A literature review examining the evidence for task shifting to assistant therapists in healthcare services

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# Abbreviations

|  |  |
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| Abbreviation | Definition |
| AHA | Allied Health Assistant |
| AHP | Allied Health Professional |
| AHRQ | Agency for Healthcare Research and Quality |
| AOTI | Association of Occupational Therapists Ireland |
| HSE | Health Service Executive |
| HIQA | Health Information and Quality Authority |
| MDT | Multi-disciplinary Team |
| NDA | National Disability Authority |
| NICE | National Institute for Health and Care Excellence |
| NQF | National Quality Forum |
| OT | Occupational Therapist |
| OTA | Occupational Therapy Assistant |
| SLT | Speech and Language Therapist |
| SLTA | Speech and Language Therapy Assistant |
| SCIE | Social Care Institute for Excellence |
| UK | United Kingdom |
| UNCRPD | UN Convention on the Rights of Persons with Disabilities |
| WHO | World Health Organisation |

# Executive Summary

## Introduction

Task shifting, the process of delegating tasks traditionally performed by professionals to less specialised workers, has emerged as a strategy to address the growing demand for healthcare services and staff shortages. In community health settings where access to trained professionals is limited, task shifting to health assistants provides a promising approach to expanding service delivery, improving patient outcomes and optimising the use of available resources.

### Aim

The aim of this review is to provide a comprehensive understanding of the benefits, challenges and implications of task shifting from Allied Health Professionals (AHP) to Allied Health Assistants (AHA) in community health care communities.

## Methods

### Search strategy

A systematic search was performed across a number of electronic academic databases, reference lists, and grey literature sources.

### Inclusion/exclusion criteria

Studies were included if they met the following criteria: (1) focused on task shifting (2) investigated the outcomes of task shifting (3) offered policy insights for task shifting. Studies were excluded if they were: (1) focused solely on task shifting in physicians, nurses or other medical grades (2) were exclusively based in a non-community healthcare setting.

### Data extraction

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

### Synthesis

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

## Findings

Evidence for task shifting from Allied Health Professionals to Allied Health Assistants can be found in the literature especially in countries such as Australia, Canada and England. Well planned and well-structured introductions of Allied Health Assistants can lead to increased client satisfaction, increased Allied Health Professional satisfaction and motivation and increased client throughput. Where task shifting is not structured this can lead to role confusion and can prevent the optimal use of Allied Health Assistants and beliefs that health services management are merely attempting to reduce costs.

The three key facilitators to successful task shifting are planning, training and supervision. Planning involves three elements: the inclusion of stakeholders, developing guidance documents and protocols, and communication. Training should encompass the Allied Health Professional and the Allied Health Assistant. Training helps protect both the users of the service and the healthcare workers. Training also helps the promotion of confidence of others in Allied Health Assistants, develops the confidence of the Allied Health Assistants and helps dispel their initial anxiety. Appropriate supervision supports the mentoring of Allied Health Assistants and allows the development of communication pathways from the Allied Health Professionals that improve support for the Allied Health Assistants.

# Conclusion

Overall, task shifting can be a benefit to the users of a service, the Allied Health Professionals in the service and the service itself. Task shifting can help reduce waiting lists, improve staff morale, and promote confidence in the service. However, if task shifting is not well planned and delivered in agreement with all stakeholders it can lead to bad feelings and the accusation that Allied Health Assistants are employed as a cost-saving exercise.

# Introduction

Task shifting, the process of delegating tasks traditionally performed by professionals to less specialised workers, has emerged as a strategy to address the growing demand for healthcare services. In community health settings where access to trained professionals can be limited, task shifting to assistant therapists provides a promising approach to expanding service delivery, improving patient outcomes and optimising the use of available resources.

Worldwide there is a shortage of medical professionals and Allied Health Professionals (AHP). (1) AHPs are a diverse group of health care practitioners who provide a range of diagnostic, technical, therapeutic, and support services. They encompass a wide range of roles including speech and language therapists (SLTs), physiotherapists, psychologists, occupational therapists (OTs), social workers and dieticians. The shortage of AHPs is causing serious problems in the delivery of healthcare services. (2) In the Global Strategy on Human Resources for Health 2030 (3) the World Health Organisation (WHO) say that Governments, professional councils and associations need to work together to introduce task shifting to overcome the shortage of staff and deliver an equitable service.

The shortage of AHPs is caused by many factors including demographic shifts in the population, scientific advancements, technological advancements, and increased expectations of what healthcare systems can deliver. (4) These factors are contributing to unmet needs and lengthy waiting lists for services. (5,6) It has been argued that the current demands on the system cannot be met without the development of new healthcare roles. (7) New roles, such as healthcare assistants may lead to improved efficiencies across the healthcare sector (8) and improvements in services for underprivileged groups. (7) Without such reorganisation healthcare services will experience a service delivery crisis. (2)

## Aim

The aim of this review is to provide a comprehensive understanding of the benefits, challenges and implications of task shifting from Allied Health Professionals (AHPs) to Allied Health Assistants (AHAs) in community healthcare settings. This information will help to inform a review of the Children’s Disability Network Team service model in Ireland which will soon see the introduction of AHAs.

# Methods

A comprehensive literature review was conducted to identify the impact of task shifting in healthcare services worldwide and the impact on the AHPs. The review aims to identify and synthesise relevant academic and grey literature about task shifting.

## Search strategy

A search was performed using the following electronic databases; Medline, SocIndex, and Google Scholar. The search strategy utilised a combination of relevant keywords, such as “task shifting\*” “healthcare assistant\*”, "\*allied health assistant\*," and variations thereof. Boolean operators (e.g., AND, OR) were employed to refine the search and maximize the retrieval of pertinent literature. Reference lists of relevant journals were checked and those who had cited the selected literature were also checked for relevant studies. A comprehensive search of grey literature sources was conducted including the databases of Cochrane library, Social Care Institute for Excellence (SCIE), Trip database, Global index medicus, NICE, World Health Organisation, Agency for Healthcare Research and Quality (AHRQ), National Quality Forum (NQF), Scopus, Lenus, HIQA, National Disability Authority, HSE Land, Open Aire and Worldcat and the websites of Allied Health Professional Associations.

### Inclusion Criteria

Studies were included if they met the following criteria: (1) focused on task shifting (2) investigated the outcomes of task shifting (3) offered policy insights for task shifting.

### Exclusion Criteria

Studies were excluded if they (1) focused solely on task shifting in physicians, nurses or other medical grades (2) were exclusively based in a non-community healthcare setting.

### Data Extraction

Full-text articles of potentially relevant studies were retrieved and assessed for eligibility according to the inclusion and exclusion criteria. All eligible articles were imported into NVIVO and data extraction was performed to capture key information.

A narrative synthesis approach was employed to summarize and integrate findings across the included studies. Themes, patterns, and commonalities were identified to highlight the current knowledge in the literature.

# Findings

## What is task shifting?

Task shifting[[1]](#footnote-1) is defined as; “the redistribution or delegation of health care tasks within workforces and communities. Task shifting occurs when a task is transferred or delegated.”(9)

According to Orkin et al.(9) task shifting is about enhancing care and improving equity of healthcare to underserved communities without compromising quality and safety standards. Task shifting gives the opportunity to diversify care options allowing health care professionals to focus on higher level tasks such as training, supervision, administration, and management of complex cases. Task shifting also allows the delivery of more culturally or contextually appropriate care; it permits the scale up of essential interventions; and it can change conventional hierarchies, where highly trained professionals work as partners with those with less training. (9)

When establishing task shifting it is important to ensure:

* there are professionals open to receiving training to deliver the intervention.
* the current staff are willing to provide the required training.
* the issue is difficult to address due to a shortage or inaccessibility of health human resources.
* the intervention can be delivered by workers with less training.
* the intervention is clinically effective.(9)

## Task shifting to allied health assistants

Whilst task shifting is not a panacea for healthcare systems, it has been recommended as one strategy to help address health workforce shortages and transform healthcare outcomes and inequalities. (10)

In line with this, the development of Allied Health Assistant (AHA) roles has emerged as a strategy to help meet increasing healthcare service delivery challenges and demands. (1) AHAs assist or support the work of qualified Allied Health Professionals (AHPs). (1) The AHA workforce encompasses a diverse range of roles - from individuals working within more general roles across multiple settings (e.g. health care assistants), to individuals employed in roles aligned to a specific allied health profession (e.g. Occupational Therapy Assistants). (1,11)

A systematic review of the roles of AHAs, conducted by Lizarondo et al., (1) outlined clear differences between the terms used to describe AHP and AHA duties. AHA duties were more commonly described as assisting, supporting, administrating, monitoring, and maintaining. AHP roles were described as evaluating, assessing, diagnosing, planning, and implementing. (1)

## Frameworks for allied health assistants

It has been noted in the literature that the employment and utilisation of the AHA workforce is not standardised, including variances in job titles, descriptions, scope of practice and required qualifications. (11)

Work has taken place in several jurisdictions to develop frameworks to support a more standardised pathway and structure for this cohort of professionals. AHA Frameworks have been developed in jurisdictions such as Australia (12–15) and in the United Kingdom (UK). (16,17)

These frameworks outline guidelines in relation to the employment of AHAs, including; education and competencies, scope of practice, delegation, supervision and governance and oversight recommendations.

In the Irish context, comprehensive frameworks have not been developed. However, several AHP professional bodies and membership organisations acknowledge that AHAs are a developing role in Ireland, (18,19) and have developed guidance and recommendations in relation to the employment of AHAs within teams – for example within the professions of SLT, (19) OT, (18) and Psychology. (20)

## Minimum training and education requirements

Minimum entry requirements for AHAs vary across jurisdictions, and the specific nature of each AHA role. In Australia, Certificates III and IV in Allied Health Assistance are nationally recognised qualifications for AHA roles (although there is recognition that equivalent qualifications, or additional qualifications, may be considered or required depending on the level and specific nature of the role). (12–15) In England, it has been reported that most AHA positions require GCSEs as a minimum entry requirement. (11)

In Ireland, minimum training and/or education requirements for AHA positions also vary depending on the specific role and discipline. Eligibility criteria have been developed for several categories of AHA that have a formal grade within the HSE, including Speech and Language Therapy Assistant (SLTA), Psychology Assistant (PA), Physiotherapy Assistant, Occupational Therapy Assistant (OTA), Healthcare Assistant and Generic Therapy Assistant. (21,22,22–24) Depending on the role, required qualifications vary from relevant experience, to any relevant health skills QQI Level 5 qualification, to a specific QQI Level 5 qualification (e.g. modules in Speech and Language Assistant Theory and Speech and Language Assistant Practice), through to QQI Level 8 Honours Degree (for Psychology Assistants). However, it should be noted that Psychology Assistant is a training role considered to be part of the wider career path to becoming a qualified Clinical Psychologist. (5)

While minimum training and education requirements for AHAs is not standardised, and can vary across roles, discipline and jurisdiction, generally the pathway to meeting the minimum requirements for AHA roles is shorter in duration to that of AHPs. For example, to work as an SLT in Ireland, it is required to complete an accredited course at minimum NFQ Level 8 (or recognised international equivalent), and to register with CORU, the regulating body for AHPs in Ireland. This requires a minimum commitment of 4 years (25). Conversely, a QQI Level 5 qualification that would meet HSE eligibility criteria for SLTA positions can be completed within 1 year (26–28). Though it is important to note that on-going supervision from an SLT is required for SLTAs when undertaking their role (19). Task shifting recommendations outlined by WHO suggest shorter training periods and fewer qualifications can make more efficient use of available human resources (10).

## Governance structures for allied health assistants

Recommendations in relation to governance and oversight considerations are available from published AHA Frameworks internationally (12–17) and the research literature relating to AHAs.

Specific guidance varies across jurisdictions and disciplines, however, commonalities include ensuring clear supervision frameworks and clear task delegation and scope of practice protocols.

In Ireland, many AHP professional bodies and membership organisations have emphasised the importance of ensuring that clear and robust governance structures are in place when employing AHAs. While comprehensive AHA frameworks have not been developed in the Irish context, these organisations have provided guidance documents, which include reference to governance considerations for AHAs. (18–20)

### Supervision

* AHAs operate under the direct supervision of a registered AHP (according to that discipline’s education and registration requirements). The supervising AHP retains full legal and ethical responsibility for the interventions and/or related work. This supervisor should have the appropriate qualifications and experience to oversee and support the AHA’s work, according to the specific context.
* In settings where an AHA may be supporting across several AHPs and/or teams, a designated primary supervisor should be assigned to the AHA. In such situations, a formal structure must be in place to clarify reporting lines and ensure accountability.
* Supervisors play a key role in developing AHAs’ competencies by observing practice, providing feedback and facilitating access to training and further continuous development opportunities. (12–15,17,19,20)

### Task delegation and scope of practice

* Delegation is in the best interests of the person who uses the service. (12)
* Tasks delegated to AHAs must align with their competency and training levels. AHAs should not undertake tasks that exceed their qualifications or experience.
* AHPs should consider the pre-existing competencies of the AHAs determined by their training and experience and evaluate whether the task being delegated is appropriate to their role (this can be determined according to the position or job description of the AHA). (18,19)
* Only activities within the scope of practice for both the AHA and AHP are delegated.
* Well-defined lines of accountability for each activity must be established.
* The AHA must be placed in an environment where they can competently complete the activity.
* The delegating AHP must be able to monitor and supervise the activity.
* AHPs and AHAs have joint responsibility for raising any issues, requesting additional delegation and supervising processes.(12)
* The type or nature of tasks that can be delegated to AHAs varies by discipline, however the following have been frequently noted as being outside the expected scope of practice for many AHA roles: conducting assessments, developing or modifying plans, making clinical decisions, providing information to clients outside of that specifically approved by the supervising clinician. (12–15,18,19)
* In terms of the client, or person who uses the service, the AHP should consider the severity and complexity of their condition, psychosocial profile and needs as well as the needs and requirements of the setting or environment where the task will take place when considering tasks to delegate to the AHA.(18)

## Benefits of task shifting to allied health assistants

The literature identifies several benefits to employing AHAs in line with Orkin et al., (9) such as Lizarondo et al. (1) who report that the use of AHAs increased client satisfaction, allowed AHPs to undertake more complex care and that AHAs contributed to improved clinical outcomes. (29) Miller reported in the UK that AHAs allowed qualified staff to deal with more complex issues. (4) AHAs have been reported as being able to work beyond a limited uni-discipline remit and can act as a link with other allied health professionals creating a well-coordinated team. (1)

Studies indicate that the inclusion of AHAs allow AHPs to spend proportionally more of their time in higher added value activities. (4) AHPs tend to use the time gained from delegating routine tasks to devote to caseload management and to quality improvements. (8,30) Evidence from Somerville (31) who investigated task shifting health services in the state of Victoria, Australia during a workforce redesign project suggests that on average between 11% and 24% of all AHP tasks were suitable to be delegated to AHAs dependent upon the setting they were working in. (31,32) In community services, the amount that could be delegated was different for each discipline and varied from 39% in podiatry to 3% in audiology and included speech pathology (34%), dietetics (30%), social work (24%), psychology (21%) occupational therapy (20%) and Physiotherapy (18%). Across disciplines in community services the two most common tasks that could be delegated were administration (25%) and treatment (23%). The tasks least likely to be delegated were complex cases (4%) and supervision (2%). Overall, 82% of AHPs reported high levels of satisfaction with work conducted by AHAs, and with the AHAs having the skills to meet clinical demand.

AHAs can add to increased AHP satisfaction and motivation, and can have a positive influence on recruitment through reducing the burden on AHPs. (29) AHAs have been reported to improve client satisfaction and in some instances have been found to improve outcomes in services where they have been employed. (1, 22–24) In Australia where AHAs have been employed it was estimated that AHPs can free up approximately 24% of their time to spend on other tasks. (31)

When physiotherapy assistants were introduced into a cystic fibrosis clinic in Ireland it was reported that physiotherapists were able to increase the number of patient reviews, increase input into MDTs, and the amount of clinical administration tasks increased. (35) The introduction of assistant psychologists in primary care psychology services led to an increased number of client engagements, reduced wait times for interventions, and a broader range of interventions were provided to clients. (5)

## Barriers to task shifting to allied health assistants

The literature highlights certain barriers to task shifting that either prevent the development of AHA roles or are in conflict with the role. These are items that require serious consideration when planning the development of such roles.

The most significant barrier to task shifting is the lack of structure and supervision, as well as uncertainty about the scope of the role. (29) Other significant barriers have included a lack of training and investment in the necessary supports (11). The World Health Organisation (WHO) have stated that for successful task shifting, countries need to remove bureaucratic structures that prevent or hinder task shifting and professional skill development. (2)

AHPs have reported being fearful around the loss of client relationship and valued parts of their job. (29) AHP related issues have also been reported about the lack of role clarity (1), a formalised structure, (29) and in many jurisdictions AHAs have been created and employed without putting in place the structures for governance and clinical supervision, (36) allowing roles to develop on an ad hoc basis. (37)

Because of the lack of structure, AHAs have been viewed as a cheap replacement for AHPs, (1,29) believed to be employed as a cost saving measure and not as a means of improving services, (4) thus undermining the role of AHPs. (8) The lack of structure means that the lines of responsibility and accountability are not clear (29) with many AHPs unsure about their supervision roles. (4,38) AHPs reported having received no guidance and training around supervising AHAs (39) and a lack of role clarity for AHAs had added to the issues identified. AHPs have also reported difficulties in understanding the AHAs competencies making delegation difficult. (38) In rural areas with small staffing allocations and multiple sites this can make delegation and supervision particularly problematic. (40) Where the AHP caseload includes more complex cases it can be time consuming for the AHPs to train up AHAs to an adequate level. (39) Complex cases may also be beyond the competency of AHAs and may mean both AHA and AHP working with a client thus effecting the client relationship and losing the efficiencies gained from employing AHAs. (8,39) Studies exploring AHA’s perspectives have reported that some AHAs do not feel they have a professional identity. (41)

Issues have been identified related to delegation, including roles not having a comprehensive task list to refer to. When a task list has been provided, AHAs have been audited on doing duties they were not assigned or were duties inappropriate to their competency level. (42) Other issues include AHAs reporting in some instances that AHPs are unwilling to delegate clinical duties. (36,41)

Studies have outlined that the boundary and distinction between AHPs and AHAs needs to be clear for professionals, assistants and employing organisations in order to maintain the two distinctive roles and to prevent confusion and potential points of conflict, for example between SLTs and SLTAs. (8) There are potential areas of role conflict where AHPs do not believe AHAs should be involved in assessment, treatment, leadership and documentation. AHPs are concerned about legal implications from the work of an AHA, where the work of an AHA could be of risk to the patient or in areas that require clinical judgement. Role conflict is also possible where the terms used in defining the AHA role are ambiguous. (43)

## Facilitators to task shifting to allied health assistants

To overcome the barriers and problems identified, the literature suggests three key areas. These are planning, training, and clinical supervision.

### Planning

The literature suggests that, prior to the establishment of AHAs, detailed workforce planning should be conducted. (11) Where there is insufficient planning and the roles are ill-defined, the utility of AHAs is compromised. (41) Planning involves three elements: the inclusion of stakeholders, developing guidance documents and protocols, and communication.

AHP Stakeholders such as SLPs (8) and OTs (18) should be included in the introduction of assistants. The inclusion of stakeholders would be empowering for the AHPs and should result in more positive perceptions of the AHAs. (8)

The development of clear guidance documents, clinical protocols and frameworks would support communication between the AHP and the AHA, helping the AHA in clarifying their role and competence. (18,36)

The findings of a project evaluating the development of the allied health support workforce in England indicated that the process of developing the support workforce required the participants to undertake detailed workforce planning in order to implement sustainable change and negotiate the infrastructure of their organisation. (11)

Once the planning is complete, it is important that the long-term strategy is clearly communicated to all stakeholders. (11) Nancarrow et al. also reported that strong leadership from senior management for the introduction of the role was a key facilitator. (30)

### Training

The training of current AHPs and new AHAs was raised across the literature as an ongoing need to overcome the barriers and problems in establishing task shifting to AHAs. The WHO state that education programmes that provide training and development opportunities for all staff are vital to strengthen the health and care workforce. (2) Ensuring both the AHP and the AHA are adequately trained helps protect both the users of the service and the healthcare workers. (29) To support greater delegation to AHAs, it is suggested that training for the AHPs should be focused on clinical supervision skills (11) and delegation skills (36,43) supported by more knowledge about the capabilities and role of the AHA (38) improving AHP confidence in the AHA role. (30) Adequate training for the AHAs is essential to ensure their confidence and competence in fulfilling their duties. (44) A study examining the experience of a small cohort of Psychology Assistants found that training also helps develop the overall confidence in AHAs which increases AHA confidence and dispels their initial anxiety. (45)

Training should be both formal and informal, allowing for personal and professional development (18) and bespoke competencies. (11) For example, in Ireland, the AOTI provides guidance in relation to learning and development for OTAs. (18) This includes initial training (including training on national policy and quality and safety standards), mandatory training (including mandatory health and safety-based training such as safeguarding, moving and handling patients, waste management etc.), and work-based training specialised towards the assistant’s role (including training related to the assistant’s role in assessments, time skills management and stress prevention). Collins (45) recommends that assistant psychologists should also receive training that is national health service based, with mandatory items that are specific to psychologists. Collins also includes a module on teamwork skills.

### Supervision

The literature suggests that supervision is one of the key elements to the successful implementation of the AHA role. Supervision should be carried out by a registered and sufficiently experienced AHP. (19) Supervision has three main functions. These include being supportive, developmental, and to provide quality assurance. (46) Appropriate supervision supports the development of communication pathways from the AHPs that improves mentoring and support for the AHAs. (30,36) Supervision in task shifting to assistants needs to be supportive using a safe environment where AHAs can be encouraged out of their comfort zone. Poor supervision leaves AHAs feeling insignificant, unsupported, exploited and unheard. (47)

Designated time for supervision needs to be structured into the workload of both AHAs and AHPs (38) and be scheduled. (48) Minimum requirements for supervision quantity may depend on the specific role or discipline (as outlined by individual AHP professional bodies or membership organisations). Assistant Psychologists in Ireland reportedly receiving on average 2.19 hours per week of supervision, according to a study which surveyed a group of participants in this cohort. (48) In a study surveying SLTs, participants reported supervision of assistants takes between 3 and 5 hours per week. (49)

## Challenges

The challenges that arise in the role of AHAs tend to come from poor communication, lack of clarity about the nature of the role and the required level of competence for the position. (38,41) From an organisational perspective, the roles are often ill-defined and not standardised. (41,50) This leads to misunderstanding about the role of the AHA which can lead to underutilisation of resources, or where assistants are expected to act beyond their clinical competence. (38)

Because of the poor understanding of the role of AHA, AHPs often report a lack of awareness of the skills, abilities or competencies of AHAs. (38) AHPs have also expressed feeling fearful when delegating to AHAs as they worry about losing the clinical and therapeutic relationship with the client. (8)

From the perspective of AHAs, some have reported not receiving adequate training to perform more complex tasks. (43) If there is a shortage of AHPs, they can experience role creep in their position (11) and oftentimes are asked to act beyond their level of competence, (49) further increasing their lack of role confidence.

Work by Stute et al. identified contentious tasks that sit in between the AHPs and AHAs. These tasks were those including documentation in medical files because of legal implications, and tasks requiring clinical judgement because of the perceived risks to patients. (43)

In terms of clients, there is the risk of experiencing a lack of clarity on the role and competency levels of AHAs. (49)

While a comprehensive review of task shifting within the medical field is beyond the scope of this review, it is important to acknowledge that there is existing literature highlighting potential negative outcomes associated with delegating responsibilities to an assistant role. For example, in the UK, the integration of Physician Associates into healthcare teams has raised concerns regarding patient safety and quality of care (51), health equity (52) and appropriate regulation of professions (53) among other concerns. It would be important for future reviews to consider learnings from this area when seeking to further develop the role of AHAs.

# Conclusion

Due to the international shortage of healthcare professionals, the delegation of tasks to less qualified practitioners, known as task shifting, has become a method of delivering more services without compromising on quality and safety standards. Task shifting in community-based services such as children’s disability services is common between AHPs and AHAs.

The AHA role tends to involve assisting, supporting, administering, monitoring and maintaining, whereas the role of the AHP tends to require more evaluating, assessing, diagnosing, planning and implementing.

The delegation of tasks to AHAs is supported by guidance from studies outlining benefits of the AHA role, however, it is not without its issues. For example, challenges have been identified relating to AHAs being delegated tasks in which they are not trained or competent in. Also, there are differences in professional expectations when delegating to AHAs, such as delegating tasks associated with medical records, which leads to ongoing tensions in the work environment.

Whilst the use of assistants has increased worldwide, there is a lack of clarity on the role of a therapy assistant and disputes about what qualifications they require to operate under. For example, an assistant is a recognised role that can form a career in psychology, however, the assistant psychologist role is a training grade enroute to becoming a qualified clinical psychologist.

The benefits of using AHAs include increased client satisfaction, increased AHP satisfaction and motivation, and increased client throughput. A lack of structure, training and investment has led to role confusion, preventing the optimal use of AHAs. However, these barriers of task shifting to AHAs can be overcome with improved planning, training, and supervision.

The challenges that arise in the role of AHAs tend to come from poor communications, poor role definition and poor support structures.

Overall, the literature has found that if the AHA roles are properly planned and structured, they can lead to improved satisfaction with services for key stakeholders and an improved service. It will be important that the introduction of AHAs into the CDNT service model in Ireland takes these issues into consideration. Close monitoring of the service will also be important particularly as CDNTs primarily serve children with more complex needs and tend to have small number of individual therapists per team.

While this review focused specifically on task shifting to inform the introduction of AHAs into Irish children’s disability services, there is a significant body of work ongoing by the World Health Organisation and others that advances the concept of task shifting and task sharing to focus more on capabilities of staff and management and effective policy responses for a future health and care workforce. This includes developing adaptive and resilient structures, investing in workforce development and education, improving governance and coordination issues, and using data driven decision making (54).

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1. Task shifting and task sharing are sometimes used interchangeably. [↑](#footnote-ref-1)