Prepared with the support of

SUBMISSION ON SUPPORT COORDINATION AND CONNECTION REFORM

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 and LHA welcome the opportunity to contribute to the reform of the NDIS. 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.

Contact

Inclusive Rainbow Voices

Name: Dr Jess Cadwallader
Position: Chief Executive Officer
Email: ceo@irv.org.au
Phone: 0408 238 205

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 that LGBTIQA+ people are over-represented among people with 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). It remains unclear how much of this has been achieved, as the Strategy's implementation has not been evaluated.

The NDIA subsequently undertook further consultation towards a renewed LGBTIQA+ Strategy, including a national summit in 2024. That renewed Strategy has still not been 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.

Support Coordination and Connection reform

IRV recognises the problems the Government is seeking to address through the proposed Support Coordination and Connection service. Participants have identified inconsistent quality, conflicts of interest, variable workforce capability and difficulties accessing effective support coordination, particularly for people with complex and intersecting needs. The proposed model offers opportunities to establish stronger quality standards, clearer accountability and more consistent expectations of providers.

At the same time, commissioning fundamentally changes the way participants will access support coordination. Under the proposed model, eligible participants would no longer use funding in their NDIS plans to purchase support coordination from the open market. Instead, the NDIA would commission organisations to provide SCC within defined geographic areas. The design of those arrangements will

therefore have significant implications for participant choice and control, particularly where only one or a small number of commissioned organisations operate within a region.

For LGBTIQA+ people with disability, the central question is not simply whether SCC can connect a participant with a service. It is whether SCC can connect them with the right service, one that is accessible, culturally safe, affirming and appropriate to their circumstances. The availability of a provider cannot be treated as evidence that a participant has meaningful choice.

Protect choice, control and trusted relationships

Support coordination is fundamentally relational. An effective worker may need to understand a participant's goals, disability support needs, relationships, living circumstances, experiences of discrimination and interactions with multiple service systems. Trust can take considerable time to develop.

This has particular significance for LGBTIQA+ people with disability, who may need to disclose sensitive information about gender, sexual orientation, variations of sex characteristics, relationships, chosen family, experiences of violence or discrimination, or previous experiences of unsafe services. A participant may understandably be reluctant to disclose this information to a worker who has not demonstrated that they are safe and affirming, or has demonstrated homophobic or transphobic attitudes.

Commissioning therefore cannot equate allocation to a provider with participant choice. Participants need meaningful opportunities to choose workers and, wherever possible, organisations. They also need straightforward mechanisms for changing a worker or organisation where the relationship is unsuitable, culturally unsafe or discriminatory, without losing access to coordination support or experiencing disruption to essential services.

Continuity also matters. Participants who have developed effective and trusted relationships with existing support coordinators may experience significant disruption if those relationships are abruptly ended when SCC commences. Transition arrangements need to enable existing trusted relationships to continue wherever practicable, including by creating pathways for experienced existing support coordinators to participate in the commissioned system.

Connection must mean connection to the right supports

The effectiveness of SCC cannot be measured by the number of referrals made or services identified. A successful connection occurs when a participant can actually access and use a service that is appropriate to them. It is vital that SCC support and guide participants in accessing the full market of disability service providers, not only those provided by the same organisation. This is key to protecting against further thinning out markets of appropriate and culturally safe service provision for LGBTIQA+ people with disability.

For LGBTIQA+ people with disability, a technically available service may be inaccessible in practice. A provider may lack capability in working with trans and gender diverse people, fail to recognise chosen family, make assumptions about relationships or sexual orientation, lack understanding of people with

innate variations of sex characteristics, or create an environment in which a participant does not feel safe disclosing or expressing who they are.

This distinction becomes even more important in regional, rural and remote areas and other thin markets, where participants may have few alternatives. Local knowledge needs to include knowledge about which services are genuinely accessible and safe for diverse participants, rather than simply maintaining a directory of available providers, and knowledge about strategies to use when local services do not provide accessible and safe supports.

Virtual provision can improve access to culturally safe and affirming workers, particularly for LGBTIQA+ participants in regional, rural and remote areas who may have no appropriate local provider. This may, however, exacerbate the difficulties with ensuring local knowledge of local services in order to help identify the best, most accessible and safe providers of supports. Conversely, virtual provision cannot simply become the default mechanism for servicing people whom commissioned organisations find expensive or difficult to reach. Some participants may need or strongly prefer face-to-face support because of communication needs, cognitive accessibility, technology access, privacy at home, trauma, relationship-building or the nature of the support required. A participant-led hybrid approach should be available.

SCC organisations consequently need demonstrated capacity to assess the suitability of services as well as their availability. Performance measures also need to examine whether referrals result in sustained, appropriate and safe connections, including through participant-reported measures of trust, safety, accessibility and suitability.

Recognise chosen family and the reality of informal support

The consultation proposes that the stability of formal and informal supports may help determine whether a participant receives SCC. IRV cautions against interpreting the existence of family or other relationships as evidence that adequate informal support is available.

As outlined earlier in this submission, family of origin can be an important source of support for many LGBTIQA+ people with disability. For others, family relationships may be rejecting, estranged or unsafe, while partners, friends and chosen family may provide the participant's most important sources of practical and emotional support.

Assessment therefore needs to establish whether informal support is actually available, safe, appropriate and sustainable. It also needs to recognise the support provided by chosen family and other significant relationships identified by the participant, rather than privileging biological or legally recognised family relationships.

The capacity of carers also needs to be considered rather than assumed. Carers may themselves be people with disability, may have changing health or support needs, or may simply not have the capacity to provide an unlimited amount of unpaid support. SCC eligibility and service intensity must not be reduced because a participant appears to have people around them. Without adequate formal support, informal supports can be overburdened, reducing their capacity to provide support and damaging their relationship with a participant.

Respond to complex and intersecting needs

IRV welcomes the consultation paper's recognition that participants can face additional barriers because of intersecting circumstances and that some participants may require more intensive SCC+ assistance. However, complexity cannot be understood only as a characteristic of the participant or their disability.

A participant may have relatively stable disability support needs while facing significant barriers when navigating health, housing, mental health, justice or other service systems. Discrimination, cultural unsafety, geographic isolation and previous experiences of violence or institutional harm can all make systems more difficult to navigate.

The SCC model needs to reflect a social model of disability by considering the barriers created by environments and systems, rather than locating complexity solely within a participant. Eligibility for SCC and SCC+ therefore needs to consider the participant's whole circumstances and the barriers affecting their capacity to access and coordinate appropriate support.

Participants' circumstances also change over time. The commissioned model needs a flexible and straightforward process for changing the intensity of SCC assistance when a participant's needs or circumstances change, without requiring people to demonstrate crisis or significant deterioration before additional assistance becomes available.

Build cultural safety into commissioning and workforce requirements

Cultural safety and intersectional capability need to be explicit requirements of commissioning rather than qualities that depend on the knowledge or goodwill of particular workers. Organisations commissioned to provide SCC need to demonstrate their capability to work safely and affirmingly with diverse participants, including LGBTIQA+ people with disability, and to support service providers to recognise and improve the cultural safety of their service delivery.

Generic diversity or awareness training will not be sufficient. Workers need practical capability to understand how disability intersects with sexual orientation, gender, variations of sex characteristics, relationships, age, culture, socioeconomic circumstances and geographic location, and how those intersections can shape a participant's experience of services and systems.

Training and workforce development relating to LGBTIQA+ people with disability need to be developed and delivered with LGBTIQA+ people with disability and their representative DPOs. Commissioned organisations also need organisational policies, supervision, quality assurance and accountability mechanisms that translate workforce learning into safe practice.

These requirements need to apply to lead organisations and any organisations or workers subcontracted to provide SCC. A commissioning model must not create a situation in which the lead organisation meets inclusion requirements on paper while participants receive services from subcontracted providers without equivalent capability or accountability.

Resource specialist expertise and community-controlled organisations

No SCC organisation can reasonably be expected to independently hold specialist expertise across every population and circumstance it may encounter. Commissioning provides an opportunity to build formal relationships between SCC organisations, DPOs and community-controlled organisations that already hold this expertise.

For LGBTIQA+ people with disability, formal partnerships with organisations such as IRV and LGBTIQ+ community-controlled organisations could support workforce development, culturally safe referral pathways, advice on complex circumstances and identification of systemic barriers affecting participants.

These relationships need to be funded. Specialist DPOs and community-controlled organisations cannot be expected to provide training, consultation, referral support and lived-experience expertise to large commissioned providers without resources. Commissioning arrangements need to recognise this expertise as part of the infrastructure required to deliver a safe and effective SCC system.

This is particularly important if a lead organisation model is adopted. Commissioning must not privilege large generalist providers while excluding smaller organisations that hold the specialist expertise required to make services genuinely accessible to particular populations.

Safeguards must include cultural safety

IRV supports stronger safeguarding and accountability requirements within SCC. Safeguarding, however, needs to encompass discrimination and cultural unsafety as well as fraud, abuse, neglect and conflicts of interest.

Participants need accessible, independent and confidential mechanisms for raising concerns about SCC workers and organisations (and other support providers, where this may intersect with the provision of SCC). A participant who experiences discrimination, cultural unsafety or inappropriate referrals needs to be able to change workers or organisations without losing access to coordination support or being disadvantaged within the commissioned system.

This becomes especially important where a lead organisation holds substantial responsibility for SCC across a region. Participants cannot be placed in a position where the organisation responsible for addressing their complaint is effectively their only route to receiving support coordination or other supports.

Complaints and participant-experience data also need to be examined for systemic patterns affecting particular populations. This provides another reason for safe, voluntary and consistent collection of demographic information, accompanied by appropriate privacy protections and transparent information about how data will be used.

Transition must minimise disruption

The transition to SCC will affect participants as well as the existing support coordination workforce. Implementation needs to recognise that existing relationships may represent years of accumulated knowledge, trust and understanding between participants and their support coordinators.

Transition planning therefore needs to begin well before July 2028 and include clear communication with participants about what will change, what choices they will retain and how existing relationships may be maintained. Participants requiring additional assistance to understand or navigate the transition need access to that assistance before changes take effect.

Particular attention needs to be given to participants with complex circumstances, limited informal support, previous experiences of service disruption or discrimination, and participants in thin markets. The transition itself must not create a period in which people lose the coordination required to maintain essential supports.

Recommendations for the Support Coordination and Connection reform

In addition to the seven commitments identified earlier in this submission, IRV asks the Department and NDIA to:

1. Protect meaningful participant choice and control within commissioned SCC arrangements, including the ability to choose and change workers and, wherever possible, organisations.
2. Preserve trusted existing support coordination relationships wherever practicable during transition to SCC and create pathways for capable existing workers to participate in the commissioned system.
3. Require SCC organisations to assess the suitability, not merely the availability, of services and supports, including whether they are accessible, culturally safe, affirming and responsive to the participant's circumstances, and ensure participants can access SCC through face-to-face, virtual or hybrid delivery according to their needs and preferences.
4. Develop strategies to protect against potential conflicts of interest where SCC organisations also provide disability supports.
5. Ensure SCC eligibility and service intensity recognise chosen family and do not assume that family or other informal supports are available, safe, appropriate, sustainable or capable of providing unlimited unpaid support.
6. Design SCC and SCC+ eligibility around participants' whole circumstances and the environmental, social and systemic barriers they experience, rather than locating complexity solely within the participant.
7. Provide flexible mechanisms for increasing or reducing SCC assistance as participants' circumstances change, without requiring participants to reach crisis before additional assistance becomes available.
8. Make LGBTIQA+ cultural safety and intersectional capability explicit commissioning, workforce, quality and performance requirements for lead organisations, subcontractors and workers.
9. Ensure commissioning and payment arrangements do not financially penalise SCC organisations for providing the additional time or specialist response required by participants experiencing intersectional barriers.
10. Resource formal partnerships between commissioned SCC organisations, LGBTIQA+ DPOs and LGBTIQ+ community-controlled organisations to provide lived-experience expertise, workforce development, culturally safe referral pathways and advice.

11. Establish independent, accessible and confidential safeguards and complaints mechanisms, including straightforward processes for changing workers or organisations following discrimination, cultural unsafety or other inappropriate service delivery.
12. Measure successful connection by the accessibility, suitability, safety and sustainability of services from the participant's perspective, rather than relying primarily on referral or service-contact measures.
13. Ensure commissioning arrangements preserve specialist expertise and do not exclude smaller DPOs and community-controlled organisations simply because they lack the scale to compete as lead providers.
14. Develop transition arrangements in partnership with people with disability and their representative DPOs, with particular safeguards for participants with complex circumstances, limited informal supports and those living in thin markets.

Conclusion

IRV recognises the opportunity presented by SCC reform to address longstanding problems with the quality, consistency and accountability of support coordination. A commissioned model can only succeed, however, if greater consistency is achieved without sacrificing the relationships, flexibility and participant choice that make effective support coordination possible.

For LGBTIQA+ people with disability, connection cannot mean simply locating an available service. It means being connected with support that is safe, accessible, affirming and appropriate to the whole person, including their identity, relationships and circumstances. The same principle applies to SCC itself: participants need workers they can trust and a system that gives them meaningful options when a relationship is not right.

The reform therefore provides an opportunity to demonstrate what genuine choice and control can mean within a commissioned system. By embedding lived-experience leadership, cultural safety, recognition of chosen family, specialist expertise and meaningful participant choice from the outset, SCC can help create an NDIS that responds to people as they actually live their lives.

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