

**Enhancing Mental Health Support in Schools Consent Form**

The Victorian Department of Education and Training has engaged **headspace** to deliver face to face and telephone counselling support to secondary students in Victorian Government Schools. The counselling support is designed to increase the availability of mental health support for students, improve mental health outcomes for students and assist students in finding the right support as appropriate.

**Information for referrer**

Please read the following to the young person and ensure that they or their parent/carer agrees (consent) to being referred to and receiving **headspace** services.

**Mature minors:** if a student has been assessed by the principal (in accordance with the Schools Policy and Advisory Guide) or their nominee as a mature minor for the purpose of deciding to consent to referral to and receipt of headspace counselling support, the student is capable of giving their own consent and will be able to sign this consent form themselves.

**Other students:** where a student is not a mature minor, the school will obtain consent for treatment from the student’s parents or carer.

Please also note that at a student’s first appointment at headspace (either phone or face to face), the headspace clinician will again seek consent from the student or their parent/carer.

**Information for the young person**

The purpose for this form is to provide you with information to help you make a decision on whether you consent to be referred to, and receive headspace counselling services.

This service provides an opportunity for you to talk about your concerns with a headspace clinician, in a safe and confidential setting. You are protected by laws that set privacy requirements such as how we collect, use, handle and destroy personal and health information.

The school will collect and provide basic information to headspace such as your name, your date of birth, the suburb you live in, school name and a brief description of concerns that you would like to talk to headspace about. If you prefer not to tell the school about your concerns, that is okay. You will need to provide this information to headspace directly instead.

headspace will collect personal and health information to assist you by undertaking an assessment of your needs, managing and responding to any issues of concern, making a decision about the best way to support you and booking you in to more appointments if you need them.

headspace may also offer feedback, strategies and tools to help you deal with your concerns and, with your permission, the clinician and you may agree together about what information (and how much detail) is provided to other people such as your school, family, or other health professionals so they can best support you too.

Confidentiality

The information you provide in these sessions is confidential and your clinician will always try to seek your consent and include you in decisions about your health and safety where they can. headspace clincians will seek your consent to refer information to people who can provide you with further help including your school or GP. *However, if the clinician is concerned about your immediate safety or the safety of others, they can disclose this information without your consent to make sure that you and others remain safe*.

I confirm that:

* I have been informed of the purpose of my contact with **headspace**
* I understand and agree to being referred by my school to headspace counselling services
* I agree to the information collected about me by my school is shared with headspace for the purposes of this service
* I understand that this service is free and voluntary and that at any time I can stop the session
* I understand that information may be kept about me. The information will be used by **headspace** clinicians in their sessions with me – this means that **headspace** staff today and in the future are able to look at the information I and they provide
* I understand there are also some rare occasions when information I have provided to **headspace** staff has to be disclosed for legal reasons (for example, a court order or subpoena). This will be explained to me by a **headspace** clinician. It is important to remember that personal information that can identify me is accessible only by **headspace** clinicians.
* I understand that my sessions with the **headspace** clinician will be confidential but if they believe there is an immediate risk to my safety or the safety of others, they may disclose this information without my consent.

**Information for parents/carers**

The purpose for this form is to provide you with information to help you make a decision on whether you consent for your child to be referred to, and receive headspace counselling services.

This service provides an opportunity for your child to talk about their concerns with a headspace clinician, in a safe and confidential setting. You and your child are protected by laws that set privacy requirements such as how we collect, use, handle and destroy personal and health information.

The school will collect and provide basic information to headspace such as your child’s name, their date of birth, the suburb they live in, school name and a brief description of concerns that they would like to talk to headspace about. If you and/or your child prefer not to tell the school about their concerns, that is okay. They will need to provide this information to headspace directly instead.

headspace will collect personal and health information to assist your child by undertaking an assessment of their needs, managing and responding to any issues of concern, making a decision about the best way to support them and booking them in to more appointments if they need them.

headspace may also offer feedback, strategies and tools to help your child deal with their concerns andmay seek permission to provide information to other people such as their school, family, or other health professionals so they can best support your child.

Confidentiality

The information your child provides in these sessions is confidential and their clinician will always try to seek their consent and include them in decisions about their health and safety where they can. headspace clincians will seek your consent to refer information to people who can provide your child with further help including their school or GP. *However, if the clinician is concerned about your child’s immediate safety or the safety of others, they can disclose this information without your consent to make sure that your child and others remain safe*.

I confirm that:

* I have been informed of the purpose of my child’s contact with **headspace**
* I understand and agree to my child being referred by their school to headspace counselling services
* I agree to the information collected about my child by their school being shared with headspace for the purposes of this service
* I understand that this service is free and voluntary and that at any time my child can stop the session
* I understand that information may be kept about my child. The information will be used by **headspace** clinicians in their sessions with my child – this means that **headspace** staff today and in the future are able to look at the information my child and they provide
* I understand there are also some rare occasions when information my child has provided to **headspace** staff has to be disclosed for legal reasons (for example, a court order or subpoena). This will be explained to me by a **headspace** clinician. It is important to remember that personal information that can identify my child is accessible only by **headspace** clinicians.
* I understand that my child’s sessions with the **headspace** clinician will be confidential but if they believe there is an immediate risk to my child’s safety or the safety of others, they may disclose this information without my consent.

I understand/I authorise my school to refer me/my child to headspace for the purpose of receiving counselling services (cross out whichever is not applicable):

|  |  |
| --- | --- |
| Name of student Name of parent/carer (if required) | School name  |
| Student or Parent /Carer signature | The school support contact is:Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone:  |
| Date \_\_\_ / \_\_\_ / \_\_\_\_\_\_\_\_ |

I understand/I authorise **headspace** to provide counselling services to me/my child (cross out whichever is not applicable)

|  |
| --- |
| Name of student or parent/carer  |
| Relationship to child (if parent/carer signing) |
| Signature  |
| Date \_\_\_ / \_\_\_ / \_\_\_\_\_\_\_\_ |