# Aspirations for the Aotearoa New Zealand We Want and Need

**A submission by Platform Charitable Trust**

**PLATFORM**

Dear Inquiry Panel members,

During your consultation you will have heard about the problems with our current mental health and addiction system.

The following pages offer you some bold solutions to the existing challenges that, at the moment, see many people and families/whānau who are experiencing mental health and addiction issues left without the support that they want and need.

**Our solutions are as follows:**

- generate cross-party commitment to setting a long term vision for the future;
- establish independent commissioning for evidence-driven action; and
- invest in the capacity and capability of the community sector.

These ideas are achievable. There are numerous examples of successful, innovative, community-based services that are currently in operation either in New Zealand or overseas. We mention a few of these services in this document.

The challenges associated with creating and sustaining wellbeing within our communities is one that is being faced across the globe. We invite the panel to imagine the possibility of Aotearoa New Zealand being amongst world leaders on this issue.

Kind regards,

Platform Trust Board

*'Action without vision is only passing time,*

*vision without action is merely day dreaming,*

*but* **vision** *with* **action** *can* **change** *the world.'*

*– Nelson Mandela*

**PLATFORM**

# About Platform

Platform is the national network of community organisations that provide a wide range of services that respond to the mental health and addiction needs of individuals, families/whānau and communities in New Zealand.

In 2016, the community sector supported more than 65,000 people in mental health and addiction services. About 91 percent of people who access specialist mental health services are seen only in a community settings (either community sector or DHB-run).[1]

**Some examples of the work our members undertake are:**

- Community support services
- Respite and crisis services
- Child and youth community mental health services
- Social housing, housing brokerage
- Employment support
- Healthy lifestyle intervention programmes
- Advice and advocacy
- Vulnerable child, child and youth services
- Peer support
- Education and training
- Family/whānau support
- Addiction counselling, clinical support and methadone treatment

- Whānau ora services
- Intellectual disability services
- Specialist services such as eating disorders, refugee and migrant trauma support
- Residential services
- Strategic sector workforce development
- Social services
- Software solutions for the sector
- Health promotion
- Arts programmes
- Suicide prevention

Platform has been in existence for 17 years and has an active national membership. The local organisations provide feedback and information to Platform about how the communities they work with are managing and what's important to them. This then drives Platform's strategic vision.

*'Ultimately, we believe that wellbeing must be addressed as a cross-sector, whole of life, whole system, whole community issue and opportunity. This requires a response that transforms the system from thinking, practices and frameworks that were designed in the last century to responses that are relevant and responsive to the needs of people and communities in this century'.*
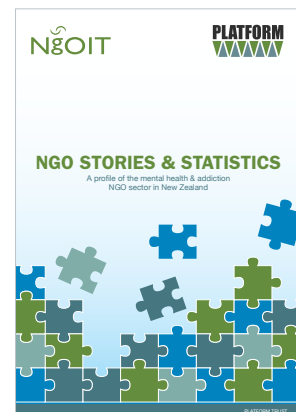
*- Platform Trustees*

# What have we done that can help you?

Since 2004, Platform has been producing material that might offer the panel some useful information about mental health and addiction community support services in New Zealand.

We've told the story of community organisations:

We've described the possibilities for the future and the challenges that we face in getting there:

We've examined the issues associated with the measurement of social outcomes[2]:

We've co-created (with The Bishop's Action Foundation and with support from the Department of Internal Affairs) a dynamic, free, online tool to support the community sector to self-assess and self-improve organisational performance in the following areas - strategic direction, governance, leadership, people, administration, finances, communication, evaluation and relationships.

Links to all of these publications or initiatives can be found on the Platform Trust website

## www.platform.org.nz
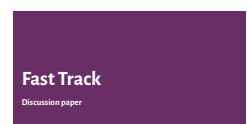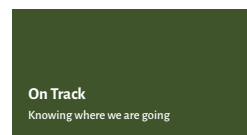
A review of the use of social outcome indicators

Suggested improvements to the collection and use of national social outcome data in New Zealand.

# Action 1: Generate cross-political party commitment

**ASPIRATION:** That there is agreement and commitment across all political parties to achieving long-term, sustainable wellbeing for people living in Aotearoa New Zealand, with a shared vision that is immune from political cycles.

As we learnt from the 1996 Mason Inquiry, fundamental changes in mental health and addictions services can take a number of political cycles to be realised. We need long-term, cross-political party will and commitment to a vision for the wellbeing of people, families/whānau and communities in Aotearoa New Zealand. This cannot be realised in one political cycle, or maybe even one generation of politicians which is why we are seeking a cross-political party accord for Mental Health in Aotearoa. In addition, we need a government agency that has the mandate to lead the work. Treasury has identified that the Ministry of Health is not in the position to lead strategic work about mental health and addictions[3].

The TOR for the Inquiry[4], the Prime Minister[5] and the Minister of Health[6] have clearly articulated that mental health and addictions issues can stem from, or be influenced by, social determinants like housing, employment and education.

*'We must shift our thinking about mental health and addiction issues as a series of medical challenges, which can have social implications to a paradigm where mental health and wellbeing is a series of social challenges, which can have medical implications.'*[7]

*- Platform Board member*

*The Prime Minister's Chief Science Advisors agree 'We need a new paradigm for mental disorder and mental health in New Zealand.[8]'*
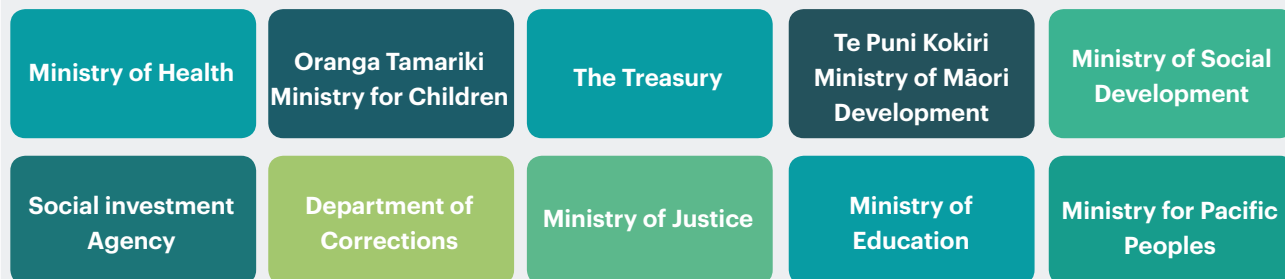
**We must see a long-term strategic vision formed with cross-party will and cross-agency leadership. So, we propose a Wellbeing Cross-Party Group.**

| Party reps | Party reps | Party reps | Party reps | Party reps |
|---|---|---|---|---|

Setting the long term strategic vision for whole of life and whole of community mental health and addictions support (or community wellbeing) based on information and advice from:

**...a cross-agency advisory group comprised of Chief Executives of:**

| Ministry of Health | Oranga Tamariki Ministry for Children | The Treasury | Te Puni Kokiri Ministry of Māori Development | Ministry of Social Development |
|---|---|---|---|---|
| Social investment Agency | Department of Corrections | Ministry of Justice | Ministry of Education | Ministry for Pacific Peoples |

**...and any other interested Departments**

...as well as advice from the Mental Health and Addiction Commissioner and any other interested Crown Entities or Crown Agents such as the Health and Disability Commissioner, the Children's Commissioner, the Human Rights Commissioner and the Police Commissioner

...and submissions and petitions from the public

This is not unheard of - we have the social investment board comprised of Chief Executives of a number of government agencies, and our select committees routinely bring together cross-party focus on an issue. In Scotland cross-party groups look at issues such as mental health, which 'provides an opportunity for Members of all political parties, outside organisations and members of the public to meet and discuss the shared interest of Scotland's mental health'[9]. Australia has Council of Australian Government (COAG) Councils, including the Disability Reform Council, to 'provide a forum for intergovernmental collaboration and decision-making. They progress COAG priorities and referrals of work, along with other issues of national significance'[10]. We believe that urgent improvement in the availability of appropriate mental health and addictions support in New Zealand has become an issue of national significance. Put simply, getting it right matters too much to us, and to almost every family/whānau in this country, for this issue to be rethought, reframed or reinvented within the term of each political cycle.

The Strategic Vision might include specific targets for particularly at-risk population groups and will also inform activity that is focused on workforce development.

*'The role of system steward falls to the Government. This is because of its unique role as the major funder of social services, and its statutory and regulatory powers unavailable to other participants. Stewardship responsibilities can be spread over several bodies or agencies – for example, responsibility for monitoring performance could be assigned to a separate, independent, government entity.'[11]*

*(The New Zealand Productivity Commission, 2015, pp. 10-11)*

A re-established Mental Health and Addiction Commission could act as the independent watchdog and could hold government agencies and service providers to account for their part in realising the future that we want and need.

## Problems Action 1 addresses:

☑ Lack of long term planning because of changeable political focus.

☑ Strategy being too nebulous or high-level to affect real change.

☑ Different or disconnected visions articulated by multiple agencies for the same people, families/whānau and communities.

☑ Policy disconnect from the 'frontline' realities.

## This is not new territory

› Cross-political party accords have already been made both formally and informally where there are positions that are considered to be beneficial for the long-term wellbeing of New Zealanders. Examples include Treaty claim processes, New Zealand's nuclear-free stand, anti-smacking legislation, superannuation and more recently Kiwisaver.

› Cross-political party approaches have more recently been suggested for climate change issues and child poverty to help address long term challenges faced by New Zealand.

› Cross-political party or inter-governmental work on nationally significant issues occurs in other nations around the world, such as in Scotland and Australia.

› National-level collaborative work, involving a range of government agencies, has precedents in the composition of the Social Investment Agency Board.

## What this means for people

John* has a lengthy history of contact with psychiatric services and has experienced intermittent long-term homelessness most of his adult life, but has had some periods of stability when he held jobs as a painter and joinery apprentice. He has previous high use of alcohol which he said made him angry. Now he uses synthetics that he reports assist him to calm his mind. After use however, further aggression and paranoia result when the initial affect wears off bringing him into conflict with friends and strangers alike and to the attention of the police. He has a history of severe childhood physical and sexual abuse. Contact with psychiatric services has led to a trail of diagnoses from antisocial personality disorder, Post-traumatic stress disorder (PTSD), anxiety, drug-induced psychosis and phobias. There are early reports of Attention Deficit Hyperactivity Disorder (ADHD) and learning difficulties. John's last formal contact with mental health services was a couple of years ago and he was under the care of a community mental health team.

*John has had interactions with Police, Justice, DHBs and MSD/WINZ, his local chemist and community organisations. Which strategy helps people like John to stabilise his life and recover? Social Housing? Employment? Health?*

*Adapted from a case study provided by a Platform member. *Name and minor details have been changed to ensure anonymity.*
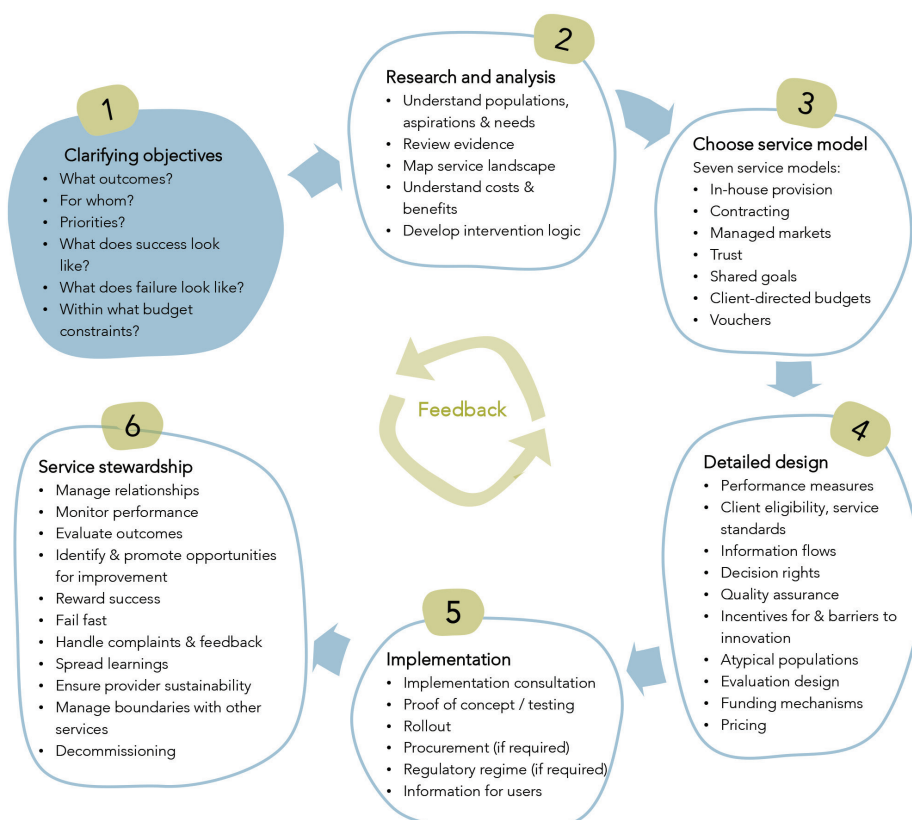
# Action 2: Establish independent commissioning

**ASPIRATION:** That the things that contribute to supporting people who are experiencing, or at risk of experiencing, mental health or addiction issues are planned, funded, delivered and evaluated in a seamless evidence-driven way.

Platform's members hold contracts with multiple government agencies: district health boards, the Department of Corrections, the Ministry of Social Development, Oranga Tamariki, the Ministry of Health, Housing New Zealand, the Ministry of Education, ACC and sometimes local government. This gives these community organisations a clear view of the often disjointed state of commissioning that leaves many New Zealanders and their families falling between the cracks.

*The thing about this is that people don't actually care who commissions the services they receive, or what they're called. People don't necessarily want to access 'mental health services', they just want support for the things that are going on in their lives.*

It is well recognised, including by the Prime Minister's Chief Science Advisors[12] and the World Health Organization[13], that mental health and addiction issues are driven and influenced by a wide variety of social determinants such as housing, poverty and unemployment. Yet we continue to commission services that do not take these factors into account. Even though people often need immediate support, current compartmentalized commissioning leads to referral-based systems that create wait lists. In addition, contractual requirements often hamstring services and hinder any potential for early intervention.



**1 Clarifying objectives**
- What outcomes?
- For whom?
- Priorities?
- What does success look like?
- What does failure look like?
- Within what budget constraints?

**2 Research and analysis**
- Understand populations, aspirations & needs
- Review evidence
- Map service landscape
- Understand costs & benefits
- Develop intervention logic

**3 Choose service model**
Seven service models:
- In-house provision
- Contracting
- Managed markets
- Trust
- Shared goals
- Client-directed budgets
- Vouchers

**4 Detailed design**
- Performance measures
- Client eligibility, service standards
- Information flows
- Decision rights
- Quality assurance
- Incentives for & barriers to innovation
- Atypical populations
- Evaluation design
- Funding mechanisms
- Pricing

**5 Implementation**
- Implementation consultation
- Proof of concept / testing
- Rollout
- Procurement (if required)
- Regulatory regime (if required)
- Information for users

**6 Service stewardship**
- Manage relationships
- Monitor performance
- Evaluate outcomes
- Identify & promote opportunities for improvement
- Reward success
- Fail fast
- Handle complaints & feedback
- Spread learnings
- Ensure provider sustainability
- Manage boundaries with other services
- Decommissioning

Feedback

*Source: The Productivity Commission (2015, p. 131)*

We propose an independent commissioning and purchasing entity that is driven by the evidence about what works for individuals, family/whānau and communities in Aotearoa New Zealand.

The independent entity could set 'local performance measures' as well as 'system-level performance measures'[14] (The New Zealand Productivity Commission, 2015, p. 143), both of which would be informed by the long-term cross-party strategic vision.  Local place-based input into commissioning is vital to reflect the local population need.  There is also greater understanding locally of the existing assets or resources within the community (making it more likely that commissioning will take an asset-based approach).

National system-level performance measures would ensure a minimum level of support is provided with a minimum standard and, where necessary, specific evidence based measures for key populations of interest could be rolled out nationally.  Pools of flexible funding ('flexi funds') could be made available locally for addressing urgent need.  Trials of flexi funds to date have given service providers the ability to immediately support service users with practical solutions to support their recovery, such as paying for the person to get their driver's licence so that they can get to and from employment.  Other uses for flexi funds include things like paying a person's bond; paying off bad debt; providing babysitting so that the person can attend appointments; and supporting someone to have dentistry work done (there are oral health issues related to some mental health medications).  All of these immediately actionable (and low cost) supports can have profound effects on a person's ability to recover.

## Changing commissioning behaviour

Of course, the creation of a new entity will not automatically create a new set of behaviours to those that have stopped cross-agency evidence-based commissioning from occurring in the past.  The learnings from Implementation Science (the study of methods and strategies to promote the uptake of evidence-based interventions into routine practice) must be used to increase the uptake of evidence-based commissioning.  We also need to take a closer look at the challenges faced by public servants who work in an environment of risk aversion, with an economic driver underpinning decisions that are often made in the absence of contextual information from people who are actually doing the work.

The good news is that we have already tested this health and social commissioning idea in New Zealand with the work on Whānau Ora. An example in Australia is the establishment of the National Disability Insurance Scheme (NDIS), which came into being with bilateral support.  The NDIS absorbed all state, territory and federal funding for disability supports, together with NDIS revenue generated from an increased Medicare levy, and rolled out the scheme that funds disability support.  Support eligibility is not pre-determined by diagnosis, but is assessed based on the disabled person's need for support to achieve the life they want.  Local National Disability Insurance Agency (NDIA) offices provide assessment support with the overarching and nationally consistent intent of the scheme enshrined in law.

## Establishing the evidence

It is important also to realise that it is not easy to measure social outcomes, as observed in *A review of the PRIMHD social outcome indicators*[15] . However, the OECD and many New Zealand organisations and government agencies have been working on finding solutions to this problem – and the difficulties are certainly not a reason to continue the status quo.  We need to look to the multitude of evaluation methodologies, outcome frameworks and measurement tools to help build the evidence of what is working at an individual, a family/whānau, a community and a population level.

The United Kingdom has the What Works Centre for Wellbeing (https://whatworkswellbeing.org/) that gathers high quality evidence on wellbeing and how to measure impact. Although Superu in New Zealand is being disestablished, the functions that are performed by that agency remain invaluable. Practice-based evidence is all too often distrusted or dismissed without consideration, leaving us without a full understanding of the best available evidence. The sector will continue to rely on an independent agency that is able to evaluate the grey literature (often produced by community organisations that are evaluating their own programmes), gather academic research and interpret findings to help inform commissioning decisions.

In the age of technological solutions, we are also much more able to create solutions to the challenges faced by inheriting cumbersome systems that have usually resulted from moving paper-based systems to technological platforms. We can reimagine the possibilities. Accreditron (www.accreditron.com), has created a technology solution to the problem of community organisations' multiple disjointed accountability requirements. With technology, community organisations can share selected information with the government agencies they contract with on a single platform. The platform also enables government agencies to easily view who is currently operating in the service provider landscape. Government agencies could use it to coordinate site visits and audits, or to verify information about community providers that have an existing relationship with government. We absolutely have the ability to innovate our way out of the problems we've created and the clunky systems we've inherited, and to shift into integrated and streamlined commissioning. A commissioning entity could use tools like this in its role as steward of wellbeing services.

## Problems Action 2 addresses:

☑ Different things being purchased by multiple agencies with many 'solutions' to the same challenges.

☑ Cumbersome, time-consuming and often duplicate accountability requirements.

NB: Fragmented commissioning inevitably comes with a range of accountability measures that health and social services need to meet. The cost of accountability is not insignificant, with one of our members indicating that the cost of auditing for them (with contracts with 14 different funders) is around $300,000 a year. This cost represents time and money that could be more constructively spent on providing support to people experiencing mental health and addictions services rather than dealing with clunky red tape.

☑ Potential conflicts with agencies, such as DHBs, being both the purchaser and provider of services.

☑ Competitive environment with government able to pay better wages than community organisations and dis-incentivising collaboration between community organisations.

☑ Too much focus on one aspect of the care continuum, such as acute services, rather than earlier intervention and illness prevention.

☑ Pockets of trials, pilots, programmes and other initiatives occurring without the shared evidence-base growing or the community organisation's work being trusted. Conversely, inquiries about incidents occurring without the system taking on the learnings.

## This is not new territory

> Treasury has acknowledged that GDP isn't the only important measure of how we're doing as a country and it is refreshing that the Living Standards Framework includes wellbeing measures in dimensions related to housing, income and wealth, jobs and earnings, social connections, education, and skills and environmental quality.

> Treasury is also co-hosting the Third International Conference on Well-Being and Public Policy with Victoria University in September 2018 to hear from other jurisdictions about their work on well-being.

> Accreditron has created a technology solution to the problem of community organisations' multiple disjointed accountability requirements.

> There are existing 'evidence' libraries with What Works for Wellbeing in the UK, the Cochrane Library and Superu.

> Whānau Ora has tested this way of operating, but with commissioning occurring outside of government.

> Place based commissioning is being explored in the United Kingdom and other jurisdictions as well as in New Zealand.  The Awhi Ora (Tamaki Wellbeing) model being piloted in Auckland is producing some excellent results with local GPs and the DHB to be able to directly 'introduce' (rather than refer) patients to community supports.

> With bi-partisan support the National Disability Insurance Scheme (NDIS) created an agency to draw in funds from dispersed state/territory and federal pools, to provide a central commissioning function with local presence and national consistency.

> The Productivity Commission received 246 submissions and held more than 200 meetings with stakeholders in the development of its More effective social services report (2015), including receiving thoughtful submissions from service users, family organisations, drug and alcohol and mental health organisations.  The report is enormously comprehensive, much respected by the social services sector, and it provides some valuable ideas on the way forward.

# PLATFORM

## ? What this means for people

Barry* was referred to us nearly four years ago. He was in the mental health unit for more than six months as they were unable to relocate him to the community due to heavy use of alcohol and tobacco. He has been diagnosed with schizophrenia and an alcohol-based dementia. The clinical team put him under the Compulsory Assessment and Treatment Order as he refused to take medications. Our consistent support has built the rapport with him and we found him accommodation in the community within two months. He is been in the community for past three years and never returned to the hospital. Progress made within last three years:

1   Moved back to community accommodation
2   Stopped drinking alcohol – he hasn't used in the past three years
3   Stopped smoking – he hasn't smoked in the past two years
4   No longer under the Mental Health Act as he responded well to medication
5   Goes to gym three times a week
6   Visits GP on time
7   Attends church regularly
9   Learned to use a mobile phone
10  Uses public transport for community programmes and clinical appointments
11  Reduced support hours as he is gaining more independence in the community
12  Reconnected with his family
13  Automatic payments to his savings account and he has good savings in his account now

*How much sooner could Barry have recovered and re-joined his community if he accessed support earlier and easier? How much of Barry's recovery is down to medical issues versus social?*

*Would Barry have accessed GP services without support from community services?*

*Adapted from a case study provided by a Platform member. *Name and minor detail has been changed for anonymity.*

# Action 3: Invest in the capacity and capability of the community sector

**ASPIRATION:** That communities are empowered to support each other, and to access formal support locally when it is needed, to promote wellbeing, prevent distress and to help people in communities to manage and/or recover from mental health and addictions issues.

The community sector is resilient, resourceful and generally holds strong values about working in a person or whānau-centred way. The sector takes a strengths-based recovery-focussed approach to the people they work with, not a diagnostic or problem-focussed approach. We don't ask 'what's wrong with you?' we ask 'what's happened?' and 'what do you need?'

*'It seems obvious, but we are in and of the community. Our workforce works in the community, in people's homes or in the streets, every day. The relationships we foster (our social capital), are vital to our success.'*

*- Platform Board member*

Community organisations are far more agile than government agencies, and have the ability to detect and rapidly respond to the needs of the communities they work in. It's not like turning a container ship, it's more like turning a jet boat. The work Platform and the team have done to negotiate a settlement for mental health and addictions support workers has highlighted the skilled nature and broad scope of work that this part of the workforce (the largest workforce group in mental health and addictions[16]) undertakes.

Support workers work alongside people to find what is needed and how they can support a person to address that need. Community sector organisations can be also run by or employ people who have lived experience of mental health and addiction issues in a number of roles, including designated peer roles. This experience allows workers in community organisations to connect with people from a place of understanding.

## If not the community sector, then who?

The cautionary note about the commissioning model described in this document is that there is a risk that mental health and addiction services will be privatised, as has occurred with aged care. We cannot see successful outcomes for people from the commodification of wellbeing. A system entirely comprised of private organisations with profit-driven motives, supporting people, families, whānau and local communities to recover, is inherently counterintuitive. There is a risk that the system incentivises services to work with only those people who require a 'light touch' while keeping the 'hard to reach' populations out of reach.

The community sector already works with people who are seen negatively by the rest of society, belong to gangs, have meth addiction and behave in odd or different ways.

Trials of support work type roles being co-located within GP clinics are being undertaken. While a navigation role can be incredibly useful in the absence of an easily navigable system, as demonstrated by Awhi Ora, we fear that over-investment in this model as the solve-all solution misses the point. Many of our most at risk populations are not engaged, and would not engage without considerable support, with general practice. For example, for one Whānau Ora commissioning agency, 58 percent of people enrolled with a GP[17] was an improved enrolment rate for those whānau. The cost barrier, real or perceived, is significant along with the ability to attend appointments due to transport[18] and care-giver responsibilities, etc. General practice appointments of 15 minutes can't be expected to reliably surface the real reasons that a person is struggling with a mental health or addiction issue - in the event that a person is confident enough and has the resources to attend an appointment. In addition, general practitioners have varying levels of expertise and understanding of mental health and addiction issues. This model also suggests that people experiencing mental health and addictions issues are actively seeking support, which our case study examples have shown is not always the case.

This is not to say that general practice and private organisations have no place in a well-functioning mental health and addiction system. It is just that they are not the only place.

*'We need a mix of access points for the mix of people in the community that want and need support. And support cannot continue to be controlled and limited, primarily by DHBs.'*

*- Platform Board member*

## We work together for the benefit of communities

In spite of a competitive environment, the community sector has worked to collaborate for the benefit of the people it works with. Strong network groups exist in the northern, central, top of the South Island and Canterbury regions of New Zealand. Organisations have created teams that work with service users from other community organisations, such as a team of health and wellbeing clinicians (occupational therapists, nurses, social workers and support workers) who support service users with goal planning, physical health and healthy eating.

Community organisations are bold and innovative, they don't wait for an action plan or a strategy. Home grown technology solutions have been developed by community organisations to support the mental health and addictions workforce and create platforms to engage online with service users.

One of Platform's members led the collaborative work in the Waikato around trialling the housing first model (The People's Project https://www.thepeoplesproject.org.nz/about/housing-first) to prove the concept that is now being introduced in other areas.  Platform and community organisations also led the collective impact work to create the Equally Well collaboration that brings into focus the physical health inequities experienced by people experiencing mental health and addiction issues.  There are a wide variety of organisations, health practitioners, NGOs and professional bodies that have agreed to work in their sphere of influence to improve things.  This is real kiwi initiative – now being replicated in Australia and England.

## *Whakapūpūtia ō kākaho e kore e whati*
## *Together we are stronger*

*(Whakataukī gifted to Platform Trust by Matua Rongo Wirapa)*

### Problems Action 3 addresses:

- ☑ Accessing and continuing to work alongside 'hard to reach' or 'challenging' people and groups.
- ☑ Sluggish or inappropriate responses to community need.
- ☑ Risk averse government agencies' inability to trial innovative approaches.
- ☑ Cumbersome tendering processes limiting availability of funding to innovate or respond to need.
- ☑ A lack of engagement by people with mental health and addiction support due to the perceived inaccessibility or intimidating nature of services.
- ☑ High presentations in acute or emergency situations, including police callouts, due to a lack of early intervention.

### This is not new territory

> Community organisations have been doing this for decades now.  We look forward to a future system that enables us to do more work from within communities to create and sustain people's wellbeing.

![PLATFORM]

## ? **What this means for people**

Janet* is a middle aged woman who is married with two children. Both children have disabilities. Janet was feeling extremely overwhelmed in her life and struggling to keep up appearances that she was managing, which led to suicidal thoughts. She had also stopped taking her medication. She sought help from the community mental health team and was referred to community respite.

Janet had never been to a respite place and had imagined a lock up facility with staff in white uniforms, and so she was relieved on arrival at the respite house. Janet felt comfortable in the house and brought her children in to show them where she would be staying to reduce both of their anxieties. Janet stayed for a little over a week, and on heading home made the following comments in her exit interview:

'I feel stronger heading home. Supports are back in place. Boundaries have been reset. Sleeping is starting to improve. Medication is on board. I'm feeling topped up with the belief system that with time things can get better.'

*'If we can provide earlier, less costly and less potentially traumatic responses to people experiencing distress, why wouldn't we?'*

*Adapted from a case study provided by a Platform member. *Name and minor detail has been changed for anonymity.*

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# Thank you

When we met together with you, the Mental Health and Addiction Inquiry Panel, you said that you aim to be the voice of the people.

As a network of organisations who work with people experiencing mental health problems and addiction issues, their families/whānau and their communities, we hope that the insights we have provided in this document have helped to shed light on some of the positive impacts that are possible if systemic barriers are removed so that people are more able to access the support that they need, when they need it.

We see the possibilities for real change, and we wish the panel members our very best as you reflect back to Government what you have heard, and as you challenge Government to create the mental health and addictions system that the people of Aotearoa New Zealand want and need.

Marion Blake, CEO of Platform Trust and the Platform Trust board.

**PLATFORM**