

Research papers

Threshold 4: an evaluation of the Threshold Assessment Grid as an aid to mental health referrals

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Abstract

Background The Threshold Assessment Grid (TAG) is a brief, standardised assessment of severity of mental health problems, for use by referrers to mental health teams for adults or the elderly.

Aim To test whether referrer TAG rating predicted mental health team view of suitability of referral, and to identify guidance thresholds for referral.

Design of study Multi-site prospective cohort study.

Setting Ten adult and elderly mental health services in London.

Method For 605 referrals to mental health teams, a TAG was completed by the referrer and by the mental health team, who were blind to each other's ratings. The team also assessed the suitability of the referral.

Results TAGS were completed by 445 (74%) referrers and 308 (88%) mental health teams. Of these, 96 referrals were rated for suitability, and the mean referrer TAG score was significantly higher for

patients assessed as suitable (6.8 vs 5.2, $t = 2.1$, $df = 94$, $P = 0.04$). The intra-class correlation between the referrer and team TAG total scores was 0.35 ($n = 226$), indicating fair agreement. Sensitivity and specificity analyses indicated that using a TAG total score (possible range 0 to 24) of 5 or more as a threshold would give 76% sensitivity and 50% specificity in matching mental health team view of suitability.

Conclusion Improved primary–secondary care communication can be facilitated when referrals are accompanied by a completed TAG. For patients whose referrer TAG total score is less than 5, the referral letter should state why the patient's mental health problems are of a severity to warrant specialist mental health service.

Keywords: mental health, primary healthcare, referral

Introduction

There is at present no standardised assessment used routinely when referring a person with severe mental health problems from primary care or other agencies to mental health services. This creates a tension for referrers – not referring a patient may deprive them of potential benefits from specialist mental health service, but referring a patient who is not seen as a suitable referral by the service wastes the time of the patient and delays the response time for other referrals. In either event, patient care will suffer. Anecdotally, this tension can manifest as poor communication between the two services, with the referrer experiencing the mental health team as unsupportive and arbitrary in which referrals it accepts, and the team feeling their efforts to focus on patients with severe mental health problems is being undermined by ‘inappropriate’ referrals.

The problem is not going away – referral rates from primary to secondary care for mental health problems have increased by a factor of 4.5 from 1971 to 1997, despite the patient preference for primary care level talking therapy over medication or referral to a mental health professional.^{1,2} Furthermore, the priorities of the referrer, the patient, and the services being referred to may differ, making identification of the ‘appropriateness’ of referrals a complex process.³ In response to this, the *National Service Framework for Mental Health* states that primary care and mental health services should have agreed referral protocols in place by the end of 2001.⁴

Agreeing referral protocols requires at least three developments: agreement that specialist mental health services should focus on the ‘severely mentally ill’, shared agreement about who the severely mentally ill are, and a currency for communication between primary care services (such as health and social services) and specialist mental health services.^{4,5} These challenges are not new – in 1994 the House of Commons Select Committee identified the need for a shared definition of severe mental illness.⁵ The Department of Health responded to this report by setting up a clinically led working party, which identified the need to develop a new assessment schedule to address the lack of consensus between agencies.^{6,7} Accordingly, innovative consensus techniques (search workshops and Delphi Consultation) were used from 1997–98 to develop an assessment that is acceptable to mental health service users and carers, primary and secondary health services, social services, housing services, care commissioners, and policy-makers. The resulting assessment – the Threshold Assessment Grid (TAG) – measures the severity of a person’s mental health problems, and is intended for use when making a referral to specialist mental health services.⁸

The aim of this study was to investigate whether the TAG is useable as the ‘currency’ for a referral protocol between primary and secondary health care agencies. The study had four goals:

- to identify the maximum response rate that can be achieved when an infrastructure is provided to support clinicians in completing the TAG
- to test whether referrer TAG score predicts the mental health team view of suitability of the referral
- to compare referrer TAG and the mental health team TAG scores, to investigate whether the TAG can be used as a means of communication between agencies
- to explore the implications of using a TAG score as a threshold for referrals to mental health services.

Method

The data presented here were collected as part of a larger study to investigate the psychometric properties of the TAG, which has been reported elsewhere.^{9,10}

Setting

Ten routine (i.e. long-term National Health Service (NHS)-funded) Community Mental Health Teams (CMHTs) in London participated in the study, between 1999 and 2000. The teams were chosen to ensure a range of locations (three inner, five outer, two suburban), deprivation levels (MINI – Mental Illness Needs Index – scores ranging from 98 to 123.6, indicating the upper end of deprivation¹¹) and client groups (eight adult, one adult day care, one elderly).

Patients

Sixty consecutive referrals to each CMHT were included in the study.

Intervention

When the referral was received by the team, the TAG was faxed to the referrer, with a request to complete and return it. This request was followed up by telephone or fax, to maximise response rate. Where an assessment by the CMHT was offered, the assessing CMHT clinician was asked to complete a TAG following initial assessment. All referrals in the last third of the study ($n = 131$) were also rated by the CMHT clinician following their assessment as to whether the referral was suitable for the CMHT. No criteria were specified for this assessment, which was made on the clinician’s judgement. A range of factors will clearly

impact on whether the referral is made and whether it is judged suitable, so the intent is not to imply that the referral was 'right' (which would require assessment from more than just the CMHT perspective), but to provide a measure of agreement about the referral.

Time of study

The study took place between June 1999 and September 2000.

Assessments

The Threshold Assessment Grid (TAG) comprises a one-page score sheet requiring one tick to indicate level of severity in each of seven domains:

- 1 intentional self-harm
- 2 unintentional self-harm
- 3 risk from others
- 4 risk to others
- 5 survival needs
- 6 psychological needs/disabilities
- 7 social needs/disabilities.

The scale is 'none', 'mild', 'moderate', and 'severe' (four-point scale) for domains (2), (3), (6) and (7), with an extra 'very severe' domain for the remaining three domains (which may require immediate action). In routine practice it takes mental health staff 3 minutes and referrers 4 minutes to complete. The TAG total score is calculated by summing the domain scores (0 for none, 1 for mild, 2 for moderate, 3 for severe and 4 for very severe), with a possible score ranging from 0 to 24. The TAG was printed in the development paper and is included with permission in Appendix 1.

Further details are available at: www.iop.kcl.ac.uk/prism/tag.⁸

Analysis

All analysis was carried out using SPSS 8.0 for Windows. Local Research Ethics Committee approval was gained for all participating sites, and the study was overseen by an advisory group.

Results

Response rate

Referrers to the ten CMHTs and referrer TAG scores are shown in Table 1.

Referrer TAGs were completed for 445 (74%) patients, including 288 (76%) of the 380 general practitioner (GP)-referred patients. For the 160 patients for whom referrer TAGs were not completed, 127 (79%) were offered an assessment, 90 (71%) were seen by the CMHT, and the mean CMHT TAG total score was 5.6 (0–14). The subsequent pathway through care for the 605 patients and the mean CMHT TAG scores are shown in Table 2.

Hence 299 of the 380 GP-referred patients were offered an assessment by the CMHT, and TAGs were completed by CMHT staff for 190 of the 217 patients actually seen. A total of 101 CMHT staff completed TAGs, comprising 39 psychiatric nurses, 41 psychiatrists, 11 clinical psychologists, 7 occupational therapists, 1 care manager and 1 art therapist. For all CMHT TAGs rated, CMHT staff had a mean of 13.7 years post-qualification experience. Overall, the return rate was 74% for all referrers, and 88% for mental health staff.

Table 1 Mental health service referrers, and referrer-completed TAG scores ($n = 605$)

Type of referrer	Referrers	Referrals	Completed referrer TAGs	
	<i>n</i>	<i>n</i>	<i>n</i> (%)	Median (interquartile range)
General practitioner	300	380	288 (76)	6.0 (3.0–8.0)
Psychiatrist	110	130	94 (72)	7.0 (5.0–19.0)
Nurse	5	34	9 (90)	6.5 (3.0–9.0)
Care manager	21	22	15 (68)	6.0 (6.0–11.0)
Liaison mental health team	6	10	26 (77)	8.0 (5.0–9.0)
Other*	12	24	13 (54)	8.0 (6.0–10.5)
Self	5	5	–	–
Total	485	605	445 (74)	6.0 (4.0–8.0)

* 2 housing offices, 3 volunteer organisations, 2 health visitors, 3 drug and alcohol services, 2 parole officers, 8 medical physicians, 4 psychologists

Table 2 Assessments offered by Community Mental Health Team (CMHT), patients assessed, and CMHT TAG scores ($n = 605$)

Type of referrer	Referrals <i>n</i>	Offered assessment by CMHT <i>n</i> (%)	Patients assessed <i>n</i> (%)	CMHT TAGs	
				<i>n</i> (%)	Median (interquartile range)
General Practitioner	380	299 (79)	217 (73)	190 (88)	5.0 (3.0–6.25)
Psychiatrist	130	107 (82)	76 (71)	67 (88)	5.0 (3.0–7.0)
Nurse	34	28 (82)	19 (68)	17 (95)	4.0 (1.0–7.0)
Care manager	22	17 (77)	14 (82)	12 (86)	6.0 (4.25–8.75)
Liaison mental health team	10	9 (90)	6 (67)	5 (83)	9.0 (3.0–11.0)
Other	24	19 (79)	16 (84)	15 (94)	3.0 (1.0–6.0)
Self	5	4 (80)	2 (50)	2 (100)	6.5 (6.0–7.0)
Total	605	483 (80)	350 (72)	308 (88)	5.0 (3.0–7.0)

Did referrer TAG score predict suitability as rated by the CMHT?

Of the 445 patients with referrer TAGs, 96 were rated for suitability of referral by the CMHT. The mean referrer TAG total score for the 76 patients assessed as suitable was 6.8 (range 1–16), and for the 20 patients assessed as not suitable was 5.2 (range 2–13). This difference was significant ($t = 2.1$, $df = 94$, $P = 0.04$).

Do referrer and CMHT scores agree?

For the 226 patients who had both a referrer (mean 6.5) and a CMHT TAG (mean 5.0) completed, the correlation between the referrer and CMHT TAG total scores was 0.35. For GP-referred patients (141

patients), the correlation was 0.29. Both these indicate fair agreement.¹²

Threshold for referral

Table 3 shows the implications of using TAG total score or three arbitrarily chosen categories as referral thresholds.

Sensitivity indicates the probability (percentage) of a suitable referral being correctly identified using the criterion, and specificity indicates the probability of an unsuitable referral being correctly identified as unsuitable using this criterion. Positive predictive value indicates the probability of an assessment rated as suitable using TAG criteria actually being suitable, and negative predictive value indicates the probability of an assessment rated as unsuitable using TAG criteria actually being unsuitable.

Table 3 Properties of different TAG referral thresholds ($n = 96$)

Referrer TAG score threshold	Referrals meeting this threshold <i>n</i> (%)	Sensitivity	Specificity	Positive predictive value	Negative predictive value
TAG score of 3 or more	85 (89)	91	20	81	36
TAG score of 4 or more	78 (81)	86	35	83	39
TAG score of 5 or more	68 (71)	76	50	85	36
TAG score of 6 or more	58 (60)	64	55	82	29
At least 1 moderate domain	76 (79)	83	35	83	35
At least 2 moderate domains	58 (60)	66	60	86	32
At least 1 severe or very severe domain	21 (22)	26	95	95	25

Discussion

The usefulness of the TAG as a means of identifying the priority group for mental health services was investigated. The completion rates were 74% from referrers and 88% from mental health staff. Referrer TAG score predicted whether the referral was seen as suitable by the mental health team after their own assessment. There was fair agreement between referrer and mental health team TAGs. Various referral thresholds were tested.

This study had four goals, which will be considered in turn. The Green and Eriksen model of practice change was used to maximise response rate, comprising phases of predisposing, reinforcing and maintaining change.¹³ The completion rates of 74% from all referrers (and 76% from the subsample of 380 GP referrals, accounting for 63% of all referrals) may represent the maximum return rate which can be initially obtained when introducing a new assessment. The second goal was to test whether referrer TAG predicted mental health team view of suitability following their assessment. This was found to be the case, providing some evidence that the referrer TAG score can be used to identify those patients requiring specialist mental health care. The TAG is therefore the first standardised assessment for which there is preliminary evidence of its relevance to *National Service Framework for Mental Health Standard 2*, which states 'any service user who contacts their primary healthcare team ... should ... be offered ... referral to specialist services ... if they require it'.⁴ The third goal was to compare referrer and mental health team ratings. Referrer ratings were lower than CMHT ratings, perhaps due to the use of different reference groups by the two groups, based on their different patient populations. However, a fair correlation was found between referrer and mental health team ratings: 0.35 for all referrers and 0.29 for GP referrers. This provides some evidence that the TAG can be used as a meaningful measure for communication between referrers and CMHTs.

Referral threshold

The final goal was to investigate the use of referral thresholds, by comparing referrer ratings with CMHT assessment of the suitability of the referral. This method has several potential problems. First, the mental health problems of the patient may have changed between referral and CMHT assessment. Second, using the CMHT rating implies this is the best measure of suitability. In this study, all referrals by definition were seen as suitable by the referrers, so the CMHT view was the only external measure possible. A more robust design would involve assessment of the multiple perspectives of the patient, referrer

and CMHT as to the suitability of the referral. Third, it could be argued that the decision of the CMHT not to offer an assessment is in itself indicating a view that the referral was unsuitable, and so this should be included in the suitability measure used. However, in practice (consistent with other research¹⁴) it was found that CMHTs used a variety of algorithms in deciding whether to offer an assessment, so this was not used to inform the suitability rating. Fourth, no rating of referral suitability was available for patients who did not attend appointments. Non-attenders are known to have more severe mental health problems and social disability than attenders, although in this study the referrer TAG total score for the 96 patients who did not attend an offered appointment compared with the 349 other patients with completed referrer TAGs did not differ (6.8 vs 6.3, $t = 1.1$, $df = 443$).¹⁵

A rigid threshold for referrals is not recommended. The data demonstrate that false positives and negatives cannot be avoided just by using TAG scores. Furthermore, to recommend that TAG scores should be the only means of deciding whether to refer or how to respond to a referral would be to ignore the complex system-level influences which helpfully operate between referrers and CMHTs. For example, where a referrer is aware that a CMHT is overstretched, they will raise their own implicit threshold for making a referral. Similarly, where a CMHT has a good relationship with a referrer, they may be more inclined to offer an assessment because they believe the referrer's judgement to be sound. These processes are positive, and maximise cost-effectiveness from mental health teams.

Bearing these caveats in mind, this study indicates that the TAG can be used to provide guidance on referral thresholds. If the concern is to ensure that all referrals are suitable (i.e. to avoid a false positive), then a threshold of at least one severe or very severe domain will ensure that 95% of referrals are suitable. However, 74% of referrals not meeting this criterion will in fact be suitable – a high false negative rate. If the concern is to ensure that all suitable referrals are offered assessment (i.e. to avoid a false negative), then using a threshold TAG score of 3 or more will ensure that 91% of suitable referrals are identified. However, 80% of unsuitable referrals will also meet this criterion – a high false positive rate. If the view is taken that the 'cost' of a false negative is the same as the 'cost' of a false positive, then the best cut-off is that which maximises the sum of the sensitivity and specificity.¹⁶ In this case, either of two referral thresholds might be chosen: a TAG score of 5 or more, or at least two moderate domains.

Using the TAG

These data may inform negotiation between primary care (as the main referrers) and secondary care as to

how TAG can be used to improve patient care, by minimising the number of unsuitable referrals and hence maximising the capacity of the mental health team to respond to referrals. This negotiation will also stimulate discussion about differences in perspective concerning the importance of severity in making referrals, since it is clear that primary care professionals are ambivalent about the policy of focusing secondary mental health services on the 'severely mentally ill' – another reason why the use of a strict TAG cut-off is not recommended.

Specifically, an empirically justified referral protocol between primary and secondary care might involve an agreement that all referral letters will be accompanied by a completed TAG, and that for those patients whose TAG total score is less than 5 the letter will state why the patient's mental health problems are of a severity to warrant specialist mental health service. The referral letter should also include background and social history, details of presenting problems, interventions tried and outcomes achieved, reason for referral, and roles expected of the CMHT.^{17,18}

Study design

A strength of this study was that it took place within routine services, with all data completed by referrers and mental health clinicians (and not researchers), which enhances the generalisability of the results. An evaluation of the suitability of the TAG for routine use is reported elsewhere.¹⁰ Mental health teams were blind to the referrer TAG scores, to allow investigation of their relationship. This study provides preliminary evidence, and the next stage of scientific development will be to investigate the impact on both primary and secondary care services when the TAG is introduced into routine practice.

Several limitations can be identified. Although data were provided by clinical staff, the information infrastructure to support the use of the TAG, such as providing forms, analysing data and giving feedback, was provided by researchers. No electronic systems of communication (e.g. email, electronic referral templates) were in place between any of the primary and secondary care services in this study. The extent to which TAG can be used routinely has not therefore been fully evaluated. Furthermore, the study only involved patients who had been referred, thus excluding those patients whom the team would have seen as suitable for referral but the potential referrer did not. There is no information on these 'false negatives', so no conclusions can be drawn as to whether TAG helps with recognition of who to refer. The next stage of research, therefore, should investigate whether using TAG leads to an increased ability to discriminate between who to refer and who not to refer. Finally,

the criteria applied by mental health staff in assessing suitability were not evaluated, and so a range of approaches may have been used.

Despite these limitations, using the TAG may be an improvement on current practice – its use as advocated here will encourage explicit negotiation between primary and secondary care, the resulting recommendations for referral guidance are empirically based, and its psychometric properties have been evaluated. The TAG can therefore be recommended as an approach to improving primary/secondary care communication, and giving guidance to all referrers about when to refer. It is feasible for routine use, with a 74% completion rate from referrers and 88% from mental health staff. This study provides guidance for referral thresholds. Improved agreement between primary and secondary care services about mental health referrals may lead to people with more severe mental health problems receiving faster access to specialist mental health care.

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Appendix 1

THRESHOLD ASSESSMENT GRID (TAG)**SCORE SHEET**

TAG ASSESSES THE SEVERITY OF A PERSON'S MENTAL HEALTH PROBLEMS

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. Further information on the TAG is available from www.iop.kcl.ac.uk/prism/tag.

		NONE	MILD	MODERATE	SEVERE	VERY SEVERE	
SAFETY	Domain 1 Intentional self-harm	No concerns about risk of deliberate self-harm or suicide attempt <input type="radio"/>	Minor concerns about risk of deliberate self-harm or suicide attempt <input type="radio"/>	Definite indicators of risk of deliberate self-harm or suicide attempt <input type="radio"/>	High risk to physical safety as a result of deliberate self-harm or suicide attempt <input type="radio"/>	Immediate risk to physical safety as a result of deliberate self-harm or suicide attempt <input type="radio"/>	
	Domain 2 Unintentional self-harm	No concerns about unintentional risk to physical safety <input type="radio"/>	Minor concerns about unintentional risk to physical safety <input type="radio"/>	Definite indicators of unintentional risk to physical safety <input type="radio"/>	High risk to physical safety as a result of self-neglect, unsafe behaviour or inability to maintain a safe environment <input type="radio"/>		
RISK	Domain 3 Risk from others	No concerns about risk of abuse or exploitation from other individuals or society <input type="radio"/>	Minor concerns about risk of abuse or exploitation from other individuals or society <input type="radio"/>	Definite risk of abuse or exploitation from other individuals or society <input type="radio"/>	Positive evidence of abuse or exploitation from other individuals or society <input type="radio"/>		
	Domain 4 Risk to others	No concerns about risk to physical safety or property of others <input type="radio"/>	Antisocial behaviour <input type="radio"/>	Risk to property and/or minor risk to physical safety of others <input type="radio"/>	High risk to physical safety of others as a result of dangerous behaviour <input type="radio"/>	Immediate risk to physical safety of others as a result of dangerous behaviour <input type="radio"/>	
NEEDS AND DISABILITIES	Domain 5 Survival	No concerns about basic amenities, resources or living skills <input type="radio"/>	Minor concerns about basic amenities, resources or living skills <input type="radio"/>	Marked lack of basic amenities, resources or living skills <input type="radio"/>	Serious lack of basic amenities, resources or living skills <input type="radio"/>	Life-threatening lack of basic amenities, resources or living skills <input type="radio"/>	
	Domain 6 Psychological	No disabling or distressing problems with thinking, feeling or behaviour <input type="radio"/>	Minor disabling or distressing problems with thinking, feeling or behaviour <input type="radio"/>	Disabling or distressing problems with thinking, feeling or behaviour <input type="radio"/>	Very disabling or distressing problems with thinking, feeling or behaviour <input type="radio"/>		
	Domain 7 Social	No disabling problems with activities or in relationships with other people <input type="radio"/>	Minor disabling problems with activities or in relationships with other people <input type="radio"/>	Disabling problems with activities or in relationships with other people <input type="radio"/>	Very disabling problems with activities or in relationships with other people <input type="radio"/>		
No. of ticks							TAG score
TAG score		0 points for each None rating: 0	1 point for each Mild rating:	2 points for each Moderate:	3 points for each Severe:	4 points for each V. Severe:	

THRESHOLD ASSESSMENT GRID (TAG)

C H E C K L I S T S F O R G U I D A N C E

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 dependants
- 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

Further information on the Threshold Assessment Grid is available from www.iop.kcl.ac.uk/prism/tag

THRESHOLD ASSESSMENT GRID (TAG)

FURTHER GUIDANCE

PURPOSE OF TAG

TAG is a brief assessment of the severity of an individual's mental health problems. Instructions for completing it are contained on the score sheet, and this page provides further guidance. TAG is very easy to complete, requiring seven ticks on the Score Sheet. It is rated by staff for people who have (or are believed to have) mental health problems. Information on diagnosis should be recorded separately, if required.

TAG can be used in different ways, including:

- by GPs and other agencies (e.g. social services) who think someone has mental health problems and want to refer to a specialist mental health team – by appending a TAG to their referral letter, specialist mental health services will be helped to prioritise those most in need of help
- to give a means of agreeing between agencies at what point in the care system people should receive help – this might be done by locally agreeing thresholds for referral
- as a routine outcome measure for patients on the caseload of a mental health team
- to give commissioners a means of specifying the way in which community mental health teams are to focus on the severely mentally ill.

COMPLETING TAG

TAG has seven domains covering the areas of **Safety** (two domains), **Risk** (two domains), and **Needs and Disabilities** (three domains). In each domain on the Score Sheet, you should tick one box, to indicate the rating of severity for that domain (ranging from 'None' to 'Very Severe'). A checklist is provided for each domain, to indicate some of the important aspects to consider. The checklists are based on evidence and current practice, but must be used in conjunction with clinical judgement. If an aspect which is relevant to the person is not on the checklist, it should still inform the ratings made.

The rating chosen should be the one that best applies to the person being assessed. The time frame is not specified, since problems (e.g. violence) may only occasionally occur, but still be ongoing causes of concern. As a general guide, however, consider problems in the last month, but also include current concerns which originate from before this period.

Example - Domain 1. Intentional Self-Harm

Looking across the row, if 'High risk to physical safety as a result of deliberate self-harm or suicide attempt' is the statement that best applies to the person, then tick this box. This rating is classified as 'Severe' (shown at the top of the grid).

When all seven domains have been ticked (once in each domain), the assessment is complete. If desired, the number of ticks for each column can be recorded in the first row at the bottom. (The total should then add up to seven.) *Example: if there are three ticks in the 'Severe' column, write '3' in the box at the bottom of the 'Severe' column.* Also, if desired, the TAG score can be calculated, by recording the total weighted score for each domain (e.g. 2 points for each Moderate rating) in the second row at the bottom, and then adding those scores together. The maximum TAG score is 24.

HOW TO USE A TAG ASSESSMENT

The two rows at the bottom of the Score Sheet indicate the severity of mental health problems. 445 TAG referrals to mental health services across London were analysed to provide *guidance* on referral thresholds. If the goal is to ensure that all referrals are suitable, then a threshold of at least 1 severe or very severe domain will ensure that 95% of referrals are suitable, but 74% of referrals not meeting this criterion will in fact be suitable – a high false negative rate. If the concern is to ensure that all suitable referrals are offered assessment, then using a threshold TAG score of 3 or more will ensure that 91% of suitable referrals are identified. However, 80% of unsuitable referrals will also meet this criterion – a high false positive rate. The best cut-off is found using either a TAG score of 5 or more, or at least 2 moderate domains.

Example: A team may agree with its referrers that a TAG will be completed for all referrals, and that the team will assess anyone referred with a Very Severe rating within 24 hours, with 2 or more Severe ratings within 72 hours, and anyone else with at least 2 Moderate rating within 2 weeks. For patients with less than 2 Moderate ratings, the referral letter will state why the patient's mental health problems are of a severity to warrant specialist mental health service.

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