Consumer-Run Organisations: An Evolving Model in Community Mental Health Services in Australia

Douglas Holmes, SUPERCRO, Boolaroo, NSW, Australia, pm@suercro.com

Lynda Hennessy, SUPERCRO, South Coogee, NSW, Australia, chairperson@supercro.com

Kristy Mounsey SUPERCRO, Rosebud, Victoria, Australia, kristymounseymh@gmail.com

Peter Hawes, SUPERCRO, North Coburg, Victoria, Australia, Oakaldokal@gmail.com

Gary J. Parker, Kansas Consumer Advisory Council for Adult Mental Health (retired Executive Director), Kissimmee, Florida, USA, garyjparker1016@gmail.com

Koleen Garrison, Kansas Consumer Advisory Council for Adult Mental Health, Great Bend, Kansas, USA, koleengarrison@kansascac.org

Mellissa Patrick, Kansas Consumer Advisory Council for Adult Mental Health, Kiowa, Kansas, USA, melissapatrick@kansascac.org

Abstract

Historically in Australia, Drop-in Centers have been a part of the Mental Health services that came under the domain of the medical professions. Since the start of the National Mental Health Strategy in Australia in 1992, Drop-in Centers have been seen as less important as part of public and private mental health services and harder for Consumers to be able to access a safe space without being watched for symptoms, where usually, records are not kept about behavior, only attendance.

The focus in Australia has been how language has changed when discussing Consumers and Consumer involvement in service delivery and planning. The other change has been the separation of the Consumer and Carer joint approach for policy development and the development of the Peer workforce. This workforce is primarily engaged in the development of positions within the public mental health system and the Non-Government Organisations sector.

SUPER CRO Incorporated is a small charity, and SUPER CRO is an acronym for Service User, Participating, Educating, Researching, Consumer Run Organisations. The group was initially composed of mental health consumers who had come together in 2006 as part of their involvement in treatment for a variety of mental health conditions at St Vincent's Hospital in Darlinghurst, Sydney.

Members of the Group travelled to the 2010 Kansas Recovery Conference to examine the Recovery Model and were pleasantly surprised to find a whole state had embraced the Consumer-Run Organization model and were willing to share their knowledge and assist SUPER CRO to bring this model to Australia.

This chapter of the book will focus on the history, development, impact, and future directions of CROs in Australia.

Keywords

Lived Experience, Mental Distress, Trauma Informed Care, Consumer-Run Organisation, Model of Care, right to self-determination, Consumer-run organisations, mental health, lived, community models, co-production, peer leadership, empowerment, recovery-oriented services.

1. Defining Consumer-Run Organisations (CROs)

1.1 Origins and Definitions

Historically, peer-run Drop-In Centers were set up as alternatives to traditionally provided services, not as adjuncts to treatment. The classic statement of this function of the Drop In is found in Judi Chamberlin's book "On Our Own", [1]. Today, Consumer-operated Service Programs are part of the continuum of community mental health care in the USA. The Substance Abuse and Mental Health Service Administration (SAMSHA) Library has a lot of information to show how this has happened. (for example, see [2]).

The consumer mental health movement is now 60 years old, and drop-ins have survived the early days of the movement when current or ex-patients might meet in someone's apartment or at a community center or in the basement of an urban church [3].

The original purpose of Drop-Ins was fivefold:

1. To provide a safe place where those economically disadvantaged by their mental health status can be off the street.

2. To provide a place where people with common treatment experiences can talk freely and be understood.

3. To provide grassroots gathering to address improvements that can be made in the system, to address wrongs, to have a common voice that will be given attention because it comes from the rubric of an organization.

4. To provide a place where usually a phone, bathroom, and information, sometimes food, is available.

5. To provide a place where people can be natural without being watched for symptoms, where usually records are not kept about behavior, only attendance.

This quote from a paper by Penney and Prescott from 2016 [4] highlights some of the issues that still need to be addressed in 2025;

> *A particular challenge facing psychiatric survivors is the widespread assumption of incompetence by virtue of their diagnoses. This iatrogenic vulnerability puts them at risk of losing the fundamental right to speak for themselves. Movement leaders insist that anyone who survives psychiatric treatment is uniquely qualified to speak, write and bear witness to those experiences. Increasingly, survivors have demanded a place in policy, practice and research discussions affecting their lives. Adopting a slogan of the South African disability rights movement, survivors continue to call for 'Nothing about us without us!'*

1.2 Distinctive Features

Mental health Consumer–run Organigations (CROs) are a low-cost, evidence-based strategy for promoting recovery. To increase CRO utilization, characteristics that promote engagement need to be identified and encouraged.

Brown and Townley's study (fFor more information, see [5]) examined individual and organizational characteristics that predict three types of engagement in CROs—attendance, leadership involvement, and socially supportive involvement. Methods: Surveys were administered to 250 CRO members attending 20 CROs. Leaders of each CRO reported organizational characteristics through a separate questionnaire. Multilevel regression models examined relationships between predictors and indicators of CRO engagement. Results: Perceived sense of community was the only characteristic that predicted attendance, leadership involvement, and socially supportive involvement ($p<.001$). Perceived organizational empowerment, shared leadership, peer counselling, and several demographic characteristics also predicted some measures of engagement. Conclusions: CROs that can effectively promote sense of community, organizational empowerment, shared leadership, and peer counselling may be better able to engage participants. The document considers several strategies to enhance these characteristics, such as collectively establishing values and practicing shared decision making.

1.3 Core Values

1.3.1 Shared Leadership **owned, controlled and operated** in the context of consumer-run organizations (CRO), refers to a collaborative approach where leadership responsibilities and influence are distributed among multiple individuals within the organization. It's a key principle of CROs, which are owned, controlled, and operated by the individuals who use the services they provide, often in the mental health field. Shared leadership encourages team members to take responsibility for tasks and value the contributions of all members. In essence, shared leadership in a consumer-run organization emphasizes the collective strengths and experiences of its members, promoting an environment of mutual respect, support, and empowerment. It shifts from a traditional hierarchical model to a more collaborative and participatory structure where everyone has a voice and the opportunity to contribute to the organization's success, *[2], [6].*

1.3.2 Empowerment CROs are fundamentally structured around a set of core values [4] that distinguish them from traditional, professionally led mental health programs. At the heart of these values is empowerment. In these settings, individuals are not merely passive recipients of care but are recognized as experts in their own lived experiences. This model places consumers at the centre of decision-making, giving them the agency to shape services that best meet their needs. Empowerment in this context challenges traditional power hierarchies and fosters a sense of ownership over the recovery process.

1.3.3 Autonomy closely tied to empowerment is autonomy**.** By encouraging self-determination, consumer-run services support an environment where individuals can independently chart their paths toward recovery. Autonomy asserts that each person's journey is unique, and that the best outcomes are achieved when decisions are made by those who experience the challenges firsthand. This self-directed approach contrasts sharply with conventional

models, where professionals often prescribe treatment paths without the same degree of consumer input.

1.3.4 Mutual support is another critical pillar of CROs. Building on the idea that shared experiences and collective wisdom are powerful tools for healing, these services foster environments where consumers support one another. Peer-led groups and networks facilitate an exchange of ideas and coping strategies that can diminish feelings of isolation, reduce stigma, and promote community resilience. The reciprocal nature of mutual support reinforces the belief that everyone has both something to gain from and something to contribute to the group.

1.3.5 Recovery orientation finally, the recovery orientation shifts the focus from managing symptoms to cultivating hope, resilience, and overall well-being. Rather than emphasizing deficits or illness, a recovery-oriented approach aims to build on strengths, resourcefulness, and the capacity for growth. This perspective helps individuals to envision a future beyond illness, which is a critical component in sustaining long-term recovery.

Research and policy analyses have consistently underscored that when these core values are effectively integrated into service design and delivery, there is a notable improvement in mental health outcomes, including enhanced self-esteem, increased satisfaction with services, and a greater sense of community belonging

2. Historical Context and Evidence Base

2.1 Early Research

Brown and Rogers' research [7] reviews the impact of CROs on transformative change in mental health. The research traces the history of mental health self-help and psychiatric survivor movements and shows how these led to the creation of CROs. Through hard-fought battles, CROs are now a normal part of the US mental health landscape. The chapter reviews the theoretical foundations of CROs, research on their effectiveness, and best practices for the promotion of transformative change, including the creation of empowering and socially supportive environments and policy and community change. It concludes by providing future directions for transformative change in and with CROs. CROs can serve as important complements to mainstream services or as alternative settings for those who view mainstream services as oppressive [8]. As such, CROs can function as mediating organizations or sites of resistance from which larger social change for mental health consumers can be made.

2.2 SAMHSA's Contributions

SAMHSA has collaborated with federal, state, tribal, territorial, and local partners including peer specialists to develop the National Model Standards for Peer Support Certification, inclusive of substance use, mental health, and family peer certifications. These National Model Standards closely align with the needs of the behavioral health (peer) workforce, and subsequently, the over-arching goal of the national mental health strategy, [9].

2.3 Peer Work Leadership Statement of Intent

Peer work leaders from Queensland, Victoria and NSW and colleagues from the USA participated in an International Initiative for Mental Health Leadership match [10], [11], in Brisbane on 27 & 28 February 2017.

The Australian peer work leaders resolved to issue a 'Statement of Intent' [12] that would communicate our intention to form a national professional association for the Australian mental health consumer peer workforce. We feel that such a statement is necessary to provide the focus for national consultations to occur that will lead to the development of a peer-run organisation that can support and sustain the development of the peer workforce across all sectors.

The 'Statement of Intent' is supported by the international peer work leaders who attended the match – Gary J Parker, Executive Director Kansas Consumer Advisory Council for Adult Mental Health and Sherry Tucker, Executive Director Georgia Mental Health Consumer Network. Both Kansas and Georgia offer certified peer specialist training, certification and support.

3. The Evolution of the Consumer Movement

3.1 Global Milestones

*3.1.1 1970s – The Emergence of the Movement***:** In the United States, the roots of the CRO movement can be traced back to the grassroots self-help and consumer advocacy movements of the 1970s. During this period, people with lived mental health experiences began to gather in small peer-led groups. These groups challenged prevailing professional hierarchies and promoted the idea that consumers could not only shape their own recovery but also redesign mental health services to be more empowering [2].

3.1.2 1980s – Formalization of Consumer-Run Organizations: The 1980s saw the evolution of these grassroots groups into more organized structures. Early consumer-run organizations, born out of a drive for autonomy and mutual support, started to formalize their operational practices. Research and early policy documents from this period began to document the unique benefits—such as improved self-esteem and community integration—provided by these consumer-led initiatives [13].

3.1.3 1990s – Recognition and Policy Engagement: By the 1990s, CROs had gained broader recognition among policymakers and mental health professionals. Formal evaluations and increased public awareness led to a more nuanced understanding of how these services contributed to rehabilitation and recovery. This era marked a turning point where consumer-run models were increasingly cited in research and integrated into mental health reform discussions (for more information – see [13]).

3.1.4 2000s and Beyond – Expansion and Global Networking: In the new millennium, international advocacy efforts and global conferences further catalysed the CRO movement. Consumer-run services began to spread across various regions including parts of Europe, Asia, and the Middle East. The global exchange of ideas and best practices helped emphasize the collective values of empowerment and recovery, setting the stage for more localized adaptations in other countries.

3.2 Australian Milestones

3.2.1 Early 1990s – Initiation in Australia: Inspired by progressive developments abroad, Australia started to experiment with consumer-run models

in the early 1990s. Initial pilot projects and community-based initiatives laid the groundwork, introducing the core tenets of consumer empowerment and peer support to local mental health services.

3.2.2 2000s – Consolidation and Advocacy: During the 2000s, consumer-run organizations in Australia began to consolidate their efforts and engage more actively in policy dialogues. These organizations emerged as vital players in the mental health landscape by pushing for service reforms that aligned with recovery-oriented practices. Advocacy materials like *The Kit: The Advocacy We Choose to Do* [14] have played an influential role in articulating the principles and practical challenges of running consumer-led services, thereby reinforcing the movement's legitimacy.

3.3 Recent Developments – Innovative Adaptations and Policy

*3.3.1 Integration***:** more recently, models that are similar to SUPER CRO have demonstrated how the consumer-run ethos can be successfully adapted to the Australian context. Recent milestones include greater integration of consumer-run services into state and national mental health policies, alongside growing partnerships with academic and advocacy groups. These developments reflect a maturing movement that is continuously learning from international experiences while tailoring innovations to meet local needs [15].

3.3.2 Significance of These Milestones

The evolution of the CRO movement—from the grassroots beginnings in the 1970s to today's integrated service models—highlights a transformative journey. Globally, milestones reflect the shift from passive receipt of care to active consumer participation and empowerment. In Australia, these milestones underscore an ongoing commitment to adapting international best practices while advocating for locally relevant reforms. This chronology not only charts historical progress but also illustrates the dynamic interplay between advocacy and practical innovation in mental health service delivery.

3.4 Policy Shifts and Recognition

Mental health policy reform (for example – see [16]) globally has taken a transformative turn over the past few decades. Traditionally, mental health care was largely dominated by biomedical models and institutional care [17] [18], which often sidelined the voices of those with lived experience. However, a significant policy shift is evident as governments and international agencies now emphasize community-based, recovery-oriented frameworks that actively incorporate consumer perspectives. For example, the World Health Organization's blueprint for mental health policy and law reform calls for care systems that are rooted in human rights, autonomy, and inclusion, thereby setting a global agenda that is at the forefront of consumer-led initiatives.

In Australia, these policy shifts have been equally impactful (for example, see [19]). National mental health strategies and reform initiatives have progressively moved away from a solely clinically driven model [20]. Rather, reform efforts now rely on various policy levers—such as regulation, financing, and community education—to foster environments that promote consumer empowerment and peer support. An analysis of policy levers used in Australia over the past two decades reveals that consumer-run services have increasingly been recognized as critical partners in delivering effective mental health care. Key policy documents

and reform analyses underscore that integrating the perspectives of CROs not only improves service quality and accountability but also enhances overall consumer outcomes [21].

Advocacy and grassroots initiatives have played a pivotal role in bringing about these policy changes. Efforts encapsulated in advocacy resources like *The Kit: The Advocacy We Choose to Do* [14] illustrate how sustained public education, lobbying, and strategic partnerships have amplified the voice of mental health consumers. These advocacy campaigns have directly contributed to policy reforms by highlighting the benefits of mutual support, self-determination, and community engagement. As a result, both local and international stakeholders now increasingly view CROs as central to constructing mental health systems that are responsive, inclusive, and recovery oriented (for more information [22]).

3.5 Challenges Faced

3.5.1Peer Drift in a consumer-run organization, particularly within the mental health field, peer drift (also known as co-opting) refers to a deviation from the core principles and values that distinguish peer support work from traditional clinical or medical-model approaches. Essentially, peer drift occurs when a peer professional's responsibilities or approach to support begin to shift away from their authentic, recovery-oriented role and toward a more clinical or directive style. Key Characteristics of Peer Drift:

- Shift towards a medical treatment-oriented position: This can involve focusing on symptoms and diagnoses rather than the individual's recovery journey and personal strengths.
- Encouraging adherence to advice: Instead of supporting individuals in making their own decisions, peer professionals might lean towards telling people what to do.
- Drifting into a clinical role: Peer professionals might adopt a more clinical approach or be tasked with duties better suited for clinical providers.
- Taking on a hierarchical position: The relationship may become less structured and more hierarchical, where the peer professional acts as a coach, sponsor, or counselor, rather than a peer.
- Drifting into menial tasks: Peer professionals may be assigned tasks that are not aligned with their intended peer support duties.
- Boundary issues: Lax boundaries can lead to a less structured and potentially less supportive relationship with the individual.
- Causes of Peer Drift:
- Peer drift can be caused by various factors, including:
- Role confusion and ambiguity: Unclear definitions of peer roles and duties can contribute to drift.
- Marginalization of peer professionals: Non-peer colleagues or the organizational structure may marginalize peer support workers, leading them to be assigned tasks that don't align with their intended duties.
- Feeling uneasy in the peer role: Peer professionals might transition towards more medical or clinical positions if they don't feel comfortable in their recovery-oriented role.

- Influence of the environment: Working in a traditional behavioral health or medically-oriented setting can lead peer support workers to adopt a more clinical approach.
- Consequences of Peer Drift:
- Peer drift can be detrimental to the effectiveness of peer support services and can have negative consequences for both the organization and the individuals they serve, including:
- Loss of unique benefits of peer support: The deviation from peer values and standards can reduce the positive impact of peer support on individuals' recovery and well-being.
- Reduced trust in peer support: When peer support workers are perceived as adopting clinical roles, it can erode trust in their ability to provide authentic peer support.

3.5.2 Stigma and Professional Resistance one of the most persistent challenges for CROs is the stigma and scepticism that exist within traditional mental health care systems. Many conventional providers are often reluctant to fully endorse peer-led initiatives because of deeply entrenched views regarding "professional expertise." This scepticism can manifest in reduced funding opportunities, limited referral networks, and an overall hesitance to integrate consumer-led services into mainstream care infrastructures (for more information – see [2]). Such resistance not only hampers acceptance but also perpetuates myths about the efficacy of services driven by lived experience.

3.5.3 Funding and Sustainability Issues CROs frequently operate with constrained budgets and inconsistent financial backing. Lacking the robust funding streams available to traditional services, many consumer-run organizations must rely on short-term grants or local fundraising efforts. This financial instability presents challenges in maintaining high-quality services, scaling operations, and investing in long-term training for peer facilitators. The chronic underfunding also limits the ability of CROs to engage in continuous quality improvement, research, and evidence-based practice development (for example – see [13]).

3.5.4 Regulatory and Governance Barriers in many jurisdictions, the regulatory framework is not well adapted to the unique operational models of CROs. Ambiguous guidelines and inconsistent certification standards can create significant operational hurdles. Moreover, balancing the need for governance and accountability with the ethos of consumer empowerment is often challenging. Many CROs struggle to align their democratic, non-hierarchical structures with regulatory requirements that were designed for traditional, professionally managed service organizations [23]. Such incongruities can delay program approvals and complicate efforts to secure sustained, institutional-level support.

3.5.5 Operational and Organizational Challenges internally, CROs face additional challenges in building and maintaining capacity. Many consumer-run services depend heavily on the dedication of peer facilitators who, while rich in lived experience, may not always have formal training or access to continuous professional development. High turnover, role ambiguity, and burnout among volunteer staff can undermine service stability and quality. Moreover, as CROs expand, ensuring fidelity to the core values of empowerment and mutual support

while implementing standardized practices becomes a delicate balancing act (for more information - see [13], [24]).

3.5.6 Integration with Established Systems Lastly, integrating CROs within the broader mental health ecosystem remains a complex issue. Traditional service providers and policymakers may be unfamiliar [25] with or even wary of consumer-led models. This disconnect can result in fragmented care pathways and missed opportunities for comprehensive, collaborative care. The challenge is to establish effective communication and referral networks between consumer-led initiatives and conventional services, ensuring that the unique strengths of CROs are recognized and appropriately incorporated into overall care strategies (for more information – see [2], [23]).

3.6 Rise of Co-Design

3.6.1 Co-design is a collaborative process (for example, see [26]) in which service providers and users work together as equal partners to design, deliver, and improve services. Unlike traditional models, which typically maintain a clear separation between "experts" and "recipients," co-production values the unique insights and experiences of service users. This approach not only enriches service quality but also democratizes decision-making, ensuring that outcomes are more closely aligned with the actual needs and preferences of consumers.

3.6.2 Relevance to Consumer-Run Organizations CROs naturally embody the principles of co-production. In these settings, consumers—those with lived experience—are entrusted with leadership roles and directly influence how services are structured and delivered. By blurring the boundaries between service provider and service user, CROs facilitate a culture of mutual accountability and innovative problem-solving. This operational model shifts the focus from a one-way provision of care to a dynamic, collaborative exchange where every participant contributes to the process, [4].

3.6.3 The Rise and Broader Recognition of Co-design the increased prominence of co-design in public and health services can be linked to ongoing critiques of top-down, clinician-led models, which often overlook the value of experiential knowledge. Academic and policy-oriented research has underscored the benefits of adopting co-design—from enhanced consumer satisfaction to more effective and adaptable service systems. Reviews and analyses have shown that incorporating co-design into service design can lead to higher levels of engagement, improved outcomes, and greater overall service sustainability [27]. Such evidence has contributed to a broader recognition of co-design's potential, influencing policymakers and practitioners alike to consider more inclusive, collaborative approaches.

3.6.4 Implications for Future Service Innovations for CROs, the rise of co-design represents both an opportunity and a guiding framework for future innovations. As consumer-led initiatives continue to evolve, adopting co-design as a core operating principle reinforces the movement's commitment to empowerment, mutual support, and recovery orientation. Moreover, by leveraging co-design, CROs can more effectively respond to emerging challenges and tailor their programs to the complex, evolving needs of the communities they serve [28], [29].

4. Where do CRO Fit In

4.1 Contextualizing CRO's and Community Mental Health Models

There is growing recognition in the fields of public health and mental health services research that the provision of clinical services to individuals is not a viable approach to meeting the mental health needs of a population. Despite enthusiasm for the notion of population-based approaches to mental health, concrete guidance about what such approaches entail is lacking, and evidence of their effectiveness has not been integrated. Drawing from research and scholarship across multiple disciplines, this review provides a concrete definition of population-based approaches to mental health, situates these approaches within their historical context in the United States, and summarizes the nature of these approaches and their evidence. These approaches span three domains: (a) social, economic, and environmental policy interventions that can be implemented by legislators and public agency directors, (b) public health practice interventions that can be implemented by public health department officials, and (c) health care system interventions that can be implemented by hospital and health care system leaders [30].

Although numerous studies have examined the effects of community-based mental health care programs in Australia, no synthesis of this literature exists. Donalds systematic review of peer-reviewed and grey literature described the types of community-based mental health care programs delivered and evaluated in Australia in the past 20 years and evaluated their impact in improving outcomes for those with a serious mental illness (SMI) [31].

4.2 Positioning CROs

The following information is taken from an article by Schell [3]. Their research supports consumer-run services as valuable and effective. Drop-ins have the lowest threshold for participation in all consumer-run programs. There is no triage to belong to. Treatment is conversation or respect for someone who seeks silence. Participants are not required to show up at a particular time or to read classroom material. One is not considered a failure if he/she gets a cup of coffee and sits in a chair or goes to sleep on the couch. It's okay to draw or sing all day. It's okay to play games on the computer. It's okay to do absolutely nothing but think and decide what you want to do later. On the other hand, drop-ins offer the greatest opportunity for volunteer and paid work and skill development from payroll to driving to reception to arranging furniture.

5. Case Study: SUPER CRO

The start-up charity SUPERCRO Incorporated [15] is being used as an example to highlight its development in Australia as it begins to take the necessary steps to grow. Varga [32] describes it as *"a very small enterprise."* Members describe it as an organisation without walls.

The foundational members of SUPER CRO initially were composed of mental health consumers who had come together in 2006 as part of their involvement in treatment for a variety of mental health conditions at St Vincent's Hospital in Darlinghurst, Sydney. They came together on a Wednesday afternoon as the SUPER Group. SUPER is an acronym for Service Users, Participating, Educating and Researching. In 2010 two of the SUPER Groups members were supported to attend the Recovery Conference in Wichita, Kansas to observe and report back to

St Vincents what was involved in becoming an effective consumer-run organisation based on the model that has been running successfully in the United States since 1985. [3]

This research was conducted by COSP- Multisite Study, FliCA site, SAMHSA in 2003 and showed that "Unlike any service that makes up mental health services, a drop-in center is distinguished by the fact that it is not prescribed for anyone by anyone. Clients self-select to attend, and this step is an act of self-determination that accounts for the value of the enterprise." SUPERCRO Incorporated's overarching and audacious goal is to demonstrate that this model can work in Australia.

In 1991 The Australian Government gave people with a mental health condition the Statement of Rights and Responsibility [33] to be involved in the National Mental Health Strategy a 20-year plan to reform mental health services across Australia. Holmes said, [34] "seeking the views of consumers on their perceptions and experiences of public and private mental health services is vital to making those services more effective, responsive and for achieving positive mental health outcomes."

In 2016, the group created a strategic plan [35] with assistance from Gary Parker from Wichita, Kansas. In 2023, 14 of the original foundational members received the news from The Australian Charities and Not-for-profits Commission (ACNC) that it is now a Health Promotion Charity endorsed to access the following tax concessions: GST Concessions, Income Tax Exemption, FBT Exemption, and is endorsed as a Deductible Gift Recipient. The main objective for SUPER CRO's members is to determine whether it is meeting its legal obligations and to put forward recommendations on how to manage any risks, such as cyber security attacks, and using existing resources.

In May 2025 the organisation has 19 active members, as Varga [32, pp. 215] said, "*While it is possible to set up a business in a short time, a big question is how to run it successfully and profitably in the longer term".* The group has regular Zoom monthly meetings with an agenda and notes from previous meetings. Members have been following the information from the ACNC website [36] on how to set up and run a charity.

SUPERCRO Incorporated has made a start on developing several policies, including the Code of Conduct, Privacy policy, and Conflict of Interest, as these were necessary to obtain authorisation from the ACNC to gain charity status. These members will focus on identifying additional policies so that the organisation can move to the next stage of its development, and the members can be confident in SUPERCRO Incorporated's longevity.

The organisation will table its first annual report in December 2025, this report will raise awareness of the issues that McRoberts reports, [37, pp. 8], "*One of the most significant issues emerging from the establishment of the Australian Charities and Not-for-Profits Commission (ACNC) has been the introduction of graduated reporting requirements for charities".* The current Authorised Representatives of the charity are realising that to meet the minimal requirements and to move to a Micro Enterprise, as Varga describes [32] in his article, will lead to changes that some members did not realise would be necessary when they signed up as members of the organisation.

Armstrong [38] reported in 2015 "studies suggests that a more judicious approach to treating mental disorders would be to replace a "disability" or "illness" paradigm with a "diversity" perspective that considers both strengths

and weaknesses and the idea that variation can be positive in and of itself. To this end, a new term has arisen within the autism rights community: neurodiversity."

Unlike CRO's in USA that are recoginsed and funded as part of the mental health system in many of the states and territories [2] except for several small grants the majority of SUPER CRO's programs and initiatives have been funded and supported by its members to build up awareness and recognition of CRO's as a model that can be supported in Australia. Our website has a range of projects and products that members of SUPER CRO have created to support SUPER CRO to become an independent consumer-led and run entity to achieve its mission.

6. Challenges and Sustainability

6.1 Funding and Resource Access

Consumer-run organizations (CROs) in Australia face considerable challenges in establishing financial sustainability. Unlike traditional mental health services that typically secure long-term funding from established government and private sources, many CROs operate on precarious, short-term grants, philanthropic donations, and ad hoc community fundraising efforts. This funding volatility restricts the ability to plan long-term programming, invest in critical infrastructure, or provide consistent training for peer facilitators, thereby affecting the overall stability and growth of these consumer-led initiatives [21].

In Australia's competitive funding environment, traditional service providers often benefit from well-established administrative systems and historical funding relationships. As a result, CROs—whose governance is usually more democratic and reliant on volunteer contributions—are at a disadvantage when competing for conventional funding streams. To address this gap, many CROs have started exploring alternative funding avenues such as social enterprise initiatives, collaborative partnerships with local government, and innovative crowdfunding strategies. These alternative models not only provide much-needed supplemental revenue but also help diversify the funding base, reducing the risk associated with reliance on any single funding source [13].

Moreover, recent policy reforms have begun to recognize the unique value of consumer-led services in achieving a recovery-oriented mental health system. Australian government and policy reviews are increasingly advocating for funding mechanisms that support community-based and consumer-run models. However, even with this policy shift, CROs often encounter funding challenges due to stringent eligibility criteria, administrative burdens, and the need to conform to traditional reporting structures. This mismatch between the flexible, grassroots ethos of CROs and the standardized demands of funding agencies remains one of the key obstacles to securing sustainable, long-term financial support [19].

Addressing these challenges requires coordinated efforts among policymakers, CROs, and funding bodies to design more flexible funding models. Capacity-building initiatives streamlined administrative processes, and strategic partnerships that leverage both public and private investment are critical steps toward creating a secure financial foundation. Establishing such a foundation will enable CROs to retain their innovative, consumer-led approaches, ultimately contributing to a more diverse and resilient mental health service system in Australia.

6.2 Navigating Power Imbalances

One of the significant challenges that CROs face is engaging with traditional, hierarchical service providers while protecting the very principles—empowerment, autonomy, and co-production—that define their identity. Mainstream mental health settings are often structured around top–down decision making, which can sometimes undermine the consumer-led ethos that CROs aim to preserve. To counter this, several strategies have been developed and implemented.

6.2.1 Establishing Clear Boundaries and Role Definitions: A foundation for equitable collaboration requires formalizing roles through mechanisms like memoranda of understanding (MOUs) or partnership agreements [39]. These documents can clearly delineate decision-making powers and responsibilities, ensuring that consumer voices are not diluted. Formal agreements help to set expectations and reinforce that CROs retain their autonomy even as they contribute to broader service frameworks.

6.2.2 Emphasizing Co–Design as a Collaborative Model: Co–design facilitates a more balanced power dynamic by integrating consumers as equal partners in service design and delivery. Through structured frameworks that promote shared decision making, CROs and mainstream providers can create joint governance models. In this setup, both groups contribute expertise—professionals bring clinical insights while consumers contribute essential lived experiences—resulting in a partnership that is less hierarchical and more mutually accountable [27].

6.2.3 Building Capacity Through Training and Empowerment Workshops: To better equip consumer representatives for collaborative engagements, dedicated training on power dynamics, implicit bias, and negotiation techniques can be invaluable. Such capacity–building initiatives not only reinforce the confidence of CRO members but also provide them with the skills needed to assert their perspectives effectively during inter–organizational meetings. This approach helps to level the playing field and reduce the risk of dominance by established service providers [40].

6.2.4 Utilizing Independent Facilitation or Mediation: occasionally, a neutral mediator can be instrumental in ensuring balanced participation during collaborative efforts. An independent facilitator can oversee meetings, manage disagreements, and make sure that all voices are heard without compromising the autonomy of the CRO. This method of conflict resolution can pre-emptively address potential power conflicts before they escalate, thereby preserving the integrity of consumer-led input [2].

Collectively, these strategies help CROs navigate the inherent power imbalances when interfacing with mainstream services. By enforcing clear guidelines, embracing co–production, investing in training, and occasionally relying on neutral facilitation, CROs can maintain their core values and continue to drive innovative, recovery–oriented practices even within larger, more hierarchical systems.

6.3 Capacity Building and Burnout

CROs often operate within resource-constrained environments where staff and volunteer burnout are a significant risk. Effective capacity building and robust staff development initiatives are critical not only for individual well-being but also for sustaining organizational resilience and long-term service quality.

6.3.1 Capacity Building and Staff Development for CROs, capacity building involves creating opportunities for professional development, mentoring, and skill-sharing among staff and volunteers. Regular training sessions, workshops on effective service delivery, and peer-supervision models can enhance the skills needed to navigate complex organizational challenges. These approaches not only empower staff to deliver high-quality, recovery-oriented services but also promote a culture of continuous learning—essential in environments where resources may be limited. For example, peer-led training and collaborative problem-solving sessions are instrumental in reinforcing a shared vision and ensuring that the principles of consumer autonomy and mutual support remain central to service delivery [41].

6.3.2 Burnout Prevention Strategies The emotionally demanding nature of delivering mental health services means that burnout is a constant threat. Burnout among staff is characterized by chronic physical and emotional exhaustion, cynicism toward one's work, and reduced professional efficacy. To mitigate these risks, CROs have adopted several strategies:

6.3.3 Structured Work Processes: Implementing clear work schedules and realistic caseloads can prevent overextension.

6.3.4 Wellness Programs: Initiatives such as mindfulness training, stress-management workshops, and resilience-building practices help individuals develop personal recovery routines that complement organizational safety nets.

6.3.5 Access to Support Networks: Continuous access to mentoring, peer support groups, and external counselling services ensure that employees do not face challenges in isolation [42].

6.3.6 Ensuring Organizational Resilience Organizational resilience is achieved when there is a robust interplay between capacity building and burnout prevention. By developing training programs that incorporate stress-management techniques and by establishing flexible staffing models, CROs can remain agile in the face of evolving service demands. Regular evaluation of staff workload, the incorporation of feedback mechanisms, and the nurturing of leadership skills within the team all contribute to a resilient organization. Such practices not only mitigate the risk of burnout but also ensure that the organization remains adaptive, sustainable, and true to its consumer-led ethos even when faced with transient funding or operational challenges [43].

Together, these components form the backbone of an enduring consumer-run organization structure—one that prioritizes staff well-being and, by extension, enhances service delivery. When CROs invest in such comprehensive capacity building and burnout prevention strategies, they not only boost individual resilience but also secure the organizational strength necessary to drive long-term community impact.

6.4 Succession Planning

Effective succession planning is critical to the long-term stability and vitality of consumer-run organizations (CROs). In these organizations, which are founded on principles of empowerment, mutual support, and recovery orientation, leadership transitions must be managed carefully to preserve not only institutional memory but also the unique consumer-led culture that defines them. Abrupt gaps or poorly managed transitions can undermine trust, disrupt service continuity, and erode the foundational ethos that drives these organizations.

Evidence from SAMHSA supports the notion that continuity in leadership is a key element of successful CROs. In its report, *Consumer-Operated Services: The Evidence*, SAMHSA emphasizes that robust internal governance—of which succession planning is a central component—is essential to achieving positive service outcomes and maintaining the integrity of consumer-led practices [2]. By preparing emerging leaders through formal mentoring, training, and structured internal processes, CROs can better ensure that the wealth of experiential knowledge and the consumer-focused approach are transmitted without dilution during leadership transitions.

A proactive succession planning strategy typically involves several core components:

6.4.1 Structured Mentoring and Training Programs: These initiatives help cultivate leadership skills among consumers by pairing emerging leaders with experienced mentors and providing targeted training in areas such as strategic planning, governance, and stakeholder engagement.

6.4.2 Formalized Leadership Transition Processes: Establishing clear policies, role definitions, and protocols for transferring responsibilities ensures that organizational momentum is not lost during leadership changes.

6.4.3 Inclusive Decision-Making Models: Incorporating co-production principles into the leadership transition process ensures that all voices are represented, reinforcing the democratic, peer-led nature of CROs.

By integrating these approaches, CROs can minimize disruptions during leadership changes, thereby sustaining their organizational momentum and reinforcing the stability necessary for long-term impact. In essence, effective succession planning enables consumer-run organizations not only to survive periods of leadership change but also to thrive by continually renewing their commitment to consumer empowerment and recovery-oriented service delivery.

7. Policy and Advocacy Perspectives

7.1 Influencing Systems Change

CROs have rapidly evolved from grassroots initiatives into influential agents in driving mental health reform [13]. By centering on peer support, empowerment, and recovery-oriented practices, CROs challenge traditional, top–down service models and help reshape mental health systems toward more inclusive and person-centred care [40].

7.1.1 Catalysts for Reform

One of the most significant impacts of CROs is the way they redefine service delivery. By actively involving consumers in the design, implementation, and evaluation of services, CROs help ensure that mental health systems are aligned with the needs of those who use them. Evidence from the SAMHSA report, *Consumer-Operated Services: The Evidence*, highlights that consumer-led initiatives not only improve individual outcomes but also foster more responsive and innovative mental health service ecosystems [2]. This consumer-empowerment model has been identified as a key catalyst in moving from traditional, clinician-dominated frameworks toward recovery-oriented systems. Hopefully CRO's will be considered as part pf the reform package for the unmet need outside the National Disability Insurance Scheme [25].

7.1.2 Bridging Gaps Between Policy and Practice

CROs play a vital role in bridging the gap between policy intent and clinical practice. Their advocacy efforts and operational successes have informed policy reforms that increasingly emphasize community-based and recovery-focused care. For instance, SAMHSA's expert panel on "Operationalizing Recovery-Oriented Systems" provides a framework that underscores the importance of integrating consumer-led components into broader mental health strategies [44]. By highlighting successful outcomes and demonstrating the feasibility of alternative models, CROs provide policymakers with evidence-based examples that support legislative, and funding reforms aimed at decentralizing mental health care and reducing reliance on institutional settings.

7.1.3 Influence on Systemic Structures

The influence of CROs extends beyond service delivery to the very structure of mental health systems. CRO-led initiatives have been instrumental in advocating for inclusive governance and participatory decision-making, which are now increasingly recognized as essential for sustainable reform. Integrating peer support roles and co-production principles into service models not only improves accountability but also helps to dismantle entrenched power imbalances in mental health care. In this way, CROs contribute to a broader shift in systems thinking—from one that is predominantly hierarchical to one that values shared leadership and collaborative problem-solving.

7.1.4 Driving Change Through Lived Experience

Fundamentally, CROs leverage the power of lived experience to drive systemic change. The firsthand insights of mental health consumers provide a credible basis for challenging outdated service paradigms and promoting practices that are truly recovery oriented. This grassroots input has influenced policy shifts at both local and international levels. As CROs continue to demonstrate their effectiveness, they increasingly serve as models for integrated, person-centred service delivery that is adaptable across various cultural and systemic contexts.

7.2 Lived Experience in Policymaking

7.2.1 Incorporating Lived Experience into Policy Design modern mental health reform increasingly recognizes that policies are most effective when they are grounded in the realities of those most affected by them. Individuals with lived experience—those who have navigated mental health challenges firsthand—offer unique insights that enrich policymaking. Their contributions have been pivotal in shifting mental health strategies from a solely clinical, top–down model to one that is collaborative and recovery oriented. This shift is evidenced by the widespread integration of consumer-run organizations (CROs) into service frameworks, ensuring that policies reflect both the challenges and the resilience inherent in lived experience.

7.2.2 Evidence from the SAMHSA Library SAMHSA has long underscored the value of consumer-operated services. In its comprehensive report, *Consumer-Operated Services: The Evidence*, presents data demonstrating that services led by those with lived experience deliver improved recovery outcomes and higher consumer satisfaction [2]. This body of evidence has been influential in advocating for policies that not only acknowledge but also actively integrate the expertise that consumers bring to the table.

7.2.3 Shaping Comprehensive Mental Health Strategies, the inclusion of lived experience in policymaking has required the development of frameworks that empower individuals to participate meaningfully in decision-making processes.

For example, initiatives such as the Lived Experience Governance Framework champion a model where decision-making is shared, ensuring that policies are reflective of real-world needs while maintaining a strong human rights orientation [45]. Such models promote co-production, wherein service users and professionals work side-by-side, thereby reducing traditional power imbalances and fostering innovative, community-responsive mental health strategies.

7.2.4 Broadening the Impact of CROs When policymakers integrate lived experience into the fabric of mental health policy, it paves the way for CROs to be recognized as essential components of the service mix. Academic discussions, such as those found in recent studies published in global mental health forums, emphasize that the practical wisdom of lived experience contributes to policy robustness. These accounts stress that the partnership between consumers and traditional providers leads to policies that are more holistic, inclusive, and adaptive to community needs [46]. Ultimately, this approach results in a health system that is better positioned to deliver recovery-focused care and reduce the systemic stigma often associated with mental health challenges.

7.3 Recommendations

Embedding CROs within national mental health strategies requires a multifaceted approach that aligns policy, practice, and resource allocation with the core principles of consumer empowerment and recovery orientation. Based on evidence from the SAMHSA report [2] and related research [47], the following recommendations can guide stakeholders in effectively integrating CROs into broader mental health frameworks:

7.4.1 Formalize Representation in Policy and Governance: National mental health strategies should explicitly recognize and incorporate consumer-run organizations by including them as key partners in policy advisory committees and decision-making bodies. Establishing formal roles for CRO representatives ensures that the lived experience of mental health service users informs policy development from conception to implementation. Evidence from SAMHSA highlights how consumer-led models drive improvements in recovery outcomes, underscoring the need for their active participation at the highest levels of mental health governance [2].

7.4.2 Develop Dedicated Funding Mechanisms: To safeguard the financial sustainability of CROs and support their growth as innovators in service delivery, governments should create funding streams that are specifically allocated for consumer-led initiatives. This includes revising grant criteria to value peer support and co-production models and aligning funding cycles with the flexible, community-based approach of CROs. Incorporating these funding mechanisms into national mental health strategies can help to reduce the competitive pressures that often marginalize consumer-run initiatives in traditional funding environments [2], [13].

7.4.3 Institutionalize Co-Production and Collaborative Partnerships: Embedding CROs requires fostering environments where co-production is the norm. Establishing collaborative frameworks that unite conventional mental health providers with CROs can help balance expertise with lived experience. These partnerships should be underpinned by clear roles, shared governance arrangements, and mutual accountability. By routinely integrating consumer-led inputs into service design and evaluation, policymakers can ensure mental health reforms remain responsive to community needs [2], [13].

7.4.4 Enhance Capacity Building and Evaluation Frameworks: The integration of CROs must be complemented by strategies that build organizational capacity and evaluate performance using consumer-centred metrics. National strategies should support training programs aimed at developing leadership and management skills among CRO staff, as well as implementing performance indicators that capture the unique contributions of consumer-led services. Establishing robust evaluation frameworks will not only drive continuous improvement within CROs but also provide compelling data to inform ongoing policy development [2].

7.4.5 Facilitate Knowledge Exchange and Research Partnerships: To further legitimize and refine the integration of CROs, national strategies should encourage collaborative research initiatives that document best practices, success stories, and challenges faced by consumer-run models. Creating national forums for knowledge exchange between CROs, academic institutions, and government agencies can promote innovations in service delivery and stimulate evidence-based advocacy. Drawn from the SAMHSA evidence base, such initiatives affirm the value of consumer-led care as a transformative element of mental health reform [2].

By advancing these recommendations, stakeholders can help ensure that consumer-run organizations are not peripheral add-ons but are central to a dynamic, responsive, and recovery-oriented national mental health system.

8. Future Directions

8.1 Innovations in Consumer-Led Models

8.1.1 Digital Transformation and Mobile Health CROs are increasingly embracing digital platforms to extend their reach and improve service quality. Mobile applications and online portals now allow consumers to engage in peer support, access self-management resources, and participate in virtual support groups from anywhere. This digital shift not only enhances service accessibility but also helps overcome geographic limitations. For instance, telehealth platforms and dedicated mobile apps enable real-time communication and personalized interventions, making it easier for CROs to deliver recovery-oriented services while maintaining a consumer-led ethos [48].

8.1.2 AI, Data Analytics, and Personalized Support Emerging practices in artificial intelligence (AI) and data analytics are further transforming consumer-led models by offering predictive insights and personalized support. CROs are leveraging machine learning algorithms and AI-powered chatbots to interpret user-generated data, tailor interventions, and monitor mental health indicators continuously. These tools help create data-driven feedback loops that improve service responsiveness and effectiveness. By integrating these technologies with traditional peer support, CROs can offer both personalized care and scalable community support—enhancing overall outcomes for mental health service users [49].

8.1.3 Collaborative Digital Ecosystems and Secure Data Management In addition to direct interventions, digital ecosystems are fostering collaboration among diverse stakeholders. Platforms that integrate blockchain technology, for example, offer secure systems for maintaining sensitive consumer data and ensuring traceability in service delivery. Such innovations support co-production models where consumers, clinicians, and administrators can share information securely, collaborate in decision-making, and contribute to continuous service

improvement. These decentralized and transparent systems help democratize mental health care by reinforcing consumer autonomy and protecting privacy [13].

8.1.4 Supporting a New Era of Consumer-Led Practices The convergence of these emerging technologies is redefining what is possible in consumer-led mental health services. Innovations are not limited to technological tools alone but extend to the development of new service delivery frameworks—such as virtual communities, online training and capacity-building platforms, and integrated feedback systems—which empower consumers in unprecedented ways. In doing so, they significantly enhance the scalability, responsiveness, and resilience of CROs. By harnessing these digital advances, CROs can continue to evolve into more agile, data-informed, and community-responsive organizations that stand at the forefront of modern mental health reform.

8.2 Scaling and Replication

In 2015, SAMHSA led an effort to identify the critical knowledge, skills, and abilities (leading to Core Competencies) needed by anyone who provides peer support services to people with or in recovery from a mental health or substance use condition. SAMHSA—via its Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) project—convened diverse stakeholders from the mental health consumer and substance use disorder recovery movements to achieve this goal. SAMHSA, in conjunction with subject matter experts, conducted research to identify Core Competencies for peer workers in behavioral health. SAMHSA later posted the draft competencies developed with these stakeholders online for comment, [41].

8.3 Integration into Health Systems

CROs have demonstrated significant potential to complement traditional mental health services by fostering peer support, empowerment, and recovery orientation. To ensure these benefits are realized on a systemic level, it is essential to adopt strategies that integrate CROs within existing community mental health frameworks. The following approaches—supported by evidence from the SAMHSA library and additional research—offer a roadmap for achieving such integration.

8.3.1 Formal Collaborative Structures and Partnership Agreements a foundational strategy is the establishment of formalized collaborative structures between CROs and mainstream service providers. This can be achieved through memoranda of understanding (MOUs) and joint governance committees that clearly define roles, responsibilities, and decision-making processes. Such formal agreements help overcome traditional power imbalances and ensure that both consumer-led initiatives and conventional clinical services work synergistically. Evidence from the SAMHSA report on consumer-operated services underscores the benefits of structured collaboration in enhancing recovery outcomes and system responsiveness [2].

8.3.2 Co-location and Integrated Service Delivery integrating CROs into health systems can be further supported by co-location strategies. By situating CROs alongside primary care clinics, outpatient mental health centres, or community health hubs, service users benefit from streamlined access to both peer support and professional care. This model not only promotes continuity of care but also facilitates the development of multidisciplinary teams where consumer insights inform clinical practices. Research into integrated mental

health models highlights that co-location can reduce fragmentation of services and improve overall mental health outcomes [49].

8.3.3 Inclusion in Policy Formulation and Decision-Making for sustainable integration, it is critical that CROs are represented in policy development and strategic planning at local and national levels. Including consumer representatives on mental health advisory boards and within governing bodies ensures that lived experience directly influences service design and resource allocation. Such inclusive governance models have been associated with higher levels of consumer satisfaction and improved system accountability, as noted in studies evaluating the impact of peer-led initiatives on mental health reform [13].

8.3.4. Capacity Building and Collaborative Training Initiatives to support effective integration, ongoing capacity building is essential. Joint training programs that bring together CRO staff, clinical personnel, and administrative leaders can promote mutual understanding and strengthen collaborative practices. These programs may focus on shared governance, quality improvement, and culturally responsive care. By investing in capacity building, organizations reinforce the legitimacy of the consumer-led model and create opportunities for innovation in service delivery.

8.3.5. Development of Coordinated Funding Mechanisms securing sustainable funding is a perennial challenge for CROs. Policymakers and funding bodies should consider creating dedicated financial streams that align with integrated community care models. Coordinated funding mechanisms that link public and private investments can help bridge the resource gap often experienced by consumer-led organizations. Such financial strategies not only facilitate integration but also empower CROs to innovate and expand their services.

Through these strategies—formal partnerships, co-location, inclusive governance, capacity building, and coordinated funding—CROs can be positioned as essential components of community mental health services. This integrated approach supports a more holistic, accessible, and recovery-oriented mental health system that leverages the unique strengths of consumer leadership.

9. Conclusion

9.1 Reaffirming CROs' Importance

CRO's stand apart by centering mental health reform on the strengths and realities of those with lived experience. Unlike traditional service models that often emphasize clinical expertise and top–down approaches, CROs leverage peer support, collaborative governance, and firsthand insights to drive more inclusive and effective care.

Empowerment and Peer-Led Engagement at the core of CROs is the principle of empowerment. By positioning consumers as active decision-makers rather than passive recipients of care, these organizations foster an environment where personal recovery is both the goal and the mechanism for change. The peer-led nature of CROs not only improves service accessibility and satisfaction but also challenges longstanding power imbalances in mental health care delivery [2]. This empowerment leads to enhanced self-determination and fosters recovery processes that are tailored to individual needs.

Redefining Service Delivery and System Responsiveness CROs have significantly contributed to reframing mental health services from a predominantly clinical model to one that values recovery orientation and

community support. By integrating lived experience into service design and evaluation, CROs provide innovative models that are more responsive and adaptive to diverse user needs. Their approaches have informed policy reforms by demonstrating that consumer-led services can drive better recovery outcomes, resulting in a more holistic mental health system [2], [13]. Through co-production models, CROs facilitate a two-way exchange of information between service users and professionals, thereby creating more balanced, accountable, and effective systems of care.

Catalyst for Broader Policy Change and Cultural Shift beyond transforming service delivery, CROs serve as catalysts for a broader cultural and policy shift in mental health reform. Their successes have underscored the value of integrating consumer voices in policymaking, promoting initiatives designed to decentralize decision-making and enhance accountability. This shift has contributed to the establishment of policies that are better aligned with the real-world experiences of those who use mental health services, thereby leading to systemic changes that support sustainable recovery-oriented care [13].

Evidence-Based Impact and Ongoing Innovation the effectiveness of CROs is further validated by studies showing improved clinical and social outcomes compared to traditional models. For example, evidence compiled in SAMHSA's report, *Consumer-Operated Services: The Evidence*, indicates that consumer-run approaches generate substantial benefits in self-esteem, community integration, and overall recovery [2]. This growing evidence base continues to inspire new innovations in service design, financing, and collaborative research, steadily solidifying the role of CROs as indispensable components of modern mental health systems.

9.2 Call to Action

CROs have emerged as vital agents in reshaping mental health care by centering peer support, lived experience, and recovery-oriented practices. The evidence compiled in the SAMHSA report demonstrates that CROs deliver enhanced recovery outcomes, greater service satisfaction, and improved community integration [2]. Despite these positive outcomes, CROs often face challenges related to funding, integration, and organizational capacity that limit their full impact.

To harness the transformative potential of CROs, it is crucial that stakeholders—ranging from policymakers and funding agencies to community organizations and academic institutions—extend their support through the following actions:

9.2.1 Embed CROs in National Health Strategies: national mental health frameworks must recognize CROs as essential contributors to service delivery. This involves formalizing their role in policy advisory boards and decision-making bodies to ensure that consumer perspectives influence the design and implementation of mental health reforms [13] [47].

9.2.2 Develop Sustainable Funding Mechanisms: creating targeted funding streams is essential for the long-term viability and growth of CROs. By establishing flexible investment models that appreciate the unique benefits of consumer-led services, funding bodies can help CROs scale operations, invest in capacity building, and innovate continuously. In doing so, the financial sustainability of CROs will reinforce a broader shift towards recovery- and community-focused mental health care [2], [13], [19].

9.2.3 Strengthen Research and Knowledge Exchange: Encouraging collaborative research partnerships among CROs, academic institutions, and traditional mental health providers will further substantiate the evidence base for consumer-led care. Regular dissemination of best practices and outcomes through national forums can facilitate knowledge exchange and foster innovation across service models.

9.2.4 Promote Collaborative Governance and Capacity Building: Empowering CROs through structured capacity building—such as mentorship programs and joint training initiatives—ensures that they are well positioned to maintain their consumer-led ethos even within integrated service frameworks. This approach not only bolsters service quality but also bridges gaps between diverse mental health service models.

By taking these steps, stakeholders will not only invest in the sustainability and expansion of CROs but also contribute to a more inclusive, innovative, and recovery-oriented mental health service ecosystem. The time is ripe for decision-makers to recognize and endorse the unique contributions of consumer-run organizations as cornerstones in the future of mental health reform.

Conclusion(s)

This chapter has explored the transformative impact of consumer-run organizations on mental health reform. The discussion highlighted the evolution of CROs—from grassroots initiatives that emerged out of the self-help and recovery movements to sophisticated models that are informing contemporary mental health policy. By integrating core values such as empowerment, autonomy, mutual support, and a deep commitment to recovery orientation, CROs challenge traditional, clinician-driven service models and foster environments where lived experience is valued as a vital source of wisdom.

We examined international and Australian milestones that chart the growth of the consumer-led movement, illustrating how shifts in policy and practice have recognized the importance of consumer engagement in modern mental health services. The chapter also addressed the hurdles that CROs face—ranging from funding instability and regulatory challenges to internal capacity issues—while offering strategies to mitigate these obstacles through co-production, enhanced collaboration with traditional services, capacity building, and succession planning.

Emerging innovations, including digital transformation and data-driven personalized care, are positioning CROs at the forefront of mental health service innovation. Moreover, the integration of CROs into broader health systems and the call for a collaborative, investment-driven approach underscores the ongoing evolution of mental health care toward a model that privileges inclusivity, recovery, and consumer empowerment.

In summary, consumer-run organizations not only provide an essential complement to conventional mental health services but also serve as catalysts for systemic change. Their unique contributions—rooted in lived experience and democratic participation—offer a compelling vision for a future where mental health care is more responsive, equitable, and sustainable. By embracing these innovative models and supporting their growth, stakeholders can help create a mental health system that truly reflects the needs and aspirations of the communities it serves.

Conflict of Interest

The authors declare no conflict of interest

References

[1] Chamberlin J, *On Our Own*. McGraw Hill, 1978.

[2] SAMHSA, "Consumer-Operated Services: The Evidence," vol. HHS Pub. No. SMA-11-4633, 2011. [Online]. Available: https://library.samhsa.gov/sites/default/files/sma11-4633-the-evidence.pdf.

[3] B. Schell, "Program Manual for a Consumer-Run Drop-In Center," 2003. Accessed: 7 April 2025. [Online]. Available: https://auspwn.wordpress.com/wp-content/uploads/2014/05/drop_in_program_manual.pdf

[4] D. Penney and L. Prescott, "The co-optation of survivor knowledge: The danger of substituted values and voice," in *Searching for a rose garden: Challenging psychiatry, fostering mad studies.* Ross-on-Wye, England: PCCS Books, 2016, pp. 35-45.

[5] L. D. Brown and G. Townley, "Determinants of Engagement in Mental Health Consumer–Run Organizations," *Psychiatric Services,* vol. 66, no. 4, pp. 411-417, 2015, doi: 10.1176/appi.ps.201400150.

[6] S. P. Segal and S. L. Hayes, "Consumer-run services research and implications for mental health care," (in eng), *Epidemiol Psychiatr Sci,* no. 2045-7960 (Print), 2016.

[7] L. D. Brown and S. Rogers, "The Impact of Mental Health Consumer-Run Organizations on Transformative Change," in *Community Psychology and Community Mental Health: Towards Transformative Change*, G. Nelson, B. Kloos, and J. Ornelas Eds.: Oxford University Press, 2014, sec. Oxford Academic, pp. 0.

[8] C. C. Vu, "CROs as activity settings: The impact of peer support and setting resource characteristics on member participation and sense of community," 2014. [Online]. Available: https://www.semanticscholar.org/paper/CROs-as-activity-settings%3A-The-impact-of-peer-and-Vu/e8fd1001df30193dd3cdbfe6248285606cb27642

[9] SAMHSA'. "SAMHSA's National Model Standards for Peer Support Certification." https://library.samhsa.gov/sites/default/files/pep23-10-01-001.pdf accessed 20 mARCH 2025.

[10] S. Appleton. "The International Initiative for Mental Health Leadership." https://gle.world/ accessed 1 June 2025.

[11] F. Quilan. "Speaking frankly." https://mhaustralia.org/civicrm/mailing/view?reset=1&id=788 accessed 13 June 2025.

[12] Eschleigh Balzamo, Jenna Roberts, Sage Green, Tim Heffernan, Sherry Tucker, and Gary Parker, "Peer Work Leadership Statement of Intent A National Professional Association for Mental Health Peer Workers," ed, 2017.

[13] S. Segal and S. Hayes, "Consumer-run services research and implications for mental health care," *Epidemiology and psychiatric sciences,* vol. -1, pp. 1-7, 04/27 2016, doi: 10.1017/S2045796016000287.

[14] Commonwealth Department of Health and Family Services, *The kit - a guide to the advocacy we choose to do : a resource kit for consumers of mental health services and family carers*. Canberra :: Commonwealth Department of Health and Family Services, , 1998.

[15] D. Holmes. "Welcome to Our New Website for SUPER CRO Incorporated." https://www.supercro.com/ accessed 16 March 2025.

[16] Dr Michelle Funk. "WHO blueprint for mental health policy and law reform: The urgent need for policy and law reform in mental health." https://www.who.int/news-room/commentaries/detail/who-blueprint-for-mental-health-policy-and-law-reform accessed 23 May 2025.

[17] M. Goddard, "The Policy Post," in *The great mental health experiment … and why it went so wrong.*, ed, 2025.

[18] C. J. Francis, A. Johnson, and R. L. Wilson, "The personal cost of repetitive mental health inquiries that fail to result in change," *Collegian,* vol. 29, no. 5, pp. 728-737, 2022/10/01/ 2022, doi: https://doi.org/10.1016/j.colegn.2022.05.001.

[19] Mental Health Australia. "Incoming Government Brief: Mental Health portfolio." https://mhaustralia.org/sites/default/files/docs/incoming_government_brief_-_mental_health_australia_-_may_2025.pdf?mc_cid=2a91a9aaa7&mc_eid=2d92760ab9 accessed 26 May 2025.

[20] J. Mendoza, S. Rosenberg, and K. Griffiths, "Obsessive Hope Disorder: Reflections on 30 Years of Mental Health Reform and Visions for the Future. Summary Report," 978-0-9922842-3-7, 2013. Accessed: 1 June 2025. [Online]. Available: https://www.researchgate.net/publication/328628737_Obsessive_Hope_Disorder_Reflections_on_30_Years_of_Mental_Health_Reform_and_Visions_for_the_Future_Summary_Report

[21] F. C. Grace *et al.*, "An analysis of policy levers used to implement mental health reform in Australia 1992-2012," (in eng), *BMC Health Serv Res,* vol. 15, pp. 479, Oct 24 2015, doi: 10.1186/s12913-015-1142-3.

[22] I. Thompson. "What's next for mental health policy reform?" https://nousgroup.com/insights/mental-health-policy-reform/?r=AU accessed 23 May 2025.

[23] W. H. Organization. "Mental Health Policy and Service Guidance Package." https://www.who.int/publications/i/item/9241546468 accessed 23 May 2025.

[24] A. Woodside, S. Sood, and K. Miller, "When consumers and brands talk: Storytelling theory and research in psychology and marketing," *Psychology and Marketing,* vol. 25, pp. 97-145, 02/01 2008, doi: 10.1002/mar.20203.

[25] (2024). *Statement from Australian Health Ministers: Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme*. [Online] Available: https://www.health.gov.au/resources/publications/statement-from-australian-health-ministers-analysis-of-unmet-need-for-psychosocial-supports-outside-of-the-national-disability-insurance-scheme?language=en

[26] A. Rosen and D. J. Holmes, "Co-leadership to co-design in mental health-care ecosystems: what does it mean to us?," *Leadership in Health Services,* vol. 36, no. 1, pp. 59-76, 2023, doi: 10.1108/LHS-06-2022-0065.

[27] M. Curtin and C. McMullin, "The co-production spectrum: conceptual blurs in theory and practice," *Perspectives on Public Management and Governance,* 2025, doi: 10.1093/ppmgov/gvaf008.

[28] S. Alden, "Co-production: Research and Practice Review Full Report,," *University of Sheffield Partnerships,* 2022. [Online]. Available: https://www.sheffield.ac.uk/sites/default/files/2022-03/Co-production%20report%20-%20Full%20Report.pdf.

[29] J. Bandola-Gill, M. Arthur, and R. I. Leng, "What is co-production? Conceptualising and understanding co-production of knowledge and policy across different theoretical perspectives," (in English), *Evidence & Policy,* vol. 19, no. 2, pp. 275-298, 01 May. 2023 2023, doi: 10.1332/174426421x16420955772641.

[30] J. Purtle, K. L. Nelson, N. Z. Counts, and M. Yudell, "Population-Based Approaches to Mental Health: History, Strategies, and Evidence," *Annual Review of Public Health,* vol. 41, no. Volume 41, 2020, pp. 201-221, 2020, doi: https://doi.org/10.1146/annurev-publhealth-040119-094247.

[31] Donnell O R, M. Savaglio, D. Vicary, and H. Skouteris, "Effect of community mental health care programs in Australia: a systematic review," (in eng), *Aust J Prim Health,* vol. 26, no. 6, pp. 443-451, Dec 2020, doi: 10.1071/py20147.

[32] J. Varga, "Defining the Economic Role and Benefits of Micro, Small and Medium-sized Enterprises in the 21st century with a Systematic Review of the Literature," *Acta Polytechnica Hungarica,* vol. 18, no. 11, pp. 209-228, 2021. [Online]. Available: https://www.epa.hu/02400/02461/00116/pdf/EPA02461_acta_polytechnica_2021_11_209-228.pdf.

[33] Australian Health Ministers. "Mental Health Statement of Rights and Responsibilities." AGPS. accessed 7 April 2025.

[34] D. Holmes, "Outcome Measures from a NSW Mental Health Consumer's Perspective," presented at the Health Outcomes 2003: The Quest For Practice Improvement 9th Annual National Health Outcomes Conference, Canberra, 2003. [Online]. Available: fhttps://www.researchgate.net/publication/322756251_Outcome_Measures_from_a_NSW_Mental_Health_Consumer's_Perspective.

[35] G. Parker, "SUPER CRO Strategic Plan," St Vincents Hospital, Darlinghurst, 2016. Accessed: March 2025. [Online]. Available: https://s3.eu-west-

1.amazonaws.com/static.fw1.biz/Templates/956594/myimages/strategic-plan-draft-v0-2-100617_1741899029705.pdf

[36] Australian Charties and Not for Profit Commission. "Before You Start a Charity." https://www.acnc.gov.au/for-charities/start-charity/you-start-charity accessed 31 March 2025.

[37] M. Andrew, "Not-for-Profit Reporting - why and how," *Governance directions no 1,* vol. 66, no. 1, pp. 8-11, 2014.

[38] T. Armstrong, "The Myth of the Normal Brain: Embracing Neurodiversity," *AMA journal of ethics,* vol. 17, pp. 348-52, April 2023 2015, doi: https://10.1001/journalofethics.2015.17.4.msoc1-1504.

[39] Justice Connext. "Memoranda of understanding (MOU)." https://www.nfplaw.org.au/free-resources/working-with-others/memorandum-of-understanding-mou accessed 29 May 2025.

[40] L. Andress, T. Hall, S. Davis, J. Levine, K. Cripps, and D. Guinn, "Addressing power dynamics in community-engaged research partnerships," *Journal of Patient-Reported Outcomes,* vol. 4, no. 1, pp. 24, 2020/04/05 2020, doi: 10.1186/s41687-020-00191-z.

[41] SAMHSA'. "Core Competencies for Peer Workers in Behavioral Health Services." https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/core-competencies_508_12_13_18.pdf accessed 20 May 2025.

[42] M. Leiter. "Preventing workplace burnout: Why resilience is not enough." https://psychology.org.au/for-members/publications/inpsych/2018/june-issue-3/preventing-workplace-burnout-why-resilience-is-no accessed 29 May 2025.

[43] Christina Maslach and Michael P. Leiter. "Organizational Check-Ups and Building Engagement." https://www.lahsa.org/documents?id=9206-capacity-building-burnout-reference-sheet.pdf. accessed 29 May 2025.

[44] SAMSHA, "Operationalizing Recovery-Oriented Systems,," 2012. Accessed: 29 May 2025. [Online]. Available: https://www.samhsa.gov/sites/default/files/expert-panel-05222012.pdf

[45] NMHCCF and LELAN. "The Lived Experience Governance Framework: Centring People, Identity and Human Rights for the Benefit of All." https://nmhccf.org.au/our-work/discussion-papers/the-lived-experience-governance-framework-centring-people-identity-and-human-rights-for-the-benefit-of-all accessed 29 May 2025.

[46] C. Sartor, "Mental health and lived experience: The value of lived experience expertise in global mental health," *Cambridge Prisms: Global Mental Health,* vol. 10, pp. e38, 2023, Art no. e38, doi: 10.1017/gmh.2023.24.

[47] Mental Health Drug and Alcohol Principal Committee. "National Mental Health Recovery Framework 2013 Implementation Strategy." https://www.aihw.gov.au/getmedia/2b9068ff-268e-469f-879f-36120196a743/recovery-framewk-implementation-strategy-mhdapc.pdf.aspx accessed 29 May 205.

[48] G. Yeo, K. L. Fortuna, J. E. Lansford, and K. D. Rudolph, "The effects of digital peer support interventions on physical and mental health: a review and meta-analysis," (in eng), *Epidemiol Psychiatr Sci,* vol. 34, pp. e9, Feb 13 2025, doi: 10.1017/s2045796024000854

[49] (201). *NATIONAL DIGITAL MENTAL HEALTH FRAMEWORK*. [Online] Available: https://www.health.gov.au/sites/default/files/documents/2022/03/national-digital-mental-health-framework_0.pdf