

Australian Psychosocial Alliance

Consultation on NDIS Support Coordination and Connection Reform

October 2026

About the Australian Psychosocial Alliance

The Australian Psychosocial Alliance (APA) is Flourish Australia, Mind Australia (incorporating One Door Mental Health and The Haven Foundation), Neami National, Richmond Fellowship Queensland, Ruah Community Support, Stride Mental Health, Open Minds and Wellways Australia. We are eight of the largest and longest service specialist providers of community managed mental health and wellbeing services in Australia. We provide support to over 120,000 people with mental health challenges and psychosocial disability every year. This includes expert support to around 5,800 NDIS participants with a psychosocial disability. We come together around a shared policy agenda to improve outcomes for people with mental ill-health and psychosocial disability, and a shared understanding of quality service delivery.

Our members deliver Medicare Mental Health Centres, headspace programs, carer connect centres, step-up step-down services (sub-acute, short-term residential care), residential rehabilitation, supported housing, employment, suicide prevention and postvention programs, individual mental health recovery support and NDIS supports. We respond across the spectrum of need and to people in priority populations, such as LGBTIQA+ individuals, culturally and linguistically diverse (CALD) communities, Aboriginal and Torres Strait Islander people, young people and people experiencing or at risk of homelessness.

We combine evidence-based practice with service delivery wisdom to provide recovery-oriented services that support people to build their capacity to participate in society and manage their lives. We focus on personal goals, participation and living a meaningful life. This can include support to sustain a tenancy, build the skills to live independently, find fulfilling work and build social connections.

Our organisations embed lived experience across our governance and service delivery. We employ a specialist cross disciplinary workforce with expertise in mental health and psychosocial disability, and with the technical skills to deliver recovery-focused, trauma-informed and person-centred support.

Introduction

The APA supports the Government commissioning support coordination, specialist support coordination and psychosocial recovery coaching, provided this is done through a commissioned market model rather than through a single lead organisation, or a small number of contracted providers, in each region. Commissioning done this way can genuinely solve the problems that currently exist in the support coordination market, while a lead organisation model would create new problems of its own.

The problems identified in this consultation paper are serious. They include inconsistent quality, unclear role boundaries between support coordination and other parts of the NDIS, conflicts of interest, variable workforce capability, and inconsistent access for people in regional, rural and remote areas.

These problems are primarily the result of inadequate market stewardship by the National Disability Insurance Agency (NDIA), not a failure of the underlying market. The NDIA has relied on a largely open market with limited oversight, inconsistent quality requirements and insufficient regulatory controls. Commissioning gives the NDIA the opportunity to fix this, through stronger stewardship and regulation of the market, rather than through its replacement with a small number of large, contracted providers.

This submission sets out the type, and principles that should guide the design of, a commissioned market model and answers the consultation questions on that basis. Our central recommendation is that the NDIA commission Support Coordination and Connection (SCC) services by setting mandatory registration and enrolment requirements, and by opening or closing enrolment by region and by participant cohort to manage supply, while keeping multiple enrolled providers available to participants in every area. This preserves participant choice, protects specialist and lived experience led providers, and gives the NDIA the tools to manage thin markets, without the risks of a single lead organisation model.

Finally, psychosocial recovery coaching should remain a separate service, or if it is folded into the SCC and SCC+ model, the specialist expertise of organisations experienced in delivering psychosocial supports must be retained. People with psychosocial disability have support needs which often fluctuate in ways that general support coordination is not well placed to respond to, a gap identified by the NDIS Review itself[1].

We recognise the consultation paper signals an intention to bring psychosocial recovery coaching into the SCC model. If this occurs, SCC should be organised into specialist streams by disability type and cohort, including a dedicated psychosocial stream, so that this expertise is not lost.

Why a lead or small number of contracted provider(s) model is the wrong approach

Support coordination requires specialist knowledge and skills tailored to different disabilities and cohorts. Fewer providers mean less specialisation.

The existing market contains providers with deep expertise across a wide range of disability types and participant cohorts, including psychosocial disability, physical disability, neurodiversity, children and young people, and people with complex support needs. Much of this expertise sits within small and medium sized providers who have developed highly specialised practice over many years. A family supporting a child with profound disability and a person with psychosocial disability and a history of homelessness need different kinds of support. A single provider, even with subcontracting or consortia arrangements, cannot easily hold that range of expertise. Support coordinators need to know about, or be able to find, the right service for each person. A review of support coordination (SC) models published

[1] NDIS Review. (2023). Fact sheet 7: For people with psychosocial disability and their families. https://www.ndisreview.gov.au/resources/fact-sheet/psychosocial-supports

by the NDIA notes that this is especially important for people with complex needs, who may have already had negative experiences accessing services in the past[2].

The current market approach has supported a growing Lived Experience led market.
In our organisations' experience working with participants and their SC, many SC and psychosocial recovery coaches (PRC) also currently bring lived experience of disability, mental ill health, caring responsibilities or recovery to their role. The current market approach has also enabled many people with disability to establish businesses and careers that are flexible and accessible.

Choice and control is important and quality concerns should be managed through regulation not fewer providers.
We acknowledge concerns about providers delivering both direct supports and intermediary supports. This can be managed through regulation rather than market replacement. As a rule, providers should not deliver both SCC and other NDIS supports to the same participant, and this should be enforced through existing NDIA payment systems. Where a participant makes an informed choice to receive both from one provider, they should be able to do so as an exception, subject to safeguards. These should include clear written disclosure of the arrangement, separation of the coordination and direct support roles within the organisation, the participant's right to change either provider at any time, and NDIA monitoring of plan spend to identify patterns of concern.

Quality concerns require stronger regulation, not just fewer providers. The sector would benefit from mandatory registration and enrolment requirements. The NDIA should have visibility of all providers and require evidence of workforce capability, governance systems, quality frameworks and service delivery competence.

Scope issues are system generated and a nationally recognised scope of practice would provide clarity.
Support coordinators and psychosocial recovery coaches are frequently expected to perform functions that fall outside their funded role. This confusion is often driven by inconsistent expectations from the NDIA and other parts of the system, not by the number of providers in the market. The NDIS Quality and Safeguards Commission's own inquiry into support coordination found that crossing professional boundaries was among the recurring issues raised in complaints[3], and a 2025 systematic review of the sector concluded that the absence of well-defined role expectations for support coordinators contributes to confusion amongst stakeholders, recommending enhanced role clarity and defined quality standards[4]. A nationally recognised scope of practice would provide much needed clarity.

Large volume contracts, which prioritise throughput over continuity of relationship, work against this evidence base.
The experience of large scale contracted service models, such as Local Area Coordination, shows the risk of services becoming standardised and throughput driven once a single provider is made responsible for an entire region. Good outcomes depend on strong relationships between participants and the people who support them. A 2025 study of psychosocial recovery coaching within the NDIS found that participant outcomes aligned strongly with the CHIME-D recovery framework, which identifies connectedness and trusting relationships as core elements of personal recovery. The study reports that overall participant experiences and outcomes of psychosocial recovery coaching align strongly with the CHIME-D recovery framework and with the NDIS stipulated goals and responsibilities of psychosocial

[2] O'Brien, L and Randjelovic, I (2020), *International Models of Support Coordination and Local Area Coordination: Evidence Review Report*, National Disability Insurance Agency, Australian Government.
[3] NDIS Quality and Safeguards Commission (2023), Own Motion Inquiry into Support Coordination, Part 1, NDIS Quality and Safeguards Commission, Australian Government.
[4] Cubis, L, McDonald, S, Dearn, E, Douglas, J and Winkler, D (2026), "Skills and characteristics of a good support coordinator for people with disability and complex needs, scoping review", Disability and Rehabilitation, DOI: 10.1080/09638288.2026.2679897

recovery coaching service delivery[5]. The same study found that feeling valued and respected was the most frequently reported positive outcome (with 79% reporting this as a positive outcome), with the consistent, trusting relationship between coach and client identified as itself a valued form of support.

Large volume contracts, which prioritise throughput over continuity of relationship, work against this evidence base. Participants who are slow to build trust, particularly those with psychosocial disabilities, are the ones who are further disadvantaged when the system is not designed around relationship continuity.

Recommendations

1. Commission SCC services through a commissioned market model, not a lead organisation or small contracted provider model. The NDIA should register and enrol multiple providers per region and manage supply by opening and closing enrolment.
2. Require mandatory registration with the NDIS Quality and Safeguards Commission and a further SCC specific enrolment process, with evidence of workforce capability, governance, quality systems and delivery competence.
3. Keep psychosocial recovery coaching separate and further develop it as a distinct service, with compliance with the mental health standards as a baseline enrolment requirement. Psychosocial recovery coaching is a different skill set from general support coordination, and this distinction should be protected. If the NDIA instead brings it into the SCC model, it should be delivered through a dedicated psychosocial specialist stream, by providers who meet the mental health standards and employ a lived experience workforce.
4. Fund the service through an enrolment model, with a baseline hours allocation and clear tiers of intensity based on assessed need, tied to standardised reports already possible through the NDIA portal.
5. Build oversight of participant plan spend into the baseline role, so SCC workers act as a frontline safeguard against fraud, using existing NDIA data systems to flag concerns.
6. Make lived experience employment and leadership a mandatory enrolment requirement for services delivering support to people with psychosocial disability and for any service delivering psychosocial recovery coaching.
7. Require training in supported decision making for all SCC workers, as a condition of enrolment.
8. Provide a minimum twelve month, and given the scale of participants involved, ideally up to eighteen-month, transition period with no hard cutover date.
9. Develop a nationally consistent scope of practice for Support Coordinators, Specialist Support Coordinators and Psychosocial Recovery Coaches.

[5] Elmes, A, Campain, R, Brown, C and Wilson, E (2025), "Psychosocial Recovery Coaching and the National Disability Insurance Scheme, Outcomes and their Alignment with the CHIME-D Recovery Framework", Community Mental Health Journal, 61, 1390 to 1405.

Responses to the consultation questions

Questions about service provider models and approaches

1. What commissioning arrangements would best balance participant outcomes, quality, sustainability and choice and control

We make two recommendations. First, the NDIA should adopt a commissioned market model rather than a lead organisation model. Second, psychosocial recovery coaching should remain a separate service from Support Coordination. If the NDIA instead decides to fold it into the SCC and SCC+ model, that model must retain the specialist expertise of organisations experienced in delivering psychosocial supports.

Under a commissioned market model, the NDIA would directly commission the service and require providers to register and enrol before they can deliver it, but it would not limit delivery in a region to one organisation or a small number of contracted providers. Instead, any provider that meets the registration and enrolment requirements could deliver services in a region, and the NDIA would manage supply by opening enrolment where a region or a participant cohort is under served, and closing enrolment where supply is already sufficient. This keeps the accountability and quality benefits that commissioning is meant to deliver, while preserving participant choice and the specialist expertise that sits across the many providers who currently deliver SC. We think a commissioned market with as many enrolled providers as the market can sustain, organised where useful around participant cohorts, would achieve better outcomes again.

What currently works well in support coordination is the ability of a participant to choose a provider that matches their cohort, culture and personal circumstances. Many support coordinators and psychosocial recovery coaches bring genuine lived experience, deep local relationships and specialist expertise built up over years. Any commissioning arrangement should build on this strength rather than replace it with a single or small number of large, generalist providers. Balanced against this, we recognise the current market has real problems, including inconsistent quality and accountability. These could be better solved through stronger regulation of the existing market, including mandatory registration and enrolment, a nationally consistent scope of practice, clearer management of conflicts of interest, and a funding model that removes the incentive for over servicing or under servicing, than through a reduction in the number of providers. The rest of this submission sets out how each of these could work in practice.

This is especially important for people with psychosocial disability. Recovery oriented practice, an understanding of fluctuating and episodic support needs, and the ability to navigate the mental health system are specialist skills. They sit within psychosocial recovery coaching, not general support coordination. Psychosocial recovery coaching was introduced in 2020 because general support coordination, as originally designed, was not meeting the needs of people with psychosocial disability[6].

For this reason, it's recommended that psychosocial recovery coaching remain a separate service. If the NDIA instead folds it into the SCC and SCC+ model, the model must retain the specialist expertise of organisations experienced in delivering psychosocial supports. At a minimum this means keeping the current workforce requirements for recovery coaches, including the value placed on lived experience, and using cohort-based enrolment so that organisations with psychosocial expertise can continue to work with people with psychosocial disability.

[6] [1] Hamilton, D., Hancock, N., Scanlan, J. N., & Banfield, M. (2020). The National Disability Insurance Scheme and people with severe and persistent mental illness/psychosocial disability: A review, analysis and synthesis of published literature. Australian & New Zealand Journal of Psychiatry, 54(12), 1162 to 1172. https://doi.org/10.1177/0004867420967747. See also National Disability Insurance Agency. (2020). Psychosocial recovery coach (Version 1.1). https://www.ndis.gov.au/media/2479/download

2. *What provider types would be best placed to be a lead organisation. Why do these characteristics matter*

Participants tell us that what matters most is being able to choose a support coordinator they trust and who understands their needs. A lead organisation model would limit that choice, regardless of which provider type takes on the role. For this reason, we do not believe any provider type should be a lead organisation for a whole region, for the reasons set out earlier and in our answer to the next question.

However, if the NDIA proceeds with a lead organisation model, we recommend that each region be contracted to a consortium rather than a single organisation. Each consortium should be required to include a minimum number of member organisations with demonstrated expertise across different disability types and participant cohorts. At a minimum this should include organisations with expertise in psychosocial disability, intellectual disability, complex support needs, and supporting First Nations and culturally and linguistically diverse participants, with Aboriginal community-controlled organisations included wherever possible. Where a region covers rural or remote areas, the consortium should also include organisations with a local presence in those communities.

Every participant brings a different disability, culture, history and set of goals. Support coordination works when the coordinator understands these things and knows the local services and people who can help. No single generalist provider can hold all this knowledge, and a single provider would also take away the participant's ability to choose who supports them. A consortium keeps that choice in place in part. Participants could choose a provider within the consortium who understands their needs, and the specialist expertise that exists across the sector today would not be lost. This includes psychosocial expertise, which we have argued should remain in a separate recovery coaching service or, if folded in, the specialist expertise required to deliver it well be deliberately retained.

3. *What are the advantages and disadvantages of the lead organisation model*

The main advantage of a lead organisation model is administrative simplicity for the NDIA. A single tender per region is easier to manage than an open enrolment market and does not need to be revisited for the life of the contract. This is not, in our view, a sufficient basis for a decision that will shape access to support coordination for thousands of people with disability.

The disadvantages are substantial.

A single provider, however capable, cannot hold the breadth of cohort specific expertise that currently exists across the market. This is the experience reported by many people with disability working with Local Area Coordinators today, where a person may be supported by someone with no understanding of their particular disability or circumstances, through no fault of the individual worker, but because one workforce is being asked to do work that requires many different kinds of expertise. This finding is echoed in the 2023 NDIS Review, which identified confusion and duplication arising from navigation support being split across Support Coordinators, Local Area Coordinators and Psychosocial Recovery Coaches, and recommended these be replaced with a differentiated Navigator model, including Specialist Navigators for people with complex needs and a dedicated Psychosocial Recovery Navigator role[7]. Consider a family supporting a child born with a profound disability, who needs help with carer support, family capacity building, education and access to school aged systems, against a person with a psychosocial disability and a history of homelessness and contact with the justice system, who needs support connecting with the mental health, alcohol and other drug, housing and justice systems. These

[7] Independent Review into the National Disability Insurance Scheme (2023), Working Together to Deliver the NDIS, Final Report, Commonwealth of Australia.

are different jobs requiring different expertise, and this is also true for First Nations participants, culturally and linguistically diverse participants, and people with other intersecting needs.

Similarly, people with psychosocial disability often have support needs that change over time, and their goals are shaped by their own personal recovery[8]. Supporting them well requires a distinct, recovery-oriented practice model, which is why psychosocial recovery coaching should remain separate from general support coordination. A lead organisation model built on one generalist workforce would struggle to protect this specialist practice.

A lead organisation model also tends to push service delivery toward lower cost, centre based or virtual channels rather than face to face support, which undermines trust and engagement for participants with complex needs. It reduces participant choice and control, which is not only an objective named in the consultation paper but a legislated object of the NDIS Act itself, the Act's stated objects include enabling people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports[9].

A lead organisation model also concentrates risk. If a lead organisation fails to perform, an entire region loses service continuity at once, rather than participants being able to move between several enrolled providers. And the approach risks abrogating the NDIA's own responsibility for market stewardship to a third party, which is likely to be more expensive and less effective than the NDIA exercising that stewardship directly, since the NDIA holds the data, the payment systems and the purchasing power.

4. *What would be appropriate regional areas to use for SCC service areas?*

Any service areas used for SCC should align with an existing boundary system rather than creating a new one. Commonwealth and state and territory social services already use many different boundaries, including Primary Health Network regions, Local Hospital Network regions and state and territory service areas, and these rarely line up with one another. Adding a new set of SCC areas would make this harder for participants, families and providers to navigate. The NDIA should use whichever existing boundary system is most consistently used and best understood.

Whatever boundaries are chosen, they should not limit where a participant can get support. People should be able to move between areas without losing continuity of support and should be able to use the provider closest to them, even if that provider sits in a different area. For examples in rural and regional areas a participant's nearest town within their own area might be two hours away, while a town across the boundary is only half an hour away. A participant in this situation should not be forced to travel further or go without support because arbitrary catchment boundaries.

A commissioned market model, as recommended above, would make this easier. Rather than awarding a whole region to one provider, it lets providers register for the areas where they operate, so participants near a boundary can choose from providers on both sides of it.

5. *How might SCC providers manage variable need among the participants it supports. Which workforce, caseload and service capacity factors should be considered?*

We recommend an enrolment-based approach. A participant would choose and enrol with an SCC provider, and that enrolment would come with a baseline level of funding, broadly equivalent to twelve to twenty hours of support a year for a participant with standard needs, alongside baseline deliverables such as a plan implementation report. Where the NDIA assesses a participant as having moderate, high

[8] https://www.ndis.gov.au/understanding/how-ndis-works/mental-health-and-ndis#psychosocial-recovery-coach
[9] National Disability Insurance Scheme Act 2013 (Cth), section 3.

or very high intensity needs, this could add further funding, for example an additional twenty hours a year at moderate intensity, a further thirty hours at high intensity, and up to around one hundred hours a year at the most complex end, each tier carrying its own reporting expectations. This approach uses systems the NDIA already has in place, including portal based reporting and existing payment infrastructure, rather than requiring an entirely new capability.

To make this work in practice, the NDIA should use the service areas to estimate need in each region and give each enrolled provider an indicative caseload, expressed as a number of participants and total hours of support. Providers could use these hours flexibly across their caseload, giving more support to a participant whose needs increase. Participants would still choose between enrolled providers, including by cohort, but providers could plan their workforce, manage waitlists and coordinate transitions when a participant moves between providers.

6. *Which payment and funding approaches would best support participant outcomes, workforce sustainability and innovation?*

We support the enrolment based model described above, with payment tied to delivery of standardised reports, such as a plan implementation report, a periodic monitoring report, and an end of year report, submitted through the existing NDIA portal. Reports should be developed with the participant and shared with them, so they reflect the person's goals and give them a clear view of what their provider is doing. Linking payment to these deliverables gives the NDIA a low-cost way to identify providers who are not delivering, without needing a new compliance function. Patterns such as payments with no corresponding implementation report can be queried from existing data.

Payment should also recognise the work involved in engaging participants. Some participants, particularly those with psychosocial disability, take time to build trust or step away from support for periods when they are unwell. Providers should be paid for reasonable outreach and engagement during these periods, even where a standard report cannot yet be completed. This means people are not dropped when they are hardest to reach and can return to a worker who already knows them.

The current unit prices for Support Coordination and Psychosocial Recovery Coaching do not cover what it costs to deliver this work well, and participants feel the effect.

Work with participants with psychosocial disability is complex and may be unpredictable. Much of the work happens outside planned sessions and often cannot be billed. Under current pricing, many providers with psychosocial expertise can no longer absorb these costs. They have regrettably withdrawn from support coordination and now deliver only Psychosocial Recovery Coaching. Participants who most need consistent support now have fewer options, are more likely to change workers, and may lose support at the times they need it most.

Psychosocial Recovery Coaching pricing reflects more closely the nature of the work, but it is still not sufficient. For participants to receive support that is safe, consistent and focused on their recovery, the price needs to cover the following.

- Workers with the right skills and experience for each person's needs and level of risk, supported by supervision and practice leadership.
- Peer workers, who bring lived experience that many participants value, with the training and supervision they need.
- Wage on costs, including superannuation, leave, backfill, penalty rates, redundancy provisions and workers compensation premiums.

- Travel, fleet, ICT, rent and insurance. Insurance premiums rose by an average of 24% between 2021/22 and 2023/24.
- Quality systems, accreditation, outcomes measurement and research so providers can show whether we are delivering outcomes for participants.
- Lived experience governance and codesign so participants shape how services are designed and delivered.
- Partnership and coordination work with health, housing and other services, which is largely unfunded.

Sector modelling puts a sustainable base rate for standard psychosocial support at around $123 an hour. This assumes 85% of hours go to direct and indirect client work and makes no allowance for backfill, after hours work or regional delivery. Programs for people with complex needs that include peer support, proper supervision and quality improvement currently run at around $130 an hour. Both are well above current NDIS price limits for support coordination and recovery coaching.

Pricing should also be built on the SCHADS Award classifications this work requires. Recovery support and case management generally sit at SCHADS levels 3 to 4. Complex case work, supervision and peer workforce support sit at levels 5 to 6, and practice leadership at level 7 and above. A price based on a lower classification forces providers to either employ less experienced staff meaning participants with complex needs end up with workers who are not equipped to support them. Alternatively, providers deliver these services at a loss – a position which is not sustainable. Prices must also keep pace with the award once set. Indexation should be directly linked to Annual Wage Review decisions, SCHADS Award changes and superannuation guarantee increases, and applied in full from the date those increases take effect.

We recommend that both prices be reviewed against the full cost of delivery at the appropriate SCHADS classification levels, with indexation linked to award and wage increases. Psychosocial Recovery Coaching should be increased, and support coordination for participants with complex or fluctuating needs should be priced at least at the same level. This increase is justified if it is paired with the quality and accountability measures set out in this submission. A well stewarded market delivers more value for the Scheme than the current arrangement, even at a higher unit cost.

7. *What quality, workforce and safeguarding requirements should apply to commissioned SCC organisations*

We recommend a three-tier baseline.

- First, mandatory registration with the NDIS Quality and Safeguards Commission, which should already be a condition of delivering any NDIS funded service.
- Second, an SCC specific enrolment process, which would also apply to psychosocial recovery coaching. This would require evidence of workforce capability, governance systems, quality frameworks and service delivery competence before an organisation or sole trader can be funded to deliver SCC services.
- Third, for psychosocial recovery coaching, or any psychosocial specialist stream within SCC, compliance with the mental health standards and employment and leadership of people with lived experience. This reflects the distinct expertise this work requires.

Enrolment should require providers to show that their workforce operates within a nationally consistent scope of practice for Support Coordinators, Specialist Support Coordinators and Psychosocial Recovery Coaches. It should also require mandatory training in supported decision making and trauma informed practice for all workers, and cohort specific expertise relevant to the people each worker supports.

Baseline expectations should also include oversight of a participant's plan spend. Good support coordinators already play this role informally through their everyday conversations with participants and providers. This should be made an explicit and resourced part of the role, with every SCC worker trained to identify signs of fraud or mismanagement, monitor expenditure, check in with providers and raise alerts with the NDIA where charges look suspicious.

These requirements also help participants feel safe enough to raise concerns. Knowing a provider has been through registration and enrolment requirements gives participants a baseline expectation of competence and accountability.

8. *How can the future SCC model attract, build and retain workforce capability, including retaining participant relationships*

A commissioned market model does this more effectively than a lead organisation model. It preserves the diversity of employers currently active in the market, rather than concentrating employment within a small number of large, contracted organisations. It also avoids the disruption of a mass workforce transition to new employers, which is one of the clearest ways to lose participant relationships and institutional knowledge built up over years.

9. *How should local knowledge and community connection be defined and assessed*

A commissioned market model supports local knowledge and community connection, because the NDIA can open enrolment specifically to invite providers with relevant local or cultural expertise into a region or cohort where a gap has been identified.

We suggest this should be assessed through evidence of established referral pathways and working relationships with local services, demonstrated cultural and cohort specific expertise, and the ability to flex delivery arrangements to community need, potentially drawing on the existing expertise of Disability Representative Organisations, Aboriginal Community Controlled Organisations and similar bodies.

10. *How can the SCC service best support participants in regional, rural and remote areas, or other thin markets, where support options may be limited*

A commissioned market model gives the NDIA a direct tool to address thin markets, by opening enrolment and actively promoting opportunities in underserved regions, while closing enrolment in areas that already have sufficient supply. This lets the NDIA target the specific problem, whether that is a region with too few providers overall, or a region with providers but no one with a particular cultural or cohort specific expertise.

However opening enrolment will not attract providers into a region if the price does not reflect the cost of delivering there. We recommend a remote area loading be built into the SCC price, on top of the base enrolment and intensity funding described above and applied to support delivered face to face in regional, rural and remote areas. The loading would account for the additional travel time, travel cost and lower achievable caseload that come with face-to-face delivery in these locations.

A loading of this kind is not a new concept for the scheme. The NDIS Price Guide already applies a remote and very remote loading, currently 40 per cent and 50 per cent respectively, to account for the additional cost of service delivery in these areas, and this loading was substantially increased in 2019 after the government recognised the earlier rate was insufficient to attract providers into thin markets[10]. We recommend extending this established mechanism to the SCC price.

[10] National Disability Insurance Agency. (2025). NDIS pricing arrangements and price limits 2025 to 26 (v1.1). https://ndis.gov.au/media/8096/download?attachment

The loading is not a recommendation that all SCC be delivered face to face. Many providers, including APA members, already deliver part of their support by telephone or online, and many participants prefer this because it gives them quicker and more flexible access to their coordinator. Participants should continue to choose the mode of support that suits them, and the loading should apply only to the face-to-face component. Without a loading, providers in regional and remote areas may default to remote delivery because of cost rather than participant choice. This would narrow choice in markets the commissioning model is meant to strengthen.

11. ***How can the SCC service best support participants who face additional barriers, including those experiencing complex and overlapping support needs or requiring decision making support***

We recommend that training in supported decision making be a mandatory requirement for every SCC worker since the need for this support is common and the NDIA and partner agencies provide online learning resources and training modules through the Supported Decision-Making Hub on the Disability Gateway to help participants and supporters build decision-making skills.

Enrolment should require providers to demonstrate the skills, training and systems in place to build and mentor staff capability in this area. For participants with complex and overlapping needs, the strongest protection is preserving specific expertise across a range of providers, which is difficult to achieve under a single, generalist workforce, as the experience of Local Area Coordination has shown.

Participants with complex needs also require time and flexibility for coordination across systems, including hospitals, allied health, mental health services and informal supports. A funding model that moves away from billing in small time units towards a baseline allocation would allow coordinators to do this work properly and support coordinated care across the health and disability systems.

12. ***What transition arrangements would minimise disruption and support successful implementation***

Given that an estimated 300,000 to 350,000 participants currently receive support coordination[11], we recommend a minimum twelve month, and ideally closer to an eighteen-month, transition period, with existing support coordinators and psychosocial recovery coaches continuing to operate throughout, the transition period. Participants should be able to remain with their existing provider where that provider meets registration and enrolment requirements and the relationship is working well, rather than being reallocated as part of a fixed transition schedule. Moving too quickly risks overwhelming new providers with more referrals than they have capacity for, and risks breaking trusted relationships that, in our experience, take considerable time to rebuild.

Continuity of relationship is especially important for people with psychosocial disability, since trust and engagement built over time are often central to whether a person stays connected with support at all[12]. Transition planning should treat continuity for people with a psychosocial disability as a priority.

Conclusion

The APA thanks the department and the NDIA for the opportunity to respond to this consultation. We recommend that SCC services be commissioned through a market model, with mandatory registration and enrolment, a nationally consistent scope of practice, and funding tied to accountability and outcomes. Within this, psychosocial recovery coaching should be further defined and kept as a separate

[11] NDIS Quality and Safeguards Commission (2026), Campaign Snapshot, Support Coordination, August 2026, National Disability Insurance Agency, citing the 2023 Own Motion Inquiry finding that approximately 45 per cent of active participants had support coordination in their plan.
[12] Elmes, A., Campain, R., Wilson, E., Brown, C., Kelly, J., & Campbell, P. (2023). Psychosocial recovery coaching: Client outcomes and experiences. Centre for Social Impact, Swinburne University of Technology. https://doi.org/10.26185/apjw-6x94

support specific to people with psychosocial disability. If it is brought into the SCC model, it should be delivered through a dedicated psychosocial specialist stream.

We are happy to discuss any part of this submission further.