



# Request for Mental Health Consumer and Carer/Family Representation

## Service and Activity Information:

Request date:		Name of service:	
Region:		Requesting staff name:	
Phone number:		Email:	

A funding source for this request must be approved by your service's manager.

- DHHS project funding
- Carer/Consumer DHHS funded activity

Name of THS/DHHS manager making this approval:	
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## Role Details:

Activity, project, panel or committee name:	
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Brief description of activity:

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Why is Consumer, Carer or Family Representation being requested? What is the intended purpose of lived experience representation, and how will this involvement influence outcomes for the service, consumers, families and carers?

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Date/timeframe of activity:

- One-off placement

Day and date:		Time (start to finish):	
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- Ongoing placement

Meeting day:		Time (start to finish):	
Timeframe:			

Example: *Monthly meetings commencing DD/MM/YYYY and ending DD/MM/YYYY. Meetings occur on (day of the month, quarter, etc.).* If an end date has not been determined, please indicate an approximate time frame.

Approx. number of hours required (including meeting & preparation time):	
Location and address of meeting:	

**Representative Request/s (Tick appropriate box/es):**

- Carer/Family member
- Carer/Family proxy
- Consumer
- Consumer proxy

**Name and contact details of Placement Support Person:**

Name:		Phone:	
Email:			

Does this activity relate to representation on a Committee? If yes, please attach a copy of Terms of Reference and other relevant documents.

- Yes     No

Does this activity relate to representation on a Selection Panel? If yes, please attach relevant documents.

- Yes     No

Will this activity be likely to make the representative privy to information that may cause distress, e.g. serious incident review findings?

- Yes     No

If yes, will support be provided, and how will it work? (e.g. debrief after meeting, EAP program, follow-up calls)

Please identify any issues regarding confidentiality or sensitive data associated with the activity:

How will the representative receive associated documents/papers?

- Email     Post     Other (please specify): \_\_\_\_\_

Is video conferencing available as an option?                     Yes     No

Is telephone conferencing available as an option?                     Yes     No

How will the representative be notified of meeting time or date changes (keeping in mind that representatives may not have access to Outlook calendars)?

- Email     Phone

## Perspective, Skills and Experience Required:

### 1a: Family member/carer representative

*A family member or carer of a person with a mental illness who provides a unique perspective based on their individual experience*

Yes  No

Provide specific details: \_\_\_\_\_

### 1b: Broad family member/carer representative

*A family member or carer representative providing a broad perspective based on the experiences of a broad range of family members/carers/people with a mental illness, and gleaned from broad consultation.*

Yes  No

### 2a: Consumer representative

*A person with a lived experience of mental illness providing advice and input based on their own unique, individual experience.*

Yes  No

Provide specific details: \_\_\_\_\_

### 2b: Broad consumer representative

*A consumer representative providing a broad perspective of the lived experience, based on consultation with a range of people with a lived experience of mental illness.*

Yes  No

### Please identify areas of skill and/or experience required:

Examples include areas of lived experience required, skills or knowledge required, and training or briefing required.

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## OFFICE USE ONLY - for Flourish and Mental Health Families and Friends Tasmania

Placement Number:			
Name of Carer Rep Appointed:		Date:	
Name of Carer Proxy Appointed:		Date:	
Placement Number:			
Name of Consumer Rep Appointed:		Date:	
Name of Consumer Proxy Appointed:		Date:	