

National Mental Health Consumer Alliance ('the Alliance')

Principles for co-creation at a national scale

To realise commitments made by governments to 'co-design' of the next National Mental Health and Suicide Prevention Agreement, and a new national psychosocial support scheme.

The following six principles reflect the Alliance's role as the national steward of consumer-led co-creation in mental health reform.

The purpose of successfully implementing these principles is to ensure Australia has an effective, reliable, consistent and equitable mental health and suicide prevention system that addresses unmet need, improves mental health outcomes, and upholds the human rights of mental health consumers.

For each of the principles below, please note:

- 'the Alliance' includes the Alliance national office, and each State/Territory consumer peak
- the Alliance will work in allyship with IALEC, Mental Health Carers Australia and the new national Peer Workforce Association
- there will be focused efforts to ensure inclusion and diversity of rural and regional; LGBTIQ+; CALD; intersecting disabilities; older; and youth consumer cohorts.

National Co-Creation Principle	Description	Methods
Principle 1: Access for all consumers	Provide opportunities for any and all mental health consumers in Australia to contribute to co-creation through methods that are low-barrier, meaningful, and reach consumers who are not currently engaged, including those outside organised structures.	• Online advertising and 'instant' engagement tools • Submission portal • Curated consumer surveys • Social researcher analysis of results
Principle 2: Intentional, intensive application of specialist lived expertise	Support and remunerate people with lived expertise in specialised areas to provide deep insights into what works, using evidence-based methods over extended periods.	• Empathy interview methods • Deliberative polling and focus group methods • Peer group projects
Principle 3a: Application of previous/emerging research Principle 3b: Application of previous/concurrent consumer engagement initiatives	Identify, analyse and apply the findings from research, consumer engagement and co-creation work already undertaken (or underway) by organisations working with mental health consumers, to minimise duplication of effort and 'reinventing the wheel'.	• Consumer-led desktop research • Application of research to co-creation processes

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Principle 4: Utilise existing consumer-led structures	Use existing and emerging structures for activated consumers to contribute to co-creation, including via STP membership; peer worker networks; and project specific outreach to discrete geographic, identity-based, and marginalised communities. Build local capacity to do this work where required.	• Member forums • Affinity groups • Consumer Advisory Groups • Expertise of consumer lived experience workers • National coordination of outputs from local and state/territory initiatives
Principle 5: Transparent application of co-creation in governance arrangements.	Ensure that co-creation efforts have a clear, realistic pathway to adoption by governments; that consumer leadership works flexibly with governments to reach practical agreement on implementation; and there is a communication 'loop' back to all participating consumers on co-creation outcomes. Build long-term consumer capacity in implementation, monitoring and evaluation of system reform. Transparency with consumers about the complexity and risks of system re-design, and bring consumers on the journey of reaching 'best possible' negotiated outcomes.	• Accountable consumer leadership embedded in government processes • Continuous communication with consumers about "the co-creation journey" • Effective governance and solidarity across the consumer movement • Contracted specialist expertise where required (for example commissioning; detailed service design; cost-benefit analysis; monitoring and evaluation etc)
Principle 6: Working with allies and sector stakeholders	To support reform feasibility and recognise cross-system needs, collaborate to the best extent possible with (among others) disability representative organisations, carers/family/kin bodies, peer workforce associations, community mental health providers, suicide prevention organisations, AOD lived experience organisations.	• Targeted exchange of information with stakeholders • Collaborative meetings, workshops, forums and events • Leadership discussions and joint positioning