

Referring to Gold Coast Child and Youth Mental Health Service

A Guideline for Schools

About Us

CYMHS is a free and confidential specialist mental health service for children and young people in the Gold Coast region. Our services may be delivered in the community or within the hospital environment and they are designed for treating individuals up to the age of 25 years who have complex mental health needs.

Services We Offer

We provide support in the following areas:

- Mental Health triage, comprehensive assessment, and specialist consultation
- Acute care and intervention
- Multi-disciplinary care for the treatment of mental illness
- Collaborative care coordination
- Carer and family support
- Referrals to other services

Accessing Care

Referrals to CYMHS can be made by young people, families, doctors, schools, or other professionals by calling **1300 MH CALL** (1300 642 255). The Access Team will provide crisis support, assessment, guidance to community services, or referral to CYMHS care teams. Existing referrals can contact the Access Team directly on (07) 5635 6392 or email CYMHSAccessTeam@health.qld.gov.au.

What happens after we receive your referral?

Once a referral is received, a clinician will contact the young person and their family for a phone triage. They may then be offered an initial assessment, crisis support, guidance to other community services, or referral to a Continuing Care Team or Specialty Program.

What if a referral does not meet CYMHS criteria?

If the young person does not meet criteria, we provide recommendations and support to connect them with the most appropriate services.

Helpful tips when referring

- Please obtain consent from the young person and their family/carer before referring where possible.
- Provide detailed information about current mental health concerns and risks.
- If there is imminent risk of self-harm or harm to others, contact the CYMHS Access Team immediately to seek guidance.
- Use the least restrictive pathway; Emergency Departments are for immediate risk only.

Contact Us

Child & Youth Mental Health Service Access Team
Proxima Level 6, Corner of Hill Street and Stanley Lane
Southport QLD 4215

Phone: 1300 64 22 55 (New referrals)
(07) 5635 6392 (Open consumers or general enquiries)

Email: CYMHSAccessTeam@health.qld.gov.au

Website: [Child and Youth Mental Health \(CYMHS\) | Gold Coast Health](#)

CYMHS Ed-LinQ Program

Mobile: 0403 604 194

Email:
cymhsedlinq@health.qld.gov.au

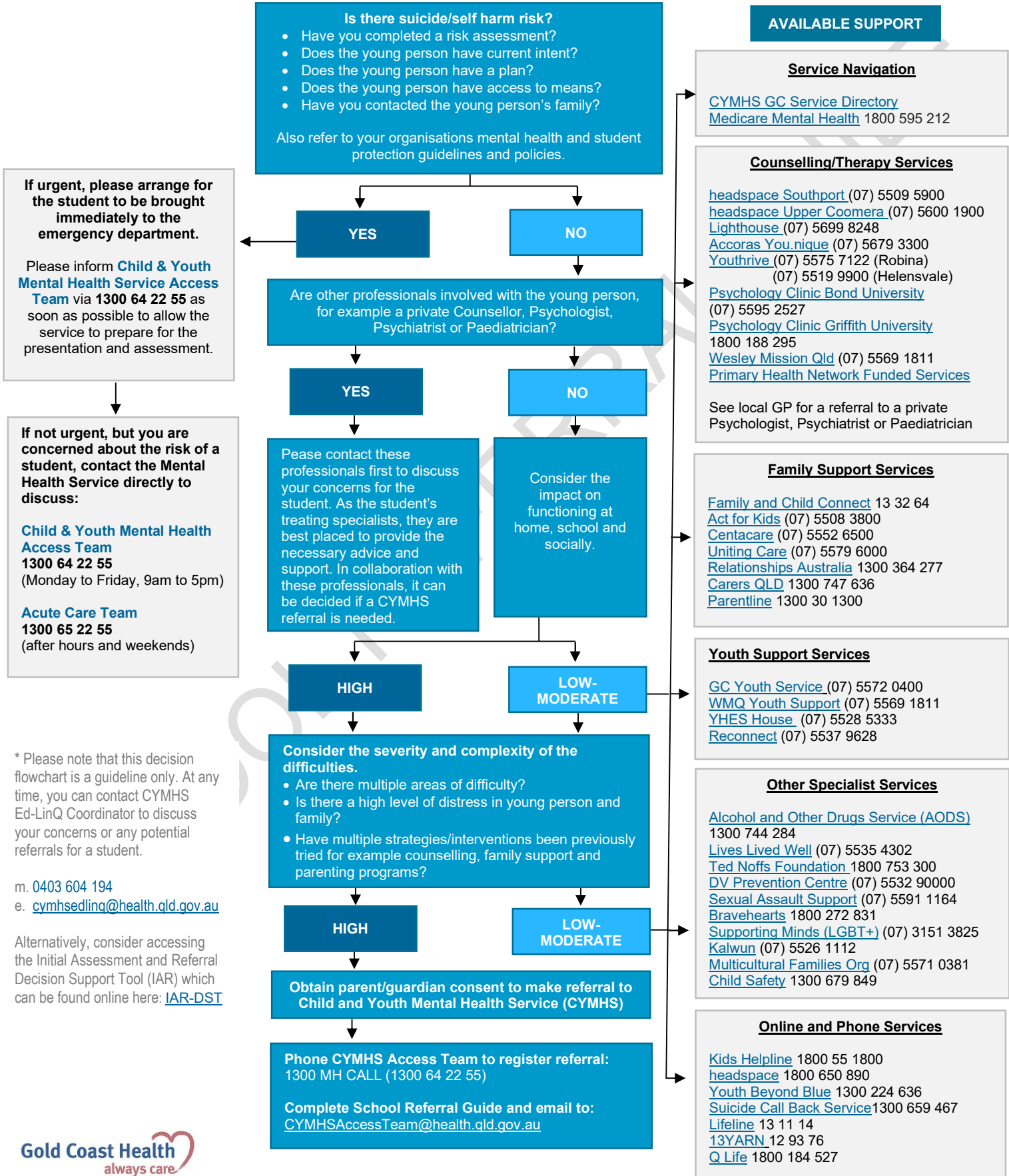
Website:
[Statewide Ed-LinQ Program | Children's Health Queensland](#)

School Referral Guide

When to consider a referral to Child and Youth Mental Health.

Is the young person experiencing any of the following and are these concerns impacting on their current functioning:

- | | |
|---|--|
| <input type="checkbox"/> Current suicidality and/or self-harm | <input type="checkbox"/> Defiant and/or oppositional behaviour |
| <input type="checkbox"/> Low mood; withdrawn; irritability, tearfulness | <input type="checkbox"/> Notable changes in sleep, weight or eating habits |
| <input type="checkbox"/> Excessive worrying; difficulties coping | <input type="checkbox"/> Body image concerns |
| <input type="checkbox"/> School avoidance or disengagement | <input type="checkbox"/> Aggression, violence and/or other anti-social behaviour |



School Referral Guide

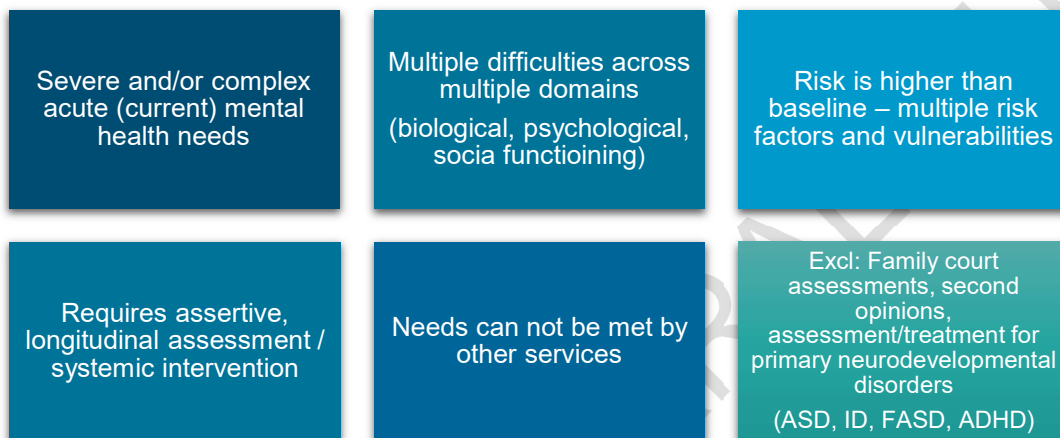
Child and Youth Mental Health Service (CYMHS) is:

- A tertiary level, specialist public mental health service for children and young people under the age of 25 who live in the Gold Coast region and have complex mental health needs.

We provide support in the following areas:

- **Acute Care** (mental health triage, assessment, and referral)
- **Brief Intervention** (up to 4 sessions – psychoeducation, symptom management, harm minimisation, safety planning, carer and family support)
- **Care Coordination** (4+ sessions – treatment package of care, therapeutic interventions, medical review, monitoring of physical health, systemic liaison and collaboration with other service providers)

Consider referral to CYMHS for the following:



Our Services

We offer a range of specialist mental health services through our community-based clinics or within the hospital setting.

Care in the Community

- Access Team (<18 years)
- Southern Continuing Care Team (<18 years)
- Central Continuing Care Team (<18 years)
- Young Adult Continuing Care Team (18-22 years)

Specialty Services/Programs

- Assertive Mobile Youth Outreach Service (AMYOS) (13-18 years)
- Early Psychosis Program (15-25 years)
- Eating Disorders Program (<22 years)
- Ed-LinQ Program (school aged young people)
- Evolve Therapeutic Service (<18 years)
- Head to Health Kids (0-12 years)
- Headspace In-Reach (12-25 years)
- Nurse Navigation (<18 years)
- Project Air Youth (12-25 years)
- Consumer, Carer and Family Participation Team

Care in the Hospital

- Wattle Unit (<18 years)
- Acacia Unit (18-25 years)
- Yangah Adolescent Day Program (12-18 years)
- Consultation Liaison (<18 years)

Further information about our services can be found on our website:

[Child and Youth Mental Health \(CYMHS\) | Gold Coast Health](#)

Still unsure if your referral is suitable? Consider completing the online Initial Assessment and Referral Decision Support Tool which can be found here: [IAR-DST](#)

School Referral Guide



GOLD COAST HEALTH CHILD AND YOUTH MENTAL HEALTH SERVICE

SCHOOL REFERRAL

Please note this document was developed to be used as a guide in supporting school staff when providing additional information to support a referral to Child and Youth Mental Health Service (CYMHS). All referrals to CYMHS must be phoned through in the first instance to ensure the referral has been received. Please ensure the personal information included on this form has been collected and distributed with the **informed consent** of the young person/parent/carer. If the young person is at immediate risk of injury to themselves or others, please call CYMHS Access Team on 1300 MH CALL (1300 64 22 55) or emergency services on 000.

REFERRER DETAILS

Name:		Date of referral:	
School:		Contact:	
Position:		Email:	

YOUNG PERSON'S DETAILS

First name/s:		Surname:	
Preferred Name:		DOB:	
Sex at birth:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Intersex <input type="checkbox"/> Other Please specify:
Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Non-Binary <input type="checkbox"/> Agender <input type="checkbox"/> Genderfluid <input type="checkbox"/> Gender Questioning
Pronouns:	<input type="checkbox"/> He/Him	<input type="checkbox"/> She/Her	<input type="checkbox"/> They/Them <input type="checkbox"/> She/They <input type="checkbox"/> He/They <input type="checkbox"/> Other:
Address:			
	Postcode:		
Phone:	(H)		
	(M)		
NDIS:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Cultural Identity	<input type="checkbox"/> Indigenous	<input type="checkbox"/> A&TSI	<input type="checkbox"/> Non- Indigenous <input type="checkbox"/> Other (please specify):
Is the young person aware of this referral?	<input type="checkbox"/> Yes		<input type="checkbox"/> No

ACCOMODATION TYPE

Rented House or Flat (Not Dept Housing)
 Rented House or Flat (Dept Housing)
 Privately owned House or Flat
 Caravan/Boat
 Hotel/Motel
 Boarding House/Hostel
 Friends/Family home
 Homeless

WHO DOES THE CHILD LIVE WITH? (tick as many as relevant)

Mother
 Father
 Step Mother
 Step Father
 Shared custody
 Sibling/s
 Other relatives
 Friends
 Other adults (who are not friends or relatives)
 Foster carer/s

PARENT / GUARDIAN DETAILS

PARENT/CARER 1

Name:		Relationship:		Contact:	
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PARENT/CARER 2

Name:		Relationship:		Contact:	
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Is there a parent/guardian consenting to this referral? Yes No

Is the young person under the care of the Department of Children, Youth Justice, and Multicultural Affairs? Yes No Unknown

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REASON FOR REFERRAL

(Please describe the mental health concerns you have identified including how they are currently impacting on the young person's functioning, and the support you are requesting from CYMHS)

RELEVANT HISTORY

(Include any known history of the identified problem/s, any developmental issues, details of any assessments conducted by school)

PAST /CURRENT TREATMENT

(if known)

CURRENT FUNCTIONING

(Home, living arrangements, family structure, education, employment, sexuality, gender, relationships, activities)

RISK CONCERNS

(Include risk of suicide, self-harm, violence, risk taking behaviour, substance misuse, family history of mental illness, vulnerability to abuse or neglect, limited social supports, legal issues)

ADDITIONAL CONTACTS

General Practitioner:		Contact:	
Private Psychologist:		Contact:	
Private Psychiatrist:		Contact:	
Paediatrician:		Contact:	
Other Service/s:		Contact:	

REFERRAL PATHWAY

Please contact Child and Youth Mental Health Service on **1300 64 22 55** to register to the referral in the first instance.

Additional information to support the referral can then be emailed to: cymhsaccesssteam@health.qld.gov.au

Please note: CYMHS will only contact the referrer to discuss the referral if additional information is required. Feedback will be provided where possible and only if consent to share information has been obtained.