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SUBMISSION ON CONSULTATION ON NDIS ACCESS CHANGES

Submitted by Inclusive Rainbow Voices, with the support of LGBTIQ+ Health Australia

About Inclusive Rainbow Voices

Inclusive Rainbow Voices (IRV) is Australia's national Disabled People's Organisation (DPO) led by and for LGBTIQA+ people with disability. IRV brings lived-experience expertise to policy and systems reform, with a particular focus on the intersecting barriers experienced by LGBTIQA+ people with disability.

About LGBTIQ+ Health Australia

LGBTIQ+ Health Australia (LHA) is the national peak organisation promoting the health and wellbeing of LGBTIQ+ people and populations. LHA provides national leadership in policy, advocacy, research and capacity building, working with its members and partners to improve health and wellbeing outcomes and address systemic inequities.

Why these reforms matter

IRV welcomes the opportunity to contribute to the reform of the NDIS, with the support of LHA. These reforms will shape how people with disability exercise choice and control over their lives, access support, live safely and participate fully in society.

For LGBTIQA+ people with disability, the stakes are particularly high. Sexual orientation, gender, variations of sex characteristics, disability, relationships and family are not separate parts of a person's life. Yet LGBTIQA+ people with disability continue to experience discrimination, exclusion and services that do not recognise or respond to the whole person.

The current reforms are an opportunity to change this. IRV brings the lived-experience knowledge and disability expertise of LGBTIQA+ people with disability, supported by LHA's national health policy expertise and connections across the LGBTIQ+ health and community-controlled sector. Together, we want to see an NDIS in which LGBTIQA+ people with disability can live safely and openly, exercise genuine choice and control, and receive support that respects who they are and the lives they choose to lead.

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Principles applying across the NDIS reform program

IRV is contributing to multiple consultations across the current NDIS reform program. The following section sets out principles, evidence and commitments that are common to our submissions, before we address the specific issues raised in this consultation.

Being LGBTIQA+ is not a luxury

LGBTIQA+ people with disability are too often told, in effect, that being LGBTIQA+ is an optional extra, something to be addressed only once every other need has been met.

IRV rejects that framing. Being LGBTIQA+ is core to a person's sense of self. The ability to express, explore and live as an LGBTIQA+ person safely is not an add-on to disability support. It is part of what health, wellbeing, choice and control must mean under the NDIS.

LGBTIQA+ people with disability do not experience disability separately from sexual orientation, gender, variations of sex characteristics, relationships, family, culture or other parts of their lives. These intersect and shape whether services and supports are genuinely accessible.

For some people, being able to live safely may depend on whether a service recognises a partner or chosen family, respects their gender, provides privacy, understands their body, or creates an environment in which they do not have to hide who they are. A service being technically available does not mean it is accessible, culturally safe, affirming or appropriate.

For some LGBTIQA+ people with disability, family of origin will be an important source of support. For others, those relationships may be rejecting, unsafe or unavailable. NDIS policy and service design must not assume that family relationships are safe or that family members are able to provide support. Carers may themselves be people with disability, and their capacity to provide support cannot simply be assumed to be unlimited.

We ask the Department to treat this as a starting principle for this reform program, not a caveat to it.

The evidence

National data indicate an important intersection between LGBTIQA+ status and disability. The ABS Survey of Disability, Ageing and Carers 2022 found that 4.9% of people with disability were LGB+, compared with 3.6% of the general population aged 16 years and over (Australian Bureau of Statistics, 2024a, 2024b). The data also indicate that younger people with disability are significantly more likely to disclose being LGB+ than older people, reinforcing the urgency of ensuring the NDIS and disability services are inclusive (Australian Bureau of Statistics, 2024a). LGB+ people with disability reported disability-related discrimination at more than three times the rate of heterosexual people with disability, 27.7% compared with 8.7% (Australian Bureau of Statistics, 2024a).

Research commissioned by the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability provides further evidence of significant inequities. Hill et al. found that 90.9% of LGBTQA+ young people with disability reported high or very high psychological distress, 15.0% had

attempted suicide in the previous 12 months, and rates of family and intimate partner violence among LGBTQA+ adults with disability reached as high as 81% (Hill *et al.*, 2022).

Importantly for these reforms, the research also identified barriers within services themselves. Only 21.5% of LGBTQA+ young people with disability felt being LGBTIQA+ was supported by the NDIS or disability services, while only 34.5% of LGBTQA+ adults with disability felt accepted when accessing a health or support service. The Royal Commission-commissioned research consequently recommended clear expectations that NDIS providers deliver culturally safe and affirming services, alongside resourcing to build provider capability (Hill et al., 2022). This is not a marginal issue. It is core disability policy.

The Disability Royal Commission reinforced that disability is part of human diversity and that laws, policies and services affecting people with disability must be grounded in human rights, inclusion and respect for personhood and choice. Drawing on the Convention on the Rights of Persons with Disabilities, the Royal Commission emphasised the right and capacity of people with disability to exercise autonomy, choose how they wish to live, and participate fully in the community. It argued for an approach to disability services centred on autonomy, voice, choice, control and social inclusion, rather than one based primarily on maintenance, care and protection. These principles provide an important foundation for the current NDIS reforms and reinforce the need for reform to recognise the diversity of people with disability and enable genuine choice, control and participation (Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 2023).

The National Disability Insurance Agency (NDIA) itself recognised the importance of intersectionality in its 2020 LGBTIQA+ Strategy, Our bodies, our genders and our relationships. The Strategy committed to cultural safety, respect for people's bodies, genders and relationships, improved engagement, increased representation and participation, and improved data collection and evaluation (National Disability Insurance Agency, 2020). There has been limited public reporting on implementation of the Strategy, making it difficult to assess progress against its commitments.

The NDIA subsequently undertook further consultation towards a renewed LGBTIQA+ Strategy, including a national summit in 2024. At the time of writing, a renewed Strategy following that consultation has not been publicly released. At a time of substantial reform to the NDIS, the commitments made through that process must not be lost.

The current reforms also need to align with the Australian Government's *National Action Plan for the Health and Wellbeing of LGBTIQA+ People 2025–2035*. The National Action Plan provides a whole-of-government framework for addressing health and wellbeing inequities experienced by LGBTIQA+ people, including through accessible and inclusive care, workforce capability, improved research and data, and stronger leadership and accountability (Department of Health and Aged Care, 2024). These commitments are directly relevant to LGBTIQA+ people with disability and need to be reflected across the design and implementation of NDIS reforms.

What we are asking for across every consultation in this reform program

Before addressing the specific issues raised in this consultation, IRV asks the Department to adopt seven commitments across the NDIS reform program.

1. Build an explicit assessment of impacts on LGBTIQA+ people with disability into the design of every consultation and policy in this reform program as standard practice, rather than relying on DPOs and advocacy organisations to identify these impacts after proposals have been developed.
2. Establish and properly resource an ongoing LGBTIQA+ disability advisory mechanism, led by LGBTIQA+ people with disability, with authority to contribute across NDIS reform workstreams and to hold government accountable for implementation.
3. Provide dedicated Disability Representative Organisation funding to adequately resource IRV and other LGBTIQA+ DPOs to participate meaningfully in NDIS policy development, co-design, implementation and evaluation. Specialist DPOs cannot be expected to contribute lived-experience knowledge and expertise across multiple simultaneous consultations without adequate resourcing.
4. Publicly report on implementation of the NDIA's 2020 LGBTIQA+ Strategy and urgently finalise, release and implement the renewed LGBTIQA+ Strategy developed following consultation with LGBTIQA+ people with disability, with clear actions, responsibilities, timeframes and public accountability.
5. Mandate consistent, safe and voluntary collection of sex, gender, variations of sex characteristics and sexual orientation data across relevant NDIA systems and reform monitoring, aligned with the *ABS Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables, 2020* (Australian Bureau of Statistics, 2021). The NDIA must be transparent about why information is collected, how it will be used, who it may be disclosed to and when it will not be disclosed. People must retain control over disclosure where sharing information could place their privacy or safety at risk. These data must never be used as a gatekeeping or eligibility mechanism.
6. Fund LGBTIQA+ and disability-led participatory research to address significant evidence gaps, particularly for trans and gender diverse people and people with innate variations of sex characteristics with disability.
7. Embed LGBTIQA+ cultural safety and workforce capability across the NDIS and associated services, including through training developed and delivered with LGBTIQA+ people with disability and their representative DPOs. This must extend beyond awareness training to organisational practice, safeguards and accountability.

NDIS access: consistency must also mean equity

IRV supports the objective of making NDIS access decisions fairer, more consistent and transparent. There are potential benefits in moving away from diagnosis as the primary gateway to the NDIS and towards consideration of how disability affects a person's everyday life. However, standardisation does not automatically produce equity. The future access process needs to recognise that people come to the NDIS from very different circumstances, including significant differences in access to diagnosis, healthcare, specialist assessment and evidence. People also experience disability within different social and physical

environments and may face discrimination, poverty, geographic isolation, trauma and other structural barriers.

These differences are particularly important for LGBTIQA+ people with disability, whose experiences may also be shaped by sexual orientation, gender, variations of sex characteristics, relationships, neurodivergence, chronic health conditions, age, culture and geography. The proposed principles for the future access process provide an important opportunity to establish equity as a foundation for the new system. IRV asks that sexual orientation and variations of sex characteristics be explicitly recognised alongside gender and other characteristics, and that intersectionality inform the design and implementation of the access process as a whole.

Ground access in a social model of disability

A move towards functional capacity assessment will only represent progress if it does not replace one form of gatekeeping with another. The future access process needs to be grounded in a social model of disability, rather than a deficit model focused predominantly on impairment and what a person cannot do. Functional capacity is not simply a characteristic residing within a person. A person's capacity to participate in everyday life is shaped by the interaction between impairment and their environment, including the accessibility of services, discrimination, social and economic circumstances, relationships and the availability of appropriate support.

For LGBTIQA+ people with disability, these circumstances can include experiences of stigma or discrimination, social isolation, unsafe family or intimate relationships, trauma, or difficulty accessing culturally safe and affirming healthcare and disability services. Assessment therefore needs to understand the circumstances in which a person actually lives rather than assessing impairment in isolation. This is also important to the way people are asked to demonstrate disability. People with disability must not repeatedly be required to define themselves by what they cannot do or construct an account of themselves based solely on deficits in order to access essential support.

Disability does not begin at diagnosis

A central principle of the new access process needs to be that disability does not necessarily have a clear starting point. A person may experience substantial challenges with everyday activities for many years without understanding why. They may develop ways of adapting to or masking those difficulties, receive incorrect explanations for their experiences, or simply live with them without knowing that specialist assessment may be appropriate. It may only be much later that the person encounters a health professional who recognises what is occurring and recommends specialist assessment. Reaching that point can itself take years, and obtaining an assessment may then involve significant expense, lengthy waiting periods or travel.

The eventual diagnosis may explain longstanding experiences of disability; it does not mean that the disability began on the date the diagnosis was made. This distinction is particularly important for people who have experienced barriers to healthcare and diagnosis. Access rules must not advantage people who have had the financial resources, geographic access, knowledge or healthcare relationships necessary to obtain extensive specialist evidence while disadvantaging people who have not. Evidence requirements

therefore need to be capable of recognising a person's history and lived experience alongside appropriate clinical evidence.

There are particular implications for LGBTIQA+ people because of important intersections between LGBTIQA+ status, neurodivergence, disability and chronic health conditions. Australian research has identified a particularly strong intersection between autism and sexual and gender diversity, including substantially higher levels of sexual orientation diversity among autistic people than non-autistic comparison groups (George & Stokes, 2018; Pecora et al., 2020). National research with LGBTQA+ young people has also identified substantial levels of self-reported neurodivergence, including autism and ADHD (Hill et al., 2021).

Gender can also affect whether and when some conditions are recognised and diagnosed. This is particularly well documented in autism, where girls and women may have less overt presentations or use masking and other compensatory strategies that can contribute to later or missed diagnosis. The Australian Government's National Autism Strategy 2025–2031 recognises that diagnosis is likely to occur later for girls, women and gender diverse people, as well as people with less overt presentations and people living in regional, rural and remote areas (Australian Government, 2025).

The evidence concerning chronic physical health conditions among LGBTIQA+ people is less complete. The Australian Government's National Strategic Framework for Chronic Conditions 2026–2035 recognises poorer physical and mental health outcomes and a higher prevalence of risk factors for chronic conditions among sexuality and gender diverse people and people with innate variations of sex characteristics, while also acknowledging significant gaps in national data on physical chronic conditions in these populations (Australian Government, 2026). These evidence gaps reinforce, rather than diminish, the importance of an access process capable of responding to complex and intersecting circumstances. Geography, income, culture and access to appropriate healthcare can further shape whether conditions are recognised, diagnosed and documented. The future NDIS access process therefore needs to recognise diverse pathways to diagnosis and support rather than assuming that disability follows a simple progression from onset, to diagnosis, to evidence, to support.

Fair and appropriate functional capacity assessment

IRV supports an evidence-based access process, but what counts as evidence, who can provide it and how much it costs to obtain will have significant consequences for equity. Specialist assessment can be expensive, waiting periods can be lengthy and appropriate practitioners may not be available locally, particularly in rural, regional and remote areas. Some LGBTIQA+ people have also experienced stigma, discrimination or culturally unsafe healthcare, affecting their engagement with health services and consequently the clinical records available to them.

Evidence requirements therefore need to be flexible and proportionate. Clinical evidence can form part of the assessment, but appropriate weight also needs to be given to longitudinal information, existing records, evidence from people who know the person well and the person's own account of their disability and functional capacity. A lack of extensive historical clinical documentation must not be interpreted as evidence that disability or functional impairment did not exist.

The assessment process also needs to work for people with fluctuating, episodic and less visible disability. A person's functional capacity may vary considerably across days, weeks or longer periods, meaning a snapshot assessment can substantially underestimate the frequency, severity or cumulative impact of their disability. At the same time, the answer cannot be to require people continually to present themselves through a description of their "worst day". This can force people with disability to construct a highly deficit-focused account of themselves. Parents and carers can face a similar dilemma when asked to describe someone they love only in terms of their greatest difficulties and may understandably qualify their descriptions by explaining that these experiences do not occur every day.

Assessment needs instead to capture the range, frequency, severity and cumulative impact of disability over time. It also needs to recognise masking. A person's capacity to perform particular activities during an assessment may not reveal the effort required to do so, the strategies they have developed to compensate, or the consequences they experience afterwards. Functional capacity assessment needs to be capable of understanding the person's life over time rather than reducing eligibility to their presentation at a particular moment.

Make assessments culturally and psychologically safe

The fairness of the future access process will depend on more than the assessment tool. It will also depend on the capability of the person conducting the assessment and the environment in which it occurs. Assessors need appropriate disability expertise as well as the capability to work safely and respectfully with LGBTIQA+ people with disability.

People need to be able to discuss their lives without fear that their sexual orientation, gender, body, relationships or family structures will be misunderstood or judged. Assessment processes also need to recognise that previous experiences of discrimination or trauma can affect how a person communicates with an assessor or engages with services. Assessment needs to be culturally safe, psychologically safe and trauma-informed, with LGBTIQA+ cultural capability embedded in the training and competency requirements for people involved in access decisions.

People must also be able to involve advocates, chosen family and other trusted supporters in the process where they wish to do so. Family of origin must not automatically be treated as the person's primary or preferred source of information or support. Recognising the relationships and supports identified by the person is an important part of creating an access process based on autonomy, choice and control.

Protect bodily autonomy when considering treatment

IRV is particularly concerned about how treatment may be considered in determining whether an impairment is permanent. The existence of a treatment does not mean that treatment is genuinely available or appropriate for a particular person. Treatment may be geographically inaccessible or unaffordable, it may not be clinically appropriate, or evidence about its effectiveness and potential harms may be uncertain. Previous experiences of treatment may also have been harmful or traumatic, and a person may make an informed decision that a particular intervention is not acceptable to them.

The access process must not create a situation in which people effectively have to submit to unwanted treatment to demonstrate eligibility for the NDIS. Determining whether treatment is genuinely available and appropriate needs to consider accessibility, affordability, clinical appropriateness, evidence of effectiveness and harm, cultural safety and, fundamentally, the person's preferences and informed consent. The mere existence of an intervention cannot establish that an impairment is reasonably capable of being remedied.

Bodily autonomy cannot become conditional on access to disability support. A system based on choice and control needs to respect a person's right to make informed decisions about their own body and healthcare, including decisions not to undertake a particular treatment.

A service that exists on paper is not necessarily accessible

Similar considerations apply when determining whether another service system can meet a person's needs. The existence of a mainstream service, Foundational Support or community service does not mean that a person can actually access appropriate support from it. Before another system is treated as an alternative to the NDIS, there needs to be evidence that the relevant service is available in practice, has capacity to provide support within a reasonable timeframe, and is accessible and appropriate for that person.

For LGBTIQA+ people with disability, this includes cultural safety. A service that does not recognise a person's gender, relationships or chosen family, or in which a person reasonably fears discrimination, cannot be treated as an equivalent source of support merely because the service technically exists. The same applies where a service is unaffordable, inaccessible or lacks the capability to meet the person's disability-related needs.

This distinction is particularly important in rural, regional and remote areas and other thin markets, where the theoretical availability of a type of service may bear little relationship to what a person can actually access. The NDIS must not transfer responsibility to another system without establishing that the alternative is real and available to the person, rather than simply available in principle.

Protect existing participants through the transition

The reforms will also affect people who already participate in the NDIS. Existing participants have organised their lives around the supports available through their plans. Those supports can underpin where and how they live, their relationships, employment, participation in the community and their safety and independence. For LGBTIQA+ people with disability, this can include making use of formal supports as more culturally appropriate than those provided by informal supports (such as family who do not accept an LGBTIQA+ person's experience, sexual orientation, gender identity and so on). Reassessment under a new access framework therefore carries significant consequences for LGBTIQA+ people with disability, particularly for people who have relied on the NDIS for an extended period.

Transition arrangements need to protect people against abrupt loss of essential supports and provide sufficient time and assistance for people to understand and respond to decisions. People affected by reassessment need clear and accessible information about what is happening and why, access to

independent advocacy, and effective review and appeal mechanisms. Particular attention is required for people who face barriers to navigating administrative processes or obtaining new evidence.

The transition also needs to recognise the consequences of uncertainty itself. People need confidence that essential supports will continue while decisions are being made or reviewed. Reform must not destabilise otherwise sustainable living arrangements or expose people to avoidable risks while the new access system is implemented.

Recommendations specific to NDIS access

In addition to the seven commitments outlined at the beginning of this submission, IRV recommends that the Australian Government:

1. Explicitly recognise LGBTIQA+ people with disability and intersectionality within the guiding principles for the future NDIS access process, including sexual orientation, gender and variations of sex characteristics, and recognise how these can intersect with neurodivergence, chronic health conditions, geography, culture and socioeconomic circumstances.
2. Ground the future access process in a social model of disability, ensuring functional capacity assessment considers the interaction between impairment and the social, environmental and structural barriers experienced by the person.
3. Ensure functional capacity assessment accurately captures diverse experiences of disability, including fluctuating or episodic disability, masking, trauma, delayed diagnosis and disability that has existed for a substantial period before formal diagnosis. Assessment also needs to recognise the impact that prolonged absence of appropriate disability supports may itself have had on functional capacity.
4. Establish flexible, proportionate and equitable evidence requirements, recognising barriers associated with cost, geography, specialist availability, discrimination within healthcare and delayed diagnosis, and giving appropriate weight to longitudinal and lived-experience evidence. The absence of extensive historical clinical documentation must not, of itself, be treated as evidence that disability or functional impairment did not exist.
5. Require assessors involved in access decisions to have appropriate disability and LGBTIQA+ cultural capability and to conduct assessments in culturally and psychologically safe, trauma-informed ways.
6. Protect bodily autonomy and informed consent in decisions about permanence and treatment. The existence of a treatment or intervention must not in itself establish that an impairment is reasonably capable of being remedied.
7. Require consideration of whether proposed treatment is genuinely appropriate for the person, including its accessibility, affordability, clinical appropriateness, evidence of effectiveness and harm, cultural safety and the person's preferences and informed consent.
8. Do not exclude or divert people from the NDIS on the basis of mainstream services, Foundational Supports, informal supports or other services unless those alternatives are genuinely available, have capacity to provide the required support, and are accessible, appropriate and culturally safe, including in rural, regional and other thin markets.

9. Ensure transition arrangements for existing participants protect continuity of essential supports and provide accessible information, independent advocacy and effective review and appeal mechanisms for people affected by reassessment.

Conclusion

IRV welcomes the opportunity presented by these reforms to make NDIS access fairer, more transparent and more consistent. However, consistency cannot be the only measure of success. A standardised process that fails to account for different starting points and structural barriers can reproduce inequality rather than address it.

The future access system needs to recognise the circumstances in which people actually live. It needs to understand disability through a social rather than deficit model, recognise that disability may substantially predate diagnosis, accommodate fluctuating and less visible disability, and ensure that evidence requirements do not privilege people with greater access to healthcare and financial resources. It also needs to protect bodily autonomy. Neither treatment nor another service system can be considered an alternative to NDIS support simply because it exists in theory. What matters is whether it is genuinely available, appropriate, safe and accessible to the person concerned.

For LGBTIQA+ people with disability, equitable access also requires recognition that disability cannot be separated from sexual orientation, gender, variations of sex characteristics, relationships, family and the social environments in which people live. The principles established through this consultation will extend beyond the access decision itself. They need to follow people through planning and into the services and supports they ultimately receive. Recognition of a person's circumstances at one point in the NDIS pathway is of little value if those circumstances are disregarded at the next.

IRV asks the Department to use this reform to create an access process that is not merely more consistent, but more equitable, accessible and responsive to the lives of people with disability.

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