centre
for better
relationships

Transitioning into residential aged care

Supporting mental health and wellbeing

March 2026

A Better Place Australia Initiative

About us

Centre for Better Relationships

The Centre for Better Relationships is the research and policy arm of Better Place Australia. We work within complex social, economic, and political systems that shape the lives of our clients. Our aim is to generate knowledge that contributes to lasting and positive change for our clients and the child and family services sector. The Centre acknowledges the efforts of Better Place Australia staff and community representative who contributed to the conception and design of this project.

Better Place Australia

Better Place Australia provides a supportive place for individuals, couples, families and children. We have a range of services that help families understand and resolve conflict, manage their finances, improve communication and grow stronger as a result. Our Older Person team provides psychological services within residential aged care facilities on the Mornington Peninsula, Geelong-Otway regions, and Northern region of Melbourne. Better Place Australia has a clear vision and purpose of empowering Australians towards resilience, well-being, and fulfilling futures.

Acknowledgement of Country

We would like to acknowledge the Traditional Owners of the lands on which we work, and recognise their continuing connection to Country, waters and community. We pay respect to Aboriginal and Torres Strait Islander cultures and to Elders both past and present, and to their children and young people who are the future caretakers of this great land.

Use of artificial intelligence

Artificial intelligence (AI) was used to support the design development, data interpretation, and writing of this report. AI-feedback was sought to confirm and refine the human author's ideas and writing. Transcripts or personal information were not uploaded. All AI-generated outputs were verified through human review and incorporated or discarded where appropriate. The author retained full responsibility for methodology, analysis, and recommendations. AI was used in accordance with Better Place Australia's Artificial Intelligence Usage Policy.

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Executive summary

Australia's ageing population and increasing admissions into residential aged care facilities highlight the importance of understanding how mental health and wellbeing are supported during the transition into care. This report identifies this transition period as a vulnerable time, with some experiencing psychological distress, social disruption, and loss of autonomy. Despite policy reforms placing greater emphasis on mental health, the findings demonstrate a persistent gap between policy intention and on-the-ground practice. This project involved a survey with nurses and personal care assistants (PCAs) and interviews with residents and family members. It examined how mental health is experienced, recognised, and supported in residential aged care during the transition period.

Mental health challenges are common and often significant during the transition into residential aged care

Across both studies, psychological distress was identified as common experience for newly admitted residents. Majority of staff (79%) rated the mental health of typical new residents as being high or very high. Resident and family member accounts reflected this, describing feelings of sadness, grief, and difficulties adjusting. Some minimised these experiences as being normal. Some adjusted quickly while others continued to feel lost or uncomfortable months after admission.

Mental health support is largely reactive, led by monitoring, referrals, and medication

Nurses and PCAs described a system of observation, wellbeing checks, and referral pathways as the primary approach to supporting new residents' mental health. PCAs were identified as the staff most likely to recognise changes in mental health, with nurses conducting follow-ups and organising necessary referrals. Staff viewed these interventions as central to their mental health support efforts.

Based on resident and family member accounts, medication appeared to be the most common intervention. While some residents reported positive outcomes, others continued to struggle with underlying grief or other difficulties. Interviews indicated limited engagement with psychological services, prompting one family member to describe professional psychosocial support as *"the missing piece of the jigsaw"*.

Meaningful engagement and social connection are central to wellbeing but unevenly supported

Group activities were mentioned as an important form of mental health support. Some staff noted the importance of purposeful, individualised activities, though others described current offerings as infrequent, repetitive, or not person-centred.

Residents' experiences of connection varied greatly. Some integrated quickly, enjoying communal activities and friendships. Others preferred one-on-one support, encountered accessibility barriers, or felt discomfort living alongside residents with higher care needs. These prompted some to withdraw or reduce participation.

Although group-based models suited socially confident residents, they were not always appropriate for those who preferred quieter or smaller-scale interaction. As staff balance resident choice and agency, residents who withdraw quietly or avoid group settings may go unnoticed if experiencing mental health decline.

Family members often supported social engagement by encouraging involvement and advocating for more tailored approaches. However, some requests for personalised support and approaches could not be accommodated, reflecting limitations in flexibility and capacity within facilities.

Relational care is highly valued but constrained by staffing patterns and time pressures

Both residents and family members emphasised the importance of relational care, including staff spending meaningful one-on-one time, getting to know residents, and demonstrating genuine interest. Positive interactions extended beyond nurses and PCAs to lifestyle staff, maintenance staff, and cleaners, and contributed to residents feeling recognised, safe, and supported. Some residents also described how impersonal, task-driven practices undermined their autonomy.

Staff identified relational care as a key area for improvement to better support the mental health and wellbeing of new residents. A few emphasised that better staffing ratios and continuity would help build stronger connections with residents.

Implications for policy and practice

The findings indicate a mismatch between the expectations set by strengthened quality standards and the practical realities faced in residential aged care facilities. Staff expressed a desire to provide holistic, relational support but lacked the structural capacity to do so. The report identifies the need to:

- embed mental health professionals in admission pathways
- broaden the workforce responsible for relational care beyond nurses and PCAs
- ensure meaningful engagement is personalised, flexible, and accessible
- stabilise funding for lifestyle and wellbeing programs
- recognise emotional and social wellbeing as equally important to clinical care in care models and funding frameworks

Overall conclusion

The transition into residential aged care is a period of heightened psychological risk requiring proactive, consistent, and person-centred support. While aged care staff recognise distress and aim to respond appropriately, structural limitations mean support often remains reactive and medication-focused, with limited preventive strategies or involvement of mental health professionals. Residents also benefit from relational care, personalised engagement, and flexible social environments; however, these practices are not universal. Addressing these gaps requires coordinated action across service-level practice and government policy to ensure that emotional and psychological wellbeing is fully integrated into transition care.

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Background

Australia's population is ageing, with people living longer than ever before. The number of people aged 85 and over is project to grow significantly from 515,700 in 2018–19 to over 1.5 million by 2058.[1] With this increase, more people will move into residential aged care.

Mental health problems are common within residential aged care, with an estimated 58% of residents experiencing mental health disorders.[2] Mental health can worsen during the transition into aged care,[2] with many experiencing 'relocation stress'.[3] Moving into residential aged care is often experienced as a major loss of autonomy, familiar routines, and social connection.[4,5] As older people adjust, they may feel a sense of grief, isolation, and disempowerment.[4,5]

Supporting the mental health and wellbeing of residents – both during the transition and beyond – remains a persistent challenge in policy and practice. Since the Living Longer, Living Better reforms in 2012,[6] aged care policy has increasingly recognised mental health and wellbeing as a priority, though progress has been slow. By 2015, significant gaps remained. Aged care residents were excluded from Medicare-funded psychological services,[7] prompting criticism from mental health experts and seniors groups for overlooking the needs of older people.[8] National strategies began highlighting older people's mental health and the need for better service integration.[9] Meanwhile, pilot initiatives – including a program co-designed by Better Place Australia – showed the positive impact of onsite psychological support.[10]

More recent reform has been driven by the Royal Commission into Aged Care Quality and Safety (2018-2021), which called for a fundamental shift to person-centred care that places mental health on equal footing as physical health.[1] It emphasised the need for routine mental health assessments, greater access to allied health, and reduced reliance on chemical restraints (including antidepressants). Overall, the final report made it clear that supporting the mental health and wellbeing of residents was central to improving people's care, dignity, and respect.[1]

Since then, the government has introduced sweeping reforms, including strengthened quality standards (in effect from November 2025),[11] and mandatory minimum care minutes in residential aged care. Since October 2024, providers must deliver 215 minutes of direct care per resident per day (including 44 minutes by a registered nurse).[12] While this policy acknowledges the importance of both clinical and one-on-one social and emotional support, it narrowly defines care minutes as specific tasks delivered by nurses and personal care assistants.[13] Other roles such as allied health professionals and lifestyle staff are excluded, and time spent facilitating group activities or broader wellbeing programs do not count towards the target. This creates tension between the vision of holistic, mental health-inclusive care and the current focus on measurable clinical and personal tasks.

Despite these policy reforms, there is limited understanding of how mental health and wellbeing are supported in practice within residential aged care facilities, particularly during the critical transition period. This project sought to address the following research questions:

- How are older people’s mental health and wellbeing supported during the transition into residential aged care?
- What factors support or hinder resident mental health and wellbeing during the transition?

The project involved two smaller studies which explored the topic from different perspectives. The first considered the perspectives of nurses and personal care assistants (PCAs) working in residential aged care, and the second considered resident and family members’ perspectives. The project received ethical approval from the Anglicare Victoria Research Ethics Committee (2023-03).

Study 1: Survey with nurses and personal care assistants

Overview of aim and methods

The first study aimed to explore **nurses' and PCAs' perspectives of mental health during the transition into aged care**. It sought to address the following research questions:

- How do nurses and PCAs perceive the mental health and wellbeing of newly admitted residents in residential aged care?
- How do they perceive that the mental health and wellbeing of newly admitted residents are currently supported in residential aged care, and how this support could be improved?

Study 1 involved an **online survey with nurses and personal care assistants** working in residential aged care. The **mixed methods survey** asked participants to complete mental health screening questions while thinking about the 'typical' newly admitted resident, and open-text questions about:

- Responsibility for identifying and responding to mental health decline in newly admitted residents
- How the mental health and wellbeing of newly admitted residents was currently supported within the residential aged care facility in which they were employed
- Their perspective of how this support could be improved

See Appendix A – Study 1 methods for detailed methods.

Survey participant characteristics

A total of **67 people completed the survey**. Participants demographics are detailed in Table 1. Nearly two-thirds were PCAs, with registered nurses making up one third of participants. The time spent working in residential aged care varied, with 13% having less than one years' experience to 21% having 9 years or more experience. While educational background also varied, nearly two-thirds had completed a bachelor's degree or higher. Nearly half of the participants were aged 25-35 years, and the majority were female. The most common birthplaces were India, Nepal and Australia. English was the most common language spoken at home, followed by Nepalese/Nepali and Punjabi.

Table 1: Survey participant characteristics (n=67)

	n	*%*
Profession		
Personal care assistant	42	63
Registered nurse	22	33
Enrolled nurse	3	4
Time working in residential aged care		
Less than 1 year	9	13
1-2 years	14	21
3-4 years	12	18
5-6 years	8	12
7-8 years	10	15
9 years or more	14	21
Education		
Year 11 or below	2	3
Year 12	2	3
Certificate I, II, III, IV	10	15
Diploma or Advanced Diploma	12	18
Bachelor’s Degree	28	42
Graduate Certificate or Graduate Diploma	5	7
Postgraduate Degree	8	12
Age		
18-24	6	9
25-34	31	46
35-44	19	28
45-54	8	12
≥55	3	4
Gender		
Female	56	84
Male	11	16
Country of birth		
India	18	27
Nepal	18	27
Australia	14	21
The Philippines	5	7
Fiji	2	3
Other	10	15
Main language spoken at home[1]		
English	25	37
Nepalese/Nepali	17	25
Punjabi	13	19
Hindi	7	10
Filipino	2	3
Other	6	9

[1] Total does not add to 100% as participants could provide multiple languages

Quantitative results: Mental health and wellbeing of a typical newly admitted resident

Survey participants completed the K-5, a measure of psychological distress, in relation to a ‘typical’ newly admitted resident. For this survey, this was defined as a resident that was admitted approximately six weeks prior, and who did not experience severe dementia or cognitive decline.

Table 2 shows the levels of psychological distress that nurses and PCAs perceived these residents experienced. All participants reported that newly admitted residents experience some degree of psychological distress, with most rating it as high (27%) or very high (52%). **In the view of nurses and PCAs, significant psychological distress is a common experience for residents entering aged care**.

Table 2: Perceived psychological distress of new aged care residents – Summary of K-5 scores (n=63)

K-5 category	*n*	%
<5	0	0
Low (5-7)	3	5
Moderate (8-11)	10	16
High (12-14)	17	27
Very high (15-25)	33	52

Several items from the Geriatric Depression Scale (GDS) were also included in the survey to further explore perceptions of the typical newly admitted residents’ mental health and wellbeing. As only selected items were used to reduce survey length, no other GDS scores were calculated.

The results shown in Figure 2, along with the K-5 results above, suggest that nurses and PCAs perceive that the typical newly admitted residents as experiencing **significant psychological distress, social withdrawal, and loss of interest in activities during the transition period**. While around half believe that newcomers are generally satisfied with life or in good spirits, the overall picture indicates that **adjustment to aged care is often accompanied by emotional challenges, boredom, and reduced engagement in meaningful activities**.

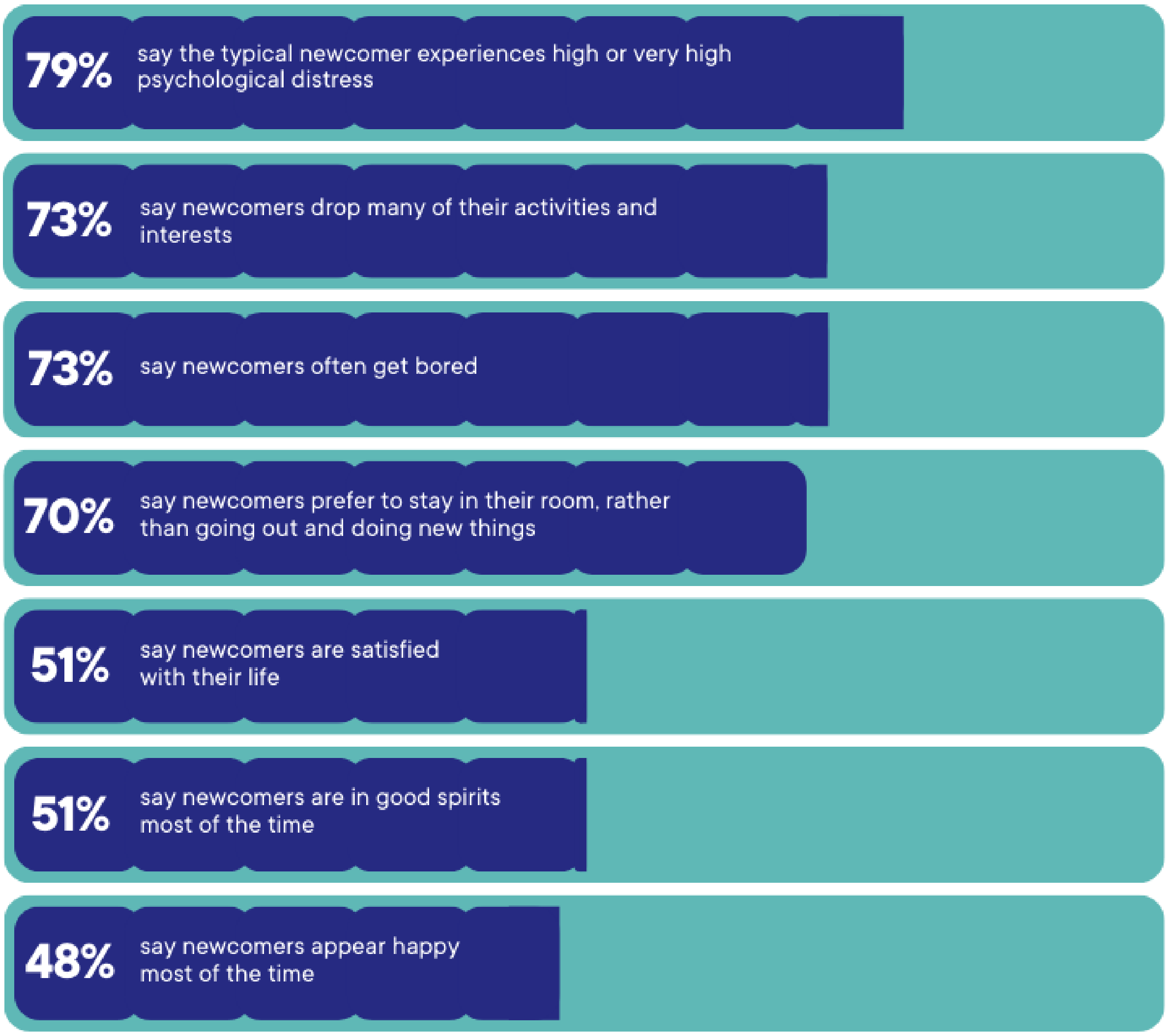

Figure 1: Nurses' and personal care assistants' perceptions of the typical newly admitted resident's mental health and wellbeing

Qualitative results: Supporting mental health and wellbeing during the transition into residential aged care

The themes below were developed from open-text responses to questions about who is responsible for identifying and responding to mental health decline, what is done to support the mental health and wellbeing of newly admitted residents, and how this support could be improved. Due to an overlap in information across these responses, these questions were analysed together to develop and understanding of what support is provided and areas for improvement.

Theme 1: Monitoring for change and providing appropriate referrals

The predominant approach to supporting newly admitted residents' mental health and wellbeing involved a **coordinated system of observation, assessment and referral**. Nurse and PCAs described formal assessments at time of admission and a daily practice of wellbeing checks to monitor residents over time. These assessments and checks focused on identifying behavioural and emotional changes. While some assigned responsibility for resident mental health to *“everyone”* or *“all staff”*, PCAs were most commonly mentioned as being responsible due to their proximity with residents, followed by nurses. When changes were detected, this was escalated to clinical staff, particularly nurses, who conducted follow-up assessments and initiated referrals as needed:

> *Personal care assistants often notice initial changes in behaviour and report concerns to nurses, who perform more detailed assessments.*

Nurses and PCAs described referrals to general practitioners, counsellors, psychologists, and geriatricians, along with specific therapeutic approaches including art, dance and music therapy. From this perspective, aged care staff supported newly admitted residents’ mental health by **noticing changes in mood or behaviour and having appropriate pathways for targeted interventions** and support:

> *Residents are being looked after on basis of their daily needs. Psychologist/ geriatrician visits are maintained in consultation with resident’s families. Counselling sessions by professionals being arranged with gained consent.*

While many described these **professional services as being a key element in supporting mental health and wellbeing**, some participants suggested that *“more services”* were needed to meet demand. Additionally, one registered nurse suggested that counselling sessions could be standardised as part of the transition period to help newly admitted residents adjust:

> *They should have a counselling or psychologist session or a few sessions at the start of every new admission to help them settle in and get to know them better.*

The role of families in mental health interventions

A small group of participants mentioned the role families play in this process, however, there were **differing perspectives on what family involvement entailed**. A few described families as having an active role such as noticing changes and providing *“insights”* about the resident or input into a personalised care plan. These responses suggest that family members may be key partners in mental health support. Alternatively, others positioned family members as being more passive with staff notifying them of changes to a resident’s mental health:

> *PCAs generally alert EN or RN, so that they can alert drs, family or necessary services.*

As some participants explicitly limited responsibility to aged care staff (particularly PCAs and/or nurses), this suggests **that family involvement may vary greatly across facilities or contexts**. In some circumstances, their involvement may be encouraged, whereas others view families as peripheral rather than central partners.

Theme 2: "Keep them busy": Provision of meaningful activities

Many nurses and PCAs described how the mental health and wellbeing of newly admitted residents was supported by providing **access to engaging and meaningful activities**. While many explained that their workplace offered a range of *"lifestyle activities"*, details of these were not generally provided. Specific activities mentioned included games, multicultural activities, exercise groups, bus trips, and reptile shows. The following PCA suggested that their workplace supported mental health by keeping residents *"busy"* with a range of activities:

> *Keep them busy with very easy activities. Music and games, walk around the garden, men's shed for men and women's group for women and 1:1 chat at times.*

A couple of participants emphasised that providing activities was not necessarily enough, and that activities needed to be *"purposeful"* and reflect the interests of residents. While a few described efforts to tailor activities, others indicated that current offerings were insufficient or not engaging. For example:

> *Very little* [is done]*. Activities are infrequent, boring and repetitive and definitely not person centred.*

Theme 3: Relational care – Allowing for meaningful interactions and support

Many nurses and PCAs emphasised the importance of **relational care as a crucial but underdeveloped aspect of supporting mental health** during the transition into residential care. These participants highlighted value in *"spending time"* with residents to engage in personal conversations and listen to their concerns. Participants framed these as informal interactions – *"conversations"*, *"chats"* and *"emotional support"* – rather than formal assessments. As demonstrated by the following two quotes, some suggested that personal connection is essential in supporting mental health during the transition into care:

> *You have to let them feel they are valued and that you are there to help them.*

> *Staff needs to spend time with residents, make them feel supported.*

While some noted that this was already part of their practice, its prominence in response to how mental health could be better supported suggests this remains a key area for improvement. This indicates that nurses and PCAs **recognise the value in providing relational care but may not necessarily be able to deliver it in practice**. One key reason identified by a few participants was not having enough time with residents, with one suggesting that changes to staff ratio were necessary:

> *Better staff ratio to give us time to spend one on one with all residents especially new ones*

Another reason was inconsistent contact with residents. The following quote reflects that for residents to develop relationships with staff, there needed to be consistent staffing arrangements to create a familiar routine:

> *More one on one time with the same few staff members where possible. This would provide a sense of routine- e.g. Jenny helps me shower of a Monday and Tuesday and Mary helps me Wednesday through to Friday*

Summary

Staff perceived that newly admitted residents commonly experience significant psychological distress, along with social withdrawal and loss of interest in activities. Support typically relied on monitoring, assessments, and referrals to health professionals, with some calling for more services or early counselling. Activities were viewed as key in supporting mental health, however, some suggested these were insufficient or not person-centred. Relational care was valued but identified as a key area for improving current practice.

Study 2: Interviews with residents and family members

Overview of aim and methods

The second study aimed to **explore the factors that support or hinder older people's mental health and wellbeing during the transition into residential aged care**. It sought to address the following research questions:

1. How do older people and family members describe residents' mental health and wellbeing during the transition into aged care?
2. How are mental health and wellbeing supported during the transition?
3. What factors support or hinder resident mental health and wellbeing during the transition?

Study 2 involved **interviews with older people residing in aged care and family members** who had a relative living in aged care. An interview schedule was used which included questions about their initial impressions of the aged care facility; the role of their family and staff in helping them settle into life within aged care; how their social connections and daily activities changed over the first few weeks; and how they perceived their mental health and wellbeing changed over time.

The analysis of the interviews was informed by the results of Study 1, with attention paid to the monitoring and response to mental health decline, engagement in activities, and relational care.

See Appendix B – Study 2 methods for detailed methods.

Interview participant characteristics

Seventeen participants were aged care residents, including 12 women. Time since their transition into care ranged from four weeks to eight years (median of appropriately 11 months). Most had been in care for six to twelve months, with a fewer newly admitted (<3 months) or long-term residents (>2 years). See Table 3 for a summary of participant characteristics.

Six family members also participated: three daughters and three sons. Most had mothers in care; one had a mother and father in care. Time since transition ranged from three months to three years. See Table 4 for participant characteristics.

Table 3: Summary of participant characteristics (Residents)

Characteristic	***n***	**%**
Gender		
Female	12	71
Male	5	29
Time since transition		
Less than 6 months	2	12
6-11 months	10	59
1-2 years	2	12
More than 2 years	3	18

Table 4: Participant characteristics (Family members)

Participant	**Relative in care**	**Time since relative's transition**
Daughter	Mother	5 months
Daughter	Mother	3 months
Daughter	Mother	3 years
Son	Mother	3 years (Deceased 1-month before interview)
Son	Father	8 months
Son	Father and mother	3 months

Theme 1: Navigating the emotional transition into residential aged care

Across the interviews, it was evident that **many residents had experienced mental health decline or challenges during the transition** into aged care. However, they did not often identify it as such, instead describing feeling sad, depressed, socially withdrawn, and crying more often. When asked further, several minimised these experiences, suggesting it was a normal part of ageing or the emotional impact of being separated from family:

> *Every now and again I'll get a bit sooky, and I think "Oh, pull yourself together. What's the matter?" and I try to work out what's wrong and then I realise I'm grieving. My family is so far away, and I do miss them. So, well, that's normal.* – Female resident, 16 months
>
> *...you can get a bit of depression, but that's kind of normal, isn't it?* – Female resident, 10 months

Family members similarly noted mental health changes among their relatives. They referred to **loneliness, grief for deceased relatives, and difficulty adjusting to life in permanent care**. Some described longstanding mental health conditions or declines that began before the transition and intensified after admission. For example, one participant, whose father's wellbeing had deteriorated following his wife's death, reflected how this grief continued to shape his mental health months after moving into care:

> *He became quite sad, basically sad, depressed and not happy about having to go in there. He was accepting of it. To be blunt, I think he would have been very happy if he could have died…And he's still probably not far removed from that mental state. It hasn't really radically improved in that sort of sense.* – Son of female resident, 8 months

Adjusting to life in permanent aged care was a challenge for many, however, **some took longer to adjust than others**. For example, one resident described how he continued to feel *"very lost"* while another found living there *"hard"*; both had transitioned over 6 months prior. Family members also observed that their relative had struggled to accept the permanency of the move. Their relatives would talk about returning home or ask when they could leave:

> *Every time I went there, she would say "I don't really want to be here" or "Am I going to be here?"* – Daughter of female resident, 3 months

Other residents adjusted more easily, often accepting that they needed additional care or felt safer in permanent aged care than their own home. A couple of these residents suggested that they preferred to *"go with the flow"* rather than anticipating what will happen or wishing things were different. The following quote highlights how accepting their current situation helped this resident to adjust and enjoy his experience in aged care:

> *I knew I couldn't live by myself anymore so there was no use fighting against it. I've quite enjoyed it.* – Male resident, <18 months

A medication-led approach to mental health and wellbeing

When a decline in residents' mental health and wellbeing occurred, the **most mentioned intervention was the prescription of medications** such as anti-depressants. Residents did not typically specify how this intervention was initiated. However, a few stated that they or a family member had raised concerns with staff directly or staff had approached them after noticing a change in behaviour, such as social withdrawal or reduced participation. For example, the following resident was prescribed antidepressants after a particularly emotional episode three weeks after admission:

> *Then I think it was about three weeks after I'd been in here, I had a bit of a - probably not a breakdown, but I didn't want to be here. Then* [the doctor] *gave me some miracle tablets and I've been fine ever since.* – Female resident, 8 years

While medication worked for some, others continued to experience mental health challenges. One family member highlighted how his father's mental health continued to be impacted due to broader circumstances despite an increase in medication:

> *I think he went from five milligrams to 10 milligrams. But his mental health is impacted by his situation in life and whilst he knows he's comfortable and safe and being looked after and his wife is safe, he's still flat. And it's not because people at the aged care facility aren't trying. It's more about his life in his eyes has turned out pretty crappy.* – Son of male and female residents, 3 months

Based on participant accounts, there was **limited engagement with psychological support**. While a couple mentioned attending individual counselling or group therapy, **mental health and wellbeing was primarily supported through medical interventions or conversations with family or staff in caring roles**. The lack of involvement from mental health professionals was a key critique of the following family member:

> *So, there was a medical element. "We can put some drugs to help with depression." There was a personal care element and there was a wellness component…But just the missing piece of that jigsaw seemed to me almost professional psychological, you know "This is how we think you might get benefit in terms of counselling," or whatever it is psychologically. That to me was the missing piece of that jigsaw.* – Son of male resident, 8 months

Theme 2: Finding connection and meaningful engagement

Across the interviews, connection and engagement were central to residents' wellbeing, with two distinct patterns: **some residents integrated quickly** into the social life within aged care, while **others faced barriers** that limited their participation and social engagement. These differences reflected not only personal preferences and capacities but also how social opportunities were designed and facilitated by peers, family members, and staff.

Early participation and peer invitations

Some residents were sociable and adaptable, readily engaging in communal life early on. They described enjoying the company of others, having activities to fill their day, and forming connections with other residents. These more sociable residents tended to have little trouble engaging in group activities and the broader social environment within the aged care facility. In a few cases, peers played an important role in inviting new residents to participate:

> *I do what the other people, what they do. I go on the bus with them. Talk with them. They invite me to go to the bingo.* – Male resident, 2 months

Several residents described early hesitancy, such as remaining in their room for the first few days. However, they increased participation once they knew people or received encouragement from peers:

> *I had meals in here, which was all right. Then some of them, a few of them said "Come down to the dining room." …Anyhow, one of them persuaded me to go. So that's fine, I go down to the dining room now*. – Male resident, <18 months

A couple of facilities fostered peer-led support, with residents describing a recently initiated Welcoming Committee to orient newcomers. These residents had a responsibility to listen, offer advice, and encourage attendance. This promoted peer-led emotional support, provided reassurance in the early weeks, and normalised participation:

> *I'm on the Welcoming Committee and I join in, and welcome people and I say to them they've got to join in. It's up to them. You can get all the advice, and you can have people come to see you but it's up to you to make up your mind to join in and do something.* – Female resident, 8 months

Barriers for others to participate

Other residents had trouble adjusting to the social environment, attending few activities and having limited contact with peers. A few experienced **accessibility barriers** to participating relating to residents' hearing, mobility, fatigue, and breathlessness, which made standard activities challenging for some residents:

> *I try to go to things. The oxygen holds me back.* – Female resident, 8 months

Family members noted that group-based activities suited residents who were socially confident, outgoing, or accustomed to organised social participation. For residents who were more introverted, anxious, or physically limited, these approaches to social engagement were not necessarily suitable. They emphasised that **some residents would benefit from additional support to engage in group activities, or from alternative approaches** that prioritised quieter connection and one-on-one interactions:

> *…for those residents who might have been at the pub every Sunday, or they've got more social skills to begin with, it's fine because they can go and have a glass of wine and strike up a conversation with the person next to them…But other people I've found that they actually do engage one-on-one*

> *and they have stories to share and things to contribute. They just need that done in a different style.* – Daughter of female resident, 3 months

Another barrier to participation was the discomfort that some felt living alongside people with high support needs related to dementia or disability. For a few, the visibility of other residents' care needs was confronting. Participants recalled residents spilling food, requiring assistance to eat, wandering into the wrong bedrooms, or disrupting shared activities. These experiences were described as surprising and, at times, distressing. Several emphasised how different they felt from other residents, recalling initial thoughts such as *"why did I come here?"* or *"what am I doing here?"* For some, proximity to visible frailty appeared to **challenge their sense of identity and independence**. One resident explained:

> *It was the type of people in the place that concerned me. The people who are incapacitated. Is that a good word or not? And people who needed help…I don't want to feel old. I don't want to think old. When you start thinking old is when you get old. Before I moved in here, I kept young. I went on cruises.* – Male resident, 8 months

For some residents, this discomfort influenced how they engaged with communal spaces. A few described choosing to eat meals in their rooms or withdrawing from activities. Some adjusted over time by finding ways to interact with residents with higher care needs; however, others experienced ongoing difficulty. One family member described how his father's discomfort with the shared environment contributed to his reduced participation:

> *…people with dementia walking in on him, the lounge full of people who have been rolled out in their recliners who are non-communicative and staring at the roof, he finds that incredibly confronting and I don't blame him for that. So, he's becoming more withdrawn and not engaging in the activities that are there.* – Son of male and female residents, 3 months

The role of family in facilitating connection

Family members took an active role in facilitating social connections. This largely involved coordinating visits and calls and taking relatives out for meals or errands to maintain links beyond aged care. For some residents, meaningful engagement largely happened outside with family and friends:

> *I tend not to have people in here. If they say, "we will come" I say, "yeah, let's go out." …To me, it's about getting out.* – Female resident, 10 months

Family members also tried to encourage facility-based engagement. This involved accompanying their relative to group activities and reminding them of other residents' names. Some also requested additional support or tailored activities of one-on-one facilitation when group formats did not fit. However, family's efforts were not always successful. While one family member was asked by staff not to attend activities with her mother, another highlighted a missed opportunity as staff were unable to accommodate alternative social opportunities:

> *We were really, really disappointed that they couldn't find three other people or even one other person to play cards with her because that would have been really important transition for her given that she loved her cards.* – Son of female resident, 3 years

Theme 3: Personhood, autonomy and the relational culture of care among staff

Residents' sense of being recognised as a person rather than a recipient of care was central to their wellbeing. Some participants spoke about staff spending one-on-one time with residents and actively checking-in when they noticed changes in behaviour. Participants highlighted the way in which staff greeted residents by name, engaged in ways that appeared genuine rather than rushed, and got to know each resident on a personal level. Personal carers and nurses were described as attentive and responsive:

> *And more importantly, the staff are lovely. You know, they treat you like they care. You know if you're in a funny mood or anything, "Would you like me to come back? Would you like to have a chat?"* – Female resident, 16 months

Some described how this relational culture was not limited to those in direct care roles, highlighting the **importance of everyday interactions with staff across the aged care facility**. This included management, chefs, leisure and wellbeing staff, gardeners, and maintenance staff. Regular interactions beyond care tasks created familiarity and connection:

> *Well, even the cleaners. I get on better with the cleaners and those people. Because I'm with them, you know. I understand them.* – Female resident, 1 year

For participants that spoke about this relational culture, these interactions built psychological safety and helped both residents and family members feel comfortable in voicing their needs and complaints. Some viewed staff as approachable and responsive to feedback. One resident who *"hated"* living in aged care initially described how supportive relationships with staff and being able to speak up helped her to adjust:

> Interviewer: *So, thinking about that change from when you first moved in to how you're feeling now is there anything specific that has helped you settle in so well?*
> Resident: *Yes. I think the fact that you can - it's the company and it's staff that make you feel happy and the people that run the place they do make you welcome and there's a lot of activities that you can go and you can complain if you want to. I think that's really about it. It makes me feel well, if I didn't like something I can speak up. No, it is what it is.* – Female resident, 8 months

A personalised approach supported residents' identity and purpose. Some residents were encouraged by staff to engage in activities and tasks that supported their wellbeing and provided purpose. This included encouraging or enabling residents to re-engage with hobbies and offering small roles and responsibilities such as delivering newspapers or being a 'Welcoming Rep' for new residents. The following family member praised staff for finding a *"clever"* way to get his dad to engage in a group activity despite his typical withdrawal:

> *But just the other day, he got asked to be the bingo caller. In some ways, he was a bit horrified by it, but it was pretty clever work by the engagement officer there because it's just a little bit of status even though he kind of rolls his eyes at himself.* – Son of male and female residents, 3 months

While family members highlighted the benefit of staff using sustained, gentle persistence to engage residents, there were **contrasting expectations about staff members' role in balancing residents' autonomy and facilitating participation**. Residents generally appreciated *"no pressure"* approaches and the freedom to choose whether to attend activities or dine in their rooms:

> *You've got a choice. "No, I don't wanna do that" so you don't go. There's no pressure.* – Female resident, 16 months

> *They leave you to yourself if you want to stay on your own. That's alright. Or join in if you want to. There's no pressure.* – Female resident, 6 months

In contrast to a relational culture, some residents discussed **task-driven or impersonal practices**. One family member described the care as *"institutional care rather than personal care"*. In these accounts, staff appeared to prioritise routines over individualised preferences, interrupting residents during private moments for non-urgent tasks, entering rooms without knocking, or failing to learn and remember personal preferences. These practices were experienced as **undermining their sense of autonomy and control over their own space and schedule**. The following quote from a resident with mobility limitations demonstrates the frustration that arose when personal preferences were repeatedly overlooked:

> *I’m tired of saying when people come in, “Could you open my drapes? I don’t like the lights on.” It’s like they come in and everyone switches the lights on. Leave the lights off, pull the drape back, give me some natural light.* – Female resident, 17 months

Summary

Residents commonly experience emotional challenges during the transition into aged care, with adjustment varying greatly. Mental health support was often medication-focused, and engagement with psychological services was limited.

Social connections strongly impacted wellbeing. Some residents integrated quickly through peer support while others faced barriers such as accessibility issues, preferences for one-on-one social support rather than group activities, and discomfort with living alongside residents with high support needs.

Families helped maintain connection by organising visits and encouraging participation, though facilities could not always accommodate individualised social support.

Positive, personalised interactions with staff supported adjustment, while task-driven or impersonal care undermined residents’ sense of autonomy.

Integrated discussion of results

The findings from the staff survey and resident and family interviews together position the transition into residential aged care as a critical period for mental health and wellbeing. The survey showed that staff perceived that psychological distress was common among newly admitted residents. While there were aware of this vulnerable period, operational realities prevented many from effectively engaging in mental health supporting care beyond monitoring and referrals. Meanwhile, residents and family member accounts shared accounts of grief, identity disruption, uncertainty, and difficulties adjusting to institutional life. These findings support previous research that has characterised the transition period as a time of distress, isolation, and boredom.[3–5] In the context of an aging population and high annual admissions to permanent care,[1,14] the **transition period represents a significant mental health risk that requires system-level responses**.

Incorporating mental health professionals into admission pathways

The findings suggest that there is **a gap between recognising transition as high risk and embedding preventative, early-stage psychosocial supports as standard practice**. Participants commonly described mental health support as being introduced only after visible distress or behavioural changes had emerged, rather than through proactive, structured transition planning, with medication prescribed as the primary form of intervention.

While there was historic exclusion of aged care residents from Medicare-funded psychological services,[7,8] the current study highlights that **access to or engagement with mental health professionals during the transition period remains a key practice gap**. Mental health support was largely handled by staff in caring roles, families, and medical professionals, with limited involvement of psychologists, counsellors, or social workers.

Aligning with recommendations to enhance allied health access and less reliance on chemical restraints (such as anti-depressants),[1] **facilities should incorporate mental health professionals into admission pathways** and the initial few weeks and months, ensuring specialised support complements the monitoring and relational care delivered by the broader residential aged care workforce. These roles should be recognised and enabled within funding models to ensure they are not discretionary add-ons but core components of transition care.

Whole-of-facility approaches can facilitate increased relational care

The findings collectively demonstrate that **mental health support in residential aged care can be relational and environmental, not solely clinical**, and that **a whole-of-facility approach could help to expand capacity for support**.

While staff responses often framed current mental health practice in terms of clinical approaches (i.e. assessments, monitoring, referrals), residents and families emphasised the everyday relational interactions the support wellbeing (i.e. being known by name, informal check-ins, and a sense of being known and heard). Residents attributed these practices not only to nurses and PCAs but to staff across the residential aged care setting, highlighting that responsibility for support can be shared across the workforce.

However, **this broader relational approach is structurally under-supported**. Current care minute definitions focus on clinical and personal tasks performed by nurses and PCAs, excluding allied health professionals, other staff not in direct caring roles, and time spent on group or wellbeing activities.[13] While staff described wanting to provide more relational care, they were often unable to due to structural issues such as limited time and inconsistent contact with residents. However, the interviews showed that when staff have time to sit, listen, and build rapport, residents felt supported and psychologically safe.

Without workforce models, funding structures, and accountability mechanisms that explicitly prioritise relational care during the transition, staff capacity to provide care that is preventative and supportive rather than reactive will remain limited.

Group-centred activity models may marginalise some residents

The study also showed that **the prominence of group-based activities in supporting wellbeing may unintentionally privilege certain residents while marginalising others**. Interviews demonstrated that residents who were socially confident and comfortable in group environments tended to adapt more readily and participate in communal living. While group activities may suit some residents, those who preferred one-to-one interaction or who felt overwhelmed by communal settings were more likely to withdraw.

Given that staff monitoring often relies on observable changes in behaviour, **quieter forms or distress risk remaining unnoticed or masked behind resident 'choice'**. Therefore, the ongoing dominance of group-activities, and evidence of an inability to accommodate individual social needs, does not align with the person-centred care principles emphasised by the Royal Commission and embedded in the strengthened quality standards.[1,15] Consistent individualised engagement approaches across residential aged care are therefore needed to support all older people regardless of the facility in which they reside.

Conclusion

The report highlights a gap between policy aspirations for holistic, person-centred care and the realities of practice shaped by care minute definitions, staffing pressures, and variable access to mental health professionals. Strengthening transition support therefore requires embedding mental health professionals within admission pathways, adopting whole-of-facility approaches to supporting emotional and social wellbeing, and ensuring facilities can deliver individualised engagement beyond group activities. Addressing these system-level barriers would help residential aged care to provide proactive, relational, and psychologically supportive transition experiences aligned with current quality standards and reform priorities.

Implications for policy and practice

Recommendations for aged care facilities

- **Adopt proactive approaches**: Move beyond reactive screening and referrals by embedding preventative support strategies into everyday practice, particularly during the transition period.
- **Embed relational care and meaningful engagement**: Embed simple, personalised interactions with residents and the provision of personalised meaningful engagement as essential routine practice, not optional extras.
- **Distribute responsibility for relational care**: Reduce the overreliance on nurses and PCAs by involving the broader residential aged care workforce in providing emotional support, therefore strengthening person-centred care and aligned with quality standards.
- **Embed mental health professionals into admission processes**: Early involvement with mental health professionals to support residents in adjusting to living within a residential aged care facility.

Recommendations for policymakers

- **Resource mental health professionals during admission processes**: Support standard involvement of mental health professionals during the admission process to ensure residents have access to support early during the vulnerable transition period.
- **Broaden the definition of care minutes**: Recognise and value the contributions of allied health, lifestyle, pastoral care, and other staff whose work is central to resident wellbeing.
- **Embed holistic outcomes in quality standards**: Ensure emotional and social wellbeing measures are incorporated into standards and reporting, with equal weight to clinical outcomes.
- **Stabilise funding for lifestyle programs**: Establish secure funding streams and staff ratios for social and recreational activities, ensuring flexible, diverse and accessible social activities are available.
- **Promote multidisciplinary models of care**: Develop policies that embed collaborative, preventative approaches where all staff contribute to residents' emotional, psychological, and social needs as part of everyday practice.

References

1. Royal Commission into Aged Care Quality and Safety. *Final Report: Care, Dignity and Respect*. (2021).
2. Amare, A. T. *et al.* The prevalence, trends and determinants of mental health disorders in older Australians living in permanent residential aged care: Implications for policy and quality of aged care services. *Aust N Z J Psychiatry* **54**, 1200–1211 (2020).
3. Polacsek, M. & Woolford, M. Strategies to support older adults' mental health during the transition into residential aged care: a qualitative study of multiple stakeholder perspectives. *BMC Geriatr* **22**, 151 (2022).
4. Brownie, S., Horstmanshof, L. & Garbutt, R. Factors that impact residents' transition and psychological adjustment to long-term aged care: A systematic literature review. *International Journal of Nursing Studies* **51**, 1654–1666 (2014).
5. Sullivan, G. J. & Williams, C. Older Adult Transitions into Long-Term Care: A Meta-Synthesis. *J Gerontol Nurs* **43**, 41–49 (2017).
6. Aged Care Reform Package 2012 - Living Longer Living Better.pdf.
7. Belardi, L. Half of aged care residents depressed. *Australian Ageing Agenda* https://www.australianageingagenda.com.au/clinical/health-medical/half-of-aged-care-residents-depressed/ (2013).
8. O'Keeffe, D. Government's mental health reforms criticised for ignoring seniors. *Australian Ageing Agenda* https://www.australianageingagenda.com.au/executive/governments-mental-health-reforms-criticised-for-ignoring-seniors/ (2015).
9. Department of Health. *The Fifth National Mental Health and Suicide Prevention Plan*. (Australian Government, Canberra, 2017).
10. South Eastern Melbourne Primary Health Network. Unique wellbeing program supports 1300 older adults in residential aged care. *South Eastern Melbourne Primary Health Network* https://www.annualreport2023.semphn.org.au/innovation/racf-wellbeing (n.d.).
11. Aged Care Quality and Safety Commission. Strengthened Quality Standards. https://www.agedcarequality.gov.au/providers/quality-standards/strengthened-quality-standards (n.d.).
12. Royal Commission into Aged Care Quality and Safety. Progress Report (2024).
13. Department of Health, Disability and Ageing. Care minutes in residential aged care. https://www.health.gov.au/our-work/care-minutes-registered-nurses-aged-care/care-minutes (2025).

14. Australian Institute for Health and Welfare. Admissions into aged care. *GEN aged care data* https://www.gen-agedcaredata.gov.au/topics/admissions-into-aged-care (2025).
15. Aged Care Quality and Safety Commission. Standard 1: The individual – provider fact sheet. *Strengthened Aged Care Quality Standards* https://www.agedcarequality.gov.au/sites/default/files/media/standard-1-the-person-provider-fact-sheet.pdf (2025).
16. National Centre for Healthy Ageing, Monash University. National Aged Care Research Network. *National Centre for Healthy Ageing (NCHA)* https://www.monash.edu/medicine/national-centre-for-healthy-ageing/national-aged-care-research-network (n.d.).
17. Lam, H. R. *et al.* Challenges of conducting research in long-term care facilities: A systematic review. *BMC Geriatr* **18**, 242 (2018).
18. McMullin, C. Transcription and Qualitative Methods: Implications for Third Sector Research. *Voluntas* **34**, 140–153 (2023).

Appendix A – Study 1 methods

Recruitment

Recruitment occurred in November and December 2024. A flyer with information about the survey was emailed to residential aged care providers within BPA's network. It was also shared via the National Aged Care Research Network which is organised by the National Centre for Health Ageing.[16] The flyer detailed an incentive to participate, with potential participants offered a $20 voucher and opportunity to go into the draw for one of two $400 vouchers. The survey directed people to the survey via a QR code and URL.

The first page of the survey provided an overview of the survey content, structure, duration, and consent information. Details of two incentives were included: a $20 voucher, and a prize draw to win one of two $400 vouchers. It was explained that to be eligible for the vouchers, participants needed to provide an email address, noting that email addressed would be stored separately from responses and used only for the distribution of vouchers and prize draw. It stated that all responses would remain confidential and that individuals would not be identified in any research outputs. Participants were directed to an Explanatory Statement for more information about the study.

Data collection

Eligible participants were PCAs, enrolled nurses, and registered nurses working within a residential aged care facility. The survey involved four sections. The first section collected participants' socio-demographic data. The second section included the Kessler 5 (K-5) which measures an individual's psychological distress. Select items from the Geriatric Depression Scale were also included; however, the full scale was not included to reduce repetition with the K-5 and reduce survey length. Participants were asked to complete these in relation to a 'typical' new resident to explore their perspectives of new residents' mental health. This was defined as a resident that was admitted 6 weeks prior and who did not experience severe dementia or cognitive decline. This was because it was understood that people experiencing severe decline required greater levels of care. The final section included open-text questions which asked about any mental health training participants had received; who is responsible for identifying and responding to changes in new residents' mental health; what is done within their workplace to support new residents' mental health and wellbeing; and how this support could be improved.

Data analysis

Quantitative data

The K-5 included five items scored on a 5-point Likert scale. Higher scores indicate higher level of distress (possible range: 5-25). Regarding items from the Geriatric Depression Scale, descriptive statistics calculated based on the proportion of participants that selected 'Yes' in response to statements (e.g. "The typical new resident often gets bored"). As only selected items from the scale were used to reduce survey length, no other GDS scores were calculated.

Qualitative data

Where identifying information as provided, such as a workplace name, was removed from all responses prior to analysis. Open-text responses were analysed using reflexive thematic analysis (Braun and Clarke 2019). This involved reading the responses to become familiar with the data, generating initial idea codes, and developing themes through an iterative process. As many responses were short, the analysis focused on surface-level meaning; latent meaning was interpreted where possible. Themes were not pre-determined but were constructed by actively engaging with the data to capture patterns of shared meaning relevant to the research questions. Attention was paid to responsibility for, and types of, actions taken to support the mental health and wellbeing of newly admitted residents, as well as factors that prevented or limited such action. Participant responses have been provided to support the themes. Some responses have been edited for grammatical errors to improve readability.

This reflexive approach recognises the researcher's role in interpreting and shaping the analysis, rather than aiming for a purely objective or replicable coding framework. The analysis was conducted within the context of a broader research project, which included interviews with residents and family members about the transition into residential aged care and mental health support; insights from these interviews informed the interpretation of the survey data.

Appendix B – Study 2 methods

Eligibility criteria

To participate, residents needed to have the cognitive ability to consent to participation. The aim was to recruit residents who had moved into a residential aged care facility within the previous month. However, this was expanded to 18-months following feedback from aged care managers.

Family members needed to be related to an older adult who moved into residential aged care within the previous 18 months and who was not experiencing severe cognitive decline.

The criteria for the length of time since the transition into a permanent aged care was applied loosely. This was because some residents who were invited by aged care staff, or family members who expressed interest in the project, did not meet this criterion. The research team decided not to turn away any potential participant based on this criterion while continuing to focus recruitment efforts on newer residents. It was emphasised to each participant that the interview would focus on the first month that the older person had resided in care.

Participant recruitment

Residents

Residents were recruited via residential aged care providers that Better Place Australia (BPA) had an established relationship with. BPA provides counselling support for low to medium mental health interventions in over 120 aged care facilities across Victoria. Recruiting and retaining aged care providers to assist in research can be challenging as owners/managers may be reluctant to participate.[17] This reluctance may be because of a perception that the research will result in undue burden on workers or attention from regulators.[17] Therefore, invitations to support the research were sent to management staff that BPA's practitioners recommended. Meetings were held with managers that expressed interest in the project to discuss their involvement and a Memorandum of Understanding was prepared to establish expectations and responsibilities. Aged care providers were responsible for identifying eligible residents; this may have introduced selection bias, with residents being more likely to have positive experiences and relationships with staff. Potential participants were provided with an Explanatory Statement with information about the project, and staff coordinated with the Research Officer to schedule a time for the interview. Some aged care managers independently decided to also seek approval the residents' family members prior to inviting residents.

Family members

An advertising flyer was created which invited potential participants to send an expression of interest to the research team via a QR code, email address and phone number. The poster was emailed to organisations within BPA's professional network such as advocacy groups, along with community groups, community centres, and local councils. Aged care providers which facilitated resident interviews were also invited to share the flyer with the family members of their residents. The flyer was also printed and mailed to residential aged care providers within BPA's network with a request to post the flyer on noticeboards within the facility.

Data collection

Semi-structured interviews were conducted with 17 residents and 6 family members. Two interview schedules were developed to guide the interviews. These schedules were tailored to the two groups but both covered the following topics: life before transitioning into residential aged care; the decision to transition; initial impressions; the role of their family and staff in helping them settle into life within care; how their social connections and daily activities changed over the first few weeks; and how they perceived their mental health and wellbeing changed over time.

The researcher gained verbal or written consent from each resident prior to each interview. One resident that had expressed interest in the interview declined to participate when approached by the researcher, and another asked for the interview to be rescheduled. All interviews were conducted in a quiet and private location within the aged care facility in which the participant resided. Most interviews were conducted in the residents' private room. Two interviews were conducted in common areas away from other residents as this was where these residents felt comfortable. Interviews with residents were an average of 38 minutes in length. Verbal consent was obtained prior to beginning the interview.

Interviews with family members were conducted via Microsoft Teams. This was to ensure the project was not limited by geographical boundaries. Interviews with family members were an average of 49 minutes in length. Verbal or written consent was received from each family member prior to beginning the interview.

Data analysis

All interviews were audio-recorded. Intelligent Verbatim Transcripts were produced, with filler words, repetitions, and other non-essential elements removed to provide a more concise representation of the spoken content.[18] The first 12 interviews conducted were transcribed by the researcher. The remaining 9 interviews were transcribed by a professional transcription company and checked for accuracy by the research team.

An inductive approach to thematic analysis was used. Each transcript was read, with initial thoughts noted about patterns across and within the transcripts. The transcripts were then individually coded, largely focusing on the surface-level meaning of the data. Attention was paid to data relevant to the research questions, and the themes identified in Study 1 (monitoring mental health, activities, and relational care). The codes were then grouped based on similar meanings and initial themes were developed. Data were collated based on these themes, and themes were reviewed and refined through comparison between coded extracts and the full dataset. Some themes were collapsed or redefined during this process, and the final themes were defined and named during the writing of the report to ensure they reflected a central organising concept and were relevant to the research questions.

Artificial intelligence (AI) was not used to code or interpret the data. It was used in the revision and clarification of text written by the author.

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