The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Senate Community Affairs References Committee

The extent and nature of poverty in Australia

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Improving the mental health of communities

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Royal Australian and New Zealand College of Psychiatrists submission

The extent and nature of poverty in Australia

About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is responsible for training, educating and representing psychiatrists in Australia and New Zealand. The RANZCP has more than 7700 members, including more than 5600 qualified psychiatrists.

Introduction

The RANZCP welcomes the opportunity to contribute to the Senate Community Affairs References Committee's Inquiry into the extent and nature of poverty in Australia (the Inquiry). The recommendations contained within this submission are based on extensive consultation with RANZCP committees, including the Section of Social, Cultural, and Rehabilitation Psychiatry Committee, which is made up of community members and psychiatrists with direct experience working with people experiencing poverty. As such, the RANZCP is well positioned to provide assistance and advice about this issue due to the breadth of academic, clinical and service delivery expertise it represents.

Living in poverty is known to worsen physical and mental health.[1] Poverty has a bidirectional relationship with mental ill-health, where people who are experiencing mental illness are more likely to experience poverty and experiencing poverty also contributes to mental ill-health.[2] Both the issue of the disproportionate number of people with a mental health condition living in poverty, and the impact of poverty on the mental health of those experiencing it, require examination to capture the full extent of the impact of poverty in Australia.

Australia adopted the United Nations' Sustainable Development Goals in 2015.[3] The first of these goals is to end poverty in all its forms.[3] The latest available data indicates that Australia has the 19th highest poverty rate out of the 34 wealthiest countries in the Organisation for Economic Co-operation and Development (OECD).[4]

In this submission, 'poverty' refers to people or households whose income falls below the poverty line; the poverty line refers to half the median household income of the total population.[4, 5]

Drivers of poverty

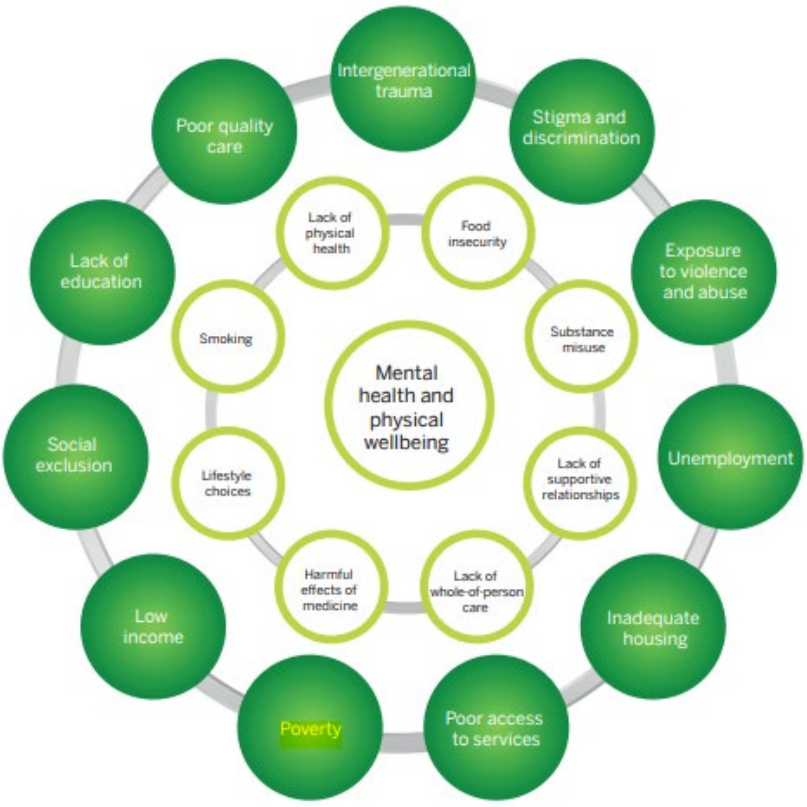
This section is related to the terms of reference matter (a) the rates and drivers of poverty in Australia.

Cost of healthcare, and cost of not accessing healthcare

Many demographics are disadvantaged by the costs of health services, in particular, affecting those who need it most (older people, and people with physical and mental health conditions). Many treatments and therapies are not covered by the public system. Private health insurance is unaffordable for vulnerable patients and families in greatest need.[6] Unexpected, high out-of-pocket costs for low-income households can lead some patients to experiencing poverty.[6]

People who have limited access to healthcare, such as those in rural areas, experience worse health outcomes, due to the low access to health and social services which would have enabled prevention and early intervention before conditions escalate.

For more information on healthcare affordability, please see the RANZCP reports Keeping your head above water: Affordability as a barrier to mental health care and Minding the Gaps: Cost barriers to accessing health care for people with mental illness and our submission to the Australian Medical Association regarding a whole-of-system approach to reforming private healthcare. The RANZCP is a signatory to the Equally Well Consensus Statement, which shows the interrelated nature of social problems through **Figure 1:**



Cost of housing and homelessness

Homelessness is an indicator of extreme poverty. Demonstrated in Figure 1, there is a significant interrelationship between homelessness and poor mental health.[7] This means that the costs of healthcare and the costs of housing exacerbate risk of poverty for this population. Discrimination against people with mental illnesses can also make it more difficult for them to find housing, resulting in higher housing costs.

As such, the RANZCP recommends that mental health, housing and homelessness supports, services and policies are integrated to best address homelessness.

The RANZCP emphasises that housing inequality and intergenerational poverty are growing in Australia, with no significant changes being made by governments to stop this.[8] This is a known issue, and there is no comprehensive national housing policy preventing people in poverty from slipping into homelessness.

The RANZCP additionally highlights that a Housing First approach is increasingly considered an effective approach to homelessness.[9] For more information and recommendations for eliminating homelessness, please see the RANZCP submission to the Productivity Commission review of the *National Housing and Homelessness Agreement*, and the RANZCP submission to the House of Representatives Standing Committee on Social Policy and Legal Affairs Inquiry into homelessness in Australia.

The RANZCP also highlights that ongoing funding is needed to ensure rapid connection with housing services and multidisciplinary psychosocial supports is made before and upon discharge from custody or inpatient facilities.[10] The RANZCP recommended in our 2022-23 pre-budget submission that there should be funding of innovative services to ensure people who are released or discharged do not become homeless. Recent estimates show that, in Victoria alone, over 500 people each year are being discharged from acute mental healthcare into homelessness.[11] There is significant evidence that the same issue is present when discharging people from other healthcare, custodial and justice settings.[10, 11] To decrease the likelihood of reoffending, agencies like Corrective Services need to develop and expand post-release transitional services that aim to reintegrate individuals leaving detention back into the community via housing and income support.

Contact with the justice system

Contact with the justice system can be both an impact and a driver of poverty. The RANZCP encourages governments to address the underlying causes of crime, which include poverty and its related measures such as lack of affordable housing and unemployment. People with mental health conditions are also more likely to experience contact with the justice system.[7]

In addition to the above section on release from justice settings into homelessness, the impact of contact with the justice system can have a flow-on poverty impact to families of people who have contact with the justice system. Evidence demonstrates that children of imprisoned parents experience higher rates of poverty, homelessness, food insecurity and lower rates of school completion.[12] The research highlights possible causes of these adverse outcomes: the trauma of parent-child separation, children being made aware of their parent's criminality, family poverty caused by the imprisonment, strained parenting by remaining caregivers, stigma, and stresses involved in maintaining contact with the imprisoned parent. For more information, please see the RANZCP submission to the Inquiry into support for children of imprisoned parents.

Climate change and disaster

While it is noted that efforts were made to support and protect people who are homeless during the COVID-19 pandemic, the RANZCP recommends that a comprehensive, ongoing framework be developed to support people who are homeless or at risk of homelessness, their support people and service providers throughout emergencies. This involves planning for future emergencies.

Emergency and disaster response services must be enhanced for women and children experiencing family violence to ensure they are connected with tailored trauma informed programs which support mental health. Such emergency and disaster planning should occur in consultation with state and territory governments, service providers and people with lived experience of being homeless.

For more information, please see the Position Statement 106: The mental health impacts of climate change, Position Statement 35: Addressing the mental health impacts of natural disasters and climate change-related weather events, Position Statement 101: Trauma-informed practice, and the RANZCP submission to the Select Committee on the Response to Major Flooding across New South Wales.

Demographics

This section is related to the terms of reference matters:

(c) the impact of poverty on individuals in relation to:

(i) employment outcomes,
(ii) housing security,
(iii) health outcomes, and
(iv) education outcomes;

(d) the impacts of poverty amongst different demographics and communities;

The RANZCP recognises the compounding effects of disadvantage and highlights the experiences of the following demographics and communities.

People with mental health conditions

People with mental health conditions are more likely to experience poverty; poverty also increases the risk of mental distress and health conditions.[7, 13] People with mental health conditions are at a significant financial disadvantage compared with the general population. They are less likely to have access to educational opportunities, and more likely to experience unemployment or low income.[3] Employment is among the highest goals of people with a severe mental illness, yet unemployment remains high.[14] In part, this is due to the difficulties of obtaining and keeping a job while managing the symptoms of a mental illness, but stigma and discrimination are also a key barrier.

About 80% of people with a mental health condition also have a physical health condition.[15] The overall impact of this financial disadvantage is that people with mental illnesses face a number of cost barriers to establishing and maintaining healthy lifestyles, including the challenges of being able to afford adequate housing, food, health care and medical services. People with mental illnesses have higher than average needs for medications and treatment for mental and physical health issues, which can result in higher healthcare expenses. This is particularly difficult for people with multiple medications.

The RANZCP recommends the development of bulk-billing incentives for psychiatry consultations for patients experiencing financial disadvantage. Means-tested bulk billing incentives (50% of the schedule fee as is the case for rural loading) must be prioritised to ensure those in poverty obtain affordable access to psychiatry services. Such reform must be supported by continual review of effective measures of financial disadvantage to ensure the long-term efficacy of funding reform and the provision of services to those in need. Recommendation 11 of the evaluation of the Better Access Initiative further demonstrates the need for increasing affordability through bulk-billing incentives.[16]

Contribution of poverty to mental ill-health

As highlighted in the 2020 report *Health Equity in England: The Marmot Review 10 years On*, living in poverty is a contributing factor to mental ill-health. Poverty is a stressful experience that creates or amplifies many day-to-day challenges, such as struggling to cover regular costs (e.g., transportation and other necessities) or to managed unexpected costs. These stressors can have a significant negative impact on a person's overall quality of life including their mental health.[2]

Experiencing poverty can also cause a person to experience a perceived loss of status which can lead to feelings of poor self-worth and a loss of optimism for the future, again contributing to mental ill-health.[2]

Aboriginal and Torres Strait Islander peoples

Aboriginal and Torres Strait Islander peoples are profoundly and disproportionately affected by poverty, with 31% of households living under the poverty line.[17] Aboriginal and Torres Strait Islander peoples also experience low employment rates, high rates of poor health and disability, lower life expectancy, higher rates of self-harm and suicide, disproportionate contact with the justice system, and higher rates of experiencing family violence.[17-21]

Data shows that 65% of Aboriginal and Torres Strait Islander peoples live rurally and are disproportionately impacted by poverty.[1] The average household income for Aboriginal and Torres Strait Islander peoples is significantly less than non- Aboriginal and Torres Strait Islander peoples.[1, 22] Dispossession of land has led to intergenerational poverty and high rates of homelessness.[23] Over half of Aboriginal and Torres Strait Islander peoples rent rather than own their homes.[23] Aboriginal and Torres Strait Islander peoples also experience racism and stigma, which has negative impacts on mental health.[21, 24]

Carers

Informal carers are at a significant financial disadvantage compared to the general population. Difficulties in obtaining and keeping a job while providing care inhibit the maintenance of a healthy lifestyle (adequate housing, food, health care and medical services). Increasing the Carer Allowance would support informal carers and the people they care for overcome cost barriers. For more information, please see the RANZCP submission to the Productivity Commission's carer leave Inquiry.

The RANZCP's Position Statement 76: Partnering with carers in mental healthcare recognises that carers are at the heart of a compassionate, empathetic and supportive society. The RANZCP emphasises that carers are at a high risk of experiencing psychological distress, loneliness, social isolation and the associated health consequences and social impacts. The RANZCP Position Statement 101: Suicide prevention – the role of psychiatry highlights that loneliness is a risk factor for a range of health consequences and social impacts including risk of suicide. Social connectedness and inclusion are a protective factor. Loneliness is often a central experience for people with mental illness, as well as their families/carers.[25] For more information, please see the Lived Experience Australia report on Understanding loneliness and mental health and the RANZCP webpage on loneliness.

Culturally and linguistically diverse (CALD) peoples including refugees and newly arrived migrants

More than 300 languages are spoken in Australia, with about 45% of Australians having been born overseas or having a parent who was born overseas.[26] These characteristics broadly make up what is often referred to as culturally and linguistically diverse (CALD) populations.[26] As a broad and varied group, there are varied impacts experienced by different subgroups. Refugees, for example, have significantly higher rates of mental illness than people born in Australia.[26]

Experiences of stigma, discrimination such as racism, loneliness, and social isolation are common among CALD peoples, and these experiences impact mental health and wellbeing.[27, 28] CALD populations experience higher rates of food insecurity, barriers to health services access, and reduced employment opportunities.[29-31] Access to income support payments is dependent on the type of visa held, leaving some people without this safety net.[30] CALD populations are also growing in rural areas.[31]

The RANZCP acknowledges that newly arrived migrants, asylum seekers and refugees are particularly vulnerable to experiencing homelessness.[32] CALD peoples face many barriers when seeking assistance for issues relating to housing, including limited access to information on housing and homelessness

supports, language barriers and culturally unsafe services.[32] The RANZCP therefore emphasises the importance of raising awareness of housing and homelessness supports amongst CALD communities and ensuring services are culturally safe and linguistically appropriate.

Older people

Older Australians, especially those with mental illness, are at a significant financial disadvantage compared to the general population. Data shows that 30% of Australians over 65 are living under the poverty line, significantly higher compared to other OECD countries.[33] Health conditions are common amongst older people, and there are associated costs. Many elderly people are unable to work, and those who can may experience difficulties in obtaining and keeping a job due to stigma and discrimination.[34]

The Age Pension rates inhibit the maintenance of a healthy lifestyle (adequate housing, food, health care and medical services), particularly for those who do not own their own home.[35] The number of people aged 55 and over accessing homelessness services has increased by 40% since 2013-14.[36] The RANZCP highlights that a lack of stable housing may lead to premature ageing and the accompanying onset of mental and physical health conditions.

Rural communities

Increasing remoteness is connected to decreasing access to health and social services, and higher costs for everyday expenses like food and petrol.[1, 13, 37] Rural households have lower incomes and lower net worth than their metropolitan counterparts.[1, 37] People in rural areas are less likely to have finished school or any tertiary education, less likely to be employed, more likely to smoke, more likely to experience family violence, and are more likely to die early.[37] People living in rural areas are also more vulnerable to the impacts of natural disasters.[38]

Although the prevalence of mental illness in rural areas is reportedly similar to that in metropolitan areas, self-harm and suicide rates increase by remoteness.[38] This may be due to the dearth of mental health services and other health and social support services available in rural Australia to help prevent conditions from escalating. People with disabilities in rural areas who are participants of the National Disability Insurance Scheme are unable to access the supports they are eligible for due to thin or non-existent markets in these areas.[39] For more information, please see RANZCP Position Statement 65: Rural psychiatry and the Rural Psychiatry Roadmap 2021–31.

Veterans

The RANZCP is concerned about the prevalence of veteran homelessness. Suicide and suicidality is more prevalent in people experiencing homelessness than those who are not.[40, 41] This must be highlighted, considering the recent interest in addressing and preventing veteran suicides.

Veterans are overrepresented in the homeless population of Australia.[42] It is estimated that over a 12 month period there were 5,800 veterans in Australia who were homeless.[42] One study found that 5.6% of people sleeping rough in Australia were veterans, with veterans more likely to spend longer periods of time sleeping rough, and more likely to report health and social issues than non-veterans.[43]

For more information and recommendations to better support veteran wellbeing, please refer to the RANZCP submission to the Royal Commission into Defence and Veteran Suicide.

Women

Women are more likely to live in poverty.[33] Due to the connection between poverty and mental health, women are also experiencing high levels of psychological distress.[44] There is an unequal distribution of power, resources and opportunity, in which there is a different value afforded to men and women, has its historical roots in societal gender norms, laws, and policies.

This unequal distribution of power creates the social context in which violence against women occurs. These factors are targets of change and prevention of violence against women and their children. Family violence is strongly connected to poverty. For more information, please see Position Statement 102: Family violence and mental health. The University of Technology Sydney 2022 report The Choice: Violence or Poverty calls for policy change to address the issue.

According to May 2022 data, women in Australia earn $263.90 less than men on average.[45] Such differences render women more likely to slip into poverty. Drivers include:

- Unpaid caring responsibilities: Career breaks and reduction of working hours to birth and care for children impact wealth accumulation, including superannuation accumulation (retiring with 22-35% less superannuation than men), but also the opportunity costs of wage raises, promotion, and networking.[46-48] Women are also more likely to undertaking caring responsibilities for elderly relatives.[48]
- The undervalued nature of female-dominated industries result in lower income for working women.[47]
- Discrimination in hiring and remuneration negotiation and decisions.[47]

For more information, please see the RANZCP discussion paper, Gender equity and the College: Why does it matter?,

Improving income including income support payments

This section is related to the terms of reference matter (e) the relationship between income support payments and poverty, and (f) mechanisms to address and reduce poverty.

Increasing income and reducing wealth inequality were identified as key issues in the *Health Equity in England: The Marmot Review 10 years On* report, which notes that low wage growth combined with the increasing cost of living has increased rates of poverty for many people. Insufficient wages mean that working while living in poverty is a reality for many. Poor quality of work, such as low-paid, insecure or casual employment, can negatively contribute to a person's mental health and may have an even greater negative impact than experiencing unemployment.[2]

During the pandemic, Australia introduced the JobSeeker COVID Supplement Payment (increasing an existing social security payment) and JobKeeper (a new social security payment for eligible employees) as two key economic policy responses. These payments reduced the number of people in poverty by approximately 32% to levels that were lower than prior to the pandemic.[49] Subsequent reductions in payments and the tightening of eligibility to access them has since pushed many people back into poverty.

The RANZCP has long recommended the provision of more accessible and reasonable income support payments. The lack of affordable housing for low-income households is well-recognised in Australia.[10]

81% of people aged 15 and over who accessed specialist homelessness services in 2020-21 were receiving some form of government payment as their main source of income at the time.[50]

On this basis, the RANZCP urges that an increased allowance rate be extended to people accessing the variety of government-funded payments and supports available, including Job Seeker, Commonwealth Rent Assistance, Carer Allowance, Age Pension (for those who do not own their own home), and the Disability Support Pension. Such income support should be available irrespective of one's visa status. For further information please see the RANZCP submission to the Senate Inquiry into the adequacy of Newstart and related payments.

The Final Report of the Inquiry into Homelessness recommends that the Australian Government commission an independent review of Commonwealth Rent Assistance.[51] The system of social support remains complex, fragmented and challenging to access. The RANZCP supports a review of the current system with the purpose of clarifying eligibility requirements and resolving barriers to access for people with mental health conditions. In addition, the RANZCP recommends that the Government ensures income support and social services are effectively integrated into an individual's mental health care pathway.

Recommendations: Mechanisms to address and reduce poverty

This section is related to the terms of reference matter (f) mechanisms to address and reduce poverty.

Throughout this submission, the RANZCP has made a number of recommendations to address and reduce poverty.

Improving access to health services

The RANZCP recommends:

- Develop bulk-billing incentives for psychiatry consultations for patients experiencing financial disadvantage.
- Ensuring that all people, regardless of their location, have access to the health services that they require, including the National Disability Insurance Scheme.
- Covering the health treatments and therapies required by the public within the public system.
- Funding the ongoing implementation of the Rural Psychiatry Roadmap 2021–31.

Eliminating homelessness

The RANZCP recommends:

- Ensuring there are no exits into homelessness from custody, hospitals, or other forms of care.
- Developing a comprehensive national housing policy preventing people in poverty from slipping into homelessness.
- Taking a Housing First approach to those experiencing or at risk of experiencing homelessness.
- Integrating mental health, housing and homelessness supports, services and policies.

- Forward-planning for future emergencies should occur to protect people who are homeless or at risk of homelessness and their service providers from the unique risks posed by crises such as the COVID-19 pandemic and natural disasters.

Supporting disadvantaged demographics

The RANZCP recommends:

- Supporting people into employment. Individual placement supports have a strong evidence base for enhancing both vocational and non-vocational outcomes.[52]
- Improving income support payments as per the below section.
- Implementing policy changes which address the drivers of the gender pay gap. These drivers and numerous possible policy solutions are known to Government.[47]

Improving income support payments

The RANZCP recommends:

- Providing more accessible and reasonable income support payments.
- Making income support be available to all people irrespective of their visa status.
- Ensuring income support and social services are effectively integrated into an individual's mental health care pathway.

References

1. Poverty in rural & remote Australia: National Rural Health Alliance; 2017 [Available from: https://www.ruralhealth.org.au/sites/default/files/publications/nrha-factsheet-povertynov2017.pdf.
2. Marmot M, Allen J, Boyce T, Goldblatt P, Morrison J. Health equity in England: The Marmot Review 10 years on. London: Institute of Health Equity; 2020.
3. Sustainable Development Report: United Nations; 2019 [Available from: https://www.sdgindex.org/reports/sustainable-development-report-2019/.
4. Poverty rate (indicator): Organisation for Economic Co-operation and Development 2022 [
5. Poverty in Australia: Australian Council of Social Services; [Available from: https://povertyandinequality.acoss.org.au/poverty/#:~:text=Our%202022%20Poverty%20in%20Australia,a%20couple%20with%202%20children.
6. Duckett S SA, Lin L. Not so universal: How to reduce out-of-pocket healthcare payments: Grattan Institute; 2022 [Available from: https://grattan.edu.au/report/not-so-universal-how-to-reduce-out-of-pocket-healthcare-payments/.
7. Funk M DN, Knapp M. Mental health, poverty and development. Journal of Public Mental Health. 2012;11(4):166-85.
8. Rääbus C. Experts say this is what Australia needs to do to solve the housing crisis. ABC news. 2021.
9. Hayhurst W. Finding a stable home base. Parity. 2020;33(6):29-30.
10. N B. Trajectories: the interplay between mental health and housing pathways. Policy priorities for better access to housing and mental health support for people with lived experience of mental ill health and housing insecurity: Australian Housing and Urban Research Institute Limited and Mind Australia; 2021

11. Inquiry into homelessness in Victoria Final Report: Parliament of Victoria, Legislative Council Legal and Social Issues Committee; 2021 [Available from: https://www.parliament.vic.gov.au/images/stories/committees/SCLSI/Inquiry_into_Homelessness_in_Victoria/Report/LCLSIC_59-06_Homelessness_in_Vic_Final_report.pdf.

12. Murphy D CM. Parents Behind Bars: What Happens to their Children? 2015.
13. Isaacs AN EJ, Meadows G, Inder B. Lower Income Levels in Australia Are Strongly Associated With Elevated Psychological Distress: Implications for Healthcare and Other Policy Areas. Front Psychiatry. 2018;9:536.
14. Ramsay C BB, Goulding S, Cristofaro S, Hall D, Kaslow N, Killackey E, Penn D, Compton M. Life and treatment goals of individuals hospitalised for first-episode nonaffective psychosis. . Psychiatry Research. 2011;189:344-8.

15. Equally Well Consensus Statement: National Mental Health Commission; 2018 [Available from: https://www.equallywell.org.au/wp-content/uploads/2018/12/Equally-Well-National-Consensus-Booklet-47537.pdf.
16. Pirkis J CD, Harris M, Mialopoulos C. Evaluation of Better Access: Conclusions and Recommendations: University of Melbourne; 2022 [
17. Davidson P, Saunders, P., Bradbury, B. and Wong, M. Poverty in Australia 2018: Australian Council of Social Service and University of New South Wales; 2018 [
18. Deaths by suicide amongst Indigenous Australians: Australian Institute of Health and Welfare; 2022 [Available from: https://www.aihw.gov.au/suicide-self-harm-monitoring/data/populations-age-groups/suicide-indigenous-australians.
19. Indigenous health and wellbeing: Ausralian Institute of Health and Welfare; 2022 [Available from: https://www.aihw.gov.au/reports/australias-health/indigenous-health-and-wellbeing.
20. Shepherd SM, Spivak B, Ashford LJ, Williams I, Trounson J, Paradies Y. Closing the (incarceration) gap: assessing the socio-economic and clinical indicators of indigenous males by lifetime incarceration status. BMC Public Health. 2020;20(1):710.
21. Aboriginal and Torres Strait Islander Health Performance Framework - summary report 2020: National Indigenous Australian Agency; 2020 [Available from: https://www.indigenoushpf.gov.au/.
22. Indigenous income and finance: Australian Institute of Health and Welfare; 2021 [Available from: https://www.aihw.gov.au/reports/australias-welfare/indigenous-income-and-finance.
23. Housing Statistics for Aboriginal and Torres Strait Islander Peoples: Australian Bureau of Statistics; 2022 [Available from: Housing Statistics for Aboriginal and Torres Strait Islander Peoples.
24. Kairuz CA, Casanelia LM, Bennett-Brook K, Coombes J, Yadav UN. Impact of racism and discrimination on the physical and mental health among Aboriginal and Torres Strait Islander peoples living in Australia: a protocol for a scoping review. Systematic Reviews. 2020;9(1):223.
25. Royal Commission into Victoria's Mental Health System: Final Report 2021 [Available from: https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/02/RCVMHS_FinalReport_Vol2_Accessible.pdf.
26. Australia's Health 2018: Culturally and linguistically diverse populations: Australian Institute of Health and Welfare; 2018 [Available from: https://www.aihw.gov.au/getmedia/f3ba8e92-afb3-46d6-b64c-ebfc9c1f945d/aihw-aus-221-chapter-5-3.pdf.aspx.
27. Ferdinand A KMPY. Mental health impacts of racial discrimination in Victorian culturally and linguistically diverse communities: Full report Melbourne, Australia: Ferdinand A, Kelaher M & Paradies Y 2013 [
28. Middleton G, Velardo S, Patterson KA, Coveney J. The value of social eating at culturally and linguistically diverse lunch clubs: a descriptive study. Food, Culture & Society. 2022:1-23.
29. Food insecurity in Australia: What is it, who experiences it and how can child and family services support families experiencing it? : Australian Institute of Family Studies; 2011 [Available from: https://aifs.gov.au/resources/practice-guides/food-insecurity-australia-what-it-who-experiences-it-and-how-can-child.
30. Khatri RB, Assefa Y. Access to health services among culturally and linguistically diverse populations in the Australian universal health care system: issues and challenges. BMC Public Health. 2022;22(1):880.

31. Javanparast SSKANM, Lillian. . Health service access and utilisation amongst culturally and linguistically diverse populations in regional South Australia: a qualitative study. Rural and Remote Health. 2020;20(4).
32. Lisette K, Mariana A, Paul F. Homelessness in culturally and linguistically diverse populations in Western Australia. 2019.
33. Sila U DV. Income poverty of households in Australia: Evidence from the Hilda survey: Organisation for Economic Co-operation and Development; [Available from: https://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=ECO/WKP(2019)8&docLanguage=En.
34. Willing to Work: National Inquiry into Employment Discrimination Against Older Australians and Australians with Disability: Australian Human Rights Commission; 2016 [Available from: https://humanrights.gov.au/our-work/disability-rights/publications/willing-work-national-inquiry-employment-discrimination.

35. Trends in poverty amongst older people: Australian Council of Social Services; [Available from: https://povertyandinequality.acoss.org.au/poverty/trends-in-poverty-among-older-people/.
36. Petersen M PC, Phillips R, White G. Preventing first time homelessness amongst older Australians Brisbane, Australia: Australian Housing and Urban Research Institute, The University of Queensland; 2014

37. Rural and remote health: Australian Institute of Health and Welfare; 2022 [Available from: https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health.
38. Mental health in rural and remote Australia: National Rural Health Alliance; 2017 [Available from: https://www.ruralhealth.org.au/sites/default/files/publications/nrha-mental-health-factsheet-dec-2017.pdf.
39. General issues around the implementation and performance of the NDIS: Joint Standing Committee on the National Disability Insurance Scheme; 2021 [Available from: https://parlinfo.aph.gov.au/parlInfo/download/committees/reportjnt/024620/toc_pdf/GeneralIssues2021.pdf;fileType=application%2Fpdf.
40. Brackertz N. The role of housing insecurity and homelessness in suicidal behaviour and effective interventions to reduce suicidal thoughts and behaviours: a review of the evidence, Evidence Check prepared by AHURI for the National Suicide Prevention Adviser and the National Suicide Prevention Taskforce, commissioned through the Suicide Prevention Research Fund, managed by Suicide Prevention Australia Melbourne: Australian Housing and Urban Research Institute; 2020.

41. Tsai J, Cao X. Association between suicide attempts and homelessness in a population-based sample of US veterans and non-veterans. J Epidemiol Community Health. 2019;73(4):346-52.
42. Fiona Hilferty; Katz IVH, Miranda; Lawrence-Wood, Ellie. How many Australian veterans are homeless? Reporting prevalence findings.

and method from a national study. Australian Journal of Social Issues. 2021;56.
43. Wood L, Flatau P, Seivwright A, Wood N. Out of the trenches; prevalence of Australian veterans among the homeless population and the implications for public health. Australian and New Zealand Journal of Public Health. 2022;46(2):134-41.
44. Callander EJ, Schofield DJ. Psychological distress and the increased risk of falling into poverty: a longitudinal study of Australian adults. Social Psychiatry and Psychiatric Epidemiology. 2015;50(10):1547-56.
45. Gender Pay Gap Data: Australian Government Workplace Gender Equality Agency; 2022 [Available from: https://www.wgea.gov.au/pay-and-gender/gender-pay-gap-data.
46. The gender superannuation gap: Addressing the options: KPMG; 2021 [Available from: https://assets.kpmg/content/dam/kpmg/au/pdf/2021/addressing-gender-superannuation-gap.pdf.
47. The Gender Pay Gap: Australian Government Workplace Gender Equality Agency; [Available from: https://www.wgea.gov.au/the-gender-pay-gap.
48. Unpaid care work and the labour market: Australian Government Workplace Gender Equality Agency; 2016 [Available from: https://www.wgea.gov.au/sites/default/files/documents/australian-unpaid-care-work-and-the-labour-market.pdf.

49. Phillips B, Gray M, Biddle N. COVID-19 JobKeeper and JobSeeker impacts on poverty and housing stress under current and alternative economic and policy scenarios. Canberra: Australian National University: Centre for Social Research & Methods; 2020.
50. Specialist homelessness services annual report 2020–21: Australian Institute of Health and Welfare; 2021 [Available from: https://www.aihw.gov.au/reports/homelessness-services/specialist-homelessness-services-annual-report/contents/summary.
51. Inquiry into homelessness in Australia: Final report: House of Representatives Standing Committee on Social Policy and Legal Affairs; 2021 [Available from: https://parlinfo.aph.gov.au/parlInfo/download/committees/reportrep/024522/toc_pdf/Finalreport.pdf;fileType=application%2Fpdf.
52. Tsang H FK, Leung A, Li S, Cheung W Three year follow-up study of an integrated supported employment for individuals with severe mental illness. . Australian and New Zealand Journal of Psychiatry. 2011;44(1):49-58.