# An exploration of UK migrants and refugees' experiences and mental health impact of the COVID-19 pandemic.

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**Portfolio Abstract**

**Background:** This thesis explores the perspectives and experiences of UK migrants and refugees during the COVID-19 pandemic, as related to impacts on mental health.

**Design:** As part of the portfolio, a systematic review was conducted, synthesising existing research on the experiences of migrants and refugees already present in the UK during the pandemic. 12 studies were included in the systematic review, and qualitative data relating to the perspectives of migrants was extracted and synthesised. Data was synthesised using a narrative synthesis method. A qualitative empirical study was conducted to explore the experiences and mental health impacts of migrant nurses recruited to work in the UK during the COVID-19 pandemic. Using semi-structured interviews, data was collected from 11 participants recruited from a single NHS Mental Health Trust. Data was analysed using Thematic Analysis (TA).

**Results:** The systematic review results highlighted three main themes: (i) adapting and coping, (ii) experiences of disturbance and (iii) systemic issues. The systematic review results showed that migrants and refugees in the UK faced challenges adapting to COVID safety measures at work and at home, heightened by their migrant, sexual and ethnic identities. Due to inadequacies in support systems, many relied on personal resilience strategies during the pandemic and lockdowns, particularly for those difficulties related to their migrant identities. The empirical study found four overarching themes each with sub-themes: 'shattered promises about hopes for the future', 'being an outsider', 'the strain of adaptation', and 'having to survive'. The work revealed that migrant healthcare professionals require more support with professional integration and mental health needs than is currently provided by the NHS.

**Conclusions:** The findings from both the systematic review and empirical study are discussed and critically evaluated at length within this thesis portfolio.

*Key words: migrant, immigrant, refugee, asylum seeker, foreign, overseas, NHS, nurses*.

**Access Condition and Agreement**

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**Chapter One: Introduction to Thesis Portfolio**

Word count: 1688

## Introduction

Migration plays a crucial role in shaping the demographic and socio-economic landscape of the UK (Anderson et al., 2021; Taylor, 2021). Recent trends indicate a complex scenario influenced by political changes, global events, and economic factors (Simpson, 2022). Understanding these trends and the contributions of migrants to host communities is crucial for informed policy-making and public discourse. According to the Office for National Statistics (ONS), net migration to the UK has shown significant fluctuations in recent years. The 2023 data shows that net migration was around 672,000, a figure influenced by various factors including Brexit, the COVID-19 pandemic, and global conflicts (ONS, 2023). The immigration system implemented post-Brexit in January 2021 has fundamentally changed the landscape, giving priority to skilled workers and impacting the flow from EU and non-EU countries differently.

Migrants make significant contributions to the UK's economy and society. According to a recent report by the Migration Advisory Committee (MAC, 2018) and The Migration Observatory (TMO, 2022), migrants play essential roles across various sectors, addressing labour shortages and complementing the skills of the native workforce. For example, the NHS heavily relies on migrant doctors, nurses, and support staff (Shahvisi, 2018). Currently, an estimated 17% of the NHS workforce are from outside of the UK (NHS, 2024). Economically, migrants contribute taxes (Ottaviano et al., 2018), and evidence suggests that they provide substantial economic benefits (TMO, 2022). Socially, migrants enrich host communities through cultural diversity, fostering innovation and creativity (Erel, 2016). The diverse backgrounds and perspectives brought by migrants can lead to increased creativity and problem-solving capabilities within businesses and communities. Furthermore, international students, a significant subset of migrants, contribute to the UK's educational sector and economy, generating an estimated £41.9 billion in the 2021/2022 academic year, through tuition fees and off-campus spending (Universities UK, 2023). They also enhance the global standing of UK universities, fostering international collaborations and research advancements.

Supporting migrants in the United Kingdom can be economically, socially and politically challenging, both for the migrants and the host communities (Suphanchaimat, 2015).

Understanding the relevant issues from the different perspectives can help develop effective support mechanisms and policies. Migrants often face barriers to employment, such as the non-recognition of foreign qualifications, low levels of host country language proficiency, and access to professional networks and information sharing (Simpson, 2022). These barriers can lead to underemployment or unemployment, hindering economic self-sufficiency, career development, and contributing to economic inequalities (Gkiouleka, et. al., 2018).

The COVID-19 pandemic has further exacerbated the challenges faced by migrants. this population has been significantly affected by the pandemic, especially in sectors with more flexible job prospects such as hospitality, retail, and healthcare. Many migrants reported experiencing job losses, reduced working hours, and financial insecurity during the pandemic (Anderson et al., 2021). The closure of non-essential businesses and the subsequent economic downturn impacted low-skilled migrant workers the most, leading to increased reliance on public assistance and community support services. Migrants also report significant challenges in accessing healthcare due to barriers such as language differences, lack of familiarity with the healthcare system, and fear of discrimination (Knights et al., 2021). Recent research indicates that these barriers were intensified by the pandemic, with many migrants avoiding healthcare facilities due to fear of contracting COVID-19 or even being unaware of available treatments (Wise, 2021).

The mental health and wellbeing of migrants is a critical aspect that requires ongoing attention. Migrants may experience stress, anxiety, and depression due to factors such as separation from family, uncertainty about their legal status, and past trauma (BMJ, 2023). Isolation and reduced access to support services during the pandemic have increased feelings of loneliness and helplessness. It is essential to design targeted mental health services and culturally sensitive support to address these needs effectively for migrant populations. Initiatives such as community mental health programs, peer support networks, and access to multilingual counselling can significantly improve the mental wellbeing of migrants but have been limited in provision during the pandemic (Mental Health Foundation, 2020).

*UK context of Migration Experiences*

The discourse regarding migration and migrants in the UK is intricate and politically charged. Over the past decade, the 2015 EU migrant crisis has been a significant factor in the UK's decision to leave the EU (Brexit). During the Brexit campaign, negative rhetoric frequently depicted migrants as a threat to UK culture and identity (Baker, 2020). The slogan "taking back control," associated with the leave campaign, was scrutinised by Simmons and Shaffer (2024), who observed that the UK never lost control of its borders within the EU framework. Wood examined the link between this slogan and a nostalgic view of the British Empire, where British identity was shaped by excluding certain racial groups. This is particularly evident in UK policies towards migrants, especially those seeking asylum. UK has implemented policies such as the "hostile environment" strategy to discourage migration to the country. As a result, refugees, asylum seekers, and even economic migrants face heavy scrutiny upon arrival, are often institutionalised, and have limited rights within the UK. Migrants and their children are also typically more likely to live in poverty than others within the UK population, and be denied access to healthcare services, limiting their acculturation into UK life (Hughes & Kenway, 2016). Research has shown that these policies, and their socioeconomic impact, collectively negatively impacts the mental health, wellbeing and integration of migrants and refugees (Van Der Zwet et al., 2020; Jeffrey et al., 2024; Pollard & Howard, 2021).

*Social theories of Migration Health*

The Psychological Antecedents of Refugee Integration (PARI) model, proposed by Echterhoff et al. (2020), aims to conceptualise the process of acculturation and integration of refugees into host communities. According to this framework, effectively managing immigration, including integration, requires an understanding of the underlying psychological processes at play. The PARI model considers perceived forcedness (i.e., coercion and loss of control from "push" pre-migration factors) and ensuing perils (risks and potential suffering during migration) as distinctive factors of forced migration, as opposed to voluntary migration. By emphasising the uniqueness of forced migration, the PARI model puts forward a new and specific hypothesis about the psychological processes that predict refugee integration into their host societies. This leads to questions about the specific psychological processes that may underpin the

experiences of migrants in general, the differences these processes might have for migrants arriving in the UK, how these experiences might have changed during the COVID-19 pandemic, and how they have influenced migrants' ideas and beliefs about their identity, their integration into UK life, and their relationship with services.

*Relevance to psychology*

This topic is of interest in clinical psychology due to the limited scope of psychological research focused on the first account COVID-19 experiences of migrants and refugees in the UK, which limits the evidence base for developing and improving targeted mental health support to this already vulnerable population. The mental health impact of COVID- 19 is well documented in general populations (Chandola et al., 2022; Khan et al., 2022; Serafini et al., 2020). Within the UK, the general population experienced negative psychological effects of the pandemic brought on by the loss of normal social contact and support networks, loss of jobs, bereavement, and the fear of infection, amongst other issues (Tsamakis et al., 2021); and this psychological impact is significantly higher in vulnerable groups, such as migrant groups (Aragona et al., 2020). Rees and Fisher (2020) postulate that the sense of imprisonment caused by quarantine rules, inactivity and the reported impact such as mental health impact (boredom, depression); altered interpersonal relationships and economic difficulties, mirroring some of the difficulties that may have been experienced by forced migrants at various stages of their migration journey. The reduction in established support services such as food banks, community assets or housing charities during the pandemic has also had a negative impact on migrants.

One group of migrants who have been largely neglected in these pandemic narratives and policies are the international health workforce, or migrants who have chosen or been recruited to work in the NHS to reduce workforce gaps. The international, or overseas workforce, is part of a national strategy by NHS England to increase healthcare professionals' numbers in the UK. During the COVID-19 pandemic, there were significant increases in the UK international health workforce, particularly from countries outside of the EU such as India, West Africa and the Philippines (The Kings Fund, 2023). Many of these health professionals are medical doctors or nurses, with a few psychological

professionals. However, it has been recently reported that a large number of these overseas health professionals are now leaving the UK for better work-life balance and prospects abroad (The Health Foundation, 2024).

Yet there is a dearth of research exploring the experiences of the international or migrant workforce in the UK. This means that research into the mental health and experiences of migrant healthcare professionals will be of relevance to clinicians, most of whom will likely offer support or supervision or work alongside migrants at some point during their professional lifetime. Research in this area will also be of significance to organisations and overseas workforce programme managers who may wish to improve the support and experiences of international colleagues provided at the organisational level. The swiftness with which the COVID-19 pandemic developed and the global impact it has had, highlights a need to ensure that attention is paid to groups that are easily overlooked in future pandemic planning.

Summary of thesis portfolio

In order to explore these topics further, this Thesis Portfolio will be presenting the following pieces of work: i) A narrative review of qualitative research exploring the experiences and mental health impacts of the COVID-19 pandemic on migrants to better understand their mental health needs and provide effective psychological support from mental health services, and ii) An empirical project in which migrant nurses in a UK mental health organisation were interviewed about their integration and work experiences during the pandemic. Collectively, these two pieces of work will provide greater insight into the voices, experiences and views of migrants living and working in the UK during the pandemic and will provide areas for how support for migrants can be considered within health practice and policy.

**Chapter Two: Systematic Review**

Word count: 9152

Systematic review paper prepared for submission to 'Journal of International Migration and Integration'

Author guidelines can be found in Appendix A

# Mental health impact of the COVID-19 experiences of UK migrants and refugees: A Qualitative Systematic Review

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**Abstract**

**Aims:** This systematic review explores the first-hand experiences of migrants and refugees present in the UK during the COVID-19 pandemic and its mental health impacts.

**Method:** Using narrative synthesis, 12 peer-reviewed qualitative studies conducted between March 2020 and January 2024 were analysed. Methodologies varied across the studies, including semi-structured interviews, thematic analysis, phenomenological approaches, grounded theory, and narrative life stories. Sample characteristics included migrants and refugees from diverse backgrounds, employment statuses, and lengths of stay in the UK.

**Results:** Three themes emerged: 1) adapting and coping 2) experiences of disturbance, and 3) systemic issues. Each of these themes had two subthemes linked to them.

**Conclusion:** This review highlights the importance of understanding the nuanced experiences of migrants and refugees during the pandemic, particularly regarding their mental health and wellbeing. It provides valuable insights into the challenges faced by these populations and highlights the need for targeted support and interventions to address their unique needs. Additionally, the findings emphasise the role of systemic factors, such as public health messaging and migrant policies, in influencing the mental health outcomes of migrants and refugees during COVID-19.

## Introduction

*Background*

Present-day migration is a global social phenomenon with a wide-reaching impact worldwide – on countries of origin from where people leave, and on host countries where people go to (Al-Kaabi, 2021). Migration here is described as "the process of people travelling to a new place to live, usually in large numbers" (Cambridge University Press, n.d.), by choice or by force, for very complex reasons such as globalisation, demographic shifts, political persecution, wars, armed conflicts, natural and environmental disasters, lack of skills, and better employment opportunities (Al-Kaabi, 2021). An estimated 281 million migrants are thought to live in a host country as of 2020, comprising 3.6% of the global population (World Migration Report, 2024). Migration is complex and can occur by choice (economic migration) or by force (refugee migration). For people who choose to migrate, the reasons informing their decision are multifaceted (Castelli, 2018). Some of the theories that underpin this include the 'push-pull' theory which suggests that the individual's decision to migrate is based on the problems faced in country of origin- limited employment/business opportunities, poor governance/infrastructure, political climate (push factors) (Edge & Hoffman, 2013); and whether overcoming such difficulties are outweighed by factors that make host countries attractive (pull factors), for example, better employment opportunities, access to healthcare and political stability. Another perspective highlights the role of 'macro' factors (the socio-economic, political, and environmental contexts that make the country of origin unfavourable); 'meso' factors (technological innovation, media/communication, and links to potential host countries); and 'micro' factors (personal attitudes towards migration, educational status, faith and marital status) in informing the choice to migrate to a new country (Castelli, 2018). The terms 'migrant', 'economic migrant', 'asylum seeker' and 'refugee' have legal and political implications (Amnesty International, 2021; Castelli, 2018) and for research. 'Forced migrant' collectively refers to asylum seekers at all stages of their asylum process and refugees whose status have been granted; and 'migrant' is used to capture both economic migrants and forced migrant groups. For this study, the group of people who choose to move to a host country will be termed 'economic migrants'.

*Mental health impact of border crossing*

While many immigrants integrate well into their new host country, others may encounter additional challenges arising from the migration experience. Negative experiences at any stage of the migrant's journey are linked to a predisposition to mental health and psychosocial difficulties (Torres Fernández, 2017; British Psychological Society, 2018). In a systematic review exploring the mental health impacts of migration, Bhugra (2004) found that though migration-related stressors can significantly impact mental health, the experiences of migrants vary greatly. It was further suggested that migrants' coping strategies play crucial roles in mitigating the risks associated with mental health issues (Bhugra, 2004; World Health Organisation, 2023). A recent study exploring the experiences of adult Syrian refugees in the UK, found that they faced ongoing mental health challenges during the process of integration into their host country. These challenges included feelings of separation, loss, and nostalgia for their home country, alongside a desire for connection to their new host country (Paudyal et al., 2021). Additionally, cultural differences and acculturative stress have been identified as significant factors impacting their mental health. The study also found that many refugees hesitate to seek help for mental health issues, due to cultural stigmas and differing perspectives on wellbeing and recovery. Instead, they often turn to faith and community support (Ben et al., 2021; Lusk, 2021). Moreover, cultural factors (such as beliefs about, and stigma towards mental illness), and language barriers impact refugees' access to services (Byrow, 2020).

Refugees' pre-migration experiences of war, displacement, cultural isolation and exposure to other traumatic experiences, have been linked to higher rates of mental health difficulties, compared to the general population (Hameed & Sadiq, 2018). These experiences result in a high prevalence of post-traumatic stress, depression and anxiety (Cratsley et al., 2021). Hynie (2018) emphasised the influence of post-migration experiences on migrants' and refugees' ability to cope with pre-migration trauma, expanding the scope beyond pre-migration and migration experiences. Through a biopsychosocial perspective, it became evident that mental health vulnerabilities in migrants stem from factors such as restricted access to power and resources, exacerbated by sociopolitical inequalities and social determinants of health (WHO,

2023; Salami et al., 2017). A study conducted by Chen et al. (2017) found that poor mental health in refugees was closely related to stressors encountered during resettlement. Many migrants find themselves in the lower social gradients in the countries they move to, which can be attributed to the type of migration they experience, whether voluntary or forced (Castañeda et al., 2015). This positioning is further complicated by prejudiced societal attitudes, biased policies, and discrimination based on factors like ethnicity, race, or religion. As a result, migrants may suffer from mental health problems caused by both pre-migration circumstances and post-migration determinants, with the latter being more likely to worsen over time (Hynie, 2018; Davies et al., 2009). Given the rise in forced migration to the UK, this indicates a need to systematically explore the literature of migrants' post-migration experiences, to understand their mental health needs better and provide effective psychological support from mental health services.

### Research Aims*:*

1. To systematically review first account qualitative empirical studies of migrants and refugees present in the UK during the COVID-19 pandemic and understand their pandemic experiences.

2. To explore these experiences within the context of perceptions on impact on mental health and wellbeing.

## Method

### *Design*

A systematic review of peer-reviewed, published qualitative literature was completed in line with both the Enhancing Transparency in REporting the synthesis of Qualitative

research (ENTREQ) guidelines (Tong et al., 2012; Appendix B); and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist (Moher et al., 2009; Appendix C).

A review of qualitative data was considered the best approach to answer the research question, aimed at understanding participants' perspectives of their experiences, from their self-reports. Data analysis was conducted from a social constructionist perspective, including data from results and discussion sections, thus allowing wider social contexts and influences to be considered. A systematic review protocol outlining inclusion/exclusion criteria, restrictions on participants, search strategies, screening guidelines and methodological approach, was registered on the International Prospective Register of Systematic Reviews (PROSPERO) database, published under the (reference number CRD42024512921).

*Ethical Considerations*

The current study is a systematic review of pre-published literature, with no recruitment or primary data collection; therefore, no specific ethical approval was required.

*Eligibility Criteria*

The Sample, Phenomenon of Interest, Design, Evaluation, Research type (SPIDER) tool (Cooke et. al., 2012) was selected as an ideal tool to define and develop key elements of search term parameters and eligibility criteria and to inform and standardise the search strategy. The SPIDER tool is considered an effective alternative to the Population, Intervention, Comparison, Outcome (PICO) tool (Methley et. al., 2014), better suited to searching for qualitative studies because it adapts the PICO components (Cooke et. al., 2012). For example, a qualitative research "Outcome" may be constructs that are either unobservable or subjective, such as perspectives or experiences. Therefore, "Evaluation" may be more appropriate to apply instead of "Outcome".

The review examined peer-reviewed, primary research, which incorporated qualitative methodology to explore COVID-19 experiences of migrants. Inclusion criteria were clearly defined to capture the relevant data as outlined in Table 2.1.

*Search Strategy/ Information sources*

Literature was searched on nine electronic databases - MEDLINE, Academic Search Ultimate, Directory of Open Access Journals, CINAHL, PsycInfo, Scopus, APA PsycArticles, Science Direct, Business Source Ultimate. The first five databases were selected for their high research volume and accessibility. Given the limited availability of published work in the area of interest, the search was expanded to include the final four additional databases.

After assimilating keywords and discussing them with research supervisors, search terms were developed, and search statements were tested and refined through scoping searches in the chosen databases. The SPIDER strategy identified key elements to be searched as being migration status, the COVID-19 pandemic and the impact of experiences (from participants' perspectives). In the 'Sample' column, search terms used included "economic migrant" OR migrant OR immigrant OR immigration OR migration. In the 'Phenomenon of Interest' column, search terms included "mental health" or "well-being" or 'well being" or "emotional health" or "psychological health" or mood or depress* or anxiety or psych*. In the 'Evaluation' column, search terms included "COVID-19" OR "COVID 19" OR coronavirus or pandemic. Both the D and R elements of the SPIDER tool {'D' being 'Design' (only peer-reviewed, published literature)} and {'R' being 'Research type' (includes qualitative methods)} were relevant to the search strategy. However, both elements were not included in the search terms and were instead applied to filter results instead. Boolean operators 'and' and 'or', wildcards, and truncation symbols '*', were adapted to each database and used to combine search terms and maximise search results. The full search terms are detailed on Appendix D.

**Table 2.1: Inclusion and exclusion criteria using the SPIDER strategy**

| | Sample | Phenomenon of Interest | Design (Published literature) | Evaluation | Research type |
|---|---|---|---|---|---|
| **Inclusion criteria** | Paper must deal with people who have crossed borders to live and work in the UK from country of origin, whether by choice or by force (migrants or refugees).<br><br>Paper must deal with data collected directly from people who crossed borders to live/work in the UK.<br><br>Paper must have adult participants over 18 years old. | Paper must deal with what people who crossed borders to live/work in the UK experienced during the COVID-19 pandemic. | Paper must deal with research conducted between March 2020 and January 2024. | Paper must include qualitative methods, even if other methods are used. | Paper must be primary research |

| | | | | | |
|---|---|---|---|---|---|
| **Exclusion criteria** | Studies were excluded where participants were not migrants or refugees present in the UK during the COVID 19 pandemic.<br><br>Papers were excluded where participants were under 18 years old. | Studies were excluded where first person accounts of COVID-19 experiences were not the primary focus. | Studies were excluded if data collection (participant interviews or focus groups) was completed before March 2020, when the first COVID-19 lockdown was implemented in the UK.<br><br>Studies were excluded which were not published in English Language were included due to the limitations of translation time and cost that any foreign language papers would require. | Studies were excluded if they only included quantitative methods. | Studies were excluded if they were review protocols, book chapters, conference abstracts or commentary articles. |

*Study selection/Screening*

Results were filtered by period (2020-2024), by geography ('UK', 'United Kingdom', 'England', 'Scotland', 'Wales' and 'Northern Ireland') and by type (peer-reviewed articles only). Initial screening of titles of all articles was undertaken by the first author using the freely accessible online systematic review tool, Rayyan. Ineligible and duplicate studies were excluded. Further screening of remaining titles and abstracts was conducted against the eligibility criteria. A full text review of all included articles was conducted by the first author and the reason for any exclusions at this stage was also recorded. Conflicts and uncertainties were resolved by discussion with supervisors in routine research supervision sessions.

Final electronic searches were conducted on 8th February 2024. The search was filtered by period (2020-2024) to yield 6179 results. Further applying language filters (English), and article type (peer-reviewed) filters yielded 3069 results. Results from databases were as follows: MEDLINE Ultimate (749), Academic Search Ultimate (707), Directory of Open Access Journals (377), CINAHL (374), PsycInfo (414), Scopus (263), APA PsycArticles (52), Science Direct (22) and Business Source Ultimate (111). Secondary data searches on Google Scholar and manual search of references did not produce additional results. Duplicates were removed, leaving 260 results.

Records were screened by the first author researcher against the inclusion and exclusion criteria. During this stage, the text screening process was guided by a constructionist research approach. The papers were thoroughly reviewed with a focus on understanding the knowledge being constructed, identifying what constituted data, and determining how participants' perspectives could be meaningfully captured. Emphasis was placed on ensuring that the results sections of the selected papers included first-person direct quotes from participants. The initial step in the screening process involved reading the abstracts and assessing them against the inclusion and exclusion criteria. Ten articles were deemed to meet the inclusion criteria at the title and abstract screening stage and moved into the full-text review stage. The full-text review stage involved reading each paper in full, to determine that the inclusion criteria was met, but also to check that there

was a results section which clearly outlined the finding of each study, and which included participant quotes in this section. Of the ten articles, one was de-selected for failing to meet the criteria, following full-text review. Another set of 10 uncertain articles (recorded as 'Maybes') progressed to full-text screening, from which 3 were deemed to meet the criteria and 7 were discarded, leading to a final total of 12 eligible papers selected for this review. The selection criteria for all papers were reviewed and confirmed by research supervisors.

### *Quality Review*

All 12 studies underwent quality evaluation using the Critical Appraisal Skills Programme (CASP) qualitative assessment checklist, as prescribed by CASP guidelines (CASP, 2023). This CASP assessment facilitated the examination of methodological robustness within the selected studies, enabling critical insights into their limitations, which in turn, informed the synthesis of findings (Noyes et al., 2018). The CASP checklist encompasses ten (10) questions exploring research objectives, qualitative methodological approaches, study design, recruitment strategies, data collection methods, researcher reflexivity, ethical considerations, data analysis techniques, presentation of findings, and their contribution to the existing body of literature (CASP, 2023). Opting for the CASP checklist was predicated on its alignment with the domains proposed by the Cochrane Qualitative and Implementation Methods Group guidance series (Noyes et al., 2018). Each paper received an overall quality rating score between 1-10, a point for each question on the CASP quality rating tool. The lowest rating was 7.5 and the maximum 10; adjudicated by the primary author in consultation with the research supervisor and documented within an Excel database. Quality review was conducted by primary researcher and ratified by primary supervisor.

### *Data Extraction and Synthesis*

Relevant data were extracted from 12 research papers using a data extraction form. These included information about the author(s)/researcher(s), research location,

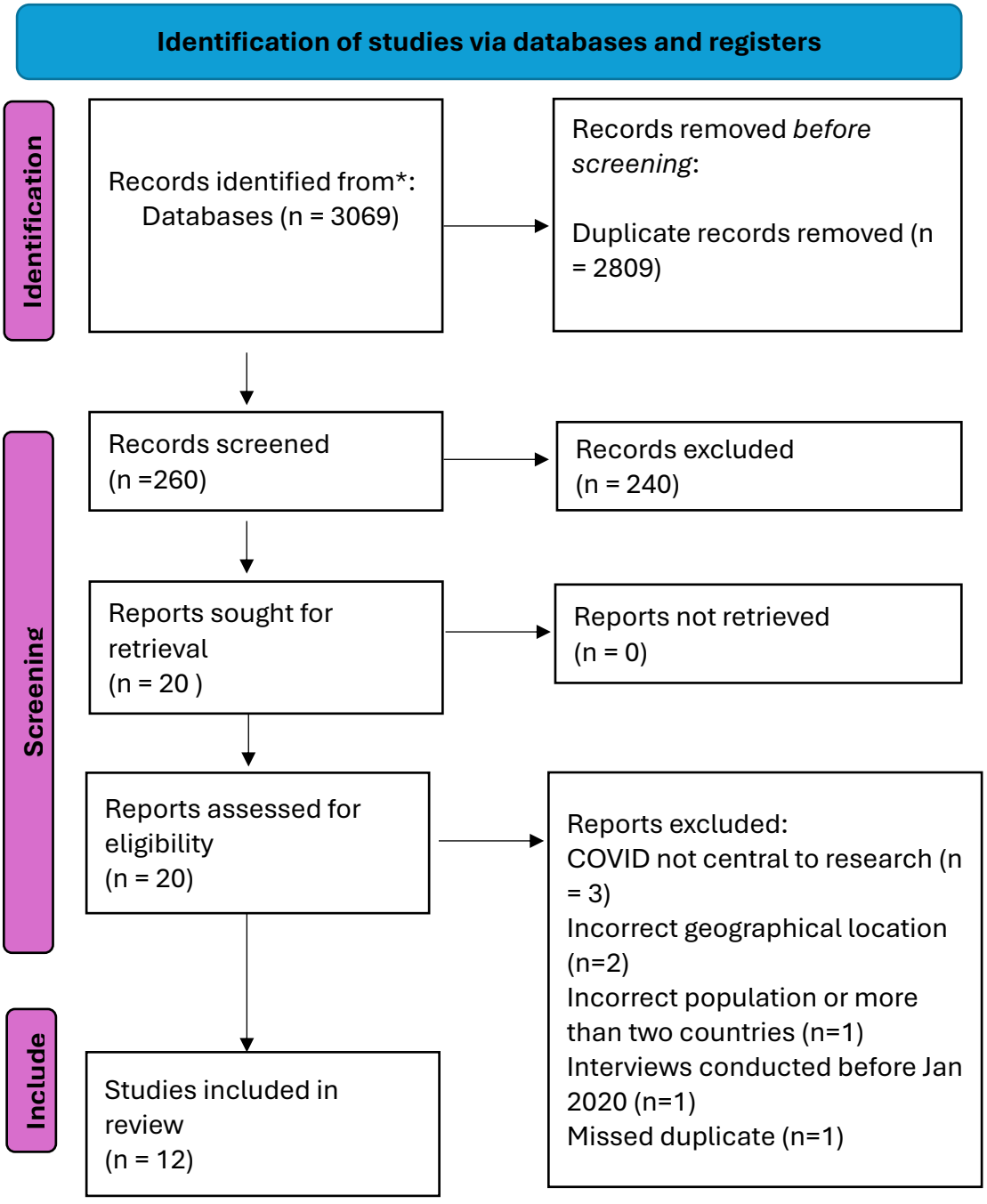
research aims, recruitment criteria, sample characteristics, sampling and data collection methods, data analysis, and main themes from findings from the results section, including participant quotes. Extracted data was separated into two spreadsheets using Microsoft Excel - one spreadsheet to capture study characteristics, and a second spreadsheet representing a simple translation matrix, with studies saved in rows and findings reported in corresponding columns. For papers with mixed methodology, data were extracted from the qualitative elements only. Additionally, if a study was conducted both in the UK and elsewhere, data were extracted only from the UK elements. The screening process ensured that all selected papers had separately reported on any such elements.

The narrative synthesis was selected as the most appropriate method for analysing the 12 featured studies due to the lack of homogeneity among them (Popay et al., 2006). Although Popay's method is traditionally used in systematic reviews to summarise findings through descriptive language and text, this approach was adapted to better suit the methodological orientation of the current analysis. Popay's framework consists of four key components: i) formulating a theory about the mechanism, purpose, and target audience of the intervention, ii) creating an initial synthesis of the results, iii) exploring relationships within the data, and iv) assessing the strength and consistency of the synthesis (Popay et al., 2006; Barnett-Page & Thomas, 2009). However, rather than beginning with a predefined theory, as recommended by Popay, this synthesis was initiated inductively, without a priori framework. This adjustment aligned with the constructionist orientation of the review, whilst still adhering to the remaining steps of Popay's method.

## Results

The initial search yielded 6179 citations. A step-by-step structured process detailed in the PRISMA flowchart (Figure 2.1) was used to filter and screen the titles and abstracts. This reduced the number of studies to 20, which were then subjected to full-text screening, resulting in a final selection of 12 studies for this review.

**Figure 2.1: PRISMA flowchart diagram**



## Study characteristics

Eleven out of the 12 studies included in the review were conducted solely in the UK. One study was conducted across two countries – the UK and Singapore; but data was analysed from the UK element of the study only. A variety of sampling methods was adopted across all 12 studies. Two studies adopted convenience sampling as their recruitment strategy. Eight studies initially used convenience sampling, followed by snowball sampling. Two studies adopted targeted sampling strategies through partner and support organisations. Participants varied across the studies, including migrants already established in the UK, migrants who recently arrived in the UK, migrants in professional jobs, migrants in non-professional jobs, asylum seekers, refugees whose statuses had been recently conferred, homeless migrants, LGBTQ+ migrants and migrant students. Sample sizes ranged from 10- 77 participants per study.

Across the 12 papers, various methods were used to collect data. Five studies chose semi-structured interviews, with two of them conducted in the mother tongue by researchers who spoke the same language. Transcripts were produced in the mother tongue first and then translated into English. Two other studies also used semi-structured interviews but with interpreters, and transcripts were produced in English. One study conducted interviews in English and recruited only English-speaking participants. In addition to semi-structured interviews, one study also used online qualitative surveys to collect data. Two other studies used 'qualitative interview' methods, but it was unclear if they were semi-structured. Two focus groups were conducted, one in English with only English-speaking participants and the other in the mother tongue by researchers who spoke the language. Transcripts for the latter were initially produced in the mother tongue and later translated into English. One study used narrative life story interviews, while another used autobiographical interviews. The final study used 'remote video/telephone interviews,' with interpreters required for half of the interviews.

Six studies used thematic analysis as their methodology, with one focusing specifically on the life stories of four participants. One study used a phenomenological approach,

another used grounded theory, and two studies employed novel analytical frameworks. Additionally, one study each, utilised content analysis and discourse analysis as their respective methodologies. A detailed description of the study characteristics is in Table 2.2.

### Quality Appraisal

The 12 studies included in the review were deemed acceptable for inclusion based on the criteria provided by the CASP quality rating tool (CASP, 2023). See Appendices E and F for CASP template and rating tool. However, one study lacked clarity regarding information governance and data storage. In three studies, the consent process outlined ethical considerations but did not explicitly specify data protection, information governance, or the potential impact of the research topic on participants.

**Table 2.2 Study characteristics**

| Paper ID | Reference | Location of research (participants) | Population | Recruitment strategy | Participant no and demographics | Focus of research | Data Collection Method | Research methods | Analytical framework |
|---|---|---|---|---|---|---|---|---|---|
| Study 1 | Saleem et. al. (2021). | United Kingdom | Pakistani migrant doctors working in the United Kingdom | Opportunity and snowball sampling | 10 (6m, 4f) Pakistani doctors working in UK hospitals. | To explore the lived experiences, beliefs, feelings, and challenges faced by Pakistani migrant physicians working in the UK during the COVID-19 pandemic. | Semi-structured telephone interviews conducted in mother tongue. | Qualitative | Phenomenological approach |
| Study 2 | Yen et. al. (2021). | United Kingdom (all but one was | International (first generation) migrants | Opportunity and snowball sampling | 60 participants (29f, 31m), 20 | "To explore migrants' experiences during | Semi-structured remote interviews | Qualitative | Novel analytical framework developed for |

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| | | based in England) | from China, Italy and Iran, who self-identified as being emotionally affected and having adapted their behaviour in an attempt to cope with the Covid-19 crisis in the UK. | | each being migrants from China, Iran and Italy | COVID-19 and discuss how they navigate through dissimilar host and home government's advice and policy regulations during their coping. " | conducted in mother tongue (Persian, Mandarin or Italian) | | the purpose of data analysis |
| Study 3 | Yen et. al. (2023). | United Kingdom | First-generation Taiwanese migrants in the UK (min of 5 years), from mainly middle-class backgrounds | Opportunity sampling | 22 Participants (14f, 8m) over 18 years. | To fully understand how COVID-19 affects specific migrant groups and their health | Two remote focus groups via Zoom of FB Messenger at T1 (March/April 2020) and T1 (October/November 2020). Conducted in Mandarin | Qualitative | Grounded theory |

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| Study 4 | Stewart & Sanders (2023) | United Kingdom | Migrants with experience of homelessness, some of whom may have received support from the specific homelessness scheme of which this study is an offshoot. | Targeted sampling via homelessness (Everyone In) scheme supporting migrants | 43 migrants | To explore life-story narratives co-produced with migrants across three urban contexts that capture their experiences of homelessness before and during the pandemic. To do this through the lens of 'Cultivated Invisibility' | Narrative life-story interviews | Qualitative | Thematic analysis of life stories, but findings presented focused on life stories of 4 participants. |
| Study 5 | Burns et. al. (2022) | Scotland | Three categorisations of participants: three | Opportunity sampling in collaboration with | 77 interviews (with an even gender | To explore the material effects of categorisation of | Remote (video and telephone) interviews, half of which | Qualitative | Thematic analysis of life stories, but findings presented |

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| | categories, though there is often fluidity between them: (1) people seeking asylum, including people refused and appealing and those considered appeals rights exhausted (and rendered destitute); (2) dispersal pathway refugees (people with refugee status granted through the asylum | project partners, as part of a wider UoG study | division) with people over 18, living in Glasgow at different stages of the asylum process or with refugee status. | migrant populations and the lived impacts of that categorisation during the COVID-19 pandemic. | required interpreters. | focused on life stories of 4 participants. |

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| | | | route) and (3) resettlement pathway refugees (people with refugee status resettled through Resettlement Programme (Vulnerable Persons Resettlement Scheme) | | | | | | |
| Study 6 | Kelly (2022) | UK | First- and second-generation migrants who were born (or whose parents were born) in a country different to the one they reside in | Opportunity then snowball sampling | 70 | To use Maslow's hierarchy of needs analysis and Urry's tourist-gaze as conceptual frames for assessing the emotional | 20 interviews and 50 qualitative surveys | Qualitative | Content analysis guided by Maslow's and Urrys frameworks |

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| | | | | | | impact of VFR (visiting family and friends) travel suspension on diasporic migrants who could not travel to their homeland for extended periods of time during the COVID-19 pandemic. | | | |
| Study 7 | Di Giuseppe (2021) | UK | Participants were people who had been granted or were seeking asylum in the UK, were at least aged 18, identified as LGBTQ+, | Sampling was via non-probability purposive critical case sampling method through partner | 27 participants | To explore how LGBTQ+ forced-migrants navigated the structural discrimination presented | 4 x 2 focus groups | Qualitative | "Instrumental case study approach's protocols, drawing on existing theory for an explanatory purpose (Yin, 2014)" |

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| | | | who attended at least 2 online social groups organised by the research partners and who were able to both communicate and understand English. | organisation | | within the system during the COVID-19 pandemic, using Meyer's minority stress model. | | | |
| Study 8 | Knights et. al. (2021) | UK | Study interviewed both PCPs and migrants. Interest is in migrant participants. | Opportunity, convenience and snowball sampling | 17 interviews were conducted with migrants: 15 (88.2%) with asylum seekers, and two with refugees (64.7% female; | To understand the pandemic's impact on recently-arrived migrants and their access to primary health care, and implications | Semi-structured interviews conducted remotely via telephone, 2 requiring interpreters. | Qualitative | Thematic analysis |

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| | | | | | mean age 38 years [range: 22–59 years]; mean time in the UK 4 years [range: 9 months–9 years]). Participants originated from 14 countries across five World Health Organization regions | for vaccine roll-out. | | | |
| Study 9 | Gordon (2023) | UK (Bristol) | Asylum seekers and migrants | Opportunity sampling via government bodies and NGOs supporting ASRs | "12 diverse purposively recruited ASRs in Bristol, together representing seven countries. Six were | To explore the attitudes to and experiences of the COVID-19 vaccination among asylum seekers and | Semi structured interviews of 12 asylum seekers and refugees. 6 required interpreters. | Qualitative | Thematic analysis |

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| | | | | | part of a UK Home Office (UKHO) resettlement programme, and six had arrived in the UK by independent means. (7m, 5f) between 23 and 48 years" | refugees (ASRs) | | | |
| Study 10 | Cheng et. al. (2023) | London (UCL) | UK international students over 18 years. | Opportunity and snowball sampling | 13 PhD students at various stages. | To explore UK international students' perspectives of migration mobility during COVID - 19, compared to Singapore international students. | Qualitative interviews | Qualitative | Thematic analysis |

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| | | | | | | Interest is in UK participants' data. | | | |
| Study 11 | Tschalaer, (2022) | Glasgow, Birmingham, Cardiff, Brighton, Belfast, and London. | UK Migrants/Asylum seekers who identify as LGBTQ+ | Opportunity and snowball sampling | Data was collected from 14 interviews with social/charity workers, asylum claimants and refugees affiliated with NGO help organisations . Interest only in migrant participants' data. | "To explore the UK Government approach to providing LGBTQI+ asylum claimants' access to safe accommodation and health service during COVID-19" | Autobiographical interviews | Qualitative | Unclear if themes AND discourse analysis |
| Study 12 | Miles et. al. (2023) | UK | Gypsy, Roma and Traveller communitie | | 27 migrant workers, including but not | To explore migrant workers' expe- | Qualitative interviews | Qualitative | Thematic analysis |

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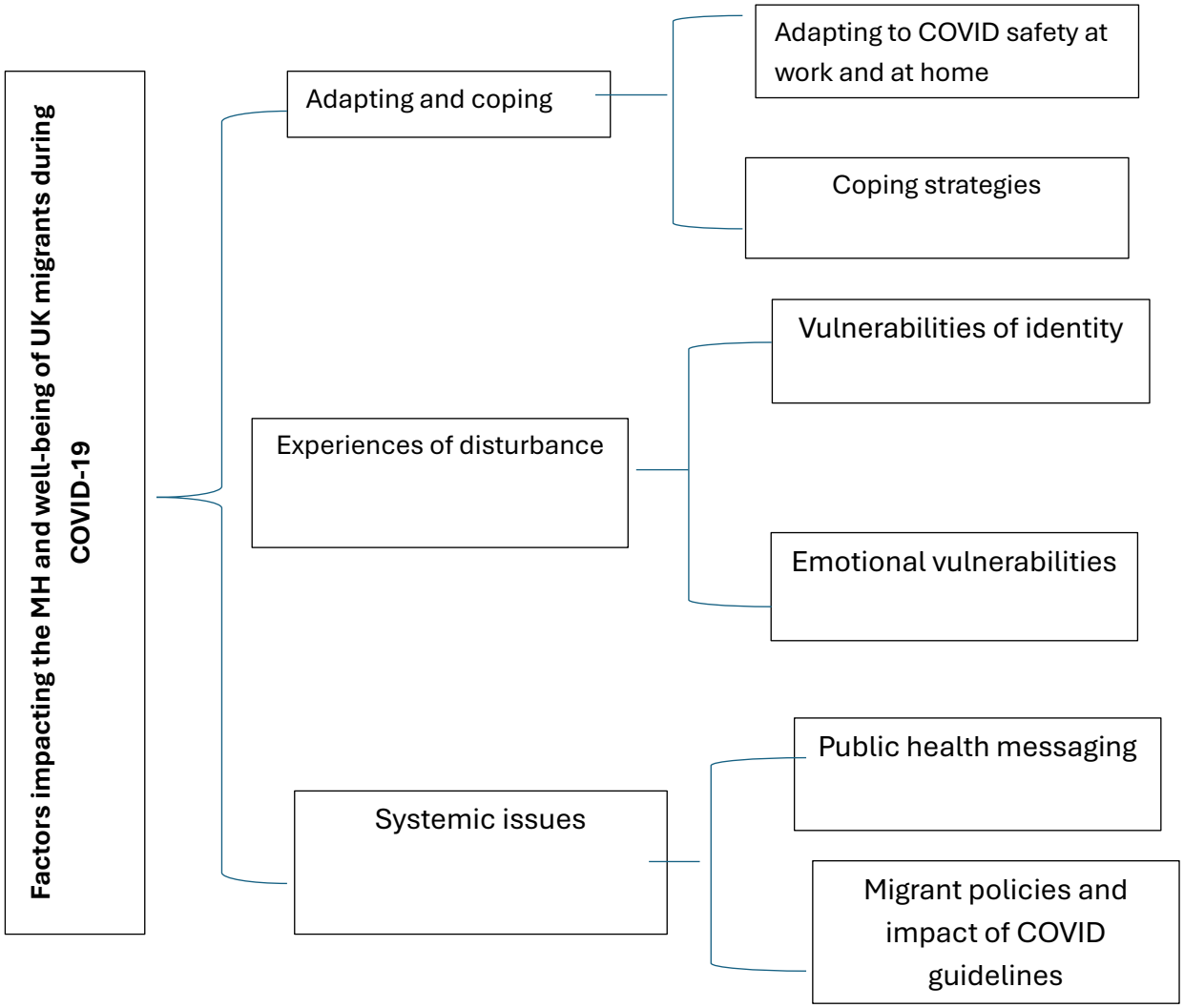
| | s and migrant workers in precarious jobs | limited to Roma migrant workers in English and Romanian with interpreters required. | riences of navigating COVID-19 risks at work and its impacts on their home space |

Narrative synthesis of results

From the final set of 12 studies included, three primary themes that impacted the mental health of migrants and refugees in the UK during COVID-19 were identified as follows: i) 'adapting and coping', ii) 'experiences of disturbance', and iii) 'systemic issues'. Although these themes are interconnected (see Figure 2.2), they are also distinct.

**Figure 2.2 Visual representation of the relationship between results**




*Theme 1: Adapting and coping*.

It was highlighted that migrants and refugees experienced difficulties adapting to the pandemic, adopting personal safety measures at work to protect themselves, and safety

measures at home to protect their families. To manage the uncertainties and anxieties of the pandemic, people relied on various resilience factors. Two sub-themes were linked to adapting and coping: adapting to COVID safety at work and at home; and coping strategies.

*i). Adapting to COVID-19 safety at work and at home:*

The study's results revealed the challenges participants faced during the pandemic and lockdown in terms of adapting to safety measures at home and in the workplace. Migrant workers who had recently arrived in the UK had to learn how to work with people from different cultures and countries while also adjusting to COVID-19 safety protocols in their workplaces. The participants compared the safety guidelines and regulations in the UK with the current COVID-19 guidelines and regulations in their home countries (Saleem et al., 2021; Yen et al., 2021).

Describing her experiences, a Pakistani doctor who recently arrived to work in the UK said:

*"…Ah, there is a huge difference in everything, from personal to professional, my life got upside down, I was only hijabi doctor in the ward, my English language accent was different had issues both to understand and to convey my message, I almost lost my confidence". (Saleem et. al., 2021, p.4).*

Various participants in healthcare roles shared their concerns about workplace safety measures, with some workplaces implementing robust protections while others failed to do so (Saleem et al., 2021; Miles et al., 2023). Many expressed concerns about inadequate personal protective equipment (PPE) distribution, the absence of social distancing measures, and the lack of sick pay benefits. Despite their dissatisfaction with the level of protection provided in their workplaces, many participants felt compelled to continue working due to financial necessity.

A factory worker expressed concerns about the limited safety policies in place in her workplace:

*"... everyone passing, touching you... you still work. People in the factory have it, but you still come into work. Nobody stay home." (Miles et al., 2023, p.7).*

Describing their experiences, a care home staff said:

*"... It was difficult, because most of the residents were not having proper care at that time. We were short of staffs [sic], people phoning in sick..." (Miles et al., 2023, p.7).*

The participants expressed their concern about the safety of their families. They were worried that they might transmit an infection to their loved ones. To mitigate this risk, they adopted safety strategies such as isolating themselves from their families, wearing masks while outside the home, washing their hands frequently, and disinfecting their clothes before entering the house.

*"...I divide my home into two areas; one is green and the other is red. The red zone is the highest risk level and is used for anything that we brought home from outside. I bought Isopropyl alcohol spray and rubbing alcohol to deep clean everywhere in my house, especially the stuff we brought from outside (in the red zone), such as jackets, clothes, mobiles, etc..." (Yen et al., 2023, p.13-14).*

Adapting to the pandemic was particularly challenging for asylum seekers and refugees, who had to deal with safety concerns while residing in temporary accommodation. One participant shared their experience:

*"When you think of the demand of social distancing, for us it is very difficult especially when living in a shared accommodation. How can the government control infections when there are other people that are unable to isolate themselves?" (Di Giuseppe 2021, p.48).*

*ii). Coping strategies:*

Participants reported several strategies to cope with the experience of lockdown. Two coping mechanisms stood out: (i) faith or belief in a higher power (Saleem et al., 2021; Miles et al., 2023) and (ii) connectedness to family or other community of support (Yen et al., 2021; Kelly, 2022; Di Giuseppe, 2021; Gordon, 2023).

Describing the resilience she got from her faith, a migrant doctor working in an NHS hospital showed that this played a role in her ability to cope with the pressure of work:

*"I reminded myself that only what Allah wants will happen, as I don't have an extended family system here to share my fears, my connection to Allah became stronger during these times". (Saleem et al., 2021, p.4).*

This was similar to how a migrant factory worker expressed her faith:

*"... only God keeping us..." (Miles et al., 2023, p.7).*

Participants would connect to online communities, and even form new ones when possible. These communities were usually connected through work, family, or through belonging to common migrant backgrounds. Within these groups, ideas about COVID safety and vaccine information were shared. An Iranian healthcare professional described this below:

*"I have a chat group with my colleagues, and we help each other with regard to what to buy and what to do. For example, at the beginning of this situation, when there was a shortage of toilet paper, eggs and rice, we used to let each other know where to go and buy them". (Yen et al., 2023, p.1232).*

For people whose families were separated by distance, technology played a significant role in keeping them connected during the lockdown, as described by one participant below:

*"... my mum had never used a laptop before COVID, and she only used her phone to call people. It was an old one so we had to try have someone help her to set up WhatsApp and Zoom..." (Kelly, 2022, p.645).*

A key point that emerged here was the impact of digital poverty on migrants who lacked access to wifi, smartphones or computers. This was mostly experienced by people seeking asylum, who did not have rights to work, and had limited access to funds, as described by this participant:

"*You have limited data just only 20GB. It's crazy because 20GB just are two hour then finish..." (Burns et al., 2022, p.4076).*

For asylum seekers and refugees who identified as belonging to the LGBTQ+ community, connectedness to a safe community was crucial to their sense of wellbeing. Describing how valued she found an online social group for LGBTQ+ asylum seekers/refugees, a lesbian refugee said:

*"The online social group has helped me to overcome my mental issues. Sometimes I am so depressed and stressed but then when I log into the socials I forget all my worries, the loss of work or being on my own". (Di Giuseppe, 2021, p.53).*

*Theme 2: Experiences of disturbance*.

Results showed that some of the difficult experiences unique to migrants and refugees in the UK were heightened during the pandemic. These included perceived discrimination, racism and marginalisation directed at them because of their identities; and emotional difficulties such as stress and anxiety. Two sub-themes were linked to this theme, as outlined below.

*i). Vulnerabilities of identity*

Findings showed that participants' vulnerabilities as migrants/refugees were linked to negative experiences reported during the pandemic. Such experiences were reported in some form across all 12 studies. In some cases, these were overt experiences of ethnic

and/or racial discrimination, and in other cases, these were indirectly experienced via participants' exposure to media accounts of racism and discrimination (Yen et al., 2021; Yen et al., 2023 and Tschalaer, 2022). Describing his experience, a Taiwanese migrant participant reported:

*"... we have to worry if anyone will attack us because of our look. I've never experienced racism until now. This experience just makes me angry, and I do not want to be part of this [Britishness]. It has made me want to be Taiwanese more." (Yen et al., 2023, p.13).*

Migrants with intersections of marginalised identities reported difficult experiences linked to this. Some LGBTQ+ asylum seekers described the impact as follows:

*"It's like double negative, because number one you are refugee, number two is sexuality". (Di Giuseppe, 2021, p.46).*

*"Where I am coming from, I was not accepted because of my sexuality. Here, I haven't been accepted because where I am coming from. Things are tougher with the lockdown because I depend on friends..." (Di Giuseppe, 2021, p.46).*

Homelessness and living in temporary accommodation contributed to difficulties experienced by migrants (Stewart & Sanders, 2023; Burns et al., 2022 and Gordon, 2023). A migrant participant described their experience of homelessness as follows:

*"Nobody can give you anything if you be sleeping rough. You've got no shaving, you've got no clean shoes, you've got no clean you, didn't have a shower for three months, four months, so I don't think that somebody will interested to give you accommodation, forget about a one bedroom flat." (Stewart & Sanders, 2023, p.137).*

Findings showed that asylum seekers also struggled with other difficulties linked to finances. This was sometimes experienced as an absence of agency or stripping of choice, as described by the two participants below:

*"I have to choose wisely how to use my £38 per week between bread, masks or money to call my mum." (Burns et al., 2022, p.4075).*

"*We need to lose the dignity and to explain every time to the shop owner or the pharmacist that we have to answer without the mask, because we are asylum seekers, and we don't have enough money to buy masks. It is very humiliating." (Burns et al., 2022, p.4075).*

*ii). Emotional vulnerabilities*

Participants described being emotionally impacted by the pandemic (Saleem et al., 2021; Yen et al., 2021; Yen et al., 2023; Kelly, 2022; Di Giuseppe, 2021; and Tschalaer, 2022).

In the words of one participant:

"*Now we have all become numb; we don't even want to watch TV or read the news. It is all useless. I change the channel as soon as I see Boris Johnson's face on the TV . . . Is this the place where I want to be for the rest of my life?" (Yen et al., 2023, p.16).*

Psychological pain, fear and uncertainty were experienced to varying degrees. Some felt disconnected from the UK society and even lost their sense of belonging. As the pandemic continued, people had to rely on their temporary coping strategies for longer periods, leading to cognitive and emotional exhaustion (Yen et al., 2023).

Due to travel restrictions, many people were unable to see their family members for extended periods. This added to the fears and worries of migrants for themselves and their loved ones, leading to feelings of loneliness and isolation. Moreover, the lockdown experience triggered symptoms of past trauma in some cases, as reported by Yen et al. (2023), Kelly (2022), and Di Giuseppe (2021). Additionally, individuals who were unable to see their family members due to lockdown restrictions reported feeling guilty following the loss of their loved ones. Below are some quotes that describe these experiences:

*"… You are not a person, you're lost. I don't have anything. During the lockdown everyone has family, they are in one place together. But you… are lonely. When you are inside the house you feel that something is missing, that you're nothing. You as a person, you are irrelevant to this world". (Di Giuseppe, 2021, p.50).*

*"… sadly, we lost my father in the first wave of COVID. The rest of my family are still in India, and they were there. I feel like I let him down, and let them all down really. I am making plans… to try make amends and to try make peace with what happened. I need to be near my father- his places, even if he is not physically there anymore". (Kelly, 2022, p.645).*

*Theme 3: Systemic issues*.

The review findings showed failings within the system to adequately include refugees and migrants. Information was not always provided in accessible language or visual formats, guidelines/rules regarding social distancing did not always account for how this may be challenging for people in temporary accommodation as many study participants were. Furthermore, the lockdown led to reduced support for some migrants and refugees, due to partial or complete closure of services they relied on for support such as charities and faith centres like churches and mosques. Two sub-themes were linked to this theme: public health messaging and migrant policies and impact of COVID guidelines.

*i). Public health messaging*:

Findings showed that public health messaging was not always inclusive of migrants and refugees due to a lack of accessible language and formats. Participants therefore turned to social media and television as their primary sources of information. (Di Giuseppe, 2021; Knights et al., 2021 and Miles et al., (2023). Primary news sources cited by participants included social media and television, however they felt that information dispersed via these channels were:

*"… lacking the existence of people who do not live the same as the British people". (Di Giuseppe, 2021, p.48).*

As a result, many felt invisible and left behind:

*"... there is nothing about the immigrants, they are just left behind like if they're nothing or they are not normal..." (Di Giuseppe, 2021, p.48).*

In the absence of relevant information, people sought out public health information from their home countries, which they sometimes compared with the UK guidelines, (Saleem et al., 2021; Yen et al., 2021). This perpetuated health illiteracy amongst the migrants, and allowed the spread of misinformation (Gordon, 2023). Describing this, one participant said:

*"Some of the people, culturally, they don't believe that such a virus exists. They think that it's 5G or something else. They rely on other news, so, that's why, in order to change their minds and kind of make them believe, there should be an effective system of information." (Knights et al., 2021, p.e589).*

Health literacy limitations and misinformation invariably had an impact on vaccine rollout, meaning that people made decisions about vaccine uptake based on whatever vaccine attitudes were prevalent in their local communities. This is better understood from this quote by a participant:

*"I ask you, you've got the jab, you said yes, of course I've got twice, so I ask another one, "Have you got the jab?" "Yeah, yes, I've had it once," so it kind of encourages* [me that] *everyone has got, why I didn't?" (Gordon, 2023, p.7).*

*ii). Migrant policies and impact of COVID guidelines***:**

The framing of the UK migration policies as supporting a hostile environment for migrants created an atmosphere of fear and anxiety which impacted migrants' healthcare help-seeking (Yen et al., 2021; Di Giuseppe, 2021 and Miles et al., 2023). Access to healthcare for migrants was further impeded by a mistrust of government, language barriers and indirect discrimination, as described below:

*"Sometimes it's very difficult when you have an appointment of five minutes because English is not my first language. Before I manage to find the words five minutes are already gone, so there is not much information I can get". (Stewart & Sanders, 2023, p.44).*

Asylum seekers and refugees were impacted by the lockdown in terms of loss of support systems. Many charities and services which offered previously support completely shut down or adapted support to be offered online only (Burns et. al., 2022; Di Giuseppe, 2021 and Cheng et. al., 2023). In the absence of statutory support, migrants were significantly impacted, as described below by an asylum seeker:

"*... before the lockdown, that's where we normally go (community group), to share, you know, share experience, we learn about things, new things. And during the lockdown, that was, that's nearly stopped, you know, no meetings, we can't meet people, you know, we can't go up there."* (Burns et al., 2022, p.4076).

## Discussion

The purpose of this review was to investigate the personal experiences of migrants and refugees who were present in the UK during the COVID-19 pandemic. Additionally, this review aims to examine the impact of COVID-19 on the mental health and wellbeing of these individuals. After conducting a thorough search and screening, 12 studies were included in this review. The final analysis resulted in identifying three main sub-themes as follows: i) 'adapting and coping', ii) 'experiences of disturbance', and iii) 'systemic issues'. All three main themes had two sub-themes each. To understand the mental health of migrants and refugees during the COVID-19 pandemic, we need to consider the various interconnected factors that affect their wellbeing. In the current study, we have identified several factors that are intertwined and influence each other in complex ways. Adjusting to safety measures can be challenging for migrants and refugees, as they navigate unfamiliar healthcare systems, cultural norms, and socioeconomic conditions. This process is influenced by vulnerabilities related to identity, including experiences of discrimination and marginalisation, which can exacerbate feelings of alienation and distress. There is a lot of uncertainty and concern around the safety and wellbeing of migrant groups. Research has shown that it is important to provide them with accessible healthcare information (Lee et al., 2013). Without such adaptions, migrant communities may feel stigmatised, which could prevent them from accessing mental health support, as suggested by Simkhada et al. (2020).

Findings from this review highlighted the role of coping strategies relied on by migrants during the pandemic. Existing research supports the role of coping strategies to reduce the impact of stress on mental health during COVID-19, however, the effectiveness of such strategies is thought to depend on the availability of resources and support networks for individuals (Budimir et al., 2021). During the pandemic, religious and faith beliefs served as a source of comfort and resilience. Unfortunately, social distancing measures and lockdown restrictions limited access to faith communities and practices for a significant period, resulting in a negative impact on the psychological wellbeing of some faith communities (Hassan et al., 2021). It has been observed that individuals who participated in online religious activities at least once a week experienced better wellbeing (Taylor, 2022). The identities of migrants can determine the resources they

have access to. Settled migrants have more support available to them than unsettled migrants and asylum seekers due to a 2-tier system of migration. This system provides support and resources based on the pathway through which an individual arrived in the UK, rather than an objective assessment of their needs. The availability of community resources can help promote resilience and wellbeing in the face of difficulties. Some migrant communities have adopted forms of psychological flexibility as part of their resilience strategies during the COVID-19 pandemic, as evidenced by research (Srivastava et al., 2021). Provision of social support and access to faith communities can support the ability of this population to draw on the resilience factors highlighted by the results of this review.

Current findings of this review show that the COVID-19 pandemic significantly impacted the emotional and psychological wellbeing of UK migrants and refugees. Multiple studies, including those conducted by Guadagno (2020), Spiritus-Beerden et al. (2021), and Garrido et al. (2023), have documented their experiences of loneliness, fear, grief, and trauma; consistent with current findings. The pandemic has led to pervasive feelings of loneliness among migrants and refugees, which can be attributed to several factors such as social isolation, language barriers, and loss of community support networks. The negative effects of social isolation on mental health are well-established, with loneliness being associated with an increased risk of depression, anxiety, and other psychiatric disorders (Brandt et al., 2022). The pandemic intensified feelings of social exclusion and alienation, exacerbating the sense of loneliness and isolation that migrants and refugees already experience due to cultural differences and discrimination. The cumulative impact of these stressors can lead to chronic mental health conditions, including depression, PTSD, and complex trauma, further compromising the overall health and wellbeing of migrants and refugees. Migrant mental health is intricately tied to social determinants of health, reflecting the impact of factors like socioeconomic status, access to healthcare, living conditions, and experiences of discrimination (Castañeda et al., 2015). These determinants contribute to mental health inequalities among migrant populations, influencing their susceptibility to mental disorders and access to care. It is crucial to address the disparities in health outcomes, as highlighted by studies aimed at reducing health inequalities in the UK population (Marmot et al., 2020). Policies and

interventions that focus on socioeconomic factors, access to healthcare, and social inclusion are essential for promoting the mental wellbeing of migrants and reducing health inequities (Artiga et al., 2019; Compton & Shim, 2015). By addressing these determinants, policymakers can work towards achieving more equitable mental health outcomes for migrants, which will also benefit the wider UK population.

## Clinical implications

The results of this review provide valuable insights into the clinical implications for psychologists and wider healthcare professionals working with migrants. By drawing from the findings of research studies focused on the COVID-19 pandemic, clinicians can adapt to deliver effective support for migrant communities and prepare for future public health crises. Understanding the clinical implications of supporting the mental health of this population is crucial for providing effective care and promoting wellbeing. A key consideration is to adopt culturally sensitive assessment and intervention (Lau & Rodgers, 2021). This includes understanding cultural beliefs, including beliefs about mental illness and help-seeking for mental health, and other cultural values and norms that may influence mental health beliefs and help-seeking behaviours. Conducting culturally sensitive assessments can facilitate rapport-building and enhance the effectiveness of interventions when supporting people with marginalised identities (Duden & Martins-Borges, 2021).

Many migrants and refugees have gone through traumatic experiences before, during, and/or after migration, including persecution, violence, and displacement. By adopting a trauma-informed approach to care, psychologists and mental health clinicians will model the principles of this framework of care: safety, trustworthiness, choice, collaboration, and empowerment to the people they support (Scottish Govt, 2021). This approach involves creating a safe and supportive therapeutic environment, validating clients' experiences, and addressing trauma-related symptoms and triggers. It is important to approach this from a place of curiosity and willingness to learn, understanding that not all migrants may have experienced trauma, but being equipped to support those who have. For those who have experienced trauma, trauma-focused

interventions such as trauma-focused cognitive behavioural therapy (TF-CBT), eye movement desensitisation and reprocessing (EMDR), and narrative exposure therapy (NET) may be beneficial (NICE, 2018). These interventions help clients process traumatic memories, manage distressing symptoms, and build coping skills to improve their overall functioning.

Although migrants and refugees face tremendous obstacles, they exhibit resilience, resourcefulness, and strengths that can be utilised in the therapeutic process. Psychologists and clinicians are encouraged to adopt a strengths-based approach that acknowledges their clients' strengths, assets, and cultural resources, empowering them to overcome adversity (Padesky & Mooney, 2012). Psychologists and mental health clinicians should consider the socioeconomic challenges encountered by migrants when developing their assessment and intervention methods. They should advocate for resources and services that tackle the underlying social determinants of health. This includes building inclusive environments that validate their clients' identities and experiences.

Beyond this, there is an urgency for psychologists and clinicians to approach the support of migrants and refugees with deep empathy and understanding, recognising the immense burden these individuals carry as they navigate systems that often fail to fully meet their needs. Migrants and refugees face the daunting task of coping and surviving within a healthcare system that may not always identify them, see them or understand their unique challenges. Clinicians must move beyond simply being open and curious, to actively reflecting on these experiences and the systemic inequities that place such a heavy burden on this population. By adopting a more compassionate and reflective approach, healthcare professionals can shift the responsibility of care from the individual to the system itself. This will require proactively identifying migrants as they encounter services and addressing their needs. When there is uncertainty about an individual's identity, clinicians can help clarify this through thoughtful questions about people's identities and experiences of integration, especially in cases where patient record systems have not been set up to adequately capture such information. Inquiries of this sort should be a fundamental part of routine assessments and psychological

formulations, not only during global crises but also in normal times, ensuring that the system takes ownership of its role in reducing the personal burden on these vulnerable populations. Ultimately, this approach fosters a more just and supportive environment, where the healthcare system is responsible for alleviating, rather than exacerbating, the challenges faced by migrants and refugees.

### Strengths and limitations

A strength of this study is that the systematic review followed established guidelines, including the ENTREQ guidelines and PRISMA statement, ensuring transparency and replicability of the review process. The use of a systematic review protocol registered on PROSPERO enhances the credibility of the study by predefining inclusion/exclusion criteria and search strategies. The review employed a thorough search strategy across multiple electronic databases, supplemented by secondary searches on Google Scholar and manual search of references. By using a combination of keywords and database-specific search terms, the review maximised the retrieval of relevant literature.

By focusing on qualitative studies, the review captured a range of perspectives and experiences related to the COVID-19 pandemic among migrants and refugees in the UK. The use of the SPIDER tool and clear eligibility criteria ensured that studies included in the review were relevant to the research question. The review provided detailed information on the screening and selection process, including the criteria used to include or exclude studies. The use of a systematic review tool (Rayyan) facilitated the screening process and minimised the risk of bias in study selection.

As part of the review process, a quality assessment was carried out on the included studies, using the CASP qualitative assessment checklist. This systematic evaluation of methodological robustness and ethical considerations enhances the credibility of the findings and informs the interpretation of results.

The review only included studies published in English, creating a language bias and potentially excluding relevant literature published in other languages. This language

restriction may limit the generalisability of findings and overlook important perspectives from non-English speaking migrant communities. The eligibility criteria for inclusion in the review were narrowly defined, focusing specifically on migrants and refugees living in the UK during the COVID-19 pandemic. While this specificity enhances the relevance of findings to the target population, it may limit the generalisability of results to other contexts or migrant populations.

The quality assessment identified a lack of reflexivity in the majority of included studies, indicating a potential limitation in the depth of self-awareness and critical reflection among researchers. This limitation may impact the trustworthiness and interpretability of study findings. The included studies employed a variety of qualitative methodologies and data collection techniques, contributing to methodological heterogeneity across the review. While a narrative synthesis was deemed appropriate for synthesising findings, the heterogeneity could have impacted the synthesis of results across studies.

The use of the CASP (Critical Appraisal Skills Programme) Quality Assessment Framework here has some limitations. The CASP tool employs a 10-point rating system that, while straightforward, may oversimplify the nuanced and complex nature of qualitative research. Additionally, CASP is generally applied only to peer-reviewed publications, introducing a risk of publication bias. This bias occurs because peer-reviewed studies are more likely to be published if they yield positive or significant findings, potentially distorting the overall research landscape. Furthermore, the CASP rating itself has minimal influence on the inclusion decisions within a paper and fails to adequately highlight areas where further research is needed. This means that CASP does not effectively highlight which studies should be approached with caution or whether it would alter the review's overarching conclusions. Another limitation of CASP is its focus on the absence of reflexivity in the studies it assesses. Reflexivity is indeed a crucial element of qualitative research; however, its omission in published articles often results from word count limitations rather than a lack of reflexive practice by the researchers. Thus, CASP's emphasis on reflexivity may not always provide an accurate reflection of the research quality or depth.

Considering these limitations, alternative quality assessment tools should be explored in future research. The LEGEND (Let Evidence Guide Every New Decision) tool (Clark et al., 2009), for example, offers a more comprehensive framework by incorporating a wider range of criteria and providing a more detailed assessment of research quality and applicability. Unlike CASP, LEGEND is designed to account for various types of evidence and reduce the impact of publication bias. It also emphasises the implications of study quality for the overall findings of a systematic review, offering a more robust approach to assessing and interpreting qualitative research. For an extended critique of CASP's limitations, see Long et al. (2020) and Garside (2014).

While the systematic review employed rigorous methods to identify and synthesise qualitative literature on the experiences of migrants and refugees during the COVID-19 pandemic in the UK, it is important to acknowledge its limitations. Addressing these limitations through future research efforts, such as including studies published in multiple languages and conducting meta-synthesis to integrate findings across diverse methodologies, can enhance the robustness and applicability of evidence in this field.

Areas of future research:

Future research could address the language bias identified in the systematic review by including studies published in languages other than English. This would involve expanding search strategies to include non-English databases and conducting translations of relevant literature. By broadening language accessibility, researchers can capture a more diverse range of perspectives and experiences among migrant communities, thereby enhancing the comprehensiveness and representativeness of findings. To mitigate potential publication bias in future research, gray literature could be included such as conference proceedings, preprint repositories, and reports from non-governmental organisations. By incorporating unpublished or non-peer-reviewed sources, researchers can provide a more balanced representation of the evidence base.

Future studies could aim to enhance the generalisability of findings by expanding the scope of research to include diverse migrant populations and geographical contexts. This could involve conducting comparative studies across multiple countries or regions to identify commonalities and differences in experiences of migration and health. Moreover, researchers could adopt mixed methods approaches to complement qualitative data with quantitative data, providing a more comprehensive understanding of the complex factors influencing migrant health outcomes.

To address methodological heterogeneity across studies, future research could employ meta-synthesis techniques to integrate findings from diverse qualitative methodologies. Meta-synthesis involves systematically analysing and synthesising findings across multiple qualitative studies to generate higher-order interpretations and theoretical insights. By synthesising heterogeneous methodologies, researchers could identify overarching themes, patterns, and conceptual frameworks that transcend individual studies, thereby advancing theoretical understanding and informing policy and practice in migrant health.

## Conclusion

This systematic review of qualitative literature on the experiences of migrants during the COVID-19 pandemic provides valuable insights into the multifaceted challenges and resilience of migrant communities. The strengths of the review, including adherence to rigorous methodological guidelines, comprehensive search strategies, and critical appraisal of study quality, enhance the credibility and reliability of the findings. However, limitations such as language bias, publication bias, and methodological heterogeneity underscore the need for further research to address these gaps and enrich our understanding of migrant health experiences.

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**Chapter Three: Bridging Chapter**

**Word Count: 373**

The previous chapter provided an in-depth systematic review and synthesis of the experiences of migrants and refugees already present in the UK during the pandemic. It also aimed to examine the impact of COVID-19 on the mental health and wellbeing of these individuals. A narrative synthesis of the 12 studies highlighted three main themes with two sub-themes each as follows: 'adapting and coping', with sub-themes 'adapting to COVID safety measures at work and home' and 'coping strategies'; 'experiences of disturbance', with sub-themes 'vulnerabilities of identity' and 'emotional vulnerabilities'; and 'systemic issues', with sub-themes 'public health messaging', and 'impact of migrant policies and COVID guidelines'. The systematic review findings showed that where migrants and refugees already face disadvantages and barriers on their post-migration journey, these were significantly exacerbated by the COVID-19 pandemic and the periods of lockdowns which occurred as a result. Results also showed the need for targeted support and interventions that contextualise the unique experiences of this population.

The systematic review findings are in line with existing research indicating that migrants generally have worse outcomes in terms of physical, mental, and social wellbeing when compared to the general UK population (Lebano et al., 2020). The findings of the review highlight a need to further understand the problems faced by migrants as they integrate into UK life. Despite the increased recruitment of migrants to support the UK healthcare workforce during the pandemic (Stievano et al., 2021), the systematic review uncovered that there is a gap in empirical research exploring the experiences and views of migrant healthcare staff recruited to work in the UK during the pandemic. Given that 17% of the NHS workforce are from outside of the UK (NHS Digital, 2024), and there were reported rises in mental health problems in healthcare professionals during the pandemic (Hill et al., 2022), the views of migrant healthcare professionals about COVID-19 and mental health is an important unexplored research area. This study aims to add to the body of work by including the perspectives of this cohort of migrant healthcare staff on working life in COVID-19 within the NHS and factors influencing their mental health. Results will aid in understanding what the current climate means for migrant nurses considering coming to the UK to work.

**Chapter Four: Empirical Paper**

Word count: 9443

Empirical paper prepared for submission to Journal of International Migration and Integration

Author guidelines can be found in Appendix A

# "It was hard for them to include us": A Qualitative exploration of mental health perspectives and experiences of international nurses recruited to work in the NHS during the COVID-19 pandemic.

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**Abstract**

**Background:** Since the COVID-19 pandemic, the NHS has increasingly relied on internationally trained healthcare staff, with migrant nurses playing a crucial role in post-pandemic care. However, they face significant challenges in professional integration. Given the current trend of nurses leaving the NHS, understanding the experiences of those who arrived after the pandemic's onset is essential for the future of UK healthcare.

**Aims/Purpose**: This study explored the following questions: (i) What are the experiences of migrant nurses who arrived to work in the UK since the COVID-19 pandemic? and (ii) What are the psychological impacts of these experiences?

**Methods:** Participants (n=11) were recruited from a single NHS Mental Health Trust for this qualitative study. A purposive sampling strategy was employed to ensure a diverse range of perspectives. Data were collected through in-depth, semi-structured interviews. The interviews were guided by open-ended questions designed to explore participants' professional integration and personal adaptation processes. Thematic analysis was employed to analyse, and report patterns within the data, providing a comprehensive understanding of the participants' lived experiences.

**Results:** Four overarching themes emerged: 'Shattered promises about hopes for the future' highlighted the gap between pre-migration expectations and harsh UK realities. 'Being an outsider' reflected participants' sense of alienation on arrival to the UK. 'The strain of adaptation' addressed emotional challenges, and 'Having to survive' detailed participants' coping strategies.

**Conclusions:** Findings highlight the urgent need for healthcare systems and teams to recognise and address the specific challenges encountered by internationally trained nurses. By understanding their unique experiences and offering targeted support, the NHS can significantly enhance their integration and retention. These actions are critical to ensuring the long-term stability and efficiency of the healthcare workforce.

UK migrants and refugees' experiences and mental health impact of the COVID-19

*Key words: migrant, immigrant, international, foreign, overseas, NHS, nurses*.

## Introduction

*Background*

Migrants play a significant role in the UK's National Health Service (NHS) workforce (NHS, 2024). The numbers of healthcare professionals migrating to the UK have been influenced year to year by demand, immigration rules, and Department of Health policies on overseas recruitment (Mitchell, 2021). The recruitment of migrant healthcare staff in the NHS is occurring amidst post-Brexit national identity anxieties, racial and ethnic tensions, and strict immigration policies (Spiliopoulos & Timmons, 2022; Ciupijus et al., 2022; Home Office, 2024 and Stievano et al., 2021). This context is significant, given some evidence suggesting that while the NHS recruits migrant workers to meet specific staffing needs, it does not always fully value them (Spiliopoulos & Timmons, 2023). Migrant nurses in the NHS face several professional inequalities, impacting their overall wellbeing and quality of life. There is also potential for health inequalities to arise due to the financial constraints faced by new migrant nurses from the costs of their own visa renewals and visa costs for any immediate family members (spouses or children) joining them in the UK. The NHS Core20Plus5 strategy aims to reduce health inequalities for the most deprived 20% of the UK population in five core areas of healthcare, including mental health (National Health Service, 2021). This strategy relies heavily on the UK mental health workforce, which includes mental health nurses, including migrant nurses. Despite the reliance on migrant healthcare workers, there is limited understanding of their perspectives and the impact of their dual positioning within the NHS: they belong to the valued NHS workforce but are also part of the migrant group often blamed for adding pressure to the healthcare system. This dual positioning may have an impact on their wellbeing (Ciupijus, 2023).

Studies indicate that Black migrant nurses, for instance, report fewer opportunities and more discrimination compared to their British and other overseas counterparts, as well as increased stress resulting from experiences of racism (Likupe & Archibong, 2013). Nurses also report perceptions of "othering", or being treated differently, within the workforce, where migrant nurses feel excluded (Spiliopoulos & Timmons, 2022). Here, 'othering' refers to the segregational dynamics through which people in one group (usually the majority), construct their perception of those they see as different, framing

them as non-belonging to the group (Akbulut & Razum, 2022). Such factors can impact their overall wellbeing and quality of life, and this is the same for migrant healthcare staff's perception of discrimination (Tuttas, 2015).

However, it remains unclear to what extent these differences apply to migrants accepted into the NHS workforce, including refugees and non-refugees (Knausenberger et al., 2022); this being under-researched. Migrant nurses face numerous challenges whilst integrating into a new healthcare system (Li et al., 2014). These experiences can be understood through the lens of psychological theories of integration such as acculturation theory (Hernandez, 2009). Acculturation here refers to the dynamic psychological and cultural processes that occur when an individual encounters a different culture (Berry, 2017). This theory acknowledges that migrants face a dual process of acculturation involving both their original culture and the host culture. This implies that UK migrant nurses must balance retaining elements of their home culture while embracing aspects of British culture (Hajro et al., 2019). To integrate effectively into the UK healthcare system while maintaining their cultural identity, migrant nurses must navigate through these strategies. Recognising and addressing migrant stressors can contribute to successful integration (Hajro et al., 2019). It is essential for the systems that invite migrant nurses to understand how to reduce the stressors embedded within its structures, so as not to cause harm.

The experiences of international nurses can be influenced by factors that contribute to health inequalities (Allan et al., 2009) and that cause them to leave the NHS and/or the UK. This study seeks to understand the impact of COVID-19 on migrant nurses in the context of their having arrived to work in an NHS permanently impacted by COVID-19. The 'COVID-19 impact' here then is not centred on their experiences of the pandemic, but rather on their experiences in an NHS now impacted by COVID-19. Examining the impact of the pandemic on these healthcare professionals, who were recruited to work since its onset, and within mental health teams vastly different from those where they trained, offers a unique research perspective to understand invisible health inequalities within the UK migrant workforce.

Research aims

This research therefore aims to:

(i). Understand the experiences of migrant nurses arriving to work in the UK since the COVID-19 pandemic.

(ii). Understand any psychological impact of these experiences - this is crucial to developing targeted support strategies and ensuring the wellbeing for this specific group (Sheraton et al., 2020).

## Methods

*Design and Approach*

This study adopted a qualitative approach. The report adheres to the guidelines prescribed in the Standards for Reporting Qualitative Research (SRQR): A Synthesis of Recommendations (O'Brien et al, 2014) to enhance the quality and transparency of the study. See Appendix G.

*Epistemology*

The current research adopts the perspective that Thematic Analysis (TA) is epistemologically and ontologically neutral by nature, as it is a method rather than a methodology (Braun & Clarke, 2021). Thus, it allows for researcher flexibility, positioning, and critical thinking (Smith, 2003). Given that the role of TA is to extract meaning from participants' self-reported experiences (Clarke et al., 2015), the research adapts to the position of critical realist/contextualist to include both the researcher's and participants' interpretations (Clarke et al., 2015). This approach enables access to participants' own reality through their language and the researcher's interpretation of their reality (Al-Saadi, 2014). It is essential to note that the researcher's position also impacts the

understanding of reality (Madill et al., 2000), highlighting the need for researcher reflexivity.

*Researcher characteristics and reflexivity*

This study was conducted by a Trainee Clinical Psychologist as part of the Clinical Psychology doctorate. The researcher identifies as a migrant and an ethnic minority in the UK. Although the researcher's pre-migration experiences and reasons for migration differ from those of the participants, they were able to relate to many experiences of integration into UK work life. As a result, the researcher was aware of potential bias and influence and reflected on this as part of the final work. A reflective journal was kept by the researcher alongside the interview data, documenting their thoughts, actions, and emotions throughout the interviews, transcription, and analysis of data. This promotes transparency, accountability, and research trustworthiness (Coffey & Atkinson, 1996). Other strategies were also employed to support reflexivity, including regular thesis supervision to explore the impact of the researcher's position on the research process and the impact of the research process on the researcher (Palaganas, 2017).

*Patient and Public Involvement (PPI) and Project Context*

This research adopted the Patient and Public Involvement (PPI) framework (NIHR, 2021). The Overseas Talent Group of a local Mental Health Foundation Trust was involved in the implementation of this framework. This group constitutes a team of mental health employees (the majority of whom themselves are immigrants), who oversee the recruitment, interviewing, visa processing, travel arrangements, accommodation arrangements, training and deployment of overseas nurses in the Trust. Contact was established through their working relationship with the primary research supervisor based on their keen interest in the study. They provided PPI support at all stages of the research, including design of the study topic and study materials, development of the interview schedule and topic guide, and recruitment. The final themes from the analysis were also shared with the group. They also served as project collaborators and gatekeepers through whom recruitment was advertised.

*Participants and Sampling Strategy*

To ensure validity, participants with similar experiences were selected to better capture their unique migration experiences in the post-COVID-19 period (Smith, 2003). Both recruitment and the entire process of participants' engagement in the project were approached with sensitivity to their unique experiences. The inclusion criteria were: (a) adults over the age of 18 who were able to provide valid informed consent for participating in the research study and to reflect on integration as an independent person into the NHS workforce, (b) migrants (economic or forced) who arrived in the UK at any stage of the COVID-19 pandemic to work, (c) nursing qualifications obtained outside the UK, and (d) currently employed to work in the NHS.

English language ability was not a specific inclusion criterion, but it was presumed on the understanding that NHS staff are expected to participate in interviews in English.

Participants were selected through convenience sampling by internally circulating a research leaflet (Appendix H) with researcher's contact details, via Trust emails. Fourteen interested participants contacted the researcher by email. They were sent participant information sheets (Appendix I) and invited to a brief screening call, during which the researcher explained the project and answered any questions the participants had. After this, interviews were scheduled via Microsoft Teams, and informed consent was obtained through consent forms that were electronically sent and signed (Appendix J).

Eleven participants were screened and interviewed for the study, consistent with the recommended number for this type of research (Clarke et al., 2015) where 8-10 participants are usually sufficient, based on data saturation and research goals (Sarfo, 2021). Three participants did not further respond to the study invitation. Further commentary on data saturation and the rationale for accepting a sample size of 11 is outlined in Appendix K.

The participants included four Indian, six Nigerian, and one Kenyan, with one male and ten female participants (Table 4.1 for participant demographic information).

Each participant received a £15 shopping voucher as a token of appreciation for their participation. No participant withdrew from the study, and all expressed interest in receiving updates on the final results of the research.

### *Ethical consideration*

The study was conducted with ethical approval from both the UEA Ethics Committee (Appendix L for UEA ethics approval letter) and with governance approval from the Health Research Authority (Appendix M for HRA approval letter).

Under the 2021 BPS Code of Human Research Ethics (Oates et al., 2021), ethical considerations were made to ensure information governance and data protection were in place. To maintain anonymity, participants were given pseudonyms at the recruitment stage, which were used throughout the study. Transcripts were fully anonymised. Interview recordings were stored on secure drives and deleted after transcription. Data storage was in line with the Guidelines for Data Protection Regulations (GDPR) and Data Protection Act (UK Gov, 2018), and the institutional data storage policy. After interviews, participants were electronically sent information about staff support services, to ensure they knew how to access support if they needed it, given the possibility, albeit low, for thesis interviews to trigger feelings that required professional support. A debrief form with research supervisors' contact details was issued at the end of each interview (Appendix N).

**Table 4.1: Participant demographic information**

| Participant No | Gender | Age | Nationality | Marital status | Qualifications | Years of pre-UK practice | Religion/faith | Immigration status | Duration in UK at time of interview |
|---|---|---|---|---|---|---|---|---|---|
| P1 | F | 30-34 | Kenyan | Married | Nursing degree | 5- 10 | Christian | Migrant worker visa | 12-18 months |
| P2 | F | 30-34 | Indian | Married | Nursing degree | 5-10 | Christian | Migrant worker visa | 6-12months |
| P3 | F | 35-39 | Indian | Married | Nursing degree, Post graduate degree | 5-10 | Hindu | Migrant worker visa | 6 -12 months |
| P4 | F | 40-44 | Indian | Undisclosed | BSc Nursing, Nursing degree 3 post graduate degrees including s doctorate | 20-25 | Hindu | Migrant worker visa | 12-18 months |
| P5 | F | 30-34 | Indian | Newly married | Nursing degree MSc | 5-10 | Catholic | Migrant worker visa | 6- 12 months |
| P6 | M | 45-49 | Nigerian | Married | Nursing degree, MSc | 20-25 | Christian | Migrant worker visa | 12- 18 months |
| P7 | F | 40-44 | Nigerian | Undisclosed | Nursing degree | 15-20 | Catholic | Migrant worker visa | 12- 18 months |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| P8 | F | 30-34 | Nigerian | Married | Nursing degree | 5-10 | Christian | Migrant worker visa | 12 - 18 months |
| P9 | F | 35-39 | Nigerian | Married | Nursing degree | 10-15 | Christian | Migrant worker visa | 12-18 months |
| P10 | F | 30-34 | Nigerian | Married | Nursing degree Postgraduate degree | 5-10 | Christian | Migrant worker visa | 12 – 18 months |
| P11 | F | 35-39 | Nigerian | Single | Nursing degree 2 additional degrees | 10-15 | Christian | Migrant worker visa | 18-24 months |

*Data Collection*

The data were collected from eleven international mental health nurses through semi-structured video interviews, recorded and transcribed on Microsoft Teams. Each semi-structured interview was approximately 45-90 minutes. The topic guide and interview schedule were developed using guidelines for developing qualitative interview questions (Roberts, 2020) and were used to steer rather than control interviews. The semi-structured interview style allowed participants to lead the conversation with their responses.

*Data analysis*

Transcripts generated by MS Teams for each recorded interview were manually reviewed by the researcher for accuracy against interview recordings.

The study used Thematic Analysis (TA) methodology (Riger & Sigurvinsdottir, 2016). To generate themes and meaning from the data, manual inductive data analysis approach was conducted. The thematic data analysis was guided by Braun and Clarke's 6 phases (Braun & Clarke, 2006; Appendix O), and the researcher actively participated in generating and organising themes through an interpretative and reflexive approach. To ensure trustworthiness, a codebook was generated from the analysis of the first interview and reviewed with the primary research supervisor before further analysis of the remaining 10 interviews. Although seeking a third party to randomly code a selection of the transcripts and compare any discrepancies may have been useful, it was not feasible within the tight deadlines of the research study and constraints of the doctoral researcher's time. In lieu of this, the researcher and primary supervisor reviewed the first transcript together. Research supervision was used to discuss the naming and description of the themes as they emerged from coding and analysis of the rest of the transcripts.

## Results

The analysis of data revealed four key themes: 'Shattered promises about hopes for the future', 'Being an outsider', 'The strain of adaptation', and 'Having to survive' (refer to Table 4.2).

**Table 4.2: Themes and Sub-themes**

| Theme | Subthemes |
|---|---|
| Shattered promises about hopes for the future. | I. Broken dreams- premigration promises vs harsh reality<br>II. Clashing expectations- personal hopes vs systemic needs |
| Being an outsider | I. Lost in translation- communication barriers and misunderstandings<br>II. Unseen and unheard – the struggle with exclusion and non-belonging.<br>III. Navigating the unequal terrain of professional Integration |
| The strain of adaptation | I. The burden of internalisation and self-blame<br>II. Acculturative stress and its toll on emotion and wellbeing |
| Having to survive | I. Resilience strategies for professional and personal survival<br>II. Strength in unity – community support<br>III. Seeking sanctuary and finding safe spaces for support. |

*Theme 1: Shattered promises about hopes for the future*.

There was a significant gap between what participants expected before migrating to the UK to work in the NHS and the reality of their experiences on arrival. Participants had assumed that high income countries would offer certain benefits, and the recruitment process which promoted opportunities, reinforced this belief. Their actual experiences once they arrived did not match their expectations. Two sub-themes were related to 'shattered promises about hopes for the future': broken dreams - pre-migration promises vs harsh reality; and clashing expectations – personal hopes vs systemic needs.

*i) Broken dreams- Pre-migration promises vs harsh reality:*

Participants felt that recruiters were very courteous and supportive. They were assured that the NHS needed them, and interview panels were experienced as warm and friendly, which helped participants perform well. Participants were promised support throughout the process and received both financial and logistical support with visas and travel.

*"... I was sweating, I was nervous, but the interviewers were very friendly. Yeah, they really assured us they would give us support, they told us how they're going to arrange for our journeys". (P1).*

*"... I requested for direct flight because... I am like educated, I did my Masters, I lived in a... big city like London... I was so good in travelling inside my country, not outside. So, they guided me, they directed me, they helped me, they booked me a direct flight... they*

*will keep on checking me... giving all the guidance... when I will reach, who will be coming, accompanying me..." (P5).*

Upon arrival in the UK, participants were taken aback and disheartened to discover that some of their expectations about their roles had not been met or had changed without sufficient notice. For instance, some were asked for their preferred client groups at interviews and told they would be offered roles with those client groups but were then deployed to wards with different client populations without discussion. Many participants expressed feeling trapped and unable to explore other job opportunities within the NHS or in other areas of the country. This was largely because the financial support they had received during the recruitment process was tied to their NHS job contracts and UK work permits.

"*During my interview, I was asked... my area of interest... mother and baby unit. They (said)... you are going to work in this particular ward... when I reached here... I was allocated to another ward... But she said... unfortunately... you were posted there..." (P3).*

*"... (my sister said)... finish your contract for two or three years, come back to London, you live with mixed people... (you) won't feel this discrimination in the workplace..." (P5).*

*(ii) Clashing expectations - personal hopes vs. systemic needs:*

Upon arrival, participants had expectations of the NHS system which were quite different from what the NHS expected of them in return. All participants had qualified in systems where mental health nursing was not a specialised training pathway but was integrated into their overall nursing training. Recruited to work as mental health nurses in the UK, they had undergone intensive training on arrival in preparation for the same mental health Objective Structured Clinical Examination (OSCE) taken by UK-trained RMNs. This OSCE training did not cover UK-specific laws such as the Mental Health Act. Participants had therefore expected to receive training (structured similar to the OSCE training) on the wards about legal aspects of mental health and ward procedures to support their integration into wards.

*"... our psychiatric nursing and here the psychiatric nursing is vast difference, sections, discharges, leave... tribunals, patient rights, the patient rights to decline... there is a policy for (inaudible) medicines. But, back in India, there is nothing... not a section... no legal rights, no... tribunal..." (P2).*

*"...most of them do not know that we are international nurses... We really do not know anything about their documentation and other things... If you keep asking them questions (they) will be like... you're supposed to know. It's something they do not know." (P11).*

The participants reported that they felt senior staff and colleagues were not aware of their knowledge gaps, as they expected that international nurses deployed to the wards would already have the required knowledge to fulfill all aspects of their role. Participants stated

that there was no proper structure or plan in place to facilitate their integration into the wards, which would have been the case if wards expected them to arrive with the knowledge required to work in the NHS. As a result, participants felt left alone to navigate the system and acquire knowledge on their own.

*"... I'm trained and educated in a different country... everything is new irrespective of my qualification or... my experience... So if... people had shown me things then that would have been good." (P4).*

Participants felt that the recruitment teams had not adequately prepared the ward teams, who were not involved in the recruitment process. The ward teams had expected the internationally trained nurses to be fully equipped to work within the NHS mental health system, which was not the case, at least during the COVID-19 international recruitment cycle.

"*Their expectation... so you're a nurse, just fit into the system, start doing everything. So... coming to the ward, I expected that they will show me... There is imbalance in both expectation..." (P9).*

*"So, when you ask people... they're like, you're a nurse, you're supposed to know it, forgetting that you are coming from a totally different background... call the overseas nurses... show them how to navigate the system... that would have really really, really helped..." (P7).*

When the teams realised the reality of the required competencies and training needed to fully integrate international nurses into the NHS mental health system, it added unexpected pressures on already overworked teams who were struggling to cope with the impact of COVID on staff numbers.

*"... that is their expectation... a nurse is coming to join us, thank God we'll be relieved, we've been short-staffed... fit into system and start helping the ward. Like... one nurse is coming tomorrow... God, that's a relief. And then the nurse comes...and then what... Are you coming to add to our burden?" (P9).*

This conflict between individual and system expectations caused tension, making it hard for participants to feel safe and accepted in the system. It also revealed system inadequacies that hindered accommodating international nurses.

*"I find it difficult because of the support that I did not get from the Trust. The Trust... was just integrating people from outside to the system... employing people from different countries to the system they were not into it fully..." (P6).*

*Theme 2: Being an outsider*

Participants reported ongoing challenges but had developed strategies to manage them professionally. Most used "us-them" language, indicating continued feelings of difference. 'Being an outsider' had three sub-themes: 'lost in translation-communication barriers and misunderstandings', 'unseen and unheard – the struggle

with exclusion and non-belonging' and 'navigating the unequal terrain of professional integration'.

*(i) Lost in translation - communication barriers and misunderstandings:*

Participants reported experiencing negative effects due to cultural differences in communication. Their foreign accents were initially challenging for their colleagues and patients to comprehend. Similarly, the participants also found it difficult to understand their colleagues' speed and tone of speech. While there was an understanding that communication barriers were to be expected, participants felt 'othered' due to their accents. Colleagues would get frustrated when asked to repeat themselves, often making comments that felt embarrassing and/or discriminatory to the participants.

*"... I will tell them, English is not my first language... don't be angry... one of them said, 'Are you sure she understands English? I'm not sure she knows how to speak English'... I was very quiet... it was as if I entered into my shell..." (P8).*

*"... Our accents, our languages, they will struggle to hear what we're saying, and we will struggle to hear what they're saying. So, communication was pretty, pretty poor..." (P1).*

Other communication barriers arose from the migrant nurses' lack of professional cultural awareness of hierarchies within NHS teams, what to escalate to whom, cultural differences in the use of emails in professional contexts, and cultural differences in what was deemed appropriate by whom, in conversations. It was suggested that this was a

consequence of being the first set of international nurses to be recruited on those teams.

*"You know in... we don't normally send emails. Now... we started sending emails, copy this person... we don't know the culture, the values... sometimes things I may say they will take it as an insult and then things they may say I may not take it lightly with them. So had it been we had like pioneers... the mistakes that were made, we wouldn't have." (P8).*

*(ii) Unseen and unheard – the struggle with exclusion and unbelonging:*

A significant number of participants were either the only international nurses working on their wards or the only nurses who were both international and ethnic minorities. This led to them feeling like they were "the only one" on teams consisting primarily of white individuals, which made them feel invisible. One participant expressed this feeling by saying:

*"... I'm just like a, like a ghost in the ward, because nobody can see me..." (P2).*

*"I'll be in the office, and someone comes in and says hello to everyone and ignores me. So, I say hi, good morning and they just look at you and ignore..." (P10).*

*"... And I'm like an antibody. So... (they) can't accept the antibody, it will take time... We need to prove ourselves... also competent..." (P2).*

Participants were made to feel they did not belong in clinical contexts, in casual interactions on the ward and in social activities outside work.

*"It was hard for them to include us." (P1).*

*"...Sometimes when there is this get together, I'm on shift. I can't cancel my shift... that's fine. We'll deal with it..." (P7).*

*(iii) Professional disadvantages:*

Participants were excluded from important meetings including multi-disciplinary team meetings, and their opinions were undervalued, making them feel professionally disadvantaged and discriminated against.

*"I want to contribute to the team or an MDT discussion. I have never been allowed to be part of the MDT discussion." (P4).*

Participants said they faced challenges in being acknowledged as leaders within their teams, especially when they were senior staff members on shifts. Their abilities were questioned, and they were not given access to mentoring or coaching. This negatively impacted on their professional confidence and career goals.

*"... nurses that train here... are encouraged to move higher... within three months in the ward they moved her to a Band 6 position... for us, there's no one encouraging you, you*

*are too even scared to say oh I'm an international nurse... So, if there were mentors... to say, try this... it's what you are good at... it will be better. They should encourage us..." (P10).*

*"... Band 7, Band 6, matrons and also ward managers and everything. So, I just dream that I will also one day I will go there, I will reach there. But... because of this current situation, I don't know whether I can..." (P2).*

*Theme 3: The strain of adaptation*

Integration into living and working in the UK was challenging for participants and caused significant stress. There were two sub-themes present, 'the burden of internalisation and self-blame' and 'acculturative stress and its toll on emotion and wellbeing'.

(i) *The burden of internalisation and self-blame:*

When individuals were subjected to discrimination, exclusion or racism, they tended to internalise these experiences and responded to them by increased goal striving and determination to 'prove themselves', 'try harder' or show that they were deserving of their place on teams.

*"... if you asked me like some months ago... people doubt you. You have to convince them... as an international nurse, you have to prove yourself, way beyond, before you can be accepted. You have to prove... I know what I'm doing, it's just that the system is*

*new to me.... most difficult because... it makes people nervous, and they doubt themselves..." (P9).*

Participants felt they should be 'grateful' to be working in the UK, and were; even when disappointed and let down.

*"... we are like zero... the Trust is paying for us... I'm feeding myself... I'm feeding my family. I should be thankful... I need to work for that. That is my attitude... not simply work, but useful work..." (P3).*

(ii) *Acculturative stress and its toll on emotion and wellbeing*:

Participants faced significant acculturative stress while integrating into the way of life in the UK. Acculturative stress refers to the psychological and physiological impact that individuals experience while adapting to a new country, including the conflicts that arise due to social, environmental, and cultural differences (Berry, 2017). Participants talked about various sources of stress, such as being separated from family, difficulties in finding suitable accommodation, adjusting to the weather, and figuring out how to commute to work.

*"I left my child at the 5th month... So, you can now understand my feeling... So ... family, personally, financially, from the ward... everything, is negative... I used to cry everyday." (P2).*

*"... It was tough for me... because... I've never left my family behind for anything, no. It wasn't easy... It wasn't easy on my husband... It wasn't easy on every one of us... we will shout on phone... we will comfort each other..." (P9).*

Most participants reached a breaking point where they felt unable to cope, resulting in significant impact on their mental health and wellbeing. For two participants, their physical wellbeing was impacted, with one signed off sick for several weeks.

*"... I had palpitation, I had pain. I was taken to the hospital, I was admitted.... they admitted me. They gave me some medication and discharged me." (P6).*

Unpleasant experiences at work added to the impact on both wellbeing and participants' hopes for future professional aspirations.

*"...I don't want to go to work... I lost interest... I have no choice because I have a visa... So, all those things affected me and I, I became physically ill. I became unwell. I became sick." (P4).*

*"It impacted pretty bad on my mental health... we all get emotional, we all get stressed, but it's at a certain point where you can manage yourself. But for me... I got to a breaking point." (P1).*

*Theme 4: Having to survive*

Participants' strategies for coping with difficult experiences in and outside work emerged, including things they had found helpful to support their integration into UK life. There were three sub-themes related to coping: 'resilience strategies for professional and personal survival', 'strength in unity – community support' and 'seeking sanctuary and finding safe spaces for support'.

(i) *Resilience strategies for professional and personal survival*

Participants described learning to be resilient, and sources of resilience came from protective factors such as family, past experiences of adversity, and faith, which all participants described as important to them. Their private faith and religious practices were sources of strength, hope and comfort in difficult times, and enriched their lives as they settled into living in the UK.

*"…temple is… kind of my coping strategy… praying is a kind of coping thing for me." (P4).*

*"… my faith in God I knew… you can get stressed, but… when I'm standing with God, I cannot afford… to overwhelm me or give me thoughts… so even my faith in God kept me moving because I knew there are better days which are coming here."*

People found themselves at a breaking point yet believed that they needed to find inner strength to avoid developing more severe mental health issues. As a result, they would

ignore their poor wellbeing and low mood, conceal their emotions and actively determine to cope. This strategy seemed to help them cope to some extent.

*"But after a period of time I was like I need to snap out of this mood. I told myself the truth, you need to snap out of this mood..." (P8).*

*"I got to a breaking point... I was a bit depressed at that time. But I didn't want to accept that. I was just trying to put up cause I knew I cannot afford to be weak... putting up this strong face, this strong personality like you had no option, but it really impacted...my mental health..." (P1).*

*(ii) Strength in unity -community support:*

Participants created various communities within local trusts and outside work, such as professional communities of international nurses created on WhatsApp, and sub-groups of nurses from specific countries. Within these groups, people helped each other with queries related to professional dilemmas and with general queries about non-work issues. Information about the rights of international nurses, training competencies and pay were disseminated within these communities and participants no longer felt isolated. They also began to advocate for themselves, supported by the community.

*"... WhatsApp groups of like nurses in your region... we have so many nurses in... so at least in this WhatsApp group, they tell they tell you all these things about Council tax, about driving..." (P2).*

*"... another thing is developing network... there is a preceptor network... So, I started to go there, and I happened to find that like me there are so many international nurses are there. So, I started to develop networking with them." (P4).*

Participants also found connection to their faith communities through joining churches or mosques. Those who practiced Hinduism expressed regret that there were no local temples but found a connection to other Hindus in their local communities and celebrated feasts together. An interesting finding was that participants often gravitated towards intersecting communities, such as those based on profession and culture, or culture and faith. For example, some participants felt more comfortable belonging to a community of international nurses from the same culture or joining a church where most members and leaders shared a specific cultural background. This suggests that people seek comfort in spaces that allow them to maintain a connection to their cultures of origin. This may also have implications for participants' experience of integration.

*"I was... distressed... Church was supporting me... it's an RCCG church [a Nigerian church] ... I was not even a member in Nigeria." (P6).*

*"... we have our own community and... church community. Yeah, every Sunday we have our own holy mass in our language." (P2).*

*(iii) Seeking sanctuary and finding safe spaces for support:*

During the study, it was found that participants were more likely to seek support from staff members who made them feel comfortable and secure. This typically involved approaching colleagues who were perceived as friendly and approachable, rather than those who appeared unfriendly or intimidating. As a result, participants often delayed seeking assistance until the next shift when a more supportive staff member was available.

*"Some staff they won't speak with us.... one or two people... want to help us (but) they won't be there in the shifts. They'll speak very nicely... with smile... we felt that she's quite approaching... she won't be there on shift." (P3).*

*"... whatever it is, I will write down and ask whichever staff I am comfortable when they are on shift, I'll ask everything to the particular staff... What I'm going to do, if I'm comfortable with any person, any charge nurse, I will, if they're free, I'll ask them..." (P5).*

Interestingly, many participants chose not to access mental health support but found the support networks set up for ethnic minority groups to be a helpful and welcoming resource.

*"... some support from the [...] network group... I have been referred to the [...] network group..." (P4).*

Participants also felt able to reach out to colleagues beyond immediate professional circles to ask for support and training, thereby expanding their professional networks.

*"... reaching out to people, for example... [specific clinical skill] ... is something very different for me, then I saw in internet there is some people who are specially trained in therapeutic observation, and they are offering some training. So, I booked myself for the training... any doubts I have, I looked to the people who are the lead in that particular area... could you please support me in this? And... they come back to me, and they say that this is what we have to do, or they have a Teams chat with me to explain things."* *(P4)*.

## Discussion

The current thematic analysis findings address two main questions: (i) What are the experiences of migrant nurses who arrived to work in the UK since the COVID-19 pandemic? and (ii) What are the psychological impacts of these experiences? Four key themes emerged from data analysis: 'shattered promises about hopes for the future', which exposed the gap between pre-migration expectations and UK realities, while 'being an outsider' captured feelings of alienation. 'The strain of adaptation' highlighted emotional challenges, and 'having to survive' explored coping strategies, including resilience, community support, and seeking safe spaces. The recruitment of foreign healthcare workers to the NHS is not new (Royal College of Nursing, 2024). However, the way job opportunities were presented to the international workforce did not consider what they needed to successfully integrate into the profession in the UK (Alonso-Garbayo, 2007). As a result, migrant staff arrived in the UK unaware of the limitations of the NHS in supporting their integration (Mechen, 2021), which the results of the current study also reflected. The current results highlight the challenges faced by NHS wards in integrating internationally trained staff when the wards are not involved in the recruitment process and appear not to have been properly equipped to support them. Ward staff had unrealistic expectations about the skills the nurses would bring and were unprepared to meet their training needs. According to a study by Alexis and Shillingford (2012) using data from international nurses, some participants felt supported in integrating professionally, while others felt insufficiently prepared. They also felt that their UK colleagues were unprepared to support them, causing significant stress. This supports current results and suggests that little has changed in the 12 years between both studies in terms of preparing international nurses to join the NHS and preparing local NHS teams to support their integration. These results outline how the NHS as a system manages change and the importance of involving all components of the complex system in this process, including clinical microsystems (Likosky, 2014). In this context, clinical microsystems can be defined as small units (such as mental health wards) where patients receive care (Likosky, 2014). A systematic review by Côté et al. (2020), found that implementing the clinical microsystems approach to change in the NHS had several positive effects. These included supporting patient-centred care, promoting multidisciplinary and quality improvement skills, facilitating the implementation of new

processes, increasing patient safety, and contributing to the satisfaction of both patients and clinicians. By implication, excluding parts of the system from the change process creates room for stress, conflict, and disturbance in the system, as shown by current results.

Findings demonstrate that international nurses are not shielded from harmful experiences in the NHS, but continue to experience racial discrimination, exclusion and professional barriers. Existing studies support these findings (Bond et al., 2020, Spiliopoulos & Timmons, 2023). These experiences had a significant impact on participants' emotional and physical wellbeing and professional confidence (West et al., 2016). Experiences of racial discrimination have been associated with negative effects on ethnic minorities (Edeh, 2022), putting them at a higher risk for racial trauma, traumatic stress, loss of motivation, panic symptoms, depression, and suicidality (Cénat, 2023). These findings are located within postcolonial concepts relevant to healthcare: race, racialisation, culture, othering, subaltern and to a lesser degree, essentialism (Bickford, 2014). Postcolonial theories are empirical and critical bodies of work addressing issues emanating from colonial relations and their consequences (Bickford, 2014); highly relevant in nursing because they provide a framework to understand historical processes that have contributed to human suffering and health inequalities that are prevalent today. They provide crucial insights into the contexts where these inequalities thrive and the societal construction of race that affects individuals' lives and opportunities. Postcolonial perspectives provide an alternative lens to understand the complexities of social dynamics and amplify the voices of marginalised people, shedding light on their experiences and perspectives within the healthcare landscape. Through these lenses, the NHS can address structural barriers and systemic injustices that contribute to health inequalities. Migrant nurses, despite their high levels of education and employment in the NHS, still face marginalisation due to their migrant identities. It is crucial to consider this when planning to support their integration into the NHS.

Ethnic diversity in the NHS has been documented in detail by the NHS Workforce Race and Equality Standard (NHS WRES, 2024). However, the current research reveals that the

diversity is not uniform across all parts of the UK. All 11 participants reported being the first internationally trained migrant nurses on the wards where they were assigned. Many of them were the first or only ethnic minority healthcare staff on those wards. Anderson (2015) discusses how Black individuals, and to a lesser extent other ethnic minorities, often face scrutiny and interrogation when they are in an environment where people are in close contact with them for the first time. In such situations, people unconsciously default to stereotypes. The ethnic minority in the position of the 'only one' experiences exclusion and separation from others (Anderson, 2015). Consequently, Black and Brown individuals feel pressured to 'perform' to prove they do not fit the stereotypes. The experiences of professional and social exclusion and feeling of not belonging, as supported by current findings, are consistent with existing studies that report similar experiences among migrant nurses (Likupe & Archibong, 2013). This raises questions about inclusion, equality, and diversity, highlighting the reality that diversity may not be safe for ethnic minorities if there is no inclusion (Rosinski, 2022). Although migrant nurses have been invited to work (diversity), there is a lack of adequate support to adapt to meet their needs at both individual and systemic levels (inclusion). This is evidenced by their feelings of professional disadvantage compared to UK-trained nurses, a finding supported by other research (Alexis, 2015).

Findings from this study show that professional aspirations and career progression were significant factors that influenced participants' decision to migrate to the UK. The professional challenges faced by migrant nurses affected how valued they felt, even when they were confident in their skills and the value they brought to their teams. Given the current focus on staff retention in the NHS Long Term plan (NHS, 2023), these findings are important to draw on in planning adequate support and mentoring to improve retention of overseas staff.

The study's findings also reveal deeply emotional experiences that may be challenging to read, especially for those who have not faced similar circumstances. Participants' descriptions of the vast differences between the hopeful promises made to them before migrating and the difficult realities they encountered upon arrival, were expressed with a sense of disappointment and struggle. These stories are not just individual accounts but

reflect broader systemic issues that need recognition and action. It's important that the participants' lived experiences are neither dismissed nor minimised, but instead acknowledged as fundamental realities that highlight significant gaps in support, inclusion, and understanding within the systems they entered. The discomfort caused by these stories can serve as a necessary catalyst for reflection and change among professionals and the public. Moving forward, there needs to be a collective commitment to listen to and believe these experiences, understand their implications, and actively work towards improving the services and support structures meant to help all individuals, regardless of their background or origin.

### *Implications for clinical practice*

The research findings have significant implications for clinical psychologists working with international workforce as colleagues or in staff support services. A culturally curious approach is essential to collaboratively plan targeted interventions and support. By listening and seeking to understand, clinicians can avoid re-enacting any harm migrant nurses may have experienced during their integration process. Supporting individuals in their wellbeing, whether in therapy or as colleagues in the workplace, may go beyond managing reported psychological distress linked to acculturative stress and professional hurdles. It may require clinicians to explore underlying cultural and systemic factors contributing to the experiences of migrant staff. By acknowledging the intersectionality of identities and experiences, psychologists can create an environment that validates the complexities of migrants' lived realities, both in therapeutic relationships and in the workplace. Psychologists are trained to do this using therapeutic skills such as active listening skills, empathy, reflection, curiosity and openness (Benuto et al., 2018).

The responsibilities of clinical psychologists and other mental health professionals include advocating for systemic changes within healthcare systems to promote inclusivity and cultural competence. This may involve providing training and education on the unique challenges faced by migrant nurses to team leaders, ward managers, and staff teams. Psychologists could also support teams in creatively thinking about

implementing policies that address systemic barriers to the integration and career progression of migrant healthcare workers. By advocating for equitable practices and fostering a culture of inclusion, psychologists can contribute to creating environments that support the wellbeing and professional growth of migrant healthcare workers, even when not directly supporting or working alongside them.

Recognising the resilience exhibited by migrant nurses navigating integration into a post-COVID NHS is crucial. By adopting strengths-based approaches to formulation and intervention, such as the Padesky and Mooney (2012) strengths-based cognitive behavioural therapy (CBT) framework, clinical psychologists can highlight individuals' inherent capacities for adaptation and growth. Reframing their experiences within a strengths-based framework will empower migrant nurses to harness their resilience in overcoming obstacles and thriving in their professional and personal lives.

These findings serve as a guide for clinical psychologists working with migrants. They highlight the importance of being culturally sensitive, open, and curious.

### *Strengths and limitations*

The strengths of the current study lie in its focus on the voices and stories of migrant nurses, an often overlooked group in research. Additionally, conducting the study within a single NHS Trust offered a valuable opportunity to understand the findings in the context of the Trust's specific organisational dynamics, policies, and culture. This makes the findings relevant not only to the Trust's workforce but also to mental health trusts in similar contexts across the country.

Aspects of the researcher's position and cultural background were a strength in terms of how they positively shaped and enhanced the research, particularly during the interviews. The researcher's own experiences as a migrant resonated with many of the stories shared, enabling a profound sense of empathy that facilitated the interviews. This connection made participants feel at ease, encouraging them to share difficult and deeply personal experiences, which provided rich, nuanced data that might not have

been accessible otherwise. The researcher's insider status, particularly when interviewing participants from the same country of origin, proved to be a significant strength. It allowed for an immediate understanding of colloquial expressions and culturally specific language, capturing nuances that might have been missed by a researcher from a different background. This cultural familiarity led to more accurate interpretation and a deeper understanding of the participants' perspectives. However, it also prompted reflection on the potential limitations when interacting with participants from different countries of origin, where some nuances might have been missed. Overall, the researcher's identity brought valuable insights and depth to the study, underscoring the importance of cultural and experiential alignment in qualitative research.

A further strength of this study is the use of the thematic analysis methodology. It allows for an in-depth understanding of the layered but specific experiences of migrant nurses within a specific NHS Mental Health Trust. It offers scope for an immersive journey into the participants' lives, fostering an in-depth exploration of their challenges, coping mechanisms, and nuanced perspectives (Braun & Clarke, 2023).

The researcher's dedication to reflexivity and rigour using principles outlined by Yardley (2000) supported more meaningful discussions and examination of how social constructs and participants' contexts shape their experiences without sacrificing the richness of their lived realities. Results could therefore be held up against other empirical work in this area and highlight any areas for further research.

The reliance on participants from a single NHS Trust may be considered a limitation, as it raises concerns about how representative these experiences might be for other Trusts or populations of migrant nurses in different healthcare settings. This may have limited the diversity of experiences captured and should be taken into account when applying the findings to different organisational contexts.

### *Future research*

To understand the organisational dynamics that influence the experiences of migrant nurses, it is important to consider the viewpoints of team leaders, managers, and other stakeholders involved in implementing systemic changes. Further research could help identify barriers and facilitators to the integration and support of migrant healthcare professionals by gathering insights from individuals involved in decision-making processes and policy implementation within the post-COVID NHS.

Longitudinal research using follow-up interviews with migrant nurses at the end of their contracts could provide valuable opportunities to track their career paths and understand the factors that influence career progression decisions and long-term professional life in the UK. This could involve exploring their progression through the NHS Bands, to understand the challenges and opportunities they encounter while advancing in their careers. It would also be valuable to explore the impacts of recent migration policies on nurses' mental health, wellbeing, and long-term career plans. The results from such a study could inform strategies to support their professional growth and retention within the healthcare workforce.

### *Conclusion*

The purpose of this study was to explore the experiences of migrant nurses who came to the UK after the start of the COVID-19 pandemic and to understand how these experiences affected their mental health and overall wellbeing. Participants spoke about their experiences without naming COVID-19, and only reflected on this when asked directly about any impact it had on their experiences (see Appendix P). Results showed that participants related to the pandemic in terms of the impact it had on healthcare staffing needs in the NHS, leading to job opportunities for internationally trained nurses (Phiri et al., 2022).

The results highlighted communication barriers, feelings of invisibility, exclusion, and professional disadvantages experienced by migrant nurses, present regardless the COVID context. This emphasises the need to foster inclusive and supportive work environments that recognise and value diversity, while also addressing systemic barriers

to equity and belonging. The strategies described by migrant nurses to cope with their experiences include resilience, community support, and safe avenues for seeking assistance. These findings highlight the need to create supportive networks and provide culturally adaptive resources.

The findings of this study add to our understanding of the experiences of migrant nurses within the healthcare system. Further research and action are needed to address their challenges and promote inclusivity, equity, and excellence in healthcare delivery for all.

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# Chapter Five: Discussion and Critical Evaluation

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This thesis portfolio set out to explore the perspectives and experiences of UK migrants and refugees during the COVID-19 pandemic, as related to impacts on mental health. Being an under-researched area, this portfolio aims to bridge the research gap and add to the existing body of work by offering insight into the voices, experiences and views of migrants living and working in the UK during the pandemic. This was accomplished by completing a systematic review relating to migrant mental health experiences and a qualitative research project relating to migrant healthcare professionals' experiences. Results showed that migrants and refugees in the UK faced significant and unique challenges in adapting to COVID-19 public health measures both in their personal and professional lives, with these difficulties being exacerbated by their migrant, sexual, and ethnic identities. Findings highlighted systemic inadequacies in existing support for migrants of various categories, with subsequent impacts on mental health. Migrant healthcare professionals were shown to require more robust support for professional integration and unmet mental health needs than currently provided by the NHS.

This chapter outlines the results of both pieces of research, providing a critical evaluation of their methodological strengths and weaknesses and both clinical and practical implications. Areas of future research will be suggested. A reflective account of the personal impact of conducting the research will also be provided.

## Overview of Findings

### Systematic Review

The systematic review aimed to synthesise first account qualitative empirical studies of migrants and refugees present in the UK during the COVID-19 pandemic and understand their pandemic experiences, and the perceived impact on their mental health and wellbeing. Twelve studies using various qualitative methodologies met the eligibility criteria and were included in the review. An evaluation of their methodological quality was also carried out.

The findings highlighted that many of the challenges faced by UK migrants and refugees were heightened during the COVID-19 pandemic. Similarly, many of their COVID-19 difficulties were worsened by their migrant identities. Participants reported difficulties adapting to COVID-19 public health safety protocols, a process that involved understanding and adhering to unfamiliar healthcare systems, cultural norms, and socioeconomic conditions, which was often overwhelming for migrants during the pandemic. Many relied on personal resilience strategies to cope with the pandemic's difficulties, finding ways to manage stress and anxiety without adequate support from external systems. Participants reported experiences of discrimination and marginalisation leading to further feelings of alienation and distress. The pandemic intensified mental health struggles, with increased uncertainty and concern about their safety and wellbeing, compounded by the lack of accessible mental health support tailored to their needs. Navigating complex healthcare systems and understanding health information were major challenges for participants, compounded by feelings of exclusion from public health updates and policy.

**Empirical Study**

The empirical paper adopted a qualitative approach to explore the professional experiences of migrant nurses arriving to work in the UK since the COVID-19 pandemic and to understand the psychological impacts of these experiences. Semi-structured interviews were conducted with eleven international nurses from India, Nigeria and Kenya, recruited to work in an NHS mental health service during the COVID-19 pandemic. Using thematic analysis, four overarching themes emerged from data analysis: 'Shattered promises about hopes for the future', 'Being an outsider', 'The strain of adaptation', and 'Having to survive'. A total of ten sub-themes were linked to these four main themes. Results showed that participants experienced a variety of difficulties whilst integrating into UK working life as migrants during the pandemic. Some of these difficulties were linked to how they had expected individuals and systems to respond to or support them, based on what they had been promised during recruitment. Adapting to the realities of professional life was made more challenging when people faced discrimination and exclusion, further impacting their health and wellbeing. To cope with

these challenges, participants relied on personal coping strategies and resilience factors. However, these experiences made participants uncertain about remaining in the UK long term.

**Thesis Portfolio**

The results of the thesis portfolio show that just like the rest of the public, UK migrants had to manage the challenges that came with the pandemic and subsequent lockdowns; however, their experiences were further impacted by their unique experiences as migrants. Participants were not always able to effectively implement COVID safety guidelines if they were homeless, in temporary or shared accommodation, or if they were in high risk or low paid jobs (such as factory work). Migrants in both the systematic review and empirical project experienced discrimination in some form. In the empirical work, for migrant nurses in the NHS, discrimination impacted their experiences of integrating into the workforce, placing them in a professionally disadvantaged position. When migrants were not actively included socially and professionally at work, they felt unseen. This was similar when they were not represented in public health messaging during periods of lockdown, as found in the SR. These experiences had a significant impact on the mental health and wellbeing of migrants and refugees, such as loneliness, anxiety and depression. For forced migrants, this mental health impact recalled pre-migration traumatic experiences. The role of faith and community support in migrants' resilience and coping was an important outcome of this portfolio, showing that people would create new communities they found safe, in order to support their resilience and mental health. During the pandemic, these communities were set up online, as in the case of migrant nurses who created WhatsApp support groups, and LGBTQ+ refugees and asylum seekers, who participated in online support groups provided during the lockdown.

Together, the results of both elements of the portfolio reveal that the needs of migrants and refugees as vulnerable groups require careful consideration within health practice and policy after their migration journey, particularly during times of national crisis when their needs are often neglected in public policy. This is a core contribution to the field of work.

## Theoretical implications

This thesis portfolio did not set out to explore any differences in the experiences of forced versus voluntary/economic migrants, however, the experiences reported by the systematic review studies conducted with forced migrants indicate that they had more difficulties in terms of availability and suitability of accommodation, limited social support systems, particularly during periods of lockdown when services that supported them were partially or completely shut down. The Psychological Antecedents of Refugee Integration (PARI) model, as outlined by Echterhoff et al. (2020), offers a comprehensive framework for understanding the psychological factors that influence refugee integration, and the work in this portfolio supports the PARI model as a way of understanding and conceptualising migrant experiences. This model specifically focuses on the unique aspect of perceived forcedness in refugee migration, distinguishing it from other forms of migration, and examines how this forcedness impacts both refugees and residents in the receiving society. Forcedness here refers to the external compulsion driving refugees to flee their home countries, often due to violence, persecution, or severe threats. For non-refugee migrants, such as the nurses who participated in the empirical study, their perception of 'forcedness' can be contextualised based on the degree to which they felt compelled to leave their home countries due to insurmountable 'push factors' (Kotzur et al., 2017; Reid, 2016).

The PARI model suggests that understanding the psychological responses of migrants to their perceptions of their migration being forced can help support their integration into host countries. Some of the psychological experiences highlighted by the PARI model include loss of control, heightened stress, anxiety, and mental health issues such as post-traumatic stress disorder (PTSD) and depression (James et al., 2019); which mirror the findings from both the systematic review and the empirical paper regarding their mental health experiences during the pandemic. The PARI model emphasises that these psychological effects are not only due to pre-migration perils but also to post-arrival challenges (Echterhoff et al., 2020). Here, barriers to healthcare and social services in the host country are key factors that could worsen mental health problems and

difficulties experienced by refugees. These barriers were identified in the findings from this portfolio. The insights from the PARI model, supported by the work in this portfolio, have significant implications for policy and practice. Effective integration programs should address the unique psychological needs of refugees, particularly those related to the trauma of forced migration. This includes providing mental health support and facilitating access to social services, especially during periods of unprecedented uncertainty in host countries, such as those generated by the COVID-19 pandemic. Adopting these strategies for all categories of migrants will aid successful integration. For any migrant healthcare staff who perceive themselves as having been forced to migrate (regardless of their government classification), supporting their integration within this framework will reduce their chances of leaving the NHS, given the current focus on staff retention in the NHS Long Term plan (NHS, 2023).

The results of the empirical study highlighting the significant acculturative stress experienced by participants while integrating into life in the UK, align with the theoretical insights provided by the Kuo (2014) review of coping, acculturation, and psychological adaptation among migrants. The challenges faced by participants such as separation from family, difficulties in finding suitable accommodation, adjusting to the weather, and learning to commute, underscore the multifaceted nature of acculturative stress as described by Berry (2013). This stress, resulting from social, environmental, and cultural differences, manifests in both psychological and physiological impacts, as evidenced by participants' narratives. Kuo (2014) draws from the PARI model discussed earlier, to frame acculturative stress as resulting from a combination of pre-migration and post-migration factors. For the participants in this study, the forcedness of their migration, driven by the need for better opportunities, exacerbated their stress levels. The emotional toll of leaving family behind, as expressed by several participants in the qualitative study, is a poignant example of pre-migration stressors that continue to affect migrants long after they have relocated. This aligns with the PARI model's emphasis on the ongoing impact of migration on psychological wellbeing.

The reliance on coping mechanisms is particularly relevant, as highlighted in findings from both the systematic review and empirical research (Kuo, 2014; Ciaramella et al.,

2022). However, although effective coping strategies are crucial for mitigating the negative impacts of acculturative stress (Liem et al., 2021), current portfolio findings indicate that coping mechanisms alone were often insufficient, leading to severe mental health issues and physical ailments, as seen in in the empirical paper, and across studies in the systematic review. Portfolio findings show that unpleasant experiences at work further compounded the stress and impacted participants' mental health and professional aspirations. This is consistent with findings that post-migration stressors, including workplace challenges and discrimination, significantly affect migrants' adaptation and wellbeing (Hajro et al., 2019). The empirical study results illustrate how professional challenges can lead to a loss of interest in work, physical illness, and a breaking point in mental health. Addressing such systemic issues can foster better integration outcomes. The empirical study highlighted that participants found resilience and strength to overcome difficulties. This is in line with limited evidence suggesting that acculturative stress does not always impact migrants negatively, but that positive outcomes such as acculturative stress-related growth are possible (Kim et al., 2013). This is an area requiring further exploration.

### Implications for clinical practice

The findings of this thesis portfolio hold clinical implications for psychologists, mental health practitioners and other health and social care professionals who work with migrants and refugees or support them in other ways. These are particularly relevant in the context of the COVID-19 pandemic and its aftermath, highlighting the need for culturally sensitive, trauma-informed, and strengths-based approaches to care. Understanding cultural beliefs and values is paramount for effective mental health support. Migrants often come from diverse backgrounds with unique perspectives on mental illness and help-seeking behaviours (Byrow et al., 2020; Nwokoroku et al., 2022). Culturally sensitive assessments can build rapport and enhance intervention effectiveness (Lau & Rodgers, 2021). This approach requires clinicians to be aware of and respectful towards the cultural contexts of their clients, which can significantly influence their mental health experiences and expectations of care (Apers et al., 2023). Culturally sensitive care also involves adapting communication styles and therapeutic techniques

to align with the cultural norms and preferences of migrant clients. Duden and Martins-Borges (2021) argue that this can lead to better engagement and outcomes. For example, using culturally relevant metaphors and examples can help clients relate to therapeutic concepts more easily. Additionally, providing information in the client's preferred language and involving community leaders or cultural mediators can facilitate a more inclusive and supportive therapeutic environment. Culturally sensitive approaches require professionals and systems to create safety by being aware of established power structures and their positions within these structures, reflecting on and interrogating their own assumptions about other cultures, for equitable healthcare (Curtis et al., 2019). This is in line with findings from the empirical study suggesting that migrants will seek support from people and spaces they consider safe.

Many migrants and refugees have experienced significant trauma related to persecution, violence, and displacement in their pre-migration lives (Morgan et al., 2017). Many also experience mental health difficulties during migration and post-migration. Adopting a trauma-informed approach to care is essential in addressing these complex experiences. By integrating the principles of trauma-informed care (safety, trustworthiness, choice, collaboration, and empowerment) into all aspects of mental health support, a safe therapeutic environment can be created that validates clients' experiences and addresses trauma-related symptoms and triggers (Scottish Government, 2021). In practical terms, trauma-focused interventions such as Trauma-Focused Cognitive Behavioural Therapy (TF-CBT), Eye Movement Desensitisation and Reprocessing (EMDR), and Narrative Exposure Therapy (NET) have been shown to be effective in helping clients process traumatic memories and build coping skills (NICE, 2018). Clinicians should be equipped to recognise signs of trauma and provide appropriate referrals and interventions to support recovery. This is as important to consider in migrant healthcare professionals who come to the UK to work, as it is in refugees, who may be flagged by clinical services as vulnerable and needing support due to their forced migrant status.

It's also important for clinicians to recognise that despite the significant challenges faced by migrants and refugees, they often exhibit remarkable resilience and

resourcefulness. Adopting a strengths-based approach can empower clients by acknowledging and building upon their inherent strengths and cultural resources. Padesky and Mooney (2012) highlight the benefits of strengths-based Cognitive Behavioural Therapy (CBT), which focuses on identifying and amplifying clients' strengths to foster resilience and adaptation. This approach is particularly relevant for migrant mental health, as it can help clients navigate the difficulties of integration and acculturative stress and support post-traumatic growth. By reframing challenges as opportunities for growth and emphasising clients' successes, clinicians can foster a sense of agency and hope for clients who may be unable to do so for themselves. This strengths-based perspective can be integrated into various therapeutic modalities and can be especially effective when combined with culturally sensitive and trauma-informed practices.

It is also important for healthcare professionals to consider wider support beyond clinical therapies. Current portfolio findings have shown that migrants often face significant socioeconomic challenges, including limited access to resources and services, language barriers, and discrimination, in line with existing research (Pollard & Howard, 2021). By advocating for policies and practices that address the social determinants of health and promote inclusivity, clinicians can support clients to overcome some of these barriers (Davies et al., 2009). Such advocacy may include providing support for navigating complex healthcare systems (for instance, making interpreters and translated materials available), advocating for language and cultural resources, and addressing systemic barriers to care. The UK government's Hostile Environment policy, which aims to make life difficult for undocumented migrants, has been widely criticised for its negative impact on health and wellbeing (Griffiths & Yao, 2021). This policy creates barriers to accessing healthcare and other essential services, exacerbating health inequalities. Where health and social care professionals may be unable to change such government policies, they can advocate for funding and resources to support culturally competent and trauma-informed mental health services for migrants. Furthermore, by researching and publishing the impact of such policies on migrant populations, evidence for reviewing and changing them can be built.

The review highlights the critical need for inclusive public health messaging that reaches all segments of the population, including migrants and refugees. During the COVID-19 pandemic, the lack of accessible information in multiple languages and formats led to confusion and misinformation, as noted by Di Giuseppe (2021) and Knights et al. (2021). This communication gap contributed to health illiteracy and impacted vaccine uptake among migrant communities. Effective public health messaging should be culturally relevant and accessible, using channels and formats that resonate with migrant populations. Engaging community leaders and leveraging trusted networks can help disseminate accurate information and combat misinformation. This approach can improve health literacy and encourage informed decision-making, ultimately enhancing public health outcomes.

**Critical evaluation**

This thesis portfolio aimed to bridge the research gap in understanding the experiences of UK migrants and refugees during the COVID-19 pandemic, using a qualitative approach to study this. The following section will examine the strengths and limitations of the work and the field of work.

**Systematic review**

The systematic review aimed to use qualitative approaches to understand the experiences of migrants and refugees present in the UK during the COVID-19 pandemic. Results highlighted both their unique experiences of the pandemic and the mental health impacts of these experiences. By including qualitative rather than quantitative studies in this review, the voices of migrants and refugees were kept central. This is useful as their voices are often missing in research. As far as the researchers are aware, there are no other published systematic reviews exploring these experiences qualitatively. The current review findings provide an articulate account that bridges the gap in existing research. Another advantage of this review lies in the inclusion of studies with participants from different migrant backgrounds. This allowed for the inclusion of the

holistic perspectives of migrants who had been settled in the UK before the pandemic, migrants who had recently arrived in the UK, economic migrants, refugees and asylum seekers, giving a robust picture of their experiences and supporting more generalisability of their views to support future research.

In terms of limitations, a narrative synthesis was appropriate to analyse the findings because the studies included varied in their methodology, data collection techniques and targeted cohorts of migrants. However, this large variety could have impacted the synthesis and transparency of results across studies, as findings are subject to subjectivity and researcher bias. Addressing these limitations through future research efforts, such as including studies published in multiple languages and conducting meta-synthesis to integrate findings across diverse methodologies, can enhance the robustness and applicability of evidence in this field.

**Empirical paper**

A major strength of the qualitative empirical study lies in its focus on the voices and stories of a specific cohort of migrant nurses, recruited to work on mental health teams during the COVID-19 pandemic. It adds to the existing body of research focused on the experiences of migrant NHS workers, by bringing in the perspectives of this part of the international workforce introduced into a post-COVID NHS. By researching a specific NHS trust, the findings show the Trust's unique context, making the findings relevant to the Trust and mental health trusts in similar contexts across the country. The use of thematic analysis (TA) as a qualitative research method in this group further strengthened this study. As a method, TA offers flexibility, allowing researchers to adapt the analysis to fit a variety of research questions and data types. This adaptability makes comprehensive exploration of complex phenomena possible (Braun & Clarke, 2023). By identifying and reporting patterns (or themes) within data, a rich, detailed account of the nuances of peoples' experiences and perspectives can be drawn.

However, conducting this study within a single mental health trust may limit the generalisability of the findings. The experiences of migrant nurses in this one trust may not reflect those of migrant nurses in other trusts or healthcare settings. Therefore, the diversity of experiences captured in the study is limited, and caution should be exercised when applying the findings to other migrant cohorts or healthcare settings. Adhering to ethical guidelines, rigorous methodology, and transparent reporting of findings ensures the validity and trustworthiness of the study, making the findings relevant to the field of study.

### Further research

A future area for research is to further explore the impact of UK immigration policies on the health and integration outcomes of migrants and refugees. The COVID-19 pandemic highlighted how public health-related policy environments can worsen or alleviate health inequalities. Research should investigate how specific policies, such as those governing asylum procedures, access to healthcare, and social services, affect the physical and mental health of migrants and refugees. This includes exploring the barriers created by policies that create a hostile environment and how these barriers affect healthcare access and utilisation. By systematically evaluating these policies, evidence-based recommendations can be provided for more inclusive and supportive policy frameworks that protect the health and rights of migrants and refugees. Such studies are essential for informing policymakers and advocating for systemic changes that promote health equity.

The resilience strategies highlighted by the empirical study findings suggest that researching acculturative stress-induced growth among migrant healthcare workers could extend understanding of their experiences. This area of study can provide valuable insights into how stressors associated with adapting to a new cultural and professional environment can lead to personal and professional development. Specifically, research should investigate the mechanisms through which migrant healthcare workers navigate acculturative stress. Understanding these processes can highlight the potential for positive outcomes despite challenging circumstances and inform the development of

support systems that foster growth and integration. Such studies could employ longitudinal methods to track changes over time and identify factors that facilitate growth, contributing to more effective policies and practices that support the wellbeing and professional advancement of migrant healthcare workers in the UK.

**Personal reflection**

My motivations for undertaking this research are deeply rooted in both personal and professional dimensions of my life, particularly my passion for equity, access, and improving care for marginalised and under-served communities. This project felt significant to me, not only due to my interest in health inequalities but also because of my sense of responsibility, given my own identity as a migrant, which resonated strongly with the subject matter. The 'social graces' framework (Burnham & Nolte, 2019; Jones, 2019) has been particularly useful in framing my identity within this research context. This framework highlights how different aspects of our identities shape our professional practice. It encourages practitioners such as therapists, teachers, and social workers to recognise and reflect on how their own identities influence their perspectives and interactions, particularly in interactions with power imbalances. By promoting awareness of personal biases and cultural influences, the social graces framework aims to enhance sensitivity and effectiveness in professional practice, ensuring that identity-related factors are considered in decision-making and client interactions. (Burnham & Nolte, 2019; Jones, 2019). Framing my identity(ies) within this model, I am a practicing Christian, racialised as Black, cis gendered as female, and I identify as both a migrant and a British citizen, with cultural values tied to both British culture and my home country. I am highly educated and employed by the NHS. Reflecting on these aspects of my identity was important for me to do throughout this project, to ensure that I was aware of how my positioning might influence my research decision making, meaning making and interpretation of results, given the areas of my identity where I might be privileged. I also considered this important to be aware of, in terms of how the process and research content might impact me, given the areas of my identity where I might be marginalised.

Other aspects of my positioning relating to epistemology and ontology have been fully discussed in the empirical paper's methods section.

My connection to the research subject drove my commitment to addressing the gaps in understanding and amplifying the voices of those often overlooked in research discourse. During the early days of the pandemic, as the world grappled with the dual pressures of Brexit and COVID-19, I was particularly struck by the lack of empirical studies that contextualised the experiences of vulnerable groups, especially those that went beyond big data and quantitative analyses to engage with individuals on a personal level. When I encountered this research topic, it felt like a natural extension of my existing interests and a crucial opportunity to explore how the pandemic uniquely impacted the integration and mental health of migrants and refugees. The normal processes of integration were severely disrupted, and I felt a strong sense of responsibility to explore this topic, ensuring that the research was approached with sensitivity to the intersecting identities involved. Ultimately, this research represents my commitment to giving voice to those who have been silenced and to empowering them to achieve better outcomes in the face of systemic challenges.

Reflecting on my identity using the social graces framework also equipped me to consider various aspects of participants' identities in my empirical project, for instance their position as members of the valued NHS workforce who also belong to the migrant population. Reflection and reflexivity became more crucial as recruitment progressed, because some participants were from my country of origin. I could relate to aspects of their pre-migration experiences and could understand some of the push-pull factors that influenced their decision to migrate to the UK, their experiences of integration, and themes about the role of faith in coping with adversity. Although our experiences were different in many ways, the similarities were significant, meaning that I needed to continuously reflect on my approach to research interviews, ensuring that I maintained professional boundaries whilst using research interview skills to elicit data relevant to the research topic. Discussing these issues with my thesis supervisors was invaluable to prepare me ahead of data collection, and so I kept a reflective journal from the beginning

of the research project and all through the process. I found it particularly challenging listening to participants' accounts of difficult experiences during the empirical interviews and (to a lesser degree), during the extraction of systematic review data; however, this was expected, given the nature of the research topic in the context of my identity. To manage my wellbeing, I ensured that research interviews were planned with sufficient gaps to allow me to engage in selfcare and nurturing activities immediately afterwards, such as journalling, going for a walk, swimming or other mindful activities. I continued to use regular thesis supervision meetings to explore these experiences during transcription and data analysis. I want to note that there were many aspects of the interviews that were comforting, such as when participants shared relatable positive anecdotes about arrival and integration into UK life.

Reflecting on privileged aspects of my identity allowed me to hold awareness of how participants might experience the interview process if they perceived me through the lens of my identities as a trainee clinical psychologist and NHS employee, particularly in the context of the difficult experiences they recounted within the NHS. A useful strategy to manage this was that I adopted the role of the researcher, explaining this during the pre-interview phone calls. By creating an 'interviewer/interviewee' dynamic, using participants' preferred names and asking them to use my first name, participants were made to understand that their stories were integral to the research process. Overall, I felt entrusted with the stories shared by these participants, and I can only hope that the final portfolio represents the effort I have put into centering their perspectives in the empirical study. It has certainly been a privilege for me to engage in this research study and hear these stories.

I faced many personal challenges whilst completing this thesis portfolio, leading to delays and interruptions. I have come to understand that even when a research project has been well planned and adequate support provided by thesis supervisors, the unexpected can happen. I also experienced the process of obtaining HRA approval for the first time, as it was required for the empirical study. Being unfamiliar with the process, I had not planned sufficiently for any delays to obtaining it when scheduling thesis deadlines. I am still learning how to manage such disruptions, however, being able

to communicate easily with my supervisors has been helpful, whether through emails to keep them updated, or through online meetings.

**Conclusion**

This portfolio has explored the perspectives and experiences of UK migrants and refugees during the COVID-19 pandemic, as related to impacts on mental health. A systematic review was conducted exploring the mental health impact of the experiences of refugees and migrants present in the UK during the COVID-19 pandemic. Three key themes (each with two sub-themes) emerged from the systematic review: adapting and coping, experiences of disturbance and systemic issues. The findings showed that many of the challenges faced by UK migrants and refugees escalated during the COVID-19 pandemic, but participants relied on personal strategies to cope for prolonged periods of the pandemic and lockdowns. An empirical study was conducted using qualitative methods to explore the experiences of migrant nurses recruited to work in the UK during the COVID-19 pandemic and to understand any psychological impact of these experiences. Thematic analysis showed four overarching themes: shattered promises about hopes for the future, being an outsider, the strain of adaptation and having to survive; with a total of ten sub-themes.

Reflecting on the findings of this research through the lens of social determinants of health, the mental health of migrants and refugees during COVID-19 cannot be understood solely through individual interventions or therapeutic approaches. Their lived experiences are shaped by the broader socioeconomic, environmental, and political contexts in which they find themselves- contexts that often exacerbate vulnerabilities and inequalities. Taking the perspective that health and wellbeing follow a social gradient, with people at the lower socioeconomic positions being more likely to have worse outcomes (Salami et al., 2017), the reality is that those at the lower end of the social gradient, such as many migrants and refugees, face significant barriers to accessing services, securing stable housing, and integrating into communities. These barriers are not merely logistical or administrative; they are deeply embedded in the social structures that perpetuate disadvantage and disempowerment. However, amidst

these structural challenges, the research also highlights the profound impact of small, humanising actions- like the simple act of smiling. Participants frequently mentioned the importance of such gestures, which, although seemingly minor, played a crucial role in making them feel seen and supported within a system that often overlooks their needs. A smile, a kind word, or a moment of genuine connection can be incredibly powerful, offering a sense of belonging and safety in an otherwise alienating environment. These actions serve as a reminder that while systemic change is essential, the day-to-day interactions within healthcare settings also hold significant potential to transform experiences and outcomes for those on the margins.

The findings of this thesis portfolio show a need to further understand the experiences of migrants and refugees in the context of how these experiences impact their mental health. They also call for a dual approach: addressing the social determinants of health that shape the broader context of migrant and refugee experiences, while also fostering an environment within healthcare systems where every interaction, no matter how small, contributes to the empowerment and wellbeing of these individuals. This requires a collective commitment from all healthcare workers, regardless of their role, to be more aware of the diverse journeys that people are on and to recognise the power they have in their hands to make a difference. Ultimately, creating a more inclusive and supportive system involves both systemic reform and the conscious, compassionate actions of individuals within that system.

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## Appendices

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APPENDIX A - Author guidelines for Journal of International Migration and Integration

**Instructions for Authors**

Editorial procedure

Double-blind peer review

This journal follows a double-blind reviewing procedure. This means that the author will remain anonymous to the reviewers throughout peer review. It is the responsibility of the author to anonymize the manuscript and any associated materials.

- Author names, affiliations and any other potentially identifying information should be removed from the manuscript text and any accompanying files (such as figures of supplementary material);
- A separate Title Page should be submitted, containing title, author names, affiliations, and the contact information of the corresponding author. Any acknowledgements, disclosures, or funding information should also be included on this page;
- Authors should avoid citing their own work in a way that could reveal their identity.

Peer Review Procedure

Manuscripts reporting primary research or secondary analysis of primary research will have at least two referees per manuscript. Final decisions to accept or reject can be made by the Editors-in-Chief.

Additional Information

*Journal of International Migration and Integration* also publishes special issues. The peer review process of any submission associated with a special issue, follows the procedure of the journal, but is handled by Guest Editors who are responsible for assigning at least two referees to each article and evaluating the reviews. Guest Editors make recommendations and request and evaluate revisions, but only the Editors-in-Chief can make final decisions of accept or

reject on any special issue article. Any articles submitted to a special issue by Guest Editors are also handled confidentially by Associate Editors or a (senior) member of the Editorial Board outside of the normal refereeing process of the special issue to ensure that the evaluation of these articles is completely objective.

## Manuscript Submission

Manuscript Submission

Submission of a manuscript implies: that the work described has not been published before; that it is not under consideration for publication anywhere else; that its publication has been approved by all co-authors, if any, as well as by the responsible authorities – tacitly or explicitly – at the institute where the work has been carried out. The publisher will not be held legally responsible should there be any claims for compensation.

## Permissions

Authors wishing to include figures, tables, or text passages that have already been published elsewhere are required to obtain permission from the copyright owner(s) for both the print and online format and to include evidence that such permission has been granted when submitting their papers. Any material received without such evidence will be assumed to originate from the authors.

## Online Submission

Please follow the hyperlink "Submit manuscript" and upload all of your manuscript files following the instructions given on the screen.

## Source Files

Please ensure you provide all relevant editable source files at every submission and revision. Failing to submit a complete set of editable source files will result in your article not being considered for review. For your manuscript text please always submit in common word processing formats such as .docx or LaTeX.

Length of Article

JIMI has a word limit of 7500 words for an original research article and a limit of 5000 words for research notes and policy matters excluding figures, tables and references.

Title Page

Please make sure your title page contains the following information.

Title

The title should be concise and informative.

Author information

- The name(s) of the author(s)
- The affiliation(s) of the author(s), i.e. institution, (department), city, (state), country
- A clear indication and an active e-mail address of the corresponding author
- If available, the 16-digit ORCID of the author(s)

If address information is provided with the affiliation(s) it will also be published.

For authors that are (temporarily) unaffiliated we will only capture their city and country of residence, not their e-mail address unless specifically requested.

Large Language Models (LLMs), such as ChatGPT, do not currently satisfy our authorship criteria. Notably an attribution of authorship carries with it accountability for the work, which cannot be effectively applied to LLMs. Use of an LLM should be properly documented in the Methods section (and if a Methods section is not available, in a suitable alternative part) of the manuscript.

Abstract

Please provide an abstract of 150 to 250 words. The abstract should not contain any undefined abbreviations or unspecified references.

*For life science journals only (when applicable)*

- Trial registration number and date of registration for prospectively registered trials
- Trial registration number and date of registration, followed by "retrospectively registered", for retrospectively registered trials

Keywords

Please provide 4 to 6 keywords which can be used for indexing purposes.

Statements and Declarations

The following statements should be included under the heading "Statements and Declarations" for inclusion in the published paper. Please note that submissions that do not include relevant declarations will be returned as incomplete.

- **Competing Interests:** Authors are required to disclose financial or non-financial interests that are directly or indirectly related to the work submitted for publication. Please refer to "Competing Interests and Funding" below for more information on how to complete this section.

Please see the relevant sections in the submission guidelines for further information as well as various examples of wording. Please revise/customize the sample statements according to your own needs.

Text

Text Formatting

Manuscripts should be submitted in Word.

- Use a normal, plain font (e.g., 10-point Times Roman) for text.
- Use italics for emphasis.
- Use the automatic page numbering function to number the pages.
- Do not use field functions.
- Use tab stops or other commands for indents, not the space bar.
- Use the table function, not spreadsheets, to make tables.
- Use the equation editor or MathType for equations.
- Save your file in docx format (Word 2007 or higher) or doc format (older Word versions).

Manuscripts with mathematical content can also be submitted in LaTeX. We recommend using Springer Nature's LaTeX template.

### Headings

Please use no more than three levels of displayed headings.

### Abbreviations

Abbreviations should be defined at first mention and used consistently thereafter.

### Footnotes

Footnotes can be used to give additional information, which may include the citation of a reference included in the reference list. They should not consist solely of a reference citation, and they should never include the bibliographic details of a reference. They should also not contain any figures or tables.

Footnotes to the text are numbered consecutively; those to tables should be indicated by superscript lower-case letters (or asterisks

for significance values and other statistical data). Footnotes to the title or the authors of the article are not given reference symbols.

Always use footnotes instead of endnotes.

### Acknowledgments

Acknowledgments of people, grants, funds, etc. should be placed in a separate section on the title page. The names of funding organizations should be written in full.

### References

#### Citation

Cite references in the text by name and year in parentheses. Some examples:

- Negotiation research spans many disciplines (Thompson, 1990).
- This result was later contradicted by Becker and Seligman (1996).
- This effect has been widely studied (Abbott, 1991; Barakat et al., 1995; Kelso & Smith, 1998; Medvec et al., 1999).

Authors are encouraged to follow official APA version 7 guidelines on the number of authors included in reference list entries (i.e., include all authors up to 20; for larger groups, give the first 19 names followed by an ellipsis and the final author's name). However, if authors shorten the author group by using et al., this will be retained.

#### Reference list

The list of references should only include works that are cited in the text and that have been published or accepted for publication. Personal communications and unpublished works should only be mentioned in the text.

Reference list entries should be alphabetized by the last names of the first author of each work.

Journal names and book titles should be *italicized*.

If available, please always include DOIs as full DOI links in your reference list (e.g. "https://doi.org/abc").

- Journal article Grady, J. S., Her, M., Moreno, G., Perez, C., & Yelinek, J. (2019). Emotions in storybooks: A comparison of storybooks that represent ethnic and racial groups in the United States. *Psychology of Popular Media Culture, 8*(3), 207–217. https://doi.org/10.1037/ppm0000185
- Article by DOI Hong, I., Knox, S., Pryor, L., Mroz, T. M., Graham, J., Shields, M. F., & Reistetter, T. A. (2020). Is referral to home health rehabilitation following inpatient rehabilitation facility associated with 90-day hospital readmission for adult patients with stroke? *American Journal of Physical Medicine & Rehabilitation*. Advance online publication. https://doi.org/10.1097/PHM.0000000000001435
- Book Sapolsky, R. M. (2017). *Behave: The biology of humans at our best and worst*. Penguin Books.
- Book chapter Dillard, J. P. (2020). Currents in the study of persuasion. In M. B. Oliver, A. A. Raney, & J. Bryant (Eds.), *Media effects: Advances in theory and research* (4th ed., pp. 115–129). Routledge.
- Online document Fagan, J. (2019, March 25). *Nursing clinical brain*. OER Commons. Retrieved January 7, 2020, from https://www.oercommons.org/authoring/53029-nursing-clinical-brain/view

Tables

- All tables are to be numbered using Arabic numerals.
- Tables should always be cited in text in consecutive numerical order.

- For each table, please supply a table caption (title) explaining the components of the table.
- Identify any previously published material by giving the original source in the form of a reference at the end of the table caption.
- Footnotes to tables should be indicated by superscript lower-case letters (or asterisks for significance values and other statistical data) and included beneath the table body.

Other guidelines are available via the link here:
https://link.springer.com/journal/12134/submission-guidelines

APPENDIX B Enhancing Transparency in REporting the synthesis of Qualitative research (ENTREQ) guidelines

S1 Table. Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ Checklist (Tong, et al., 2012)

| Item No | Guide and Description | Report Location |
|---|---|---|
| 1. Aim | State the research question the synthesis addresses | Introduction- p.19 |
| 2. Synthesis methodology | Identify the synthesis methodology or theoretical framework which underpins the synthesis, and describe the rationale for choice of methodology (e.g. meta-ethnography, thematic synthesis, critical interpretive synthesis, grounded theory synthesis, realist synthesis, meta-aggregation, meta-study, framework synthesis) | Data Extraction and Synthesis p.25-26 |
| 3. Approach to searching | Indicate whether the search was pre-planned (comprehensive search strategies to seek all available studies) or iterative (to seek all available concepts until they theoretical saturation is achieved) | Study search strategy and process – p.*20-21* |
| 4. Inclusion criteria | Specify the inclusion/exclusion criteria (e.g. in terms of population, language, year limits, type of publication, study type) | Literature search and selection – p.*20, p.22-24* |
| 5. Data sources | Describe the information sources used (e.g. electronic databases (MEDLINE, EMBASE, CINAHL, psycINFO), grey literature databases (digital thesis, policy reports), relevant organisational websites, experts, information specialists, generic web searches (Google Scholar) hand searching, reference lists) and when the searches conducted; provide the rationale for using the data sources | Study search strategy and process – *Electronic searches & searching other resources* p.24-25 |
| 6. Electronic Search strategy | Describe the literature search (e.g. provide electronic search strategies with population terms, clinical or health topic terms, experiential or social phenomena related terms, filters for qualitative research, and search limits) | Full search terms outlined on p.24-25 and Appendix D. |
| 7. Study screening methods | Describe the process of study screening and sifting (e.g. title, abstract and full text review, number of independent reviewers who screened studies) | Study selection – Fig 2.1 PRISMA flowchart diagram p.27 |

| | | |
|---|---|---|
| 8. Study characteristics | Present the characteristics of the included studies (e.g. year of publication, country, population, number of participants, data collection, methodology, analysis, research questions) | Table 2.2 - Study characteristics p.30-40 |
| 9. Study selection results | Identify the number of studies screened and provide reasons for study exclusion (e.g. for comprehensive searching, provide numbers of studies screened and reasons for exclusion indicated in a figure/flowchart; for iterative searching describe reasons for study exclusion and inclusion based on modifications to the research question and/or contribution to theory development) | Fig 2.1 PRISMA flowchart diagram p.27 |
| 10. Rationale for appraisal | Describe the rationale and approach used to appraise the included studies or selected findings (e.g. assessment of conduct (validity and robustness), assessment of reporting (transparency), assessment of content and utility of the findings) | Appraisal of the methodological limitations of included studies p. 28-29 |
| 11. Appraisal items | State the tools, frameworks and criteria used to appraise the studies or selected findings (e.g. Existing tools: CASP, QARI, COREQ, Mays and Pope [25]; reviewer developed tools; describe the domains assessed: research team, study design, data analysis and interpretations, reporting) | Appraisal of the methodological limitations of included studies – p.29 Appendices E and F |
| 12. Appraisal process | Indicate whether the appraisal was conducted independently by more than one reviewer and if consensus was required | Quality Review subheading p.25 |
| 13. Appraisal results | Present results of the quality assessment and indicate which articles, if any, were weighted/excluded based on the assessment and give the rationale | Appraisal of the methodological limitations of included studies – Appendix F |
| 14. Data extraction | Indicate which sections of the primary studies were analysed and how were the data extracted from the primary studies? (e.g. all text under the headings "results /conclusions" were extracted electronically and entered into a computer software) | Methodology of synthesis – *"all relevant qualitative data" p.25-26* |
| 15. Software | State the computer software used, if any | Microsoft Excel p.25-26 |
| 16. Number of reviewers | Identify who was involved in coding and analysis | Quality Review subheading p.25 |
| 17. Coding | Describe the process for coding of data (e.g. line by line coding to search for concepts) | NA – Narrative synthesis. See Data Extraction |

| | | |
|---|---|---|
| | | and Synthesis subheading p. 25-26 |
| 18. Study comparison | Describe how were comparisons made within and across studies (e.g. subsequent studies were coded into pre-existing concepts, and new concepts were created when deemed necessary) | Findings mapped to a table and links between findings made. See Data Extraction and Synthesis subheading p. 25-26 |
| 19. Derivation of themes | Explain whether the process of deriving the themes or constructs was inductive or deductive | Inductive process - See Data Extraction and Synthesis subheading p. 25-26 |
| 20. Quotations | Provide quotations from the primary studies to illustrate themes/constructs, and identify whether the quotations were participant quotations of the author's interpretation | Findings - *p.41-50* |
| 21. Synthesis output | Present rich, compelling and useful results that go beyond a summary of the primary studies (e.g. new interpretation, models of evidence, conceptual models, analytical framework, development of a new theory or construct) | Discussion - *P.51-58* |

APPENDIX C. Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist

| Section and Topic | Item # | Checklist item | Location where item is reported |
|---|---|---|---|
| **TITLE** | | | |
| Title | 1 | Identify the report as a systematic review. | p. 15 |
| **ABSTRACT** | | | |
| Abstract | 2 | See the PRISMA 2020 for Abstracts checklist. | p. 16 |
| **INTRODUCTION** | | | |
| Rationale | 3 | Describe the rationale for the review in the context of existing knowledge. | p. 17-19 |
| Objectives | 4 | Provide an explicit statement of the objective(s) or question(s) the review addresses. | p. 19 |
| **METHODS** | | | |
| Eligibility criteria | 5 | Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses. | p. 22-23 |
| Information sources | 6 | Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted. | p. 24-25 |
| Search strategy | 7 | Present the full search strategies for all databases, registers and websites, including any filters and limits used. | p. 20-23, Appendix D |
| Selection process | 8 | Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process. | p. 22-25 |
| Data collection process | 9 | Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process. | p. 25-26 |
| Data items | 10a | List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect. | p. 25-26 |
| | 10b | List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information. | p. 25-26 |
| Study risk of bias assessment | 11 | Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process. | p. 28-29 |
| Effect measures | 12 | Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results. | NA for qualitative systematic review |
| Synthesis methods | 13a | Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)). | p. 25-26 |
| | 13b | Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data | NA for qualitative |

| Section and Topic | Item # | Checklist item | Location where item is reported |
|---|---|---|---|
| | | conversions. | systematic review |
| | 13c | Describe any methods used to tabulate or visually display results of individual studies and syntheses. | p. 25-26 |
| | 13d | Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used. | p. 25-26 |
| | 13e | Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression). | NA for qualitative systematic review |
| | 13f | Describe any sensitivity analyses conducted to assess robustness of the synthesized results. | NA for qualitative systematic review |
| Reporting bias assessment | 14 | Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases). | NA for qualitative systematic review |
| Certainty assessment | 15 | Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome. | NA for qualitative systematic review |
| **RESULTS** | | | |
| Study selection | 16a | Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram. | p.27 |
| | 16b | Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded. | NA |
| Study characteristics | 17 | Cite each included study and present its characteristics. | p. 30-40 |
| Risk of bias in studies | 18 | Present assessments of risk of bias for each included study. | NA |
| Results of individual studies | 19 | For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots. | NA |
| Results of syntheses | 20a | For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies. | p. 25, P.56 |
| | 20b | Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect. | p. 41-50 |
| | 20c | Present results of all investigations of possible causes of heterogeneity among study results. | NA for qualitative systematic review |
| | 20d | Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results. | NA for qualitative systematic review |
| Reporting biases | 21 | Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed. | NA for qualitative systematic review |
| Certainty of evidence | 22 | Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed. | NA for qualitative systematic review |

| Section and Topic | Item # | Checklist item | Location where item is reported |
|---|---|---|---|
| **DISCUSSION** | | | |
| Discussion | 23a | Provide a general interpretation of the results in the context of other evidence. | p. 50-58 |
| | 23b | Discuss any limitations of the evidence included in the review. | p. 55-57 |
| | 23c | Discuss any limitations of the review processes used. | p. 55- 57 |
| | 23d | Discuss implications of the results for practice, policy, and future research. | p. 53- 55; p.57-58 |
| **OTHER INFORMATION** | | | |
| Registration and protocol | 24a | Provide registration information for the review, including register name and registration number, or state that the review was not registered. | p. 20 |
| | 24b | Indicate where the review protocol can be accessed, or state that a protocol was not prepared. | p. 20 |
| | 24c | Describe and explain any amendments to information provided at registration or in the protocol. | NA |
| Support | 25 | Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review. | NA |
| Competing interests | 26 | Declare any competing interests of review authors. | NA |
| Availability of data, code and other materials | 27 | Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review. | NA |

*From:* Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

For more information, visit: http://www.prisma-statement.org/

APPENDIX D. Systematic Review full search strategy

Full search terms using the SPIDER strategy where:

S = Sample

P = Phenomenon of

I = Interest

D = Design

E = Evaluation

R = Research type

In the ‘Evaluation’ column, search terms included “COVID-19” OR "COVID 19" OR coronavirus or pandemic. Both the D and R elements of the SPIDER tool {‘D’ being ‘Design’ (only peer-reviewed, published literature)} and {‘R’ being ‘Research type’ (includes qualitative methods)} were relevant to the search strategy. However, both elements were not included in the search terms and were instead applied to filter results instead. Boolean operators ‘and’ and ‘or’, wildcards, and truncation symbols ‘*’, were adapted to each database and used to combine search terms and maximise search results.

Search terms were therefore as follows:

"economic migrant" OR “migrant” OR “immigrant” OR “immigration” OR “migration” AND "mental health" or "well-being" or 'well being" or "emotional health" or "psychological health" or mood or depress* or anxiety or psych* AND COVID-19” OR "COVID 19" OR coronavirus or pandemic

Results were filtered by period (2020-2024), by geography (‘UK’, ‘United Kingdom’, ‘England’, ‘Scotland’, ‘Wales’ and ‘Northern Ireland’) and by type (peer-reviewed articles only).

## APPENDIX E. CASP Qualitative Assessment Checklist


www.casp-uk.net
info@casp-uk.net
Summertown Pavilion, Middle Way Oxford OX2 7LG

**CASP Checklist:** 10 questions to help you make sense of a **Qualitative** research

**How to use this appraisal tool:** Three broad issues need to be considered when appraising a qualitative study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

**About:** These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

**Referencing:** we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

APPENDIX F. CASP quality assessment table

| Paper ID | Reference | Was there a clear statement of the aims of the research? | Is a qualitative methodology appropriate? | Was the research design appropriate to address the aims of the study? | Was the recruitment strategy appropriate to the aims of the research? | Was the data collected in a way that addressed the research issue? | Has the relationship between researcher and participants been adequately considered? | Have ethical issues been taken into consideration? | Was the data analysis sufficiently rigorous? | Is there a clear statement of findings? | How valuable is the research? | Quality rating |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Study 1 | Saleem et. al. (2021). | Yes | Yes | Yes | Yes | Yes | No conflicts were declared, but researchers did not include any reflection/reflexivity about their identity/values relative to that of participants. | Yes, but no details about information governance and data storage was detailed. | Yes | Yes | Yes, valuable to understand aims. | 8.5 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Study 2 | Yen et. al. (2021). | Yes | Yes | Yes | Yes | Yes, but curious about sample size (60) for a primary source qualitative study and implications for data saturation. | No | No- this was implied by outlining the consent process but not explicitly specified in terms of data protection, information governance or the potential impact of research topic on participants. | Yes. However, the framework is novel, and it would have been interesting to see this analysed with a more commonly used qualitative | Yes | Yes, valuable to understand aims. | 7.5 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | framework. | | | | |
| Study 3 | Yen et. al. (2023). | Yes | Yes | Yes | Yes | Yes. | No | No- this was implied by outlining the consent process but not explicitly specified in terms of data protection, information governance or the potential impact of | Yes | Yes | Yes, valuable to understand aims. | 8 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | research topic on participants. | | | | |
| Study 4 | Stewart & Sanders (2023) | Yes | Yes | Yes | Yes | Yes | No | No- this was implied by outlining the consent process but not explicitly specified in terms of data protection, information governance or the potential impact of | Yes | Yes | Yes, valuable to understand aims. | 8.5 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | research topic on participants. | | | | |
| Study 5 | Burns et. al. (2022) | Yes | Yes | Yes | Yes | Yes, but curious about sample size (77) for a primary source qualitative study and implications for data | No | Yes | Yes | Yes | Yes, valuable to understand aims. | 9 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | saturation. | | | | | | |
| Study 6 | Kelly (2022) | Yes | Yes | Yes | Yes | Yes, but curious about sample size (70) for a primary source qualitative study and implications for data | Yes | Yes | Yes | Yes | Yes, valuable to understand aims. | 9.5 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | saturation. | | | | | | |
| Study 7 | Di Giuseppe (2021) | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes, valuable to understand aims. | 10 |
| Study 8 | Knights et. al. (2021) | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes | Yes, valuable to understand aims. | 10 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Study 9 | Gordon (2023) | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes | Yes, valuable to understand aims. | 9 |
| Study 10 | Cheng et. al. (2023) | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes | Somewhat | 8.5 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Study 11 | Tschalaer, (2022) | Yes | Yes | Somewhat - Yes it contextualised many types of voices | Perhaps structured interviews rather than a mix of different data sources. | Yes | Yes | Somewhat | Yes | Yes, valuable to understand aims. | 8.5 |
| Study 12 | Miles et. al. (2023) | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes | Yes, valuable to understand aims. | 9 |

APPENDIX G. Standards for Reporting Qualitative Research (SRQR)

## Standards for Reporting Qualitative Research (SRQR)*

http://www.equator-network.org/reporting-guidelines/srqr/

| | Page/line no(s). |
|---|---|
| **Title and abstract** | |
| **Title** - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended | p. 66 |
| **Abstract** - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions | p. 67-68 |
| **Introduction** | |
| **Problem formulation** - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement | p. 69-71 |
| **Purpose or research questio**n - Purpose of the study and specific objectives or questions | p. 71 |
| **Methods** | |
| **Qualitative approach and research paradigm** - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale** | p. 71-72 |
| **Researcher characteristics and reflexivity** - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability | p. 72 |
| **Context** - Setting/site and salient contextual factors; rationale** | p.72 |
| **Sampling strategy** - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale** | p. 72-73 |
| **Ethical issues pertaining to human subjects** - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues | p. 74 |
| **Data collection methods** - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale** | p. 77 |

| | |
|---|---|
| **Data collection instruments and technologies** - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study | p. 77 |
| **Units of study** - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results) | p. 75-77 |
| **Data processing** - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts | p. 77 |
| **Data analysis** - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale** | p. 77 |
| **Techniques to enhance trustworthiness** - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale** | p. 77 |

**Results/findings**

| | |
|---|---|
| **Synthesis and interpretation** - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory | p. 78-94 |
| **Links to empirical data** - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings | p. 78-94 |

**Discussion**

| | |
|---|---|
| **Integration with prior work, implications, transferability, and contribution(s) to the field -** Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field | p. 95-102 |
| **Limitations** - Trustworthiness and limitations of findings | |

**Other**

| | |
|---|---|
| **Conflicts of interest** - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed | p. 120-123 |
| **Funding** - Sources of funding and other support; role of funders in data collection, interpretation, and reporting | NA for thesis portfolio |

*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

**The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

**Reference:**
O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. **Standards for reporting qualitative research: a synthesis of recommendations.** *Academic Medicine*, Vol. 89, No. 9 / Sept 2014
DOI: 10.1097/ACM.0000000000000388

APPENDIX H – Research study leaflet

## Invitation to take part in a research study.

# ARE YOU A MIGRANT WORKING AS AN NHS NURSE? DID YOU ARRIVE IN THE UK DURING THE COVID-19 PANDEMIC?

Frontline healthcare staff working during the COVID-19 pandemic have been shown to have been impacted in various ways over the past two years. In the UK, many frontline healthcare staff are migrants who, as a whole, are under-represented in research. It is important now more than ever, to include such groups in psychological research, in order to achieve better mental health outcomes for society. This study aims to explore the experience of migrant healthcare professionals recruited into (NHS) during COVID-19, understanding their experience of migration and integration into the NHS workforce within the context of any psychological impact of these experiences.

I would like to invite you to take part in this research, which involves speaking to me in a 1-1 interview (either online via video conference or face to face at a location convenient to you) and talking about your experiences during the pandemic.

This research has the potential to benefit migrant healthcare workers, helping to understand what their experiences of migrating to the UK during the pandemic has been, and how the process can be improved to ensure that adequate wellbeing and support is provided. If you decide to take part, we will say thank you with a small token.

I would very much appreciate you participating in this important study. If you have any questions about the research, or would like to take part, please do get in touch by:
1.Contacting me directly using the information below.
2.Consenting for your contact details to be sent to us by the person who gave you this leaflet, for us to contact you.

Thank you.

**Zinny Obi Oriaku**
**Trainee Clinical Psychologist**
**University of East Anglia**
**Norwich Research Park**
**Norwich NR4 7TJ**
**Email: z.obi-oriaku@uea.ac.uk**
**Tel: (07596506431)**

**Supervisors:**
Dr Bonnie Teague.
Email: b.teague@uea.ac.uk

Dr Imogen Rushworth
Email: i.rushworth@uea.ac.uk

**This study has been approved by the University of East Anglia Faculty of Medicine and Health Ethics Committee.**

APPENDIX I – Participant information sheet

**PARTICIPANT INFORMATION SHEET**

**Study title:** Exploring the psychological impact of the COVID-19 pandemic on UK migrant and refugee nurses. A qualitative exploration using thematic analysis (TA).

**Invitation:**
*You are being invited to take part in a research study into the experiences of migrant and refugee healthcare staff coming to the UK for work during the COVID 19 pandemic. This study is being conducted by a student of the Doctorate in Clinical Psychology (Trainee Clinical Psychologist), University of East Anglia (UEA).*

**What is the study about?**
*The research is focused on exploring the integration and wellbeing of migrant and refugee healthcare staff who have joined the NHS during the pandemic.*

**Purpose of and background to the research and invitation**
*The pandemic has affected the mental health and wellbeing of people in frontline healthcare. Many those people are migrants who have come to the UK to work in the NHS.* We do *not know exactly what the experiences of migrants and refugees who arrived in the UK during the pandemic has been, and what it has been like for them to work in the NHS at such a busy time. We don't know this because very few people have tried to find out. This study is going to find out by asking them about their experiences during COVID-19 and what it has been like for them to move to the UK and work in healthcare looking after people here. The results will help provide support for this group in their places of work and in looking after their mental health.*

**Why have I been invited to participate in this study? Do I have to take part?**
- *You have been invited to participate because you arrived in the UK and joined the NHS workforce during the COVID –19 pandemic.*
- *Your participation in this study is voluntary. While we would be pleased to have you participate, we respect your right to decline. If you decide not to participate this will not affect you in any way. You can withdraw from the study at any time up to the analysis stage without giving a reason.*
- *If you do decide to take part, you will be given this information sheet to keep and will be asked to sign a consent form.*

**What would taking part involve?**
- *The research involves speaking about your experiences of joining the NHS workforce during the COVID-19 pandemic in a 1-1 interview with the researcher. Interviews will be conducted via video conference on Microsoft Teams.*
- *The interview will last about 60-90 minutes.*

- *The interview will be video-recorded on Microsoft Teams for the sole purpose of producing an accurate transcript of the recording, which will be analysed as part of the research. In the final write-up, your responses may be quoted. If this is done, it would remain anonymous to protect your confidentiality. All recordings will be deleted within a week of interview, as soon as the transcript has been verified.*

**What are the possible benefits of taking part?**

- *You will have the opportunity to help create an understanding of the needs of the migrant NHS workforce which will help services adapt to meet them more adequately.*

**What are the possible disadvantages of taking part?**

- *Some of these experiences might be difficult to speak about, however, information will be available during the interview about where to get additional support if you require it.*

**Will my participation be kept confidential?**

*In this research study we will only use information that we need for the research study, which is limited to anonymous demographic information. We will let only the researcher know your name or contact details, and this will only be for this study.*
*Everyone involved in this study will keep your data safe and secure. We will also follow all privacy rules.*

*At the end of the study we will save the interview transcripts in case we need to check it. We will make sure no-one can work out who you are from the reports we write.*
*The information pack tells you more about this.*

**How will we use information about you?**

*We will need to use demographic information from you, which are recorded without your name or other details that identifies you. This information will include:*

- *your age*
- *any religion or faith*
- *residency status*
- *educational status*
- *training and qualifications*
- *years of professional practice outside the UK*
- *your family status (single, married/partnered, any kids/other dependents)*

*This information will be used to do the research and to make sure that the research is being done properly. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.*

*We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.*

**What are your choices about how your information is used?**
*You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.*

**Where can you find out more about how your information is used?**
*You can find out more about how we use your information*

- *at https://www.uea.ac.uk/documents/20142/8071027/final_research_data_management_policy_v2-0_02_11_22.pdf/58c84e80-7b89-c619-9347-dec7fb0657a7?t=1667898762007*
- *from our leaflet available from the Overseas Talent Group*
- *by asking one of the research team*
- *by sending an email to the sponsor (UEA) Data Protection Officer at **dataprotection@uea.ac.uk**.*

**What happens to my research data after the study?**
*Researchers must make sure they write the reports about the study in a way that no-one can work out that you took part in the study.*
*Once they have finished the study, the research team will keep the research data for several years, in case they need to check it. You can ask about who will keep it, whether it includes your name, and how long they will keep it.*

*Any information that could show who you are will be held safely with strict limits on who can access it.*

**What will happen to the results of the research project?**

- *The final report from this study may be published in journals or other publications, and results may be provided to you if you would want to read it. if you do, please let us have your contact information for this purpose.*

**What if I require further information?**

- If you would like to discuss any aspect of this study, please feel free to contact either Dr Bonnie Teague (email: b.teague@uea.ac.uk) or Dr Imogen Rushworth (email: i.rushworth@uea.ac.uk), who would be happy to discuss any aspect of the research with you.

**What if I have a complaint or concerns?**

- *This research has been approved by the University of East Anglia Faculty of Medicine and Health Ethics Committee.*
  *If you have concerns or complaints about the conduct of this study, please contact either Dr Bonnie Teague (email: b.teague@uea.ac.uk) or Dr Imogen Rushworth*
  *(email: i.rushworth@uea.ac.uk).*

APPENDIX J – Consent form

**Doctorate in Clinical Psychology (ClinPsyD) University of East Anglia**

**Participant Identification Number for this study:**

**CONSENT FORM**

Exploring the psychological impact of the COVID-19 pandemic on UK migrant and refugee nurses: A qualitative exploration using thematic analysis (TA).

**Name of Researcher:** Zinny Obi Oriaku

Please initial box

☐ I confirm that I have read the information sheet dated..... for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐ I consent to my interview being video and audio recorded by the researcher for the purpose of producing a recording transcript.

☐ I consent to the use of my anonymised direct quotes in the final write-up.

☐ I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

☐ I understand that the information collected about me will be used to support other research in the future and may be shared anonymously with other researchers.

☐ I agree to take part in the above study.

☐ I consent to the filing arrangements for this consent form: 1 copy filed on the investigator's site file, and 1 copy for me, the participant.

| _____ | _____ | _____ |
|---|---|---|
| Name of Participant | Date | Signature |

*Filing:*

*1 copy saved to investigator's site file.*

*1 copy given to participant*.

APPENDIX K – Commentary on data saturation

## Commentary on data saturation

Data saturation in qualitative research refers to the point in the data collection process where researchers find enough information has been obtained to develop a comprehensive understanding of the research topic (Guest et. al., 2020). At this stage, further data collection provides no new insights or perspectives, as the themes and patterns have already been identified and analysed, and further coding is not feasible (Fusch & Ness, 2015). Braun and Clarke (2021) argue that the concept of 'data saturation' and other alternative concepts do not typically reflect the values and assumptions of reflexive TA when they guide the researcher to determine the point at which to end data collection. They suggest that reflexive TA generates meaning through the "interpretation of", rather than "excavation from" data. Their suggestion to account for the epistemological position of the research was taken into consideration throughout the process, along with recruitment and timeline constraints when settling on the current sample size of 11.

## APPENDIX L – UEA ethics approval letter

**From: Ethics Monitor** no-reply@ethicsreview.uea.ac.uk **Subject:** Decision - Ethics ETH2122-0226 : Mrs Zinny Obi Oriaku

**Date:** 11 January 2023 at 15:10
**To:** Zinny Obi Oriaku (MED - Postgraduate Researcher) Z.Obi-Oriaku@uea.ac.uk

**Study title:** Exploring the psychological impact of the COVID-19 pandemic on UK migrant and refugee nurses: A qualitative exploration.

**Application ID:** ETH2122-0226

Dear Zinny,

Your application was considered on 11th January 2023 by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee).

The decision is: **approved**.
You are therefore able to start your project subject to any other necessary approvals being given.

If your study involves NHS staff and facilities, you will require Health Research Authority (HRA) governance approval before you can start this project (even though you did not require NHS-REC ethics approval). Please consult the HRA webpage about the application required, which is submitted through the IRAS system.

This approval will expire on **12th September 2023**.

Please note that your project is granted ethics approval only for the length of time identified above. Any extension to a project must obtain ethics approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) before continuing.

It is a requirement of this ethics approval that you should report any adverse events which occur during your project to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) as soon as possible. An adverse event is one which was not anticipated in the research design, and which could potentially cause risk or harm to the participants or the researcher, or which reveals potential risks in the treatment under evaluation. For research involving animals, it may be the unintended death of an animal after trapping or carrying out a procedure.

Any amendments to your submitted project in terms of design, sample, data collection, focus etc. should be notified to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) in advance to ensure ethical compliance. If the amendments are substantial a new application may be required.

Approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) should not be taken as evidence that your study is compliant with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018. If you need guidance on how to make your study UK GDPR compliant, please contact the UEA Data Protection Officer (dataprotection@uea.ac.uk).

Please can you send your report once your project is completed to the FMH S-REC (fmh.ethics@uea.ac.uk).

I would like to wish you every success with your project.
On behalf of the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics

Subcommittee) Yours sincerely, Dr Paul Linsley

**Ethics ETH2122-0226 : Mrs Zinny Obi Oriaku**

APPENDIX M – HRA approval letter

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Mrs Ezinne (Zinny) Obi Oriaku
Trainee Clinical Psychologist (Student)
University of East Anglia Clin Psy D, Faculty of Medicine and Health, UEA
Norwich Research Park
Norwich
NR4 7TJ

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

06 June 2023

Dear Mrs Obi Oriaku,

**HRA and Health and Care Research Wales (HCRW) Approval Letter**

| | |
|---|---|
| **Study title:** | **The psychological impact of the COVID-19 pandemic on UK migrant and refugee nurses: A qualitative exploration.** |
| **IRAS project ID:** | **325084** |
| **Protocol number:** | **Unapplicable** |
| **REC reference:** | **23/HRA/1696** |
| **Sponsor** | **University of East Anglia** |

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

**How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?**
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report

(including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

**How should I work with participating non-NHS organisations?**
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

**What are my notification responsibilities during the study?**

The *"After HRA Approval – guidance for sponsors and investigators"* document on the HRA website gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

**Who should I contact for further information?**
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **325084**. Please quote this on all correspondence.

Yours sincerely,

Margaret Hutchinson
Approvals Specialist
Email: approvals@hra.nhs.uk
*Copy to:* *Ms Sarah Ruthven*

**List of Documents**

The final document set assessed and approved by HRA and HCRW Approval is listed below.

| *Document* | *Version* | *Date* |
|---|---|---|
| Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [UEA ethics form ] | | 14 April 2023 |
| Copies of materials calling attention of potential participants to the research [Study leaflet] | 1 | 14 April 2023 |
| Covering letter on headed paper [Sponsor cover letter] | | 14 April 2023 |
| Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [UEA Insurance info] | | 14 April 2023 |
| Interview schedules or topic guides for participants [Interview topic guide] | 2 | 30 May 2023 |
| IRAS Application Form [IRAS_Form_27042023] | | 27 April 2023 |
| IRAS Checklist XML [Checklist_06062023] | | 06 June 2023 |
| Organisation Information Document [UEA OID] | 1 | 14 April 2023 |
| Other [Interview schedule] | 1 | 14 April 2023 |
| Other [UEA Ethics Decision ] | 1 | 11 January 2023 |
| Other [Imogen Rushworth CV AS2] | 1 | 14 April 2023 |
| Other [Interview schedule] | 2 | 30 May 2023 |
| Participant consent form [Consent form] | 2 | 30 May 2023 |
| Participant information sheet (PIS) [Participant Information Sheet] | 2 | 30 May 2023 |
| Research protocol or project proposal [Research proposal] | 2 | 30 May 2023 |
| Schedule of Events or SoECAT [Schedule of events] | 1 | 14 April 2023 |
| Summary CV for Chief Investigator (CI) [CI CV] | | 14 April 2023 |
| Summary CV for student [Student CV] | | 14 April 2023 |
| Summary CV for supervisor (student research) [Primary supervisor CV] | | 14 April 2023 |
| Summary of any applicable exclusions to sponsor insurance (non-NHS sponsors only) [UEA indemnity info] | 1 | 01 August 2022 |

| IRAS project ID | 325084 |
|---|---|

**Information to support study set up**

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

| Types of participating NHS organisation | Expectations related to confirmation of capacity and capability | Agreement to be used | Funding arrangements | Oversight expectations | HR Good Practice Resource Pack expectations |
|---|---|---|---|---|---|
| Research activities and procedures as per the protocol and other study documents will take place at participating NHS organisations. | Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study in accordance with the contracting expectations detailed. Due to the nature of the activities involved, organisations will be expected to provide that confirmation to the sponsor Within **35 days** of receipt of the local information pack After HRA/HCRW Approval has been issued. If the organisation is not able to formally confirm capacity and capability within this timeframe, they must inform the sponsor of this and provide a justification. If the sponsor is not satisfied with the justification, then the sponsor may escalate to the National Coordinating Function where the participating NHS organisation is located. | An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other agreement to be used with participating NHS organisations of this type. | Study funding arrangements are detailed in the Organisation Information Document | A Local Collaborator should be appointed at participating NHS organisations. | Where an external individual is conducting only research activities that are limited to access to staff, or staff data (in either identifiable or anonymised form), or anonymised patient data then a Letter of Access is required only if these activities will take place in NHS facilities. This should be issued be on the basis of a Research Passport (if university employed) or an NHS to NHS confirmation of pre-engagement checks letter (if NHS employed).<br>These should confirm Occupational Health Clearance.<br>These should confirm standard DBS checks and appropriate barred list checks.<br>Where these activities will not take place in NHS facilities then no arrangements under the HR Good Practice Pack are required. |

**Other information to aid study set-up and delivery**

| *This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.* |
|---|
| The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio. |

APPENDIX N – Debrief form

**Doctorate in Clinical Psychology (ClinPsyD) University of East Anglia**

**Title of Project:** Exploring the psychological impact of the COVID-19 pandemic on UK migrant and refugee nurses: A qualitative exploration using thematic analysis (TA).

**Participant Debrief Sheet**

Thank you for participating in an interview for this research. We hope that you have found it interesting and have not been upset by any of the topics discussed. However, if you have found any part of this experience to be distressing and you wish to speak to one of the researchers, please contact: Dr Bonnie Teague (email: b.teague@uea.ac.uk) or Dr Imogen Rushworth (email: i.rushworth@uea.ac.uk), both of the Doctorate in Clincal Psychology (ClinPsyD) programme, University of East Anglia.

A welfare information leaflet will also be given to you with details of organisations to contact if you require additional support.

APPENDIX O– Braun & Clarke's 6 phases of thematic analysis.

Braun and Clarke (2006) 6 phases of inductive thematic analysis - summary

Phase 1: transcripts are read and meaningful units of texts relevant to the topic are identified and noted.

Phase 2: Here initial codes are consistently and systematically generated in a codebook, using this to search for patterns of text across all transcripts in a process conducted as inclusively of all text as possible.

Phase 3: Involves a search for emergent themes, conducted by grouping meaningful units of text dealing with the same issues in analytic categories and identifying and labelling connections.

Phase 4: Data is systematically reviewed at this stage to provide exhaustive sets of data supporting each theme.

Phase 5: Broad themes are defined and named and smaller sub-themes assigned.

Phase 6: The writing up of findings.

APPENDIX P – Commentary on COVID-related results.

Commentary on COVID-related findings

Participants spoke about their experiences without naming COVID-19, and only reflected on this when asked directly about any impact it had on their experiences. Participants related to the pandemic in terms of the impact it had on healthcare staffing needs in the NHS, leading to job opportunities for internationally trained nurses (Phiri et al., 2022).

*"… COVID brought about the opportunity for us to travel here in the first place, that's why we needed more nurses, you know to join the NHS… living in a world where it initially was very stressful, having to wash your hands and do all those things at work. But now it's just one of those things that we have to live with and deal with it as it as it comes…" (P10).*

*"I've not had COVID throughout until now. I'm lucky so and I think… there is a lot of challenges that the NHS is experiencing because of COVID and one of this is the staffing system… there was a time that we had like 6 or 7, 6 service users that had COVID… as service users are having it, the staff too, we had like three of our staff with COVID. So, you can imagine the pressure on the other staff… So I think challenges is the staffing system is really, really, really suffering because when you are, when you're sick, you are sick, you can't, there is nothing you can do about that. You can't help yourself about that and COVID has made that one difficult, like being a challenge, a barrier that the NHS has not been able to like, really break the challenge…" (P9)*

*"… I think the UK has been recruiting a lot and that's, we are grateful because that's how we got the opportunity... all developed countries are recruiting this time of COVID…" (P1).*

*"When I came in, I think COVID was already elapsing... it didn't really affect anything when it comes to my learning process..." (P7).*

These job opportunities fed into the pre-migration 'pull factors' reported by participants (Palmer et al., 2021). The absence of specific COVID-related incidents, fears, or anxieties can be understood through the lens of Maslow's hierarchy of needs as outlined by Poston (2009). The basic physiological and safety needs, which include COVID-related needs such as access to suitable or 'good enough' housing/shelter that they did not have to share, access to soap and water for frequent hand washing, access to masks and gloves at work, access to vaccination, are at the lower end of the hierarchy, indicating their high priority. The findings suggest that for migrant nurses in the post-COVID NHS, safety and survival needs were met. However, reported unmet needs were psychological and self-fulfillment needs, located at the middle and higher ends of Maslow's hierarchy. These results differed from other recent research. Using

data captured in the first 12 months of the pandemic, Mbiba et. al. (2020) found that migrant NHS staff reported impact from COVID-specific events, for example, experiencing discrimination in the allocation of PPE and other equipment, experiencing moral injury, and experiencing mental health impacts from traumatic stress (Mbiba et al., 2020). This indicates that although migrant nurses reported being impacted directly by the pandemic in its early stages, its felt impact appeared to have changed over time.