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Mental Snapp the learnings:

Company closure report 2020

**Introduction**

This is a strange time to be writing about the winding up of a mental health social enterprise. Never has mental health had the same prevalence in the public discourse as now. Broad sections of society are aware of their need to actively manage their mental health in a way as never before. With the lockdown enforced by Covid-19, there is awareness of the importance of mental health on a parity with physical health, and the massive strides made with anti stigma campaigns over the past few years have been consolidated.

Mental Snapp was established in 2015 and wound down in 2020. In that time huge progress has been made in the mental health market place. Consumer awareness is high. Yet there is an increasing divide where the people who can afford to pay for mental health management are divorced as consumers from those who cannot, and who really have need of services.

At this time of massive mental health need it is good to reflect on the learnings of the last five years, putting Mental Snapp into context and drawing conclusions to see what can be applied to mental health companies, social enterprises and charities in the future.

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**Background**

## Origins of the idea

Mental Snapp was founded in 2015 out of Barrage Media, the mental health film production company run by Hannah Chamberlain and Tex Dunstan, which specialised in films representing people with a mental health condition, making corporate communications for Mind, Time To Change, Together and Mental Health Media. Hannah Chamberlain in particular took her personal experience of managing a mental health condition and her career as a service user film maker into the idea of the company.

Mental Snapp was formed as an idea to diversify the offering of Barrage Media and to teach the recovery from self stigma through the Recovery College network. Realising that a course teaching behaviour change would require an interactive element, Hannah formed the idea of running it with video diaries and set about applying for funding to make an app where people could record video as part of mapping their progress.

It soon became clear that the app had further applications and needed to be a separate entity. It is worth pointing out the origins of the idea as self stigma and self perception continued to be at the heart of the enterprise. Mental Snapp was designed to be an exercise in self development, with a community element in terms of the meetups and the taught course.

Throughout the development of the idea to get to product/market fit, the balance between the user’s individual personal journey and the community surrounding the idea of video diaries continued to be refined.

## The app and its ambitions

Mental Snapp’s app was developed in response to founder Hannah Chamberlain’s observations throughout her professional career, as a film maker and storyteller, on the power of film in raising confidence and validating a person’s story. Drawing on the theories behind participatory video in validating the experience of communities, the video diary format was devised to document an individual’s journey of recovery from self stigma.

The first business model proposed was to supply Mental Snapp to the NHS and to give users the option to add video to their Electronic Health Record. The complexities of doing this were not the only thing that ruled it out within the market testing period. Neither clinicians or users wanted it, being unsure of the boundaries and risks of recording video that might not be watched and the clinical responsibilities.

A pivot to a model where the user recorded the video for their own private use followed – and was felt to be empowering to the user in that the user had their own record and version of events when they went into the clinical room.

The inevitable implication of this however was that the payment model changed, and Mental Snapp became a direct to consumer model. This had profound implications for the long term financial sustainability of the app.

## Why close

The decision to close a company is never taken lightly. In the event of notifying our users that we intended to close, it has emerged that there is interest from our contact list in using the code of the app Mental Snapp, to supply software to the NHS. So it may yet be that the company continues for a few years yet as a licence provider of software which will be developed and modified by the purchasing company. This is in development.

The decision to walk away, however, was prompted by a number of factors, to do with the team resilience and the learnings that we had gathered, which formed a gut instinct of ‘feel’ to where we were in the journey, and a rational sense of what would be a wise decision. This was more specifically to do with the probability of raising investment and a realistic sense of what we would need financially in order to realise our ambitions.

The final year of the company was a year of hiatus. We had been offered investment by a specific, disability friendly investor, who delayed and extended the process to an extent which in the end we found unacceptable. Casting around for alternatives, we were offered investment by a blue chip investment group, but the terms were punitive. At this point, it seemed better to walk away. It may yet be that this decision, with the offer of licencing now on the table, was the only realistic alternative.

## Project timeline – investment, grants, pivots

2015 Formation of company

 UnLtd Do It Award - £5k

 Market research

 Company development – theory of change, developing network

 Business model: to attach video diaries to NHS records, and sell the app to the NHS

2016 Paul Hamlyn Ideas and Pioneers fund - £27.3k

 Formation of advisory board

 Formation of user board to develop guided exercises within the app and advise on user interface

 Evaluation agreed with London Southbank University

 Business model pivot – video diaries to be private for the consumer. Therefore model pivoted to B2C app.

 First version of the app developed and launched end 2016. No paywall included.

2017 Investment by Bethnal Green Ventures - £20k

 Company development – user testing, website redesign, social media reach, press and PR

 London Southbank University evaluation

 Stelios Award for Disabled Entrepreneurs - £30k

 Next version of the app – model = 20 videos free then paywall

2018 Launch, press and PR for next version

 Follow on funding Paul Hamlyn Foundation - £30k

 Intensive research of usage patterns

 Growth hacking and experiments

 Planning for Instagram based interface for next version

2019 Founding of community #mentalhealthartists

 Pivot business model to include workshops, ebook, and product upsell

 Workshops and social media drive

 Waiting on investment from one investor

2020 Decision to close company.

Highlights of the journey

## Business model

There are a range of challenges facing mental health tech solutions in terms of business model. In Mental Snapp we pivoted from a model that looked to supply to the NHS to a consumer facing model, so have experience of the B2B and B2C market in mental health.

Findings in the B2B market, specifically in looking to supply to the NHS, are around the complexity of the system. When supplying B2B solutions in mental health frequently the **buyer** of the tech is not the same as the **user** of the tech, and this creates a double facing product development process, where both customers are important in the sales process. Further, due to the complexity of the NHS market, cost saving benefits to using the tech are frequently not felt where the purchasing department is sited. For example, a tech innovation that saves money to A&E departments will have to be purchased by GPs or CCG’s, and thus the cost saving benefits are not felt by the purchasers, but further down the line in the system.

There is further complexity in terms of linking to the NHS spine in terms of data. Our original plan was to link to Electronic Health Records, and while there are tech platforms that provide bolt on interfaces to allow this, the cost was high for something that would only be a test attached to one trust initially. Realising that the NHS marketplace would require us to sell to trust purchasing departments one at a time, and that there was not yet the cost saving or impact evidence available, we pivoted to a B2C model. This fundamentally changed the mission and therefore the message.

There was a third way option, which we had not yet the data to explore in detail. This was B2B in mental health in terms of selling to third parties in bulk, such as insurers, therapy solutions, or fitness chains.

The B2C market in mental health consists of two main sectors. There is the health and wellness sector, which is a wider, mass market. Solutions in this area tend to be preventative and ‘feel good’ rather than specifically targeted at severe and enduring mental health conditions. It tends to be where customers are less economically deprived and there is more disposable income. Solutions such as Headspace and Calm apps occupy this area.

The mental health market for those with severe and enduring mental health is more narrow and tends to be dominated by charities, social enterprises and free to end user solutions. Solutions such as Big White Wall and Mind’s Elefriends exist in this space. Recently, both of these have pivoted, Mind has relaunched their offer, and Big White Wall, which used to be bulk purchased by CCG’s and GP’s, has reduced its commitment to online community space, focusing on IAPT solutions for individuals and delivering blended online therapy via the NHS.

## Evidencing impact

Film is not a neutral medium, it is a catalyst for change. Like journaling, the observation alters the outcome.

The theories behind Mental Snapp were based on participatory film theory, the filming of communities, and adapted from personal experience after a career in mental health film making observing the effect of filming on self confidence for people with a mental health diagnosis.

Film theory, in particular participatory film theory, speaks of the self validation of the subject by representation on film. This assumes an audience for the film, and is older research, largely conducted before cameras were on every phone. The status shift of being recorded on film is not as great now as it was before the advent of smartphones. Likewise, the films of Mental Snapp were not designed for a public screening. However, it is still true that the framing of a moment by recording it on film gives it a privilege and an importance to the recorder.

The evidence for journaling is more established than video diaries, and suggests that video diaries have the potential for therapeutic intervention. The theory behind the app was also based on personal and professional observation through film making practice.

The theory of change was that the recording of video diaries would enable people to develop their confidence and self efficacy.

In terms of evidencing impact, the most used scale of mental health is the Shorter Warwick and Edinburgh Mental Wellbeing Scale. (SWEMWBS). This can be used to demonstrate self efficacy.

However, our research with Mike Slade of Nottingham University noted the difficulty of creating an intervention which makes more than a tiny immeasurable shift on the scale. His opinion was that the majority of interventions make a difference in some form, simply by doing something. There is a psychological effect created by taking an action.

Doing something, anything, for mental health, has in itself a positive benefit, particularly if done consciously in order to improve mental health. It creates feelings of agency and empowerment which are wholly beneficial.

This raises the question of what interventions can do to make them stand out in the market place, be easily integrated into routines, and make a long term and lasting difference to the individual’s mental health. It also shows that there is room in the market for a wide variety of interventions, which may be appropriate to different people, different tastes and personality types, or at different stages in their lives.

Due to the difficulties of integrating a measuring scale into the app, we didn’t conduct SWEMWBS analysis, but rather relied on qualitative testimony and feedback, the results of which are detailed below.

The criteria that was used to assess the significance of this was the Self Determination Theory of mental health, which has three components of mental wellbeing - autonomy, competence and relatedness.

Mental health tech - what the evidence shows so far in terms of behaviour change and uptake.

## a. Literature review

This is a rapidly evolving field. Mental Snapp was evaluated by London Southbank University at an early stage in its technical development, and the following text is an extract from the literature review conducted by Chelsea Muich MSc as part of this evaluation.

“With new technology, especially concerning the mental wellbeing of those that use it, risk and challenge are involved from monitoring the distress of a user to the responsibility of the professionals involved in prescribing and developing such programs (Lewis & Wyatt, 2014; Olff, 2015). Use of an online platform is associated with benefits including the ability to provide “…treatment that is more cost-effective…[reduce] waiting lists, [and compensate] for the lack of trained professionals…” (Richards, 2009). Although this technology is quite new compared to more traditional methods of mental health support, studies have observed promise in improving services and offering innovative treatment (Ben-Zeev et al, 2013; Luxton et al, 2011). However, the success of mobile mental health technology could be based on the age of the users. The potential to target younger users is evident as mobile phone use is popular in this demographic (Giota & Kleftaras, 2014; Kauer, Mangan, & Sanci, 2014). It’s been shown in some cases, however, that those in low income households who potentially struggle to maintain a job due to their mental health problem, could be less likely to own a mobile phone and therefore would not have the benefit of such technology (Giota & Kleftaras, 2014).

Research surrounding the apps’ effectiveness is challenging traditional methods and hoping to reach a wider audience to give access to those that cannot afford professional therapy or those who prefer privacy or a self-help approach while confronting their mental health problem (Donker et al, 2013; Giota & Kleftaras, 2014; Harrison et al, 2011). In fact, one study discusses the impact of mental health applications on the market stating that “…the development and utilization of behavioral intervention technologies (BITs), such as mobile apps, offers the potential to greatly expand the portfolio of available mental health resources” (Lattie et al, 2016, p. 152). Some mental health applications were researched in a meta-analysis designed by Donker et al (2013) and upon review, data suggested that mental health apps may only be effective in supporting those with mild to moderate mental health issues and have not been shown to treat more severe mental health problems such as schizophrenia. With mental health apps having only been available for about a decade, these avenues could potentially support severe mental health problems in the future; however, more research is needed in this area. Mental health applications emerged into the technological marketplace beginning in the early 2000’s and were compromised of “…[about] 6% mental health outcomes…[while] 18% focused on related health issues, such as sleep, stress, relaxation, and smoking behaviors” (Donker et al, 2013, p. 2). The link between mental health apps and the aforementioned symptoms was also corroborated by Giota and Kleftaras (2014) as they stated that mental health apps had positive effects on “…a range of mental health problems, such as depression, stress, anxiety, and smoking cessation” (2014, p. 20).

Since the introduction of mental health apps, researchers have observed whether consumers actually find them useful and whether the experience of negative symptoms is reduced. The apps have been found useful in monitoring and accurately matching the symptoms of a mental health problem according to Giota and Kleftaras (2014; Gaggioli & Riva, 2013). Hind and Sibbald (2015) found that mental health apps were effective in valid symptom monitoring, improvement of access, and positive regard was noted in doctors and their patients, although the researchers did find the effects to be short term. Mental health apps, also referred to as mobile health or mHealth, can also support those who cannot afford traditional treatment and can give access to those that may not be fully educated on mental health (Leung et al, 2016). In previous studies, qualitatively observing the progression of the mental health stigma within mental health apps has not been the sole focus. Much of the mental health app research monitors symptoms and/or compares traditional methods of therapy as can be seen in a study by Torous, Friedman, and Keshavan (2014). In this study it was noted that an interest and willingness by the service user existed to self-monitor their mental health symptoms, suggesting this is due to the anonymity of using an app (Torous, Friedman, & Keshavan 2014).”

Additional literature reviews on these themes include: :

Dubicka and Theodosiou (2020): *Technology use and the mental health of children and young people*

<https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr225.pdf>

Burger, Neerincx and Brinkman (2020): *Technological State of the Art of Electronic Mental Health Interventions for Major Depressive Disorder: Systematic Literature Review*

<https://www.jmir.org/2020/1/e12599/>

Schønning, Aarø, Skogen (2019): *Central themes, core concepts and knowledge gaps concerning social media use, and mental health and well-being among adolescents: a protocol of a scoping review of published literature*

<https://bmjopen.bmj.com/content/10/1/e031105>

## Customer feedback and usage

In summer 2017, London Southbank University’s Psychology department headed by Professor Paula Reavey partnered with Mental Snapp and three Psychology MSc students, Lopez, Osman and Muich, undertook to write their dissertations on the use of Mental Snapp. NHS ethics were undertaken and the study approved for use in NHS settings, which were flyered, and clinicians recruited to promote the study. However, due to a low turnout, the participants for the study came from a community setting, Dragon Cafe in Southwark, or from emails out to Mental Snapp users inviting participants, and there were six recruits in total.

The study used mixed methods of usage data (excluding the original recordings but including time and date stamps and tags attached), focus groups and semi structured interviews, which were transcribed and subjected to thematic analysis.

Of the dissertations, all focused on Mental Snapp in relation to a specific aspect of mental health, and most useful for our purposes is the study that Lopez conducted, which looked at the effect that Mental Snapp has on relationships with the self and with others.

Comments that Lopez highlighted were to do with the effect of using video as opposed to written diaries, commenting on the impact on participants of the rich data of video. The effect of seeing your face was positively commented upon.

“ One participant stated that the use of Mental Snapp was much more beneficial than using a standard mood diary:

“…with Mental Snapp because you have a video recording…you can see from my facial expression from the way I am speaking with the language I’m using its much more detail and much easier to do then write a mood diary. But you get so much more information from it.”

The effect of video was inadvertently to improve confidence, Lopez found:

“….after getting used to seeing their own faces the participants were no longer so critical of their appearance and became self-compassionate, which can be a beneficial part of mental health recovery.”

Lopez comments that using Mental Snapp helps participants form a stronger relationship with themselves and their feelings.

“the use of the application helped them start a dialogue with themselves about what was going on within themselves. “. The effect of this, Lopez notes, was to improve their communication skills with other people and with themselves.

In conclusion Lopez states:

“The use of Mental Snapp as a type of psychological intervention has been found to be beneficial for the participants that took place in this study. It helped the participants with their confidence with their physical appearance and their ability to talk about their mental health, communication skills and their ability to self-reflect on their mental health troubles. The participants found that while using the application they were able to be completely honest with themselves about what was going through their heads without relying on another person.”

## User patterns from the Mental Snapp database

In summer 2018, we went through a period of extensive study of the Mental Snapp user database. The figures below are taken from that period. The Mental Snapp user’s mean or average age was 34.7, and this only differed slightly from the median user age, which was 32. The youngest user was 18 and the oldest 79. 205 out of a total of 450 users didn’t declare their age.

The gender split was:

Other - 12 - 2.84%

Male - 114 - 27.01%

Female - 237 - 56.16%

Didn’t declare - 53 - 12.56

The mean number of recordings was 0.95. As a percentage of total profiles created, 22.5% of users made one recording or more, 1% of total profiles made more than 12 recordings. 72% of the total number of recorders made more than 3 recordings.

What we found was that there were a majority of users who were curious and recorded a small number of videos, up to 6 being their comfort bracket. There were a small minority (0.5%) of users who were extremely comfortable with the video format and recorded over 50 videos. The maximum number of videos recorded was 94.

We split our users into user personas.

Ecclectic Emily, aged average 30, was our core user, interested in journals and creative living, single or in a relationship but no dependents, a demographic that isn’t catered for in traditional mental health provision but one with mental health needs that centre around life meaning and purpose. Ecclectic Emily represented 22% of our users, recorded around 6 recordings, and was curious about the process and what it would tell her about herself.

Chatty Chris, extreme user, male and more likely to be from the LGBTQ community. Highly prolific recorder. In the LSBU study, the persona that saw the most benefit from Mental Snapp. 1% of users, but recording a high number of recordings, the top Chris recorder recorded 94 videos.

Busy Bea was the majority of our downloads, making a profile but not recording. Older, female, we struggled to get her to tip into recording. 77% of users made a profile and didn’t make a recording.

Maternal Megan was a significant persona, a young mum dealing with childcare. We were unable to get stats as to how many of our users had children.

The final persona was Romantic Rosa, an older woman 45 - 55. c. 10% of our users. Concerned with relationships, family dynamics and juggling older dependents.

## d. User feedback

Over 50 hours of in depth interviews were conducted over the course of developing Mental Snapp. Pain points were examined, current and potential users of the app interviewed in depth.

We collaborated with General Assembly on a research sprint, and these were the results of their interviews on pain points:



Here is a sample extracted interview from a user who fits the profile for an Eclectic Emily:



The quantity of the interviews means that any summary here is a barebones one. The most consistent piece of feedback that people said again and again was that using Mental Snapp they felt like they got to know themselves and their face really well. Many people commented that it was like making a new friend, and that it was good feeling to have a private space to check in with themselves.

This was encouraging feedback, and a sign that we were making an impact on our users. However the behaviour change required to keep up the habit of video diaries was a high bar for our users over time.

## e. Expert testimony

Interview conducted with Victoria Betton, MindWave.

Key points from Victoria Betton interview:

* direct to consumer tech is competing with big firms with deep advertising pockets eg Headspace and Calm
* Blended therapeutic approaches have been shown to be more effective, ie clinician/peer relationship in conjunction with tech intervention
* Signposting to resources eg the NASSS framework as to why tech fails to be adopted.

In 2019, the NASSS framework looked at why mental health tech doesn’t get adopted.

The name is an acronym of the five key problem areas the study identified:

“digital technologies are either **Not Adopted** or soon **Abandoned** by professionals and/or their patients and clients, or the technology-supported service succeeds as a small-scale demonstration project but fails to **Scale up** locally, **Spread** to other comparable settings or be **Sustained** over time.”

The study is summarised here:

<https://www.nationalelfservice.net/treatment/digital-health/nasss-framework-mindtech2019/>

This develops the work presented by Simon Gilbody of York University to Mind Tech conference December 2018:

* there is a difference between the efficacy of mental health technologies as demonstrated in studies and evaluations, and their effectiveness in real life conditions.
* the psychological difference made to the participants by being part of a study increased adherence to the technology adoption and made it more likely that the technology would be adopted as part of a routine, and that benefits felt as part of the effect of being observed, would be attributed to the technology.
* the effect that the relationship with the researcher running the study has a significant uptick in mental health.
* There is a growing body of evidence that blended approaches in technology are most effective in creating shifts in mental health on scales such as IAPT and SWEMWBS. This means blending a technological or digital approach with an intervention based on a relationship with a professional or peer.

## f. Summary of evidence

In terms of creating behaviour change and lasting uptake from users, there is evidence to suggest that the most effective form of tech interventions come in the form of blended therapy, a mix of face to face and virtual.

To be adopted within the health service, it requires in team champions to push it forward. Frequently, there is a disconnect between the tech and the clinicians and there is no engagement there.

Relationships are important in mental health for transformation, and can effect change.

When seen as part of a peer intervention, this creates a tricky minefield of issues.

Businesses are **systems**. Books like The E-Myth (Michael E. Gerber) demonstrate that in order to create a scalable business, the entrepreneur needs to move from artisan to systems thinker. Rather than working out how to produce, for example, the perfect artisan pie, the entrepreneur needs to work out how to create a system that will produce those pies at scale, and teach that system to their employees. They write the recipe, not make the pies.

To move this analogy to peer to peer mental health solutions is problematic.

We’ve learnt that individuals need to move beyond their labels and find a way to see themselves outside their mental health condition. **But** producing a systematic way to conduct relationships inevitably involves roles, and role playing, which keeps people stuck in position, and moves towards ‘peer expert’ and ‘peer user’ in a hierarchical system rather than a flat one.

Relationships which aren’t systematised are more effective in creating change, but harder to measure.

The clearest way to create measurable change is to gather a community around shared objectives which are smart and measurable goals. Hashtags and other forms of shareable goals can help consolidate these communities, which can be facilitated by tech.

A good example of this is Club Soda, the mindful drinking movement, where people gather around the goal of reducing or eliminating their drinking. Having a concrete goal which is driven by a pain point in their lives is a powerful motivator, and leads to other lifestyle changes as people absorb the ethos of the movement.

Mental health as an area for social enterprise, an overview.

## Mapping social impact onto a sustainable business model

Mental health interventions are of two types - traditional provider/user, or peer based. Mental Snapp was a peer based intervention that ended up as a community, so that is the lens of this analysis.

A peer to peer community is ethically sound in principle, and empowering for the individuals that join it. It raises a number of questions which have to be answered as part of the business model, and some of them are to do with personal politics.

A good example of a successful peer to peer community is the mindful drinking movement, Club Soda. Club Soda, after many years of operating on Facebook, has just launched a paid for community, and is making the transition to a paid offer. This is not without community resistance. They stand a good chance of making the transition, however, because the motivation for someone to join Club Soda is a pain point, rather than a vitamin - ie they join because they need to look at their drinking, and this is highly motivational, rather than a ‘nice to have’.

Communities need a cause and a one line proposition to make them successful. The founder of Mighty Networks, a community platform which Mental Snapp used, describes it as ‘gathering together to master something interesting together’. If you can describe the purpose of your community as a one line manageable skill that will draw people to it, then you are in a good place to attract consumers.

Communities need to be seeded, they need a cause. They also need management, and in a peer to peer environment this means you have to take a stance on the flatness or otherwise of the hierarchy. We found that without professionals on board, we had problems describing our offer to insurers in such a way that we didn’t incur crippling insurance bills. These kinds of issues need to be considered and addressed.

Particularly if you want to work with, or at least not exclude, severe and enduring mental health conditions, you have to confront these issues, either by getting a professional on your board, or by developing, as we did, a robust safeguarding procedure. I did, however, meet one start up who just threw people off the platform if they demonstrated mental health needs that were too complex for the team to address. Not a stance we wanted to take.

To run a peer community you need to be robust in your attitude and gather lots of people who are engaged quickly and often. This means seeding the community with in real life meet-ups and events and encouraging conversation online with an active team of volunteers and co-opted community members. There will need to be a clear purpose to what you are doing, which means keeping the scope manageable. The business model will need to be worked towards, and may not be obvious at first.

Third parties may be a source of income and are the option that are worth considering, particularly if you are strong on sales. CSR from bigger firms, CCG commissioning, insurance packages or employee wellbeing schemes are all worth considering, and member get member or pay what you can in order to subsidise people on a lower paying point.

## The scale of the challenge, breadth and depth

The mental health market is a fast moving area and since 2015 when we started then the conversation has changed. We hope that Mental Snapp has been part of that conversation shift.

There are however still service users who get left behind. There are a growing number of mental health influencers on instagram and other and a lot of material available for the 20 - 30 something market is highly accessible. There are younger mental health service users who are finding their feet who are less catered for, and there are older service users, who are not as digitally native, who may have lower incomes and less to spend.

This means that to be a market leader requires deep advertising pockets or a clear cause. It is better to think of mental health in terms of the blended approach that makes a difference, and to network together a series of smaller interventions in a loose collaborative. Pockets of interventions in a nationwide network stand the most chance of making lasting change. Unfortunately in terms of startup investors, few think beyond the need for scale. This means that mental health continues to be a space where charities and CIC’s make the most impact.

## A possible model for future exploration and next steps.

In conclusion, the most viable model for future exploration is a network of interventions linked by technology. This relationships network should be on a charity/CIC model rather than a business model to be most accessible to the people who really need it. It should bear in mind the importance of relationships in real life, and be based on the Self Determination Theory of mental health, valuing the three components of wellbeing as Autonomy, Competence and Relatedness.

A blended intervention in partnership with mental health gyms would be one approach, or mental health art interventions. The motto from the charity TLAP is a good watchword for this ‘Think Local, Act Personal’.

There is one final provocation to end on - who is the expert? How can these relationships in real life be framed so that people don’t get stuck in receiving mode, where they are yet again in receipt of a service that is ‘done for’ them, but are actively co-creating it and developing their own leadership. This can be done within the service or signposted to, but is an important aspect of it to make sure that peer to peer interventions do not simply become another form of professionalised role based services.