Journal of Multidisciplinary Healthcare

Dovepress
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REVIEW

Implementation of the Allied Health Assistant Workforce in the Australian Context: An Integrative Review

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Abstract: The Allied Health Assistant (AHA) workforce plays a critical role in enhancing the capacity, efficiency, and accessibility of allied health services across Australia. Considering significant structural reforms in sectors in which AHAs are employed, including the introduction of the National Disability Insurance Scheme (NDIS) and changes to aged care funding, this integrative review synthesizes current evidence on the utilization of AHAs across diverse settings, disciplines, and sectors. A comprehensive search of peer-reviewed and government literature from 2007 to 2025 identified 38 studies and 18 policy documents. A concept analysis identified four key concepts: service efficiency and quality, capacity building through training, contextual and structural determinants of role implementation, and tensions between role innovation and professional boundaries. Findings highlight the positive impact of AHAs on therapy access and service delivery, the importance of context-specific training and supervision, and the need for supportive organizational structures. Despite growing recognition of the AHA role, gaps remain in outcome-focused research, particularly in mental health, disability, and aged care settings. This review underscores the need for targeted workforce strategies and policy development to optimize the integration and sustainability of the AHA workforce in Australia's evolving health landscape.

Plain English Summary: This review looks at how Allied Health Assistants (AHAs) help deliver healthcare in Australia. AHAs work under the guidance of qualified health professionals to support therapy and improve access to care. The review covers research and government documents from 2007 to 2025. The authors found that AHAs make a positive difference in four main areas:.

(1) Improving Services: AHAs help more people get therapy and allow health professionals to do more of the tasks they are trained to do. This leads to better care and more efficient services.
(2) Training and Support: AHAs need training that fits their specific work setting. While formal qualifications are useful, hands-on training at work is often more effective. Supervisors also need training to guide AHAs properly.
(3) Workplace Conditions: Where AHAs work, such as in cities or rural areas, affects how well they can do their job. Clear guidelines, good supervision, and supportive workplaces help AHAs succeed.
(4) Balancing Roles: Some health professionals worry that AHAs might take over parts of their job. AHAs often have limited chances to grow in their careers, which can lead to high staff turnover.

The review shows that AHAs are valuable, but more research is needed, especially in mental health, disability, and aged care. To make the most of AHAs, services that employ AHAs should invest in training, create flexible job roles, and build a culture that supports teamwork.

Keywords: allied health assistant, workforce utilization, training & supervision, allied health professions, scope of practice, health system

Introduction

The Allied Health Assistant (AHA) workforce plays an increasingly important role in supporting the delivery of allied health services across the Australian healthcare system.[1] AHAs work under the delegation and supervision of qualified

Received: 28 August 2025
Accepted: 2 December 2025
Published: 13 December 2025

allied health professionals (AHPs) to deliver care that enhances service capacity, accessibility, and efficiency.[2] Following the 2007 development of the Certificate IV in Allied Health Assistance, a vocational qualification that provides specialized skills and knowledge, a significant body of research and policy development between 2010 and 2015 focused on strengthening the AHA workforce by clarifying training pathways, qualifications, and the parameters for supervision and delegation.[3,4] Government-supported initiatives during this period helped define the value of the AHA role and contributed to a more consistent understanding of the AHA scope of practice across healthcare settings.[4]

Much of the foundational work to develop the assistant workforce focused on acute and subacute public health settings where most AHAs were employed. However, since then, there have been major structural reforms in the Australian health, aged care and disability services landscape. This has included the introduction of the National Disability Insurance Scheme (NDIS) in 2013 and changes to the aged care funding model,[5] which have significantly altered service delivery models and workforce composition across settings.[6] In the context of the NDIS, AHA roles have expanded within disability services; however, this expansion has occurred largely in the absence of a robust evidence base or clear policy guidance.[1] Likewise, the integration of AHAs into mental health services remains under-explored. This is despite the potential for AHAs to support workforce sustainability, expand service delivery, improve access, enable AHPs to practice at full or extended scope, and to enhance care quality, job satisfaction and staff retention in this area.[2,7]

The growing complexity and ongoing reform activities across these sectors and the increasing use of the AHA workforce raises important questions regarding consistency in role definition, training quality, and delegation and supervision frameworks across sectors and allied health professions. Given this complexity, there is a clear need to synthesize current knowledge regarding the utilization of AHAs in the Australian context. This integrative review aims to examine how the AHA workforce is being utilized across various settings, disciplines, and sectors, with the goal of identifying current practices, gaps in the literature, and implications for workforce policy and service delivery.

Review Aims and Objectives

This review aimed to understand how the AHA workforce is being utilized within the Australian context.

The research objectives were to:

1. Identify and describe research undertaken in relation to AHAs in the Australian context, considering the types of allied health professions working with AHAs, as well as the clinical and geographical settings represented.
2. Identify and describe how research undertaken in relation to AHAs in the Australian context references government documents, policy, frameworks and training.
3. Synthesize the key findings of research undertaken in relation to AHAs in the Australian context to identify gaps in the research, and implications for workforce policy and service delivery.

Methods

The research undertaken in relation to AHAs comprises diverse methodologies and is often focused on small sample sizes and/or one service setting. This, combined with the aim of the review being to appraise the evidence relating to utilization rather than to examine definitive outcome measures, led the authors to select the integrative review as the most appropriate approach.[8,9] An integrative review provided the opportunity to present a thorough and holistic understanding of the utilization of AHAs in the Australian context, to provide a synthesis of the current body of knowledge and to identify gaps to guide future research in terms of theory, methodology, and practice.

An integrative review approach consists of five steps: problem identification, literature search, data evaluation (quality appraisal), data analysis and presentation of results.[8]

Problem Identification

A preliminary literature review was undertaken to identify key concepts and variables of interest. Subsequently, the research team convened to establish the review's aims, guiding questions, and scope. The team comprised individuals with diverse expertise and experience related to the AHA workforce, including: a professional lead with a decade of experience working as an AHA; a member of the Board of Directors of the Allied Health Assistants' National

Association (AHANA); an occupational therapist working in a leadership position in mental health, justice health, and alcohol and drug services; a senior occupational therapist working within an outpatient rehabilitation setting; and an occupational therapy academic with clinical and research experience related to the AHA workforce.

Literature Search: Search Strategy

A comprehensive search strategy was developed in consultation with two research librarians to capture studies exploring the utilization of the AHA workforce in Australia. The identification of suitable search terms was an iterative process, informed by extant literature and previous reviews on AHAs that were reviewed during the problem identification phase.

Relevant keywords, search terms, and wildcard symbols were applied to each database (see Supplementary File 1 for the complete search strategy). Complete inclusion and exclusion criteria are described in Table 1.

Appropriate studies published between January 2007—June 2025, were retrieved from MEDLINE, CINAHL, PsycINFO, SCOPUS, Web of Science Core Collection, and the Cochrane Central Register of Controlled Trials (CENTRAL). This timeframe was chosen to capture studies published after the Certificate IV in Allied Health Assistance became available in Australia. These were retrieved from Trove and ProQuest. A further search was undertaken using the Google Advanced Search function (see Supplementary File 2). This aimed to identify publicly available government documents relating to the allied health assistant workforce. An initial search primarily identified job advertisements, so further filters were applied to focus on government documents. This resulted in 18 documents. This search and identified documents are summarized in Supplementary File 2.

Screening

Three of the authors were involved in the screening process (CP, RP, RM) as listed in Figure 1. Two reviewers independently screened titles and abstracts based on the inclusion and exclusion criteria, with a third reviewer resolving any conflicts. This process was repeated with a full text screen. Articles focusing on medical, scientific, or technician assistant roles such as imaging assistants, dental assistants, pharmacy assistants, and laboratory technicians were excluded from this review due to the substantial differences in scope, training, and functional responsibilities compared to traditional allied health assistant roles which focus primarily on direct therapeutic interventions. Including scientific assistants would have introduced significant heterogeneity, limiting the relevance and applicability of findings to the allied health assistant workforce.

Two reviewers independently screened all articles using Covidence. Where discrepancies concerning the eligibility of an article occurred, a meeting was held to determine consensus. If consensus could not be reached, a third reviewer was consulted to make the final decision.

Table 1 Inclusion and Exclusion Criteria

Inclusion	- Studies including Allied Health Assistants (AHAs), defined as support staff who complete therapeutic clinical and non-clinical tasks under the supervision and delegation of an allied health professional. NOTE: papers could also include allied health professionals, but data and/or discussion need to explicitly include AHAs - Studies conducted in Australia and/or on the allied health assistant workforce in Australia. - Studies conducted from 2007 onwards, as the Certificate IV in Allied Health Assistance has been offered since 2007 in Australia. - Studies published in English.
Exclusion	- Studies not conducted in Australia - Studies that focus on assistants undertaking technical roles. - Studies that focus on aged care or disability support workers. - Studies which focus on allied health generally rather than the AHA role. - Studies published prior to 2007 (prior to introduction of Certificate IV in Allied Health Assistance). - Studies published in languages other than English.

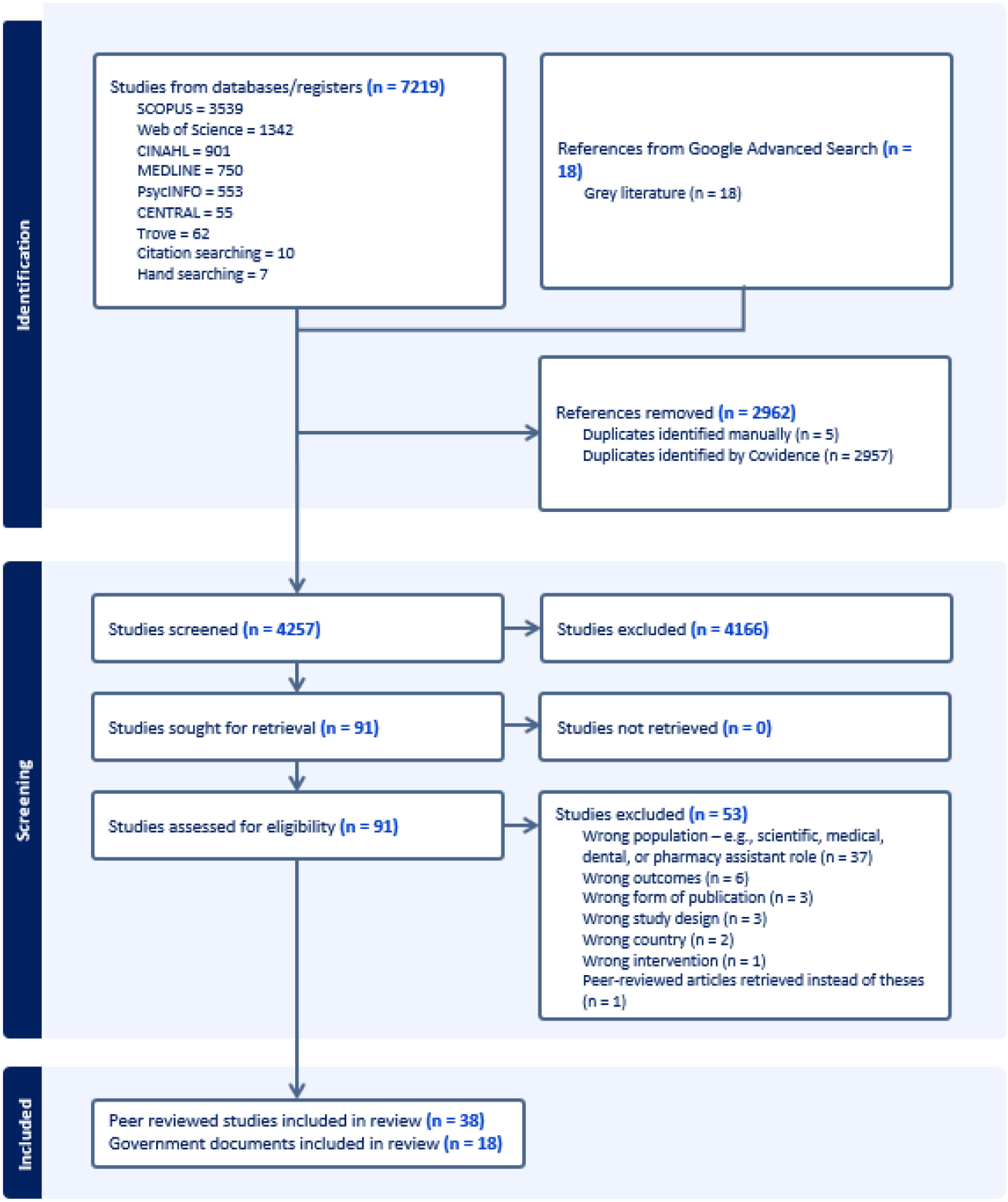

Figure 1 PRISMA flow chart showing screening and selection process for Utilization of the allied health assistant workforce in the Australian context: an integrative review. Adapted from Page MJ, McKenzie JE, Bossuyt PM et al. The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *Int J Surg*. 2021;88,105,906.

Quality Appraisal

The Quality Assessment for Diverse Studies (QuADS) tool was used independently by two of three authors (CP, RP, RM) to assess the methodological quality of included studies, due to its applicability across qualitative, quantitative, and mixed method studies.[10] The maximum score that could be attributed for each category was 3 and there are 13 categories giving a maximum score of 39. Disagreements were resolved via discussion, or by a third author (RM). The QuADS tool was chosen due to its applicability to methodologically diverse studies and its focus on the theoretical underpinnings, clarity of aims, methodology, stakeholder involvement, and reported strengths and limitations. One reviewer was an author of an included article and was purposefully not assigned to appraise this study. Results were analyzed narratively, and no studies were discarded based on low scoring to maintain inclusivity and comprehensiveness, as suggested by Oermann and Knafl.[11] The quality appraisal did not include the government documents.

Data Extraction and Analysis

To extract data from the peer reviewed literature, a data extraction table was developed by three reviewers (CP, RP, RM). This data extraction table was initially piloted by each reviewer on three studies selected at random and then further refined following discussion. For each of the included studies, key data were extracted into the data extraction table by one reviewer then checked by a second reviewer for accuracy. As summarized in Table 2, data extraction focused on the study design, as well as the allied health profession(s) represented, the clinical setting and geographical location. As this review aims to inform policy and practice, reference to government documents, policy, frameworks and training of AHAs was also noted.

Analysis of the article findings was structured using inductive content analysis to identify, organize, and interpret patterns and themes within the included literature findings. Content analysis is a suitable approach within an integrative review when including qualitative and mixed-methods data to maintain a balance between data-driven analysis and interpretive understanding.[46] For this review, content analysis commenced following data extraction when articles were re-read by two independent reviewers, with a particular focus on the results, discussion and conclusion. Notes were made before the three reviewers met to discuss and summarize. This was followed by the generation of codes with subcategories[47] as summarized in Table 3.

For the government documents, a data extraction table was developed to summarize the core content of each document, as shown in Table 4. The coding framework created based on indicative content analysis of the empirical research was applied using deductive content analysis to the government documents.

Results

Study Characteristics

The search identified 38 articles that met the inclusion criteria, as illustrated in Figure 1. Most articles reviewed took a qualitative (18/38) or mixed-methods (10/38) approach, with the remaining 10 consisting of nine quantitative studies and one literature review. Sample sizes ranged from interviews with small numbers of AHPs and AHAs from one profession or one team (n=21), to sampling large numbers of staff and/or patients across several health settings (n= 17). The clinical setting was predominantly public health care services, with only three explicitly including services external to public health care.[1,6,33] Ten of the included studies included a focus on rural, remote, or regional settings.[13,18,19,22,26,27,29–31,33,40,41]

The search of government websites identified 19 documents. Three were generated by the federal Department of Health, so are explicable across all states and territories. The remaining 16 were from five state governments.

The allied health professions considered included occupational therapy, physiotherapy, speech and language therapy, dietetics, podiatry, social work and medical imaging. All states and territories were represented in the data, with the greatest volume of research undertaken in Queensland;[12,14,18,26,31,34–37,42,43] Victoria;[1,6,16,22,32,38–41] the Australian Capital Territory[3,15,23–25] and New South Wales.[20,27,29,30]

Table 2 Data Extraction Table

Author Year	Research Method & Study Design	Study Objective	Data Collection Methods	Sample Size	Client Population Clinical Setting Geographical Setting	Profession	Description of Intervention/Program
1. Cox et al 2014[12]	Quantitative Quasi-experimental cohort study	To implement an advanced occupational therapy assistant (OTA)-led group program in a subacute aged care rehabilitation setting and to evaluate the impact on clinical outcomes.	Demographic data and standard outcome measures (FIM, AusTOM), discharge destination, LOS, Client Satisfaction Questionnaire (CSQ-8). Historical control comparison	30 patients (intervention group), 40 (control group - RP historical control group when an OT was running the group)	Aged care, excluded non-English speakers. Subacute aged care rehabilitation, tertiary referral hospital Metropolitan (Brisbane)	OTAs only (Advanced AHA role)	The group programme comprised up to six groups per week and included meal preparation groups and domestic training groups.
2. Frowen et al 2021[7]	Quantitative Pre-test post-test design	The aim of this study was to evaluate the introduction of a new delegation model for swallow screening and education in the head and neck radiotherapy clinic.	Demographic data from medical records, screening, patient education, surveys Modified PSCNS Optimal care compliance speech- language pathology time spent with complex patients, swallowing related admissions	26 (pre-implementation), 35 (post-implementation)	Specialist tertiary referral hospital Metropolitan (Melbourne)	SLP	Allied Health Assistants only. They were required to have a Cert III or IV in AHA and were already working within the Nutrition team performing malnutrition screening and provision of basic nutrition intervention to patients across the hospital.
3. Goodale et al 2007[13]	Qualitative Quality Assurance Project report	To develop an efficient and effective means of delivering distance training to therapy assistants, to reduce the training load placed on AHPs, and increase the skills and competencies of TAs. To standardise the foundational competencies for TAs across the Western Australia Country Health Service (WACHS).	Survey with four point scale; open ended questions; purposive sample interviews	416 evaluation forms Purposive sample of 5 TAs and 5 AHPs	Variety of client populations Variety clinical settings Rural WA	SP, OT and PT AHAs and AHPs	Training for TAs across country WA was well-attended and positively received, especially modules with clinical content and interactive scenarios. While it reduced allied health professionals' workload and helped TAs gain qualifications, mandating standardised qualifications for rural and remote TAs is not feasible for health services.
4. Hall et al 2021[14]	Mixed Qualitative / Quantitative Pragmatic pre-post design	To determine the impact of the inclusion of an AHA role on physiotherapy service delivery in an acute respiratory care setting (adult CF centre) in terms of service provision, scope of practice and skill mix changes.	Staff recorded all activities using a portable scanning system, noting details like date, time, location, activity type, duration, and staffing level. Clinical data for CF patients included admissions and outpatient clinic attendances. Staff and patient perceptions were gathered through anonymous surveys distributed via email. Open-ended survey responses were also collated.	2 x full-time senior, and 2 x full-time junior physiotherapists, and 1 x full time AHA.	Acute adult respiratory service (CF centre). Queensland, metro	PTs and AHAs	Physiotherapy services across two 3-month periods: current service delivery [P1] and current service delivery plus AHA [P2]. Clinical and non-clinical activity quantified as number, type and duration (per day) of all staff activity categorised for skill level (AHA, junior, senior).

5. Huglin et al 2021[6]	Mixed-method design within an interpretive description framework	To examine factors that promote the effective utilisation of Allied Health Assistants (AHAs) across health, aged care, and disability sectors and identify potential factors that could support optimal AHA utilisation, governance, education, and training requirements in Victoria.	Workforce survey, semi-structured interviews (individual and focus groups)	727 survey participants, including 284 AHAs, 443AHPs and allied health leaders; and 119 participants in 13 group interviews and 25 individual interviews	Consumers of Victorian health, disability, or aged care services. Metropolitan and regional Victoria	Various: AHAs, AHPs and Leaders Educators, Managers, and Students of allied health assistance training in the Vocational Education and Training (VET) sector	Not specific- range of services
6. Isbel et al 2014[15]	Mixed methods - Descriptive study.	To develop, implement, and evaluate the effect of an Allied Health Assistant (AHA) in assisting a small cohort of older people (aged >65 yr) in the Australian Capital Territory (ACT) as they return home from an acute hospital admission	The study was conducted in three phases: collection of baseline data: development of a new workforce role; and application and assessment of the workforce role. Outcome measures included the Centre for Allied Health Excellence (CAHE) Patient Post-Discharge Questionnaire, Barthel Index, Lawton Instrumental Activities of Daily Living (IADL) Assessment, Australian Quality of Life Measure (AQOL) CAHE Carer Post-Discharge Questionnaire	A convenience sampling method was used. 17 participants in phase one (9 females; Mean Age: 77.94 years), 14 participants in phase three (7 females; 83.28 years).	Older adults > 65yrs living in the ACT, who were admitted to hospital, were to be discharged home to an ACT residence or an aged care facility.	MDT- AHA role	The study involved developing a simple process map of an ideal client journey and superimposing problem points along the journey. This helped in identifying where participants experienced difficulties and informed the development of the new workforce role.
7. King et al2022[16]	Qualitative study involving semi-structured interviews	To explore the experiences and perspectives of allied health assistants (AHAs) working in healthcare settings.	Individual semi-structured interviews conducted in person or via telephone. The interview questions prompted participants to consider the team, health service, and other contextual factors that shape their role as an AHA. Participants were also asked how they could be supported to maximise their role in their health service.	Purposive sampling was used to select 21 AHAs f	One regional, and three metropolitan health services in Victoria, Australia.	AHAs under delegation of PT, OT, SP, dietetics, SW, and medical imaging.	N/A

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https://doi.org/10.2147/JMDH.S561660

Table 2 (Continued).

Author Year	Research Method & Study Design	Study Objective	Data Collection Methods	Sample Size	Client Population Clinical Setting Geographical Setting	Profession	Description of Intervention/Program
8. Kiss et al 2019[17]	Quantitative: Prospective pre- and post-test comparing two consecutive, independent cohorts of patients attending a multidisciplinary head and neck clinic.	To evaluate the effectiveness of a nutrition assistant (NA) role in a multidisciplinary head and neck cancer clinic in maintaining or improving patients' nutritional status during and after radiotherapy, optimising dietitian time, and enhancing patient satisfaction.	Participant demographics and clinical characteristics; nutritional data including % change in weight. Enteral feeding data, including the number of patients with percutaneous endoscopic gastrostomy (PEG) tubes or nasogastric feeding tubes, the total amount of dietitian time (minutes) spent with each patient categorised according to patient risk (high, intermediate, low). The Modified Patient Satisfaction with Clinical Nutrition Services (PSCNS) mailed on discharge to assess overall patient satisfaction care	91 patients (43 pre-implementation, 48 post-implementation)	Patients over 18 years of age, with a primary diagnosis of head and neck cancer receiving attending a twice-weekly multidisciplinary head and neck clinic for curative treatment at specialist cancer centre in Melbourne	Nutrition Patient experience of AHA role	New model of care was established to introduce a NA role to support dietitians. An eight-week training module was developed to upskill two NAs to perform malnutrition screening and basic nutrition interventions.
9. Kuipers et al 2015[18]	Mixed: Quality improvement report	To conduct a comprehensive audit and evaluation of the roles of AHAs within Queensland public health services, emphasis on utilisation in rural/regional and metropolitan settings. Identify and analyse differences in AHA qualifications, access to training, supervision, performance, duties, and scope of practice between AHAs working in rural/ regional and metropolitan areas.	Audit of AHA roles conducted over a two-day period and included document review of role descriptions, duty statements, orientation and induction plans, training plans, competency assessments, supervision agreements, meeting records, and clinical documentation; Interviews: were conducted with key departmental staff, AHAs, AHPs, line managers/ team leaders, and members of the immediate healthcare team; Direct Task Observation was used to observe AHAs performing their duties in their workplace.	41 allied health assistant (AHA) roles	Regional and rural public health services in Queensland	Disciplines not listed- eight different professionals involved	Audit

10. Lin et al 2007[19]	Quantitative: Cross-sectional survey	To characterise multidisciplinary therapy assistants (TAs) in rural and remote areas including the number and location, practice variables, supervision practices, roles, and work scenarios to support the planning and development of TA programs in these regions.	Questionnaire administered via telephone interviews or email. Deidentified survey data were entered into SPSS for descriptive statistical analysis.	42 respondents via snowball sampling	Therapy assistants (TAs) worked across various clinical settings, including schools, community centres, hospitals, clients' homes, and multiple settings in rural and remote regions of WA	SP, PT, OT, dietitians, audiologists, and psychologists.	N/A
11. McLean et al 2022[20]	Qualitative	To explore the perspectives of dietitian following the implementation of a formal competence and professional development program.	Semi-structured interviews	9 dietitian assistants	Hospital, Sydney	Dietitians- AHAs only	N/A
12. Mickan et al 2018[21]	Qualitative	Explore whether university education for AHAs could help to shape consistent roles and expectations of AHAs for the future workforce.	Semi-structured interviews, thematic analysis	12 participants	N/A	AHAs only	N/A
13. Missen et al 2021[22]	Quantitative evaluation study	Explore whether the introduction and use of a waitlist system, which included an AHA role, decreased waitlist times	Pre and post clinician intervention done before and after introduction of waitlist system.	456 clients	Adults, Community Health, rural Victoria	OT, AHPs and AHAs	Waitlist system that identifies steps able to be completed by AHAs, decreases wait times
14. Moran et al 2012[23]	Qualitative descriptive	To explore the processes and outcomes of a 'trainee' approach to introducing a podiatry assistant (PA) role to a community setting	Interviews and focus groups	20	Adults Public community based in ACT	Podiatry- AHPs and AHAs	Introduction of podiatry assistant to manage low risk clients

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https://doi.org/10.2147/JMDH.S561660

Table 2 (Continued).

Author Year	Research Method & Study Design	Study Objective	Data Collection Methods	Sample Size	Client Population Clinical Setting Geographical Setting	Profession	Description of Intervention/Program
15. Nancarrow et al 2012[24]	Qualitative: Retrospective evaluation of change process against the Calderdale Framework (CF)	Explore the utility of the Calderdale Framework (CF) as an appraisal tool to assess whether adherence to the tool influences outcomes including effective and efficient use of the role, role flexibility and career development opportunities for assistants, and role sustainability.	Retrospective mapping of data from three projects against the key steps within the seven stages of the CF. An analytical template was developed by dividing the CF into the seven stages with the key components of each stage as subheadings.	**Project 1**: speech pathology assistant (n=1), service users and carers (n=5), speech pathologists (n=3), managers (n=5) **Project 2**: podiatry assistant (n=1), service users (n=5), consumer group (n=3), podiatrists (n=3), enrolled nurses (n=3), nursing and allied health managers (n=5)	Adults Project 1: rehabilitation, aged, and community care service Project 2: community health and continuing community care service	**Project 1**: speech pathology assistant service users and carers speech pathologists, managers **Project 2**: podiatry assistant (service users consumer group, podiatrists enrolled nurses nursing and allied health managers	Project 1: delivering group therapy, direct client contact, indirect client contact, file reviews and preparation of files, resource preparation and administration. Project 2: provision of basic foot hygiene, assist in nail surgery, do basic modifications to orthotics, padding and strapping.
16. Nancarrow et al 2015[25]	Qualitative: thematic analysis	Explore the impact and mechanisms for successful implementation of a speech language pathology assistant (SLPA) role into a rehabilitation setting using a traineeship approach.	Semi structured interviews with key stakeholders (service managers, assistants, services users and carers), documentary evidence (competency frameworks and policy documents) and workload audit of all SLP activities for 4 consecutive weeks of which the SLPA was absent for 2 weeks.	3 SLPs 1 SLPA 5 AH managers 4 service users 1 carer 1 activities coordinator	Population and setting not specified, based in ACT	SLP	Incorporating SLP assistant via traineeship model
17. Newman et al 2018[26]	Quantitative: Non-inferiority study design	Assess the accuracy and confidence of AHAs trained to conduct the subjective global assessment (SGA) compared with dietitians.	*administration of the Subjective Global Assessment (SGA) *Rater confidence assessed using a 10 point scale	45 patients 5 AHAs 3 dietitians	Adult inpatients, acute and subacute, rural and remote Queensland	Dietetics	Comparing inter-rater reliability of SGA administration between AHAs and dietitians

18. O'Brien et al 2013[27]	Qualitative: Interpretative phenomenological	Provide insight into the perceptions of Speech language pathologists of working with AHAs.	Semi-structured interviews	8 Speech Language Pathologists	Range of clinical settings rural NSW	SLP	N/A
19. O'Brien et al2020[28]	Literature Review: narrative summary	Explores current perceptions and barriers to utilising AHAs in speech-language pathology and proposes some possible solutions.	Provides a summary of existing literature but does not include any information about the search used or how articles were selected.	Not specified	Not specified	SLP	N/A
20. O'Brien et al2018a[29]	Qualitative: Inductive qualitative methodology - interpretative phenomenological analysis (IPA)	Explore SLPs' perceptions of their professional identity in response to working with assistants.	Semi-structured interviews	20 SLPs	Adult and paediatric caseloads; Public health, community hospital; NSW remote, rural and metro	SLP	This current study is part of a larger research project investigating how SLPs perceive working with assistants prior to assistants being introduced by the health organisation.
21. O'Brien et al 2018b[30]	Qualitative Interpretative phenomenological	Understand the perceptions that engender professional resistance and identity factors that may lessen such resistance.	Semi-structured interviews	20 SLPs	Adult and paediatric caseloads; Public health, community and hospital; NSW remote, rural and metro	SLP	This current study is part of a larger research project investigating how SLPs perceive working with assistants prior to assistants being introduced by the health organisation.
22. Pearce & Pagett, 2015[3]	Qualitative descriptive	Summary of project to scope the role of the advanced AHA in its potential to contribute to the allied health service and to outline an education pathway that provides skills escalation and career development to a diploma or equivalent	Literature review Consultation with other services Surveys and focus groups with AHAs Interviews with allied health managers	36 AHAs (focus groups) 31 AHAs (surveys) 22 allied health managers (interviews)	Community and hospital-based services ACT	Various - PT, OT, podiatry, nutrition, SP, and EP.	N/A

(*Continued*)

Table 2 (Continued).

Author Year	Research Method & Study Design	Study Objective	Data Collection Methods	Sample Size	Client Population Clinical Setting Geographical Setting	Profession	Description of Intervention/Program
23. Phillips et al, 2021[31]	Mixed methods - quantitative and qualitative Descriptive Study	Describe the development of a new model of care (MOC) for the rehabilitation of rural and remote paediatric burns patients.	Survey of families	Not clearly stated (28 children attended the clinic but it's not stated whether all families returned the survey)	Children with burn injuries OT Led Paediatric Burn Telehealth Review Clinic Rural and remote North Queensland	OT	Tasks delegate to the AHA *coordination telehealth booking, checking quality of telehealth connection *Obtaining information via a pre-telehealth phone call utilising a structured script*request a digital still photograph of the scar*Complete outcome measure
24. Pinson et al, 2023[32]	Mixed methods - quantitative and qualitative A two-phase explanatory, sequential mixed methods study design	Determine: 1. The tasks medical imaging assistants perform 2. The proportion of assistants' workingday performing clinical or non-clinical tasks. 3. The assistants' perspectives on theirroles, responsibilities and contribution to the imaging team.	Time motion survey (Participants recorded tasks completed on a time motion proforma across two days) Qualitative interviews	4 medical imaging assistants	Three publicly funded health services, Victoria, metro and regional	Medical imaging professionals	N/A
25. Roberts et al, 2024[33]	Qualitative case study	To identify barriers and facilitators contributing to the successful implementation of the AHA role in private disability practice to better meet population needs.	Semi-structured interviews	3 AHAs 3 AHPs 2 managers with AH backgrounds	Broad range of client ages and diagnostic groups Private disability practices Regional Northern Territory	Not specified	One of few articles looking at use of AHAs in NDIS space. This raised issue of cost ie ability to bill for AHA hours

https://doi.org/10.2147/JMDH.S561660

26. Rushton et al al 2021[34]	Quantitative descriptive	Aimed to explore knowledge, attitudes and practices of dietitians and dietitian assistants regarding delegation of malnutrition care activities.	Questionnaire (tailored from the Malnutrition Knowledge, Attitudes and Practices Survey). Considered aspects of the Nutrition Care Process and the Allied Health Assistant Framework	87 dietitians 37 dietitian assistants	Adult inpatient hospitals Queensland	Dietetics	Surveys were undertaken as part of a state-wide malnutrition care implementation program (SIMPLE II), aimed to embed the Systematised, Interdisciplinary Malnutrition Program for Implementation and Evaluation into routine clinical practice.
27. Rushton et al, 2022[35]	Qualitative Inductive thematic analysis	Identify barriers and enablers to delegating malnutrition care activities to dietitian assistants.	Interviews	23	Adults Inpatients- 7 public hospitals Brisbane	Dietetics	Delegation of malnutrition care activities to assistants
28. Schwarz et al, 2019[36]	Quantitative with qualitative elements Test validity of assessment, staff perceptions, costs analysis	Explore the feasibility and initial validity of using trained AHAs to complete structured mealtime observations of patients as part of dysphagia management	Structured observation form, comparison between SPLT and AHA; interviews with staff, length of time for assessments (as cost)	50 observations, 8 interviews	Adults Inpatients Brisbane	SLP	Dysphagia screening by AHAs
29. Schwarz et al, 2022[37]	Qualitative Interview analysis guided by Consolidated Framework for Implementation Research	Examine enablers and barriers to service implementation for new screening service	Semi-structured interviews	AHAs= 4, SLTs= 4	Inpatients with dysphagia Metro hospitals x3 in Brisbane	SLP	Dysphagia screening by AHAs
30. Snowdon et al, 2022[38]	Quantitative: Time motion study	Determine proportion of AHA time spent on patient related tasks relative to experience, setting and AHP profession delegating	Self-reported	51 AHAs	Various (acute, community) Victoria, 3 Melbourne, 1 regional setting	Various EP, dietitian, psychology, PT, OT, SLT, SW, podiatry	Measuring quantity of time spent on individual task categories

(*Continued*)

Table 2 (Continued).

Author Year	Research Method & Study Design	Study Objective	Data Collection Methods	Sample Size	Client Population Clinical Setting Geographical Setting	Profession	Description of Intervention/Program
31. Snowdon et al, 2024[39]	Quantitative with qualitative elements: RCT (feasibility, acceptability, demand, implementation, practicality)	Determine feasibility of AHA managing people with hip fracture	Patient and organisation data from medical records; patient satisfaction survey; staff semi-structured interviews	50 pts (25 AHA Rx, 25 PT Rx)	Adults with surgically managed hip fractures Acute Melbourne	PT	Comparing AHA and AHP post-surgery mobilisation
32. Somerville et al, 2015[40]	Mixed methods, descriptive	Identify areas where AHAs not working to full scope	Baseline- workforce survey, focus groups to determine tasks for AHAs, quantification survey to measure time spent by AHPs on AHA potential tasks	83 organisations; 2703 AHPs and 350 AHAs	Adults Public health, community and hospital, Regional and rural Victoria	Various	Part of larger study- Victorian Assistant Workforce Model
33. Somerville et al, 2018[41]	Mixed methods, descriptive	Quantify time AHPs spend on tasks that can be allocated to an AHP; document confidence levels in delegating to AHAs	Survey of AHP time use, focus groups, workforce surveys	27 organisations, 1112 AHPs, 135 AHAs	Adults Public health, community and hospital, Regional and rural Victoria	Various- 14 disciplines	Part of larger study- Victorian Assistant Workforce Model
34. Stute et al, 2013[42]	Qualitative: Delphi	Define and establish consensus on allied health assistant roles at three levels.	Delphi 3 rounds reviewing statements describing AHA role at trainee, full or advanced scope (agree or disagree)	107-188 AHPs and AHAs (for different rounds)	Public Health Queensland	Various. Largest group OT, PT and speech pathology	N/A: part of larger project resulted in key tasks and roles being defined and contentious aspects clearly identified.

35. Stute et al 2014[43]	Qualitative: trial AHA positions developed, implemented and audited	1. Describes the process of testing and evaluating new AHA positions at trainee level, full scope of practice and advanced scope of practice level 2. Explore whether greater role clarity would improve utilisation of AHAs at the different levels, highlight potential aspects of AHA career pathways, and inform their training and supervision arrangements.	Document review, task observation and interviews	51 roles commenced, 41 audited (staff turnover)	Mix: metropolitan hospital, rehabilitation inpatient, home based care (9 sites). Public health, Queensland	Various	New AHA roles developed
36. Thomas et al 2022[44]	Quantitative	Evaluate whether remote completion of a physical examination using still images captured by AHAs is a valid alternative to an in-person physical examination inpatients admitted to a home rehabilitation service.	Statistical analysis of agreement between physical assessment conducted by dietitian using still images collected by AHA and in-person assessment	104 clients	Adults admitted to the home rehabilitation service Adelaide	Nutrition	
37. Thwaites et al, 2025[45]	Qualitative descriptive nested within RCT	Understand factors that impact the feasibility of supplementing usual care with patient falls education delivered by supervised allied health assistants.	Focus groups and interviews	Twelve AHAs seven allied health professionals and two managers	Adults at risk of falls Inpatients Melbourne	PT and OT	AHAs delivering components of falls prevention so patients could receive falls education withing 48hrs of admission
38. Whelan et al 2024[1]	Qualitative: Interpretivist perspective	Evaluate engagement with resources developed to optimise use of AHA role in health, disability, aged care and VET sector	Semi-structured interviews with AHPs AHAs, AH leaders, thematic analysis	35 AHPs, 10 AHA	Varied settings in Victoria	Various	Resources developed to optimise role- evaluation of engagement with these

Abbreviations: ACT, Australian Capital Territory; AH, Allied Health; AHA, Allied Health Assistant; AHP, Allied Health Professional; AusTOMs, Australian Therapy Outcome Measures; Cert I/IV, Certificate I or IV in Allied Health Assistance; CF, Cystic Fibrosis; CSQ-8, Client Satisfaction Questionnaire; EP, Exercise Physiology; FIM, Functional Independence Measure; LOS, Length of Stay; NA, Nutrition Assistant; NSW, New South Wales; OT, Occupational Therapy; OTA, Occupational Therapy Assistant; PSCNS, Patient Satisfaction with Clinical Nutrition Services questionnaire; PT, Physiotherapy/Physiotherapist; RCT, Randomised Controlled Trial; SLT, Speech-Language Therapy; SP, Speech Pathology; TA, Therapy Assistant; VET, Vocational Education and Training; VIC, Victoria; WA, Western Australia.

Table 3 Content Analysis

CONCEPT	SUBCATEGRORY
1. Service Efficiency and Quality	1a. Improved Patient Access and Outcomes - No decline and/or improvement in patient outcomes due to AHA role[1,7,12,15,17,23,39,44,45] - Increased therapy time[13,14,17,22,25,26,40,]
	1b. Optimisation of Allied Health Professional Roles - Increased opportunity for allied health professionals to undertake complex work and/or manage competing demands[7,12,14,17,23,31–33,37]
2. Capacity Building Through Training	2a. Foundational and Ongoing Training for AHAs - Training of allied health assistants is essential[1,3,6,7,12–14,16–21,23,24,26–28,32,33,36,37,39,43,45] - Certificate IV training supports on the job training[6,7,12,23,25,26,39]
	2b. Training for Supervisors - Allied health professionals need training to supervise and delegate to AHA[27–29]
	2c. Supporting AHA Career Development - Training supports the development and progression of AHAs[6,16,18,20,24]
3. Contextual and Structural Influences on AHA Role	3a. Workforce Characteristics and Team Dynamics - Experience of AHA[3,6,12,39] - Other team member characteristics influence AHA role[1,3,18,24,25,35,37,38]
	3b. Service and Role Context - Context of Role- type and location of service influences scope[1,18,37,38,41] - Location: Access to different training and support rural vs metro[1,18,19,]
	3c. Structural and Organisational Enablers - Clear guidelines (including delegation) and/or competencies[1,7,14,16–19,21,23–28,34,37,42,43,45] - Supervision and professional development of AHAs[6,18,23,24,28,32,35,36,39,]
4. Tensions	4a. Professional Identity and Role Protection - Perception that AHA roles may be used as substitute for AHPs[27,29,30,32] - Delegating clinical tasks to assistants was seen by some participants as decreasing the individualised treatment that most participants valued[30,] or AHPs losing accountability[43]
	4b. Career Structure and Role Sustainability - Limited career progression for AHAs[1,3,6,16]
	4c. Funding Limitations - Financial cost of employing vs billing for AHAs[33,38]

Data Quality

The methodological and reporting quality of the included studies varied. The average overall QuADS score for the studies included in this review was 28.5 (range 12–34) out of a total possible score of 39 (based on a maximum score of 3 for each of the 13 criterion). Studies tended to score highest on the statement of research aim/s (mean of 2.6), research setting and target population (mean of 2.8), appropriate study design (mean of 2.6), description of data collection (mean of 2.4), and method of analysis criterion (mean of 2.5). The lowest scoring criterion at an average of 1.3 and 1.4, respectively, were "Justification for analytic method selected"; and "Evidence that the research stakeholders have been considered in research design or conduct", indicating that there was typically limited justification for the method of analysis, and limited stakeholder involvement in the design or conduct of the studies. Articles with lower overall QuADS scores (ie Isbel et al (2014), Pearce & Pagett (2015), Phillips et al (2021) and Stute (2013)) commonly exhibited methodological limitations in relation to unclear sampling strategies, a lack of clarity regarding the appropriateness of the data collection and analytical methods employed to address the aims or outcomes of interest, and limited discussion of strengths or limitations. The full quality appraisal evaluations are presented in Table 5.

Table 4 Government Documents Data Extraction

URL	Document Title & Author	AHA Specific?	Document Inclusions					Comments
			Delegation Supervision and/or Governance	Scope of Practice	Models of Care	Training	Workforce Data	
Health.gov.au	*2020 Aged Care Workforce Census Report* Department of Health[48]	NO Support workforce in general, including AHAs					X	Report on aged care workforce data rather than information on how workforce implemented
	Allied health workforce data gap analysis Department of Health[49]	NO Allied health workforce in general					X	Report on allied health workforce data
	Improvement of access, quality and distribution of allied health services in regional, rural and remote Australia Department of Health, Disability & Ageing[50]	NO Allied health workforce generally, including AHA	X		X	X	X	Data and discussion on improving accessibility/ distribution of AHP workforce, including AHAs in rural areas
Health.nsw.gov.au	*Allied Health Assistant Horizon Scanning and Scenario Generation Report* NSW Health[51]	YES	X		X	X		Report to outline themes in the literature and by Allied Health Assistant stakeholders to inform workforce planning for NSW Health
	Allied Health Assistant Framework NSW Health[52]	YES	X	X		X		Governance framework for the effective employment and utilisation of Allied Health Assistants (AHAs) in the NSW Health workforce

(*Continued*)

Table 4 (Continued).

URL	Document Title & Author	AHA Specific?	Document Inclusions					Comments
			Delegation Supervision and/or Governance	Scope of Practice	Models of Care	Training	Workforce Data	
health.qld.gov.au	*Allied Health Assistant Framework* Office of the Chief Allied Health Officer, Queensland Health[53]	YES	X	X	X	X		Governance framework for the effective employment and utilisation of Allied Health Assistants (AHAs) in the Queensland Health workforce
	Allied Health Assistant Orientation Workbook Office of the Chief Allied Health Officer, Queensland Health[54]	YES	X	X		X		AHA orientation workbook for workers commencing in an AHA role in Queensland Health
	Allied Health Assistant Project Phase II Completion Report Allied Health Workforce Advice and Coordination Unit, Queensland Health[55]	YES	X	X	X	X		Evaluation of project aimed at defining the role and scope of practice of AHAs
	Delegation Framework- Allied Health Office of the Chief Allied Health Officer, Queensland Health[56]	YES	X					Guide for implementation of delegation practices to AHAs working in Queensland Health
	Allied Health Assistant Framework Self-audit Tool Queensland Health[57]	YES	X	X		X		Tool for allied health teams to audit delegation and scope

https://doi.org/10.2147/JMDH.S561660

Health.vic.gov.au	*Guidelines to scope and introduce new allied health assistant roles* Department of Health[58]	YES		X	X	X		Guide developed assist health and community services across Victoria to identify the need for, and to introduce, new and amended AHA roles within their workforce.
	Supervision and delegation framework for allied health assistants Department of Health[59]	YES	X	X	X			Guide for AHPs to support effective and safe working with AHAs
	Supervision and delegation framework for allied health assistants Case studies Department of Health[60]	YES	x	x	x			Case studies to provide examples of implementation of AHA role
	Victorian allied health assistant workforce recommendations Department of Health[61]	YES	X	X		X		Recommendations and resources to assist key stakeholders such as allied health workforce and employers in their utilisation of the Allied Health Assistant workforce.
	Supervision and delegation framework for allied health assistants and the support workforce in disability Department of Health and Human Services[62]	YES	X	X		X		Framework to guide allied health professionals in safely and effectively working with allied health assistants and disability support workforce to provide therapeutic services in disability services
Health.wa.gov.au	*Allied Health Assistants Policy* WA Country Service[63]	YES	X	X				Policy guidance on the delegation of tasks to AHAs
	Supporting and Developing the Allied Health Assistant Workforce Department of Health	YES	X	X		X	X	Project to understand the clinical settings where AHA are of most value to AHP, patients, carers and the community in the delivery of best practice care
Health.tas.gov.au	*Allied Health Assistant Supervision and Delegation Framework* Office of the Principal Allied Health Advisor[64]	YES	X	X		X		Promote understanding of AHA scope of practice, supervision and delegation responsibilities of allied health professionals working with assistants
OTHER	*The Allied Health Assistants Good Practice Guide* Jobs Queensland[65]	YES	X			X		Guide to introducing AHAs into NDIS practice

Table 5 Quality Appraisal of the Reviewed Studies Using the Quality Assessment for Diverse Studies Tool (QuADS)

	QuADS Score by Item													QuADS Total Score
Author (Year)	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	
Cox et al 2014[12]	2	3	3	2	2	2	2	2	1	2	3	1	3	28/39
Frowen et al 2021[7]	2	3	3	3	2	2	3	3	3	2	3	2	3	34/39
Goodale et al 2007[13]	1	3	3	2	1	1	1	2	3	0	1	2	0	20/39
Hall et al 2021[14]	2	3	3	3	2	2	2	2	2	2	2	3	3	31/39
Huglin et al 2021[6]	2	3	3	2	2	2	2	2	2	2	2	3	2	29/39
Isbel et al 2014[15]	1	3	2	2	2	3	2	2	2	0	1	0	2	22/39
King et al 2022[16]	2	3	3	3	2	2	3	3	3	2	3	1	2	32/39
Kiss et al 2019[17]	2	3	3	3	2	2	3	3	3	2	3	2	3	34/39
Kuipers et al 2015[18]	2	2	3	2	2	3	2	2	1	1	1	3	0	24/39
Lin et al 2007[19]	2	2	3	3	3	3	3	2	3	1	3	2	0	30/39
McLean et al 2022[43]	2	3	3	3	3	2	3	3	3	0	3	3	3	34/39
Mickan et al 2018[21]	3	3	3	3	2	1	2	3	3	1	3	1	1	29/39
Missen et al 2021[22]	2	3	3	2	2	1	2	2	2	0	3	1	1	24/39
Moran et al 2012[23]	3	3	3	3	3	3	3	3	1	2	3	2	1	33/39
Nancarrow et al 2012[24]	3	3	3	3	2	3	3	3	3	3	3	0	3	35/39
Nancarrow et al 2015[25]	3	3	3	3	2	2	2	2	1	1	3	0	3	28/39
Newman et al 2018[26]	3	3	3	3	2	2	3	3	2	2	3	1	3	33/39
O'Brien et al 2013[27]	3	3	3	3	2	2	3	3	3	2	3	0	2	32/39
O'Brien et al 2018a [21]	2	3	3	3	2	2	2	2	3	2	2	1	2	29/39
O'Brien et al 2018b [22]	2	3	3	3	2	2	2	3	2	2	2	2	3	31/39
O'Brien et l 2020[28]	3	3	3	3	3	2	3	3	3	2	3	0	2	33/39
Pearce & Pagett 2015[3]	2	2	2	2	2	1	0	1	1	0	2	1	0	16/39
Phillips et al 2021[31]	3	1	1	1	0	0	1	1	1	0	0	3	0	12/39
Pinson et al 2023[32]	2	3	3	3	2	3	3	2	3	1	3	0	3	31/39
Roberts et al 2024[33]	3	3	3	3	2	3	3	3	1	0	3	0	2	29/39
Rushton et al 2021[34]	2	3	3	3	2	3	3	3	3	0	3	0	3	31/39
Rushton et al 2022[35]	3	3	3	3	2	2	3	2	2	0	3	0	1	27/39
Schwarz et al 2019[36]	2	3	2	3	2	2	2	3	2	1	2	1	2	27/39
Schwarz et al 2022[37]	3	2	2	3	2	2	2	2	2	0	2	0	3	25/39
Snowdon et al 2022[38]	1	1	3	2	2	3	3	3	1	3	3	2	2	29/39
Snowdon et al 2024[39]	1	2	3	3	2	3	3	3	3	3	3	2	3	34/39
Somerville et al 2015[40]	1	3	3	3	3	3	3	3	3	2	3	3	0	33/39

(*Continued*)

Table 5 (Continued).

	QuADS Score by Item													QuADS Total Score
Author (Year)	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	
Somerville et al 2018[41]	1	2	2	3	2	2	2	2	2	2	3	2	0	25/39
Stute et al 2013[42]	2	2	3	3	2	2	3	2	3	2	3	3	1	31/39
Stute et al 2014[43]	2	2	2	2	2	2	1	2	2	1	1	2	1	22/39
Thomas et al 2022[44]	1	2	3	2	3	2	2	3	3	3	2	2	2	30/39
Thwaites et al 2025[45]	2	2	3	2	2	2	2	3	3	1	2	2	2	28/39
Whelan et al 2024[1]	2	2	3	2	2	2	2	2	2	1	3	2	2	27/39

Notes: (1) "theoretical or conceptual underpinning to the research", (2) "statement of research aim(s)", (3) "clear description of research setting and target population", (4) "appropriateness of study design to address research aim(s)", (5) "appropriate sampling to address the research aims", (6) "rationale for choice of data collection tools", (7) "appropriateness of the format and content of data collection tools", (8) description of data collection procedures, (9) "recruitment data provided", (10) justification for analytic methods", (11) "appropriateness of analytic methods to answer research aims", (12) "evidence of stakeholders involvement" and (13) "critical discussion of strengths and limitations".

Content Analysis

A review of the study results and discussions identified four concepts that impact the utilization of AHAs in Australia. The concepts with subcategories are summarized in Table 3.

Concept 1: Service Efficiency and Quality

Most of the studies focused on the characteristics of the AHA workforce rather than the impact of the AHA role. Of those that did attempt to measure service efficiency and quality, all found a positive impact, both in terms of clinical outcomes not changing when compared to AHP delivered care,[7,12,15,17,23,36,39,44,45] and access to therapy, with the availability of the AHA increasing overall therapy time.[13,14,17,22,25,26,40] The AHA role may also provide an opportunity to free up allied health professional time to undertake more complex work and manage competing demands.[7,12,14,17,22,25,26,40] One study highlighted a perception that AHAs would not lead to increased capacity for allied health professionals, due to the increased demands of training and supervising the AHAs.[27] However, it is noted that this qualitative study was undertaken in a rural setting where the AHA role was more novel and included a small number of speech and language pathologists who, as a profession, were less represented in the studies.

The government documents, while acknowledging the value of AHAs, did not focus specifically on efficiency or quality, but rather on the pragmatics of incorporating the AHA role. Two of the documents which specifically considered workforce data, provided numbers of AHAs in relation to other professions[48,49] but this does not necessarily support services to understand what the impacts are in relation to efficiency or quality.

Concept 2: Capacity Building Through Training

A significant proportion of the included studies identified training as a key concept. Fundamentally, there was a consensus that context-specific and ongoing training of AHAs is essential for the role to be safe and effective.[1,3,6,7,12–14,16–21,23–28,32,33,36,37,39,43,45] As determined by the search parameters of this review, whilst all the studies were undertaken after the introduction of the Certificate III and IV in Allied Health Assistance, currently the only formal qualifications available for AHAs, only a small proportion of the studies explicitly referenced the training as being a tool to support, not replace, on the job training.[6,7,12,23,25,26,39] The remaining studies did not explicitly identify if AHAs had or were required to have a Certificate IV. Training was framed as being both important for the safety and quality of service delivery, as well as supporting the development and career progression of AHAs.[6,16,18,20,24] One study investigated the option of moving formal training from the vocational sector to the university sector but found that role-specific training delivered in the work setting was more impactful than formal training so this change was not warranted.[21] Whilst many studies acknowledged supervision and delegation as being important to the success of the AHA role, only O'Brien

et al's[27,28,30] work examining speech and language pathology assistant roles explicitly addressed training for supervisors of AHAs. With limited formal training in delegation and supervision skills AHPs often feel underprepared to supervise AHAs. Suggested actions include embedding supervision competencies into undergraduate curricula, ensuring structured support and clear role boundaries in workplace settings, and advocating for professional bodies to provide guidelines and training resources.

Of the 18 government documents identified, the majority addressed training to varying levels of detail including mentioning the Certificate IV in Allied Health Assistance,[51–53,58–62,64–67] as well as highlighting the need for on the job and/or role specific training.

Concept 3: Contextual and Structural Influences on AHA Role

The generalizability of the studies included in this review are limited by factors including sample size and sample variance. However, there were common contextual and structural determinants which may inform the AHA role. Whilst the AHA role does not have a requirement for completion of compulsory training in the same way as allied health professionals, the experience of the AHA needs to be considered when determining how the role is utilized, including scope and degree of autonomy.[3,6,12,39] Other team member characteristics, including their previous experience of supervision and delegation and attitude towards the AHA role also influence implementation.[1,3,18,24,25,35,37,38] The type of service and location, particularly in terms of rural versus metropolitan also have an impact on both determining the scope of the AHA role[1,18,37,38] and the access to training and support for the AHA,[1,18,19,41] with studies considering AHAs working in rural or regional areas identifying reduced access to robust governance structures, on-site clinical supervision and formal training compared to their metropolitan counterparts.[1,18,19,41]

At a health service level, there are structural and organizational factors which when present, enable the successful implementation of the AHA role. These included clearly documented guidelines governing factors such as delegation and AHA competencies,[1,7,14,16–19,21,23–28,34,37,42,43,45] as well as framing the processes for supervision of AHAs and recommendations for their ongoing professional development.[6,18,23,24,28,32,35,36,39]

This concept was a feature of all the government documents, the intent of which was to provide practical guidance regarding incorporating AHAs into a service. This included documents which focused on workforce data, with the intent of providing an overview of workforce size and configuration, so that gaps might be identified, along with opportunities to expand service offerings.[48,49]

Concept 4: Tensions

The AHA role is framed as one that can support health services to deliver increased frequency, volume and quality of care, while creating capacity for allied health professionals to deliver care specific to their scope of practice. However, there is tension between this potential for innovation and a perceived threat to the professional identity and role of the allied health professions. There continues to be a perception in some professions that AHAs will be employed to substitute, rather than support or complement, allied health professions.[27,29,30,32] It is to be noted that these studies were conducted with allied health professions that have only more recently begun to incorporate the assistant role. It is important to consider the other factors which may impact on the successful implementation of an AHA role into a service including the impact of limited career progression for AHAs,[1,3,6,16] which can lead to a high turnover of position holders, negating the important impact of AHA experience as highlighted in Concept 3.

As with all health and social care systems, finances need to be considered. This was not an element that was prominent within this review, which may reflect the limited research undertaken outside of the public health care system. In some areas of service delivery, particularly the National Disability Insurance Scheme (NDIS), the funding model presented challenges for employers in balancing cost-effective service provision through the utilization of AHAs with the need to generate sufficient billable hours to offset the costs of their employment and training.[33,38] This concept was not a feature of the government documents which focused on services with block funding and considered the AHA role as being an opportunity to provide efficiencies within this funding model.

Discussion

The AHA role is well established within the Australian health and social care context, across a range of allied health professions.[1,6] The role is aimed at implementing services based on the clinical reasoning of allied health professionals rather than delivering autonomous care.[2] As such, it can be difficult to explicitly evidence specific clinical outcomes of AHA interventions. However, as demonstrated in the synthesis of evidence included in this review, it is possible to understand the positive contribution of AHAs to service efficiency, access and quality. Studies that broadly evaluated clinical outcomes and therapy access reported improvements in both domains,[7,12,15,17,23,36,39,44,45] suggesting that AHAs enhance the capacity of health services to deliver timely and effective care. Importantly, the presence of AHAs was associated with increased therapy time and the ability of allied health professionals to focus on tasks specific to their scope of practice.[13,14,17,22,25,26,40]

Whilst the literature reveals a gap in robust outcome-focused research, it is important to consider the learnings that may be garnered from studies examining workforce characteristics and context factors. Training emerged as a critical enabler of safe and effective AHA practice, with services developing bespoke packages to allow for contextual factors such as AHA and supervisor experience, clinical setting and geographical location.[12,17,25,36,43] While the Certificate III and IV in Allied Health Assistance provides a foundational qualification, the literature underscores the importance of ongoing, context-specific training to support role development and service quality. Notably, on-the-job training was frequently cited as more impactful than formal education alone. It was suggested that this was due to the existing qualification package not being fit for purpose but stemmed more from the breadth of settings and individualized role requirements for AHAs within these settings.

Despite the centrality of supervision and delegation to the successful implementation of the AHA role, few studies addressed the training needs of allied health professionals in supervisory relationships with AHAs. This may reflect the time frame and setting of most of the included studies, as public health care services have access to supervision and delegation policies and guidelines developed at a state level. However, with the expansion of the AHA role into services funded through the NDIS and ongoing aged care reforms, considering the skills of the delegating allied health professionals will be central to ensuring consistent and safe utilization of the AHA role across these settings. Whilst not specifically addressed within the literature, consideration needs to be given to incorporating supervision and delegation to AHAs as a competency for all entry level AHPs.

The four concepts identified in this review align with those proposed in a recent study looking at opportunities to promote the AHA workforce across all sectors in Victoria. This mixed-methods study proposed four interrelated factors- system, training, individual and workplace- as being the core contributing factors to the utilization of AHAs.[6] Whilst not a core concept within this framework or within the literature, it is important to also continue to address any concerns raised in relation to professional identity and role boundaries. Some AHPs perceive AHAs as a threat to their scope of practice, particularly in disciplines where the assistant role is less frequently utilized.[27,29,30,32] This tension may hinder the full realization of the AHA role's benefits. Additionally, limited career progression opportunities for AHAs contribute to workforce instability, undermining the value of experience and continuity.

Despite many of the government documents identifying mental health as a practice area in which AHAs currently work, no studies were identified that examined the implementation of AHAs within mental health, justice health, or alcohol and drug services in the Australian context. This represents a significant gap in knowledge regarding how AHAs can be effectively utilized to provide safe and effective services within the mental health sector in Australia.

Similarly, though underexplored in the literature, financial considerations will also shape the development and utilization of AHAs, especially in emerging funding models such as the NDIS and changes implemented under the new Aged Care Act. Within the Australian landscape, these sectors provide vital services to support people to live well in the community, thereby reducing demand on already overstretched health services. To staff these services, as reflected in the National Allied Health Workforce Strategy,[68] the various sectors will need to develop innovative models of care supported by staffing models that are safe, efficient and sustainable. Whilst definitive figures are not available, according to the Allied Health Assistant National Association, 50% of their members work in disability services.[50]

A recent scoping review[69] aimed to understand the governance arrangements for therapy assistants and support workers within the disability sector, with a specific focus on rural and remote communities in Australia and internationally.[69] Whilst acknowledging that it considered international settings and a broader workforce, it is of note that the review did draw similar conclusions, namely that training and supervision along with contextual factors impact the effectiveness of support roles within the disability sector.

The evidence elucidated through this review provides further guidance on how to ensure that the AHA workforce plays an effective part in the health and social care workforce. Whilst there is a dearth of published evidence in the mental health and disability sectors, there are opportunities to integrate the core elements identified through this review to support expansion of the AHA role into these sectors.

Strengths and Limitations

This review used a comprehensive search strategy involving seven academic databases, and searches for grey literature on government websites, and with input from two health research librarians.

This review primarily presented research and policy relating to public health care services. There may be AHA documentation available that is not publicly available but as this review only accessed published literature, not all areas of health and social care could be fully considered. The heterogeneous nature of the research methodologies and methods means this review cannot draw definitive conclusions but rather present a synthesis of the evidence. As the review was based on research and documents relating to the Australian context, generalizability to international settings may be limited.

Conclusion

This review underscores the factors that support the integration of the AHA role in the Australian health system. While the evidence points to clear benefits in terms of service efficiency, quality of care, and workforce capacity, the successful integration of AHAs depends on a range of interrelated factors. Effective training, supportive organizational structures, and context-specific implementation strategies are essential to maximize the value of the AHA role. To optimize the contribution of AHAs, policy and practice must address these identified enablers and barriers. This includes investing in training for both AHAs and their supervisors, developing flexible role descriptions that accommodate local needs, and fostering a culture that values the complementary nature of the AHA role. As the healthcare system continues to evolve, and new funding models are introduced, AHAs have the potential to play an increasingly vital role in delivering accessible, high-quality care. Expanding research into the cost-effectiveness and long-term outcomes of AHA integration, particularly within disability services, mental health and aged care, will be essential to inform sustainable workforce planning.

Author Contributions

All authors developed the study aims and method. RM conducted literature search. RM, CP and RP undertook article screening, quality appraisal and data extraction. CP undertook data analysis in consultation with RM and RP. CP drafted introduction, results and discussion. All authors contributed to final version of manuscript, contributing to introduction, results, discussion and conclusion and approved final version for submission.

Disclosure

The authors report no conflicts of interest in this work.

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