


# **Suffolk Drug & Alcohol Action Team**

## **Guidance for using the Triage/Brief Assessment Form**

## **Guidance - Triage / Brief Assessment**

This form is to be completed for those clients requiring treatment modalities of Tier 2 and above, following completion of the Suffolk Treatment System Screening Form. The information in the screen should be reviewed prior to Triage assessment being undertaken.

The information gathered throughout these documents will inform the client's initial care plan. The initial care plan will be agreed with the client at the end of the Triage assessment.

Each substance misuse treatment agency is required to send information to the NDTMS (National Drug Treatment Monitoring System) monthly. The questions on the Triage form that are marked with  are the NDTMS fields. They have been highlighted to remind practitioners that they must be filled in, and they stand out for administrative staff when inputting the relevant data.

### **Electronic version**

The form is available for download from the DAAT website [www.suffolkdaat.org.uk](http://www.suffolkdaat.org.uk)

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## Referral Information

### Referral Source

Name of agency/organisation that referred the client.

### 🕒 Date referral received

*This information is core data. It is crucial that it is collected.*

Enter the date you received this referral. If a Suffolk Treatment System Referral form (formerly known as the screening form) was not received, enter the date a referral letter was received or a phone call or fax requesting an appointment was received.

### How did you hear about this service (if self referral)?

This is to identify informal referral sources.

### 🕒 Client Reference/Name

*This information is core data. It is crucial that it is collected.*

This is to identify a client. Reference may be unique to your service.

### 🕒 Triage agency name / code

*This information is core data. It is crucial that it is collected.*

Name/code of agency completing triage.

### Triage undertaken by

The name of worker completing assessment should be entered here. This information is crucial if this assessment is forwarded to another agency or worker.

### 🕒 Date Triage commenced

*This information is core data. It is crucial that it is collected.*

The date that the client made the first face-to-face presentation to this treatment agency.

### 🕒 DAAT of residence

*This information is core data. It is crucial that it is collected.*

The DAAT in which the client currently resides.

### 🕒 PCT of residence

*This information is core data. It is crucial that it is collected.*

The PCT area in which the client currently resides.

### 🕒 Local Authority

*This information is core data. It is crucial that it is collected.*

The local authority in which the client currently resides (as defined by their postcode of their normal residence).

## Current Substance Use

### ☉ Primary (1)

*This information is core data. It is crucial that it is collected.*

Substance that brought the client into treatment at the point of triage even if they are no longer using this substance. If a client presents with more than one substance the agency is responsible for clinically deciding which substance is primary.

### ☉ Secondary (2) or Third Drug (3)

*This information is core data. It is crucial that it is collected.*

An additional substance that brought the client into treatment at the point of triage, even if they are no longer actively using this substance.

### ☉ Days used in last 28 days

*This information is core data. It is crucial that it is collected.*

Note that if a problem substance is alcohol – enter the number of ‘drinking days’ there has been in the 28 days before today. (NDTMS will only record this in relation to alcohol).

### ☉ Age of first use

*This information is core data. It is crucial that it is collected.*

The age that the client recalls first using the problem substance (NDTMS only records this in relation to first substance).

### ☉ Typical daily use in last 28 days (units if alcohol)

*This information is core data. It is crucial that it is collected.*

Note that if a problem substance is alcohol - enter the average number of units drunk on a typical day in the last 28 days

### Typical Consumption (Daily, Weekly, Monthly, Occasionally)

As described by the client.

### ☉ Route/method of use; oral, sniff, I.V., smoke or other

*This information is core data. It is crucial that it is collected.*

Ask the client which choice best matches how they use their identified problem substances. (NDTMS only records this in relation to primary problem substance).

### Cost

a) Calculate roughly how much the client is spending per week on drugs/alcohol.

b) Clients may use varying ‘measures’ to describe an amount – cost/weight/wraps etc.

### Day of last use

This is useful for giving a complete picture of the client’s drug/alcohol misuse. It may also be an indicator of need and/or urgency.

## Alcohol Assessment Profile

This section only needs to be asked of clients who have indicated that alcohol is a problem substance for them.

### **Client's self assessment of their drinking problem**

The client should be asked to give their own assessment of the extent of their alcohol use on a scale of 1 (no problem) to 9 (serious problem).

### **Drinking Pattern**

Clients should indicate at what times of day and in what locations they drink alcohol. More than one response is permitted.

### **Average Units Consumed**

The client should be asked to provide information on the average units of alcohol they consumes on a daily/weekly basis. Information should also be sought about the type, quality, quantity and strength of the alcohol they drink.

### **Symptoms of drinking**

Clients should indicate whether they experience any of the listed in symptoms in relation to their alcohol consumption.

### **Days in the last 28 that binge limit has been exceeded**

Enter the number of days in the last 28 that the client has exceeded their binge limit

### **Alcohol Users Disorders Identification Test (AUDIT) Score**

Enter a score 0-40 based on the client's score on the AUDIT assessment tool.

**Note to staff** If your agency is currently not using this tool, please contact Tanya Kimber at Suffolk DAAT (01473 265209) who will be able to advise further.

## Other Prescribed Medication

### **Are you currently taking any other prescribed medication?**

This is for any prescribed medication the client may be taking that has not already been disclosed in section 2 of the triage form ('Current Substance Misuse').

## Injecting History

**Note to staff:** If appropriate at any point in this section you must provide the relevant harm reduction information and/or take action to arrange a referral to a specialist service; this would form part of an initial care plan.

### **ⓐ Have you ever injected?**

*This information is core data. It is crucial that it is collected.*

To identify whether the client has ever used via IV route and may have been exposed to risk.

### **At what age did you first start injecting?**

The age at which the client first injected any substance.

### **Are you currently injecting?**

Is the client currently injecting. If so, they may have been exposed to risk and/ or may be experiencing problems with injecting sites.

**Note to staff:** this is also an opportunity to ensure the client is aware of safer injecting practice.

### **ⓐ Have you injected in the last 28 days?**

*This information is core data. It is crucial that it is collected..*

Has the client been at risk (as above) within the last 28 days?

### **Do you always inject yourself?**

To identify whether the client is aware of safe injecting practice and the risks of sharing.

**Note to staff:** are clients aware they are at risk if they share any of their drug equipment?

### **ⓐ Have you ever shared?**

*This information is core data. It is crucial that it is collected..*

As above, if client has ever shared any of their drug equipment (not just injecting equipment), they will have been exposed to risk.

### **Where are you injecting and what condition are your sites in? Have assessors observed sites?**

Clients should indicate where their injecting sites are and with client's permission, assessors should observe injecting sites for infections etc and overall condition of the sites.

### **Client statement on injecting practices or other routes and methods**

This may be another opportunity to discuss safer injecting practice, elements of risk and access to needle exchange.

## **Risk Factors**

**Note to staff:** If appropriate at any point in this section you must provide the relevant harm reduction information, vaccinations and/or testing. If you do not have the facility within your service to carry out vaccinations and testing, action should be taken to arrange a referral to the clients GP or specialist service; this would form part of an initial care plan.

### **ⓐ Have you ever been previously infected/diagnosed with Hepatitis B?**

*This information is core data. It is crucial that it is collected.*

#### **Have you had course of 3 hepatitis B vaccinations?**

Has the client ever been hepatitis B infected or been in a position where they could have been exposed to Hepatitis B? Have they ever had a course of hepatitis B vaccinations in the past?

### **ⓐ Have you had a blood test confirming immunity to Hepatitis B (completed a course of 3 vaccinations)?**

*This information is core data. It is crucial that it is collected.*

If 'yes', the date of the test should be recorded where this is known. If the exact date is not known, either enter month and year (if date of month unknown) or 1<sup>st</sup> January of the year tested (where date of month and month unknown).

If 'no' is recorded, a test should be offered or arranged and included in initial care plan.

Please indicate from the options given the client's current hepatitis B status (e.g. whether accepted or refused offer of vaccinations, whether immunised already or have acquired immunity, or whether the test was not offered or it was not appropriate to offer test).

**Note to staff:** If appropriate you must take action to arrange for this to form part of an initial care plan. It is the workers responsibility to identify what action is necessary – giving information or making a referral.

Vaccinations can be provided by the treatment agency or elsewhere, such as in Primary Care. Where this or a partner agency provides one vaccination to a client but this actually completes the course, then 'immunity confirmed' should be recorded.

Ⓢ **Dates of hepatitis B vaccinations**

*This information is core data. It is crucial that it is collected.*

As each vaccination is given to the client, their electronic record must be updated to show the latest vaccination given. Dates can be entered on triage form as appropriate.

Ⓢ **Are you Hepatitis C Positive?**

*This information is core data. It is crucial that it is collected.*

**Have you ever had a test for Hepatitis C?**

*This information is core data. It is crucial that it is collected.*

The client may already be aware of their Hepatitis C status.

If the client says they have previously had a test for Hepatitis C, the date that the client was last tested should be entered. This test may be within the current treatment episode or previously to the episode. If the exact date is not known then the 1<sup>st</sup> of the month should be used if that is known. If only the year is known then the 1<sup>st</sup> of January for that year should be used.

If no, the client should be offered a Hepatitis C test and one of the options ticked on the form (e.g. offered and accepted, offered and refused, not offered, assessed as not appropriate to offer).

If the client is tested for Hepatitis C by your agency, the date on which they were tested should be recorded in this field. This date supersedes the date of any previous test the client may have had.

Ⓢ **Have you ever been referred to Hepatology (hospital liver specialist)?**

*This information is core data. It is crucial that it is collected.*

Has the client been referred to a Hepatology unit or has it ever been

suggested that they might need to be?

**Are you HIV Positive? Have you ever had a HIV test?**

The client may already be aware of their HIV C status.

**Note to staff:** ask if the client requires HIV test. If yes, appropriate action must be taken to arrange for this to form part of an initial care plan.

**Since you were last tested have you been at risk of BBV? (e.g. sharing equipment, unprotected sexual contact)**

This is important information to decide on what harm minimisation information the client might need.

**Have you ever overdosed or nearly overdosed using any substance (including alcohol)?**

This is important information to decide on what harm minimisation information the client might need. This may also be an indicator of risk and urgency of need of the client. A useful prompt might be “Why do you think you overdosed at that time”?

**Have you ever experienced any other negative health effects relating to your substance use (including alcohol), such as fits/seizures, or infections, abscesses or circulation problems?**

This is important information to decide on what harm minimisation information the client might need. This may also be an indicator of risk and urgency of need of the client.

## **Sex Worker**

Ⓒ **Are you a sex worker?**

*This information is core data. It is crucial that it is collected.*

This is important information to decide on what harm minimisation information the client might need. This may also be an indicator of risk and urgency of need of the client.

**Working / selling on the street or from a premises?**

This is important information to decide on what harm minimisation information the client might need. This may also be an indicator of risk and urgency of need of the client.

## **Healthcare Assessment**

The full scope and depth of the Healthcare Assessment will vary according to the presenting needs of the client, and not all questions within this section will apply to all clients. The Healthcare Assessment should include an initial assessment of the client's physical health and mental health needs. Any arising needs should form part of the care plan and would be directly responded to by the drugs agency itself or, where health needs are more specialised (e.g. dental care, sexual health) a formal referral is made to an appropriately qualified professional and followed up and reviewed by the drugs worker as part of the on-going delivery of the care plan.

All questions in this section appear in the National Treatment Agency guidance on what represents a general healthcare assessment.

**Have you seen a doctor in the last month?**

Indicate whether the client has seen their GP in the last month. It may be appropriate here to investigate further the reasons for this visit if the client confirms that they have.

**PHYSICAL HEALTH NEEDS: Have you any significant health conditions or symptoms that require treatment, for example asthma, epilepsy, diabetes, liver disease?**

This is information that will indicate whether there are any conditions that it is important to be aware of and which could impact on the client's treatment.

**Are you smoking or have you ever smoked tobacco?**

Indicate whether the client is currently, has previously or has never smoked tobacco.

**Are you experiencing any breathing difficulties, e.g. wheezing and breathlessness?**

Indicate whether the client is experiencing any breathing difficulties.

**Are you coughing anything up?**

Indicate if the client is coughing anything up, and obtain further details if the client confirms they are.

**DENTAL HEALTH NEEDS: Have you visited your dentist in the last year?**

This question should establish whether the client is registered with a dentist but assessors should also establish whether there are any dental health needs that are not currently being met.

**MENTAL HEALTH NEEDS: Are you currently receiving care for mental health needs?**

This is important information; if there is a significant mental health issue(s) such as depression, psychosis or schizophrenia, a CPN would normally assume the role of care coordinator.

**Ⓒ DUAL DIAGNOSIS**

**Is this care for reasons other than substance misuse?**

*This information is core data. It is crucial that it is collected.*

Is the client currently receiving care from mental health services for reasons other than substance misuse?

This is important information, if there is a significant mental health issue/ issues such as depression, psychosis or schizophrenia a CPN would normally assume the role of care coordinator.

**SEXUAL HEALTH NEEDS: Have you any sexual health needs that require treatment?**

Where health needs are more specialised (e.g. sexual health) a formal referral is made to an appropriately qualified professional and followed up and reviewed by the drugs worker as part of the on-going delivery of the care plan. Some useful prompts might be "have you had un-protected sex"? "have you had unprotected sex with multiple partners"?

**(Women only) When did you last have a smear test?**

This question only relates to women over the age of 25. Smear tests are routinely offered to all women over the age of 25 as an early warning of any abnormal cell formations, they are offered to all women routinely every 3 years. If they have not had their routine test or are due one, ask if the client would like a smear test, if yes, appropriate action should be taken and entered into the clients care plan.

**(Women only) Are you experiencing any problems with your periods?**

If a client is experiencing any abnormal bleeding, this is an indication that they require a health screen. If appropriate this should be included in the client's care plan. Please note: There is a NHS campaign targeting people under 25 for Chlamydia screening.

**Are you at risk of harming yourself or others?**

In such cases, normal service procedures would be followed

**Are you at risk of being harmed by partner, ex-partner/family member (physically or mentally)?**

In such cases, clients should be referred to the appropriate services and this should form part of the initial care plan.

**Are you at risk of being harmed by anyone else (physically or mentally)?**

In such cases, clients should be referred to the appropriate services and this should form part of the initial care plan.

**Do you have a history of any blood related infections or illness, e.g. blood poisoning or blood clots (DVT)?**

This information will provide further detail around the client's health and highlight whether referral to a healthcare specialist is required to treat any identified conditions.

**Do you have any or do you have a history of skin infections, e.g ulcers, abscesses, cellulitis?**

This information will provide further detail around the client's health and highlight whether referral to a healthcare specialist is required to treat any identified conditions.

**GENERAL HEALTH AND EATING HABITS**

**What are your eating habits like? (including what is your appetite like)**

The answer to this question is an indicator of the client's general well being and may also highlight self-neglect or an eating disorder.

**Do you always have access to food?**

**Do you have money available to spend on food?**

The client may currently not have access to food or money available to them to spend on food. Information and support about what is available to the client should be explored at this point.

### **Are you experiencing any sleeping problems?**

The answer to this question is an indicator of the client's general well being and may also highlight health issues or a sleeping disorder.

### **ⓐ Healthcare Assessment Completed - DATE**

*This information is core data. It is crucial that it is collected.*

The date the healthcare assessment is completed must be recorded. If all *previous* sections of the triage form have been completed, this represents the completion of the general healthcare assessment as defined by the National Treatment Agency.

## **Parental Status**

### **ⓐ Do you have any children under the age of 18?**

*This information is core data. It is crucial that it is collected.*

A child is defined as a person who is under the age of 18. Best practice states that as much information about a client's children or children other than theirs who are currently living with them be collected at triage. This is to flag up any risks concerning the child at an early stage in the assessment process.

The client should be asked whether they have any children under the age of 18, and then tick one option that most closely represents the client's parental status situation.

### **Are there any other children that live with you at least some of the time that are under the age of 18?**

To include children other than the clients own, who currently live with them.

### **How many children in total live with you?**

*This information is core data. It is crucial that it is collected.*

Whether client's own children or children other than the client's own.

### **Information about children – Statutory Requirement**

If the client has children, information should be collected about those children in the section provided.

### **Do you need any help with childcare arrangements?**

To assess whether the client may need help in this area to access treatment

### **Alternative childcare arrangements**

To collect information about current childcare arrangements or arrangements that could be put in place by the client if needed.

## **Diversity**

**Note to staff:** Questions asked in the following section may be felt to be of a sensitive or personal nature. It is therefore important that the "note to the service user" at the beginning of this section is read to the client.

The following questions are asked at the point of triage to identify any specific

needs the client may have or any barriers that may effect treatment options. Any such needs would form part of an initial care plan.

**Are there any cultural traditions that need to be upheld during your treatment?**

i.e. will there be periods during the treatment process the client may not be able to attend.

**Are there any issues relating to your diet/meal preparation?**

i.e. does the client require anything specific from you relating to their diet or meal preparation during their treatment.

**Have you any previous experiences of disadvantage on grounds of ethnicity, sexual orientation, gender, disability or age when accessing treatment?**

i.e. Can the client identify any previous issues that may have been a block to them accessing treatment in the past.

**Is there anything related to a health condition/impairment that we could do to support or assist you in accessing this service?**

Is there any specific support or equipment required by the client, which will enable them to access treatment? Any such needs would form part of an initial care plan

## **Religion, Spirituality and Guiding Values**

**Do you identify with a religious tradition?**

Does the client have any daily/weekly/monthly traditions that need to be upheld during the treatment process? Any such needs would form part of an initial care plan.

**Is there any help or support we could offer in relation to your religion? For example, should a service be provided in a particular way?**

i.e. would there be an issue attending a mixed sex group?  
Or could any alternative therapies cause concern or be inappropriate?

## **Accessibility**

**Do you have any access requirements?**

Does the client have any specific needs such as disability, language or supported access (may include family members)? If so, these will need to form part of the initial care plan

## **Sexual Orientation**

Ⓒ **Please let me know how you prefer to be defined**

*This information is core data. It is crucial that it is collected.*

Different life situations can generate specific needs. In order to be *able to*

offer services appropriate to meet those specific needs, it is important to learn about different life situations from the outset. For that reason, the question about sexual orientation has been included in this document; and this is a mandatory requirement. By asking this question sensitively, access to specialist services can be offered.

Whilst this question is sensitive and personal, by making a small statement about why the question is being asked, will empower the service user to make *their own* decision about how, or whether, to disclose.

- **Note to staff:** Further information related to this question can be found on page 17

## Marital Status

Lesbian Gay and Bisexual (LGB) communities have achieved the right to form legally recognised relationship partnerships. It is now important to include 'Civil Partnership' within questions relating to marital status, to show that Civil Partnerships are validated and recognised. For some members of the LGB community who may prefer not to answer a question about their sexual orientation directly, there is an opportunity for them to confirm that they have a Civil Partnership; thus making the process of disclosing their sexual orientation less personal or sensitive. Likewise, it can be important for a member of the LGB community who is also a parent, to have the ability to state that they are in a legally recognised relationship.

- **Note to staff:** Further information related to this question can be found on page 17

**Note to staff:** ask if the client is pregnant, does she need to be referred to a GP, or is Child Protection action necessary? If appropriate action must be taken to arrange for this to form part of an initial care plan. It is the workers responsibility to identify what action is necessary – giving information or making a referral as per care plan.

### Ⓒ **Are you pregnant?**

*This information is core data. It is crucial that it is collected.*

This is vital information to indicate risk. If the client is pregnant it may alter their prioritisation for some types of treatment. If you tick 'not known' this is inputted on NDTMS as 'No' (i.e. not pregnant).

### **Is your partner pregnant?**

This is vital information to indicate risk. If the client's partner is pregnant it may alter their prioritisation for some types of treatment.

### **If yes, do you know the date your baby is due?**

#### **Is specialist midwife involved?**

This may be an indication of urgency and/or help in the planning of treatment.

## FURTHER INFORMATION

### ⓐ How would you best describe your accommodation?

*This information is core data. It is crucial that it is collected.*

#### **Living with?**

This will allow the client to raise any issues they may have around their current housing situation. This may form part of the initial care plan.

Indicate whether and who the client is currently living with.

#### **Have you ever slept rough?**

Indicate whether the client has ever slept rough.

### ⓑ Employment status

*This information is core data. It is crucial that it is collected.*

To determine whether the client is employed and if not, are they receiving benefits/ or do they require any assistance to access benefits. This may form part of the initial care plan.

#### **Are you in receipt of any benefits?**

Indicate whether the client is receiving any benefits and if so note which ones.

#### **Driving**

##### **Do you drive?**

##### **Do you hold a current driving licence?**

It is the client's responsibility to inform the DVLA if they are on methadone. The DVLA guidance on drug and alcohol misuse and dependency can be downloaded from the DVLA website.

#### **Have you ever driven under the influence of drugs or alcohol?**

This could be useful information in terms of risk or harm to self or others.

## Criminality

#### **Do any of these currently apply to you?**

This is important information, if the client is currently subject to any of these orders, the Probation service would normally assume the role of care coordinator.

#### **Have you ever been to prison?**

#### **Have you ever been given a Drug Rehabilitation Requirement?**

Indicate whether the client has ever been to prison or ever been given a Drug Rehabilitation Requirement.

#### **How are you currently funding your drug/alcohol use?**

This will provide information around issues that may arise from the client's substance misuse.

## Service Requested

### What help do you think you need?

This question is helpful, offering the client the opportunity to put in their own words the specific help they think they may need. Alternatively, they may use this opportunity to ask what options are available to them. Questions such as these encourage partnership working and will help in the following section to form an initial care plan.

### Treatment Goal

*This information is core data. It is crucial that it is collected.*

This is an opportunity to find out what the client wants to achieve during their time in treatment.

## Proposed Actions for Initial Care Plan

The following section forms the basis for an initial care plan if required.

### Outcome of Triage

This section is designed to form the basis of an initial care plan, the appropriate box should be ticked and comments describing any subsequent actions to be put in comments box provided and/ or on additional information sheet and /or on agencies own initial care plan form. Any such care plan being fully agreed with the client and dated.

### Date Care Plan agreed with client

Enter the date the initial care plan agreed with client.

The initial care plan will 'hold' the client until a comprehensive care plan is drawn up following comprehensive assessment.

### Additional Advice or Information Given, Referrals Made or Interventions Undertaken

This offers a checklist to clients and workers to inform an initial care plan, depending on need and/or urgency, advice and information maybe given or a referral made.

### Agency referral is now being sent to

This section should only be filled in if the client has mutually agreed to being referred for a comprehensive assessment.

### Ⓢ Date referred to modality

*This information is core data. It is crucial that it is collected.*

The date mutually agreed with client that they require a referral to tiers 3 or 4.

### Consent to communicate information

Enter the full name and date of birth of client, followed by a contact name and details of someone they would like contacted in an emergency.

Mandatory services are all of the services that make up the Suffolk Treatment System. Information may be shared with any of these agencies during the course of the clients journey

Ⓞ **Sharing information with the NDTMS**

*This information is core data. It is crucial that it is collected.*

Whether the client has agreed for their data to be shared without any personal identifiers to regional NDTMS teams and the NTA.

Sharing information with other agencies may be required at different stages of the client's journey. This is an opportunity for the client to give specific consent or not to the agencies listed.

**Confidentiality**

This is an opportunity for the client to confirm that they have understood and accepted the terms and conditions of the triaging agency's confidentiality policy.

## Appendix 1

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### **Sexual Orientation:**

Fear of judgement, or fear of being treated badly, can be a barrier to anyone who wants, or needs, to access services. It is important that service providers show that they recognise and value difference and that this diversity is not a barrier to accessing services.

Different life situations can generate specific needs. In order to be *able to offer* services appropriate to meet those specific needs, it is important to learn about different life situations from the outset. For that reason, the question about sexual orientation has been included in this document; and this is a mandatory requirement. By asking this question sensitively, access to specialist services can be offered.

For example, there are national support services available specifically for members of the lesbian, gay and bisexual (LGB) community, which provide direct support around same-sex domestic violence relationships, housing, advocacy, healthcare, counselling, childcare, fostering, adoption, abuse, sexual abuse, rape, hate crime and discrimination. Experience of one or any of these issues can be a trigger long-term substance misuse.

By identifying sexual orientation, services may then offer access to these other support services to assist in addressing underlying or holistic needs; while providing ongoing substance misuse treatment. Not seeking to identify sexual orientation could mean that a service user misses the opportunity to access other appropriate support.

In asking the question, services are also then obliged to learn more about the LGB community and about what local or national support networks and services exist for their service user. Increasing this type of knowledge will potentially attract more members of the LGB community to feel safe to come forward, as they will trust that their needs are taken seriously and can be supported.

Whilst this question is sensitive and personal, by making a small statement about why the question is being asked, will empower the service user to make *their own* decision about how, or whether, to disclose.

### **Marital Status:**

Different life situations can generate specific needs. In order to be *able to offer* services appropriate to meet those specific needs, it is important to learn about different life situations from the outset. For that reason, the question about sexual orientation has been included in this document; and this is a mandatory requirement. By asking this question sensitively, access to specialist services can be offered.

Additionally, the LGB community has achieved the right to form legally recognised relationship partnerships. It is now important to include 'Civil Partnership' within questions relating to marital status, to show that Civil Partnerships are validated and recognised. For some members of the LGB community who may prefer not to answer a question about their sexual orientation directly, there is an opportunity for them to confirm that they have a Civil Partnership; thus making the process of disclosing their sexual orientation less personal or sensitive. Likewise, it can be important for a member of the LGB community who is also a parent, to have the ability to state that they are in a legally recognised relationship.