Poche Centre for Indigenous Health

BUILDING THE RURAL AND REMOTE ALLIED HEALTH ASSISTANT WORKFORCE

EVALUATION REPORT 2025

Services for Australian Rural and Remote Allied Health

PROJECT INFORMATION

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The consultations and interviews that informed this report were undertaken by a consortium led by researchers from the Poche Centre for Indigenous Health at the University of Queensland, Toowong, Queensland.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ACRONYMS

ACCHO	Aboriginal Community Controlled Health Organisation
AH	Allied Health
AHA	Allied Health Assistant
AHP	Allied Health Professional
BRAHAW	Building the rural and remote Allied Health Assistant workforce
PIMS	Patient Information Management System
SARRAH	Services for Australian Rural and Remote Allied Health
UQ	University of Queensland

ACKNOWLEDGEMENT OF COUNTRY

The evaluation team would like to acknowledge the the Jagerah and Turrbal peoples on whose land the University of Queensland is situated. The Services for Australian Rural and Remote Allied Health (SARRAH) acknowledge the Ngunnawal peoples on whose land their office is situated. We also acknowledge the traditional owners of the lands where allied health professionals participating in this research live and work. We pay our respects to their Elders past, present, and emerging. We recognize and respect their cultural heritage, beliefs, and relationship with the land, which continues to be of great importance to Aboriginal and Torres Strait Islander people living today. We also pay our respects to Aboriginal and Torres Strait Islander Peoples from across Australia who have participated in this work.

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SARRAH is very grateful to Commonwealth for the opportunity to undertake this important work and to the staff of the department for their support and encouragement. We also gratefully acknowledge the enthusiasm and contribution of the Allied Health Assistants (AHAs), Allied Health Professionals (AHPs) and Managers from services participating in the project. The BRAHAW project would simply have been impossible without their willingness to engage with SARRAH and the evaluation team, and contribute their knowledge and expertise.

The evaluation of the BRAHAW project was undertaken by a team of researchers from the Poche Centre for Indigenous Health, University of Queensland.

EXECUTIVE SUMMARY

Background

This report details the results of a process evaluation undertaken in eight out of 18 services that participated in the Building the Rural and Remote Allied Health Assistance Workforce (BRAHAW) program in rural and remote areas of Australia. The eight services that participated in the evaluation were located in New South Wales, Queensland, the Northern Territory, South Australia and Western Australia.

Purpose

The purpose of the BRAHAW program was to assist rural and remote Allied Health Professionals (AHPs) working in private and non-government organisations to build their Allied Health Assistant (AHA) workforce, roles and models of service delivery. The keystone to achieving this was the provision of a tailored package of practice and workforce support developed by the Services for Rural and Remote Allied Health (SARRAH) and funded by Health Workforce Division. of the Commonwealth Government of Australia, Department of Health and Aged Care.

Methods

The evaluation of the BRAHAW program employed mixed methods, including qualitative interviews with AHAs, AHPs and Managers, and quantitative analysis of health service data.

Results

At the time of reporting the BRAHAW program showed an excellent success rate of 87%. Participant interviews showed that the education and support, workplace training grants and governance framework elements of the program were highly valued. The impact of BRAHAW, as perceived and experienced by participants perceptions included the professional and personal development of the AHAs, facilitated integration of AHAs into the allied health workforce, enhanced relational care between clients and their healthcare team. Challenges were noted in the suitability of AHA training courses, viability of funding mechanisms to employ AHAs, organisational constraints, and the influence of social and cultural determinants on work readiness and capacity of AHAs.

Quantitative demonstration of impact was constrained due to limited data availability.

KEY FINDINGS AND RECOMMENDATIONS

Key Finding 1:

The increased involvement of AHAs in allied health service delivery observed by service providers and quantified in two services suggests that the BRAHAW program is likely to be an effective model for increasing the number of AHAs to support allied health practitioners to deliver local allied health services in rural and remote Australia.

Recommendation 1

a. Explore opportunities for additional funding for BRAHAW to build the rural and remote allied health assistant workforce.

b. Explore opportunities to research or evaluate the impact of an allied health assistant workforce on service capacity access; including standardising routinely collected measures of allied health service delivery across participating services to enable routine evaluation.

Key Finding 2:

Financial support, resources and coaching is critical to the success of the BRAHAW program.

Recommendation 2

Future programs supporting the development of rural and remote AHAs must include financial and other support for allied health service managers and professionals involved in the training and establishment of the model.

Key Finding 3:

The adaptability of the BRAHAW program was critical for its successful implementation as it meant that its core components could be tailored by services to meet the needs and preferences of their allied health workforce.

Recommendation 3

That program adaptability remains a core tenet of future implementation of the BRAHAW program. The key learnings from the evaluation could inform this adaptability, further increasing the likelihood of successfully implementing the BRAHW program in additional services looking to build the capacity of their AHA workforce.

Key Finding 4:

The feedback provided in interviews and high demand evidenced in large number of applications and waitlist demonstrate that BRAHAW is an acceptable and desirable program for service providers. However the experiences of clients receiving the AHA model of service delivery and their perceptions of its acceptability was not examined.

Recommendation 4

a. Explore opportunities for implementing the BRAHAW program in services that expressed interest in this current project but were unable to participate
b. That future work explores clients' experiences of receiving the AHA model of service delivery and their perceptions of its acceptability

Key Finding 5:

Social and cultural factors had a profound influence on the recruitment and retention of Aboriginal and/or Torres Strait Islander AHAs and the type and level of support they needed to develop and thrive in their role. This was especially the case for AHAs new to the health sector and those living in areas characterised by high levels of unemployment, a lack of social services, and a higher cost of living.

Recommendation 5

Establish a virtual network where AHAs across geographical locations and working in various allied health specialties can connect, share lived and work experiences, and access professional development opportunities through digital platforms like dedicated websites, forums and video conferencing tools.

1 PROJECT DESCRIPTION

Background and context to the BRAHAW program

On average, Australians living in rural and remote areas have shorter lives, higher levels of disease and injury and poorer access to and use of health services, compared with people living in metropolitan areas [1]. Concurrently, rural and remote Australia experiences high and chronic shortages of allied health professionals (AHPs). The resulting gap in allied health (AH) services impedes access to health services that enable wellbeing and prevention; reduce levels of avoidable illness, disease and disability; promote early diagnosis and treatment of chronic and other conditions; aid rehabilitation and recovery, productivity and independence.

In a context where need and expressed demand for allied health services clearly exceeds the availability of the rural and remote workforce, AHPs are adept at innovating and adopting a variety of service delivery models, tools and strategies to optimise their service delivery capacity and reach.

While rural practitioners may be well disposed to innovations that enhance service capacity, having space to innovate, capacity to invest in required infrastructure and training, promote and communicate services requires time and resources. Consequently, AHPs are often constrained by the thin margins associated with current funding structures and the often-precarious viability of rural and remote businesses[2].

Investing in the development of a fit-for-purpose rural allied health workforce will both improve health outcomes for Australians living in rural and remote communities and realise potential savings to the Australian healthcare budget [3] and broader budget bottom-line. Effective investment should consider adjustments to funding structures to support more enabling services, but also to promote and encourage workforce training, workforce development and service capacity within rural and remote allied health services.

Utilising Allied Health Assistants (AHAs) is one strategy that rural and remote AHPs can consider to increase their service capacity and reach [4, 5]. It is one example of where services adapt to better meet community need in response to persistent and challenging environments, coupled with growth in community demand. Managed (and supported) appropriately, incorporating AHAs into AHP led services can facilitate improved service access, continuity of care and service quality, help develop practice networks and business viability [6]. A report for the Minister for Regional Health, Regional Communications and Local Government, on the Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural

and Remote Australia (2020), proposes two key benefits of AHAs for improving access to allied health services. These include the delegation of tasks by AHPs to AHAs and a locally trained allied health workforce, including Indigenous Health Workers and allied health assistants, able to deliver early intervention and prevention and facilitate culturally safe care [2]. This is supported by interviews and surveys undertaken with AHPs which found that 17% of clinical tasks could be delegated to an AHA, enabling the AHP to focus on higher complexity clients [4].

However, implementing AHA service delivery models with the capacity to buffer rural allied health service workloads, requires education and training, professional trust, and governance [2]. Furthermore, long term viability depends on viable practice models with appropriate fee for service/renumeration available through funding structures like Medicare and NDIS. These developments require a shift toward greater focus on the services delivered, and increasing community access to services, rather than to who actually delivers a service; noting the service must be quality controlled and directed by a responsible, suitably qualified and registered practitioner. What's more, rural health consumers are open to innovation and practical alternatives to improve their access to high quality healthcare [7].

AHA service models depend on rural and remote communities having access to a potential workforce of AHAs, who have appropriate education, job specific training opportunities, appropriate governance, supervision, and support. The investment required to achieve this will deliver local jobs, further AHP service capacity and reach, and improve local health and wellbeing outcomes.

Many AHPs in rural and remote Australia, deliver services through a small business model. Building the Rural and Remote Allied Health Assistant Workforce (BRAHAW) can enhance conditions for them to build, expand and deliver local allied health service capacity in rural Australia.

Ahead of the 2021 Federal Budget, SARRAH submitted a proposal to further expand the Allied Health Rural Generalist pathway in the private and non-government sector. To complement this, SARRAH also proposed additional supports to improve viability, reach and sustainability of allied health services in rural and remote communities. The May 2021 Federal Budget included funding for BRAHAW. In September 2021 the Commonwealth Grant Agreement was executed, with $1.83 million committed until June 2024 to this project.

The Purpose of the BRAHAW Program

The purpose of the BRAHAW program was to assist rural and remote AHPs to extend their capacity and reach of their service by establishing and implementing AHA models of service delivery. As documented in the Commonwealth grant agreement, the planned outcomes in relation to project objectives are summarised in Table 1.

Table 1. Planned outcomes for each project objective

Project Objective	Planned outcomes
1. Develop the Allied Health Assistant (AHA) workforce, that will assist allied health practitioners deliver more service capacity within the practice, complementing and incorporating initiatives to improve rural service access and distribution	Increase the number of AHAs to support allied health practitioners and assist allied health practices to deliver local allied health services in rural and remote Australia. Allow growth and effective utilisation of the AHA workforce in rural and remote private and/or community-based practices.
2. Support allied health practitioners and assist practices to deliver local allied health service capacity in rural and remote Australia.	Provide support to private and not for profit service providers, to build capacity and expand allied health service delivery in rural and remote locations

Implementation of the BRAHAW Program

To achieve project objectives and contribute to outcomes, SARRAH provided training and support packages for services which included education funds for AHAs to pursue Certification, and a tailored package of practice and workforce support (see Figure 1 BRAHAW Building blocks).

1. Education funds for AHAs to pursue Certification

   Funds of up to $7,500 were available for AHAs to pursue their Certification III or IV in Allied Health Assistance. Workplaces and AHAs were responsible for selecting an RTO,

allowing them to choose based on their preferences for access (local or online training), and acknowledging any pre-existing experience or relationships with RTOs that they may have.

2. Tailored packages of practice and workforce support

   Practice and workforce support included funding, resources and coaching and support.

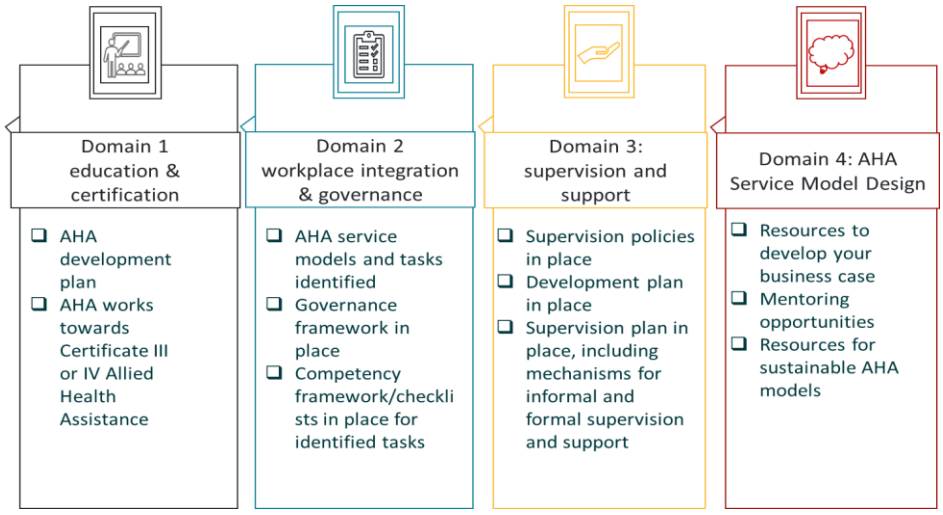
   a. Workplace training grants of up to $26,000 per AHA training package were available to workplaces to enable them to undertake the required activities of the program (Figure 1, Domains 2, 3 and 4)

   b. Bespoke resources were developed by SARRAH and provided to participants including orientation resources and templates and the BRAHAW Handbook – which provided organisations with a roadmap to develop their service delivery model and ensure the adequate governance structures for safety and quality were in place.

   c. Coaching and support provided by SARRAH included regular meetings with workplaces and AHAs to coach through the BRAHAW handbook; networking workplaces and AHAs with others if similar styles of service delivery or geography identified; facilitation of the BRAHAW implementation network forum; access for managers and supervisors to SARRAHs online courses in *Leadership*, *Project Management* and *AHA Service Delivery Models*.

Together, these two elements were designed to enable rural and remote allied health service providers to implement allied health assistant service delivery models, develop operational capability to deliver services, and improve community access to allied health services.

Figure 1. BRAHAW Building Blocks



Through the grant agreement, a total of 30 training packages was available. Of these, according to the grant agreement 15 training packages were for mainstream allied health service providers and 15 training packages were to support development of AHA service models within Aboriginal Community Controlled Health Organisations (ACCHOs).

Selection of Organisations and their uptake of Training Packages

To be eligible for the BRAHAW program, organisations had to be:

1. a private practice (including sole practitioner) or non-government organisation providing allied health services in rural and remote communities; or
2. located within an area classified as per Modified Monash Model as MM 3-MM 7 or be located within an MM2 and provide the majority of services within MM 3-MM 7 regions; and
3. willing to develop and implement an AHA service delivery model.

The application period for BRAHAW was open for three weeks in June 2022. Applications were received and managed using SmartyGrants. During the application period, SARRAH received applications for 79 AHA training positions from 47 private and non-government organisations. One application was from an ACCHO requesting two AHA training packages, and the remaining 46 applications were from mainstream organisations requesting 77 training packages. At the initial eligibility screen, four applications (6 training packages) were declined as the organisations were located in metropolitan areas.

A selection panel comprising the projects director and two project officers from SARRAH assessed the applications using a decision making matrix with the following criteria: proposed service model, rurality, organisational professional mix, organizational size, other factors; aiming for a representative mix of workplaces (Appendix 2). Panel members individually rated applications yes, no or maybe, then convened to discuss their ratings. Applications rated yes were discussed and selected, however, some organisations were only offered one training package (instead of their requested 2) due to availability. The number of organisations that were rated yes exceeded the number of training packages available. Organisations that were rated suitable but did not receive a training package were kept on the shortlist to replace organisations that did not commence or withdrew from the program.

Concurrent to the promotion, advertising and application period the SARRAH project team were undertaking nationwide engagement and consultation with regional, rural and remote ACCHOs. This resulted in applications from eight ACCHOs for 23 AHA training packages. Refer to Figure 2 in Section 3 for a summary of the number of mainstream organisations and ACCHOs that received, commenced, and completed training packages.

2 SCOPE AND AIMS OF THE BRAHAW EVALUATION

The scope of the BRAHAW evaluation explores the value, benefits and impact of funding, support and related activities delivered by SARRAH to build Allied Health Assistant workforce capacity and expand allied health service delivery in rural and remote services. The aims of the evaluation are outlined below.

2.1 Aims

Aim 1: Explore AHP, AHA and manager perceptions and experiences of the BRAHAW program and support from SARRAH for building the capacity of the Allied Health Assistant workforce.

Aim 2: Explore AHP, AHA and manager perceptions of the impact of the BRAHAW program on the capacity of the allied health workforce and allied health service delivery.

Aim 3: Examine the impact of the BRAHAW program on occasions of allied health service delivery.

2.2 Challenges and Limitations

While this evaluation provides evidence of the value, benefits and impact of the BRAHAW program there are three key limitations. Firstly, the BRAHAW program commenced around the end of national and jurisdictional government's travel restrictions and social distancing regulations in response to the COVID pandemic. This meant that during the early stages of implementation of the BRAHAW program, some services were in the process of recovering to 'business as usual.' This delayed or protracted implementation of the program in these services. Additionally, not all services commenced at the same time, due to services replacing those that did not commence or who withdrew, and a longer engagement period with ACCHOs. As a result, there was considerable variation between some services in the length of time they had been implementing the BRAHAW program at the time of this evaluation, and some were not close to completion/ready to participate in evaluation activities. Secondly, allied health service data was only available from two services and therefore the impact of the BRAHAW program could only be quantified in these services. Thirdly, the unavailability of routinely collected data in all but two services precluded an economic analysis of the BRAHAW program.

2.3 Evaluation Methodology

The evaluation of the BRAHAW program employed mixed methods, including qualitative interviews with AHAs, AHPs and Managers, and quantitative analysis of health service data. Table 2 lists the method used for each aim of the evaluation.

Table 2. Method applied for each aim of the evaluation

Aim	Methods
Aim 1: Explore AHP, AHA and manager perceptions and experiences of the BRAHAW program and support from SARRAH for building the capacity of the allied health assistant workforce. Aim 2: Explore AHP, AHA and manager perceptions and experiences of the impact of the BRAHAW program on allied health service delivery.	Semi-structured individual interviews with AHAs, AHPs and managers of services.
Aim 3: Examine the impact of the BRAHAW program on occasions of allied health service delivery in two services.	Quantitative analysis of allied health data routinely collected by services.

2.3.1 Semi-structured interviews with stakeholders – AHAs, AHPS and Managers.

Allied Health Assistants (AHA), Allied Health Professionals (AHP) and Managers from services participating in the BRAHAW program were recruited for individual interviews. SARRAH project staff emailed relevant managers in each service inviting them and the AHA and AHP in their service to be interviewed about their experiences of the BRAHAW program. An interview question guide (Appendix 1) was developed by SARRAH project staff and the evaluation team. The guide included generic questions for all participants and specific questions for AHPs and managers. Generic questions asked participants about how their team works together, the training, roles and scope of practice of AHAs, and how the role of the AHA has changed since implementation of the BRAHAW program in their service. Specific questions asked AHPs and managers for their perceptions of program support from SARRAH and the impact of AHAs on

allied health service delivery in their service. Interviewers prompted participants when seeking additional information or clarification of issues.

A female project officer from SARRAH interviewed AHAs and a senior male researcher from the Poche Centre for Indigenous Health interviewed AHPs and Managers. The project officer was Indigenous and known to participants through her work supporting AHAs participating in the BRAHAW program. The researcher from Poche was non-Indigenous and unknown to all participants. All interviews were conducted virtually, audio recorded and transcribed using Microsoft Teams. NVivoPro 12 Software was used for data management and analysis.

Interview transcripts were analysed using key aspects of a well-established thematic analysis approach that uses 'open' and 'axial' coding [8]. Open coding involved reading through interview transcripts to increase familiarity with the material and to prepare 'theoretical memos' as analytical reminders for generating ideas and making links between different findings. Axial coding linked and organised open codes into themes and sub-themes and provided evidence to support thematic findings. A framework of themes and their sub-themes was developed and discussed with project staff from SARRAH. The framework was revised in response to feedback from SARRAH.

2.3.2 Quantitative analysis of allied health data routinely collected by services.

Data on occasions of allied health service delivery was obtained from two services for the period 01 January 2021 to 30 September 2024. This time frame included a one year pre-implementation, 18 month BRAHAW implementation, and one year post implementation period. Services extracted de-identified data from their electronic patient information systems and shared it with the evaluation team in Microsoft Excel format. Data was analysed using descriptive statistics to examine changes in occasions of allied health service delivery from before to after implementation of the BRAHAW program. No inferential statistical tests were performed.

3 COMPLETION OF TRAINING PACKAGES

Thirty-four BRAHAW training packages commenced in 18 organisations across seven states and territories. Sixteen services eligible for training packages were held on a waitlist in the event of future funding. The number of services on the waitlist has grown to 88.

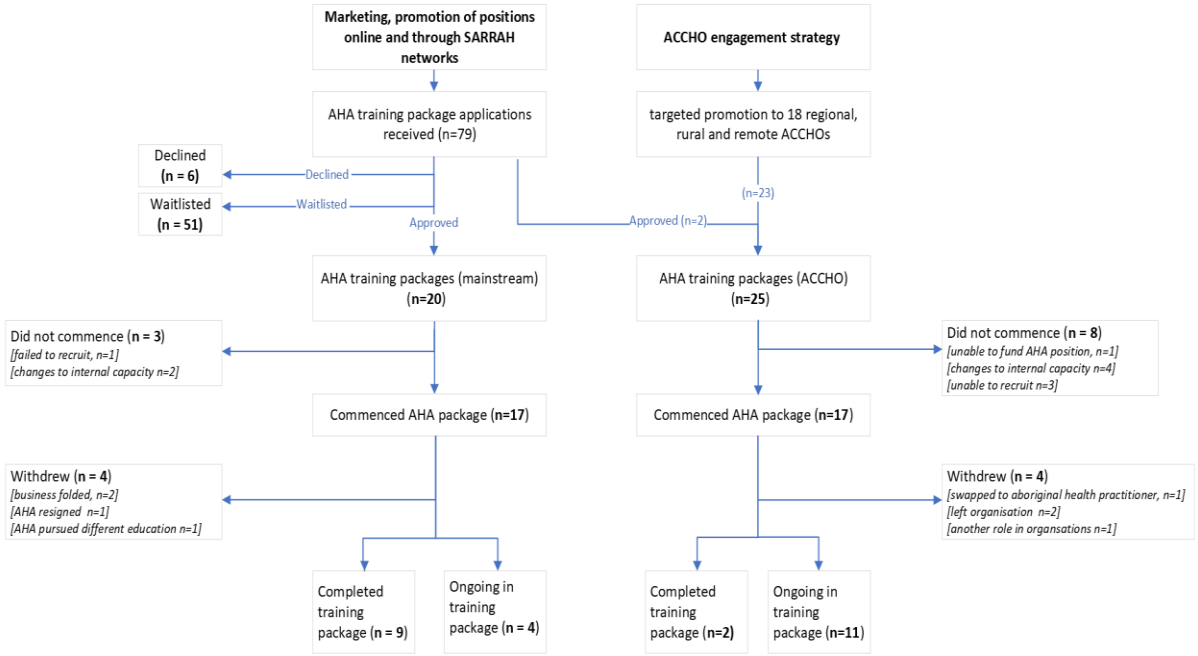
An additional 11 training packages were allocated to seven organisations but did not commence. The reasons for this were due to services' failure to recruit AHAs, a lack of organisational readiness and capacity of AHPs to take on additional supervision and training responsibilities; and/or an inability to fund AHA positions.

A total of 25 AHA training packages for ACCHOs were created over the course of the implementation period. The majority of these positions were created at different times during the implementation period in response to ACCHO engagement and readiness to participate, and to fill packages that did not commence or withdrew, providing there was sufficient time remaining in the grant agreement. Of the 25 packages created, 8 packages did not commence. This was due to organisations' inability to:

- sustainably fund AHA positions;
- identify capacity (internal or contracted) to undertake the work of supervising the AHA, creating the governance frameworks and developing the model of care; and/or
- successfully recruit to AHA positions.

At the time of this report, 11 training packages were completed, 15 are ongoing and due to finish in 2025, and 8 were withdrawn from services. This represents a projected success rate of 87%. Reasons for the withdrawal of training packages included closure of business, preference for Aboriginal Health Worker qualification instead of Allied Health Assistance, resignation, and AHA turnover that was unable to be accommodated within program timelines. Figure 2 summarises the number of organisations that received, commenced and completed training packages.

Figure 2. The number of organisations that received, commenced and completed training packages



4 FINDINGS OF QUALITATIVE INTERVIEWS

Interview participants were from nine services implementing the BRAHAW program. A total of 22 participants were interviewed, including ten Allied Health Assistants (AHAs), six Allied Health Professionals (AHPs) and six managers. Twelve (55%) interview participants identified as being Aboriginal and/or Torres Strait Islander, including ten AHAs and two managers. Participants were predominantly employed in private organisations (55%), 45% were employed in community controlled organisations. No participants were employed in government organisations.

4.1 AHP, AHA and manager perceptions and experiences of the BRAHAW program and support from SARRAH.

Managers and AHPs reported multiple benefits to the resources and support they received from SARRAH to implement the BRAHAW program in their service. Their perceptions of specific support and resources they received from SARRAH are described below, with similarities and differences between services highlighted.

Education and Support

Support provided by SARRAH to services implementing the BRAHAW program was primarily delivered in virtual format. According to Managers and AHPs, this support included regular check-ins, provision of information and resources, troubleshooting problems, and tips and advice for improvement. SARRAH support staff were described as accessible, approachable, responsive and helpful.

> 'SARRAH, were there, I suppose, like a good friend, they're not there all the time. But, you know, you can call them up when you need them and know that they'll be there for you.' (AHP 1)

> 'Very (SARRAH) easy to have a yarn with and just, they were just there whenever we needed them, which for us again like we didn't need them that much because we were already doing the job, but they were there to have a yarn and to help with the, doing up writing up our model of care and doing that sort of thing.' (Manager 1)

Services received tailored education and support from their onboarding through to their delivery of the AHA model of care. There was variation in the type and intensity of support provided by SARRAH due to differences between services in their models of care and conceptualisation of the role of an AHA. For example, SARRAH staff invested considerable time in working with

ACCHOs reliant on an externally contracted allied health workforce to problem solve how they could safely supervise and support AHAs.

> ‘So they (ACCHOs) need a lot of work with somebody externally to kind of come in and talk about what an allied health system is, how that would look, how you can use remote supervision and but use it safely. How you can engage existing services like allied health services to provide that supervision and delegation stuff.’ (Support staff 1)

Workplace training grant

Managers identified the workplace training grant as vital for the clinical supervision of AHAs.

> ‘For us that training grant was absolutely amazing because I was able to provide them with that clinical supervision that they needed and then they can get their assessment signed off by those clinicians.’ [Manager 1]

The grant enabled managers to build clinical supervision and mentoring of AHAs into the roles and responsibilities of AHPs without loss of time and productivity.

> ‘I could communicate really clearly to my staff and say if you're a mentor, you're gonna, you know, commit this amount of time each week or fortnight to supervising and mentoring this person.’ [Manager 2]

In one service where in-house staff were unavailable to supervise AHAs the grant funded an external supervisor.

> ‘I think that was one of the biggest benefits for us is that we're able to provide the girls with clinical supervision because we didn't have the in-house staff or in-house staff couldn’t do it.’ (Manager 1)

Irrespective of the origin of funding for AHA education, the workplace training grant was crucial to the supervision of AHAs and the establishment of an AHA model of allied health service delivery. As evidenced by some managers already having found funding for the education and training of AHAs in their service.

> ‘I had already applied for and received a grant for the staff to do their certificate four with ` North Queensland Primary Health, so BRAHW didn't pay for their certificate for, but they paid for the supervision that was required.’ (Manager 3)

Governance Framework

Managers and AHPs described the governance framework using language consistent with how it was operationalised in their service. Those who described the framework as 'practical' spoke about implementing it in a stepwise manner.

> 'I tried to go through it step by step. I think the handbook was very good and practical. In fact, it was excellent.' (Manager 3)

> 'I'm a very practical person. I like to look at things, read them, and then see how it's gonna fit into how we work, but I think it suited our, our team and our organization because it is quite good.' (Manager 1)

Whereas managers and AHPs working for ACCHOS typically described the framework as 'flexible' and spoke about adapting it for implementation in their setting. This often involved modifying language and terminology to make the framework handbook more culturally appropriate for their setting and comprehensible for staff.

> '…getting the wording right on the framework took some time, and I sort of did the bulk of that and then also met with key people to get them to read through. There's a lot in the AHA world of supervision and delegation. But we didn't feel like that those terms were appropriate here.' (AHP 2).

> 'Well, we didn't quite call it a governance document. We didn't call it a handbook. We kind of called it a workforce framework, but I reckon it was both of those two things into one.' (Manager 2)

Another important adaptation to the framework by ACCHOS involved placing a greater emphasis on the cultural and community knowledge of AHAs. This was done to privilege the lived experience that AHAs bring to their role and to address the power imbalance implied in the word 'Assistant' in their title.

> 'With the workforce framework thing that [name withheld] worked on was way for, you know, to work as equals the AHA and the other health professional in that bicultural model. And we were wanting to privilege AHAs own cultural and community knowledge, if that makes sense.' (Manager 2)

4.2 AHP, AHA and manager perceptions and experiences of the impact of the BRAHAW program on allied health service delivery.

Professional and personal development of AHAs

The BRAHAW program had a positive impact on the professional and personal development of AHAs. Working alongside AHPs, AHAs developed the knowledge, skills and confidence to deliver allied health services within their scope of practice.

> 'I'm definitely more aware now since I've studied of scope of practice and I feel a lot more confident about knowing, you know, where the line is.' (AHA 1)

> 'I definitely wasn't so much at the start, but after doing a bunch of supervision and kind of just wrapping my head around it a bit more, it's been great. Now I'd say I'm pretty confident with majority of the physiotherapy sessions.' (AHA 2)

The knowledge, experience and skills of AHAs commencing the BRAHAW program varied considerably and influenced their progression through the program, completion of studies, and satisfaction with supervision. AHAs new to the health sector were more likely to report feeling dissatisfied with their progress.

> 'I was just mostly improvising with the information that I had. Since I started with them, they haven't kept me updated on anything or about anything that they want me to do next or what's my next mentoring.' (AHA 3)

Where AHAs felt unsupported, this was often reflected in the challenges their service faced finding additional time and resources to meet their training and support needs.

> 'It was a big undertaking for the, for the centre and I think. They provide a lot of other services, so it was kind of. Can we do this? Senior managers being busy. Time poor and just making that decision.' (AHP 1)

Encouragingly, two AHAs expressed a desire to broaden their range of skills and take on leadership roles. Their desire not only reflected improvement in their confidence and skills during the BRAHAW program, but also the quality of supervision and support they received that facilitated their ongoing professional development.

> 'But recently I've, you know, in getting at that kind of higher level AHA role, I've been seeking out further supervision to support more complex clients.' (AHA 2)

> ‘I developed a bit of an orientation presentation so that when we do employ AHAs, whether they have experience, whether they've got qualifications or they're looking to study, they understand that scope of practice is something that we encourage.’ (AHA 4).

For two AHAs, the BRAHAW program facilitated connections with AHAs working in other services, providing them with a sense of camaraderie and comfort that others with shared histories and experiences were facing similar challenges. In this way, the BRAHAW program not only prepared and supported the AHA to work in allied health but created opportunities for the establishment of culturally safe professional networks to assist them through challenging times.

> ‘I got connected or felt connected to other AHAs around Australia and knowing that, you know, I wasn't alone in some of the barriers that we're facing as allied health systems…’ (AHA 4)

For some AHAs, the connections they made through these networks were the difference between feeling on the margins, or a part of an allied health workforce that recognised their potential and capabilities.

Integration of AHAs into the allied health workforce

The BRAHAW program facilitated the integration of AHAs into the allied health workforce in services. The process and level of integration, however, varied across services. Managers and AHPs of services that recruited AHAs internally reported fewer barriers integrating them into the allied health workforce and a higher level of integration than those that recruited AHAs externally. AHAs recruited internally were already a part of the working culture of a health service; the values, beliefs, and behaviors that guide the actions of its staff [9]. As such, they typically had knowledge and understanding of allied health work when moving into an AHA role. Their decision to become an AHA was based on their growing interest in allied health work and a workplace that fostered and created opportunities for their professional and personal development. Conversely, AHAs recruited externally were typically new to the health sector and unfamiliar with allied health work. Moreover, AHAs recruited from more rural and remote communities were more likely to lack work experience and face higher levels of social disadvantage. Not surprisingly, AHAs experiencing greater levels of social disadvantage required a greater investment in time, support and resources if they were to be appropriately and safely integrated into the allied health workforce.

> ‘I just think that two years is actually not a very long time or one a half years in terms of bringing in and getting a culture and how we utilise them (AHAs) cause sometimes if staff are really under pressure and busy, but they've got to teach at the same time, that can be a real barrier.’ (AHP 2)

> ‘So you know those types of things need to be better funded unless you've got a big organization that has a lot of working capital. And they can sort of like slot those positions in. And then grow them within their model of care. But keeping people engaged in work in (-) is very challenging.’ (Manager 5)

The broad scope of the AHA role meant that AHAs could be integrated into the allied health workforce to work across or within different allied health streams. Managers and AHPs identified this flexibility as a strength for building the capacity of the allied health workforce and professional pathways for AHAs.

> ‘The AHA can be really flexible and we can get them working across the aged care sector, the disability sector across lots of different allied health streams... oral health or community health or the chronic conditions. So yeah, [Name withheld] is building a strategy, I would say, but it is very clear that that's one of its most important and highest priorities.’ (AHP 1)

> ‘Basically I wanted them to have the qualification to be able to say I am an AHA. Now I wanna move them in to say speech OT psych. So we're kind of building pathways for them within the organization to move bigger.’ (Manager 2)

The broad scope of the AHA role and the opportunities this presented for multiple professional pathways was also reflected in AHAs’ accounts of their day-to-day work. The following accounts from three AHAs highlight the scope and diversity of their work which included:

- Developing resources and maintaining equipment.

  > ‘I'm also working with speech and OT. So I've done an intense block of speech supervision with the senior speech pathologist, which is really cool. And then the other kind of tasks that I've been doing like making resources and then following up on equipment, ordering as well.’ (AHA 2)

- Delivering programs to clients.

  > ‘I work across those professions so I can do allied health programmes that clinicians make for speech or OT. They make the programme and then give us the skills to be able

to deliver it. And then another thing, we'll just be working within a team environment as well.' (AHA 5)

- Working with different health professionals and organisations.

'Now I attend the physio meetings and like I'm kind of involved in their correspondences and things like that. So I'm kind of in the loop a lot more and then they're in the loop with me a lot more. So... it just flows pretty easily. I do a lot of work with NDIS, disability and OT, some paediatrics and aged care.' (AHA 6).

Enhanced relational care

Relational care – strong and trusting relationships between clients and their healthcare team, with a focus on building connections – is central to culturally responsive high-quality Primary Health Care. [10] The integration or involvement of AHAs in allied health service delivery strengthened relationships between allied health teams and their Indigenous clients and families.

'And if we hadn't had BRAHAW we wouldn't be able to provide this excellent service to our rural community. Which is so important. But AHAs are able to service and you know develop skills and support families within our rural community which is gold. You know that's what you know it's really that beautiful thing.' (Manager 3)

AHAs commonly spoke about how their work helped Indigenous community members better connect to allied health services and the health professionals that deliver them. They described establishing and strengthening relationships with Indigenous clients, families and communities through their cultural knowledge and community connections.

'And I do love going out into, community and building that rapport and connection, and just, yeah, knowing that I've made a way for, you know, whoever goes in as a professional, you know, medical in whatever medical field, to build on the relationship.' (AHA 4)

Where AHAs were effectively integrated into the allied health workforce and able to strengthen relationships with Indigenous clients, allied health service delivery was positively impacted in the following ways:

- The expansion of allied health services into communities with high levels of unmet needs.

‘You know expanded practice like being able to see more clients. These were bonuses of having an AHA build relationships.’ (Manager 1)

‘And if we hadn't had BRAHAW, we wouldn't be able to provide this excellent service to our rural community.’ (Manager 2)

- An allied health workforce more culturally responsive to the needs of Indigenous individuals, families and communities.

  ‘So for us, their (AHA) role is very, very important to our non-Indigenous clinicians because of that cultural aspect and like the girls really do appreciate having the AHA there because they can bounce off each other, their position is there to build that rapport between the families and the clinicians.’ (Manager 1).

  ‘Because of the detailed knowledge of the community they (AHAs) are able to advise me on how to proceed with wisdom so. We stay away? Way to approach? What to do? I really value that input.’ (AHP 1)

- Improved efficiency in the delivery of allied health services by optimising the use of AHAs.

  ‘Now once that that prescription's been made, the physio doesn't necessarily have to be the person to... implement that intervention. So that means that the physio is now freed up to go and see someone who's a little bit more complex or may need to do an assessment. So I would say that's one of those areas of efficiency.’ (Manager 2)

  ‘...what the AHA has enabled us to do is to look at another way of delivering services, albeit slightly modified to you know, at our typical day-to-day services, but a way of delivering services to people who have high need for service.’ (Manager 5)

4.3 Challenges to building the capacity of the allied health assistant health workforce.

Stakeholders commonly reported four main challenges to building the capacity of the allied health assistant workforce. These are detailed below.

Suitability of AHA training courses

The attainment of qualifications by AHAs is important for expanding their scope of practice and enabling them to address complex healthcare needs in their communities. According to Bainbridge et al. (2018), higher qualifications improve healthcare delivery and outcomes in underserved areas, particularly through enhanced cultural competence and specialised skills

[11]. Notably, AHAs, AHPs and managers all raised concerns around the suitability and accessibility of allied health assistant training programs. Generally, course subjects in the areas of workplace policy, health, practice and safety were deemed appropriate.

> 'Like they cover things like work health and safety, first aid, infection control. They're really practical skills in any workplace. And I think they're really transferable.' (Manager 2)

Conversely, there was widespread dissatisfaction with the relevance of course content to the skills required of AHAs in their role. The content was considered too generic or too targeted at a specific healthcare setting.

> 'There's a lot of content there and sometimes I question the relevance of a lot of it. So when you get to a direct supervision and you start doing your work, sometimes that what you've learnt and the course doesn't really gel or kind of align with what you're doing?' (AHA 2)

> 'You need a specific units to make them really relevant to the role, and that's where the circle comes in and you can do more specific units, but then of course you've got to consider whether RTO offers them... I don't think they do.' (Manager 2)

One manager expressed concern about the quality of the course the AHA in their service was undertaking.

> '...it was not very well written. It was not specifically targeted, it was clearly not written by an occupational therapist, probably a nurse, by the look of it...and it just displayed an ignorance in a lot of areas.' (Manager 3)

The lack of relevant course content delivered by RTOs meant that service providers had to find alternative ways for AHAs to develop the knowledge and skills they required to adequately fulfill their role. Three managers reported increasing the level of on-the job training for AHAs to compensate for the lack of relevant course content delivered by RTOs. Variation in scopes of practice, however, sometimes meant that AHAs were unable to acquire the knowledge and experience in some competencies. This finding is consistent with the views of Stajic who contends that organisational barriers sometimes prevent Aboriginal health professionals from fully applying their skills and qualifications [12].

Two managers reported searching for specific units in allied health for their AHA to study in adjunct to a generalist course they had recently completed.

> ‘We went through a lot of different aspects and the one through foundation education was just a generalist one because when you look at AHA, they all specialize in speech or OT. There's no dual. Umm, so we had to do the general one and then we're looking at either doing specific disciplines next year.’ (Manager 1)

In one extreme case, the AHA withdrew from their course of study, and with agreement from SARRAH, the AHA service delivery model was still implemented in the workplace.

In addition to the unsuitability of course content, some AHAs faced logistical challenges that delayed or prevented their completion of studies. Challenges explicitly identified by AHAs were low levels of technical literacy and connectivity, non-responsive teaching staff, and struggling to balance work, study and family commitments.

> ‘I'm really behind with my assignments and this is my first experience with online TAFE. I'm just improvising and just browsing around and getting missed of it. I tried to contact one of my teachers, but it's been pretty busy for them as well and they haven’t got back to me.’ (AHA 3)

Some managers and AHPs reported helping AHAs to overcome these challenges by providing them with additional study support and advocating to RTOs on their behalf for more teaching contact and support.

Viable funding mechanism to employ AHAs

The lack of viable funding mechanisms to pay for an AHA was a major challenge to the creation of, and recruitment to these positions in some services.

> ‘And it's been very challenging to secure funding specific for AHAs, I must say. So it's, I guess one thing I'd really love to articulate that I just don't... not really sure why it's so difficult to create the positions that are so important to our future and current workforce.’ (Manager 2)

Even when services were able to find funding to employ an AHA, personnel were not always available to adequately supervise and support AHAs.

> ‘You need to get really solid supervision frameworks in place, and it's really hard when you've got like us, our podiatrist comes three days a week, so she was providing supervision for a full time person.’ (AHP 1).

Several managers spoke about the difficulties of attracting AHPs to work in rural and remote areas and the negative impact this had on building a rural and remote allied health workforce

with the capacity to support the creation and maintenance of an AHA model of service delivery. This was especially the case for ACCHOs. Compared to other service providers (e.g. government and private) in rural and remote areas, ACCHOs were less likely to attract AHPs due to their less competitive salaries, location in geographic areas with a higher cost of living, and greater reliance on an externally contracted allied health workforce.

Program block funding tied to specific health outcome areas was the most common way ACCHOs funded AHP positions. The ability to employ AHAs within these models however was limited by grant funding agreements. This meant services often had to find other funding sources to employ AHAs.

> 'If I didn't get the funding from the Primary Health network to support it (the AHA service delivery model), we never would have been able to do it. Because there wasn't enough money involved in the project to be able to do it.' (Manager 4)

Organisational constraints

A lack of time and staff were key organisational constraints to implementing the BRAHAW program without compromising its integrity or redirecting resources away from other priorities. For example, in one service only a part-time AHP was available to supervise their AHA who was new to the health sector. The lack of full-time supervision restricted the AHA to administrative tasks on days their supervisor wasn't in the clinic, delaying their professional development and leaving them feeling unsupported.

> 'She (SARRAH support staff) found it very disappointing that no one on the side was actually supporting me and trying to really take it serious, 'cause I really wanna succeed at this and I really don't wanna fail because this is a really good opportunity, you know?' (AHA 3)

Managers and AHPS emphasised that AHAs need full-time supervision and support and that this requires considerable ongoing investment.

> 'The time that (-) was able to spend with people is really important. And we really noticed when (-) wasn't available. So one of the big learnings for us is to invest in support. You know, to effectively bring new people in the workplace.' (Manager 2)

To address this issue, two AHAs identified a need for virtual support and check-ins to enable AHAs to connect and support each other during their studies. Furthermore, one AHP proposed a virtual network where AHAs could access professional development and support.

> ‘I think like in terms of feeling overwhelmed when studying, I think maybe having like a check insurance with someone online or if there's any other students in the area to connect with you know… I think that would maybe a weekly or fortnightly check in just to answer any questions, see how they're going.’ (AHA 7)

Structures and programs that provide Aboriginal and Torres Strait Islander health professionals with safe spaces and opportunities to support each other, develop professionally, and share their lived experiences are important because they reduce feelings of being an outsider, provide navigational assistance, and foster agency and belonging [13].

Influence of social determinants on work readiness and career progression of AHAs

For Aboriginal and Torres Strait Islander people to grow and thrive in a health professional role, equally as important as a culturally safe workplace, professional recognition, adequate remuneration [13], and workplace support and supervision, is the influence of social determinants. For two AHAs, competing family and community responsibilities impacted their ability to complete studies and regularly attend work. Both AHAs were living in areas with high levels of unemployment, a lack of social services, and higher cost of living.

> ‘She had no childcare and she had DV at home. And there were lots of people living in her house. She couldn't trust people to look after her children. I get it. Like what do you do about those things?’ (Manager 5)

The ongoing and profound impact of social determinants was reflected in one AHAs’ recommendations for more flexibility in how the BRAHAW program supports AHAs in the workplace.

> ‘I think that would probably be my biggest take away of how it (BRAHAW) can probably be delivered a little bit better, especially for AHAs like for me, I, you know, when it comes to my son, I need to focus on him and I put him first so the rest kind of goes to the side.’ (AHA 5)

One AHA left the BRAHAW program for a higher paying job in the health service that offered more opportunities for career advancement. Studies of Aboriginal health practitioners report that wage disparity and limited career advancement opportunities contribute to their high turnover [14]. Where career progression pathways were unclear, AHAs struggled to see the value in pursuing further education because it would not lead to financial advancement.

> “She just didn't come to work and she said, oh, yeah, but I can get more. Was just getting my payments as a sole parent and I can and I said look, I get it. I do. I understand.”[Manager 5]

Where AHAs experiences were that additional qualifications do not result in higher pay or expanded roles, they were less likely to commit to or complete the BRAHAW program of training and support.

5 FINDINGS OF THE QUANTITATIVE ANALYSIS OF ALLIED HEALTH SERVICE DELIVERY

Given that the BRAHAW program was designed to build the capacity of the allied health assistant workforce, its impact on the delivery of allied health services at the service level was assessed. Only data from two of the eight services who participated in the BRAHAW program evaluation were analysed. Differences in data collection methods and systems between services, and the lack of a standardised minimum data set across services, were key barriers to services extracting data from their electronic Patient Information Systems (PIMS) in a comprehensible format in time for this report.

Both Service 1 and Service 2 commenced the program in October 2022, the formal component of the program finished in April 2024. The primary outcomes were the:

The number of occasions of service delivered by ~~AHP~~ AHAs.

Exploring total number of AHA occasions of service gives an indication of the impact of the AHA model of service delivery by measuring actual clinical service delivered.

Table 3 shows that in both services there is an increase of AHA activity with implementation of the BRAHAW program. A slight decrease of activity is noticed in the last year of data for service 2. Commentary from the Service 2 indicates that the AHA had a significant period of leave during this time.

The reporting time period is not long enough to appreciate whether the AHAs have reached their service capacity or growth is still expected. Further monitoring over time would be required to better understand this.

Percentage of occasions of service delivered by AHAs.

Exploring the percentage of occasions of service delivered by AHAs gives an indication of impact on capacity within the workplace.

In Service 1 an increase in percentage is visible across the 2023-2024, and Service 2 shows an increase across 2022-2023, and a decrease in 2024, likely related to the extended leave of the AHA.

The percentages have been calculated using a denominator of total occasions of service for the service. The sensitivity of the percentages may be improved by using a denominator of the relevant geographical site, or specific team that the AHA works with. Furthermore, the reporting time period is not long enough to appreciate whether the AHA service delivery model has

reached it's full potential within the team. Further monitoring over time would be required to better understand this.

New occasions of service.

New occasions of service for AHP are considered as a proxy for increased capacity within AHP workforce in terms of impact on waitlists (where waitlists haven't been measured)

Only Service 1 has provided this information. Table 3 does not demonstrate any change. Again this data is limited as it does not allow differentiation to the level of AHPs directly impacted by AHA delivery. Further monitoring over time, better data differentiation and more services for consideration would be required to truly understand this impact.

Table 3. AHP and AHA occasions of service at each site by year

	Service 1				**Service 2**			
	2021	2022	2023	2024[+]	2021	2022	2023	2024[+]
AHP Occasions of Service	25351	27308	24246	18550[+]	27286	44448	70928	64070[+]
New occasions of Service[ϕ]	*2456*	*2069*	*1965*	*1455*[+]	~	~	~	~
New Clients[ϕ]	*1179*	*910*	*787*	*588*[+]	~	~	~	~
AHA Occasions of Service	0	0	329	1001[+]	215	670	967	567[+Θ]
Percentage of annual total Occasions of Service delivered by AHA	*0*	*0*	*1.3%*	*5.1%*	*0.8%*	*1.5%*	*1.3%*	*0.9%*
Annual Total Occasions of Service	**25351**	**27308**	**24575**	**19551**[+]	**27501**	**45118**	**71895**	**64637**[+]

AHP: Allied Health Professional.
AHA: Allied Health Assistant.
+ Reporting period did not include a full year of service. Only data from January to mid-September are reported.
~ Data was not provided for analysis.
ϕ New occasions of Service and New Clients counts are for treating AHP only
Θ Includes a period of significant leave for the AHA in the first quarter of 2024.

6 KEY FINDINGS, IMPLICATIONS AND RECOMMENDATIONS

The implications of key findings and their related recommendations for future work are:

Key Finding 1:

The increased involvement of AHAs in allied health service delivery observed by service providers and quantified in two services suggests that the BRAHAW program is likely to be an effective model for increasing the number of AHAs to support allied health practitioners to deliver local allied health services in rural and remote Australia.

The implications of this finding is that further program funding for BRAHAW would likely be effective for continuing to grow the rural and remote allied health assistant workforce. Further evaluation is required to understand the long term impact of increasing the rural and remote allied health assistant workforce on accesses to allied health service delivery. This could be achieved by embedding standardised measures of allied health service delivery into services providers' data collection systems to facilitate the routine and systematic collection of data necessary to quantify the impact of an AHA service delivery model. Quantifying the impact of programs using routinely collected data relies heavily on the availability of skilled statisticians and data scientists to manage and analyse data, and this expertise is unlikely to be available within services. As such, there would likely be value in SARRAH establishing an ongoing partnership with service providers and researchers. The expertise of SARRAH is critical to ensuring improvements have clinical and policy relevance, in addition to service and patient level benefits.

Recommendation 1:

a. Explore opportunities for additional funding for BRAHAW to build the rural and remote allied health assistant workforce.

b. Explore opportunities to research or evaluate the impact of an allied health assistant workforce on service capacity access; including standardising routinely collected measures of allied health service delivery across participating services to enable routine evaluation.

Key Finding 2:

Financial support, resources and coaching is critical to the success of the BRAHAW program.

The implication of this finding is that in rural and remote Australia, funding and support is essential for enabling services to innovate and invest in the required infrastructure and training for developing their workforce and service delivery.

Recommendation 2:

Future programs supporting the development of rural and remote AHAs must include financial and other support for allied health service managers and professionals involved in the training and establishment of the model.

Key Finding 3 : The adaptability of the BRAHAW program was critical for its successful implementation as it meant that its core components could be tailored by services to meet the needs and preferences of their allied health workforce.

The implication of this finding is that while BRAHAW is inherently scalable, future growth and implementation should not be at the cost of a flexible approach that enables locally driven solutions.

Recommendation 3:

That program adaptability remains a core tenet of future implementation of the BRAHAW program. The key learnings from the evaluation could inform this adaptability, further increasing the likelihood of successfully implementing BRAHW program in additional services looking to build the capacity of their AHA workforce.

Key Finding 4:

The feedback provided in interviews and high demand evidenced in large number of applications and waitlist demonstrate that BRAHAW is an acceptable and desirable program for service providers. However the experiences of clients receiving the AHA model of service delivery and their perceptions of its acceptability was not examined.

The implication of this finding is that the implementation of the BRAHAW program in services that participated in the application/onboarding process but were unable to commence or complete program implementation, could be revisited.

Further, future work should explore the experiences and perceptions of clients receiving the AHA model of service delivery. Understanding client experience is critical to help inform and promote their participation in health care. Client experiences could be collected using quantitative and/or qualitative methods. Quantitative measures, for example, could include validated measure/s of client health care experience. The selected measure/s could be integrated into the electronic Patient Information Systems (PIMS) of services to facilitate their routine collection. These quantitative data could be complemented by qualitative data collected from clients in individual or group yarns, as determined by service providers.

Recommendation 4:

a. Explore opportunities for implementing the BRAHAW program in services that expressed interest in this current project but were unable to participate
b. That future work explores clients' experiences of receiving the AHA model of service delivery and their perceptions of its acceptability.

Key Finding 5:

Social and cultural factors had a profound influence on the recruitment and retention of AHAs and the type and level of support they needed to develop and thrive in their role. This was especially the case for AHAs new to the health sector and those living in areas characterised by high levels of unemployment, a lack of social services, and a higher cost of living.

The main implication of this finding is that AHAs new to the health sector and living in more remote areas are likely to benefit from additional support, such as mentoring or support from AHA networks. There is a growing body of literature highlighting the importance of Indigenous knowledge systems and support for building the confidence and skills of First Nations Australian health professionals to strategically and successfully navigate challenges so that they can develop and thrive in the health workforce. The development of an AHA network would enable AHAs to access the knowledge, strength, and support of First Nations peers and leaders in the allied health workforce, build connections and encourage the sharing of ideas and experiences. The network could likely be established and supported with minimal additional resource input from SARRAH and project partners.

Recommendation 5:

Establish a virtual network where AHAs across geographical locations and working in various allied health specialties can connect, share lived and work experiences, and access professional development opportunities through digital platforms like dedicated websites, forums, or video conferencing tools.

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8 APPENDICES

Appendix A: Selection process for mainstream organisations

Appendix B: Interview Guide for managers, AHAs and AHPs

Interview Guide for managers, Allied Health Assistants (AHAs) and Allied Health Professionals (AHPs) in organisations participating in the BRAHAW program.

Aim

The overall aim of these interviews is to gain an in-depth understanding of the value and benefits of the BRAHAW program for building capacity and expanding allied health service delivery, from the perspectives of managers, AHAs and AHPs.

Introduce and orientate participants to the interview.

1. Thank participants for their time and for taking part in the evaluation.
2. Stress there are no right or wrong answers – we are just interested in finding out their views and opinions. Explain that we want to have a talk to hear their stories about the BRAAHW project.
3. Reassure participant of confidentiality and anonymity – we will not attribute comments to them or note who gave what answers/opinions to remove risks resulting from their involvement.
4. Explain the objectives of the BRAHAW evaluation.
5. Discuss the processes that the evaluation team will use to ensure that participant identity is kept confidential in reports and publications that discuss study results.
6. Explain to the participant that they can choose whether to answer the questions or not and can opt out at any point during the conversation if they become uncomfortable.
7. Inform participant of the broad topic areas to be covered in the interview:

    1. The team you work in and your role.
    2. The members of your team and how they work together.
    3. The roles of AHAs and their scope of practice in your team and model of service delivery.
    4. How the role of AHAs has changed since the BRAHAW program.
    5. Vocational and on-the-job training for AHAs (i.e. undertaken and needed)
    6. Your experiences of support from SARRAH.
    7. Your perspectives on the impact of AHAs in your service, the sector, and broader community.

Topic areas	Questions
The team you work in and your role.	- What is your work role? - How long have you worked in this role? *prompts: in this organisation, in your work career.* - Which team you do work for in your organisation?
The members of your team and how they work together.	- How many are in your team? - What are their roles? - Who defines these roles? - How do team members work together? - Who has been involved in this process/had exposure to the resources?
The roles of AHAs and their scope of practice in your team and model of service delivery.	**Managers** - How long has there been AHAs in your organisation? - How did the AHA position come about? *Prompts: where do AHAs come from, recruitment, retraining, redeployment, school leavers, AHWs.* - How is the AHA position funded? - Did you have to change your insurance cover? - How long did it take you to recruit an AHA/s? - What are your organisation's plans for developing the capacity of AHAs and AHPs? *Prompts: training, promotions, increased pay, ongoing study.* **AHPs** - How long has there been AHAs in your team? - Tell me about your experiences of working with AHA. *Prompts: AHAs scope of practice, supervision of, and delegation to AHAs, remote supervision, confidence in AHA skillset.* **AHAs** - How long have you been working as an AHAs in your team?

	- Tell me about your experiences of working with AHPs. *Prompts: supported scope of practice, supervision, and delegation by AHPs, remote supervision, confidence in AHA skillset.*
How the role of AHAs has changed since the BRAHAW program.	- Tell me about how AHAs worked in your team/organisation before and after the BRAHAW program. *Prompts: scope of practice, confidence, skills, support, challenges.*
Vocational and on-the-job training for AHAs (i.e. undertaken and needed)	- Did the AHA in your organization participate/complete a Cert III or IV as part of the BRAHAW course? - If no, why? - If yes, what is your/the AHA's experience of the training? - How relevant was course training to AHA practice? - What on the job training was needed for AHAs?
Experiences of support from SARRAH.	**Managers and supervisors** - How did the materials from SARRAH help you with establishing the governance framework? - How closely did you follow the format of the handbook? - Were the handbook timeframes realistic? - What was it about SARRAHs material that makes it successful? - How well did the AHA resources apply to your organisation? - Tell me about your experience of the support you got from SARRAH? *Prompts: strengths, limitations, areas for improvement* - What role did the workplace training grant play in your ability to participate in the program?
Perspectives of the impact of AHAs in your service, the	**Managers and supervisors** - How have AHAs impacted on how allied health services delivered by your organisation? *Prompts: workforce capacity, mix and distribution; type quality and coordination of care*

sector, and broader community.	- How have AHAs impacted on allied health service delivery in the sector and rural/remote settings? *Prompts: workforce capacity, mix and distribution; type quality and coordination of care* - How have AHAs impacted on how people in the community access allied health care? *Prompts: mode, frequency, location* - How financially viable is the current model without further support? - How could your organisation's use of AHAs be improved? - ***Business owners:*** What is your advice and recommendations for other businesses when it comes to the AHA workforce?

Final remarks from interviewer

- Explain that we will remain in touch about the progress of the evaluation.
- Thank participants for taking part.
- Close interview session and stop recording