NDIS Support Coordination and Connection Reform Consultation – MJD Foundation Response

Prepared by: Jacquie Hatt, Chief Executive Officer, and Libby Massey, Director Clinical and Community Services
Date: 30 September 2026

Executive Summary

The MJD Foundation supports the Australian Government's objectives of improving quality, consistency, safeguarding and accountability within Support Coordination and Connection services. We acknowledge concerns about inconsistent service quality, workforce capability, inappropriate practices and unmanaged conflicts of interest. We support reforms that strengthen participant outcomes and confidence in the NDIS.

However, the reforms must not unintentionally dismantle specialist, culturally safe and relationship-based models that are already achieving positive outcomes. For Aboriginal people living with Machado-Joseph Disease (MJD) and Spinocerebellar Ataxia 7 (SCA7) in remote and very remote communities, effective support coordination cannot be separated neatly from culture, family, language, clinical knowledge, community relationships, trust and continuity.

The MJD Foundation has both experienced and documented these issues and, in a 2016 peer reviewed study, found that limited cultural competence during assessment and planning contributed to participant confusion and distrust, while culturally safe communication, appropriate interpreter use, trusted relationships, family participation and involvement of trusted established service providers produced best outcomes (Ferdinand et al 2016).

Other research supports MJDF's experience. Participatory research undertaken in the Fitzroy Valley found that Aboriginal kinship systems are a community strength and source of support for people living with disability, and there is a significant body of work attesting that Aboriginal understandings of disability differ significantly from Western medical models. (Puszka et al., 2022; Gilroy et al.) Research also identifies a need to focus on functional needs, bridge different understandings of disability and decolonise disability services. It also identified the effects of colonialism and deficit-based service models as barriers in remote Aboriginal communities (Stubbs et al., 2025).

A 2023 qualitative meta-synthesis similarly found continuing barriers to service engagement, including mistrust of government services, lack of culturally appropriate support, marginalisation and disempowerment. The authors concluded that culture must be recognised as influencing all participant-provider interactions and that disability services need to align more closely with culturally appropriate models of support (James et al., 2023).

These findings support a fundamental principle for the reform: **integrated service provision should not be presumed to create an unacceptable conflict of interest**. For some participants, integration precedes engagement and is the mechanism through which cultural safety, specialist knowledge, family engagement, continuity and effective coordination are achieved. Conflict of interest should always be closely monitored however the objective should be to identify and manage any conflicts transparently while preserving integrated models that demonstrably improve participant outcomes. This is especially important for vulnerable cohorts whose geographical and cultural barriers to effective engagement are compounded by very rare progressive disability culminating in communication loss. It is neither fair nor reasonable to expect effective communication and informed decision-making without specialist communication support and cultural safety. Neither is available in mainstream outsourced support coordination models.

MJDF recommends that the future model:

- commission multiple providers rather than appointing a single exclusive lead organisation in each region;
- combine place-based commissioning with cohort-specific commissioning;
- permit specialist providers to work across regional and jurisdictional boundaries;
- use Northern Territory Government regional boundaries as an administrative starting point in the NT, without limiting participant choice or provider operation to those boundaries;
- adopt blended funding that includes core funding and remote and complexity loadings;
- recognise integrated specialist models where conflicts are transparently managed;
- recognise cultural brokerage, family-centred practice, specialist clinical input, relationship-building and cross-system navigation as core SCC functions;
- protect existing participant-worker relationships and specialist workforce capability;
- assess the effects of reform on the viability of integrated providers and thin markets before withdrawing existing funding; and
- implement staged transition arrangements with market monitoring, contingency measures and sufficient funding certainty.

Proposed changes would destabilise hard-won capacity to understand and match supports to clients' changing needs, with catastrophic consequences for our clients' dignity and human rights. Ten roles within MJDF are funded in part through support coordination, with their remaining funding drawn from grants and other NDIS support services within our integrated care model. Loss of SCC funding would reduce MJDF's annual revenue by approximately $300,000 per annum, equivalent to three full-time positions. The consequences would extend beyond support coordination because that funding contributes to an interconnected workforce that includes specialist therapists and nurses, community services staff and Aboriginal workers.

The design of the future model must therefore consider the cumulative impact on participant capacity, choice, workforce capability, provider sustainability and market stability. Reform should strengthen accountability without fragmenting effective supports or destabilising specialist services that would be difficult to rebuild.

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

MJDF recommends a **blended commissioning model that combines place-based and cohort-specific commissioning and supports multiple commissioned providers**.

Commissioning based solely on geography may be administratively convenient, but it can disadvantage participants who require specialist, culturally specific or disease-specific expertise. A provider may hold responsibility for a large region while having limited cultural knowledge, few established community relationships and little experience supporting people with rare, progressive neurological conditions.

Conversely, a specialist provider may operate effectively across several regions because it has deep expertise and longstanding relationships with a particular participant cohort. For Aboriginal people living with MJD and SCA7, cultural understanding, specialist clinical capability and continuity are fundamentally more important to participant outcomes than the location of a provider's office.

Extensive research findings document the critical importance of Aboriginal kinship systems as an important community strength and support for people living with disability, and that Western medical understandings of disability differ from Aboriginal perspectives. These findings caution against a system that treats coordination, health, disability, family and community supports as unrelated service transactions and fails to consider the importance of culturally aligned and integrated care (Stubbs et al., 2025; Puszka et al., 2022; Gilroy et al 2013.).

The MJDF does not support appointing a single provider with effective exclusivity in each region. Commissioning multiple providers would improve genuine engagement and participation in the scheme and further:

- preserve participant choice and control;
- enable access to specialist and Aboriginal community-controlled providers;

- reduce dependency on one organisation with attendant risks of lack of oversight of decision-making;
- maintain continuity where participants already have trusted relationships;
- provide alternatives where one provider cannot meet cultural, clinical or geographic needs; and
- reduce the consequences of provider withdrawal or workforce shortages.

Integrated providers should remain eligible to deliver SCC where robust safeguards are in place. The MJDF's existing model assigns distinct functions to Support Coordinators, Therapists, Community Services Specialists, Family Support Workers and Aboriginal Community Workers enabling each to contribute specialist knowledge while enabling multidisciplinary collaboration. This approach supports continuity, more informed and integrated planning, cultural engagement, earlier identification of risks and navigation across disability, health and community systems through complex case coordination.

Recommendations

The commissioning framework should:

1. commission multiple providers within each service area;
2. combine place-based and cohort-specific commissioning;
3. preserve direct access to specialist/cohort specific knowledge and Aboriginal providers;
4. permit providers to operate across regional and jurisdictional boundaries;
5. preserve participant choice between commissioned providers wherever practicable;
6. allow integrated service delivery where conflicts are effectively managed; and
7. assess performance through participant outcomes, cultural safety, accessibility, continuity and sustained engagement.

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

MJDF does not support relying on a single lead organisation in each region. If lead arrangements are adopted, there should be **multiple commissioned lead organisations or an approved provider panel**, with participants able to choose between suitable providers.

No single organisation is able to hold all the capabilities required across Aboriginal cultural knowledge, specialist disability practice, clinical complexity, remote service delivery and cross-system navigation. Concentrating responsibility in one organisation could fracture engagement reduce participant choice, exclude capable specialist providers and create a single point of market failure.

Suitable commissioned providers may include:

- Aboriginal community-controlled organisations;
- specialist disability and rare disease organisations;
- organisations with demonstrated remote and very remote service capability;
- providers with relevant clinical and allied health expertise;
- community-based organisations with established local trust; and
- consortiums that bring together complementary cultural, clinical, specialist and place-based expertise.

Capability should be determined by evidence, not organisational size or administrative reach. Relevant characteristics include:

- demonstrated cultural safety;
- trusted relationships with participants, families and communities;
- relevant specialist disability and clinical knowledge;
- remote service delivery experience;
- capability to work across health, disability, housing, aged care and community systems;
- participant-centred supported decision-making practices;
- a stable and appropriately supported workforce;
- sound governance and safeguarding;
- transparent conflict-of-interest management;
- evidence of sustained participant engagement; and
- willingness to collaborate with other providers.

Relevant contemporary published literature indicates that disability services currently do not adequately consider the cultural needs of Aboriginal and Torres Strait Islander people or communicate in culturally appropriate ways and identified culture as a central influence on interactions between participants and providers. These findings demonstrate why cultural capability cannot be treated as a secondary procurement criterion (James et al., 2023; Puszka et al., 2022; Gilroy et al.).).

Procurement arrangements that disproportionately favour scale, turnover or broad geographic coverage will exclude smaller specialist and Aboriginal organisations whose value lies in cultural authority, deep expertise, community relationships and outcomes.

Recommendations

The framework should:

1. appoint multiple commissioned providers rather than one exclusive regional lead;
2. establish panels that include specialist, Aboriginal and remote-capable organisations;
3. evaluate providers on relationships, capability and outcomes rather than scale alone;
4. allow partnership and consortium models where capabilities are complementary;
5. prevent lead organisations from restricting access to other commissioned specialists; and
6. ensure procurement requirements are proportionate and accessible to specialist and community-controlled organisations.

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

A lead organisation model may provide:

- clearer responsibility for regional coverage;
- consistent governance and quality assurance;
- simplified contracting and communication;
- coordinated workforce planning;
- improved visibility of service gaps; and
- a defined point of contact for participants and other systems.

However, these benefits do not require regional exclusivity. A single lead provider could create significant disadvantages, particularly in remote and thin markets:

- reduced participant choice;
- concentration of funding and decision-making;
- displacement of specialist and community-controlled providers;
- disruption of established participant relationships;
- standardisation across culturally and geographically diverse communities;
- subcontracting arrangements that transfer risk without adequate funding;
- additional administration between participants and frontline services;
- conflicts between a lead organisation's commercial interests and its obligation to facilitate choice;
- reduced innovation; and

- severe disruption if the lead provider cannot recruit or withdraws.

There is also a risk that a lead organisation model fragments support by separating coordination from therapy, cultural brokerage, family engagement and practical assistance. For many Aboriginal participants, these are interconnected elements of effective support rather than independent service transactions.

Kinship and relational practices are a source of support and there is ample evidence of differences between Aboriginal perspectives and the Western medical model of disability. Importantly, a focus on individual choice, control and independence as a central outcome may conflict with established values prioritising contribution, belonging, reciprocity, and family participation and where family decision-making appropriately involves family and trusted community members A commissioning model built predominantly around individualised and organisationally separated services may therefore fail to reflect how disability and support are understood and experienced within some communities (Stubbs et al., 2025).

The consultation should consider both sides of the conflict-of-interest question. Unmanaged conflicts can create risks, but enforced fragmentation can also create harm through lack of genuine engagement and poor specialist knowledge, reduced continuity, repeated assessments, weaker information-sharing, participant fatigue and loss of culturally informed support.

If a lead model proceeds, the lead role should be a coordination and assurance mechanism, not a monopoly or gatekeeper.

Recommendations

MJDF recommends:

1. multiple lead organisations or provider panels within each area;
2. direct commissioning pathways for specialist and Aboriginal providers;
3. transparent and equitable partnership arrangements;
4. no exclusive referral networks;
5. meaningful governance involvement for delivery partners;
6. full and fair funding for subcontracted services;
7. independent oversight of referral practices; and
8. participant rights to select another commissioned provider.

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

Within the Northern Territory, **Northern Territory Government regional boundaries** provide the most practical starting point for administrative planning because they reflect established NT service-planning arrangements.

However, these boundaries should be planning and accountability tools, not rigid restrictions on participants or providers.

Remote communities differ substantially in:

- language and cultural protocols;
- family and community structures;
- local governance;
- workforce availability;
- transport and infrastructure;
- digital connectivity;
- service availability;
- community priorities; and
- existing provider relationships.

A provider may have specialist expertise and trusted relationships with a cohort across several NT regions or across state and territory borders. This is particularly important for rare and progressive conditions, where capability may be concentrated in a small specialist workforce.

Restricting providers to one region or jurisdiction could:

- interrupt established participant relationships;
- fragment specialist services;
- require participants to change to less-experienced providers;
- create unnecessary duplication;
- undermine specialist provider viability;
- disregard family and cultural connections across boundaries; and
- reduce meaningful choice.

Research identifying unequal access to health and disability services and barriers arising from Western, deficit-based models reinforces the need to avoid rigid service structures that are poorly adapted to remote Aboriginal communities (Stubbs et al., 2025; Ferdinand et al., 2021).

Recommendations

MJDF recommends:

1. using NT Government regional boundaries as an administrative starting point;
2. not restricting providers or participants to a single region;
3. allowing providers to operate across jurisdictions;
4. commissioning cohort-specific providers across multiple regions;
5. evaluating coverage at community level rather than assuming that a regional contract ensures access; and
6. recognising cross-border family, cultural and specialist relationships.

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

Participant need should be assessed across disability, clinical, cultural, geographic, family and systemic factors. It should not be determined solely by diagnosis, contact hours or plan value.

People living with MJD and SCA7 experience multiple barriers to participation in every facet of life and may require coordination across disability, health, housing, aged care, transport and community services. Needs inexorably change because of disease progression, equipment and care requirements, hospital admission, discharge planning, changes in family support or emerging safety risks.

For Aboriginal participants in remote communities, complexity may also arise from:

- language and communication barriers;
- limited digital connectivity;
- distance from assessment and service providers;
- limited local provider options;
- the need to engage family and trusted decision-making supporters;
- cultural obligations;
- interaction with multiple government systems; and
- risk of disengagement from fragmented or culturally unsafe services.

SCC+ eligibility should recognise rare diseases, progressive neurological conditions, remote residence, cultural and language barriers, complex family arrangements and risk of disengagement. Cultural

brokerage, relationship-building, specialist disability expertise and cross-system navigation should also be recognised as core SCC functions.

Caseloads should be **complexity-weighted**, not determined through uniform participant-to-worker ratios. A participant requiring remote travel, specialist clinical input, family engagement and coordination across several systems requires significantly more capacity than a participant with stable supports in a well-serviced market.

Within MJDF's integrated model, therapists may contribute to complex coordination when specialist clinical knowledge is necessary to navigate the health-disability interface. The place-based community services specialists navigate day to day and planned supports and Aboriginal workers assist with language, participant and family understanding, cultural brokerage and community engagement.

Recommendations

The SCC framework should:

1. use complexity-weighted caseloads;
2. allow movement between service levels as needs change;
3. fund multidisciplinary participation;
4. recognise travel, cultural brokerage, family engagement and cross-system liaison as legitimate SCC work;
5. provide funded surge capacity;
6. avoid uniform national/proscribed caseload ratios; and
7. consider supervision, leave, vacancies, travel and workforce turnover in capacity settings.

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

MJDF supports a **blended funding model with remote and complexity loadings**.

A purely activity-based or direct-contact model would not reflect the actual work needed to deliver effective SCC. High-quality coordination involves preparation, travel, liaison, case conferencing, advocacy, family engagement, cultural brokerage, relationship-building and follow-up across several systems.

The model should include:

- core funding to maintain workforce and service capacity;
- a participant or activity component;
- complexity loadings for intensive, multidisciplinary or cross-system needs;

- remote and very remote loadings;
- funding for travel, outreach and accommodation;
- funding for cultural brokerage, interpreting and family engagement;
- workforce development and supervision funding;
- transition and establishment funding; and
- carefully designed outcome components.

Ten MJDF roles are funded in part through support coordination. Their other funding comes from grants and other NDIS support services within MJDF's integrated model. Loss of SCC funding would reduce annual revenue by approximately $300,000 per annum, equivalent to three full-time positions.

The effect would not be confined to designated support coordination positions. It would weaken the financial base supporting an interconnected workforce and could reduce therapy input into complex navigation, Aboriginal worker involvement in cultural brokerage, multidisciplinary collaboration and service availability.

This risk is particularly important in the broader First Nations disability market. Research commissioned by the Disability Royal Commission described a lack of available, accessible and culturally appropriate services as a time-sensitive national crisis. It also identified under-resourcing of Aboriginal community-controlled organisations, underrepresentation of First Nations people in the workforce and particular workforce gaps in remote communities (Disability Royal Commission, 2023).

Funding models should therefore assess sustainability at the level of the whole service ecosystem. Removing a funding stream from an integrated provider can have consequences extending well beyond the function nominally attached to that revenue.

Recommendations

The model should:

1. combine core and activity funding with appropriate outcome measures;
2. include transparent remote and complexity loadings;
3. provide multi-year funding certainty;
4. fund cultural brokerage, travel, outreach and family engagement;
5. support multidisciplinary and integrated models;
6. assess effects on overall provider viability;
7. provide transition funding before existing revenue is withdrawn; and
8. avoid incentives that encourage providers to select participants with less complex needs.

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

Commissioned organisations should meet robust governance, quality, workforce and safeguarding requirements. Quality should, however, be assessed through participant outcomes and experience as well as compliance and be recognised by participants

Relevant indicators should include:

- participant engagement;
- effective plan implementation;
- participant understanding and exercise of choice;
- cultural safety;
- continuity of relationships;
- service accessibility;
- connection with family and community;
- cross-system coordination;
- timely identification and escalation of risk; and
- participant-defined outcomes.

A 2023 meta-synthesis of disability workforce issues found that culturally inappropriate support and communication contribute to underutilisation and concluded that services need to align better with culturally appropriate models. Cultural safety should therefore be treated as a core quality requirement, not an optional workforce attribute (James et al., 2023).

Workforce requirements should cover:

- role-specific training;
- professional and cultural supervision;
- cultural safety;
- remote practice capability;
- access to specialist clinical advice;
- supported decision-making;
- family-centred practice;

- clear role boundaries;
- manageable, complexity-weighted caseloads; and
- continuity and succession planning.

Integrated service delivery should not automatically be classified as an unacceptable conflict of interest. Appropriate safeguards include:

- clear separation of relevant decisions;
- transparent conflict registers and policies;
- informed consent;
- accessible complaints processes;
- independent governance oversight;
- monitoring of referrals and participant outcomes;
- protection from coercive referral practices; and
- access to alternative providers.

The MJDF's model assigns distinct accountabilities to Support Coordinators, Therapists, Community Services staff, Family Support Workers and Aboriginal Community Workers while allowing those roles to collaborate. The documented benefits include continuity, reduced repetition, better coordination, earlier identification of risks, cultural safety and participant engagement.

Recommendations

The framework should:

1. combine compliance, participant experience and outcome measures;
2. include cultural safety and continuity as safeguarding indicators;
3. require appropriate supervision and specialist capability;
4. assess how conflicts are managed rather than prohibiting integration;
5. include participant and community feedback; and
6. monitor workforce turnover and relationship disruption as quality risks.

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

Workforce capability is built over time through training, supervision, community relationships and practical experience. It can be lost quickly when funding is uncertain or services are restructured without adequate transition.

Participant relationships are not incidental. Trusted relationships can support communication, informed decision-making, identification of emerging risks and continued engagement. Retaining those relationships should be treated as a quality and safeguarding priority.

The national evidence indicates that the First Nations disability workforce is underrepresented, particularly in remote communities, and that service availability and cultural appropriateness remain significant concerns (Disability Royal Commission, 2023).

MJDF's integrated model builds capability by bringing together complementary expertise:

- therapists contribute clinical knowledge where coordination intersects with health;
- Aboriginal workers support language, cultural brokerage and participant understanding;
- support coordinators navigate NDIS processes;
- community services staff respond to individual contexts to coordinate broader supports; and
- Family Support Workers maintain practical, day-to-day connections.

Without SCC funding, Aboriginal worker roles could become more narrowly transactional, with reduced capacity for cultural brokerage, relationship-building and helping participants and families understand disability-related supports. Fragmenting the model may also narrow career pathways, weaken collaboration and make specialist roles less sustainable.

The approximately $300,000 per annum in SCC revenue supports an ecosystem involving ten partly funded positions, with the direct loss equivalent to three full-time roles. Workforce-impact assessment must therefore examine the whole integrated model, not only positions labelled as support coordination.

Recommendations

The future model should:

1. provide multi-year contracts and implementation certainty;
2. support continuity of participant-worker relationships;
3. provide pathways for existing capable workers and providers to transition;
4. recognise specialist clinical and cultural capability;
5. fund supervision, professional development and remote practice support;
6. support multidisciplinary career pathways;

7. require workforce-impact plans;
8. monitor workforce attrition during transition; and
9. recognise avoidable disruption of trusted relationships as a safeguarding risk.

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

Local knowledge and community connection should be demonstrated through relationships, proof of tenure and workforce retention, capability and accountability, not simply the location of an office.

Local knowledge should include understanding of:

- community governance and cultural protocols;
- local languages and communication requirements;
- family and kinship contexts;
- available health, disability and community services;
- transport, infrastructure and digital access;
- service gaps and provider turnover;
- barriers to participation; and
- appropriate ways to engage participants and families.

Community connection may be evidenced through:

- appropriate communication and engagement practices accounting for worldview and English proficiency differences
- sustained relationships with participants and families;
- employment and support of local Aboriginal workers;
- partnerships with community organisations;
- evidence of co-design;
- participant and community feedback;
- regular community presence;
- responsiveness to local priorities; and
- demonstrated ability to maintain engagement.

The Fitzroy Valley research used Aboriginal Participatory Action Research, including community contextualisation, validation and co-design of recommendations. This supports an assessment approach in which communities help define credible connection and accountability rather than government applying a uniform national definition (Stubbs et al., 2025). Our research shows that culturally safe communication, appropriate interpreter use, trusted relationships, family participation, and involvement of established service providers improve effectiveness and minimise confusion and distrust. (Ferdinand et al., 2021)

Local knowledge and specialist expertise should be treated as complementary. Participants should not be forced to choose between a local provider without specialist expertise and a specialist provider without a permanent local office.

Recommendations

The framework should:

1. define connection through relationships and accountability, not postcode;
2. involve communities in assessment criteria;
3. recognise Aboriginal workforce participation and cultural brokerage;
4. evaluate sustained presence and responsiveness;
5. support partnerships between local and specialist providers; and
6. prevent local-presence requirements from excluding cross-regional specialists.

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

Thin markets require a different commissioning and funding response from metropolitan markets. Choice is not meaningful where services are unavailable, intermittent or financially unsustainable.

Remote delivery requires investment in:

- cultural and community relationships;
- local workforce;
- outreach travel;
- coordination with health and community services;
- specialist advice;
- flexible communication;

- contingency planning; and
- sustained engagement.

The national evidence identifies inadequate availability, accessibility and cultural appropriateness of services for First Nations people living with disability, together with workforce shortages and under-resourcing of community-controlled providers (Disability Royal Commission, 2023).

The SCC model should combine place-based delivery with access to specialist expertise. MJDF's experience in Ngukurr demonstrates the value of local presence and relationships within an integrated specialist model. Place-based capability can strengthen engagement, communication and early identification of changing needs, while the broader MJDF workforce provides specialist knowledge of MJD and SCA7.

Digital delivery may supplement but cannot replace in-person engagement. Remote participants must retain access to cross-regional specialist providers where the required expertise is unavailable locally.

Recommendations

The model should include:

1. specialist remote-provider streams;
2. dedicated pathways for Aboriginal community-controlled and culturally capable providers;
3. remote and very remote loadings;
4. funding for travel, outreach and non-contact coordination;
5. locally based or regularly present workforce;
6. cross-regional access to specialists;
7. collaboration between local, specialist and mainstream services;
8. flexible delivery methods; and
9. active market stewardship and contingency arrangements.

11. How can the SCC service best support participants who face additional barriers, including those experiencing complex and overlapping support needs or requiring decision-making support?

Complexity must be understood broadly. It may arise from the interaction of disability, health, communication, culture, geography, family circumstances, service availability and previous experiences of government systems.

SCC+ eligibility and service intensity should recognise:

- rare diseases;
- progressive neurological conditions;
- remote and very remote residence;
- worldview difference;
- significant language or communication barriers;
- cognitive and decision-making support needs;
- complex family arrangements;
- involvement with multiple systems;
- unstable formal or informal supports;
- safety risks; and
- risk of disengagement.

These cultural, geographic and systemic dimensions of complexity should be recognised in SCC+ eligibility and service design. People living with MJD and SCA7 may require coordinated support across health, disability, housing, aged care and community services, particularly where progressive disease, remoteness, language, family circumstances and limited local service options intersect.

Supported decision-making should include time and capability to:

- explain options accessibly;
- involve appropriate cultural and communication supports;
- engage family and trusted supporters with consent;
- revisit decisions as understanding develops;
- account for disease progression;
- support expression of preferences; and
- prevent service scarcity from determining decisions.

The evidence that culture influences all participant-provider interactions supports funding Aboriginal workers and cultural brokerage as substantive elements of SCC, not ancillary activities (James et al., 2023).

Recommendations

The framework should:

1. adopt a broad, culturally responsive definition of complexity;

2. recognise rare and progressive conditions in SCC+ eligibility;
3. fund supported decision-making and cultural brokerage;
4. permit appropriate family and trusted-supporter engagement;
5. provide multidisciplinary advice;
6. fund cross-system coordination;
7. allow service intensity to change with participant need; and
8. avoid repeatedly requiring evidence of established progressive conditions.

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

Transition should be gradual, participant-led and informed by formal workforce, provider-viability and market-impact analysis.

Continuity of trusted relationships should be a primary transition principle. For people living with MJD and SCA7, relationships may develop over many years and extend across generations of families. Disruption may lead to disengagement, reduced engagement, access and poorer outcomes and impact human rights. Transition arrangements should therefore explicitly protect continuity, participant choice and the preservation of specialist providers.

Participants should be able to remain with an existing provider where:

- the participant chooses to do so;
- the provider meets quality and safeguarding requirements;
- conflicts are transparently managed; and
- continuity supports the participant's interests.

The Government should assess the consequences before existing support coordination revenue is withdrawn.

Possible consequences include:

- loss of specialist support coordination;
- reduced therapy input into complex navigation;
- narrowing of Aboriginal worker roles;
- loss of disease-specific and community knowledge;
- disruption of relationships;

- reduced remote service capacity;
- withdrawal of specialist providers; and
- increased reliance on organisations without equivalent cultural, clinical or remote capability.

This risk must be considered in the context of existing evidence of limited culturally appropriate service availability and First Nations workforce shortages.

Successful implementation cannot be measured merely by whether new contracts commence on schedule. It must consider whether participants retain effective support, experienced workers remain in the sector and viable service options remain available.

Recommendations

Transition arrangements should include:

1. a staged and publicly communicated implementation plan;
2. workforce, provider-sustainability and thin-market impact assessments;
3. no withdrawal of existing funding until replacement services are operational;
4. adequate transition funding;
5. continuity arrangements for established participant-provider relationships;
6. participant-led transition plans;
7. pathways for existing capable providers and workers to join the commissioned model;
8. protection of workforce continuity and recognition of prior experience;
9. monitoring of provider withdrawal, vacancies, participant disengagement and service gaps;
10. contingency arrangements where commissioned providers cannot deliver;
11. capacity to pause or adjust implementation where market harm emerges; and
12. independent evaluation involving participants, families, Aboriginal organisations, specialist providers and remote communities.

Conclusion

MJDF supports reform that strengthens quality, consistency, safeguarding and accountability. However, the future SCC model must not pursue administrative simplicity at the expense of participant choice, cultural safety, specialist expertise, workforce continuity or market sustainability.

The research evidence shows that Aboriginal understandings and experiences of disability may not align with individualised Western medical and service models. Kinship, culture, communication, relationships

and community context influence how disability is understood and how people engage with services (Stubbs et al., 2025). The evidence also identifies continuing barriers arising from mistrust, culturally inappropriate support, fragmented systems and inadequate service availability. (James et al., 2023)

For Aboriginal people living with MJD and SCA7, coordination, therapy, cultural brokerage, family engagement and practical support are often interconnected. Artificially separating these functions could weaken the relationships and shared knowledge that enable safe and effective support.

Conflict-of-interest safeguards are necessary, but integration should not itself be presumed harmful. The appropriate policy response is to require transparent governance, role clarity, informed consent, genuine choice, independent oversight and outcome monitoring. This would distinguish unmanaged conflicts from integrated specialist models that improve continuity, cultural safety and participant outcomes.

The reforms must also recognise that funding streams cannot always be removed from integrated providers without affecting their broader workforce and service capacity. In thin markets, the loss of specialist capability or a trusted provider may have consequences that are difficult and costly to reverse.

A sustainable future SCC system should therefore commission multiple providers, enable specialists to work across boundaries, fund the true costs of complexity and remote delivery, preserve well-governed integrated care, and protect established participant relationships.

For Aboriginal people living with MJD and SCA7, these are not peripheral implementation matters. They are central to whether the future system is accessible, culturally safe, sustainable and capable of delivering meaningful outcomes.

References

Australian Government Department of Health, Disability and Ageing and National Disability Insurance Agency. (2026). *NDIS Support Coordination and Connection Reform Consultation Paper*.

Disability Royal Commission. (2023). *The lack of NDIS services for First Nations people with disability "a national crisis"*, summarising the commissioned research report *Options to improve service availability and accessibility for First Nations people with disability*.

Ferdinand, A., Massey, L., Cullen, J., Temple, J., Meiselbach, K., Paradies, Y., ... & Kelaher, M. (2021). Culturally competent communication in Indigenous disability assessment: a qualitative study. *International Journal for Equity in Health*, *20*(1), 68.

Gilroy, J., Donelly, M., Colmar, S., & Parmenter, T. (2016). Twelve factors that can influence the participation of Aboriginal people in disability services.

James, M. H., Prokopiv, V., Barbagallo, M. S., Porter, J. E., Johnson, N., Jones, J., & Smitherson, T. (2023). *Indigenous experiences and underutilisation of disability support services in Australia: a qualitative meta-synthesis*. Disability and Rehabilitation.

Puszka, S., Walsh, C., Markham, F., Barney, J., Yap, M., & Dreise, T. (2022). Towards the decolonisation of disability: A systematic review of disability conceptualisations, practices and experiences of First Nations people of Australia. *Social Science & Medicine*, *305*, 115047.

Stubbs, T., Bedford, M., Bear, E., Carter, E., Pickard, A., Davies, J., Thomas, S., Martiniuk, A. L. C., Elliott, E. J., & Rice, L. J. (2025). *What are the Aboriginal worldviews of disability in the Fitzroy Valley? Aboriginal Participatory Action Research to develop strategies for decolonising disability services*. BMJ Open, 15, e093608.