



NDIS Support Coordination and Connection Reform

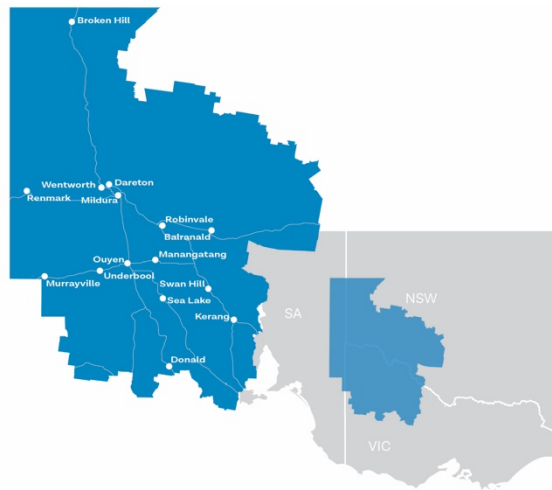
Submission to the Department of Health, Disability and
Ageing

Mallee Family Care | October 2026

www.malleefamilycare.com.au

1. About Mallee Family Care

Mallee Family Care (MFC) is a not-for-profit, place-based community services organisation headquartered in Mildura and delivering services across the Mallee region of north-west Victoria, south-west New South Wales and the Riverland of South Australia since 1979. With around 300 staff delivering more than 70 programs, MFC provides family support, child protection, foster and kinship care, financial wellbeing, family violence response, mental health services and disability support under the NDIS.



MFC has delivered support coordination since the Scheme commenced in the region and currently provides support coordination and specialist support coordination to around 184 active participants. A substantial part of that caseload is people living with psychosocial disability, frequently alongside drug and alcohol use, and at times with concurrent involvement from justice, child protection or clinical mental health services. MFC also delivers community mental health services, early childhood services under the key worker model, and operates the Mental Health and Wellbeing Connect Centre for carers and families. It is, for much of its catchment, the only provider of these services, and its workforce is recruited from the communities it serves.

The perspectives in this submission draw on the practice experience of MFC's support coordination and specialist support coordination team and the manager responsible for MFC's NDIS and mental health services. Examples have been de-identified and, where they could identify a person in a small community, reduced to the systemic point they illustrate.

2. What MFC supports

Mallee Family Care supports the Government's decision to commission Support Coordination and Connection services and the objectives set out in the consultation paper. The problems the paper identifies with the current market are real. MFC's practitioners have encountered providers that do not offer participants a choice of coordinator, that fold support coordination into their own service delivery, and that see no reason to ask a participant whether they wish to stay. Inconsistent quality, unclear role boundaries and conflicts of interest are not abstractions in the Mallee, and the fee-for-service model has produced both over-servicing and under-servicing.

MFC also sees the move from individually funded, hourly support coordination to a commissioned, block-funded service as an opportunity that would allow the intensity of support to follow a participant's circumstances rather than their remaining hours. It would remove the pressure on coordinators to ration contact against a funding period.

It must however be well designed to improve meaningfully on the current system. MFC's concern is that a commissioning process designed to reward scale and administrative efficiency will not, on its own, protect the things that make support coordination work in a thin



market. Relationships built over years, knowledge of local services and their limits, a workforce drawn from the community, and the trust of participants who have disengaged from every other system are the assets that produce outcomes here. This submission sets out how the commissioning design can secure them.

3. Summary of MFC's position

Block funding is the opportunity in this reform, and flexibility is what it must deliver

The current hourly model forces coordinators to ration contact against a funding period, to withdraw from participants whose hours are exhausted, and to spend time checking budgets rather than working with people. Need in MFC's caseload is largely episodic. A person may need three hours in a week of crisis and nothing for a month. A commissioned model that funds the service rather than the hour can follow that pattern. One that replaces hourly caps with caseload targets will reproduce the same rationing in a different form.

Place-based organisations with existing delivery should be the default lead, and the procurement criteria should reflect that

A tender will reward scale, national reach and administrative efficiency unless the criteria are written to weight local presence, an existing participant base, a workforce drawn from the community, and demonstrated partnerships with local services. MFC has seen participants moved to statewide or national providers disengage from the Scheme and re-emerge in crisis or statutory systems. The cost of that is borne by other services and by the participant.

A lead organisation in a one-provider region must be required to build in choice

MFC is candid that a single lead organisation creates a risk to choice and control, particularly for participants who do not wish to work with that organisation or who need a culturally specific service. The answer is a lead organisation obligated to partner and subcontract, with a governance framework that can evidence choice, not a multi-provider model that a thin market cannot sustain.

Face to face should be the default, with opt-out

Trust is built in person. The participants who need Support Coordination and Connection (SCC) most are those for whom a voice on the phone is not a relationship, and a virtual-first service would quietly exclude them.

Every first plan should carry an implementation period of coordination

Participants entering the Scheme do not know what is available or what their plan means. A defined period of support coordination on every first plan, ending in a capacity report to the National Disability Insurance Agency (NDIA), would set people up to succeed and give the Agency an evidence base for who needs ongoing SCC rather than a guess.

The existing workforce is the asset the reform most risks losing

The consultation paper's criticisms of the market are fair, but the people who do this work well are already doing it. A model that does not deliberately retain them, and the participant relationships they hold, will start from behind.

4. Recommendations

MFC recommends that the SCC service be designed to:

Recommendation 1

Fund flexibility, not caseload. Set the payment model so that intensity of support can vary with a participant's circumstances, and load explicitly for travel and distance.

Recommendation 2

Weight place in procurement. Write the criteria for a lead organisation around local presence, an existing participant base, a locally recruited workforce and demonstrated local partnerships.

Recommendation 3

Require a lead organisation to build in choice. Make partnership and subcontracting arrangements, including with Aboriginal Community Controlled Organisations (ACCOs), a condition of the contract, and require a governance framework that can evidence participant choice.

Recommendation 4

Make face to face the default, with virtual delivery on the participant's election.

Recommendation 5

Fund an implementation period of coordination on every first plan, ending in a capacity report that informs eligibility for ongoing SCC.

Recommendation 6

Retain the existing workforce and its relationships. Require commissioned organisations to prioritise existing support coordination and recovery coaching staff, and to maintain continuity of worker for participants through transition wherever the participant wishes it.

Recommendation 7

Value experience alongside qualifications in workforce requirements, and require supervision, EAP access and independent participant check-ins as conditions of the contract.

Recommendation 8

Fund the specialist tier properly. Ensure SCC+ covers the work of supporting people with complex, intersecting needs, including worker safety, trauma-informed practice and engagement with systems outside the NDIS.

Recommendation 9



Give participants fair warning. Communicate the transition early, plainly and in person to participants and nominees, and do not suspend or transfer support before the receiving arrangement is in place.

The specific measures under each recommendation are set out against the relevant consultation questions below.

MFC's responses are set out against the questions in the consultation paper, grouped where the questions overlap. The first set is answered from the perspective of MFC's practitioners on what participants need from the service.

5. What participants need from the service

What is working now, and what should improve (questions 1 and 2)

What works is relationships. MFC holds a network of around 184 active participants and their nominees, many with histories of support stretching back to the Scheme's commencement in the region, and a level of trust that has been built over years. It holds working relationships with the limited provider base in the region and, for participants in the NDIA's complex team, with allocated delegates who know the participant's history. Where an allocated delegate exists, plan reviews and changes of circumstance are faster and better informed. Where they do not, requests go to a generic inquiries inbox and may not be answered.

What works is also the substance of the role. Local Area Coordinators receiving participants whose support coordination has been removed have told MFC's practitioners that they cannot replicate what support coordination provides, and that the participant will move from monthly contact to an attempted contact once a year. The value is in deciphering the plan, knowing what reports are needed, monitoring the budget, communicating with the NDIA and adjusting supports as circumstances change.

What should improve is the funding model. Periodic funding and capped hours mean coordinators are checking budgets rather than working with people, withdrawing from participants whose hours are exhausted, and unable to respond to a crisis without exhausting a quarter. The role is desirable and the workforce is committed. The model has made it stressful and hard to retain.

Face to face or virtual (question 3)

MFC's position is that the service should be offered face to face by default, with the participant able to elect virtual delivery. Introductions, service agreements and the conversation about how to raise a concern all happen better in person, and for participants with limited capacity or fragile trust, a voice on the phone is not a relationship. Some participants prefer phone contact and should have it. The risk is a virtual-first model that becomes the default because it is cheaper, at which point the place-based character of the service is lost.

Who benefits most (question 4)

The participants who benefit most are those with the least capacity to manage a plan themselves, and that group is broad. It includes people with intellectual disability, people with acquired brain injury, people with psychosocial disability, and people whose physical disability is moderate but who cannot use the internet or understand what a plan means. MFC's



practitioners can identify very few participants on their caseload who could safely self-coordinate. MFC also cautions against using proxies for capacity. A formally appointed guardian is sometimes treated as a reason a participant does not need coordination, but guardian decisions are routed through an inquiries inbox and the person may have no individual contact. Guardianship is information about a person's circumstances, not evidence that they can navigate the Scheme.

MFC also proposes that every first plan carry a defined implementation period of support coordination, regardless of disability type. A person new to the Scheme does not know what services exist or what their plan funds. An implementation period would allow them to explore and set up supports, and would end in a report to the NDIA on the person's capacity to manage the plan going forward. Where capacity is established, coordination would cease. Where it is not, the report would ground a decision on ongoing SCC. MFC's practitioners regularly receive referrals for participants with plans that have gone unspent for successive periods because nobody helped them use it.

What an SCC worker needs (question 5)

MFC's team combines university and diploma qualifications with prior experience in the Victorian disability department, the NDIA, community mental health, children's services and NDIS finance. Each practitioner has an area of particular strength, and the team allocates participants to the practitioner best placed to work with them. That diversity is a feature, not an accident, and it has been possible because the NDIA has required experience in the field for level 2 coordination without prescribing a qualification. MFC has had complex participants declined level 3 coordination because of a regional shortage of allied health professionals, without regard to the skills held in-house or the relationship already established. Workforce requirements for SCC should value demonstrated experience and local knowledge alongside formal qualifications.

Feeling safe and able to raise a concern (question 6)

MFC builds this into its intake model. The intake conversation gives the participant and their informal supports the opportunity to understand what they can and should expect from an NDIS-funded provider. During this engagement, the participant is offered the opportunity to provide feedback and reminded that they can engage the services of other organisations if they wish. They are told who they can go to if they want to escalate a concern. Check-ins on how the service is going are made by the intake worker or Team Leader, a staff member other than the participant's coordinator, so that a participant can feel safe to express their true experience and feel empowered to request an alternative worker or service without fear of repercussions. Every participant is asked at least annually whether they wish to remain with MFC. Practitioners report that this is not standard practice across the market, and that some providers have asked why they would do themselves out of a job. Independent check-ins and a documented, participant-facing pathway for concerns should be conditions of an SCC contract.

Other considerations (question 7)

Where a participant would prefer a culturally appropriate service, MFC's practice is to support a referral or partnership with an ACCO. The commissioned model should make that possible within a lead organisation's obligations rather than dependent on goodwill.

MFC recommends that the SCC service:

- Be offered face to face by default, with virtual delivery on the participant's election. (Recommendation 4)
- Fund a defined implementation period of coordination on every first plan, ending in a capacity report to the NDIA that informs eligibility for ongoing SCC. (Recommendation 5)
- Not treat guardianship or nominee arrangements as a proxy for capacity to manage a plan. (Recommendation 5)
- Value demonstrated experience and local knowledge alongside formal qualifications in workforce requirements. (Recommendation 7)
- Require independent participant check-ins, a documented pathway for concerns, and an annual choice conversation as conditions of the contract. (Recommendation 7)

6. Commissioning, lead organisations and regions

Commissioning arrangements (provider question 1)

MFC's view is that the shift from individual funding to a commissioned, block-funded service is the most significant opportunity in the reform, and the arrangement chosen should be judged first on whether it preserves that flexibility. Need in MFC's caseload is episodic. Psychosocial disability fluctuates by its nature, and any participant's need will spike with family violence, homelessness, a hospital admission or a change in living arrangements. A commissioned model can allow a coordinator to respond to that without reference to remaining hours. MFC expects that the model will come with targets and a triage of need, and does not object to that, provided the arrangement leaves room for intensity to vary within a service rather than fixing it per participant.

Provider types best placed to lead (provider question 2)

MFC's answer is place-based, not-for-profit organisations already delivering services in the region. The characteristics that matter are an existing participant base and the relationships that come with it, a workforce recruited from the community, knowledge of which local services exist and which do not, established referral pathways into health, housing, justice and mental health systems, and a track record of engaging specialist providers when a participant's needs require it. MFC has these characteristics because it has delivered support coordination since the Scheme began in the region, alongside the mental health, family and community services that its participants also use.

MFC is direct about the risk it sees in procurement. A national or statewide provider can build efficiencies into a contract across a large geographic region that a place-based organisation cannot match on price. MFC has seen participants moved to such providers in other program areas disengage from the Scheme, then re-emerge through community services or the statutory system with multiple and compounding vulnerabilities. The cost of that outcome does not appear in the tender. Procurement criteria should therefore weight local presence and connection explicitly, and should treat an existing participant relationship as an asset to be protected rather than a market share to be reallocated.

Advantages and disadvantages of the lead organisation model (provider question 3)

The advantage is coherence. One organisation accountable for a region can build the partnerships, referral pathways and governance that a fragmented market cannot, and can be held to national standards through contract. The disadvantage is choice. In a region where the lead organisation is already the dominant or only provider, some participants will not want to work with it, whether because of a past experience or because they want a culturally specific service. MFC does not think the answer is a multi-provider model, which a thin market cannot sustain. The answer is a lead organisation that is required to partner and subcontract, and whose governance can evidence that a participant who wants a different arrangement gets one.

MFC already operates under this constraint. In community mental health it is the sole provider for the Mildura public hospital catchment, and its governance includes arrangements for a person who does not connect with their allocated worker to be offered an alternative. It would expect an SCC lead organisation contract to require the same, including partnership arrangements with ACCOs for participants seeking a culturally appropriate service.

Regional areas (provider question 4)

MFC's primary concern is that the region chosen aligns with how participants actually move and where services actually sit. A boundary that places Mildura with a distant regional centre, or that splits the Mallee across state lines in a way that does not reflect the cross-border service use of participants in the Riverland and Sunraysia, will make the service harder to deliver and harder to navigate. Of the options canvassed, Primary Health Network areas are too large to support the place-based approach described throughout this submission. MFC would support a boundary that keeps the Mallee catchment together and that is small enough for a lead organisation to hold genuine local knowledge across all of it (such as by Local Government Area).

MFC recommends that the commissioning model:

- Preserve flexibility of intensity within a commissioned service, rather than fixing hours per participant. (Recommendation 1)
- Write the criteria for a lead organisation to weight local presence, an existing participant base, a locally recruited workforce, and demonstrated partnerships with local health, housing, justice and mental health services. (Recommendation 2)
- Treat an existing participant relationship as an asset to be protected in procurement, and require any transfer of participants between providers to be justified against continuity of support. (Recommendation 2)
- Make partnership and subcontracting arrangements a condition of a lead organisation contract, including with ACCOs, and require a governance framework that can evidence participant choice within a single-provider region. (Recommendation 3)
- Define regions that keep functional catchments together and are small enough for a lead organisation to hold local knowledge across all of them. (Recommendation 2)

7. Variable need, payment, quality and workforce

Managing variable need (provider question 5)

MFC manages variable need through a team model. Participants are allocated to the practitioner whose experience best fits their circumstances, the team leader holds oversight across every caseload, and the team absorbs a colleague's participants during planned and unplanned leave without loss of continuity. Practitioners know when to escalate and to whom. This is sustained by regular supervision, which recognises when a caseload needs to change and is the first thing to be dropped in organisations under pressure. The factors an SCC provider should be assessed on are the presence of a team structure rather than sole practitioners, oversight across caseloads, supervision, and the capacity to redistribute work without a participant losing their point of contact.

Payment and funding approaches (provider question 6)

MFC's practitioners were unanimous that the hourly, periodically funded model is the single largest source of stress in the role and the main constraint on the quality of support they can provide. Practitioners who have worked in block-funded programs describe the difference as the ability to do the work the principles describe. To sit with a participant face to face, to implement a plan properly, to refer into drug and alcohol or housing services and follow through, and to respond to a crisis without calculating what it will cost the participant in a later quarter. The current model has coordinators telling participants that support has to stop because a funding bucket is empty.

MFC's position is that the payment model should fund the service, not the hour, and should allow intensity to vary within it. Two design points follow. First, whatever caseload or output measure is used, it must not recreate hourly rationing under another name. A fixed per-participant amount that assumes uniform need will underfund the people who take the most time and quietly ration service to them. Second, the model must load explicitly for travel and distance. Face-to-face support across the Mallee involves significant travel, and a flat rate that does not fund it will push providers towards phone contact for the participants furthest away.

Quality, workforce and safeguarding requirements (provider question 7)

MFC supports national practice standards, conflict of interest controls and performance reporting, and considers the paper's proposed elements broadly right. It would add three requirements drawn from its own practice. Regular clinical supervision for all SCC workers, access to an employee assistance program, and independent participant check-ins conducted by someone other than the participant's own coordinator. Each protects the participant, and each protects the worker in a role that carries significant emotional load.

Attracting, building and retaining workforce (provider question 8)

The reform will affect a large existing workforce whose skills, relationships and commitment are the foundation of whatever the new service becomes. MFC's practitioners bring backgrounds in the disability department, the NDIA, community mental health, children's services and NDIS finance, and the diversity of that experience is what allows the team to match participants to the right worker. The consultation paper's criticisms of parts of the market are fair, but the answer is not to start again. Commissioned organisations should be required to prioritise the existing support coordination and recovery coaching workforce in recruitment, and to maintain continuity of worker for participants through the transition wherever the participant wishes it.



Beyond that, the most effective retention measure available is the payment model. A role in which workers can do the work well is a role people stay in.

Defining and assessing local knowledge and community connection (provider question 9)

Local knowledge and community connection must be assessed by evidence, not assertion. Relevant indicators include the number and duration of existing participant relationships in the region, the proportion of the workforce recruited locally, documented referral pathways and partnership agreements with local health, housing, justice, mental health and ACCOs, and the organisation's history of delivering services in the region across program areas. Each of these can be verified in a tender. A claim to be place-based cannot.

MFC recommends that the SCC model:

- Fund the service rather than the hour, allow intensity to vary within it, and load explicitly for travel and distance. (Recommendation 1)
- Assess providers on team structure, cross-caseload oversight, supervision and the capacity to redistribute work without loss of continuity. (Recommendation 7)
- Require regular supervision, employee assistance access and independent participant check-ins as contract conditions. (Recommendation 7)
- Require commissioned organisations to prioritise the existing support coordination and recovery coaching workforce, and to maintain continuity of worker through transition where the participant wishes it. (Recommendation 6)
- Assess local knowledge by verifiable indicators, including existing participant relationships, local recruitment, documented partnerships and delivery history in the region. (Recommendation 2)

8. Thin markets, complex needs and transition

Regional, rural and remote areas (provider question 10)

This submission answers this question throughout. Two points are specific to thin markets. First, subcontracting and partnership are not optional in a region like the Mallee. They are the only way a lead organisation can offer culturally specific services, cover towns with no service presence, and give a participant a genuine alternative. The contract should require them and fund them. Second, the paper's own list of organisations with expertise in thin markets, including ACCOs and Remote Community Connectors, describes MFC's existing partners. A lead organisation should be assessed on whether those partnerships already exist, not on whether it undertakes to form them.

Complex and overlapping needs, and decision-making support (provider question 11)

MFC's specialist support coordination caseload is largely people living with psychosocial disability, often alongside drug and alcohol use, and often with concurrent involvement from justice, child protection or clinical mental health services. Many spend extended periods in mental health facilities. Some do not accept that they are unwell, and will describe to a stranger



a reality that differs from the one their treating team and support workers see. Some present, on the phone or in person, in ways that a worker without background and training would find confronting or unsafe.

The work of supporting this cohort is not the same work as supporting a participant with a stable plan and a capable nominee, and the SCC+ tier needs to fund it as different work. That means the time to build and maintain a relationship that survives the person being unwell, the behaviour support planning and safety measures that let a worker keep engaging, the trauma-informed practice that keeps the person at the centre rather than treating them as the problem, and the capacity to work across systems the NDIS does not fund. MFC's practitioners describe supporting participants to reach the point of engaging with drug and alcohol services at all, which is the precondition for the other system's involvement, not a substitute for it.

Transition arrangements (provider question 12)

MFC's practitioners report that participants are already fearful, and that the absence of clear information has left room for speculation. Transition should be communicated early, plainly, and in person to participants and nominees, and MFC would expect to be resourced to have those conversations with its own participants rather than leaving them to a letter. Continuity of worker should be offered to every participant through the transition, and no participant's support should be suspended or transferred before the receiving arrangement is confirmed and introduced. For participants with complex needs, a warm handover involving the current coordinator, the new arrangement and any treating team should be standard. Providers need clarity on procurement timing, eligibility criteria and workforce arrangements well before mid-2028 if they are to plan for the transition rather than react to it.

MFC recommends that the SCC model:

- Require and fund partnership and subcontracting arrangements as a condition of a lead organisation contract in thin markets, and assess lead organisations on existing partnerships rather than undertakings to form them. (Recommendation 3)
- Fund SCC+ to cover relationship maintenance through periods of unwellness, worker safety and behaviour support, trauma-informed practice and engagement with systems outside the NDIS. (Recommendation 8)
- Provide that involvement with drug and alcohol, justice or other systems is an indicator of complexity for SCC+ eligibility, not a basis for reducing coordination. (Recommendation 8)
- Communicate the transition early, plainly and in person, resource current providers to have those conversations with their participants, offer continuity of worker to every participant, and not suspend or transfer any participant's support before the receiving arrangement is in place. (Recommendation 9)
- Provide providers with procurement timing, eligibility criteria and workforce arrangements well ahead of July 2028. (Recommendation 9)

9. Concluding remarks

MFC supports the direction of this reform and sees in it an opportunity to deliver support coordination in the way its practitioners have long wanted to. It would welcome the opportunity



to discuss this submission with the Department and the NDIA, to contribute to the design of the commissioning approach for regional and thin markets, and to work with the Agency on transition planning for its own participants. MFC has delivered this service in the Mallee since the Scheme began, and intends to be part of delivering what replaces it.

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