CLIENT SERVICE RECEIPT INVENTORY

An evaluation of a new psychiatric day hospital for acute treatment

Client ☐ ☐☐

Interview no. ☐ **Date of interview** ☐☐/☐☐/☐☐ (d d m m y y)

1. SOCIODEMOGRAPHIC INFORMATION

1.1 Date of birth ☐☐/☐☐/☐☐ (d d m m y y)

1.2 Sex **1** Female **2** Male Code sex ☐

1.3 Marital status *(from a legal perspective)*
1 Never married
2 Married
3 Separated/Divorced/Widowed
9 Not known Code marital status ☐

2. USUAL LIVING SITUATION

2.1 What kind of accommodation does the client usually live in?
Refer to manual for definitions

Domestic / family
1 Owner occupied flat or house
2 Privately rented flat or house
3 Rented from local authority/ housing association

Community
4 Residential or nursing home
5 Hostel
6 Sheltered housing
7 Staffed group home
8 Unstaffed group home
9 Foster care
10 Supported lodging
11 Bed and Breakfast
12 Homeless / roofless
13 Hospital ward
14 Other _____

Code accommodation type ☐☐

2.2 How much does the client pay in rent/charges PER WEEK for this accommodation?
Amount paid (nearest £) ☐☐☐☐

2.3 How bedrooms in this accommodation? Number of bedrooms ☐☐
How many adults live here, including the client? *(16 years or over)* Number of adults ☐☐
How many children live here? *(Under the age of 16)* Number of children ☐☐

2.4 How many times has the client's home address changed in the previous 3 months/over treatment period? Number of changes ☐☐

3. EDUCATION AND EMPLOYMENT

3.1 What <u>further</u> education or vocational training has the client completed or is s/he doing?
(Tick all boxes that apply)

- Specific vocational training (< 1 year) ☐
- Specific vocational training (> 1 year) ☐
- Tertiary level qualification /diploma ☐
- University degree (undergraduate) ☐
- University higher degree (postgraduate) ☐

3.2 What is the client's usual employment status?

1 Paid or self employment
2 Voluntary work
3 Sheltered employment
4 Supported employment (TEP, vocational, rehabilitation,etc.)
5 Unemployed
6 Student
7 Primary home-maker (housewife/husband)
8 Retired
9 Exempt through disability
10 Other _____

Code employment status ☐☐

3.3 ***If s/he is employed***:

Please state his/her occupation _____

How many hours per week does s/he usually work? Hours worked per week ☐☐

How many days has s/he been absent from work due to illness in the last 3 months/treatment period? Days absent from work ☐☐

If s/he is unemployed:

For how many weeks has s/he been unemployed in the last 3 months*/treatment period?

* Assume 13 weeks = 3 months

Number of weeks ☐☐

4. INCOME

4.1 Does the client receive any social security benefits?

1 Yes
0 No ☐

If yes: What benefits does s/he receive? *(Please tick all boxes that apply)*

Income support	☐
plus disability premium	☐
plus severe disability premium	☐
Jobseeker's allowance	☐
Disability working allowance	☐
Disability living allowance	
care component	☐
mobility component	☐
Attendance allowance	☐
Statutory sick pay	☐
Housing benefit	☐
Council tax benefit	☐
State retirement pension	☐
Child benefit	☐
Family credit	☐
One parent benefit	☐
Other_____	☐
Other_____	☐

4.2 What is the client's total personal gross income PER WEEK from all sources?
(Note: if gross income not known, please give net income, i.e. after tax and other deductions)

1 Under £149 **4** £300 - £399

2 £150 - £199 **5** £400 - £499

3 £200 - £299 **6** £500 or more

Code for gross income per week ☐

OR

Code for net income per week ☐

5. SERVICE RECEIPT: BASELINE AND FOLLOW-UP INTERVIEWS

5.1 What **inpatient services** has s/he used over the last 3 months? *Enter '0' if service not used.*

Service	Name of facility	No. admissions	Total no. days
Special hospital (e.g. Rampton)			
Secure/medium-secure unit			
Acute psychiatric ward			
Rehabilitation ward			
Emergency / crisis centre			
General medical ward			
Other (describe)			

5.2 What **outpatient services** has s/he used over the last 3 months? *Enter '0' if service not used.*

Service	Name of facility	Unit	No. units
Psychiatric outpatient visit		Appointment	
Other outpatient visit		Appointment	
Accident and Emergency Dept. visit		Appointment	
Day hospital (e.g. for minor operation)		Days attended	
Other (describe)			

5.3 How many times in the last 3 months has **ECT** been administered?

Enter'0' if service not used. Number of ECT ☐☐

5.4 What **day activity services** has s/he used over the last 3 months? *Enter'0' if service not used.*

Service	Name of facility	No. attendances	Av. Duration per attendance
NHS day activity service			
LASSD day activity service			
Vol. org. day activity service			
Social club			
Sheltered workshop			
Education classes			
Other (describe)			

5. SERVICE RECEIPT: BASELINE AND FOLLOW-UP INTERVIEWS (cont)

5.5 What other **community care services** has s/he used over the last 3 months?
*Do **not** include services provided by staff in the accommodation facility, hospital or day activity service. Enter '0' if service has not been used.*

Service	**No. contacts at a clinic or office**	**No. contacts in client's home**	**Average no. hours per contact**
Care Programme Approach key worker			
Case/care manager			
Community mental health team member			

Service *(Note: **exclude** services above)*	**No. contacts at a clinic or office**	**No. contacts in client's home**	**Average no. hours per contact**
Psychiatrist			
Psychologist			
Community psychiatric nurse			
Individual counselling / therapy			
Group counselling / therapy			
General nursing services			
Occupational therapist			
Physiotherapist			
Speech therapist			
Chiropodist			
Social worker			
Home help / home care worker			
Outreach worker / family support			
General practitioner			
Practice nurse (GP-based)			
Dentist			
Optician			
Other (describe)			
Other (describe)			
Other (describe)			

6. SERVICE RECEIPT: DURING THE TREATMENT PERIOD

6.1 How many days has the client spent as an **inpatient** in hospital? *Enter '0' if service not used.*

Hospital_____Ward_____No. days ☐☐☐
Hospital_____Ward_____ No. days ☐☐☐

Hospital_____Ward_____ No. days ☐☐☐

6.2 How many times has the client attended an **outpatient/A&E clinic**?
Enter '0' if service not used. No. attendances ☐☐☐☐

6.3 On how many days has the client attended the **East Ham psychiatric day hospital**?
Enter '0' if service not used. No. days ☐☐☐☐

6.4 On how many days has the client attended any other **day activity service**?
Enter '0' if service not used. No. days ☐☐☐☐

6.5 How many times during the treatment period has **ECT** been administered?
Enter'0' if service not used. No. ECT ☐☐
☐☐

6.6 What **other services** has the client used over the treatment period which have **not** been recorded at Q6.1 – Q6.4?

Service	**No. contacts at a clinic or office**	**No. contacts in client's home**	**Average no. hours per contact**
Care Prog. Approach key worker			
Case/care manager			
Community MHT member			
Counselling service			
Social worker			
Home help/home carer			
General practitioner			
Practice nurse (GP-based)			
Other (describe)			
Other (describe)			
Other (describe)			
Other (describe)			

7. PLEASE COMPLETE REMAINDER OF QUESTIONS FOR ALL TIME PERIODS

7.1 Over the last three months or during the treatment period, which **complementary therapies** has the client used? *Please exclude services provided from within the hospital or day services. Enter '0' if service not used.*

Service	No. contacts at a clinic or office	No. contacts in client's home	Average no. hours per contact
Acupuncture			
Osteopathy			
Homeopathy			
Other (describe)			
Other (describe)			

7.2 Over the last 3 months or during the treatment period, how many times has the patient had contact with the **criminal justice services**? *Enter '0' if service not used.*

How many contacts with the police? Contacts ☐☐
(Note: contact = interview or stay of some hours, but not overnight)

How many nights spent in a police cell or prison? Nights ☐☐

How many psychiatric assessments whilst in custody? Assessments ☐☐

How many (criminal or civil) court appearances? Criminal courts ☐☐

Civil courts ☐☐

How many other detentions in policy custody or prison? No. detentions ☐☐

7.3 Over the previous **one month**, what medication has been prescribed for the client?

Name of drug	Dose (if known)	Dose frequency	Prescribed for…
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE