDL emphasises the importance of customers' operant resources, SFP prioritises the utilisation of clients' knowledge, strengths, and resources, with practitioners following clients' lead in determining what progress looks like and how progress is made as opposed to the other way around. At its core, this approach is built on the assumption that clients (and not practitioners) are the 'experts' in their own lives and in their own choices of goals and solutions (de Shazer, 1985; O'Hanlon and Weiner-Davis, 1989; Selekman, 1993).

Thus, as in SDL, clients are not merely acted upon but are active agents and creators of value. Having arisen in the context of family therapy and under the influence of a systems perspective (Bateson, 1972), the purview of SFP is also inherently interactional, for example including 'relationship questions' which enquire as to how a client's significant others think and feel about their problem situation, and to what others are noticing or would notice if and when progress is made (Berg, 1994). This is thus compatible with a holistic and ecosystems-based approach, within which value (and specifically transformative value) creation is situated in a broader context beyond a service interface (e.g. Anderson and Ostrom, 2015; Helkkula, Kelleher, and Pihlström, 2012).

SFP is therefore an interesting and pertinent methodology for consideration here, both as a potentially effective tool in addressing the state of the UK mental health system and as an approach which appears naturally aligned with the service-dominant thinking underlying the TTT. It is not, however, without its critics. Rigid adherence to the methodology has been associated with negative client impressions (which are themselves associated with poorer outcomes), with some clinicians and researchers highlighting the potentially detrimental effects of 'forcing solution' (Nylund and Corsiglia, 1994) or coming across as 'too positive' (Lee, 1997).

The potential for SFP to meaningfully influence mental health service effectiveness is also undermined somewhat by evidence on common factors. Lee (1997) found that the element SFBT clients found most helpful was feeling supported and validated, a finding which is consistent with more general findings about the constituents of effective therapy (Rounsaville

et al., 1987) but is not suggestive of any special quality unique to SFP. Further research is required to establish the extent to which SFP impacts upon customers' experiences and perceptions, in terms of both an overriding philosophy and specific techniques employed.

2.7 Research Questions

In accordance with the above discussion, a total of four research questions have been established:

1. What are the key elements and processes underlying the co-creation of transformative value in the experience, within the specific context of Company X?
2. What (if anything) is the apparent impact of introducing different degrees of SFP to the Company X service experience?
3. What (if any) opportunities for innovation can be uncovered through this research?
4. What does this pilot study tell us about the usability and efficacy of this adaptation of the TTT?

This chapter has identified and explored the multiplicity of concepts and approaches informing this work, synthesising and highlighting the parallels between research and ideas from diverse sources and culminating in a set of research questions. Concepts of and arguments for the co-creation of value, value in the experience, and transformative value have been integrated and applied to the specific context of mental health services and Company X (Research Question 1). Evidence on the constituents of an effective mental health service has also been considered. This led on to an overview on the specific methodology of SFP, the application of which forms the basis of one component of the service evaluation (Research Question 2).

A discussion of the potential for design thinking and customer-centred healthcare to affect positive change in health services explicated some of the theoretical underpinnings of this application of the TTT. These approaches and their usefulness are central both to investigating opportunities for innovation, as one element of the Company X service evaluation (Research Question 3), and to an evaluation of the methodology itself (Research Question 4). The subsequent chapter will delve more deeply into the theoretical underpinnings of the adapted TTT, also providing a detailed account of its practical development and application in this study.

Chapter Three: Methodology

The preceding chapter consisted of a review of the literature on the co-creation of different forms of value, service design, customer-centered healthcare, and mental health service design and evaluation. This review revealed significant gaps in understanding and evaluating the constituents of effective mental health services, which this application of the TTT strives to address. It is the aim of this chapter to explain the process of data collection for this research, in terms of the practicalities and of the reasons behind the decisions made.

This chapter begins with an exploration of the philosophical and practical considerations underlying the selection of this artefact (3.1), before moving on to an account of how the artefact was designed and a brief description of the end result (3.2). The next section covers the breakdown of participants (3.3), followed by a detailed description of how interviews were actually conducted (3.4). Finally, primary ethical considerations are discussed (3.5).

3.1 Justification of Methodology

This study has been designed both to provide specific feedback to a particular service, pertaining to the service itself and to the utility of the TTT in this context, and to serve as a pilot study for a PhD focusing in-depth on the development of a version of the TTT for mental health service evaluation. It is the ultimate aim of the TTT to effectively map the customer journey, in order that instances of value co-creation and opportunities for innovation may be effectively highlighted and used to inform the further development of this and related services.

The conception of the TTT unfolded in the context of an overall health sector that has continued to rely heavily upon formal complaint mechanisms and patient satisfaction surveys for evaluation purposes, and that rarely uses these to proactively gauge perceptions of service quality (Gill, White, and Cameron, 2011). Furthermore, the majority of healthcare research has focused almost exclusively on dimensions of clinical care, failing to encompass an entire service experience (Rosenbaum and Smallwood, 2011). Within mental healthcare specifically, a rhetorical focus on the concepts of collaboration and empowerment has been broadly lacking in real-world applications, with a dearth of in-depth research on customer preferences, expectations, and value creation (Newman et al., 2015). Emblematic of this issue is the fact that much of the mental health research allegedly addressing a customer

perspective has failed even to directly involve customers as participants (e.g. Braye and Preston-Shoot, 1993), let alone to grant them licence to define quality and value in their own terms.

While quantitative and 'objective' ways of measuring service quality, such as pre-defined customer (perceived) value measurement scales, do have an important role to play in terms of explaining attitudes and behaviours (e.g. PERVAL; Sweeney and Soutar, 2001), their preponderance within healthcare may have negative implications for the illumination of value creation processes. Such measures are based on a positivist approach, seeking to approximate the natural sciences as closely as possible through adopting a 'hypothetico-deductive' and 'outcome-oriented' approach to research (Cook and Reichardt, 1979, p.10). Conversely, Helkkula and Kelleher (2010) argue 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' (Langdridge, 2007).

While the positivist approach operates on the assumption that human behaviours are objectively quantifiable and measurable (Deshpande, 1983), research conducted within the phenomenological paradigm is underpinned by a belief that the 'subjective reality' each individual experiences is no less real than 'an objectively defined and measured reality' (Fetterman, 2010, p.5), due to the real-world consequences of people acting on their individual perceptions. A phenomenological approach to research is therefore appropriate when seeking insights into the meanings that different individuals ascribe to different situations (Bloor and Wood, 2006), and encompasses qualitative methods such as interviewing, diary analysis, and narrative analysis (Creswell, 1998).

Furthermore, the intention in producing this service evaluation is not to focus solely on the customer-provider dyad but rather to adopt a broader perspective, encompassing both the complex, dynamic ecosystems and networks within which practitioners operate (Barile et al., 2016) and the broader 'life worlds' of participants. This involves exploring and analysing the nature of everyday lived experiences and the prioritisation of meaning within different individuals' social contexts (Husserl, 1970; Merleau-Ponty, 1962; Stroh, 2000). Such an aim naturally lends itself to a qualitative approach, which prioritises the gathering of rich and detailed data on a relatively small number of individuals (Holdaway, 2000), and pays greater

heed to in-depth explorations of processes than to the inference of relationships between variables (Maxwell, 2004a; Merriam, 1998; Mohr, 1982).

There have been some notable attempts at creating tools and techniques for this purpose within the field of service research. The two most relevant of these are service blueprinting, which consists of a diagrammatic representation of time dimensions in relation to the main functions of a service (Shostack, 1982), and customer journey mapping (CJM) (Batra, 2017), comprising the mapping of touchpoints across a customer's full service experience. The concept of a touchpoint was traditionally defined as all points of contact between a customer and a provider (Lemon and Verhoef, 2016), but has since been expanded in line with SDL, encompassing for example the roles of customer-to-customer interactions, self-service activities, and resources drawn from third parties (Barile et al., 2016; McColl-Kennedy et al., 2012; Pine and Gilmore, 2013; Vargo and Lusch, 2008; Varnali, 2019).

While the TTT does emulate CJM in the centrality of the TTT and the customer journey concept, it also strives to redress some of the major limitations associated with this and with service blueprinting. Both have been criticised for falling short in terms of centring the customer role, with service blueprints failing to adopt a customer perspective at all (Følstad and Kvale, 2018; Zomerdijk and Voss, 2010) while CJM lacks active customer involvement and operates on the assumption that all customers experience the same touchpoints (Glushko, 2013; Rosenbaum, Otalora, and Ramirez, 2017; Shaw and Ivens, 2002).

The TTT aims to overcome these limitations, centring customers as active agents and value creators (Helkkula, Kowalkowski, and Tronvoll, 2018; Trischler et al., 2018). Originally administered in the context of hospice care, the TTT was developed to provide a 'deep dive' into customers' lived experiences, in order to better comprehend all aspects of a service experience (Sudbury-Riley and Hunter-Jones, 2017, p.2). As opposed to the traditional, question-led interview structure, in the TTT participants are presented with a series of 'touchpoint' images, printed onto A4 cards, and asked to comment on as many or as few as they wish.

Touchpoints are grouped in accordance with different phases of a customer journey, beginning with pre-referral and ending with post-service experiences. The TTT procedure strives to enhance customer agency through asking customers to discuss as many or as few of the pictured touchpoints as a customer considers relevant, also encouraging them to raise any additional touchpoints they do not see pictured. Opportunities for identifying and elaborating

upon these additional touchpoints are provided throughout the interview, every time a customer appears to come to the end of discussing the images on a given card and before the interviewer moves on to the next card (Sudbury-Riley and Hunter-Jones, 2017).

3.2 Development of Data Collection Instrument

The first stage in developing the adapted TTT was accruing a detailed understanding of the original TTT, and specifically of the theory and strategy underlying its development. This consisted in part of in-depth reading of the original paper, examination of the original cards, and detailed discussions with the creators of the original methodology, all of which have remained consistent reference points throughout the entire research process. Gaining a truly thorough understanding of the technique also required further research into the approaches underlying its construction, particularly DSR, service design, and SDL.

The original TTT cards were used to give a basic structure to the tool, from pre- to post-service experience. Company X also provided documentation and engaged in several informal discussions on the subject of the different service stages and the different areas the work with their customers covered, giving an overall shape to the service experience and also aiding the determination of which themes from the literature and the original TTT were relevant/irrelevant. For example, the disclosure that the vast majority of customers' interactions with service providers occurred within the customers' own homes detracted significantly from the importance of the physical servicescape.

Desk research encompassed a combination of service research, mental health literature, and mental and general health policy documents. Examples of key terms and phrases entered into Google Scholar and specific journals (e.g. Journal of Service Research; JSR) are given below:

All Service Research	General Health	Mental Health
“Customer journey”.	“Health customer journey”/ “patient journey”.	“Mental health customer journey”/ “mental health patient journey.
“Service evaluation”.	“Health service evaluation”.	“Mental health service evaluation”.
“Co-creation of value.”	“Health service co-creation of value”.	“Mental health service co-creation of value.”

Table 1: Overall themes and examples of search terms entered.

All images used on the cards were taken from Google Images, and were marked as ‘free to share or use commercially’. Ongoing discussion with the creators of the original TTT, the supervisors of this project, were also highly beneficial in selecting the most appropriate images, getting a sense of how those originally chosen were perceived/potentially misinterpreted by others and removing or replacing them when necessary.

The end result of this process was the creation of six touchpoint cards (Appendix 1) –

1) Beginning the Journey to Company X.

This relates to the stage before customers’ first meeting with Company X, beginning from the first mention of the service. Touchpoints include barriers (e.g. WHO, 2010), advice about help available (e.g. Healthwatch, 2018), and online informational sources (e.g. Fottler et al., 2000).

2) First Meeting.

This is about the first time that the customer met with anybody from Company X. Touchpoints include access to options (e.g. Care Quality Commission, 2012), customer engagement in planning (e.g. Newman et al., 2015), and service provider attitude, knowledge, and skills (e.g. Bedi et al., 2005; Sudbury-Riley and Hunter-Jones, 2017).

3) Relationship with Service Provider.

This covers the way that customers experience their relationship with their support worker and anybody else from Company X they have come into contact with, including interactional elements and perceived service provider attributes. Touchpoints include listening skills (e.g. Bedi et al., 2005; Healthwatch, 2018), co-creating value (e.g. Arbuckle et al., 2012; Catty et al., 2012), and balanced interactions (e.g. Bedi et al., 2005; Flückiger et al., 2018).

4) Building Skills and Resources.

This explores how Company X have impacted upon customers' capacities for managing various areas of their lives, both directly and indirectly. Touchpoints include building confidence and resilience (e.g. Healthwatch, 2018; WHO, 2010), practical skills (e.g. Blocker and Barrios, 2015; Healthwatch, 2018), and financial difficulties (e.g. Blocker and Barrios, 2015; House of Commons Briefing Paper, 2018).

5) Connecting to Broader Support Network.

This directly addresses how Company X connect with broader service ecosystems and customers' lifeworld contexts. Touchpoints include ease of navigation between services (e.g. Fottler et al., 2000; Leather et al., 2003), coordination between different parties and services (e.g. Healthwatch, 2018; House of Commons Briefing Paper, 2018), and connection to physical healthcare (e.g. Company X, 2018; Shattell, Starr, and Thomas, 2007).

6) End of Service and Follow-Up.

The final card pertains to customers' experiences of ending the service and post-service experiences, during and after the six-month follow-up period that Company X offer to all of their customers. Touchpoints include unanswered questions (e.g. Irwin, 2002; Zomerdijk and Voss, 2010), the clarity of a path forward (e.g. Fottler et al., 2000; Irwin, 2002), and ease of contact if needed (e.g. Irwin, 2002; Peterson et al., 2010).

3.3 Participants

Interviewees were drawn from the Company X tenancy support customer population, from each of the three treatment groups being employed in the project –

Group 1

This group received simple pragmatic support, which was not informed by any psychotherapeutic methodology. This consisted of regular (typically weekly or biweekly) meetings with an assigned support worker, who provided practical and emotional assistance and advice. These customers did not receive any structured one-on-one counselling.

Group 2

This group received standard support enhanced by some elements of SFP, incorporated as part of other helping conversations in regular meetings with their assigned support worker. These customers also did not receive any structured one-on-one counselling, but some solution-focused techniques were applied, such as the future-focused questions described in Chapter 2.6.

Group 3

In addition to the aforementioned regular meetings with an assigned support worker, this group also took part in structured SF sessions of 45-60 minutes, with a trained SF counsellor employed by Company X. Within these sessions, the counsellor followed a defined SF structure, based around a customer describing their best hopes, preferred future, and progress.

Though the intention was to recruit at least 20 participants, with this being the point at which saturation is typically reached with the TTT (Sudbury-Riley and Hunter-Jones, 2017), a high drop-out rate, and support workers' difficulties encountered in re-arranging/recruiting further participants after this, meant that this proved impossible. The total number of participants ultimately came to 17, with three participants in Group 1, seven in Group 2, and seven in Group 3. Five of these participants were former customers, with the other 12 all still within the service at the time that they were interviewed.

3.4 Data Collection Procedure

Firstly, Company X tenancy support workers participating in the study contacted a sample of their current and former customers to enquire as to whether they would potentially be interested in participation. Customers were selected on the basis that support workers believed they would be physically and mentally capable of participating in a telephone interview and, in the case of former customers in particular, in accordance with their reachability.

Having initially established the number of clients who wanted to participate as 25, a total of 30 'interview packs' were posted to Company X. The extra five were sent out in case of any errors. After a high (around 50%) drop-out/non-attendance in the initially scheduled interviews, a further 15 interview packs were sent out to prolong the recruitment and interviewing process.

All packs included –

1) An instruction sheet for support workers, explaining what was required of them (Appendix 2).
2) An information sheet, describing the nature and purpose of the study, to be read by participants (Appendix 3).
3) A consent form, to be read and signed by participants (Appendix 4).
4) A set of the touchpoint cards, for participants to keep and refer to throughout the interviews.
5) A stamped envelope, addressed to the University of Liverpool, in which support workers were asked to insert and post the signed consent form prior to the interviews.

Interviews were conducted over the phone, with participants sent out the touchpoint cards prior to the interview and the interviewer also having a copy of each to consult throughout. The decision to conduct telephone interviews was made as a result of ethical and logistical issues. It was felt by support workers that many customers would not be willing to come in to the branch office, given that the majority of the service experience takes place within customers' own homes and considering difficulties with practicalities (e.g. travel) made more likely by the high prevalence of socioeconomic disadvantage across this population. Though interviewing people within their own homes was considered as an option, this raised further

issues, as a support worker's presence would be required for safety purposes (of both the participant and the researcher) but may influence participants' accounts of the service.

Telephone interviews were therefore selected as the most feasible and desirable option. Evidence indicates that telephone interviews can be methodologically effective and economically efficient within the context of interpretive phenomenological research (Sweet, 2001), and specifically in addressing such sensitive topics as mental health (Marks et al., 1998). There are certain benefits of conducting telephone interviews, including facilitating greater anonymity and privacy (Sweet, 2002) and allowing participants to remain 'on their own turf' (McCoyd and Kerson, 2006, p.399). However, there are also significant drawbacks and limitations associated with this method, the implications of which will be discussed in Chapter 5 (5.2.2).

Interviews ranged in length from 30 minutes to 1 hour and 20 minutes. All interviews were recorded using a tape recorder, with the original recordings destroyed after verbatim transcription. The process of recording allowed for the constant re-examination of findings and removed the need for a reliance upon interviewer memory, thus enhancing the 'dependability' of findings, reducing the impact of analytical bias, and ultimately increasing the precision of conclusions (Guba, 1981; Heritage, 1984). The preliminary stages of thematic analysis, in terms of seeking and identifying patterns of meaning and issues of potential interest, could therefore begin even before the transcription of interviews (Braun and Clarke, 2006).

The process of transcription further increased familiarity with the data, facilitating the emergence of key concepts and themes (Bryman, 2008). All transcripts were also read through once before the initiation of coding (Braun and Clarke, 2006; Ryan and Bernard, 2000). Coding was carried out using NVivo software. This consisted in part of 'theory-driven' analytic induction, in which data was actively sought out to insert into predetermined categories (Braun and Clarke, 2006, p.18). In this instance, these predetermined categories were those derived from the research questions, relating to:

1. The co-creation of transformative value in the experience.
2. The impact of introducing SF.
3. Opportunities for innovation.
4. Usability and efficacy of the TTT.

Sub-themes were developed through a combination of analytic induction, influenced by the broader literature in addition to the predetermined main themes, and a more ‘data-driven’ approach (Hammersley and Andersen, 2008). The latter of these was beneficial in identifying some unanticipated themes, such as the concept of a ‘turning point’ initiating transformative value creation. In accordance with the requirements of ‘credibility’ in qualitative research (Guba, 1981), careful attention was paid to those responses that deviated from the norm, some of which are highlighted and discussed in Chapters 4 and 5. Effort was also taken to acknowledge broader lifeworld contexts and the multitude of factors that constitute the ‘whole’ of each individual’s ‘reality’ (Guba, 1981, p.4), in opposition to the quantitative rationalist approach of ‘untying’ certain variables from a design (Brunswik, 1955).

3.5 Ethical Considerations

In designing the study, care was taken to ensure that high ethical standards were upheld, prioritising the comfort and safety of participants and also ensuring that researchers were not put at undue risk. Informed consent was obtained through providing each potential participant with a detailed information sheet (Appendix 3) and consent form (Appendix 4). Both documents stressed that customers were under no obligation to participate and that this would not affect the service they received from Company X in any way.

The destruction of audio files (following transcription) and the pseudonymisation of transcripts were carried out to ensure the greatest possible level of anonymity of data, in keeping with recommendations for the avoidance of psychological harm (Bryman, 2008). Accordingly, all participants quoted are referred to by their assigned participant numbers and service groups throughout Chapters 4 and 5. Other potentially identifiable details, such as the names of other people and organisations, have also been removed from the transcripts.

3.6 Conclusion

This chapter has sought to provide a detailed insight into the methodology used, including both the reasoning and the practical processes underlying its development. While the original TTT has been successfully applied in a variety of health-related contexts, this specific context and population necessitated some new considerations, in terms of the relevant literature, practicalities, and ethics. This included the administration of the TTT over the phone, the

implications and possible limitations of which will be discussed in Chapter 5. The final two chapters will further present and evaluate the evidence generated by this application, considering the implications both for Company X and for the efficacy of the methodology.

Chapter Four: Findings and Discussion

The previous chapter detailed and justified the methodology used, which attempted to effectively integrate the relevant literature on mental health, general health, and service research. It is the purpose of this chapter to share and explore the research findings with reference to each of these literature streams, considering how the findings of this study corroborate or conflict with various studies and theories that informed its conception.

This chapter is divided into two main sections. The first of these relates to the service evaluation of Company X and is structured around research questions 1-3 (4.1.1, 4.1.2, and 4.1.3). The latter section relates to the methodological evaluation of the adapted TTT, and thus addresses research question 4 (4.2.1). The answering of each of the research questions is further divided into sub-themes, emergent from the data and influenced by the context of the relevant literature.

Throughout this chapter, participants will be referred to by a participant number and a group number, denoting which of the three service groups (discussed in Chapter 3) they were in. For example, Participant 1, who is in Group 2, will be referred to as "P1, G2". A brief description of each of these groups is provided in the table below:

Group	Description
G1	Simple pragmatic support (no psychotherapeutic methodology).
G2	Standard support enhanced by some SF work.
G3	Application of SFP in a structured setting.

Table 2: Brief descriptions of each of the three treatment groups.

4.1 Service Evaluation

4.1.1 What are the key elements and processes underlying the co-creation of transformative value in the experience, within the specific context of Company X?

4.1.1.2 Evidence and influence of a customer-centred approach

An important theme which emerged throughout the interview and analysis processes was the degree of overlap between the three approaches at the heart of the study, and the extent to

which the apparent impact of this shared philosophy could be identified throughout participants' accounts of the customer journey. Underpinning the approaches of SDL, SF, and Company X's stated aims was the importance of co-construction and collaboration, with customers' own knowledge, strength, and resources taking centre stage.

In accordance with these stated values, descriptions of collaboration and co-creation were prevalent throughout the interviews, with customer's choices being respected and individual needs and preferences being accommodated throughout the different stages and touchpoints of the customer journey. This collaborative approach reinforces the SDL vision of customers as active value creators making use of 'operant resources', as opposed to passive consumers of value (Grönroos and Voima, 2012; McColl-Kennedy et al., 2012; Vargo and Lusch, 2004b, 2008). Furthermore, this approach appeared, for several participants, to set Company X apart from their earlier (and sometimes ongoing) service experiences within physical and mental healthcare.

In responding to the first and second cards (*Beginning the Journey to Company X* and *First Meeting*), some customers described their past experiences of being subjugated and controlled as a cause of concern prior to their getting to know the service and the support workers. For example, P5 (G3) described feeling 'apprehensive' and 'cautious' at the first meeting, 'because [he] thought, oh, here we go, another one of these ones that try and alter things', while P15 (G1) described how he was used to 'not really [being] given a choice' where other people and organisations were concerned.

After actually entering into conversation with their support workers, however, participants often described a great sense of relief, provoked by a strong and often almost immediate sense that 'this is different' (P5, G3). Underlying this overall impression was a combination of the ways in which support workers explained the nature and purpose of the service, reassuring customers 'that they were there to help and not interfere' (P15, G1), and the ways in which they actually addressed and interacted with customers throughout the course of the first meeting. Participants described feeling 'at ease in…a short space of time' (P1, G2), in part because of a sense that they were treated as 'an actual person' as opposed to merely a 'number or…a name' (P5, G3).

Participants described the attitudes and behaviours of support workers in their first meetings, leading to their feeling heard and respected. Listening was a fundamental element of these

interactions, and was highlighted as a two-way process, with support workers and customers communicating as equals as opposed to the former simply instructing the latter:

He had a way of speaking to me that made me respond…it wasn't like a teacher talking to a pupil. It was, like, on a personal level (P14, G3).

This sense of mutual attentiveness and respect appeared to play an important part in determining the way in which the first meeting unfolded, influencing the beliefs and expectations that customers held by the meeting's end. This indicates that the co-creation of value is important to customers, both in their direct experiences of an interaction and in their expectations and optimism about an unfolding service journey. The association of the perception and anticipation of value co-creation with raised expectations for a service is particularly significant in a mental health context, in virtue of evidence that the ability to raise expectations is a central driver of change to negative mental health states (Rutherford et al., 2014; Wampold, 2015).

Descriptions of support workers' attitudes and behaviours, in the first meeting and beyond, are consistent to an extent with the 'common factors' argument, revealing some 'relational and ritual' (van Os, 2019, p.390) elements which appeared to positively influence the service experience regardless of psychotherapeutic methodology. For example, descriptors such as 'patient' (P10, G3), 'kind', and 'respectful' (P4, G1) were prevalent across participants from all three treatment groups. While some participants from G3 did describe the positive effects of specific SF techniques (discussed in 4.2), the fact that the aforementioned perceived attributes were associated with benefits across all groups does nonetheless suggest that these were influential as determinants of service quality perception.

However, to focus on providers' skills and attributes alone is to do an injustice to the pivotal role of customers themselves. Several participants employed metaphors of co-construction within the context of the customer/service provider relationship. P4 (G1) described how the image, on the *Relationship with Service Provider* card, of an image of two cartoon figures with building blocks resonated with him as representative of the notion that 'it requires two', while P1 (G2) similarly asserted that Company X worked 'as a team with [him]'. Thus, it was not only important to customers that support workers exhibited certain traits and skills but also that they demonstrated willingness and allowed the space for customers to also play an active role in setting and moving towards their personal goals. Such descriptions are also

illustrative of how value is co-created in moments of interaction and engagement, as opposed to being predetermined in the service development phase (Blocker and Barrios, 2015).

The pacing of customer journeys was emergent as a crucial aspect of the service experience over which participants seemed to feel that they exerted significant control, and which was again contrasted with their earlier experiences. Participants described a feeling that they were not being rushed into anything or having anything forced on them but were encouraged to take action and make changes in their own time, with no 'time limit' (P14, G3) on any part of the process. One participant compared the impression of a relaxed willingness of the support worker to spend as long as was necessary and appropriate with a customer with past service experiences, in which they had often felt that a service provider was 'looking at their watch' and even that they were being 'fobbed off' (P17, G1) in providers' efforts to limit the length of their interaction.

Flexibility was further exhibited in the ability and willingness of support workers to arrange and re-arrange meetings at short notice, fitting around customers' often hectic and unpredictable schedules:

They do fit around my life…definitely. I can give [counsellor] and [support worker], I don't know, maybe two days' notice – I can send a text (P7, G3).

The customer-centered approach was evident even in the attitude and actions of other Company X employees besides customers' individual support workers and counsellor, with whom they had relatively little interaction. The positive impact of feeling that they could rely on the organisation as a whole, as opposed to just one trusted individual, appeared to enhance customers' sense of security and trust in the service. The implications of this therefore extend beyond customers' primary contacts, demonstrating the importance of an organisational culture which is present at every level and in every interaction (Lee, 2004). In this case, a general sense of being treated respectfully and as an individual was present in even the briefest of customer/service provider interactions.

The inclination of all employees with whom customers came into contact to treat and respond to them as an individual was in stark contrast with the dismissive and impatient attitudes that some described having encountered at other services:

Even when I go down the office, everybody treats me with respect, not like, oh, what are you doing here? And I think that's brilliant (P5, G3).

Individual needs and preferences were also accounted for in signposting. In contrast with past experiences of feeling forced into an undesirable situation, the Company X approach was non-invasive and prioritised customer choice. Support workers simply made informed suggestions and then allowed the customers themselves to decide if they wished to follow through, also leaving it up to then if they opted to 'pack it in' (P5, G3). This alternative approach was associated with a greater sense of agency and a propensity to engage with signposted services, due to a sense that this was being done on customers' own terms:

She wasn't pushy about it. It's been a good few months, and she sort of mentioned it, then didn't say anything about it, and then mentioned it again…you know what I mean? She didn't push me – I'm going because I wanna go, not because she's trying to force me or…anything like that (P12, G3).

The effectiveness of this approach to signposting suggests that the role of an organisation in effectually interacting with broader service ecosystems is not always as straightforward as simply possessing and sharing the requisite knowledge and connections. On the contrary, an appropriate and beneficial approach to connecting to other organisations and services appears reliant upon an appreciation of a customer's broader lifeworld context, and ultimately of a respect for their individual agency and knowledge of their own abilities and preferences. This leads on to the next identified theme, which pertains to the ways in which value co-creation impacted and was impacted upon by broader lifeworlds and service ecosystems.

4.1.1.2 Broader lifeworlds and service ecosystems

Interviews also uncovered instances of and opportunities for value co-creation which extended beyond the service interface, interacting with and influencing the broader service ecosystems and lifeworlds in which customers operated. A common sub-theme within this category of descriptions pertained to support workers acting as a form of mediator between customers and the manifold other organisations and services relied upon for navigating everyday life. This was often a significant aspect of the goal setting and planning components of the first meeting:

Payments – rent and water, because we've been behind. He phoned them up and he explained to them, and he sorted out a plan to do the payments and all (P8, G2).

The speed with which support workers turned their attention to these practical matters of communication was also remarked upon as a positive and encouraging sign, again tying in with the importance of raising customer expectations (Rutherford et al., 2014; Wampold, 2015):

All of a sudden, I felt a bit more secure and confident that my situation was going to get better… [because of] just watching her deal with all my issues straight away (P10, G3).

While important phone calls were often made in a first meeting, it was typically later in the customer journey that support workers physically accompanied customers to important meetings, which included doctors' appointments, support groups, and court hearings. In this context, support workers' presence proved beneficial in assisting customers trying to navigate various challenging situations and communicate effectively with others. The presence and assistance of support workers could also expose a striking contrast between the attitudes of support workers and those of other professionals:

The psychiatrist was a bit harsh – a little bit impatient with me, which I thought was ridiculous considering he's a psychiatrist…but I was getting offended with the way he was cutting me off…she had more patience and understanding than he did, and she was in there with me, and she helped support me (P10, G3).

Having somebody else with them, who had their best interests at heart, could make a big difference to customers, helping to compensate for example for difficulties with concentration or communication. Some believed they simply lacked the requisite knowledge for, for example, effective communication with utilities companies, whereas support workers' specialist knowledge and years of experience enabled them to get the most out of such interactions:

Because she's – I think she's done the job for, I don't know, twenty, thirty years, or something, she knows how they run things (P12, G3).

Support workers' guidance proved a valuable resource for customers in navigating forms, phone calls, and face-to-face appointments, assisting them in the translation of 'jargon' and through their knowledge of the 'right words to say to people' (P12, G3). This tied in with skills and resources, in the sense that support workers themselves became valuable and reliable resources which customers could call upon in times of difficulty and stress:

I know that they're there if I need any help. If I get a form in that I don't understand, I can call them up and my support worker will help (P5, G3).

Furthermore, value co-creation in the broader context was also achieved in a more indirect sense through building customers' own skills, strengths, and knowledge. Several customers described the lessons that they had learned from working with Company X and how they planned to apply, or were already applying, these to navigating potentially difficult and confusing systems and situations:

It's better – don't bury your head in the sand, phone [financial body] up as soon as you get any issues, and go from there, basically (P2, G2).

Moreover, participants commonly felt that, when represented or accompanied by support workers, their needs and concerns were taken more seriously than was generally the case when they attempted to navigate these systems by themselves. Medical and financial bodies and figures were described as more receptive, personable, and helpful than customers were used to, both in direct dealings with support workers and apparently by virtue of their presence at a given meeting or appointment.

The involvement of a support worker seemed to customers to bestow a certain legitimacy upon them and their issues, allowing them to make progress within these systems with substantially greater ease and speed. This highlighted the potential for support workers' actions to have a knock-on effect on the other services and individuals in customers' lives:

I feel confident that, when she's with me, I know I'm not going to be messed around or walked all over…it's actually going to be taken seriously and dealt with (P10, G3).

In addition to engaging with those already involved in participants' everyday lives and (primarily financial) difficulties, support workers could play an active role in reaching out to and collaborating/coordinating with 'new' organisations and services they signposted their customers to. However, this was done only with the express 'permission' (P2, G2) or 'confirmation' (P10, G3) of the customer themselves, highlighting the importance of customer choice in setting the boundaries of their own unique lifeworlds.

Similarly, despite the importance of their mediation, support workers nonetheless appeared to customers to avoid crossing the line into interference, actively acknowledging and respecting the extent of active mediation that different customers desired and required:

[Support worker] knows, for me, to just let me say and do it, but she does help if I need help (P10, G3).

Furthermore, support workers' mediation did not always have to move a customer journey forward, at least in the most straightforward sense. As well as aiding and guiding customers in becoming involved with new organisations or services, support workers employed direct intervention in efforts to prevent customers from being forced into situations that they did not feel comfortable with or ready for, again demonstrating the centrality of customer choice in determining the pacing of the customer journey:

There was a point when the job centre was trying to put me on this long – basically, looking for work skills course for a few weeks…and there was no way I was ready for it, but I thought I had to do it. And [support worker] intervened, and basically told the job centre that I'm in no fit mental health state to even be trying to do this just yet (P10, G3).

Evidence of the importance of connections to broader lifeworlds and ecosystems is indicative of a need for coordination, continuity in care, and joint working across sectors, factors which have been already acknowledged by UK policymakers and researchers within the context of mental health and well-being (Healthwatch, 2018; House of Commons, 2018). However, these findings go further in offering specific insights into the ways in which joint working can be achieved, and to how services in themselves can adopt a more holistic and comprehensive understanding of a customer's life.

In particular, and in line with the aforementioned customer-centred approach, feedback highlighted the importance of not merely following a standardised procedure in signposting customers to certain organisations or persuading them to take certain steps, but instead taking into account the huge variation in factors such as preferences, personalities, and abilities. This approach highlights the importance of individualisation and is consistent with the premise of 'culture' over 'strategy' (Lee, 2004) as a fundamental element of an effective service.

In talking about the end of service and follow-up, customers described how support workers' direct involvement in their lives was gradually reduced over time. This was never revoked fully, however, with participants in the follow-up period maintaining access to support workers as a resource in times of need:

I can call [support worker] any time and say I've got another letter from whoever, and she'll explain it to me, and, if it needs dealing with, I know she's able to deal with it (P15, G1).

This sense of security continued even after the follow-up period formally came to a close:

She said, if I ever need anything or anything, I can just pick up the phone and it can restart at any time (P17, G1).

Ultimately, support workers' connections and past experience with other relevant services were significant factors throughout a customer journey, from providing customers with an initial sense of hope and improved expectations in the first meeting to leaving them with an ongoing feeling of security and a resource to utilise in and after the follow-up period. While this was important at all stages of the journey, the significance of hope and expectations in the initial stages of a service experience was a recurrent theme which appeared especially strongly linked to transformative value creation, and which will be explored in further detail in the subsequent section.

4.1.1.3 'Turning points' and transformative value creation

Evidence of transformative value creation specifically was also uncovered through this application of the TTT. While habitual value creation serves to maintain order and stability (Blocker and Barrios, 2015), customers frequently described a sense of change in direction and/or personal transformation as emergent from (or partially from) their experiences with Company X, indicating that the form of value that was co-created by customers and service

providers within Company X was indeed transformative in nature. The initiation of transformative value creation was associated with the sense of a turning point, which was prevalent within first meeting accounts.

Many participants recalled a feeling of great relief and newfound confidence in the potential of the service experience to meaningfully improve their lives. These feelings were ascribed to the support workers' attitudes and approaches, which again were sometimes contrasted with the treatment participants had come to expect from similar and related services:

Obviously, the rapport I got with [support worker] is really nice to have, because sometimes you can be sitting with people and…yeah, they're doing the job, but you don't really feel that comfortable. But, with [support worker]…I feel so relaxed and I've got a really good rapport with her…that's what made me feel, all of a sudden, a bit more secure, and I had hope for the first time in a long time that things might end up turning out not so bad (P10, G3).

An image of a crossroads, featured on the *First Meeting* touchpoint card, was referred to by some participants in describing what they experienced as a change of direction in their lives from this point. The turning point moment was typically followed by a sense of meaningful 'movement', towards a specific goal(s) and/or a generally improved state of being, significant due to the feeling of finally 'getting somewhere' after a long time 'stuck in the same rut' (P1, G2).

The importance of raising customer expectations (Rutherford et al., 2014; Wampold, 2015) seems highly pertinent to this concept. In customer accounts, sudden increases in hope, direction, and trust in their new support system marked a decisive change in their expectations for the service and their futures, heralding the beginning of a personal transformation/the creation of transformative value. This seemed in turn to promote a greater degree of receptiveness and openness towards the service than customers themselves may have anticipated, tying in with the argument that inspiring engagement is fundamental to effective provider/customer collaboration (Wampold, 2015).

Numerous participants described a dramatic transformation since beginning their work with Company X, which they attributed in large part to the assistance, advice, and general support they had received from Company X support workers:

[Company X] definitely gave me tools in my toolbox – because nothing was there before, absolutely nothing – a big black void – and then, all of a sudden, I'm given new tools (P7, G3).

Operating within a context of social and economic disadvantage and vulnerability, transformative value creation appeared to be facilitated by Company X's role in meeting their most fundamental needs:

We are now sustained – we are able to cope with bills, and able to buy food – simple things (P7, G3).

He's put my mind at ease, and it's a lot better (P8, G2).

The positive impact of addressing customers' most urgent (financial and/or physical) needs within an initial meeting is interesting to consider in light of participants' 'vulnerability' and the alleged association between vulnerability and the potential for TSR/transformative value creation to enact meaningful change in people's lives (Blocker et al., 2013; Corus and Saatcioglu, 2015; Mick et al., 2012). In this case, meeting the most prominent needs and desires associated with BoP consumers (i.e. those relating to basic survival and security) arose as a fundamental component and facilitator of transformative value creation, both improving customers' lives directly and granting them the time and space to focus on less urgent, more long-term goals.

While it may seem obvious, the importance of meeting individuals' most fundamental needs to transformative value creation is often unacknowledged, even by those operating within a context of extreme vulnerability (e.g. Blocker and Barrios, 2015). Although it is obviously not within the jurisdiction of every mental health-related organisation to also provide for customers' fundamental physical needs, these may be better addressed through coordination and joint working across sectors (Healthwatch, 2018; House of Commons, 2018), as well as through a more holistic appreciation of the different influences, absences, and drives affecting an individual's life (Anderson and Ostrom, 2015).

The metaphor of seeing or being shown a path forward appeared to resonate with multiple participants:

[Support worker] just knew where to go – you know, the right avenues and things, in regards to the debt (P4, G1).

At the same time, participants were often keen to emphasise the centrality of their own active engagement and decision-making, asserting that support workers' role was in informing customers of their options and helping them on their way as opposed to directly and forcefully taking control of their lives:

She just helps me with my things – phone calls and stuff, and she keeps a diary and stuff, about what I need to be doing. The plan and the goals – we talk about it, but she doesn't need to intervene. I don't need help with things like that (P13, G1).

Ultimately, the licence that participants were granted in defining their own goals and making their own decisions was arguably as important as the practical guidance and assistance that support workers provided. The sense of a turning point and subsequent experiences of transformative value creation described by participants were underpinned by confidence in support workers' knowledge and abilities, but also by a sense that support workers were willing to work *with* them and by the beginnings of a positive relationship of equals.

Co-creation therefore emerges as a critical component of transformative value, including in circumstances of extreme vulnerability and disadvantage. Fulfilment of fundamental needs is a necessary but not sufficient condition of transformative value creation in this context, as the space which participants are granted to move towards more long-term goals may be restricted by service providers who do not allow them to determine their own goals and define their own progress.

4.1.2 What (if anything) is the apparent impact of introducing different degrees of SFP to the Company X service experience?

There were some common themes specific to Group 3, which directly related to specific components of SF. Customers described how Company X differed from other services in that they focused more on everyday life and how things could get better – an attitude which is at the core of the SF approach –, rather than trying to change them or dig deep into the causes of their issues:

Company X have taught me about feelings. Where all the others have tried to get to the root of the problem, they haven't gone to the fact of, you know, how would Joe Bloggs feel if you were sad?...They've tried to, like, calm me down and stuff like that, but Company X is totally different (P5, G3).

There were also benefits associated with particular components of SFP. The use of best hopes and preferred future descriptions was associated with making clients' goals and how to get there seem clearer and more doable. Discussing how others would feel and react to them being a certain way was associated with clients getting on better with family and friends, and with family and friends remarking on how they had improved:

[Counsellor] was asking, how do your friends feel about you having help and that…[and] one of my friends actually, which I've known since I was fifteen, actually turned around and said, the way you are now is like going back in time to when you were fifteen.

These findings reinforce previous research demonstrating the efficacy of SF in a variety of contexts (e.g. Abbasi et al., 2017; Gong and Hsu, 2015; Bond et al., 2013), and further contribute towards the literature by suggesting that this is also effective in the specific context of a tenancy support unit. Equally, these expressed preferences are in opposition with a majority of other psychotherapeutic methodologies, such as the cognitive behavioural therapy (CBT) focus on solving problems and 'correcting' negative thought patterns (Jordan, Froerer, and Bavelas, 2013) and the emphasis within psychodynamic and related therapies on exploring how an individual's past experiences have affected them (e.g. Adler, 1927; Erikson, 1950; Freud, 1910).

Furthermore, while it does not necessarily preclude the possibility that its success results from factors shared across a variety of approaches, the apparent effectiveness of the SF approach is at odds with the alleged importance of an explanatory model (van Os et al., 2019) to a useful psychotherapeutic methodology, indicating that a concrete focus on the everyday is sufficient and may even be superior to attempting to establish a causal model. Conversely, one participant described how they 'didn't really know what talk about' within structured SF sessions, as they personally felt a need to talk about the past:

[Counsellor's] kind of counselling is about looking forward, but I'm still sort of stuck in the past a bit… I just feel like, if I say something out to loud to somebody else, maybe I can get

them off my mind (P12, G3).

It is feasible that this future focus may have discouraged other customers from engaging with the structured SF sessions, leading to an overrepresentation of customers for whom these sessions were appropriate and effective within the Group 3 sample. Even if this is not the case, the fact that even one participant felt that the SF sessions were not appropriate for her needs suggests that this cannot be viewed as a panacea for all issues and that, in this instance, respecting customer choice may actually have been most effectively achieved through providing this customer with a safe space to talk about her past experiences. This is one area in which an SF approach can potentially conflict with a customer-centered approach, despite the generally high level of compatibility between the two.

4.1.3 What (if any) opportunities for innovation can be uncovered through this research?

4.1.3.1 Areas for improvement

Overall, it was quite rare for participants to make any kinds of negative comments about their experiences at Company X; on the contrary, the overwhelmingly positive nature of feedback was amongst the most striking of all research findings. Nevertheless, it is important to consider the areas in which feedback was more critical. Critical comments pertained primarily to the earlier stages of the customer journey, specifically to the shortage of information or difficulty accessing relevant information prior to actually entering into the service.

One participant explicitly stated that they felt Company X should ‘advertise more’ (P14, G3), while many others also stated that they had not been aware that such help was an option prior to entering into the service. This gap in knowledge was associated with an extended period of hardship:

I never knew that I could have help from people like I have been having (P1, G2).

The dearth of information received before the first meeting was also associated with feelings of doubt, worry, and uncertainty, and at times with an initial reluctance to engage with the service:

I was sceptical, because I didn't know what they'd actually do, if you know what I mean (P8, G2).

Furthermore, some participants were not even aware that they had been referred to the service until support workers arrived at their door:

It was a complete surprise when they turned up (P15, G1).

The beginning stage of the customer journey is therefore the most significant in considering areas for innovation within Company X specifically, which will be explored in further detail in the subsequent chapter.

4.1.3.2 Overcoming barriers to access and engagement

In addition to the aforementioned points for consideration in improving the initial stages of the customer journey, it can also be informative to explore how customers in this study were successful in overcoming a multitude of barriers to service access and engagement. For several participants, this came after years of trying and failing to seek help, in financial and physical health contexts and most prominently in the context of mental health:

I've been asking for twenty-odd years, if not a bit longer, for help with depression, and I've just never been given it (P12, G3).

From the outset, it was clear how customers' personal histories could impact upon and detract from their willingness to engage with certain services, or with people in general (Blocker et al., 2011; Flint, 2006; Helkkula, Kelleher, and Pihlström, 2012). Some described being put off by negative or inadequate experiences with other services: For example, one participant described how she was affected by a bad experience with another support worker (not associated with Company X), who behaved in a 'bullying' and 'horrible' way towards her:

I didn't have anybody for a while, and it actually really put me off (P17, G1).

Furthermore, past negative experiences did not necessarily need to relate to a service experience in order to impact upon participants' expectations for and approach towards the service:

I'm very choosey, because I got hurt in the past by friends, and it's made me very wary of people (P8, G2).

In much the same way as an organisation's competition can usefully be seen as anybody with whom they are compared by a customer (Lee, 2004), these findings indicate that barriers to access can emerge from any area of a customer's life. This broad concept of barriers is also compatible with the concept of value in the experience, extending beyond the service use experience in itself to encompass past experiences in broader lifeworld contexts (Helkkula, Kelleher, and Pihlström, 2012).

Another prominent factor was participants' personal reluctance to address their issues through seeking help, either because their problems seemed overwhelming and unmanageable or because they felt ashamed and that they should be able to handle everything by themselves (or, at times, a combination of the two). In addition to describing this barrier, some participants also elucidated upon the behaviours and perceived characteristics of support workers which helped to counteract these barriers, enabling participants not only to enter into but also to get the most out of the service:

She made me feel like I could show her how bad I actually was. I feel like I can say anything to her, and she'll understand and won't make me feel like I'm being too much (P10, G3).

As demonstrated in the above quote, having entered into the service, support workers' attitudes were highly significant in eliciting trust and encouraging engagement. The willingness of Company X to deliver home visits was also significant for numerous participants who struggled to get out of the house:

All the way through this, because I said I wasn't able to interact with people properly, instead of me having to go into office buildings and all that, and interact with people… they do home visits (P7, G3).

Even without necessarily having to leave their own home, a lack of structure and predictability could serve as an additional barrier to service engagement:

If somebody knocked at the door, and I wasn't expecting anybody, then I'd be sitting here

panicking like hell (P12, G3).

Issues with talking on the phone were similarly common amongst participants, leading to difficulties seeking support which they believed were not widely acknowledged:

People generally say, oh, you should phone these people, or you should speak to these people, but my issue was actually doing that. I'm not going to pick up the phone and phone somebody (P15, G1).

Such issues could be further exacerbated by financial and practical limitations. Even participants who did not struggle with making phone calls per se could be unable to do so due to lack of funds. P14 (G3) criticised the 'infuriating' set-up of some phone services, with long waiting times and human contact subordinate to automated messages and options. Another key element identified by participants was transportation, which could pose physical, mental, and financial challenges to customers accessing this and related services:

I can't come every week – I can't afford that, because I'm on benefits and I don't drive (P5, G3).

Company X's role in value creation within broader lifeworld and service ecosystem contexts could also be beneficial in terms of overcoming barriers to engagement with other services:

She's support, isn't she? I don't have to go on my own [to appointments] – because I suffer badly with agoraphobia (P17, G1).

While organisations such as Company X clearly cannot affect the treatment an individual receives before entering into the service, an understanding of obstacles and how they are overcome may be informative in understanding how services can best reach out to and engage with those whose past experiences have led them to be suspicious and distrustful. Though participants in this study were, by definition, those that had made it past any barriers to accessing Company X (and also, by their own accounts, to engaging effectively with the service), this is not to say that there are not customers or prospective customers who find one or more of the aforementioned barriers insurmountable. An examination of how these can be mitigated and overcome therefore has important implications for both Company X and other

organisations, which will be explored in Chapter 5.

4.2 Methodology Evaluation

4.2.1 What does this pilot study tell us about the usability and efficacy of this adaptation of the TTT?

4.2.1.1 Difficulties encountered

The main issues which arose throughout the study can be divided into two broad categories: those which stemmed from participants' difficulties in recalling the details of the different stages of the customer journey, and those which stemmed from their misunderstanding of and/or confusion around certain themes and images. Memory issues were particularly pertinent for the first two cards (*Beginning Journey to Company X* and *First Meeting*), as a combination of memory issues or impairments and a long, complex history with this and related services meant that customers could quite often struggle to recall the specifics of how and when they had first come into contact with the service:

[About information received before the first meeting] Erm…gosh…it was nearly a year ago…I don't know. I can't remember (P12, G3).

This is a major point of difference with the original application of the TTT, as individuals typically come to hospices within their final months of life and thus do not stay there for very long. The other two contexts in which this technique has been tested, of a veterinary practice and a hospital medical/surgical unit, are also associated with far shorter service experiences. Memory issues have thus not been a significant cause for concern within these past applications (Sudbury-Riley and Hunter-Jones, 2017), but may have important implications for a mental health service context (discussed in Chapter 5).

Confusion around different images could manifest in participants completely misunderstanding what an image was intended to represent or in their simply not grasping the purpose of them (either a particular image or the images in general) at all, often resulting in reticence and reluctance to discuss the images at all. One participant exhibited a degree of resistance to the images from the outset, asking to be asked 'a specific question' (P15, G1) about the first card. Though he did later attempt to engage with some of the images, this

participant continued to struggle to understand their purpose, and had to ask what a number were intended to represent.

Connecting to Broader Support Network was the card which seemed to create the greatest confusion, both in terms of specific images and of the overall theme. A few participants stated that they could not understand it, and one participant thought he was being asked about an online 'network', leading him to respond that he couldn't use a computer (P1, G2). Literal interpretations of images intended to evoke metaphors/descriptions of feelings were one manifestation of participant misunderstanding which also arose with other images, particularly in the case of P6 (G3), who for example responded to an image of a crossroads with a description of navigating the local area.

While there were only two participants who repeatedly struggled to effectively engage with the images, in a small sample this is not so insignificant, particularly when striving to develop a tool which is accessible and easy to understand for individuals of all abilities (Sudbury-Riley and Hunter-Jones, 2017; Tuunanen and Peffers, 2018) and specifically for a disproportionately disadvantaged population. The confusion some participants experienced regarding the images did not preclude their interviews from uncovering some valuable insights but does seem likely to have prevented their discussion of some relevant touchpoints as a result of not recognising these on the cards. It also made the interview process less straightforward and potentially more challenging for interviewees, whose explicit feedback on the cards will be explored in the following section.

4.2.1.2 Feedback from participants

When asked for their thoughts on the cards, and specifically the images and themes used, participant feedback was largely positive. The cards and images were described as 'clear' (P2, G2), 'colourful' (P8, G2), and accessible:

I think they're great. Everyone can understand them, so it's not a problem (P3, G2).

Participants further expressed how they had been pleasantly surprised by how well the cards had worked and how smoothly the interview had gone, describing a degree of uneasiness about receiving 'a phone call from a stranger' (P14, G3) and confusion about the purpose of the cards:

It worked really well. I mean, I was – I think I was puzzled as to how it would work, but just the kind of natural flow of conversation – it was quite – there were no barriers in talking about the images, you know (P4, G1).

Several participants stated that the images were good for triggering memories, through what one participant described as 'supermarket syndrome':

The cards are very simple and helpful, and, you know, they're right there in front of us – and they're good. They make us think of everything…I call it supermarket syndrome. You need bread, you need milk, and you go to a supermarket and forget what you're in there for…but, with these cards, it's all there in front of us, and they just make learning and support easy. I do like the cards (P14, G3).

The structure of the interview was further described as helpful in terms of 'breaking down' (P3, G2) different concerns and keeping them 'focused' (P10, G3), with the images clearly demonstrating what each of the different topics was about. Both when asked for feedback and when asked for any further comments, participants often expressed a sense that the interview had comprehensively covered all aspects of their experience with Company X, with P2 (G2) for example stating that the cards had showed them 'everything [they] needed' to talk about their service experience in full.

Some customers went even further, describing the experience of going through the cards as resonating with and even benefitting them on a more personal level:

I do find them really helpful…I find them easy and not confusing or anything – so yeah, they're really beneficial, they are (P3, G2).

[This conversation] has helped me a heck of a lot (P1, G2).

Conversely, as would be expected from the difficulties encountered by a minority of the participants throughout the interviews, a few participants again expressed confusion about the purpose of the cards and the meanings of the images. One participant, who was the most prone to misinterpretations of metaphorical images in literal terms, felt that the images were initially unclear but became apparent, and even helpful, with the 'help and understanding' (P6, G3) of the interviewer. P15 similarly stated that he found the interviewer's help beneficial, but that without this he struggled to understand what the images sought to convey:

To me, they all seem a bit obscure. But that's me…because my brain will interpret a picture differently from most people (P15, G1).

At the other end of the spectrum, another felt that the images were superfluous for them personally, as the themes were sufficient for generating talking points, but recognised the potential value that they held for others:

I can take things in, and I can see the purpose of them – but…I know that there are a lot iller people than me, and perhaps it would be more beneficial, I suppose, to somebody like that, that can't concentrate (P12, G3).

Individual differences therefore seemed to play an important role in determining how helpful and accessible customers found the cards to be, in addition to more widespread issues with memory and misunderstanding limiting responses to specific cards. The implications of these findings for the ongoing development of the adapted TTT will be discussed in Chapter 5.

4.3 Conclusion

This chapter has described and explored the findings of this study, in relation to both the service evaluation of Company X and the methodological evaluation of the adapted TTT. Service evaluation findings were largely positive and informative. Customer accounts illustrated how the co-creation of transformative value in the experience was promoted by a customer-centred approach, by engagement with broader lifeworlds and service ecosystems, and by the experience of a turning point, generated by a combination of support worker attributes and behaviours and the meeting of fundamental needs. The impact of SF techniques was also discussed as a generally compatible, complementary addition to a customer-centred approach, though with some potential caveats. Finally, opportunities for innovation were highlighted within the early stages of the customer journey, through investigation of difficulties and barriers faced and how these were overcome.

The methodological evaluation was also predominantly positive, though some notable issues did arise in the areas of participant memory (particularly in *Beginning the Journey to Company X*) and misunderstanding (particularly in *Connecting to Broader Support Network*). The managerial and theoretical implications of both evaluations will be explored in greater

detail in the following chapter, in which limitations of the study will also be discussed before overall conclusions are drawn.

Chapter Five: Implications and Conclusions

Chapter Four presented and discussed the research findings within two distinct sections, relating respectively to the service evaluation of Company X and to the methodological evaluation of the adapted TTT. Insights into the co-creation of transformative value in the experience, the impact of SFP, and opportunities for innovation highlighted by the study were all discussed, with reference to the relevant mental health and service literature. Evidence regarding the usability and effectiveness of the TTT was also discussed, demonstrating its displayed benefits and highlighting some problematic areas in need of further consideration.

This chapter follows a similar structure to Chapter Four, beginning with the service evaluation (5.1) and then moving on to the evaluation of the methodology (5.2). The service evaluation section covers managerial implications, for Company X and others (5.1.1), and theoretical implications for the field of mental health service research (5.1.2). The methodology evaluation again covers theoretical implications, this time in relation to the continued development of the TTT (5.2.1), before addressing some potential limitations of this study (5.2.2). Finally, the study is summarised, and overall conclusions are drawn (5.3).

5.1. Service Evaluation

5.1.1 Managerial Implications

Although feedback on Company X was overwhelmingly positive, the one area for improvement which was highlighted repeatedly regarded the dispersal of information about the existence and nature of the service at the beginning of the customer journey, before customers first met with their support worker and/or another representative of Company X. As a lack of information was associated with negative emotions and with a delay in customers receiving the help they needed, attention should be directed towards ensuring that information about the organisation is widely available from a variety of sources, such as helplines and medical professionals, in addition to the local council by which the majority of customers are currently referred.

Even after learning of the organisation’s existence, not knowing what to expect or when to expect it could also invoke anxiety in customers, highlighting the importance of providing prospective customers with detailed information on how the service works. If at all possible,

it could also be highly beneficial to provide customers with up to date information and advice on the kind of waiting period they should expect, and on what to do and who to contact if they reach a crisis point within that waiting period.

Furthermore, the principal description of the Company X customer journey as a positive and ultimately transformative experience, which was often contrasted with earlier bad or unsatisfactory service experiences, suggests that this may be viewed in many ways as an exemplar of good practice from which other services have much to learn. Themes highlighted in the previous chapter should help to inform the design and development of mental health services and related services seeking to facilitate and enhance the co-creation of transformative value in the experience.

Specifically, customer accounts offer clear illustrations of how customer choice and collaboration can be centred at every stage and every level of a customer journey and of the attitudinal, interactional, and practical elements conducive to transformative value creation. An in-depth understanding of and integration with the other services in customers' lives should also be prioritised when possible, requiring that services move out of their individual silos for consistent communication and cooperation with others.

5.1.2 Theoretical Implications

The findings of this study also have important implications for the broader field of mental health service research, highlighting a number of factors which facilitate value co-creation and contribute towards the transformative potential of a service experience. Future research should address the extent to which these factors are also applicable outside of the specific context of Company X and, if they are, how other services may be designed and developed to enhance the customer journey and its transformative potential. For reasons explicated in Chapters 2 and 4, this research should specifically address transformative, as opposed to habitual, value creation (Blocker and Barrios, 2015), and embrace the broad construct of value in the experience (Helkkula, Kelleher, and Pihlström, 2012).

As was attempted in this study, an in-depth investigation of the value creation process is best suited to interpretive and phenomenological methodologies (Helkkula et al., 2012; Langdridge, 2007). In the long term, it is hoped that an adapted version of the TTT may be widely used to evaluate the fullest possible spectrum of different mental health services, generating both rich evaluations and detailed comparisons of customer journeys at different

services. However, there is also an important place for quantitative research in investigating the impact of different characteristics of a service experience, and in particular for a more in-depth exploration of the question of whether the psychotherapeutic methodology of SFP significantly impacts upon service outcomes.

While in some cases specific components of SF were highlighted by Company X customers as influential, customers in Group 1, whose journey was not in any way structured by a psychotherapeutic methodology, also described predominantly positive experiences and positive outcomes. In order to evaluate if and how outcomes vary between the three participant groups, quantitative research will need to be conducted, recruiting a significantly larger sample of the target population than were interviewed in this study and comparing changes in SF scaling questions as well as in externally validated measures of mental well-being in the first and last sessions of the service. Such research is already in process at Company X and will also need to be conducted on a larger scale and in a variety of contexts, preferably in conjunction with application of the TTT or a similar qualitative technique for a more in-depth processual understanding.

5.2 Methodology Evaluation

5.2.1 Theoretical Implications

Implications for future research are a fundamental outcome of this study, one of the primary drivers of which was the need to test a preliminary adaptation of the TTT in a mental health service context before embarking on a larger scale project to develop and effectively utilise this technique. In terms of the technique itself, findings were generally very promising, suggesting that the technique is in essence applicable to this context whilst also highlighting some key areas in need of further investigation and revision.

These key areas, relating to participants' difficulties with memory issues and with grasping the meanings of certain images and themes, will inform the forthcoming stages of development, beginning with a more in-depth literature review and continuing into far more extensive field research. Existing research into the most effective communication tools for engaging those with various cognitive impairments will be one novel element of the extended literature review, including the way in which aides can most effectively be employed to invoke recollections in those with memory issues.

As they generated the most confusion amongst participants, the more 'metaphorical' of the images will also have to be considered particularly critically, evaluating whether all of them are necessary and if it would be feasible to replace some of these with more easily recognisable images. Following the same logic, critical attention should be paid in particular to Card 5 (*Connecting to Broader Support Network*), which was experienced as obscure by a number of participants and which may therefore have to be removed, renamed, and/or otherwise reconsidered.

The direction of fieldwork will draw from the development of the original TTT (Sudbury-Riley and Hunter-Jones, 2017), including unstructured interviews with both service users and practitioners around the subject of (what they consider) the most significant stages and elements of a service experience. In line with the aforementioned issues, as well as with the overall objective to maximise ease of use, the recruitment process should strive to include a diverse range of individuals from a broad variety of mental health services, in particular ensuring that multiple forms of neurodiversity are represented. The possible impact of demographic factors (such as age, gender, and education level) on the accessibility of the technique should also be considered, necessitating the collection of personal data which was not included in this study.

Observation taking place within services is another avenue for development which was pursued for the original TTT, and which may be effectively utilised here. While it does not negate the importance of accommodating for those with poorer memories in the development of the TTT, this additional data source may somewhat mitigate any negative effect that memory issues may have on attaining a clear, chronological picture of the different customer journey stages, facilitating a closer view of the full service experience as it unfolds in real time.

However, the degree to which observation will be ethical and feasible in this context is yet to be determined, considering the sensitive nature of the subject of mental health and the understandable discomfort that customers may feel at having a stranger sit in on a highly personal session with a mental health practitioner. Ultimately, customer comfort and safety must always be prioritised, even if this means a reduction in data for analysis. Any deficiency in this area may be somewhat compensated for conducting in-depth interviews with customers at different stages of the customer journey, in order to increase the likelihood of clarity in customer recollection.

5.2.2 Limitations of Methodology

Many of the potential limitations of this study are common to interview research and/or to qualitative research as a whole. Certain limitations are inevitably associated with a smaller sample size, some of which are largely irrelevant to the purpose of this research but others of which are a potential cause for concern. While the inability to generalise to the full Company X customer population (let alone a broader population of mental health service customers) is not such an issue considering the study's interest in individual lifeworld contexts, the possibility that significant segments of Company X's customer population are excluded may be problematic from a service evaluation perspective. This is particularly true in light of the risk of self-selection bias, as it may be that, for example, customers with more positive experiences of the service were more likely to be willing to participate in the study.

Furthermore, while the TTT overcomes many of the limitations associated with traditional interviewing techniques, there are certain areas in which any form of interviewing is limited, particularly if this is conducted as a one-off event rather than at multiple points across time. Compared to longitudinal ethnographic research, interviews have been criticised for a lack of 'credibility', which Guba (1981) asserts can be achieved only through a prolonged period of engagement and persistent observation. Though the TTT specifically has been demonstrated to effectively generate rich narrative accounts of service experiences, longitudinal ethnographic research has been argued to be the best option for maximising the depth and richness of data (Bryman, 2008). Furthermore, it has been argued that the best contextual design occurs when service users are observed in action (Tuunanen & Peffers, 2018).

The evidence base for this version of the TTT is also somewhat limited. While the creators of the original TTT utilised several qualitative methods in addition to a literature review, time and space constraints on this work meant that, aside from consulting the original, the creation of the adaptation was based entirely on a literature review. While efforts were made to incorporate the specific Company X perspective, through consulting Company X documentation and talking informally with support workers about the process, there was nonetheless a heavy reliance upon the literature, potentially increasing the likelihood that customers felt a (unintended) pressure to discuss topics that were not actually relevant to their experience.

Most importantly, customers themselves played no role in selecting the touchpoints used, detracting somewhat from the research focus on a customer-led co-creation process. Efforts

will be made to redress this in the ongoing development of the TTT, including through consideration of customer feedback on the cards and images accrued in this study. Nonetheless, responses in this particular study may have been limited by the omission of important touchpoints which could have been identified through conducting prior interviews with customers.

This application of the TTT further diverged from the norm in that interviews were conducted over the phone, rather than face-to-face as was the case in the original study (Sudbury-Riley and Hunter-Jones, 2017). While evidence generally suggests that this can be an effective method in this context (e.g. Marks et al., 1998; Sweet, 2002), it is also associated with some potential issues and limitations which may have detracted from the quality of research findings. Some researchers have found that, in comparison to face-to-face interviewing, telephone interviews produce less detailed responses and higher levels of missing data (e.g. Einarson et al., 1999; Herzog and Rodgers, 1988), potentially resulting in gaps in customer accounts in this instance.

Telephone interviews have also been associated with greater respondent anxiety (Frey, 1983). Though those who did participate in the interview typically described this as a positive experience, some did express having experienced anxiety in advance of the phone call. Anxieties around talking on the phone may also have contributed towards difficulties in recruiting sufficient participants and to the fairly high dropout rate. This is particularly significant considering the final number of participants ultimately came to 17, which was three less than the saturation point identified in previous applications of the TTT (Sudbury-Riley and Hunter-Jones, 2017).

In addition to there being fewer participants overall then was intended, there are also limitations associated specifically with the nature of the sample. While there were equal numbers of participants in Groups 2 and 3, less than a quarter were in Group 1, making it harder to draw comparisons between this group (who did not receive any degree of SF treatment) and the others. Data on the final (*End of Service and Follow-Up*) stage is also limited as the majority of participants had not yet come to the end of their time with Company X, resulting in partial representations of the customer journey and an inability to explore this stage as thoroughly as all others.

5.3 Conclusion

In summary, customer narratives were accrued using an adapted version of the TTT and analysed to produce a service evaluation for Company X, while customer responses to and direct feedback on the cards also formed the basis of a pilot evaluation of the adapted TTT. Findings on the Company X customer experience were overwhelmingly positive, providing valuable insights into the co-creation of transformative value in the experience. The application of specific SF techniques also appeared to have a positive impact in the majority of cases, though further investigation is required into the nature and extent of this influence.

Opportunities for innovation pertained to the initial stages of the customer journey, highlighting the crucial importance of mitigating barriers and reducing help-seeking delays through the improvement of customer (/prospective customer) knowledge. These findings are directly relevant to Company X but would also benefit similar and related services, particularly in light of the evidenced importance of service ecosystems and joint working across sectors.

Finally, the methodology itself proved largely effective in generating rich and detailed customer accounts, but with some notable issues stemming from a combination of memory issues and misunderstandings. These findings will contribute towards the ongoing development of the adapted TTT across the next few years, which will comprise an in-depth literature review, fieldwork, and extensive testing of the artefact. On a broader level, it is hoped that these findings can contribute towards ongoing conversations about value creation in services, the effectiveness of mental health services, and how both concepts are to be meaningfully investigated, providing in-depth insights into how value co-creation processes occur within mental health services and how these can be captured using the TTT.

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APPENDICES

Appendix 1: Touchpoint Cards

Card 1: Beginning the Journey to Company X.

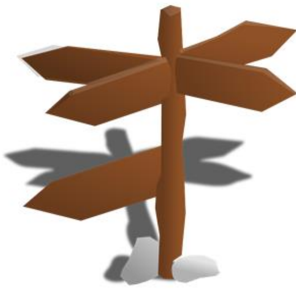
Card 2: First Meeting.

Relationship with Service Provider(s)

Card 3: Relationship with Service Provider(s).

Building Skills and Resources

Card 4: Building Skills and Resources.



Connecting to Broader Support Network

Card 5: Connecting to Broader Support Network.

End of Service and Follow-Up

Card 6: End of Service and Follow-Up.

Appendix 2: Instruction Sheet

Instruction Sheet

This pack contains a set of materials related to a University of Liverpool research project. This will involve Company X clients being interviewed over the phone about their experiences of the service. The interviews will consist of discussing images on a set of A4 cards, called 'Touchpoint Cards'. These should be opened by a client at the beginning of an interview. More details on the interviews are given in the Participant Information Sheet.

This pack contains –

1. **Participant Information Sheet.**

Explaining what the study is about and what it will consist of.

2. **Participant Consent Form.**

For a client to sign to give their consent to taking part.

3. **Touchpoint cards (in sealed envelope).**

For a client to look at during the interview.

4. **Envelope for returning consent form.**

Stamped and addressed to the University of Liverpool. Ready to send after consent form is inserted.

Please see below instructions for what to do with each of these.

1. Please share the consent form and information sheet with your client. Explain to the client that these are about a study that is being done by the University of Liverpool and that they are free to decide if they want to take part or not.

2. Ask the client to read through the consent form and information sheet and decide if they would like to take part.

3. If the client does choose to take part, ask them to sign the consent form and return it to you.

4. Place this consent form in the envelope addressed to Pippa Hunter-Jones. Take this with you and post it as soon as you can.

5. The envelope titled 'Touchpoint Cards' should be left with the client. **Please ask them to hang on to these and open them before the interview.** They will need the cards to look at during the interview.

Thank you very much for all of your help. Please feel free to contact me at Chloe.Spence@liverpool.ac.uk if you have any questions.

Chloë Spence
Student Researcher (University of Liverpool)

Appendix 3: Information Sheet

Project Title: *An evaluation of tenancy support and mental health service experience*

Version 2: 30/04/2019

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.

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 Company X (Swansea). This project will also be a first attempt at using a version of the Trajectory Touchpoint Technique (explained below) in evaluating mental health services, and findings will inform further research on this subject based in Liverpool, Merseyside.

Why have I been chosen to take part?

You have been contacted because you are either a current or a former service user at Company X.

Do I have to take part?

You do not have to participate in this study, and this will not affect your relationship with Company 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 tape-recorded and are expected to last roughly 30-60 minutes.

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?	Masters dissertation, Conference, Journal Publications, and PhD
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
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

Company 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 the service you receive from Company 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 Company 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 Company 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 Master's dissertation in September 2019, in a summary report for Company 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. These findings may also be included or referenced in a PhD thesis to be completed in September 2022.

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. This will take place within two weeks of the completion of the interviews.

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 4: Participant Consent Form

Participant Consent Form

Version 2, 10/04/2019

Research ethics approval number: 4444

Title of the research project: *An evaluation of tenancy support and mental health service experience*

Name of researcher(s): Chloë Spence, Professor Pippa Hunter-Jones, Dr Lynn Sudbury-Riley, Steve Flatt, Jim Bird-Waddington

Please initial box

1. I confirm that I have read and have understood the information sheet dated 10/04/2019 for the above study, or it has been read to me. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

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: Master's dissertation, academic journal articles, a PhD thesis, conference papers and presentations. ☐

5. *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. ☐

6. *Disclosure of criminal activity:* 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. ☐

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 5: Selected Interview Quotes

1. Co-Creation of Transformative Value in the Experience

1.1 Evidence and Influence of a Customer-Centred Approach

P1 (G2)

‘I did feel at ease in such a short space of time with them.’

They do work as a team with me.’

P4 (G1)

‘Also, the two people building some bricks or whatever, because, erm, it requires two…and I could probably talk about the ear, because…she obviously had listened to what I had said, because her answers are so precise, and I obviously had listened because it’s interesting.’

P5 (G3)

‘A bit apprehensive at first – you know, like everything else – I’d been with MIND and I’d been with others as well. I was a bit cautious, as they say, because I thought, oh, here we go, another of these ones that try and alter things and – but, I’ve got to say, I’d recommend them to anybody.’

‘I was a bit apprehensive at the first meeting – I thought, oh, here we go, another one of them…clubs, as I put them. And, when we started talking, I thought, woah, this is different.’

‘Whereas you’re basically a number or just a name in other places, whereas with [counsellor], you’re an actual person, if you get my drift.’

‘Even when I go down the office, everybody treats me with respect, not like, oh, what are you doing here? And I think that’s brilliant.’

‘I told them everything, and they said about *[counsellor]*, and I said, oh, don’t know – and she said, just give it a go. If you don’t like it, we can always pack it in.’

P7 (G3)

‘They do fit around my life…definitely. I can give [counsellor] and [support worker], I don’t know, maybe two days’ notice – I can send a text.’

‘There’s comfort, and a protection barrier as well. They don’t chuck me into a situation, like what happened with the psychiatrist – because he did recommend this place, and I tried it – no thank you, never again.’

P12 (G3)

'She wasn't pushy about it. It's been a good few months, and she sort of mentioned it, then didn't say anything about it, and then mentioned it again…you know what I mean? She didn't push me – I'm going because I wanna go, not because she's trying to force me, or…she's not doing anything like that.'

P14 (G3)

'I didn't know much about the support network, so I thought he might've been like my father and he might've said you've gotta do this, you've gotta do that, you've gotta eat that, you've gotta cut down on the drink, you've gotta get up in the mornings.'

'He had a way of speaking to me that made me respond. And he didn't put a time limit on it – he said just do it in your time, how you feel, and he really…it wasn't like a teacher talking to a pupil. It was, like, on a personal level.'

P15 (G1)

'A lot of the time, with other people, I'm not really given a choice. It's just, this is being done, whether you want it to or not.'

'They understood, and, erm…yeah – gave me reassurance that they were here to help and not interfere.'

'She never overstayed – because I get uncomfortable around people.'

P17 (G1)

'I don't ever feel fobbed off by her, if that makes any sense.'

1.2 Broader Lifeworlds and Service Ecosystems

P1 (G2)

'*[Support worker]* now, he helped me with…Welsh Water. Because they kept sending me bills and I wasn't paying it – I'd just chuck it in the bin, and I didn't have a clue about how to cope with talking to people from, like, Welsh Water.'

P2 (G2)

'She helped me with my debt, sorted out it being paid back so much a month. She got them to pay what they should've been paying me before I was with them, so that was taken off the arrears as well. She gave me the tools to know who to phone and what to say and things like that.'

‘It’s better – don’t bury your head in the sand, phone [financial body] up as soon as you get any issues, and go from there, basically.’

‘She obviously asked for my permission, and then she spoke to them and explained everything. And yeah, it all went really well.’

P3 (G2)

‘She contacted [the council] on my behalf, because I didn’t have a clue how to talk to them.’

P5 (G3)

‘Before, I’d have a letter and it’d be on the mantelpiece for weeks on end, and I just wouldn’t look at it. And everybody calls me lazy, and whatnot, but…my head couldn’t cope with all the forms and whatnot.’

‘I know that they’re there if I need any help. If I get a form in that I don’t understand, I can call them up and my support worker will help.’

P7 (G3)

‘*[Support worker]* was taking me, erm, to the psychiatrist, because I’m not comfortable going in on my own – I’m just not comfortable, to a point that I’m just not going to turn up. I won’t go in there on my own.’

P8 (G2)

‘Payments – rent and water, because we’ve been behind. He phoned them up and he explained to them, and he sorted out a plan to do the payments and all.’

‘It’s a large weight off my mind – because, when people explain things to him, he understands. And, when he explains them to me, he does it in a way that I can understand him.’

P10 (G3)

‘When I met up with her, if I can remember rightly, I basically explained my situation, all the issues I had, and the things I was finding hard to deal with, and she basically dealt with it all for me. She was making phone calls from the first meeting, and she made progress right away – she really did help.’

‘It was just watching her deal with all my issues straight away – making phone calls, and…obviously, sometimes, if you’re not somebody like that and if you’re trying to phone the benefits and things, they do mess you around. And, with *[support worker]*, there was no messing around. It was all, done and done with, and straight to the point, and results.’

‘She helped me in there as well, because the psychiatrist was a bit harsh – a little bit impatient with me, which I thought was ridiculous considering he’s a psychiatrist…but I was getting offended with the way he was cutting me off when I was trying – like I said, I speak a lot, and it’s hard to control. He didn’t – she had more patience and understanding than he did, and she was in there with me, and she helped support me. I can’t remember exactly what she said, but there was a moment when she intervened and spoke for me, and I was happy that she did.’

‘I feel confident that, when she’s with me, I know I’m not going to be messed around or walked all over…it’s actually going to be taken seriously and dealt with.’

‘Debt…she’s helped me with that – all the phone calls, dealing with a debt charity to help me set up that.’

‘She made a couple, and then, appointment by appointment, we dealt with everything – and all I had to do was give confirmation on the phone that she was allowed to speak for me, and she just dealt with everything.’

‘*[Support worker]* knows, for me, to just let me say and do it, but she does help if I need help.’

‘There was a point when the job centre was trying to put me on this long – basically, looking for work skills course for a few weeks. And I – my anxiety was awful over it, but I thought I had to do it, because the job centre was telling me to, and I was in a right state – and there was no way I was ready for it, but I thought I had to do it. And [support worker] intervened, and basically told the job centre that I’m in no fit mental health state to even be trying to do this just yet.’

P12 (G3)

‘When *[support worker]* first met me, she brought me a food parcel, because I didn’t have any food here for, like, five days.’

‘It’s just…if you haven’t got anybody in your life, it’s great just having that person with you. Because I go to all these appointments, and sometimes I feel like I’m not all there and concentrating, because concentrating can be difficult for me – so it’s just good to have…she’s there, like, you know.’

‘Because she’s – I think she’s done the job for, I don’t know, twenty, thirty years, or something, she knows how they run things.’

‘What I noticed as well was, when I ring up, like, DWP or whoever, I don’t get anywhere with them. As soon as [support worker] goes on the phone, and says she’s a support worker and stuff, it gets done straight away.’

‘She knows the doctor, and, because it’s her ringing, they give her an appointment. Because, normally, you’d ring at eight in the morning and then the doctor might call you back later in the morning to see if it’s worth you coming down or not.’

P13 (G1)

'Just from the first instance, like, they fixed everything.'

P15 (G1)

'Because I wouldn't have gone…and the [Personal Independence Payment] meeting – had I gone on my own or with somebody else, it could have gone really differently.'

'It's not personal for them.'

'I can call *[support worker]* any time and say I've got another letter from whoever, and she'll explain it to me, and if it needs dealing with I know she's able to deal with it.'

P17 (G1)

'I'll talk to her on the phone sometimes, if she's coming here or if I've had a letter and I don't understand – because that's a part of condition. If I get a letter and I didn't understand it, I'd start to fret, and that'd make me worse.'

1.3 'Turning Points' and Transformative Value Creation

P1 (G2)

'It's like a weight off my shoulders. Whereas I thought, you know, I can do it myself, and…well, I can't. But yeah, we've got a good relationship there. And, you know, any time I need him, I can get hold of him, and, erm – oh, they will help, and they'll also listen to me as well. So, I'm just happy with the help I'm getting, 'cause, erm…I can see that I'm getting somewhere now, not stuck in the same rut all the time.'

P3 (G2)

'They've shown us the way to go forward, basically.'

P4 (G1)

'*[Support worker]* just knew where to go – you know, the right avenues and things, in regards to the debt.'

P7 (G3)

'Strength…what a transformation.'

'Definitely gave me tools in my toolbox – because nothing was there before, absolutely nothing – a big black void – and then, all of a sudden, I'm given new tools.'

‘We are now sustained – we are able to cope with bills, and able to buy food – simple things.’

P8 (G2)

‘He’s put my mind at ease, and it’s a lot better. Because, erm…we’re in a lot of debt, and he’s been helping us out. He did a plan for us, and…I just wish I had support a long time ago.’

P10 (G3)

‘Obviously, the rapport I got with [support worker] is really nice to have, because sometimes you can be sitting with people and…yeah, they’re doing the job, but you don’t really feel that comfortable. But, with [support worker], I can feel…not like she’s a friend, but I feel so relaxed and I’ve got a really good rapport with her…that’s what made me feel, all of a sudden, a bit more secure, and I had hope for the first time in a long time that things might end up turning out not so bad.’

‘Honestly, I feel like she’s a fairy godmother with a magic wand – honestly. I tell her that all the time.’

P12 (G3)

‘After the first meeting – oh, I was so happy I had somebody in my corner, if you know what I mean, helping me.’

2. Impact of SF

P5 (G3)

‘I was a bit cautious, as they say, because I thought, oh, here we go, another of these ones that try and alter things and – but, I’ve got to say, I’d recommend them to anybody.’

‘[Company X] have taught me about feelings. Where all the others have tried to get to the root of the problem, they haven’t gone to the fact of, you know, how would Joe Bloggs feel if you were sad?...They’ve tried to, like, calm me down and stuff like that, but Company X is totally different.’

P7 (G3)

‘[Counsellor] always asks me about goals, and…the thing is, he sees so much potential, and I don’t see it. That’s what it is. Erm…yeah – he tells me I’m brave and things like that, but I don’t see it.’

P12 (G3)

'[Counsellor's] kind of counselling is about looking forward, but I'm still sort of stuck in the past a bit… I just feel like, if I say something out to loud to somebody else, maybe I can get them off my mind.'

P14 (G3)

'I didn't know much about the support network, so I thought he might've been like my father and he might've said you've gotta do this, you've gotta do that, you've gotta eat that, you've gotta cut down on the drink, you've gotta get up in the mornings…but none of that. He had a way of speaking to me that made me respond. And he didn't put a time limit on it – he said just do it in your time, how you feel, and he really…it wasn't like a teacher talking to a pupil. It was, like, on a personal level.'

3. Opportunities for Innovation

3.1 Areas for Improvement

P1 (G2)

'I never knew that I could have help from people like I have been having.'

'I didn't know what really, erm…they were about and which way they could help me.'

P8 (G2)

'I was sceptical, because I didn't know what they'd actually do, if you know what I mean.'

P12 (G3)

'I didn't realise at the time that Citizens' Advice had passed my name on to them for help.'

P14 (G3)

'I do think Company X should advertise more. Because they're doing a great job, but not a lot of people know about them.'

P15 (G1)

'It was a complete surprise when they turned up.'

3.2 Barriers to Access

P1 (G2)

'I just got sick of having appointments and that.'

P4 (G1)

'I got answers to some unknown problems – because I had so many, I didn't, erm, want to address any of them – you know what I mean? Some things I didn't address – so I got some answers. Like, the financial one, I really put that on the backburner.'

P5 (G3)

'I can't come every week – I can't afford that, because I'm on benefits and I don't drive.'

P10 (G3)

'Because, you know, when you've got mental health issues and somebody doesn't know, really understand, or hasn't experienced anything like it, sometimes they can get you wrong, and you can see that the way you are affects them and stresses them out – especially when you have anxiety.'

'Obviously, I had to go into detail about absolutely everything and explain, and I've had to repeat my situation so many times over the past year…it's grueling, and it does trigger my PTSD and my anxiety.'

P12 (G3)

'I just got up and walked out of there, you know? So, then, for a good few years, I didn't bother going back to the doctor about depression.'

'I've been asking for twenty-odd years, if not a bit longer, for help with depression, and I've just never been given it.'

4. Usability and Efficacy of the TTT

4.1 Difficulties Encountered

P1 (G2)

[In response to *Connecting to Broader Support Network*] 'Erm, I can't use a computer. I've had the chance, but I don't like them.'

P4 (G1)

[About waiting period] ‘I can’t remember, because it was back in winter.’

P6 (G3)

‘I do have plans. I like planning which route to take when I go out, and I follow a plan coming back.’

‘All the streets on Swansea are so different, and if you want to catch your breath somewhere and you’re not sure where to get off, people in Swansea are always helpful.’

P12 (G3)

[About information received before the first meeting] ‘Erm…gosh…it was nearly a year ago…I don’t know. I can’t remember.’

P15 (G1)

‘Can you ask me a specific question?’

‘What does [the sunset image] mean?’

4.2 Feedback from Participants

P1 (G2)

‘[This conversation] has helped me a heck of a lot.’

P2 (G2)

‘I think it’s pretty clear really, innit? It says what it is, you know.’

‘You knew the kinds of questions and answers that were there, because the pictures helped you out. It did show you everything you needed really.’

P3 (G2)

‘I think they’re great. Everyone can understand them, so it’s not a problem.’

‘I’d say they are really helpful, because obviously the pictures do help to, like, break down some of the concerns people have.’

‘I do find them really helpful…I find them easy and not confusing or anything – so yeah, they’re really beneficial, they are.’

P6 (G3)

'The pictures…it's like – I found it all helpful. Because I haven't seen these before, but…like I said, because I suffer from mental health, I didn't half the time understand the pictures and that. But, with your help and understanding, you helped me understand what it is.'

P8 (G2)

'The way you've done them – they're bright and colourful, they're not small pictures, and so people who can't see properly could actually see them, if you know what I mean.'

P10 (G3)

'Looking at the pictures and the symbols, they can sort of trigger little things off.'

'It does keep you to the point and more focused. Seeing it section by section is easier than going through it all in one big go – you know, on one page. It does help – I do think that.'

P12 (G3)

'I can take things in, and I can see the purpose of them – but…I know that there are a lot iller people than me, and perhaps it would be more beneficial, I suppose, to somebody like that, that can't concentrate.'

P14 (G3)

'I think having a phone call from a stranger could be a bit, erm…what's it called…but the cards are very simple and helpful, and, you know, they're right there in front of us – and they're good. They make us think of everything. Perhaps – I call it supermarket syndrome. You need bread, you need milk, and you go to a supermarket and forget what you're in there for, and all this happens…but, with these cards, it's all there in front of us, and they just make learning and support easy. I do like the cards.'

'Images and language are really closely related, aren't they? Putting a positive image with a conversation is good.'