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26 years of the Client Service Receipt Inventory (CSRI)

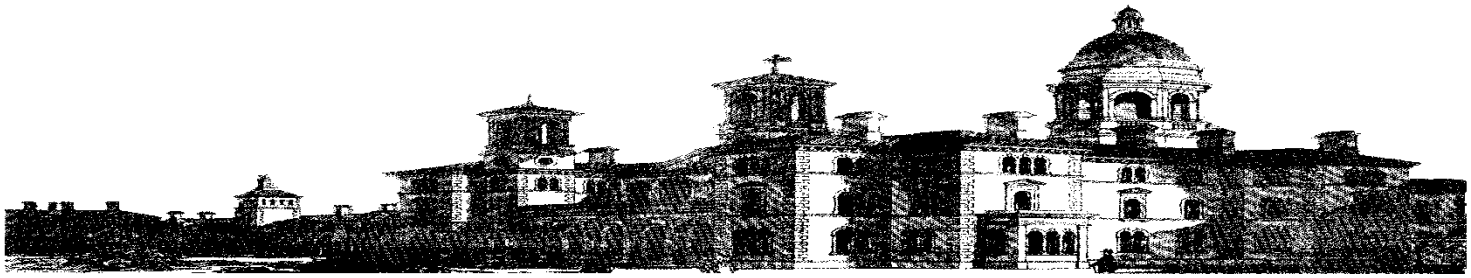
Martin Knapp
London School of Economics & Political Science
King's College London, Institute of Psychiatry
NIHR School for Social Care Research

Structure

- Roots
- CSRI/CSSRI versions
- Contents
- Some principles
- Process and uses
- Reflections

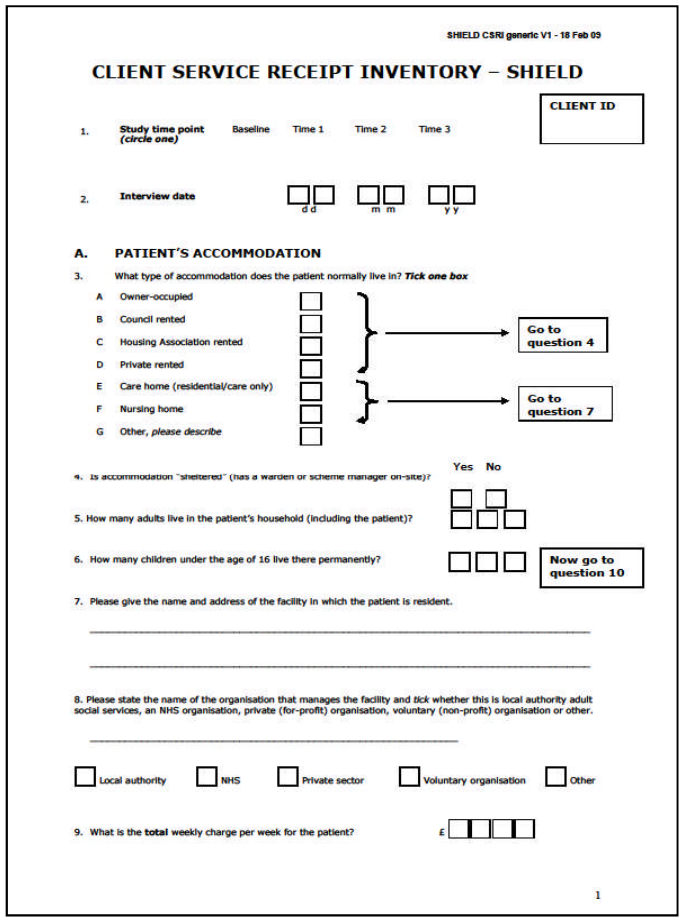
Roots

- CSRI (Client Service Receipt *Interview*) has roots in Care in the Community demonstration programme (closure of long-stay hospitals) and TAPS study (closure of two psychiatric hospitals in London) – 1985/86
- Built on earlier work on children in care (late 1970s) and young offenders



Knapp et al, various papers 1980-85; Beecham and Knapp 1990 chapter; Chisholm et al BJPsychiatry 2000

CSRI / CSSRI versions (c.400?)



SHIELD CSRI generic V1 - 18 Feb 09

CLIENT SERVICE RECEIPT INVENTORY – SHIELD

CLIENT ID

1. **Study time point** *(circle one)* Baseline Time 1 Time 2 Time 3

2. **Interview date** ☐☐ d d ☐☐ m m ☐☐ y y

A. PATIENT'S ACCOMMODATION

3. What type of accommodation does the patient normally live in? ***Tick one box***

A Owner-occupied ☐
B Council rented ☐
C Housing Association rented ☐
D Private rented ☐
E Care home (residential/care only) ☐
F Nursing home ☐
G Other, *please describe* ☐

→ **Go to question 4** (A–D)
→ **Go to question 7** (E–G)

4. Is accommodation "sheltered" (has a warden or scheme manager on-site)? Yes ☐ No ☐

5. How many adults live in the patient's household (including the patient)? ☐☐

6. How many children under the age of 16 live there permanently? ☐☐☐ **Now go to question 10**

7. Please give the name and address of the facility in which the patient is resident.

_____

_____

8. Please state the name of the organisation that manages the facility and *tick* whether this is local authority adult social services, an NHS organisation, private (for-profit) organisation, voluntary (non-profit) organisation or other.

_____

☐ Local authority ☐ NHS ☐ Private sector ☐ Voluntary organisation ☐ Other

9. What is the **total** weekly charge per week for the patient? £☐☐☐☐

1

Many people (100?) have contributed to CSRI adaptation and development

CSRI / CSSRI versions vary:

- Location within data collection strategy (free-standing; embedded)
- Timing (baseline; follow-up)
- Need/disorder group – started with social care, mental health, learning disability → now wider use in other LT conditions and acute settings.
- Also used in criminal justice, education and housing studies
- Language (c.15)
- Mode of administration (face-to-face; telephone; postal; …)
- Mode of recording (paper; laptop)
- With or without manual
- Respondent (user/patient; carer; case manager; other professional)

Contents (up to 20 mins)

- Background and client information
- *[CSSRI added socio-demographic data]*
- Accommodation and living situation
- Employment history
- Benefits
- Service receipt
- Informal care support

Of course, content varies with version, driven by need group, study design, mode of administration etc

Some principles (sometimes dropped)

- Breadth – not just health
- Identify sector
- Identify payer
- Prompt cards
- Proportionality
- Translations – focus groups, back translation etc
- Cross-check with other sources (e.g. primary care or hospital records)
- Be sensitive to the need group (cognitive problems, depression, psychotic episodes, addiction problems …)
- Be sensitive to the topic in some situation (e.g. loss of benefits, income sensitivity, crime, children taken into care …)

Processes and uses

- Interview
- SEAN form (no more)
- Costed care packages → link to PSSRU *Unit Costs* volumes

Uses for research:

- Service use patterns
- Costs (total and disaggregated)
- Cost-effectiveness analyses
- Analyses of inter-personal, -provider, -area variations

Wider uses:

- Dowry levels ; funding transfers between agencies
- Grant-setting by central government
- Price negotiation
- Self-evaluation by providers
- Care questions (HSE etc)

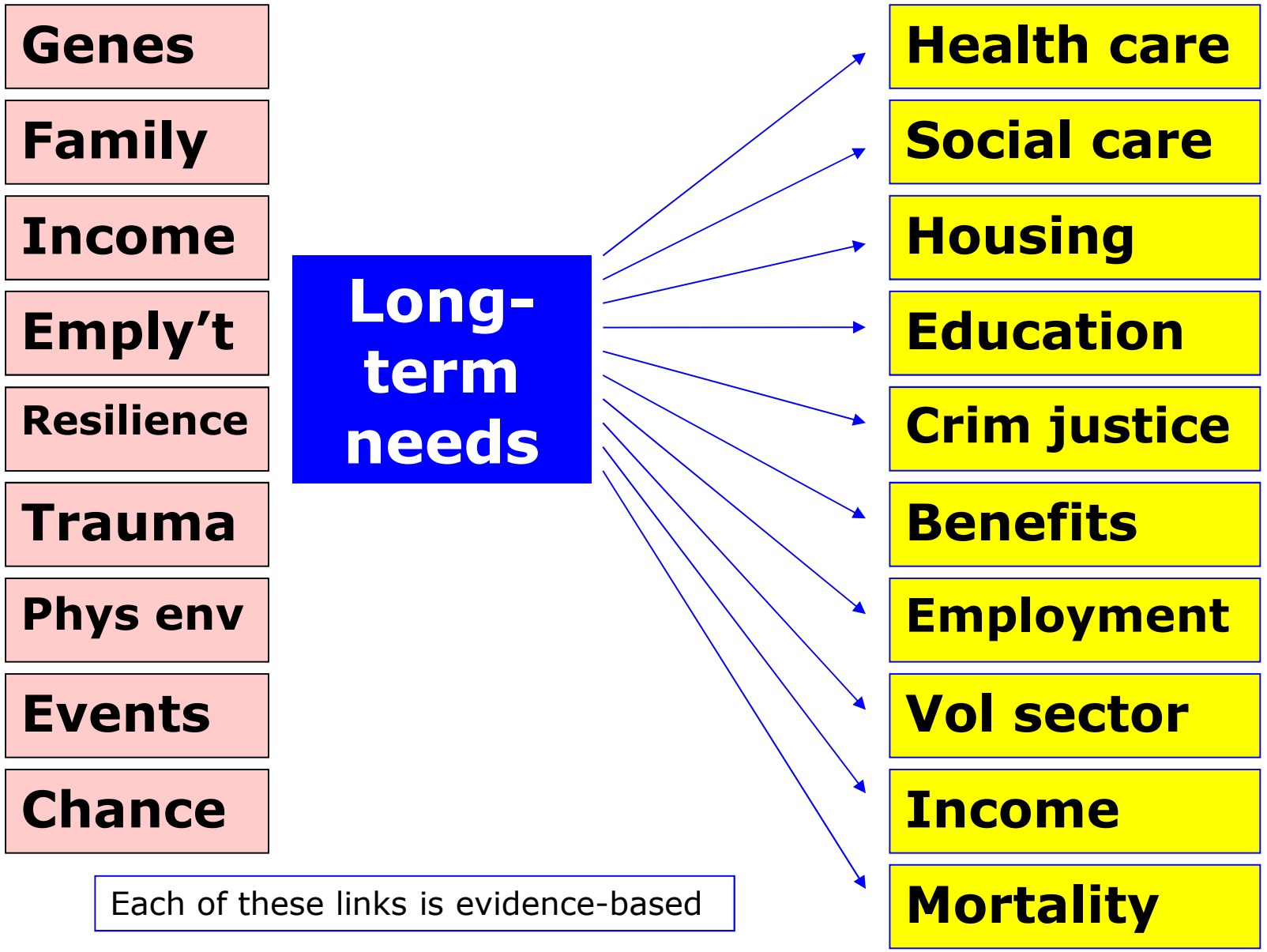
Validity / reliability

- Corney, Beecham et al *HTA* 2000 - depression
- Patel et al *Family Practice* 2005 – primary care (personality disorder and wider)
- Byford et al *Health Economics* 2007 – deliberate self-harm
- Mirandola et al *Social Psychiatry and Psychiatric Epidemiology* 1999 – all adult mental health needs
- probably others …
- Work in progress – Henderson et al – long-term conditions (COPD, diabetes, heart failure, social care needs) using data from WSD (telehealth and telecare) trials

Reflections

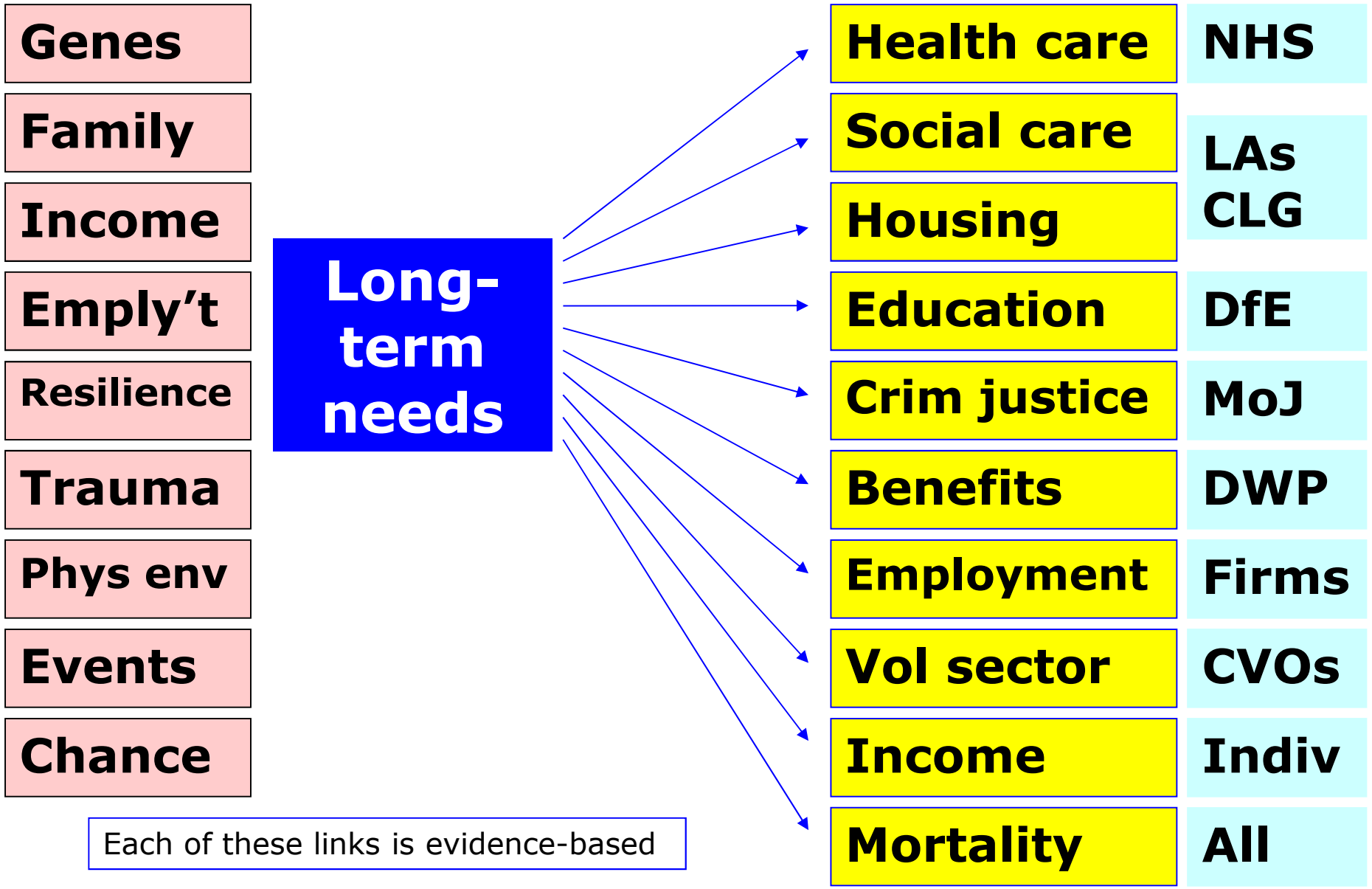
- If I'd known then what I know now…

Many causes; widespread impacts



Each of these links is evidence-based

…on many different budgets (England)



Reflections /issues

- If I'd known then what I know now…
- Breadth – multi-system; multi-sector … vs slim-line approach
- Recall accuracy – what retrospective period?
- Direct payments, personal budgets
- Self-funders
- Cross-checking – but which is 'correct'?
- Confidentiality (cf. benefit entitlements, sensitivities)
- Blinding difficulties (e.g. psychological therapies)
- Proportionality and relevance (Knapp & Beecham *Health Economics* 1993)
- Standardise on principles, not necessarily on detail