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Title: Community professionals' management of client care: a mixed-methods systematic review

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Summary

Objectives To review research- and experience-based published literature regarding individual community professionals' caseload management (i.e. behaviours related to assessment, treatment and discharging of clients). To: identify the number, nature and frequency of papers published; investigate their scope and quality; identify the main themes and concepts; and synthesise the findings to inform practice, policy and research.

Methods Publications were systematically identified from electronic databases, hand searches of bibliographies, and contact with professional organisations. Inclusion criteria were applied. There were no restrictions on language, the nature of publications or publication year. Procedures were systematically applied for quality appraisal and data extraction. Qualitative and descriptive quantitative methods were used for data analysis and synthesis.

Results Search criteria yielded 2048 papers of which 42 papers met the inclusion criteria. 35% of these were research-based. The papers covered 16 professional and 20 client populations, and their quality was generally poor. Analysis identified six broad themes: definitions of caseload management, caseload measurement and 'tools', models of caseload management practice, client-professional relationship, discharging, and professional guidance. Six papers presented issues that related to but did not fit within these themes. Current caseload management tools and models of caseload management practice had poor evidence-base. Several papers (n=5) described benefits of team-based approaches. Professional guidance for caseload management is limited in detail and relevance to daily practice.

Conclusions Although the published literature presents considerable discourse about caseload management the strength of evidence is limited and it is not possible to make summative conclusions. Policy makers and professional bodies should encourage and support development of a cumulative evidence-base about the ways to achieve effective, efficient and equitable caseload management. Health and social care services considering implementing caseload management tools or models of practice should critically appraise their basis, and consider their potential advantages as well as disadvantages.

1. Introduction

Accessibility and equity, underpinned by efficient management of resources, are amongst the key priorities for health care provision¹⁻³. Following the shift from acute services to community health care, increasing referral rates, growing waiting times, rising caseload numbers and low discharge rates are becoming increasingly challenging to community services both in the UK⁴⁻⁶ and internationally⁷⁻¹⁰. Community services include a wide range of locally provided care, for example, local hospitals' out-patient clinics, mental health services, learning disability teams, child and school health services, and palliative care. The care may be provided by a range of professionals, for example, nurses, occupational therapists, physiotherapists, health visitors, and midwives. A particular feature of community professionals' caseloads is that they cannot become 'full' in the same way as hospital wards; the physical context does not limit the number of clients that can be placed on community professionals' caseloads. Yet, professionals' capacity to attend to clients is limited by the time available to them and unmanageable caseloads could have implications on waiting times and quality of care (e.g. access to and equity of treatment provision).

A range of issues at different levels¹¹, including ecological, organisational, team, individual professional and service user levels can impact on the accessibility and equity of service provision. Previous research in occupational therapy, physiotherapy and speech and language therapy⁴ has identified that some of the variation in service delivery is likely to relate to differences in how individual professionals manage their clients. This is particularly plausible in a light of wider literature in health care

professionals' autonomy. For example, individual medical practitioners have been found to shape service provision by rejecting practices that they believe are unfavourable and by implementing practices they believe to be beneficial (even where scientific evidence is not strong)¹². Yet, in current discourse about variation in service provision, individual professionals' management of client care (e.g. frequency of treatment provision, policies for discharging) has remained largely unexplored. For example, variation in waiting times has been assumed to relate to organisational and ecological factors⁵.

This paper reports findings from a systematic review of research- and experience-based published literature regarding individual community professionals' caseload management (i.e. behaviours related to assessment, treatment and discharging of clients). This review did not focus on case management, which differs from the former in that case management commonly refers to co-ordination of multiple services for a particular client. The existing literature was summarised and explored, and a conceptual thematic framework of the issues was developed in a way that informs practice and research. The overarching questions were: what are the main issues in caseload management discussed in the current literature, and what is the evidence about these issues?

Specific objectives were to:

- identify the volume, nature and frequency of relevant papers published to date;
- investigate scope and quality of the papers;
- identify the main themes and concepts emerging from the included papers; and

- synthesise the findings

Systematic reviews can be used to review effects of selected interventions or for developing (conceptual) theory of contextual variables potentially linked to desired outcomes¹³. Our review falls into the latter category, with the specific methods described below.

2. Methods

For search strategy and inclusion of relevant papers, established procedures for systematic reviews¹⁴ were followed. Due to the heterogeneous nature of the included papers, an approach that imitated a framework for mixed methods systematic reviews developed by Popay et al¹³ was applied to quality appraisal, data extraction, analysis and synthesis. A flowchart of the methods used is presented in Figure 2, with further details for each step provided below.

Electronic searches were undertaken of the following bibliographic databases to identify potentially relevant papers : MEDLINE (1966-Week 49 2006), EMBASE (1980-Week 49 2006), CINAHL (1982-Week 49 1980), Applied Social Sciences Index and Abstracts (ASSIA) (1987-October 2006), PsycINFO (1967-October 2006), British Nursing Index (BNI) (1994-October 2006), Allied and Complementary Medicine Database (AMED) (1985-September 2006), Health Management Information Consortium (HMIC) (October 2006) and OTSeeker (October 2006). The searches incorporated both thesaurus-controlled subject heading terms and text words or phrases. Sensitivity was prioritised

over specificity, to ensure an inclusive search strategy. Two search facets; 'community health care/services' and 'caseload/ workload management' were developed. Each consisted of relevant subject headings and text words combined with the Boolean operator "OR" and then the resulting sets were combined using the Boolean operator "AND". Full details of all the search strategies used are available from the authors. Additional references were located through screening the bibliographies of articles included in the review and contacting the College of Occupational Therapists (UK), Royal College of Speech and Language Therapists (UK), the Royal College of Nursing (UK), Canadian Association of Occupational Therapists, and National Association of Paediatric Occupational Therapists (UK) to identify potentially relevant papers. No restrictions were placed on language, the nature (e.g. qualitative, quantitative, opinion) or the publication year of papers.

The two search facets listed above, and an additional facet 'professional', were further defined to form a set of relevance criteria that were applied to select papers for inclusion. 'Community' referred to clients living at home; 'professional' referred to any individuals involved with direct assessment and treatment of clients (e.g. nurse, social worker); and 'caseload/ workload management' referred to judgements, decision and actions related to assessment, treatment and discharging of clients. Papers were included in the review if they met all three relevance criteria. Papers were excluded if they focused purely on clinical (e.g. effectiveness of a clinical intervention) or financial issues, validation of clinical tests, or organisational issues without direct reference to individual professionals. Papers focusing on general medical practitioners were

excluded as the context of their caseload management was considered to differ from that of other professionals.

Qualitative and quantitative information was synthesised. There is no standard, recommended approach for quality appraisal, data extraction, analysis and synthesis for mixed methods reviews¹³. The methods used in this review were consistent with those recommended by Popay et al¹³. Quality appraisal was conducted by categorising the papers first into those that did and did not describe a research design and methods (from here after labelled as 'research-based' and 'not research-based', respectively), and then further into one of six mutually exclusive domains (Figure 1). Within each domain, the quality of papers was assessed using a descriptive checklist based on published quality appraisal criteria as indicated in Table 1. The quality appraisal was used to modify the conclusions from the synthesis by taking more notice of the higher quality papers, not to make decisions about inclusion/ exclusion of individual papers.

Following the quality appraisal, the first author familiarised herself with the papers and extracted descriptive data (e.g. aims, populations, key findings) from the papers into a summary table. Individual papers were then analysed in-depth to identify key issues within each paper, and the issues were compared and contrasted across papers to identify higher level themes. These themes were further integrated, refined and synthesised through critical discussion within the research team, until an agreement about the final themes, and their groupings and labels, was reached. From the themes, key concepts that were considered relevant to overall caseload management process

were identified. Concepts were considered relevant if they were central to several papers within a theme, or if they mirrored caseload management concepts found in hospital care literature. The final themes also guided a revision and structuring of the descriptive summary table, and the table was used to develop visual summaries of the descriptive data (e.g. distribution of publication years and types of papers).

Paper inclusion, quality appraisal, data extraction and data synthesis were undertaken by the first author. Twenty percent of the papers were independently assessed for inclusion/ exclusion and 10% were checked for match regarding qualitative, emerging themes by the second and third authors respectively. Agreements on these were high and disagreements were resolved by discussion and clarification. Copies of the full search strategy, list of excluded papers, and detailed quality appraisal and data extraction tables are available from the first author.

3. Results

Description of the included papers

Volume, nature and frequency

From the electronic searches, a total of 2048 abstracts were retrieved and screened. From these, 127 were identified as potentially relevant and the full text versions of these papers were read and assessed for relevance. 34 papers met the inclusion criteria. In addition, 8 papers were included from grey literature, totalling 42 papers (Figure 3, Table 2). The majority of included papers (65%) were not research-based, and came from either the UK or US. Visual display of publication years (Figure 4) demonstrated an

overall trend of increasing numbers of papers about caseload management since 1995. This was largely associated with an increase in practice-based papers and opinion pieces. There was no increasing pattern of conceptual or research papers over time. Of the 42 included papers, only seven provided quantitative findings. These papers were so diverse in terms of their aims and methods that a meta-analysis was not possible.

Scope and quality

Included papers covered 16 professional (e.g. health visitors, psychiatrists, physiotherapists) and 20 client populations (e.g. children, cancer patients, elderly, patients with cardiac problems). From application of the quality criteria it was apparent that the quality of the papers was generally poor. The main quality limitations (Table 2) were: non-research based papers were low on reference to theory or relevant research and did not include critical discussion of alternative viewpoints; qualitative papers were low on description of methods as well as sensitivity to the context; and quantitative papers were low on description of methods and information about validity and reliability of outcome measures.

Themes and concepts identified from included papers

The key issues discussed in the literature related to six broad themes: (i) definitions of caseload management, (ii) caseload measurement and 'tools', (iii) models of caseload management practice, (iv) client-professional relationship, (v) discharging, and (vi) professional guidance. Six papers presented issues that related to but did not fit within any of these main themes. These are presented under an additional theme 'other

issues'. Papers of higher quality are presented in more detail than those of poorer quality.

Definitions of caseload management

Five papers focused on defining caseload management. Henke et al¹⁵ conceptualised caseload management as a co-ordinating element of providing care to more than one client. They argued that: movement of individual cases through the care process (i.e. *throughput*) is the essence of effective caseload management and that throughput should be measured at all stages of the care process in order to ensure that individual cases progress towards their goals. None of the other papers within this theme presented operational definitions for caseload management, but listed caseload management decisions and actions^{16,17} and discussed general aspects of caseload management [e.g. employee accountability, cost-effectiveness, professionals' values¹⁸, resources¹⁹ and prioritisation¹⁷]. The theme was solely based on papers that were not research-based. There was no evidence of empirical evaluations of *throughput*.

Caseload measurement and 'tools'

This theme constituted the largest number of papers (n=11) and described caseload measurement variables²⁰, tools for caseload measurement²¹⁻²⁶ and management²⁷⁻²⁹, and a qualitative implementation evaluation³⁰. Caseload measurement covered two dimensions: size²³ (i.e. a number of cases on professional's caseload) and 'weight'^{20-22,24-26} (i.e. size multiplied by case complexity). Caseload weight stemmed from an argument that caseload size alone is not a meaningful measure due to differences

between individual cases. King et al²⁰ conceptualised a range of variables (e.g. contact frequency, level of need, intervention provided) that could be used to operationalise caseload weight, but presented no evidence of their use in practice. None of the papers presented evidence about a relationship between caseload size/ weight and care process outcomes.

Papers that focused on caseload measurement and management tools are summarised in table 3. Four of these were built on the assumption that there is an optimum, standardised caseload size or weight. One paper²² challenged this approach, arguing that subjectivity is inevitable in caseload 'weighting' systems because 'complexity' of a case will always be dependent on professional-related factors (e.g. knowledge and skills). They claimed that caseload weighting tools should make such subjectivity transparent.

Seven of the nine tools had emerged from practice^{21,22,24,25,27-29} and were characterised by limited reference to empirical research and limited replicability. The only research-based tool²⁶ provided little information about methods used for its development, and the conceptual paper²³ presented no evidence of the tool's use in practice. All nine papers suffered from similar limitations: the tools' impacts were anecdotally reported as advantageous to therapists and a service manager rather than as improvements in service provision or benefits to clients; none of the tools had been empirically evaluated in professional practice; and regarding validity, reliability, effectiveness and acceptability to clients of the tool was rarely reported.

A final paper³⁰ within this theme discussed implementation and acceptability of caseload management tools. It was identified that tools can have several disadvantages as well as advantages, including feelings of anxiety for both professional and clients and interruptions in the client-professional relationship. Although using the tool may have increased consistency between professionals, there was variation in the way professionals used it, and clients' perceptions and experiences of the tool were related to their perceptions of their relationship with the professional. The importance of evaluating consequences and acceptability of caseload management tools to both professionals and their clients was identified.

To summarise this theme, there are major limitations in the existing knowledge base, specifically, a lack of empirical evidence about the relationships between caseload size/weight and professionals' caseload management. The validity, reliability, effectiveness, acceptability to professionals and clients, and feasibility of implementing existing tools are largely unknown.

Models of caseload management practice

Nine papers described models of caseload management practice. Five of these^{7,31-34} described team-based caseload management systems. A qualitative study³¹ investigated 'zoning'; a system in which professionals openly reviewed and discussed each others' caseloads in regular team meetings. Zoning aimed to target services to those who needed them the most; ensure clients did not miss out on services they

required; and ensure everyone in the team was working coherently. Zoning operated through three main functions: normative (managerial oversight and adherence to policy), restorative (space for discussion and peer support) and formative (development of skills through sharing). Although staff perceptions of zoning were mainly positive, it was reported that increased awareness of difficult cases might generate stress. Some professionals perceived that limiting resources to only those who needed them was a negative effect of zoning.

The other four papers^{7,32-34} reported that team-based approaches were perceived to have the benefits of sharing knowledge and skills³² and enhanced management of complicated cases^{7,34} as these increased a sense of coping and support⁷. Team meetings were used to identify and agree clients' health needs³² and it was suggested that agreements at team-level reduce undesired variation in practice between professionals³³. However, another side of reduced variance was perceived to be lower levels of flexibility for individuals' practices³³. Some professionals were reluctant to give up individual caseloads, with related concerns about losing *relationships with clients*^{32,33}.

With respect to other models of caseload management practice, Pertile and Page³⁵ briefly described a development of the Maroondah Approach to Caseload Management (MACS). This model emerged from practice and was aimed at reducing waiting times for treatment (as opposed to waiting times for assessment). A key element was prevention of the carer's dependency on the professional through carer education.

Professionals who implemented the MACS³⁶ felt that involving carers was useful. The challenges in implementation included resistance by carers, resources issues and incompatibility with some of the current clinical approaches.

In 'active caseloads'³⁷ 'active' status was given to families that had an identified health need, an agreed care plan and a timed evaluation. Management of 'inactive' families was not reported. In 'total caseloads'³⁸ a professional managed the client's care process from assessment to discharge as opposed to a task-oriented approach with a daily list of newly allocated clients.

In the absence of empirical evaluations, limited conclusions can be drawn about the potential effectiveness of these different models of caseload management practice. Reporting of the feasibility and acceptability of the models was limited. The papers discussed challenges in changing professionals' caseload management as well as perceived facilitators of change. Five out of nine papers reported perceived benefits of team-based approaches.

Client-professional relationship

The client-professional relationship –theme was the main theme in four papers, but it was also mentioned as a sub-theme in several other papers^{e.g.30,32,33} included in this review. One of the key concepts frequently linked with this was a '*need*'. A qualitative investigation³⁹ reported that professionals' construction of a *need* was related to their social context of practice and personal framework as well as available resources. These

guided their actions in identifying certain needs over others and allocating resources to certain clients.

An opinion⁴⁰ was reported that investing time early in the process (to build the relationship) is helpful and that providing hope is important. A survey⁴¹ found that the frequency of therapeutic limit-setting actions was positively correlated with client-related factors (e.g. past history of hospitalisation or substance abuse) and negatively correlated with professionals' perceived level of alliance with the client. Another survey⁴² found that professionals who perceived more client-related barriers to treatment were more likely to employ strategies to overcome the barriers. Both papers suffered from quality limitations regarding methods and neither reported investigations of possible mechanisms underlying the correlations, direction of any causality or impact on the care process.

Discharging

Discharging emerged as a key theme from four papers. While covering other issues, some papers described discharging as a particularly challenging stage of the care process. The concept of *need* continued to appear as important. An audit⁴³ identified that one of the main reasons for discharging was that professionals no longer perceived a need for input or that the client was supported by other services. A qualitative study⁴⁴ concluded that post-discharge support should be planned at early stages of the care process, but that there were challenges in doing this (e.g. time constraints, difficulties in identifying what was needed). Two further studies^{45,46} found that in some instances

professionals carried out 'long-term management' (e.g. monitoring rather than providing treatment) even when the need for involvement was not clear and it was suggested that providing care had become a habit that was difficult to stop. Professionals' dissatisfaction about meeting clients' needs was higher with those who had stayed on caseloads for long (>5years)⁴⁵. Long-stay clients were perceived to be 'stuck' or difficult to discharge.

Professional guidance

Three papers were structured around professional guidance for caseload management. The British Dietetics Association's safe caseload management guidelines⁴⁷ focused mainly on organisational and contextual issues (e.g. policies and standards). Guidance for individual professionals was at a very general level (e.g. advice to adhere to policies and standards). The Canadian Association of Occupational Therapists⁴⁸ had developed a draft framework for effective caseload management. The recommendations included broad 'guiding principles' such as combining client-centeredness with evidence-based practice; cost-effectiveness; accountability and professional leadership and expertise. The third paper⁴⁹ noted that professionals must adhere to their code of conduct and that they are personally accountable for their practice.

Other issues

A mixed group of papers (n=6) were not able to be classified into the themes described above. These covered contextual issues, cognitive processes, and knowledge and skills. Inclusion of these papers in the review was largely a function of the inclusive

search strategy. In brief, a survey⁵⁰ and a conceptual paper⁵¹ discussed, respectively, the frequency of various ethical issues faced by professionals when managing client care, and perceived uncertainty and risk of a given situation as factors influencing professionals' decisions and actions. Two qualitative research papers^{52,53} described professionals' thinking processes in relation to clinical tasks. Both suggested that situational aspects of decision-making were important. Finally, a survey found that rehabilitation counsellors' caseload management performance (measured as clinical outcomes, throughput and use of resources) was positively correlated with their educational level⁵⁴, and a qualitative research study found that newly qualified clinical psychologists reported fewer caseload management strategies than experienced ones⁵⁵.

4. Discussion of the key issues from the existing literature

The 42 included papers indicated high practice-based interest, a lack of research-based papers and the absence of a cumulative knowledge base in health and social care professionals' caseload management. Papers covered a wide range of professional and client populations, suggesting that caseload management is a concern in a range of fields. The quality of the papers was generally poor, and it was not possible to make any firm conclusions. However, inclusion of different types of papers in the review allowed identification of the main problem areas for professional practice. This will inform practitioners', decisions makers' and researchers' future endeavors to investigate and improve caseload management as discussed below.

Key concepts for future investigation

Some key concepts that would benefit from further exploration were evidenced in the literature reviewed. One of these was *throughput*, a concept that has already been found relevant for service-level caseload management in hospital care. One of the papers in this review suggested that, in community care, throughput at a service level can be seen as a function of throughput in individual professionals' caseloads¹⁵.

Further, throughput in individual professionals' caseloads can be seen as a function of duration and intensity of care provided to individual clients. Future research should investigate whether throughput at individual professional -level could provide a useful approach to ensuring client flow through community services and, subsequently, improved access to new clients.

Efficient throughput relies on timely discharging. Yet, in the current review the findings suggested that in some instances professionals continue to provide services to clients longer than clinically needed. One explanation for this could be that discharging requires professionals to make judgements about clients' *needs* – a concept emphasised in a number of papers across the themes. In many fields of health care, particularly with clients with long-term conditions, a 'need' (i.e. a condition or an activity limitation) is likely to continue despite interventions. It may not be possible to fully 'meet a need' (i.e. to cure the condition). In such circumstances, judgements about benefits and cost-benefits of continuing interventions would be required. Yet, the included papers provided some indication that attempts to consider cost-benefits and provide more targeted services could be perceived negatively by some professionals. Further

work and debate is required around the role of community services with clients with long-term conditions, and the boundaries that professionals should adhere to when deciding about provision of interventions. The requirement for this is particularly pertinent in the services where the care is provided by nursing or allied health professionals as the clinical evidence to guide the decision making process is likely to be limited.

It can be argued that defining a client's need, and matching this with the most efficient and appropriate intervention strategy, is one of the core aspects of individual professionals' daily caseload management. It is therefore not surprising that the review identified a number of caseload management tools that have been developed for quantifying clients' needs, and the subsequent demand of the professionals' caseload. This approach is underpinned by a concept of '*caseload weighting*'. This involves establishing the time demand of professionals' caseload by multiplying the number of clients on their caseload by the complexity of the cases'. However, this review identified a lack of evidence for this approach and for the perception that caseload weighting can be used to improve caseload management and service provision. Further, the majority of caseload weighting tools identified in this review shared a fundamental problem: the scoring systems to define a 'weight' (e.g. complexity) of a case were not based on empirical evidence and their validity and reliability were unknown. This raises a dilemma. That is, if no tool is used, professionals' judgements about variables such as complexity and time demand are subjective. However, the use of a numeric system can create a false impression of objectivity, but if their reliability and validity are unknown

they may be no more objective than clinicians' (possibly expertise-based) judgements. Consequently, the use of tools that may be invalid or unreliable has the potential to create 'hidden bias' that is not readily open to scrutiny. Considering the amount and breadth of discourse regarding caseload weight, an operationalisable definition of this concept would need to be established and evaluated. Further, possible relationships between weight and care process outcomes should be further empirically investigated before a numeric system of caseload management can be reliably and validly used.

Implications for policy

Future work in improving caseload management should consider the different levels and stakeholders involved, including individual professionals, and interactions between them. Further, in light of a wider evidence in quality improvement⁵⁶, it may be that focusing on the complete care process, rather than its discrete dimensions (e.g. needs assessment or discharging alone), would be a useful way to provide services with evidence about effective models of organising their overall practice.

This review found the current guidance for caseload management to be limited by a lack of high quality evidence to support the recommendations. Policy makers should allocate resources for systematic investigation of the factors related to effective, efficient and equitable caseload management in community care, including issues such as throughput, role of professional-client relationships, and ways to achieve satisfactory discharging. High quality evidence of these issues would facilitate development of guidelines that were specific to professionals' practice, and thus more likely to be

effective in improving practice⁵⁷. Collection of meaningful routine data about client flow and professionals' activities would provide one, but not the only, approach to the development of such an evidence-base.

Finally, the current policy discourse encourages service managers and professionals to focus on providing services to those who (clinically) 'need' them. As emphasis in service provision moves increasingly from acute interventions and curing patients to management of long-term conditions and maintenance of good health, solely focusing on needs may no longer be appropriate. Policy makers are in a position to encourage managers and professionals to consider not only their patients needs but also the likely benefits, and cost-benefits, of the interventions.

Implications for practice

The findings from this review indicate that it is of paramount importance that services systematically critique the validity and reliability of any caseload management tools they consider using, including those that rely on calculating caseload 'weights'. The acceptability and consequences (both positive and negative) of any tool to the clients and professionals should also be considered. There is currently limited evidence to support services to select the best models of caseload management practice. It may be that team-based approaches have helpful features (e.g. they may encourage sense of support and sharing of skills), however, further investigation is required before any one approach can be recommended.

Implications for researchers

Methods for the quality appraisal, extraction, analysis and synthesis for mixed methods systematic reviews are still developing. It was acknowledged that the basis for using of quality appraisal outcomes to weight the evidence for synthesis is extremely limited and further consideration is required about how this should be done in mixed-methods studies.

The key concepts that would benefit from future research have been identified in this review. Other areas of further research include the role of client-professional relationship and team-based approaches in caseload management. In terms of the client-professional relationship, the magnitude and nature of any relationships, and the underlying mechanisms, require further exploration. In terms of the team-based approaches, benefits on caseload management outcomes (e.g. access and consistency of service provision) and feasibility of use should be further investigated. In order to improve the quality of the evidence in the field, researchers should ensure that in reporting the findings they provide a comprehensive description of the methods used, specifically, consideration given to the research context, validity and reliability of outcome measures.

Limitations

Qualitative data extraction and formation of themes are, in general, subjective processes. However, in this review emphasis was placed on transparency of the process, to enhance the validity of the synthesis. A narrative approach allowed

investigation of the broader discourse and inclusion of a range of perspectives into the synthesis, which was particularly valuable in a field where summative knowledge is scarce. This review did not aim to establish effectiveness of particular caseload management approaches or practices, nor did it investigate organisational aspects of caseload management. Although the focus of this review was at the level of the individual professional, it is acknowledged that professionals make decisions and take actions in the context of dyadic relationship with their clients and within variety of team and organisational contexts. Therefore, it is likely that there are topics beyond those identified in this review (e.g. tensions between social service and health service managers and practitioners about service boundaries, staff mix issues, and workload and service quality relationships) that are relevant to professionals' caseload management and that would provide a logical expansion for this review in the future.

5. Conclusions and Recommendations

The literature about community professionals' caseload management is mainly experience- (as opposed to research-) based. It is not possible to draw firm conclusions, but key concepts and issues for future research were identified. The use of team-based approaches may facilitate effective caseload management processes. There was little evidence to support the currently used caseload management tools and models of caseload management practice, and current professional guidance was limited in detail and in relevance to daily practice. Services considering implementing caseload management tools or models of practice should critically evaluate their evidence-base; policy makers should ensure guidance provided is specific; and researchers should

build a cumulative knowledge-base including evidence about the main variables that predict effective, efficient and equitable caseload management.