**Literature review on determining appropriate caseloads and workloads for Children’s Disability Network Teams**

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# Statement on Language

In this report, we use the term “children with disabilities” which reflects person first language. This is in line with what is commonly used in disability services and reflects the language used in the UNCRPD (persons with disabilities). We recognise that the term ‘disabled persons/people’ which is considered to be identity first or social model language is preferred by some people. Identity-first language acknowledges the fact that people with an impairment are disabled by barriers in the environment and society and so aligns with the social and human rights model of disability. We also acknowledge that some people do not identify with either term.

For further information on disability-related language and terminology, please refer to the NDA’s Advice Paper on Disability Language and Terminology[[1]](#footnote-1)

Abbreviations

| Abbreviation | Definition  |
| --- | --- |
| AOTA | American Occupational Therapist’s Association  |
| AOTI | Association of Occupational Therapists Ireland  |
| ASHA | American Speech-Language-Hearing Association  |
| BC | British Colombia |
| CDNT | Children’s Disability Network Teams |
| CMPt | Caseload Management Planning Tool |
| EIT | Early Intervention Team |
| HIQA | Health Information Quality Authority |
| HSE | Health Service Executive |
| IDEA | Individuals with Disabilities Education Improvement Act |
| MaST | The Management and Supervision Tool |
| NDA | National Disability Authority |
| NHS | National Health Service |
| NICE | National Institute for Health and Social Care Excellence |
| ODE | Oregon Department of Education |
| OT | Occupational Therapist |
| PDS | Progressing Disability Services |
| PT | Physical Therapist |
| SAT | School Age Team |
| SCIE | Social Care Institute for Excellence |
| SLP | Speech Language Pathologist |
| SLT | Speech and Language Therapist |
| WAT-T | Workload Assessment Tool for Therapists |
| UK | United Kingdom |
| USA | United States of America |

# Executive Summary

## Introduction

The HSE requested that the National Disability Authority (NDA) conduct a review of Children’s Disability Services and in particular the functioning of Children’s Disability Network Teams (CDNTs). This is an action in the Roadmap for Service Improvement 2023-2026 of Disability services for children and young people.

Part of the project plan included an in-depth review of all the literature available about workload and caseload optimisation in children’s disability services and other similar services.

Determining the correct caseload and workload for a therapist is critical in-service planning and development. The Association of Occupational Therapists in Ireland was critical of the caseload size carried by some occupational therapists working within CDNTs.

In general, caseload is the number of children that are seen by the therapist over a specified time periodand **‘**workload’ refers to all the activities required to effectively manage a caseload.

With the development of the Progressing Disability Services (PDS) for children and young people model, staff were brought from specialist disability services (i.e. services that may have focused on a particular disability type) into CDNTs. CDNTs use an interdisciplinary approach and the teams consist of staff from multiple disciplines that may not have worked in an interdisciplinary manner. Whilst caseloads were developed based on a uni-discipline basis within specialist services, CDNTs operate interdisciplinary teams in a non-specialist disability service catering for children with complex disabilities. This service therefore requires a different approach to calculating caseload and workload.

## Aim

The aim of this literature review was to examine the international literature to determine whether there are any existing guidelines or best practice recommendations for determining appropriate caseloads or workloads for teams that deliver children’s disability services in interdisciplinary teams.

## Research Questions

1. Is there a best practice model for determining caseload/workload allocations?
2. How do other jurisdictions operate caseload and workload?
3. What factors influence caseload and workloads?
4. What are the consequences of unmanageable caseloads and workloads?

## Methods

A systematic search was performed across a number of electronic academic databases and grey literature sources. Additionally, the professional bodies representing therapists in a number of countries were contacted.

Studies were included if they met the following criteria: 1) focused on caseload or workload management; 2) were available in English; 3) were in the domain of children’s disability services.

After screening against eligibility criteria, data extraction was performed to capture key information, including the type of article, jurisdiction, and associated profession.

A narrative synthesis approach was employed to summarize and integrate findings across the included studies.

## Findings

In keeping with the previous NDA report on children’s disability services in Ireland the literature indicated that there is a lack of evidence and guidance around determining appropriate caseloads and workloads for therapists delivering services to children with disabilities.

### Caseload Vs workload approach

The literature identified a clear shift towards adopting a workload rather than a caseload approach to service planning. Caseload approaches are generally not accepted as accurate or effective measures of therapists’ productivity as they do not recognise the complexity of therapy roles in current best practice. The Workload approach, on the other hand, has been promoted as a means of enabling more efficient and effective service delivery that aligns with best practice. This was particularly evident among Speech and Language, Occupational and Physical Therapists.

### Factors that influence caseloads and workloads

The literature indicates that it is difficult to designate an appropriate workload or caseload for therapists as there are so many influencing factors that must be considered. These include child-related factors such as the range and complexity of their needs; family-related factors such as the complexity of the family’s needs the family and community environment; Service-related factors such as the service delivery model adopted by the agency; and team related factors such as the number of vacancies on the team and the level of experience of the team members.

### Guidelines and tools for determining and managing caseloads and workloads

A small number of tools and guidelines that various professions use to calculate or determine caseloads and workloads were identified by the review. These included practice guidelines, legislative guidelines for various US States, workload calculators, workload assessment tools, and caseload planning management tools.

### Consequences of unmanageable caseloads and workloads

The literature highlighted the numerous consequences of unmanageable caseloads and workloads. These include high levels of stress and burnout among staff leading to poor job satisfaction, high staff turnover and role vacancies. It is unsurprising then, that unmanageable caseloads and workloads were also consistently noted as having a detrimental impact on the quality of care and services delivered, client outcomes and waiting lists.

## Conclusion

This literature review has added to previous findings by the NDA that there is no conclusive evidence as to what constitutes an appropriate caseload for therapists providing children’s disability services. Most of the existing literature or guidance comes from the professions of Occupational Therapists, Speech and Language Therapists and Physical Therapists and relates to caseloads and workloads for individual therapists rather than multi-, inter-, or trans-disciplinary teams.

The literature highlighted the inefficiency of traditional ‘counting methods’, such as relying on a Caseload approach for service planning, as this method does not consider the complexity of individual cases and other influencing factors. A Workload approach, on the other hand, ensures all influencing factors are considered and therefore, is the most effective method for planning and delivering impactful disability services for children.

When service planning, it is recommended that a workload analysis is conducted first, and this information is then used to determine appropriate caseloads. Therefore, work needs to be conducted with CDNTs on the ground to establish current workloads, caseloads and current workload/caseload management practices. These data can then be used to develop and implement appropriate improvement strategies.

# Introduction

Adequate staff are needed to manage caseloads and workloads in an efficient and effective manner. Knowing how many staff are needed for a particular caseload or workload is an intractable problem.

A previous report by the National Disability Authority (NDA) on children’s disability services in Ireland (1) had looked at the research supporting workload or caseloads and found there was no hard evidence that could be used to guide workloads and caseloads in therapy services. The report did say that a caseload approach may not reflect best practice and may restrict service provision as it devalues indirect and consultative work that maybe carried out.

In general, caseload sizes are determined by the number of children that a therapist provides services to over a given time period, and takes into account the number of intervention sessions. (2–5) However, not all children and families create the same workload for a therapist. (6) Therefore, it is important to distinguish between ‘Caseload’ and ‘Workload’. Although definitions can vary slightly, the general consensus is that ‘Workload’ refers to all the activities required to effectively manage a caseload. (3,3,7–10) In other words, ‘Workload’ encompasses all the direct and indirect activities a therapist performs as part of their day-to-day role. Direct services refer to direct interactions with the client, such as delivering interventions; indirect services refer to administrative activities, attending meetings, travel times and so on. When thinking about workload, it is also important to consider the ‘workload ratio’ which represents the percentage of time spent on client related tasks such as assessment, intervention, and consultation activities, including documentation, and travel specific to a client, compared to non-client related tasks such as continuing professional education, or mentoring other staff. (3,10)

A number of issues with implementation of the Progressing Disability Services (PDS) for children and young people model have been reported. Issues include, but are not limited to, difficulties providing continuity of service because of high staff turnover and an inability to fill vacancies quickly; long waiting times for services; delays in access to services once the child is accepted into a CDNT service due to vacancies and waiting lists; a shortfall in administration resources; and difficulties for teams working with other specialist services, such as mental health services. (11–13) Additionally, a survey conducted by AOTI in 2023 highlighted that caseloads are increasing and this, in conjunction with a shortfall of staff, is contributing to significant stress and burnout among CDNT staff, which is negatively impacting staff retention. (11)

## Team working

The nature of the CDNTs is that team-working is a key component of service delivery. Teams in health and social care are generally considered as multi-, inter- or trans-disciplinary teams. The distinction between these terms is important and refers to the ways in which the team members from various disciplines work and interact with each other. (14,15) They can be thought of as existing on a continuum of interaction between the various professions with each being used based on what is perceived to suit the style of service delivery.

### Multidisciplinary teams

The Health Service Executive (HSE) defines a multidisciplinary team as a group of health care workers who are members of different disciplines with each providing specific services to the patient. The team members independently treat various issues a patient may have, focusing on the issues in which they specialise. (14)

### Interdisciplinary teams

An interdisciplinary team is a number of professionals from different disciplines who work with the child and family, sharing information, decision-making and goal-setting. They have common procedures and policies and frequent opportunities for communication. They work collaboratively to meet the identified needs of the child with a joint service plan and see the child separately or together as appropriate. The interdisciplinary team approach is supported by national and international best practice. This model of practice aims to enable each child and family to experience and access a holistic, unified continuum of service delivery where a family centred planning approach is central to the process. (16)

### Transdisciplinary

Transdisciplinary is explained as ‘across; beyond; through’ and constitutes a greater blurring of professional boundaries than in inter-disciplinary teams and patient/client participation. (14) In a trans-disciplinary model, common goals are shared, and disciplines plan together using systematic processes. Fundamental to trans-disciplinary working is the sharing of roles, working across discipline boundaries, sharing of expertise and building capacity among colleagues of other disciplines, referred to as role release. (2,14)

The Report of the National Reference Group on Multidisciplinary Disability Services for Children aged 5-18 endorsed interdisciplinary team working as the most effective way to provide services for children with disabilities and their families. (17)

## Aim of the review

The aim of this literature review was to examine the international literature to determine whether there are any existing guidelines or best practice recommendations for appropriate caseloads or workloads for multi-, inter or trans-disciplinary teams that deliver children’s disability services.

# Methods

## Search Strategy

A search was performed using the following electronic databases; EBSCO, ProQuest, Medline, SocIndex, and Google Scholar, and the following grey literature sources Cochrane Library, Social Care Institute for Excellence (SCIE) Trip Database, Global Index Medicus, National Institute for Health and Social Care Excellence (NICE), World Health Organisation, Agency for Healthcare Research and Quality, National Quality Forum, Lenus, Health Information and Quality Authority (HIQA), WorldCat and Scopus. The search strategy utilised a combination of relevant keywords, such as ‘caseload’, ‘workload’, ‘staff ratios’, ‘therapists’, ‘children’s disability services’, and variations thereof. Boolean operators (for example, AND, OR) were employed to refine the search and maximize the retrieval of pertinent literature.

The research team also contacted member organisations for physiotherapists, occupational therapists, speech and language therapists, social workers and psychologists in Ireland, UK, USA, Canada, Australia, and New Zealand to seek out relevant materials.

The reference lists of key documents were searched and the lists of those citing key documents were also searched for additional material.

## Inclusion criteria

Studies were included if they met the following criteria: 1) focused on caseload or workload management; 2) available in English; 3) were in the domain of children’s disability services.

## Data extraction

Data extraction was performed to capture key information, including the type of article, jurisdiction, associated profession (for example Occupational Therapists, Speech and Language Therapists), caseload and workload guidance.

## Synthesis

A narrative synthesis approach was employed to summarize and integrate findings across the included studies. Themes, patterns, and commonalities were identified to highlight the current knowledge in the literature regarding caseloads and workloads for teams in children’s disability services.

# Findings

The literature indicated that there is a lack of evidence and guidance around determining appropriate caseloads and workloads for therapists delivering services to children with disabilities. This is similar to previous findings by the NDA, (3) and other authors. (8) Some professional bodies, such as the American Occupational Therapy Association (AOTA) and the American Speech-Language-Hearing Association (ASHA), actively recommend not defining specific caseload numbers. ASHA, for example, currently state the following reasons for not recommending a specific caseload for therapists delivering services to children in school settings:

* There is no research to support a specific caseload size,
* The needs of children receiving speech-language services vary greatly, and a specific caseload number does not take into account this variation,
* A specific caseload number could be interpreted as a ‘minimum’ number and, if the SLP’s caseload is below that number, then the SLP could be assigned additional duties.

## Shift towards workload approaches

The literature identified a clear shift towards adopting a ‘Workload’ rather than a ‘Caseload’ approach to service planning. Caseload approaches are generally not accepted as accurate or effective measures of therapists’ productivity as they do not recognise the complexity of therapy roles in current best practice and are perceived to be reflective of the medical model. (3,18–21) The Workload approach has been promoted as a means of enabling more efficient and effective service delivery that aligns with best practice. (5,22–24) This was particularly evident among Speech and Language, Occupational and Physical Therapists. The AOTA, American Physical Therapy Association (APTA), and the ASHA state that:

Given the increasing roles, responsibilities, and demands on Occupational Therapists (OTs), Physical Therapists (PTs), and Speech and Language Pathologists (SLPs) in school-based practice settings, a workload approach seems most likely to ensure compliance with Individuals with Disabilities Education Improvement Act (IDEA 2004) requirements and state and local mandates. (25)

Further, in a recent mixed methods study conducted by Oregon State’s Department of Education (ODE), which included surveys, interviews, and literature reviews to determine the appropriate number of students in a caseload for OTs, PTs, and SLPs, the ODE recommended that the State adopt and make available a workload approach. (26)

A recent study conducted by Seruya and Garfinkle (22) found that 45% of school-based OTs in the USA used a blend of a caseload and workload approaches, 34% used a caseload approach only, and 21% used a workload approach only. The study also found that the majority (75.7%) of respondents reported a desire to implement a workload approach but faced barriers in doing so. The barriers included a lack of administrative support (51.5%), high caseload numbers (48.5%), lack of time (39.0%), and uncertainty over how to make the transition (35.8%).

## Factors that influence caseloads and workload

The majority consensus from the literature appears to be that it is not possible to designate an appropriate workload or caseload for therapists as there are too many influencing factors that must be considered. This has been outlined in various professional body and State guidelines. For example, the Guidelines for Provision of OT Services in Massachusetts Public Schools states:

“It is not possible to provide a definitive range or number of students that constitute an appropriate OT workload. Many factors contribute to determining a reasonable and appropriate workload, and these factors vary between districts and schools”(pg. 40, 25).

The factors that need to be considered when establishing a workload or caseload include, but are not limited to:

* the range and complexity of needs of the individual children, (2,6,10)
* the equipment needs of the child, (6,9)
* the complexity and needs of the family, (6)
* the type and amount of assessment and intervention required, (6,9)
* client maturity (that is how long the child has been on the caseload), (6)
* the service delivery model adopted by the agency (for example emphasis on prevention services would increase the percentage of time spent on non-client related activities), (10)
* the number and distance between the various community settings where therapy services are to be provided, (9,10)
* documentation requirements and methods, (10)
* the experience and expertise of the therapist, (10)
* the number of vacancies in the team/service, (27)
* Professional development activities. (28)

## Guidelines and tools for determining and managing caseloads/workloads

Although no conclusive evidence was found to determine ideal caseloads and workloads, the searches revealed a small number of tools and guidelines that various professions use to calculate or determine caseloads and workloads.

## Canada

### BC Therapy Preferred Practice Guidelines

In response to a recruitment and retention crisis in paediatric therapy settings, in 2008, Therapy British Columbia (BC) published a Preferred Practice Guidelines document. (10) The aim of the guidelines was to assist therapists, administrators, managers and funders involved in the delivery of paediatric therapy services to work towards manageable workloads. The guidelines were based on the literature regarding therapy workload and were informed by the paediatric therapy community in BC.

The guidance document outlined the following recommendations for Early Intervention Teams (EIT) and School-Aged Teams (SAT).

### EIT Workload Ratio:

A full-time clinical paediatric EIT therapist, without administrative responsibilities, is recommended to spend 70%-80% of their time on client-related activities and 20%-30% on non-client related activities.

### Caseload Size for EIT:

For a full-time paediatric EIT therapist with no administrative responsibilities and a workload percentage of 70% to 80% for client-related activities, the recommended monthly caseload range is 30-40 children. This breakdown includes approximately 20-25 children considered 'active' and 10-15 children considered 'inactive.’

### SAT Workload Ratio:

In the school-aged setting, non-client related activities such as program planning and continuing education are equally important as in the early intervention setting. Thus, the workload ratio guideline for a full-time clinical paediatric SAT therapist without administrative responsibilities is similar to EIT: 70%-80% of the therapist's time should be spent on client-related activities, while 20%-30% should be allocated to non-client related activities.

### Caseload Size for SAT:

For a full-time clinical SAT therapist with no administrative responsibilities and a workload percentage of 70% to 80% for client-related activities, the recommended monthly caseload range is 50-65 children. This breakdown includes approximately 25-35 children considered 'active' and 25-30 children considered 'inactive'.

### Workload Assessment Tool for Therapists

The Workload Assessment Tool for Therapists (WAT-T) is a points-based caseload measure for early intervention paediatric therapists. (5) It works on the underlying assumption that the same child may be more, or less, complex to therapists with different experience and expertise, and that the workload generated by each child is subjective. The WAT-T is designed to allow therapists to use clinical reflection coupled with their experience to assign complexity points to each client. Therapists can then determine the total number of complexity points on their caseload, rather than the number of children. The tool also works on the assumption that ‘workload manageability’ is also subjective, with the possibility of external personal factors playing a role in a therapist’s perception of manageability. Further research studies were outlined for the WAT-T but no published documents could be found.

### Caseload Management Planning Tool

In 2011, the Canadian Association of Occupational Therapists, the Canadian Association of Speech and Language Pathologists and Audiologists and the Canadian Physiotherapy Association collaboratively developed the Caseload Management Planning Tool (CMPt). (29) The evidenced-based tool was designed for use by SLPs, OTs, PTs and other healthcare professionals. It guides users through a structured process to determine the number of clients that individual therapists can manage effectively, or the number of therapists required to manage the client needs of a particular service. The CMPt provides a mechanism to model caseloads to determine the time and human resource requirements for effective caseload/workload management. The tool brings users through a three-step process that matches available human resource time to clients’ time requirements based on the complexity of interventions. The steps are:

1. Determine Human Resources time,
2. Determine Client intervention time,
	1. Classify Clients,
	2. Rate Complexity of interventions,
	3. Estimate intervention times,
3. Match Client intervention times to Human Resources time.

The CMPt is intended to be used primarily by managers and administrators for human resources planning and workload allocation. Clinicians may also use the CMPt to examine and reflect on their caseload and practice management and in collaboration with managers to discuss strategies to address the demands that therapists face. The CMPt can be used when working with clients on an individual or group basis. The tool is free to members of the professional organisations and can be purchased by non-members.

## USA

### State-by-state guidance

Seruya and Garfinkle compiled a list of available guidelines related to providing school-based OT and PT services in the United States. Available guidelines were searched by the author to identify state specific guidance for caseloads and workloads. A minority of states provide specific guidance around appropriate caseloads (a summary of a sample of these are presented below). Most States guidelines did not recommend or stipulate a specific number, however, they acknowledged that this is difficult to determine (for example, 28,29). From data gathered through a 2022 Schools Survey, ASHA compiled a state-by-state list of recommended minimum and maximum caseloads for SLPs in the United States. Most states did not have recommendations for maximum caseloads. Those that did, varied widely and ranged from a maximum of 30 students per therapist (Alabama) to 80 students per therapist (Ohio), with an average of 55 children per therapist. The reasons for such variability include, but are not limited to, that some states (for example, Louisiana, Oklahoma and Indiana) use formulas, others do not; there is likely variability in how ‘caseload’ is defined and understood across states; some states might include the number of students receiving intervention in general education while others may only include those receiving services outside general education; some states may only consider direct and not indirect services; and some states may consider the difference between pre-school and school age while others do not. (32)

### Nevada Department of Education

In their guidance for OTs for filling out caseload reports, the Nevada Department of Education advises that a general figure that can be used to begin caseload design is to consider a ‘one day a week’ caseload of up to 10 students at up to two sites. For a full-time OTs, this translates to a full caseload of 40-50 students across 8-10 different sites.

### North Carolina

North Carolina has a legislated caseload cap of no more than 50 students per practitioner. (33) North Carolina’s OT, PT, and SLP Workload Calculator and associated guidance supports building and district-level administrators in determining staffing and workload allocation for OT, PT, and SLP staff in North Carolina schools. The Calculator is an adapted version of ASHA’s Workload Calculator (see below). (7)

### Maine Department of Education

Maine Department of Education state that, for OTs, PTs and Speech and Language Therapists (SLTs), the maximum child-therapist caseload, including case management, consultation, and direct services, shall not exceed 50 for each full-time equivalent therapist. (34)

### Wisconsin Department of Public Instruction

In their publication ‘Occupational Therapy and Physical Therapy, a Resource and Planning Guide. (35) The Wisconsin Department of Public Instruction outline the Caseload requirements for OTs and PTs. The minimum caseload for a full-time therapist is 15 students. The maximum caseload for a full-time therapist is 30 students, but with a licensed assistant(s), this may increase to 45 students. Caseload is prorated for part-time therapists. Variance is permitted based on several identified factors, including the frequency and duration of the service, travel time, evaluations, preparation, and other student-related activities.

### ASHA Workload Calculator

ASHA, who strongly advocate for a Workload approach to managing caseloads, have developed the Workload Calculator (7) which SLPs can use to calculate and analyse their workload. The calculator allows practitioners to determine the amount and frequency of workload activities including direct and indirect services, administration tasks and so on. SLPs can choose from three available calculators: Weekly (to determine workload responsibilities over a typical week), Monthly (to determine workload responsibilities over a typical month) or the Telepractice editions (to identify the amount of time spent preparing, learning and using technology to deliver speech-language services). SLPs enter the time spent on direct and indirect services, compliance and other activities into the calculator. The calculator then generates high level and detailed reports and visualisations of the data that the SLP can use to analyse and manage their workload.

ASHA also developed a companion tool called the ASHA Workload Analysis Calculator. This tool allows SLPs to examine how much each student on their caseloads contributes to their overall workload. This is also available as a weekly or monthly calculator. Therapists enter the number of hours spent each day/week on various activities for each student on their caseload.

After completing the Workload Calculators, SLPs are encouraged to create a Workload Action Plan to address their specific workload issues using another tool developed by ASHA. The Workload Action Plan requires SLPs to list and prioritise the three most time-intensive activities identified by the calculator, identify next steps to address the issues, identify the resources required and develop an estimated timeline for completion. The tool is available online.

Time studies

Time studies are a simple way for therapists to analyse how much time they spend completing each of the responsibilities in their workload. To conduct a time study, the therapist documents how much time they spend on each activity for a working week. At the end of the week, the therapists categorise their activities and determines the percentage of time they spent performing each workload responsibility. Seruya and Garfinkle, have developed resources that are freely available online to assist therapists to conduct accurate times studies. (23)

## UK

The Management and Supervision Tool (MaST)

In response to rising caseloads among community mental healthcare teams in the UK, Mersey Care Health Service (NHS) Foundation Trust developed the Management and Supervision tool. (36) This is a decision support tool that uses predictive analytics to help mental health staff make better decisions about the resources they use to provide safer and higher quality care. It relies on a Risk of Crisis algorithm which uses retrospective data from mental health electronic health records. MaST determines the likelihood of any given client using crisis services within the following 28 days. By using these insights, clients can be grouped into cohorts to understand the resources required to support their care. MaST allows the practitioner to prioritise their interventions and move to a preventative rather than treatment focused model of care. Reported benefits of implementing MaST in relation to caseload management include:

* improved identification of people at high risk of crisis,
* improved identification of people who are lower risk and less complex who may require a different level of care,
* Increased number of people stepped down from community mental health teams to a more appropriate service for their needs such as primary care, voluntary sector services or other community support,
* enabled proactive contact with people who are vulnerable and may otherwise be lost to follow up,
* improved staff engagement with technology to support better clinical decisions day to day,

## Consequences of unmanageable caseloads and workloads

The importance of developing effective methods of establishing appropriate caseloads and workloads is evident when the consequences of unmanageable caseloads and workloads are examined. In a survey of OTs providing children’s disability services in Ireland, conducted by AOTI, (11) respondents reported that high caseload numbers (cited by 91% of respondents) and poor staffing levels (cited by 90% of respondents) were having a negative impact on their current practice. Respondents felt that they were ‘firefighting’ and trying to ‘keep above water’ rather than providing comprehensive OT services. Respondents also felt that the allocated number of therapists was inadequate and unsafe. Similarly, in a recent survey of OTs in Oregon, USA, 83% of respondents reported that their workload impacted their ability to provide services to children in school-based settings. (26) These results are consistent across the literature with numerous papers reporting that high caseloads meant that therapists were unable to provide adequate services and meet the expectations of families. (2,7,8,10,11,23,35,37,38)

Considering these findings, it is unsurprising that high caseloads and workloads have been consistently linked to poor job satisfaction among therapists. (10,11) For example, it was noted that high caseloads made it difficult to allow time for training and upskilling, which is an important component of job satisfaction. (11) High caseloads and workloads are also strongly linked to increased stress, feelings of being overwhelmed and burnout among staff, (11,23,39–41) which can lead to high staff turnover and role vacancies. (11,35,41) Further, a recent study also found that high caseloads prevented intra-professional collaboration in the delivery of services. (40) In terms of consequences to children and families receiving services, high caseloads have been cited as having a negative impact on client outcomes (5) and waiting lists and are linked to increased parental complaints. (27,38)

It is, therefore, clear that the consequences of unmanageable caseloads are detrimental to the quality of services delivered and have negative impacts on the service providers and the children receiving services.

## Limitations

The findings in this literature review have several limitations that must be taken into consideration. First, most of the literature focused on either PTs, OTs or SLTs, whilst the CDNT staff census for 2023 listed over 17 different disciplines including nurses, play therapists and social workers, all of whom could have very different procedures and therefore different caseloads and workloads would apply.

Much of the literature reported is from educational settings where the therapist works within a specific school. This again is different to the CDNT structure where therapist can work in a dedicated therapy space, in school or in the community. Therefore, further research is needed to understand how location affects the therapists’ caseload.

Finally, most of the cited literature was from North America where there are different work patterns, service models and cultural expectations all of which question the applicability of the findings in an Irish context. Further research is needed into work practices in an Irish context to fully understand the work of staff within CDNTs.

# Conclusion

This review of the literature has added to previous findings by the NDA that there is no conclusive evidence as to what constitutes an appropriate caseload for therapists providing children’s disability services. Most of the existing literature or guidance comes from the professions of OTs, SLTs, and PTs and relates to caseloads and workloads for individual therapists rather than multi-, inter-, or trans-disciplinary teams. (3)

The negative impacts of high caseloads are clearly laid out across jurisdictions and professions. High caseloads are consistently linked to stress and burnout among staff, high staff turnover, increased parental complaints and overall poorer quality services. In addition, the finding that high caseloads have been found to negatively impact on intra-professional collaboration has direct implications for CDNTs which operate under the interdisciplinary model and therefore rely on intra-professional collaboration.

Traditionally, there is a tendency to focus on the number of children that make up a caseload when planning services. However, the inefficiency of these traditional ‘counting methods’ came through very strongly in the literature. It has been well established that this method does not take into account the complexity of individual cases and other influencing factors such as administrative tasks and the environment in which services are delivered, and how these impact on the therapist’s or team’s actual workload. A Workload approach, on the other hand, ensures all influencing factors, beyond caseload numbers, are taken into account and is considered the most effective method for planning and delivering impactful disability services for children. It is, therefore, recommended that a workload analysis is first conducted. This information should then be used to determine specific recommendations as to what constitutes an appropriate workload, and therefore an appropriate caseload. As such, work needs to be conducted with CDNTs on the ground to establish current workloads, caseloads, and current workload/caseload management practices. These data are needed to ascertain what needs to change and to inform the development and implementation of appropriate improvement strategies.

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