



**Brotherhood of St Laurence**  
Working for an Australia free of poverty

# Support Coordination and Connection Reform

## Submission to the Department of Health, Disability and Ageing by the Brotherhood of St. Laurence

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### Summary

The Brotherhood of St. Laurence (BSL) welcomes the opportunity to provide input to the consultation for the Support Coordination and Connection (SCC) Reform.

BSL is a social justice organisation working towards an Australia free of poverty. Our purpose is to advance a fair Australia through our leadership on policy reform, our partnerships with communities and the quality of our services. Our approach is informed directly by people experiencing disadvantage and uses evidence drawn from our research, together with insights from our programs and services, to develop practical solutions that work.

In BSL's view an inclusive society is one where people face no barriers to participating in economic, cultural, civic and social life to the degree that they choose. Diversity is embraced and people can access support, have a voice, and feel valued and respected. Economic, social and political systems enable people to flourish and live with dignity, through broad civic engagement.

BSL has operated as a National Insurance Disability Scheme (NDIS) Partner in the Community (PITC) since 2016. We are contracted by the National Disability Insurance Agency (NDIA) (the Agency) to deliver Local Area Coordination (LAC) and the early childhood approach in Victoria across North East

Melbourne, Hume/Merri-bek, Brimbank/Melton, Western Melbourne and Bayside Peninsula areas. This work includes building community capacity and inclusion through place-based projects.

This submission responds to both sets of questions presented in the consultation paper: on participant views and service provider models.

This submission draws on our long-term practical experience across programs, service development and innovation initiatives and insights drawn from our research and policy analysis. It also draws from consultation with staff working within the scheme, with many staff also being people with disability, participants of the scheme or primary caregivers of a participant. Around 60 staff participated in the consultation process, either by providing feedback in the facilitated online session, or through the survey. A summary of recommendations to both sets of questions is presented below, followed by discussion to support each recommendation. A final comment is provided in relation to consultation processes and timeframes.

## **Recommendations: questions about what participants want from the new SCC service**

**Recommendation 1:** The new model needs to continue enabling complex rostering to ensure participants can access support that they need at short notice outside of hours.

**Recommendation 2:** The new model needs to ensure proactive delivery of SCC services within participant care teams, so participants can avoid falling into crises that (later) require a more complex and costly response.

**Recommendation 3:** SCC worker role specification needs to be improved to ensure workers are clear about the scope of their role, and so that SCC workers function within this.

**Recommendation 4:** Participants need to be better matched to SCC workers, so workers can meet their needs. This may be more easily achieved through a led organisation model.

**Recommendation 5:** The handover process when participants change workers should adopt a shared case management approach.

**Recommendation 6:** SCC workers need to have a strong understanding of wider human services systems and how they can support participants to connect

**Recommendation 7:** Face-to-face service delivery should be available for safeguarding and quality, to respond to participant preference or communication needs, and should be a core component of the new SCC model. Virtual service delivery should be opt-in only, and not a default setting.

**Recommendation 8:** The SCC role should focus on both connection and coordination. SCC should continue to provide assistance to participants with supported decision-making needs, and should also be available to participants during periods of transition.

**Recommendation 9:** SCC workers need refreshed service standards and training framework to ensure appropriate skills. Organisations providing SCC should be registered and certified.

**Recommendation 10:** All organisations providing SCC services should be accountable to the NDIS Quality and Safeguarding Commission and follow aligned complaints processes.

## **Recommendations: questions about service provider models and approaches**

**Recommendation 11:** The future SCC model should be designed as a more comprehensive commissioning model (drawing on lessons from outcomes contracting), with clear objectives to support participant agency, an initial structure with scope for flexibility, and a comprehensive approach to managing potential risks.

**Recommendation 12:** Lead organisations should be selected on the basis of demonstrated capability, independence, local connection and strong governance.

**Recommendation 13:** SCC service areas should be designed to balance scale, sustainability and local connection.

**Recommendation 14:** There should be a flexible, tiered SCC model that matches support intensity to participant need and allows support to increase or decrease as circumstances change.

**Recommendation 15:** Funding arrangements should recognise the full cost of quality SCC delivery, including direct participant work and the enabling activities required to support safe, effective and community-connected practice.

**Recommendation 16:** Commissioned SCC organisations should be registered and accredited with the NDIS Quality and Safeguarding Commission, and have clear conflict-of-interest arrangements.

**Recommendation 17:** A workforce strategy should be developed that attracts, develops and retains skilled practitioners through structured capability development, a credentialing framework, clear career pathways and strong practice support.

**Recommendation 18:** Local knowledge and connection to community and tertiary services should be defined broadly and assessed through evidence of active engagement, partnerships and outcomes – not simply through service-directory knowledge.

**Recommendation 19:** SCC delivery in regional, rural, remote and thin-market areas should be designed to address equity of access, local credibility and practical service reach.

**Recommendation 20:** SCC arrangements for participants with additional barriers, overlapping support needs or decision-making assistance should include provision for specialist consultation, multidisciplinary practice, cultural responsiveness, knowledge of supported decision-making principles and trauma-informed practice and strong links with child protection, housing, justice, Office of the Public Advocate and public trustees, and mental health and health systems.

**Recommendation 21:** Transition should be treated as a critical implementation risk and should be planned as a staged process that protects participants, trusted relationships and workforce capability.

## 1 Reform vision and objectives

BSL supports the proposed SCC reform vision of an SCC service that delivers high-quality, outcome-focused support to NDIS participants and the proposed objectives of participant outcomes; choice and control; equity and inclusion; safety and safeguarding; and capability and sustainability.<sup>1</sup>

## 2 Response to questions from Section 1 on participant needs

### **Question 1: What is working well in support coordination today that you would like to see in the new SCC service?**

Staff identified two features they thought needed to be carried over into the new model. Firstly, complex rostering services delivered through the Roster of Care process were identified as effective for providing contact out of hours, and in addressing service cancellations outside of normal working hours for participants. This supports the objective of delivering strong participant outcomes. Staff were of the view that this should continue to operate in the new model as it currently does.

Secondly, staff highlighted that within the current system, support coordinators had the scope to proactively anticipate potential issues for their clients in coordination with care teams. For participants who had fluctuating conditions which had long periods of stability punctuated by periods of increased need, support coordinators being able to respond quickly the first time help is needed was important. For some, such as participants with psychosocial disabilities, this ensured that more negative consequences from an episode could be avoided (for example, avoiding having a corrections order issued).

**Recommendation 1:** The new model needs to continue enabling complex rostering to ensure participants can access support that they need at short notice outside of hours.

**Recommendation 2:** The new model needs to ensure proactive delivery of SCC service within participant care teams, so participants can avoid falling into crises that (later) require a more complex and costly response.

### **Question 2: What would you most like to see improved in the new SCC service?**

Within the current model, BSL staff reported that issues regularly arose where some support coordinators would give incorrect information to participants about what they might be eligible for, and this created challenges around expectation management. Staff also reported that at times

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<sup>1</sup> DHDA 2026, [NDIS Support Coordination and Connection Reform: consultation paper](#), Canberra.

support coordinators were not familiar with the work they should be doing, and would ask LACs to help with tasks that should be completed by support coordinators independently.

**Recommendation 3:** SCC worker role specification needs to be improved to ensure workers are clear about the scope of their role and its interaction with the wider system, so that SCC workers function within this.

Staff noted that there can be a poor match in the fit between a participant and their support coordinator. This is especially important for SCC+ participants. Staff identified three areas in particular where alignment between coordinator and participant could be improved. First, some participants might have communication preferences (frequency and type) that a support coordinator was not able to provide. Second, others had support coordinators who did not properly understand the impacts of their disability and could not fully comprehend the service they were procuring on the participant's behalf. Staff suggested that a simple checklist, including frequency and type of communication, could be developed to match participant communication preferences to SCCs. Staff also suggested that disability-specific knowledge should be strengthened so participants could be matched with support coordinators who properly understood their needs. A lead-organisation model, with scope to better match participants with support coordinators based on their experience of and expertise in different support needs, could improve this. Third, Lead organisations should also have access to networks for specialist supports and knowledge, for example First Nations organisations.

**Recommendation 4:** Participants need to be better matched to SCC workers, so workers meet their needs. This may be more easily achieved through a lead-organisation model.

Another issue identified through the consultation was the current handover process when support coordinators changed. Because of high degrees of staff turnover in the current system, there were often cases where support coordinators were not available to complete a handover process. Gaps in the quality of service could emerge, there could be a loss in the continuity of services, and participants may have to reshare information they had already provided to the previous support coordinator. It was suggested that within a lead-provider model, there should be a requirement for shared case management, including handover processes. This would enable smoother handover because information had been shared with the care team across the case.

**Recommendation 5:** The handover process when participants change workers should adopt a shared case management approach.

Staff noted that due to the complexity of the system environment, there could be gaps in some support coordinators' understanding of what should be provided by different parts of the system. Support Coordinator also face a complex disability services environment and how the scheme and its intermediaries (SCCs, LACs, Plan Managers) interact. This meant that support coordinators who were not aware of their participants' entitlements, were not able to properly ensure that their

participants were receiving all their necessary services or supports. It can also result in coordination and delivery gaps for participants. If a lead-organisation model were to be implemented, the time and work required to build knowledge of the systems would need to be adequately funded to ensure SCC workers can deliver quality services that align with participant needs.

**Recommendation 6:** SCC workers need to have a strong understanding of the wider systems and how it can support participants.

### **Question 3: When should SCC be a face-to-face service or a virtual service?**

In both our consultation sessions and their written feedback, staff emphasised the importance of face-to-face service delivery. Staff noted that face-to-face services are important for quality and safeguarding as they provide an opportunity for the support coordinator can observe participant wellbeing.. They thought, if that was how they wanted to interact, it was important for participants' choice and control to be able to see their support coordinator, and they saw virtual service as an option that should only be used when it was the participant's or carer's preference. In particular participants with complex communication needs may find face-to-face interactions easier to navigate. One staff member shared an example where they had visited a participant and seen a letter containing a legal notice that the participant had not understood the significance of. The worker was able to explain the document's importance and assist the participant to avoid a negative outcome.

While face-to-face service delivery offered benefits, it is important to recognise that some participants may prefer virtual service delivery for its accessibility and convenience. For participants that wanted to access SCC services virtually, they should be able to do so easily.

**Recommendation 7:** Face-to-face service delivery should be available for safeguarding and quality, to respond to participant preference or communication needs, and should be a core component of the new SCC model. Virtual service delivery should be opt-in only, and not a default setting

### **Question 4: What participant groups will benefit most from the SCC service? What do their needs for connection and coordination of supports look like?**

Staff noted that participant groups that would benefit most from the SCC service were varied, and have complex and different needs for connection and coordination of supports. One group staff identified as critical for receiving SCC services were those with supported decision-making needs. This is especially important when a participant is transitioning from family to formal support. For example, a person with an intellectual disability whose parents' health has declined due to ageing may need to receive SCC assistance to navigate their services. For participants receiving decision-making support in situations like this, proactive legacy planning should be in place so when their circumstances change they do not need to wait for their support to become available.

Staff noted that there are also other periods of transition where additional support would be beneficial. This could include instances like a transition into a new housing situation (like moving out of home), where participants may need help to understand lease agreements and managing utilities. Other transitions where additional support could be valuable were things like a relationship break up, finishing education, or getting ready for or starting employment, or simply navigating scheme complexity. It is also important that the newly shaped SCC role consider community connection as equally important to coordination.

**Recommendation 8:** The SCC role should focus on both connection and coordination. SCC should continue to provide assistance to participants with supported decision-making needs, and should also be available to participants during periods of transition.

### **Question 5: What experience, skills and knowledge do you look for in an SCC worker?**

Staff identified a mix of core experience, skills and knowledge which they saw as central to being an effective SCC. SCC workers saw a need for the current service standards and training framework to be refreshed to, and for staff to be credentialled against this, to ensure appropriate skills in areas including:

**Disability skills and knowledge:** Having specialisation related to the disabilities that an SCC worker interacted with was viewed by BSL staff as a key factor in ensuring they could deliver good outcomes for participants in their caseload. Staff highlighted the importance of having a good understanding of how the six NDIS domains<sup>2</sup> are affected by participant's disability. Linked to this, staff need to have a better understanding of how services are actually used by participants, so that they can help them decide between different providers.

**System skills and knowledge:** SCC workers require strong knowledge of the system and how it aims to support participants, so they can hold providers to account when service quality is not being delivered. Staff suggested mandatory training to ensure that SCC staff stay up-to-date with changes that occur within the NDIS (and potentially in their area depending on the service model that is used).

**Administrative skills and knowledge:** Strong administrative skills are particularly important for complex case and complex care arrangement.

**Stakeholder and relationship skills and knowledge:** SCC workers must be comfortable managing relationships – with government and participants, to support service delivery and quality.

In addition, at an organisational level, any commissioned lead organisation should be registered under the scheme and certified against the practice standards.

<sup>2</sup> The NDIS domains used by the NDIS in functional capacity assessment (mobility, communication, social interaction, self-management, learning and self-care). [What is a functional capacity assessment | NDIS](#)

**Recommendation 9:** SCC workers need a refreshed service standards and training framework to ensure appropriate skills. Organisations providing SCC should be registered and certified.

**Question 6: What would help you feel safe when receiving SCC services and encourage you to report an issue if needed?**

Staff raised two issues related to safety accessing SCC services and reporting issues related to SCC services. Firstly, they pointed out that having to manage complaints through a process with the provider was uncomfortable and may stop participants raising issues. They suggested the NDIA instead have a central authority to manage reporting and issues with SCC services. Any organisation providing SCC services should be accountable to the NDIS Quality and Safeguards Commission. The complaints process should be aligned with the current Quality and Safeguarding Commission requirements. .

**Recommendation 10:** All organisations providing SCC services should be accountable to the NDIS Quality and Safeguarding Commission and follow aligned complaints processes.

Where a participant cannot work with that particular organisation, a lead-organisation model could present challenges (including in cases where a person has reported an issue that cannot be resolved). In situations where participants are unwilling to work with the lead-organisation for their region, providing flexibility by exception, to work with other providers should be available, as currently occurs with PITS program.

**Question 7: What else should we consider when designing the future SCC service?**

With a number of reforms occurring simultaneously it can be difficult to get a full picture of how the different parts of the system are going to interact with each other, or operate together as a whole. One element of the system that it is currently unclear is how participants, SCCs and the role currently held by LACs will work together to support planning for participants. It will be important to specify how these roles will work together to avoid gaps that impact participants.

### **3 Response to questions from Section 2 on service provider models and approaches**

BSL supports reforming current support coordination to improve quality, safeguarding, consistency and accountability in SCC, provided the commissioned model protects participant choice, local connection, trusted relationships and access for people with complex or changing needs.

This position is informed by concerns with current arrangements identified to BSL by people with disability.

BSL also notes there are many support coordinators in the system who provide excellent support to a high standard to some of the most complex participants in the NDIS. Learning from these individuals and services should also be a priority of the review.

**Question 1: What commissioning arrangements would best balance participant outcomes, quality, sustainability and choice and control?**

The future SCC model should be designed as a more comprehensive commissioning model, not simply a procurement exercise. This wider commissioning approach should include planning based on participant need, market stewardship, clear quality and safeguarding requirements, participant feedback, performance monitoring and continuous improvement. Procurement should be viewed as a purchasing mechanism within this broader commissioning approach.

BSL notes the Department of Social Services (DSS) is exploring the application of outcomes contracting (previously relational contracting) to government Families and Children Activity programs,<sup>3</sup> which offers lessons and potential application for the SCC model. Outcomes contracting is a longer-term, more flexible (than traditional contracting) partnership approach between government and providers. This approach gives organisations better ability to achieve impact. Outcomes contracting can also reduce administrative burden, support learning and adaptation, and allow greater focus on delivery of outcomes. BSL considers there is scope for SCC reforms to learn from, and be informed by, the outcomes contracting approach being examined and developed by DSS.

We have identified three considerations to inform the SCC model:

- Objectives and principles that support participant agency.
- An initial structure with scope for adjustment where needed.
- Risk management.

**Clear objectives and principles that support participant agency**

Within the new commissioning arrangement, the SCC service should build participants' capacity to understand, access and coordinate the supports they need to pursue their goals and take part in community life. This includes support to understand NDIS plans and service options; connect with disability, mainstream and community supports; coordinate across providers and systems; respond to service breakdowns or changing circumstances; strengthen informal and community connections; and use escalation pathways when matters require NDIA intervention. BSL considers the commissioning approach should be informed by the following design principles:

- **Clear accountability with local delivery:** A single accountable lead provider should be responsible for outcomes, quality, safeguarding and workforce capability, while partnerships ensure supports remain locally grounded and responsive to community need.

<sup>3</sup> Relational contracting – consultation on draft documents – [engage.dss.gov.au](https://engage.dss.gov.au)

- **Participant choice, control and relationship continuity:** Commissioning arrangements should preserve participant influence over who they work with and protect trusted relationships wherever possible.
- **Capacity building and prevention:** Funding and performance settings should reward connection, prevention, skill development and community capacity building; not only coordination activity.
- **Capacity building as a core function:** Providers should help participants build the skills, confidence and resources to manage supports more independently where possible.
- **Sustainable scale without over-centralisation:** Service areas and provider models need enough scale to support quality, supervision, specialist expertise and surge capacity, while remaining small enough to preserve local relationships and knowledge.
- **Clear Agency responsibilities:** The SCC service should not replace Agency responsibility for plan adequacy, funding decisions, crisis escalation or complex participant pathways requiring Agency-level intervention.

### **An initial structure with scope for adjustment where needed**

Under this approach, BSL suggests that one (or two at most) accountable lead organisations per state would be responsible for quality, safeguarding, workforce capability, performance and outcomes, while being required to work through genuine local, community-controlled, culturally specific and specialist partnerships. This combines the consistency and accountability sought by government with the local knowledge, cultural capability and participant-centred practice needed for effective support coordination.

It will be important this structure retains sufficient flexibility to manage and respond to provider underperformance. There is a risk that a lead provider (once commissioned) underperforms and leaves participants 'locked-in' and unable to access an alternative provider. To manage this risk, the model should include an initial 'probation' period (two years, for example) within a longer contract period (five years, for example) to allow provider performance to be reviewed and corrective action taken. A menu of corrective actions should be available to government, ranging from active engagement to formal warnings to contract termination.

### **Risk management**

A number of design and operational risks will need to be managed in the areas of service geography, funding, workforce requirements, safeguarding, transition and market stewardship. These risks apply to many question responses below and we have consolidated them into a table for ease of reference.

**Table 1 Risk management matrix**

| <b>Strategic risk</b>             | <b>Why it matters</b>                                                       | <b>BSL's recommendation</b>                                                                                                                                 |
|-----------------------------------|-----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Excessively large service regions | May weaken local knowledge, local relationships and community connectedness | Service areas should be large enough to support sustainability, but small enough to preserve local identity, service ecosystems and community relationships |

| Strategic risk                                                | Why it matters                                                                   | BSL's recommendation                                                                                                                                                                     |
|---------------------------------------------------------------|----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Solely lowest-cost commissioning approaches                   | May reduce quality, destabilise the workforce and increase turnover              | Commissioning should assess quality, workforce capability, safeguarding and participant outcomes; alongside price                                                                        |
| Separation of specialist functions from primary relationships | May increase 'hand-offs' and impact participant experience                       | Specialist input should be available through the care team and consultation and practice support while maintaining one primary SCC worker or coordination relationship wherever possible |
| Overly prescriptive funding models                            | May reduce innovation, prevention and community capacity building                | Funding should include core service infrastructure, complexity loadings, workforce development and community capacity-building activity                                                  |
| Failure to recognise complexity differences                   | May create unsustainable caseloads and poorer participant outcomes               | Navigation intensity should flex according to participant need, with tiered support and structured reassessment                                                                          |
| Workforce transition uncertainty                              | May result in the loss of experienced support coordinators and LAC expertise     | Transition arrangements should include workforce retention strategies, recognition of existing expertise and staged implementation                                                       |
| Market concentration in a small number of providers           | May reduce participant choice and local responsiveness                           | Lead-provider models should require genuine local partnerships, transparent subcontracting and mechanisms to preserve participant choice                                                 |
| Inadequate focus on thin markets                              | May perpetuate inequitable access in regional, rural and underserved communities | Commissioning should require outreach, hybrid delivery, local partnerships and locally credible providers in thin markets                                                                |
| Insufficient safeguarding and supervision requirements        | May increase service quality, participant safety and reputational risks          | Commissioned organisations should meet quality and safeguarding standards                                                                                                                |

**Recommendation 11:** The future SCC model should be designed as a more comprehensive commissioning model (drawing on lessons from outcomes contracting), not simply a procurement exercise, with clear objectives to support participant agency, an initial structure with scope for flexibility, and a comprehensive approach to managing potential risks.

### Question 2: What provider types would be best placed to be a lead organisation? Why do these characteristics matter?

BSL recommends that lead organisations be selected on demonstrated capability independence, local connection and strong quality governance. Lead organisations should be able to demonstrate:

- a strong record of community-based, relationship-led practice and local presence (rather than relying solely on centralised service models)
- independence from direct support delivery where conflicts of interest may arise, or be given clear safeguards to ensure participants exercise genuine choice and are not directed towards connected services
- ability to coordinate effectively across disability, health, housing, mental health, education, justice and community service systems – particularly for participants with overlapping or escalating support needs

- cultural safety, lived experience partnerships and the ability to work with community-controlled, culturally specific, regional and specialist organisations
- experience delivering large-scale government service contracts, including governance, performance reporting, risk management, quality governance and safeguarding requirements
- use of data, participant feedback and practice evidence to support continuous improvement
- capability to provide feedback to government to address problems (e.g. service gaps) and improve system performance and participant outcomes.

These capabilities will support the new SCC model to deliver better outcomes for participants through improved quality, consistency and safeguarding. A lead organisation should not be expected to hold every local, cultural or specialist capability internally. Commissioning should require local commissioning, brokerage or subcontracting arrangements so participants can access local knowledge, cultural capability and specialist expertise through genuine partnerships.

**Recommendation 12:** Lead organisations should be selected on the basis of demonstrated capability, independence, local connection and strong governance.

### **Question 3: What are the advantages and disadvantages of the lead-organisation model?**

BSL considers that a lead-organisation model can improve quality, consistency and accountability if it is designed with strong partnership and local delivery requirements.

The key advantages are stronger implementation and monitoring of practice standards, stronger workforce development, better supervision and safeguarding, improved data and evaluation, and the capacity to develop specialist functions. Larger lead organisations may also be better placed to manage changes in demand, workforce shortages and any changes in participant complexity.

However, these benefits need to be balanced against risks. Without clear design safeguards, a lead-organisation model could reduce participant choice, concentrate the market, weaken local providers, create overly centralised delivery models and disrupt trusted relationships between participants and existing workers or providers.

BSL recommends that these risks be managed through mandatory commissioning conditions that preserve participant choice, continuity of relationships, genuine local partnerships and transparent subcontracting arrangements.

### **Question 4: What would be appropriate regional areas to use for SCC service areas?**

BSL recommends that SCC service areas be designed to balance scale, sustainability and local connection. Regions should be large enough to support viable commissioning, workforce capability, supervision and consistent quality, but not so large that they weaken local knowledge, community relationships or responsiveness to local service systems.

Service area design should consider existing NDIA and community service boundaries, travel times, community identity, thin-market conditions, existing service ecosystems and the ways participants naturally access services, informal supports and community networks. Administrative boundaries should not override natural communities or the relationships participants rely on to access support.

In larger jurisdictions, broader geographic coverage may be appropriate, but only where the model includes practical mechanisms to maintain local presence, such as regional hubs, locally employed staff, funded travel, mobile or outreach delivery, and clear expectations for local engagement.

Service geography should therefore be treated as a quality and equity issue, not just an administrative design question.

**Recommendation 13:** SCC service areas should be designed to balance scale, sustainability and local connection.

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

BSL recommends a flexible, tiered SCC and SCC+ model that matches support intensity to participant need and allows support to increase or decrease as circumstances change. A fixed caseload model would not adequately recognise changes in participant needs over time, and would risk misallocating resources. A flexible, tiered model would address both of these challenges.

The model should include structured referral, triage, allocation and reassessment processes, with clear pathways, timeframes and decision-making criteria. Allocation should consider need, complexity, risk, participant preference, cultural and language requirements, disability, location and access to specialist expertise.

Support intensity should flex across service tiers. Some participants may require brief assistance, while others will need intensive support across multiple systems. The model should allow participants to move between tiers as their needs, risks and circumstances change, supporting both efficient use of workforce capability and sustainable service delivery. This 'mobile' cohort would need to be supported by an appropriately qualified and experienced workforce.

The model should clearly define the scope and purpose of each tier. SCC+ should be designed for participants whose circumstances, such as complex mental health, disability, insecure housing, being in the justice system, health issues, family violence, substance use, span multiple systems. It should not simply be standard coordination with additional rules.

Caseload and funding settings should reflect intensity and complexity (including functional capacity and disability type), and mobility of participants between levels of support, not only participant volumes. This is essential to maintain quality, safeguard the workforce and ensure participants receive the right level of support at the right time.

Demand for SCC should be managed through transparent eligibility, triage, review and intensity settings, not through blunt reductions to access, support hours or service quality. The model should ensure participants can access the right level of support, with review and escalation where needs change.

**Recommendation 14:** There should be a flexible, tiered SCC model that matches support intensity to participant need and allows support to increase or decrease as circumstances change.

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

BSL recommends funding arrangements that recognise the full cost of quality SCC delivery, including direct participant work and the enabling activities required to support safe, effective and community-connected practice. Funding should include:

- blended funding that includes core service infrastructure and participant-related activity
- complexity loadings that reflect participant need, regional delivery challenges and specialised capability
- funding for workforce development, supervision, structured debriefing and safeguarding
- explicit funding for community engagement, local commissioning and capacity-building activity
- quality and outcome measures that reward prevention, connection and participant outcomes, not only contact hours.

Purely activity-based funding risks discouraging preventative, community-development and capacity-building work. Funding models should therefore explicitly support activities that strengthen local networks, build participant confidence and reduce unnecessary reliance on formal services over time.

Any block-funded model must be designed carefully to avoid reducing participant access, support intensity or service quality. If access to SCC is expected to reduce, commissioning arrangements must include transparent eligibility, referral, triage and review processes so participants are not excluded due to funding constraints.

BSL cautions against commissioning approaches that solely (or overwhelmingly) preference a short-term lowest-financial-cost outcome. This may, in the medium to longer-term, reduce quality and safety, increase staff turnover and limit supervision. Funding should recognise the true cost of quality practice, workforce capability, safeguarding, travel, outreach, multi-agency coordination and community capacity building.

**Recommendation 15:** Funding arrangements should recognise the full cost of quality SCC delivery, including direct participant work and the enabling activities required to support safe, effective and community-connected practice.

### **Question 7: What quality, workforce and safeguarding requirements should apply to commissioned SCC organisations?**

Commissioned SCC organisations should be required to demonstrate strong quality, workforce and safeguarding arrangements as core commissioning conditions. This should include:

- mandatory supervision, practice leadership and practice governance standards
- workforce capability in generalist navigation, trauma-informed practice, cultural responsiveness, supported decision-making and cross-system coordination
- access to specialist consultation and multidisciplinary practice support where participant complexity increases
- cultural safety standards and meaningful involvement of people with lived experience
- independent complaints, escalation and safeguarding pathways
- consistent outcome measures, participant feedback and experience monitoring
- community connection indicators that measure local relationships, outreach and community capacity building.

Given the potential for one or a small number of providers to hold significant responsibility, BSL recommends registration and accreditation with the NDIS Quality and Safeguarding Commission.

Commissioned organisations should also demonstrate robust conflict-of-interest arrangements, including clear separation between coordination advice and any direct service delivery, purchasing or referral interests.

The SCC model should clearly define role boundaries – between SCC providers, PITC coordinators (Local Area Coordinators/Early Childhood Coordinators), NDIA planners, specialist health and justice liaison officers, support providers, plan managers, psychosocial recovery coaches, mainstream services and escalation pathways. This is essential to reduce confusion, duplication, conflicts of interest and inappropriate transfer of Agency responsibilities to SCC providers. In addition, the model should clarify provider-of-last-resort arrangements.

**Recommendation 16:** Commissioned SCC organisations should be registered and accredited with the NDIS Quality and Safeguarding Commission, and have clear conflict-of-interest arrangements.

### **Question 8: How can the future SCC model attract, build and retain workforce capability, including retaining participant relationships?**

BSL recommends a workforce strategy that attracts, develops and retains skilled practitioners through structured capability development, clear career pathways and strong practice support. This strategy should include:

- support for capability-based workforce models that recognise experience as well as formal qualifications

- a requirement for credentialling through a newly developed capability framework
- career and vocational entry pathways, including recognition of existing support coordination, LAC and navigation expertise
- generalist practice capability supported by specialist consultation
- reflective supervision, communities of practice and structured learning and development
- psychological safety processes, structured debriefing and access to employee assistance or equivalent supports for complex or high-risk work.

Workforce shortages cannot be addressed through recruitment alone. The future SCC model should invest in alternative workforce pathways, structured capability development, quality supervision and opportunities for specialisation while preserving strong generalist navigation capability.

Workforce requirements should emphasise demonstrated competencies and capabilities, including relationship-based practice, cross-system navigation, risk escalation, cultural responsiveness, supported decision-making, capacity building and conflict-of-interest management.

Retention should be treated as a core implementation priority. Continuity of participant–worker relationships depends on retaining experienced practitioners and practice leaders during reform, with clear communication, transition pathways and recognition of existing capability.

**Recommendation 17:** A workforce strategy should be developed that attracts, develops and retains skilled practitioners through structured capability development, a credentialling framework, clear career pathways and strong practice support.

### **Question 9: How should local knowledge and community connection be defined and assessed?**

BSL recommends that local knowledge and community connection be defined broadly and assessed through evidence of active community engagement, partnerships and outcomes, not simply through service-directory knowledge.

Local knowledge includes active participation in community networks, relationships across mainstream and community service systems, co-design with people with disability and their communities, understanding of local barriers and opportunities, and demonstrated community-development, outreach and capacity-building capability.

Knowledge and connection are also important to tertiary services (e.g. health and justice), particularly where participant movement into and out of these services is frequent.

Local delivery should be supported through practical mechanisms such as regional hubs, local employment, outreach, brokerage and partnership arrangements. Commissioning should not assume that a single provider can hold every form of local, cultural and specialist knowledge internally.

Assessment should therefore focus on evidence of active community engagement, partnership depth, participant experience and participant outcomes, rather than the maintenance of service directories alone.

**Recommendation 18:** Local knowledge and connection to community and tertiary services should be defined broadly and assessed through evidence of active engagement, partnerships and outcomes – not simply through service-directory knowledge.

**Question 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?**

BSL recommends that SCC delivery in regional, rural, remote and thin-market areas be designed to address equity of access, local credibility and practical service reach. Commissioning should require:

- hybrid delivery models that combine local, outreach, face-to-face and digital support
- outreach services, regional hubs, mobile delivery and trusted local access points
- local partnership arrangements with community-based, regional, Aboriginal community-controlled and specialist organisations
- digital support to supplement, not replace, local and face-to-face access
- flexible workforce models that can respond to distance, workforce shortages and fluctuating demand
- community connector functions that strengthen local networks and improve access to mainstream, community and informal supports.

Rural, regional and remote communities should have access to locally credible partners, rather than relying solely on metropolitan or centralised service delivery. Without explicit thin-market requirements, commissioned arrangements risk continuing inequitable access for people in underserved communities.

Thin-market responses should be built into commissioning requirements, not treated as optional local adaptations. Solutions should prioritise local relationships and community presence, while using technology appropriately to improve access to specialist expertise where it is not available locally.

Minimum access requirements should include options for participants who cannot rely on phone or digital contact, including outreach, regional hubs, mobile delivery, face-to-face appointments and partnerships with local organisations that can provide a trusted access point.

The service scope should define expected operating hours, any extended weekday coverage and the funding required to support the staffing model. BSL does not support an assumption that SCC provides a 24-hour crisis response. Crisis and emergency responsibilities, including Agency responsibilities for funded support packages and highly complex situations, should remain clearly defined.

**Recommendation 19:** SCC delivery in regional, rural, remote and thin-market areas should be designed to address equity of access, local credibility and practical service reach.

**Question 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?**

BSL recommends that for participants with additional barriers, overlapping support needs or decision-making assistance would best fit within the proposed SCC+ service, and include:

- provision for specialist consultation with participant care teams
- cultural responsiveness
- knowledge of supported decision-making principles
- trauma-informed practice and strong links with child protection, housing, justice, Office of the Public Advocate and public trustees, and mental health and health systems.

Lead organisations should be able to bring together generalist SCC capability, specialist advice and cross-system coordination, so participants can maintain continuity as their circumstances change.

Complexity should not be understood as a characteristic of the participant alone. It often arises from fragmented, withdrawing or poorly coordinated service systems (including community and tertiary services). Effective SCC may involve negotiating with providers, preventing service withdrawal, coordinating multiple systems and maintaining support arrangements even where direct participant contact is limited.

For participants with highly complex circumstances, commissioning should enable SCCs to work as part of participant care teams, so responsibility is not carried by one worker alone. While this is a feature of the current model, it is not applied consistently in practice. This should include access to expertise in mental health, housing, justice, service interfaces and other relevant systems, supported by structured debriefing and supervision.

SCC should not be expected to manage every complex situation alone. The model should retain clear Agency-based complex pathways and escalation links, including access to relevant Agency functions such as health and justice liaison pathways where additional funding, risk resolution or Agency-level intervention is required.

The future model should clarify how psychosocial recovery coaching relates to SCC, including whether it remains a distinct function or is integrated into SCC+. This should avoid parallel pathways that exclude people with undiagnosed, intersecting or fluctuating psychosocial support needs.

**Recommendation 20:** SCC arrangements for participants with additional barriers, overlapping support needs or decision-making assistance should include provision for specialist consultation, multidisciplinary practice, cultural responsiveness, knowledge of supported decision-making

principles and trauma-informed practice and strong links with child protection, housing, justice, Office of the Public Advocate and public trustees, and mental health and health systems.

### **Question 12: What transition arrangements would minimise disruption and support successful implementation?**

Transition is a critical implementation risk and should be planned as a staged process that protects participants, trusted relationships and workforce capability.

BSL recommends transition arrangements that include:

- gradual, phased implementation that begins with less complex needs and moves to more complex. This will allow development of systems and skills that can then support more complex needs
- protection of participant–worker relationships wherever possible
- early and accessible communication with participants, families, providers and the workforce
- safe transfer of participant information, plans and current support arrangements
- workforce transition supports and recognition of existing support coordination, LAC and provider capability
- provider readiness assessment before commencement
- opportunities for existing providers to participate through partnerships, subcontracting or consortia
- arrangements for data governance to manage participant data that may be held in multiple systems.

A key transition principle should be that reform minimises disruption to participants by preserving trusted relationships wherever possible while improving quality, consistency and safeguarding.

Preserving existing relationships reduces participant burden by avoiding unnecessary repetition, reassessment and the need to re-establish trust. Transition planning should also prioritise workforce retention, recognising that uncertainty may lead to the loss of experienced practitioners and disrupt participant–worker relationships.

Transition should include ongoing monitoring of participant experience and outcomes so implementation issues can be identified and addressed early.

Given the proposed commencement date of 1 July 2028, transition planning should begin well before implementation and include staged communication, workforce transition planning, provider readiness assessment, participant information and mechanisms to protect continuity for people currently receiving support coordination.

Implementation should also define escalation responsibilities where support arrangements break down outside business hours, making clear what sits with the SCC provider, what remains an Agency responsibility and how participants, providers and families can access timely guidance.

**Recommendation 21:** Transition should be treated as a critical implementation risk and should be planned as a staged process that protects participants, trusted relationships and workforce capability.

## 4 Additional comment – consultation timeframe

The consultation timeframe process for the SCC (less than one month) has limited the time available for consultation with, and input from, key stakeholders and the wider disability community. Insufficient time impacts the inclusivity of the process and makes it harder for people with disability to meaningfully contribute to shaping policy that directly affects them. Future consultation processes should ensure adequate time is given for organisations to engage with, and collect feedback from, key stakeholders to better inform consultations.