**Trafford Domestic Abuse Services - Children & Young People’s Service**

TDAS is a charity offering support to those affected by domestic abuse.

We offer a range of services that support children and young people who have witnessed or experienced domestic abuse. We provide emotional and practical support; please note we are not a counselling or therapy service.

|  |  |  |
| --- | --- | --- |
| **121 (5-18years)** Child-led, tailored support around domestic abuse, emotional wellbeing, healthy relationships, and safety planning. Held in schools and community venues.  | **Rspace (5-14years)**6 week awareness and support programme focusing on domestic abuse, feelings family and safety planning. Held in community venues after school.  | **Children & Family Support (5-16years)**Supporting children and their parents/carers move forward following the impact of domestic abuse. Combination of 121 and family sessions in the family home and school.  |

Our process is to initially assign every child/young person to a group for support, further support can then be discussed following the group. If you feel this is not appropriate please state within the referral.

**As a victim service it is our policy not to contact any alleged perpetrators. If both parents/carers are identified as alleged perpetrators, please provide third-party contact information eg school or social worker. Please ensure the third-party is aware of the referral.
We would never knowingly contact or pass information on to an alleged perpetrator.**

|  |  |
| --- | --- |
| Date of referral:  |  |
| Referrers details Name, job title, email, and phone number: |  |
| Has the parent/carer consented to this referral?:  |  |
| Has the child/young person consented to for this referral?: |  |

|  |
| --- |
| **Other professionals involved with the child/young person, please add as appropriate**  |
| Agency  | Contact  |
| *School* |  |
| *Social worker*  |  |
|  |  |
|  |  |

|  |
| --- |
| **Who are you referring to us?**  |
| Child/Young Person’s name:  |  | Child/Young Person’s DOB: |  |
| Address: |  |
| Contact number (if 13+):  |  |
| Child/Young Person’s school and point of contact: |  |
| Parent/carer name and contact number:  |  | Relationship to child/young person: |  |
| About the child/young person you are referring to us |
| Disability (whether diagnosed or suspected) and any adaptions required: | *eg ADHD – requires bigger tasks to be broken down*  |
| Does the child/young person present any risk?:  | *eg weapons, drug use*  |
| How does the child/young person feel they learn?:  | *eg prefers to read information, prefers to watch videos*  |

|  |
| --- |
| Reasons for the referral |
| Please provide an overview to why you are referring into our service: |
|  |
| Voice of the child – what does the child/young person want from TDAS?: |
|  |
| Alleged perpetrator information and relationship to child/young person:  |
|  |
| Is there anything else we need to be aware of? |
|  |