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CLIENT SERVICE RECEIPT INVENTORY

ADAPTED FOR USE IN THE EVALUATION OF A NEW PSYCHIATRIC DAY HOSPITAL FOR ACUTE TREATMENT

BACKGROUND AND INFORMATION FOR INTERVEIWERS
CEMH and PSSRU, JUNE 1999

Background Information

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 for 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 variety of service contexts has meant that different emphases have been placed on particular questions to ensure the schedule best suits each research project's needs. Over the period, refinements have also been made to the way questions are asked and the way information is recorded.

The current version of the *Client Service Receipt Inventory* has been developed for use in an evaluation of a psychiatric day hospital for acute treatment[2]. This new service is being compared with inpatient hospital care in a randomised controlled trial led by Professor Stefan Priebe of the Academic Unit at East Ham Memorial Hospital, London. A full assessment of clients' care packages and their associated cost is required for this study. Inpatient hospital services generally provide a 7-day per week, 24-hour service; users receive shelter, hotel services, psychiatric treatment, general health care and social support. By contrast, the day hospital provides access to a specific set of psychiatric services between the hours of 9.30am and 4.30pm. To make sensible cost comparisons, based on the principles of economic evaluation, we must ensure that the scope of measurement employed is the same for both the intervention and the control group.

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[1] Beecham, J. and Knapp, M. (1992, 1999) Costing psychiatric services, in G. Thornicroft, C. Brewin, J. Wing (eds) *Measuring Mental Health*, Gaskell, London.

[2] If you have any queries about the CSRI, please contact Dr Jennifer Beecham at the address above or at J.K.Beecham@ukc.ac.uk.

Introduction to the CSRI

The overall aim of the *Client Service Receipt Inventory* is to collect information that describes in detail the types and level of services which 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.

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. Detailed financial and activity data are required to estimate a unit cost for services which are likely to absorb a high proportion of the total costs or those which are innovative or specific to the local area. 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[3].

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. Only on completion of this stage are the costs data ready to be analysed.

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. For this evaluation, the primary information source will be the clients themselves but some data required for the economic component of this research will be contained on other schedules such as the MANSA. For the major treatment services (inpatient hospital care and attendance at the day hospital), information on the type, frequency and duration of treatment will be collected by the staff on the participating wards and the day hospital.

Often, researchers who are unfamiliar with the many and varied service contexts that comprise community care collect the data required to complete the CSRI. It is also likely that the researchers 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 as data are collected***. In addition to the computerised data, researchers responsible for the cost estimation commonly have to consult about 10 per cent of the 'hard copy' questionnaires and notes such as these can be very useful in explaining the service or cost context more clearly or solving perceived inconsistencies in the coding.

The remainder of this document defines some of the terms used in the CSRI and clarifies coding issues.

[3] Netten, A., Dennett, J. and Knight, J. (1998) *Unit Costs of Health and Social Care, 1998*, Personal Social Services Research Unit, University of Kent at Canterbury.

CLIENT SERVICE RECEIPT INVENTORY

An evaluation of a new psychiatric day hospital for acute treatment

INFORMATION FOR INTERVIEWERS

Q.1 Sociodemographic information

Information on clients' date of birth, sex and marital status is requested as a check to ensure the correct client is identified when data files are merged.

Q.2 Usual living situation

Q2.1 The questions refer to the study members' usual/normal living situation: only one option can be selected.

Domestic/family accommodation is when clients live with no permanent staff cover during the day and no staff cover at night. However, study members in domestic housing may receive *ad hoc* staff support from peripatetic workers. Such support should be recorded at Q5.5 or Q6.6.

In this project we expect most study members to be living in independent accommodation. Where specialised accommodation is used, the following definitions provide broad guidelines for coding. Please also ensure the address is recorded correctly.

- 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.
- ***Supported lodgings*** is 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.

Q2.2 Please complete this question for all study members, including people living in specialist accommodation. 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.

Q2.4 How many adults live there? This number should **include** the study member.

Q.3 Education and employment

Q3.3 Occupations will be coded according to the Standard Occupation Classification as the data are computerised.

Q.4 Income

Q4.1 To clarify which benefit is being claimed it may be helpful to ask to see the client's "book". Please record the *name* of any "other" social security benefits claimed. This might include benefits available under an earlier system, those introduced since this list was compiled, or benefits less commonly claimed by people with mental health problems.

Q4.2 This is an example of a question where it is useful for the interviewee to have a copy of the questionnaire in front of them - selecting an income band (for example, the letter "C") is far less embarrassing for interviewees than stating an amount for weekly income.

Q.5 Service receipt at baseline and follow-up interviews

Note: at the entry-to-study and follow-up interviews all service receipt data are collected over a retrospective period of **three** months.

Q5.1 Please specify the name of the hospital or other facility and ensure the **total** number of days for **all** admissions in each category is entered in the final column.

The following definitions provide broad guidelines for identifying hospital ward types.

- ***Acute psychiatric ward***: Acute facility providing overnight beds within a hospital to which patients are routinely admitted because of deterioration in mental health, behaviour or social functioning that is related to a psychiatric disorder.
- ***Rehabilitation ward***: Non-acute facility providing overnight beds to which patients are referred, usually for a fixed maximum period of residence.
- ***Emergency/crisis centre***: Acute facility with overnight beds and which is not based in a hospital. Patients are routinely admitted because of deterioration in mental health, behaviour or social functioning that is related to a psychiatric disorder.
- ***General medical ward***: Facility within a hospital whose core function is the care of inpatients outside the speciality of psychiatry.

Q5.2 **Outpatient clinics** are provided within a hospital setting. For example, if a psychiatrist is seen at a health centre or in the client's home, please record this contact at Q5.5.

In this question, **day hospital** refers to a general health care facility where some procedures and minor operations are undertaken but where the patients cannot stay overnight.

Please ensure the **total** number of appointments or days attended in each category is entered in the final column.

Q5.4 Please ensure column asking for the average duration of attendance at a day activity service is completed as well as the number of attendances. Thus a client who regularly attends a day centre three mornings each week over a three month period will have a total number of attendances of 3*13 = 39, and the average duration per attendance will be, say, 3.5 hours. The duration of attendance should be recorded to the **nearest half-hour**.

Q5.5 Please ensure that you do not record in these tables the services or support provided by staff paid from the accommodation facility, hospital or day activity service budgets.

Please ensure that support from professionals that has been recorded in the first table (for example, the CMHT members) are not 'double-counted' in the second table.

You are asked to enter separately the total number of contacts that occurred in the client's home **and** the total number of contacts that occurred over the previous three months in an office/clinic. Average duration per contact should be recorded to the **nearest half-hour**.

When you are completing the 'other' categories for services, please be as precise as possible in describing the service. A locally-relevant name can help but try and find out which professional groups provide the service and where it is located. Average duration per contact should be recorded to the **nearest half-hour**.

Q.6 Service receipt at the post-discharge interview – the treatment period

Note: At the post-discharge interview, service receipt data is recorded at Q.6 and should cover the whole "treatment period", i.e. from entry-to-study to discharge **FOR THIS CLIENT**. For any individual client, this period might be anything from a couple of days to many months around the predicted estimate of two months. More detailed information on admission and discharge dates and intensity of treatment will be obtained from other sources.

The format is similar to that for recording services at Q.5, however, it is likely that a narrower range of services will be used as the main treatment and support will be provided through the inpatient ward or day hospital. For Q6.6, average duration per contact should be recorded to the **nearest half-hour**.

Q.7 Complementary therapies, criminal justice services and medication

Note: Please complete these questions for all time periods.

Q 7.1 The question follows the format used in Q5.5 and Q6.6.

Q.7.2 It is likely that these services will be rarely used, however, when used they are expensive. Client-based information tends to under-represent involvement with the criminal justice services but reported involvement provides a useful guide.

Q.7.3 Please record all drugs prescribed over the previous month, including those for physical health problems.

If you have any queries about the CSRI, please contact Dr Jennifer K Beecham; J.K.Beecham@ukc.ac.uk