

2 October 2026

Department of Health, Disability and Ageing
GPO Box 9848
Canberra ACT 2601

Submitted online

Dear Support Coordination and Connection Consultation team,

APS response to the NDIS Support Coordination and Connection Reform Consultation

The Australian Psychological Society (APS) is the peak professional body for psychologists in Australia. The APS welcomes the opportunity to respond to the Department of Health, Disability and Ageing (the Department) and National Disability Insurance Agency (NDIA) Consultation Paper on the NDIS Support Coordination and Connection (SCC) Reform.

Our members include thousands of psychologists who provide essential, evidence-based supports to NDIS participants, and who increasingly provide practice leadership and supervision to other parts of the disability workforce. The APS therefore has a direct interest in how the SCC service is designed and in how it will work alongside the psychological supports participants use.

The APS is committed to the success and sustainability of the Scheme. We support the reform's central aims of improving the quality and consistency of support coordination, clarifying role boundaries across intermediary supports, removing conflicts of interest, and strengthening safeguards for participants.

Summary of key considerations

- *SCC is a psychologically informed practice.* The participants who will need SCC and SCC+ have needs that are psychological, relational and situational, not only administrative. A purely administrative model, or a model which is not psychologically informed and safe, would ultimately fail to meet the needs of the people the service is designed to support.
- *Psychologists should have a defined role in the SCC service.* This includes as leaders within SCC organisations, and as supervisors and consultants to the wider SCC workforce.
- *Professional practice governance should be a condition of commissioning.* Every commissioned SCC organisation should be required to demonstrate a professional practice governance framework, including psychologist-led leadership, regular supervision and reflective practice, access to specialised advice, and multidisciplinary case review. These elements must be funded within the payment model.
- *Independence must be protected.* SCC organisations should be separate from direct service provision, and psychologists who are in professional practice leadership or supervision roles should not deliver direct supports to the same participants.

- *Regulation should be risk-based and proportionate.* Quality and safeguarding requirements should focus on SCC workers who are not already regulated and recognise the existing regulatory framework that applies to psychologists to avoid duplication and unnecessary administrative burden.
- *Co-design and ongoing collaboration with professions is essential.* The APS is ready to partner with the Department and the NDIA to develop the professional governance, supervision and workforce capability frameworks for the proposed SCC service.

Thank you for the opportunity to provide input into this consultation. If further information is required from the APS, I would be happy to be contacted through the National Office on (03) 8662 3300 or by email at z.burgess@psychology.org.au.

Yours sincerely

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Chief Executive Officer

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NDIS Support Coordination and Connection Reform Consultation – APS Response

The role of psychologists in the SCC service

Psychologists are registered health professionals with expertise in human behaviour, cognition, emotion, trauma, development and relationships. Registration requires a minimum of six years of combined university education and supervised practice, and psychologists are regulated by the Australian Health Practitioner Regulation Agency (Ahpra) and the Psychology Board of Australia (the Board), including through a binding Code of Conduct, mandatory continuing professional development that includes ongoing supervision, and established complaints and disciplinary processes.

Within the NDIS, psychologists currently provide therapeutic supports, comprehensive assessments and behavioural interventions. Psychologists are skilled in risk assessment, trauma-informed practice, understanding of behaviour and capacity, and communication.

Psychologists also contribute through multidisciplinary collaboration, professional leadership, supervision and professional development of other providers, and research. These are the capabilities the SCC service will need, particularly for participants with complex needs. The APS has identified distinct contributions psychologists can make to the SCC service:

- *As professional practice leaders.* Psychologists can hold professional leadership roles within SCC organisations, participate in professional and practice advisory groups and multidisciplinary case review, provide real-time psychological advice to SCC workers on complex presentations, and help workers to interpret assessment reports and risk information appropriately.
- *As supervisors and mentors.* Psychologists are trained in, and are required to engage in, supervision. With Board-approved supervisor status, they can provide individual and group supervision, reflective practice, consultation and training to SCC workers, supporting consistent, ethical and evidence-informed practice and protecting workers from the effects of vicarious trauma and burnout.

The APS recognises that there is a shortage of psychologists available to NDIS participants, and that psychologists' time is best used where it has the greatest effect. Professional practice leadership and supervision by psychologists can extend psychological expertise across a much larger workforce.

Section 1: What participants want from the new SCC service

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

The strongest support coordination practice is relational and psychologically informed. It occurs where coordinators take the time to understand a participant as a whole person, including their goals, strengths, functional needs, history and sociocultural context, rather than basing decisions on diagnosis or impairment category alone. Good practice gives weight to the participant's dignity, respect and autonomy, and reflects a practical understanding of how psychological and therapeutic supports build capacity in the complexity of everyday life.

With the participant's consent, effective coordinators also communicate with service providers and allied health professionals so that supports remain aligned with the participant's goals.

The APS encourages the new service to preserve and formalise this person-centred, strengths-based and relational approach rather than defaulting to a narrower, deficit-focused or transactional model. The continuity of trusted relationships identified in the Consultation Paper is central to this.

2. What would you most like to see improved in the new SCC service?

The most important improvement in the new SCC service would be a formal professional practice governance framework, led by psychologists and other appropriately qualified health professionals. The framework should guide how SCC workers interpret and act on technical information such as assessments, functional and diagnostic reports and risk information, when they should seek specialist input, and how models of care are applied. It should not extend to SCC workers making or determining diagnoses, which sits outside the role described in the Consultation Paper. The framework should include:

- Designated professional practice leadership roles within each SCC organisation, held by registered psychologists or other appropriately qualified health professionals;
- Regular individual and group supervision, structured reflective practice and mentoring, so that SCC workers can routinely review their practice and their decision-making;
- A professional advice line to give SCC workers real-time support with difficult decisions and complex presentations; and
- Baseline training for all SCC staff in the main evidence-based therapeutic approaches and frameworks, so that they can respond meaningfully to participant questions about support provision and goal-setting, and recognise when psychological input is needed, without themselves providing therapy or a professional opinion.

Together, these measures would lift consistency and professional credibility across the workforce.

3. When should SCC be a face-to-face service or a virtual service?

The mode of delivery should be determined by participant need, risk and preference, rather than by administrative convenience or cost. The APS supports a blended approach. Face-to-face contact is particularly important for initial engagement and relationship-building, for plan reviews and support decisions, for participants with more complex presentations (and, where relevant, their guardians), and at any point where risk, disengagement or a change in circumstances is identified. Virtual contact is well suited to routine check-ins and progress updates for participants whose circumstances are stable.

Participant preference should be built into the decision. Some participants engage better virtually, including where travel is a barrier in regional areas, while others, such as some people with cognitive disability, sensory needs or trauma histories, may find virtual contact more difficult. SCC workers should be supported by professional leadership to make these judgements, and virtual delivery should never become a default that erodes the trusted relationships on which the service depends.

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

Participants who will benefit most include people with complex or co-occurring conditions, people with intellectual or cognitive disability, people with psychosocial disability, people under public or private guardianship, and people with limited capacity or support to advocate for themselves.

This also includes participants who may be vulnerable to exploitation by service providers, participants with trauma histories, and participants from culturally and linguistically diverse and First Nations communities for whom culturally safe practice is essential.

For these groups, connection needs centre on building and strengthening links to community, mainstream and NDIS supports that the participant or their guardian may not otherwise know how to access. Coordination needs centre on ensuring that supports work together rather than in isolation, with issues escalated early rather than left to compound. In practice, this requires sustained, trust-based relationships, careful monitoring of service quality, and active safeguarding against poor or predatory practice, rather than episodic or transactional contact. For participants with fluctuating needs, including many people with psychosocial disability, the service must be responsive to changes in circumstances. For SCC+ participants in particular, it also requires specific skills, including access to psychological expertise.

5. What experience, skills and knowledge do you look for in an SCC worker?

SCC workers require demonstrated experience in disability and would ideally have a relevant tertiary qualification together with experience in complex case management. The SCC workforce should have:

- Mental health and trauma-informed training beyond simple awareness. Mental Health First Aid is a reasonable baseline, but it is not sufficient preparation for working with SCC+ participants;
- An understanding of therapy supports for physical and psychosocial disability and how these build a participant's capacity, so that workers can help participants and families to understand, seek and make good use of available services;
- Working knowledge of the health, hospital and mental health systems, and of relevant agencies such as public guardians and advocates and state and territory child protection, community services and justice agencies;
- An understanding of supported decision-making, human rights, dignity of risk and participant autonomy, and of cultural safety and diversity within the disability sector; and
- The ability to work within a professional governance framework, including seeking and using supervision and professional advice.

SCC+ workers should have ready access to psychologist-led supervision and consultation. The APS would welcome the opportunity to contribute to the development of a workforce capability framework and associated training, drawing on our organisational expertise and that of our members.

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

Participants are more likely to feel safe when the SCC function is independent and clearly separated from service provision, so that there is no conflict of interest in the advice they receive. Transparency about how decisions and processes work is essential, as is having an SCC worker the participant can trust and with whom they can build rapport.

To encourage reporting, there must be a clear, accessible and independent complaints pathway that sits outside the participant's own SCC organisation, so that raising a concern is less likely to affect the support relationship. Information about complaints and independent advocacy, which the Consultation Paper confirms the SCC service will not itself provide, should be given to participants in accessible formats that suit their communication needs.

SCC workers should also be trained in trauma-informed practice and receive professional and ethical guidance on how to respond to disclosures of abuse, neglect or exploitation and to concerns about a participant's wellbeing.

7. What else should we consider when designing the future SCC service?

The APS calls on the Department and the NDIA to consider the following in the design of the service:

- Embed professional, ethical and psychological expertise into the SCC and SCC+ distinction. The participants with the most complex presentations are not likely to have their needs met by a purely administrative model. Service levels should specify the professional leadership, supervision and skills that apply at each level.
- Define the interface with other intermediary supports. The model should clearly set out how SCC works with Local Area Coordinators, Early Childhood Partners, plan managers and Psychosocial Recovery Coaches, so participants are not left navigating overlapping or duplicated roles.
- Define the interface with therapeutic supports. SCC workers should understand the role of psychologists and other allied health professionals, know how to coordinate around participants' therapy and other goals, and share information only with the participant's consent.
- Build relationships with providers. SCC workers should be equipped to understand a participant's capacity, not just their plan, and person-centred care should be the organising principle behind structural and operational decisions.
- Evaluate the service. Participant outcomes and experience should be measured from the outset, with independent evaluation, so that the design can be refined on the basis of evidence.
- Co-design the service. Effective services will require ongoing co-design with participants, providers and peak bodies, rather than limited or confirmatory consultation.

Section 2: Service provider models and approaches

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

Commissioning arrangements should be structured to prevent the conflicts of interest that currently undermine trust in the system. Organisations delivering SCC should be kept separate from those delivering direct supports, consistent with the provider characteristics outlined in our response to Section 2, Question 2.

Contracts should include built-in accountability, including regular performance reporting and independent review, so that participant outcomes and quality, rather than throughput, are the central measures of success. As a condition of contract, commissioned organisations should be required to demonstrate a professional governance framework, including psychologist-led professional practice leadership, supervision and access to professional advice (see our response to Section 1, Question 2). Sustainability should be supported by funding that reflects the actual complexity and time required for good practice.

Choice and control should be preserved by ensuring participants retain a meaningful say in who supports them and how, including a clear right to request a change of worker, even where a single organisation is commissioned for a region. Professional bodies such as the APS should be engaged in co-designing the service specifications and outcome measures.

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

In addition to the factors outlined in 1. Above, lead organisations should be able to demonstrate a workforce with a mix of skills, established local links, capacity to deliver culturally safe practice, and the ability to partner with or subcontract to skilled providers. Independence should extend to practice roles: psychologists engaged by an SCC organisation as professional leaders or supervisors should not also deliver direct therapeutic supports to participants within that organisation. Professional expertise can be provided through a combination of employed and contracted psychologists, including psychologists in private practice, so that smaller organisations are not disadvantaged.

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

A lead organisation model, in which a single independent provider is responsible for SCC across a defined region, offers clearer accountability, more consistent practice standards and simpler oversight for the NDIA, which should support a smoother transition and stronger safeguarding.

The main disadvantages are reduced participant choice where only one organisation operates in a region, and the risk of reduced local responsiveness or uneven professional capability if the lead organisation lacks capacity or links across a diverse community, particularly for participants with culturally specific or highly complex needs. These risks should be actively managed through minimum service and governance standards, subcontracting arrangements with skilled local providers, transparent performance reporting, and a clear mechanism for participants to raise concerns or request a change of worker within the lead organisation, rather than being left to seek a different provider altogether.

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

The APS supports service areas aligned with health system geography, namely Local Hospital Network (LHN) and Primary Health Network (PHN) regions and appropriate sub-regions within them, rather than broader administrative boundaries such as Statistical Area Level 4 (SA4) regions.

LHN and PHN regions already align with existing referral relationships, governance structures and, in the case of PHNs, the commissioning of mental health services. This would make it easier for SCC organisations to build the referral pathways and service linkages on which the model depends, particularly for participants with complex health-related needs. SA4 regions are drawn for population statistics rather than service delivery and may not reflect where participants actually access health and community supports. Flexibility should be allowed for large or remote regions.

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

Providers should be able to size caseloads according to complexity rather than treating all participants as equivalent. Participants with complex needs, guardianship arrangements or heightened vulnerability require substantially more time and skilled input than those with straightforward, stable needs. This points to a weighted caseload model, in which each participant is assigned a complexity rating that determines how much of a worker's capacity they occupy, rather than a flat number of participants per worker.

Workforce planning should consider the mix of skills across a caseload, including mental health and psychosocial expertise for higher-complexity participants. Providers should build in capacity buffers, such as unallocated capacity or a shared pool of skilled workers, so that a sudden increase in one participant's needs does not compromise support to others.

Regular caseload review, undertaken as part of professional supervision and informed by psychological expertise, would help providers identify early when participants' needs are escalating and when a worker's caseload has become unsustainable. This is also important for workforce wellbeing, as high-complexity caseloads carry a real risk of vicarious trauma and burnout.

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

A funding model that reflects the intensity and complexity of participants' needs, rather than a flat hourly fee-for-service rate, would better support outcomes and sustainability and reduce incentives for over- or under-servicing. A blended model would be appropriate, combining a base per-participant loading, which funds relationship-building and connection work that does not always translate into billable hours, with a higher loading for SCC+ participants. Such a model should also avoid incentives for organisations to favour lower-complexity participants.

The model must explicitly fund the elements that drive quality, including leadership, supervision, reflective practice, ethical decision-making and advice, training and governance structures (see our response to Section 1, Question 2). As the APS has consistently stated in relation to NDIS pricing more broadly, funding must reflect the actual cost of safe, high-quality and sustainable services.

A well-supported workforce, rather than throughput-based incentives, is what ultimately drives consistent and positive participant outcomes.

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

The APS supports a risk-based, proportionate approach that aligns with existing regulatory frameworks and recommends that commissioned SCC organisations be subject to:

- Minimum practice standards and a professional practice governance framework, including psychologist-led leadership, professional advisory groups to support independent decision-making, and multidisciplinary team approaches so that complex decisions are not left to a single worker in isolation;
- Supervision requirements, setting minimum expectations for the frequency and type of supervision and for the qualifications and experience of supervisors, consistent with established professional supervision standards;
- Audit and performance reporting, with results made transparent so that participants and the sector can see how organisations are performing, and with a focus on participant outcomes and experience;
- Conflict of interest controls and independent complaints pathways, as outlined in our responses above; and
- Workforce capability requirements, proportionate to the service level and to the risk of the role.

Requirements should be targeted at those SCC workers who are not already subject to professional registration and regulation.

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

Retention depends on workers feeling supported and equipped. As previously stated, the model should include ongoing training and regular updates on professional knowledge, structured supervision and reflective practice, manageable caseloads, and career pathways that include professional leadership and advanced SCC+ roles.

Psychologists are well placed to provide supervision and mentoring across the workforce. The APS can additionally support this through relevant supervisor training resources and professional development offerings.

To protect participant relationships, the model should include a formal handover protocol whenever a worker or organisation changes. It should provide for a documented transfer of the participant's history (with the participant's consent), a joint introductory meeting with the outgoing and incoming worker where possible, and a minimum notice period, so that continuity is protected during transitions, including the 2028 changeover. The expertise of the existing support coordination and Psychosocial Recovery Coaching workforce should be recognised and retained wherever possible.

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

Local knowledge and community connection should be defined by concrete, verifiable indicators rather than general familiarity. These include an organisation's established referral pathways with local health, mental health, allied health (including psychology), community and mainstream services; documented partnerships with Disability Representative and Carer Organisations, Aboriginal Community Controlled Organisations and Aboriginal Community Controlled Health Organisations where relevant to the region; and evidence of existing relationships with key local contacts such as PHN and LHN liaisons.

Assessment should also include a participant- and community-focused test: whether community groups are aware of, and able to identify, the supports and key people linked to the SCC service. This indicates real embeddedness rather than a superficial regional presence built on paperwork. Local connection should be assessed both at commissioning and on an ongoing basis through performance monitoring and participant feedback.

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?

Strong linkages with health providers already operating in regional areas would give SCC workers a practical foothold in thin markets rather than starting from scratch. An optional fly-in-fly-out service, backed by online service provision, could extend SCC capacity into areas that cannot sustain a permanent presence. Training a key contact person within the local PHN or health district to liaise with the SCC lead organisation would help bridge national consistency and local knowledge.

Telehealth and other digital modes can also make psychologist-led leadership, supervision and advice available to SCC workers in regional, rural and remote areas regardless of location, so that they are not without support. The model should also invest in developing the local workforce, recognising that psychological and other allied health services are themselves in short supply in many thin markets.

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?

SCC workers need structured education on complex and overlapping needs and how they affect a person day to day, rather than generic training. The service must also be culturally safe, trauma-informed and accessible for participants facing barriers related to culture, language, geography, gender, sexuality or socio-economic circumstances, with access to interpreters and culturally specific expertise where needed.

For participants requiring decision-making support, SCC workers need clear training and boundaries on how to work alongside existing supported decision-making and guardianship arrangements.

Workers should not substitute their own judgement for the participant's, which is consistent with the Consultation Paper's position that the service will not make decisions on behalf of participants or replace supported decision-making arrangements. Workers should understand who holds decision-making authority in a given situation and ensure the participant's own will and preferences remain central even where a guardian or support person is also involved. Where questions about a participant's cognitive or functional capacity arise, psychologists have relevant expertise in cognitive and functional assessment and can advise on communication and decision-making supports. Training in human rights, dignity of risk and participant autonomy should be provided to SCC workers and to decision-makers across the NDIS ecosystem, including within the NDIA.

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

Transition arrangements should be well planned and participant centred. Providers, participants and guardians should be engaged early, timelines should be clearly defined so that all parties know what to expect and when, and communication should set realistic expectations about what the transition will involve. Participants should be actively engaged for feedback and given a role in shaping how the transition unfolds, rather than simply being informed after decisions are made.

Change of this scale can be distressing for participants who rely on trusted relationships. Communication should therefore be tailored to different needs, and participants at heightened risk of disengagement should be identified and monitored. Transition arrangements should also protect the continuity of participants' existing therapeutic supports so that changes to coordination are not disruptive. Consideration should be given to sequencing any changes so that participants with the most complex needs experience the least disruption. The existing workforce should be supported to move into the new service through training and supervision, and professional bodies such as the APS could be engaged to provide high-level and psychologically informed support for transition planning.

As experts in communication and behaviour change, psychologists can help develop effective communication strategies, and the APS would be pleased to partner with the NDIA in this work.

Conclusion

The APS supports the objectives of the SCC reform and believes that its success will depend on embedding professional and psychological expertise into the design of the service, alongside case management expertise. The APS stands ready to partner with the Department and the NDIA to co-design the governance, supervision and workforce capability frameworks for the SCC service, and to support the workforce through training, CPD and professional practice resources.