Submission to the Psychology Board of Australia
Consultation: Redesigning the Higher Education Pathway for Psychology

Psychology Board of Australia
GPO Box 9958
Melbourne VIC 3001

4th of May 2026

Re: The Proposal Lowers Australian Psychology Below Its Current Standard. An Employer Submission on the Higher Education Pathway

IN SHORT

We support a single pathway. We oppose the design as drafted.

The current pathway terminates at AQF 9 (Master of Professional Psychology). The proposal classifies the new 5-year qualification at AQF 8 (Bachelor Honours). This lowers the qualification level of an independently practising regulated health profession by one level on Australia's own national qualifications framework. We can identify no precedent for it in Australian health regulation. Other reforms in medicine, nursing, and pharmacy have moved qualifications up, not down. Psychology going down would be a first.

The proposal also produces a clinical quality reduction the consultation paper does not name. And fixing the qualification without fixing the supply constraints solves nothing.

Three problems need to be addressed before the model goes any further:

1. **AQF 8 is the wrong floor.** It should be AQF 9. AQF 8 lowers Australian psychology below its current standard and below every comparable peer at the moment those peers are moving up.
2. **Removing the supervised internship year requires a structured replacement.** The proposal has none. The replacement must be external, not employer-led.
3. **The psychology assistant tier is too underdeveloped to be in this consultation.** Take it out.

This submission also proposes six supply strategies that don't require lowering the qualification floor.

WHO WE ARE

Unbound Minds Psychology. Two locations in Sydney (Gledswood Hills, Kingswood). 33 practitioners. Full lifespan, full complexity range. Neurodevelopmental assessment, trauma,

suicide and self-harm risk, complex comorbidity including personality, eating, and substance use disorders.

Both catchments are confirmed psychology workforce shortage areas with large CALD populations. We hire and supervise provisional psychologists through the 5+1.

This submission is from an employer perspective. We have no commercial interest in the AQF level beyond getting good clinicians into our rooms.

THE PROPOSAL LOWERS THE EXISTING AUSTRALIAN STANDARD

The current 5+1 pathway terminates with the Master of Professional Psychology, an AQF 9 qualification. The proposed 5-year pathway is classified at AQF 8. The Board is proposing to lower the qualification level of the profession it regulates by one level on Australia's own national qualifications framework.

This is unusual. Other Australian health professions have moved their qualifications up, not down. Medicine moved to AQF 9 (Masters Extended). Pharmacy moved to AQF 9. Physiotherapy added an AQF 9 entry pathway. Nursing has progressively raised its entry requirements over decades. We can identify no Australian precedent for a National Board lowering the qualification level of an independently practising health profession on its own framework. The Board owes the profession and the public a clear answer to one question: what is the public-interest rationale for being the first?

The downward movement is the underlying problem. Everything that follows in this submission, the international comparison, the indemnity consequences, the parity loss, the quality safeguards, sits on top of that single fact. AQF 8 is below the standard the same Board approved as recently as 2024 for the same scope of practice.

THE INTERNATIONAL PICTURE

Psychology training globally is moving up, not down. The countries we lose graduates to all train above Masters.

- **United States.** PhD or PsyD required in all 50 states. 8 to 10 years. AQF 10 equivalent.
- **United Kingdom.** DClinPsy required for HCPC. 6 years. Doctoral-labelled, Masters-equivalent in volume.
- **Canada.** Most provinces require PhD or PsyD. The trend is doctoral.

AQF 8 would be the lowest entry-to-practice qualification for psychologists in any comparable jurisdiction. We can't find one in the OECD. Australian graduates at AQF 8 will struggle to be recognised in those markets. Indemnity insurers, who reinsure internationally, will price the risk against the international standard. Skilled migration recognition will drop.

Total training time matters more than label. UK DClinPsy: 6 years. Current Australian 5+1: 6 years. The architecture this submission proposes (5-year AQF 9 plus 12-month externally accredited post-registration program): also 6 years. The reform doesn't need to reduce total training time. It needs to redistribute the assessed competency layer.

THE BOTTLENECK

Reform is needed. The Mental Health Workforce Strategy 2022 to 2032 forecasts only 35 per cent of the required workforce by 2030 without intervention. Around 10 per cent of psychology students complete the postgraduate qualification required for general registration. The funnel narrows by design.

Postgraduate clinical placements are unpaid. The barrier falls hardest on socioeconomically disadvantaged and CALD candidates, the cohort our catchments most need. Length is one factor among several. Postgraduate program funding is the structural ceiling. Supervision capacity is another. Placement poverty is the equity barrier. The proposal addresses one and ignores the others.

THE QUALITY SAFEGUARDS BEING REMOVED

The proposal removes three independent clinical safeguards at once: the supervised internship year, the national psychology exam, and provisional registration. Each does different work. The internship builds practical competence on real cases. The exam tests minimum knowledge against an external standard. Provisional registration limits the harm a developing practitioner can cause. Removing all three produces a graduate with materially less assessed competence on day one of independent practice. That is a clinical quality reduction. The consultation paper does not name it.

The Board's implicit answer is that embedded undergraduate placements substitute for the internship year. They don't. Universities have a commercial incentive to pass students. AHPRA-approved internship supervisors carry personal professional liability and operate outside that incentive. They produce different decisions in marginal cases. Universities also can't replicate internship case mix: placements are short, supervised indirectly rather than in real time, and structured around teaching objectives rather than the presentations a working psychologist sees. The exam removal is the cleanest version of the same problem. Without an external standardised check, program quality variation translates directly into practitioner quality variation, with no profession-wide floor.

The clinical consequences are predictable: graduates less prepared for suicide risk assessment, complex differential diagnosis, and acute distress; more notifications to AHPRA; more indemnity claims; more misdiagnosis; more early-career burnout. AQF 8 compounds all of this. AQF 9 plus an external post-registration program (set out below) replaces the safeguards with structurally equivalent mechanisms.

This is the third successive reduction in structured supervised practice. The 4+2 pathway, closed in 2022, delivered 2 years of supervised practice on real cases and produced clinically strong graduates. The 5+1 reduced this to 1 year. The current proposal removes it as a discrete year entirely. Each reform was justified as workforce expansion. The cumulative clinical effect has not been examined.

ON THE AQF LEVEL

AQF 8 is the Bachelor Honours degree level. It sits one step below the Masters Degree (AQF 9) and one step above the standard Bachelor (AQF 7). The current 4-year Bachelor of Psychology (Honours), where the graduate cannot practise without further training, is already AQF 8. Setting independent psychological practice at AQF 8 means a registered psychologist would hold the same formal qualification level as the unregistered Honours graduate they were 12 months ago.

A generally registered psychologist in Australia practises with relative independence. They assess and manage suicide risk. They diagnose neurodevelopmental conditions. They work with people in acute distress, sometimes without immediate clinical backup. The indemnity settings and AHPRA's existing supervision framework reflect the clinical risk: independent diagnosis, autonomous treatment decisions, high-stakes risk management. AQF 8 doesn't change any of that. It just changes how the Board describes the qualification.

Four further consequences:

- **International recognition collapses.** Three comparable countries require doctoral. AQF 8 graduates face automatic non-recognition or substantial bridging overseas. AQF 8 also drops skilled migration categorisation.
- **Profession-wide parity is lost.** Medicine, dentistry, optometry, and veterinary practice all sit at AQF 9 (Masters Extended). These are the doctor-equivalent professions whose scope is closest to psychology: autonomous diagnosis, independent treatment authority, high-stakes risk decisions. Allied health professions with narrower scope (physiotherapy, OT, speech pathology, social work) operate at AQF 7 or AQF 9 entry pathways. Psychology's scope sits with the doctor-equivalent group. AQF 8 would put it below every doctor-equivalent profession in Australia, and below the existing 5+1 pathway it replaces.
- **Indemnity pricing rises.** Insurers price against AQF level. A Bachelor-Honours-classified independent profession means higher premiums. Employers absorb them. Medicare and out-of-pocket fees pass them through. The reform aims to make psychology more accessible. AQF 8 makes it more expensive to deliver.

- **Public perception shifts.** AQF level is publicly accessible information. Patients, GPs, school principals, employers, and insurers can read it. A reduction affects referral patterns, career attractiveness, and salary parity over time.

The qualification level should follow the work. The work has not become less complex. The classification should not be reduced.

WHY AQF 9 IS THE RIGHT ANSWER

AQF 9 is the Masters Degree level. Masters Extended (3 to 4 years post-Bachelor) is the structural template used by medicine, dentistry, optometry, and veterinary practice. They all sit at AQF 9.

AQF 9 mandates Masters-equivalent volume of learning, learning outcomes covering research methods and autonomous practice, and feeds into mutual recognition agreements with the UK HCPC, US ASPPB, and Canadian provincial regulators. It sets skilled migration categorisation and aligns psychology with the doctor-equivalent professions.

AQF 9 alone won't fix everything. It doesn't set Medicare items, scope of practice, or practice readiness. The post-registration program below does that work. But the post-registration program needs AQF 9 underneath it. Built on an AQF 8 base, it inherits the international recognition and parity problems above.

On AQF 10: we considered it. Psychology carries autonomous diagnostic authority and high-stakes risk decisions, and the international standard is doctoral. We didn't land on it because AQF 10 requires substantial original research, which adds duration without proportionate clinical benefit; no Australian health profession enters practice at AQF 10; and Doctor of Psychology programs already exist at AQF 10 for the practitioners who want them. The destination is available. The entry floor doesn't need to be doctoral. If the Board concludes a 5-year qualification is non-negotiable and won't reach AQF 9, the right alternative is to maintain the current 5+1 and address supply through the strategies below. Reducing the qualification floor is the wrong fix.

ON WHAT REPLACES THE INTERNSHIP YEAR

The proposal removes provisional registration, the supervised internship year, and the national exam at once. Even 5+1 graduates with the exam need structured support in their first year. Under the proposed model, new graduates arrive with materially less practical experience and no exam pass. Someone has to do the practice-readiness work. The question is who.

It cannot be the employer because employer-led certification fails on regulatory grounds. The employer carries a commercial incentive to pass the practitioner: failing a graduate means losing a billable resource the practice has invested in for 6 to 12 months. The supervisor and

the boss being the same person is the structural problem the medical model fixed decades ago, which is why GP registrars are not signed off by the practice that hires them. Employer-led certification is also inconsistent by design: a graduate hired into a practice with structured early-career development completes one version of practice-readiness, a graduate hired into a practice without one completes a different version, and the public cannot distinguish at the point of service. A new psychologist's clinical preparedness should not depend on which employer happened to hire them. Even good employers cannot self-certify against a national standard if no national standard exists.

The work needs to be done by an external body, accredited by the Board, with a published curriculum, externally assessed competency milestones, and sign-off authority outside the workplace. This is not about who pays. It is about who carries the regulatory authority to certify a graduate as ready for independent practice. That authority cannot sit with the same entity that benefits commercially from the certification.

The model exists in medicine. GP registrars complete a fellowship-style program run externally by a college, with workplace placements as a required component. The graduate cannot transition to independent practice until the external program is complete. The UK DClinPsy uses an analogous structure. The same architecture for psychology:

- **Externally accredited program.** 12 months. Board-accredited, run by an operator selected through competitive tender, with externally assessed competency milestones.
- **Workplace-based supervision.** The employer provides supervision and case mix. The external operator carries assessment authority.
- **Funded.** Through Medicare, AHPRA fee redistribution, or a combination, sufficient to remove the cost barrier for small and regional employers.
- **Restriction on autonomous practice rights until completion.** No private practice principal status, supervisor status, or sole-practice approval until the program is complete.
- **Retention of a national knowledge examination.** Either as the program's exit assessment or as a separate AHPRA-administered examination. Removing it without replacement is a quality reduction.

Operator selection will be politically contested. APS currently runs the registrar program for endorsement. Other professional bodies will object to APS extending that role. The Board should commit to a competitive tender process before any legislative change.

ON THE PSYCHOLOGY ASSISTANT TIER

The paper introduces an assistant pathway as an exit point at year 3 and acknowledges the role, scope, demand, and structure remain unclear. If those things are unclear, the tier shouldn't be in this consultation.

If the scope is loose, NDIS-funded therapy and PHN-commissioned programs will substitute psychology assistants into work currently done by registered psychologists. We've watched this play out with allied health assistants and counsellors. A new lower-cost tier without scope discipline accelerates it. If the scope is tight, "tight" needs defining. Administrative work, assessment administration under direct supervision, and structured psychoeducation are different jobs to independent therapy delivery. The paper doesn't pick. There is also no workforce modelling of how an assistant tier would interact with mental health social work, counselling, and registered psychology.

Take the assistant tier out of this consultation. Run it as separate policy work with workforce modelling, consumer testing, and engagement with the professions that already occupy the lower-cost layer. Properly scoped, an assistant tier could be a meaningful capacity multiplier: assistant-administered standardised assessment, structured psychoeducation under supervision, and parent-training delivery would free registered psychologists to work at top of scope.

SIX STRATEGIES TO EXPAND SUPPLY

The constraints we observe are postgraduate program capacity, placement poverty, supervision capacity, geographic distribution, workforce diversity, and overseas qualification recognition. Each can be addressed without reducing the qualification floor.

1. Solve placement poverty. Pay clinical placements at provisional psychologist rates or fund stipends through Department of Health workforce expansion grants. The barrier filters out the cohort the workforce most needs (socioeconomically disadvantaged, CALD, regional, First Nations). Cost is small relative to scheme expenditure. Diversity gain is substantial. Highest-return intervention available.

2. Fix postgraduate program funding. Universities lose money on postgraduate psychology programs. Places are capped artificially. Index funding to cost recovery and ringfence places to demand-mapped catchments.

3. Service-bonded scholarships. Subsidise full training in exchange for 3 to 5 years of paid service in confirmed shortage catchments. The Bonded Medical Program already does this for medicine. Apply to psychology. Direct service obligations to PHN-defined shortage catchments and First Nations communities.

4. Funded supervision infrastructure. The supply of supervisors caps the supply of registrants. Pay supervisors through Medicare items, AHPRA fee redistribution, or a dedicated grant. Without funded supervision, the post-registration competency program will fail at scale.

5. Targeted CALD and First Nations pathway support. The most clinically effective psychologists for these catchments are bilingual or bicultural practitioners with lived experience of their clients' communities. They face the steepest barriers in the current pathway. Targeted scholarships, mentoring, placement coordination, and supervisor matching.

6. Streamlined overseas qualification recognition. The current pathway for AQF 9-equivalent overseas-trained psychologists is slow, bureaucratic, and inconsistent. Establish a fast-track pathway from comparable jurisdictions, with conditional registration and structured competency assessment within 6 months of arrival.

A properly scoped assistant tier would be a seventh strategy. It requires its own consultation. The combined effect of these strategies, executed alongside the alternative training architecture, would address the workforce shortage more effectively than the proposed AQF 8 pathway.

ON IMPLEMENTATION

Three principles before the next round. Provisional psychologists currently in the 5+1 keep the right to finish under existing rules. Employers built around the existing model need 24 to 36 months to redesign. Existing higher-degree programs cannot be unwound quickly; the transition must keep postgraduate program capacity in place until the new pathway is producing graduates at scale.

WHAT WE'RE ASKING FOR

4. **Keep the single 5-year pathway.**
5. **Classify at AQF 9.** AQF 8 is below every comparable peer. AQF 10 is the wrong target.
6. **Establish an externally accredited 12-month post-registration competency program.** Workplace supervision required. Operator by competitive tender. Funded through Medicare or AHPRA fee redistribution. Autonomous practice rights restricted until completion.
7. **Retain a national knowledge examination.**
8. **Remove the psychology assistant tier from this consultation.** Run it separately.
9. **Solve placement poverty.** Pay placements or fund stipends.
10. **Index postgraduate program funding to cost recovery.** Ringfence places to demand-mapped catchments.

11. **Implement service-bonded scholarships** modelled on the Bonded Medical Program.
12. **Fund supervision infrastructure.**
13. **Targeted CALD and First Nations pathway support.**
14. **Streamline overseas qualification recognition** for AQF 9-equivalent psychologists from comparable jurisdictions.
15. **Publish implementation principles before the consultation closes.**

CLOSING

AQF 8 lowers the existing Australian standard. The current 5+1 pathway terminates at AQF 9. The proposal moves the floor down to AQF 8. There is no Australian precedent for a National Board reducing the qualification level of an independently practising health profession on its own framework. The proposal also removes three independent quality safeguards (the supervised internship year, the national exam, and provisional registration) and replaces them with embedded undergraduate training that cannot do equivalent work. Layering AQF 8 on top of that produces the version of the reform with the largest quality cost.

A 5-year AQF 9 qualification combined with an externally accredited 12-month post-registration program produces a 6-year total pathway, matching the UK DClinPsy in volume and the same total length as the current 5+1. The reform is delivered through redistribution of the assessed competency layer, not qualification reduction.

We urge the Board to revise the model along these lines. We're happy to engage further and can provide practice-level data on supervision burden, recruitment patterns, and Fellowship outcomes.

Yours sincerely,

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