SUBMISSION 2 OF 2 · SUPPORT COORDINATION AND CONNECTION REFORM

Trusting Support Coordination experience

Support Coordination providers on the Support Coordination and Connection reform · October 2026

Disability Intermediaries Australia

Keeley Goldrick, Acting CEO · 2 October 2026 · Response to the Support Coordination and Connection Reform Consultation Paper (service provider questions)

Who we heard from

279 Support Coordination and Psychosocial Recovery Coaching providers answered DIA's Provider Survey on Support Coordination Reforms between 17 September and 2 October 2026. They range from 69 sole traders to organisations employing more than 100 Support Coordinators, across every state and territory, and 78% work in regional areas. The Consultation Paper puts the national workforce at around 11,000 Support Coordinators, so the counts in this submission come only from the providers who completed this survey and national figures would be far higher. Their evidence makes two things clear: participants rely on being able to change provider when a relationship breaks down or their needs outgrow what a provider can offer, and that ability to move is already protecting them from poor quality and unsafe services.

The Australian Government's own evidence, from the Independent Review into the National Disability Insurance Scheme (NDIS Review), the Disability Royal Commission and the Productivity Commission inquiry that led to the NDIS, shows the profound problems with one provider per region. The Productivity Commission designed the National Disability Insurance Agency (NDIA) to assess and fund supports while participants choose who provides them. One provider per region would have the NDIA make that choice for every participant in a region, and its closest existing model, Partners in the Community, is the one the NDIS Review found was not working. If the preference for a lead organisation rests on one contract per region being simpler to manage, it would mean returning to the kind of system the NDIS was created to replace.

This is the second of two DIA submissions; the first, *In their own words*, sets out what 387 participants and families told us. Here we answer questions 1, 3, 5 and 7 to 12 of the Support Coordination and Connection Reform Consultation Paper's questions on service provider models and approaches. DIA does not support a lead organisation model, so we do not answer questions 2 and 4, which ask who should lead and how regions should be drawn. We did not survey providers on payment (question 6).

Commissioning arrangements and the lead organisation model (questions 1 and 3)

Choice is already working as a safety net. Providers who completed this survey estimate that around 6,700 participants moved to them from another Support Coordination provider in the past year. The most common reasons were a relationship that had broken down (58%), a provider that could not meet the participant's level of complexity (53%), a provider that stopped delivering Support Coordination (44%) and quality concerns (42%).

Quality, safeguarding and conflicts of interest, the problems the Consultation Paper wants the new Support Coordination and Connection (SCC) service to fix, are among the reasons participants are leaving providers today. Under a lead organisation model, these participants would have had no alternative provider within their region.

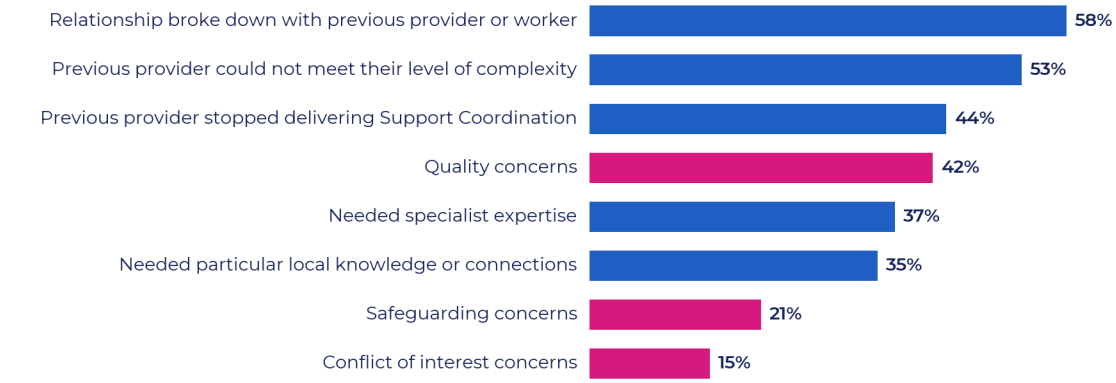
The lead organisation model concentrates risk. Providers close today, and participants move to another: 44% of the providers who completed this survey took on participants in the past year whose provider had stopped delivering Support Coordination. If a lead organisation failed, every participant in its region would be affected at once, with no other provider to turn to. The model also puts at risk the

local and specialist providers participants seek out: 66% of the providers who completed this survey say more than half their participants came to them for particular expertise or local knowledge.

A lead organisation would create new conflicts of interest. The Consultation Paper proposes separating SCC from the delivery of other NDIS supports, which DIA supports. A lead organisation, however, would both deliver SCC and decide which subcontractors receive work and funding. If Partners in the Community organisations, which the NDIS Review found focus mainly on access and planning, also deliver SCC, one organisation could shape a participant's plan and then coordinate it. Primary Health Networks, whose regions the Consultation Paper lists as one option for SCC boundaries, commission mainstream health and mental health services. If such an organisation held an SCC contract, a participant's coordination and their health and mental health services could all sit under one umbrella. Participants told us in our first submission that they do not want every part of their support in one organisation's hands, and would not feel safe raising concerns when everyone works for the same service.

Why participants moved to a new Support Coordination provider in the past year

Pink: problems the Consultation Paper says it wants to fix



DIA Provider Survey on Support Coordination Reforms, 17 September to 2 October 2026. 238 providers; more than one reason could be chosen. Transfer numbers are estimates from 169 of the providers who completed this survey.

The Australian Government has already chosen a better model. When it rebuilt disability employment services as Inclusive Employment Australia, it offered funding to 84 organisations, including more specialist providers than before, and built in accountability that redirects funding away from providers who underperform (Minister's announcement). Participants can choose any provider, even outside their local area, and change at any time (JobAccess). Support Coordination, which depends even more on trust, deserves the same design.

DIA's model: a selected national panel, led by participant choice

The NDIA selects a **panel of high-quality Support Coordination providers** through a merit-based process, judged on quality, worker capability, local knowledge and specialist expertise. Participants choose any provider on the panel, not only one assigned to their region. Providers must meet a set of expected standards and deliverables to keep their place, and those that fall below lose it. The market becomes smaller and better, without handing any one organisation control of a region.

It is easy for participants to find a provider. Every participant has a clear path, from most choice to least effort:

- **Keep what works.** A participant whose current coordinator is with a panel provider stays with them.
- **Name any provider.** Participants can choose any panel provider, inside or outside their region.
- **A matched shortlist.** The NDIA's system, not a planner, offers around three suitable providers based on location, specialist needs, language, culture and capacity, rotating fairly between them.
- **A default with the right to change.** A participant who does not choose is matched to a suitable provider with capacity and can change at any time.

A public directory shows each provider's areas, specialist expertise, languages, availability and performance, in Easy Read, Auslan and by phone. No participant is worse off than under a lead organisation: anyone who does not choose is allocated a provider, with the right to change.

It is simple to run. One national panel, one standard contract, shared reporting and NDIS Quality and Safeguards Commission audits give the NDIA clear oversight. A lead organisation model instead relies on one organisation to manage subcontractors the NDIA cannot see, and means re-tendering a whole region if it fails.

How the panel fixes the problems the Consultation Paper names

Problem named in the Consultation Paper	How DIA's model fixes it	What providers told us
Poor and inconsistent quality; inconsistent participant experience	Merit-based selection, national practice standards, and providers below the standard lose their place	Training (66%), national standards (62%) and registration (59%) drive quality
Variable workforce capability	Defined worker competency and supervision requirements in the panel contract	72% say their Support Coordinators average more than six years' experience; 70% supervise at least monthly
Conflicts of interest	Panel providers deliver Support Coordination separately from other NDIS supports	66% already deliver no other NDIS supports to the participants they coordinate
Fraudulent practices; inconsistent oversight	Mandatory registration, NDIS Quality and Safeguards Commission audits, shared outcome reporting and removal from the panel	76% call for mandatory registration; 77% already record outcomes for all or most participants
Unclear role boundaries; duplication	One standard contract setting out the SCC functions the Consultation Paper defines: collaboration, connection and coordination	49% name clear SCC role boundaries as a key to quality
Access in regional, remote and thin markets	Direct commissioning of specialist and local providers, choice across regional boundaries, and extra panel places where gaps appear	84% rank participant choice and 81% retaining capable local providers first
Over- and under-servicing under fee-for-service	The panel works with whichever payment approach the NDIA chooses	Not surveyed

The NDIA's own reasons for a lead organisation are better met by a panel. The Consultation Paper says the NDIA prefers a lead organisation because it is most likely to provide enough capacity, raise quality, ensure a smooth transition and improve safeguarding.

- **Capacity.** Providers say capacity comes from enough experienced Support Coordinators (77%) and multiple providers able to take referrals (75%); one large organisation was chosen by 2%. A lead organisation is a single point of failure for a whole region (60%).
- **Quality.** A panel lets the NDIA compare providers and move participants away from poor performers. A lead organisation with no competitor has no one to be compared with.
- **Transition.** A panel keeps existing relationships wherever the provider meets the standard. A lead organisation forces every participant in a region onto one provider at once.
- **Safeguarding.** Providers rank the participant's ability to change provider as the first safeguard (70%). One accountable organisation ranks last (3%).

The evidence the Consultation Paper cites does not support a lead organisation

The Support Coordination and Connection Reform Consultation Paper says its proposed model draws on the NDIS Review, the Disability Royal Commission and the NDIS Quality and Safeguards Commission's inquiry into Support Coordination. None of them recommends one provider per region. DIA understands other material is also informing the decision. We have not seen it, and ask that it be published so participants and the sector can respond to it.

Independent Review into the National Disability Insurance Scheme (NDIS Review). The NDIS Review recommended commissioned navigators, but its own frequently asked questions state that it expected a range of navigators to choose from. Its supporting analysis, Support for all people with disability to better navigate mainstream and disability supports, documents what happened under the closest existing model: Partners in the Community were diverted almost entirely to access and planning, caseloads were very high, relationships became transactional, and large-scale contracting left them without deep local knowledge and disability expertise.

Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability Royal Commission). Its Final Report, Volume 10: Disability services found that being denied choice and control can increase the risk of violence, abuse, neglect and exploitation. Its Support Coordination recommendations concern independence, adequate funding and quality, not fewer providers.

NDIS Quality and Safeguards Commission. Its Own Motion Inquiry into Support Coordination and Plan Management, Part 1 (August 2023) recorded choice being overridden as a harm in 23% of complaints about Support Coordinators. Part 2 responded with mandatory registration and practice standards, not a smaller market.

We have been here before

One provider per region is not a new idea. Before the NDIS, support was largely block-funded and allocated by governments, often through regional service centres. The Productivity Commission's Disability Care and Support inquiry report (2011), which led to the NDIS, found that system *"underfunded, unfair, fragmented, and inefficient"*, giving people with disability *"little choice"*. Choice and control was the answer, not an accident of design.

A provider who once worked inside that system described a participant who went through 13 years of service breakdown and homelessness, and was moved to another region when things went wrong. With small specialist services, he has had the same provider since 2020 and home since 2022.

> *"He was one of many people who were failed by a system that was too big to care, and so big they could hide many similar problems."*
> **— Specialist Support Coordinator, formerly of that state government department**

Providers see the Partner in the Community model failing now

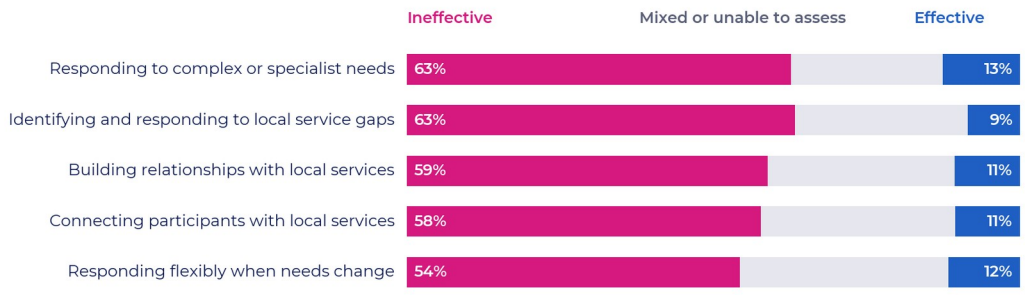
Providers who work alongside Partner organisations rate them as ineffective far more often than effective, especially for participants with complex needs.

86% of providers say participants came to them because their needs were more complex than a Local Area Coordinator or Partner could meet, and 72% have had to resolve an issue a Partner organisation was involved in but could not fix. One provider took on a participant who had waited 12 months for a prosthetic leg, because the application had not been submitted correctly.

> *"We support deaf people who use Auslan. No partner providers have specific expertise in deafness or Auslan."*
> **— Specialist provider**

The timing adds risk. The NDIA has extended Partner in the Community agreements only to 30 June 2027 (NDIS announcement), while SCC procurement runs through 2027. Organisations whose own contracts are ending, and whose role is still being redesigned, could be asked to take on Support Coordination in the same year.

How providers rate Partner in the Community organisations in their areas



DIA Provider Survey on Support Coordination Reforms. 197 to 199 respondents per function.

Managing changing needs, local knowledge and thin markets (questions 5, 9 and 10)

Need changes often, and fast. 60% of providers say participants often or very often have a significant, unplanned increase in need, and 39% spend more than 20 hours a month responding to crises. The median caseload is 30 participants per full-time worker. What lets providers respond is established local relationships (77%), experienced Support Coordinators (76%) and the ability to increase support quickly (72%); only 32% rely on redistributing caseloads.

Local knowledge is built over years, and can be assessed. 87% of providers have spent four or more years building their networks, and 66% say over half their participants came to them for particular expertise or local knowledge. Government should assess relationships with mainstream services (73%), a locally based workforce (72%), established NDIS provider networks (72%), community relationships (64%), participant and community feedback (62%) and length of time in the region (62%).

Thin markets need choice, not a single gatekeeper. Providers in regional, rural and remote areas rank participant choice (84%) and retaining capable local providers (81%) first, and half want access to providers outside regional boundaries.

Quality, workforce and safeguarding (questions 7 and 8)

The workforce is experienced and accountable. 72% of providers say their Support Coordinators average more than six years' experience, 68% that more than half hold a relevant tertiary qualification, and 70% supervise at least monthly. 71% are registered with the NDIS Quality and Safeguards Commission, and 66% deliver no other NDIS supports to the participants they coordinate. 77% record participant outcomes for all or most participants.

Quality comes from standards, not size. Providers rank ongoing training (66%), national practice standards (62%), sustainable funding (60%) and registration (59%) as the keys to consistent quality; organisational size was chosen by 13% and one organisation per region by 3%. For safeguarding, the ability to change SCC provider ranks first (70%); one accountable organisation ranks last (3%).

A lead organisation would weaken this workforce. A guaranteed regional market rewards cutting costs, with every reason to replace experienced Support Coordinators with cheaper staff on bigger caseloads; one provider described Local Area Coordinators carrying caseloads of over 300.

Relationships last, and are the point. 83% of providers say more than half their participants have worked with the same Support Coordinator for 12 months or longer.

Participants with complex needs and additional barriers (question 11)

Specialist providers take the people others cannot. In the past year, 87% of providers accepted participants who had struggled to find a provider, around 3,000 people across 134 of the providers who completed this survey. The barriers were complexity (77%), complex behaviours (65%), psychosocial complexity (58%), the need for specialist knowledge (54%) and safeguarding risk (51%).

This work keeps people out of crisis. In the past year, between 94 and 122 of the providers who completed this survey estimate they helped participants leave hospital or a mental health unit with supports in place (1,526 people), avoid an admission (1,047), secure housing (1,365), keep a tenancy at risk (933), move out of crisis or an unsafe home (1,097), and enter employment (1,496). 971 participants reduced or stopped needing Support Coordination because they could manage themselves.

Transition (question 12)

18,228 participants would be at significant risk of harm, crisis or disengaging from supports if they lost their current Support Coordinator, based on estimates from 137 of the providers who completed this survey. The reasons are trust that took a long time to build (92%), limited or no informal supports (92%) and support arrangements that depend on the coordinator's knowledge (86%).

> *"I have so much knowledge about my clients that has taken years to gather. You can't pass these details over in a simple "handover"."*
> **— Support Coordinator**

The market is already shrinking. Providers are already closing, as the participants moving between them show. Under a lead organisation model, providers not selected have no reason to keep running at a loss until 2028, and experienced Support Coordinators will not wait to learn whether they have a job. Participants could lose their coordinator before the new service exists.

What providers are asking for

DIA recommends:

1. **A selected national panel, not a lead organisation.** Commission a panel of quality providers on merit, including specialist and local providers, with participants choosing between them.
2. **Choice made simple.** Participants keep a panel coordinator they already have, choose any panel provider in or outside their region, or receive a rules-based shortlist or default match, with the right to change at any time.
3. **One enforceable standard.** Mandatory registration, national practice standards, worker competency and supervision requirements, and separation from other NDIS supports.
4. **Performance managed across the panel.** Outcome reporting, published performance information and the ability to move participants from underperforming providers, as in Inclusive Employment Australia.
5. **A planned transition.** Keep existing relationships wherever the provider meets the standard, give longer transitions to people with complex needs, and keep providers viable until handover.
6. **Partnership on the design.** Build the transition pathway with the sector through a working group of DIA, the NDIA and the Department of Health, Disability and Ageing.

A national panel with one clear standard, built on the workforce already supporting people with complex lives, gives the Australian Government quality and oversight without the risks the evidence warns against.