CLIENT SERVICE RECEIPT INVENTORY (CSRI)

Care Programme Approach & 12 year follow-up of the

Care in the Community Initiative

CLIENT SOCIODEMOGRAPHIC AND SERVICE RECEIPT INVENTORY

AS ADAPTED FOR USE IN THE
CARE PROGRAMME AND 'TWELVE YEARS ON' STUDIES

BACKGROUND INFORMATION AND MANUAL OCTOBER 1998

Introduction

The *Client Service Receipt Inventory* (CSRI) was originally developed at the Personal Social Services Research Unit, University of Kent in 1986 for the first evaluation of the Care in the Community Initiative programme and the economic evaluation of psychiatric reprovision in North London[1]. Its antecedents, however, go back even further to research at the PSSRU on the economics of child care, residential services for elderly people and the case management projects of the early 1980s.

Since 1986, the schedule has been used in over 100 evaluations of care for people with needs related to mental health, learning disability, physical disability and old age. For each evaluation, the overall structure and content of the schedule has remained the same although the service context of each research project has meant that a different emphases on particular questions is necessary to ensure it best suits the project's needs. In addition, refinements have been made to the way questions are asked and the way information is recorded.

As this version of the CSRI was developed we drew on work undertaken in a study funded by the European Union when sociodemographic details and clearer definitions of service types were incorporated. The current version of the *Client Service Receipt Inventory* has been developed for concurrent use in two research projects in which the study members are likely to be living in very different situations and therefore support services are likely to be delivered in different ways. For example, in the *Care Programme* research, study members are likely to be living at home in domestic accommodation. In the *Twelve Years On* research, clients are more likely to be living in accommodation that has been specially arranged and which has formal staff on-site. These very basic differences in support components will have knock-on effects for delivery and receipt of other services.

Introduction to the schedule

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[1] Beecham, J. and Knapp, M. (1992) Costing psychiatric services, in G. Thornicroft, C. Brewin, J. Wing (eds) *Measuring Mental Health,* Gaskell, London.

The overall aim of the *Client Service Receipt Inventory* is to collect information that describes in detail the types and level of services that comprise the care package of each study member. These data are important in their own right as they can inform decisions about planning, commissioning and providing services to meet the needs of particular populations. However, the schedule is designed so that service use data are recorded in a standardised way that best facilitates the estimation of the component and total costs of support for each client. Just as needs or outcome data are collected at the individual level, in an economic evaluation it is important to measure the costs of the resources used to generate those outcomes for each client. For example, it is possible that in Care in the Community (CinC) projects where a range of accommodation arrangements are employed, the care package costs for individual clients could vary by a factor of ten.

The collection of service use data is the first of three stages in the 'costing' process. The second stage is to list all services used by all clients in the study and estimate a unit cost for each service, or service type. For services which are likely to absorb a high proportion of the total costs (accommodation facilities or day activity services, say) or those which are innovative or specific to the local area (such as care programme or project management arrangements) detailed financial and activity data are required to estimate a service-specific unit cost. For other services, say, social workers or community psychiatric nurses, the variation in costs between service contexts and between geographic areas is likely to be small and unit costs can be taken from an annual compilation of nationally-applicable unit costs[2].

The third and final step in the costing process is to combine information on the frequency and duration of service use with the unit costs of each service. Thus the cost ascribed to each person reflects the intensity with which they use a range of support services. On completion of this stage, the costs data are ready to be analysed.

The following sections of this document clarify the meaning of some questions and define some of the concepts and terms used. As this version of the CSRI has been designed for use with a computerised data-entry system, this document should be read in conjunction with information on how to complete the schedule.

General information on completing the CSRI

It is important to note that the schedule is called an 'inventory' rather than an 'interview'. This is because information on service receipt may have to come from a number of sources. Whereas it is likely that the officer-in-charge or key-worker in a residential facility will know about all the services a client uses, for people living in more independent arrangements, the formal carers (case manager or care programme key-worker) may be less familiar with the full pattern of a client's life. In some cases, an informal carer or the study member themselves is the best source of information, for other clients a number of different sources will be required. For example, where data are collected on other schedules or on clinical or management information systems (computerised or not), some service use and other information can be transferred. It should be remembered, however, that case records tend to contain information on the receipt of support provided by that service: hospital records, for

[2] Netten, A. and Dennett, J. (1997) *Unit Costs of Health and Social Care, 1996*, Personal Social Services Research Unit, University of Kent at Canterbury.

example, are unlikely to record attendance at a social services or voluntary sector day activity facility; CMHT records are unlikely to record visits to the chiropodist, GP or dentist.

In many research projects, the data requested in the CSRI will be collected by researchers unfamiliar with the many and varied service contexts in which study members can be found. It is also likely that the people collecting the data are unfamiliar with the activities involved with an economic evaluation. For these reasons ***we are more than happy if researchers write clarification notes on the schedule***. It is usually the case that the researchers responsible for the cost estimation have to consult the 'hard copy' questionnaires for about 10 per cent of the sample and these notes can be very useful in explaining the service or costs context more clearly and solving perceived inconsistencies in the coding.

In the sections below, there are notes for each section of the CSRI and the question numbers refer to the version of the CSRI which has been specially adapted for this research. The CSRI was integrated into the staff interview for the *Twelve Years On* research project.

Sociodemographic information

Q1.7 The term 'general education' refers to education received in mainstream or special schools, including hospital schools. Start from the beginning of compulsory schooling.

Q1.11 Current legal status refers to where, for example, the study member is subject to a particular section of the Mental Health Act.

Usual living situation

Q2.1 If study members are living in an accommodation facility with other clients please code this as "living with others" (6). The box requesting the amount of rent paid should be completed for all study members, including people living with others. The figure should reflect the amount of money the study member pays for shelter or shelter and care from their own resources, including income from social security benefits. Note that residents living in the same facility could be paying different amounts.

For the *Twelve Years On* project, please complete the **accommodation code** box using the numeric identifier for each individual accommodation facility. This number should also appear on the CSRI-Community Accommodation Supplement for that facility.

Q2.2 These questions refer to the study members' usual/normal living situation. Thus only one option from domestic/community/hospital can be selected.

Q2.2 Domestic/family accommodation is when clients live with no permanent staff cover during the day or at night. However, study members living in these situations may receive *ad hoc* staff support from, for example, CMHT or CPA workers.

Q2.2 The following definitions provide broad guidelines for coding the specialist accommodation types.

- A ***residential or nursing home*** has accommodation for at least six residents, providing continuous cover by day and waking staff cover at night.

- A ***hostel*** has accommodation for at least six residents, providing continuous or intermediate but regular cover by day and sleeping-in or no staff cover at night.

- ***Sheltered housing units*** provide continuous, intermediate or ad hoc cover by day and waking, sleeping-in or on-call staff cover at night. The number of places in the whole facility is greater than the number of places in each individual unit (usually flats for one or two people or bed-sits).

- A ***staffed group home*** provides continuous or intermediate staff cover by day and waking, sleeping-in or on-call staff cover at night. The facility has more than one but less than six resident places.

- An ***unstaffed group home*** again accommodates between one and six residents but has ad hoc or no staff cover during the day and on-call or no staff cover at night.

- ***Foster care*** is where the client moves into an established household in which 24-hour family-type support is provided, including on-call support at night. Sometimes called adult family placements.

- ***Supported lodgings*** are where the client moves into a pre-existing household in which ad hoc or no daytime staff cover is provided and staff are on-call at night.

Where people are resident in specialist accommodation facilities (the first five categories above) more information will be required about the facility to enable an accurate assessment of the cost. More detail will be needed about which clients are resident at which specific addresses, how many other people live there, and the level of staff support provided. While collecting data on-site, researchers should complete a copy of the ***CSRI Community Accommodation Supplement*** (see attached) and obtain copy of the expenditure accounts for each facility for the financial year 1997-98 These accounts should be in disaggregated form so that amounts spent on, for example, staff, food, light, maintenance, etc., can be distinguished.

Q2.2 Please specify the name of the hospital or other facility. The following definitions provide broad guidelines for coding hospital ward types.

- ***Acute psychiatric ward***: Acute facility to which patients are routinely admitted because of a deterioration in their mental health state, behaviour or social functioning which is related to psychiatric disorder.

- ***Rehabilitation ward***: Non-acute facility to which patients are referred, usually for a fixed maximum period of residence.

- ***Long-stay ward***: Non-acute facility to which patients are referred, usually for an indefinite period.

- ***General medical ward***: Facility whose core function is the care of inpatients outside the speciality of psychiatry.

Q2.3 How many adults live there? This number should **include** the study member.

Employment and income

Q3.2 Please make sure you complete the box indicating how many hours are worked per week.

Q3.4 Note that many of the *Twelve Years On* study members may still be paid social security benefits that existed when they left hospital ten years ago but are no longer available. (Severe disability allowance is one example where it is not always to the benefit of the client if they change to new configurations of DSS benefits.) In these situations, benefits should be listed under 'other'; please note the amount client receives per week or fortnight.

Q3.5 This is an example of a question where it is very useful for the interviewee to have a copy of the questionnaire in front of them - selecting an income band is far easier than stating an amount for income.

Service receipt

- Note that all service receipt data is collected over a retrospective period of **three** months.

Q4.1 Some assessment and treatment services, particularly those for people with learning difficulties, which were provided within a hospital ('inpatient services') are now provided in community-based facilities. If these services are used, for example the Maidstone CinC project members might access such services, please record the services under the 'other' category and include the name and address of each facility.

Please ensure the **total** number of days for **all** admissions in each category is entered in the final column.

Q4.2 As above, please ensure the **total** number of appointments/days attended in each category is entered.

Q4.3 Please ensure the average duration of attendance is completed as well as the number of attendances **over the last three months** for each day service attended. Thus the client who regularly attends a LASSD day care service for three times each week will have a total number of attendances of 3*number of weeks. Please round the duration of attendance to the nearest whole number of hours.

The costs of day attendance for this client would be estimated as
(total no. attendances * average duration) * unit cost of LASSD day care per hour.

Q4.4 & 4.5
Please ensure that you do not record in these sections services or support provided by the staff who are paid from the accommodation facility budget.

Please ensure that professionals who may belong to teams listed in Q4.4 are not ‘double-counted’ in Q4.5

Q4.4 & 4.5

If more than one sector is involved in providing a service, please record the sector of the main provider. When coding the provider sector, please note that:

- ‘voluntary organisation’ refers to the non-profit sector, this might include provider units which have been ‘hived off’ from public sector agencies;
- ‘private’ includes both private (for-profit) organisations and private (for-profit) individual professionals or peripatetic staff.

Please enter the total number of contacts; those that occurred in the client's home **and** those that occurred over the previous three months in an office/clinic.

Q4.5 Please ensure that outpatient appointments are not double-counted. For example, only those consultant and senior registrar contacts which have occurred away from an outpatient department should be listed here.

When you are completing the ‘other’ categories for services, please be as precise as possible in describing the service; do not use a locally-relevant name but try and find out what professional groups provides the service or what type of service it is and where it is located.

For the *Care Programme* research an extra page in the CSRI asks researchers to record the service components of study members’ care packages, the average number of minutes per week that the service was used (thus combining measures of frequency and duration), and the unit cost for each service used. This sheet will be scanned by the data-entry programme.

Medication

Q5 Please record all drugs and medication taken, even if it is not related to the client’s primary diagnosis.

THANK YOU.

If you have any queries about the CSRI, please contact

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