Australian Autism Alliance

Submission to the consultation on NDIS Support Coordination and Connection reform

Eligibility should assess the support required to maintain stability, not wait for stability to fail.

2 October 2026

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1. Introduction

The Australian Autism Alliance ('the Alliance') 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 proposed Support Coordination and Connection ('SCC') service. This submission responds to each of the 19 consultation questions and sets out the conditions the Alliance considers necessary if a commissioned SCC service is to work well for Autistic participants.

The Alliance is a funded national peak body and Disability Representative Organisation (DRO), providing a strong unifying voice for autism and authoritative policy expertise on autism. We work with Australian governments at all levels to strengthen policy and service systems affecting Autistic Australians. Our membership is a national network of organisations with diverse roles in autism, including organisations led by Autistic people, advocacy organisations, peak bodies, service providers and researchers, and includes organisations that deliver specialist disability supports, therapy and clinical services to Autistic people and their families across metropolitan, regional and remote Australia.

Autistic people are the largest primary disability cohort in the NDIS, representing approximately 44 per cent of all active NDIS participants as at 31 March 2026. The NDIS Quality and Safeguards Commission reported in 2023 that 45 per cent of active participants had support coordination in their plans (Attachment A, section 1). The consultation paper proposes that from 1 July 2028 support coordination will no longer be funded in participants' plans, that not every participant will be eligible for the commissioned service, and that participants may need to change the worker they rely on if their current support coordinator is not part of the future local SCC organisation. The design of the eligibility criteria, the transition and the pathway for participants who are not eligible will therefore affect a very large number of Autistic people and their families.

This submission reflects written input from Alliance member organisations received through the Alliance's Policy Committee in September 2026, including autism-specific service providers, organisations providing therapy and clinical services, and organisations led by and working with Autistic young people and their families. It draws on the Alliance's wider NDIS reform work, including its submission to the department's consultation on Supported Independent Living (SIL) commissioning and its membership of the SIL Commissioning External Advisory Group, and is consistent with the positions the Alliance put to the Senate Community Affairs Legislation Committee on the National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026. The Alliance's role is not to aggregate member positions but to bring an autism-specific perspective and a systems level test across eligibility, transition, commissioning, continuity and accountability. Several member organisations are also lodging their own submissions and the Alliance commends that detailed, practice based advice to the department.

The submission also draws on the Alliance's national evidence base, including the national consultation of more than 3,800 Autistic people, families and carers undertaken by Australian Catholic University for the Senate Select Committee on Autism, the NDIS Review, the Disability Royal Commission, the NDIS Quality and Safeguards Commission's Own Motion Inquiry into support coordination and plan management, and the Australian and international research on executive functioning, masking, Autistic burnout and fluctuating capacity summarised at Attachment A. Attachment B offers practical implementation and accountability tests for the SCC reform drawn from the Alliance's Systems That Work™ approach.

2. Overall position

The Alliance supports the stated objectives of improving quality, consistency, safeguarding, workforce capability and clarity of role. Whether the proposed commissioned model achieves those objectives will depend on its final design and implementation. Support coordination has been delivered to a variable standard, role boundaries have been unclear, conflicts of interest are real and the hourly fee for service model has produced both over servicing and under servicing. Member organisations that are autism-specific service providers confirm these problems from their own practice and support nationally consistent practice standards, stronger workforce capability requirements, clearer role definitions, improved participant safeguards and measurement of participant outcomes rather than service activity.

The Alliance's support is conditional on how the reform is designed, sequenced and implemented. The strongest aspects of current support coordination are relationship-based and individualised practice, participant choice, continuity of coordinator, flexible intensity, practical problem solving, knowledge of the participant and their circumstances, and the capacity to coordinate across multiple systems. For some Autistic participants an effective coordinator holds knowledge that no file captures: how the person communicates, what contributes to regulation or overload, how executive functioning affects implementation of their plan, which approaches and providers have previously worked, and when an apparent lack of engagement indicates that a different approach is required. Reform that improves consistency at the cost of these features would leave many Autistic participants worse off.

Four concerns shape this submission. The first is eligibility. The proposed eligibility factors, including decision making capacity, safety risk and the stability of formal and informal supports, risk excluding Autistic participants whose apparent stability depends on substantial and invisible scaffolding, including the very coordination the reform proposes to withdraw. Eligibility should assess the support required to maintain stability, not wait for stability to fail. The second is continuity. Continuity of a trusted relationship is a relational safeguard and not only a preference, and the transition to a commissioned service should be treated as a heightened safeguarding period. The third is the pathway for participants who are not eligible. The existence of Local Area Coordination or another pathway is not by itself evidence that equivalent coordination will be available, and no participant should lose an effective coordination function until the pathway intended to replace it is demonstrably available, accessible, capable and effective for them. The fourth is commissioning. A commissioned network model, in which a lead organisation provides regional stewardship while multiple organisations deliver participant-facing SCC, is more likely to preserve exercisable choice and specialist capability than a single participant-facing provider in each region.

These concerns rest on a principle the Alliance put to the department in the context of SIL commissioning and applies equally here: commissioning should follow support need, and support need should not be reverse engineered to fit commissioning. Regional configuration, provider capacity, available workforce and the commissioned funding envelope should not become proxies for participant need. National consistency should establish a consistent floor for rights, quality, safeguards and outcomes rather than standardising how support is delivered to each person.

SCC should be considered within the wider NDIS reform environment, including New Framework Planning and Support Needs Assessment, the access changes, Foundational Supports and the broader intermediary reforms, rather than as an isolated service change. The Alliance applies its Systems That Work™ readiness before reliance test across the reform as a whole: eligibility,

transition, the alternative pathway, commissioning and choice, continuity and accountability (section 3(c) and Attachment B). The Alliance's participation in this consultation should not be read as endorsement of the removal of funded support coordination from participants' plans or of the eligibility factors as proposed. It reflects the Alliance's intention to make the reform as safe and effective as possible for Autistic people.

The Alliance has attached an evidence summary drawing together what Autistic Australians have told us and the research most relevant to coordination, connection and trusted relationships (Attachment A), and implementation and accountability tests for the reform (Attachment B).

Summary of recommendations

The Alliance's recommendations are summarised here and developed through the submission.

How to read the recommendations

The recommendations below identify both the design features the Alliance considers necessary and, for several critical decision points, a **decision rule**. Decision rules are included where implementation requires a clear test for determining whether it is safe or appropriate to proceed, including eligibility, alternative pathways, participant choice, service intensity, transition and corrective action. They are intended to translate broader policy principles into practical and accountable implementation tests. Importantly, not every recommendation requires a decision rule.

Recommendation 1 (headline recommendation): Eligibility based on functional need

Eligibility should assess the support required to maintain stability, not wait for stability to fail. Base SCC eligibility on functional need for coordination, assessed as the support required to maintain stability, rather than on diagnosis, categorical assumptions about complexity or a snapshot of current functioning. The criteria and guidance should expressly recognise autism relevant factors, including executive functioning, communication differences including augmentative and alternative communication, sensory and cognitive load, fluctuating capacity, Autistic burnout, masking, difficulty recognising or communicating emerging problems, co-occurring and psychosocial disability, significant transitions, multiple system involvement, fragile informal supports and reliance on predictability and familiar people. Assessment should ask what is currently making the person's supports and life work and what is likely to happen if that coordination is removed, and the loss or anticipated loss of a significant informal supporter should trigger additional coordination or reassessment before arrangements deteriorate. Where a participant currently receiving support coordination is found not eligible for SCC, they should receive accessible written reasons explaining how their functional need for coordination was assessed, the alternative pathway intended to meet that need, and how to seek reassessment where circumstances change or the alternative pathway proves ineffective.

> **Decision rule:** Assess functional need both with and without the formal and informal coordination and scaffolding currently in place, including the likely consequences of its withdrawal. Current stability should not, by itself, be treated as evidence that coordination is unnecessary.

Recommendation 2: Retain what works

Retain in the SCC service the features of support coordination that work now: meaningful choice of coordinator and provider; continuity of effective relationships wherever practicable; flexible intensity as circumstances change; practical assistance to implement and sustain supports; specialist disability knowledge; effective coordination across NDIS and mainstream systems; and participant-chosen involvement of family, supporters and advocates. National consistency should establish a floor for rights, quality, safeguards and outcomes, not standardise how support is delivered to each person.

Recommendation 3: Clear role and accountability

Define the SCC role and scope of practice clearly. SCC workers should assist participants and families to understand information, coordinate services, implement agreed recommendations and escalate concerns through appropriate pathways; they should not provide clinical opinions outside their expertise or override allied health recommendations about functional support needs. Apply conflict of interest controls consistent with the Disability Royal Commission's recommendation on independent support coordination, and require provider and service traceability so that participants can identify the organisation responsible for their SCC, any delivery partner or subcontractor, their respective roles and where accountability rests.

Recommendation 4: Participant choice of delivery mode

Determine the mode of delivery by participant need and preference, with face-to-face, virtual, telephone and written communication all available and participants able to change modes as their circumstances change. Virtual delivery should not become the default response to regional or thin market limitations, and geographic location should not result in a lower level of service or reduced access to specialist expertise.

Recommendation 5: Workforce capability

Require all SCC workers to meet a nationally consistent core competency framework complemented by specialist capability relevant to the participants they support, with autism capability forming part of the national framework and specialist capability pathways available. Capability should be demonstrated through practice, supervision and outcomes rather than completion of training alone, and neuro affirming, trauma informed and culturally safe practice should be embedded in practice standards.

Recommendation 6: Safety and accessible complaints

Build **safety into the service rather than relying on complaints alone**: clear information about what SCC can and cannot do, who is accountable and how to change worker or provider; complaint and feedback mechanisms available through multiple communication modes and with a trusted person, nominee, independent advocate or communication supporter; monitoring capable of recognising disengagement, repeated failed referrals, increasing distress, loss of informal supports, workforce turnover and loss of trusted relationships; explicit protection from adverse consequences for raising concerns; and a clear external escalation pathway.

Recommendation 7: Effective alternative pathways

Apply a readiness before reliance test to the pathway for participants who are not eligible for SCC. No participant currently receiving support coordination should lose access to an effective coordination or navigation function until the pathway intended to replace it is

demonstrably available, accessible, capable and effective for them. The commissioned model should also include an accessible, autism informed navigation and escalation pathway for participants who do not require ongoing SCC but need skilled support at critical points of change, such as plan reassessments, unexpected funding reductions, changes in providers, reviews and complaints, hospital discharge, housing instability and family or carer stress.

> **Decision rule:** A referral or transition should not be treated as successful until the receiving service has accepted the referral, made accessible contact with the participant and commenced the coordination or navigation function required. **No referral without reception.**

Recommendation 8: Commissioning, choice and specialist capability

Adopt a commissioned network model in which a lead organisation provides regional stewardship, workforce development, quality assurance, coverage and accountability while multiple organisations can deliver participant-facing SCC. Effective network delivery should not require hierarchical control of all delivery partners: organisations should be able to retain clear accountability for their own service delivery while participating in shared regional governance, referral and capability arrangements.

The model should preserve access to disability-led, autism-specific, culturally specific and other specialist organisations. Lead organisations should be selected on capability rather than organisational type or scale, with formal and equitable partnerships with specialist organisations, clear participant pathways to specialist expertise, and transparency and commissioning oversight of material changes to the network.

Regional stewardship should not become regional gatekeeping. A lead organisation should not be able to use control of intake, referrals, provider selection or funding flows to preference its own services, unreasonably restrict participant choice, commercially subordinate delivery partners or marginalise specialist capability represented at procurement.

> **Decision rule:** Participants should have an exercisable choice of participant-facing SCC provider wherever practicable, including access to specialist capability. Where appropriate capability is not available within the region, participants should be able to access it across regional boundaries. The lead organisation should coordinate the regional network without controlling the participant pathway.

Recommendation 9: Regional and thin-market access

Define SCC regions by participant and service realities rather than administrative convenience alone, allow specialist capability to operate across regional boundaries where expertise cannot reasonably be replicated in every location, recognise the additional costs and constraints of regional, rural, remote and thin market delivery in commissioning, and assess local knowledge through demonstrated relationships and successful connections rather than the location of an office.

Recommendation 10: Responsive SCC/SCC+ intensity

Weight caseloads by complexity and intensity rather than participant numbers alone, require providers to maintain surge capacity where circumstances change, and enable responsive movement between SCC and SCC+.

> **Decision rule:** SCC and SCC+ intensity should be determined by assessed participant need, not predetermined quotas or service capacity. Participants should be able to step up or down promptly as circumstances change, without having to demonstrate sustained deterioration or crisis.

Recommendation 11: Sustainable funding and outcomes

Adopt a blended funding approach that combines core funding for regional infrastructure and workforce sustainability with adjustments for participant complexity and risk, travel and thin market costs, specialist capability and legitimate accessibility costs. Payment arrangements should avoid incentives to minimise contact, avoid participants with more complex needs, transfer coordination work to families, prematurely reduce intensity or substitute virtual support where face-to-face assistance is required. Outcome measures should concern whether participants can establish, access and sustain appropriate supports, exercise choice and control, navigate change and avoid preventable breakdown, rather than reductions in service use or contact.

Recommendation 12: Quality, safeguarding and early warning

Apply national quality, workforce and safeguarding requirements to commissioned SCC organisations covering core competencies, supervision, continuing professional development, communication accessibility, conflicts of interest, safeguarding responsibilities, incident escalation, complaints, outcome reporting and specialist capability. Test quality in actual practice rather than documentary compliance alone, including participant experience obtained through appropriately independent and accessible mechanisms, and establish early warning arrangements capable of identifying failed referrals, disengagement, workforce instability, loss of trusted relationships or informal supports and loss of specialist capability before these result in service breakdown.

Recommendation 13: Warm referral and escalation

Give SCC a clear warm referral obligation and an effective escalation pathway. With consent, a referral should include facilitating the connection, transferring relevant information, confirming that the receiving service can respond and following up where necessary; giving a participant a telephone number, website or generic referral should not constitute a successful connection where disability related barriers prevent the person progressing it independently. Escalation arrangements should identify who receives an escalation, what authority they have, required response timeframes and what happens where agencies disagree about responsibility, on the principle that **a real-time pathway requires capacity to act, not merely capacity to refer**.

Recommendation 14: No-Gap SCC Transition Guarantee

Treat individual transition to the commissioned SCC service as a heightened safeguarding period and adopt a No-Gap SCC Transition Guarantee (section 4B(l)): no existing support coordination ending before the participant's SCC eligibility and future pathway are determined; no gap between existing coordination and the replacement pathway; preservation of trusted existing worker relationships wherever practicable; participant

specific transition planning where disruption presents greater risk; early and accessible communication; supported choice of SCC provider; warm handover rather than administrative referral; transfer of relevant information with consent and appropriate privacy protections; rapid review and escalation where the new arrangement is not effective; and monitoring of disengagement, failed connections, increased family burden, loss of specialist capability and other adverse transition outcomes. Procurement and transition arrangements should enable capable existing coordinators to enter the new system and reward credible workforce retention.

> **Decision rule:** Existing support coordination should cease only when the NDIA has confirmed that the participant's SCC or alternative coordination pathway is in place and operational. The commencement date alone should not trigger cessation of an effective support.

Recommendation 15: Accountability and corrective action

Involve Autistic people, families and autism representative organisations in the design, testing, implementation and evaluation of the SCC service through genuine co-design, and apply the **Systems That Work™ implementation and accountability tests** at Attachment B. This should include published and appropriately disaggregated outcome reporting, early-warning indicators and predefined authority to investigate, intervene, modify, sequence, pause or correct implementation where the reform produces disengagement, service gaps, inequitable outcomes or harm.

Where a lead organisation model is used, commissioning oversight should also monitor **provider concentration, referral patterns, funding flows between lead and delivery organisations, subcontracting arrangements, changes in network membership, access to specialist providers and exercisable participant choice**. Material deterioration in provider diversity, specialist capability or participant choice should trigger timely commissioning intervention and corrective action.

> **Decision rule:** Implementation monitoring should, at minimum, track continuity of trusted worker relationships; time from eligibility decision to service commencement; failed or uncompleted referrals; participant-requested provider or worker changes; movement between SCC and SCC+; gaps in coordination; and increased reliance on family or informal supporters. Results should be appropriately disaggregated, including for Autistic participants, with predefined thresholds for investigation and corrective action.

3. The three framing points that shape this submission

a. Continuity of trusted relationships is a safeguard, not only a preference

The consultation paper lists continuity of trusted relationships among the things people consistently identified in earlier consultation, and names continuity of participant services as the first of three implementation priorities. The Alliance asks the department to take that priority further. For some Autistic participants, an effective coordinator holds knowledge about how the person communicates, what contributes to regulation or overload, how executive functioning affects the implementation of their plan, which approaches and providers have previously

worked, and when an apparent lack of engagement indicates that a different approach is required. That knowledge is built over time and is rarely written down.

Continuity should therefore be recognised as more than a participant preference. Continuity of a trusted relationship is a relational safeguard: a familiar worker may recognise subtle changes in communication, health, distress or regulation that an unfamiliar worker may not. The Disability Royal Commission identified trusted relationships, community connection and the number and diversity of people who know a person as elements of natural safeguards, and social isolation as a risk factor for violence, abuse, neglect and exploitation (Attachment A, section 4). For some Autistic people, developing trust, communication and shared understanding with a new worker can take substantial time, and the loss of that relationship may itself affect the effectiveness or safety of support.

The NDIS Review recommended that the navigation function be designed, tested and implemented gradually, prioritising continuity of support for participants and their families and a smooth transition for the workforce and market (Attachment A, section 5). This framing point shapes the Alliance's responses on transition (section 4B(l)), workforce retention (section 4B(h)) and procurement (section 4B(c)), and the No-Gap SCC Transition Guarantee at Recommendation 14.

b. Eligibility should assess the support required to maintain stability, not wait for stability to fail

The consultation paper proposes that eligibility for SCC would turn on factors including decision making capacity, safety risk, the stability of formal and informal supports, the stability and predictability of support needs, understanding of the NDIS and other systems, engagement with multiple systems and risk of disengagement. Several of these factors describe a person's current state. For Autistic participants, the current state is often the product of the supports around the person rather than evidence that those supports are no longer required.

Apparent independence or stability may depend on substantial invisible scaffolding: family and chosen supporters, familiar workers, established routines, environmental predictability, communication support, specialist knowledge and community relationships. Removing one component can have consequences that are not apparent from a snapshot assessment. The research summarised at Attachment A explains why coordination need is so often invisible for Autistic people: executive functioning differences are broad and relatively stable across development, so initiation, planning, sequencing and follow through can be affected even where a person presents as capable; masking conceals effort and need; and Autistic burnout produces loss of skills and reduced capacity without any new impairment, so capacity measured on one day is a moving target (Attachment A, section 3). Member organisations working with Autistic young people also note that support needs may change, or become more apparent, as developmental, educational, social and employment demands increase, so an assessment made at one point in a person's life should not be treated as settled.

Member organisations providing therapy and clinical services add a further observation: for many Autistic people who do not have support coordination in their plans, support needs are not continuous but become critical at particular points of change or risk, including plan reassessments, unexpected funding reductions, changes in providers, complaints and reviews, hospital discharge, housing instability and family or carer stress (section 4A(g)). An eligibility model built only around ongoing, continuous need will miss these people.

SCC assessment should therefore ask not only how the participant is functioning now, but what is currently making the person's supports and life work, and what is likely to happen if that coordination or scaffolding is removed. The loss or anticipated loss of a significant informal supporter should be capable of triggering additional coordination or reassessment before arrangements deteriorate. Assessment should consider functioning in everyday life, across settings and over time, rather than what a person can demonstrate under ideal or highly supported conditions. The Alliance's eligibility principle is that eligibility should assess the support required to maintain stability, not wait for stability to fail.

c. Readiness before reliance: no one should lose coordination until the replacement pathway is demonstrably ready

The consultation paper states that participants who are not eligible for SCC may be able to access other coordination supports, for example through Local Area Coordinators and Early Childhood Partners. The existence of another pathway is not by itself evidence that equivalent coordination support will be available. The relevant question is whether the alternative pathway has sufficient capacity, capability, accessibility and intensity to perform the function the participant requires, and whether the participant is actually receiving it. A referral is not an outcome.

In the implementation phase, readiness before reliance is not a test of whether the SCC reform should proceed. It is a safeguard against relying on a new or alternative pathway for an individual participant before that pathway is capable of performing the coordination function the person requires. Where implementation evidence identifies a safety, access or capability gap, the response should be to preserve continuity while the gap is addressed and, where necessary, modify or sequence the relevant implementation step.

The Alliance applies its Systems That Work™ readiness before reliance framework to this question, as it has in its recent submissions on the Inclusive Communities Fund and the restrictive practices indicator framework and in its response to the NDIS access changes. No participant currently receiving support coordination should lose access to an effective coordination or navigation function until the pathway intended to replace it is available, accessible, capable and effective for them. The required coordination function could be provided through the commissioned SCC service or another appropriately resourced coordination or navigation pathway, such as Local Area Coordination and other trusted channels, where that pathway is demonstrably capable of performing the required function. Whatever the pathway, it must exist and works for the participant before the existing support ends. **Independent advocacy should remain separately available where a participant requires assistance to protect their rights, challenge decisions or address failures in those systems, and should not be treated as a substitute for coordination.** The same test applies to transition, where the Alliance proposes a No-Gap SCC Transition Guarantee (section 4B(l)), and to the pathway for participants with episodic need at critical points of change (Recommendation 7).

The principle the Alliance put to the department on SIL commissioning is directly relevant: commissioning should follow support need, and support need should not be reverse engineered to fit commissioning. Regional configuration, provider capacity, available workforce and the commissioned funding envelope should not become proxies for participant need. A commencement date is not a readiness test.

Recommendation 1 (headline recommendation): Eligibility should assess the support required to maintain stability, not wait for stability to fail. Base SCC eligibility on functional need for coordination, assessed as the support required to maintain stability, rather than on diagnosis, categorical assumptions about complexity or a snapshot of current functioning. The criteria and guidance should expressly recognise autism relevant factors, including executive functioning, communication differences including augmentative and alternative communication, sensory and cognitive load, fluctuating capacity, Autistic burnout, masking, difficulty recognising or communicating emerging problems, co-occurring and psychosocial disability, significant transitions, multiple system involvement, fragile informal supports and reliance on predictability and familiar people. Assessment should ask what is currently making the person's supports and life work and what is likely to happen if that coordination is removed, and the loss or anticipated loss of a significant informal supporter should trigger additional coordination or reassessment before arrangements deteriorate. Where a participant currently receiving support coordination is found not eligible for SCC, they should receive accessible written reasons explaining how their functional need for coordination was assessed, the alternative pathway intended to meet that need, and how to seek reassessment where circumstances change or the alternative pathway proves ineffective.

Decision rule: Assess functional need both with and without the formal and informal coordination and scaffolding currently in place, including the likely consequences of its withdrawal. Current stability should not, by itself, be treated as evidence that coordination is unnecessary.

4. Responses to the consultation questions

The Alliance's responses follow the structure of the consultation paper: seven questions about what participants want from the new SCC service (Part A) and twelve questions about service provider models and approaches (Part B). The table below maps each of the department's questions to the relevant sections, recommendations and attachments of this submission.

No.	Consultation question	Traceability in this submission
A1	What is working well in support coordination today that you would like to see in the new SCC service?	Section 4A(a), section 3(a); Recommendation 2; Attachment A sections 2 and 4
A2	What would you most like to see improved in the new SCC service?	Section 4A(b); Recommendation 3; Attachment A sections 5 and 6
A3	When should SCC be a face-to-face service or a virtual service?	Section 4A(c); Recommendation 4
A4	What participant groups will benefit most from the SCC service? What do their needs for connection and coordination of supports look like?	Section 4A(d), section 3(b); Recommendations 1 and 10; Attachment A section 3
A5	What experience, skills and knowledge do you look for in an SCC worker?	Section 4A(e); Recommendations 3 and 5

No.	Consultation question	Traceability in this submission
A6	What would help you feel safe when receiving SCC services and encourage you to report an issue if needed?	Section 4A(f); Recommendation 6; Attachment A section 4
A7	What else should we consider when designing the future SCC service?	Section 4A(g), section 3(c); Recommendations 7 and 15; Attachment B
B1	What commissioning arrangements would best balance participant outcomes, quality, sustainability and choice and control?	Section 4B(a); Recommendation 8
B2	What provider types would be best placed to be a lead organisation? Why do these characteristics matter?	Section 4B(b); Recommendation 8
B3	What are the advantages and disadvantages of the lead organisation model?	Section 4B(c); Recommendation 8
B4	What would be appropriate regional areas to use for SCC service areas?	Section 4B(d); Recommendation 9
B5	How might SCC providers manage variable need among the participants it supports? Which workforce, caseload, and service capacity factors should be considered?	Section 4B(e), section 3(b); Recommendation 10
B6	Which payment and funding approaches would best support participant outcomes, workforce sustainability and innovation?	Section 4B(f); Recommendation 11
B7	What quality, workforce and safeguarding requirements should apply to commissioned SCC organisations?	Section 4B(g); Recommendations 5 and 12; Attachment B
B8	How can the future SCC model attract, build and retain workforce capability, including retaining participant relationships?	Section 4B(h), section 3(a); Recommendations 5 and 14
B9	How should local knowledge and community connection be defined and assessed?	Section 4B(i); Recommendation 9
B10	How can the SCC service best support participants in regional, rural and remote areas, or other thin markets, where support options may be limited?	Section 4B(j); Recommendations 4, 9 and 11
B11	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?	Section 4B(k); Recommendations 7 and 13
B12	What transition arrangements would minimise disruption and support successful implementation?	Section 4B(l), sections 3(a) and 3(c); Recommendation 14; Attachment B

Part A: What participants want from the new SCC service

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

The strongest aspects of current support coordination are relationship-based and individualised practice, participant choice, continuity of coordinator, flexible intensity, practical problem solving, knowledge of the participant and their circumstances, and the capacity to coordinate across multiple systems.

For some Autistic participants, an effective coordinator holds important knowledge about how the person communicates, what contributes to regulation or overload, how executive functioning affects implementation of their plan, which approaches and providers have previously worked, and when an apparent lack of engagement may indicate that a different approach is required. Continuity should therefore be recognised as more than a participant preference. Continuity of trusted relationships is a relational safeguard: a familiar worker may recognise subtle changes in communication, health, distress or regulation that an unfamiliar worker may not (section 3(a)).

Member organisations that are autism-specific service providers describe the same features from a provider perspective. For many participants, support coordination is the bridge between NDIS funding, service systems and meaningful outcomes, and effective practice is characterised by trusted relationships, specialist knowledge, participant led planning and strong local networks. Autistic people and people with complex support needs benefit in particular from coordinators who understand their goals, communication styles, family contexts and support environments over extended periods of time.

The new model should retain:

- meaningful choice of coordinator and provider;
- continuity of effective relationships wherever practicable;
- flexible intensity as circumstances change;
- practical assistance to implement and sustain supports;
- specialist disability knowledge;
- effective coordination across NDIS and mainstream systems, including health, education, housing and employment; and
- participant-chosen involvement of family, supporters and advocates.

National consistency should establish a consistent floor for rights, quality, safeguards and outcomes, rather than standardising how support is delivered to each person. This is consistent with the Alliance's position on SIL commissioning that national consistency should not become standardisation.

> **Recommendation 2:** Retain in the SCC service the features of support coordination that work now: meaningful choice of coordinator and provider; continuity of effective relationships wherever practicable; flexible intensity as circumstances change; practical assistance to implement and sustain supports; specialist disability knowledge; effective coordination across NDIS and mainstream systems; and participant-chosen involvement of family, supporters and advocates. National consistency should establish a floor for rights, quality, safeguards and outcomes, not standardise how support is delivered to each person.

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

There is an opportunity to improve consistency of quality and capability across support coordination, including clearer role boundaries, stronger conflict of interest arrangements, more consistent workforce competencies, disability specific expertise, effective escalation pathways, safeguarding and complaints arrangements, and better interfaces with mainstream and community services. The NDIS Quality and Safeguards Commission's Own Motion Inquiry found that conflicts of interest accounted for around a quarter of all complaints it examined about support coordination, and that inadequate support and poor communication were the most common quality concerns (Attachment A, section 5).

Member organisations report that support coordinators have provided variable levels of support to Autistic participants and their families. While some provide highly effective assistance, there have been instances where inconsistent or inaccurate advice has created confusion, increased stress and placed Autistic participants at risk of disengagement or disruption to essential supports. Examples reported to the Alliance include support coordinators providing incorrect information about funding categories, recommending changes to service providers on the basis of their own preferences without regard to long established therapeutic relationships, and commenting on functional support needs in ways that override or contradict allied health recommendations.

Two improvements follow. The first is clear role definition and scope of practice for SCC roles. SCC workers should not provide clinical opinions outside their expertise or override allied health recommendations regarding functional support needs. Their role should be to assist participants and families to understand information, coordinate services, implement agreed recommendations and escalate concerns through appropriate pathways. The second is a consistent and reliable source of information, so that families receive accurate advice and equitable support regardless of which organisation or worker they are allocated.

A further issue is provider and service traceability under the proposed commissioned model. Participants should be able to identify the organisation responsible for their SCC, any delivery partner or subcontractor involved, their respective roles and where accountability ultimately rests. The Alliance's SIL commissioning submission adopts the principle 'Universal identification. Proportionate regulation. Transparent accountability.' A similar principle should apply to SCC so that commissioning does not create opaque tiers of service delivery.

Member organisations also ask that the future model measure participant outcomes rather than service activity: independence, community participation, stability of supports and achievement of personal goals, together with better integration with foundational, mainstream and community supports and improved access in regional, rural and remote communities. The objective throughout should be greater consistency of quality without unnecessary loss of individualisation, specialist capability or participant choice.

> **Recommendation 3:** Define the SCC role and scope of practice clearly. SCC workers should assist participants and families to understand information, coordinate services, implement agreed recommendations and escalate concerns through appropriate pathways; they should not provide clinical opinions outside their expertise or override allied health recommendations about functional support needs. Apply conflict of interest controls consistent with the Disability Royal Commission's recommendation on independent support coordination, and require provider and service traceability so that participants can identify the organisation responsible for their SCC, any delivery partner or subcontractor, their respective roles and where accountability rests.

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

The mode of support should be determined primarily by participant need and preference. Neither face-to-face nor virtual support is inherently more accessible for Autistic people. Some people communicate more effectively online because it reduces sensory and social demands. Others may require face-to-face support because of communication needs, technology access, cognitive load, complexity, risk or the need to establish and sustain trust.

A hybrid model should therefore be available, including face-to-face, virtual, telephone and written communication, with participants able to change modes as their circumstances change. Member organisations that are autism-specific service providers identify circumstances in which face-to-face engagement should always be available: complex communication needs, intensive relationship building, significant life transitions, psychosocial or behavioural complexity, engagement across multiple support systems and limited access to technology. Virtual delivery can provide effective and efficient access for routine contact, reviews and participants who prefer remote engagement. The Disability Royal Commission recommended that support coordination funding for participants at heightened risk of violence, abuse, neglect or exploitation be sufficient to enable at least monthly face-to-face contact (Attachment A, section 4); the commissioned service should not fall below that standard for participants at heightened risk.

Virtual delivery should not become the default response to regional or thin market limitations. Geographic location should not result in a lower level of service or reduced access to specialist expertise.

> **Recommendation 4:** Determine the mode of delivery by participant need and preference, with face-to-face, virtual, telephone and written communication all available and participants able to change modes as their circumstances change. Virtual delivery should not become the default response to regional or thin market limitations, and geographic location should not result in a lower level of service or reduced access to specialist expertise.

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

Eligibility should be based on functional need for coordination, rather than diagnosis or categorical assumptions about complexity. For Autistic participants, relevant factors may include executive functioning affecting initiation, planning, sequencing and follow through; communication differences, including augmentative and alternative communication; sensory and cognitive load; fluctuating functional capacity; Autistic burnout; masking; difficulty recognising or communicating emerging problems; co-occurring disability or psychosocial disability; significant transitions; multiple system involvement; fragile informal supports; and reliance on predictability or familiar people. The evidence for each of these factors is summarised at Attachment A, section 3.

A key issue is apparent independence or stability. Apparent independence may depend on substantial invisible scaffolding, including family and chosen supporters, familiar workers, established routines, environmental predictability, communication support, specialist knowledge and community relationships. Removing one component can have consequences that are not apparent from a snapshot assessment. SCC assessment should therefore ask not only how the participant is functioning now, but what is currently making the person's supports and life work, and what is likely to happen if that coordination or scaffolding is removed. Assessment should consider functioning in everyday life, across settings and over time, rather than what a person can demonstrate under ideal or highly supported conditions, and should recognise that for children and young people functional impact and support needs may change or become more apparent as developmental, emotional, educational and social demands increase.

The loss or anticipated loss of a significant informal supporter should be capable of triggering additional coordination or reassessment before arrangements deteriorate. A useful eligibility principle is that eligibility should assess the support required to maintain stability, not wait for stability to fail (section 3(b) and Recommendation 1).

Member organisations identify participants with intersecting circumstances who are likely to have the greatest need for connection and coordination: Autistic participants with complex support needs; participants with intellectual disability; people with psychosocial disability; participants experiencing housing instability; First Nations participants; culturally and linguistically diverse communities; participants transitioning between life stages; individuals with limited informal supports; participants living in regional, rural and remote locations; and participants requiring supported decision making. The Alliance's view is that these circumstances should inform the assessment of functional need for coordination rather than operate as categorical eligibility criteria, and that the SCC+ level should provide sufficient flexibility to respond to fluctuating complexity and to prevent crisis, rather than responding only once a crisis has emerged (section 4B(e) and Recommendation 10).

Need for coordination is also not always continuous. Member organisations providing therapy and clinical services report that many Autistic people who do not receive support coordination funding need skilled, autism informed navigation at critical points of system change. That need is addressed in section 4A(g) and Recommendation 7.

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

All SCC workers should meet a nationally consistent core competency framework, complemented by specialist capability relevant to the participants they support. Member organisations suggest that core capabilities should include disability rights and NDIS expertise, a thorough understanding of supported decision making, risk assessment and safeguarding, service system navigation, family centred practice, cultural responsiveness, trauma informed approaches and community capacity building, with specialist capability pathways available in areas such as autism, positive behaviour support, psychosocial disability, mental health systems, complex communication needs, housing and homelessness supports, and justice and child protection systems.

For Autistic participants, capability should include contemporary autism understanding; neuro affirming and trauma informed practice; communication and augmentative and alternative communication; sensory processing; executive functioning; masking and Autistic burnout; co-occurring disability and psychosocial disability; supported decision making; safeguarding and risk; working appropriately with participant-chosen families and supporters; and NDIS and mainstream system navigation. Neuro-affirming practice should be embedded within workforce

expectations and quality standards, and the framework should recognise the diversity of Autistic people and the diversity of their support needs.

Capability should be demonstrated through practice, supervision and outcomes rather than completion of training alone. The Alliance's SIL commissioning submission provides a useful assurance principle: quality should be tested in actual practice rather than inferred from documentation. For SCC, quality assurance should therefore consider whether workers can demonstrate how relevant competencies apply to individual participants. SCC workers should also understand the limits of their role. They should not provide clinical opinions outside their expertise or override allied health recommendations about functional support needs (section 4A(b) and Recommendation 3).

> **Recommendation 5:** Require all SCC workers to meet a nationally consistent core competency framework complemented by specialist capability relevant to the participants they support, with autism capability forming part of the national framework and specialist capability pathways available. Capability should be demonstrated through practice, supervision and outcomes rather than completion of training alone, and neuro affirming, trauma informed and culturally safe practice should be embedded in practice standards.

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

Safety requires more than an accessible complaints mechanism. Participants should receive clear information about what SCC can and cannot do, who is accountable for their service, how to change worker or provider, how to raise concerns and what will happen when they do. Complaint and feedback mechanisms should be available through multiple communication modes and allow involvement of a trusted person, nominee, independent advocate or communication supporter.

Importantly, safeguarding should not depend on a participant first recognising that something is wrong, identifying it as a complaint and independently navigating a complaints process. Emerging problems for some Autistic people may first become apparent through changes in communication, regulation, behaviour, participation or relationships rather than through a formal complaint. SCC monitoring should therefore be capable of recognising patterns such as disengagement, repeated failed referrals, increasing distress, loss of informal supports, repeated disruption, workforce turnover or loss of trusted relationships.

There should also be explicit protection from adverse consequences for raising concerns and a clear external escalation pathway. Member organisations recommend that the quality and safeguarding framework include national accreditation and registration requirements, independent complaints mechanisms, clear participant rights information, strong worker screening arrangements, transparent performance reporting, regular auditing against quality standards, participant feedback and co-design mechanisms, and that safeguarding promote participant autonomy, self determination and inclusion rather than focusing solely on compliance.

> **Recommendation 6:** Build safety into the service rather than relying on complaints alone: clear information about what SCC can and cannot do, who is accountable and how to change worker or provider; complaint and feedback mechanisms available through multiple communication modes and with a trusted person, nominee, independent advocate or communication supporter; monitoring capable of recognising disengagement, repeated failed referrals, increasing distress, loss of informal supports, workforce turnover and loss of trusted relationships; explicit protection from adverse consequences for raising concerns; and a clear external escalation pathway.

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

SCC should be considered within the wider NDIS reform environment rather than as an isolated service change. The eligibility factors will be applied to participants planned under the current framework and to participants who undertake a Support Needs Assessment under New Framework Planning, at the same time as access changes, Foundational Supports and pricing reforms are being implemented. Each of these interacts with the others, and a participant's need for coordination is likely to be highest precisely when several of them change at once.

A particularly important issue is the pathway for participants who do not meet the SCC eligibility threshold. The existence of another pathway, such as Local Area Coordination, is not by itself evidence that equivalent coordination support will be available. The relevant question is whether the alternative pathway has sufficient capacity, capability, accessibility and intensity to perform the function the participant requires. This should be considered through the Alliance's Systems That Work™ readiness before reliance framework (section 3(c) and Attachment B). A principle from the Alliance's SIL commissioning submission is directly relevant: commissioning should follow support need, and support need should not be reverse engineered to fit commissioning. Accordingly, regional configuration, provider capacity, available workforce or the commissioned funding envelope should not become proxies for participant need.

No participant currently receiving support coordination should lose access to an effective coordination or navigation function until the pathway intended to replace it is available, accessible, capable and effective for them. The required coordination function should be provided through SCC or another appropriately resourced coordination or navigation pathway demonstrably capable of performing that function. Independent advocacy should remain separately available to protect rights, assist participants to challenge decisions and respond to system failures, but should not be treated as a substitute for coordination.

The design should also provide for participants whose need for coordination is episodic. Many Autistic people do not receive funding for support coordination. For some, support needs are not continuous but become critical at key points of change or risk, such as plan reassessments, unexpected funding reductions, changes in providers, complaints, reviews, hospital discharge, housing instability or family and carer stress. One member organisation providing therapy and clinical services described a family it is currently supporting.

De-identified example reported by an Alliance member organisation, September 2026

- A 22 year old Autistic woman lives at home with her parent. She had received capacity building and core supports funding in her NDIS plan for multiple years and had been self managing her supports.
- Without warning, all core supports funding was withdrawn, capacity building funding was reduced by 50 per cent, and the plan was changed from self managed to NDIA managed.
- The family is unsure why these changes occurred. They contacted the NDIS planner but were unable to obtain a clear explanation or rationale for the funding reduction and the change in plan management.
- The family does not currently have the capacity to lodge a formal complaint or navigate a plan review process independently.
- The therapist is supporting the family to understand and respond to the situation; however, this work is unfunded and sits outside the intended scope of the therapy role.

Participants and families in this situation require timely, autism informed support to navigate significant changes to their NDIS plans, including access to clear reasons for decisions, information about review and complaints pathways, and assistance to escalate concerns when needed. A commissioned model should include an accessible navigation and escalation pathway for Autistic participants who may not require ongoing SCC but need skilled support at critical points of system change. Without it, that work will continue to fall to therapists, families and advocates, unfunded and outside their roles.

Finally, Autistic people must be meaningfully involved in the design, testing, implementation and evaluation of the SCC service, alongside families, carers and autism representative organisations. This should extend beyond consultation to genuine co-design, and should be reflected in the practice standards through an explicit neurodiversity affirming approach that recognises the diversity of Autistic people and the diversity of their support needs.

> **Recommendation 7:** Apply a readiness before reliance test to the pathway for participants who are not eligible for SCC. No participant currently receiving support coordination should lose access to an effective coordination or navigation function until the pathway intended to replace it is demonstrably available, accessible, capable and effective for them. The commissioned model should also include an accessible, autism informed navigation and escalation pathway for participants who do not require ongoing SCC but need skilled support at critical points of change, such as plan reassessments, unexpected funding reductions, changes in providers, reviews and complaints, hospital discharge, housing instability and family or carer stress.

Decision rule: A referral or transition should not be treated as successful until the receiving service has accepted the referral, made accessible contact with the participant and commenced the coordination or navigation function required. **No referral without reception.**

> **Recommendation 15:** Involve Autistic people, families and autism representative organisations in the design, testing, implementation and evaluation of the SCC service through genuine co-design, and apply the **Systems That Work™ implementation and accountability tests** at Attachment B. This should include published and appropriately disaggregated outcome reporting, early-warning indicators and predefined authority to investigate, intervene, modify, sequence, pause or correct implementation where the reform produces disengagement, service gaps, inequitable outcomes or harm.

Where a lead organisation model is used, commissioning oversight should also monitor **provider concentration, referral patterns, funding flows between lead and delivery organisations, subcontracting arrangements, changes in network membership, access to specialist providers and exercisable participant choice**. Material deterioration in provider diversity, specialist capability or participant choice should trigger timely commissioning intervention and corrective action.

Decision rule: Implementation monitoring should, at minimum, track continuity of trusted worker relationships; time from eligibility decision to service commencement; failed or uncompleted referrals; participant-requested provider or worker changes; movement between SCC and SCC+; gaps in coordination; and increased reliance on family or informal supporters. Results should be appropriately disaggregated, including for Autistic participants, with predefined thresholds for investigation and corrective action.

Part B: Service provider models and approaches

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

A commissioned network model warrants consideration, rather than assuming that one organisation should become the sole participant-facing SCC provider in each region. A lead organisation could provide regional stewardship, workforce development, quality assurance, coverage and accountability while multiple organisations deliver participant-facing SCC. The model should preserve meaningful participant choice and access to disability-led, autism-specific, culturally specific and other specialist organisations.

Effective network delivery does not require all participant-facing services to sit hierarchically beneath a lead organisation. Commissioning should allow collaborative models in which participating organisations retain clear accountability for their own service delivery while contributing to shared regional governance, referral, workforce development and capability arrangements. The lead organisation's role should be one of stewardship and coordination of the network, rather than control of participant pathways.

This distinction is important because control of intake, referrals and funding flows can create significant market power. Regional stewardship should not allow a lead organisation to preference its own services, restrict participant access to other delivery partners, or weaken the viability of specialist providers. Transparent decision rights, referral arrangements and funding flows should therefore be built into the commissioning model.

Choice should also be measured in practice. The Alliance's SIL commissioning submission makes the relevant distinction that choice must be **exercisable, not merely theoretical**. It recommends considering whether participants actually have an alternative provider capable of meeting their needs rather than simply counting commissioned providers. The same test should apply to SCC.

Member organisations that are autism-specific service providers recognise potential benefits of a commissioned model, including greater consistency, accountability and quality assurance. They emphasise that commissioning should establish clear accountability for outcomes, maintain participant choice, enable specialist providers to contribute expertise, encourage innovation and continuous improvement, and promote collaboration across the disability ecosystem. Commissioning should not inadvertently reduce participant choice, specialist expertise or local responsiveness.

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

Organisational type or size should not, by itself, determine suitability to act as a lead organisation. Relevant criteria should include governance and financial sustainability; disability rights and person centred practice; commissioning or network stewardship capability; meaningful disability leadership; capacity to work equitably with specialist and community organisations; workforce capability; safeguarding; local relationships; accessible complaints arrangements; data and outcomes capability; and capacity to share authority and resources across a network.

These characteristics matter because the lead organisation will shape the pathways available to every eligible participant in a region. Organisational scale should not be treated as a proxy for quality or specialist capability. The model should also avoid a structure in which smaller or specialist organisations are nominal consortium members but have little practical influence over delivery, funding or participant pathways.

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

Potential advantages include clearer regional accountability, more consistent standards, coordinated workforce development, improved coverage planning, stronger governance and a mechanism for addressing gaps in service availability.

Potential risks include reduced participant choice, regional monopoly or oligopoly, loss of specialist expertise and of local specialist providers, additional bureaucracy, homogenisation, reduced innovation, conflicts of interest, dependence of smaller providers on a dominant contractor, workforce disruption during implementation, and regional disruption if the lead provider fails.

There is also a consortium integrity risk. A lead contractor should not be able to obtain a contract partly on the strength of smaller, local, autism-specific or culturally specific consortium members and subsequently remove or marginalise those organisations in a way that materially changes the commissioned solution. If a lead model is adopted, the capability and diversity represented at procurement should be protected over the contract term, with transparency and commissioning oversight of material changes. Member organisations also recommend that lead organisations be required to establish formal partnerships with specialist and community based organisations and to maintain clear participant pathways to specialist expertise.

Shared functions should enable the network rather than operate as control points: common systems, workforce development, quality assurance and regional coordination need not require centralised control of participant intake, referral or provider selection.

A further risk is that regional stewardship becomes regional gatekeeping. Where the lead organisation controls intake, referrals, allocation of participants and funding flows, it may acquire substantial influence over both participant choice and the viability of other providers in the

network. These functions should therefore be designed with transparent decision rights, conflict-of-interest controls and commissioning oversight.

The lead organisation should not be both the gatekeeper to the regional SCC network and the default beneficiary of the referrals it controls without specific safeguards against self-preferencing.

> **Recommendation 8:** Adopt a commissioned network model in which a lead organisation provides regional stewardship, workforce development, quality assurance, coverage and accountability while multiple organisations can deliver participant-facing SCC. Effective network delivery should not require hierarchical control of all delivery partners: organisations should be able to retain clear accountability for their own service delivery while participating in shared regional governance, referral and capability arrangements.
>
> The model should preserve access to disability-led, autism-specific, culturally specific and other specialist organisations. Lead organisations should be selected on capability rather than organisational type or scale, with formal and equitable partnerships with specialist organisations, clear participant pathways to specialist expertise, and transparency and commissioning oversight of material changes to the network.
>
> **Regional stewardship should not become regional gatekeeping.** A lead organisation should not be able to use control of intake, referrals, provider selection or funding flows to preference its own services, unreasonably restrict participant choice, commercially subordinate delivery partners or marginalise specialist capability represented at procurement.
>
> **Decision rule:** Participants should have an exercisable choice of participant-facing SCC provider wherever practicable, including access to specialist capability. Where appropriate capability is not available within the region, participants should be able to access it across regional boundaries. The lead organisation should coordinate the regional network without controlling the participant pathway.

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

Regions should reflect participant and service realities rather than administrative convenience alone. Relevant considerations include participant distribution, travel distances, community and service ecosystems, First Nations and culturally diverse communities, health and human service boundaries, workforce availability, thin markets, specialist capability and cross border service patterns.

Regional boundaries should not prevent specialist capability operating across regions where expertise cannot reasonably be replicated in every location. Autism-specific capability is a case in point: it will not be available at the same depth in every region, and participants should be able to reach it wherever they live. The objective should be regional accountability without creating artificial barriers to expertise or participant choice.

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

Caseloads should be weighted according to complexity and intensity, rather than participant numbers alone. Factors should include communication requirements, decision making support, safeguarding concerns, number of systems involved, geographic travel, cultural requirements,

transition intensity, service instability and the frequency of active coordination required. Providers should maintain surge capacity where circumstances change.

Movement between SCC and SCC+ should be responsive to changing need. Participants should not have to demonstrate sustained deterioration before additional intensity becomes available. Importantly, assessment should consider what currently maintains stability. A person whose support network is working effectively may require significant coordination to keep that arrangement functioning, and the SCC+ level should have sufficient flexibility to respond to fluctuating complexity and to prevent crisis rather than responding once a crisis has emerged.

> **Recommendation 10:** Weight caseloads by complexity and intensity rather than participant numbers alone, require providers to maintain surge capacity where circumstances change, and enable responsive movement between SCC and SCC+.

Decision rule: SCC and SCC+ intensity should be determined by assessed participant need, not predetermined quotas or service capacity. Participants should be able to step up or down promptly as circumstances change, without having to demonstrate sustained deterioration or crisis.

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

A blended funding approach warrants consideration, combining appropriate core funding for regional infrastructure and workforce sustainability with adjustments for participant complexity and risk, travel and thin market costs, specialist capability and legitimate accessibility costs.

Payment arrangements should avoid incentives to minimise contact, avoid participants with more complex needs, transfer coordination work to families, prematurely reduce intensity or substitute virtual support where face-to-face assistance is required. Outcomes should concern whether participants can establish, access and sustain appropriate supports, exercise choice and control, navigate changes and avoid preventable breakdown, and not simply reductions in service use or contact.

Provider sustainability is also a participant issue where provider failure could disrupt trusted relationships, specialist knowledge and essential coordination. The Alliance's SIL commissioning submission similarly treats market sustainability and provider diversity as potential safeguarding considerations.

> **Recommendation 11:** Adopt a blended funding approach that combines core funding for regional infrastructure and workforce sustainability with adjustments for participant complexity and risk, travel and thin market costs, specialist capability and legitimate accessibility costs. Payment arrangements should avoid incentives to minimise contact, avoid participants with more complex needs, transfer coordination work to families, prematurely reduce intensity or substitute virtual support where face-to-face assistance is required. Outcome measures should concern whether participants can establish, access and sustain appropriate supports, exercise choice and control, navigate change and avoid preventable breakdown, rather than reductions in service use or contact.

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

National requirements should cover core competencies, supervision, continuing professional development, communication accessibility, conflicts of interest, safeguarding responsibilities, incident escalation, complaints, outcome reporting and specialist capability. Autism capability

should form part of the framework. Member organisations recommend that the requirements also include national accreditation and registration, independent complaints mechanisms, clear participant rights information, strong worker screening, transparent performance reporting, regular auditing against quality standards and participant feedback and co-design mechanisms (section 4A(f)).

Quality assurance should test actual practice rather than documentary compliance alone, including participant experience obtained through appropriately independent and accessible mechanisms. The model should also establish early warning arrangements. Quality monitoring should be capable of identifying patterns such as failed referrals, disengagement, workforce instability, loss of trusted relationships or informal supports, provider distress and loss of specialist capability before these result in service breakdown.

Conflict of interest controls should be consistent with the Disability Royal Commission's recommendation that support coordination providers not simultaneously deliver other funded supports to the same participant, with exceptions confined to limited circumstances such as thin markets and specialised or culturally appropriate services (Attachment A, section 4). The consultation paper's proposal that SCC workers not provide other NDIS supports is consistent with that recommendation; the traceability principle at Recommendation 3 is needed so that the same separation is visible to participants where delivery partners and subcontractors are involved.

> **Recommendation 12:** Apply national quality, workforce and safeguarding requirements to commissioned SCC organisations covering core competencies, supervision, continuing professional development, communication accessibility, conflicts of interest, safeguarding responsibilities, incident escalation, complaints, outcome reporting and specialist capability. Test quality in actual practice rather than documentary compliance alone, including participant experience obtained through appropriately independent and accessible mechanisms, and establish early warning arrangements capable of identifying failed referrals, disengagement, workforce instability, loss of trusted relationships or informal supports and loss of specialist capability before these result in service breakdown.

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

The reform should seek to retain high quality existing support coordinators and the expertise they hold. Procurement and transition arrangements should enable capable workers to enter the new system and reward credible workforce retention, supervision, professional development and specialist capability. Member organisations ask for investment in workforce development, capability and retention, including workforce transition and retention strategies during implementation and specific incentives for workforce attraction and retention in regional, rural and remote areas.

Workforce transition should also be considered from the participant's perspective. Where an effective coordinator moves into the commissioned system, continuation of that relationship should be facilitated wherever practicable. For some Autistic people, developing trust, communication and shared understanding can take substantial time and the loss of that relationship may itself affect the effectiveness or safety of support (section 3(a)). Retaining participant relationships is therefore a workforce objective and a safeguarding objective at the same time, and should be recognised in procurement criteria, transition planning and contract performance measures (Recommendations 5 and 14).

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

Local knowledge should be demonstrated through relationships and effective connections, rather than the location of an office. Local knowledge should also be treated as accumulated capability. Established relationships, referral pathways and community trust take time to build and should not be unnecessarily lost through regional restructuring or provider turnover.

Evidence could include established relationships with disability and advocacy organisations, health and mental health services, housing providers, education, employment services, local government, community organisations, Aboriginal Community Controlled Organisations and First Nations organisations, and culturally specific services, together with demonstrated understanding of local gaps and referral pathways.

Assessment should consider whether the organisation can translate that knowledge into successful connections for participants. Member organisations put the same point in provider terms: assessment of local capability should extend beyond geographic coverage to demonstrated and meaningful community partnerships. A provider's postcode should not be treated as sufficient evidence of local capability.

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

Commissioning should explicitly recognise the additional costs and constraints associated with regional, rural, remote and thin market delivery, including travel, outreach, workforce attraction and retention and lower caseload density. Member organisations recommend that future SCC arrangements include flexible service delivery approaches, outreach and mobile workforce models, partnerships with local community organisations, technology enabled supports, specific incentives for workforce attraction and retention, and investment in local capability development.

Virtual delivery can improve access for some participants but should not become the default response to market failure. Specialist capability should be able to operate across regional boundaries, including through partnerships between local and specialist organisations. The model should measure whether participants have a genuine alternative capable of meeting their needs, rather than treating the nominal presence of more than one commissioned organisation as sufficient evidence of choice. No participant should experience reduced access because of where they live.

> **Recommendation 9:** Define SCC regions by participant and service realities rather than administrative convenience alone, allow specialist capability to operate across regional boundaries where expertise cannot reasonably be replicated in every location, recognise the additional costs and constraints of regional, rural, remote and thin market delivery in commissioning, and assess local knowledge through demonstrated relationships and successful connections rather than the location of an office.

k. 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 should coordinate across complexity without absorbing functions that properly belong to independent advocacy, supported decision making or other systems. Member organisations note that participants experiencing multiple and overlapping challenges often require intensive coordination, multi agency collaboration, specialist disability expertise, long term relationship-

based support, decision making assistance and crisis prevention through flexible early intervention, and that these participants frequently experience the greatest risk of disengagement from services.

Where another service is required, SCC should have a clear warm referral obligation. With consent, this should include facilitating the connection, transferring relevant information, confirming that the receiving service can respond and following up where necessary. Giving a participant a telephone number, website or generic referral should not constitute a successful connection where disability related barriers prevent the person progressing it independently. Member organisations that are autism-specific service providers describe the gap between referral and access as the hardest part of the current system: a list of services makes no difference if the person's executive functioning does not support the intensive requirements of onboarding into a new service, and for true impact participants must be guided through entry until they are actually receiving the service.

There must also be an effective escalation pathway. A real-time pathway requires capacity to act, not merely capacity to refer. For SCC, escalation arrangements should identify who receives an escalation, what authority they have, required response timeframes and what happens where agencies disagree about responsibility. The participant should not bear the consequences while organisations determine jurisdiction or responsibility. The consultation paper proposes that SCC would escalate relevant issues to the NDIA; the Alliance asks that the NDIA side of that pathway be designed with the same clarity about who receives the escalation, what authority they hold and how quickly they must respond.

For participants whose need for skilled navigation arises at critical points of change rather than continuously, the accessible navigation and escalation pathway at Recommendation 7 is the relevant response.

> **Recommendation 13:** Give SCC a clear warm referral obligation and an effective escalation pathway. With consent, a referral should include facilitating the connection, transferring relevant information, confirming that the receiving service can respond and following up where necessary; giving a participant a telephone number, website or generic referral should not constitute a successful connection where disability related barriers prevent the person progressing it independently. Escalation arrangements should identify who receives an escalation, what authority they have, required response timeframes and what happens where agencies disagree about responsibility, on the principle that a real-time pathway requires capacity to act, not merely capacity to refer.

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

Transition into the commissioned SCC model should itself be treated as a heightened safeguarding period. Changes in provider, workforce, contractual relationships or familiar systems can destabilise arrangements even where the intended end state is better. The Alliance recommends identifying, for each participant, what currently keeps the person safe and stable: trusted relationships, communication knowledge, specialist capability, informal supporters, foreseeable transition risks and who has authority to intervene if transition begins to fail.

The NDIS Review recommended that the navigation function be designed, tested and implemented gradually, prioritising continuity of support for participants and their families and a smooth transition for the workforce and market (Attachment A, section 5). Member organisations recommend early communication to participants, families and providers, preservation of existing

participant worker relationships wherever possible, staged implementation across regions, workforce transition and retention strategies, readiness assessments prior to commencement, continuous monitoring of participant outcomes during transition and independent evaluation of implementation progress.

A No-Gap SCC Transition Guarantee should therefore be adopted, comprising:

1. no existing support coordination ending before the participant's SCC eligibility and future pathway are determined;
2. no gap between existing coordination and the replacement pathway;
3. preservation of trusted existing worker relationships wherever practicable;
4. participant specific transition planning where disruption presents greater risk;
5. early and accessible communication;
6. supported choice of SCC provider;
7. warm handover rather than administrative referral;
8. transfer of relevant information with consent and appropriate privacy protections;
9. rapid review and escalation where the new arrangement is not effective; and
10. monitoring of disengagement, failed connections, increased family burden, loss of specialist capability and other adverse transition outcomes.

This would give practical effect to readiness before reliance. The key question before transition should be: what is currently making this arrangement work, what must be preserved through the transition, and who has responsibility and authority to act if the new arrangement begins to fail?

> **Recommendation 14:** Treat individual transition to the commissioned SCC service as a heightened safeguarding period and adopt a No-Gap SCC Transition Guarantee (section 4B(l)): no existing support coordination ending before the participant's SCC eligibility and future pathway are determined; no gap between existing coordination and the replacement pathway; preservation of trusted existing worker relationships wherever practicable; participant specific transition planning where disruption presents greater risk; early and accessible communication; supported choice of SCC provider; warm handover rather than administrative referral; transfer of relevant information with consent and appropriate privacy protections; rapid review and escalation where the new arrangement is not effective; and monitoring of disengagement, failed connections, increased family burden, loss of specialist capability and other adverse transition outcomes. Procurement and transition arrangements should enable capable existing coordinators to enter the new system and reward credible workforce retention.

Decision rule: Existing support coordination should cease only when the NDIA has confirmed that the participant's SCC or alternative coordination pathway is in place and operational. The commencement date alone should not trigger cessation of an effective support.

5. Conclusion

A commissioned SCC service could give Autistic participants more consistent, better safeguarded and more capable coordination than the current market provides, or it could remove a trusted relationship and an invisible layer of scaffolding from people whose stability depends on both. Which of these happens will be decided by design choices that are still open: whether

eligibility assesses the support required to maintain stability or waits for stability to fail; whether continuity of trusted relationships is treated as a safeguard or a preference; whether anyone loses coordination before the pathway intended to replace it is demonstrably ready; and whether commissioning preserves exercisable choice and specialist capability or consolidates them away.

The Alliance's recommendations are directed at those choices. They ask for an eligibility model that recognises how Autistic people actually function across settings and over time; a service that retains what works now, with clear roles, autism-capable workers and safety built in rather than complained into; a commissioned network model in which lead organisations steward rather than monopolise; funding and caseload arrangements that reward keeping people stable; a warm referral obligation and an escalation pathway with capacity to act; a No-Gap SCC Transition Guarantee; and transparent, disaggregated reporting with the authority to correct what the data reveal. Commissioning should follow support need, and no one should be referred out of coordination without reception on the other side. None of this prevents reform. It is what makes reform safer, more accountable and more likely to achieve its intended outcomes.

The Alliance would welcome the opportunity to discuss any aspect of this submission, to contribute to the design of the eligibility criteria, the commissioning approach and the transition arrangements, and to participate in the further consultation the department and the NDIA have foreshadowed as the model is developed. Please do not hesitate to contact us with any queries or requests for further information.

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Attachment A: What Autistic Australians have told us and what the evidence shows about coordination, connection and trusted relationships

The Alliance's recommendations are informed by a substantial body of Australian autism community evidence gathered over several years, including its national consultation of more than 3,800 Autistic people, families and carers undertaken by Australian Catholic University for the Senate Select Committee on Autism, subsequent lived experience work undertaken for the NDIS Review and the National Autism Strategy, and the research literature on executive functioning, masking and Autistic burnout. This attachment summarises the evidence most relevant to the design of the SCC service. Numbered references are listed at the end of the submission.

1. Scale and relevance

Autistic people are the largest primary disability cohort within the NDIS. As at 31 March 2026, 338,099 active NDIS participants had autism recorded as their primary disability, representing approximately 44 per cent of active participants.[1] In its 2023 Own Motion Inquiry the NDIS Quality and Safeguards Commission reported that 45 per cent of active participants had support coordination in their NDIS plans, approximately 276,000 participants at that time, and the consultation paper reports that participants currently purchase support coordination from approximately 11,000 providers.[2,3] The Alliance does not have access to data on the proportion of Autistic participants with support coordination in their plans; on any reasonable assumption, however, the reform will change the coordination arrangements of a very large number of Autistic people, and the eligibility criteria will determine how many of them retain any funded coordination at all.

2. What Autistic Australians have told us about connection and support

The Alliance's national consultation, undertaken by Australian Catholic University to inform the Senate Select Committee on Autism, received more than 3,800 responses. The Senate Committee subsequently reported that 67.5 per cent of Autistic adults and 73.4 per cent of parents and carers reported feeling socially isolated; that 61.2 per cent of Autistic adults had lost friends because of the way others responded to their autism; that 47.5 per cent of Autistic adults sometimes felt unable to leave home because of fear of negative reactions; and that 34 per cent of Autistic NDIS participants aged 15 to 24 and 41 per cent aged over 25 had no friends other than family or paid staff.[4] The Committee identified contributors to poor social inclusion including limited opportunities to participate and build social connections, lack of community understanding of autism, inaccessible environments, reduced community mobility and low levels of independent living.[4]

For some Autistic people, meaningful participation depends on sensory accessibility and appropriate pacing, accessible and supported communication, predictable environments and routines, trusted relationships, transport, decision making support, assistance navigating social environments and individualised support.[4,5,6] Connection and coordination are the mechanisms through which these conditions are put in place and kept in place. The people who told the Senate Committee that they had no friends other than family or paid staff are the people for whom a trusted coordinator may be the only person outside the family who knows how they communicate and what keeps them well. That is why the Alliance treats continuity of trusted relationships as a safeguarding issue (section 3(a)).

3. Executive functioning, masking, burnout and fluctuating capacity

The consultation paper's eligibility factors turn on a person's current capacity, stability and engagement. The research explains why those things are so often misread for Autistic people. A meta-analysis of 235 studies involving 14,081 participants found a moderate overall reduction in executive function in autism (Hedges' g = 0.48) that is broad rather than selective, affecting concept formation, mental flexibility, fluency, planning, response inhibition and working memory, and relatively stable across development.[7] Executive functioning differences of this kind affect initiation, planning, sequencing and follow through: the very capacities needed to progress a referral, chase a provider, respond to a plan change or recognise that an arrangement is failing. They are frequently invisible in conversation and in a single assessment encounter.

Camouflaging, the conscious or unconscious masking of Autistic characteristics, is effortful and costly, with consequences including exhaustion and threats to self perception.[8] A systematic review of 29 studies found that camouflaging is measurable and that higher camouflaging is associated with worse mental health.[9] Autistic burnout is now well characterised in the research literature, including in Australian work. It arises from cumulative life stressors and the demands of masking and involves chronic exhaustion, loss of skills and reduced tolerance to stimulus, without any new impairment.[10,11] Burnout episodes may be short or long, recur, and are frequently misread as psychiatric illness.[12] Co-occurring mental health conditions are the norm rather than the exception in the Autistic population.[13]

The implication for SCC eligibility is direct. A person who presents as stable and engaged may be masking substantial effort, may be sustained by informal scaffolding that is not visible in the assessment, and may lose capacity rapidly if that scaffolding is withdrawn or if burnout follows. Capacity measured on one day is a moving target, and an assessment that treats a period of relative stability as representative will underestimate need. The design response is to assess the support required to maintain stability, to consider functioning across settings and over time, and to treat the loss of an informal supporter as a trigger for reassessment (section 3(b) and Recommendation 1).

4. Trusted relationships, conflicts of interest and safeguarding

The Disability Royal Commission identified social isolation as a risk factor associated with violence, abuse, neglect and exploitation. It also identified trusted people, community participation and employment as important elements of natural safeguards and highlighted risks associated with social isolation and the absence of friends and family.[14] Relevant indicators of a safeguarding environment include community visibility, trusted relationships, informal networks, opportunities to communicate concerns, access to independent people and the number and diversity of people who know and interact with the person. A trusted coordinator is often one of those people.

In Volume 10 of its Final Report the Royal Commission also made specific recommendations on support coordination: that the NDIS Rules be clarified so that support coordination providers do not simultaneously deliver other funded supports to the same participant, with exceptions confined to limited circumstances such as thin markets and specialised or culturally appropriate services (Recommendation 10.2); that participants at heightened risk of violence, abuse, neglect or exploitation have support coordination funding sufficient to enable at least monthly face-to-face contact (Recommendation 10.3); and that the NDIS Quality and Safeguards Commission examine the quality and consistency of support coordination, with particular attention to First Nations people, culturally and linguistically diverse people, people in remote areas and people

experiencing housing insecurity (Recommendation 10.4).[15] The SCC reform gives effect to the first of these and should not fall below the second for participants at heightened risk.

5. What the reviews and inquiries found about support coordination

The NDIS Quality and Safeguards Commission's Own Motion Inquiry into support coordination and plan management examined complaints about the largest support coordination providers. It found that quality concerns featured in 87 per cent of the complaints it examined, most commonly inadequate provision of support (253 complaints), poor communication (179), overcharging (72), depletion of participants' NDIS funds (56) and cessation of supports without notice (29). Integrity concerns featured in 43 per cent of complaints, and 121 complaints, 26 per cent of the total, raised conflicts of interest.[2] The Inquiry also recorded that support coordinators demonstrated a safeguarding role by reporting incidents and assisting participants. These findings support both halves of the Alliance's position: the case for consistent standards, role clarity and conflict of interest controls, and the case for retaining the safeguarding function that good coordinators already perform.

The NDIS Review recommended that all people with disability be supported to navigate mainstream, foundational and NDIS service systems (Recommendation 4). It proposed that the NDIA be the lead commissioner of a local navigation function and of a specialist navigation function for participants whose needs cannot reasonably be met by general navigation support, within a nationally consistent framework developed with other governments (Actions 4.1 to 4.3). It also recommended that the NDIA design, test and implement the navigation function gradually, prioritising continuity of support for participants and their families and a smooth transition for the workforce and market (Action 4.4).[16] The consultation paper records that across the NDIA's own engagement since December 2024 people consistently identified the need for clearer role definitions, stronger quality standards, improved safeguards, a highly capable workforce, continuity of trusted relationships, stronger support for people with complex and intersecting needs, improved access in thin markets and preservation of participant choice and control in a commissioned model.[3] The Alliance's recommendations are directed at holding the reform to those findings.

6. What Alliance member organisations report

Member organisations contributed practice based observations to this submission in September 2026. Organisations providing therapy and clinical services to Autistic adults report variable quality in current support coordination, including incorrect advice about funding categories, provider changes recommended without regard to long established therapeutic relationships, and coordinators commenting on functional support needs in ways that contradict allied health recommendations; they also report that Autistic people without support coordination in their plans regularly need skilled navigation at points of system change, and that this work currently falls to therapists and families unfunded (section 4A(g)). Organisations that are autism-specific service providers report that the gap between referral and access is the hardest part of the current system, that a list of services makes no difference where a person's executive functioning does not support the demands of onboarding into a new service, and that participants must be guided through entry until they are actually receiving the service (section 4B(k)). Organisations working with Autistic young people and their families note that support needs may change or become more apparent as developmental, educational and social demands increase, and ask that Autistic people be involved in the design of the service through genuine co-design rather than consultation alone.

Implications for the design of the SCC service

Taken together, the evidence suggests four questions should sit across the design, commissioning and monitoring of the SCC service:

- Need: does the eligibility assessment capture the support required to maintain stability, across settings and over time, with and without the informal and formal scaffolding currently in place, and does it recognise executive functioning, masking, burnout and episodic need at points of change?
- Continuity: is continuity of trusted relationships treated as a safeguard, protected through transition and procurement, and measured in contract performance?
- Readiness: before anyone loses funded coordination, is the pathway intended to replace it demonstrably available, accessible, capable and effective for them, and is the person actually receiving it?
- Accountability: are outcomes published and disaggregated for Autistic participants, including disengagement, failed referrals and loss of specialist capability, and is there authority to pause or correct where the reform produces harm?

The SCC service should ultimately be able to demonstrate not simply that coordination is delivered consistently, but that the people who need it are receiving it, that the relationships and knowledge that keep Autistic people stable have been preserved, and that no one has been left without coordination while the new arrangements were being built.

Attachment B: Implementation and accountability tests for the SCC reform

The Systems That Work™ Framework provides a practical way of testing whether the SCC reform, as it is designed, commissioned and implemented, is producing the intended outcomes for Autistic people. The tests should be applied across the diversity of the Autistic community, including people with very high support and dependency needs and people with complex communication needs. The Alliance applies these tests in two ways: as a systems level test across the six domains of the SCC pathway, and through the five Systems That Work™ lenses. The reform should be assessed as a system, not simply as a commissioning model: a well designed contract cannot compensate for an eligibility assessment that misses invisible need, an alternative pathway that does not exist in a person's community, a lost relationship that took years to build, or a referral that never becomes access. The test follows the person from eligibility assessment, through transition, into the commissioned service or the alternative pathway, and on through every referral, escalation and change of worker.

A systems level test across the SCC pathway

Domain	Test
Eligibility	Does the assessment capture the support required to maintain stability, across settings and over time, with and without the informal and formal scaffolding currently in place; does it recognise executive functioning, masking, burnout, fluctuating capacity and episodic need; and is the loss of an informal supporter capable of triggering reassessment before arrangements deteriorate?
Transition	Does any existing support coordination end before the participant's SCC eligibility and future pathway are determined; is there any gap between existing coordination and the replacement pathway; are trusted worker relationships preserved wherever practicable; and is there participant specific transition planning where disruption presents greater risk?
Alternative pathway	Before a participant is found ineligible and directed to Local Area Coordination or another pathway, is that pathway demonstrably resourced, available, accessible, capable and of sufficient intensity in the person's community, and is the person actually receiving it? Is there an accessible navigation and escalation pathway for people whose need arises at points of change?
Commissioning and choice	Do participants have an exercisable choice of provider and worker capable of meeting their needs, rather than a nominal count of commissioned organisations; can they reach autism-specific, disability-led and culturally specific expertise across regional boundaries; and has the capability and diversity represented at procurement been protected over the contract term?
Continuity	Is coordination continuous through every hand over, referral and change of worker, so that no one experiences delayed, reduced or interrupted coordination while the new arrangements are being built; and is receipt of the service, not referral or acceptance, the measure of a successful connection? No referral without reception.

Domain	Test
Accountability	Is there an identified decision maker accountable for whether each participant is coordinated; are outcomes published and disaggregated; are there predefined indicators of disengagement, failed referrals, loss of specialist capability and increased family burden with thresholds for investigation and the authority to pause, intervene, modify or correct implementation; and at each interface can it be answered who is responsible, for what, from when, until when, what happens when the pathway fails, and who owns escalation and continuity?

The five Systems That Work™ lenses then apply across the reform as a whole.

Lens	Implementation question
Outcomes	Are Autistic participants who need coordination receiving it; are they able to establish, access and sustain appropriate supports, exercise choice and control and navigate change; and are participation, independence, wellbeing and stability improving or deteriorating for participants who are found eligible, found ineligible or transitioned, measured against each person's own circumstances rather than against reductions in service use?
Safeguarding	Is anyone losing coordination before they are actually receiving it from an alternative; are participants in burnout, crisis or transition being found ineligible on a snapshot; are trusted relationships being lost through procurement; and are patterns of disengagement, failed referrals, workforce turnover and increased family burden being detected before they become service breakdown?
Equity	Are eligibility, transition and service outcomes examined separately across disability cohorts, age, gender, geography, cultural background and complexity of support need, including Autistic people with very high support and dependency needs and complex communication needs, and is any disparity explained and acted on?
Learning, accountability and correction	Are baselines established before transition; are eligibility outcomes, reassessment rates, complaints, escalations, referral outcomes, worker changes and provider exits published by cohort and region; are predefined equity and quality thresholds in place; and is there authority to pause, investigate, modify or correct eligibility rules, regional configurations and commissioning arrangements where implementation evidence identifies systematic harm, inequitable outcomes or material service gaps.
Voice and participation	Have Autistic people, families and autism representative organisations shaped the design, testing and evaluation of the service through genuine co-design; do participants report that they understood their eligibility decision, chose their provider and were heard when they raised a concern; and does the service work for people who communicate differently?

These lenses should be supported by an implementation safety test:

> *Before a participant's funded support coordination ends on the basis that the commissioned service or another pathway will meet their needs, is that service or pathway demonstrably resourced, available, accessible, capable and effective in the person's community, and is the person actually receiving coordination from it? And before a region is commissioned, is network capability, provider diversity, workforce capacity and participant access being actively tested, with continuity arrangements and authority to intervene where implementation gaps create material risk?*

The purpose is not to prevent or slow the SCC reform. The purpose of these tests is to support safe and effective implementation: to identify problems early, preserve continuity where implementation gaps emerge, and ensure that commissioning, eligibility and transition arrangements can be corrected in response to evidence. A commencement date should not, by itself, determine whether an individual participant's existing coordination can safely cease.

The ultimate test should therefore be:

> *Did the SCC reform identify the Autistic people who need coordination, assess their need as they actually live, preserve the relationships and knowledge that keep them stable, and maintain continuity of coordination through implementation while the new arrangements were being built?*

Reference list to Attachment A

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14. Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. (2023). Final Report, Volume 3: Nature and extent of violence, abuse, neglect and exploitation, Chapter 2: Risk and protective factors.

15. Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. (2023). Final Report, Volume 10: Disability services, Recommendations 10.2 (Independent support coordination), 10.3 (Adequate support coordination) and 10.4 (Quality of support coordination). (link)

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