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ORIGINAL PAPER

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Threshold Assessment Grid (TAG): the development of a valid and brief scale to assess the severity of mental illness

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Abstract *Background*: Lack of consensus about the meaning of severe mental illness makes it difficult to prioritise the severely mentally ill for specialist mental health care. The goal of this study was to develop a valid and brief assessment of severity of mental illness. *Method*: Six search workshops ($n = 57$) using consensus techniques developed a draft assessment acceptable to users, carers, practitioners and policy makers. A two-round Delphi consultation ($n = 58$) was held to identify consensus on this instrument. *Results*: Search workshops agreed seven domains relevant to identifying the severely mentally ill: intentional and unintentional self-harm, risk from and to others, and survival, psychological, and social needs and disabilities. The Delphi consultation indicated at least agreement with all aspects in both rounds. *Conclusions*: The Threshold Assessment Grid (TAG) is a brief method of identifying the severely mentally ill, which has adequate face, concurrent, construct and content validity.

Introduction

In Britain, the National Health Service and Community Care Act (1990) specifies that the severely mentally ill be prioritised for mental health care. This requirement was refined with the publication of The Spectrum of Care (Department of Health 1996), which stated that there should be a spectrum of mental health services, ranging from those covered by a primary health care team to specialist services. The policy goal is to develop a hierarchical system of care, with services allocated in proportion to need. There is strong evidence that this process is not yet operating effectively. For example, the Audit Commission (1994) found that Community Psychiatric Nurses were not consistently targeting the severely mentally ill. One identified reason is that there is no agreement on how to define severe mental illness or (consequently) how it should be identified (House of Commons Select Committee 1994; Slade et al. 1997). The goal of this study was to develop a valid and brief assessment tool for measuring the severity of mental illness.

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Methods

The meaning of 'severe mental illness' changes over time. It is defined in part by experts and in part by other factors, such as the increased prominence given by politicians and society to risk assessment in the 1990s. Traditional methods of assessment tool development are inappropriate for a socially defined construct, and hence this study utilised two innovative methods: search techniques and a Delphi consultation.

Stage 1: search workshops

Search workshops are a structured approach to identifying innovative solutions to issues that are characterised by disagreement. This study used principles from the "Future Search" model (Weisbord and Janoff 1995) of search workshops: a large, diverse group of stakeholders are involved, the events are participative, with no hierarchy or expert speakers, participants help mould a definition (which may need refinement later, but all views are listened to), diversity of input is encouraged, output is in a language that can be accepted and used by all parties, and the overall aim of the process is to identify common ground.

Six search workshops were held, with an overall goal of developing a means of identifying the severely mentally ill that was at best supported by, and at least acceptable to, a range of stakeholders. The goal of the first workshop (held in January 1997) was to identify the primary use for a definition of severely mentally ill, and to define the essential dimensions along which the severity of

mental health problems might be measured. The goal of workshops 2–5 (October–November 1997) was to elaborate the dimensions identified in workshop 1 (i.e. to identify sub-domains of each dimension). The goal of the final workshop (February 1998) was to integrate the results of previous workshops. The workshops were attended by invitation only, to ensure a cross-section of expert representatives, and were hosted by the Department of Health in London. Documentation was sent to participants prior to attending. The workshops were facilitated by a professional consultant with expertise from outside the mental health field, who used search techniques to work towards identifying a consensual solution to the issue being addressed in each workshop. Each workshop used the same format: an introduction to the background to the issue, description of the search techniques to be used, and small or large group work using search techniques. Search workshops differ from focus groups in being highly directed, in identifying unresolvable issues, and in being orientated towards developing a "product" (in this case, a means of identifying the severely mentally ill).

Participants were invited to attend the first workshop on the basis of being involved in either the development or use of a definition, or to ensure a range of perspectives. This led to the development of a framework comprising six dimensions (see Table 1), which was the subject of four further, half-day workshops (2–5). Each workshop identified sub-domains of dimensions, as shown in Table 2. All identified sub-domains were then analysed by the Threshold team (R.P., M.S. and G.S.) to identify redundancy. Decisions were also made about which sub-domains could be operationalised, i.e. where sufficient knowledge exists to be able to measure it. This resulted in a draft set of domains for an assessment tool. A literature survey was undertaken on relevant assessment approaches for each domain. A national survey was undertaken of how health and social services agencies ($n = 128$) identify the severely mentally ill in practice, replicating an earlier study (Slade et al. 1997). The main finding was that there continues to be substantial variation in eligibility criteria, though many good-practice sites were identified. These resources were used to compile samples of developed and (where available) standardised assessment tools for each sub-heading. The final, full-day integration workshop was then held. Participants were supplied with a briefing pack containing the survey results and minutes from previous workshops. The best language for domain headings was identified by consensus. Small groups were then asked to identify which (if any) of the available assessments were most suitable for use, using the criteria that the ideal assessment would be comprehensive, operational, brief and easy to use in practice, be appropriate in language and values, be "politically" neutral (i.e. not seen as owned by one factional interest), be evidence based, systematically developed, reliable and valid.

Stage 2: instrument development

The results of the six workshops were integrated by the Threshold team to produce a draft assessment tool, using the following criteria for the assessment:

1. Suitable for the primary use identified in workshop 1
2. Derived from the findings from the workshops
3. Operational (i.e. each domain should be measurable)
4. Has ascending levels of severity (i.e. can be used to differentiate between people)
5. Uses widely acceptable terminology and minimal jargon
6. Brief, short and easy to use

The assessment was developed by deciding (1) the domains and (2) the levels of severity for each domain, and (3) then incorporating as much of the workshop information as possible into the scale.

Stage 3: Delphi consultation

The Delphi technique, named after the oracle of ancient Greece, is a method for measuring consensus in lay or expert groups (Linstone and Turoff 1975). It is suitable for problems where there is insufficient or contradictory scientific evidence and has been used in health care research to inform service planning (Kooperman et al. 1985) and prioritising (Moscovice et al. 1988), training (Crotty 1993) and clinical practice (Mobily et al. 1993). Delphi processes typically involve a consultation with a defined and stable group of participants, to determine the extent of agreement about an issue. This consultation, in keeping with accepted Delphi methods (Jones and Hunter 1995), had a number of features. Consultation was by *anonymous* questionnaire, to avoid the dominance of the group by any individual. Consultation was *iterative*, taking place in two rounds, which allowed participants to change their views. In the second round there was *controlled feedback* from the first round, which identified the participant's response and characterised the response of the whole group. The *statistical degree of consensus* was identified between the results of the two rounds.

For this study, the Delphi consultation involved rating agreement with the aspects shown in Table 4. Each of the 38 questions were rated on a five-point Likert scale (1 = strongly disagree, 5 = strongly agree). Response rate was maximised by sending a reminder letter, leaving up to two telephone messages, and sending a fax.

Delphi round 1 involved a copy of the assessment tool developed in the workshop stages. This was sent out in April 1998 to 77 experts, comprising representatives of service users and carers, clinical psychologists, general practitioners (GPs), nurses, psychiatrists, social workers, occupational therapists, housing workers, provider managers, researchers, policy-makers, and commissioners. Their responses were analysed, and Delphi round 2 took place in June 1998. For each question, participants were given their rating from round 1, along with the median and semi-interquartile range of all responses. Participants were asked to consider their previous response and those of others before answering once again.

Results

Stage 1: search workshops

The workshops were attended by a total of 57 people, named in the Acknowledgements, with several attending more than one workshop, so that workshops 1–6 were attended by 20, 12, 13, 16, 13 and 24 people respectively. Participants comprised senior representatives from the voluntary sector (including Manic Depressive Fellowship Society, Mind, National Schizophrenia Fellowship, Revolving Doors Agency, SANE and Sainsbury Centre for Mental Health), experienced members of relevant health professions (clinical psychologists, general practitioners, occupational therapists, psychiatric nurses, psychiatrists, public health doctors), social services practitioners, housing workers, provider managers, Trust chief executives, commissioners, researchers (from mental health, health economics and health policy backgrounds) and representatives of the Department of Health.

Six dimensions were identified in workshop 1, and are shown in Table 1.

Table 1 The spectrum framework

Mental health problems/Diagnosis
Duration
Potential to benefit/Complexity of need
Safety
Disability/Functioning
Use of definition

These appeared in the policy document The Spectrum of Care (Department of Health 1996). The goal of workshop 1 was to identify rather than elaborate the dimensions. Nonetheless, there was a broad range of components identified within each dimension. For example, Potential to benefit from help was seen as linked to the Complexity of need, and incorporated items such as the balance of care and informal support, the capacity to benefit, whether children or families benefit from interventions, whether the sufferer is in contact with more than one person or organisation, the capacity *of the service* to refuse to help, adherence/compliance/co-operation, and the views of users and carers. Safety incorporated risk to others, risk to self, risk of relapse, risk to children, risk of consuming lots of resources (i.e. risk to Health Authority budget), level of insight, and the level of assessment and uncertainty. Disability/Functioning included social disablement, disability affecting employment, personal care, domestic skills or interpersonal skills, and psychological or social functioning. The unresolved issues were quality of life, dual diagnosis, dementia, personality disorder, and learning disability.

Potential users of a definition of the spectrum of mental health problems were identified as including research and audit, Community Mental Health Teams, GPs and primary care teams, commissioners and public health, Social Services, voluntary agencies, residential care, benefits agencies, government/politicians, the criminal justice system, and training and development agencies. Potential uses to which a definition might be put include determining eligibility for access to services, resource management/planning at the local and national level, audit, research, and deciding entitlement to services, e.g. benefits. Participants agreed that the priority was the development of an operational definition that could be used for determining access to services.

Subsequent to this workshop, it was decided by the Threshold team that duration was a theme common to each of the other dimensions, and was not a separate dimension. The priority use of a definition had been identified (determining access to services), so four further workshops were held, to consider Safety, Disability/Functioning, Potential to Benefit/Complexity of Need, and Mental Health Problems/Diagnosis. Table 2 shows the sub-domains identified in workshops 2–5.

For each workshop, elements of each sub-heading were identified. For example, risk from self (unintentional) comprised lack of self-care, not eating, unable to manage accommodation, lack of self-hygiene, not claiming benefits, lack of or withdrawal from social interaction, physical ailments, not coping with finances or electricity, lack of literacy, no daily routine, lack of awareness of own safety in home, risky sexual behaviour/health, exposing self to risk, avoiding or refusing services, wandering behaviour, substance misuse, and being open to abuse or exploitation.

The domains were integrated by the Threshold team. Workshop participants had identified a difficulty with assessing Potential to benefit, so this domain was omitted. Seven domains were identified: mental health problems/Diagnosis, Risk from self (intentional), Risk to others, Risk from self (unintentional), and Survival/Physical, Psychological and Social needs and disabilities. These were the focus of the integration workshop. Participants identified that the existence of a mental health problem/diagnosis was the starting point for referring to specialist mental health teams, but did not intrinsically contain information about severity. Furthermore, the identification of the best assessment tools was problematic, with a need identified for amended or composite instruments for most domains. A new domain of Risk from others was identified as necessary, resulting in a total of seven domains.

Table 2 Sub-domains identified in workshops 2–5

Topic	Identified sub-domains
Safety	Risk from others Risk from self (unintentional) Risk from self (intentional) Risk to others
Disability/Functioning	Survival Psychological Social Occupational
Potential to benefit	Individual Knowledge Structural factors Services and resources
Complexity of need	Psychological Emotional Spiritual Physical Social
Mental health problems/ Diagnosis	Self-report of symptoms Community report of symptoms "Professional" report

Stage 2: instrument development

A draft of the assessment tool was developed, called the Threshold Assessment Grid (TAG). Duration was difficult to integrate into the other dimensions, reflecting that clinical judgement is based on a combination of frequency, intensity and duration. Hence any sampling time frame (which would be a measure of frequency) might be more reliable, but would be less valid as a means of recording clinical judgement. The suggested time frame is approximately 1 month, with the option of including items of concern (such as a history of violence) that arise from more than 1 month ago. This decision may compromise reliability, but increase validity. The seven domains of the draft assessment instrument are shown in Table 3.

An issue in deciding the levels of severity for each domain was the incommensurate nature of the components to consider for the different domains. Another issue was that the particular anchor points to use will

Table 3 The Threshold Assessment Grid (TAG) domains

	Domain
Safety	Intentional self-harm Unintentional self-harm
Risk	Risk from others Risk to others
Needs and disabilities	Survival Psychological Social

vary in differing parts of the mental health care system – high suicide risk means different things in a GP surgery and an acute psychiatric ward. The workshops indicated that real practice involves dynamic judgement, which is not based on a stable weighting of different variables. Therefore, each domain was broken into four or five cells according to levels of severity: none, mild, moderate, severe and extreme. The "extreme" category was intended for situations requiring immediate action by services, and hence was only available for Intentional self-harm, Risk to others and Survival needs. Each cell described the level and domain, e.g. the Extreme cell for Intentional self-harm reads "Immediate risk to physical safety as a result of deliberate self-harm or suicide attempt", and the Moderate cell for Psychological needs and disabilities reads "Markedly disabling or distressing problems with thinking, feeling or behaviour". One box is ticked for each domain, so the assessment involves ticking seven boxes. The findings from the workshops were incorporated into evidence-based guidance checklists for each domain. Brief (one-page) instructions were also written.

Stage 3: Delphi consultation

Delphi round 1 was completed by 58 participants (75% response rate), comprising seven representatives of service users, three representatives of carers, five clinical psychologists, seven GPs, three nurses, five psychiatrists, five social workers, five occupational therapists, four researchers, four housing workers, four provider managers, four commissioners, and two policy makers. Quantitative results of rounds 1 and 2 are shown in Table 4. Round 1 provided 42 qualitative comments, many of which resulted in numerous amendments to the TAG, the checklists and the guidelines. For example, the severity rating of Extreme was changed to Very severe, and additions were made to the guidance checklists. The revised TAG was circulated in Delphi round 2. All participants completing round 1 also completed round 2. Further minor changes were made from comments received in round 2.

The finalised assessment tool therefore comprises a score sheet to rate the seven domains (one page), evidence-based checklists of items relevant to each domain (one page), and instructions (one page). The score sheet and checklists are included as an appendix.

Discussion

This study used novel techniques of search workshops and a Delphi consultation to develop an assessment tool for measuring the severity of mental health problems – the Threshold Assessment Grid (TAG). The TAG is intended for use in determining access to services, and comprises seven domains of severity: Intentional and Unintentional self-harm, Risk from and to others, and Survival, Psychological, and Social needs and disabilities. For each domain, evidence-based guidance checklists were produced to identify aspects that should be considered in rating severity. The checklists need not be rated, and completing the TAG involves ticking seven boxes on the score sheet. The development process focused on producing an assessment tool that is valid, brief, and suitable for inter-agency use.

This study differs from traditional approaches to developing an assessment instrument. Usually, the focus is on reliability, with piloting of each iteration of the assessment resulting in a new version. The development of the TAG, however, had a focus on validity. This is because the concept of "severe mental illness" is socially defined, and the key challenge is therefore to develop a valid approach.

Face validity was intrinsic to the development process. Insofar as severe mental illness is a socially defined construct, comparing with current views represented by the range of participants in the Delphi consultation

Table 4 Delphi consultation ratings ($n = 58$): 1 = strongly disagree, 5 = strongly agree (*CMTH* Community Mental Health Trust)

	Round 1	Round 2
The instructions are comprehensible	4.02	4.10
The language is appropriate in describing severity	4.25	4.34
TAG would be helpful to a CMHT in deciding whether to accept a referral	4.02	4.17
For each domain		
It is clear what each domain is assessing[a]	4.20 (4.10–4.39)	4.35 (4.16–4.45)
The language on the grid is acceptable[a]	4.19 (4.10–4.26)	4.33 (4.32–4.38)
The language on the checklist is acceptable[a]	4.26 (4.19–4.33)	4.38 (4.36–4.41)
The checklist is relevant to the domain[a]	4.30 (4.27–4.35)	4.35 (4.27–4.39)
There are items missing from the checklist[a]	2.32 (2.24–2.37)	2.14 (2.07–2.21)

[a] Mean and range of means for the seven domains

provides a measure of concurrent validity. There was at least agreement with all aspects investigated, indicating *concurrent validity*. Agreement uniformly increased in the second round, suggesting that the developing assessment tool was iterating towards possessing maximum possible *construct validity*. Finally, the high agreement on the content of checklists is indicative of *content validity*.

The inclusion of levels of severity for each domain, without prior specification of cut-off points, makes TAG suitable for use as a currency for *local inter-agency negotiation*. The inclusion of experts from a wide range of professional backgrounds improved the extent to which TAG is suitable for inter-agency use. Finally, the brevity and ease-of-use of TAG is intended to make it suitable for *routine use*. TAG would therefore appear to meet the goals of being a valid and brief tool for assessing the severity of mental health problems, which is suitable for inter-agency use. It is particularly relevant to identifying the priority group for mental health care, and hence aiding GPs and others in deciding whether a referral to specialist mental health services is appropriate.

The next stage in the development of TAG will be to evaluate its reliability. This will involve determining whether an approach that tries to mimic clinical judgement can be used reliably, and whether the judgements of different professionals about the same person differs. This study is currently in progress at several sites around London.

It might be argued that the epistemological base for this study is flawed, and that other approaches to defining severe mental illness have been developed. Our review of the literature indicates that there is no widely accepted definition of severe mental illness that has an empirical base (Slade et al. 1997). One of the most common approaches to identifying the severely mentally ill is to consider the three "D"s – diagnosis, disability and duration. This is cited as being based on the work of Goldman and colleagues (1981), but their basis for selecting these three characteristics was pragmatic and clinical, rather than empirical. The lack of empirical base is also shown by the fact that the three "D"s are also used in Australia, but there they refer to diagnosis, disability and danger. Nonetheless, there is clearly further work to be done, such as integrating the unresolved issues of quality of life, dual diagnosis, dementia, personality disorder, and learning disability into the assessment. Similarly, diagnosis may need to be included if the TAG is being considered for another use.

The Delphi consultation proved to be very useful in fine-tuning the draft TAG. However, the normal use of a Delphi consultation is to measure consensus, and in both rounds of the consultation uniformly high consensus was evident. This may have been due to a ceiling effect in the Delphi questionnaire, which was unable to detect differences in agreement. Alternatively, this may be due to a sample bias, since 58% of the Delphi participants had taken part in the workshops (which may compromise the concurrent validity). Workshop participants may be expected to have high agreement with an assessment tool developed using their contributions. This could be addressed by a Delphi consultation that excludes people involved in earlier stages of development. Finally, the TAG development process may have produced an assessment tool that is acceptable to most groups of stake-holders. There is some evidence for this, since the responses in round 1 indicated at least "agreement" with all aspects surveyed, and every aspect had slightly (i.e. non-significantly) improved agreement from round 1 to 2. There may, of course, be sub-groups of stake-holders for whom there is not agreement, which could be investigated by using groups of stake-holders of a size large enough to analyse individually.

Ensuring representativeness in both the search workshops and the Delphi consultation can be problematic in two ways. Firstly, identifying stake-holder groups may be controversial. In this study, for instance, no members of the general public were included, although there could be a case for the need to represent society's perspective in a process that influences who is seen by mental health services. Secondly, once participants are selected there is no guarantee that their view will be representative of their organisation. Conversely, a strength of the methods used in this study is that they reduce the opportunities for any individual participant to dominate the decision-making process.

Workshop participants considered access to services primarily in terms of specialist mental health team referrals by a GP or Social Services. One future study would be to evaluate the extent to which TAG impacts on the practice of referrers when making a referral, and hence may improve working at the primary/secondary care interface. Furthermore, if the TAG has good external validity – it identifies the set of people who are appropriate for specialist mental health services – then it may also have a research use as an inclusion criteria for studies. It can be unclear how much the findings of studies involving strict inclusion criteria – with high internal validity – can be generalised to routine clinical settings. Efficacy studies using tightly defined clinical samples could be compared with effectiveness studies using "typical" clinical samples (identified using the TAG), to investigate the trade-off between internal and external validity.

A common concern of specialist mental health services is that they receive inappropriate referrals or insufficient referral information. The TAG may provide a useful forum for negotiating at a local level about suitability of referrals, and for identifying what information is required in a referral. The intention would be to augment, rather than replace, the referral letter, but the TAG is brief enough that it may be feasible for routine clinical practice.

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THRESHOLD ASSESSMENT GRID (TAG)

SCORE SHEET

TAG ASSESSES THE SEVERITY OF MENTAL HEALTH PROBLEMS IN AN INDIVIDUAL

For each domain (numbered 1 to 7), tick ONE statement that best applies to the person being assessed. There should be a total of 7 ticks on the completed grid (one for each domain). Then for each level of severity (e.g. 'None', 'Very Severe') add the number of ticks and record in the box at the bottom of the column. 'Very Severe' is only available for domains where life-saving emergency action by specialist mental health teams may be required. The checklists overleaf provide some guidance on the issues to consider when assessing each domain - they are not intended to be prescriptive.

		NONE	MILD	MODERATE	SEVERE	VERY SEVERE
SAFETY	**Domain 1** Intentional self harm	No concerns about risk of deliberate self-harm or suicide attempt ○	Minor concerns about risk of deliberate self-harm or suicide attempt ○	Definite indicators of risk of deliberate self-harm or suicide attempt ○	High risk to physical safety as a result of deliberate self-harm or suicide attempt ○	Immediate risk to physical safety as a result of deliberate self-harm or suicide attempt ○
SAFETY	**Domain 2** Unintentional self harm	No concerns about unintentional risk to physical safety ○	Minor concerns about unintentional risk to physical safety ○	Definite indicators of unintentional risk to physical safety ○	High risk to physical safety as a result of self-neglect, unsafe behaviour or inability to maintain a safe environment ○	
RISK	**Domain 3** Risk from others	No concerns about risk of abuse or exploitation from other individuals or society ○	Minor concerns about risk of abuse or exploitation from other individuals or society ○	Definite risk of abuse or exploitation from other individuals or society ○	Positive evidence of abuse or exploitation from other individuals or society ○	
RISK	**Domain 4** Risk to others	No concerns about risk to physical safety or property of others ○	Antisocial behaviour ○	Risk to property and/or minor risk to physical safety of others ○	High risk to physical safety of others as a result of dangerous behaviour ○	Immediate risk to physical safety of others as a result of dangerous behaviour ○
NEEDS AND DISABILITIES	**Domain 5** Survival	No concerns about basic amenities, resources or living skills ○	Minor concerns about basic amenities, resources or living skills ○	Marked lack of basic amenities, resources or living skills ○	Serious lack of basic amenities, resources or living skills ○	Life-threatening lack of basic amenities, resources or living skills ○
NEEDS AND DISABILITIES	**Domain 6** Psychological	No disabling or distressing problems with thinking, feeling or behaviour ○	Minor disabling or distressing problems with thinking, feeling or behaviour ○	Disabling or distressing problems with thinking, feeling or behaviour ○	Very disabling or distressing problems with thinking, feeling or behaviour ○	
NEEDS AND DISABILITIES	**Domain 7** Social	No disabling problems with activities or in relationships with other people ○	Minor disabling problems with activities or in relationships with other people ○	Disabling problems with activities or in relationships with other people ○	Very disabling problems with activities or in relationships with other people ○	
	TOTAL					

THRESHOLD ASSESSMENT GRID (TAG)

CHECKLISTS FOR GUIDANCE

Also consider any other aspects which are relevant. The tick-boxes are provided for optional use to identify concerns, but the TAG rating is made on the score sheet.

1. Intentional Self-Harm

Individual factors:
- ❍ expressing suicidal intent
- ❍ clear plan
- ❍ available means
- ❍ preparations
- ❍ hopelessness
- ❍ no confidant, e.g. partner, friends, professionals
- ❍ poor coping resources
- ❍ lack of blocks to self-harm

Consider risk factors:
- ❍ past history of deliberate self-harm
- ❍ (i) alcohol/drug abuse *OR* (ii) diagnosis (e.g. depression, schizophrenia, personality disorder)
- ❍ (i) AND (ii) = increased risk
- ❍ physical illness/disability
- ❍ recent GP contact
- ❍ recent psychiatric hospitalisation
- ❍ recent loss
- ❍ no friends/family
- ❍ living alone
- ❍ unskilled worker
- ❍ unemployment
- ❍ older people
- ❍ male (especially young males)

2. Unintentional Self-Harm

Consider self-neglect:
- ❍ lack of self-care
- ❍ not eating or drinking appropriately

Consider unsafe behaviour:
- ❍ not seeking help for problems posing risk
- ❍ refusing appropriate help e.g. not taking medication
- ❍ not claiming benefits
- ❍ lack of awareness of own safety in home e.g. fire risk
- ❍ risky sexual behaviour
- ❍ substance misuse
- ❍ wandering

Consider the inability to maintain a safe environment:
- ❍ unable to manage accommodation
- ❍ not paying rent
- ❍ running up debts

3. Risk From Others

Consider different types of abuse or exploitation:
- ❍ physical
- ❍ sexual
- ❍ emotional
- ❍ racial
- ❍ financial
- ❍ neglect

Consider risk from:
- ❍ staff
- ❍ relatives
- ❍ friends
- ❍ neighbours
- ❍ strangers
- ❍ treatments

Consider risk of abuse by carer:
- ❍ severe stress
- ❍ mental illness/alcohol /drug abuse in carer
- ❍ carer refusing help
- ❍ history of abuse by or to carer

Consider risk from society:
- ❍ history of abusive/exploitative relationships
- ❍ harassment from public
- ❍ use of home by unwanted others
- ❍ inadequate home security
- ❍ fear of retaliation for reporting abuse

4. Risk To Others

Consider risk to:
- ❍ children & other dependents
- ❍ partners
- ❍ carers
- ❍ staff
- ❍ neighbours
- ❍ strangers

Consider risk factors:
- ❍ current threats, especially to a named person
- ❍ history of violence to people/property
- ❍ carer's concern
- ❍ access to weapons
- ❍ no blocks to violence e.g. fear of consequences
- ❍ history of arson
- ❍ unemployment
- ❍ drug/alcohol abuse
- ❍ stress
- ❍ voices telling person to harm someone
- ❍ paranoia
- ❍ risky sexual behaviour
- ❍ anti-social behaviour e.g. unsafe driving
- ❍ lack of information about person's history
- ❍ no trusting relationship with professionals

5. Survival

Consider whether the person has problems with:
- ❍ a home
- ❍ heating for the home
- ❍ essential amenities (e.g. washing facilities, toilet, cooker, bed)
- ❍ the ability to look after their home
- ❍ the ability to keep adequately clean and tidy
- ❍ enough food & fluids
- ❍ clothing
- ❍ enough money to live on
- ❍ mobility
- ❍ the ability to use public transport
- ❍ the ability to cope with physical health problems

6. Psychological

Consider:
- ❍ overactive, aggressive, disruptive or agitated behaviour
- ❍ problems with hallucinations & delusions
- ❍ cognitive problems with memory, orientation & understanding
- ❍ mood problems e.g. depressed, manic, anxious
- ❍ problems with reading or writing
- ❍ a lack of coping strategies
- ❍ attitude to problems
- ❍ help seeking behaviour
- ❍ spiritual problems
- ❍ feelings of alienation

7. Social

Consider problems in relationships with others:
- ❍ lack of ability to make or maintain friendships
- ❍ lack of supportive relationships
- ❍ lack of intimate relationship
- ❍ sexual problems
- ❍ communication problems
- ❍ unable to handle daily hassles

Consider problems in activities:
- ❍ leisure
- ❍ unpaid work
- ❍ paid work
- ❍ education
- ❍ travel
- ❍ lack of personally meaningful life

Byng, Sheila Coates, Alan Cohen, David Crepaz-Keays, Jacqueline Curtis, Martin Davies, David Dodwell, Margaret Edwards, Gyles Glover, Hilary Guite, Anna Higgitt, Peter Huxley, Jude Ibbe, Rachel Jenkins, Judy Jones, Wendy Kelsey, Tony Kendrick, Andy Kent, David Kingdon, Aideen Lucey, Steve Marsh, David Meltzer, Celia Millington, Steve Morgan, Glenys Parry, Jo Paton, Rachel Perkins, Michael Phelan, Nick Powell, Robin Powell, Judy Renshaw, Anne Richardson, Ruth Sargent, Liz Sayce, Hari Sewell, Mike Slade, Alan Slater, Geraldine Strathdee, Mike Took, Crispin Truman, Aviva Trup, Yvonne Webb, Simon Wessely, Martin Whittle, Chris Wright, Diana Wontner-Smith, Helen Wood and Til Wykes. We thank the participants in the Delphi consultation, and the Department of Health for hosting the search workshops.

Appendix

The Threshold Assessment Grid, comprising score sheet
and evidence-based checklists

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