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NDIS Support Coordinator Referral Report 2026

From Referral to Delivered Support

Therapy Near Me Research Team
Chief Editor: Dr Benedict de St. Amatus

THERAPY NEAR ME
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Research at a glance

The following headline indicators describe market activity and expenditure. They do not measure whether individual referrals led to a service starting.

$1.238bn
Support coordination payments
Financial year 2025–26 [1]

291,832
Participants accessing coordination
July–December 2025 [2]

34.7%
Payments received by 201 larger providers
July–December 2025 [2]

1 July 2028
Planned commissioning transition
Government-announced model [7]

Proposed referral-to-delivery measurement pathway

A suggested operational framework, not a nationally measured conversion rate.

1	2	3	4	5	6
Referral recorded	Provider contacted	Provider decision	Participant engaged	Support commenced	Continuity checked

Publication details and suggested citation

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Companion guide: Available alongside this report on the publication page.

Transparency and limitations

This secondary research reviews government data and proposes a referral-outcomes framework; it is not a participant-level study or a peer-reviewed paper. Therapy Near Me also delivers services. No NDIA or NDIS Commission endorsement is implied. Imagery is illustrative.

Executive summary

Support coordination is meant to help NDIS participants use their plans, select providers and establish effective supports. Financial expenditure, provider counts and plan implementation reports describe important parts of the system; however, they do not themselves establish that a referred person has been accepted, has begun the intended support or remains connected to it. That distinction is the central finding of this report. [1–4]

The NDIA recorded $1.238 billion in support coordination payments for the year ending 30 June 2026. In the preceding July–December 2025 period, 291,832 participants accessed coordination-related supports across 11,129 active providers. The largest 201 providers, 1.8% of active providers by count, received 34.7% of the payments to support coordination providers. These are descriptive market facts, not estimates of referral failure or poor quality. [1,2]

A period of significant policy change raises the importance of continuity measurement. A September 2026 Ministerial pricing determination governs NDIA-managed and plan-managed price limits. Funding resets affecting parts of two support categories commenced in October 2026, with specified exclusions; new support coordination and connection services are scheduled for commissioning from July 2028. Mandatory registration reform specific to support coordination is currently paused. [5–9]

This report proposes a practical six-stage Referral-to-Delivered-Support (RDS) framework that can be adopted by coordinators, service providers, organisations and researchers. It distinguishes referral initiation, provider decision, first contact, first delivered support and subsequent continuity. That is a proposed measurement method, not a new validated population statistic.

HEADLINE FINDING Australia can count support coordination payments much more readily than it can publicly compare referral attempts with confirmed service commencement. Published sources reviewed here do not supply a national, person-level referral conversion rate.

Key conclusions

- Provider counts should not be treated as a measure of appointment capacity; provider presence is different from acceptance of a clinically or functionally suitable referral.
- NDIS-funded psychology requires a disability-related functional purpose and appropriate plan funding. Clinical mental-health assessment and treatment are generally the responsibility of mainstream health services.
- Participants should be supported to choose among genuinely suitable services; connected-provider referrals require clear conflict declarations and meaningful alternatives.
- Reform evaluation should publish a denominator: referrals received, accepted, commenced and retained—not simply providers funded or amounts claimed.
- A standardised de-identified dataset would permit future measurement without presenting hypothetical rates as established Australian findings.

How to read the evidence

Evidence class	Included in this report	Permissible interpretation
Official administrative data	NDIA payments, participant and provider counts	Market scale and distribution in the stated period
Regulatory / consultation	Targeted campaign and feedback	Risks and respondent views; not national prevalence
Current government guidance	NDIS supports, provider rules, funding, pricing	Rules at the research verification date
TNM proposed methods	Referral funnel and recommended indicators	A proposed approach; not a finding measured in the field

1. Research question, method and scope

Research question: What can Australian national evidence establish about support coordination and access to the supports identified in a participant's plan, and what is missing between making a referral and confirming that a suitable service starts?

Method. We reviewed NDIA 2025–26 fourth-quarter appendix tables, the June 2026 Annual Pricing Review, the 24 September 2026 pricing schedule, current NDIA provider and participant guidance, the NDIS Commission's support coordination resources and targeted regulatory campaign, and official legislation-implementation materials. Searches and source verification were undertaken to 22 October 2026. [1–15]

The analysis is national and descriptive. No participant-level NDIA or Therapy Near Me case records were inspected; no practitioner waiting-list or referral-conversion dataset was obtained. The original contribution is the proposed outcome definitions, data dictionary and analytic protocol, rather than a claimed new empirical sample. The source material was cross-checked against official NDIA and NDIS Commission documents to 22 October 2026.

2. National market baseline: what the numbers establish

Indicator	Value	Period / source
Support coordination payments	A$1.238 billion	12 months ended June 2026; [1]
Total NDIS payments	A$51.452 billion	12 months ended June 2026; [1]
Support coordination share of all payments	2.41% (TNM calculation: 1,238 / 51,452)	Same 12-month payment categories; [1]
Participants accessing coordination-related supports	291,832	July–December 2025; [2]
Active providers of coordination-related supports	11,129	July–December 2025; [2]
Support coordination payments	A$618.1 million	July–December 2025; [2]
Year-on-year change in participants	+11.0%	Compared with July–December 2024; [2]
Year-on-year change in payments	+9.4%	Compared with July–December 2024; [2]

The first two expenditure rows are financial-year payment categories. The subsequent market rows are a separate six-month provider and participant series, so they should not be combined as if they measure the same cohort or date. "Active provider" is an entity appearing in payment data—not evidence that a clinician or individual support worker has immediate capacity. [1,2]

3. Concentration: why provider counts can mislead

The 201 providers supporting at least 251 participants made up just 1.8% of active support coordination providers yet received 34.7% of coordination payments in July–December 2025. At the other end, 5,666 providers serving no more than five participants represented 50.9% of providers yet received 3.7% of payments. [2]

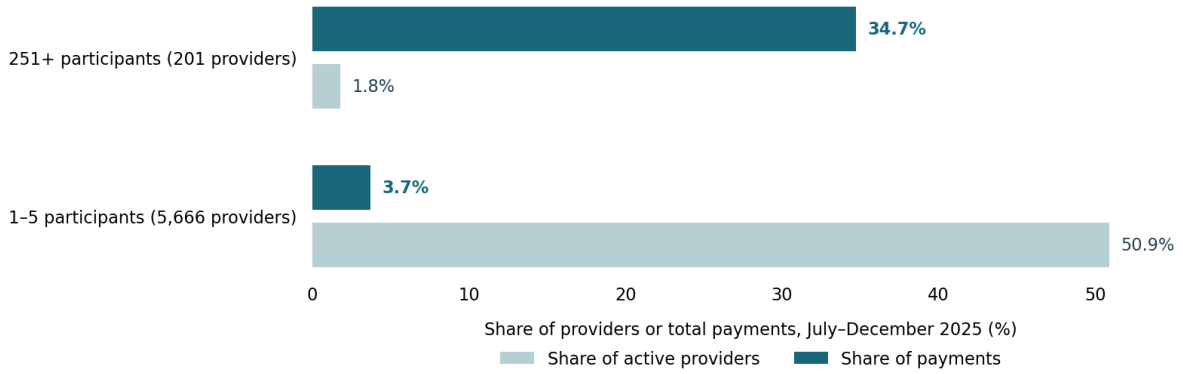


Figure 1. Provider-count shares and payment shares by size band; independently redrawn from NDIA Annual Pricing Review Table 32 (July–December 2025). These are payment measures, not service-quality rankings. [2]

Interpretation. The size-band distribution describes payments across groups of providers; it is not evidence that a handful of businesses dominates the whole market. The NDIA separately reports that the ten largest providers received 7.2% of support coordination payments in July–December 2025, down from 7.9% in an earlier 2023 period. The NDIA describes overall market concentration as low and declining. Nominal provider choice may nevertheless coexist with uneven local delivery capacity. Neither small nor large providers should be presumed clinically better or worse from these aggregates. To assess access, provider counts need to be paired with confirmed capacity, catchment, modality, eligibility, referral acceptance and time-to-start measures. [2]

4. The hidden interval: referral is not receipt of support

A support coordinator may identify a suitable therapy, transmit a referral and document it as an implementation activity. Yet administrative progress is not the same as an appointment attended. Delays can arise at different stages: incomplete consent, unsuitable support purpose, provider availability, financial or registration mismatch, unsuccessful contact, cancellation, or the participant declining an offered service.

Stage	Observable event	Suggested measure
0. Need recorded	Participant agrees that a support need exists	Documented goal and support purpose
1. Referral sent	Complete referral transmitted with consent	Date/time of referral
2. Provider decision	Accepted, declined, waitlisted, redirected	Decision status + reason
3. Contact achieved	Two-way contact with participant/nominee	Elapsed days to contact
4. Support commenced	First eligible support actually delivered	Date and service modality
5. Continuity checked	Active, completed, paused or ceased at follow-up	30-, 90- and 180-day status

A MEASURABLE ENDPOINT For access research, count a “successful referral” when the appropriate support is delivered—not when a referral email is sent or a future appointment is booked.

The proposed Referral-to-Delivered-Support (RDS) indicator is the share of eligible, consented referral episodes for which an appropriate first service is confirmed within a defined observation period (for example 30 or 60 days). A research release must publish eligibility rules, denominator, start date, exclusions, follow-up duration, case mix, unknown outcomes and the treatment of censored records. This measure is not an NDIA-endorsed or externally validated standard.

5. Reporting the referral funnel responsibly

5.1 A core indicator set

Metric	Numerator / denominator	Interpretation
Referral acceptance rate	Accepted referrals / all provider-decided referrals	Provider willingness; excludes still pending unless separately reported
30-day commencement rate	Referrals with first service within 30 days / eligible referral episodes with ≥30-day observable follow-up	Realised access. Separately show pending, withdrawals, lost-to-follow-up, exclusions and observation
Median days to commencement	Median(first service date – referral date)	Use time-to-event methods when not all cases have commenced
No-capacity decline rate	Declines due to unavailable capacity / all referrals with provider decisions	Capacity signal, not diagnosis of market-wide shortage
90-day continuity rate	Active or appropriately completed supports / commenced cases eligible for 90-day check	Distinguish planned completion from unwanted discontinuation
Choice documentation rate	Referrals with options and disclosed conflicts recorded / all audited referrals	Process safeguard, not proof of coercion-free choice

5.2 Interpretation safeguard: volume is not an outcome

A dashboard may record many referrals without establishing that services commenced. A valid commencement rate needs a defined denominator of eligible referral episodes with sufficient observation time; report the follow-up window and separately identify pending, declined, participant-withdrawn, incomplete, lost-to-follow-up and unknown outcomes. State whether the analysis uses all referrals or only those with observed 30-day outcomes, as restricting the denominator without disclosure can bias the estimate. No national conversion percentage is inferred or supplied by the evidence reviewed in this report.

5.3 Minimum statistical safeguards

- Define the sampling unit as a referral episode, with participant IDs de-identified and linked episodes handled transparently.
- Stratify by support type, location, age band, disability support needs, funding management and referral complexity rather than assuming all referrals have comparable difficulty.
- Capture participant-directed pauses and declined offers so these are not misclassified as provider failure.
- Report missing outcomes, right-censoring and case-mix changes; use Kaplan–Meier or comparable event-time methods when appropriate.
- Avoid comparing organisations without auditing their referral mix, capacity, service scope, intake practices and data completeness.

6. Psychology: the critical NDIS–health boundary

Not every referral to a psychologist is an NDIS claim. The NDIS funds capacity-building and maintenance therapy only where it is an eligible disability-related support that addresses functional capacity and is consistent with the participant's plan. Mental-health diagnosis, symptom monitoring and clinical treatment generally belong to the health system, even where an NDIS participant also has psychosocial disability. [10,11]

Referral purpose	Likely pathway to assess	Necessary clarification
Build daily-living self-management, communication or psychosocial functioning skills related to disability	NDIS-funded functional therapy may be appropriate	Specified functional goals, evidence, funding, qualified practitioner and relevant support item
Diagnose or treat anxiety, depression, trauma or other psychiatric symptoms as clinical treatment	Mainstream health, GP/Medicare, community/public mental health or private care	Clinical treatment is not converted into NDIS therapy by participant status alone
Both clinical treatment and disability-related functional support are needed	Parallel, distinct pathways may operate	Separate goals, documentation, services and funding/claims; avoid double charging
Participant in acute crisis, immediate safety concern	Emergency or urgent clinical response	Support coordinator is not a substitute for emergency or clinical crisis service

Psychology and related allied-health supports must be delivered by appropriately qualified and registered or accredited practitioners. Therapy support funding is described by the NDIA as stated rather than freely interchangeable; coordinators should check the actual support line and current plan before advising that a referral can be claimed. [10]

CLINICAL EXAMPLE A participant requesting more sessions to reduce symptoms of anxiety does not automatically have an NDIS-funded therapy claim. A separate, evidence-based intervention to build disability-related independent living or psychosocial functioning may be considered where it satisfies the plan and NDIS funding rules. [11]

7. Funding, provider eligibility and current price controls

The Minister's current 2026–27 pricing determination incorporates the NDIS pricing schedule effective 24 September 2026. It sets maximum amounts for NDIA-managed and plan-managed supports; the published limits do not operate as the same cap for self-managed participants. Current item and pricing applicability must be confirmed for each referral. [5]

Illustrative support	National hourly maximum	Reference
Support coordination L1 – Support Connection	$80.06	07_001_0106_8_3
Support coordination L2 – Coordination of Supports	$100.14	07_002_0106_8_3
Support coordination L3 – Specialist Coordination	$190.54	07_004_0132_8_3
Psychology – functional therapy direct service	$252.99	15_054_0128_1_3

Table 4. Illustrative national (non-remote) maximum amounts from the 24 September 2026 schedule; remote and very remote caps differ. An item's appearance in the schedule does not establish that it is suitable or funded for a particular participant, nor does it guarantee a full-hour claim for shorter services. [5]

NDIA-managed funding ordinarily requires a registered provider. Self-managed or plan-managed participants can usually use registered or unregistered providers, subject to mandatory-registration categories and individual circumstances; specialist behaviour supports and some other categories have additional requirements. [12]

Registration of all support coordinators is NOT currently mandatory as a standalone blanket rule. The Commission says that reform was paused in December 2025; registered and unregistered providers remain subject to the NDIS Code of Conduct. More general high-risk registration reform is separately scheduled to proceed in stages. [8,13]

8. Referral independence, conflicts and participant choice

Support coordinators should be alert to actual, potential and perceived conflicts. The NDIA specifically identifies arrangements where a coordinator promotes a connected organisation, limits alternatives or a single group controls coordination, service delivery and payment as circumstances requiring scrutiny. An internal referral is not in itself proof of misconduct; the key issues are disclosure, management, alternatives and the participant's supported choice. [14]

A practical choice record

- Record the participant's functional or clinical objectives and non-negotiable access needs.
- Show at least the suitable options actually available, noting when geographic or specialist capacity restricts choice.
- Declare organisational ownership, commissions or other referral benefits; avoid incentives or exclusive referral requirements.
- Record who chose the provider and how supported decision-making was accommodated.
- Maintain a straightforward exit, transfer and complaint path, including access to independent advocacy.

Therapy Near Me provides clinical and disability-related services; referrals to its practitioners, like referrals to any other provider, should follow independent choice, conflict management and suitability checks. This publication does not authorise preferential or mandatory placement with its publisher.

9. Reform timetable and impact on referrals

Implementation date	Verified change	Practical referral implication
20 August 2026	NDIS amendment legislation received Royal Assent	Do not describe the legislation as merely proposed. [7]
24 September 2026	Current pricing schedule took effect	Verify maximum amounts and applicable codes. [5]
1 October 2026 onward	Budget resets begin for parts of participation and improved daily living categories	Check exemptions and the individual plan; no assumption of uniform cuts. [6,7]
1 February 2027	Changes apply to renewals under published timetable	Reassess planned service continuity before renewal. [6,7]
1 October 2027	Plan management panel and six-month transition scheduled	Check the participant's chosen plan manager when relevant. [7]
1 July 2028	New commissioned support coordination and connection service scheduled	Measure handover delays, real choice and preservation of existing supports. [7,9]

The stated 50% and 10% budget allocation reductions refer to affected participation and improved daily living categories, respectively, with explicitly excluded subgroups and phased implementation. They must not be converted into a prediction that every participant loses 50% or 10% of actual therapy sessions. The NDIA states the impact differs by plan and that some relevant supports are exempt. [6,7]

10. Safeguarding and quality: evidence without exaggeration

In a targeted support coordination campaign, the NDIS Commission conducted 51 voluntary visits to providers between March and June 2025. Eight visited providers were identified with non-compliance in specified areas, including conflicts and service quality. Those eight cases are a finding about the inspected sample and should not be presented as the nationwide non-compliance rate. [15]

In the NDIA's 2026 Annual Pricing Review consultation, 54% of participant respondents identified losing their existing support coordinator as a risk with pricing changes and 65% were concerned about receiving fewer hours. These percentages reflect participants who responded to the consultation, not a representative estimate of all NDIS participants; they describe anticipated risks, not observed service reductions. [2]

11. A higher-quality referral-to-delivery protocol

Step 1 — Identify the person's actual need

Document a functional goal, participant preference, urgency, availability requirements, communication and accessibility needs, and whether the request is a disability support or a clinical treatment. Obtain participant input rather than relying on a diagnosis label alone.

Step 2 — Confirm plan fit and billing eligibility

Check the funded support category, whether funds are stated, remaining available funds, current plan, pricing arrangements, management method, provider registration requirements and any special conditions. Resolve doubtful cases with the NDIA or plan manager rather than treating referral acceptance as evidence of funding approval.

Step 3 — Identify suitable choices and conflict disclosures

Compare professional competence, disability experience, mode of delivery, accessibility, actual intake capacity, location, cost, travel and reporting requirements. Record connected-provider interests and provide meaningful alternatives where available.

Step 4 — Obtain informed consent and transmit securely

Obtain and record consent proportionate to the recipient and purpose; disclose only information needed for triage and safe delivery. Document the sent date, referral purpose, attachments, preferred response route and safe contact methods.

Step 5 — Close the loop

Confirm provider response, participant contact, first service delivery and whether the support remains suitable. Capture outcomes in the support coordinator's regular reporting and discuss unresolved barriers with the participant. [3]

12. Proposed minimum national data dictionary

Field	Permissible categories / format	Reason
Episode ID / pseudonymous client ID	Unique referral and privacy-safe participant key	De-duplication; repeat referrals
Support sought	Psychology functional / OT / speech / behaviour / support work / other	Stratified analysis
Funding method / eligibility	NDIA / plan managed / self managed / non-NDIS / uncertain	Billing pathway
Need and urgency	Routine / time-sensitive / safety escalation; reason	Case-mix adjustment
Provider type / location / modality	Profession, MM category, in-person / telehealth / home	Availability and equity
Decision outcome	Accepted / declined / waitlist / incomplete / withdrawn / unknown	Referral attrition
Key timestamps	Sent, decided, contacted, first delivered	Time-to-event metrics
Documented choice / conflict	Options available, participant decision, declared interests	Independence safeguards
Follow-up outcomes	30, 90, 180 days + reason for closure	Continuity and appropriate completion
Missingness / censoring	Unknown, declined follow-up, no response, pending	Reporting transparency

13. Proposed research implementation design

A feasible first study would be a 90–180-day prospective audit of consecutive de-identified referrals from a sample of unrelated support coordinators, psychosocial recovery coaches and provider intake teams. The reporting unit should be a referral episode; each participating site should record every eligible attempt, including declined referrals. Oversample regional/remote and high-complexity referrals and pre-specify exclusions and service categories.

Primary endpoint: appropriate first service delivered within 30 days. Secondary endpoints: 60-day commencement; provider decision within seven days; participant contact; participant-initiated withdrawal; reason for decline; 90-day retention or appropriate completion. Apply transparent data governance, participant privacy and consent requirements, ethics review where relevant, and independent statistical review prior to external claims.

An eventual TNM-led dataset would need strict separation between marketing and research; referrals should not be required to go to Therapy Near Me. Any published rate must disclose provider selection, data provenance, exclusions, nonresponse and financial interests.

14. Recommendations for policy and practice

Priority	Action	Test of progress
National reporting	Publish referral-decision and first-delivered-support indicators alongside market statistics	Rates have explicit denominators and coverage
Continuity	Set baseline and publish transfer indicators before 2028 commissioning	Handover success, time and participant choice tracked
Coordinator practice	Use structured closure-of-loop reporting	Provider response and first service evidenced
Choice and safeguards	Document options and manage connected referrals	Independent choice and disclosure audits
Clinical boundary	Separate disability-functional supports from clinical treatment	Funding and purpose clear in referral requests
Regional equity	Measure provider acceptance and wait by region and support type	Capacity rather than directories alone
Research infrastructure	Enable independent de-identified multi-site analysis	Reusable protocol, disclosed exclusions

15. Limits and careful interpretation

- National payments and provider counts are not person-level referral trajectories. This report cannot estimate a national NDIS referral failure rate or therapy waiting time.
- The NDIA's six-month active-provider measure is not equivalent to practitioners available for new referrals; the time period ended December 2025.
- Consultation percentages describe survey respondents, who may differ materially from the participant population.
- The NDIS Commission's 51 voluntary visits cannot support national regulatory prevalence statements.
- The 2026–28 reform timetable and implementation details may change; current legislation, determinations and operational notices should be rechecked before publication updates.
- The report is secondary research with a proposed measurement framework; no new participant data, causal analysis or randomised comparison has been conducted.

Appendix A — Structured support referral request (copy-ready)

The following is a suggested minimum-content template, not a substitute for a provider-specific intake form or consent process.

Field	Information to record
Referral ID / sent date	[Local identifier] / [date]
Participant / representative	[Minimum identifying details necessary for secure triage]
Consent and contact method	[Consent recorded?] [Email/telephone/accessibility preference]
Request and purpose	[Specific everyday functional outcome or mainstream clinical objective]
NDIS plan/management status	[Relevant funded support and management method; do not transmit complete plan by default]
Service sought / modality	[Profession, goals, preferred location, telehealth/home/clinic]
Constraints and safety	[Accessibility, communication, interpreter, relevant risks, response urgency]
Provider decision	[Accepted / declined / waitlist + response date]
Outcome follow-up	[First contact, first delivered service, plan for review]

Appendix B — Referral outcomes worksheet

Episode	Sent	Decision / date	First contact	First service	30d status
R-001	DD/MM/YY	[A / D / W]	DD/MM/YY	DD/MM/YY	[Started / pending / closed]
R-002	DD/MM/YY	[A / D / W]	DD/MM/YY	DD/MM/YY	[Started / pending / closed]
R-003	DD/MM/YY	[A / D / W]	DD/MM/YY	DD/MM/YY	[Started / pending / closed]

Status conventions. A = accepted; D = declined; W = waitlisted. Keep pending, participant withdrawal, unsuccessful contact, and unknown outcomes distinct; do not code an appointment merely scheduled as a delivered service.

Publication citations and companion guide

Suggested citation - research report

Therapy Near Me Research Team. (2026). From NDIS Referral to Delivered Support: Support coordination, disability-related psychology, provider choice and the measurement of real service access in Australia (Version 1.1). Therapy Near Me Pty Ltd.
https://therapynearme.com.au/ndis-support-coordinator-referral-report-2026/

Suggested citation - companion practical guide

Therapy Near Me Research Team. (2026). Australian NDIS Support Coordinator's Practical Referral Guide 2026 (Version 1.1). Therapy Near Me Pty Ltd.
https://therapynearme.com.au/ndis-support-coordinator-referral-report-2026/

The report and its companion guide are available together from this publication page.

Sources, methods and reproducibility

Primary sources were selected over commentary or general news coverage. Dates below refer to source publication/effective date or access as applicable. Figures reproduced as numbers are attributed in text; Figure 1 is an original redrawing from NDIA figures. Accessed/verified 22 October 2026. The most recent pricing schedule at the cut-off was effective 24 September 2026.

[1] NDIA. Quarterly Report Q4 2025–26, Appendices, Table D.26. June 2026. Source link

[2] NDIA. Annual Pricing Review for 2026–27 prices, s 9, Tables 26, 32 and consultation findings. June 2026. Source link

[3] NDIA. What are support coordinator reporting requirements?. 27 July 2026. Source link

[4] NDIA. How to help participants connect with NDIS supports. 2026. Source link

[5] NDIA / Minister. NDIS Pricing Schedule 2026–27, effective 24 September 2026. 24 September 2026. Source link

[6] NDIA. Changes to support budgets from 1 October. 1 October 2026. Source link

[7] Department of Health, Disability and Ageing. About the changes to the NDIS. 2026. Source link

[8] NDIS Quality and Safeguards Commission. Mandatory registration: support coordination registration paused. accessed Oct 2026. Source link

[9] NDIA. Have your say on the support coordination and connection service. 7 September 2026. Source link

[10] NDIA. What are therapy supports?. 17 July 2026. Source link

[11] NDIA. Would we fund it? Psychology supports and mental health. Official worked examples, accessed 22 October 2026. Source link (NDIA PDF)

[12] NDIA. How to find and choose a provider. 10 June 2026. Source link

[13] NDIS Quality and Safeguards Commission. Support coordination and plan management: registration pause and inquiry. accessed Oct 2026. Source link

[14] NDIA. What is a conflict of interest?. 10 June 2026. Source link

[15] NDIS Quality and Safeguards Commission. Campaign Snapshot: Support Coordination. March 2026. Source link