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Cost-of-living and the mental health of Australian caregivers and their children: Findings from a national cross-sectional surveyAnna M. H. Price^{1,2,3} *Mary-Anne Measey^{2,4}Sharon Goldfeld^{1,2,3}Anthea Rhodes^{2,3,5}**Affiliations**¹ Centre for Community Child Health, The Royal Children's Hospital, Parkville, Vic., Australia² Population Health, Murdoch Children's Research Institute, Parkville, Vic., Australia³ Department of Paediatrics, The University of Melbourne, Parkville, Vic., Australia⁴ Health Services Research Unit, The Royal Children's Hospital, Parkville, Vic., Australia⁵ Department of General Medicine, The Royal Children's Hospital, Parkville, Vic., Australia**Correspondence***Dr Anna Price anna.price@mcri.edu.au

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Abstract

Financial hardship is a well-established determinant of mental health. From 2021 to 2025, Australian families faced sustained increases in cost of living, yet little evidence exists on how these pressures are perceived to affect families' mental health. This study draws on data from the November–December 2024 wave of the nationally representative Royal Children's Hospital National Child Health Poll, which has tracked the financial and mental health experiences of Australian families with children aged 0–17 years since 2020.

Using weighted proportions, we described: (1) caregivers' perceived impact of cost of living on their own and their children's mental health with responses on a five-point scale ('large positive' to 'large negative') and (2) variation in these perceived impacts by demographics (gender, child age, sole caregiver status, caregiver education, home language, regionality, neighbourhood socioeconomic status), financial hardship (material deprivation and low-income) and caregiver and child mental health.

Responses were received from 1,991 caregivers for themselves and 3,274 children. Most caregivers reported that cost-of-living pressures negatively affected their own mental health, with 41% reporting a small negative impact and 24% a large negative impact. More women reported negative impacts than men. For children, 65% of caregivers reported no impact, although negative effects were more common among adolescents than younger children. Notably, 11% of caregivers and 14% of children were reported to experience positive mental health impacts of cost of living. A bimodal pattern was evident: both large negative and positive impacts were more common for caregivers experiencing low income, material deprivation, lower education, sole caregiving or poor mental health. Conversely, caregivers in two-caregiver households, with higher education or income, or without deprivation, more commonly reported small negative effects.

This is the first national survey to measure perceived cost-of-living impacts on caregiver and child mental health. The study demonstrated clear social patterning, and provides timely, policy-relevant evidence for early childhood, family and mental health systems. The findings underscore the need for universal responses that are proportionate to need, alongside integrated approaches that address the complex adversities and challenges families face, as financial pressures persist.

Keywords:

Australia, caregivers, children, cost-of-living, family wellbeing, mental health, poverty, social determinants.

Introduction

Financial hardship means not having enough money to pay for what you need. Often defined by household income (e.g. poverty), financial hardship is a well-established determinant of mental health (Croak et al., 2025; Reiss, 2013). From 2021 to 2025, Australian families faced sustained increases in cost of living, which refers to the average amount households must spend on essentials like housing, food, energy and transport to maintain a basic standard of living. The narrative around this 'crisis', as it is commonly referred, is that increased cost of living is increasing financial hardship. While the financial trends have been documented (Price et al., 2024a), less is known about the relationship between cost of living and mental health. This study addresses this gap by drawing on representative data from families with children from the Royal Children's Hospital (RCH) National Child Health Poll.

Cost of living in Australia

In Australia, increases in cost of living have been driven by a combination of domestic inflationary pressures and global supply shocks. This includes the lingering effects of the COVID-19 pandemic and disruptions to energy and food markets related to geopolitical events (Broadbent et al., 2023; Tingle, 2025). From late 2021 to mid-2022, inflation rose from 3.5% to 6%, prompting the Reserve Bank of Australia to begin raising interest rates from 0.10% to 0.35% in May 2022 (RBA, 2025). These pressures disproportionately affected working-age families with mortgages, whose average annual repayments rose by 30% between 2021 and 2023 (RBA, 2025). In Australia, essential costs such as food, energy and insurance also surged, with price increases continuing into 2025. Public concern over affordability increased, with 65% of voters identifying cost of living as their top issue before the federal election in May 2025, up from 32% in 2019 and 49% in 2022 (IPSOS, 2025; Tingle, 2025). National reports show that at least one in three children were living in households experiencing 'material

deprivation', which is the inability to afford the material basics for health such as food, housing and health care (ACOSS, 2025; Price et al., 2024b)

Cost of living and mental health

A substantial body of research demonstrates the association between financial hardship and poor mental health across the life course. In adults, financial strain, including low income, difficulty managing bills, food insecurity and energy insecurity, is consistently linked with elevated psychological distress and poorer wellbeing (Clair & Baker, 2022; Croak et al., 2025; Giles et al., 2024; Jackson et al., 2023; Phan et al., 2025; Price et al., 2024a). An emerging body of research points specifically to cost-of-living pressures as a contributor to mental health difficulties. In a 2023 cross-national survey of more than 8,000 adults across Europe, most participants reported negative mental health impacts attributable to cost-of-living increases, with negative effects more common among women, middle-aged adults, lower-income groups and those with pre-existing health conditions (Grailey et al., 2024). Similar patterns have been observed in Britain, where difficulty with housing arrears or managing finances was strongly associated with psychological distress (Jackson et al., 2023), and in Wales, where financial stress had stronger mental health impacts among adults with greater childhood adversity, suggesting cumulative vulnerability (Hughes et al., 2024).

For families raising children, these pressures operate within a broader developmental context. The Family Stress Model offers a widely accepted framework for understanding how economic strain contributes to caregiver distress, reduced parenting capacity, and poorer child outcomes (Conger & Donnellan, 2007). While typically conceptualised as a pathway from financial hardship to mental health, evidence also highlights bidirectional dynamics, whereby mental health difficulties may themselves intensify financial stress (Abshire Saylor et al., 2024). Longstanding research has demonstrated strong socioeconomic gradients in child and adolescent mental health (Rainer et al., 2024; Reiss, 2013; Robson et al., 2025), particularly when financial hardship is persistent or

worsening. Yet, evidence specifically examining cost-of-living impacts on children and adolescents remains limited. A UK rapid review identified children in single-parent and multigenerational households as particularly vulnerable during the cost-of-living crisis (Meadows et al., 2024), and international studies show rising food and energy insecurity disproportionately affecting households with children (Champagne et al., 2023; Polsky, 2024). Australian qualitative research also highlights how cost-of-living pressures affect children's daily lives, including disrupted routines, reduced participation in school and social activities, and compromised access to food, transport and health care (CPC, 2025; Booth et al., 2023).

Structural and policy contexts shaping cost-of-living impacts

Policy settings play an important role in shaping how families experience and respond to rising cost-of-living pressures. Recent analyses argue that high-income countries must address intersecting economic conditions, such as inflation, housing stress and wage stagnation, through social policies that support families raising children, who are particularly affected by these pressures (Broadbent et al., 2023). Evidence from the USA provides further insight into how policy environments can buffer or exacerbate inequalities. Two studies using Adolescent Brain and Cognitive Development cohort data found that lower family income was associated with smaller hippocampal volumes and higher internalising symptoms, but these associations were weaker in US states with more generous antipoverty programs such as cash transfers and tax credits (Weissman et al., 2023; Williams et al., 2024).

A related body of work focuses on food security policy, one of the key pathways through which cost-of-living pressures influence family wellbeing. Food insecurity has direct effects on health through inadequate nutrition and hunger, and indirect effects through stress, stigma and reduced social participation. In a US survey of families, universal free school meal policies were widely perceived to reduce household stress and improve child wellbeing (Cohen et al., 2024). Concerns were raised that reverting to means-tested school meal programs would introduce barriers around affordability, stigma and administration, and disproportionately affect low-income households. Similar calls for upstream action have been made in the UK to address structural drivers of food insecurity (Stone & Papadaki, 2025), while Australian research with Aboriginal and/or Torres Strait Islander caregivers highlights the need for improved food access, electricity rebates and more regular income payments to meet basic needs (Booth et al., 2023).

Study rationale and aims

Rising cost-of-living pressures are shaped both by household circumstances and broader system-level conditions, including social protection frameworks, food security policies and the adequacy of income and material supports. These structural factors help explain why families experience financial pressure differently and highlight the need for population-level evidence on how caregivers perceive the mental health impacts of cost of living on themselves and their children.

In Australia, recent early childhood and family wellbeing reforms, such as the National Early Years Strategy (DSS, 2024) and the National Children's Mental Health and Wellbeing Strategy (National Mental Health Commission, 2021), have emphasised equity, prevention and the importance of timely data to guide system responses. These policy directions underscore the relevance of understanding families' lived experiences of cost-of-living pressures; particularly, how these pressures are perceived to affect mental health across demographic and socioeconomic groups.

This study addresses these evidence gaps using data from a nationally representative sample of Australian caregivers. Specifically, we aimed to describe:

1. Caregivers' perceived impact of cost of living on their own and their children's mental health; and
2. How the distribution of these perceived impacts differs across:
 - a. Demographic characteristics;
 - b. Indicators of financial hardship (material deprivation and low income); and
 - c. Caregiver and child mental health.

Methods

The Royal Children's Hospital (RCH) National Child Health Poll comprises periodic cross-sectional surveys of approximately 2,000 Australian caregivers of children aged 0-17 years. To achieve high response rates and population representativeness, the surveys are intentionally brief and ask simple, closed-ended questions. Data collection was contracted to the Online Research Unit, which obtains written informed consent and draws a nationally representative sample of caregivers using stratified random sampling from their panel of over 350,000 adults aged 18 years or older, composed of over 30% caregivers to children aged less than 18 years, who live in Australia and have internet access. Surveys are administered in English, with a reading level equivalent to sixth grade (the end of primary/elementary school). Responses are anonymous and respondents are remunerated with points exchangeable for department store gift vouchers.

For this wave of data collection, conducted 25 November to 4 December 2024, caregivers were asked about cost-of-living impacts on their own and their child's mental health, in addition to the Poll's standard demographic, financial and mental health measures. Consent was obtained online. The protocol, including secondary analysis of de-identified data, was approved by the RCH Human Research Ethics Committee (HREC 35245A).

Patient and public involvement

The research questions and design were informed by previous RCH Poll surveys, which asked caregivers to identify child health issues of most concern and topics of future surveys. At the end of each survey, participants were informed of the study website where all research reports are accessible to the public, as well as provided with reputable help-seeking resources. Respondents were not directly involved in the recruitment or conduct of each survey.

Measures

Perceived impact of cost of living on mental health was measured using the following 5-point study-designed item: *In the past 12 months, what would you say the overall impact of the ‘cost of living’ has been on your mental health?’*

For children, it was presented as follows: *‘A child’s mental health and wellbeing affects how they feel, think, behave, and relate to others. When a child has good mental health they feel good and function well. When a child has difficulties with mental health they may have problems that affect their thoughts, mood, feelings or behaviour. These problems might be temporary and can result from the stresses of life. In the past 12 months, what would you say the overall impact of the ‘cost of living’ has been on your child’s mental health?’*

Response options for caregivers were: ‘large positive’, ‘small positive’, ‘none’, ‘small negative’ and ‘large negative’. For child reports, caregivers were given the same five response categories plus a ‘not sure’ option. The item was adapted from earlier waves of the RCH National Child Health Poll to assess perceived mental health impacts of the COVID-19 pandemic (Price et al., 2022,

2024b), where it was used repeatedly across 2020–2023 with the same 5-point response scale. For the current study, the item replaced the references to COVID-19 with cost of living. The source for the original item was the United Kingdom Young Minds Matter Study (Young Minds, 2020).

Before inclusion in the 2024 poll, this new cost-of-living item was piloted with 106 caregivers (with 179 children) to assess completion and the response distribution. Pilot testing showed good spread across all categories and no concerns regarding completion, so the wording and scale were retained unchanged. Consistent with poll design principles, no examples or definitions were provided for the positive or negative response categories. For analysis, ‘small positive’ and ‘large positive’ responses were combined due to small cell sizes, with separate Ns shown in the descriptive tables.

Responding caregivers also reported on two measures of financial hardship (material deprivation and low household income), as well as their mental health (Kessler-6 (K6); Furukawa et al., 2003) and the mental health of each child in their care (Self-Rated Mental Health item; Ahmad et al., 2014). Table 1 describes these measures and the binary cut-points for analysis.

Table 1. Cost of living, demographic, financial hardship and mental health measures

Measure	Description
Perceived impact of cost of living on mental health	A 5-point study-designed item describing the perceived impact of cost of living on mental health was adapted from previous waves of the Royal Children’s Hospital National Child Health Poll describing the perceived impact of COVID-19 (Price et al., 2024a, 2024b). Response options were ‘large positive’, ‘small positive’, ‘none’, ‘small negative’ and ‘large negative’. The item was reported by caregivers for (1) themselves and (2) each child. The question for children also included a ‘not sure’ option. Due to small response proportions, ‘small positive’ and ‘large positive’ were combined, with separate <i>N</i> reported in the results table.
Demographics	
Gender	Response options for caregivers were ‘male’, ‘female’ and ‘other’ (identified by three caregivers). As this subgroup was too small to analyse separately, only the female and male categories are presented for the descriptive gender analyses. Child options were ‘male’ and ‘female’. These naming conventions of the survey questions are reflected Tables 2 and 3, with acknowledgment that this is not best practice.
Age	Collected for caregivers and children, reported in years. Child age was used as a proxy for educational level and categorised to represent pre-school (ages 0–4 years), primary/elementary school (ages 5–11 years) and high school (ages 12–17 years).
Sole caregiver	Question ‘Are you the sole (single) parent or carer of a child 17 years of age or younger?’, binary response options ‘yes’ (one-caregiver household) compared with ‘no’ (multi-caregiver household).
Caregiver education	Question ‘What is the highest level of schooling / education you have completed?’ Responses were trichotomised into categories that meaningfully represented education as a socioeconomic measure for Australians: (1) ‘Year 12 or less’ (response options: less than year 10, Year 10 or equivalent (e.g. school certificate), Year 12 or equivalent); (2) ‘vocational training certificate’ (response options: trade/apprenticeship (e.g. carpenter), certificate/diploma (e.g. Cert IV Childcare)); or (3) ‘university degree’ (response options: undergraduate university degree, postgraduate university degree (e.g. Masters, Doctorate, PhD).
Home language	Question ‘Do you speak a language other than English at home?’, binary response options ‘yes’ (other than English) compared with ‘no’ (English).
Regionality	Australian Bureau of Statistics (Jul 2021–Jun 2026), Remoteness Structure, dichotomised into ‘metropolitan’ (‘major cities’) versus ‘regional/remote’ (‘inner regional/ outer regional/ remote/ very remote’).
Neighbourhood-level disadvantage	Families were assigned the Australian Bureau of Statistics’ (ABS) Socio-Economic Indexes for Areas (SEIFA) Index of Relative Disadvantage, a national area-level index derived from census data for all individuals living in a postcode, with higher scores indicating greater advantage. Presented as quintiles: quintile 1 represents most disadvantage and quintile 5 represents least.
Financial hardship	
Deprivation	Eight items adapted from the Household, Income and Labour Dynamics in Australia (HILDA) Survey Wave 18 Household Questionnaire Material Deprivation Module (Wilkins & Lass, 2018) asking ‘In the last month, because of money pressure did you miss or put off’ (binary response options: ‘yes’ compared with ‘no’): mortgage or rent repayments; electricity, gas, water bills; food; healthcare; prescription medicines; home or car insurance; mobile phone bills; or internet. A total count, and a binary summary variable were created; the latter compared the inability to pay for one or more essential items ‘any material deprivation’ with ‘none’.

Low income	A binary variable based on current total household income before tax, categorised into 10 options ranging from 'less than \$500 p/week' to 'more than \$3,000 p/week', plus 'prefer not to say'. Income was dichotomised as low versus not according to the thresholds for the Australian Government Low Income Card (LIC), a means-tested benefit within Australia's social welfare system that defines low income. The primary purpose is to offer concessions for prescription medicines; however, the LIC entitles holders to access a limited range of health, education, recreational and transport expenses (Australian Government, 2024a). In 2025, all sole carers or couples with income up to \$1,343 per week (income variable categories 1–6) were LIC eligible, with \$34 per additional dependent child. <i>n</i> = 215 (10.8%) caregivers preferred not to report income.
Mental health	
Caregiver mental health	Six items of the Kessler-6 (K6) assessing caregivers' self-reported anxiety and depressive symptoms encountered in the last 4 weeks. Scored on a 5-point Likert scale from 1 'none of the time' to 5 'all of the time'. In Australia, this is dichotomised into a binary variable indicating 'poor mental health' (total score 19 or more) compared with not (total score 6–18) (Furukawa et al., 2003). The K6 performs strongly for screening mood and anxiety disorders according to the WHO Composite International Diagnostic Interview and 30-day Diagnostic and Statistical Manual-IV disorders (Area Under the Curve: 0.89, 95% confidence interval: 0.88–0.90), and outperforms the General Health Questionnaire-12 (Furukawa et al., 2003). The K6 was collected in all six surveys.
Child mental health	The single 5-point Self-Rated Mental Health (SRMH) scale (Ahmad et al., 2014) scored on a 5-point Likert scale from 'poor' to 'excellent', dichotomised into 'poor/fair' versus 'good/very good/excellent' (Price et al., 2022). The poor and fair SRMH categories in adult studies have shown moderate correlations with validated mental health scales such as the Kessler Psychological Distress Scale and Patient Health Questionnaire, and associations with physical health, social determinants of health and health service use. Published psychometric data for children and young people are lacking.

Analysis

Our research questions were descriptive, focusing on summarising caregivers' perceptions of how cost-of-living pressures affected their own and their children's mental health at the population level. Descriptive analyses are the most appropriate analytic approach for this purpose because the aim was not to test hypotheses, infer causal relationships or build predictive models, but rather to characterise population patterns, quantify the prevalence of perceived impacts and describe how these perceptions are distributed across demographic and socioeconomic groups. Population-level descriptive estimates are essential for policy and service planning (Gray et al., 2026; O'Connor et al., 2026), particularly in rapidly changing economic conditions, and provide insights that cannot be gained through multivariable or inferential modelling alone.

Consistent with this descriptive aim, we calculated frequencies, weighted proportions and 95% confidence intervals (CIs) for all outcome categories. No hypothesis testing or multivariable modelling (e.g. regression, MANOVA) was conducted, because such analyses would not align with the descriptive purpose of the study and could imply causal or predictive intent that is neither appropriate nor interpretable for these data.

Weighting

To reduce non-response and non-coverage bias and approximate national population distributions, caregiver-level estimates were weighted using raking procedures based on caregiver age, gender, family structure (sole caregiving, number of children and children aged <5 years), regionality, state/territory and Socio-Economic Indexes for Areas (SEIFA). Child-level estimates were weighted to the national distributions of children by age, sex and state/territory. Because weighting may increase the influence of respondents assigned large weights, particularly those from under-represented groups, we provide unweighted prevalences for all outcome categories and key indicators in **Supplementary Table S1** to allow comparison with weighted estimates. All *Ns* presented in tables reflect unweighted counts; all proportions and CIs reflect weighted estimates.

Clustering of children within families

Because some caregivers reported on more than one child, all child-level CIs were calculated using cluster-robust standard errors at the caregiver (family) level, ensuring that standard errors were not underestimated due to non-independence of observations within families.

Interpretation of confidence intervals

CIs were used to convey estimation precision, not statistical significance. We did not interpret overlapping or non-overlapping CIs as indicators of meaningful differences, nor did we conduct any hypothesis tests. Instead, we describe group patterns where differences in the estimated proportions were substantively or policy relevant. This estimation-focused approach aligns with best practice for descriptive epidemiology.

All analyses were conducted in Stata/IC v18 (StataCorp, College Station, TX, USA).

Results

Participant characteristics

In total, 2,928 caregivers were approached, and 1,991 (68%) participated, providing data for themselves and 3,274 children. **Tables 2 and 3** describe the respondent characteristics using unweighted counts (*N*) and weighted proportions. Caregivers had a mean age of 43.1 years (standard deviation (SD) 9.6 years, range 19 to 70 years), 49.5% were female, and they cared for an average of two children (range 1–7). Just over one-quarter were sole caregivers, 23.6% spoke a language other than English at home, and 17% lived in regional or remote areas. Children had a mean age of 9.4 years (SD 5.1) and 48.2% were female. No data were available to compare responding caregivers with non-respondents; however, socioeconomic characteristics indicated a strong response bias toward more advantaged groups, with 58.1% of caregivers holding a university degree and 50.8% of respondents in the two most advantaged SEIFA quintiles. This pattern underscores the rationale for applying sample weights in the descriptive analyses to better approximate the Australian population.

Because our research questions were descriptive, Tables 2 and 3 report weighted proportions with 95% CIs to convey estimate precision rather than statistical significance. Corresponding unweighted percentages are presented in Supplementary Tables S1 and S2 for comparison. The unweighted distributions closely mirrored the weighted estimates, indicating that weighting had only modest effects on the overall patterns of results. The sections below summarise patterns in the weighted proportions, focusing on differences that are descriptively meaningful and policy relevant.

Perceived cost-of-living impacts on caregiver mental health

Table 2 summarises caregivers’ perceived cost-of-living impacts on their mental health. Overall, nearly two-thirds of caregivers reported a negative impact, most commonly a small negative impact (41.1%, 95% CI 38.2–44.1%), followed by a large negative impact (23.7%, 95% CI 21.1–26.5%). Around one-quarter perceived no impact (23.9%, 95% CI 21.4–26.6%), and 11.3% (95% CI 9.5–13.4%) reported a positive impact.

Patterns differed across demographic, socioeconomic and mental health groups. A greater proportion of female caregivers reported large negative impacts compared with males, while positive

impacts were more commonly reported among males. Caregivers in sole caregiver households showed a more polarised pattern, with higher proportions reporting both positive and large negative impacts than those in multi-caregiver households. Caregivers with lower educational attainment also more commonly reported large negative impacts than those with vocational or university qualifications.

Families who spoke a language other than English at home more often reported positive impacts than English-speaking households. Caregivers in rural or regional areas had a higher prevalence of large negative impacts than those in metropolitan areas, who more frequently reported no impact. Patterns by neighbourhood socioeconomic status (SEIFA) were not consistent.

More polarised responses were seen among caregivers experiencing material deprivation or low income, with these groups more commonly reporting both positive and large negative impacts than their more advantaged counterparts. A similar pattern was observed for caregivers with poor mental health, who more frequently reported both large negative and positive impacts, whereas caregivers with optimal mental health more commonly reported small negative impacts.

Table 2. Perceived cost-of-living impact on caregiver mental health, described with the number of respondents and weighted proportions (95% confidence intervals (CIs))

Measure	Total	Large/small positive			None		Small negative		Large negative	
		Large	Small	Combined						
	<i>n</i>	<i>n</i>	<i>N</i>	% (95% CI)	<i>n</i>	% (95% CI)	<i>n</i>	% (95% CI)	<i>n</i>	% (95% CI)
Overall	1991	85	126	11.3 (9.5, 13.4)	490	23.9 (21.4, 26.6)	849	41.1 (38.2, 44.1)	441	23.7 (21.1, 26.5)
Caregiver gender										
Female	986	41	54	9.4 (7.3, 12.0)	204	21.3 (17.9, 25.1)	430	42.4 (38.3, 46.5)	257	26.9 (23.3, 31.0)
Male	1002	43	72	13.7 (10.8, 17.4)	286	27.3 (23.6, 31.3)	417	39.5 (35.3, 43.9)	184	19.5 (16.1, 23.4)
Sole caregiver										
Yes	552	45	76	22.7 (18.1, 28.0)	135	25.1 (20.1, 31.0)	166	26.7 (22.0, 31.9)	130	25.5 (20.4, 31.3)
No	1439	40	50	6.6 (5.0, 8.6)	355	23.4 (20.6, 26.4)	683	47.1 (43.6, 50.6)	311	23.0 (20.1, 26.2)
Caregiver education										
Y12	314	13	21	14.0 (9.1, 20.7)	74	26.3 (19.5, 34.5)	115	29.8 (23.5, 37.0)	88	29.9 (23.0, 38.0)
Cert.	520	25	43	14.3 (10.5, 19.2)	98	14.9 (11.6, 19.0)	220	42.8 (36.9, 48.8)	134	28.0 (22.5, 34.1)
Uni.	1157	44	62	9.2 (7.2, 11.7)	318	27.2 (23.8, 30.9)	514	43.5 (39.7, 47.4)	219	20.1 (17.0, 23.5)
Home language other than English										
Yes	470	45	45	19.7 (14.1, 25.2)	104	21.0 (16.4, 26.5)	173	36.7 (30.9, 42.8)	103	22.7 (17.6, 28.6)
No	1521	40	81	8.2 (6.5, 10.3)	386	24.9 (22.0, 28.1)	676	42.8 (39.4, 46.2)	338	24.1 (21.1, 27.4)
Regionality										
Rural/regional	351	13	26	11.9 (8.1, 17.2)	68	13.0 (9.1, 18.2)	153	45.0 (37.6, 52.7)	91	30.1 (23.2, 37.9)
Metro	1640	72	100	11.2 (9.2, 13.5)	422	26.1 (23.2, 29.2)	696	40.3 (37.1, 43.6)	350	22.4 (19.7, 25.5)
SEIFA quintile										
Q1–2	552	34	46	13.6 (10.2, 18.0)	137	23.6 (19.1, 28.9)	212	39.3 (33.9, 44.9)	123	23.5 (18.9, 28.8)
Q3	427	13	31	11.1 (7.9, 15.3)	92	19.7 (15.5, 24.8)	188	41.5 (35.7, 47.6)	100	27.7 (22.2, 33.9)
Q4–5	1012	35	49	9.2 (7.0, 12.0)	261	26.5 (22.9, 30.5)	449	42.6 (38.6, 46.8)	218	21.7 (18.3, 25.5)
Deprivation										
Yes	761	64	72	18.2 (14.6, 22.3)	108	17.0 (13.4, 21.4)	214	24.8 (20.9, 29.1)	303	40.1 (35.2, 45.1)
No	1230	21	54	6.4 (4.8, 8.5)	382	28.7 (25.4, 32.3)	635	52.7 (48.8, 56.5)	138	12.2 (9.7, 15.2)
Low income										
Yes	429	34	48	18.8 (14.1, 24.5)	95	22.5 (17.2, 28.9)	115	24.4 (19.2, 30.6)	137	34.3 (28.0, 41.2)

No	1347	44	72	9.8 (7.7, 12.2)	338	23.8 (20.9 to 27.0)	631	46.1 (42.5, 49.8)	262	20.3 (17.4, 23.6)
Caregiver poor mental health										
Yes	257	21	42	28.0 (20.5, 36.9)	46	20.3 (13.9, 28.8)	48	17.0 (11.6, 24.2)	100	34.7 (26.9, 43.4)
No	1734	64	84	8.6 (7.0, 10.6)	444	24.4 (21.8, 27.3)	801	45.0 (41.8, 48.2)	341	22.0 (19.3, 25.0)

N: Number, SD: Standard deviation, SEIFA: Socio-Economic Indexes for Areas Index of Relative Disadvantage.

Highest education coded as Year 12 or less (up to the end of high/secondary school; Y12); vocational training certificate ('Cert'); or university degree ('Uni'). Regionality coded as metropolitan (Metro) or regional/remote (Regional).

Denominators are subgroup totals. *N* = 215 caregivers preferred not to report household income. Due to small response proportions, 'small positive' and 'large positive' perceived cost-of-living impacts were combined, with separate *N* reported.

Proportions and 95% CIs for the caregiver were weighted using national population distributions for caregiver age, gender, family structure (sole caregiving, number of children and any under age 5 years), regionality, state/territory and SEIFA.

Perceived cost-of-living impacts on child mental health

Across all children (*N* = 3,274), most caregivers (65.5%, 95% CI 62.5–68.2%) reported no perceived cost-of-living impact on their child's mental health. Smaller proportions reported small negative (17.2%, 95% CI 15.1–19.5%) or large negative impacts (3.1%, 95% CI 2.3–4.2%), while 14.2% (95% CI 12.1–16.7%) perceived a positive impact. Patterns varied by child age and household circumstances. Caregivers of adolescents (aged 12–17 years) more commonly reported both small and large negative impacts than caregivers of younger children. Positive impacts were reported across all age groups, appearing slightly more common among children aged 5–11 years.

Children in sole caregiver households had higher proportions of both positive and negative impacts compared with those in multi-caregiver households. Positive impacts were also more commonly

reported for children in households where a language other than English was spoken at home, who less frequently reported no perceived impact. Slightly higher proportions of negative impacts were reported for children living in regional or rural areas compared with metropolitan areas.

Clear gradients were observed by material deprivation, low income and child mental health status. Children in households experiencing deprivation or low income more often had both small and large negative impacts reported, as well as higher proportions of positive impacts – a pattern similar to that self-reported by caregivers. Caregivers of children rated as having fair or poor mental health reported substantially higher proportions of negative impacts and lower proportions of no impact compared with caregivers of children rated as having good/ very good/ excellent mental health.

Table 3. Perceived cost-of-living impact on child mental health, described with the number of respondents and weighted proportions (95% confidence intervals (CIs))

Measure	Total	Small/large positive			None		Small negative		Large negative	
		Small	Large	Combined						
	<i>n</i>	<i>n</i>	<i>n</i>	% (95% CI)	<i>n</i>	% (95% CI)	<i>n</i>	% (95% CI)	<i>n</i>	% (95% CI)
Overall	3164	166	236	14.2 (12.1, 16.7)	2065	65.5 (62.5, 68.2)	585	17.2 (15.1, 19.5)	112	3.1 (2.3, 4.2)
Child age (years)										
0–4	723	26	67	13.3 (9.8, 17.7)	522	75.6 (70.6, 80.1)	64	9.5 (6.8, 13.1)	12	1.6 (0.9, 3.0)
5–11	1234	80	89	16.2 (13.0, 20.1)	795	65.9 (61.5, 70.0)	208	15.9 (13.1, 19.3)	30	2.0 (1.2, 3.3)
12–17	1317	60	80	12.8 (9.9, 16.2)	748	57.4 (52.8, 61.9)	313	24.3 (20.6, 28.5)	70	5.5 (3.7, 8.1)
Child gender										
Female	1695	84	132	14.7 (12.2, 17.7)	1063	64.0 (60.4, 67.5)	312	18.9 (16.1, 22.0)	50	2.4 (1.6, 3.4)
Male	1579	82	104	13.6 (11.0, 16.9)	1002	67.0 (63.3, 70.5)	273	15.4 (13.1, 18.0)	62	3.9 (2.7, 5.6)
Sole caregiver respondent										
Yes	844	102	118	29.2 (23.9, 35.1)	392	48.0 (42.1, 53.9)	167	18.7 (14.7, 23.5)	44	4.1 (2.5, 6.7)
No	2430	64	118	8.1 (6.3, 10.4)	1673	72.6 (69.4, 75.6)	418	16.6 (14.2, 19.2)	68	2.7 (1.9, 4.0)
Responding caregiver education										
Y12 or less	536	36	45	20.8 (14.6, 28.8)	317	61.9 (53.9, 69.4)	87	13.6 (9.2, 19.5)	24	3.6 (2.1, 6.4)
Cert.	558	47	84	18.1 (13.7, 23.5)	509	56.8 (50.8, 62.6)	175	21.8 (17.2, 27.3)	36	3.3 (1.9, 5.8)
Uni.	1853	83	107	10.8 (8.5, 13.6)	1239	70.2 (66.6, 73.6)	323	16.1 (13.6, 18.9)	52	2.9 (1.9, 4.5)
Home language other than English										
Yes	773	83	79	22.2 (17.3, 27.9)	436	59.1 (52.9, 65.1)	125	16.1 (12.1, 21.0)	26	2.6 (1.3, 5.3)
No	2501	83	157	11.3 (9.1, 13.9)	1629	67.8 (64.5, 70.9)	460	17.6 (15.2, 20.3)	86	3.3 (2.4, 4.6)
Regionality										
Rural/Regional	649	29	42	14.8 (9.8, 21.8)	396	59.9 (52.4, 67.1)	130	20.8 (15.5, 27.4)	23	4.3 (2.1, 9.0)
Metro	2625	137	194	14.1 (11.8, 16.7)	1669	66.6 (63.4, 69.6)	455	16.5 (14.2, 18.9)	89	2.9 (2.1, 4.0)
SEIFA Quintile										

Q1–2	951	78	89	19.4 (15.0, 24.6)	563	61.9 (56.2, 67.3)	136	15.7 (12.0, 20.2)	37	3.0 (1.8, 5.2)
Q3	709	36	52	12.7 (9.1, 17.5)	428	63.7 (57.7, 69.3)	139	19.6 (15.3, 24.7)	28	4.0 (2.2, 7.4)
Q4–5	1614	52	92	10.4 (8.1, 13.4)	1074	69.7 (65.9, 73.3)	310	17.2 (14.4, 20.3)	47	2.7 (1.8, 4.1)
Deprivation										
Yes	1312	121	156	24.3 (20.1, 28.9)	586	47.0 (42.1, 51.9)	305	23.0 (19.3, 27.2)	86	5.8 (4.1, 8.2)
No	1962	45	80	7.3 (5.4, 9.8)	1479	78.2 (74.8, 81.2)	280	13.2 (10.9, 15.9)	26	1.3 (0.7, 2.4)
Low income										
Yes	714	75	102	26.8 (21.0, 33.4)	336	46.3 (39.7, 53.0)	126	20.5 (15.4, 26.6)	41	6.4 (4.0, 10.4)
No	2214	80	124	10.8 (8.7, 13.4)	1522	70.5 (67.2, 73.7)	391	16.4 (14.0, 19.1)	58	2.2 (1.5, 3.3)
Child mental health										
Fair/poor	370	13	10	10.0 (4.5, 20.8)	154	43.6 (35.4, 52.3)	114	31.2 (24.3, 39.0)	52	15.1 (9.8, 22.5)
Good/very good/excellent	2904	153	226	14.7 (12.4, 17.2)	1911	67.7 (64.6, 70.6)	471	15.8 (13.6, 18.1)	60	1.9 (1.3, 2.8)

N: Number, SD: Standard deviation, SEIFA: Socio-Economic Indexes for Areas Index of Relative Disadvantage.

Highest education coded as Year 12 or less (up to the end of high/secondary school; Y12); vocational training certificate ('Cert'); or university degree ('Uni'). Regionality coded as metropolitan (Metro) or regional/remote (Regional).

Due to small response proportions, 'small positive' and 'large positive' perceived cost-of-living impacts were combined, with separate *N* reported. *N* = 110 caregivers who reported that they were not sure about the impact of cost of living on the child's mental health were excluded. Caregivers of *N* = 346 children preferred not to report household income.

Proportions and 95% CIs for the caregiver were weighted using national population distributions for caregiver age, gender, family structure (sole caregiving, number of children and any under age 5 years), regionality, state/territory and SEIFA, and clustering at the level of family.

Discussion

This nationally representative cross-sectional study shows that the perceived impacts of cost of living on families' mental health are not distributed equally. We found clear social patterning in caregivers' perceived mental health impacts, with both positive and large negative effects more commonly reported by those experiencing low income, material deprivation, sole caregiving, lower education or poor mental health, and small negative impacts more commonly reported by families without these challenges.

Synthesis with existing literature

These findings align with a robust body of research showing that families with lower income, material deprivation, sole caregiving responsibilities or lower education more often experienced poorer mental health (Clair & Baker, 2022; Croak et al., 2025; Jackson et al., 2023; Price, et al., 2024a, 2024b). The Family Stress Model provides a useful theoretical lens, suggesting that financial hardship generates caregiver distress, which in turn impacts parenting quality and child outcomes (Conger & Donnellan, 2007). In the present study, the proportions of caregivers reporting large negative effects of cost of living on their own mental health were higher among those also reporting indicators of social and economic disadvantage. Patterns were similar for their children, consistent with Australian and international research showing socioeconomic disadvantage is associated with poor child mental health (Rainer et al., 2024; Reiss, 2013; Robson et al., 2025).

These patterns are also echoed in recent studies examining post-pandemic cost-of-living impacts. Grailey et al. (2024) and Jackson et al. (2023) found that perceived negative impacts on wellbeing and mental health were more common among women, families with children, renters and individuals with prior mental health conditions (Grailey et al., 2024; Jackson et al., 2023). Notably, our findings build on this literature by incorporating a child mental health perspective by describing perceived positive impacts, which have received limited attention in existing cost-of-living research.

Our data showed that higher proportions of caregivers with low income, material deprivation, sole caregiving responsibilities or poor mental health reported both large negative and positive impacts of cost-of-living pressures. This polarised pattern suggests that cost of living may shape experiences at both ends of the spectrum for these families. One possible explanation is that because the 'crisis' has affected large segments of the population, including middle- and higher-income households, public narratives around financial strain may have shifted, with reduced stigma around seeking support. This may have increased the availability and uptake of supports. For example, the Commonwealth Government allocated an additional A\$14.4 million in 2023–2024 for emergency and food relief services, distributed across Foodbank (<https://www.foodbank.org.au>), SecondBite (<https://secondbite.org>) and other emergency providers (Rishworth, 2024). This is alongside additional government measures such as the \$300 energy bill rebate for households in May 2024 (Klapdor & Thomas, 2024), a 10% boost to Commonwealth Rent Assistance (Australian Government, 2024b), across-the-board tax cuts and targeted programs like NewAccess for Small Business Owners (Australian Government, 2024c). These broad-based and visible supports may have improved access for families who previously felt excluded, while also giving those in longstanding hardship additional strategies to manage financial strain.

Additionally, some families who have lived with financial hardship over a prolonged period may have developed strategies to navigate the supports available, which are now more broadly accessible and politically backed. While our data do not include indicators of chronic hardship or duration of adversity, these interpretations align with qualitative studies (e.g. Booth et al., 2023; Stone & Papadaki, 2025) that highlight how longstanding experiences of adversity can foster adaptation, resourcefulness and stronger connections with local service networks. Thus, positive impacts reported by these families may reflect a complex

combination of reduced stigma, improved access to support and increased capability to navigate systems that were previously underfunded or less inclusive.

The patterning of child mental health findings adds further nuance. Most caregivers reported no perceived cost-of-living impact on their child's mental health; however, when negative impacts were reported, they were disproportionately concentrated among children living in households experiencing deprivation, low income or sole caregiving. These findings resonate with international evidence of widening inequalities in food and housing insecurity (Champagne et al., 2023; Polsky, 2024), as well as emerging evidence that child wellbeing is increasingly shaped by financial strain and service access during the cost-of-living crisis (Meadows et al., 2024).

Notably, the perception of cost-of-living impacts was also influenced by child age, with more adolescents perceived as negatively affected than younger children. This likely reflects greater awareness among adolescents or increased exposure to stressors outside the home. In addition, adolescence is a particularly sensitive period for mental health vulnerability, and there is a broader developmental and societal context in which mental health concerns are more readily recognised and understood in older children (Robson et al., 2025). Older children may also be more vulnerable to material deprivation because social participation and peer inclusion become increasingly important in adolescence, and reduced access to these opportunities may contribute to perceived mental health impacts.

At the same time, these patterns may reflect how caregivers interpret or report children's mental health. Some caregivers may feel they are carrying the 'load' themselves and buffering their children from financial strain, consciously or unconsciously downplaying child impacts. Others may lack confidence in identifying early mental health difficulties in younger children, particularly when these manifest through behavioural or developmental changes rather than emotional symptoms. In this sense, the apparent absence of cost-of-living effects in younger children may reflect both real protective buffering by caregivers and limits in caregiver mental health literacy, highlighting the importance of developmental stage and caregiver perception in shaping reported outcomes.

Strengths and limitations

This study has several strengths. First, it draws on a large, nationally representative sample of Australian caregivers using the RCH National Child Health Poll. The use of robust population weights ensures the findings reflect the broader population of families with children across Australia. The poll's online panel-based methodology allows rapid capture of caregiver views and experiences during evolving social and economic conditions, such as the recent increases in cost of living. The inclusion of validated measures such as the Kessler-6 (K6) strengthens the internal validity of the findings, and the breadth of demographic data allows for the description of social patterning across key groups.

This study provides insights by including both caregiver- and child-focused questions on the perceived mental health impact of cost-of-living pressures, areas that remain under-researched in current literature. The inclusion of caregiver-reported child mental health impact, stratified by child age and other household characteristics, offers new population-level evidence on how these macroeconomic shifts are experienced within families.

The study also has limitations. Families experiencing long-term financial hardship may experience reciprocal effects between mental health and hardship. However, the primary measure of interest investigated the perceived impact of cost of living on mental health. All data are cross-sectional and self-reported, limiting causal inference and introducing the possibility of social desirability or recall bias. The study-designed item on perceived mental health impacts has limited validation, and this was the first time it has been used in a population-based survey. The mental health impacts attributed to cost of living reflect caregivers' perceptions rather than clinical assessments, and may be influenced by their own mental health or household circumstances. Similarly, caregiver reports of child mental health may be affected by developmental stage and caregiver awareness, particularly for younger children whose distress may be harder to recognise.

While our results were weighted to represent the national population, response bias remains possible due to the online panel survey format and potential under-representation of families experiencing extreme adversity or digital exclusion. In addition, weighting may increase the influence of respondents with large weights, particularly from under-represented groups. However, weighted and unweighted patterns were very similar, suggesting minimal influence on the descriptive findings. Finally, the data capture a single time point in a rapidly evolving economic context. Cost-of-living pressures and related policies continue to shift, and longitudinal data are needed to understand how these perceived impacts develop over time, especially for families living in persistent hardship.

Implications and future research

The findings from this study highlight the need for policy and practice responses that recognise the unequal mental health impacts of cost-of-living pressures on families with children. While most caregivers reported no perceived impact on their child's mental health, both small and large negative effects were concentrated among families experiencing low income, material deprivation or sole caregiving. This underscores the need to address financial hardship within child and family policy. Universal supports are essential and need to be complemented by proportionate and targeted measures for those most affected. At the same time, families with higher education, higher income or two-caregiver households reported smaller negative impacts, reinforcing the need to monitor outcomes across the socioeconomic spectrum.

These findings sit within a rapidly evolving policy environment in Australia. Initiatives such as PLACE (Partnerships for Local Action and Community Empowerment; <https://www.placeaustralia.org>) and IDAC (Investment Dialogue for Australia's Children; <https://www.investmentdialogue.org.au>) are designed to improve

local responses and strengthen the evidence base for children's wellbeing. The Thriving Kids reform further emphasise that access to integrated, community-based services are fundamental. Our data reinforce these policy directions by showing how financial hardship and cost of living intersects with mental health, and why multi-level, cross-sector strategies are needed.

The finding that some caregivers in more financially constrained households reported positive impacts suggests opportunities to potentially build on adaptive coping strategies, and on the reduction of stigma around seeking help when hardship is widespread. This could include embedding access to supports such as food relief and financial counselling within mainstream services, and ensuring these are culturally safe and non-stigmatising. Strengthening integration between mental health, social care and financial wellbeing services, particularly within early years platforms like Child and Family Hubs, schools and primary healthcare could help mitigate both current and future impacts of financial hardship.

From a practice perspective, multi-opportunity platforms are well placed to identify families experiencing both large and small negative impacts, provide early intervention and connect them with coordinated financial, social and mental health supports. For early years services, this may mean enhancing training in recognising caregiver stress, understanding the interplay between financial hardship and parenting and routinely enquiring about cost-of-living pressures as part of holistic family assessments.

Future research should prioritise longitudinal designs to track how perceived mental health impacts evolve over time, particularly in the context of new reforms, such as energy relief payments, renters' assistance increases and tax cuts, as well as forthcoming prevention-focused policy debates (including the Productivity Commission inquiry on prevention). Further investigation is also needed into the pathways underlying reported positive impacts, including whether these reflect improved access to assistance, community solidarity or longer-term adaptation among families experiencing persistent hardship. Understanding these mechanisms could inform the investment in services and supports that not only buffer against harm, but also actively promote wellbeing during economic downturns.

Conclusion

This study shows that cost-of-living pressures are a widespread experience, with more than two-thirds of caregivers reporting negative impacts on their own mental health. Importantly, these impacts were not confined to families experiencing adversity: while those with low income, deprivation or sole caregiving responsibilities were most likely to report large negative impacts, families who were typically better off also reported small negative effects. These findings reinforce that cost-of-living pressures affect the breadth of the population, though with differing severity and consequences.

Our results highlight that families experiencing financial hardship are navigating both heightened challenges and, in some cases, positive outcomes. It may be that these positive impacts relate to reduced stigma in seeking support and increased availability of

community-based assistance such as food relief. These patterns sit alongside international evidence indicating that financial hardship is linked with poorer child and caregiver mental health, and that supportive policy environments may buffer these effects. Recent US research suggests that more generous state-level supports can protect children's development during periods of rising cost-of-living and financial strain (Weissman et al., 2023; Williams et al., 2024).

In Australia, the Early Years Strategy (DSS, 2024), National Children's Mental Health and Wellbeing Strategy (National Mental Health Commission, 2021), and Measuring What Matters framework (Australian Government, 2023) together provide an authorising environment for more integrated action. While not yet funded at scale, they signal a strong Commonwealth policy commitment to equity, wellbeing and financial security. State and territory governments now have scope to translate this commitment into funded supports that reduce family stress. IDAC also provides an opportunity to align investments and ensure that early years systems, schools and community hubs function as integrated, multi-opportunity platforms to connect families with financial, mental health and social supports.

By recognising financial hardship as a critical driver of family wellbeing and embedding proportionate responses within existing policy momentum, Australia can move beyond describing the cost-of-living crisis to actively reducing its mental health consequences for families and children.

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Conflicts of interest

None.

Ethical standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the National Statement on Ethical Conduct in Human Research (2023) in accordance with the *National Health and Medical Research Council Act 1992* and with the Helsinki Declaration of 1975, as revised in 2008. This study was approved by The Royal Children's Hospital Human Research Ethics Committee (#35254).

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