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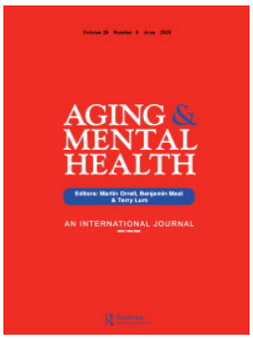

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Caring for older adults with severe mental health problems in care homes: a qualitative study of staff experiences

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ABSTRACT

Objectives: Severe mental health problems are often overlooked within the older adult population. Older people with severe mental health problems are at higher risk of discrimination and may experience a variety of complex needs. Within a care home setting, these factors may pose additional challenges for staff. This research explores the experiences of caring for older adults with severe mental health problems within a care home setting.

Method: Qualitative semi-structured interviews were conducted and analysed using reflexive thematic analysis. Thirteen interviews were completed face to face or via online video call with current or previous care home or residential care staff within the North of England. Reflexive thematic analysis was used.

Results: Three key themes were identified: (1) a system that does not support staff, (2) the importance of relationships and connections for staff and residents, (3) the realities of caring for someone with severe mental health problems within a care home setting.

Conclusion: This study highlights the systemic challenges which impact the time and resources needed for staff to provide appropriate person-centred care for older people with severe mental health difficulties within care homes. Clinical implications, recommendations and strengths and limitations are discussed.

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Care home; severe mental health; older adults; qualitative; thematic analysis

Severe mental health problems (SMHP) include experiencing symptoms of bipolar disorder, psychosis (including schizophrenia),'personality disorder'/complex emotional needs and eating disorders (NHS England, 2024). An increased number of adults are ageing with SMHP (Bucy et al., 2022), however the experiences of older adults with SMHP are poorly understood (Hanan et al., 2024). Individuals with SMHP often have complex cognitive, medical and psychosocial care needs (Cohen et al., 2015). Public stigma around SMHP remains, such as beliefs that people with schizophrenia are violent (Pescosolido et al., 2019). Older people with SMHP face heightened discrimination due to their age and diagnosis (Dening & Milne, 2011). Health and social care providers are now recognising the importance of addressing health inequalities faced by people with SMHP that placed them at increased risk of needing health and social care (Bartels et al., 2018) and developing specific services (Alderwick & Dixon, 2019).

Ninety percent of care homes across the UK are owned by the private sector, with 78% being for-profit organisations and 12% not-for-profit (Grant Thornton UK LLP, 2025). Care home quality is regulated through national sector regulators; however, the large number of care home providers across the UK leads to variation in training and practices across care homes (Health Innovation Network, n.d.). Around 6,00,000 people within England work in older adult care homes (Skills for Care, 2022). High sickness and turnover rates are creating a workforce crisis, with 88% of UK care homes facing recruitment challenges and 48% struggling with retention (CQC, 2023). Almost a third of staff in care homes experienced high burnout (Costello et al., 2020), which impacts care experiences and resident well-being (Cooper et al., 2018; Woodhead et al., 2016).

Most of the available literature exploring SMHP in older adulthood has been conducted in America (Cen et al., 2018; Depla et al., 2005, 2006; Hanan et al., 2024; Jester et al., 2022; Muralidharan et al., 2019; Rahman et al. 2013). Residents with SMHP are not always appropriately distinguished from residents with cognitive impairment (Hanan et al., 2024; van der Wolf et al., 2019) and assumptions that their needs are already being met in care homes makes them less visible to the community and to mental health services (Dening & Milne, 2011). Older adults experiencing SMHP are at risk of displaying violent behaviour; however, the literature around SMHP without dementia in older adults is limited (Goldhagen & Davidtz, 2021). In Canada, care home managers are reluctant to accept individuals with SMHP to care homes due to the higher risk of perceived aggression (Lane et al., 2010); however, evidence suggests these concerns are unfounded, and access to nursing homes may be impacted by stigmatising beliefs (Cen et al., 2018).

Older people with SMHP in residential homes are lonelier than those in psychiatric hospitals (Depla et al., 2005). Perceived stigma in care homes is linked to lower well-being, particularly when mental health issues are unrecognised or dismissed by staff (Depla et al., 2006; McCormack & Skatvedt, 2017). Behaviours that challenge are often thought about within the context of dementia, however, can also be understood within SMHP, and may be misunderstood within care home settings (Howard et al., 2021). Behaviours that challenge include verbal or physical acts

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that are considered disruptive, distressing or challenging to other people in the environment (Dupuis et al., 2012). Such behaviours can indicate unmet needs (Palese et al., 2018), an inappropriate environment or poor care practices (Kales et al., 2015). Staff exposed to this are more likely to experience burnout, feelings of incompetence and negative feelings towards the resident (Edward et al., 2014; Holst & Skär, 2017; Song et al., 2023) which in turn can impact the quality of care received by residents (Roberts & Bowers, 2015). Caring for residents with SMHP has been associated with staff burnout and turnover (Muralidharan et al., 2019). However, a higher prevalence of SMHP in a care home is associated with lower quality of care (Rahman et al., 2013), and disproportionate levels of abuse, neglect and involuntary seclusion were identified in nursing homes with more residents who were experiencing SMHP (Jester et al., 2022). The balance of providing care whilst respecting resident autonomy, needs and wishes within care homes comes with ethical and legal challenges for care staff (Podgorica et al., 2021).

Care home staff have reported limited training in providing quality care for people with SMHP. Training and knowledge of severe mental illness symptoms is crucial to reduce stigma and improve communication (Birtley & Phillips, 2020; Muralidharan et al., 2019). Currently, training available for care home staff within the UK varies by care provider, although all staff are required to complete mandatory training such as health and safety, manual handling and safeguarding adults (The Health and Social Care Act, 2008). Currently, UK care home staff are not required to complete mandatory training around mental health. The rise of 'housing with care' – where residents live in their own homes and pay separately for care services – has created competition for care homes. As a result, care home operators are increasingly focusing on providing care for people with more complex needs (Grant Thornton UK LLP, 2025). Given this increase in complexity and continued rise of older people with SMHP residing in care homes (Bucy et al., 2022), specialised training is needed for care staff in long-term care facilities who care for residents with SMHP. This should cover interactions and communication, stigma of mental health and understanding how to work with residents with SMHP alongside other comorbidities including dementia (Čížková et al., 2024).

Recognising that the needs of individuals experiencing SMHP are different to those without SMHP is integral for staff to create a culture that promotes dignity, respect and high-quality care (Howard et al., 2021). However, limited research to date has considered staff experiences and reflections. Hanan et al. (2024) identified barriers to caring for residents with SMHP included limited time, the need to adapt care to meet the mental health needs of the individual and trying to understand the world for the individual with SMHP. Taking time to get to know the individual, flexibility, choice, respect and adapting care facilitated the care experience. Unfortunately, the current challenges with staff turnover and burnout within UK care homes may make it challenging for care home staff to implement these recommendations. This study aimed to explore and understand care home staff experiences of caring for older adults with SMHP.

Method

Design

An exploratory qualitative study was conducted, consisting of individual semi-structured interviews analysed with reflexive thematic analysis (Braun et al., 2022).

Sample and recruitment

Participants were recruited from care homes across North England, through care home networks and visits to care homes and via social media. Participants either currently or had previously worked in a care home. Purposive sampling was used to include participants with a range of roles and demographics.

Procedure

Semi-structured interviews were conducted in the care home where the staff member worked or via Microsoft Teams. A topic guide was developed based on existing literature. This focused on understanding of SMHP, experiences of supporting/caring for older people with severe mental health difficulties in a care home, and training/support experiences and needs (see supplementary material 1 for interview schedule). Interviews were transcribed verbatim. Participants received a £20 voucher to acknowledge their time. Recruitment was stopped when data saturation was determined, as no new themes were evolving from interviews.

Ethical considerations

Ethical approval was obtained from University of Liverpool research ethics committee (reference: 12848) prior to data collection. Participants provided written informed consent and were offered the opportunity to review their transcript before analysis. Participants were made aware of the potential for distress within interviews and were able to pause or end the interview at any point.

Data analysis

Reflexive thematic analysis was used (Braun et al., 2022), involving six phases: familiarisation; coding; initial theme generation; reviewing and developing themes; refining, defining and naming themes; and producing the report. Following familiarisation, three transcripts were coded by the full research team, and initial themes were developed. TC coded remaining transcripts. Refinement of themes continued throughout data analysis, to develop the narrative and select indicative quotes.

Reflexivity

The research team consists of three women with personal and professional experience in care homes, and expertise in qualitative research. The research team engaged in regular reflective discussions and kept a reflective log. Conscious attempts were made to recognise biases throughout data collection and analysis, including reflections on how to incorporate perspectives that conflicted with the research team's beliefs and positionality.

Results

A total of 13 participants were recruited (see Table 1 for an overview of demographics). Nine interviews were completed face to face and four via Microsoft teams. Interview times ranged from 16 min to 1 h 5 min. Three main themes were identified, each containing several subthemes (see Table 2 for an overview).

Table 1. Participant demographics.

Participant number	Sex	Gender	Age	Ethnicity	Role	Current or previous[a]
1	Female	Female	32	White British	Deputy Manager	Current
2	Female	Female	33	White British	Carer	Current
3	Female	Female	30	White British	Clinical Lead	Current
4	Female	Female	45	White British	Carer	Previous
5	Male	Male	27	White British	Carer (agency)[b]	Previous
6	Female	Female	46	White British	Manager	Current
7	Female	Female	40	White British	Carer	Current
8	Female	Female	54	White British	Deputy Manager	Current
9	Female	Female	52	White British	Care Team Lead	Current
10	Female	Female	30	White British	Carer	Previous
11	Female	Female	24	White British	Carer	Current
12	Female	Female	40	White British	Deputy Manager	Current
13	Male	Male	19	White British	Carer	Current

[a]Current or previous: whether participants worked in this role at the point of the interview or had previously worked in this role.
[b]Agency carer describes temporary workers provided by external agencies to support care homes in delivering care to residents.

Table 2. Summary of main themes and subthemes.

Main theme	Subtheme
1. A system which leaves staff unsupported	1.1 Lack of training and awareness of SMHP
	1.2 Challenges with accessing external mental health support
	1.3 Lack of resource
	1.4 The influence of stigma
2. The importance of relationships and connections	2.1 Important connections for staff
	2.2 For residents
3. The realities of caring for someone with SMHP in a care home	3.1 Risk
	3.2 The emotional impact of the role
	3.3 Caring for an older person with SMHP

A system which leaves staff unsupported

Participants work within a social care system that presents multiple challenges related to the operation of care homes and the training provided to staff. These factors had a negative influence on the care that participants were able to provide to residents with SMHP.

Lack of training and awareness of SMHP. Participants received insufficient training around SMHP and felt unprepared.

> "I know here we're not really overly trained on severe mental health and I do think it is needed." [P3]

This was particularly felt to be the case in care homes who do not have a nurse.

> "It can be very hard for staff in a residential care home setting if we do get anybody with mental health issues because the staff don't have the relevant training." [P7]

Some participants had no training on SMHP and felt that there was an assumption they had the relevant skills.

> "None at all. Your training is basically you're going into a care home to just look after people—no mental health training whatsoever." [P10]

Limited training left staff feeling uncertain around how to approach care for residents with SMHP. Some participants depended on adapting what they learned within previous roles.

> "We do not have the right training in the home so somebody like myself who's worked with mental health is more willing to handle it than someone that hasn't and that's nothing against them, it's just they haven't had the training so don't know how to approach it." [P7]

Training around SMHP was not considered a priority in care homes.

> "It's not actually a big thing that's looked on in a care home, to be honest. A lot of training on stuff like that." [P11]

Comparisons were drawn with other conditions, where participants had more in-depth training.

> "We're all trained to look after people with dementia, but you don't get really in-depth training on mental health conditions." [P6]

There were also disparities between the training that staff had received. Some talked about receiving training based on the needs of residents they were caring for. This was responsive to who entered the home, rather than being delivered in a proactive manner.

> "We had somebody with schizophrenia, so we went on schizophrenia training. We had the lady with borderline personal disorder, so we had training around that." [P7]

The decision to obtain specific training depended on the number of residents experiencing SMHP within the care home, showing a reactive approach to identifying training priorities.

> "We sought other training so that we could give staff more support to understand people's conditions. Now, we got that because of the size of the home. We had 40 residents. In the other homes where you might have one, two, or three, it wasn't feasible for somebody to come out and do that training." [P6]

Accessing external mental health support. Alongside training, participants accessed external mental health support, such as Care Home Mental Health Teams (also known as care home services, community in-reach teams, care home liaison team, intensive care home team) provided by the NHS. This helped staff to reflect on their practice and develop person-centred care strategies.

> "We get most [support] from care home mental health teams, so I work alongside the nurses, and a couple of people are mental health nurses here as well." [P1]

Participants however highlighted multiple barriers to accessing mental health services to support care staff. Care home mental health teams did not always feel accessible for staff. The processes in place to accessing care home mental health teams were a barrier. The referral delay was problematic for staff who were required to continue delivering care in the meantime.

"Then that person's got to wait for 2 to 4 weeks to get seen. But you can refer them and then you can ring the crisis team so like it's alright but … it would be nice if you could just ring them." [P1]

Care assistants also reflected that more senior staff did not always communicate with them who external healthcare professionals were, which meant that their recommendations were not always cascaded down and implemented.

"You see people coming in. You don't fully understand who they are because the seniors are dealing with them, not us {the carers}" [P12]

The demands placed on care staff by mental health care home teams were challenging to meet, leading to delays in staff and residents accessing further support. Paperwork requirements needed for referrals were felt to place additional burden.

"We were trying to get her a 1:1 because … I will admit we got complacent because her behaviour became very normal to us, so we stopped documenting because at one point we were documenting about 10 behaviours a day and we did it for months and it just kind of run down and then when we tried to get the 1:1 they were like 'where's your documentation?' So now we have to do it all over again, document everything again." [P2]

Care homes did not seem to be prioritised for specialist mental health support. There were times when participants felt residents were referred to the wrong services or not referred at all. For example, a generic referral being given for a dietitian rather than considering the psychological needs of someone with an eating disorder.

"We're trying to say, 'she's got an eating disorder'. And it was just dietitians that were coming out. So, I don't think they had as much knowledge as the specialist eating disorder clinic she's been known to before, through her life."[P1]

Lack of resources. Staffing levels impacted on the ability to care for people with SMHP. Poor staffing levels meant that at times, staff felt that they met only the basic needs of those they cared for. This was particularly the case when staff were supporting multiple individuals with complex needs.

"It's difficult when you see how many people you're caring for on very low numbers and meeting everybody's basic needs is one thing, but actually promoting and giving a bit more quality of life without extra staffing to facilitate these things…" [P10]

This meant that staff could not engage in best practice. For example, when low numbers of staff were available, documenting behaviours in behaviour charts was not possible, which as outlined above impacted accessing external support. Staff also reflected on the challenge of balancing the needs of all the residents within the home on low staff numbers.

"When there was four [staff], we would stop documenting because we just don't have the time. It was stopping us caring for someone else… you have two corridors upstairs so two carers on one side and two carers on another, so if those carers are busy and those carers are busy, who's watching the people in the lounge?" [P3]

Participants often felt like they needed to spend more time with residents who experienced SMHP to comfort them but struggled to do this. They reflected on whether they needed more time or patience to provide person-centred care.

"Actually a lot of care staff don't have the patience, or perhaps it's time rather than patience. I would really try and spend as much time as I could with that person to kind of comfort them and do whatever I could to help." [P5]

Participants felt residents with SMHP need staff to take the time to understand and listen to them. However within the context of many demands on staff time, they reflected on how challenging this is, within the context of many demands on their time. At times, participants felt exhausted and hoped that residents would not become distressed.

Participant: "Their needs? Just somebody to understand, somebody just to listen."

Interviewer: "Do you think people do?"

Participant: "No. I can be guilty of it myself. I ain't got time, I want to get home for eight o'clock. Come on, don't kick off… I'm overworked, paperwork… we're all guilty of it." [P9]

Supporting a resident who was distressed took time away from other mandatory parts of the job.

"If somebody's dealing with a distressed person, they're dealing with a distressed person, and then afterwards, you think, ' I've got to go do a medicine round now,' and then after your medicine round, you've got to write all your daily notes." [P6]

Some participants reflected on the interaction between the size of the care home and how well they were able to deliver person-centred care.

"I came from a 78-bed residential advanced dementia home to a 14-bed residential home …. here, I've got all the time in the world for them. I can spend hours and hours with them." [P12]

The influence of stigma. Participants highlighted stigma and negative beliefs around age and mental health diagnoses held by care home staff which influenced how they work with residents with SMHP. Participants noted the challenge of talking about mental health with residents, often leading to unrecognised mental health difficulties in care homes. The taboo nature of these conversations left care staff lacking confidence to initiate discussions.

"I think mental health gets missed quite a lot. People don't ask them questions. They don't want to offend someone if you're asking about someone's mental health. So especially when someone is, like asking an older person, 'Are you suicidal?'. They're quite taboo subjects, aren't they? People don't want to ask these questions because they're not confident." [P10].

Diagnostic labels of SMHP were associated with negative beliefs and prejudgements about residents.

"I think people try not to say that they judge or stereotype people, but I think it does happen. You hear like all these stories of people and they're like 'Oh [resident] has got psychosis' and they see psychosis and think psycho." [P1]

These concerns led to avoidance of caring for individuals and development of fear, perpetuating stigma.

"They might say 'aw he's got schizophrenia; watch he might kick off when you go in and then you go in and they're lovely. And I just think [shakes head] this is when people who have got lack of experience will just go 'I'm not going in, I'm not going to go and see that person'" [P4]

Perceived unpredictability of residents with SMHP was concerning and led to nervousness.

> "People's ideas of what, say, schizophrenia is, you know, there's still a massive stigma, isn't there? People think, 'They've got schizophrenia, what are they going to do?'" [P6]

The importance of relationships and connection

Important connections for staff. Participants reflected on the importance of relationships and connection when caring for someone with SMHP. As staff received little training around caring for someone with SMHP, they often relied on each other to learn how to provide care.

> "We've not got a massive team there and a lot of them are very, very experienced, like 20 plus years in care. So, they've got loads of knowledge. If I'm struggling with something, I can say, 'I'm struggling with this challenging behaviour, for example, how can I deal with it?' and they'll tell me or give me ways to manage it." [P13]

Whilst participants learned from each other, it was acknowledged that this method of learning may not always lead to providing the right care for the resident. Sharing may lead to unhelpful or poor care practices cascading through care homes.

> "I would just be taught off somebody else, so you just go off what you think is best and it's not necessarily the right way."[P10]

The relationship between management and care staff was important for staff to feel supported. Accessible senior staff guided care staff and promoted learning.

> "Handing it over to someone who might know a bit more about that, like, go and hand it over to a manager"[P13]

Gathering information about a resident with SMHP could sometimes be difficult, as staff did not easily have access to a resident's healthcare records due to confidentiality policies. Relationships with family members were important in helping to gather information. It was difficult for staff to obtain this information from families where families were not fully aware of the resident's mental health needs and experiences.

> "It's more from families we're gathering information. But sometimes they're probably never going to know the full extent if they've chose to you know… it's their mums and dads. Usually they might hide it from the children." [P1]

Gathering information from family was particularly important if residents could not communicate this information themselves.

> "You're relying on the families a lot, hoping that they've got a good support network to give you information that will help care for them that they can't give you." [P12]

Participants also talked about what motivates them to stay in this role. Caring for people with SMHP and supporting them through difficult times was rewarding, providing a sense of purpose.

> "And avoiding that situation, or learning how to deal with it—that's always rewarding, especially when you can bring it down so they're not as agitated." [P13]

For residents experiencing SMHP. Participants recognised the importance of connections with others for residents. Strong relationships between staff and residents with SMHP were linked to providing person-centred care.

> "You get to know the resident and you learn and then you can always try from day one, deliver person-centred care, but you need to be able to know that person to really, for it to start making the difference, you know?" [P8]

Continuity of care was thought to help residents feel a sense of safety, which could improve the quality of care being delivered.

> "It's sort of continuity isn't it and getting to know the ways about a person, reading them better, also on the person's side they're getting to know you and feel maybe more safe with someone they know who's familiar." [P4]

Building relationships with residents also enabled participants to recognise early warning signs of distress, helping them address this. Participants acknowledged that they did not always have the answer.

> "You might be more aware that they're about to spiral than they are. So, if you can spot that and engage them soon and maybe drag them out of that mood, again it's not something that works every time but you've got to try" [P7]

These relationships were integral to residents' quality of life. The importance of happiness and laughter was shared.

> "He can be getting quite angry and upset and storm off and [staff member] can go to him and within five minutes she's got him laughing. He never laughed when he came here, never laughed." [P8]

Participants also reflected on how relationships created a sense of belonging and involvement for residents with SMHP.

> "She'd [resident with schizophrenia] say 'I love it when it's like this' and she'd nip down the shop and come back with a load of goodies and we would sit there laughing and she'd make us cups of tea, and they were the good times." [P9]

The realities of caring for someone with SMHP

Risks associated with care. Participants acknowledged the positive aspects of caring for residents with SMHP but also highlighted the risk of violence and aggression, witnessing both verbal and physical aggression towards staff and residents.

> "When she was triggered, she would stalk the corridors she would be telling people she's going to kill them, swearing at them, swinging her handbag at them." [P7]

Some participants mentioned care staff refusing to work with certain residents due to their violence and aggression, leading other staff to take on more responsibility.

> "Some staff fully refuse to go and work with somebody because of how aggressive they are. Sometimes, say I am working on that side, I'll get asked to go on that side just to change one person because some staff won't do it." [P2]

Participants often associated violence and aggression with SMHP, including this being a sign of undiagnosed symptoms.

> "I'd not seen that sort of behaviour in kind of the previous year of looking after people, that certainly stood out as like, there's something else [other than dementia], if that makes sense." [P5]

Staff found changes or deterioration in mental health difficult. Being present when residents were experiencing significant distress was challenging.

> "I remember that lady having the injections and screaming the place down. When she knew the care homes team nurse was coming she used to stay up and she would barricade herself in." [P9]

Fluctuations in a resident's mental health could be uncomfortable for staff to experience, making them unsure about how to provide care.

> "There was a lady who had schizophrenia and one minute she would be your best friend and the next minute she'd probably peel the wallpaper off the walls by just looking at you." [P9]

At times, staff and the care home couldn't meet the needs of residents with SMHP, leading to further deterioration.

> "We've previously had people come from [hospital], unfortunately it hasn't worked out because there's been a decline in their mental health, we haven't been able to meet their needs. They've got to a point where they were a danger to themselves or others, so they've had to go back." [P7]

The emotional impact of the role. Meeting the needs of residents with SMHP was emotionally difficult. Participants often felt like they were not doing enough.

> "it can be frustrating as a carer to go into somebody who you just don't feel like you're helping." [P1]

Staff did not always know how to respond to symptoms of SMHP, which had a negative impact on their well-being. They worried about care quality and the impact on residents.

> "We knew that this was purely psychosis, but the staff didn't know how to react to that but felt like they weren't meeting her needs. If we don't meet people's needs, we feel like we're neglecting them." [P7]

Some participants experienced times when they could not reduce residents' levels of distress and prioritised safety in these moments.

> "The lady on the top floor, when her mood went, there was nothing you could do. She would stalk around the corridor, throw things, attack staff. Eventually, she would calm down, but there was nothing you could do in that moment, just try to keep her and the other residents safe." [P7]

Reflecting on these experiences allowed participants to consider the boundaries between protecting the safety and well-being of themselves and residents.

> "It's that fine line between protecting them, protecting you, and safeguarding them. It's really, it's heartbreaking, really, when you're in that situation sometimes." [P6]

Participants sometimes felt fear when caring for someone with SMHP, particularly the first time they provided this care, as it felt unfamiliar.

> "That was my first time I ever experienced it and it was quite an eye opener… it was quite scary." [P9]

Staff recognised ways that caring for residents with SMHP impacted on their ability to detach from their role when their shift ended.

> "I think for me it was how do I not feel overwhelmed by that scenario and that presentation? I found it quite hard to disconnect from." [P5]

Providing care to someone with SMHP impacted staff's well-being and health. At times, this led to increased sick leave.

> "One of the girls literally took a week off with stress because she said I can't come into work and do another day with him." [P2]

Participants often felt underappreciated and unheard, especially when concerns about SMHP were dismissed, which affected the quality of care they could provide.

> "It really does affect you as a staff member because you just don't feel listened to, so you're not giving the best to the resident that you know they should be getting." [P10]

Direct care staff believed that their concerns were not always taken seriously by health care professionals.

> "We know when we're screaming out 'we're not thick but we're also not doctors, are we?'" [P9]

Caring for an older person with SMHP. Participants highlighted the complexities of caring for someone with SMHP who is older. Diagnostic overshadowing, increased care needs and comorbidity made it more difficult for staff to provide person-centred care to residents with SMHP.

Participants reflected that recognising SMHP is challenging and complex. This means SMHP may go unrecognised in care homes for people with dementia given overlap in symptoms.

> "So you'd have families coming in, sometimes with patients who were saying they had, like, dementia, but was it psychosis?" [P10]

Some participants talked about how SMHP may not be considered at all when making sense of a resident's distress. Symptoms were often considered within the context of dementia by other professionals.

> "If the person has got mental health issues, and they go into a home it's just 'right that's dementia' and it'll be brushed aside if they've got bipolar." [P4]

Participants described conflicts with management that prevented residents from accessing additional support around potential SMHP. Management did not always wish to pursue a diagnosis for the resident.

> "If they're having delusions or whatever, I would talk to the most senior member of staff in that home. They would always be like, 'Oh well, what does it matter?' That person's kind of already got dementia? They're already in this scenario." [P5]

Diagnostic overshadowing occurred, where nuanced assessment and diagnostic procedures were not necessarily followed.

> "You know you might, they might have dementia, but they might also have a mental health condition, and that could get overlooked if they think it's dementia." [P8]

Participants highlighted the challenges of supporting residents with additional care needs such as personal care, incontinence and risk of falls.

> "[We] were struggling to assist her to get her changed; she was incontinent. You've got all those things that come with getting older, vaguely incontinent, so they need that care, whereas when somebody's younger, you wouldn't have to get so up close and personal with them to do things that are quite intrusive, aren't they?" [P6]

The dignity of the person with SMHP was at the forefront of care-related decisions. Balancing resident needs to make important decisions quickly was key to delivering high-quality care. Staff found themselves in situations that placed risk to themselves, to support the resident's personal care needs.

> "You try not to touch them because you don't want to hurt them. You know you've got to be careful anyway. But then you can't even leave them because they're at risk of falls, so say somebody's got their trousers halfway down, they've been incontinent, they're highly stressed, they're hallucinating, they think you're there to kill them, you've got all these things going on, and you just think, right, everybody just stop, because we don't want to make this worse. You can't walk away because they've got their trousers halfway down." [P6]

Participants talked about how changes to physical health may trigger SMHP symptoms.

> "Which, from my experience recently with an older gentleman, is that his physical health has been so, so poor, we couldn't medicate his mental health, so that has been so difficult." [P10]

The complexity of residents experiencing comorbid SMHP and dementia brought additional challenges. Staff sometimes had to make decisions against residents' wishes, when residents were deemed to not have capacity.

> "The gentleman with bipolar that I used to look after, when he went dead high, he would want to book holidays. But with him having dementia we couldn't allow him to do things like that. So it became a bit of a downfall for us, having to tell him no, and then dealing with that." [P11]

Staff found communication challenging with residents having both dementia and SMHP, as the combination seemed to significantly affect verbal communication.

> "I suppose one marked difference is if someone has dementia or memory loss and they're going through this as well, it's far more difficult for them to tell us what's going on." [P6]

Discussion

This study aimed to understand the experiences of providing care to older adults with SMHP in a care home setting. Three main themes were identified: a system which leaves staff unsupported, the importance of relationships and connections, and the realities of caring for someone with SMHP.

Care home staff face multiple challenges within the systems they work in which add barriers to providing care for residents with SMHP. Staff felt they did not have the appropriate training, external support, awareness, resource or staffing to provide person-centred care. Whilst some staff had received specific training on SMHP, this varied by care home. Given increased complexity (Bucy et al., 2022; Dudman et al., 2018) and poor 'visibility' of older adults with SMHP within care homes (Hanan et al., 2024), it is reasonable to assume that all staff will likely care for residents with SMHP at some point. These systemic and workforce challenges highlight the urgent need for coordinated policy action for the care of residents with SMHP in care homes. Various national policies and government drivers are working to address organisational challenges across the health and social care sector, for example the Casey Commission (HM Government, 2025) and the NHS Long Term Plan (Alderwick & Dixon, 2019). The Casey Commission has recently been established to address the long-standing challenges across social care in England, with plans to develop better integrated care between social care and the NHS. Such policies and government drivers should be aware of and address the organisational challenges which impact the care for residents with SMHP.

Stigmatising beliefs about severe mental health diagnoses lead to fear and avoidance in staff (Thornicroft et al., 2016). Older people with SMHP who experience stigma are vulnerable to exclusion and poorer quality of life (Holst et al., 2024). It is likely that these responses to residents with SMHP negatively impact the well-being of this population. Care staff experienced a range of emotions when caring for residents with SMHP. Staff described feelings of fear and frustration and reflected on being subjected to violence and aggression. Whilst Cen et al. (2018) suggested that those experiencing SMHP display less aggressive behaviours compared to residents with dementia in long-term care settings, our findings suggest that staff associate violence and aggression with SMHP rather than dementia. Being exposed to a high level of emotional distress can lead to burnout (Harrad & Sulla, 2018), which was highlighted in the present study, when staff took sick leave due to stress levels associated with caring for someone with SMHP.

Positive relationships and connections help staff develop skills and strategies. Effective teamwork where staff can draw on each other's knowledge and skill promotes individualised high-quality care (Spilsbury et al., 2024). Strong relationships were important for resident well-being, creating a sense of safety, belonging and connectedness (Holst et al., 2024; Kang et al., 2020). Loneliness is a major unmet need for individuals with SMHP (Perese & Wolf, 2005), making positive relationships especially important. Relationship-centred care builds on person-centred care by emphasising reciprocal relationships between staff and residents to deliver high-quality care (Hirschmann & Schlair, 2020). This approach improves residents' well-being, care quality and family satisfaction, but is hindered by systemic pressures such as high workload and staff turnover (Gurung & Chaudhury, 2025). Its quality also depends on staff attitudes and understanding of a residents' health need. Negative attitudes or limited knowledge about SMHP may therefore reduce the quality of relationship-centred care for residents with SMHP.

Caring for older adults with SMHP adds complexity due to physical needs including frailty, fall risk and personal care (Bucy et al., 2022; Cummings & Cassie, 2008). Participants witnessed diagnostic overshadowing for residents, where symptoms were attributed to one condition, rather than recognising the interaction between conditions (Aldridge & Dening, 2021). Staff reflected on times when symptoms were considered in the context of dementia, where they believed this did not make sense or fully explain symptoms. This may lead to inadequate care and treatment (Hallyburton, 2022).

Unfortunately, our sample was more homogenous than anticipated. Care homes often have a diverse and multicultural workforce (Chen et al., 2020). A more diverse sample may have highlighted difference within staff experiences and be more representative of the workforce. We only considered the perspective of care home staff, who reflected on care provided over their entire careers. Future research should explore the views of care home residents who experience SMHP and their families, as well as UK care home staff who are of the global majority population, to understand their experiences and develop strategies to promote person-centred care.

Staff should be trained to care for residents experiencing SMHP proactively, rather than receiving training after they experience challenges caring for someone. Providing mandatory training around SMHP in care homes should reduce fear and avoidance within care home staff. Muralidharan et al. (2019) highlighted key topics for SMHP training in care homes: recognising symptoms, a recovery model focus, challenging stigma, connection and communication, cognition and whole health. However, based on the findings of the present study, this training is not being systematically implemented. Improved access to mental health services for care homes should be prioritised, including psychological assessment, formulation and intervention for residents and their care teams, using evidence-based psychological models (NHS England, 2024).

Relationship building between staff and residents with SMHP should be prioritised, to address emotional and physical needs. For example, residents may need to feel psychologically safe to receive personal care. However, this requires increased staffing levels. Stakeholders should recognise the impact of staffing on the quality of relationships and care for residents, alongside well-being of both residents and staff (Spilsbury et al., 2024).

Conclusion

This research highlights the experiences of caring for older adults experiencing SMHP within a care home setting. Whilst staff highlighted positive experiences within this role, the systemic pressures that impact the role are exacerbated when caring for older people with SMHP. It is best practice for care home staff to implement person-centred care for the well-being and care experience of residents with SMHP. Limited training and awareness around SMHP makes it increasingly difficult for care home staff.

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No potential conflict of interest was reported by the authors.

Data availability statement

The dataset analysed in the article is available upon reasonable request to the authors.

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