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

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)

Many people (100?) have contributed to CSRI adaptation and development
Contents (up to 20 mins)

- Background and client information
- \[CSSRI \text{ added socio-demographic data}\]
- 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)
- 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

Genes
Family
Income
Empty’t
Resilience
Trauma
Phys env
Events
Chance

Long-term needs

Health care
Social care
Housing
Education
Crim justice
Benefits
Employment
Vol sector
Income
Mortality

Each of these links is evidence-based
...on many different budgets (England)

Genes
Family
Income
Empty’t
Resilience
Trauma
Phys env
Events
Chance

Long-term needs

Health care
Social care
Housing
Education
Crim justice
Benefits
Employment
Vol sector
Income
Mortality

NHS
LAs
CLG
DfE
MoJ
DWP
Firms
CVOs
Indiv
All

Each of these links is evidence-based
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