Recovery by Design:

Developing tools to initiate and sustain engagement in creative recovery from substance use and associated mental health difficulties.

Thesis

Volume One of Two

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> *It isn't the drug that causes the harmful behavior—it's the environment. An isolated rat will almost always become a junkie. A rat with a good life almost never will, no matter how many drugs you make available to him. As Bruce put it: he was realizing that addiction isn't a disease. Addiction is an adaptation. It's not you—it's the cage you live in.*
> (Hari, 2019 p172)

> *You need your nausea. You need your pain. It is a message, and we must listen to the message. All these depressed and anxious people, all over the world – they are giving us a message. They are telling us something has gone wrong with the way we live. We need to stop trying to muffle or silence or pathologize that pain. Instead, we need to listen to it, and honor it. It is only when we listen to our pain that we can follow it back to its source – and only there, when we can see its true causes, can we begin to overcome it.*
> (Hari, 2018 p318)

These two quotes from author Johann Hari emphasise the importance of considering the wider picture for those in recovery. Rather than simply considering an individual's addiction or symptoms, it is essential to understand the whole person and the environment they inhabit. This insight can then help to find ways to build a connected and fulfilling life, through recovery from addiction or mental health difficulties.

Abstract

This research explores the use of a design tool called a cultural probe to co-produce research with individuals experiencing from substance use and mental health difficulties. The aim is to use creative research activities, directly with service users, to amplify the participant's voices and lead to discoveries on how individual recovery journeys might be supported and developed.

The study uses a mixed method qualitative design research approach. The research was undertaken using participatory workshop activities and design review sessions with staff and service users. These were held at three different rehabilitation centres in Brighton and Hove during 2017-19. The collected data were analysed through thematic coding of the participant responses at each stage.

The research was initially intended to engage participants and generate intervention ideas through a self-reporting method (cultural probe), as one of three initial Design Experiments. However, the data collected revealed the potential of therapeutic value for the participants who undertook the tasks. Therefore, a dedicated recovery Toolkit was developed over the course of three iterative Pilot studies, involving participatory workshops. At each stage the design was refined further through participant testing and feedback.

The Toolkit is shown to engage participants in telling their unique recovery story, to share experiences and reflect on their progress. It assists in the building of creative confidence and recovery capital, which aims to reduce the likelihood of relapse. The tasks provide flexible activities which can link with established recovery methods. The Toolkit also helps participants to identify opportunities for engaging with worthwhile activities during recovery and signposts service users to relevant groups which may not be known to them. Therefore, the tool encourages and empowers participants to develop new ways of being creative and to embrace their recovery opportunities in a local community setting.

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1.0 Context and Introduction

This chapter provides context for and introduces the research project described in this thesis. The increasing use of design methods being used in disciplines outside of the design field is discussed. This assisted in formulating the research aim and associated objectives, for the design of an intervention for use in recovery from substance use and mental health difficulties. The chapter concludes with a summary of the chapters in the thesis and introduces the research method as a series of Design Experiments and Pilots.

1.1 Academic Interest, Personal Background and Researcher Perspective

The concept for this research project developed from the completion of a Masters degree in Architecture at the University of Brighton in 2011. This involved site research, stakeholder interviews and extensive mapping activities in Brixton, London. Interviews and research experiments were conducted alongside the local council, police and anti-social behaviour teams. This activity uncovered a network of members of the street community, who were engaged with damaging and often illegal behaviours, with substance use and mental health challenges key to driving these. Design proposals were produced in an attempt to address these issues through architectural interventions, which won a nationally recognised award for the socially inclusive nature of the design. This experience highlighted an opportunity that design has to assist in addressing complex social issues and proposals were developed to further explore the potential of design in this sphere through a PhD project. This experience had an influence on the approach that I planned to employ in the resulting research project. As I felt from this previous research, that approaches which focused on minimising anti-social behaviour and not on the root cause of the behaviour, were not strength based or empathetic. Therefore, proposals that initially came to the research from a policing viewpoint, shifted lens through which the research was viewed and consequently conducted.

Alongside this academic interest in the subject developed through previous study, I have personally faced the challenge of on-going mental health issues in my own life, for many years. As such, I am acutely aware of the difficulties that this brings to living life day to day. Furthermore, people in my circle of friends and close family have also faced the challenge of significant mental health conditions and substance use problems. Through this experience I have been able to witness first hand the damaging nature of these conditions and the difficulties faced in developing sustained recovery. I therefore brought this experience and associated empathy to this project as a researcher, and it this experience which led to the altering of the lens through with this research was undertaken as the project developed. This shift was from a criminal justice and anti-social behaviour focused lens, to looking at a strength based approach which advocates for the personal recovery of individuals.

As a researcher, I had little prior knowledge of design applied in the fields of substance use and mental health before undertaking this research. I also had no prior experience of working in residential rehabilitation settings. Having no experience working directly with service users and support staff in rehabilitation settings or in applying the design research methods used in this project, was considered to be a positive element to my undertaking this research. In this respect, as a researcher I felt less likely to be influenced by prior assumptions of biases towards working in this setting, than someone who has been exposed to the institutional politics and ongoing challenges associated with working in rehabilitation settings. This allowed me to conduct the design experiments with a new target group, through a more objective lens. I could also draw on my personal experience of mental health and substance use, through a research design which would be weighted towards an empathetic approach to engagement with participants. It is acknowledged that no research can be fully objective but I feel in this project my role as a researcher influenced the research in a positive methodological sense, whist my influence on the data collected was minimised.

1.2 Research Context

More individuals are unable to successfully complete recovery treatment for substance use and mental health difficulties, than manage to successfully complete it. This is highlighted in the statistics for substance misuse treatment for adults in England (Fig. 1.2-1). For example, of the total number of individuals who left drug and alcohol treatment in the period from 2019 to 2020, under half (47%) successfully completed their treatment. The remaining 53% left treatment due predominantly to dropping out or unsuccessful transfers to other services. There has been a steady decline of those leaving treatment, having successfully completed it, from a high point of 53% during the period from 2013-2014, to 47% currently. In terms of those starting treatment, over half (59%) stated that they required assistance with a mental health need, with a quarter of those individuals not receiving any mental health treatment at all. Additionally, almost all (99%) of those in treatment received a structured treatment option with a psychosocial element, with the vast majority (98%) receiving a community treatment. Finally, individuals are highly likely to have more than one treatment journey, with 40% having had four or more treatment journeys and over a quarter (26%) having been treated for their condition continuously (Public Health England, 2020).

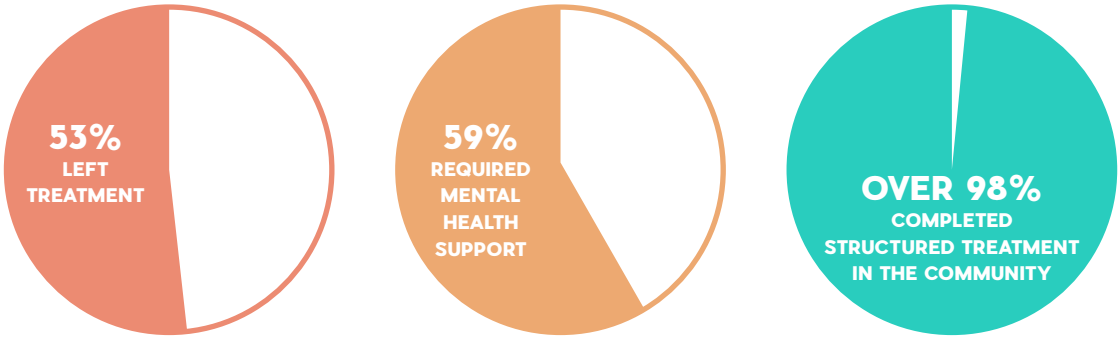

Figure 1.2-1 Statistics infographic

Substance use has a widespread effect, for example, the most dependant of those with alcohol addictions are responsible for a significant strain on public service funding, through the impact their addiction and behaviours have on emergency, police, and social care services. Alcohol causes thousands of deaths each year and over one million hospital admissions. It also is a factor in almost half of all violent crimes and over a third of domestic violence incidents. Alcohol is estimated to cost the economy in the region of £50bn per year in England (Anderson, 2013). In this research project's locale of Brighton and Hove, this impact will be felt more acutely as the substance use incidence is higher when compared with the South-East and England as a whole (Safe in the City Partnership, 2020).

1.3 Policy overview

Since around 2010, UK drugs policy and the field generally, has been shifting emphasis towards a recovery model, from a 'treatment and cure' model, to include a more patient centred approach. This move acknowledges the wider influences that need to be addressed through recovery (including mental health issues) and also the social dimensions of recovery (Daddow and Broome, 2010).

As will be set out in more detail in chapter 2.0, policy and concepts of recovery in both the mental health and substance use fields have been developing towards a 'recovery' model (Fig. 1.3-1). However, this has taken place for the two separate fields in isolation. Attempts have been made by researchers to consider the similarities and differences of these two models and to find ways to forge common ground. Unfortunately, even though these attempts have been made, the reality is that individuals who present with substance use and mental health conditions together still often find themselves excluded from services (The Recovery Partnership, 2015).

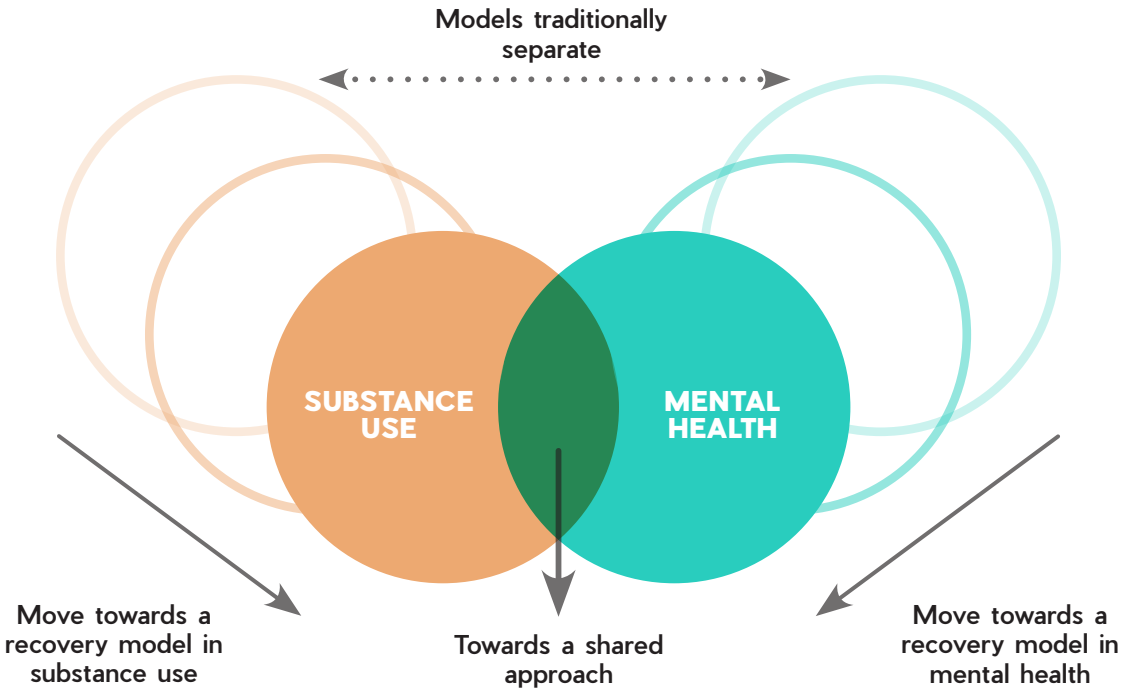

Figure 1.3-1 Towards a shared recovery model

Public Health England (PHE) is an executive agency of the Department of Health and Social Care, existing to protect and improve the nation's health and well-being, and reduce health inequalities. They have been attempting to find a way to help commissioners and service providers address this issue. They have developed guidance which supports the NHS Five Year Forward view for Mental Health and NICE guidance on treatment, by encouraging two key points to achieve this. Firstly, recognising that this issue is 'everyone's job' to help to address and secondly, encouraging service providers to have an 'open door policy', to allow those with combined conditions easier access to treatment. In their guidance PHE advocate an approach of 'therapeutic optimism' where recovery workers should be optimistic in their belief in individuals' capacity to recover and employ a 'whole person' approach, as developed by the RSA in the Whole Person Recovery project (Daddow and Broome, 2010). This includes community participation and involvement in recovery communities during their recovery journeys. Also, support staff in rehabilitation settings are encouraged to facilitate an open and positive therapeutic relationship between themselves and

individuals in recovery (Public Health England, 2017). These policy points form the basis for the intentions of this research to:

- Jointly consider substance use and mental health in the development of a recovery tool.
- Encourage the consideration of a whole person approach to understand those in recovery.
- Develop positive therapeutic relationships between participants through a creative peer support interaction.

1.4 Social Care Crisis

It is well documented in the British media that there is a crisis in health and social care in the UK. As Dowling (2021 p1) observes, this crisis involves:

"...an ageing population and the increase in dementia without the necessary care facilities or resources do deal with it; reduced mental health services; fragmenting community services..."

This current crisis can be traced back to the strain on public services initiated by the 2008 financial crash. This is compounded by the need to address the demands put on social care by the increasing ageing population, at a time when the funding for service provision is continually being reduced by Councils. This is being felt acutely in the area of mental health, as the current system struggles to match demand (Care Quality Commission, 2019). This situation is becoming increasingly unsustainable, meaning than more individuals than ever are struggling to cope with their long-term conditions (RSA, 2013).

It is small grass roots organisations, Community Interest Companies and charities which often take up some of the shortfall in social care provision. However, these also suffer from the challenges in securing funding to make their services

viable, especially when they are not supported by Council funding. Lack of funding is one of the major barriers to adopting a modern recovery model in addiction and mental health (Daddow & Broome, 2010).

In this context there are calls amongst the most high profile advocates in reforming methods in public health, to look at innovative solutions to this current crisis (APPG, 2017), with this approach also emphasized by the NHS Five Year Forward View (NHS, 2014). With that in mind, it is in this spirit that this research project is being undertaken, with the view to using design methods to innovate in the recovery fields and design a new intervention which follows as more distributed peer-support approach in a community setting.

The situation described above was observed first hand during the research, through the workshops undertaken and interactions with support staff at the different organizations collaborated with throughout the project. As is documented at points throughout the field notes in the Appendix, there is significant pressure on support staff in terms of their case load, their time with service users and funding available to run services effectively. For example, staff were noted as going on to long-term leave due to stress and mental health conditions. Services also regularly used food poverty charities such as Fare Share, to provide ingredients to make meals for residential clients, due to reduced funding.

1.5 Recovery definition

Those writing on recovery generally acknowledge that there is no single definition of recovery which is universally agreed within the substance use field. However, a consensus panel of the UK Drug Policy Commission reached a description of substance use recovery as:

> "The process of recovery from problematic substance use is characterised by voluntarily-sustained control over substance use which maximises health and

well-being and participation in the rights, roles and responsibilities of society." (UKDPC, 2008 p6)

Alongside this the 2010 UK Drugs Strategy describes recovery as:

"...is an individual, person-centred journey, as opposed to an end state, and one that will mean different things to different people." (HM Government, 2010 p18).

This second description moves the emphasis of recovery, from a focus on the substance and its management, to a more holistic view. It frames recovery as something which is individual and evolving which is indicative of a general shift in the substance use field towards a recovery model.

In a similar manner, the mental health field also has no universally agreed single definition of recovery. Roberts and Bell (2013 p79) suggest that recovery in mental health can be considered as:

"...a set of ideas and values which place people's own priorities at the centre of the services they get, and which enable users to 'make their own lives better on their own terms'.".

As such, the definition of mental health recovery can be seen as focusing more on quality of life compared with the conception of substance use recovery. As argued by Best and Laudet (2010 p2), in both sectors the essence of recovery can be viewed as:

"...a lived experience of improved life quality and a sense of empowerment; that the principles of recovery focus on the central ideas of hope, choice, freedom and aspiration that are experienced rather than diagnosed and occur in real life settings rather than in the rarefied atmosphere of clinical settings.".

This research views recovery as a combination of these definitions, as a process which is evolving, empowering, person centred and concerned with improving individual quality of life and the understanding of individuals' conditions.

1.6 A complex problem

The challenges faced by those in recovery are often wide reaching and complex. Such complexity can be much more than deficits, such as the addiction itself and combined disorders (such as with associated mental health difficulties) (Daddow and Broome, 2010). It can also be more than practical concerns, such as access to housing and future employment. For example, neurobiological research suggests that drug users can struggle to imagine a better or different future due to the damage done to the frontal lobes in the brain (Ingvar, 1985). This makes it much more challenging to visualise what life could be like and keep this in mind during the recovery process.

Figure 1.5-1 Word cloud showing the complex issues faced by those in recovery

Therefore, navigating such a complex landscape to develop interventions with impact is a significant challenge and can be described as attempting to address a 'wicked' design problem (Buchanan, 1992). This is where the issues around a social problem are affected by a wide variety of stakeholders and the interaction between all the strands can be confounding. As such, wicked problems are a: "class of social system problems which are ill-formulated, where the information is confusing, where there are many clients and decision makers with conflicting values, and where the ramifications in the whole system are thoroughly confusing." (Churchman, 1967) (Fig. 1.5-1). As each individual's recovery is unique, which compounds this complexity, any methods used to assist in attaining long term recovery need to be tailored to individual experiences, for the process to be at its most effective and supportive (Roberts, 2009). The nature of those with 'complex needs', a definition which includes those with co-existing mental health and substance use conditions, is considered a 'wicked problem' by DrugScope, and they highlight that such problems are not unsolvable but require a unique or holistic approach and that:

> "Innovation, flexibility, a commitment to continuous review and a willingness to work across organisational boundaries can all contribute to overcoming even the most significant obstacles." (DrugScope, 2015b p7).

1.7 An opportunity to intervene

The above statistics and project background indicate that there is scope for improving the numbers of individuals engaging with and successfully completing treatment. This would help reduce the number of treatment journeys for individuals, to successfully sustain a long-term recovery. The need for innovative recovery interventions, which also consider the mental health of individuals as an integral part of the process, can be considered imperative. In turn, successful interventions have the opportunity to assist in easing pressure on public service funding, the health service and the criminal justice system. This is a field where innovation in recovery methods is lacking and where new strategies are needed to

help sustain engagement in recovery and improve outcomes for those engaging with treatment, once they have taken the first steps to access help.

1.8 Design Thinking

An emerging, flexible and intuitive approach which lends itself well to tackling such wicked problems and fostering social innovation, is the use of the principles of design thinking. This is because designers are educated to frame problems and reason through abductive thinking, which is to make observations of an issue and then work towards the simplest, most practical solution based on the knowledge at hand (Dorst, 2011) by synthesising and reflecting on initial observations to make sense of the design problem (Kolko, 2010).

Designers also naturally adapt their approach to account for changes in the problem over time (Braun et al., 2014). The design process inherently uses problem solving, creative thinking and tacit knowledge, which can all combine to nurture innovative solutions to wicked problems. This project will attempt to capture tacit knowledge through the deployment of a prototype intervention, which was iterated to capture these nuanced responses from participants. The knowledge gained from these responses will be reflected on and used to inform the design process and outputs.

In recent years designers have been applying the principles of design thinking to tackle complex social problems and a shift has taken place where users have become considered key to the design process. This shift in focus from designing *for*, to designing *with* users, is bringing design into a variety of disciplines outside of the design field. The rise of terms such as co-design, co-production and co-creation illustrate this shift towards a collaborative way of thinking and aim to embed users in the process (Sanders and Stappers, 2008).

Design research is part of this trend towards the increasing use of innovative methods in research. With tools being increasingly used by designers to conduct

research, including: Probes, toolkits and prototypes. Conducting research through making such devices helps designers and non-designers to:

> "...describe future objects, concerns or opportunities. They can also provide views on future experiences and future ways of living." (Sanders and Stappers, 2014 p6).

However, this emerging trend has attracted some criticism of design methods and their application. There has been some scepticism of the use of design methods, from those engaging in collaboration with designers. Possibly as a result of some "overblown claims that design methods are uniquely placed to tackle complex, holistic problems..." (Mulgan, 2014 p5). However, as a constantly evolving area, the use of design thinking in new sectors is generally considered an: "exciting new paradigm for dealing with problems in a variety of fields outside of the design discipline" (Dorst, 2011 p521). Especially as there is evidence that the expertise of designers, who are using techniques to engage with hard to reach groups is growing, particularly in the field of healthcare (Chamberlain et al., 2015). This project aims to work in the space between the fields of design, creative practice and healthcare.

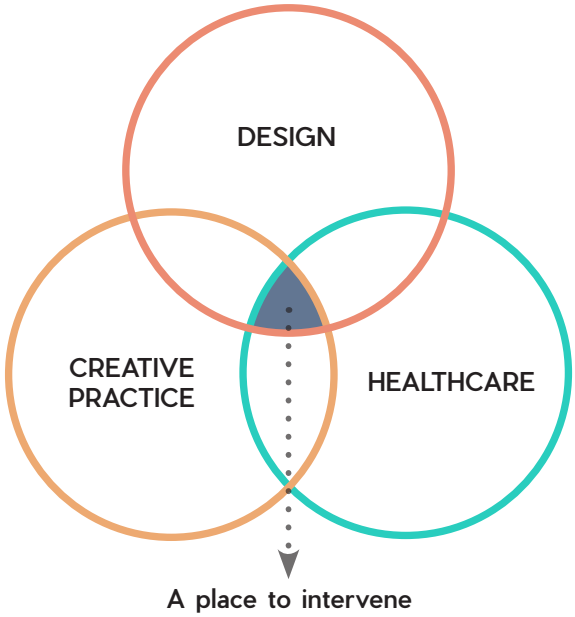

Figure 1.8-1 Intervention in the space between design, healthcare and creative practice

1.9 Designers and artists working in the healthcare field

With the increasing use of design methods outside of the design field there have been many examples of designers working in the healthcare field, for example, these techniques are being used increasingly to innovate and redesign patient experiences in the National Health Service (NHS) (Schaeper, 2014). The NHS is the publicly funded healthcare system of the United Kingdom. However, outside of the NHS a variety of design methods are being used in many healthcare settings to assist with different conditions, as surveyed by Chamberlain et al. (2015). The increasing competence and experience of designers working in healthcare is also documented and explored through specific journals and conferences. The rise of dedicated health design publications and events illustrates the increasing interest and rigour that is developing in this field of research and practice. One leading journal and conference is Design for Health, which has held conferences in 2018 and 2020, with a journal also in publication from 2017.

Alongside the rise of designers working in healthcare settings, there is also increasing use of creative methods to help people in recovery from a variety of illnesses. This concept is explored further in the literature review (chapter 2.0). There is a large and expanding body of research which evidences that participation in the arts can be a powerful aid to those recovering from illness (APPG, 2017). The use of creative methods to work with those in recovery is a key approach employed alongside design methods in this research. The NHS Five Year Forward View (2014), describes the requirement to redefine the patient and community relationship, with discussion of empowerment and engagement, which are central and established concepts in both design and creative approaches to user participation (Chamberlin et. al, 2015).

1.10 Research location

The research set out in this thesis was conducted in Brighton and Hove. Brighton and Hove is appropriate as the base for this research for the following reasons. Firstly, the city has a prevalence of problems caused by drugs and alcohol use which is more acute when compared with figures for the wider South East or England as a whole (Brighton & Hove Community Safety Partnership, 2020). Secondly, in the period of 2017/18 7% of residents reported that they had low levels of happiness and also 26% reported that they had high levels of anxiety, with both figures being higher than those for the South East and England (Brighton & Hove Community Safety Partnership, 2020). Finally, Brighton and Hove has a long tradition of the arts being used to improve well-being (Murray, 2013). These statistics show there is not only the need for interventions to improve substance use and mental health, there is an existing culture of the use of creative practice used to improve well-being in the city.

1.11 Formation of the research aim and objectives

The above context illustrates the use of design methods as an increasingly accepted approach within the healthcare field. As is set out in the literature review (chapter 2.0), there are key points in existing recovery approaches which lend themselves to the application of design methods and creativity. Chapter 5.0 surveys identified existing engagement tools. A gap is identified in this provision for an intervention which aims to assist with substance use and mental health difficulties at the same time. From these initial investigations (the literature review, existing engagement tool review and initial Design Experiments) a methodological framework (chapter 3.0) was developed to achieve the overall aim of this research to:

Design, test and evaluate an intervention to assist in recovery from substance use and the associated mental health difficulties, through the use of creative practice. From this aim the following objectives were derived to achieve it:

1. Review existing literature to identify key themes and the context for intervention development.
2. Conduct three initial Design Experiments, based on initial findings from primary research, and select one for further development into a novel design-led intervention.
3. Develop a methodology to pilot and iterate a therapeutic intervention in a residential rehabilitation setting.
4. Identify and interpret similar selected existing interventions to identify key approaches and successful design features.
5. Conduct a series of pilots to iterate and refine the design of the chosen Design Experiment (Cultural Probe) to produce data for analysis. Therefore, providing a novel designed intervention which expands the application of a Cultural Probe into a new realm.

Figure 1.11-1 Research aim and objectives

Objective 1 will be investigated through the literature review (chapter 2.0). This assisted in the identification of themes and the key considerations which were highlighted by existing research material and drawn on in the development of a new intervention. In total eight themes were identified and explored through the literature review:

1. Service user voices
2. The interplay between substance use and mental health
3. Contemporary recovery models and systems
4. Recovery Capital
5. The role of creativity in recovery
6. Confidence and self-esteem
7. Peer support recovery groups and communities
8. Traversing boundaries

Objective 2 will be addressed through chapter 4.0, which details the deployment of three experimental initial design interventions. This led to a choice of one of the three (Cultural Probe – chapter 6.0), to prototype and test in more detail through a further designed methodology. The aim was to investigate the journey taken by individuals from three different points of view:

1. An individual's typical journey in and out of addiction from the individual's point of view (Persona Journey Map Experiment)
2. An individual's typical journey through treatment from a service perspective (Service Blueprint Experiment).
3. Individual stories from those currently in formal treatment. (Cultural Probe Experiment).

Objective 3 will be explored in chapter 3.0. This will set out the epistemology, theoretical perspective and methodology for conducting this design research. This chapter will clearly determine to research methods used to collect data during the project.

Objective 4 will be addressed through an existing engagement tool review in chapter 5.0. This will summarise intervention tools which currently exist in the field. The aim is to identify a range of key attributes considered to be beneficial to the success of these interventions and then take them forward to form a design brief for a new recovery tool. This review will consider fourteen existing recovery tools and interventions, which have been identified on a scale from 'clinical' to 'creative'. Analysis of these will then be themed according to: Design communication, The Clinical-Creative Scale and collaboration.

Objective 5 will be detailed through chapters 7.0 and 8.0. These will explore three stages of design iteration of the Cultural Probe Pilot (I) into a new recovery tool. These stages involve design testing, evaluation and refinement, with an increasing emphasis on participant involvement through the process. Firstly, The Creative Recovery Toolkit Pilot (II) (Chapter 7.0) is described as a

development of the cultural probe which was iterated using previous feedback and observations. Secondly, The Creative Discovery Kit Pilot (III) (Chapter 8.0) was then developed using the feedback and responses from the Creative Recovery Toolkit Pilot (II). In this final pilot more detail was captured regarding participant experiences and the tool also tracked and measured how participants scored their impressions of each task, alongside providing further feedback for design development.

2.0 Literature review

The following chapter discusses relevant identified literature, which was drawn on in the development of this research project. The sources are organised into eight themes, describing different elements which are critical to understanding recovery from substance use and mental health challenges. The chapter concludes with the identification of a further three general themes, which are shared with those drawn on in the existing engagement tool review (chapter 5.0).

2.1 Introduction

The literature review was undertaken using a conceptually driven narrative approach. The focus of this review began with a very broad initial scoping review, to quickly and efficiently define a space for the research project to be conducted, by identifying gaps in existing research and opportunities for intervention. As the review developed with the project, it become a narrative review, describing several key themes, which are explored in more detail below. This was beneficial for placing the design research project in context, inform the development of the designed intervention and look critically at recovery through creativity, as a concept to understand and explore further.

Over the course of the review the aims and objectives for the project were defined. The review themes were structured to demonstrate the background context for the design work being undertaken and to highlight the knowledge gap into which this research project would contribute. Existing knowledge was synthesized into the seven key themes, which were considered most critical for informing the development of a novel and impactful design intervention.

The themes follow a structure which has some similarities with that used to guide the existing engagement tool review (Chapter 5.0). The structure charts recovery from its history to formally evidenced ideas and then to more informal

innovative approaches. This is preceded by a discussion of the importance of the service user voice in the research and in recovery, which is a key consideration throughout the project. Structuring the review in this way helped to understand the range of ideas and approaches in the field and position the designed recovery intervention.

The breadth of the review was cast as wide as possible within the scope of the research project. However, there were limits to the amount of material reviewed. For example, due to the large amount of research conducted on mental health recovery, mental health sources were reviewed which either related to or were discovered via a focus on substance use recovery sources. This decision was made due to the link made in the project between these two fields and this limited the amount material from the mental health field which would need to be considered.

During the review, focus was paid to identifying sources based on their relevance rather than simply finding material with the aim of comprehensiveness. This decision was made to ensure that key sources were identified and considered in amongst the large amount of material available. This helped focus the process and reduced the chance of being overwhelmed with information. As Maxwell (2006) advises, relevant sources have important implications for the design, conduct, or interpretation of the study, and are not just simply related to the field in which the research is being conducted.

These sources were identified through online search (for example, via Google Scholar), by using the search capacity of Kingston University library catalogue, attending conferences, networking and by reviewing reference lists in studies of particular relevance.

Searches were conducted using a selection of relevant keywords related to recovery, creativity and design methods. Identified sources include: peer

reviewed journals, books, websites, government publications, selected reports produced by leading recovery organisations and television programmes. Sources were concentrated on that were more recent in date, to ensure this research was positioned amongst current thinking. However, all sources were considered regardless of date, if they were still relevant to this enquiry.

The literature search identified relatively few directly relevant peer-reviewed research papers, which could inform this project. Therefore, an approach of drawing on only peer reviewed papers was not achievable. Some grey literature was therefore drawn upon as it was deemed to be high quality output and could contribute significantly to the understanding of the research focus. Grey literature includes sources which are produced outside of traditional publishing (Adams et al, 2016), as such the rigour in which it is produced can be considered variable.

So, as grey literature is abundant in the recovery fields, reference to grey literature has been limited to reports and papers produced through rigorous research by leading research centres, on behalf of established recovery organisations. The identified lack of directly relevant research provides an opportunity for this study to contribute to this gap in existing research. Additionally, as there is an interplay between mental health and substance use and as both these issues were considered in this project, related references were be drawn from both fields, as significantly more relevant literature had been identified in the mental health field.

Several key sources have been identified which have a direct geographical and stakeholder relationship to this research. These include, firstly, Voices of Experience (Hough and Rice, 2011), which includes a research team who were overseen by a steering group of representatives from Alcohol Concern, CRI

and Brighton Equinox. Individuals from these three organisations have all been consulted with and have supported the development of this study. Secondly, the Whole Person Recovery project (Broome and Daddow, 2010), which was conducted in conjunction with agencies in West Sussex, with a direct geographic and demographic similarity to the area of this research in East Sussex.

The literature review brought out the following eight interconnected themes, which will be explored below:

1. Service user voices
2. Recovery and the interplay between substance use and mental health
3. Contemporary recovery models and systems
4. Recovery Capital
5. The role of creativity in recovery
6. Confidence and self-esteem
7. Peer support recovery groups and communities
8. Traversing boundaries

Where appropriate throughout this review, the concepts highlighted will be supported by referencing back to relevant instances observed in the research project field notes. These links use a specific notation, which can be used to identify the points in the field notes located in the appendix. The notation is constructed as follows:

(pilot number . session number . individual and point number)
for example the notation (P1.S3.SSW4) means:
(pilot number 1 . session number 3 . senior support worker - point number 4)

More detail on the method of recording the field notes can be found in the methodology chapter 3.0.

2.2 Service user voices

The voices of service users in organisations has gradually become considered more important over the past quarter of a century. Today it is considered standard practice that service users are consulted in the development of interventions (Omeni et al., 2014) and that service users should benefit from personalised and user-directed support (Golightly and Holloway, 2018). This takes place within individual services where service user forums are used to provide feedback for making improvements to the design of the service. Support worker interactions are also generally less hierarchical in recent times, with less emphasis on "... medical models of diagnosis and treatment, disturbing notions of professional superiority that underpinned intervention." (Golightly and Holloway, 2018 p1). Therefore, this has resulted in the users of recovery services having more weight given to their opinions in relation to how the service they attend operates and also how their treatment is individualised. This increased service user voice is most evident in mental health recovery compared with substance use recovery (Bell and Roberts, 2013).

The developing emphasis on providing a voice to service users has in recent years been encouraged by the increasing use of design methods in services, through: service design, co-production and co-design activities (Nesta, 2013). Increasingly high profile organisations such as the Royal Society of Arts (RSA) are using design methods in significant projects, such as the Whole Person Recovery project (Broome and Daddow, 2010). As discussed in the introduction, these methods have the potential to signal significant improvements as service users have transitioned from: "...being passive to active, from being powerless to powerful, and from consumers to producers." (Broome and Daddow, 2010 p18). However, as highlighted by one of the organisations collaborated with in this research, determining the views of service users can still be difficult to implement due to time constraints, which suggests that this doesn't always take place in the context of the current social care challenges (P1.S2.SM9).

As service users have become more active in the recovery environment, they have benefited from this new role. Service user involvement can have a range of benefits, including the following: increasing confidence, helping to share experiences, overcoming personal fears, feeling valued, having a better understanding of a service and developing better coping mechanisms. Through this involvement service users have been shown to improve their skills, including communication and creative skills. Another important aspect of involvement is through increased social interaction and having the opportunity to meet others with common interests (Curwen et al., 2019). An increased voice also allows services to understand a service user's story and to help tailor appropriate interventions to them based on their experiences (P1.S1.SM26).

Being part of the development of interventions and services, through having an active voice, is highlighted by service users as making them feel more respected. Service users also feel that recovery key worker attitudes, which can sometimes be negative, can be influenced by this collaboration. As one participant commented in a study which explores the experiences of those involved in service user participation: "It made me more empowered because I was sitting on panels and I was having a say of who comes in and who doesn't come in" (Curwen et al., 2019 p5). The insight that service user involvement has the potential to influence the attitudes of support staff, may in turn have a positive influence on the therapeutic support relationships built between service users and support workers. The additional respect that service users feel due to changing attitudes is an example of the reduction of the professional / client hierarchy, giving service users greater agency in recovery interactions. It is at this level of individual treatment that increased service user voice and involvement appear to be having a greater influence than that of service changes at an organisational level. Consequently, individuals are more likely to have influence on decisions regarding their own treatment, than more widely in service or intervention design (Omeni et al., 2014). Along with these benefits, there are also several challenges

to involving service users, including: staff or organisational resistance, ineffective initiatives and 'tokenism' in delivering service user involvement opportunities (Omeni et al., 2014). This on-going change in the active voice of service users in their treatment is very important, as building confidence and providing agency are key components to long term recovery from both substance use and mental health difficulties.

The above discussion focuses on the service user voice in influencing individual treatment and wider service provision. However, service user voice is also important in the expression of individual life narratives and recovery experiences. This voice is essential for facilitating the following: engaging effectively with talking therapies, describing a personal situation through assessment with services, for service research or providing peer support to others. The ability to be involved in peer support and to contribute to a research project can be very empowering for individuals who themselves have come through a recovery process successfully (Nesta, 2013).

One research project where participants were given the opportunity to use their experience to tell their story is Voices of Experience (Hough and Rice, 2011). This project shows that when structured, these stories can be used to provide a manual to advise others who are helping entrenched drinkers in recovery (Hough and Rice, 2011). Service users also report relief in the opportunity to tell their stories, even thought some of the details were challenging, as this is not something which they normally have the opportunity to do (Bayley & Thickett, 2013).

However, having a voice in treatment is not always a positive experience, as it can be frustrating as service users who often have to re-tell their stories repeatedly to various professionals in their recovery journey (Cranwell et al., 2017). This is a situation which was also identified through initial meetings with the organisations collaborated with for this research (P1.S3.SRW7); (P1.S1.SM19).

This frustration can subsequently become a barrier for service user engagement in the future. Therefore, it is important that if service users are consulted in the treatment process, either for service improvement or personalisation of treatment, that it is conducted in the most inclusive way possible. Service users should be encouraged to contribute and the process should ideally lead to them feeling empowered and with increased levels of confidence. Therefore, initiatives should aim to give service users an active voice in the process without expecting them to continuously relay their stories.

One way to work with individuals who are from marginalised groups, which can reduce the service user and professional hierarchy, is via creative activities and design-led approaches to engagement. This can help to give participants a voice in a field such as health and social care, which can inherently be bureaucratic and restrictive (Chamberlin et al, 2015). Such a voice is also important for changing attitudes of those in positions of power, who work with those in recovery (P1. S1.SM3). This is an approach which will be drawn on through this research.

2.3 Recovery history and the interplay between substance use and mental health

During the various civil rights and independent living movements of the 1960s, it was advocated that:

"...people of colour did not need to be white, women did not need to be men, and lesbian/gay/bisexual/transgendered individuals did not need to be confined to heterosexuality in order to be considered, treated as, and accorded all of the rights and responsibilities of full citizens." (Davidson et al., 2009).

In a similar way the independent living movements advocated for those living with physical disabilities. As it is when individuals are living with a long-term disability, they require their rights of autonomy and community inclusion the most (Davidson et al., 2009).

It is in this cultural context that concepts of mental health and addiction recovery began to change significantly. Prior to the middle of the 20th century, those with addiction issues were routinely stigmatised, therefore concealing their damaging behaviours, meaning the act of seeking out treatment was uncommon. This was a time when drug treatment approaches were increasingly punitive in nature and were linked directly to the criminal justice system. The birth of the civil rights movements began to change this and non-punitive mutual aid groups and what has become known at the 'recovery movement' emerged. Alcoholics Anonymous (AA) advocated a 12-step approach, which was the most prominent of the mutual aid groups for addictive behavioural change emerging from this time (White, 1998).

AA grew quickly, even in a UK context, with the first meeting held in 1947 and then steadily continuing to grow to over 4,300 local groups today (Lopez Gaston et al, 2010). Its aims contrasted with the predominantly punitive approaches prevalent around the time of its conception, as: "...identification and hope, prescriptions for daily living and mutual support". Today mutual aid groups such as AA are widespread in the recovery field and have a strong scientific evidence base for their effectiveness in recovery (Best, 2012).

In terms of mental health recovery, reforms originated from two places. Firstly, clinical research stimulated by the World Health Organisation and secondly the Survivor Movement initiated by individuals with a history of institutionalisation in mental health settings. These two sources came together in the middle of the 1970s, to form what has become referred to as the Community Support Movement (Davidson et al., 2009).

A second significant development in recovery from severe mental health conditions was the concept of 'being in recovery', in contrast to 'recovered from'. This also has its roots in the civil rights and independent living movements of the 1960s and 1970s. The concept was informed by a view of recovery, which is central to

the addiction recovery self-help community (groups such as AA) (Davidson et al., 2009). Here individuals began to describe themselves as 'being in recovery', at the point when they had achieved a level of abstinence from alcohol or substances, and were actively in the process of positively moving forward with their lives. These individuals did not consider that they had 'recovered' and acknowledged that their new life would include an element of continual warding off relapse and vigilance towards their recovery. It is this concept which those innovating in the mental health field found valuable. The idea that with a long-term condition, individuals could gain back some control and have agency in discovering the ways that damaging effects of their condition could be reduced, whilst not being fully eradicated (Davidson et al., 2009).

The above ideas form the basis for the modern 'recovery movement'. This movement is as White (2000 p8) describes in the context of addiction recovery:

"...an organised effort to: 1) remove barriers to recovery for those suffering from alcohol and other drug problems, and 2) to improve the quality of life of those recovering from alcohol and other drug problems..." .

Mental health treatment has also developed through a recovery movement, with a shift towards a more patient orientated and recovery based approach. During the end of the 1960s and early 1970s, previously institutionalized patients began to gather and protect their own civil rights. This can be seen as part of the wider civil rights and advocacy movements of this time (Ostrow and Adams, 2012). This mental patients' liberation movement (Survivor Movement) developed so that:

"...rather than becoming passive recipients of institutional 'care', troubled people would be helped to see the strong and positive aspects of themselves as they, in turn, help other's..." (Chamberlin, 1978 p19).

These cultural movements were critical, as many of the most significant barriers to change in the mental health field were social and political. More recently advocates in the addiction field have also begun implementing a socio-political stance, to an extent inspired by the advances made in the perspective of mental health recovery (Davidson et al., 2009). Another important factor, which is missing from these modern approaches to recovery and the recovery movement in general, is the idea of conditions being 'cured'. As such, the recovery movement offers an alternative approach to recovery when compared to the traditional approach originating from clinical research, where clinical recovery suggests the absence of diagnosed clinical symptoms (Davidson et al., 2009).

Here it is worth including a description of the difference between 'personal recovery' and 'clinical recovery' in mental health. In clinical recovery, as noted above, the symptoms of a mental health disorder cease, and the condition could then be described as having been cured in a clinical sense. However, often individuals self-report as being 'recovered', even though they are still experiencing the symptoms of a condition. This is a modern understanding of recovery which is called personal recovery, and advocates of a personal recovery model, suggest this would constitute a significant shift in mental health services, a shift which should be embraced as the main aim of services going forward (Slade, 2009). Personal recovery means that individuals can increase their quality of life greatly by managing symptoms and not waiting for symptoms to cease completely (and be 'cured'), before moving on with their lives.

The above description acknowledges that there is some interdependence and interplay between the concept of and development of recovery in the substance use and mental health fields. The relationship between the two in modern conceptions of recovery will be explored in more detail below.

The number of individuals that suffer from a mental health issue if they have an alcohol or substance use issue is high. Up to 75% of drug service users and 85% of alcohol service users identify a mental health problem alongside their

alcohol or drug addiction (Weaver et. al, 2003). This statistic highlights the fact that mental health and substance use disorders very often present together and that this is an important consideration in substance use recovery, which is identified by the 2017 UK Drugs Strategy (HM Government, 2017).

The reason for the connection between the two is partly due to the pressures placed on individuals by society. Once this pressure becomes unmanageable then substances are always available and can lift an individual's mood when it is low. This allows individuals to carry on with their daily lives through times when the pressure on their individual experience has become too much. Therefore, the effect of psychoactive substances can, in the short term, mask symptoms and aid mental distress, however, over the longer term the use of psychoactive substances in this way can become negative and develop into one element of a very complex mental health issue (Hill, Penson and Charura, 2016).

In this way mental health and emotional issues are a primary reason for individuals to self-medicate with alcohol or substances. However, even though there is a high proportion of mental health problems within the substance use population, those suffering from addiction can often find it difficult to access mental health services. The Voices of Experience project (Hough and Rice, 2011) found that many participants in the research felt excluded from generic mental health services due to their addictions. The authors also suggest that the likelihood of making change in recovery is low unless the associated mental health issues are addressed alongside measures to tackle addiction, such as abstinence or controlled drinking strategies (Hough and Rice, 2011). This situation is also found by the Whole Person Recovery project, where participants who had been assisted with their health issues considered recovery as more attainable and therefore had an increased likelihood of recovery (Broome and Daddow, 2010). Also Cao et al. (1998) found that individuals who are involved in substance use treatment that aims to deal with mental health needs, can further reduce dependence on substances.

Often the literature on recovery from alcohol or substance use separates the focus onto one or the other. However, in this study they will be considered as similar enough to be categorised simply as 'substances'. It is beyond the scope of this research to consider separate substances, which likely do have varying degrees of harm causing potential and propensity to lead to addiction. In essence, some could be considered to be more 'dangerous' than others. However, this decision was taken as both alcohol and substances are psychoactive in nature and are separated only by prohibition (Hill, Penson and Charura, 2016) and all psychoactive substances, including legal highs, can alter mood and emotional states, which can subsequently affect mental health. Individuals may have a mixture of alcohol, substance use and mental health difficulties and the interplay between substance use and mental health issues is likely to have complex interactions (Glossop, 2007). This complex interplay can be considered as a 'wicked problem', as discussed in the introduction, such problems are challenging to address but can be overcome by using innovation, a flexible approach and working across service boundaries (DrugScope, 2015b).

When substance use and mental health issues present together the medical term is 'dual-diagnosis'. There are several definitions that dual-diagnosis can take as a term used within the health and social care professions, it is essentially the identification of combined disorders (either a substance use and mental health problem or a learning disability and mental health problem) (Rasool, 2009).

However, there are challenges with dual-diagnosis, as clients may exhibit both conditions, but they might not have a formal diagnosis for either one. Also, the term can stigmatise individuals who already may be subject to significant levels of discrimination. This is because support workers can use the term to describe clients who have not received a formal diagnosis for one of the conditions (Hamilton, 2014). Support workers in both individual fields can often be resigned to the idea that dual-diagnosis clients have less recovery potential than clients with a singular mental health or substance use diagnosis, due to the additional challenges they face. Whilst this is often the case in practice, national

guidance promotes that care practitioners should undertake engagement with an optimism to the possibility of recovery and consider a 'whole person' approach (Public Health England, 2017). Substance use service managers and staff are also encouraged to build links with mental health services, which makes it easier to access support for service users when they need it (Ward and Holmes, 2014).

Another significant challenge is that often dual-diagnosis service users are supported largely from either a mental health or a substance use service, not both at the same time. Their overriding condition will generally determine if they are primarily a user of one or other service, and with different services prioritising certain variants of mental health and substance use, service focus may not align with the needs of users which access both services. This makes it much more difficult to provide clients with individual person-centred journeys and more challenging to implement when clients are accessing multiple services. As such, navigating services has traditionally been problematic for individuals with a dual-diagnosis, as services are discrete and often work with different methods, although this situation is slowly changing (Roberts and Bell, 2013).

Recently there has been a renewed push in mainstream recovery media towards ensuring that service users with mental health and substance use difficulties are being treated through a whole person approach. An example of this is the Phoenix Futures treatment service, which focuses on delivering and develop ing services that sustain recovery, through psychosocial methods (Phoenix Futures, 2022). They has implemented a strategy of developing staff skills to hold onto clients once they had engaged and to forge strong links with other services and support pathways, for use when clients move out of the service (Biggs, 2021).

Therefore, in this research participants will not be referred to as 'dual diagnosis' service users, due to the stigma and challenges outlined above. As it is considered crucial that appropriate descriptions are used when engaging with and describing participants. Instead participants will be described as having co-existing conditions. Also, the use of substances will be referred to as substance

use rather than substance misuse, as there are many reasons why individuals use drugs, alcohol or even tobacco, and the line between recreational use and addiction is not necessarily easy to define.

2.4 Contemporary Recovery Models and Systems

The definitions of substance use recovery and mental health recovery were identified in the context and introduction (chapter 1.0). The substance use field traditionally focuses on achieving control over the substance that is responsible for dependence. The mental health field traditionally describes recovery in terms medicalisation and clinical outcomes. This can be described as the emergence of personal recovery vs clinical recovery, which was defined in the previous section. However, in recent years a shift has taken place in both sectors towards a recovery model (Roberts and Bell, 2013). In terms of the approach to building a recovery model, both fields have developed in slightly different ways.

These developments are guided by the 2010 UK drug strategy, which has a strong focus on 'Recovery Capital' (discussed in more detail below), however this is not carried forward into the 2017 version of the strategy. Peer support and recovery networks are also highlighted (in both versions) as important considerations alongside the call for 'recovery champions' to be implemented at different levels: strategic, therapeutic and community. It is at the community level that recovery champions operate as peer supporters with previous personal experience of recovery (Roberts and Bell, 2013).

This emerging recovery model favours individual outcomes in terms of re-integration into society over an emphasis on reducing crime and the health effects of addiction. There is a trend towards a more social concept of recovery and with an attempt to see addiction in the context of the complex relationships that individuals form. This new conception of recovery focuses on how an individual's relationship with an addictive substance affects their relationship with other people and vice-versa. (Adams, 2008).

In the mental health field, the recovery approach is also becoming more widely accepted as a strategy for addressing mental health difficulties. Those with mental health issues are encouraged to improve their quality of life alongside their symptoms. Whilst it is acknowledged that clinical considerations around care planning and risk management are essential, these do not constitute a recovery model and are secondary to a person's own life priorities. The essence of recovery is therefore considered to be the fact that those in recovery should not wait to be clinically well enough before they focus on what is most important to them in their lives going forward (Shepherd, Boardman & Slade, 2008).

In mental health services which are following a recovery model, the use of co-production methods is also becoming more widespread, with users able to determine their own care plans and personalise their care (Perkins et al., 2012), as being client led is one of the main benefits of the recovery movement.

The recovery movement and the historical cultural advances towards the increased agency of individuals in their recovery and care, is a trend which continues to develop today. This trend has brought the idea of personalised care and treatment to the centre of health strategies. Recently, the NHS predicts that 2.5million individuals will benefit from personalised care by 2023/24. The intention being to provide individuals with control and agency over their care and address the need to treat the complexities of individuals' needs, rather than simply continuing with a generic approach to treatment (NHS, 2019).

This increased level of patient involvement and participation of community members as stakeholders in the design of health initiatives, is attempting to further address current complex health problems. Specific types of design activity are central to this process, with terms including co-design, co-creation and co-production, often used interchangeably to describe design activity in public health. However, while there are similarities, there are also fundamental differences in the role of stakeholders and engagement timing. Co-creation is a

collaborative process between a range of different stakeholders during a project. It can be seen as overall framework for undertaking co-design or co-production activity. Co-design is a process of collaborative design focused on consumer (or service user) insights into a particular challenge or problem. Co-production, in contrast, is focused more widely and service user input helps inform service delivery and can be viewed as generally more organization centric (Vargas et al., 2022). These collaborative patient centred innovation approaches, such as co-production, also originally emerged from the civil rights movement and social care in the USA, alongside the recovery movement as described above (The Health Foundation, 2010).

Today co-creation and other design innovation techniques, are used widely in the NHS. The NHS uses co-production as one of the primary drivers for informing personalised care which: "...ensures that the voice of people with lived experience is integral to the development and delivery of personalized care." (NHS, 2019). The purpose in the use of 'strategic' co-production in the NHS, is to give a voice to individuals who have lived experience of long-term mental and physical health conditions, to then inform the development of strategic decisions related to personalised care. The NHS also highlights the importance of developing relationships with individuals which build trust and focus on collaboration, with people playing an active role in the design of services (NHS, 2019). It is important here to consider the difference between co-creative approaches, such as co-production, and more traditional forms of patient involvement in services. Public involvement has been undertaken via consultation or advisory groups, with researchers and facilitators determining the agenda. In co-creative approaches the power dynamic shifts towards participants being involved in the design of the research and agenda setting for the project.

Another key benefit of a recovery model is that the process can be centred on the community (Hill, Penson and Charura, 2016). As such, the contribution that the individuals who use services can make, as described above, can take other

forms. For example, increasing numbers of mental health services are valuing the contribution which can also be made by peer support staff, in both informal and formal positions (Roberts and Bell, 2013). The increasing use of peer support, can give those in recovery the opportunity to share similar experiences with others (Campbell, 2005). This concept is important to this research and will be explored in more detail later in this chapter.

Another important factor is that this approach to recovery fosters an increased voice for service users in the treatment they receive, both individually and also increasingly at a service level. This increased voice has the power to build confidence and self-esteem through both empowerment and contribution, a point which will be discussed in more detail below.

In recent definitions and literature there have been attempts to find common ground between the separate recovery approaches in both fields, with the aim of working towards a shared approach. Both fields have an ambition for recovery to improve well-being and quality of life alongside making those in recovery from both mental health and substance use 'active' participants in the process. As such there are distinct similarities between the mental health and substance use recovery models (DrugScope, 2015b). A notable paper produced by Roberts and Bell discusses that the developing visions of a recovery model across both fields, which are primarily concerned with making individual lives and opportunities better. This happens when those in recovery settings work against the commonly held belief that because of the difficulties they face, it will be difficult for individuals to live an enjoyable and purposeful life. As described above, both models developed separately, however, they both developed to disrupt the status quo of current working practices. Substance use moved away from an over-emphasis on the treatment of the substance addiction itself and maintenance through prescribing substitutions, such as methadone. Mental

health care, on the other hand, developed its recovery model from a focus on clinical outcomes. Both fields have also independently moved towards a shared focus on recovery being driven by addressing basic needs and developing social connections (Roberts and Bell, 2013).

Whilst the above similarities in the recovery approach between the two fields have brought them closer to a point at which a shared definition of recovery might start to be defined, there is one fundamental difference between the two which is important to consider. In mental health recovery there is a concept that a person with symptoms of a mental health problem should be able to build a life alongside the symptoms of their mental illness. In terms of priorities this locates the management of their symptoms lower than the pursuit of their life goals. The key difference is that in the substance recovery field there is much greater focus on removing the symptoms of addiction (through abstinence), as this is considered preferable to living with the substance use issue. This pre-occupation with overcoming the addiction first and foremost, means that access to other support which focuses on working towards life goals and quality of life, is often delayed until abstinence is achieved (Roberts and Bell, 2013).

This distinction is important as whilst there are significant similarities between the two approaches, the opportunity for an integrated approach is made more difficult due to this difference. As there is resistance in the substance use recovery sector to begin working on building quality of life activities before abstinence is achieved (especially in residential treatment settings), which excludes individuals from beneficial activities until this criterion is met, providing an additional barrier compared with mental health recovery. As with the above similarities between the two versions of recovery, the shared goal of offering "...hope, control and opportunity..." (Repper and Perkins, 2003) to service users can act as a solid foundation to treatment in both fields. In this way, a recovery model that promotes the building of a brighter future can help counter some of the negative attitudes encountered and increase expectations for individual outcomes for both service users and professionals (Roberts and Bell, 2013 p82).

This discussion of the possible integration of both fields illustrates a gap in existing work in this area. There is an opportunity to consider an intervention which can be applicable to both substance use and mental health clients, along with those who have co-existing conditions. As will be discussed further in the existing engagement tool review (chapter 5.0), tools are overwhelmingly designed for one diagnosis or the other. This study will focus on the similarities in the two approaches towards a recovery model, with the aim being to develop a tool which will be widely applicable across the spectrum of substance use and mental health difficulties.

Relevant to this PhD are two differing formally defined theoretical recovery models, which are widely used in the fields of substance use and mental health recovery. These will assist in the positioning of an appropriate point where an intervention may be most beneficially employed. It is commonplace in the UK and in the recovery organisations worked with to use a theoretical model called the Stages of Change (Fig. 2.4-1). This is aligned with the evolving concept of a recovery model, with importance put on both peer support and building recovery capital. Also known as the Transtheoretical model, this was originally conceived by Prochaska and DiClemente in the early 1980s. Since its conception the model has become used in a wide variety of situations in which behaviour change is the goal. It is most widely applied in the addiction recovery field and also secondly to support mental health recovery (Littell and Girvin, 2002).

Therefore, in this study it is appropriate as a method due to the dual application to both addiction and mental health fields. For addiction recovery the model is considered effective as it "emphasises the need for individuals to develop functional attitudes and beliefs towards their substance abuse." However, for clients with more than one identified difficulty, there are often more than one factor which can affect motivation to change behaviour (Hill, Penson and Charura, 2016 p80).

The Stages of Change model moves through six distinct stages:

1. Pre-contemplation stage - Individual cannot recognise or actively denies having a problem.
2. Contemplation stage - Individual begins to see they have a problem but may still be ambivalent towards making changes.
3. Preparation stage - Individual has decided to make a change and are making a plan for this change.
4. Action stage - Individual has made significant changes to their lifestyle over the previous six months.
5. Maintenance stage - Individual has made considerable progress and is considering how this change can be maintained.
6. Relapse stage - Individual returns to previous damaging behaviour patterns.

(Hill, Penson and Charura, 2016)

Figure 2.4-1 Stages of Stages of Change model

This PhD developed to target the maintenance stage of the model for implementation of an intervention. The maintenance stage occurs when individuals have achieved significant progress and improvement in their recovery, here service users are in a position to be able to think about how this change can be maintained in the longer term (Hill, Penson and Charura, 2016). The maintenance stage can be where participants actively manage their sobriety and mental health symptoms, whilst engagement in activities such as the arts, can help the transition back into society and provide a 'high' as previously gained from substance use (Adams and Stickley, 2019).

Participants who are treated in therapeutic community settings which are residential, have addiction and/or mental health issues which are severe enough to warrant residential rather than outpatient treatment. Service users in residential treatment are also likely to have required medical intervention. The intention of this project is that a new intervention design would be targeted at such

participants that have stabilised on medication or previously undertaken a detox. This means that they will have made significant progress and be approaching or within the maintenance stage. Therefore, participants will be those who are settled in their recovery and aiming to build connections and skills, to understand their experiences through a less chaotic or medicalised lens.

One limitation identified with the Stages of Change model is that it assumes that there are stages in common between different problem behaviours (for instance substance use and mental health). This is, however, not supported by the data from a study by Littell and Girvin. They argue that whether individuals achieve change is dependent on several factors, including:

- The nature and complexity of the target behaviour
- Presence of other problems, external stress and supports
- Cultural context

The above factors vary with each service user and every recovery is different, so attempting to define a 'generic' model of change can result in generalisation in the stages and consequently assumptions being made. Littell and Girvin suggest that a continuous model of change would fit with other existing theories and also fit their data better (Littell and Girvin, 2002).

For this study, the Stages of Change model is the one model available which has been directly applied to both substance use and mental health recovery. Also, by concentrating on the maintenance stage, it provides a point in recovery which is most likely to be broadly applicable to both fields. As substance use and mental health recovery both need to be maintained successfully, as an ongoing process, and the maintenance stage is broadly equivalent between the disciplines.

A contrasting model to this is the 12-step approach, as introduced above, which is associated primarily with Alcoholics Anonymous. It is another model which is

widely adopted and evidenced. As a model it is often associated with religious practice and connecting with a higher power, which makes it not suitable for those who do not follow a faith in God (Spring, Smith & DaSilva, 2017). This is another factor which led to the decision to focus on the Stages of Change as a model in this research project, as this factor may potentially exclude a number of participants from the research. The 12-step model is predominantly focused on alcohol or substance use and not directly applicable to mental health recovery.

The second recovery model referenced in this study is the Whole Person Recovery project (Broome and Daddow, 2010). In contrast to the linear model of the Stages of Change described above, this model uses systems thinking to explore and define the interconnecting systems which act as drivers for behaviour, pulling and pushing individuals towards recovery or relapse. This is a significant addition to the discourse on substance use recovery. The project prioritizes the importance of local recovery networks and also the value of engaging service users to inform services, which can make it more likely that services can focus their efforts effectively for individual recovery journeys (Broome and Daddow, 2010). As such, the Whole Person Recovery project is a prime example of a recovery approach which has developed in response to the shift generally towards a recovery model in the substance use sector. Being based on user-centred approaches, it responds to the change in the recovery movement, with increased emphasis on personalisation in service provision. However, the level to which user-centred approaches are supported can vary widely between support services and alcohol teams (Broome and Daddow, 2010).

There are challenges to personalisation in the recovery field, which include that user experiences, when obtained, are often not used in ways that are beneficial to the needs of the user. Also, there is a tendency for "...narrow framing of 'the problem' and 'the solution' by commissioners and service providers." (Broome and Daddow, 2010 p69). The Whole Person Recovery project aims to develop a holistic approach which uses user-centred approaches combined with research on recovery and concepts of recovery capital, defined in more detail below, as

an emerging model (Broome and Daddow, 2010). One aim in the Whole Person Recovery project for employing a user-centred approach was to aid marginalised groups in having a voice and allowing their input to be appropriately actioned within a project. The authors discuss how embedding a user-centred focus can create "expectation and momentum" (Broome and Daddow, 2010 p73). This can contrast with the structures in place in support services, which can be inflexible to new approaches. They quote a leading service provider who highlighted that this adversarial relationship can position service-users and peer supporters against support staff and organisations. It was suggested that implementing a user-centred approach must therefore not make this dynamic more of a barrier (Broome and Daddow, 2010). This will be carefully considered in this research, where user-centred approaches are employed in the development of an intervention, with service users considered central to the design process, via the adoption a 'bottom up' approach.

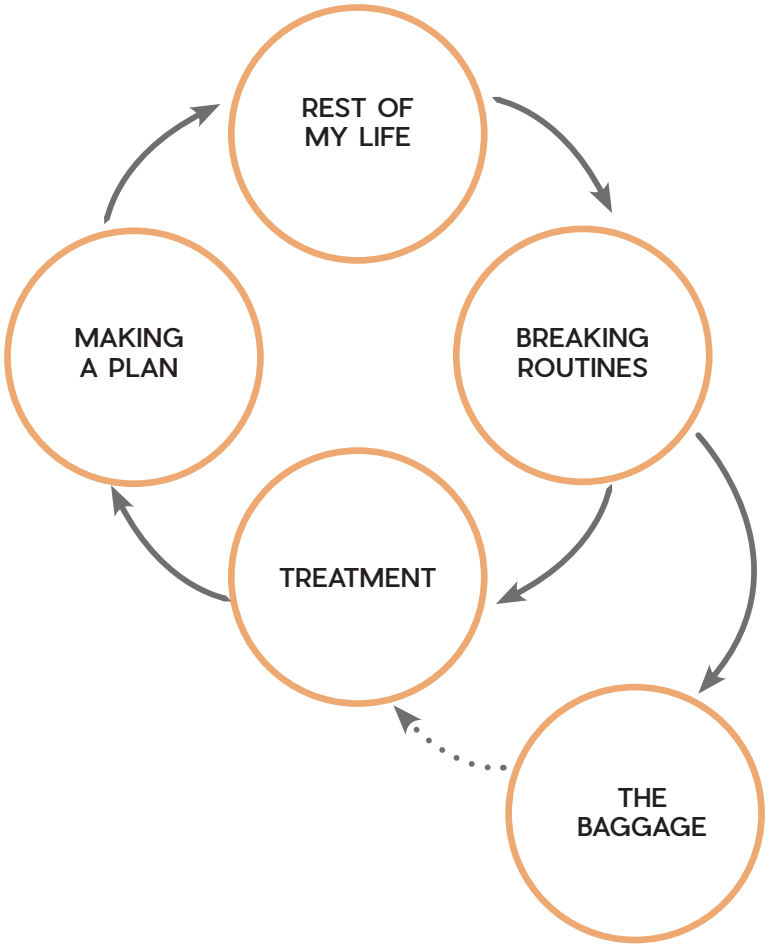

Figure 2.4-2 Illustration of the recovery sub-system (Broome and Daddow, 2010)

As a recovery model the Whole Person Recovery project focuses on the interconnecting systems of addiction. The important element identified to consider for this study is the recovery sub-system (Fig. 2.4-2). This is illustrated in the system as a framework and was developed alongside accounts from participants attending workshops as part of the research. The recovery sub-system is made up of the following five elements:

1. **Treatment:** this is the formal and informal treatment services and support.
2. **Making a Plan:** this is the formal and informal recovery planning (such as Whole Person recovery plan (formal) or recovery without formal support (informal).
3. **Rest of my Life:** this is setting goals for the future and building confidence and belief to reach these goals.
4. **Breaking Routines:** this is acquiring skills and coping mechanisms which can assist in increasing an individual's ability to deal with the difficulties of recovery and to be more resilient.
5. **The Baggage:** this is past experience which can delay recovery progress. This experience if not dealt with can lead to relapse. (Broome and Daddow, 2010)

Figure 2.4-3 Recovery sub-system components

There are various points of entry into this sub-system and the efficiency of recovery early in the journey is dependent on how easy it is to access treatment and how it is delivered. The researchers found that the response from participants highlighted that individuals had a wide range of difficulties, which were linked. As discussed previously, this is a challenge for support workers to manage in terms of providing support, which is personalised for individuals with multiple issues. Participants in the project stated that they found support workers could appear to lack empathy or not realise the challenges that they faced, as they had not experienced similar difficulties personally (Broome and Daddow, 2010). This

highlights a key challenge for individuals who are accessing formal treatment in the recovery sub-system and is particularly important as building strong participant and support worker relationships is a key factor in long term recovery.

An intervention will need to relate to all the elements of the recovery sub-system within this model, to varying degrees. However, one element which is a key part of any developed intervention is 'Breaking Routines'. As it is through breaking routines that behavioural change takes place.

The researchers found that it is the group who have the greatest difficulties who require more control over their treatment, for example, individuals with multiple difficulties, poor support networks and isolated situations. This group is reported to want more control over their treatment but due to low levels of recovery capital and difficulties with reading and writing, they are in a difficult position to achieve this (Broome and Daddow, 2010).

The whole person recovery project approach is introduced here primarily as a key relevant example of a user-centrerd design led approach, which mirrors the approach of this research. This approach has elements which can inform the positioning of an intervention, for example, the recovery sub-system. However, the key theoretical recovery framework used to inform the study is the Stages of Change model, for the reasons outlined above. As such, the critical use of this framework will be to determine an appropriate point of intervention for design and secondly, to refer back to this framework, in order to ground the study in this as an established approach.

2.5 Recovery capital

Both of the recovery models outlined above use the concept of 'Recovery Capital'. Recovery capital as a concept is traditionally associated with substance use recovery and established in that field. For an individual to recover from

substance use their likelihood of doing so can be predicted by their levels of recovery capital. Recovery capital is therefore the amount of supportive elements that can be drawn on to begin and maintain recovery from substances (Granfield and Cloud, 2008). There are four proposed components to recovery capital:

1. Social capital: the sum of resources that each person has resulting from their relationships.
2. Physical capital: assets such as property and money which can increase recovery options.
3. Human capital: skills, positive health, aspirations and hopes, and personal resources that will enable the individual to prosper.
4. Cultural capital: values, beliefs and attitudes that link to social conformity. (Best and Laudet, 2010)

Figure 2.5-1 Recovery capital components

Best and Laudet argue that the key individual factors, which when combined to achieve an assessment of recovery capital at a social or group level are: social, human and cultural (Best & Laudet, 2010). Positive recovery capital is a recovery motivator and negative recovery capital can be a barrier to continued recovery or it can slow the recovery progress down. Granfield and Cloud conceive of recovery capital on a continuous scale, where positive aspects increase the likelihood of a sustained recovery and negative elements reduce it (Granfield & Cloud, 2008).

When individuals have low levels of capital due to reduced positive elements, substance use is used to fill the gap left by this lack of capital. Negative elements can include: individual capacities such as low self-esteem and poor social networks (such as all friends being involved in the drug scene) or factors in the local community (such as limited opportunities or stigmatisation) (Broome & Daddow, 2010). Another important example of negative recovery capital is mental illness, which can be a barrier to an individual's ability to successfully recover (Granfield & Cloud, 2008).

Often substance use is not primarily the issue in itself, instead it is used as a device to mask underlying distress. As such, these damaging behaviours are good at 'filling a void', especially if individuals are searching for meaning and purpose in their lives. Therefore, once established in a social circle of addictive behaviours, individuals fearfully anticipate their isolation and boredom if the substance is removed along with their social circle. Thus leaving the individual once again exposed to a void (Svanberg, 2018). This is where it is vitally important to have in place positive aspects of recovery capital, including meaningful activity and positive social connections during the process of recovery.

Whilst recovery capital is primarily associated with substance use recovery, due to the similarities between the two fields, it can be acknowledged as a key driver for 'recovery' generally (be that from mental health or substance use), as both fields are focused on improving quality of life. Many of the aims of developing recovery capital are also applicable to improving mental health in participants, as both require the building of a new life without either substances or symptoms of mental illness (DrugScope, 2015a). Therefore:

> "...the essence of recovery is a lived experience of improved life quality and a sense of empowerment; that the principles of recovery focus on the central ideas of hope, choice, freedom and aspiration that are experienced rather than diagnosed and occur in real life settings rather than in the rarefied atmosphere of clinical settings." (Best and Laudet, 2010 p2)

Tew (2013) considers how mental health services, which have traditionally been focused on medicalisation and risk management, could consider recovery capital as a framework for mental health recovery. Tew describes mental health recovery as being driven by social factors and resources rather than medical interventions. Also, as sufficient overlap has been identified between substance use and mental health recovery, with both fields having the overall aim of improving quality of life. For the purposes of developing this research, recovery

capital as a concept will be applied generally for recovery from substance use and the associated mental health challenges. Which further develops the idea of a combined approach to working with clients with combined disorders.

The realities of building recovery capital are illustrated by the Voices of experience research project (Hough and Rice, 2011). The authors found that for many drinkers life can feel boring, lonely and meaningless. They suggest that those in recovery have a desire to develop skills and do 'positive things' and that this is crucial to maintaining change. However, this is tempered by the reality that change requires time and that individuals may need to receive support for several years during change to maintain it. The authors also acknowledge the importance of building social networks to sustain long term recovery, as when individuals leave a social drinking group, a void is created, which can quickly lead to isolation unless opportunities are available to establish new friendships (Hough and Rice, 2011).

Therefore, the continuation of recovery after discharge from formal treatment, also known as after-care, is imperative to individuals building recovery capital. After-care can take the form of those in recovery becoming involved in groups which provide peer support and activities to structure their days after formal treatment has ended (Moos, 2007). Having support which continues after formal treatment and forges connections with services in the community, is promoted by the UK Government drugs strategy (HM Government, 2010).

Individuals in residential community treatment will need to build their levels of recovery capital substantially before they are able to sustain their recovery. This involves changing routines and associated habits, which the researchers in the Whole Person Recovery project found as one of the most challenging parts of the recovery sub-system, due to the motivation to alter habits varying from one person in recovery to another. The authors suggest that to break routines individuals need to practice and 'train' themselves, as self-control is not inherent.

Building recovery capital and engaging with social groups and activities can make it simpler to break routines. With this in mind, participants in the Whole Person Recovery project suggested that one element which was often missing from services was a focus on purposeful and meaningful activity. Having activities to undertake is essential to reduce boredom, which can be a trigger for clients (P1.S4.SRW2). Service users felt this left them: "...poorly equipped to reintegrate and contribute to their communities and therefore sustain their recovery." (Broome & Daddow, 2010 p63).

One of the key reasons why group treatment is beneficial is that it helps to rebuild positive relationships and offers opportunities to share experiences. As Duffy and Baldwin identified, a theme among those in recovery from substances is that they become detached from positive relationships. Participants in their study expressed that peer support was particularly valuable and the benefit of spending time with others in recovery was critical. Participants also expressed the value of giving something back, by getting involved with helping others in recovery. This happens via engagement with peer support training, as those in recovery often have ambitions to work in the recovery sector in the future. Participants in this study stated that various forms of after-care were beneficial to them, especially with opportunities for activities with a focus other than on recovery itself. For example, spending time outdoors or engaging in creative activity, including: drama, dance, creative writing or music (Duffy & Baldwin, 2013).

2.6 The role of creativity in recovery

The value of using creativity as an elicitation tool and the benefits of being creative in recovery settings are well documented. This approach has the potential to assist with improving outcomes in a variety of areas including: health and homelessness, social care and justice (Arts Council England, 2010). The use of creative activity in research, such as photography, can assist with reflection and communicating feelings and topics, which may otherwise be difficult to express

(Drew et al, 2010). Creative activities have also been shown to be beneficial for those in recovery from psychosocial problems (APPG, 2017). The idea for using creativity in this study was therefore to employ activities which were less structured and formal, as an alternative way of connecting with a challenging group.

There is a large and expanding body of research which evidences that participation in 'the arts' can be a powerful aid to those recovering from illness. The arts (both visual and performing) have also been shown to help address some of the biggest challenges facing health services, including: ageing, long term conditions, loneliness and mental health. This has the potential to help reduce public spending on these conditions, with research and practice taking place both at national and local levels (APPG, 2017; Clift & Camic, 2016; Fancourt, 2017; Stickley, 2018).

The All-Party Parliamentary Group on Arts, Health and Well-being, was formed in 2014. This group has the aim of improving awareness of the benefits that the arts can bring to health and well-being, and to stimulate progress towards making these benefits a reality. In July 2017 the inquiry Creative Health: The Arts for Health and Well-being (APPG, 2017) was published and has become a key reference text for informing and guiding this research project.

The APPG acknowledge that whilst there is a strong evidence base for the value of engaging with publicly funded arts projects, the level of engagement is low amongst those who are from economically or socially disadvantaged backgrounds. Therefore, it is with these groups that it is critical to increase the opportunities to engage and benefit from this as a catalyst to develop and maintain healthier and more fulfilling lives (APPG, 2017). A marginalised group forms the focus of this research project and one of the key ways creativity has been shown to be helpful for individuals in recovery, is to help express difficult

and challenging emotions. This takes place through the ability of arts therapies to provide a method of communication which is non-verbal and can be useful in expressing and exploring difficult memories and past experiences (APPG, 2017).

Whilst the benefits to the use of creativity in healthcare are well understood, there are challenges to widespread acceptance in the healthcare field. Most notably, how participation can be evaluated and evidenced, in a field which often relies on clinical controlled trials to assess treatment options (Daykin, 2019). However, parallels can be drawn between the use of arts in healthcare and the application of design thinking, as discussed earlier. Both approaches are forging new ground, with significant opportunities existing to engage through the arts or design, with the potential for successful outcomes and beneficial collaborations.

The process of creating is a uniquely individual expression, which can positively impact both physical and mental health (APPG, 2017). As Arts Council England explained back in 2010, arts participation is now mainstream and being employed successfully by many organisations which are providing "remarkable outcomes" for many individuals (Arts Council England, 2010 p6). They also describe the value of creativity as an asset, both for individuals and wider social networks and communities, which has value not just for well-being but also for the economy and civic society as a whole (Arts Council England, 2010).

In terms of the application of the arts in therapeutic ways, there are generally considered to be two approaches: art therapy and therapeutic participation. Art therapy is an approach which intends to achieve a specific clinical outcome compared with participation in creative practice. This in contrast results in positive health effects by virtue of the process, which is consequently therapeutic to the participant (APPG, 2017). Traditionally arts therapies (delivered by therapists) and arts based activities (delivered by artists) have been positioned in opposition to one another in terms of recovery. However, more recently a change has taken

place with the focus shifting to the shared goal of these practices, which is considered to be an emphasis on facilitating recovery and well-being (Adams & Stickley, 2019).

Art therapy that is used to treat those with substance use difficulties can broadly be divided across two recovery models: the 12-step model and the Stages of Change model (as described earlier). Therefore, another reason for choosing the Stages of Change model, is that studies which consider art therapy in British literature predominantly consider its use in line with this model. In comparison with studies produced in an American context, which generally consider the 12-step model (Horay 2006). As this research is being undertaken in a British context, the Stages of Change model is appropriate. Art therapy has also been explored as a sympathetic approach to implementing the principles of Motivational Interviewing, which has close links with the Stages of Change model and will be discussed further in chapter 5.0.

The Arts and Humanities Research Council (AHRC) Cultural Value project found that participation in the arts can provide aesthetic detachment, which allows individuals to be more reflective. This reflection facilitates an:

> "...improved understanding of oneself, an ability to reflect on different aspects of one's own life, an enhanced sense of empathy...". (AHRC, 2016 p42).

Creative exercises can also be very simple and still therapeutic, as the participant does not have to make too many decisions, it focuses the mind quickly on a single activity. During this type of activity participants can inhabit the 'flow'. However, the activity itself must be pitched to a group of participants at the right level. In order to be in the 'flow' and be engaged with the activity, it must be challenging enough to not be boring but also not too challenging that it causes

anxiety in participation. If pitched at the correct level then the activity can be beneficial and enjoyable to the participant (Csikszntmilhalyi, 1990).

Fields such as counselling use a variety of tools which try to increase emotional language and attempt to help clients widen their emotional vocabulary (P2. S1.SSW14). This is where employing a creative process can help clients to express emotions in different ways. As progress in recovery occurs when individuals see their situation from different angles, to gain a fresh perspective on habitual ways of thinking (P2.S1.SSW14); (P3.SA8.SW1.1). Using creativity in recovery is therefore a more individual approach compared to the more standardised traditional assessment and treatment methods (P2.S2.SSW9) and having more individualised treatment helps service users feel that they are not 'lost in a big system' (P2.S2.SSW10).

Participation anxiety is another element to consider, as to reduce uncertainty and anxiety in participation, the process should have a resemblance to existing support work. Otherwise, the concepts of the activity might be too different to easily grasp and increase uncertainty. This research study is working with a marginalised recovery group. This is a group of individuals which may have not previously experienced opportunities to show their creativity. In this instance they will benefit more from an activity which is of high quality but where the level of artistic quality in the output is less important. This is a central part of art therapy, as when emotions and feelings are investigated through creativity, the work produced is not expected to be aesthetically competent or intended to be exhibited or shared outside of the therapy space (APPG, 2017).

Social prescribing is where individuals are referred to link workers by their GP, who spend time helping people to concentrate on what matters to them through a holistic approach. People are then signposted to services and community organisations for emotional and practical help (NHS, 2021a). Arts groups focusing on participation in creative practice are an example of the type of

activity which can be socially prescribed. Social prescribing is part of a focus on 'Universal personalised care', which in the NHS Long Term plan aims to make personalisation mainstream in healthcare and social care by 2023/24 (NHS, 2021b). A challenge with implementing social prescribing is that it sits between clinical treatment and social activity. Therefore, it can be problematic in terms of recovery organisations being satisfied that patient safeguarding procedures are being met by those undertaking the sessions (APPG, 2017). That being said, artists often work therapeutically in community settings and even though these sessions are not undertaken in a clinical environment, artists and community workers are generally trained to ensure safeguarding of participants (APPG, 2017).

Social prescribing is becoming a national priority for the NHS in England. However, whilst there is evidence that social prescribing is effective and being used in some GP surgeries and healthcare facilities, there is a lack of awareness regarding the availability of these activities. The majority of GPs are still not aware that they can draw on them to support their patients. Activities involving the arts are also not emphasised in current guidance. NICE guidance, for example, advocates psychosocial interventions (for example, cognitive behavioural therapy for mental health issues) but no arts interventions are suggested as psychosocial interventions for the treatment of mental health issues (APPG, 2017). Another key point to note is that NICE guidance does not suggest participatory arts or arts on prescription as a recommended method to work with clients in recovery. This suggests a lack of long term clinical research into its effectiveness, even though the benefits are widely acknowledged and reported in the field (APPG, 2017).

Another aspect of employing creative techniques is the importance of playfulness The encouragement of creativity and play in society was a key concept advocated by the situationists (Plant, 1992). Situationist concepts were drawn on by Bill Gaver and his colleagues for developing the original concept of cultural probes,

which became a central method in this research (discussed later in the existing engagement tool review, chapter 5.0). The inclusion of creative elements, therefore, appears to be a logical extension and development of the research activity from a cultural probe starting point. As the ludic and playfulness extends to how individuals explore the world, build relationships and find valuable and meaningful activities to participate in (Crabtree et. al, 2003).

The use of arts interventions, which relate to mental health issues, is an area which is extensively researched (Adams and Stickley, 2019). However, there are very limited occurrences in the literature generally, referring to group interventions which are targeted at individuals who are suffering from substance use issues. Although the benefit of being creative in recovery from substance use is gradually being presented more in mainstream recovery publications such as Drink and Drugs News (SteelDoorStudios, 2021). Therefore, this is an area which in contrast to the mental health field is not widely researched (Adams and Stickley, 2019). This highlights a gap in existing research and is one aspect being addressed by this research PhD.

2.7 Confidence and self-esteem

A significant challenge in mental health and substance use recovery is dealing with low self-esteem and building confidence, which can be slowly eroded through years of difficulties. The stigma attached to the use of illegal drugs is a key contributor to the low self worth felt by those in recovery (UKDPC, 2010). Building recovery capital, as described previously, is an established method of building confidence both in an individual's self-worth and in their ability to continue their recovery long term.

Building recovery capital is a method for helping individuals to rebuild their lives in recovery and increase the likelihood of sustaining recovery. Especially when participants are successful in improving their human capital, as this can be a catalyst for increasing confidence (Laudet, 2007). Another way is building

social capital, which can assist successful recovery. This can take place through helping social networks to develop and solid networks of support are often forged through mutual aid and community groups and renewed friend and family connections, outside of the scope of formal treatment (Pascoe and Robson, 2015). All of this activity assists in building confidence both individually and socially confidence, helping to re-integrate into society.

The focus of Voices of Experience (Hough and Rice, 2011) is street drinkers, who have a unique set of challenges, which include mental health issues and entrenched drinking. When consulted during the project this group considered that their self-confidence and self-esteem was gradually lost, and some respondents were particularly self-critical. The authors suggest this is a consequence of both stigma and a sense of personal failure. As one participant described:

> "I just feel like I'm an empty dustbin really [...] At the moment I don't feel up to doing anything, even though I know I've got to do something. [...] haven't got no get up and go, no motivation. And I've got no confidence, my confidence is shattered." (Hough and Rice, 2011)

The project found that respondents "...wanted to 'do things'..." (Hough and Rice, 2011 p18) and felt this could assist with their recovery, however, a barrier was their lack of confidence and motivation levels. The project also found that having meaningful activities available to help fill days was a key contributor to individuals being able to sustain their recovery over extended periods of time. There was also a feeling from the respondents that meaningful activities were in themselves a confidence builder, especially after achieving things which they could feel proud of (Hough and Rice, 2011). The use of creative methods in recovery can be used effectively to boost self-esteem and increase confidence, as another of the participants of Voices of Experience suggested:

> "Painting, photography, poetry – anything that allows you to sit down and express your feelings can only be good [...] Seeing your name in print, it's an ego boost, every time. It's the recognition. Especially when you spend 70 per cent of your time sitting in the doorway, swinging Special Brew or cider. You spend a large proportion of your day being looked down on by society and then suddenly you find that you can express yourself and not only can you express yourself and get it down, you're getting recognition for it." (Hough and Rice, 2011 p45)

Boosting participants' self-confidence is one aspect of recovery, however, building 'Creative Confidence' is a separate endeavour and is defined by Kelley and Kelley. Their writing describes how most people are born creative but lose this natural ability through their engagement with society as they grow older. The authors suggest that undertaking formal education makes people more cautious and analytical, which results in many people simply being content with being 'non-creative types' (Kelley and Kelley, 2012).

They suggest four fears, which if overcome, can lead to being more creative with projects and ideas:

1. Fear of the messy unknown

This is described as the fear of getting out of your creative comfort zone into the messy 'real world'. This is a space which is much more unpredictable but where "you find insights- and creative breakthroughs" (Kelley and Kelley, 2012 p3). The authors suggest that allowing yourself to venture out of your creative comfort zone will allow you to access these insights and creative breakthroughs.

2. Fear of being judged

This is the fear of coming forward in discussions, "sticking with safe solutions or suggestions" and "allowing others to take risks" (Kelley and Kelley, 2012 p4). The authors suggest that this can be overcome by taking small steps, each time

being willing to follow ideas and to listen to your own intuition rather than being concerned about what others will think.

3. Fear of the first step

This is a fear of beginning a new journey and deviating from established working patterns. The suggestion to overcome this fear is to take a very small first steps, which will be less intimidating. As, if you encourage yourself to take one very small step towards an idea, immediately you are more likely to make progress when compared with "stalling and allowing your anxiety to build" (Kelley and Kelley, 2012 p5).

4. Fear of losing control

This is a fear of abandoning your own idea, to instead accept an idea from another person. Sometimes to achieve the highest creative gains, this control needs to be relinquished to collaborate with others and embrace their ideas (Kelley and Kelley, 2012).

Establishing innovative ways to build confidence generally, alongside creative confidence, is important as finding employment is one of the main goals for those who are able to continue their recovery long term. As, service users can also experience a fear of failure, low self-confidence and have low expectations in terms of finding employment following recovery, as highlighted by the Interventions Unit (Interventions Unit, 2001). One of these methods is service user involvement, as previously described. Service user involvement has several important outcomes and a key one is that it has been shown to increase confidence in service users (Neale et. al, 2006). Service user involvement and becoming peer supporters is one way that those in recovery can build confidence and enter employment.

2.8 Peer support recovery groups and communities

Peer support as an approach is highlighted as "...an essential component of effective recovery..." (HM Government, 2017 p34) in the 2017 UK Drugs Strategy, and it suggests that peer support should be available before, during and after involvement in structured treatment. The strategy also highlights the fact that mutual aid groups are well evidenced in their effectiveness and that mutual aid and peer support can help to both maintain and extend progress made in formal recovery treatment (HM Government, 2017).

The focus of peer support is on people and how they relate, which diverts the focus from institutions and services. This helps to give value to all who are involved in the process, including patients, and it facilitates individuals taking:

> "...control of their own health, gaining confidence and self–respect through supporting others and building stronger social connections through friendships and mutual support." (Nesta, 2013 p6).

As such, peer support has become a well-tested element of social care and it can form the structure of social connections with family, support workers and the wider community, which is understood to be beneficial to well-being (Nesta, 2013).

As an asset based approach peer support concentrates on the abilities of individuals rather than their perceived shortcomings. In this way peer support is a recovery model focused on how well individuals are able to cope and it has a hopeful emphasis towards the future, instead of the traditional focus on problems and associated symptoms (Repper & Carter, 2010). Individuals see the negative experiences they have suffered and they realise that this experience can be used to help others through peer support (P2.S1.SSW11).

Peer support as a practice is not a new phenomenon, it has been in use successfully for many years through groups such as Alcoholics Anonymous (Nesta, 2013). Such groups are examples of the developing recovery movement, as described previously. Other examples include: residential recovery homes, recovery community centres and recovery colleges (White et al., 2012). However, whilst in use a long time, peer support interactions can still be considered peripheral to 'medical care' and the process of using peer experiences, whilst becoming more widely adopted, still remains an underused resource (Nesta, 2013).

There are many residential rehabilitation centres in which individuals voluntarily choose to live alongside others in recovery and support staff, which provide both professional and peer support. These are also referred to as 'therapeutic communities' (Jhanjee, 2014) and it is these residential programmes which are the context for the three Pilots in this study. One challenge associated with therapeutic communities is that often remaining abstinent from substances is a requirement to remain in the residence. However, abstinence can cause psychological difficulty as the substance is no longer available to 'mask' psychological symptoms. Therefore, in these instances a strategy of harm reduction may be more appropriate for those with combined conditions (Hill, Penson and Charura, 2016). These communities are generally closed groups, however, recent documentaries such as Netflix *Recovery Boys,* provide a first hand view of the power of peer support and value of alternative approaches to recovery. In this case individuals formed a close recovery bond in a residential programme based on living and working on a farm (Netflix, 2018).

The beneficial use of creativity and the visual arts was discussed previously. Group arts activities can help facilitate peer support and there are several key studies identified by Adams and Stickley (2019) in their recent review of studies involving group art therapy. They found that all the reviewed studies provided a way for participants to share their experiences. They also highlighted how art

therapy could help individuals become more aware of their addictions (Feen-Calligan, 2007; Hanes, 2007), recognise ambivalence (Holt & Kaiser, 2009; Hong, Guo, Huang & Yin, 2017), provide a distraction for substance use (Hong, Guo, Huang & Yin, 2017) and could be beneficial where talking based therapies had failed (Skeffington & Browne, 2014). One key study involves the use of art therapy in assessment, to help the therapist to understand how to work with clients to have the best motivation to pursue long term change (Klingemann & Klingemann, 2016).

When group arts are used to engage those in recovery, the important factors in terms of the interaction are: being able to produce a piece of work, taking part in a group and through the development of trusting therapeutic relationships, rather than involvement in any specific type of creative activity. The opportunity to discuss the work produced helps to define the point that participants are at in their recovery stage and to explore ambivalence towards making changes, which links to the themes of Motivational Interviewing (described in chapter 5.0). Therapies based on group arts activity provide an alternative way to bring to light challenging feelings, at a pace which can be more comfortable and accessible than talking therapies. A facilitator can help support participants and the group can support each other to help vocalise what these feelings are and gently bring them out for discussion. These arts approaches can help to counter stigma and social exclusion, whilst helping to identify new ways that those in recovery can be assisted to move back into the community (Adams and Stickley, 2019).

Therefore, activities that use the approach of group visual arts activities to facilitate peer support with participants, have been identified as a valuable activity for those in recovery, which will be drawn on in this research project. There is an opportunity to integrate the use of arts participation (through groups arts) with the peer support of individuals, as described above.

2.9 Traversing boundaries

As described in context and introduction (chapter 1.0), designers are increasingly working in new fields, especially in healthcare. This is an example of professionals traversing the boundaries of their field to collaborate with others. However, there are two other important situations where professionals cross boundaries to open up new avenues, which are relevant to this project. Firstly, the shared outlooks of social care professionals and designers, which provide opportunities for collaboration and secondly, individuals working across interdisciplinary boundaries in recovery settings.

Occupational therapists share many of the goals that key workers and support workers have in working with service users in recovery. As with arts participation therapists working in social care, occupational therapists also traditionally value the use of creative practice in their process. Occupational therapists themselves view their profession as creative due to the requirement for finding new ways to adapt existing methods to help personalise recovery methods. However, due to the mainstream clinical focus prior to the recent developments in a recovery model, creative practice in occupational therapy has declined greatly (Schmid, 2004).

There are also similarities between the approaches of occupational therapists and designers. With significant opportunities for collaboration existing. Both professions should "...take notice of natural entry points that invite collaboration and initiate joint activities." (Wagenfeld, Reynolds & Amiri, 2017 p189). Whilst the potential exists, in reality collaborations of this type are rare, caused by few opportunities existing for participants in the two fields to meet and also to a limited understanding of each other's roles (Wagenfeld, Reynolds & Amiri, 2017). One recent example of a successful collaboration between health care professionals and designers, was to deliver arts based co-creative projects in a healthcare

setting. This took place by empowering health care staff to work creatively with patients through designed materials (Sanin, J., Spong, L. & McRae, C., 2021).

The therapeutic relationship between individuals in recovery and support workers is evidenced to be a significant catalyst for improved recovery outcomes and these interactions can have a therapeutic effect and therefore could be considered as therapy in itself. This is therefore an important consideration when discussing traversing boundaries. Seldom is any specific training actually provided to support workers in communication skills. This applies across different healthcare settings but is particularly relevant to mental health. Whilst there is little research into interventions which can help build the connection between clinician or support worker and patient, that which does exist shows positive outcomes. Evidence also points to strong relationships increasing engagement of individuals with sessions and adhering to suggested treatments.

There are three distinct aims of these relationships:

1. Engagement – Whether the patient keep coming back to the sessions.
2. Adherence – Once engagement is achieved, will the patient adhere to treatment suggestions.
3. Behaviour change – Once treatment is established, will the interventions lead to behaviour change.

There is strong evidence for good therapeutic relationships positively effecting the first two points but less on the effect of the relationships on the third point (Priebe and Mccabe, 2008). It is considered that the therapeutic relationship is key to positively impacting the lives of those with mental health problems. The significance of this relationship is expressed by service users, who value professions who nurture this relationship. Therefore, creating a genuine emotional connection in these interpersonal relationships can help facilitate positive outcomes and inspire individuals to work towards their personal recovery goals.

Another group traversing boundaries are artists working in social care, which can be described as 'boundary spanners'. Artists work in a wide variety of environments, including mental health and substance use recovery organisations. It is in these contexts that artists, like designers, are required to build trust, develop relationships and negotiate complex power structures involving many different stakeholders. Artists who work successfully in this manner are able to make connections between stakeholders and also identify potential weaknesses in established structures (Matarasso, 2019). However, artists working in this way can often find themselves in an isolated position, as there can be the impression that their work is supplemental to clinical provision and therefore they have little influence on the structures they find themselves working within (Daykin, 2019).

These types of interactions are often described as 'boundary work' and whilst much of the evidenced work of this type exists within healthcare organisations, it also occurs in the community through arts organisations (Daykin, 2019). Working in these settings as boundary spanners can be complex with "...roles including knitting disconnected people into community life, mediating and connecting marginalised participants with health and care services, and intervening to prevent the escalation of conflicts." (Daykin, 2019 p14-15). As such, there are significant benefits to this activity, which include facilitating arts interventions that can enhance social connection between participants (Daykin, 2019).

Whilst the above describes the work of individuals who cross boundaries, objects can also perform this role. Known as 'boundary objects', these could, for example, be the records of patients. As these records can have different meanings depending on who interacts with and interprets them, which is a key component of boundary objects (Cramer et al., 2018). Boundary objects which achieve their aims are considered to assist different users as they foster conversations and new insights as the object travels between stakeholders (Akkerman & Bakker, 2011).

Therefore, significant opportunities exist for collaborations between individuals in different disciplines, especially between designers, support workers and artists. There are also opportunities for stakeholders to come together through the use of designed 'boundary objects'. These are two themes which will be explored further in the following research.

2.10 Conclusion

This PhD research aims to build on the ideas and opportunities outlined in the above review, which will be achieved through the development of an intervention which draws on this existing literature and combines these ideas with new approaches developed through this research. To take the key ideas forward, three themes have been identified following this review:

1. Communication
2. Creative vs Clinical
3. Collaboration

Communication

Providing participants with the opportunity to communicate their recovery story in a unique creative way can develop a platform to build confidence, be empowered and feel valued. Participant involvement in a peer support process, can allow participants to communicate their ideas whilst being involved and supported. It is important to focus on the service user voice through building on the increasing level of user consultation and agency in the recovery fields over recent years.

Communication can also take the form of how services communicate with users and also how service users develop strong levels of trust and communication with their support workers. This aspect of communication can be assisted via

methods which encourage building recovery capital and through participation in creative activities, as discussed. This is a point which will be explored in more detail in the existing engagement tool review (chapter 5.0).

Clinical to Creative

More established recovery methods and systems traditionally have more 'clinical' evidence underpinning their use. This can cause tension or scepticism in settings where these methods are used if new ideas are introduced, for example, creative recovery techniques or design methods being used in healthcare settings. Therefore, a new intervention will need to work within and support the established recovery concepts (such as the Stages of Change model, Motivational Interviewing or Recovery Capital) and bring in novel concepts, which are becoming increasingly recognised as beneficial to recovery (such as user-centererd approaches and creative participation). This will help to ensure that an intervention is practically applicable by support workers, specifically in the maintenance stage of Stages of Change and the recovery sub-system of the Whole Person Recovery model. Providing a creative element to an intervention should help participants to build their creative confidence, through creative practice and group support.

Collaboration

Collaboration is important in a variety of ways and the level of service user collaboration with support staff and peers is often increased through encouraging good communication, as discussed above. Collaboration between services (for example between substance use and mental health support) can be lacking in practice. Therefore, effective collaboration between these two separate fields must be improved if a shared model of recovery can be achieved. Working across interdisciplinary boundaries effectively will be essential for this research, where designers and creative practitioners will be working together and with professionals in the healthcare field.

An intervention should help participants collaborate with peer supporters and allow space for sharing experiences with others. This will be through activities based on creative practice or co-design work. This is where the concept of boundary objects is interesting, as a way to design a meaningful and supportive intervention, which encourages collaboration (and communication) between participants, peers, support professionals and designers.

3.0 Empirical Method

This chapter outlines the development of a research methodology to investigate the use of design methods in the iteration of a recovery intervention. The study design for each stage will be discussed in more detail in the chapters for the individual research experiments. However, below will set out the general methodological and theoretical framework underpinning all the experiments conducted.

3.1 Four elements of the research process

The research process involves four elements which are followed as a basis for identifying and justifying the use of the methodologies and methods employed. It is critical that the methods chosen through which to conduct the research are capable of assisting the researcher in answering the research question. (Crotty, 2003). The selection of these methods also touches on "...assumptions about reality that we bring to our work..." (Crotty, 2003 p2). To define these assumptions the researcher must determine a theoretical perspective, which is the philosophical stance which informs the methodology. In turn this theoretical position is informed by epistemological questions, which constitute: "the theory of knowledge embedded in the theoretical perspective and thereby in the methodology." (Crotty p3). It is therefore important that a researcher presents the stance taken in their research in terms of the acquisition of knowledge and ascription of meaning (Crotty, 1998). Therefore, illustrating clearly the research process via these four elements will: "constitute a penetrating analysis of the process and points up the theoretical assumptions that underpin it and determine the status of its findings." (Crotty, 1998 p6).

3.2 Epistemology

Epistemology, as Maynard (1994, p10) explains: "is concerned with providing a philosophical grounding for deciding what kinds of knowledge are possible and how we can ensure that they are both adequate and legitimate" and is

also: "how we know what we know'" (Crotty, 2003 p8). There are several epidemiologies, which each have a different perspective on meaning and truth when considered in terms of how human beings relate with the world.

This research study follows a constructivist epistemology. This epistemology maintains that there is no objective truth which exists separately to consciousness. As such, truths and meaning are constructed through engagement between the mind and the world. Different individuals may construct meaning in differing ways, which can be observed when considering different cultures, and in this view the subject and object construct meaning together. Through maintaining a constructivist position, means that this study rejects other epistemologies. For example, objectivist episiotomy is rejected as this posits that meaning exists independently of the human mind or consciousness (Crotty, 2003).

3.3 Theoretical Perspective

As a researcher we bring to the research various assumptions to the methodology that is chosen. It is through identifying the theoretical position that we can attempt to state what these assumptions are in terms of the pursuit of knowledge. (Crotty, 2003)

This research study follows a constructivist conception of meaning generation and consequently takes an interpretivist theoretical perspective, which looks to explore human and social realities (Crotty, 2003). As mentioned above, this contrasts with a positivist approach, which to understand the above would: "... follow the methods of the natural sciences and, by way of allegedly value-free, detached observation, seek to identify universal features of humanhood, society and history that offer explanation and hence control and predictability." (Crotty, 2003 p67). Therefore, this study in following an interpretivist position: "...looks for culturally derived and historically situated interpretations of the social life-world." (Crotty, 2003 p67).

The interpretivist position in the research study relates to the concept of symbolic interactionism. Symbolic interactionism has a central notion of "...putting oneself in the place of the other..." (Crotty , 2003 p75). And as Denzin (1978 p99) states:

"Methodologically, symbolic interactionism directs the investigator to take, to the best of his ability, the standpoint of those being studied.".

As such, symbolic interactionism is just that, role taking as an interaction which is symbolic. The symbols, for example, language, are those which human beings have in common and communicate via. By adopting a symbolic interactionism perspective this study maintains that the development of meaning is generated through social interactions and cultural immersion.

This study also considers a new understanding of phenomenology, as discussed by Crotty (2003, p83), as an "effort to identify, understand, describe and maintain the subjective experiences of the respondents.". This relates directly to symbolic interactionism in terms of: "...putting oneself in the place of the other..." (Crotty, 2003 p83).

It is through the empathetic consideration of participants perspectives that allows: "...an exploration, via personal experiences, of prevailing cultural understandings." (Crotty, 2003 p83). As such, symbolic interactionism is also rooted in pragmatist philosophy which is described by Rescher as follows:

"The characteristic idea of philosophical pragmatism is that efficacy in practical application-the issue of 'which works out most effectively'-some-how provides a standard for the determination of truth in the case of statements, rightness in the case of actions, and value in the case of appraisals" (1995, p710)

Social interactionism also draws on ideas of research methodologies developed in cultural anthropology, specifically ethnography. The central element to an

ethnographic approach is '...putting oneself in the place of the other...', as highlighted above (Crotty, 2003). An ethnographic approach is summersied by Hammersley, as follows:

"...ethnography is a form of research in which the social settings to be studies, however familiar to the researcher, must be treated as anthropologically strange; and the task is to document the culture-the perspectives and practices-of the people in these settings. The aim is to 'get inside' the way each group of people sees the world." (1955 p152).

This approach and the philosophical underpinnings of the descriptions above, provide the framework in which this research study is being conducted. The aim is to understand the different ways that participants in the research make sense of their situation in recovery and to view this through their perspective. The research is also conducted in a pragmatic fashion, an approach which is aligned with the use of a design process framework, to structure the development of an intervention, which is applicable to real world application. Through this adopted theoretical perspective, the cultural context in which the research is being undertaken is therefore acknowledged as having an influence on the study.

3.4 Emergence of the research methodology

The research methodology is developed from the epistemology and theoretical perspective of the researcher, as defined above. This position influenced the decisions in identifying the methodology and methods used. The overriding focus in the choice of these methods was to conduct the research from an empathetic perspective and to investigate the problem from the point of view of the participants and engage them in the research. This accounts for the choice of Participatory Action Research to guide the project and cultural probes as a primary data collection method (discussed in more detail below).

The methodology developed into three initial Design Experiments alongside a critical review of existing literature, which evolved as the project was developing (Fig. 3.1-1). These initial experiments were intended to prototype ideas for interventions, which were initiated from discussions with key stakeholders in the recovery field. As identified in the context and introduction (chapter 1.0), design methods have the potential for use in this area and were explored through these initial experiments.

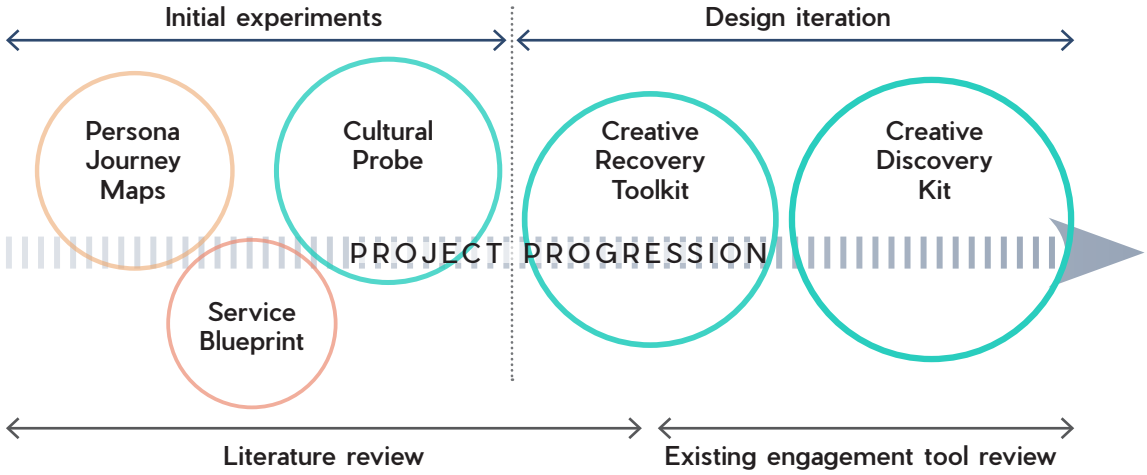

Figure 3.4-1 Project overview diagram

The methodology was developed through the consideration of the following three points:

1. Considering the context of recovery interventions explored through a critical review of existing research and practice.
2. Conducting three initial Design Experiments to identify one to develop further into a novel design-led intervention.
3. The piloting and iteration of a toolkit developed directly from the chosen experiment (Cultural Probe) to produce data.

3.5 Design-led approach to research

The initial experiments provided the opportunity to develop outline proposals to begin working in the recovery field. This assisted in the development of an approach which would be appropriate in this context. Through these experiments design techniques from a wide variety of design disciplines were explored, including to varying degrees the following:

- Graphic design
- Interaction design
- Communication design
- Product design
- Service design
- Critical / speculative design

It rapidly became apparent during the early interactions with stakeholders, that a limited understanding of the breadth of the applications of design methods was a potential barrier to collaboration. As discussed in the context and introduction (chapter 1.0), a level of scepticism of design methods was also experienced. Therefore, as the initial experiments were developing, a focus was paid to the more practical design approaches, including: graphic, product, service and communication design, rather than more speculative approaches. As the innovative nature of this approach needed to be balanced with the need for the method to be accessible to both stakeholders and participants, who may have little understanding of the use of design methods. An approach which was more speculative, abstract and difficult to grasp the potential benefits of quickly, may have put the research at a disadvantage, as stakeholders would be less likely to engage with the ideas of the project. As stakeholders, with time pressures and large case-loads, would be less likely to engage with a project if the potential

benefit to their clients was not clear. This balancing of innovative and established concepts was part of the key consideration that, rapidly building trust with stakeholders was essential to the success of the research.

During the delivery of the initial experiments, challenges were faced due to the difficulties outlined above, which severely limited the amount of formal feedback which was received. Informal impressions were offered by stakeholders, which were then used to inform the choice of the experiment to continue developing. This could be partly explained by the time pressures on staff to respond to queries which would take focus away from working with clients. As a researcher I was reluctant to request that early meetings were recorded for the research, due to the meetings being considered a single chance to make an impression and that this request could be off-putting to respondents, who may in time become integral to the research.

3.6 Participatory Action Research (PAR)

As discussed in the literature review (Chapter 2.0), co-design and co-production are guided by the idea of co-creation as an overarching principle. These design-led methods can be described as specific PAR-type methods (Vargas et al., 2022). Engaging stakeholders in the design and delivery of public health initiatives can be considered to fall under the umbrella of Participatory Action Research (PAR) (Schneider, 2012).

PAR projects have several common factors, which align with the intentions of this research project, as defined by McIntyre (2008):

1. A collective commitment to investigate an issue or problem.
2. A desire to engage in self- and collective reflection to gain clarity about the issue under investigation.
3. A joint decision to engage in individual and/or collective action that leads to a useful solution that benefits the people involved.

4. The building of alliances between researchers and participants in the planning, implementation, and dissemination of the research process.

PAR is different from more established research approaches for the following reasons:

1. A focus of PAR is designed to enable action. This is achieved through cycles of reflection of the researcher and participants, with further research and reflection conducted in iterative cycles.
2. PAR is concerned with the power dynamics which exist in research and aims for power to be shared between researcher and participants. Therefore: "...blurring the line between them until the researched become the researchers." (Baum, MacDougall & Smith, 2008 p854).
3. PAR advocates that those being researched in the process are active rather than passive, in contrast to more traditional methods of health research (Baum, MacDougall & Smith, 2008).

It is through engaging in critical dialogue and collective reflection that individuals participating in PAR see that they have a stake in the project. This is where PAR develops in to a dialectical process. This is a process which changes both the researcher, participants, and the situations in which they are in (McTaggart, 1997).

PAR contrasts to other more traditional approaches to research in public health, as it helps to: "...consider ways to listen and respond to the voices of people who had previously been silent in healthcare." (Koch & Kralik, 2006). As such, PAR facilitates the 'participation' of individuals in a research process, in contrast which them simply being 'involved' in a project (McIntyre, 2008). In the 21st Century PAR is becoming increasingly used and evidenced in the sphere of public health research and crucially in mental health research projects (Baum, MacDougall & Smith, 2008).

PAR as a methodology can be seen as differing fundamentally from a positivist theoretical perspective that views the world as a single reality, which could be scientifically measured and observed, for example under strictly control laboratory conditions. In contrast PAR identifies that: "...the observer has an impact on the phenomena being observed and brings to their enquiry a set of values that will exert influence on the study..." (Baum, MacDougall & Smith, 2008 p854). This stance is in line with the description above of this research epistemology and theoretical perspective. As such, PAR was chosen as a methodology and framework to drawn on as it is compatible with an interpretivist theoretical perspective. As touched on above, this study aligns with the new perspective of phenomenology as defined by Crotty (2003). PAR therefore makes use of phenomenologist's work who:

"...expand the breadth and importance of experience when they argue that humans cannot describe an object in isolation from the conscious being experiencing that object; just as an experience cannot be described in isolation from its object. Experiences are not from a sphere of subjective reality separate from an external, objective world. Rather they enable humans to engage with their world and unite subject and object." (Baum, MacDougall & Smith, 2008 p856).

It is through the framework of Participatory Action Research that this research was conducted. Alongside the reasons outlined above, PAR was selected as an appropriate methodological framework to this research project due to the following features which align with both the theoretical position of the researcher and the context in which this enquiry was conducted:

1. As action research the methods are embedded in the community to promote change.
2. Iterative cycles of reflection
3. Sharing of power dynamics between researcher and researched
4. Participants are active in the research process

3.7 Practice-led research

This research can be considered as 'practice-led' in nature, as the research is primarily concerned with design practice and advancing knowledge within that practice (Candy, 2006). Within the context of this project it means that the research methodology was designed to lead to the following:

1. Advancement in knowledge in the design discipline with a focus on the use of cultural probes as a base method to advance into a new domain.
2. Discover new methods that designers could use to collaborate effectively on shared aims with professionals in social care.
3. Raise awareness of design in a new field with the application of methods and to translate design ideas to reach new audiences.

As a practice-led design researcher, research is undertaken which is primarily concerned with producing innovative creative outcomes, as opposed to only text-based output (Candy, 2006). The focus from the beginning of the project was on using the interaction with users to directly inform the design development of a practical intervention. By approaching the problem through the lens of design meant that techniques such as co-design were understood from the outset to be powerful ways to engage users and support staff in the process. This ensured that lived experience was drawn on and made a critical element of the design research process.

3.8 Design process framework – Double Diamond

The framework for using a design approach in this research followed the Double Diamond process (Fig. 3.4-1), as promoted by the Design Council. This approach uses four distinct phases: Explore, Reframe, Create and Catalyse. Alongside these central stages to the process there are wider strategic areas which feed into the Double Diamond. As a framework, the Double Diamond is structured

but also flexible for designers to work within to undertake a design project. This theoretical design framework was used to guide the design process undertaken during this research study and how the different stages were used to inform and develop the project will be described in more detail below.

Prior to beginning the first point of the first diamond in the process, there is a strategic stage called *orientation and goal setting*. This is where the outlook for the project is defined and where a designer's influences and values begin to influence the design process. In the case of this project it is the value as a design researcher that was placed on using a user-centrerd, empathetic approach to the project, as previously defined in the introduction, which was the starting point for the design element of this project. These same values of the researcher influenced the choice of an interpretivist approach and the selection of PAR as a research methodology, as outlined above (Design Council, 2021).

The project then followed the first two phases of development which were aligned to the Double Diamond process:

1. *Explore phase*
   During this initial phase of the Double Diamond, work was conducted to discover more about the issue being considered and explore different potential solutions. This exploration involved the beginning of the literature review for the project. This stage also included the initial interactions, meetings with stakeholders and the piloting of the initial three Design Experiments (Persona Journey Maps, Service Blueprint and Cultural Probe). This stage was used to address research objective 1 (Design Council, 2021).

2. *Reframe phase*
   Here the work from the Discover phase was synthesised to shift perspective by re-framing the issued based on what was learnt through the explore phase. This work led to the definition of the overall research aim and objectives and

the methodology for conducting the research was developed for the final two prototyping phases. This stage also involved completing and using the knowledge gained from literature and existing tool reviews, to help define and converge towards a fixed design research brief. (located at the centre of the two diamonds in the process) (Design Council, 2021).

Radiating out from this central point in the process and actually spanning the entirety of the project were two further strategic stages which informed the design process. Firstly, *connections and relationships*, a stage which continued throughout the project. Here the strategy was to maximise a collaborative approach as determine which stakeholders and gatekeepers to build relationships with, to achieve the aims and overall objective of the project. This strategic stage involved working closely with service providers and service users, to build trust and draw on professional expertise to successfully undertaken the design research.

Secondly, another strategic stage spanning the entire project was *leadership and storytelling*. This stage involved promoting the research activity and effectively communicating the project to stakeholders and participants. This stage is strongly connected to connections and relationships, described above. Here the research was promoted at a variety of academic events and also crucially within support services, communicating directly with service users.

This stage was particularly important for me as a developing researcher. I am not a natural leader, storyteller or relationship builder. As such, I had to work particularly hard on these two stages, to ensure the success of the project. This was made more challenging as a design researcher working in a new field, especially one where relationships had to be built quickly due to the pressures on the stakeholders and service users, who it was desirable to engage with. This meant regularly moving outside of my comfort zone to conduct the research. However, I really grew as a researcher through this

precess and feel I developed as a leader, working in on a new line of design and research enquiry.

Following the definition of the project design brief over the two phases in the first diamond, the primary data collection began with Pilot studies (II) and (III). This led into the two stages of the second diamond.

3. *Create phase*

This phase is another divergent phase where design ideas are implemented and tested. This was where the Toolkit was iterated in two stages of development through testing with participants following the successful Pilot of the Cultural Probe. After each stage the Pilot was reviewed and re-designed to be delivered again, learning from the previous data and feedback collected (Design Council, 2021).

4. *Catalyse phase*

The aim for this phase was to come to a design solution which meets the project brief. This was delivered via iterating the design for a final time after feedback and data was reviewed from the last Pilot (III) study. This Toolkit was then prepared as a final version for inclusion as a finished product within this thesis and for further use with participants in the future (Design Council, 2021).

The final strategic stage in the Double Diamond framework is called *continuing the journey.* This stage starts as the final design product is finished and as a reflection begins to take place on how the design works in practice and how it might be disseminated and developed going forward. This reflection on the design takes places in the conclusion chapter of this thesis.

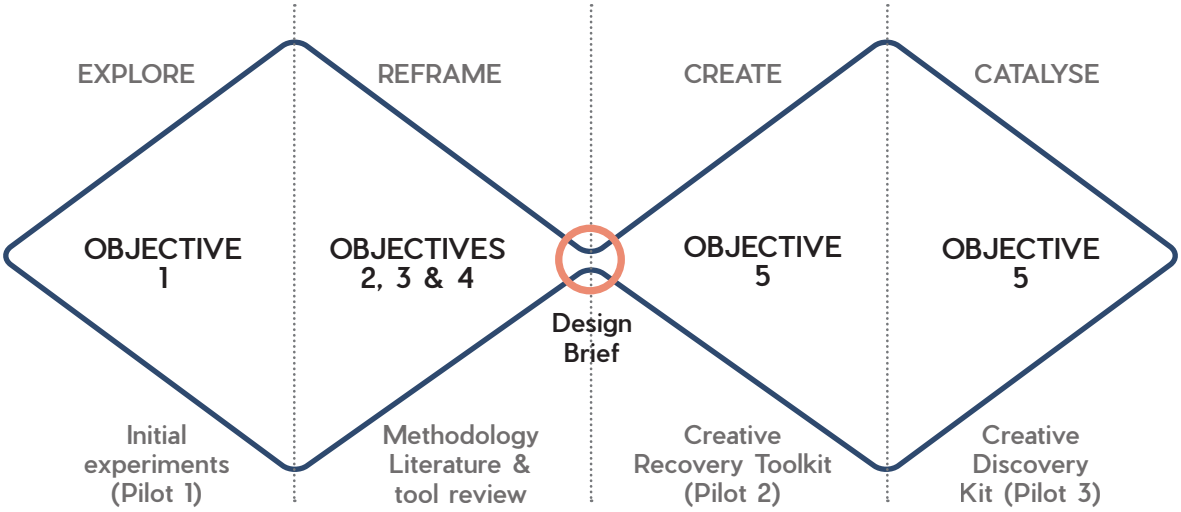

Figure 3.8-1 Classic Double Diamond process

3.9 Emergence of a recovery tool

The initial Cultural Probe experiment was implemented as an engaging approach in a sensitive setting to collect data, from those currently in recovery. Analysis from this activity highlighted the potential for a dedicated recovery tool to be developed, based on the original principles of a cultural probe, which was used initially in the 'traditional' way that cultural probes are generally deployed.

The elements that make the cultural probe effective as a research tool are also those that give it potential as a recovery tool, these include:

1. It is an auto-ethnographic approach (personal reflection) rather than using traditional ethnography (reflecting on other's behaviours), which was considered more appropriate in this setting.
2. As a tool it is self-contained, with all the equipment provided.
3. The tasks are finite in length and provide variety for the participants.
4. It provides an engaging activity which is different to the normal daily activities in recovery.
5. The process is straightforward and easy to complete.

A cultural probe is used to elicit information from participants of a distinct group, to understand them and to highlight opportunities for design interventions. Therefore, an adapted cultural probe was anticipated to enable participants to discover insights about their own habits and uncover information to help them design their own recovery, in the manner of conducting research on themselves.

It was essential at this stage to understand the context in which a tool would sit in terms of similar interventions. Therefore, to develop a recovery tool as a product, a thorough review of existing recovery engagement tools was undertaken (chapter 5.0).

Following this, to then develop and iterate the design of a dedicated recovery tool, the Cultural Probe was developed via two further direct Pilots with participants. Through these Pilots the tool was iterated with feedback from the participants and support staff used to inform the design development.

3.10 Co-design as an engagement process

Staff and participants were engaged with the design process and they assisted in the development of the design through a co-design process, which took place at varying levels during the research project. Co-design in health research has been shown to benefit researchers and practitioners, alongside assisting the research process and outcomes, as discussed above (Slattery, Saeiri and Bragge, 2020). Co-design is also suggested to be beneficial specifically in supporting mental health recovery (Illarregi, Alexiou & Zamenopoulos, 2020). Co-design assists in giving a voice to the participants and ultimately aims to benefit them through a therapeutic process of participation, by knowing that they will be helping others through their involvement. By feeling they are helping others, this may also take the pressure off participants focusing on their situation, which could result in

deeper engagement with the tasks, making participation in the process about more than exploring a participant's personal recovery. It was intended, that being involved in the development of the tool would help to increase the levels of engagement and benefit that individuals received from participating.

Whilst co-design would ordinarily bring all the stakeholders together for an interaction, healthcare situations can present challenges which may mean a 'distributed' co-design approach is adopted (Langley et al, 2018). In this research, the existing power structures and hierarchies in place between staff and service-users were considered to have the potential to disrupt a free and open discussion on the tool development. Therefore, it was decided to conduct the co-design activity separately with the groups of participants and support staff.

This co-design activity was structured into the Toolkit development, starting from the Cultural Probe, and it continued to increase in implementation through the iterative design process. The co-design element at each stage was implemented as follows:

Involvement	Cultural Probe	Creative Recovery Toolkit	Creative Discovery Kit
Consultation	P		
Co-design workshop	SW	P	P + WT
Co-design encouraged as a continuous process		SW	P + SW

P=Participant SW=Support worker WT=Wider staff team

Table 3.10-1 Co-design process in the project for each pilot

1. Cultural Probe - Pilot (I)

At this stage participants were asked a single question regarding support service access, with a view to highlighting design opportunities by consulting 'experts by experience' in the process. This process was not strictly a co-design activity with participants. However, at this stage staff engaged with a co-design workshop to develop the tool.

2. Creative Recovery Toolkit - Pilot (II)
During Pilot (II) a co-design workshop was held with the participants at the end of the process, to consult them on the design. However, at this stage staff engaged with co-design as an ongoing reflection on the process between sessions.

3. Creative Discovery Kit - Pilot (III)
Pilot (III) contained the most integrated co-design activity. A continual discussion and review was encouraged with the participants and a full session was provided at the end to complete and discuss formal feedback forms. The support worker and wider staff team were engaged in a co-design workshop to develop ideas to improve the design.

3.11 Qualitative research

The majority of methods and analysis used in this project are aligned with qualitative research and as such this is considered a qualitative study. However, within the project is a small amount of basic quantitative analysis. This is limited to counting the number of responses which arose for specific tasks in a measurement activity. These data are to assist in drawing conclusions and supports the qualitative data. No statistical analysis was used with these quantitative data due to its simplicity as a data set.

Therefore, this study will be considered a qualitative approach rather than a mixed-methods study and as such no triangulation of the data was deemed to be necessary. A qualitative study is appropriate as it uses an approach that collects emerging data, which is open ended (Fancourt, 2017). Also, in an arts based research project qualitative research "...can help to establish how participants personally experience an intervention and the meaning it has for them..." (Fancourt, 2017, p223), which is the aim of this investigation. As Robson (2011) describes in relation to the use of qualitative methods in research, several features of this approach make it appropriate for use in this instance:

1. Accounts and findings are presented verbally or in other non-numerical form.
2. Situations are described from the perspective of those involved.
3. The design of the research emerges as the research is carried out and is flexible throughout the whole process.
4. It takes place in natural settings.
5. It is usually small-scale in terms of numbers of persons or situations researched.
6. Openness and receptivity of the researcher is valued. (Robson, 2011 p19)

These points support the aims and objectives of undertaking this study, alongside the intended methods which fit well within the scope of a qualitative research approach.

3.12 Participant recruitment

All participants were recruited for the Pilots through the three different support services that were collaborated with. Support workers at these services assisted in identifying and approaching participants to be involved with the research, who in their opinion were able to comfortably understand the aims and process. In general, across the final two Pilots (II) and (III), a balance across the participant sample was achieved in terms of age, gender and symptom severity. However, for the Pilot (I) (Cultural Probe), participants were predominantly men of a similar age. This was simply due to the participants being those who were resident at the rehabilitation settings at that time, which restricted any attempts to achieve a more balanced sample, which could result in more widely applicable findings.

Another consideration for recruitment was the decision to concentrate on clients who had a combined substance use (alcohol and/or drugs) and mental health diagnosis. This choice in the study had the potential to limit the numbers of

participants who could be recruited, however in practice the proportion of individuals who exhibited symptoms of both conditions, even if one was not formally diagnosed, was very high.

3.13 Towards a recovery tool

To refine a design for a new recovery intervention and then evaluate its use in practice, the project was conducted in two distinct phases:

1. Initial Design Experiments
2. Recovery tool iteration process (through the Toolkit Pilots)

The initial experiments phase was less formal and more speculative in nature, this phase consisted of three discrete experiments:

1. Persona Journey Maps
2. Service Blueprint
3. Cultural Probe

These were all aimed at exploring the following points:

1. Develop researcher understanding of the issues faced by those in recovery and existing recovery routes.
2. Begin to build trust with stakeholders and introduce design approaches through terms which could be easily understood (through the application of design methods to the recovery process).
3. Test initial prototype ideas, which were derived from early meetings with stakeholders and wider literature review.
4. Explore the use of different design methods for developing an intervention.
5. Identify potential 'touchpoints' for design intervention.

Figure 3.13-1 Initial experiments aims

These points were explored through each of the initial experiments by focusing on varying perspectives of a recovery journey, which were defined as follows:

Persona Journey Maps

These were designed to look at the motivators and barriers as an individual moves into substance use and out again into recovery, by using historic real life case study data as a basis. The focus here was on the individual from a holistic perspective.

Service Blueprint

This was designed to chart the journey an individual makes through the range of local services and provide information about the different options that can support recovery. The focus here was on the individual from a support service pathway perspective.

Cultural Probe

This experiment was designed to elicit information about recovery from those who are currently in treatment. To provide a live snapshot of the concerns, habits and hopes of those currently engaged in the recovery process. The focus here was on the individual from the perspective of their personal point of view, as an auto-ethnographic approach.

More detail about how these experiments were conducted in practice can be found in chapters 4.0 and 6.0.

3.14 Methodological Framework

The second phase of the project implemented a methodological framework for design iteration. The Cultural Probe was chosen as the initial experiment which would be developed further. This was due to it having the most encouraging reaction from professionals after sharing and discussing it. In order, to then evaluate the development of a cultural probe into a recovery tool, an evolving

methodology was designed to structure the process and make the piloting of the intervention consistent across the different pilot stages, with the changing variables identified. In developing this methodology the following three points were considered to iterate the initial cultural probe into a recovery tool:

1. The desire to move beyond the use of a cultural probe, as defined in literature and practice as a research tool, to provide therapeutic value to participants.
2. To develop a rigorous approach to the design of the tool from the initial Cultural Probe experiment to a final working version for widespread application.
3. To test the use of an adapted Cultural Probe across three Pilots and analyse the responses, to determine its effectiveness and potential for use as a recovery tool and also to define its limitations.

The three pilots (one of which was the original Cultural Probe experiment) were conducted with participants who had substance use and mental health difficulties. As the research Pilots evolved with the project the following four variables changed:

1. The level of participation in the design development from support staff and participants increased as this element was developed in the project.
2. The amount of data collected increased as the Toolkit and design process became more sophisticated.
3. The balance of mental health and substance use issues varied as organisations partnered with changed through the process (more detail on the background to these changes can be found in the chapters 6.0, 7.0 and 8.0).
4. The role of the designer, developed through the research from designer, to observer and then to facilitator.

As the project developed, each stage had a slightly different mixture of these four variables, which were present in each Pilot as follows:

Pilot (I) - Cultural Probe

1. Participant involvement in design development was limited to a single question posed about service access.
2. Data collected included: the completed task cards, field notes from meeting the facilitator to review the process and field notes from initial meetings.
3. Participants were primarily substance use clients with underlying mental health issues.
4. The designer role was as designer.

Pilot (II) - Creative Recovery Toolkit

1. Participant involvement in design development included a design review conversation with participants at the end of the process.
2. Data collected included: the completed task cards and field notes from the workshops.
3. Participants were considered as clients with a coexisting diagnosed substance use and mental health conditions.
4. The designer role was as observer.

Pilot (III) - Creative Discovery Kit

1. Co-design involvement included a continual process of consideration with users (who were aware of this process) and a dedicated review session at the end of the process. Also, a review session with the wider staff team was held to inform the design further.
2. Data collected included: the completed task cards, field notes from the workshops, field notes from a review session with the staff team and data from a rating system for the tasks.
3. Participants were mental health service users with previous experience of substance use.
4. The designer role was as facilitator.

Whilst these variables changed across the pilots, participatory workshops conducted for this research all followed a consistent format, which was as follows:

1. Participants were introduced to the tool as a group and talked through the research conditions.
2. Participants individually completed the tasks over a set time period.
3. Participants fed-back about their experience of the process at a conclusion session through discussion.

3.15 Methods of data collection and analysis

Within the research process both design specific research methods and more traditional social research methods were used to gather data from participants. Each method was carefully chosen to ensure it was appropriate for the collection of the required data for each element. Each research method was then designed individually to ensure rigorous data collection was achieved with reference to best practice advice derived from existing literature.

The subsequent analysis of the data collected was intended to assess the value of the method in fulfilling the research objective to test a recovery elicitation tool and not simply to analyse the generated data. The primary data collected included the Pilot Toolkit returns (task cards and self-measurement ratings). These were formally analysed through thematic coding of the data and the quantitative assessment of responses. Supporting primary data collected included field notes and feedback forms, which were used to fulfil a supporting role to the data analysis for drawing conclusions on the themes identified.

All the primary data collection during the project took place within a participatory workshop setting or during separate stakeholder meetings. The following section will discuss the application of the different data collection methods that were

employed during the participatory workshops and stakeholder meetings. The method used for analysing the primary data will also be set out in detail. The amount of data collected increased with each pilot, as the design of the interaction and data sought from the participants expanded in scope. The specific types of data collected are shown in the following table:

Data collected	Cultural Probe	Creative Recovery Toolkit	Creative Discovery Kit
Task cards	o	o	o
Field notes (Staff)	o	o	o
Field notes (Participants)		o	o
Measurement scale			o
Feedback sheets			o

Table 3.15-1 Data collection methods for each Pilot

Below provides a general discussion of the rationale behind the choice of each of these methods based on the data each method was intended to collect and how the data collected was handled after collection.

3.15.1 Task cards

The task cards for each of the Toolkit Pilots were originally developed during Pilot (I) (Cultural Probe) and these were subsequently iterated through Pilots (II) & (III). A detailed account of the reasons for choosing and then developing the Cultural Probe task cards can be found in chapter 4.0. Completed task cards can be found in appendices E, G & J.

3.15.2 Method of data analysis (task cards)

The returned Cultural Probes were analysed using thematic analysis, which is a technique for uncovering themes which can emerge from the responses provided. The analysis was conducted following the guidance on this method provided by Braun and Clarke (2006).

The following stages were undertaken:

1. Initial familiarisation of data by the researcher.
2. Generating initial codes from the data.
3. Using these codes to look for themes.
4. Reviewing and refining the initial codes and themes.

Graphic layouts were produced, which structured all the data collected for each participant in the pilot. The data was visualised on a single page to allow a simple comparison between participant responses within each Pilot and also across the data set as a whole. This also provided a way for the researcher to thoroughly familiarise themselves with all the data before analysis.

To code the data set for each pilot the following system of colours and symbols was used:

Colours were used to identify certain themes within the data, which were part of three groups. Positive and negative factors were differentiated by opposing hues of colour on opposite sides of the colour wheel.

1. Cooler colours (Purple, Blue, Green) were given to positive factors.

PURPLE	Social connections (Friendship / family)
BLUE	Symptoms or activities relating to health
GREEN	Activities relating to recovery
LIGHT GREEN	Nature / Sanctuary
LIGHT BLUE	Rejuvenation (Food / rest / relax / sleep)

2. Warmer colours (Yellow, Red, Orange) were given to negative factors.

YELLOW	Intoxication, feeling good due to substance use (high)
RED	Symptoms or activities relating to health
ORANGE	Addiction, damaging substance use

The aim was that through this distinction it would be visually apparent if a participant defined their responses as broadly positive or broadly negative throughout a task or for part of a task. This would also allow for rapid comparisons to be made in tasks which compare the past with the future, for example.

3. Factors which were more general were given remaining colours (Pink, Brown and Grey).

PINK	Element of bravado, self-glorification and/or arrogance
BROWN	Place or space relating to housing, home or hostel
GREY	Incident of monetary or goods exchange

Sub-themes were coded with circle symbol letters and added to the locations in which they arose in the data layouts. These sub-themes included the following:

Fo	Formal recovery activities
In	Informal recovery activities
Le	Legal exchange
Il	Illegal exchange
Ph	Physical health
Me	Mental health
Sk	Skills development
Mo	Recovery motivator
Ba	Recovery barrier
Cr	Creativity reference

3.15.3 Feedback forms

Feedback forms were employed only for the final Pilot (III) and were implemented using a three stage process:

1. Participants were introduced to the forms to ensure the questions were clear.
2. A group discussion took place regarding the process so that participants could share their ideas and also gain a better understanding of what the questions were asking before completing the forms.
3. Participants then completed the forms individually.

The purpose of participants completing the feedback sheets was to identify the their feelings about the following three aspects of the process:

1. Whether the participants found the tool easy to use.
2. Identify any concerns the participants had about the process.
3. Identify improvements that could be made to the design, including additional task suggestions.

As such, the feedback forms were a type of questionnaire design. The approach falls in between a self-completion questionnaire and interview based questionnaire, as participants were able to openly discuss the questions before completion. A facilitator can have an effect on the responses, but this was limited by the group discussion format, allowing participants to discuss the questions amongst themselves, rather than being led by a facilitator. However, the researcher was present and could gauge the attention that participants were paying to the completion of the survey and be available if difficulties were being faced with comprehension. These factors were considered in terms of Robson's (2011) discussion about the pitfalls of self-completion vs interview-based questionnaires,

with a view to minimising these in the research. The format of the questionnaire was designed with consideration of the following points, to make it appropriate for the situation in which it was being used:

1. Open questions were used to capture a better assessment of how respondents really felt and to allow them to go into more depth than with closed questions. This helped to produce novel responses which were not anticipated (Robson, 2011). Also, the responses were to be used as supporting information for data analysis and not coded, which meant that the inherent challenges of coding open responses was not an issue.
2. The number of questions was limited to five, which was deemed appropriate for the time allocated for completion and the identified limited attention span of the participants. The length of the questions was kept to a minimum for clear comprehension.
3. The space provided for responses was judged to be large enough to provide detail in the response but not too large that participants felt they were expected to write a lot, which may have become a barrier.
4. The graphic format of the forms was attractive, clear and designed to be easily understood.

For an example of the feedback sheet used in the research please see appendix J. The data received from the feedback sheets was not coded but instead used as supporting information in the analysis and for determining steps to be taken to advance the design of the Toolkit.

3.15.4 Measurement scale

The measurement scale was included in the Pilot (III) task cards and was designed to capture how the participants felt before and after completing each of the tasks. This data collection method is a form of simplified Likert scale (Likert, 1932) or ordinal scale. This type of scale was chosen as it is simple, intuitive and quick to complete alongside the main task activity.

These types of scales can appear intriguing for participants to complete, similar to rating a film or leaving a star review for a product. This is important as participants needed to remember to answer the scale before and after the process, to capture how they were feeling at that moment. So, if the activity appears interesting then they are more likely to remember and to give a considered answer (Robson, 2011). Completed task cards with measurement scales can be found in appendix J.

3.15.5 Method of data analysis (measurement scale)

These data were simply analysed by counting and then comparing the feeling level before the task to the feeling level after. This aimed to provide a way of indicating participant attitudes to individual tasks, via feelings across the process and feelings toward the process as a larger group.

3.15.6 Field notes

Early in the research process difficulties were faced engaging individuals working in the alcohol and drug recovery field. Firstly, the time pressure on those contacted resulted in individuals feeling unable to engage with the research, even if they were interested in the concepts presented, as often they stated that they simply did not have time to provide a considered response. Secondly, as discussed previously, a level of scepticism was experienced regarding the application and value of design methods, which the project was attempting to use in the recovery field. This was a concern when planning early meetings as the intention was to audio record conversations for documentation. Early encounters with individuals illustrated a reluctance to be recorded, due to issues such as client confidentiality and sensitive details regarding service provision.

Therefore, early meetings were documented through detailed note-taking. As Bell (2005 p165) describes, note-taking or shorthand taken during an interview can be an alternative to audio recording, as long as the process is carefully planned and the content is written up as soon as the meeting or interview is complete, to ensure all the detail is captured. Bell also recommends sending a copy of the notes to the interviewee for confirmation of the correctness of statements recorded. These recommendations were implemented in the note-taking approach that was adopted, as it was considered less intrusive and informal compared to recording.

The field notes were used in the research to support points made through the analysis of the data received from the Toolkit responses. Reference to these notes is made via a three part notation system which links back to the notes in the appendix. The notation system follows the following format:

(pilot number . session number . individual and point number)
for example the notation (P1.S3.SSW4) means:
(pilot number 1 . session number 3 . senior support worker - point number 4)

Participants were all asked if a copy of the notes should be provided to be checked for accuracy. However, in practice individuals would either be content with the discussions at the end of the interview or request a copy but not respond to a request for comments or simply accept them, presumably again due to time pressures and workload restricting further engagement with the researcher. The researcher also ensured that the notes, when provided in the final thesis, would not refer to individuals' names, in effect to make the content anonymous. Completed field notes can be found in appendices E, G & J.

Through anticipating the next stages of the research, where data collection would be completed, the researcher had concerns over the disadvantages of recording workshops being exaggerated through direct engagement with service users.

The target group would likely have concerns over confidentiality, anxiety about recording and potential disclosure of previous illegal behaviours. Therefore, the note-taking approach was viewed as an opportunity to put participants at ease, whilst still recording the detail of the interactions. As a technique this approach to note-taking was perfected in the early stages of the project, so that it could be more confidently and effectively implemented in the research as it developed.

4.0 Initial Design Experiments

As identified in the previous methodology chapter, three initial Design Experiments were designed to explore the points identified in figure 3.9-1. The following chapter will set out the development of these three initial Design Experiments and conclude with a rationale for choosing the Cultural Probe experiment to form the first Pilot (I) study and to develop further into a recovery tool.

4.1 Development of the initial Design Experiment concepts

A key meeting for the research took place in December 2015, with the service manager for St. Thomas Fund, a residential rehabilitation centre in Brighton and Hove. The service manager was contacted and showed interest in the idea for the research and they agreed to meet face to face for a discussion. During the meeting a general discussion took place regarding the following three topics:

1. Alcohol and drug use in the community
2. The type of assessment and interventions used with service-users
3. Existing tools in use in the recovery field

The full meeting field notes can be found in appendix E. From the discussions were derived three clear paths to pursue in terms of further research exploration of individual recovery journeys. These three points were raised in the preliminary meetings and also identified in the wider literature, which are as follows:

1. Different services do not use a universal tool to track a client's journey through all stages and retain all the information at each stage (P1.S1.SM21). Whilst this has been attempted the lack of a lasting solution may be due to the reluctance of some services to share information (DrugScope, 2015).

2. Services and clients can be unaware of the range of recovery organisations available (P1.S1.SM35). This is especially true of groups or services which provide creative interventions in the community (APPG, 2017).
3. Service users can become frustrated when having to tell their story repeatedly to different services or staff whilst being assessed (due to the lack of a universal tool). (P1.S1.SM19); (Cranwell et al., 2017).

These three key considerations were taken forward to inspire the basis for the initial prototype experiments. Each of the three experiments were initially designed to consider one of these identified points for design intervention.

Design Experiment (I) – Persona Journey Maps

The intention with this experiment was to design a prototype intervention to address point 1 above. However, this experiment was already in progress when the meeting with the service manager took place in December 2015. The Journey maps were identified by the service manager as having potential to be developed to help build a picture of a client's history. This was the first design output to be presented to stakeholders in the recovery field.

Design Experiment (II) – Service Blueprint

The intention here was to test a way of designing an intervention which could address point 2 above. This was envisaged to be a tool which could be used by services to identify a client's journey through different services and as a method for services to have a regularly updated document. This included details of all the referral routes available to them for different client challenges to be addressed.

Design Experiment (III) – Cultural Probe

The intention here was to test a way of designing an intervention which could address point 3 above. This was conceived as being a tool which could help clients to tell their stories in detail and through an alternative engaging way which was different to existing assessment techniques.

4.2 Personal Journey Maps - Design Experiment (I)

Design Experiment (I) involved the development of a series of 'Persona Journey Maps', which were designed to chart the typical events and drivers that influence an individual when they develop damaging behaviours during their lives and eventually engage with treatment. This was approached from a holistic perspective of the individual. Techniques from service design were used, including: journey mapping and persona development.

The 'maps' produced were a simplified graphical time-line representation of addiction and recovery journeys, which used real life case study data. Inspiration for this experiment was taken from research projects which used mapping techniques and worked with a similar target group to this research. These are detailed in the existing engagement tool review chapter 5.0.

This Design Experiment was iterated across several versions, from a basic version 1 to a much more resolved and detailed final version 4. These four versions were developed as follows:

4.2.1 Journey Map version 1

Using a single real-life case study as the base, this first map (Fig. 4.2.1-1) was produced as a simple linear journey which charted each significant life event and attempted to identify the various drivers behind these events. An individual was mapped from childhood to the point at which support was accessed for the first time.

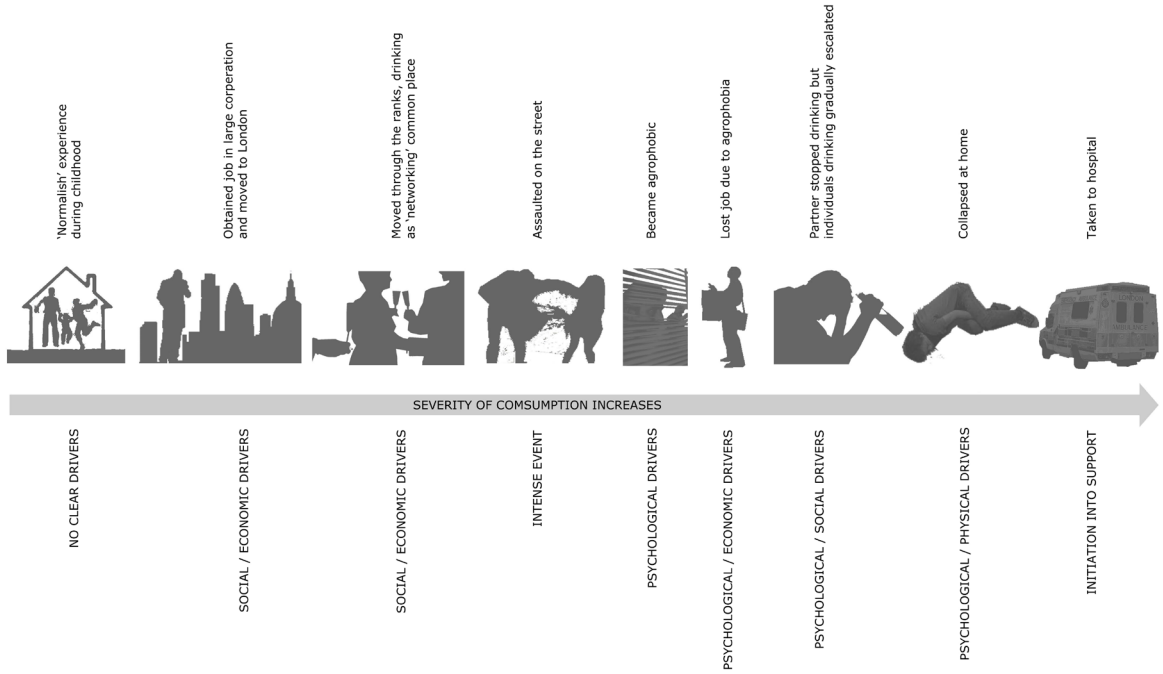

Figure 4.2.1-1 Journey Map version 1

4.2.2 Journey Map version 2

The second iteration of the map (Fig. 4.2.2-1) developed the event and behaviour images into descriptive icons. The icons were designed to be less specific, which allowed more flexibility in their representation. The simplified symbols also allowed for quicker identification of the type of situation they represent. It was clear that much more detail would be required to represent the complex situations and behaviours which were being investigated. Support was given a separate green colour, with driver events and behaviours in black, to differentiate support from behaviour drivers. A graph line was introduced to chart the level of anticipated mental, physical and monetary health of the individual during the journey.

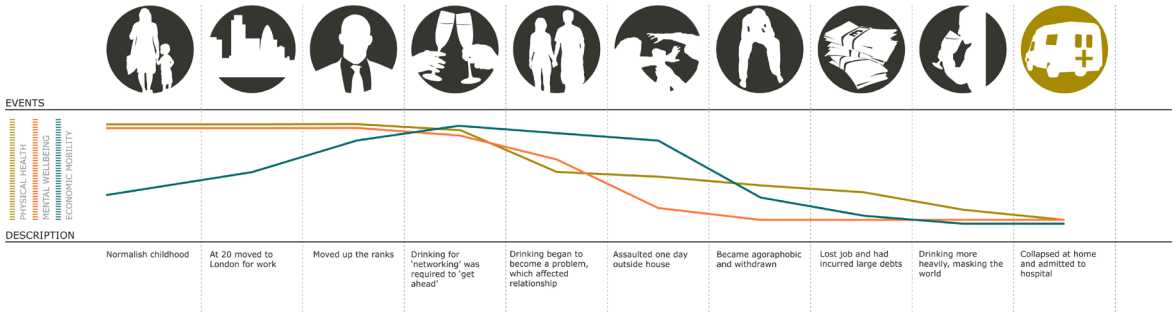

Figure 4.2.2-1 Journey Map version 2

4.2.3 Journey Map version 3

In the third iteration of the map (Fig. 4.2.3-1), the icons were simplified once again, to make them more quickly comprehensible from a graphic perspective. Here events were assigned the colour black, support services green and damaging behaviours or mental health issues assigned orange. The tone of the colours was also updated to resemble the NHS identity colours, which was intended to add a level of familiarity for stakeholders from NHS service providers, who the maps may be presented to.

For this revision, the line graphs from the previous version were replaced with bars, to sequence and illustrate the intensity of the various aspects of an individual's behaviour. The same colours were used but in a slightly different way, green here was used to represent positive behaviours and orange represented negative behaviours. A key was also added to further make the diagrams easier to decipher. A key reference for the way the information was presented graphically, was the book Information is Beautiful by David McCandless, specifically the visual 'Making the book - the last 6 months - Emotional state sequencer' (McCandless, 2012). Inspiration for the symbols included iOS mobile application logos by Apple. As apps are instantly recognisable for large numbers of people and this familiarity makes the icons easy and quick to understand. Also the simplified logos were inspired by *Communi-Cards 1 and 2*, developed by Poulin + Morris, as a tool to increase non-spoken communication and to reduce anxiety in patient and staff interactions (Schrauwen, Roberts and Wright, 2017).

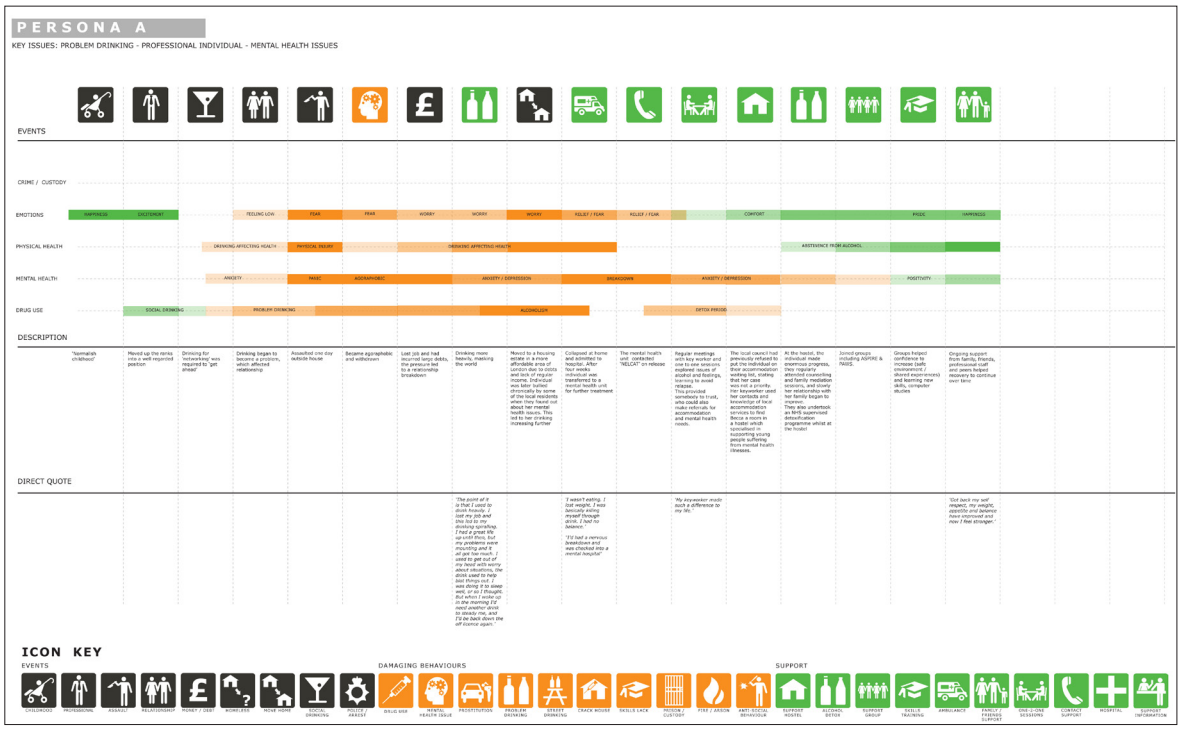

Figure 4.2.3-1 Journey Map version 3

4.2.4 Persona Journey Map

In the final version of the maps (Fig. 4.2.4-1) more information was included to make the tool more useful for reference and attempt to capture the complexity of the journeys. Therefore, research was undertaken to locate further case studies relevant to the behaviours and narratives being presented. In total 31 real life case studies were collected and used to inform the journeys. Three maps were then produced which focused on different challenges faced by three different individual narratives, which related to the challenges around substance use. Eventually, it was concluded that no three individual case studies could be chosen which would provide the desired broad cross section of issues.

Therefore, to achieve this sections were cut and combined from similar case studies, so that all relevant issues were represented across the three narratives. Key points from the case studies were identified and these were themed. The overall narrative for each map was taken from three specific case studies which formed the structure to the narrative, with other supporting points from further

case studies slotted in. It was at this point that the Journey Maps began to develop an element of Peronas. As the real-life case study narratives were combined. This moved the resulting diagram away from describing a single real narrative and began to describe a general but more detailed description, which would be useful going forward to inform the research and initiate discussions with support service providers.

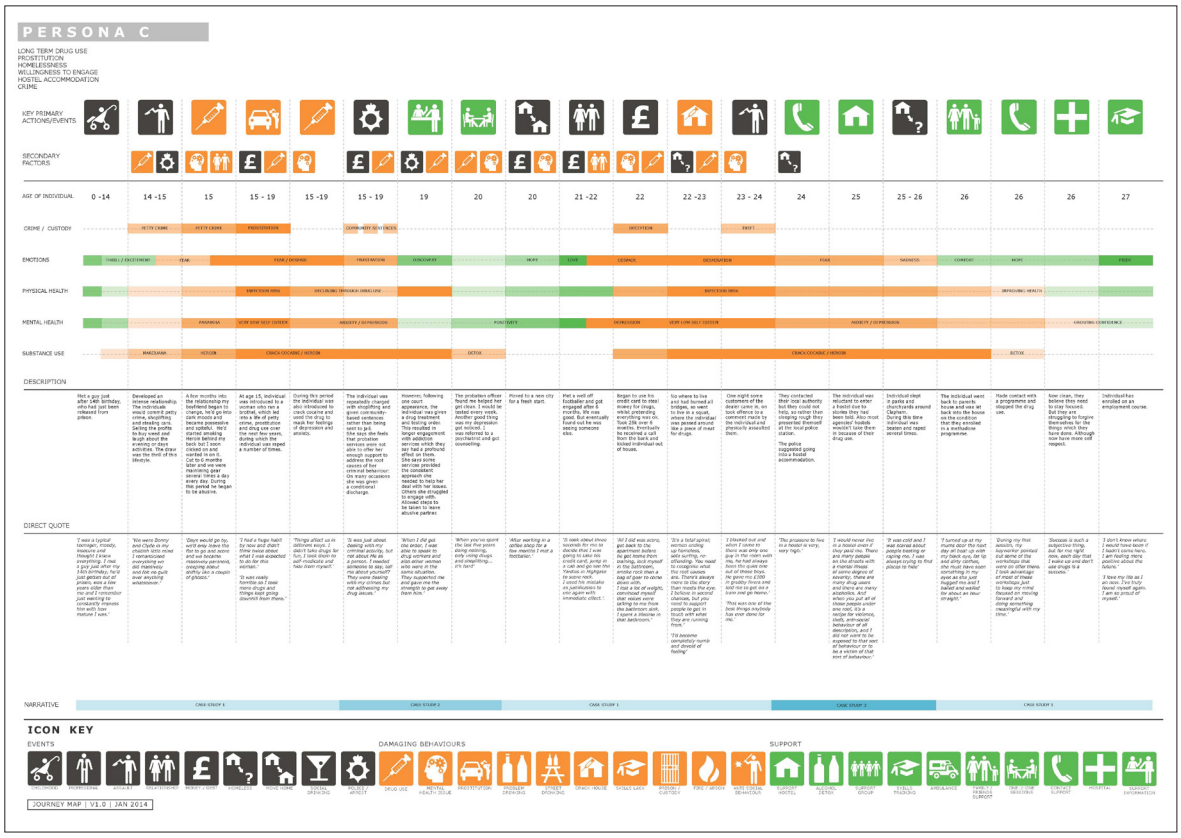

Figure 4.2.4-1 Persona Journey Map (map C)

Time was also a factor which was considered essential to include, this was illustrated as a numeric value for each event. Also a secondary driving factors and influences row was added. This row of symbols under the main event symbols, allowed the maps to illustrate other factors, which were also important to each event, whilst not being the primary driving factor.

4.2.5 Issuing information to stakeholders

Stakeholders were identified to provide feedback on the Persona Journey Maps, including: Police representatives, social care providers, outreach services, homeless workers and key workers. The intention was that as a first Design Experiment this could lead the way with introducing the project and the use of design methods to stakeholders.

Stakeholders were offered a choice of the three maps to review, as they would have had experience in different areas. By sending all three maps and asking them to choose the one which was the most appropriate to their area of work, they could then provide feedback on the map which contained content that they had the most experience with.

After the maps were initially issued to stakeholders, the number of responses was disappointing. Although four responses were obtained, these were as follows:

A Senior Consultant from Alcohol Concern responded:

> "It is an interesting read and thought provoking - the question is how to make it link into the work setting. Did you have any thoughts on how this would be used. As a life history it is good but to judge it I would need a sense of how you would want to use it."

Another stakeholder, Manager of the Brighton Community Alcohol Team was also not sure how the tool could be used:

> "I'm not sure I was clear before; I think the examples are fine and suitably representative of how things might happen for someone. What I don't understand is how design interventions could facilitate behaviour change, as the concept is new to me."

Through an exchange of emails he verified the 'authenticity' of the narratives presented in the drawings but had evidently not heard of design methods being used in the alcohol harm prevention field. This illustrates that the drawing works as a conversation starter and provokes questions but may not have a obvious application practically in the field. This response could also illustrate the innovative nature of using design methods in this field, due to a lack of awareness of their growing use.

A Senior Manager at CRI in Brighton, suggested that the maps could be a really useful tool for assessors to go through to help them then build the right assessment, as they didn't think that services necessarily built that (P1.S1.SM29). This suggests the potential for the initial experiment to be developed into a practical tool.

The experience of developing Design Experiment (I) and engaging with stakeholders helped the researcher to understand the range of challenges faced by the target group and to begin to engage with key stakeholders in the field. Following this experience, work started on developing Design Experiment (II) – Service Blueprint.

4.3 Service Blueprint - Design Experiment (II)

Design Experiment (II) involves the development of a Service Blueprint, which attempted to identify and record all the organisations related to recovery in the research locale. These were organised into a diagram, which adopted the perspective of navigating recovery through existing support pathways, to see which recovery options were available at each stage.

The Service Blueprint was developed over two iterations:

1. Version 1 – Initial design
2. Version 2 – Design development

4.3.1 Service Blueprint version 1 – Initial design

This initial Design Experiment involved providing a diagram which contained icons for the different recovery organisations in Brighton & Hove. The icons were structured so that a recovery route could be navigated for an individual through the existing organisations. The identified services were detailed through desk study research, with the version 1 drawing produced as an early draft, which was only developed to a basic level of detail (Fig. 4.3.1-1).

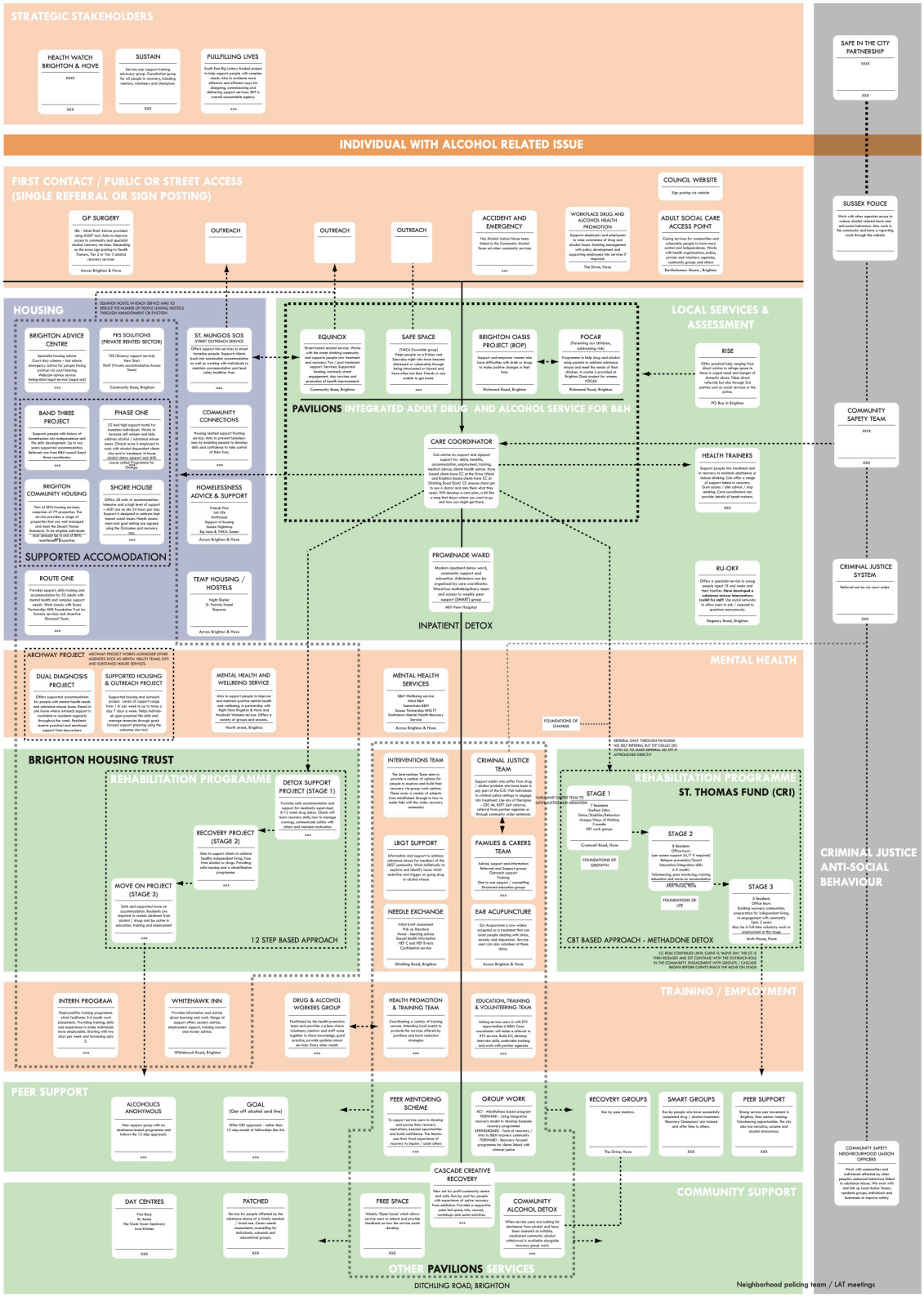

Figure 4.3.1-1 Service Blueprint version 1

4.3.2 Stakeholder meetings

To further develop this experiment and forge more links with local recovery organisations, meetings were organised with 12 key support service providers. Field notes from these meetings are organised in the appendix. These meetings were intended to test the Service Blueprint idea in a professional 'field' environment. It was hoped that this would help develop networking with organisations and increase awareness of the developing design research practice.

The organisations consulted were the following:

Organisation name	Purpose	Contact
Equinox Brighton	Drug and alcohol outreach team	Interim Service manager
Alcoholics Anonymous Brighton	Mutual help organisation	Recovery worker
Health Trainers (Brighton Council)	Confidential health and well-being service	Service Manager and Alcohol Recovery Project lead
Drugs and alcohol commissioning team	Manage budget and commission services	Commissioner
Community Safety casework team	Addresses anti-social behaviour (ASB) and hate incidents by supporting individuals with complex needs	Service Manager
Brighton Hospital	Alcohol advice service within hospital (A&E)	Alcohol liaison nurses
Cascade cafe	Community recovery cafe	Founder
Kennedy Street CIC	Community organisation providing recovery mentoring	Founder
Fulfilling Lives	Lottery funded initiative providing support for individuals with multiple complex needs	Service Improvement Officer & Area Lead
Pavilions	Drug and alcohol advice and support service	Service manager & Health and Training team manager
SafeSpace	In-situ support for binge drinkers	Service Coordinator
Mind	Mental Health Charity (Brighton office)	Drug and alcohol liaison

Table 4.3.2-1 Stakeholders consulted with for the Service Blueprint experiment

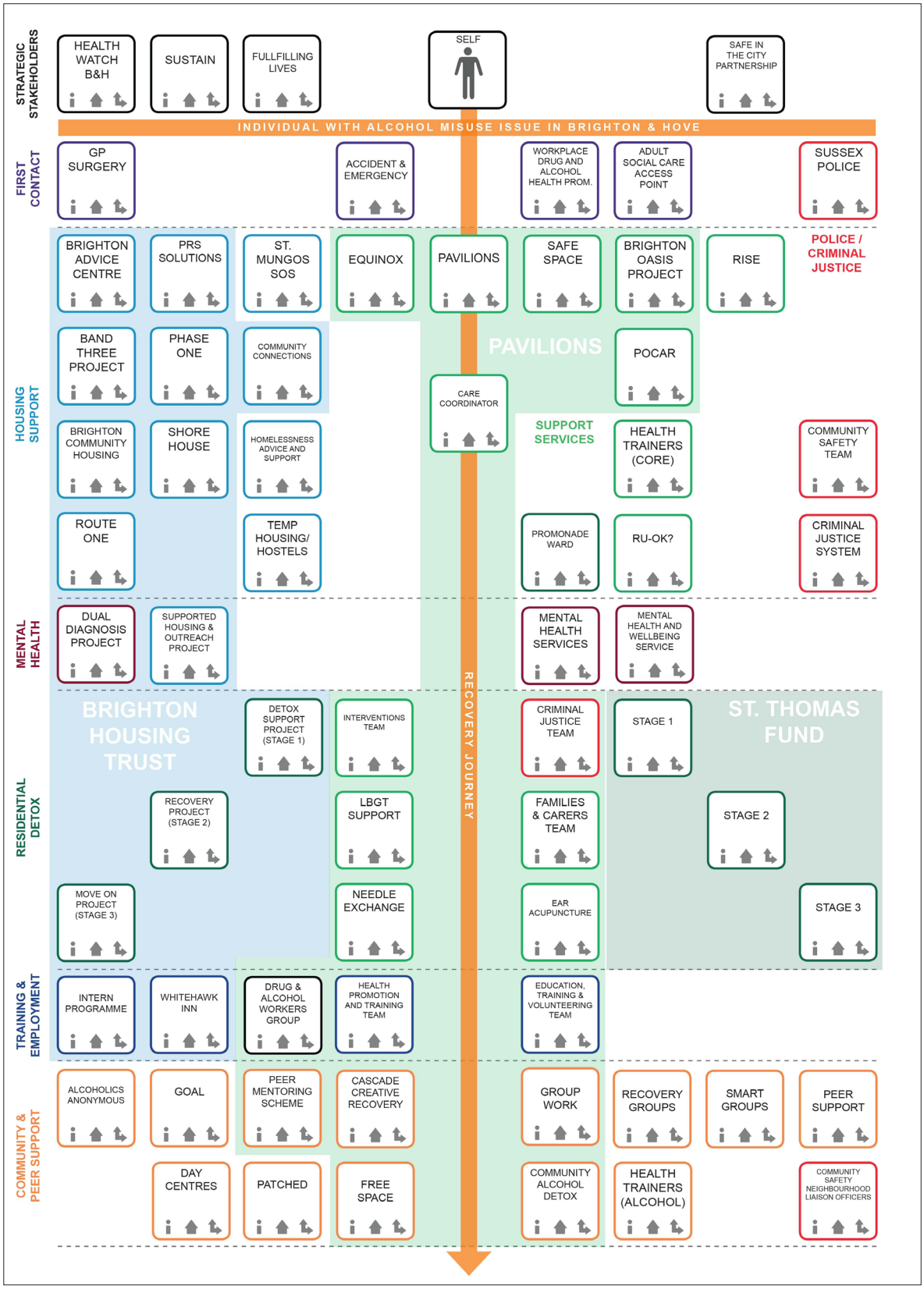

Figure 4.3.3-1 Service Blueprint version 2

4.3.3 Service Blueprint version 2 – Design development

Once these meetings had taken place and the feedback on the drawing received, the design was updated with this information (Fig. 4.3.3-1). Alongside updating the information from the organisations consulted, the following two design developments were made:

1. Additional sub-icons were added within the main icons for the organisations. These used the following interactive pdf elements added to the base pdf (Fig. 4.3.3-2)
    - A. Description of the service provided (Fig. 4.3.3-3)
    - B. Link to the organisations website / contact page (Fig. 4.3.3-4)
    - C. Referral routes (Fig. 4.3.3-5)

2. The structure of the route an individual takes through the organisations was amended.

The sub-icons, as interactive pdf elements, displayed information boxes for A and B, with hyper-links to the organisation website when the cursor was moved over the icon. For referral routes (C), the organisations who would take clients from another organisation became highlighted in the pdf, when the cursor is moved over the referral routes icon. The aim was that this would provide staff with an up to date index of organisations which could help to support and signpost their clients. Useful information about available local organisations would also be provided in a single location. As a pdf document it was universally accessible and did not require specialist software to access, as organisations all already have different systems in place for administrating their client cohorts.

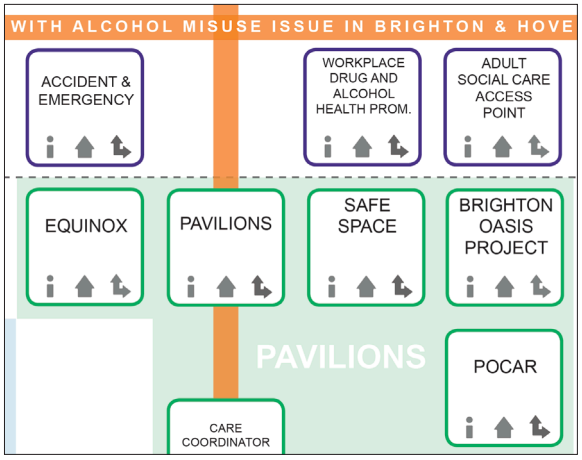

Figure 4.3.3-2 Base PDF

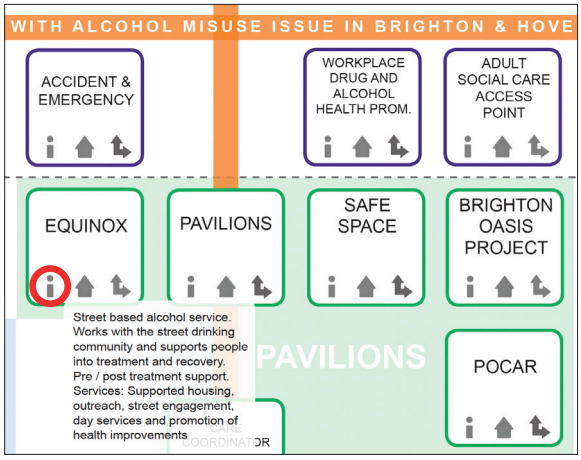

Figure 4.3.3-3 Organisation info icon button

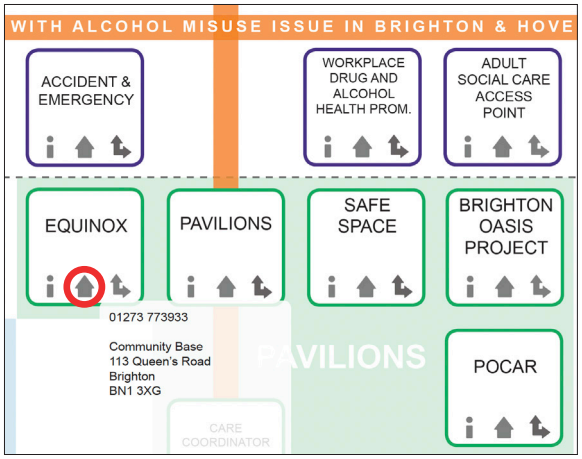

Figure 4.3.3-4 Contact info icon button

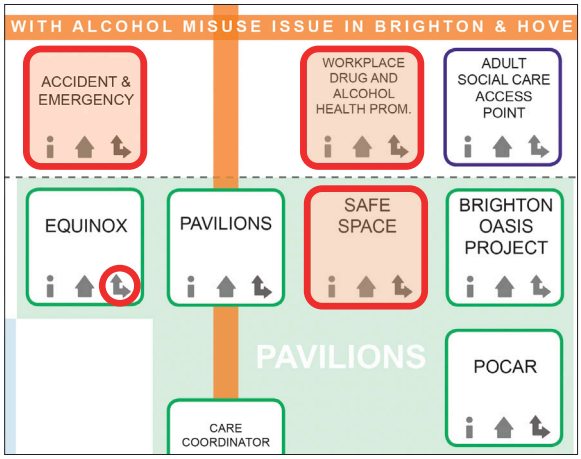

Figure 4.3.3-5 Referral routes icon button

These developments provided a final prototype version. However, this Design Experiment was discontinued after Design Experiment (III) - Cultural Probe was completed, as this proved to be more promising in terms of continued development through the research.

4.4 Cultural Probe - Design Experiment (III)

Design Experiment (III) involved the development of a Cultural Probe, which was deployed with service-users currently in treatment. This was focused on the individual in recovery from a personal point of view. The Cultural Probe Design Experiment was chosen from the three initial Design Experiments to be developed further in to a recovery tool. As such, the detail of how this experiment was developed and tested will be described in detail in the next chapter, as part of the series of intervention iterations. However, the rationale for choosing this as a research method is explained in more detail below.

4.4.1 The cultural probe method

Cultural probes are a design research method developed by researchers at Goldsmiths University in the late 1990s. They were initially used in the Presence Project, which was funded for two years under the European Union's 13 initiative. Eight partners from four countries were exploring technologies to increase the presence of the elderly within their local communities. These 'probes' were sent out into a research target group and then data and responses were returned over time (Gaver et al., 1999). As such the process is self-reporting which was innovative when compared to traditional questionnaires or participant interviews.

The cultural probes themselves were packs including a variety materials, including: maps, several different postcards, a single use camera, for example, which were intended to elicit novel responses from the participants. This method allows qualitative knowledge to be obtained from a target group and affords a "...more impressionistic account of their beliefs and desires, their aesthetic preferences and cultural concerns." (Gaver et al., 1999 p25). This technique provides a much more engaging method of working with a group of participants and an alternative to: "using official- looking questionnaires or formal meetings" which "...seemed likely to cast us in the role of doctors, diagnosing user problems and prescribing technological cures." (Gaver et al., 1999 p25).

The authors acknowledge that they are not trying to define the needs of the participants during this process, they are instead looking for inspiration to inspire designs. As user needs can already be broadly determined through other means, for example: traditional interviews, focus groups and questionnaires. In the recovery field client needs are often already determined through existing assessment procedures and during treatment. However, what is often ignored is the opportunity to tell individual stories and identify personal preferences. It is here that the cultural probe approach was identified as potentially useful to help participants explore their unique recovery journeys and personalities.

4.4.2 Cultural probes compared with a traditional ethnographic approach

In a situation where a design researcher aims to investigate the way in which a specific group behave in a certain setting, a traditional ethnographic (or rapid ethnographic) approach might be considered most appropriate (Rodgers & Anusas, 2008). However, within a setting where individuals are experiencing challenging circumstances, a traditional ethnographic approach might make them feel vulnerable. The presence of a researcher observing participants or becoming deeply involved in this setting to understand the group, might be considered intrusive and even inappropriate. A researcher working in this setting has the potential to not only unsettle participants in an already difficult situation but could interrupt or interfere with their ongoing recovery and treatment. This is even more likely if alongside their addictions, they are suffering from mental health conditions which could be aggravated or triggered, if they consider themselves to be observed. Crabtree et al. capture this:

> “Indeed, the presence of an ethnographer kitted out with standard research tools tape recorders, videos, and notebooks – may, on occasion, not only be unwelcomed and disconcerting, but also highly damaging: consider the potential effects of such an intrusion for somebody suffering from paranoid schizophrenia, for example.” (Crabtree et al., 2003).

In practice, any type of research activity which engages vulnerable participants should be carefully considered ethically and planned before being undertaken. This is to ensure any impact that participation in the research might have on the participants is minimised and so that the research does not endanger or jeopardise the participants ongoing recovery. Therefore, the cultural probe method, as described above, felt more respectful to the personal nature of the issues faced by the participants, by allowing them to undertake the research themselves rather than being passive in the process. This provided a way to engage and empower people with the process and encourage self-expression, rather than to simply conduct research on clients. Therefore, it was considered that the use of cultural probes as a method, had the potential to encourage participants in the project to open-up more, have a voice and be creative, which it was hoped would give a much richer and deeper insight into their personal recovery, life-worlds and experiences. For further detail on the deployment of the Cultural Probe activity, see chapter 6.0.

4.5 Conclusion

The Persona Journey Maps were developed to understand the drivers in and out of recovery for individuals with alcohol and substance use issues. These were compiled from case study data to provide a detailed overview and cover as many issues as possible, offering a holistic view of the difficulties faced by those suffering from addiction and to identify barriers and motivators to recovery.

Whilst useful for initial investigations and contacting support services, the major limitation for designing with this information, was its generality, as this was essentially a desk study. The Persona Journey Maps covered a full range of issues faced by those recovering from addiction, however, they simply described detailed but semi-artificially constructed life histories in their prototype form.

The value in completing the Service Blueprint was the opportunity it provided to survey the variety of recovery organisations across Brighton and Hove and to make contacts which organisations, whilst raising awareness of the research project locally. Both the Persona Journey Maps and the Service Blueprint also provided excellent conversation starters with stakeholders, which helped to facilitate discussions around the use of design methods in recovery.

To provide a more specific view of individual recovery journeys, a Cultural Probe was deployed. This method was intended to facilitate direct engagement with service users in the research process, which in contrast to a reliance on historical case study data, was intended to provide data directly from those currently in recovery.

Following the deployment of the Cultural Probe and the development of the other two Design Experiments. It was decided after review of the feedback provided and assessment of the potential impact of the different approaches, that the Cultural Probe would be taken forward for further development. This was due to the potential for therapeutic value for participants uncovered in the returned data and that it directly involved service users in the research project and provided opportunities for increasing their voice. The Cultural Probe also provided scope for the addition of creative elements to build confidence and to link with existing recovery methods and systems, as described in the literature review (chapter 2.0).

Following the identification of the Cultural Probe as a method to develop into a dedicated recovery tool. It was considered essential to conduct a detailed review of existing engagement methods which were currently being used in the recovery field. This was to position a new recovery intervention in the context of these other methods and determine the successful elements of these designs. This existing engagement tool review is documented in the following chapter.

5.0 Existing engagement tool review

This chapter will examine a series of selected interventions which are considered similar, related to or complementary, to the type of intervention being developed through this research. The interventions will be considered via three themes: Design Communication, Clinical-Creative Scale and User Collaboration. The chapter will conclude with the definition of 22 key points for development which will form a flexible design brief for the intervention design and development.

5.1 Introduction

The following review of existing tools will identify interventions which have been designed to reduce the harm caused by, and aid recovery from, substance use and mental health issues. The tools will be considered in terms of the following three key themes: Design Communication, Clinical-Creative Scale and User Collaboration

Firstly, the effectiveness of the way that the interventions communicate their concepts visually through both graphic and physical design will be commented on for each of the interventions. As it is important that tools can communicate concepts clearly to those participating, for them to be understood.

Secondly, the tools will be considered on a scale from 'clinical' interventions (those which to varying degrees rely on formal clinically evidenced approaches) to 'creative' interventions (those which to varying degrees are based on informal creative approaches to recovery). This scale indicates the level of evidence available for the effectiveness of each method, as clinical methods generally have a greater evidence base behind them compared to creative interventions. Using this scale does not mean that creative interventions cannot be delivered in a clinical setting, but the scale refers to the level of clinical acceptance of the techniques used in the intervention. There is potential for interventions

to move on the scale if, for example, changes in facilitation are made to the delivery of the tool through the incorporation of established clinical approaches. The scale also highlights the difference between 'art therapy' and 'therapeutic participation' in the interventions. As art therapy is generally considered to be an intervention which aims to achieve specific clinical outcomes, whereas therapeutic participation refers to engagement in creative activities which can have a benefit to the participant (APPG, 2017).

Finally, tools will be considered in terms of the level of user collaboration involved in their use. Tools will be reviewed to determine the extent to which they successfully initiate collaboration between user and professional and whether this collaboration leads to empowerment of those participating in the process of engaging with each tool.

These themes have been chosen from the previous literature review (chapter 2.0) for the development of a new intervention and the consideration of these themes will be approached in this review in terms of the following six questions:

Design Communication

1. Are the tool materials visually clear, easy to understand and communicate the project concepts?
2. Is the use of graphic design or product design engaging for the participants?

Clinical-Creative Scale

3. Where on the Clinical-Creative Scale is the tool positioned?
4. Is the effectiveness of the tool well evidenced?

User Collaboration

5. Does the tool involve collaboration between the user and professional?
6. Does the tool have potential to empower the user through collaboration?

Figure 5.1-1 Existing engagement tool review themed questions

The consideration of the interventions in relation to design communication and user collaboration is intended to determine the different ways tools are effective at communicating and encouraging collaboration and potentially fostering empowerment. The consideration of the interventions on a scale from clinical to creative intends to highlight a balance point between clinically evidenced approaches and purely creative approaches. However, on reflection of the design of the scale, the creative agency of individuals undertaking the process may be low even though the creative approach to developing the tool was high. Therefore, to help consider this in the following discussion, each tool includes a graphic scale bar showing its position on the scale and a separate rating for creative agency on a 1-5 scale. This helped to identify creative agency as a separate element to the use of creativity in developing the approach defined for each tool in the scale.

The resulting discussion will aim to highlight key elements from the interventions, which were carried forward in this research project for prototyping and to position the research in the context of these existing approaches.

5.2 Rethink Your Drink

An intervention which sits at the far clinical end of the scale is the Rethink Your Drink campaign. This was launched in July 2016 in response to the reduction of the recommended alcohol limit for men to 14 units per week, from a previous level of 21 units. The purpose of this campaign was to:

> "...provide local residents with accurate information about alcohol and its health risks so they could make informed decisions about their drinking behaviour". (Cooper, 2016 p1)

The campaign packs were produced to deliver the following three objectives:

1. Inform participants of the alterations to the recommended alcohol limits.
2. Engage participants in an alcohol brief intervention.
3. Raise awareness of some of the key guidelines for men and women. (Cooper, 2016)

Packs were distributed to pharmacies in the Brighton and Hove area, with staff encouraged to use a scratch card to undertake a brief intervention with customers. The scratch card (Fig. 5.2-1/2) provided a novel way for participants to consider their alcohol intake (Cooper, 2016). The scratch card included visual and text based reminders of alcohol intake levels and 'AUDIT' scores on the reverse side.

An alcohol brief intervention is a short, structured conversation about alcohol and provides motivation to consider making changes in consumption. In primary care a tool frequently used for this intervention is the AUDIT-C assessment, which consists of three initial questions (brief intervention) from a full 10 question screening tool. If the participant scores 5 or more on the three question tool, than it prompts the further completion of the comprehensive 10 question tool. The scratch card uses this same initial three question method, followed by the remaining questions asked by a professional, if required (Drinkaware, 2021).

Whilst the underlying method used has well evidenced effectiveness, the scratch card technique itself is not evidenced as more effective than the traditional delivery of a brief intervention. However, the value in this method is that most alcohol brief interventions take place in GP surgeries and primary care settings such as hospitals. This intervention can be completed in a pharmacy settings, and if it is not completed on the premises, than the scratch card can be taken away (in prescription bags) for completion later. This method, therefore, has the potential to greatly increase the number of individuals who can undertake the intervention and subsequently decide to change behaviour pattens.

ILLUSTRATION REMOVED FOR COPYRIGHT REASONS

Figure 5.2-1 Illustration of Brighton scratch card (Cooper, 2016)

Figure 5.2-2 Used scratch card

In terms of the design there is an exciting element to completing a scratch card and as such this appears to be the designers intended 'hook' to encourage engagement with the task. The original graphic design approach reproduces a form of fairground aesthetic resembling the Brighton Palace pier. The aesthetic appears to be a product of the location in which the design was developed and first piloted. However, it is questionable whether this design is suitable for use

in other locations, as the familiarity of place is something which would make the design appealing and familiar to those living in the Brighton and Hove area. This is an alternative method of delivering an intervention which is clinical in nature and traditionally delivered through text and tick boxes. The original scratch card is clearly presented and the information is easy to understand and is communicated effectively. Interestingly, an alternative version has subsequently been produced by Alcohol Change UK, which includes a simplified and generic aesthetic, which may be more suitable for use in a wider variety of locations. The completion of this intervention is not intended to include any collaboration between the user and the professional.

5.3 Node-link mapping

Node-link mapping allows information to be visualised in a diagram to improve the client and support worker interaction. This takes place by providing a focus for the session which can bring attention from the service user to the map instead. This is particularly helpful for individuals who are anxious about making eye contact. The maps are also useful for individuals to take away from each session to work on in their free time and also as a record of the conversations in previous sessions. The maps provide the opportunity for both the client and key worker to rate the usefulness of the mapping produced and this can be used as a method of tracking progress (PHE, 2013). As a technique, mapping is increasingly being used in recovery practice as a graphic treatment alternative to writing and talking (P1.S1.SM28). Node-link mapping can be used to:

> "...help facilitate clear, concise, and impactful communication at all levels of a treatment system, including multilevel interactions among and between counsellors, clients, evaluators, administrators, and clinical supervisors." (Simpson & Dansereau, 2009 p1).

The mapping activities fit into three categories:

1. Knowledge maps: These have high levels of structure and are produced by the support worker.
2. Free maps: These have less structure and the client and key worker collaborate to visualise the discussion spontaneously.
3. Guide maps: These are a combination of knowledge and free maps, which start with structure and then include space for a freer exploration of thinking and decision making. (PHE, 2013)

The maps focus broadly on the following four topics:

1. Strengths and weaknesses
2. Setting goals
3. Defining social networks
4. Exploring problems faced and barriers to progress (PHE, 2013)

Figure 5.3-1 Illustration of original node-link mapping activity worksheet (NHS, 2008)

The design of the original materials relied heavily on clip art and were often cluttered and visually confusing (Fig. 5.3-1). Whilst each sheet contains all the information to complete the task, the ideas of each task were not always clearly communicated. However, these were updated with a cleaner aesthetic, with the design making completion of the materials more straightforward, with a less institutional feel (Fig. 5.3-2).

Figure 5.3-2 Illustration of updated node-link mapping activity worksheet (PHE, 2013)

The relationship building aspect of the mapping activity means that the intervention can be collaborative, as the user and support worker can work together on the completion of the maps. Collaboration is most evident in the free mapping activities, providing that the user is capable of working effectively in the process. The mapping process is simply intended as a recovery focused activity and is not empowering for participants outside of improving recovery outcomes.

5.4 Motivational Interviewing

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Motivational Interviewing (MI) is a method of counselling that aims to elicit changes in the behaviour of participants. It is often used alongside Node-link mapping, as the two approaches complement each other. The principal idea is that through the MI process, participants are able to define where they have

been and where they would like to be. Strategies can then be agreed for clients to move toward their goal (Public Health England, 2013). This is achieved by helping clients to identify and resolve 'ambivalence' toward recovery. As Rollnick and Miller describe in their work, MI is defined primarily by the 'spirit', rather than simply by technique, and it provides a method of developing the support worker and client relationship (Rollnick and Miller, 1995).

In their description of the 'spirit' of MI, Rollnick and Miller describe seven points which embody this:

1. Motivation to change is elicited from the client and not imposed from without.
2. It is the clients task, not the counsellor's, to articulate and resolve his or her ambivalence.
3. Direct persuasion is not an effective method for resolving ambivalence.
4. The counselling style is generally a quiet and eliciting one.
5. The counsellor is directive in helping the client to examine and resolve ambivalence.
6. Readiness to change is not a client trait, but a fluctuating product of interpersonal interaction.
7. The therapeutic relationship is more like a partnership or companionship than expert / participant roles. (Rollnick And Miller, 1995)

Figure 5.4-1 The spirit of Motivational Interviewing points

MI is primarily a talking therapy and there are no dedicated materials, so the design communication cannot be commented upon. The process is collaborative in so far as the user and the professional collaborate on the identification of ways forward with recovery. However, whilst it is a talking therapy and situated

towards the clinical end of the scale, MI can be used successfully alongside creative approaches, such as art therapy. This is because, as the authors suggest:

> "The act of creating is an active process, which may include both conscious and unconscious expressions. The artwork can be a safe container for exploration of emotions, thoughts, perceptions, beliefs, and experiences with the art created serving as a tangible image that provides opportunity for immediate feed-back, an avenue for self-assessment, a means of emotional relief, and ultimately opens the door for building the internal motivation for change." (Holt & Kaiser, 2009)

5.5 The Outcomes Star

The Outcomes Star is an assessment and outcome measurement tool developed from participatory research. The tool features a set of scales which are arranged in the shape of a star (Fig. 5.5-1). Each scale is a defined 'key outcomes area' and by completing the star participants can measure their relationship with the various life areas represented by each scale. A variety of scale points for every outcome area are clearly defined and this enables participants to measure change. This process is supported by the accompanying journey of change model to support individuals to make sustainable change (Triangle, 2017). The Outcomes Star is an example of a tool which can be applicable across fields, for example, in substance use, mental health and homelessness recovery. The structure of the process and interaction remains the same but the content of the star changes to benefit the different types of challenges being faced.

Figure 5.5-1 Illustration of completed Alcohol Star worksheet (Burns & MacKeith, 2011)

The authors argue that the key to the popularity of the Outcomes Star lies in the design of the tool being more in tune with the individuals that deliver services, when compared to traditional techniques for outcome measurement. The tool was originally designed to fill a gap in outcomes measurement, as services were increasingly being required to measure change outcomes. However, tools did not exist which were easy to use for support workers, where their time was limited. The tool is based on participatory action research methods which have the following three core values in common with the design research approach employed in this research study:

1. Empowerment: Where solving social issues is best achieved by engaging with those suffering from them and using their agency as 'primary agents of change'.
2. Collaboration: Collaboration between researchers and the subjects of research, with both working collaboratively on a problem.
3. Integration: Research which aims to have real world application, where the research is implemented into action. (Triangle, 2017)

The authors suggest that other assessment and measurement processes can place the participants as passive in this process, which can remove their sense of empowerment and self-esteem. Therefore, the value of the tool is in the contrast that it has to existing methods, as it puts the participants at the centre of the data collection process and assessment takes place through a conversation.

As one service user commented:

> "I felt fully involved: it was clear and easy to understand and focused on me as a whole person, not just as a problem...it felt like a conversation; felt like the first time someone had really listened to me." (Triangle, 2009 p3)

This indicates that the tool can provide a voice to participants through the process. Whilst the interaction is not playful or free in nature, it does involve a visual element which is novel. This is satisfying for the participants as they can see the shape of the star changing over time, which illustrates the progress made. The visual nature of the tool is portrayed as important by another service user:

> "You can see the progress you've made. It's visual, powerful. Some people can't understand from written reports, but can understand this" (Triangle, 2017 p8).

And also by a support manager, who comments on the design as follows:

> "The visual aspect (of the star) is easy for service users to understand, the language is clear and simple, it structures key-work...". (Triangle, 2017 p2).

The materials are clearly presented and easy to understand, with a simple structured graphic design approach. Once the concept of working on a star is learned, the process of collaborating on the materials is intuitive with guidance

from the support worker. This process is empowering for participants, by putting them at the centre of the process. The Outcomes Star is visual but there is no freely creative activity, as the materials are essentially 'filled in', which means the process does not have a creative element.

5.6 Participatory mapping

Researchers from the Drug and Alcohol Research Centre at Middlesex University produced a report for Alcohol Research UK in 2013. This involves a study aimed to investigate the potential benefits of employing innovative participatory mapping techniques with Polish street drinkers. Two specific techniques were used: participatory mapping interviews and time-line interviews. The authors felt that to engage such a hard-to-reach target group it would be beneficial to employ innovative methods for the research. The aim was that the stories of participants could be captured, and potentially be used to explore the impact of social networks on alcohol use and also participant engagement with support services. The authors hoped this method would help elicit specific significant 'trigger' events, which may have led to them becoming involved in street drinking (Bayley and Thickett, 2013).

These two techniques are discussed as having the potential to enhance elicitation from participants, especially those (such as the Polish migrants) who may have language barriers, which could prevent them from engaging meaningfully with the research process. This is because both use an element of creativity and graphic recording, as opposed to participants simply responding via speech or writing (Bayley and Thickett, 2013).

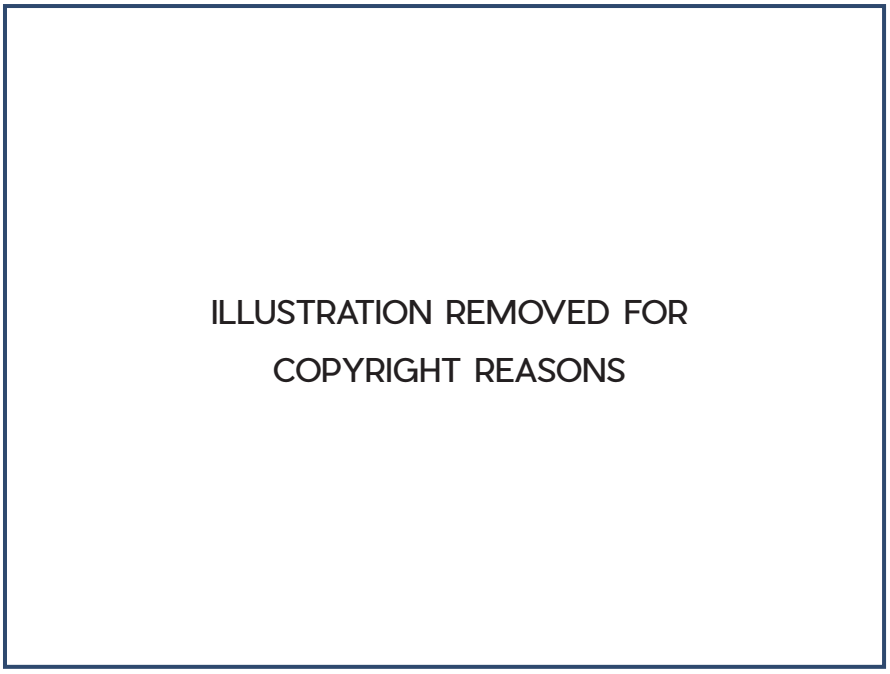

Figure 5.6-1 Illustration of participatory mapping (Bayley and Thickett, 2013)

The mapping (Fig. 5.6-1) was intended to explore how the participants viewed their social networks, alcohol use and their access to support. Initially in the research participants were asked to produce the map independently, however, the results, although rich in detail about individuals in their network, were low on the connections in between. So, in the following interviews the mapping activity was supported by a researcher to guide the process, with intervention kept to a minimum (Bayley and Thickett, 2013).

As highlighted in the quotes from participants below, the researchers found that there were tangible benefits from this method in terms of increasing disclosure, engaging participants and also:

> "...providing a relaxing yet involved activity via which participants could take pride in making an important contribution to the research..." (Bayley and Thickett, 2013 p10).

The authors acknowledge that a power shift can take place by using alternative techniques. Through this power shift participants can take pride in their contribution to the research and also take ownership over their involvement in the research process. The nature of the method is stated to assist in the reduction of the formality of the interview process. This is because having a focus, such as the map or time-line, enables a conversation and rapport to build between the two sides (Bayley and Thickett, 2013).

The participants themselves were positive in response to the process. Two of those who responded mentioned an interest in the creative focus as a reason that the process was enjoyable:

> "By doing this I relaxed my stress, by doing, by drawing, by thinking, I'm more relaxed now...I'm very thankful because I'm really relaxed now" (Bayley and Thickett, 2013 p8).

> "I think it's good, I like drawing...I like to talk as well" (Bayley and Thickett, 2013 p8).

The researchers found that the process, even though it encouraged participants to reflect on difficult previous experiences and events in their lives, meant that the participants:

> "...felt relieved that they had been able to tell their stories, an opportunity rarely afforded to them." (Bayley and Thickett, 2013 p11).

The researchers highlighted that one of the co-researchers was a support worker and also a translator for the research, who assisted with the participatory activities and helped them to put together a fuller understanding of their clients' previous lives. As normally, due to a lack of time and resources, this may not otherwise

have come to light in the day-to-day interactions with support workers. The support worker had a familiarity with the participants and vice versa, which meant that trust had already been built in the recovery relationship (Bayley and Thickett, 2013).

In terms of the Clinical-Creative Scale, the research is rigorously conducted by using social research methods, but the intervention is not based on a specific clinical intervention and uses the creative process as a key element to the engagement method. Therefore, this intervention sits towards the middle of the scale. As highlighted above, the participants found the process enjoyable and creative, so the tool has a creative agency rating of five. The mapping process simply included a piece of paper and a pen and there was no structure provided to work within, with structure being provided by interaction with the facilitator. This tool does not use graphic design in its implementation. The process is collaborative, with both the researcher and participant working on the mapping activity together. This interaction is empowering for the participant as they are involved directly in the research and is a different form of empowerment then the node-link mapping technique described above. Here the empowerment is facilitated by involvement in a research project, the findings from which may assist in understanding behaviours and helping others in the future.

5.7 Life History Calendars

Researchers at The Public Health Institute also produced a report for Alcohol Research UK, which used (among other methods) life history calendars, to explore how significant life events affected a participant's living situation and alcohol consumption. This method involved semi-structured interviews, which were centred around the mapping of significant life events on the life history calendar (Fig. 5.7-1). This mapping exercise was used during the interviews to link to changes in consumption (Ross-Houle et al., 2017).

The research found that one key theme was that alcohol was used as a way of coping with difficult life events. The researcher highlights the importance of social capital and recovery capital and shows that the life history calendars highlight where social capital has been lost by participants. This resulted in a reduced ability to cope when problems occurred at the same time (Ross-Houle et al., 2017).

Figure 5.7-1 Illustration of life history calender (Ross-Houle et al., 2017)

Participants involved in the research stated that the visual aspects of the project, including the mapping activity and taking photographs as part of a separate Photo-voice activity, were enjoyable. The life history calendars when combined with semi-structured interviews, were highlighted as providing a 'useful aid', which worked especially well with those participants who had cognitive difficulties due to their addiction or chaotic lifestyles. The participants also stated that they would be happy for the images produced to be used as part of a public display. Their willingness for the data produced to be disseminated, coupled with the fact that they enjoyed the process, highlights the value and importance of developing

the research with participants. This creates an empowering environment and provides agency if participant involvement helps to develop the research narrative (Ross-Houle et al., 2017).

Participants further highlighted the importance of recovery capital, as several stated that they had previously completed rehabilitation programmes, during which they felt that insufficient social resources and support resulted in them relapsing and being unable to sustain recovery long term. This research shows the importance of developing resilience to prevent relapse. Lower levels of social capital and resilience were identified as increasing the risk of relapse, prior to coping strategies having been developed. The research explores novel ways that the lived experiences of participants can be investigated, as a way of identifying possible sources of social and recovery capital in participants lives, which can in turn, help to tailor motivation and effective support (Ross-Houle et al., 2017).

The life history calendars were co-produced between the researcher and the participants. They were produced on a simple line grid with post it notes representing different life events. A column was provided in the table with pre-defined historical events, which were designed to help participants with the recall of life events. The line grid is simple with no graphic design input, however, it is functional, clear and easy to understand. As with the following tool, this approach sits in the middle of the Clinical-Creative Scale and through the co-production of the research materials, is empowering due to participant involvement in the research.

5.8 Design and Sexual Health

The Designs of the time 2007 (Dott 07), was a year-long programme of grassroots community projects using design methods, with exhibitions and events in the North of England, initiated by the Design Council and OneNorthEast. The projects were small in scale but importantly they aimed to promote and enable sustainable living in the present and expand into the future (Thackara, 2007).

The Design and Sexual Health (DaSH) project was an early example of designers working in new fields outside of design and specifically in the healthcare sphere. As a design led project it focuses explicitly on exploring and improving the user experience through service design techniques. DaSH was a collaboration between Dott 07, Gateshead PCT and Design Options. The project aimed to improve access to sexual health screening and treatment services. Design Options carried out research to investigate the daily activities of individuals who might use the service. They then used this information to design ways in which communication and procedures could be improved in the service and specifically the user experience. This was through collaboration with a wide range of stakeholders, resulting in a local service which was much better suited to Gateshead residents.

The design team acknowledged that they needed to:

> "...spend a huge amount of time making initial contact with people and gaining their trust, before they even started on co-design activities." (Thackara, 2007 p72).

This is an experience which is common in projects where designers are working in fields outside of the design discipline. The project stakeholder map (Fig. 5.8-1) shows the wide range of stakeholders (including service users), which were consulted with to develop the project. The information is clear, easy to understand and presented in an innovative manner. The project also uses a variety of design research methods, including: visual mapping, cultural probes, service user workshops and care journey mapping.

This intervention sits towards the middle of the Clinical-Creative Scale, with creative design innovation techniques being used in developing options for a clinical service. The new service was evidenced in its effectiveness through the first year and users provided some excellent feedback. Collaboration during the

service design stage involved engagement with a wide range of stakeholders, as described above. This collaboration within the project may have been empowering in a similar way to the other research engagement activities described above.

5.9 Drink Informed

This project considered how design could be used to help problem drinkers initiate change in their behaviours. The aim was to "...empower and support clinical staff to educate and engage those individuals whose drinking habits are causing them harm." (Royal College of Art, 2015). This took place through supporting participants to make informed choices about consumption and to promote beneficial changes leading to healthier lifestyles. The research was undertaken alongside the Specialist Nurse Service at Queen Alexandria Hospital in Portsmouth.

The researchers used observation, cultural probes, questionnaires and workshops with both staff and patients. The research output included a resource kit which was designed to foster dialogue between clinicians and patients using explanation documents and 3D educational models of the body. This included the liver, allowing patients to understand the vital nature of this organ. The resource kit included two sides, firstly, a patient facing side which was used to work with patients on their recovery and education. Secondly, the other side was used to help educate support staff in the hospital. This project developed into an digital application for wider dissemination and it used the Double Diamond technique, as advocated by the Design Council (Royal College of Art, 2015).

Figure 5.9-1 Illustration of Drink Informed models of a healthy and diseased liver (Royal College of Art, 2015)

The project materials include the novel approach of using a physical 3D model to engage in conversations (Fig. 5.9-1). These 3D materials communicate the aims and ideas of the project in an innovative way to participants in the educating process and could constitute a boundary object, as discussed in the literature review. Another unique aspect of the project is having different sides to the tool, this allows both patients and support staff to benefit from engagement in the interaction. The project sits towards the creative end of the Clinical-Creative Scale, as an example of a design intervention using design thinking to prototype in a clinical setting.. Collaboration with a variety of stakeholders was documented, including the end users during the design process. Also, patients collaborating with staff through the sessions were empowered through the educational nature of the tool to change behaviour around alcohol use (Royal College of Art, 2015).

5.10 Mindnosis kit

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The Mindnosis Kit was designed by a graduate MA Industrial Design student at Central Saint Martins (UAL), London. The idea was developed following the designer's negative experiences whilst previously being assessed by mental health services. The kit works to allow self-assessment, with users able to determine the assistance they need and where to go for help. The designer describes the toolkit as "...a set of exercises to help understand emotional distress and how to feel better about it." (Morby, 2017).

The kit can be used as a communication tool, if the user is finding it difficult to express how they are feeling. The user is able to explore these thoughts through the kit, before sharing them with others once they feel more comfortable (Morby, 2017).

The tool was designed jointly with individuals who have previously experienced mental health difficulties, to make the experience of using the kit empathetic. The designer conducted research on the current thinking in mental health research and the different types of therapies available, alongside mental health doctors, patients and commissioners. This initial research led to the realisation that it is the first conversations with GPs that can be a particularly difficult point for those with undiagnosed mental health issues (Morby, 2017).

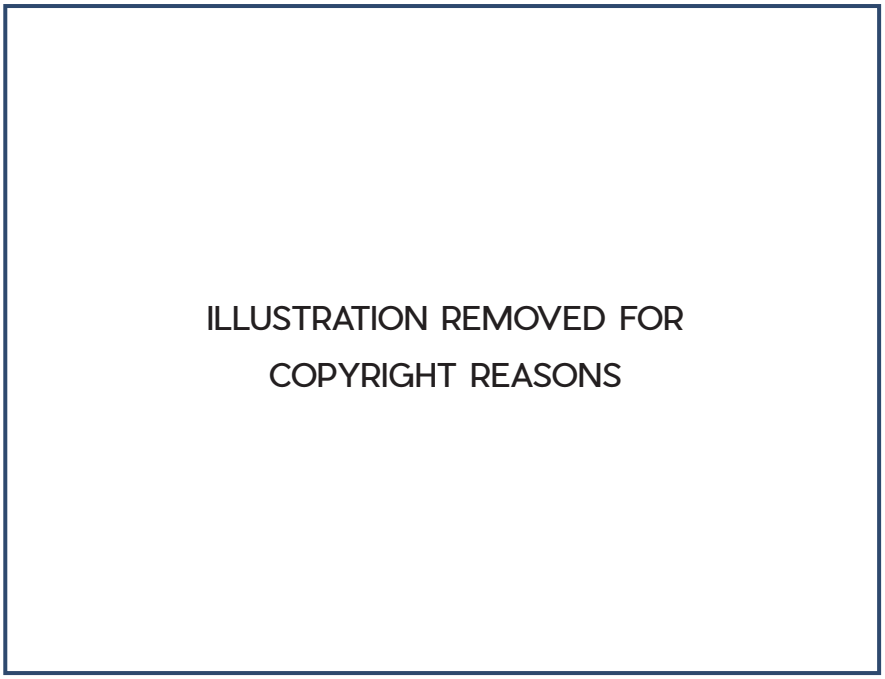

Figure 5.10-1 Illustration of Mindnosis kit tools (Ibanez, 2017)

The kit comprises of four tools (Fig. 5.10-1):

1. Discover: The participant chooses coloured triangles (each colour represents an area of life which may be negatively affecting the participants' well-being).
2. Record: The most appropriate triangles are then stuck into a record book, which can be combined with thoughts and reflections.
3. Try Out: Eight activity cards are based on mindfulness, cognitive behavioural therapy and tips from peers, which can be drawn on by participants if they are feeling unwell.
4. Learn: Six coloured cards relate to the triangles in the Discover part and include simple explanations of the issues which may lead to negative well-being.

There is also a Crisis Help page, which points participants towards services and relevant helplines (Morby, 2017).

This intervention uses both effective graphic and product design, with the individual pieces and packaging of the toolkit carefully designed to be satisfying and straight forward to complete. The design effectively communicates the concepts of how to use the tool. This approach is a designed product and it is developed with professionals, to make it effective in use but it is not based on clinically proven methods, so it sits towards the creative end of the Clinical-Creative Scale.

The tool is intended to be used by participants to complete independently, which initially does not include collaboration with a professional. However, the completed kit can be used to bridge the gap with beginning conversations about mental health with professionals. This can be empowering for participants if it helps them to make connections and take the first steps toward reaching out for help.

5.11 Pause for Mind

Pause is a subscription service offered by the mental health charity Mind. A box with activities is delivered each month and this includes tasks which:

> "...encourage relaxation, creativity and reflection – to focus on and improve personal well-being..." (Mind, 2020).

A fee is paid for each month by one person, which supports the work of Mind and in return the box is sent to another person, whom they feel could benefit from a boost to their mental health. The activities in the box are organised across three areas:

1. Notice: Assists participants with identifying how they are feeling.
2. Learn: Encourages new skills, goals and challenges to improve self-esteem and well-being.

3. Connect: Helps participants to feel less disconnected by encouraging sharing and communicating with friends and family. (Mind, 2020)

Figure 5.11-1 Illustration of Pause for Mind pack of materials (Mind, 2020)

The intervention materials have a simple graphic, which is clear and easy to understand, with a calm and engaging design (Fig. 5.11-1). The tool sits towards the creative end on the Clinical-Creative Scale, as whilst the activities provided have an evidence base for being beneficial to mental health, they are designed to use therapeutic participation as opposed to therapy (APPG, 2017). There is no collaboration involved in the completion of the activities, as the tool is designed to be completed autonomously at home rather than jointly with a support worker. As such this tool does not aim to empower participants through involvement in research or a clinical method but could empower them to be more mindful of their mental health.

5.12 MindJournal

Clinical ◇◇◇◇◇◇◇◇◇◇◇◇◇ Creative
Creative Agency 5

MindJournal was created by a designer with previous experience of mental health issues. They realised through their own journalling activity that it helped them and they saw an opportunity to develop a specialist journal to help men express themselves through writing, as: "...many guys like me...struggle with their emotions and communicating them to others." (Aplin, 2017). The journal includes questions and tasks which are designed to help participants think of ideas to write about (Aplin, 2017).

The journal was developed over the course of three years alongside:

> "...psychology professors, therapists and research from over 200 peer-reviewed papers." (Aplin, 2020).

The concept is based on the benefit that expressive writing can have on mental and physical health, based on the work of Psychology Professor James Pennebaker (Aplin, 2020).

Figure 5.12-1 Illustration of MindJournal activities (Aplin, 2020)

The designer acknowledged that a barrier to their own journalling in the past was having 'pre-journal anxiety', as the blank page of the journal was often a barrier. MindJournal attempts to solve this by providing repeating structure to work within and therefore it becomes a familiar process as journalling develops (Aplin, 2017). The guidebook that accompanies the journal is careful not to overload participants by suggesting that there are no right or wrong answers and that you do not have to use all the space provided. The intention here is to reduce pressure on participants and make the process as relaxed and enjoyable as possible (MindJournal, 2020).

The journal sets out a series of tasks which encourage the participant with ideas for entries, they begin with simple suggestions and build in complexity as the journal is worked through (Fig. 5.12-1). Each activity includes the following five steps:

1. Timestamp: Dating the entry so that progress can be tracked and entries reflected upon later.
2. Feeling: The participant ticks how they are feeling from a list or adds their own.
3. Intentions & Achievements: Intentions and achievements are stated to boost productivity and confidence.
4. Gratitude: Things can be listed that the user is grateful for.
5. Happy Hour: The user defines a time in the day to do something that allows them to look after themselves and makes them happy (Aplin, 2020).

MindJournal is similar to the Mindnosis kit as it was developed by a designer with personal experience of mental health issues, which is also the case with this PhD. This was the designer's catalyst for developing a new intervention for a particular need, in this case specifically for use by men. The structure provided for working within is very carefully designed to provide a starting point for the creative process for each entry. A useful feature is the 'check-in' at the beginning

of each journal entry. This is similar to the process of 'feelings check', which takes place at the beginning of formal recovery sessions in residential settings. This provides an excellent 'soft start' to each time an individual comes to journalling and helps overcome potential for writers block. As when a participant can identify how they are feeling, this then provides a subjects for focusing writing.

The graphic design of the journal is well set out and each prompt is clear to understand. With the accompanying manual the tool communicates the ideas behind it effectively. This tool sits at the creative end of the Clinical-Creative Scale due to journalling being a significant creative activity. The process is not collaborative as it is designed to be completed privately and not through interaction with a support worker. However, it may be empowering due to the potential for elicitation of thoughts and feelings, which could help the participant better understand their recovery.

5.13 Cultural probes

As discussed in the previous chapter, the researchers explain cultural probes as an alternative method to understand a target group in more detail. At the time this research was conducted in 1999, this approach was very innovative, and it has been used widely since by designers investigating in a variety of areas.

In terms of engagement with users, the authors discuss the challenge of combating several distances between themselves and the participants. Firstly, in geographical terms, the participants were in Italy and the researchers in the UK. Secondly, there was the presence of cultural and generational distance between themselves and the group. For this reason, the probe materials needed to work hard to combat these distances, with one strategy being face to face meetings with the group as an introduction, and then to discuss responses (Gaver et al., 1999). One of these meetings led to key findings from testing this approach,

this was that there was value in the debate which could be instigated between participants and the researchers. The researchers also noted that this approach offered the elderly participants the opportunity to be playful, and learn new things about their environments (Gaver et al., 1999).

There is little evidence of this technique being used with individuals in recovery from addiction and mental health issues. However, cultural probes have been applied in a variety of contexts since their conception, with the following examples drawn upon in this research. Cultural probes have been used to work with marginalised street communities in Brazil (Judice & Judice, 2007). They have been adapted to be deployed via the medium of a t-shirt, to understand novel material concepts and sensory experiences (Ivanova, 2015). Cultural probes have also been used to help develop assistive technologies in residential care settings (Crabtree et al, 2003). This final instance of probe use will be considered in more detail below.

This key example research project using cultural probes investigates the adaptation of this technique in residential care or 'sensitive settings', to explore the user needs of a complex group. Such a setting requires the consideration of the methodological problems which may arise, and this research suggests solutions for including 'unconventional end-users' in the design process to develop interventions. The authors discuss the challenge of using traditional ethnographic research methods in a setting such as a hostel for former psychiatric patients or care home for the elderly. With the main concern being the reluctance to be observed and the potential anxiety generated through direct observation (as discussed). Therefore, an alternative method was proposed to use an adapted cultural probe, as a self-reporting method, to facilitate the active participation of participants in the process (Crabtree et al, 2003).

This method also provides the opportunity for the returned cultural probe data to be used as a trigger for self-analysis. Crabtree et al. suggest that the act of asking participants to express themselves through the cultural probe process

means they become active enquirers into their everyday lives, rather than being passive, as subjects of research. This means they are empowered in the process to contribute and may discover useful personal insights to their own recovery. However, this is tempered with the suggestion that there is a limit to the level of change that information from the process might be capable of facilitating. However, the they acknowledge that the returned information provided a great deal of insight and contributed directly to a ongoing conversation regarding the participants' daily lives in sensitive settings (Crabtree et al., 2003).

Cultural probes as a method are intended to provoke individual responses from participants, which may be unexpected. This is in contrast with other tools which have a more rigid and standardised format such as the Outcomes Star or node-link mapping. This contrast can take the form of a tension between the free and standardised, which in turn mirrors the tension between the clinical and creative sides of treatment in recovery.

Whilst this method has been widely used, it is not a clinical intervention and is not evidenced as a therapeutic recovery method. As an activity the cultural probe is not intended to be collaborative in nature, as completing the tasks is an independent exercise. However, groups could be organised with the researchers after completion of the activity, to discuss the responses provided (Gaver et al., 1999).

Figure 5.13-1 Illustration of cultural probe pack of materials (Gaver et al., 1999)

The graphic design of the cultural probe materials is arguably the most provocative of the designs used for these selected interventions (Fig. 5.13-1). They are intended to provoke responses, rather than be straightforward to complete. However, the instructions for each activity were required to be very clear, as the activities were to be completed by participants autonomously. On the Clinical-Creative Scale this technique falls on the creative side, as the intervention is both research based and creative in its approach to engaging participants. As an intervention which is designed to be completed by participants alone, Cultural Probes are not collaborative in nature. Although, collaboration could be implemented through group conversations facilitated by the returned data.

5.14 Tools for Therapy

Clinical ◇◇◇◇◇◇◇◇◇◇◇◇ Creative
Creative Agency 5

This project produced a designed object based toolkit for use in psychotherapy interactions, to help users communicate with their therapist. The designer found that having experienced therapy personally over a number of years, the sessions always involved talking therapies. They eventually they found that specific therapies called psycho-motor and creative therapy were the most effective for them, as these were based around visualising (Morby, 2016).

Figure 5.14-1 Illustration of Tools for Therapy interaction (Bodewes, 2016)

The tool includes a set of building blocks and 12 other 'complex objects' which are based on ideas of Carl Jung (Jungian Archetypes). The designer uses materiality strategically, for example, the mother archetype is a tactile soft leather figure as an object in the kit. The shapes can be combined on a base with paper, where the user can also draw to represent situations, people, feelings or thoughts. A workbook is included which allows the psychotherapist to refer to and record notes. Also, the materials used for each object are designed to be affordable to purchase. (Morby, 2016). The designer describes the objects in the toolkit as follows:

> "They're designed to have multiple angles to talk about and the intention is the objects can represent things that can be positive or negative, the user can decide." (Bodewes, 2016).

This tool is collaborative with both the user and therapist discussing together the construction of objects in space and their potential meaning (Fig. 5.14-1). The tool relies on the presence of a trained therapist to assist the participant in interpreting their arrangement and description of objects. As mentioned, materiality is used in the product design to allow the objects to represent different things through discussion. This intervention has been positioned far towards the creative end of the Clinical-Creative Scale, as the user constructs the arrangement of objects as a creative process, with little to no clinical evidence underpinning its use as a recovery intervention.

Another toolkit of mention, which uses tactile objects (and also co-design activity), to prompt conversations around mental health and allow sharing of personal stories, was designed by Today in Melbourne, Australia. The authors highlight that this prototype allows: "...participants to explore mental health topics while building empathy with each other...". (Szczepanska, 2018).

5.15 Recovery amulet

The artist Grayson Perry worked with a group of adults in recovery from substance use, in collaboration with the Basement Project in Halifax. The Basement uses alternative recovery approaches, including dance as a recovery vehicle. The service believes that substances trap individuals in an eternal childhood and when clients put them down they learn to grow up. Recovery is presented as a growing up process, meaning a new chapter in life. Those in recovery are considered to have more responsibility and be facing up to difficult feelings, which have previously been masked by alcohol or drugs, through the process of 'coming of age' (Perry, 2018).

Perry goes on to design a coming of age ceremony for the service users. This is inspired by the realisation that true adulthood is found within a community with others and not individually. This discovery took place through the artist attending a ceremony with the Amazonian Tikuna people (Perry, 2018).

Perry works on the design for a recovery 'amulet' (Fig. 5.15-1), as a symbol which is traditionally felt to have protective properties for the owner. One side of the amulet depicts the addictive life and the reverse side depicts the cycle of life balance and reminds recipients of how to create a new life. The amulet is conceived as a medal that the service users have earned for going through the process and becoming sober. It is large in size for a medal and made of a heavy mild steel, which gives a sense of the weight and burden of addiction, as those in recovery are carrying it around. It also acts as a reminder of the struggle to get clean and sober.

The coming of age ceremony was designed to mark the moment of transition to becoming abstinent and was attended by the family and friends of participants. During the ceremony each participant was presented with an amulet and they spoke about their past life and thanked the people that had helped them recover (Perry, 2018).

ILLUSTRATION REMOVED FOR COPYRIGHT REASONS

Figure 5.15-1 Illustration of Recovery amulet design (Perry, 2018)

The artist gets immersed with the users, through conversation with both staff and support workers, to understand the difficulties faced by this group. The method used by the artist is an anthropological approach to understanding a group, which he then creates art for (the amulet). This output is not based on collaboration with the users, however the participants may be empowered by the process of the coming of age ceremony. As an art intervention with no clinical framework underpinning it, there is no evidence for the effectiveness of the recovery amulet or ceremony as an intervention. Therefore, this tool is positioned at the far creative end of the Clinical-Creative Scale, as it is based on a purely creative exercise, to creative the amulet and the event and not grounded in any clinical framework.

5.16 Discussion

The following discussion will interpret the key aspects outlined for the tools and draw out 22 relevant key points to be taken forward to form a design brief for a new tool or intervention. The three themes of Design Communication, Clinical to Creative and Collaboration, will again be considered and used as a basis for the following discussions. The tools have been organised and rated in response to the six questions posed in figure 5.1-1, these are tabulated in table 5.16-1 below.

The points drawn out from the tool review were either posed as: 'a design that *should* ...' or 'a design that *could*...'. The difference here was that the *should* points can be considered essential and core to the design. Then the *could* points were to be incorporated into the design to varying degrees but were considered less essential then the core points. These secondary points were not all expected to be met fully but integration of their 'spirit' into the design was aimed for as a minimum. The *should* and *could* points were split, so that 11 points were considered core and essential to the design, with a following 11 considered to be supplemental but desirable.

Tool	Q. 1	Q. 2	Q. 3	Q. 4	Q. 5	Q. 6	Creative Agency
Rethink your Drink	♦♦ (original) ♦♦♦ (revised)	♦♦♦ (original) ♦♦ (revised)	1	♦♦♦	♦	♦	1
Node-link mapping	♦ (original) ♦♦♦ (revised)	♦ (original) ♦♦ (revised)	2	♦♦♦	♦♦♦	♦♦	2
Motivational Interviewing	N/A	N/A	3	♦♦♦	♦♦	♦♦	1
The Outcomes Star	♦♦	♦♦♦	4	♦♦♦	♦♦♦	♦♦	1
Participatory mapping	♦♦♦	♦♦	5	♦♦	♦♦♦	♦♦♦	5
Life history calenders	♦♦♦	♦♦	6	♦♦	♦♦♦	♦♦♦	2
Design and Sexual Health	♦♦♦	♦♦♦	7	♦♦	♦♦	♦♦♦	2
Drink Informed	♦♦	♦♦♦	8	♦♦	♦♦♦	♦♦	1
Mindnosis kit	♦♦	♦♦	9	♦	♦	♦	1
Pause for Mind	♦♦♦	♦♦♦	10	♦♦	♦	♦	3
MindJournal	♦♦♦	♦♦	11	♦♦	♦	♦	5
Cultural probes	♦	♦♦♦	12	♦♦	♦♦	♦♦	4
Tools for Therapy	♦♦	♦♦♦	13	♦	♦♦♦	♦♦	5
Recovery amulet	♦♦	♦♦♦	14	♦	♦	♦♦	1

Rating scale: ♦ Not very much ♦♦ Partly ♦♦♦ Very much 1 = Clinical 14 = Creative

Table 5.16-1 Existing engagement tool review themed questions

5.16.1 Design Communication

The clearest to understand materials amongst the tools are the ones produced by designers, which include: Pause for Mind, Mindnosis kit, MindJournal and Drink Informed. The content in these projects is attractive, well-structured and straight forward to grasp. The design of the original cultural probe pack includes a variety of tasks and the materials have arguably the most provocative graphic design. They have a design which is intended to provoke, which might be too abstract as an aesthetic for the concepts to be clear. Especially for a participant group who have potentially reduced cognitive function, due to prolonged substance use or taking medicines. Only one tool, Rethink your Drink, uses an aesthetic which is linked to the place in which the intervention is to be used, which may be less effective if it is to be used more widely. However, it could be more widely distributed as a stripped back design like the Alcohol Change UK version of the scratch card.

1. The design should be clear and easy to understand with a simple, calm and welcoming aesthetic. The materials should not be overly place specific to allow wider use, and include a level of engaging playfulness similar to the scratch card concept.

Several tools use graphic structure to work within. The participatory mapping and life history calendar activities are less engaging in terms of structure. Here the design is utilitarian, simply as a basic structure for the activity to be undertaken within. The least effective tool in terms of the graphic design of structure, is the original node-link mapping materials, which are cluttered and rely on the use of 'clip art' in their designs. Whilst they are usable, a cluttered design has the potential to confuse participants during the process and give the impression that the activities are not serious. These have, however, since been overhauled in design to be much clearer and straightforward. The MindJournal provides structure to allow participants to easily begin the activities. This helps to deal with writers block and the anxiety of encountering a blank piece of paper. The journal is also careful not to overload participants by requesting too much information for each task, with the steps in each journalling session being manageable sizes.

2. A tool should use structure sparingly in the design to reduce the chance of user confusion and provide tasks in manageable sizes.

Three of the tools rely on three dimensional products in their designs. Firstly, Drink Informed uses physical props of the body, which can communicate the potential damage unhealthy levels of drinking could be causing to the liver. Secondly, the Recovery Amulet is a product design example, which uses materiality to achieve the aim of reminding the owners of the weight and solidity of their recovery journey. Thirdly, Tools for Therapy uses a selection of objects which are used to increase communication between the user and the professional. This helps to make the interaction more tactile, via the objects symbolising things in a persons life.

3. A design could use physical objects to base conversations around, as this is more immediate and tactile in nature and may assist in working with users who have reduced cognitive function due to substance use or being on medication.

4. A design could use materiality to communicate ideas around recovery.

The Outcomes Star uses a novel method of engaging the user, with life areas located around a star, which provides a visual representation of progress when the person plots their own mapping. This activity also gives a detailed measure of the change being made by the user over time. The materials have been carefully designed to be clear and provide a framework for the activity without visually overpowering the marks made by the participant. The node-link mapping materials also provide a method for the measurement of the task, in the form of a 1 to 10 rating system at the bottom of each card. However, this is more simplistic and only measures the effectiveness of the activity and not a holistic change measure as provided by the Outcomes Star.

5. A useful aspect of a new tool could be a method of measuring the impact of the activities individually and the resulting change over time.

5.16.2 The Clinical-Creative Scale

Clinical interventions sit at one end of the scale from clinical to creative, with research based methods towards the middle and creative interventions (design and arts based) at the other end, as discussed above. These methods are all innovative in their approaches, with some being newer, and some have been established for longer. However, they all share the commonality of approaching recovery from a new perspective.

6. A new tool should aim to innovate through its method for working with a group which can be hard-to-reach.

The first three tools use clinically evidenced interventions, these are: Rethink your Drink, Node-link mapping and Motivation Interviewing. Of these tools Rethink your Drink repackages the 'Alcohol Brief Intervention' to make it more engaging via the use of a scratch card approach. The visual nature of the scratch card makes conducting the intervention more like a game then a clinical test. It also opens up opportunities for the test to be conducted in a wider range of settings, including local pharmacies and even the participants own homes. Node-link mapping is used alongside Motivational Interviewing, which is traditionally a talking therapy, to structure the relationship between support worker and service user and to increase elicitation from this interaction. Motivational Interviewing as a method has been designed to complement the style of therapy that the key worker uses.

7. A design could repackage an existing method to be more engaging.

8. A new tool or intervention should be flexible enough in its design to allow its use with different established therapeutic approaches. For example: cognitive behavioural therapy, acceptance commitment therapy or gestalt therapy.

One overriding theme amongst the interventions is the visual and/or tactile nature of the methods and materials. The mapping activities and the Outcomes Star are visual and to varying degrees also creative in nature. Others, including: Rethink your Drink, Drink Informed, Pause for Mind, Tools for Therapy and the Recovery Amulet, use objects that participants can engage with. These elements are important as they make the process more interactive and make language and written communication less important, which can be beneficial to participants with reduced cognitive function. These could be considered 'boundary objects', as defined in the literature review chapter. Another element to consider is that having a visual or tactile aspect to a tool, does not necessarily mean that participants completing the tool will experience creative agency during the

process. This is evident from the creative agency rating of the tools compared to their position in terms of the creatively produced end of the spectrum. This was the identified during a review of this scale and is the reason for introducing the creative agency rating of each tool. Creative agency is important as it can make the process more enjoyable, therapeutic and empowering for participants.

9. A tool should use creative and visual methods to reduce reliance on written and spoken interactions to make participation more accessible and facilitate creative agency.

The interventions described here are either based on well evidenced clinical methods, part of a rigorous piece of research or are developed in collaboration with professionals in the recovery field. However, the level of evidenced effectiveness of each approach follows the graduation of the scale from clinical to creative. Rethink your Drink is therefore the intervention with the strongest clinical evidence behind its method and the Recovery Amulet has the least clinical evidence behind its method but it was still produced in collaboration with an establish recovery organisation.

10. Rigour in development should be taken forward into the design of a new tool or method.

Another theme which comes out of the Clinical-Creative Scale is that predictably, the more creatively developed interventions have the higher opportunities for participants to be playful and have creative freedom. For example, how the objects are arranged in the Tools for Therapy interactions or the content of the journal entries in the MindJournal. The Recovery Amulet, however, does not facilitate participants creative agency even though it is the most creatively produced. The scratch card technique used in Rethink your Drink is a fun activity to undertake but this does not involve creative agency and the free mapping activities in the node-link materials and the participatory mapping sessions have some potential

for 'open expression', and therefore creative agency is not strictly limited to the creative end of the scale. Playfulness is also a key element of the concept behind the cultural probe technique, as described above. The opportunity to be playful in the activities within an intervention is important as this increases enjoyment in the process, as highlighted previously through participant comments in the participatory mapping research (Bayley and Thickett, 2013).

11. Playfulness is a factor which should be taken forward into a designed intervention.

The next three tools on the scale are research based interventions. The Outcomes Star was initially developed from participatory research but has since become widely used by recovery services as an outcomes measurement tool. It has a visual element but as per the clinical interventions above does not include creative agency during the activity.

Following this the next two tools were based around the use of design methods. DaSH and Drink Informed were both produced using design techniques to facilitate outcomes. DaSH uses service design methods and design thinking to create a new more effective service provision. Drink Informed is produced by the design-led Helen Hamlyn Centre at the Royal College of Art (RCA), using the Double Diamond process of design development advocated by the Design Council.

The final four projects include the most creative in the approaches. Pause for Mind includes activities in a kit which are based on creative and relaxation tasks for reducing symptoms. MindJournal uses the creative process of journalling to help users understand their thoughts and emotions. Cultural probes use a series of tasks to find out more about the lives and habits of the target audience, through creative completion of the tool materials.

5.16.3 Collaboration

The majority of the interactions are designed to be used jointly between the user and the professional. However, there are several, including: Rethink your Drink, Pause for Mind, Cultural Probes, MindJournal and the Mindnosis kit, which are designed to be used autonomously. When participants are working with challenging emotions there are limits to the amount they will be willing to share with a professional in the beginning (Mindnosis kit, for example, attempts to bridge this gap). Also, the ability to be used autonomously means a tool has the potential to reach more people (in the case of Rethink your Drink).

12. A new intervention should have the ability to be used in two ways. By being clearly self-explanatory for individual use but also be useful for delivery by a professional. As participants may prefer to (at least initially) work on the intervention in private, before sharing the responses later with a professional.

The tools involve a variety of different interactions which take place between the user and professional. Rethink your Drink provides a simple intervention based around the completion of brief intervention questions, then following the outcome, potentially further questions, advice and signposting. Other interactions are designed to be therapeutic, for example, Motivational Interviewing and node-link mapping involve the completion of activities which are designed to facilitate behaviour change. The Outcomes Star is interesting as this is primarily designed to investigate and measure where an individual is in their recovery journey at set intervals. The activities undertaken during participatory mapping are completed as part of a research project to investigate specific objectives. However, whilst participants commented that they enjoyed the process, they are not designed to be therapeutic.

Several tools consider a key value in their use being that they are able to improve the client and key worker relationship. This is important as regular sessions will be attended by the service user and the relationship with their support worker needs to be strong and trusting, to increase the likelihood of a sustained recovery. Other tools which have this effect are the Outcomes Star and Motivational Interviewing.

13. A tool could help build the client and key worker relationship to help galvanise progress in recovery.

These same tools assist in increasing elicitation from the user through professional interactions, which is also evident in the research based methods (participatory mapping, life history calendars and the Outcomes Star). The tools which are research based aim to increase elicitation from using research methods which are innovative.

14. A tool should increase elicitation from participants, which may further help to strengthen the user and professional relationship.

By increasing elicitation and encouraging users to open up more, a tool has the potential to help participants communicate when they find it difficult to express emotions. This is the specific aim of the Mindnosis kit and is something which is essential to ensure that participants do not get stuck at the beginning of the recovery process.

Participants who are especially reluctant to open up may find it difficult to trust a support worker enough to start the process of sharing. This was found in the participatory mapping with street drinkers, where a familiar trusted support worker was brought in to the process. Also, for creativity based methods such as art therapy, specialist facilitators are generally brought in to run groups with services users. This is due to the fact that support workers may not have the confidence to engage clients using creative practice.

15. A new intervention could be used by existing support workers without requiring specialist facilitation. As interaction with a familiar person can help accelerate the initial stages of trust building.

In this way it is important that an interaction is straightforward and intuitive for use by support workers, which was one intention in the design of the Outcomes Star.

16. A tool could be in tune with the individuals who deliver services, complement existing ways of working and be deliverable in practice.

The Drink Informed tool specifically considers the interaction from two sides: the patient perspective and the side of the professional.

17. A tool could consider the experience of both the user and professional to ensure it is effective at supporting the interactions.

Another element which is key in the early stages of using an intervention is making the process accessible, which can be achieved by reducing the formality of the interaction. For example, the participatory mapping activity is referenced by the researchers at achieving this. This is also a factor which is employed to varying degrees by the majority of the tools detailed above.

18. A new tool could reduce the formality of the user and support worker discussions, to make them more accessible.

Throughout these interventions they help to build confidence, trust and agency with support workers, with the aim being to allow participants to feel less disconnected and encourage communication with others. This is something which building recovery capital aims to do and several of these interventions directly assist in building recovery capital (via social capital).

19. A tool could aim to identify levels of recovery capital alongside highlighting where social capital has been lost by the participants.

Increased elicitation allows participant stories to be told through the outputs produced, for example, during the mapping of social networks or completing life history calendars. This can be empowering for participants either through revelations about their own recovery journey or in the knowledge that they will be helping others through involvement in research. This provides agency and purpose, placing them at the centre of the process, so that they are active participants rather than passive observers.

20. A tool should attempt to assist participants to tell their stories. This might provide an empowering experience which facilitates agency through involvement.

Confidence when relaying a recovery story with others through group therapy (a peer support network) can also be very beneficial to those in recovery.

21. A tool could provide outputs which can facilitate a debate in a group setting.

One method to empower participants is to directly involve those who have previous experience of substance use and mental health issues in the design process. This took place in the development of both the Mindnosis and MindJournal projects and some of the other tools will also have piloted versions with those in recovery during the design process.

22. The tool should involve service users as 'experts by experience' in the design process, which is considered key to ensuring the experience of completing a tool is empathetic.

6.0 Cultural Probe - Pilot (I)

The Cultural Probe bridges between the initial three Design Experiments conducted at the start of the research and the design iteration Pilots. The following chapter describes the study design, development and deployment of the Cultural Probe as both Design Experiment (III) and Pilot (I) from the research. The rationale for using cultural probes as a method was discussed in chapters 4.0 and 5.0. Here the methodology, data and findings from the deployment of this Pilot will be discussed in detail.

6.1 Role of the researcher

It was decided that the researcher role would be to design and manage the development of the Cultural Probe, which would include instructions for participants. The researcher would not act as the facilitator in the workshops, instead the experienced support staff would undertake the workshop facilitation. This was because the process might bring to light difficult past experiences and feelings, which would need to be managed carefully and sensitively. This approach was intended to protect participants, as the researcher did not have the required experience to manage all the challenging situations which may be brought out during the sessions. The absence of the researcher from the data collection would also minimise researcher reactivity. Researcher reactivity is when the presence of the researcher during the data collection period and resulting interaction with participants, may influence or create errors in the data. This is a common risk factor in qualitative research (Maxwell, 2012).

6.2 Design development

The prototype Cultural Probe pack was designed to be self-contained and include all materials required by the participants to respond to the tasks (instructions, pens, pencils and a disposable camera). Tasks were outlined on postcards, with

space provided to allow the recording of answers. The physical design was intentionally low-cost and low-tech, to allow quick and simple production. The graphic design aim was not to appear too polished, overly institutional or clinical. Therefore, the design of the cards was kept minimal and clear, without the use of distracting superfluous graphics. The postcards were blank and the questions for each card were printed on a A4 sheet of stickers which were then applied to the cards individually. The intention was to be allow the production of one kit by simply printing a single sheet of stickers, rather than being required to individually print all the different cards. This helped to give the kit a homemade feel as it was considered critical that participants did not view the kit as something not be spoilt or for mistakes to made on. The intention was to infer permission to be creative and to scribble out and start again if needed. The wording of the task questions was carefully designed not to lead responses and to ensure the tasks were straightforward and easy to understand, to minimise any difficulties which may be faced by participants with language barriers or reduced cognitive function. The tasks were focused on the following activities:

1. Asking participants to describe themselves and pick a nickname (to maintain anonymity in the research).
2. Mapping the places visited during periods of alcohol or substance use on a local city map.
3. Completing past and present day diaries.
4. Offering thoughts on current recovery support provision and access.
5. Drawing graphic maps of relationships to damaging substance use and social networks.
6. Photographing significant places in the city which symbolised recovery. Followed by places, people or things, which were significant to the participants or inspired them.

These initial activities were defined to provide a broad picture of the participant in recovery and they were inspired by the knowledge gained from the literature review and consideration of the original cultural probe tasks.

6.3 Prototype Cultural Probe compared with the original

The structure of the Cultural Probe was based largely on the original produced by Gaver and his colleagues, however, there were several differences. Provocative images were not provided, this was to minimise the risk of leading responses based on the specific images selected. Additionally, there was a concern that participants might become confused with the aim of the activity if it was too abstract and become disengaged, unless the tasks were very straightforward and clear. The postcard format was chosen for the same reason, as postcards are a familiar, friendly and an informal mode of communication. A photo album was not included due to the practicalities of the participants having printed photos available to be used. Finally, enquiries were not made through the kit into participants media consumption or telephone calls, as the concern was that this might feel intrusive and constitute a barrier to engagement.

Two additional tasks were added for the Cultural Probe, firstly, a mapping activity. This was considered an appropriate activity as service uses are already familiar with mapping, which is undertaken widely during drug and alcohol recovery key work sessions. Secondly, a task which asked participants about support service access was added to involve participants in the design development of the tool. Here the intention was to attempt to identify potential 'touch-points' for intervention via participant involvement.

As will be described in more detail below, the Cultural Probe was tailored more closely to existing techniques used by support services, enabling staff to deliver the tasks and explain them to the participants, in the absence of the researcher.

6.4 Increasing inclusiveness in participation

Generally, service users have a variety of abilities in terms of communication, including written and spoken English. Some may find talking about their feelings difficult but are more comfortable mapping or trying to photograph them. By using visual methods alongside written ones, the aim was to help participants communicate thoughts or issues, which may otherwise be difficult to express effectively (Drew et al, 2010) and overcome barriers of language or low creative or self-confidence. Using a variety of recording methods (writing, drawing, mapping and photography), was intended to make the activity more inclusive to participants, as there would likely to be at least one task that individuals were able to enjoy and participate fully in.

Discussion with support staff suggested that to deploy the Cultural Probe with their service users, consideration would need to be made to the substance use focus. Staff suggested that the kit tasks would need to include reference to both substance use and alcohol, as participants with alcohol addiction may not see themselves as substance users and vice-versa, which could make them reluctant to participate (P1.S3.SRW10).

By increasing inclusiveness in the design, the aim was that this would allow a richer quality of data to be produced by the process. As the approach would make it a more enjoyable and engaging series of activities and also help to assist in reducing any anxiety that participants may have towards the process.

6.5 Task Cards

Introduction

This card was designed to give participants a brief introduction to the research aims and to make them feel welcome and part of the project (Fig. 6.5-1). It was intended that the participants should feel that they were contributing their experience directly to a research project rather than simply being investigated. It was also considered important to make participants aware that there are not right or wrong answers. The aim was to provide a simple and clear opening to the tasks that put individuals at ease and comfortable moving forward, without overloading them with initial information.

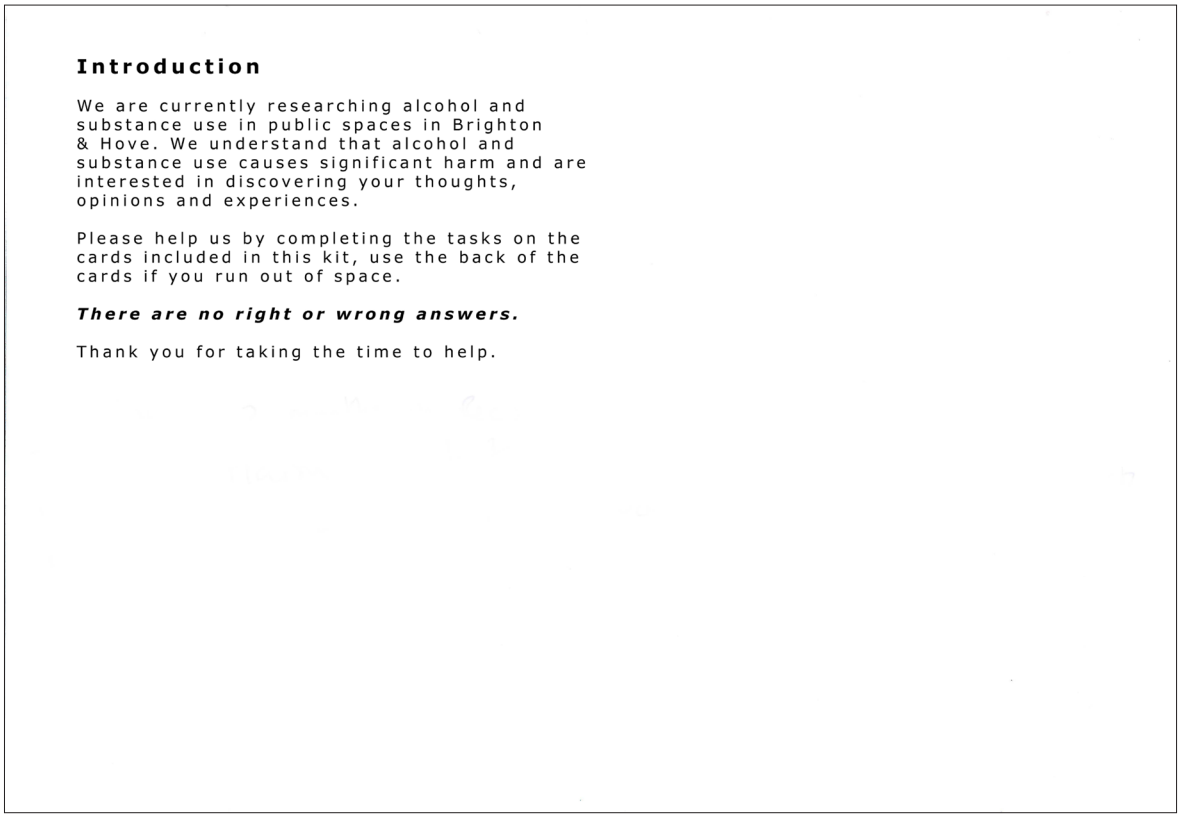

Figure 6.5-1 Pilot (I) - Introduction card

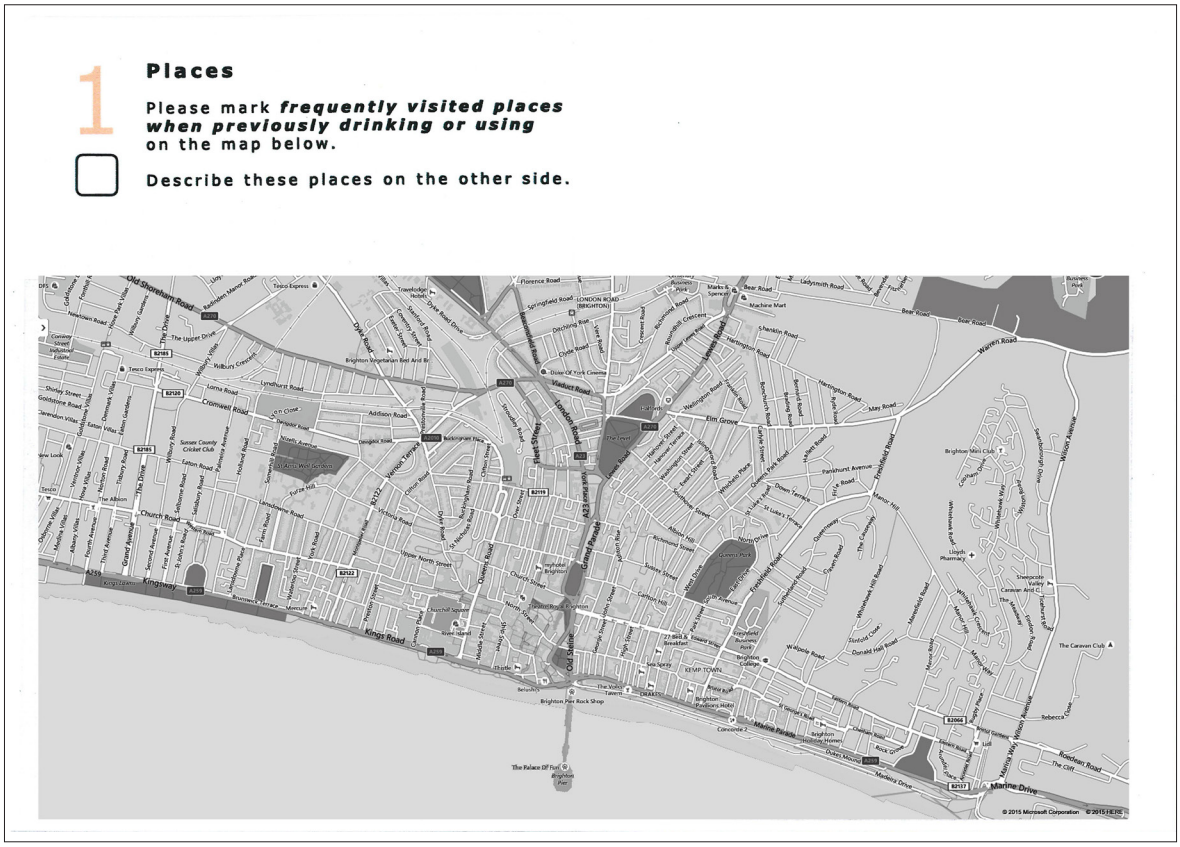

Figure 6.5-2 Pilot (I) - Places card

Task 1 - Places

This task was designed to identify the locations inhabited by participants which were specific to their individual recovery journeys. Respondents were encouraged to think back to their behaviours and movements whilst they were drinking or using and mark them a map of the local area (Fig. 6.5-2). It was thought that this could provide an understanding of the key places which influenced each of the participants during the time before recovery. This information also had potential to be useful to services for identifying nodes or hotspots of damaging behaviours or key recovery spaces in the local community. Information, which in turn, could be used to inform treatment provision both for individuals and the residents as a group.

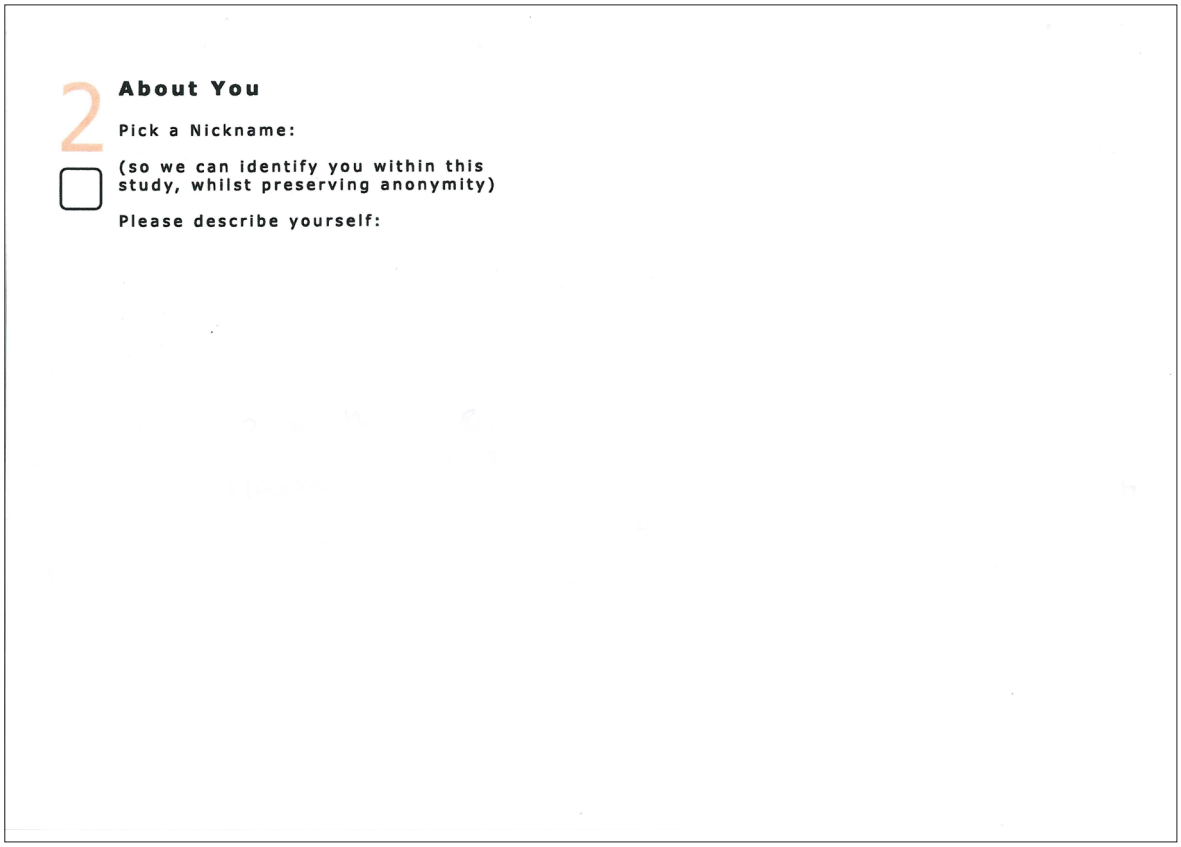

Figure 6.5-3 Pilot (I) - About You card

Task 2 - About You

This task aimed to give participants the opportunity to introduce themselves and provide an alias or nickname, which would enable them to be identified by staff within the research but would be anonymous outside of the project (Fig. 6.5-3). The task asked participants to simply describe themselves, a question which was intentionally left open so that respondents could describe the things that seemed important to them.

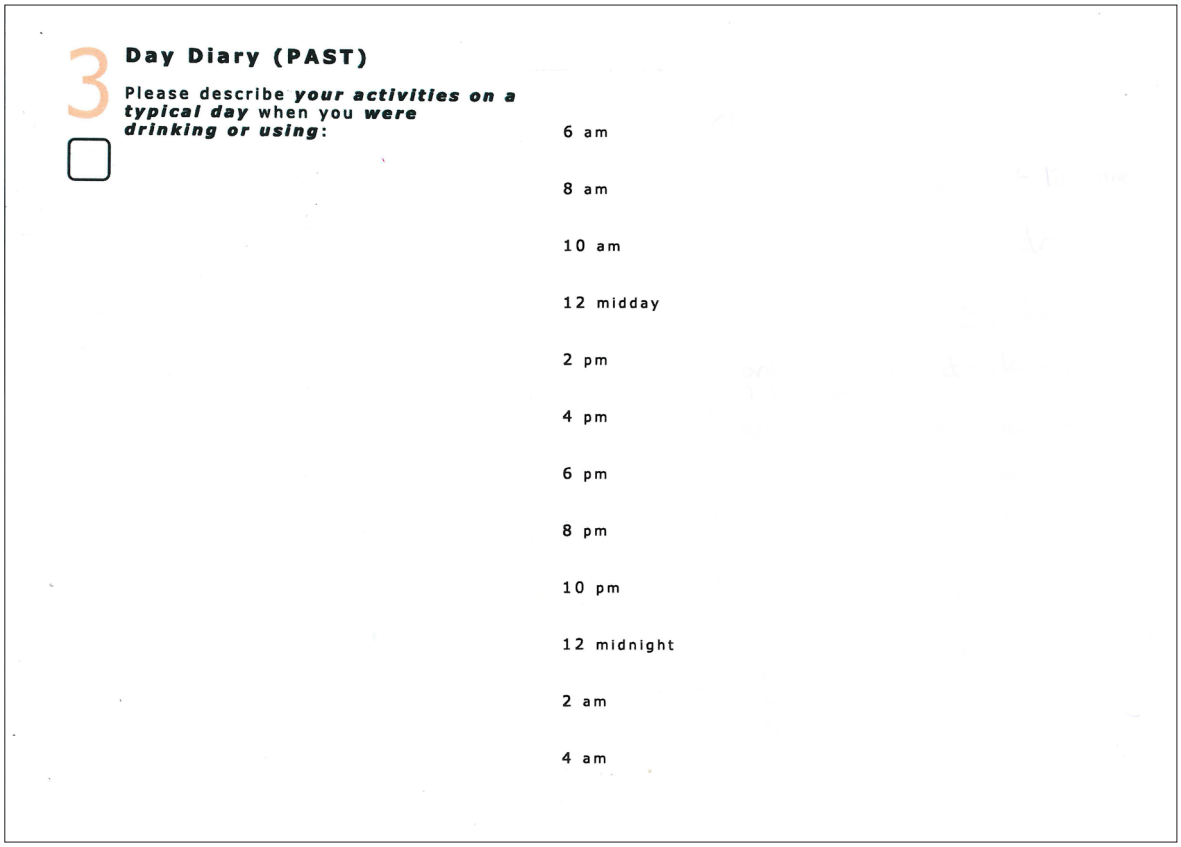

Figure 6.5-4 Pilot (I) - Day Diary (PAST) card

Task 3 - Day Diary

This task asked participants to plot their typical daily activities on structured cards for both past (Fig. 6.5-4) and present (Fig. 6.5-5). This was intended to provide detail about participants more predictable and stable lives whilst in recovery, and contrast this with detail about participants less predictable and chaotic past lives. The task was also aimed to provide individual descriptions of daily habits and rhythms.

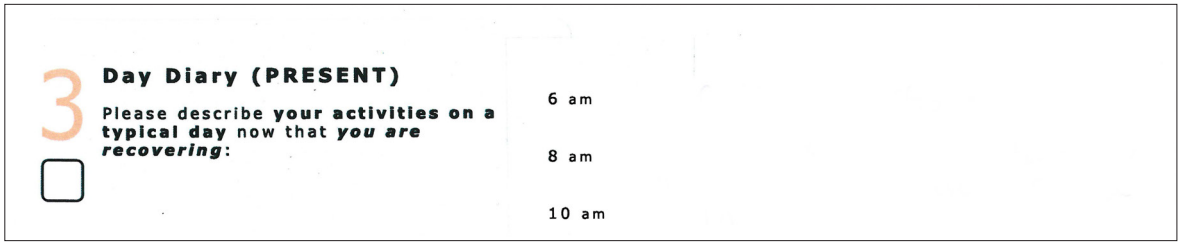

Figure 6.5-5 Pilot (I) - Day Diary (PRESENT) card excerpt

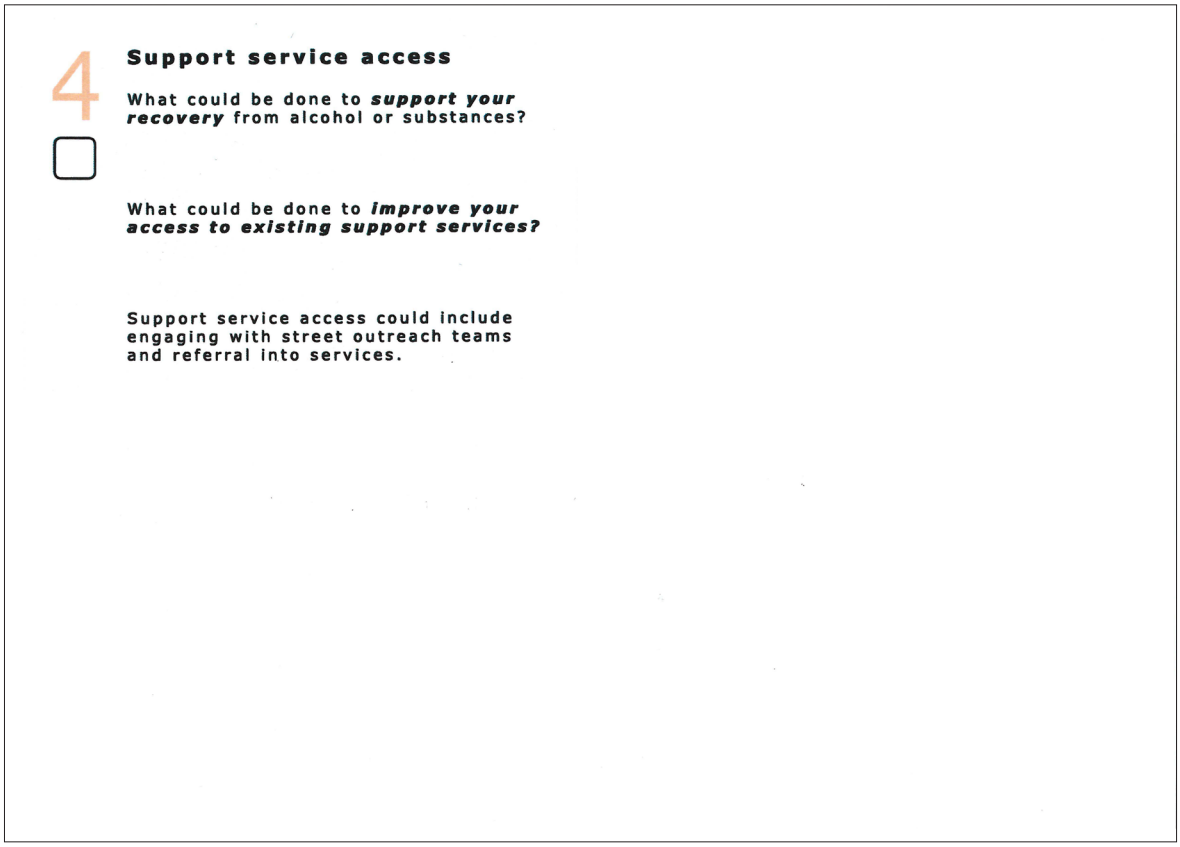

Figure 6.5-6 Pilot (I) - Support service access card

Task 4 - Support service access

This task asked participants for their suggestions on how their individual recovery could be supported (Fig. 6.5-6). Their opinions were valuable as they have been through the assessment, detox and maintenance stages of the recovery process. They were asked how they felt that service access could be improved, so the service could gain feedback. It was considered useful to pose a service specific question to draw on service users views as 'experts by experience' of using the service. This was intended to help service users to feel part of research, with their opinions used to inform the service.

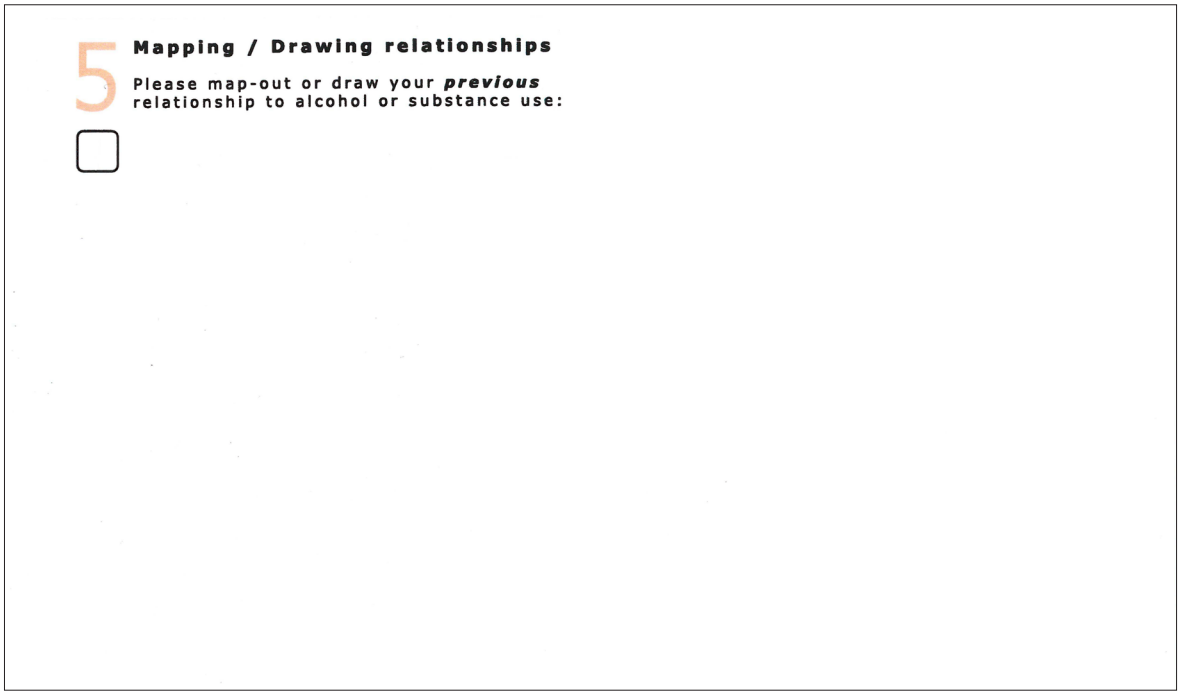

Figure 6.5-7 Pilot (I) - Mapping / Drawing relationships (PREVIOUS) card

Task 5 - Mapping / Drawing relationships

This task aimed to give participants the freedom to be more creative with a free mapping exercise. The intention was that they could draw their relationship towards substance use as a node-link map, to show connections to substance use or through an illustrative drawing of how they felt substances had affected them (Fig. 6.5-7). The aim was that this activity would bring to light participant attitudes towards their own substance use and allow them to contrast this with future abstinence goals or changing attitudes to damaging behaviours (Fig. 6.5-8). Participants would already be familiar with producing maps as the service uses node-link mapping, as described in the existing design tool review (chapter 5.0).

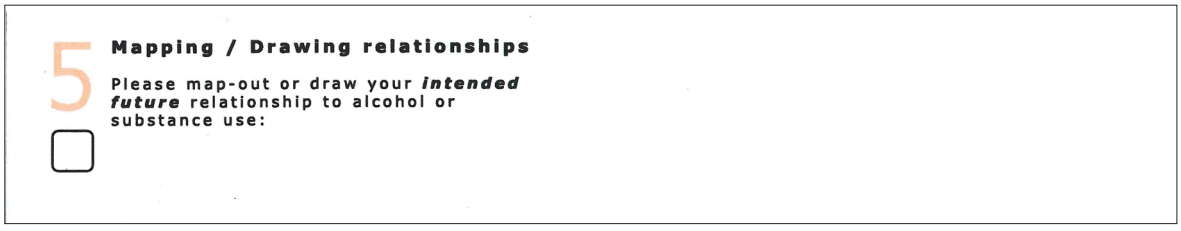

Figure 6.5-8 Pilot (I) - Mapping / Drawing relationships (INTENDED FUTURE) card excerpt

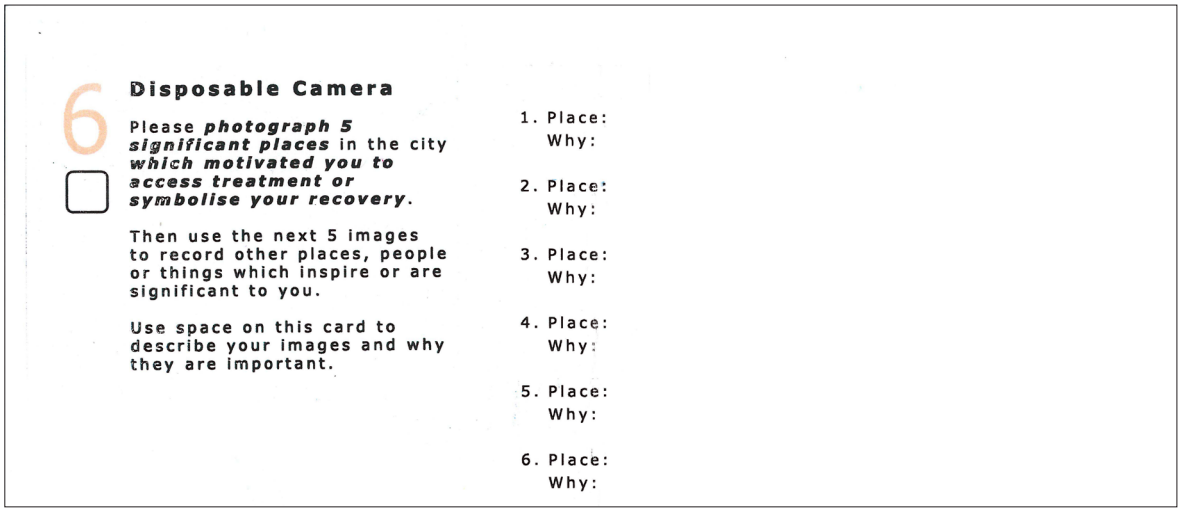

Figure 6.5-9 Pilot (I) - Disposable camera card excerpt

Task 6 - Disposable Camera

A disposable camera was included and repackaged to allow it to fit visually in with the other kit materials (Fig.6.5-10). One key adaptation to the original cultural probe was that the camera task and map task were linked. Participants were asked to use half the film to document the places highlighted in the places task and then use the other half of the images to generate more speculative data (Fig. 6.5-9). The intention was to make these places change meaning for the participants, by encouraging them to revisit and document them from a different perspective. Participants would already be familiar with using a disposable camera as the service had previously run a photography creative group with residents (P1.S2.SM6). This is another example of the attempt to reduce anxiety towards participations by building in elements which are already familiar to the participant group.

Figure 6.5-10 Pilot (I) - Disposable camera instructions on camera

INTRODUCTION TO THE RESEARCH

A research project is being undertaken by Kingston University and St. Thomas Fund to find new ways to improve service access. As part of this research we would like service users to play a key part in data collection and if willing, complete the activities contained in the research packs. The research is voluntary and you can end your involvement at any time and this will not affect your ongoing treatment at St. Thomas Fund in any way.

Why is it being done? What does it hope to achieve?

We aim to discover ways in which access to support services in Brighton & Hove can be improved. As part of this process it is important for us to understand difficulties faced by service users and the reasons why people may not want to or be able to access the support which is currently available. This will hopefully lead to improvements which increase service access and engagement, to support lasting life changes.

How long will it take?

We aim to collect responses from service users over three workshop sessions. Although extra time will be provided if requested.

What information will be available and when?

Information collected is part of an ongoing project. Service users contributions are anonymous and as such nobody will know contributors identities. Information will be compiled in a report for St. Thomas Fund, which will be complete by the end of the year. Collected information will be confidential and stored securely, with all participants remaining anonymous.

TASK 1 Places

Please mark ***frequently visited places when previously drinking or using*** on the map below. Describe these places on the other side.

What I did there *Why I went there* *What stops me going back*
How do I feel about these places

TASK 2 About You

Pick a Nickname:
(so we can identify you within this study, whilst preserving anonymity)

Please describe yourself:

What is important to me *My skills* *What I like doing*
What I would like to do in future

{please prompt individuals by randomly choosing suggestions for each task from grey boxes only if asked for ideas or help]

TASK 3 PAST Day Diary

Please describe ***your activities on a typical day*** when you ***were drinking or using***.

PRESENT Day Diary

Please describe **your activities on a typical day** now that ***you are recovering.***

What you liked / disliked / felt about these activities

TASK 4 Support Service Access

What could be done to ***support recovery*** from alcohol or substances?

What could be done to ***improve access to existing support services?***

Barriers to service access *Lack of personal support*
Problems with services *Attitude of people* *Lack of information*

TASK 5 Mapping / Drawing Relationships

Please map-out or draw your ***previous*** relationship to alcohol / substance use.

Please map-out or draw your ***intended future*** relationship to alcohol / substance use.

Verbal / Physical abuse *Mental / Physical health* *Socialising*
Harm Caused *Friends / Family* *Service access*
Friends / Family *Opportunities* *Service support*

TASK 6 Disposable Camera

Please ***photograph 5 significant places*** in the city ***which motivated you to access treatment or symbolise your recovery***. Then use the next 5 images to record other places, people or things which inspire or are significant to you. Use space on this card to describe your images and why they are important.

What I am proud of *What frustrates me* *Places I am fond of*
What I am grateful to have *Someone/thing I respect*
Objects with meaning *What I like most* *What I wish I had*

STAFF SHEET V6.0 MARCH 2016

Figure 6.5-11 Pilot (I) - Facilitator sheet

Facilitator sheet

The facilitator sheet was designed as a tool to assist the workshop leader during the sessions (Fig. 6.5-11). The instructions for each task are recorded here as they appear on the task cards as a reminder. The sheet also includes prompts, which could be chosen at random, as suggestions to a participant if they became stuck with responding to a task. This was an element which was requested by the support service to help facilitate the sessions and provide structured guidance to participants during the process, if required.

6.6 Cultural Probe testing with MA design students

The tool was tested with MA Sustainable Design students at Kingston University. The Sustainable Design course undertakes projects based on addressing social issues, so they were an appropriate test group, whilst not being in recovery themselves. To make the workshop more realistic three case study Personas were simplified and refined from the previous extensive case study research. The Personas (a technique used in service design) were each based on a fabricated person, the character of which embodies key attributes of an existing social type. Participants could then embody each Persona and are, to an extent, able to bridge the empathy gap. The Persona enables the characteristics, demographics, desires and challenges of a group to be represented and comprehended (Tassi 2009). Whilst it is understood that this process is a simulation, the workshop did allow the students to complete the tasks in the kit. The process provided a method of testing the tool in practice and provide insight into the legibility of the tasks and process structure, although no data was collected from the session.

6.7 Organisation and participant description

To trial the completed prototype a research collaboration was initiated with a national organisation called Change Grow Live, which assists people to make positive changes in their lives. As part of this collaboration, a local substance use rehabilitation facility arranged access to a group of their service users. This facility offers places to adults who have a connection to Brighton and Hove and are allocated following referral. The majority of the clients have experience of rough sleeping, the criminal justice system, complex mental or physical health needs and problematic drug and alcohol use. The participants of the pilot were at that time residents in one of the organisation's recovery programmes, undertaking Stage 1 as described below.

This stage was targeted following a meeting which took place in April 2015 with the manager of the residential rehabilitation centre (P1.S2). During this meeting ideas were shared on an prototype of the Cultural Probe to gather feedback for development. Ideas for how the kit could be implemented were also discussed, it was suggested that the return rate of kits from the street community would likely be low due to their chaotic lives, as the kit maybe be discarded or lost during the process (P1.S2.SM1). This point in recovery aligns with the pre-contemplation or contemplation stages in the Stages of Change model, as referenced in section 2.4. This is when an individual is currently in a state of denial about the challenges that they face or are beginning to recognise that they have problems that need to be addressed. However, they are likely to still be ambivalent about making changes to their lives (Hill, Penson and Charura, 2016). Therefore, it was considered to be an inappropriate stage of recovery to intervene.

The decision was taken to target a less chaotic group of individuals. An appropriate group was those who were already in a rehabilitation setting, as these individuals were not in chaos. Such a group exits in the rehabilitation centre and whilst stabilised, these clients still have recent experience of entrenched drinking and drug use and would be well placed to compare and reflect on their transition during the process. This point in recovery aligns with the preparation or action stage in the Stages of Change model, as referenced in section 2.4. At this point in recovery individuals are either making preparations to make change in their lives or are making significant changes to their lifestyles (Hill, Penson and Charura, 2016). The was considered as a much more appropriate stage in recovery to target with a creative intervention, as the likelihood of engaging the target group would be higher, with individuals already having developed a motivation to make changes.

All eight residents participated in the pilot, all were male and between the ages of 18 and 55 years and predominantly former street drinkers. All were in the early stages of their recovery and abstaining from substances and alcohol. All the

individuals would also previously have been drinking at hazardous levels, even though some would not consider alcohol as their main addiction and several were suffering from significant mental health issues.

Support staff were on site 24 hours a day and the residence could accommodate up to eight residents. Residents undertook Cognitive Behavioural Therapy based activities and detoxification (if required). They were also:

> "...supported to reflect on and address the reasons behind their drug and alcohol use, as well as engaging with other recovery activities including creative groups, gardening and literacy support." (Change Grow Live, 2017 p1)

6.8 Workshop description

Group work sessions took place in the lounge area, which consisted of sofas and arm chairs arranged around a coffee table with a television in the corner. The room was similar in set up to a domestic living room. In the accommodation there was also a kitchen for residents to cook meals together and separate staff offices.

The tasks were completed over the course of three one and a half hour workshop sessions and during each session the activities were introduced by an experienced facilitator, who was briefed prior to the sessions by the researcher. The individual tasks were then completed by the participants, which was followed by a group discussion and review of the responses at the end of the process.

The workshop facilitator was briefed before the workshops and talked through the facilitator notes which were prepared as a single A4 sized page. The facilitator was requested to only prompt participants if they requested help, this was aimed at preventing the participants inadvertently being led towards answers or ways of interpreting the activities.

The facilitator then introduced the kit to participants by firstly explaining what the activities during the sessions involved. Participants were then asked if they had any questions about the project and asked to read through the participation disclaimer, which included information about anonymity. Participants were then requested to sign the form to confirm that they understood the purpose of the research.

The partner organisation were provided with eight finalised Cultural Probe kits. The completed kits were returned six weeks later and of the eight kits provided, four were returned complete, one mostly complete and three had been misplaced.

6.9 Ethical considerations

As this project was intended to inform the development of design tools and not to collect and analyse client data, the aim was to ensure that participants felt as secure as possible participating. Therefore, anonymity and was ensured for all the information produced. This was to give participants the freedom to express themselves and to photograph anything they desired (for example service staff who they felt were important to their recovery). Nicknames instead of real names were recorded, however, there was still a danger that individuals might use street names, which could then be recognisable from the responses.

Responses might also have contained candid descriptions of past behaviours, which involved criminality, as several participants had previously been involved with the criminal justice system. As the activity was group based, the data might include descriptions or images of others in the group, who might be recognisable. Therefore, full anonymity for participants was considered critical to promoting confidence and strong engagement, whilst minimising the potential for anxiety towards participation due to the considerations discussed above. Essentially, it was important to the research process that participants felt that

they were participants in the process through telling their story rather than being 'subjects of research' or having their data collected to then be analysed and disseminated.

Meetings with support staff raised one key ethical issue to consider and manage. The service did not want to ask clients to go where they used to drink and then take photographs, especially when they were very early in their recovery (P1. S3.SRW16). As they felt that even if they were chaperoned, there was a risk they may relapse or return to old behaviours. However, the service felt that clients that were more established in recovery could do this task and may get benefit from it, as they may look at certain places in a different way. It was decided that stage 2 clients were sufficiently established in their recovery to minimise this risk.

Participants were talked through the aims, objectives, and process of the activities prior to the sessions. They then signed a simplified and easy to understand consent form (see appendix B) to participate. It was made clear that the process was entirely voluntary and that they could withdraw at any time without prejudice or jeopardising their ongoing treatment. Individuals were made aware that whist the responses in the sessions were anonymous, workshop staff may need to act if any information arose that raised concerns over the safety of the participants, staff or others. Kingston University Ethics Committee approval was granted for the research in October 2015 (see appendix E).

6.10 Key meetings with support staff

Pre-workshop review session with staff

Once a prototype cultural probe pack was complete, it was reviewed with senior staff at the partner organisation and tabled at an internal meeting to obtain comments from the wider staff team. Feedback from these meetings was implemented to develop the design further prior to undertaking Pilot (I).

Development and delivery ideas from the review of the draft tasks were as follows:

1. Important that the tool is accessible to both service users with substance use and alcohol issues. (P1.S3.SRW10)
2. Important to provide time and space for clients to complete the tasks properly and not rush. (P1.S3.SRW15)
3. Useful to have prompts for the facilitator to assist if clients are stuck with a task. (P1.S3.SRW11)
4. Important that clients have a clear brief and structure to work within but have space to be creative with their answers. (P1.S3.SRW14); (P1.S2.SM4)
5. Important to provide a time frame for the completion of the materials. (P1.S2.SM8)

Post-workshop review session with staff

Following the completion of the Pilot (I) workshops, a review session was held between the researcher, service manager and workshop facilitator. The staff member who facilitated the workshops had regular contact with clients and knew them well (P1.S4.SRW8). Staff at the partner organisation expressed that the kit was easy to deliver (P1.S4.FAC5) and that participants enjoyed the experience overall and got a lot from the process (P1.S4.FAC1). Some participants had difficulty maintaining and being responsible for the kits between the workshop sessions, which accounted for three misplaced kits (P1.S4.FAC4). The workshop facilitator stated that the participants enjoyed the process, with the reflective part helping them to see where their substance use had taken them (P1.S4.FAC2). As, for some clients, this appeared to open their eyes to exactly the places that their alcohol and substance use had previously taken them to, as was evident in the types of descriptions and images taken (P1.S4.FAC3). For example, lots of photographs were taken of car park stairwells and bin stores, which is where a lot of clients had ended up living and using substances. This could increase

participants motivation to continue progressing with change as they move from the action stage to the maintenance stage of the Stages of Change model, as referenced in section 2.4.

A concern raised by the facilitator during the first task was that clients started to not take the process seriously when they were asked to pick a nickname. They began giving each other overly exaggerated names and the facilitator felt there was a possibility of loosing the group focus at this point. They felt that someone facilitating a session who had less experience might not be able to get the group back. This could be exaggerated by tasks which are likely to bring up uncomfortable feelings for individuals, as it is easy for clients to lose concentration if they are sitting with uncomfortable feelings. So, if the opportunity arose to move to a less serious place, they would be likely to use the opportunity to escape the uncomfortable feelings or discussions (P1.S4.FAC9).

During the last session the group had a long discussion about how participants were left feeling. This discussion was generated by the facilitator who raised in the question: how do you feel? This was improvised as there was no focus on feeling included in the tasks. The facilitator highlighted that being in recovery is largely about feelings and how individuals respond to how they feel. They also felt that this discussion left several clients quite down and depressed about where their lives had ended up before coming into treatment. However, the session was ended on an upbeat note about the positives of now being in treatment (P1.S4.FAC11). This point is discussed in more detail in the ethical considerations section of the next Pilot (section 7.7).

In terms of individual tasks that were particularly successful, the facilitator felt that the Day Diaries were useful for residents to get a contrast between past and present life (P1.S4.FAC7). Even though it was acknowledged that the present daily activities for all the residents are approximately the same, as this structure is given to residents by the support service.

The facilitator didn't feel there was anything obviously missing from the Cultural Probe and found it relatively self explanatory. They commented that tasks were easy to understand, although a couple of participants needed certain tasks breaking down (P1.S4.FAC5). The sessions were considered useful as the service aims to keep residents occupied and stop them getting bored, which really helps them with their motivation levels (P1.S4.FAC8). However, the facilitator noted that it is only really valuable to the clients to complete the tasks once in treatment (P1.S4.FAC6).

Development of a graphic template for data analysis

The service suggested that it would be beneficial for participants to have access to their responses from completing the Cultural Probe tasks (P1.S4.SRW19). As they felt that the information would be useful to individuals for further discussion and recovery work. Therefore, following Pilot (I) each participant's responses to the tasks, including the photographs taken, were collated into graphic templates (see appendix E) and these were provided to the service staff and users as a paper copy. This summary of the kit responses provided a reminder of the process of completing the tasks and the responses given. The intention here was that this document could act as a relapse prevention tool and as a piece of work to discuss in key work sessions. Following the completion of Pilot (I) the researcher realised that the format of this graphic template was useful for data analysis, as it was easy to see all the data in one sheet.

6.11 Data analysis and discussion

(See methodology chapter 3.0 for a detailed description of analysis methods).

Task 1 - About You

During the personal description task participants were very creative with their responses to picking a nickname. There appeared to be a level of bravado in the names chosen and associated descriptions. As noted previously, the facilitator

felt there was a danger of losing the focus of the group at this stage, due to participants enjoying the task of thinking of a nickname.

Most descriptions begin with a physical depiction of the individual, again largely with a level of self-glorification. All but one respondent mentions the length of time that they have been in recovery and end the description on their recovery hopes, progress and aspirations regarding change. This later part of the task appears to be the point when the facilitator gained back the focus and control over the group, as amongst the bravado there are some clear and honest personal goals.

One particularly complete and interesting response was from an individual calling themselves *The Horse*. Their description contained the most self-glorification and also the most self-awareness. They openly state previous alcohol and drug use and acknowledge that they can be deceitful, use disguises and suffer from anxiety. They also state that they have no remorse for previous behaviours as a repeat offender. This initial description of the self is followed by a strongly contrasting section on recovery, stating they are a changed person and working hard to address their issues. This contradiction is suggestive of the struggle which those in recovery go through as they try to transition from a chaotic, overtly confident life of addiction to a stable, structured and more domestic life. This response illustrates the difficulty that can be faced in letting the past life go, along with previous social connections, as identified by the support staff as a requirement of the program (P1.S4.SRW1).

Task 2 - Places

All respondents marked and described places where they used to live, drank alcohol or used substances. All participants except one recorded between 1 and 24 places. The maps were overlaid in an attempt to identify any hotspots of use but this did not show any specific patterns.

The most illuminating response to this task was provided by an individual identified as *Gringo*. They recorded a large number of places, 24 in total. This suggests that their existence pre-recovery was particularly chaotic, which could mean they were a member of the street community or suffered from a particularly severe addiction situation or complex combination of problems.

Task 3 - Day diary (Past)

All respondents describe a daily pattern of:

1. Walking up late.
2. Finding money to buy drugs, either from shoplifting, busking or begging.
3. Drinking or buying drugs to use and then repeating this cycle until bedtime.

All noted that they go to bed late. Two of the respondents mention eating food during the day. Two respondents mentioned sexual activity during the day.

Task 3 - Day diary (Present)

All respondents describe a pattern of:

1. Walking up earlier.
2. Attending structured recovery sessions throughout the day, interspersed with leisure time. Several respondents mentioned engaging with social activities.
3. Relaxing in the evening and going to bed earlier.

All the respondents describe damaging, chaotic and often illegal past activities (which are detrimental to mental and physical well-being) and contrast these with structured and positive present activities (which are supportive to mental and physical well-being).

Task 4 - Support service access

This task differed from the other tasks as it was focused on access to support services rather then directly relating to individuals themselves. All participants attempted to answer and offered suggestions which included the following:

- Recovery community to continue support network
- Services better advertised and signposted
- Need for social networks in the community
- Training and housing opportunities
- Grants provided
- Detox programme
- Exercise

The participant who called themselves *Mr Perfect*, provided the most interesting response. From their other responses it was evident that in contrast to the other participants they were isolated and drinking at home. They suggested that there is a need for more activities in the local community which could provide social networks, such as drama groups or book clubs. As discussed in the literature review it is very important that to sustain recovery, individuals have access to opportunities to build new social networks. These groups do currently exist in the local community, therefore this is a question more of visibility and signposting, rather then a lack of existing community groups. This participant may have been unable to locate them or felt anxious about approaching these groups for the first time.

Task 5 - Mapping / Drawing relationships

All but one of the drawings produced by participants showed an awareness of the cyclical nature of their addictions and the damage they were causing to their physical and mental health. Responses also highlighted problems in earlier life

leading to addiction and obsessional thoughts about substances. Graphically, the responses were a mix of flow diagrams, lists and pictures. This task illustrated to participants a clear contrast between previous cycles of behaviour and their life currently in recovery.

One notable observation was made from the response provided by *Gee Money*. They drew a bottle of vodka and marked it with 20% alcohol content. This illustrates a lack of awareness of the correct alcohol content for this spirit, which for vodka is typically 40%. This could be accounted for as a lack of knowledge, or possibly wilful self-delusion. However, it is important as the individual may feel they are consuming half the alcohol content than in reality they are. This information is valuable to the support service to highlight this point and allow them to provide education across the cohort of residents at the centre.

Task 6 - Photography

The photography task highlighted that the activity allowed participants a more objective eye through which to view the places they previously inhabited locally. Predictably, various photographs were taken of places previously inhabited when drinking or using substances. Contrasting to these were a wide variety of images taken which symbolised recovery and overall these were images suggested recovery networks, including: support groups, volunteering locations, family and friends and key support workers. Two participants focused on past drinking and using locations, whilst the other two focused on the future, which may be a consequence of the participants going out to complete the task in pairs.

The most illuminating response came from an individual named *Guy Fawkes*. They stated on the card that “It’s more people and things which inspire me not places”. This is reflected in the images taken, which include the following things which were identified as important to them: feeling good, friendship, a secure

comfortable home, community social connections, formal recovery support and family. The response shows a real desire to change and the ability to identify through photography the key factors which will assist in long-term recovery.

General observations

Across the sets of data the participants mention an interest in forms of creative activity, including: playing instruments and possible involvement in drama groups or book clubs. Participants also attempted a drawing in the mapping relationships task rather then simply writing a list, which illustrates a willingness to try a creative approach.

Another notable pattern which was evident across the data set was the reference to mental health issues. All participants mention a negative mental health symptom at some point in their responses and overall this is mentioned a total of 11 times across all the responses.

6.12 Conclusion

The most significant finding from Pilot (I) was that involvement in the activity of completing the tasks may have therapeutic value to individual recoveries. Almost all of the participants engaged with each of the tasks in some way, even though the activity was voluntary. This suggests that the pilot group found the activity novel and engaging, even though some tasks brought out emotionally challenging feelings. Therefore, the deployment of this research activity, which was initially designed to discover more about the lives of service users and gauge opinion on improving access and engagement, resulted in providing a workshop activity that appeared to have potential as a recovery tool itself. This point was supported by the feedback from the facilitator that the group got a lot from the process and were engaged (P1.S4.FAC1).

The first task (About You) highlighted how easily a group at this stage of recovery could loose focus on the activity. Therefore, it is very important to carefully consider the stage at which any intervention is targeted. As in this instance, it required an experienced peer support facilitator to bring the focus back to the group for the remainder of the session.

The facilitator commented that one of the most successful elements of the activity was the reflective nature of the process (P1.S4.FAC2). This allowed participants the space to see where their addictions had taken them. The tasks which encouraged this the most were: Day Diary, Mapping / Drawing relationships and Photography tasks. In these activities the participants were able to see a contrast between past and present behaviours and reflect on their feelings about the differences and the progress made (P1.S4.FAC7). This was also found by the Arts and Humanities Research Council (AHRC) during the Cultural Value project (AHRC, 2016).

The images taken by several participants during the photography task and the responses to the mapping activity show the importance of friends, family and support workers to the participants in their own recovery journeys. This activity shows potential to help service users develop awareness around the importance of building networks and recovery capital generally, to sustain abstinence and avoid future relapse (Granfield and Cloud, 2001), as previously discussed in the literature review (chapter 2.0).

Four out of five participants mentioned some form of creativity in their responses, either current creative activity or possible future activity. This suggests that creative practice is something which those in recovery are engaged with. There is a body of evidence which illustrates the benefit that participatory arts can have on recovery from illness, including addiction and mental health issues (Howarth, 2017), as explored in the literature review. Also, participation in creative (non-recovery related) activities and involvement with community groups can help

to reduce social isolation and are considered essential by those in recovery to avoid relapse (Duffy and Baldwin, 2013). Therefore, tasks which can assist in highlighting the importance of building these connections and interests whilst resident in structured treatment are valuable, especially if the tasks themselves contain a reflective and creative element, which can inspire recovery and an interest in developing creative skills. As once structured treatment has ended, it is vitally important for individuals to have enjoyable and accessible activities to attend in the community and places to go to socialise and meet new people (Daddow and Broome, 2010).

One task which appeared to provide the least useful information was the task related to support service access. Whilst responses to this task were valid, they did not necessarily provide any novel insights into how service provision might be improved. Also, the feel of this task was different to the others and did not fit well with the overall approach of the Cultural Probe. This is something which was also observed by the team undertaking the Whole Person Recovery project (Daddow and Broome, 2010). They found that service users who were asked directly for their ideas on improving services responded with limited iterative suggestions, such as adapting the skills and attitudes of support staff, opening hours and improving access (Daddow and Broome, 2010).

One important issue that Pilot (I) raised was the presence of mental health issues with all the participants. This suggests that alongside addiction, mental health issues are a significant barrier that needs to be overcome or managed to assist with recovery. This was discussed in detail in the literature review (chapter 2.0). Managing mental health issues alongside addiction was therefore an important consideration for this research, as it progressed to the next stage to build interventions which are effective.

6.13 Summary of key findings

1. The activity provided an engaging reflective approach with therapeutic potential.
2. It is important to carefully consider the intervention positioning in terms of the participants stage in recovery.
3. Tasks can be particularly beneficial which provide contrast and illustrate progress made between past and present behaviours (reflection).
4. Building recovery support networks it critical.
5. There is a willingness of those in recovery to engage with creative activities.
6. There is a high level of mental health difficulties amongst those in recovery from substance use.

6.14 Challenges and limitations

During Pilot (I) several difficulties were experienced through engagement with the partner organisation. Firstly, during the planning phase of the Pilot it was often difficult to arrange meeting dates and ensure the correct staff were available on the dates that were organised. This was due partly to time pressures of working staff but also there were situations where staff went on long term sick leave due to stress. This hindered the progress of the research, even though the staff appeared committed to supporting the project, often the resources to enable the Pilot and evaluate the process were simply not available from the partner organisation.

Secondly, due to the decision to remain as a designer and not workshop facilitator, there was not an opportunity to engage with the participants. Whilst this was beneficial in terms of ensuring that the researcher not being present meant the data would not be influenced, it resulted in difficulties gauging the

experience of the participants whilst undertaking the process. To consult the participants after the process on their experience seemed to contradict the purpose of the Cultural Probe and therefore was not undertaken.

Thirdly, whilst to an extent participants were stabilised in recovery, the Pilot group were still in the relatively early stages and working through a variety of significant issues. This resulted in a situation where the group could become jeopardised and 'lost' easily to a state of not taking the activity seriously. Therefore, it may be that this client group were still too embedded in their previous life and thought patterns to fully engage with the aims of the Cultural Probe activity. Therefore, a group which is slightly more established in recovery might engage with the process more readily. However on reflection, this client group did gain positively from engaging with the process, so it may be that a tool could work at different levels with participants at different stages of recovery.

7.0 Creative Recovery Toolkit – Pilot (II)

The Cultural Probe Pilot (I), as described in the previous chapter was designed to discover more about the lives and individual recovery journeys of a particular group of participants and to provide an alternative method for individuals to tell their recovery stories. The feedback suggested that the process may provide some therapeutic value for those involved, which provided an opportunity for this method to be developed further into a recovery tool. The following chapter describes the development and testing of the second iteration of this tool.

7.1 Creativity focus

Feedback from the Senior Recovery Worker (SRW) during the Cultural Probe Pilot (I) identified that creativity can be beneficial in recovery, which is supported by the literature, as previously discussed in chapter 2.0. The SRW also identified that concentrating on creative tasks can increase engagement (P1.S4.SRW15) and that creative methods can help to elicit social histories, bringing things to light (P1.S4.SRW24). Creative tasks also provide an alternative to written assessments which are not generally popular with service users (P1.S1.SM34). Participants in this research identified a variety of creative activities which were used to support recovery (P1.S1.SM13); (P1.S3.SRW8); (P2.S5.DG1); (P2.S6.PT2); (P3.SB11.LJC1); (P3.SB6.PD1). A creative focus was therefore considered for the evolving tool as the research developed. As such, a conference bringing together creative led organisations, who work with vulnerable individuals, was organised to investigate the use of creativity for well-being further.

7.2 Designing Participation conference

To explore further the role that engagement in creative activity has on recovery and well-being, a conference was organised to bring together relevant organisations, to share knowledge and examples of best practice. In the UK there are a wide

variety of organisations which engage participants through involvement in the arts. Participatory arts programmes are offered in a wide variety of settings, which include: prisons, refugee centres, rehabilitation centres and hospitals. Many of these organisations are charities and community groups in the third sector and funding to sustain these organisations is scarce, with many organisations struggling to provide the programmes and activities as fully and widely as they would like.

Figure 7.2-1 Designing Participation conference attendees

Specifically, this research is interested in the fact that community groups using the arts to engage participants often do so to work with individuals and groups who are marginalised and vulnerable in their communities. Those suffering from addiction and mental health issues are a significant group who can be both marginalised and vulnerable. The creatively led programs offered by these organisations have the potential to benefit participants in a wide variety of ways, as identified in the literature review (chapter 2.0), including:

- To build confidence, increase self-esteem and reduce isolation.
- To develop skills, qualifications and employment opportunities.
- To provide a space for better self-understanding.

- To provide a place to meet, socialise and build social networks.
- To work with individuals from marginalised and excluded communities .
- To improve physical well-being.
- To improve mental well-being.

The event was organised with two other design researchers who shared a similar focus in their research, from the London Doctoral Design Centre (LDoc). The conference took place during a single day in London at the Royal Society of the Arts (RSA), in late May 2016 (Fig. 7.2-1).

The basis for the event was a report produced by Arts Council England (ACE) in 2010 entitled: Adult Participatory Arts: Thinking it Through. Arts Council England champions artistic experiences that enrich people's lives and works as a major funder for small arts based community organisations. The objective of this report as described by the authors was to:

> "...gain a better understanding of the work of a range of organisations that have participation and engagement at their heart." (ACE, 2010 p5)

This was demonstrated via examples of best practice uncovered and defined by the 13 participatory arts companies working in the UK, whose projects were funded by ACE. During the event research was generated through the consideration of three of the follow-up recommendations from the ACE report, these were:

1. That the 13 companies share expertise and intelligence on their work within the charitable and third sectors and disseminate this to a wider audience.

2. That an evidence base for participatory work is developed, to be shared between the 13 review companies, similar arts organisations and Arts Council England, so that they can respond more easily to government policies and targets.
3. That a widely accessible and effectively managed participatory arts knowledge base is developed in partnership with an appropriate organisation, such as a higher education institution. (ACE, 2010 p28)

For the day all thirteen companies who were originally included in the report, were invited to participate alongside other established participatory arts organisations, facilitators, academics and researchers. The event used a series of research activities during which the delegates considered these workshop questions in groups. These questions were designed to respond to the ACE recommendations defined above and the responses were recorded and collected by the three organising researchers.

Access All Areas	Haringey Shed	Spare Tyre
CoolTan Arts	Immediate Theatre	Streetwise Opera
Create Arts	Magic Me	Tender
Entelechy Arts	Monkey Tree Projects	Young Vic
Green Candle	Photovoice	Utopia Arts

Figure 7.2-2 Designing Participation attendee organisations

The responses provided below are from the first activity of the day, entitled: *Benefits, Challenges and Methodologies*, which was introduced and analysed for by the researcher for this PhD. This was the relevant part of the undertaken research for the day, due to the focus on employing innovative methods with participants. Organisations which use participatory arts employ a wide variety of methods through which they engage members of the community (Fig. 7.2-2). Therefore, this activity was designed to identify some of these methodologies and discover the benefits and challenges of the methodologies used. The following three questions were considered by the groups:

1. What are the benefits of delivering participatory arts programmes to the communities involved?
2. What are the challenges with delivering effective participatory arts programmes and projects?
3. What are the most effective types of methodologies to deliver participatory arts programmes and projects?

Figure 7.2-3 Designing Participation conference activity

The groups were asked to confer and respond to each of the three questions on separate large pieces paper (appendix F), with each group focusing on one of the three questions (Fig. 7.2-4). Following this exercise one member from each of the groups then presented the discussions to the wider group (Fig. 7.2-3). The key points raised are as follows:

Question 1 (Benefits) group feedback key points:

- Participatory organisations provide high social value and value for money.
- Projects connect people and increase social inclusion among marginalised groups.
- Bridges integration into communities and can be a safety net to help people out of a crisis.

- Can foster a sense of pride and a space to be creative.
- Helps build confidence, self-esteem and skills. Providing a sense of authorship and ownership.
- Can be life changing.
- Allows voices to be listened to and initiates a shared language.
- Assists community cohesion and provides agency.
- Gives people permission to fail and permission to succeed.
- Chance to reflect, give time and generosity.
- Connecting to a wider development of education goals.
- Providing social space.

Question 2 (Challenges) group feedback key points:

- Time is very important for building trust and relationships.
- We don't live and work in the types of social structures which lend themselves to participative forms of working.
- Retaining the structure of your methods throughout a project.
- Accepting and embracing whatever happens and not slipping into the language of failure.
- Considering whether it is possible to fail or if failing is all part of participation and can therefore still become a successful outcome for participants.
- Qualitative vs quantitative approaches – there is an always an inherent conflict between these two in delivering set outcomes.
- Breaking down internal stereotypes in organisations.
- Building up confidences and support amongst participants, so they can fully participate. As confidence is required to share things, to be able to have a sense of confidence and choice to share with workshop leaders and with other participants.

Question 3 (Methods) group feedback key points:

- Providing accessibility by supporting travel and picking up people to bring them to a workshop or activity session.
- Finding effective ways to communicate with participants and the other people involved.
- Embracing new forms of social media, including: Facebook messaging and texting through online texting services to increase attendance.
- Balancing communication to ensure people feel welcome and are encouraged but not pressurized to attend.
- Continuous encouragement throughout a project, especially for vulnerable people, is important to foster a sense of ownership over a project.
- Allowing project user led ownership of a space means projects are then defined by participants rather than practitioners.
- Importance of flexibility around projects and shifting the parameters as you go along to see what is working and what is not working. This helps with project planning so that you know who the people involved are, their needs and achievement goals.
- Manipulating funders by stating what you are going to do in such a way, even when the outcome is different to that which was expected.
- Trying to protect the people that you are working with by making sure that there is a space for them which is not overly determined by the funders' input (financial support and evaluation techniques).
- Important to establish if projects are being delivered to, delivered by or delivered for the community. Language is important, which community is being served and in which way.

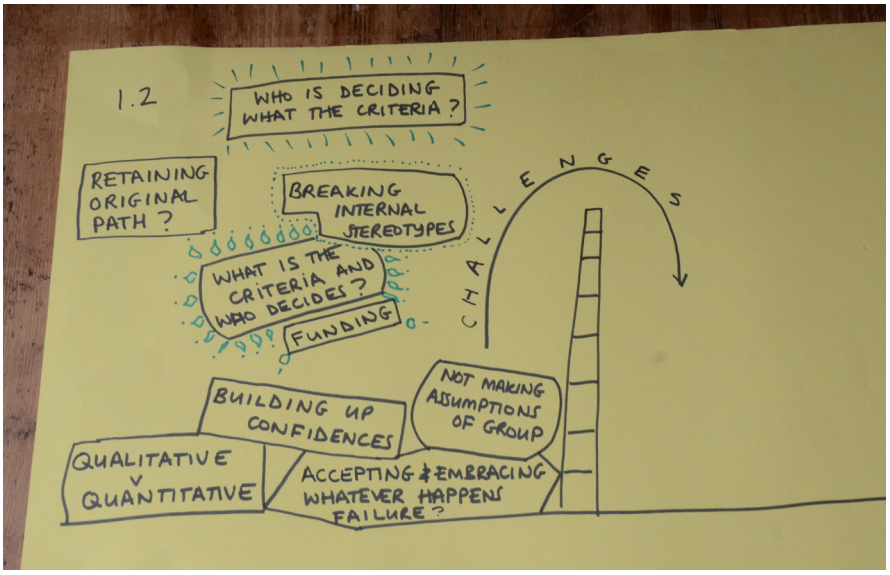

Figure 7.2-4 Designing Participation conference activity sheet

The following themes were synthesised from the group responses and resulting discussions on the day.

Confidence, Trust and Ownership

Delegates expressed the importance of building trust and providing participant ownership of programmes. It was accepted that whilst trust takes time to build, the benefits of participants trusting in practitioners are far reaching. Once individuals trust in the process, they can fully participate and the opportunity to have their own voice, socialise and take ownership can ultimately be life changing.

Community

Projects can really add social value and value for money, helping to include marginalised groups and bring integration and support into local communities and also directly to individuals. However, discussions took place around the importance of using the language of community carefully: Who is the community? Are projects delivered to, by or for this group?

Funding

Whilst organisations can provide excellent value for money, concerns were raised regarding obtaining and justifying funding. One group spoke candidly about the need to manipulate funders to ensure programmes survived, even when outcomes were not as expected. The view that projects should prioritise the needs of their users and members over meeting the stringent evaluation requirements of funders were also expressed.

Holistic view

Delegates were keenly aware that participation is not something currently ingrained in existing social structures and working relationships. For programmes to be successful it was suggested that the whole project needs to be considered, to ensure that the structures put in place to guide the project are maintained throughout and that there is flexibility to adapt or make changes to the structure, if required. For the entire course of projects, it is also very important for particularly vulnerable individuals to be supported during successes and failures, to ensure their journey is beneficial.

Communication

Communication was considered key to engaging with participants and maintaining connections. The use of social media and digital communication was viewed as an excellent method of achieving solid and regular contact. However, it was highlighted that there must be a balance struck between effective communication and bombarding participants with messages and pressurising participants to attend.

These identified themes from the conference aligned well with the research conducted during the literature review (chapter 2.0) and existing engagement tool review (chapter 5.0). This gave confidence that the themes being considered to inform the research were appropriate and relevant to the target group of participants.

7.3 Changing role of the researcher

For Creative Recovery Toolkit Pilot (II) the role of the researcher was developed slightly. In the previous Cultural Probe Pilot (I) the researcher role was as a designer who briefed the workshop facilitator prior to the workshop sessions. During Pilot (II) the researcher was present during the workshops. This change was made to allow the researcher the opportunity to observe the sessions, which was beneficial to the research development for the following three reasons:

1. To allow the researcher to observe the sessions and to use this experience to further understand the participant group.
2. To ascertain the participants' experience of the process and use this feedback to guide and review the development of this method as a recovery tool.
3. To assist the workshop facilitator with any questions or concerns that participants had about the tasks and process, to ensure that ethical sign-off for the activity was provided, that participants understood the process as voluntary and to explain what the collected responses would be used for.

As with the previous pilot the researcher did not act directly as facilitator during the sessions. The researcher undertook the sessions with an awareness that their presence may influence the data collected and was careful not to lead any of the participants responses or coach participants during the sessions. To further reduce this, any researcher interaction directly with the participants was kept to a minimum.

The observation allowed the researcher to employ design ethnography as a way to:

> "...investigate everyday social life and culture as a tool for promoting and developing innovation and creativity..." (Rogers and Anusas, 2008 p1)

As discussed previously, the use of a cultural probe method with this particular group of participants was considered preferable to an ethnographic approach, to avoid the individuals feeling anxious or like 'subjects of research'. This consideration was still considered important and valid for Pilot (II), however, the presence of the researcher was considered important for the reasons outlined above. Therefore, the observation was coupled with the opportunity for the researcher to provide reassurance if required and even though the dynamic of the workshops was altered slightly, the participants still completed the process and provided data as individuals through the Toolkit.

Using the Toolkit in this way provided a catalyst to learn more about the participant group in a structured way, which still allowed the researcher to gain a 'natives' point of view on recovery habits, challenges and opportunities through observation and documentation of the interactions during the workshop sessions (Rogers and Anusas, 2008). Through recording detailed field notes and asking open ended questions of the participants, ethnography was an additional tool which allowed this insider perspective to be captured. It was therefore felt that the combination of research through completion of the tasks and 'light touch' ethnography would be appropriate in this context.

In addition to this ethnographic approach, the Centre for Medical Humanities at Durham University proposes five guidelines which creative individuals should follow when working in healthcare environments. These are as follows:

1. The well-being of participants is paramount.
2. Practitioner attempts to draw out the creative potential of participants in a way that is both challenging and realistic.
3. A collective creative process is generated through the building of mutual trust.
4. Practitioners recognise the importance of evaluation and their duty to contribute to it.

5. Practitioners abide by a code of good practice consistent with the ethos of the supporting institution. (Centre for Medical Humanities at Durham University, 2009)

Throughout Pilot (II) and engagement with organisations and service users for this research generally, these guidelines have been used to inform and shape this activity, alongside the ethical considerations previously discussed.

The approach for documenting meetings during Pilot (II) was the same as that used during the Cultural Probe pilot and Service Blueprint stakeholder meetings. Due to the altered role of the researcher in becoming observer in the sessions, there was opportunity for the recording of detailed notes during the workshops. Time was set aside after each workshop to ensure the field notes were completed with the detail of the activities fresh in the researcher's mind. This was to ensure that the notes accurately captured as much detail about the workshop interactions as possible.

The changing role of the researcher was also aimed at building trust and empathy with both the participants of the research and also support workers. Several activities outside of the Toolkit Pilots and Design Experiments were employed to help develop this. Firstly, the researcher undertook some voluntary graphic design projects for the main drug and alcohol service in the city. Examples of work produced are included in appendix H. This activity helped the researcher to build relationships with staff and increase understanding of the issues facing support workers in their roles. Secondly, a summer photography group was held with service users at Sanctuary Supported Living, as this was not a creative group that was currently on offer. This activity helped to further build trust with support staff between Pilots (II) and (III), and to better understand how creativity could benefit participants in a recovery setting. Finally, the researcher attended several core drug, alcohol and mental health training events run by Brighton and Hove Council. This attendance was to demonstrate the rigorous intentions of the research, to inform the tool development and to provide opportunities for networking.

7.4 Design development

The following points were identified from the Cultural Probe Pilot (I), as iterations to improve the Toolkit (Fig. 7.4-1). The discussion below identifies how these points have been implemented in the design for the Pilot (II) Toolkit. These are referenced against the meeting notes, which are included in appendix G.

Figure 7.4-1 Pilot (II) - The evolving design

Staff suggested developments

1. Day diaries are useful for clients to get contrast between past and present life (P1.S4.FAC 07).

The facilitator identified that for the Day Diary task participants found the contrast and comparison between past and present habits and behaviours was useful to reflect on. Therefore, for the revised Toolkit, all the tasks were split into two halves (past and present), as this technique appeared to have potential for other tasks also. The comparison is powerful, as for individuals who are reluctant to look at the past, they can first look at the present. After which they can then

look at the past, if they feel comfortable, to see the progress made. If they do not feel comfortable they can simply complete the present, in this way they are still able to participate. An exception to the past and present split was 'About You', which as an introductory task remained as a single tense for participants to simply describe themselves in the present.

Figure 7.4-2 Pilot (II) - Emoji sticker sheet added

2. Currently there is no focus on 'feeling' in the kit (P1.S4.FAC11).

To bring a focus on feeling into the Toolkit, emoji stickers were added (Fig. 7.4-2). These were to offer a fun and accessible alternative to writing or verbalising emotions, as some clients find it very difficult to openly share their emotions. Whilst it is accepted that the meaning of individual emoji can be ambiguous, this was addressed by the facilitator, as they requested that participants suggest the meaning of the emoji used in their responses. The set of emoji used was a standard set, widely available as stickers and on smart phones. Originally the icons which were developed earlier in the research for the Persona Journey Maps, were considered for use in this second iteration of the Toolkit. However, these mainly depicted events and behaviours rather than emotions, so the

decision was taken to use the standard set of emoji symbols for this purpose instead. Staff felt that the use of emoji was a positive introduction (even if they were initially sceptical) (P3.SA8.SW2-4); (P3.SA8.SW1.3).

3. Support service access task could be removed (P1.S4.FAC12).

The support service access task did not fit with the overall kit structure and was removed for Pilot (II), as the Toolkit was evolving to focus more on the individual rather then generally to inform the support service.

4. Quality of the facilitation notes is important, the facilitator should be involved in the process of development (P1.S4.SRW9).

As discussed previously the researcher role was developed to observe the sessions. This allowed the researcher to learn about how to improve the facilitation notes for future iterations.

5. Useful to run a post kit completion group with clients as a reflection (P1. S4.SRW10).

An end of workshop reflection, summary and feedback session was added to the process.

6. The Day Diary task could be used to help clients structure and fill their days with activity as they are preparing to leave residential treatment (P1. S4.SRW11).

During the Day Diary task, clients were encouraged to reflect on a comparison of days in the past and present, rather than as a way to structure their days. The option of using the Day Diary task for structuring days in recovery was instead added to the facilitation notes.

7. Responses could go to key workers for use during one on one sessions (P1. S4.SRW12).

The workshop information was made available for key workers with consent from individual participants.

8. Bring photography task forward to use as a basis for later tasks, with the photos developed at the end (P1. S4.SRW13).

The photography task was brought forward in the process, so that the places identified could be drawn on in the later tasks. During the Cultural Probe Pilot (I), the photography or 'Disposable camera' task was the last task that participants undertook. This was brought forward to number three out of five tasks for Pilot (II). The intention was that clients could use the places identified in the 'Places' task to document using the camera. This re-positioning of the task also allowed the photographs to be developed and then returned to the participants at the final summary session.

9. Take kits back in at the end of the session (P1. S4.SRW14).

The kits were taken back in at the end of each session by the designer, and securely stored on site in the staff office to prevent damage or loss.

10. Concentrate on creative and visual tasks (P1.S4.SRW15).

The revised Toolkit focuses more on creative and visual tasks, building on those designed for the Cultural Probe. More creative materials were included with the kit, including: Coloured pens, pencils and emoji stickers. The intention during this revision was to make the Toolkit more creative and visual to complete and therefore, rely less on the written or spoken word. This included updating the graphic design of the task cards, which is described in more detail below.

11. Ask for initials rather than 'nicknames' (P1.S4.SRW16).

In the About You task initials were requested in the Pilot (II) version instead of nicknames, to reduce the likelihood of participants becoming distracted and losing focus, as previously highlighted by the workshop facilitator.

12. Use half of the camera film for negative past places and the other half for positive current places (P1.S4.SRW17).

During the Photography task participants were asked to split the film between past negative places and positive current places. This ensured that participants had the opportunity to also focus on positive aspects of recovery.

13. Use pictures or maps to explore social networks (P1.S4.SRW18).

The Mapping / Drawing relationships task card was updated to Drawing Connections. This included more structure on the card relating to social networks, allowing the participants to work within this structure when completing the task.

14. Clients could be given summary sheets as a reminder and relapse prevention tool (P1.S4.SRW19).

At the end of Pilot (II) participants were provided with a summary graphic layout of their responses, which could serve as a relapse prevention reminder and be shared with key workers. The graphic layouts of the answers were also used to undertake the analysis on the returned data and are included in appendix G.

15. Put a person in the middle for intended future with arrows coming off to show where they want to be (P1.S4.SRW20).

A person was included to show where the intended start point was for the Mapping Connections activity and this represents the participant in the centre of the identified connections.

16. Could be a task around impacting the community (P1.S4.SRW21).

Rather than have a dedicated task about impacting the community, this was encouraged as an option to explore during the Mapping Connections task, when identifying community connections. This is detailed in the facilitator notes.

17. Include a piece of reflective work around feelings and thoughts (P1.S4.SRW22).

Participants during this version were encouraged to explore and express feelings and thoughts through the process. As previously described, emoji symbol stickers were added, as an accessible way to start conversations around feelings. Reflection could then take place in the time for sharing during each of the workshop sessions.

18. Visualise goal setting in a diagram to show connections (P1.S4.SRW23).

Participants were encouraged to identify progress made and goals through the task generally. Therefore, a specific tasks which focused on this element was not required.

Designer identified developments

19. Improve the quality and materials of the Toolkit.

The quality of the materials was improved to make the product feel like something of value rather than the basic prototype feel of the Cultural Probe (Fig. 7.4-3). Higher quality pens were provided alongside coloured pencils, with variety in the

included stationary intended to make the Toolkit more versatile as a creative tool. The weight of the task cards paper was increased, again to improve the feeling of a quality product. The Toolkit materials were placed into a solid cardboard box rather than a plastic pouch. Kraft (brown) cardboard was chosen rather than white or a colour, to create a sense of craft around the Toolkit packaging, and retain the impression that it was something to be used in a creative way. Another practical concern this addressed was that a kraft coloured box was less susceptible to finger marks. As most of the returned packs from the Cultural Probe Pilot (I) activity had finger marks, and it was considered important that the box retained its fresh and new quality even after use.

Figure 7.4-3 Pilot (II) - Improved quality of materials

Tangible objects were used for the process, rather than being delivered via an app. An app could be realistically considered in an age where many people rely on apps day to day. However, physical stationary was used for the Toolkit for the following reasons:

1. Using a pen is more tactile, familiar and satisfying then using digital tools for being creative.
2. Participants would not necessarily own a smart-phone or tablet.

3. Participants may be anxious about using technology.
4. Physical stationary is much more affordable than digital technology.
5. Participants can keep the Toolkit, after all the sessions are completed. They can then add to it over time, by collecting other physical objects in the box, which may help build memories.

Whilst better quality materials were used, the Toolkit was still produced at a low cost, as there was a possibility of accidental loss or damage. This was experienced during the Cultural Probe Pilot (I), where participants lost the Toolkits during the process or started the process and then did not return. If more expensive equipment was used, digital cameras for example, then they could easily have been lost or damaged during the process.

Figure 7.4-4 Pilot (II) - Improved graphic design language

20. Improve the graphic design language

The graphic language of the Toolkit labels and cards was developed further for Pilot (II). This was to make the design look more refined and appealing (Fig. 7.4-4). More colour was added to the cards, using the same colours for past

and present as were used in the Persona Journey Maps. Orange was used for the past as it draws attention and is energetic, combining red and yellow. It was considered appropriate as orange is a calmer colour than red. Red was considered to have connotations of 'stop', in the traffic light system. Therefore, suggesting to stop looking at the past, when the Toolkit was intended to consider the past in relation to the present. For the present cards the colour green was chosen, as green is often considered to represent positivity, tranquillity, luck and health. It can also be considered to represent 'go' or 'move' in the traffic light system (Cherry, 2020). These are the intentions which the Toolkit was intending to encourage when thinking about the present and into the future.

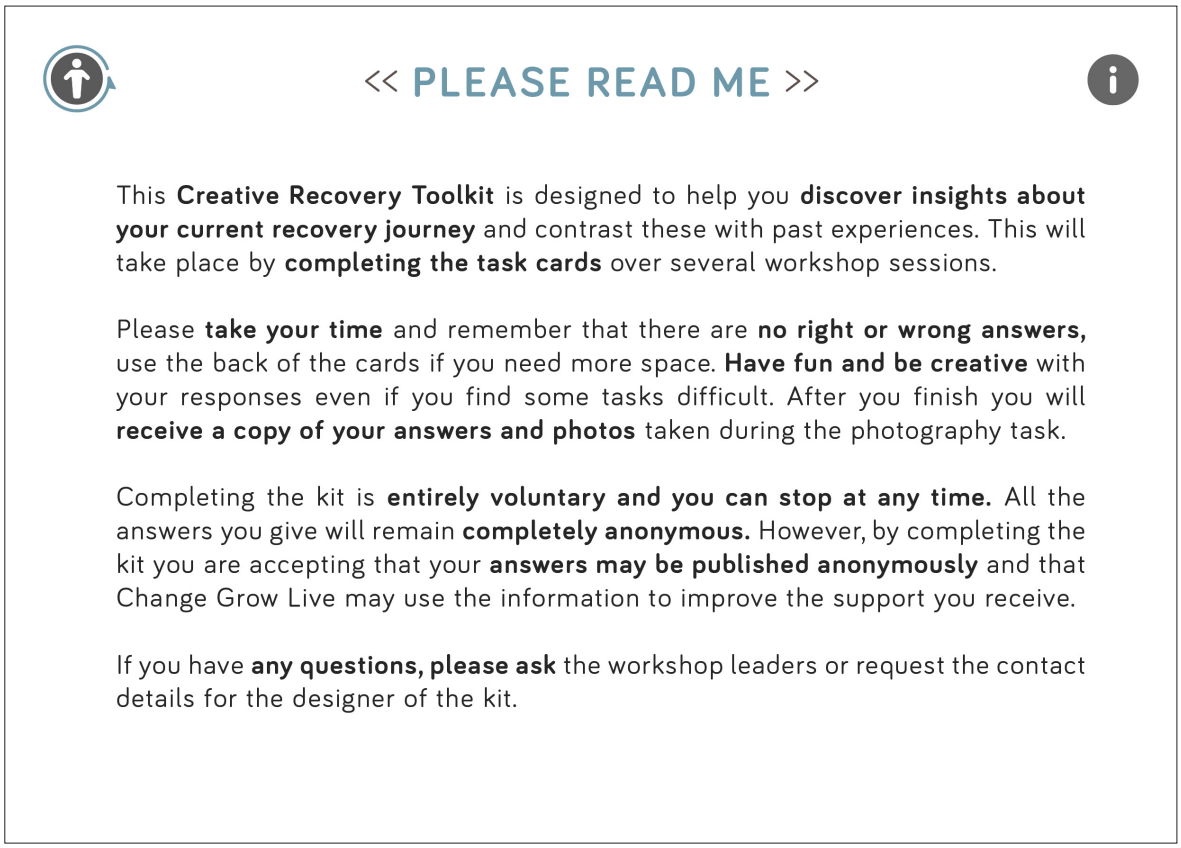

Figure 7.4-5 Pilot (II) - Please Read Me card

21. Please Read Me card added

A Please Read Me card was included in the box as a basic introduction to the Toolkit (Fig. 7.4-5). Participants were read through this card during the initial introduction session. It also acted as a reminder of the key points of the process going forward, each time the Toolkit was opened.

22. Participant sign off procedure updated

During the Cultural Probe (Pilot I), the participant 'sign-off' was undertaken formally as a form which was explained before the workshops began. On reflection and during discussions with staff (P1.S4.FAC13), this process whilst important, was deemed excessive and potentially anxiety provoking for the participants. Therefore, it was agreed that as the research was working within the context of the service safeguarding and ethical procedures, in the future the Toolkit could be delivered after the introduction session, which ensured the participants understood and consented to participating in the process. Essentially, by marking the task cards the participants were agreeing to participation and the conditions for participation, as previously highlighted. Participants were regularly reminded that participation was voluntary and they could stop at any point, if they felt they did not want to participate any longer.

23. Photography task amended

During the Cultural Probe Pilot (I), participants went out to take photographs in pairs, so that they could focus more on individual images and cover more ground than if they were within a larger group. However, this resulted in some similar images between the pairs, suggesting that the individuals photographic subjects

were being influenced by each other. For the Pilot (II), a group photo walk was undertaken during a session to practice with the cameras and understand the task. Then the main photos for the task were to be captured individually as a self-directed homework activity. This was aimed at reducing the influence of the participants on each other's responses, due to the practical challenge of travelling to each of the places identified by all the participants in one session.

24. About You task moved

The About You task (Fig. 7.4-6) was moved to the beginning of the process. This was to provide it as an introductory task. Written descriptions and communication are a familiar safe place for participants to start, as this is the standard method of communication with support staff. Following this participants could then move on to the more creative tasks and build creative confidence.

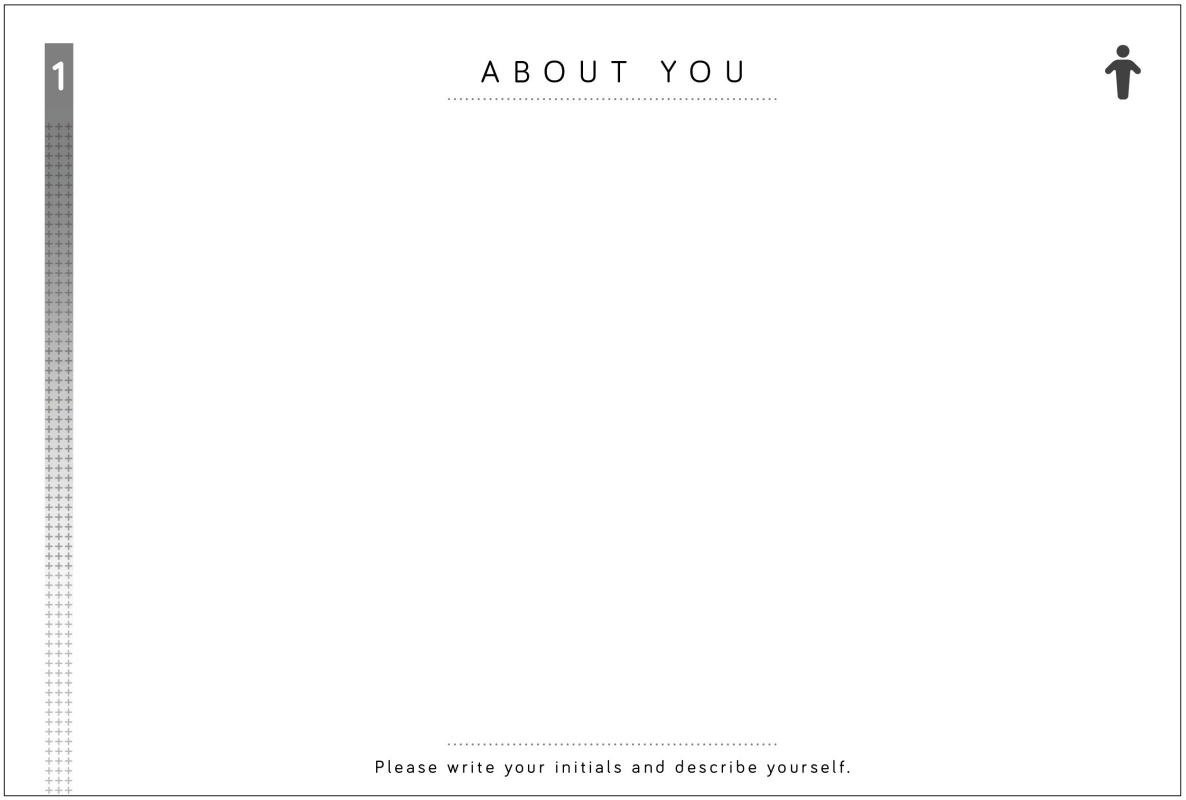

Figure 7.4-6 Pilot (II) - Developed task card design

25. Recovery capital implementation

The intention was to use the principles of developing recovery capital and implement these in the Toolkit design, as recovery capital is such a fundamental principle of contemporary recovery thinking. This meant that the Toolkit could assist in highlighting opportunities for participants to further build their recovery capital assets. Therefore, the tasks were considered in terms of the social, human and cultural aspects of recovery capital, as discussed in the literature review (chapter 2.0). The progression of the tasks was then used to explore and elicit thoughts from participants, which relate to these themes. The tasks relate to the three aspects of recovery capital as follows:

Social capital

The Mapping Connections task helps participants to explore the social capital that they have available to them and whether individual relationships are positive or negative. The task also helps participants to identify how their relationships are changing over time and how the quality of social support is subsequently changing. Participants are able to define opportunities to work on certain relationships, to make them more supportive or to distance themselves from relationships that are have a negative effect on their mental health.

Human capital

The Day Dairy task is designed to illustrate to participants the key aspects of human capital in their past, present and future. This can include, personal skills, aspirations, interests, health and personal resources. These can be both identified (in the past and present) and also highlighted in 'ideal days', as goals to aspire to in the future.

Cultural capital

Cultural capital and how individual participants relate their values, beliefs and attitudes to others, is explored throughout the Toolkit, this takes place through

the discussions in the group brought about by sharing of responses. The About You task also provides opportunities for identification and discussion of how individuals view themselves and potentially how this relates to others.

7.5 Organisation and participant description

The organisation chosen for Pilot (II) was also a national organisation called Sanctuary Supported Living, which operates across several residential treatment houses in the Brighton & Hove area. The organisation supports individuals who are working towards independence to develop confidence, self-esteem and the life skills that are required for independent living. 32 clients are supported across four houses. Staff are present on the site between the hours of 8am to 8pm, with clients resident for up to 18 months, which is a similar structure to the Cultural Probe Pilot (I) organisation. All residents have access to communal facilities consisting of: kitchen, bathroom, lounge and garden (Sanctuary Supported Living, 2021).

The organisation works with clients who were further ahead in recovery, compared with the clients who undertook the Cultural Probe Pilot (I). This point in recovery aligns with the maintenance stage in the Stages of Change model, as referenced in section 2.4. At this stage in recovery individuals have made significant progress in their recovery and are beginning to consider how this established change came be maintained over time (Hill, Penson and Charura, 2016). As in early recovery, individuals will be addressing the physical effects of withdrawal and stabilising on medication, with basic needs being met, through residence in a rehabilitation centre. This relates to the safety and physiological in Maslow's hierarchy of needs. Maslow's hierarchy proposes that:

> "...humans have to satisfy their biological needs first, then they can seek order and predictability within their lives, a sense of personal worthiness and

> importance, love and affection with important others, and finally, a sense that they are moving toward an ideal version of themselves." (Desmet and Fokkinga, 2020 p4)

Therefore, those more established in recovery should comfortably be able to meet their own basic needs and will be looking to address 'psychological' needs. This is the stage at which the Toolkit is aimed at as an intervention, to help clients understand their lives in terms of the second stage of Maslow's hierarchy and potentially through the creative elements of the sessions to provide opportunities for 'self-actualisation'. However, discussion with support staff during Pilot (I) raised the possibility that if certain tasks were not suitable earlier in recovery, then the Toolkit could be pitched through differing versions to different recovery stages (P1.S3.SRW17), although this was beyond the scope of this PhD.

The clients who undertook the Toolkit tasks were observed by their support workers as group with low energy levels, who struggled with some basic tasks such as household chores (P2.S1.SSW2). Also the residents in the house were taking medication for their conditions, however, their cognition was generally good compared with some of the other residences (P2.S1.SSW6).

Through this second partner organisation clients were recruited who were not only stable in recovery but who had a diagnosed mental health issue, alongside addiction. These challenges were being addressed through treatment and this allowed a focus in the research on mental health. The participants for the workshops were a mixture of four men and one woman, with ages ranging from early twenties to mid-fifties. As such, this group was closer to the desired intervention stage in the Stages of Change model, as discussed in the literature review.

7.6 Workshop description

The workshops were arranged to coincide with an existing weekly recovery group, which was held at one of the residential houses (Fig. 7.6-7). At the beginning of each session the participants shared how their week had been and how they were feeling with the rest of the group (P2.S1.SSW8). This section of the workshop was not recorded in the notes to keep this part personal to individuals. Following this 'feelings check', the first half of a task was completed, and participants then shared their responses with the group. This was followed by a break to regain concentration and then the participants completed the other half of the task before sharing with the group again.

Figure 7.6-7 Pilot (II) - Workshop environment

The group size was limited to a maximum of five participants. This size was chosen as it would allow adequate time for each participant to complete the task and share their response. Using a smaller group size with people who were already familiar with each other, also aimed to reduce participatory anxiety and make it a more comfortable space for sharing. Participants were of a similar age range to the previous Cultural Probe Pilot (I) and the sessions again took place

in the lounge area of the residence, with one task completed per weekly session. Six sessions were completed in total, which included a final feedback session for the participants to share their experience of the process and ideas for design development. During the process the Senior Support Worker was unable to attended a couple of sessions due to illness. These sessions were facilitated by another staff member who was supported by the researcher (as observer) to deliver the tasks.

7.7 Ethical considerations

During the review session for the Cultural Probe Pilot (I), the group had an extended discussion about how participants were left feeling after the process. The facilitator felt that this discussion left several clients quite down and depressed about where their lives had ended up before coming into treatment. The facilitator supported the group by ending the discussion on the positives of being in the recovery process (P1.S4.FAC11). This positive ending to the session is critical, as participants should not leave the session feeling negative about having participated.

The Toolkit was being designed to explore how participants felt about aspects of their lives and therefore was likely to bring to light memories which could trigger powerful emotions. Therefore, it was imperative that the research was conducted sensitively in the facilitation approach and within the safeguarding guidelines of the partner organisation. The possibility of this situation re-occurring in Pilot (II) was acknowledged. As such, an experienced facilitator led the group and the same precautions were taken in regard to participant well-being, to ensure the benefits of participation outweighed any negative experiences. This all took place within the research ethics permission granted previously by Kingston University for this research.

7.8 Data analysis and discussion

Participant	Task 1	Task 2	Task 3	Task 4	Task 5
DG	o	o	o	o	o
PT	o	o	o	o	o
SD	o	o		o	o
SL	o	o			
RB	o				

Table 7.8-1 Participant attendance for the Creative Recovery Toolkit Pilot (II)

Task 1 - About You

Five participants mentioned mental health symptoms in their responses, except RB whose only recording was their initials. RB stated that they felt anxious about writing anything down on the card. The Senior Support Worker (SSW) felt that it was positive that they stayed and sat with difficult feelings to participate, they felt it was a big step for them to participate with a stranger present due to their mental health issues (P2.S1.SSW15). None of the participants acknowledged previous alcohol or substance use issues, whilst being a group of clients with co-existing conditions. This could be explained by the fact they were currently focusing on their mental health after the physical addiction has been addressed, making managing their mental health symptoms their primary concern.

All participants (except RB) mentioned an interest or hobby alongside their diagnosis. These were things about themselves that were important to them, for example: spending time outside, being creative or academic pursuits. Three out of five participants mentioned previous or current employment and the effect their diagnosis had on this. One participant (PT) used the task as an opportunity to tell a vivid story of their life from childhood and the difficulties faced through symptoms and ongoing treatment.

From the responses it is apparent that whilst all the participants are stabilised in recovery (highlighted by the focus on the mental health component of their diagnosis). The task illustrates that the participants were all at slightly different stages of recovery. For example, the responses suggest that PT and DG are more comfortable to now look forward and begin to think about life after treatment. However, with SD and RB, whilst significant progress may have already been made, they are still significantly restricted in their lives by their symptoms.

Task 2 - Places

RB didn't attend this session as they felt it was too much for them (Table 7.8-1). Three out of four participants focused on positive things or places for both their past and present cards. One participant (SD) focused solely on the places where they suffered symptoms in the past and highlighted that they do not go to many places on the map currently. This fits with the fact that they are still working on their recovery and experiencing significant symptoms. SD also stated that sometimes even their own room is not a good place for them to be, which highlights the severity of their symptoms (P2.S2.SD4). DG admitted that a reason why they did not write down many places was that they did not have the energy to go and photograph them afterwards (P2.S2.DG5). The SSW observed to the group that this can signal a barrier to participation and recovery, which resulted in a discussion about energy levels in recovery (P2.S2.SSW13).

One participant (SL) used the task to describe all the places that they enjoy visiting and spending time, which keep them active, so they do not get overly depressed (P2.S2.SL3). One participant (DG) stated that places did not cause them symptoms or triggers but suggested that a person did (although they did not want to talk about this person) (P2.S2.DG2). DG subsequently listed places which triggered positive emotions (P2.S2.DG4). We can see from one participant

response (PT), that social factors and groups are very important structures for their recovery. PT also stated that they have been attending football matches, which by their own admission, is an intense environment and also they find the bus journey challenging (P2.S2.PT7). The SSW was able to highlight to PT that when they are passionate about something they can achieve it, even if it is challenging. The SSW felt that this may allow PT to slowly push further out of their comfort zone (P2.S2.SSW16).

Task 3 - Photography

SL did not join the session and subsequently left the process. SD did not join the session due to agoraphobia and anxiety about using the camera. Two participants completed the photography task (DG and PT). Images taken were a mixture of those depicting their local area during the photo walk (Hove recreation ground), other recovery groups and support service interactions.

There is a clear contrast between the two responses, which suggests that DG does not generally engage with recovery focused groups within the support service. This is illustrated in the images, with the majority documenting the local area, including only one image taken which related to structured treatment (of a support staff member).

Participant PT, in contrast, has significantly more images of structured group work, for example: woodwork group, activity group, Friday café, Brighton and Hove Albion (Albion in the Community). This suggests PT is building recovery capital through structured group sessions, an idea which is also suggested by the number of group activities listed in the present places task.

The responses also highlight that DG has a smaller sphere of activity, which is supported by their comment that they struggle to go too far away from the local area and their housing (P2.S3.DG2). This suggests how challenging it can

be for those in recovery to venture out into the community, something which was also highlighted by the SSW (P2.S3.SSW3). That being said, DGs response shows they are volunteering at an organisation which is not associated with structured treatment and also engaging with a Recovery College, which is a separate local recovery organisation. This suggests that whilst having a smaller sphere of activity within the service, in terms of building recovery capital outside of the service, DGs engagement is in fact wider than PTs (P2.S2.SSW14).

Task 4 - Day Diary

SD rejoined the group. Two participants described the past experience of being in hospital, which consisted of rest and structured recovery. The third participant (PT) described before, during and after recovery.

All participants describe a significant change between the past and the present and mention leaving the house daily in the present, compared with describing being restricted to inpatient treatment in the past. The responses also indicate more positive activity in the present, in the form of social interactions, leisure activities, creative work or volunteering. All participants mention daily contact with family in the present, which suggests the ongoing building of recovery (social capital). All participants acknowledged after the task that they were doing much more in the present and the group discussed how important activity is in recovery in order to remain positive (P2.S4.DG3); (P2.S4.SD1); (P2.S4.PT6).

Task 5 - Mapping Connections

All participants used colours in their diagrams, which do not appear to have any structure or significance to explaining their response (even though DG included a key). SD used coloured lines to represent the different categories that the connections relate to.

All participants listed the same number or more connections in the present compared to the past. All participants highlighted that their relationships had

changed over time. PT and DG illustrate how friends had been lost between the past and present due to their illness (P2.S5.SD2); (P2.S5.DG3). The participants recorded varying degrees of relationships with the local community, from actively being afraid of the local community (SD) (P2.S5.SD3), to being active in the recovery community (PT and DG). All participants have maintained connections with family. All used the emoji stickers to describe emotions towards different connections. Emoji used are on the whole positive, apart from two participants using the 'scream' expression to represent feelings towards the crisis team (as they felt this was a very difficult period). SD uses negative emoji to represent interaction with the public and local community. These responses illustrate the complex nature of the participants' relationships in their lives and highlight that they have changed over time.

Feedback Session

Generally, clients provided feedback that they liked the tasks and design of the Toolkit. DG was excited that everyone was given a Toolkit each (P2.S6.DG7). SD suggested it was quite fun and that the tasks were a good length (P2. S6.SD5). DG felt the box was well designed and represented a personal story once completed (P2.S6.DG7).

In terms of feedback on specific tasks, DG stated that the Mapping Connections task was particularly useful for them to understand that they are now more sociable and understanding of their illness (P2.S6.DG6). Suggesting that this task helped them to develop new perspectives on their recovery. SD highlighted the photography task as problematic for them, as they are both agoraphobic and not comfortable using cameras (P2.S6.SD4).

Two participants raised challenges which they felt the Toolkit might bring up. Firstly, DG suggested that for some participants it might be difficult to openly discuss feelings or problems in the group (P2.S6.DG4). Secondly, SD thought there might be a potential to focus on loss with the past and present comparison. However, they also acknowledged this risk was small and stated that it was not their personal experience with the process (P2.S6.SD2).

7.9 Conclusion

The responses from Pilot (II) provided a different impression than those from the first. There was no evidence of bravado or self-glorification in the Pilot (II) responses. In contrast, the responses could be described as much humbler overall. This could be due to the more advanced stage in the recovery process of the Pilot (II) group. These participants were more established in recovery and appeared to use the opportunity in a different way, arguably gaining more from the experience then the participants of the Cultural Probe.

A second observation from the Pilot (II) data is that some of the participants showed anxiety towards participating in the process, which was not evident in the data from the Pilot (I). However, in Pilot (I), the previously mentioned bravo in the responses may have been masking anxiety toward the process. Two participants expressed anxiety towards participating, with the reasons for the anxiety identified as follows:

1. RB was concerned about writing anything down (P2.S1.RB1).
2. SD was concerned about using the camera and going outside to take photographs (P2.S1.SD1).

RB left the process before completing any tasks and SD finished the process but did not participate in the photography session or homework activity.

It appears from the responses that for the Cultural Probe Pilot (I) participants substance use difficulties were primary and mental health symptoms secondary. For the Creative Recovery Toolkit Pilot (II) participants, it seems mental health difficulties were primary and substance use secondary. More ingrained mental health issues appear to have affected confidence to participate, with all participants completing Pilot (I) and only half completing Pilot (II). This reluctance to engage with elements of the process is symptomatic of mental health challenges. This illustrates a lack of confidence generally, which also appears to link to ideas of creative confidence, and of not being a creative person, as DG suggested (P2. S4.DG1).

The data illustrates that the process can highlight the level of recovery capital that the participants have. The three participants who completed the process show varying degrees of social and human capital. Both PT and DG have more social connections and capital than SD. SD appears more isolated due to their agoraphobia but does recognise a network of music production connections online (P2.S4.SD1). The data shows that DG has a wider human capital sphere than PT, as they are involved in more skills based activities outside of the support service. PT has a high level of human capital developing but these activities are almost all within the service itself. The data from this pilot again shows the importance of meaningful activity in recovery, including creativity.

Alongside illustrating the amount of recovery capital being built by participants, the data also suggests that the activity is effective as an elicitation tool, as it highlights barriers to the ongoing building of capital. This is illustrated by the responses as follows: PT can feel overwhelmed on public transport (P2.S2.PT7), SD has severe anxiety (P2.S2.) and DG often does not have the energy to go out for activities (P2.S2.SD4).

The increased number of creative materials appears to have helped participants to engage with the tasks. This was especially true of the emoji sticker set,

which was used by most respondents to help describe emotions which related to their social connections and daily activities. Participants also made use of the additional colouring pencils, whilst attempting to code some of their responses to the tasks.

In general, the participants provided feedback that the process was enjoyable, even if they admitted being sceptical in the beginning. For example, PT suggested that early in the process they did not feel the tasks were affecting them (P2.S1.PT1). They later felt that it was a relief to get things out and even though the process required mental effort, it maybe therapeutic due to offloading things by putting them down on paper (P2.S6.PT4); (P2.S6.PT5). This suggests a change in perception of the value of the process as it develops, as participants become more familiar and comfortable with the group. Similarly, SD stated that they were simply writing down factual things (P2.S1.SD2), however, later in the feedback session they stated that they could see what they had lost and gained in the comparison between past and present (P2.S6.SD2). DG admitted that they were not convinced by the Toolkit at the beginning but stated that they could see how it might be used by professionals (P2.S3.DG5).

These responses suggest that the Toolkit 'grew' on participants and that it was engaging enough to hold attention over the course of the sessions, leading participants to the completion of the process. In terms of how engaging the process was, DG stated that even though they felt they were not a creative person, they were able to complete the tasks (P2.S4.DG1) and SD suggested that the kit engages people, which they suggested was difficult to achieve (P2.S5.SD1).

7.10 Summary of key findings

1. This group is at a more appropriate stage for engagement, as they are more established in recovery.
2. Anxiety towards participation is evident, which is linked to confidence and creative confidence. This may be a difference between mental health and substance use recovery engagement.
3. Meaningful activity in the process of building recovery capital is important and the tool can highlight levels of recovery capital for participants.
4. Value in increased creative encouragement and materials in the Toolkit.
5. Participants enjoyed the process even if unsure at first and the Tool has value as an elicitation method.

7.11 Challenges and limitations

Initially the intention was to pilot the revised Pilot (II) Toolkit with the same partner organisation as the Cultural Probe. However, after agreeing this and the researcher providing the blank Toolkits, several delays were experienced due to the organisation undergoing a restructuring process and staff members going on to long term sick leave. This meant that the organisation was unable to commit the time and resources required to undertake the process successfully for a second time. It was decided to approach a different organisation and this situation was turned into an opportunity, to develop the Pilot (II) Toolkit with an increased consideration of mental health recovery. An organisation was therefore sought who worked with clients that were in recovery from both a diagnosed mental health condition and also a substance use condition. The resulting collaboration with Sanctuary Supported Living lead to the successful completion of Pilot (II), as described above.

8.0 Creative Discovery Kit - Pilot (III)

The Creative Recovery Toolkit Pilot (II), as described in the previous chapter, was a successful development of the design to bring more creativity into the process. Feedback from participants confirmed that they were engaged and used the opportunity to explore their personal recovery journeys through the completion of the tasks. The altered role of the researcher from designer to observer during the workshops allowed a greater insight into the facilitation process. This also assisted in the definition of the specific ways in which the process and the design could be improved through iteration. The third iteration is called the Creative Discovery Kit, which will be discussed in this chapter.

8.1 Changing role of the researcher

It was highlighted during Pilot (II) that the role of the researcher and the quality of the facilitation on the benefit to participants is critical, as was also suggested through discussion with a Senior Support Worker during the previous pilot (P2. S2.SSW4). Therefore, for Pilot (III) the researcher assumed the role of designer as facilitator. The experience of directly facilitating the sessions was aimed at enabling the development of detailed facilitation notes to accompany the Toolkit (contained in appendix J). These could be used to enable facilitators, who may be new to the process, to get the best out of the Toolkit and ensure the facilitation approach is well informed and structured.

Another consideration in this changing role of the researcher, was that the process involved co-design activity and the workshops involved encouraging the creativity of the participants undertaking the tasks. Therefore, as a design researcher, the role needed to adapt to be able to facilitate and guide the sessions, to get the best outcome for the participants who engaged with the process (Sanders & Stappers, 2008).

The process for documenting the sessions was also revised slightly for this version, due to the changing role of the researcher from observer to facilitator. The practical consideration arose that there was less opportunity for the group facilitator to make detailed notes in the sessions. This was mitigated through a design change to the card set used by the facilitator during the session, which had structured space for note-taking on the reverse. These notes were again written up immediately following the session to capture the detail while still fresh in the memory, and are included in appendix J. Additionally, during the workshops the designer as facilitator completed the tasks and shared their own experiences with the group. The aim here was to reduce hierarchies in the power dynamics of the session, and to build empathy and trust with the participants as the process developed over time.

As part of this change in the role of the researcher, steps were in place to ensure any concerns were relayed to senior staff after the sessions, as they were not present. The workshops that took place in Sanctuary Supported Living required the completion of a peer support worker summary sheet (an example can be found in appendix J). This form was completed following each session and submitted to a Senior Support Worker within the service, to provide an overview of the session and highlight any safeguarding concerns which arose with the participants (P3.SA1.SSW2). The workshops that took place at Southdown did not require this form to be submitted, however, a brief sign-off conversation took place with a Senior Support Worker after the session, again to ensure any safeguarding concerns were raised and actioned.

Acting as the workshop facilitator meant that as a researcher I would need to manage any situations where individuals were sitting with difficult past experiences in the sessions. As identified previously in section 6.1, at that stage I felt that I did not have the skills required to manage these situations. However, as the research developed and I regularly observed sessions, I gradually developed a solid understanding of the facilitation technique (Pilot II). I was therefore, then able

to see how these situations were managed. To minimise any risk to participants, experienced staff were always present in the building, if I required any assistance during the sessions. To manage risk further over the course of this whole Pilot, monitoring forms were also completed after each of the sessions for review with supervision staff.

There was also an increased risk that my involvement in the sessions would negatively influence the data collected. Due to the relatively prolonged engagement I had with participants through conducting weekly sessions over the period of two months. This allowed the reduction of the risk of reactivity and respondent bias, as I built trust and became more accepted in the setting. The length of time I was in the setting, however, was not long enough to significantly increase researcher bias or the 'going native' treat, as discussed by Robson (2011). Therefore, I considered the influence of my engagement with the group to have a low risk of significantly effecting the data collected.

8.2 Design development

For Pilot (III), two key new concepts were introduced to the design. Firstly, one of the prominent traits of those in recovery is a lack of self-confidence, which can present itself as a reluctance to engage with creativity due to the impression of not being able to draw or write 'well' creatively. For example, the Senior Recovery Worker suggested a reluctance to draw by service users due to low creative confidence during discussions for the Cultural Probe (P1.S3.SRW5). This reduced confidence is common among those beginning to rebuild their lives from substance use (Hough and Rice, 2011). Therefore, to ensure this research accommodates this and is designed to encourage and support creative development effectively, it was considered important to ensure the process assisted participants in developing their creative confidence and that creative tasks were achievable for a wide range of participants. Confidence was further considered as a theme in the literature review (chapter 2.0).

Secondly, whilst the Toolkit showed therapeutic value, it was important to find a way that it could be flexible enough to be used with existing recovery approaches. One such approach which is widely used for addiction and mental health recovery is Motivational Interviewing. This technique was suggested as a possible complementary approach by one support worker who was consulted during a workshop at one of the pilot organisations (P3.S8.SW2.5). Motivational Interviewing was also considered in detail through the existing engagement tool review (chapter 5.0).

The integration of these two new concepts into the design was intended to help build trust with both staff and participants. By showing staff how the Toolkit could be used alongside existing recovery methods, means they would be more confident about delivering it and more likely to trust the method. Also, by attempting to help participants build creative confidence, it would allow them the confidence to trust the process and participate more freely.

Creative confidence

As highlighted above, one element that participants may have in common is a lack of confidence due to the difficulties they have faced in their lives. One element of this lack of confidence which was important to consider in the design, was that the participants' creative confidence may be affected by their general confidence. This is because participants may have engaged in very little creative activity in their lives to date, and if they have done so, then this may be to a reduced level, due to the reasons outlined above.

As Kelley and Kelley have outlined in their writing, there are four fears which are barriers to building creative confidence:

1. Fear of the Messy Unknown
2. Fear of Being Judged
3. Fear of the First Step
4. Fear of Losing Control (Kelley and Kelley, 2012)

Whilst it is accepted that the target group in their writing is a professional audience, the ideas are applicable to anyone aiming to build creative confidence. Therefore, this version of the Toolkit aimed to address these fears and allow the process to be beneficial for building creative confidence. The four fears were considered in the design as follows:

Fear of the Messy Unknown

Participants were informed that there were no right or wrong answers and that they could produce as much or as little creative work as they felt comfortable during the sessions. This helped to reduce the pressure on participants, by stating that there was not a required minimum amount of creative output and output of a certain standard required. Also, during the process they were exposed to a variety of small and simple creativity based exercises, which over time allowed them to be more comfortable with creative approaches, especially if they were new to them.

Fear of Being Judged

The workshop tasks were anonymous outside of the sessions and were undertaken in a small group environment. Participants were able to test out ideas with a group of individuals that became more familiar as the weeks progressed, and who they may already be familiar with in their organisation. So, this became a safe space to share ideas, which aimed to help participants feel more comfortable sharing and attain increasing confidence in their own responses and creative work.

Fear of the First Step

The tasks were designed to be simple and therefore easy to embark on with guiding structure to work within. The tasks allowed participants to make very small first creative steps, which built on each other week by week. The aim was to slowly build up creative confidence rather than asking too much of participants early in the process, as this had the potential of leading to frustration and becoming a barrier to progress.

Fear of Losing Control

Participants were encouraged to share their responses and ideas at the end of each session, which allowed an element of collaboration and a space for open discussion. This is where ideas may be challenged and realisations about recovery could be inspired. This allowed participants the opportunity to let go of certain ideas and embrace ideas raised by others in the group. The aim was to allow participants the creative space to 'lose control' through collaboration.

Motivational Interviewing

Motivational Interviewing was identified as an example of a widely used existing recovery technique and the following points describe in more detail how the Toolkit can link with the approach or 'spirit' of Motivational Interviewing (Rollnick And Miller, 1995). These points were previously defined in the existing engagement tool review (chapter 5.0). The following discussion highlights how these can be integrated into the Toolkit.

1. Motivation to change is elicited from the client and not imposed from without.

The Toolkit tasks were designed to help the participant understand their situation in more detail. Through this process participants can define their own individual values and goals, which could be explored further through Motivational Interviewing techniques.

2. It is the client's task, not the counsellor's, to articulate and resolve his or her ambivalence.

The Toolkit allows a comparison between past and present. For example, healthier decisions in the present compared to unhealthier habits in the past. This aims to facilitate a conversation around how to get from one point to another, to facilitate change, show progress and provide motivation for change. The tasks are intended to allow participants to identify conflicts in their thinking

through discussion, which can be worked through jointly with the facilitator to find resolutions to these conflicts. The visual and creative nature of the tasks also assists with the Motivational Interviewing process, as it helps participants to express feelings and opinions, which they may have previously found challenging to define and verbalise.

3. Direct persuasion is not an effective method for resolving ambivalence.

The aim of the Toolkit is to elicit and illustrate the reality of the things which are important to a participant's recovery. Through this process there is no element of persuasion or coercion. The tasks offer time and space to reflect and discuss, rather than insisting on the urgency to change.

4. The counselling style is generally a quiet and eliciting one.

The facilitation method for the groups is calm and sensitive to the client's needs, as it is intended to be a client led activity. This provides a quiet and eliciting space for interactions between the facilitator and the participants, and also between the participants themselves, through peer support.

5. The counsellor is directive in helping the client to examine and resolve ambivalence.

The Toolkit is designed as a creative elicitation tool, and as such it provides material for a key worker or peer group to use in helping direct participants towards resolving their ambivalence and instigating change.

6. Readiness to change is not a client trait, but a fluctuating product of interpersonal interaction.

The Toolkit tasks provide a method for the participant and facilitator to build a 'therapeutic relationship'. It also provides opportunities for delivering different

'motivational strategies', to approach the interaction from different angles and from different perspectives. Especially if there is evidence of a resistance to change and therefore unreadiness.

7. The therapeutic relationship is more like a partnership or companionship than expert and participant roles. CHECK THAT THERAPEUTIC RELATIONSHIP IS DEFINED EARLIER IN THESIS

The Toolkit relies on and champions a therapeutic relationship, which is more like a partnership or a joint venture. The tasks can support the Motivational Interviewing facilitator through a focus on informal and creative activities, to help nurture this relationship, rather than simply discussing and verbally exploring ideas and methods for behavioural change. The Toolkit is designed to place the participant at the centre of the process and reduce the chance that the interaction with a support worker would put them into a 'passive role' in the process.

Alongside consideration of how the above two elements could be integrated into the Toolkit prior to Pilot (III), the design development points were also considered which were identified from Pilot (II). These points were integrated into the design as follows:

Figure 8.2-1 Pilot (III) - Revised Read Me sticker

Task 0 - Please Read Me

The 'Please Read Me' card was previously used as an introduction card placed inside the box. For Pilot (III) this became a sticker placed inside the box lid rather than a separate loose card, to provide regular encouragement for recovery during the Toolkit process (Fig. 8.2-1). As participants see the card each time the Toolkit is opened, it acts as a regular reminder of the key points of the process and of how to approach the sessions. The design of the text structure was also developed further to bring out the key points of the message to participants attention. These were colour coded based on the points being made and spaced out equally, with the intention that each time the box was opened several points about the process could be refreshed in the memory.

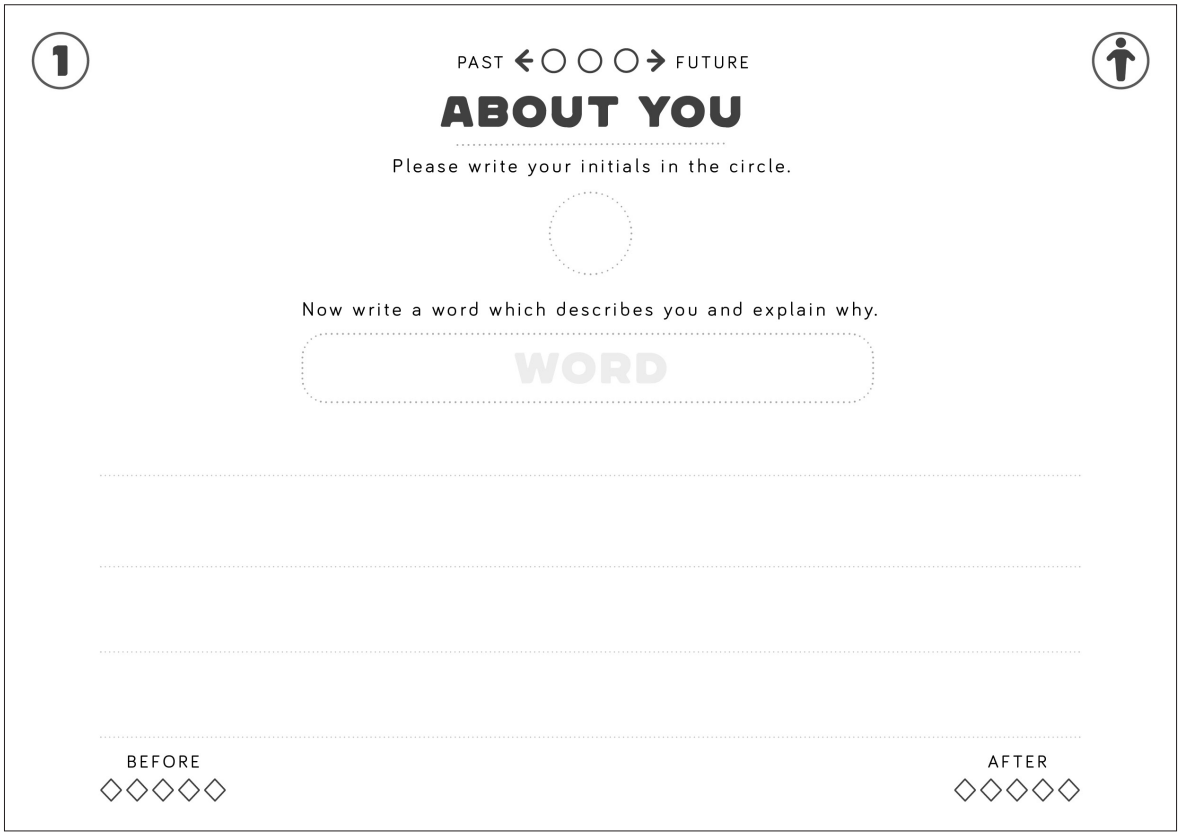

Figure 8.2-2 Pilot (III) - Revised About You card

Task 1 - About You

During the Pilot (II), the responses to the About You task provided a brief written description of a participant's recovery story. Whilst this is important, it was felt that this task could be more creative and also potentially collaborative. When faced with a blank sheet of paper and tasked to write about yourself in general terms, especially when recent events life have may been uncomfortable, it could be intimidating as a starting point for the process. Therefore, a more manageable amount of information was requested, which instead asked for a single word and description about each participant (Fig. 8.2-2). It was considered that participants should be able to think of a single word and describe it about themselves, and that this provided a more accessible 'soft' starting point. Participants could then complete multiple cards for different tenses (past, present and future) and they were also able to collaborate and possibly share words during the task, helping

to familiarise themselves with others in the group. In general, the spacing of the structured lines on the cards was considered, which was highlighted in the student workshop (SW.S1.SS7). The lines were spaced to allow different sizes of handwriting and suggest that only a limited amount of description was required.

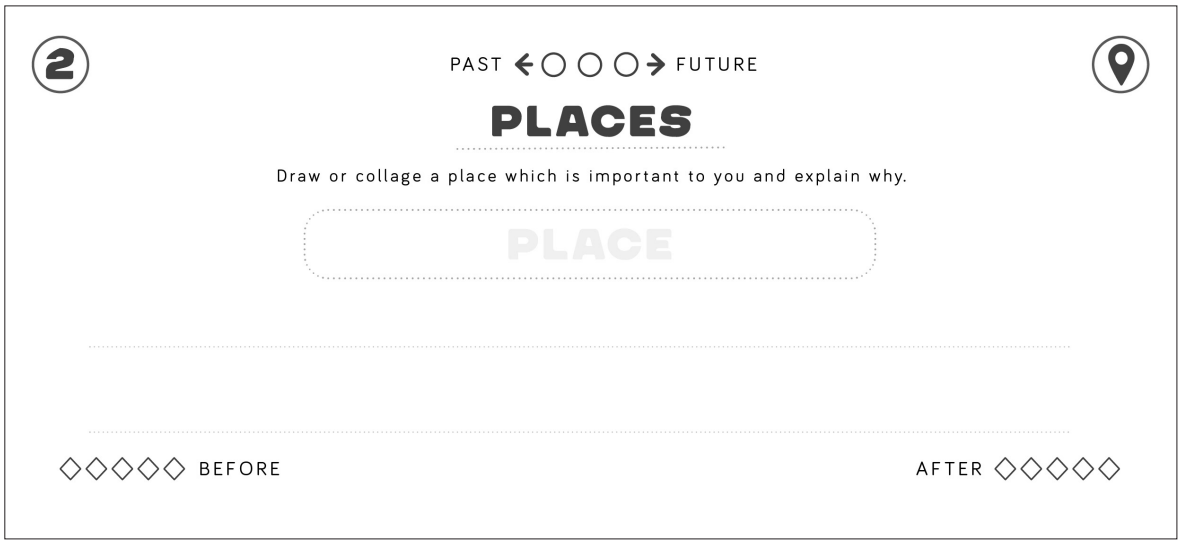

Figure 8.2-3 Pilot (III) - Revised Places card

Task 2 - Places

During the Creative Recovery Toolkit Pilot (II) (chapter 7.0) one participant (PT) provided feedback that the size of the map was too small and therefore difficult to read (P2.S2.PT2). Another participant (SD) suggested that the map did not include enough of Hove (P2.S2.SD1). These practical concerns caused frustration and created a barrier to participation. Following this feedback, using a specific local map in the Toolkit was reconsidered, as in the future the Toolkit might be used in other locations, so it might not be practical to include a bespoke map for each location. This was due to the graphic style of the map being produced from scratch for the Toolkit, to allow it to be clear at a small scale. Another consideration was that the activity of simply recording a dot or circle on the map, did not facilitate exploration of the sense of a place. Therefore, for this iteration of the Toolkit the physical map was removed and replaced with a task where participants were asked to identify a single place per card (Fig. 8.2-3).

As another early task this was designed to again request a manageable amount of information. Participants were then asked to represent the place through drawing or collage, with the intention that this experience would encourage participants to think more carefully about the detail of the place. Collage was offered as an alternative to drawing, as some participants can have an initial reluctance in feeling confident enough to draw (P1.S3.SRW5). Collage is a more approachable activity, which appears to require less skill and was identified as a good alternative to drawing in the student workshop (SW.S1.SS2).

By exploring places more creatively it also opened up the possibility of participants including imagined or metaphorical places. This could be useful in the exploration of their impressions and memories, which related to their unique recovery journeys. For example, for participants to see the places where addiction or mental health has taken them in the past (P1.S4.FAC2). Finally, to provide more space for drawing and collaging this task card was changed to a folded A4 format rather than A5. This change also suggested during the student workshop sessions (SW.S1.SS5).

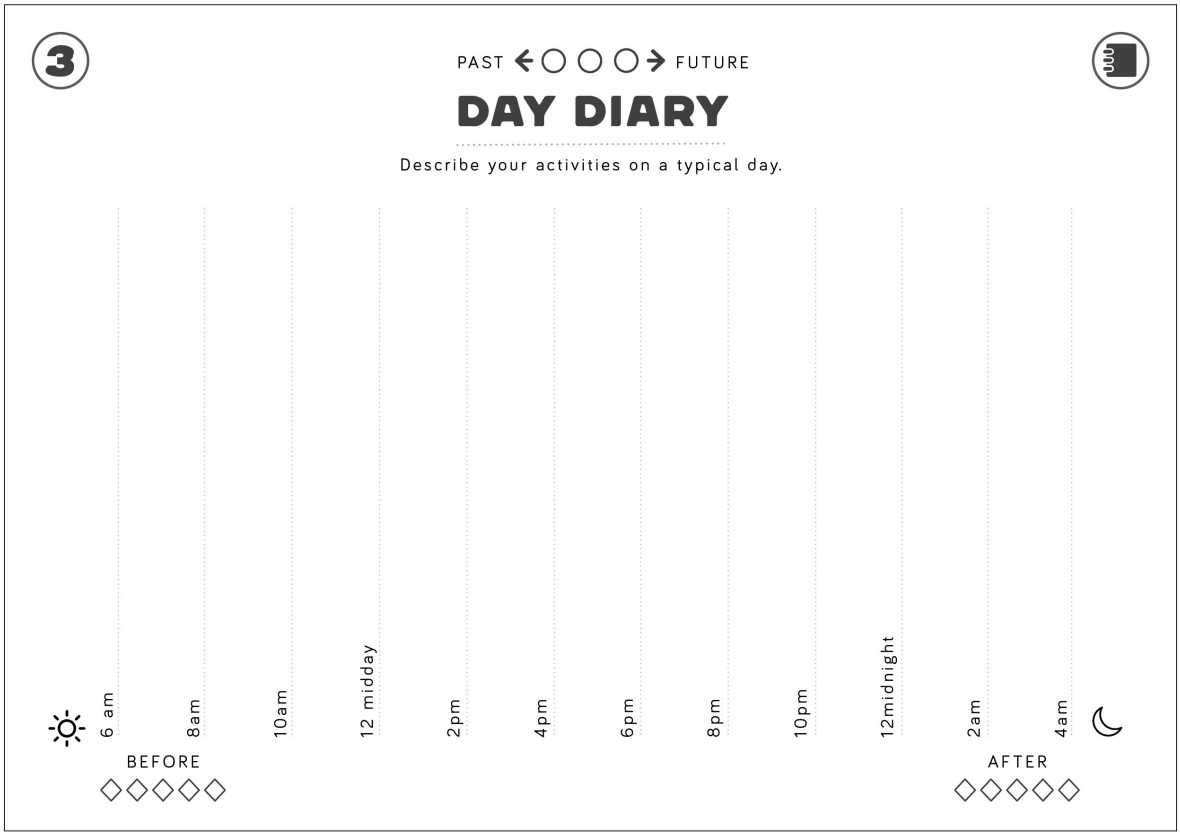

Figure. 8.2-4 Pilot (III) - Revised Day Diary card

Task 3 - Day Diary

This task remained largely unchanged for this iteration. Although sun and moon symbols were added to graphically represent day and night, which made it easier to visually discern the morning and night ends of the time-line (Fig. 8.2-4).

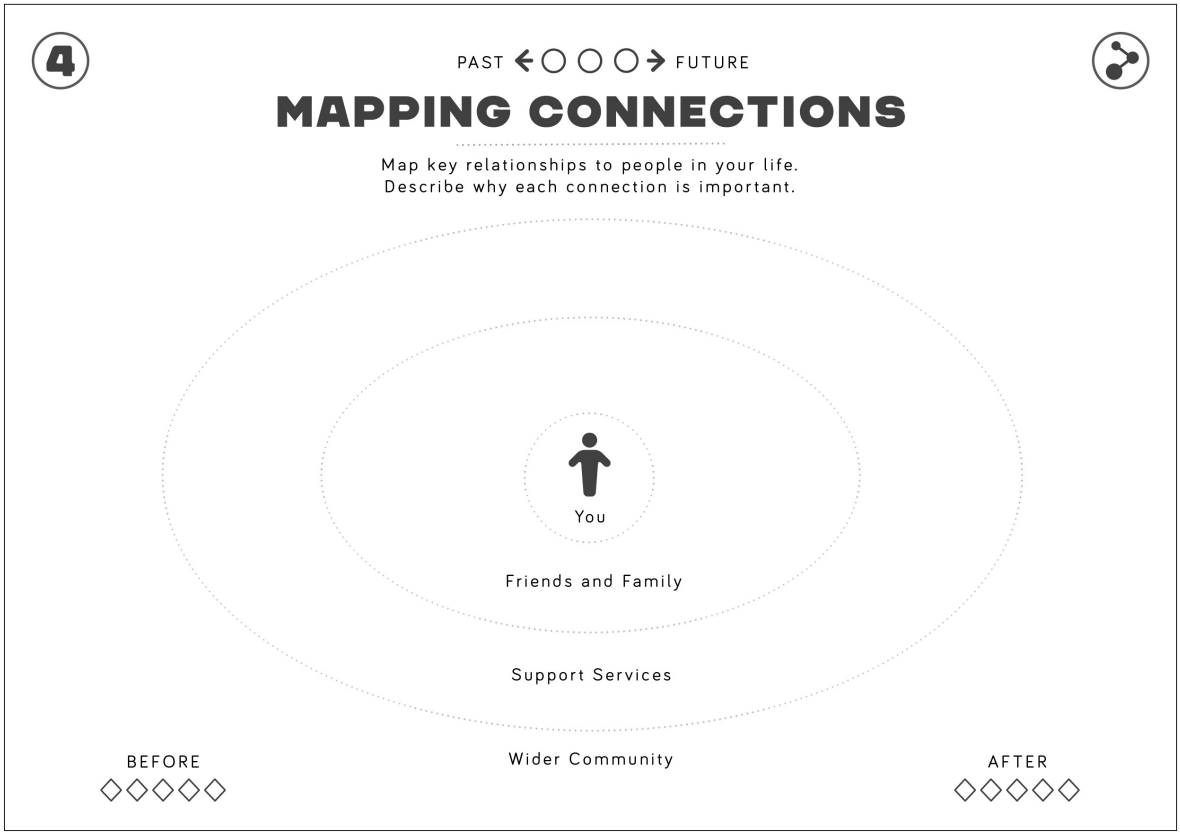

Figure 8.2-5 Pilot (III) - Revised Mapping Connections card

Task 4 - Mapping Connections

One participant found that the instructions for this task were not clear enough (P2. S5.PT1). These were simplified for this version and a more detailed explanation was added to the facilitator notes to help the group facilitator assist participants in fully understanding the activity. The card structure was also amended slightly to elongate the circles and provide more space for adding friends, family and support staff (Fig. 8.2-5). This was to make better use of the space available on the landscape format of the card.

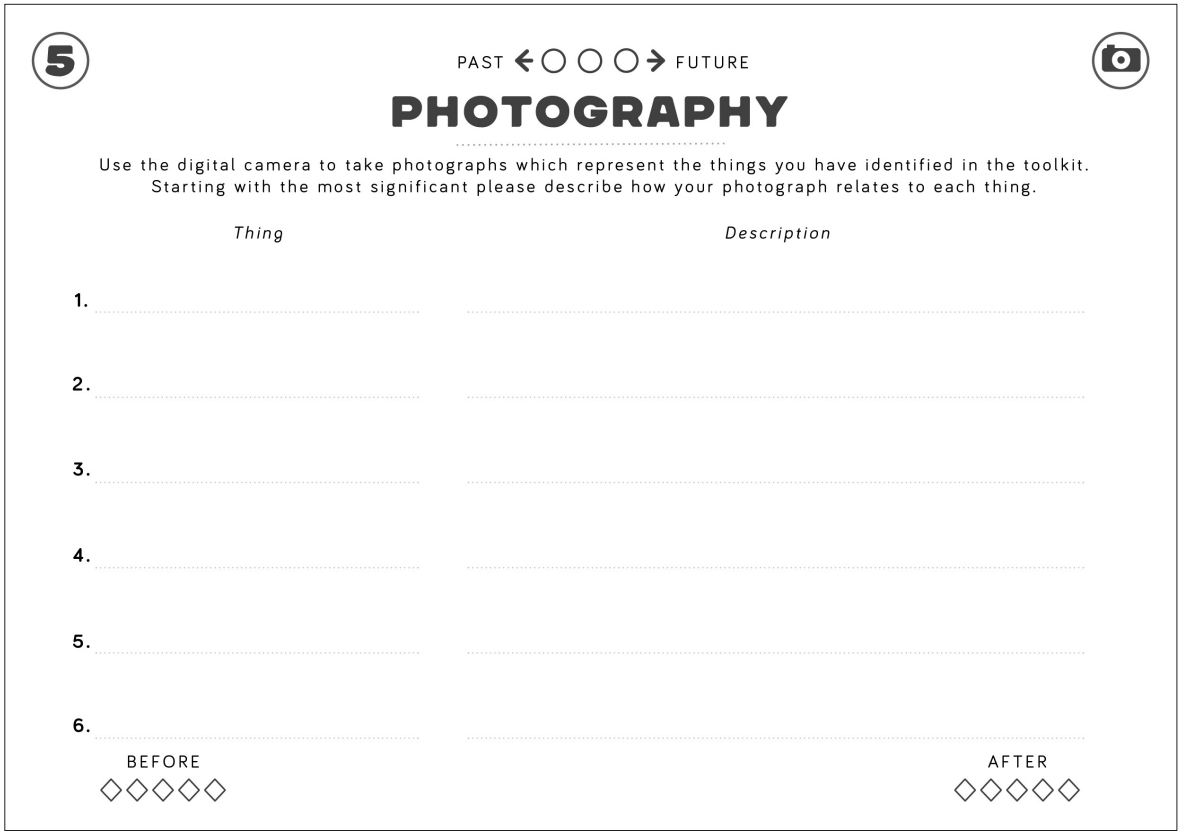

Figure 8.2-6 Pilot (III) - Revised Photography card

Task 5 - Photography

Due to participant reluctance towards going out to take photos or simply using a camera due to inexperience, anxiety or low energy (P2.S6.SD4); (P2.S2.DG5), it was decided to provide an option for participants to download and print images from online sources (or use personal photos). This was intended to help prevent the above becoming a barrier to participation in the activity.

To provide the option for printing images during the workshops, a solution needed to be found, as it would not be practical for the facilitator to bring a traditional desktop printer to each workshop or rely on the facility having reliable printing capacity available. To facilitate this step in the process, a small instant printer was used during the workshops (similar to a Polaroid camera), this printer allowed the creation of physical prints directly from a smart phone. The small

size of prints produced worked well with the small format of the task card and the images had an adhesive backing, which allowed them to be easily stuck down during the sessions, to further document previous responses to the tasks (Fig. 8.2-6).

Figure 8.2-7 Pilot (III) - Improved quality of materials

New tasks and inclusions

Recovery measurement

For this version a method of measuring the process was introduced, as support workers are already familiar with regularly measuring client outcomes (Fig. 8.2-8). This included a scale of 1 to 5, located on either side of the card, for participants to record how they felt before and after completing the task. The 1 to 5 structure was amended from 1 to 10 after testing the tool at a student workshop (SW.S1.SS8), as it was felt that 1 to 5 felt more informal (such as rating something for a review). Participants were encouraged to colour half a diamond if the 1 to 5 scale did not have enough increments for them. Diamond shapes were used as symbols rather than stars, as these are easier to colour in quickly and to colour in only half. This method of measurement was useful for the process in the following two ways:

1. To gauge the impact the activities were having on the participant (both for each individual task and over the course of the process). The act of identifying a measurement of the session before and after it is completed was designed to help each participant to reflect on any difference in feeling the task has facilitated. Alongside discussion with the facilitator, this could enable discovery in recovery and help highlight areas which may require future exploration.
2. To evaluate the effectiveness of the Toolkit. The scoring system competed by the participant could determine whether each task is valuable. This could then be drawn on to improve the tool implementation when combined with feedback provided in the final workshop summary session.

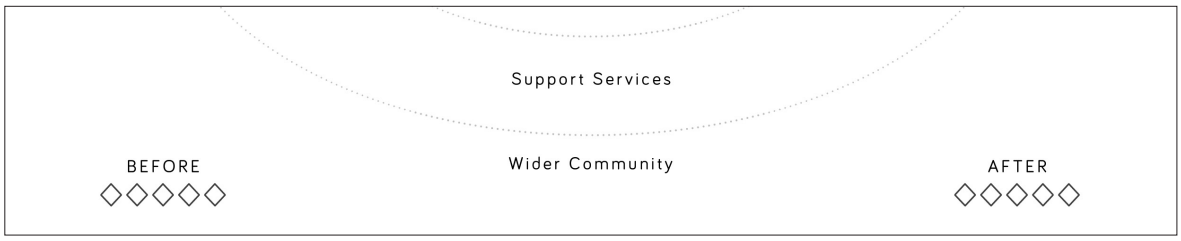

Figure 8.2-8 Pilot (III) - Measurement activity on Mapping Connections card excerpt

The scale simply records feeling low (1) to feeling good (5), it does not record nuances or types of feelings. However, participants were encouraged to vocalise the specific feelings which were being described, which is recorded in the facilitation notes.

Task 6 - First Aid

The first of two new tasks, First Aid (Fig. 8.2-9), employs a technique previously suggested by the Senior Support Worker at the Pilot (II) partner organisation. This idea asks participants to use the Toolkit box to collect things which are useful for their personal recovery, to then use in a situation where emotional 'first aid' is required. For example, if they are having a particularly difficult time

with recovery, these items may provide motivation at a low point. The items could be anything but examples include: a song, photographs, phone numbers, chocolate or anything that could help in a time of crisis (P2.S2.SSW2).

Figure 8.2-9 Pilot (III) – Added First aid card

Self-care is an important skill for participants to learn, which can potentially extend the use of the Toolkit and its value beyond the structured sessions. This task and the following journalling task are examples of self-care techniques. Having the first aid tool can act as a safety net to provide motivation if coping strategies fail, which could provide comfort. As part of this new task, participants were also asked to write a letter to themselves to assist during a difficult time. This would be kept by a trusted friend or support worker and sent back to the participant if they needed some additional emotional motivation to persevere with their recovery journey.

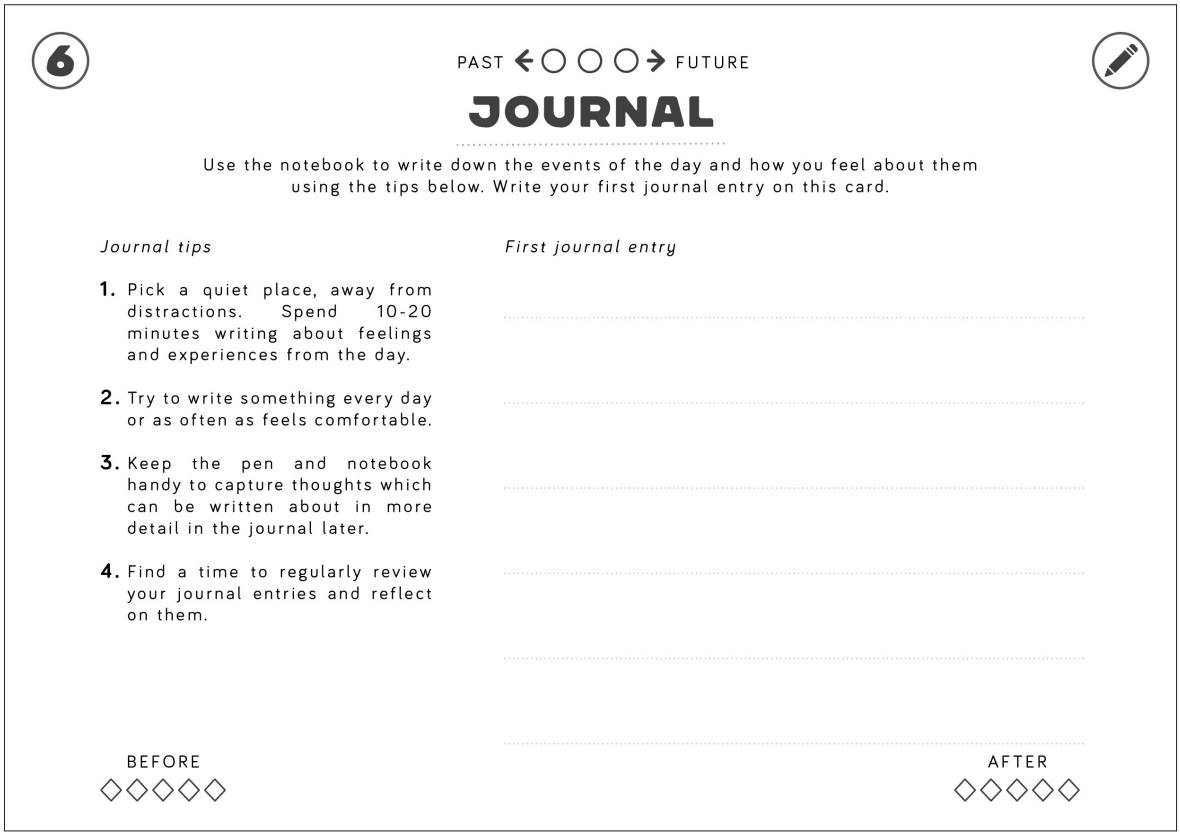

Figure 8.2-10 Pilot (III) – Added Journal card

Task 7 - Journal

The second new task, Journal (Fig. 8.2-10), involves participants being asked to begin keeping a journal in the notebook which is included in the Toolkit. Keeping a journal shows potential for use as a self-care method and as a tool for collaboration (Harvey, 2011). Journalling was also identified as helpful for recovery by two participants in Pilot (III) (P3.SB6.PD1); (P3.SA7.SBP12) and an example called MindJournal was explored in the engagement tool review. Participants wrote the first journal entry as part of the workshop and were then encouraged by the facilitator to continue this activity after the workshops had finished.

General card structure and design

The card design and task structure were updated based on workshop feedback and design iteration. One general element that was updated was that less information was asked for in the early tasks. For both the About You and Places

tasks, initially only a single word is requested. This more refined request was considered more approachable, as it required less effort to achieve and resulted in richer information being elicited and explored by participants.

One participant commented that the card numbering (i.e. the sequence of the cards) jump as you go through the process (P2.S2.GRP2). This was due to the tasks previously being split into past and present halves. This was addressed by making the task numbering sequential, with separate notation on the cards to select past, present or future. Participants could then complete multiple cards during each workshop and identify the 'tense' that they would like to explore on the card. One participant suggestion was to include an option to consider the future (P2.S4.DES1), this was added to the notation on each card. This design change simplified the process and reduced the chance of confusion amongst participants. Another participant suggested change was that the instructions for the tasks could be more general (P2.S2.SD2), and where appropriate this has been changed in the card instructions.

The structure provided on the cards was also amended, with all cards now including some form of framework for guiding participation. This was to reduce the chance of a blank card feeling intimidating to begin working on. A balance of how open the tasks were was intended, with enough structure to make the task easy to understand and follow, whilst still allowing space for creative responses and avoiding a tick box exercise. Formal recovery is based around structure, which can include set times for medication, chores, key work and groups. Those earliest in recovery require the most support and structure, for example, in a residential rehabilitation centre or hospital detox. Then as recovery develops service users move from higher support levels and structured activities, to gradually reaching a lower level of support and structure, eventually leading to independent living. The point at which the pilot group are at in their recovery is still a very structured environment, with evidence from Pilot (II) confirming that structure is beneficial for the participants.

Another structural change, involved moving the task description from the bottom of the card to the top. This creates a linear process of reading the task information, moving visually down the card and completing the task in sequence. This reading from the top to the bottom avoids jumping around the card with the eye. This was aimed to reduce the chance of causing confusion to the participants.

Due to the researcher role changing to include workshop facilitation in Pilot (III), a method was required to allow effective note taking during the sessions. To address this requirement, the Toolkit cards used by the facilitator were designed in a different way to those used by the participants. On one side of the facilitator card set was the same card as used by the participants. This allowed the facilitator to talk through the card by holding it up to the group and highlighting things such as the tense option boxes or the recovery measurement diamonds. The facilitator could also complete the task alongside the participants. The other side of the card included facilitator specific sections, these were as follows:

1. Session structure overview: this allows the facilitator to tick off each stage of the workshop so that parts are not missed.
2. Task ideas: the facilitator could write ideas for further development of the Toolkit, either from their own observations or ideas suggested by participants.
3. Participant notes: each participant had a line which included space to write their initials and the responses to the facilitator through the recovery measurement exercise. Also included was a space to write observations on individual participants' progress in the task, their approach to the process or other factors which may be helpful for further discussion.
4. Task reminder: a reminder of the task and instructions are included at the top, for quick reference if questions are posed by participants.

The inclusion of this dedicated section enables the facilitator to lead the session, complete the task alongside the participants (if required) and to make notes on the process all from a single card (Fig. 8.2-11).

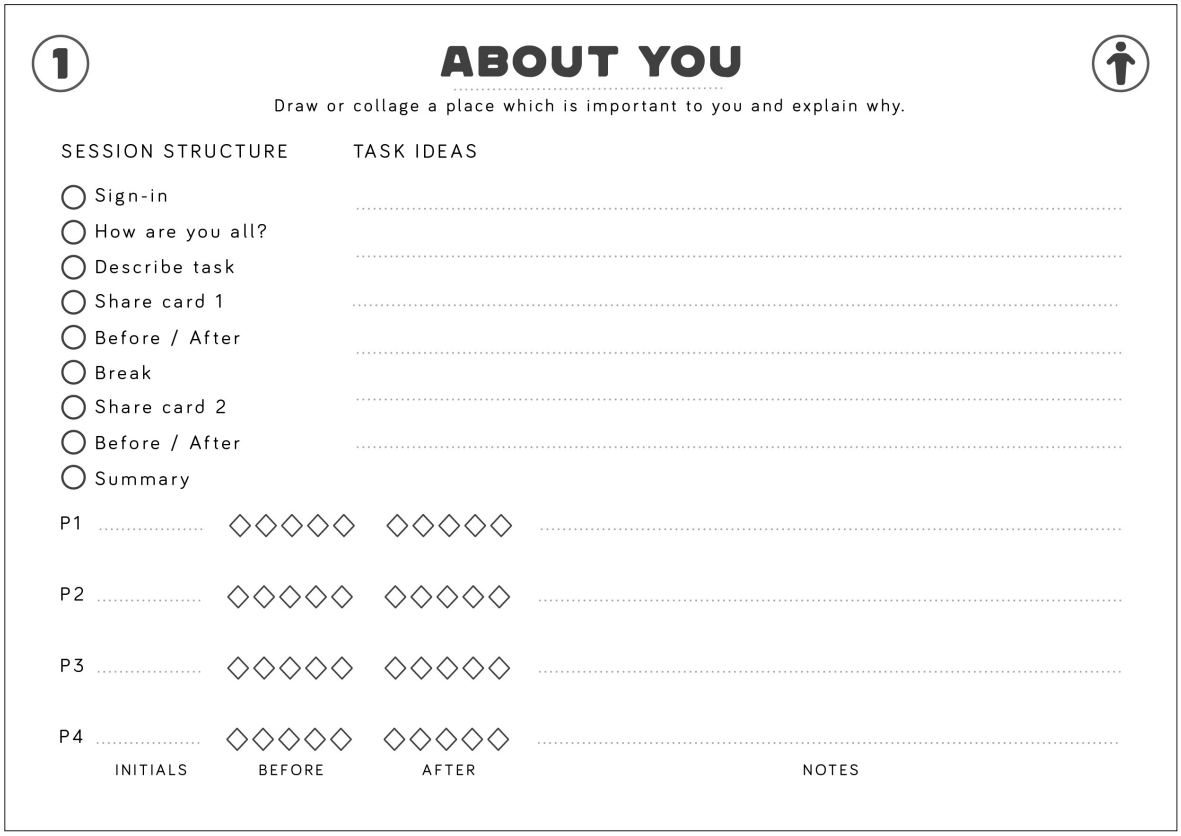

Figure 8.2-11 Pilot (III) – Facilitator side of About You card

Individuals develop creatively at different speeds and also work through creative activities at different speeds, which can be the result of their level of creative confidence, enjoyment of the particular activity or dexterity. It needs to be managed that individuals do not feel they have too much to do during each task but will also not run out of activity to complete. Therefore, the kit structure was changed to use a single card per task, with participants able to continue on additional cards. This meant that individuals who wanted to take more time over the task could do so, whilst others could ask for additional cards if they finished quickly.

Graphic and physical Toolkit design

The graphic and physical design of the Toolkit was updated from the feedback received (Fig. 8.2-7). One participant thought the quality of the pens was frustrating (P2.S6.SD1), so for Pilot (III) these were replaced with higher quality pens. The quality of materials and included items was also generally improved in the Toolkit. Initially, the intention was that the Toolkit should be inexpensive for services to purchase to use with clients, meaning that the cost of the Toolkit was not a barrier to support services using them regularly. However, through the process it became increasingly clear that the quality of the materials included was very important. As one participant commented (P2.S6.DG7), the better quality materials help to increase a sense of value in being part of the process.

The single-use camera was replaced with an inexpensive digital camera. The cost of the digital camera was double the cost of purchasing and developing a single use camera. However, to reduce the cost of delivering the Toolkit, support services could retain the camera at the end and reuse this for future client workshops. The digital camera is better for taking images indoors, which is important, as several images from the Creative Recovery Toolkit Pilot (II) did not expose properly and were therefore unusable. This makes the digital camera more reliable for the process and allows participants more flexibility in the images that they can capture. In the Cultural Probe Pilot (I), it was considered that if more expensive equipment was used, digital cameras for example, then they could easily be lost or damaged during the process. However, as the kits are taken in by the facilitator between workshops, the chance of the materials being mislaid was minimised. Clients in the Creative Recovery Toolkit Pilot (II) and also Pilot (III), were more established in recovery and further removed from previous chaotic lives, therefore they were better able to maintain the Toolkit and be responsible for the camera between sessions (if required), further reducing the risk of loss.

One participant was not sure how to use the camera (P2.S2.PT3). It was assumed prior to the sessions that participants would know how to use a single-use camera, however this comment highlighted that this was not the case. Therefore, the camera instruction book was included in the box and participants were introduced to the basic functions of the camera at the beginning of the photography task week.

The overall graphic design of the Toolkit was updated based on participant comments. Comments included that the writing on the cards was too pale and small, reducing contrast and legibility (P2.S6.PT1). This was made darker and slightly larger for Pilot (III). The font and colour used for the design of the Toolkit and the external box were redesigned (Fig. 8.2-12), as the choice of colour could influence psychological resonses, mood, self-esteem and well-being (McLeod, 2016). Typefaces used for the Toolkit logo and titles were 'humanist san-serifs', which encourage a warm and personal feeling to the text compared to geometric typefaces, which may produce a colder clinical feeling (Shoaf, 2020). The intention was to make the design welcoming, approachable and non-threatening, via the typefaces and colours used. For the 'Please Read Me' label inside the lid, colours were used to highlight specific points being made in the text. The colours were chosen as follows:

- 1. BLUE for the background.

  A rich deep shade of blue was chosen for the background, as it represents a sky or deep pool of water, which can encourage reflection and feelings of safety. Blue is also a calming colour, which was important as participants may be approaching the Toolkit whilst suffering anxiety (McLeod, 2016).

- 2. GREEN for text relating to recovery and the Toolkit process.

A shade of green was used to represent highlighted points in the text relating to recovery. As green is associated with nature, health, healing and refreshing or replenishing (McLeod, 2016).

3. RED for important points to remember in the text.

A shade of red was chosen to represent things to bring attention to, as red is the colour for a warning or alertness (McLeod, 2016).

4. ORANGE for things which are about having fun and discovering.

As orange is an energetic, creative and uplifting colour (McLeod, 2016).

The intention was that this colour choice could encourage enthusiasm towards the activities and discovery through the process.

Figure 8.2-12 Pilot (III) – Improved graphic design language

The idea was explored to include a folding box, to allow the building of the Toolkit, which would add a craft element. However, due to the reduced dexterity of some members of the Pilot (III) group, the Toolkits were pre-made for the

workshops. As an option for future workshops, the participants could start the process by building the kit themselves. One participant in Pilot (II) was concerned by not knowing what was to come in the process, however, another wanted to do it step by step (P2.S1.DES6). The option to build the kit from parts before starting the sessions, could provide a brief understanding of the materials included and the tasks prior to starting. This could help reduce anxiety by allowing participants to familiarise themselves with the process and to view as much of the content prior, as they felt they would like to. Therefore, this method could provide a balance between these two points of view.

Finally, during this version of the Toolkit development the name was changed from Creative Recovery Toolkit to Creative Discovery Kit. This was due to a conversation with a Senior Support Worker at Sanctuary Supporting Living, who suggested that service users can be put off by the use of the term 'recovery' (P3.SA8.SSW6); (P3.SA7.SSW6). This was also confirmed by one potential participant who called to ask questions about the process before signing up, they subsequently did not participate (P3.SA9.PP2). The word Toolkit was also changed to simply 'Kit', it was felt that this fitted better with the informal approach of the process.

8.3 Creative Discovery Kit testing with MA design students

As a pre-workshop exercise to refine the Toolkit, it was again tested with Sustainable Design students at Kingston University, London. This was to investigate not only the tasks themselves but the practicalities of facilitation (as the role of the design researcher was developing further for Pilot (III), which is described in more detail above).

The tool was tested with 10 design students during a 2.5hr workshop, prior to the final Pilot (III) workshop sessions. The students once again inhabited three Personas, which were based on real life case study information, in a similar way

to the previous student workshops. However, during this session, the students were split into pairs and they took turns to act as both the participant and the facilitator. This was to simulate the process of delivering the task cards and designed to test how easily the tool could be delivered in practice. This process also helped to inform the developing of facilitator notes to accompany the Toolkit. The task enabled the students to consider both sides of using the kit and then to feedback their thoughts to the group.

It is important to highlight that different pairs of students interpreted the activity in slightly different ways. For example, in the feedback form some students simply expressed general comments about the process and others used the forms to split their responses into feedback as participants (inhabiting Personas) and as facilitators. It is the general comments and feedback as facilitators that have been used to inform the ongoing design development of the Toolkit (referenced later in this chapter). Full responses and completed feedback forms are included in appendix I. The reason for only using part of the responses was that the inhabitation of Personas was not useful for the development of the Toolkit design. This is due to the fact that this workshop was used to test the method and not to generate data for analysis. The development points that came out of this session and completed feedback sheets can also be found in appendix I.

8.4 Organisation and participant description

Pilot (III) was undertaken across two organisations. Firstly, Sanctuary Supported Living clients from a different residence to the Creative Recovery Toolkit Pilot (II) undertook the workshops. In addition, clients participated from an organisation called the Southdown Recovery Centre, who work with clients who are recovering primarily from mental health difficulties, with secondary substance use issues. Southdown Recovery Centre "...provides a welcoming and supportive environment in which people with mental health support needs can learn new

skills and get involved in a variety of groups and activities." (Southdown, 2021). Many of the structured groups organised in this service are based around creative activities and mindfulness, which is a good fit for the focus of this research. More detail on the rationale for introducing a new organisation can be found in section 8.9.

Nine clients in total engaged with the process, with seven completing the Toolkit entirely and providing feedback about their experience. Participant ages ranged from 20s to 50s, with the split of male to female being three to six. Participants from Sanctuary Supported Living included four participants, two of which completed the Toolkit and two were not able to complete all the sessions. Participants from Southdown Recovery Centre included five participants, all of which completed the process.

8.5 Workshop description

At Sanctuary Supported Living the sessions took place in a creative space in the garden of the residential rehabilitation facility. The group sat in a circle to complete the tasks and discuss responses (Fig. 8.5-1). There was no central table available, so the tasks were completed on participants laps, using the Toolkit boxes to lean on. The second set of workshops at Southdown Recovery Centre took place in a room specifically booked for the workshop each week. This room had a central table and all participants sat in a circle and completed the tasks at the table and then shared responses. In total seven weekly workshop sessions were completed at each organisation, which included a feedback session at the end for participants to communicate their experience of the process and highlight areas for design development. These suggested points for development are recorded below.

Figure 8.5-1 Pilot (III) – Round table workshop

Participant suggested improvements

1. Extra cards provided to continue process in the future (P3.SA7.SPB6).

One extra task card is provided to participants for each activity at the end of the process. Participants can then continue with the tasks in the future and add to the Toolkit.

2. Perforations provided on box label (P3.SA1.GRP1).

Participants had difficulty opening the label which seals the Toolkit. A perforating tool was used for the completed Toolkit to create a break-line for easier opening. This small detail has the potential to avoid the initial participant frustration at not being able to break the seal, which may be a barrier to engagement and enjoyment.

3. Day Diary task hour divisions increased to show each hour of the day (P3. SB3.CW1).

One participant suggested that each hour could be shown on the Day Diary card, instead of two hourly intervals. This was amended in the final version to provide time in hourly increments, with the additional increments faded. This detail aimed to satisfy both participants who would be happy with more space to write and those who would prefer the hourly structure included on the card.

4. Structure for writing adjusted (P3.SB6.ZN1).

One participant found that the lines for writing in the journal task were too widely spaced, so they ran out of space to write. The lines were brought closer together, to include extra lines for writing on the card. A facilitator note was also included, to suggest to participants that if they ran out of space on the card they could either continue on the back or in the journalling book provided in the Toolkit.

Designer and staff suggested improvements

1. Signposting could be added by participants highlighting specific cards showing their interests and where to go next. Key workers could then encourage participants to begin making connections in the community through these interests and attending groups.
2. Include a stamp for the postcard, as the requirement for participants to purchase a stamp prior to posting their first aid card, could create a barrier to participation.
3. The progress measurement diamonds and the past, present and future (PPF) markers require clearer labels as a reminder of their function. This was updated on the final version task cards.
4. In the Pilot (III) tasks cards the PPF and measurement scale notation was included on all of the task cards. However, following Pilot (III) it was evident that they were not required on some of the latter self-care tasks and were removed.

5. Include a memory stick to store digital creative information (P3.SA8. SW2.9).

8.6 Data analysis and discussion

Participant	Task 1	Task 2	Task 3	Task 4	Task 5	Task 6
Sanctuary						
S	o	o				
AW	o	o				
JP	o	o	o	o	o	o
SPB	o	o	o	o	o	o
Southdown						
CW	o	o	o	o	o	o
LJC	o	o	o	o	o	o
TKPL	o	o	o	o	o	
ZN	o	o	o	o	o	o
PD	o	o		o	o	

Table 8.6-1 Participant attendance for the Creative Discovery Kit Pilot (III)

Task 1 - About You

Creative was the most common word chosen by participants, this was chosen six times out of 13 choices. Unique was the second most chosen word with three participants choosing it. Participants describe participation in a wide variety of creative activities, including:

- writing songs
- using recycled materials
- painting
- music production
- craft
- drawing
- collage

Six out of nine participants describe creativity as something which is important to recovery or that they find things more difficult when they are not able to be creative and that they would like to do more creative activities in the future (P3. SA1.JP1); (P3.SB1.LJC2); (P3.SB1.PD2); (P3.SB1.TKPL3). This again highlights the importance of creative activity to those in recovery. As unique was the second most chosen word, this illustrated a desire for participants to show their individuality through completing the task.

In the responses there were eight mentions of the negative mental aspects of the words which had been chosen. Compared with 10 mentions of positive mental aspects, including goal setting or future desires. An emphasis on looking forward and positive emotions is also highlighted in the measurement scoring for the task, with all participants recording that they felt equal to or better when they had finished the task, compared with when they started it. This also shows that the process is capable of eliciting and exploring both positive and negative aspects of recovery.

Several participants mentioned that they felt anxious about attending the first session, which was highlighted through the reflection on the tasks (P3.SB1.CW2); (P3.SB1.LJC3); (P3.SB1.ZN1). These participants were anxious even though the recovery centre was a familiar place to them. This level of participation anxiety was also identified during the previous Creative Recovery Toolkit Pilot (II). However, the majority of participants in the process overcame their initial anxiety to complete the process and state that they found it beneficial and enjoyable.

Task 2 - Places

For the Places task the first workshops at Sanctuary Supported Living (which included four participants) produced two task cards and in the second set of workshops at Southdown Recovery Centre (with five participants), produced only one task card. This was due to time restrictions and to the other conversations which were taking place within the group session.

In the Sanctuary group of four participants, all chose to use one place to describe a feeling of home. These were either a place which made them feel safe, belong or where they spent their childhood, with all of these places related to the past. The second card was then used to describe a mixture of places that they enjoyed being in, would like to live in the future or places where they felt a sense of achievement. For example, AW described a trip to the Lake District where they climbed a hill, which due to their fear of heights was an emotional experience but they identified that they achieved it and felt good about it (P3. SA1.AW2). All of the participants described emotional ties to the places that they identified. During this task AW discovered an advert for Brighton Music School which they subsequently began attending. This suggests an opportunity to use the Toolkit to signpost participants to activities in the community, which they show an interest in. All participants described both a place with mixed memories (positive and negative) and one that produced only positive thoughts or feelings, weighting their responses towards places in a positive light.

In the Southdown group of five participants, only one card was completed during the session. Responses were mixed between positive and negative experiences of places. One participant (TKPL) chose 'dark' as a place and stated that it represented difficulties caring for a partner who struggled with alcohol (P3. SB1.TKPL1). Both ZN and LJC described places which were both negative and potentially positive. For example, LJC drew a spare room which had become a 'burden' storage room but had the potential to be organised and made into a music and art studio (P3.SB1.LJC1). One participant (CW) provided a purely positive place which produced good emotions and was a comfort when they spent time there (P3.SB1.CW1).

From the responses, the participants used the task to identify places which they felt safe, places where they achieved something or places that caused challenging emotions. The value of this task was confirmed by the positive response to the

measurement activity. All except one card resulted in the participants recording that they felt better after completing the task. The exception was S, who stated that thinking of one place made them feel slightly worse due to recalling those memories (P3.SA1.S4).

Task 3 – Day Diary

All participants (to varying degrees) described either a day in the past or present and compared that with a more positive idealised day in the present or future. Of these, two participants (CW & LJC) described a bad day in the past and compared it with a good present or ideal day. The comparison in the data here is stark, the better days include more recovery, social and creatively based activities, compared to negative days during which the participants generally stayed at home due to their symptoms.

Half the respondents described two days which were similar with minor differences such as waking up earlier, developing healthy mental attitudes, being more careful using public transport or meditating. One participant described a more dramatic lifestyle change of moving to Spain.

During this task all participants stated that they felt the same or better after completing the task, which was recorded through completion of the measurement activity. This shows again that the process was beneficial to the participants. The value of comparison in the Toolkit appears to be best reflected by this task, where participants are able to see contrast between points in their recovery and use this as motivation.

Task 4 – Mapping Connections

In the Mapping Connections task, four out of seven participants were able to complete two cards. Three participants described the difficulties experienced previously (or presently), when engaging and interacting with others. They did this by describing how they set up a brick wall around themselves, had anxiety

about engaging or difficulty reaching out. Generally, in the responses participants' past and present connections were similar, but in the future they included more recovery focused individuals and community groups.

Three participants included a commentary on the card which described difficulties and hopes for the future. All participant responses display a mix of connection types, including: family, colleagues, friends, support workers, community groups and partners. All but one of the participants stated that during the measurement activity, they felt the same or better after completing the task.

Several participants expressed anxiety about this task, during the session. The reasons for the anxiety included: initial anxiety about the task (P3.SB4.TKPL1), due to recent relationship breakdown (P3.SB4.PD1) or due to feeling they had a lack of close contacts (P3.SB4.ZN1). All three participants stated either that this anxiety turned to positivity during the task or that peer support during the session reduced anxiety about the task.

Task 5 - Photography

Participants generally documented the points identified throughout the completion of the previous Toolkit tasks. These included the elements of: connections, places and daily habits. The photographs highlight the importance of these elements in recovery (especially creativity in recovery), getting out into and appreciating nature, formal support activity and key close connections. In the context of the rest of the data, the photography task helps to make the identified points in the tasks even more visceral, through visual examples of these individualities documented in the Toolkit.

Task 6 - Journal

For those that completed the journal activity (five), the journal entries described past, present or future days. These generally gave more detail on the information provided in the Day Diary task. Some were simply descriptive, and some went

into more depth about how they felt about their days. Participants made an effort to be descriptive and honest in these journal entries. For those who completed the measurement activity, all felt either the same or better after completing the task. However, uptake on completing the measurement activity was low on this task.

Measurement activity

Participant	Card	Task 1		Task 2		Task 3		Task 4		Task 6		TOTAL	
Sanctuary		*B*	*A*	*B*	*A*	*B*	*A*	*B*	*A*	*B*	*A*	*B*	*A*
S	*1*	4	4	4	3	-	-	-	-	-	-	12	12
	2	-	-	4	5	-	-	-	-	-	-		
AW	*1*	2	4	2	3	-	-	-	-	-	-	11	16.5
	2	4	5	3	4.5	-	-	-	-	-	-		
JP	*1*	3	4	-	-	5	5	3	3	-	-	19	24
	2	3	4	2	4	-	-	3	4	-	-		
SPB	*1*	3	4	3	3	3.5	4	2	4	-	-	20.5	27.5
	2	2.5	3	3	3	2	3.5	1.5	3	-	-		
Southdown													
CW	*1*	3	3	3	4	2	2	2	2	4	4	22	26
	2	2	3	-	-	3	4	3	4	-	-		
LJC	*1*	2	4	2	3.5	1	2	4	3	3	5	21	31
	2	2	4	-	-	3	4.5	4	5	-	-		
TKPL	*1*	2.5	3	2	4	3	4	0.5	3	-	-	15	22
	2	3	3.5	-	-	4	4.5	-	-	-	-		
ZN	*1*	3	4	3	4	-	-	1	2	3	4	12	19
	2	2	5	-	-	-	-	-	-	-	-		
PD	*1*	3	3	3	5	-	-	0	2	-	-	9	14
	2	3	4	-	-	-	-	-	-	-	-		
TOTAL		47	64.5	34	46	26.5	33.5	24	35	10	13		
Difference		+17.5		+12		+7		+11		+3			

Table 8.6-2 Measurement activity responses

As indicated in table 8.2-2 above, it is clear from the measurement activity introduced to assess how participants felt about the tasks and the process overall, that it was a positive experience. All participants reported feeling the same or better in every task (with the two exceptions of S in task 2 and LJC in task 4). We can see from the differences between before (B) and after (A),

that participants felt significantly better over the process having completed the tasks. Some measurement responses were obscured by creative activity on the cards and were therefore not counted.

Feedback session

Feedback was provided via written forms completed by each participant (see appendix J). The following review considers the themes arising from the feedback provided.

All participants felt that the tasks were easy or "relatively" easy to understand and complete. With three participants commenting on the tasks as: being "deep" for a private person (JP), "take some thinking about" (SPB) and "sometimes found it hard to look at my life" (TKPL). Which suggests that the experience, whilst simple in principle, brought out things from the participants, i.e. "some time help to bring yourself out" (TKPL) and as "a lift and a distraction from depression" (SPB). One participant commented that the tasks needed explaining to be understood (CW) and one participant thought that the tasks were "flexible" in nature (PD).

Several participants felt that the process was able to make the user consider their lives, including: what is working, plans and goals, things they enjoy (PD) and that the process was interesting and probing (JP). One participant (ZN) found it helpful and enjoyable but stated the importance of being part of a closed group to safely explore personal feelings. Another participant (SPB) felt it brought important things to light and the protected time and space to complete the tasks was valuable.

In terms of inspiring creativity, one participant (SPB) stated that the Toolkit helped them to think creatively, and another felt that the Toolkit encouraged them to use creative activities to "make sense" of their own recovery (LJC). All participants reported that they enjoyed the process or found it interesting.

Several participants commented on the quality of the Toolkit materials being well designed and good quality, which they felt was important. One participant suggested that the Toolkit felt more personal and creative than some existing recovery strategies (for example, the Outcomes Star, detailed in chapter 5.0) (SPB). One participant (LJC) liked the fact that the task was not revealed until each session, which they thought made it feel "fresh & new". With the pieces becoming "part of the bigger picture as the course went on". One participant (PD) found the Toolkit a "wonderful thing" and stated it was "interesting and simple enough to not be confusing" and it was "cute and fun". Three other participants could not think of anything to improve the Toolkit, suggesting it was "fine as it is" or "love it as it is" or "not sure" how to improve it. In terms of potential improvements to the Toolkit, the following were suggested:

1. More image variety provided for collaging. (JP)
2. Numbers added to the rating system diamonds, with before and after clearly labelled. (LJC)
3. Some of the task cards would be better in landscape. (CW)
4. Clearly stating that the Toolkit should be used in such a way as the user would gain the most benefit. i.e., using emoji stickers or taking the time to describe feelings with vocabulary. (SPB)

Two participants (SB, ZN) stated that anxiety was caused by the Mapping Connections task. Both felt the task highlighted their isolation, as they perceived a reduced number of connections identified compared to others. However, both qualified this with comments that they still found the task a useful reflection. Two participants raised concerns about not being able to go out and take photos, either due to poor weather or it being a busy time for them.

Participants suggested the following ideas for new additional tasks:

1. Postcard sent to yourself and one to a friend. (TKPL)
2. Toolkit could be good for carers or family to look at themselves. (TKPL)
3. Task about hobbies, beliefs or thoughts. (ZN)
4. Letter to your younger self (more spiritual). (JP)
5. Group photo walk outdoors – either during the process or after the sessions have finished. (LJC)
6. Something purely graphic. (CW)
7. Deep or spiritual writing which is not shared. (SPB)
8. Taking a photo to represent where you are at the moment, finding an object and taking a picture, drawing of where you would like to be or something that represents a dream for you. (SPB)

These responses will either be integrated into the Toolkit design for the completed version, or they will be added to the facilitator notes as options to suggest during sessions.

8.7 Conclusion

The findings from Pilot (III) can be considered to reinforce those from the Cultural Probe Pilot (I) and Creative Recovery Toolkit Pilots (II). These are summarised below.

Creativity was again a central theme in the responses. With most participants choosing creative as a word to describe themselves and the majority of participants describing creativity as important to recovery.

The data also highlighted the importance of structure in participants' days (through the Day Diary task), alongside meaningful activities and social connections, for

recovery to be sustained. Half the respondents described two days which were similar with minor differences such as waking up earlier, developing healthy mental attitudes, being more careful using public transport or meditating. Here participants were able to see that good days, when compared to more challenging days, were in fact attainable through small changes in habits.

Anxiety towards participation was a theme in the responses, with several participants stating that they felt anxious about attending the first session. The Mapping Connections task was highlighted by the participants in particular as being potentially anxiety provoking. This has implications for research ethics, as it appears to have potential to leave participants feeling low after the session, if they feel they have identified few connections compared with other participants. The intention through the research was always to minimise such instances where the research may have a negative effect on participants. In the sessions this was addressed through discussion and the facilitator ended the task on a positive note, so that the participants did not leave the session feeling low. This situation was also identified by a support worker during the process, with the suggestion that instances where clients may be demotivated by certain tasks should provide extra space for peer support discussions and be closely monitored (P3.SA8. SW3.5).

Overall, the participants were very positive about the experience of completing the Toolkit. Some specified how they felt it was enjoyable or allowed them to consider their lives in a different way. One participant felt the creative elements helped to “make sense” (LJC) of their recovery. This positive outlook was confirmed by the measurement activity, with participants all scoring the experience as having a positive effect within individual tasks and therefore also cumulatively across the whole process.

8.8 Summary of final key findings

1. Creative activities are important to participants and those in recovery are willing to participate in such activities.
2. The tool can highlight the level of recovery capital and help participants build recovery capital.
3. There is evidence of participant anxiety towards the process.
4. The tool has value in creative encouragement and empowering through design engagement.
5. Participants enjoyed the process and found it beneficial.

8.9 Challenges and limitations

After a successful pilot of the Creative Recovery Toolkit Pilot (II), it was decided to deploy the Creative Discovery Kit Pilot (III) with the same organisation. However, difficulties were experienced with recruiting participants for the workshops. Support staff observed that the culture of the groups within the service had changed over time (P3.SA8.SSW3-4). Previously, clients understood that attendance of group sessions was expected, if they had signed up to a group. This was not generally being respected and attendance at organised groups was becoming less reliable. This was compounded by the low energy levels of the residents, who would often sleep in the morning and would need to be woken up to attend groups (P2.S2.SSW7). To combat this the groups were held in the afternoon, however, the researcher was disappointed with the level of attendance and commitment to the process once it began.

Several participants stopped attending even when support staff had checked with them that they felt they wanted to continue, and they had stated their intention to attend. This could in part be explained by the fact that Pilot (III) was open to clients across all three of the organisations residential rehabilitation sites. With the Creative Recovery Toolkit Pilot (II), all the participants were in the same place, however, with Pilot (III) clients were travelling from different sites. This additional

barrier to participation may have increased levels of sporadic attendance, as they would have to travel independently to the group each week (P3.SA8.SW1.4). Due to this situation the decision was made to approach another organisation and to use this challenge as an opportunity to pilot the Toolkit with another client group, increasing the number of participants which had completed the process.

Following the completion of Pilot (III), the difference between the two services in terms of attendance for the Toolkit sessions was clear. For the sessions at the initial organisation (Sanctuary Supported Living), several individuals started the process and then stopped attending. Two clients completed the whole Toolkit, but only gradually, with several missed or reorganised sessions. By comparison, all the participants that started the sessions with the new organisation (Southdown Recovery Centre) finished the process and in the time-scale set out at the beginning (although a couple of participants missed one or two sessions).

At the Southdown Recovery Centre there was a formal process in place for reminding clients of the sessions or following up if they had missed a week, which happened through emails and text messages sent directly to clients. Sanctuary Supported Living also reminded clients but rather than being sent directly to clients, reminders were sent on an ad hoc basis to the staff at the different sites and this would not always filter through to clients, as they may be sleeping, be out of the house or staff may forget. This encouragement to attend from one service appeared to have a significantly positive impact on the attendance rate of participants. This highlighted the effect of the service culture on group attendances and how the value of encouraging participation is viewed at different support services. This is a consideration that was also highlighted by participants at the Designing Participation conference held earlier in the research.

8.10 Completed Creative Discovery Kit

Following the completion of Pilot (III), both the participant and designer development points were incorporated into the design. This resulted in a completed version of the Creative Discovery Kit, which is documented in appendix K. The completed design forms a set of materials which can be used by support staff to recruit participants and facilitate the workshops in the future.

Task cards

The finalised task cards are included for all the activities undertaken during the Toolkit workshops. These are provided to the facilitator before the sessions and introduced to the process week by week.

Poster

A poster is included, which was used by services to advertise the sessions during Pilot (III) and has been adapted for use by services for future delivery. The poster does not include the date, time or location of the workshops, so that it can be used universally, without the need for adaptation. Support staff can inform participants of the workshop details when they sign up to attend.

Facilitator guide

A facilitator guide synthesises all of the observations by the designer during the three Pilots. These observations were recorded in the field notes and expanded in scope to form the basis for a simple guide. This document can easily be printed by services at A4 size and folded to form a booklet. The aim is that it will enable staff to confidently deliver the sessions, and be mindful of the key points which should be considered and presented to participations during the process.

Additionally in appendix K, images are provided to document the physical design of the Toolkit, as a designed object during this PhD study.

9.0 Conclusion

This chapter summarises the overall research process and discusses the findings from each individual Pilot iteration, to draw out general themes and conclusions. The research aims and objectives, which were identified in context and introduction (chapter 2.0), are shown to have been addressed by the research. This leads to illustrating how a recovery tool has been successfully developed from a cultural probe and clearly identifies the contribution to knowledge made by this project. The chapter concludes with a critique of the research and highlights the limitations of the research, with opportunities discussed for further research.

9.1 Summary of the research journey

This project began from an interest in the ways that design research methods could be employed in the development of an intervention, to benefit those in recovery from substance use and the associated mental health difficulties. As discussed in the introduction, design methods have become increasingly used in fields outside of the design field, most notably for this research in healthcare. From these initial considerations of using design methods for research, this led to the definition of the research aim as:

Design, test and evaluate an intervention to assist in recovery from substance use and the associated mental health difficulties, through the use of creative practice.

From this aim the following objectives were derived to achieve it:

1. Conduct three initial Design Experiments, based on initial findings from primary research, and select one for further development into a novel design-led intervention.

2. Review existing literature to identify key themes and the context for intervention development.
3. Develop a methodology to pilot and iterate a therapeutic intervention in a residential rehabilitation setting.
4. Identify and interpret similar selected existing interventions to identify key approaches and successful design features.
5. Conduct a series of pilots to iterate and refine the design of the chosen Design Experiment (Cultural Probe) to produce data for analysis. Therefore, providing a novel designed intervention which expands the application of a Cultural Probe into a new realm.

The literature review (chapter 2.0) assisted in the identification of eight themes, which were drawn on in the development of a new intervention (research objective 2). Alongside these themes, three further themes were identified which were also applied to the existing engagement tool review.

Chapter 3.0 set out the development of a general research methodology (research objective 3), which facilitated the exploration of design methods to satisfy the research aim. This chapter explained the approach of conducting three initial Design Experiments (research objective 1) and was aimed at investigating the journey taken by individuals from three different points of view:

1. An individual's typical journey in and out of addiction from the individuals perspective.
2. An individual's typical journey through treatment from a service perspective.
3. Specific individual stories of those currently in treatment.

The chapter described the method behind further developing of one of the experiments through iterative design. The above journeys were explored through the following initial Design Experiments:

1. Persona Journey Maps

The Persona Journey Maps were intended to chart an individual's journey into and out of damaging behaviours, using real life case study data and depicting the journey graphically.

2. Service Blueprint

The Service Blueprint was designed to be a tool used by services to illustrate the journey of an individual from a services point of view. This also identified opportunities for signposting, as an up to date document which contained basic information about all the groups and services available locally (as this did not exist).

3. Cultural Probe

This was intended to conduct research directly with those currently in treatment and was chosen for the following five reasons:

1. It could provide an insight into individual lives in recovery.
2. It was an alternative to existing recovery activities.
3. It could give participants a voice.
4. It could be completed individually, with minimal facilitator intervention.
5. It offered participants the opportunity to be creative with their responses.

Initial Design Experiments (I) and (II) served the purpose of exploring different avenues of design intervention but were ended at the prototype stage. They also served as excellent vehicles for networking, building relationships and trust, with a range of relevant stakeholders in the local recovery sphere. From these three initial experiments the Cultural Probe experiment (III) was selected for further development and piloting to become a recovery tool. An opportunity and a gap in existing research was identified in furthering the use of a cultural probe for therapeutic benefit. The Cultural Probe Pilot (I) resulted in the following key findings:

1. The activity provided an engaging reflective approach with therapeutic potential.
2. It is important to carefully consider the intervention positioning in terms of participants stage of recovery.
3. Tasks can be particularly beneficial which provide contrast and illustrate progress made between past and present behaviours (reflection).
4. Building recovery support networks it critical.
5. There is a willingness of those in recovery to engage with creative activities.
6. There is a high level of mental health difficulties amongst those in recovery from substance use.

Prior to further development of the Cultural Probe Design Experiment, an existing engagement tool review (chapter 5.0) was undertaken, which summarised the existing intervention tools in the recovery field (research objective 4). The discussion drew out factors which were deemed to be the most important to aid the development of an effective new intervention. These factors formed the basis for a design brief, which was drawn on in the development of the recovery tool.

The existing engagement tool review (chapter 5.0), considered 14 existing recovery tools and interventions. The interventions were identified on a scale from 'clinical' to 'creative' and analysis of these was themed according to design communication, clinical to creative scale and collaboration. A range of key attributes were identified which were assessed to be beneficial to the success of the interventions or novel in their approach.

Chapters 7.0 and 8.0 documented the iterations of the design through testing, evaluating and refining, with an increasing emphasis on participant involvement through the process (research objective 5). The Creative Recovery Toolkit Pilot

(II) was a development of the Cultural Probe, which was iterated using feedback and observations, building on the findings from the Cultural Probe Pilot (I). The data from Pilot (II) suggested that the following key findings:

1. This group is at a more appropriate stage for engagement, as they are more established in recovery.
2. Anxiety towards participation is evident, which is linked to confidence and creative confidence. This may be a difference between mental health and substance use recovery engagement.
3. Meaningful activity in the process of building recovery capital is important and the tool can highlight levels of recovery capital for participants.
4. There is value in increased creative encouragement and materials in the Toolkit.
5. Participants enjoyed the process even if they were unsure at first and the tool has value as an elicitation method.

These points confirmed the appropriateness of the design decisions made and provided more feedback for development of the Creative Discovery Kit Pilot (III). During this final Pilot more detail was captured regarding participant experiences and measuring how they scored their feelings towards each task took place, alongside providing more feedback for design development.

9.2 Summary of research findings and holistic analysis of the combined Pilot studies

As outlined above, findings were discovered and analysed separately for each individual Pilot activity. However, when considered as a full data set, trends emerged through the development of the tool from Cultural Probe to Creative Discovery Kit. Themes can be identified in the key findings above and through the Toolkit development over the three Pilot iterations, which form the basis for the holistic findings outlined below.

Increasing levels of creative output and confidence with the evolving design

The data shows that across the three Pilots there is a general trend towards more creative responses. In the Cultural Probe Pilot (I), the responses generally document the participants' habits and experiences. For example, in the Day Diary task, the descriptions are factual responses regarding past and present days. The same is true for the Places task, where places are simply listed or marked on the map. The Mapping / Drawing relationships task shows participants attempting to map recovery journeys. The mappings produced are again factual, with intended future mappings showing some identified but vague goals, such as: 'get on with life', 'try to stay positive' or 'getting on with it'. There are also attempts at drawing with stick figures and showing bottles of alcohol crossed out to illustrate the intention to remain abstinent. The Photography task follows this theme, by broadly documenting places either where substances were used or places which motivate or inspire recovery.

Arguably, the most creative approach to any of the tasks in Pilot (I) was the first, where the majority of the participants were enjoying coming up with nicknames and descriptions about themselves, which related to or glorified their appearance and negative behaviour patterns.

The Creative Recovery Toolkit Pilot (II) continued with similar documentary approaches. However, in the About You task the descriptions from participants were more humble, factual and detailed, compared to Pilot (1.) The emoji stickers were used effectively to describe emotions during some of the tasks, which were not available in Pilot (I). Also the coloured pencils were used to differentiate between groups and also to shade emotions in the mapping task, which were available in Pilot (I).

The Creative Discovery Kit Pilot (III), produced the richest and most creative data set out of the three, with participants producing a combination of: drawings, collages, descriptive writing and mapping activities. Participants also imagined future days and habits in detail. This increase in creativity in the responses can be explained by the following ongoing developments during the process:

- Refining the task cards to include more structure
- Refining the facilitation approach
- Refining the best recovery stage for the intervention
- Increasing the variety of the activities

Creativity can be contagious as participants are inspired by the attempts of others during the workshops. Also, the tasks are simple and it appears from the responses that participants are willing to attempt tasks, even if their confidence about completing them to a level that they would like to is low. Therefore, it is evident from the data that the developments made from the initial Cultural Probe Design Experiment to the final developed recovery tool, helps participants to be more creative in their responses, engage with the tasks and subsequently increase their creative confidence as the process developed.

There is value in a tool which is able to engage participants in creative activities in a recovery setting. As identified in the literature review, there is a growing evidence base for the effectiveness of creative activities for improving recovery outcomes. The tool has shown potential to engage participants in tasks which would be beneficial for recovery approaches using both creative practice as therapy and being creative through therapeutic participation. Especially, as recently these two approaches which traditionally were seen as opposing each other and are now moving towards a shared goal of facilitating recovery and well-being (Adams & Stickley, 2019).

The designed structure and variety of creative tasks engages participants and provides opportunities for peer support

The variety of tasks included in the Toolkit appears to make it easier for participants to engage with the whole process (if willing), even if they miss a task. In Pilot (I), Mr Perfect did not participate in the photography task but contributed to the rest of the process and group discussion. In Pilot (II), SD did not undertake the photography task due to anxiety, however, they continued with the process and stated that they got benefit from it. In Pilot (III) several participants missed certain sessions during the process. However, all those who eventually completed the Toolkit had the motivation to try and catch up on the tasks that they missed, either at the end of the next session or as an activity to complete independently between the sessions.

The data shows that participants enjoyed some tasks more than others. With the Photography task (due to being outside) and the Mapping Connections task (due to its potential to highlight a perceived lack of social connections), were two tasks that participants were more reluctant to complete. However, alongside the motivation to catch up there was a supportive element to the group setting, with the other participants acting as champions and peer supporters for each other when they found activities challenging. Therefore, the variety meant that in the group there was likely to be participants who were more confident with certain tasks than others and able to support and encourage each other through the process and build confidence collectively. In these ways, the tasks and the Toolkit can be considered accessible to a wide variety of participants and the data suggests that the Toolkit can help participants work through ambivalence towards recovery and barriers to participation.

Conversations with support staff documented through the process also emphasise the value in the process of engagement employed by the Toolkit. During these conversations staff highlighted the following observations about the Toolkit:

1. Tasks help to transport clients into the community through imagination and to explore their boundaries (P2.S3.SSW4).
2. It allows participants to 'dip in' to the past, which they can be reluctant to do due to the often painful memories it holds for them (P2.S2.SSW18). However, it can be quite triggering to move from a safe space of the present to consider the past, but the creative nature of the Toolkit may help to facilitate this and to help clients consider their own recovery and which methods work best for them (P2. S3.SSW5-7). The ability to move outside of the safe zone is also about trust, with the Toolkit appearing to allow participants to trust the process and 'go deep' (P3.SA7.SSW2)
3. The tasks can highlight how a person sees themselves and how they think others see them, which can help them test their safe space and the stigma associated with sharing (P2.S6.SSW3).
4. It provides a space to tell an individual's story and provides a tangible artefact which can document a point in time and be reflected on in the future (P2.S6.SSW3).
5. The Toolkit can be a springboard with clients able to take the tasks as far as they feel comfortable (P3.SA7.SSW4).
6. It can spark creativity and the motivation to be creative (P3.SA7. SSW5).
7. Through consideration of the past, present and future, participants are considering recovery as a journey. This approach encapsulates the recovery models that the support service promotes (P3.SA8.SW3.4); (P3.SA8.SW1.2)
8. The process could link well with key work: as an introduction (P3. SA8.SW2.1), to highlight gaps in support (P3.SA8.SW2.7), to provide quality alternative to scraps of paper often used in key-work (P3.SA8. SW2.8) and for clients who are particularly stuck (P3.SA8.SW2.10).
9. The process can be pitched to clients without an 'agenda' and is independent of the service (P3.SA8.SSW2).

The data also shows that across the Pilots, peer support conversations increased during the workshops. In Pilot (I) the facilitator held a single group discussion at the end of the process. In Pilot (II) the Senior Support Worker initiated conversations with individual participants around the information which was arising. Finally, in Pilot (III) multiple conversations took place between participants, which were initiated by the workshop dynamic and then supported by the facilitator. This shows that changes in the facilitation approach during the process increased the frequency of valuable peer support conversations between participants. These peer support conversations allowed participants to be supported by others in the group and to raise awareness of certain issues. The conversations covered a wide variety of topics centred around recovery, mental and physical well-being, including:

1. Concerns about attaining future employment (P2.S1.GRP2).
2. Importance of making small steps towards goals (P2.S3.SSW2).
3. Potential for relapse (P3.SA1.GRP4).
4. Importance of creativity to those in recovery (P3.SA1.GRP6); (P3.SB1.GRP3).
5. Improved social connections are achievable (P3.SA4.GRP2).
6. Advertising and media portraying and idealised life and the effect this has on mental health (P3.SB1.GRP2).
7. Procrastination and striving for perfection (P3.SB1.GRP3)
8. Importance of finding a sympathetic GP with mental health experience who is accessible (P3.SB1.GRP5); (P3.SB5.GRP1).
9. Sleep patterns and the benefit of routine on recovery (P3.SB2.GRP1); (P3.SB3.GRP3).
10. Emotional connection with possessions and associated memories (P3.SB2.GRP2).
11. Difficulties of family substance use and the link with mental health (P3.SB2.GRP3).
12. Importance of staying hydrated for energy levels (P3.SB2.GRP4).

13. Value of physical exercise to relieve tension pain caused by stress (P3. SB3.GRP1); (P3.SB5.GRP2).
14. Benefit of some food supplements health (P3.SB3.GRP3).
15. Benefit of quality social connections in life ((P3.SB5.GRP1); (P3.SB4. GRP1) and that it is ok to have only a few close connections (P3.SB4. GRP3).
16. Difficulties with accessing and working with some support service providers (P3.SB4.GRP2).
17. Benefit of journalling and different methods (P3.SB6.GRP1).
18. Ways to introduce more structure to lives (P3.SB6.GRP3).

This discussion illustrates the value of peer support in recovery and the benefit to participants if opportunities for peer support are increased, as identified in the literature review. One of the key elements here is building confidence and trust, which are central elements to developing effective therapeutic relationships between service users, peer supporters and support staff. However, it should be acknowledged that this is dependent on how quickly participants build confidence, especially in a group setting, where participation anxiety can be a barrier. Building confidence is a also a key component to building recovery capital, as a resource to sustaining recovery. The experience in this study was that the nearly all participants appeared to gain confidence through the process.

The variety and simplicity of the activities is evidently engaging for participants based on the positive participant feedback on the process. The tool also shows promise as a confidence builder and primer for further related activities. For example, participants might find this a more manageable experience to initially complete, prior to undertaking formal node-link mapping activities or creative groups within the service.

The structure applied to the tasks and developed over the Pilots, appears to allow participants to engage with the process at different levels and therefore the amount of structure provided seems appropriate. The tasks are simple

enough (especially the earlier tasks), that they can be attempted by participants with varying levels of cognition. As straightforward (even tick box) tasks provide important structure as anxiety can prevent individuals participating if the tasks are too open (P2.S1.SSW12). The facilitator can then build up complexity to the level that participants feel comfortable working with. In a similar way to node-link mapping (chapter 5.0), where there are maps that are filled in and ones that are more free, therefore, being aimed at the varying abilities of participants. The level of structure is important as participants with low levels of cognition may not be able to work in a 'free' way and those with higher levels of cognition may find too much structure restrictive.

Overcoming anxiety to participation

Having the appropriate levels of structure for the activities is also important for reducing anxiety to participation. As described above, varying levels of cognition with participants will cause anxiety, if the task is too open for some participants and frustration if too closed for others. Therefore, having a structure which allows the facilitator to introduce complexity in the tasks and that they can work at different levels, will help to reduce anxiety towards participation.

Anxiety towards participation was evident during the Pilot (II), with SD not able to participate in the Photography task due to agoraphobia and RB not able to participate due to paranoia. There appears to be an element of participant anticipation anxiety about future tasks in the process (P2.S2.SSW21). In Pilot (III), several participants stated that they were nervous about beginning the process. Overall participants overcame these anxieties to complete the process and provided feedback that they found it beneficial and enjoyable. This suggests that the Toolkit design is able to quickly put participants at ease and also has a variety of activities, which means it can be engaging even if participants find one type of task too challenging to complete.

Another form of participation anxiety can stem from a lack of confidence in creative abilities. However, this was addressed through the facilitation, which was intended to make it clear to participants that the process is the most important factor and not the quality of the creative product. This helped participants especially in Pilot (III), with several using negative terminology to describe their creative efforts. Following this, their confidence appeared to be increased (and anxiety decreased) by receiving support from other members of the group.

Whilst there will always be the potential for participants to feel that their contributions are not of an adequate quality graphically (especially when comparing themselves to others in the group), the Toolkit is designed to reduce this as much as possible. This appears to be supported by the data and responses with increasing creative confidence and output present as the Pilots progressed. This is again where having the appropriate amount of structure is important, as it gives the right amount of creative freedom and provides some uniformity to the data produced by participants.

Anxiety towards participation raises the important consideration that some participants may be left feeling concerned about their responses. For example, as previously discussed, the Mapping Connections task showed the potential to leave participants feeling that they lacked connections and an adequate support network. Other situations with the tasks are also easy to imagine, for example, in the places task, if one participant has travelled widely and others have not, it could lower the mood of certain participants. In these instances it is important that the facilitation approach ends the tasks on a positive note for all the participants and that peer support conversations are encouraged throughout the sessions. Whilst it is clearly important to consider the potential for unintended consequences of the tasks, the data collected across the Pilots is overwhelmingly positive, with a couple of exceptions. These were managed through facilitation

and subsequently informed the design of the facilitation approach, to reduce the likelihood of occurring in the future. Therefore, the Toolkit can be considered to work well to reduce and manage anxiety towards participation.

As discussed above it is important that the tool allows participants to engage with the activities, as this is essential for the Toolkit to be effective at helping to nurture therapeutic relationships, within the group (peer support) or with support workers. If participants are anxious towards the process they are far less likely to engage. There are two parts to this, firstly, what might be described as 'competence' anxiety towards to activities, as described above. Secondly, social anxiety towards participating in a group session. From my personal experience of mental health difficulties, it is this element that would stop me engaging with a process such as this. I would find it challenging to be involved actively in group activities, whilst feeling anxious. This is a reason why as a researcher the aim has been to address both of the factors in relation to participation anxiety, to minimize the effect of this on the process by carefully designing the tasks and also by making the group an inclusive, safe space for participants. This approach is documented in the facilitation notes in the appendix.

Evidence that the process works at different stages of recovery and with different participant diagnoses

Recovery stage	Pilot (I)	Pilot (II)	Pilot (III)
Post detox resident	o		
Established resident		o	o
Day centre participant			o

Table 9.2-1 Varying participant recovery stages

The three Pilot activities were implemented at different stages of recovery (Table 9.2-1), with Pilot (I) participants earliest in their recovery (shortly after detox in residential treatment). Pilot (II) participants were further ahead in recovery, having been in residential detox for up to eighteen months and more established in their treatment. Pilot (III) participants were a combination of participants who

were established in residential treatment and participants who were attending the sessions at an activity day centre. The furthest developed Pilot (III) Toolkit was the most successful in terms of the data and feedback collected, which illustrated its effectiveness. However, the previous two Pilots were also evidenced as beneficial in recovery by the responses, either by the facilitator in Pilot (I) or by both the participants themselves and supporting staff in Pilot (II). Benefit from the tool can therefore be seen at different stages of recovery, with all three Pilots evidencing varying degrees of benefit through participation.

Diagnosis	Pilot (I)	Pilot (II)	Pilot (III)
Primarily substance use	o		
Co-existing conditions		o	o
Primarily mental health			o

Table 9.2-2 Varying participant diagnosis

As documented in the Stages of Change recovery model, discussed in the literature review, individuals in recovery can be placed at certain points on this cycle. In this study participants were engaged in the preparation, action and maintenance stages of this cycle. Initially, through participant recruitment and reflection and then iteration, from one Pilot to the next, the targeted participants were engaged at different stages of this model. The intention was to determine the most appropriate and effective point of intervention on the cycle, as individuals who are engaging at different stages of the recovery cycle require different approaches. For example, a person in the contemplation stage may be shown how their substance use and person issues are connected. Whereas, a person in the action stage could be introduced to behavioural change and coping strategies to help deal with temptation (Hogson, 2002).

It appears from the data collected that the Toolkitl can be used across different stages of this recovery cycle. As discussed, the effectiveness of the tool may vary between stages but it is promising for future development of the tool that it shows this flexibility. The flexibility can be explained by considering the Toolkit as

a vehicle for support workers or facilitators to use to ellicit relevant information about individuals, which can then be used to support needs at different stages. The generality and variety of the tasks assists with this, as a support worker can adapt the tasks slightly depending on the stage of engagement. On reflection this was observed through the Toolkit Pilots, where facilitators would take the information gained by the task responses and then tailor their interpretation of it to support therapeutic steps that individuals needed to take to further their recovery.

In a similar way to the above, the tool was piloted with participants with differing diagnoses (Table 9.2-2). Pilot (I) participants were considered primarily substance use clients with secondary underlying mental health issues. Pilot (II) participants were considered to have co-existing conditions, with a formal diagnosis of both substance use and mental health issues (they were however more focused as a group on addressing the mental health challenges at that particular point in their recovery). Pilot (III) included a combination of clients with co-existing conditions and mental health clients who had historically experienced substance use difficulties. Therefore, the tool can be considered beneficial to those with combined disorders (diagnosed or not), as each pilot produced positive results and was used with clients with varying combinations and severities of substance use and mental health challenges.

The tool can link to existing recovery approaches

Two widely used recovery approaches which the Toolkit was designed to link with are building recovery capital and Motivational Interviewing. Chapter 8.0 details how the Toolkit is designed to link with the principles of the 'spirit' of Motivational Interviewing. Broadly the aim of linking the Toolkit with a widely used technique such as Motivational Interviewing have been confirmed by the data collected from the Pilots. The Toolkit helps participants to do the following, which respond to the different elements of the 'spirit' of Motivational Interviewing, as previously defined (see Fig. 5.4-1).

1. Helps participants to understand their situation in more detail.
2. Through comparisons, the tasks help individuals to resolve conflicts and develop motivation for change.
3. Elicits information, which can then be used by the participants themselves rather than using techniques of persuasion.
4. The delivery of the tasks is calm and client-led in nature.
5. Elicits information which helps clients to 'resolve ambivalence'.
6. Helps to build strong interpersonal relationships between themselves and both the facilitator and peers in recovery.
7. Positions the participants in a partnership with professionals and reduces hierarchies.

Additionally support staff recognised the potential for the Toolkit to link with Motivational Interviewing during the co-design workshop held after Pilot (III) with staff at Sanctuary Supported Housing (P3.SA8.SW2.5). The tasks use comparisons to help clients imagine an ideal day in the future and build motivation to facilitate that change. In the data from Pilot (III), half the respondents described two days which were similar with only minor differences such as waking up earlier, developing healthy mental attitudes, being more careful using public transport or meditating. However, these small changes when practiced over time will make a significant impact on recovery and this illustration can be used to provide motivation to make these small changes. Therefore, the Toolkit has the potential to help the client notice the difference between what they are doing now and how they would like life to be. This awareness can then assist in building motivation and help the client begin making the necessary changes to get there. The ability to show and record graphically these routes to individual's recovery goals, is especially important as substance users can find it very challenging to image a better future for themselves due to the damage caused to the brain from drug use (Ingvar, 1985). Therefore, the ability to visualise this and have a record which can be referred back to when motivation is required could be instrumental in overcoming ambivalence.

In terms of the Toolkit helping to highlight levels of recovery capital. The data shows that specific tasks are able to achieve this. For example, Mapping Connections is able to chart social networks and allows participants to assess their levels of social capital. This was highlighted in the data for Pilot (II) where PT and DG had differing social spheres within and outside the residential project. In Pilot (III) two participants ZN and SPB discovered a perceived lack of social capital during this task, which prompted peer support conversations with the other participants.

As discussed above the Toolkit shows that it can be beneficial to developing one element of recovery capital – social capital. However, there are two other relevant elements to recovery capital, human and cultural (Best and Laudet, 2010). From the discussion on the link with Motivational Interviewing above it suggests that the Tool can be beneficial for goal setting, identifying small lifestyle changes and motivation, through comparisons. However, these second two aspects of recovery capital are likely to be best developed in practice through established recovery approaches, such as Motivational Interviewing or Cognitive behavioural therapy. As this Toolkit has not returned data which supports the development of these.

Additionally staff highlighted during Pilot (III) that the Toolkit would link well with the Outcomes Star, detailed in chapter 5.0 (P3.SA8.SW2.2); (P3.SA8.SW3.9). This tool is currently used by the support services collaborated with in this research (P2.S1.SSW7); (P2.S2.SSW8). Participants highlighted their use of the Outcomes Star and suggested that the Toolkit was an good alternative creative activity to help them understand themselves (P3.SA7.SPB7); (P3.SA3.JP2). This suggests that the Toolkit could be employed well as a complementary approach to the use of the Outcomes Star in recovery.

The Toolkit is seen through this study to positively impact the relationship been support staff (as facilitators) and service users, by improving methods of communication and elicitation from participants of thoughts which could benefit

recovery when explored further. Therefore, in the context of the situation in social care, as outlined in the introduction, this is a valuable tool which could potentially ease pressure on the time support staff spend with clients individually and in groups, through assisting in building routes of communication. The act of building engagement in trusting therapeutic interactions with clients more rapidly, will allow for more time to cement adherence of suggested recovery strategies, and in turn, begin to catalyse behaviour change through established techniques such as cognitive behavioural therapy.

The link to established recovery approaches and tools highlighted above, shows the Toolkit as valuable to play a supporting role in eliciting information, which can then be used as subject matter for recovery support interactions. However, further research would be required to test whether employing the Toolkit alongside these existing interventions, would increase their efficacy and influence recovery outcomes.

9.3 Contribution to knowledge

The development of a cultural probe into a dedicated recovery tool, which can link to established recovery methods

This research involved the development of a cultural probe into a recovery tool. This practice goes beyond the deployment and use of cultural probes in existing research as data gathering devices, and produces a device capable of inspiring behaviour change and motivating substance use and mental health recovery. Cultural probes are used widely and include materials which help elicit information about participants everyday lives, which in turn can be used to inspire design interventions. The process presented here advances the use of a cultural probe, to elicit information to benefit an individual's understanding of their own recovery journey, through both the data produced and the process of completing the tool. A further novel development here is formalising the use of

creativity in a manner which is usable by support workers, and can link with the existing recovery tools which they use on a daily basis.

Process of engagement

The Pilot data shows that the variety of activities is important for participants, especially if anxiety towards participation may be experienced with certain tasks. Participation anxiety can occur due to low confidence, especially due to low creative confidence, when those in recovery are to engage in creative activities. This variety addresses a gap in existing research and practice in the recovery field, where interventions are normally based on a single creative activity, for example: art, photography, drama or dance. The variety of simple tasks allows participants a taster to see which activities they enjoy, as well as keeping each session fresh and different. Another aspect of the innovative engagement approach is that the tool formalises a combination of peer support activities and creative recovery activities. Traditionally, peer support activities are verbal and creative recovery activities, whilst often group based, are not intended to involve sharing experiences in the group. This is something which is formalised by the Toolkit approach.

A further novel aspect to the process of engagement is the use of co-design activity in the workshops. As the Pilots developed, involvement by the participants in informing the design process increased. The final Pilot explicitly used co-design to engage participants in a form of peer support, where they used their experiences in the knowledge that this would improve the Toolkit design and subsequently help others in the future. Here the Toolkit can be seen as a perpetual co-design experiment, as participants can also contribute in future workshops to develop the tool further. The integration of a co-design process in the Toolkit, aimed to empower participants with agency in the process.

A tool which can work with mental health and substance use clients at varying stages

As identified in the existing engagement tool review (chapter 5.0), there are no confirmed examples of tools which have been designed to specifically target recovery from substance use and mental health issues at the same time. All of the tools have either been designed specifically for use with one condition or the other. It is however acknowledged that some tools use psychological approaches to work with substance use issues. The Outcomes Star is one example which has two different versions for substance use and mental health recovery, both of which were developed from the original version. However, the developed Toolkit uses much less specific and freer activities, which can be applicable to both groups via subtle changes in the group facilitation. As discussed, this approach addresses the need for a tool which can work with both conditions simultaneously, as they are so closely interconnected. There is often also stigma attached to both conditions, which may deter participants from participating, if the tool is labelled exclusively for substance use or mental health recovery use.

Finally, as designers can be thought of as sense making (Kolko, 2010) by decoding situations through all the other surrounding noise via the application of design methods. The Toolkit aims to help individuals make sense of their substance use and mental health challenges, by providing a means by which they can decode and explore new vistas in life as they move through recovery.

9.4 Challenges to the wider deployment of the Toolkit

Whilst the above is a clear opportunity of the Toolkit to be implemented widely in recovery settings, the social care situation also raises challenges to wider implementation. Firstly, pressures on time and funding in organizations could prove to be a barrier, as organizations may feel that support staff and managers do not have adequate time available to consider and then learn a new process

to work with alongside current commitments. This challenge will become more significant if funding continues to decrease, whilst need is increasing. Secondly, the Covid pandemic has made changes to the ways that people interact, with consultations and some support sessions moving to a virtual based approach, (outside of residential settings at least). Therefore, a tool which has a physical nature could face implementation barriers if virtual interactions become more widespread going forward. Both of these challenges are not insurmountable, however careful consideration will be needed to determine the effect they may have on increasing the use of the tool. For example, toolkits could be posted to clients which could then be filled out virtually with service users and responses shared. Also, trial kits could be provided to organizations to test before committing to purchasing or a facilitator could go in to services for trial sessions with service users to then quickly illustrate the value of the tool and process alongside their suite of available recovery approaches to used with clients.

9.5 Reflecting on rigour in the research process

As a designer working in a new field, this meant many new experiences and much learning required from the outset. As discussed in the introduction, some scepticism of the value of design methods was encountered during the early experiments. The experimental nature of the early design approach, may have made interacting with stakeholders more challenging than if employing more established and accepted methods.

However, as progress was made, trust was built and ideas were developed. The consultations and interactions with stakeholders helped to develop the scholarly level of the research. This learning curve culminated in the rigorous development, testing and analysis of the three Pilots conducted in this study. This rigour was developed gradually during the early testing process, which provided the opportunity for experimentation, self-reflection, learning and growth as a design researcher.

Rigour in the research was also developed through continual development of papers for publication and attendance at conferences. Please refer to the list of conferences attended, workshops facilitated and papers written in appendix A.

The decision to develop the researcher role from designer, to observer and then to facilitator, also assisted in the rigour taken in the research process. The researcher became closer to the participants, a group who were potentially vulnerable individuals, which focused the ethical considerations of the research. This required the study to be undertaken with a high degree of sensitivity and seriousness, with the particular research methods employed chosen carefully for their appropriateness. The changing role of the designer also assisted in increasing the level of empathy and responsiveness in the approach to undertaking the research.

9.6 Limitations of the research study

A principal challenge of the study centred around the recruiting and engagement of participants. As the research was centred on a specific research locale (Brighton and Hove), there were limited opportunities for working as a designer with the specific target group (those in residential substance use and mental health treatment). As such, significant time was spent to identify participants and to build up a level of trust with an organisation to allow the research workshops to be undertaken. This meant that it was not possible to test the Toolkit in several locations and to compare data sets and findings across locations.

Another limitation which should be considered is the size of the workshop groups, which were limited to a maximum of five participants. This was due to limiting the workshop time scales to two hours in length. This was considered the maximum time for participants to maintain concentration on the activities. However, this meant that if participants left the process the group size and dynamic diminished. Furthermore, having a small group size for each Pilot limited the number of data sets that could be completed and then be drawn on for analysis and findings.

Two of the initial Design Experiments were not chosen for further development, the Persona Journey Maps and Service Blueprint. This was due to the limited opportunity within the scope of the PhD to explore all three in detail. Therefore, this represented a limitation to the research that all three initial experiments could not be resolved and tested in more depth.

A final limitation of the research is that it is undertaken via physical objects, these being pens, paper and stickers. This limits the reach of the Toolkit to dedicated workshop sessions, where the participants are provided with the Toolkit to complete with a facilitator present. Participants are currently unable to easily participate from their own homes, for example.

9.7 Identified avenues for further research

Whilst this research project has covered as much ground as its scope provided the opportunity for, there are research avenues left unresolved which could benefit from further investigation.

Firstly, due to the limitation described above regarding the Toolkit being Piloted in a single location. Further research could be undertaken to test the Toolkit in multiple locations with different demographics to the Brighton and Hove area. This would provide additional data, which could then be analysed to draw comparisons with the original data set and could assess the tools effectiveness and potential impact more widely.

Secondly, the number of participants undertaking the process could be increased by running the workshops again. This would address the limitation of the number of participants per workshop, as described above. Increasing the number of participants completing the tool would result in more data sets being recorded. This would provide a clearer picture of the impact of the process on the participants and more certainty in the conclusions drawn.

Thirdly, the two initial Design Experiments, which were not chosen to develop further, could be researched in more detail. The Persona Journey Maps was used to plot an individuals route in and out of addiction. This provided an excellent taking point for stakeholder networking and opportunities to explore service design techniques in the project, however, this research ultimately followed a route of user-centred and interaction design. There is an opportunity to explore the Persona Journey Maps as a tool to record an individual's journey in more detail. The Service Blueprint also provides opportunities for further research, as there remains a need for a universal tool to be used by support services to document the most recent treatment pathway for individuals, which includes both formal and informal treatment opportunities. Non-profit organisations are regularly coming into existence to support those in recovery, however, they do not necessarily have the resources to promote the support they can provide and potential beneficiaries can be unaware of their existence. Providing a method of keeping all organisations up to date with the details of organisations and initiatives locally would be of real benefit to support workers.

Finally, another limitation of the use of the Toolkit is that it has been designed to use tangible objects and for participants to complete the tasks on paper. As such, in a contemporary world which relies heavily on digital applications, there is an opportunity to conduct further research which provides the experience of completing the Toolkit through an online application. This would allow participants to join an online group and complete the Toolkit from their own homes, therefore broadening its reach significantly.

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