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Self-reported mental health effects of changing migration policies on immigrant health and allied care professionals in the UK

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Abstract

This study explores the impact of changing migration policies on the mental health of immigrant health professionals in the UK and their access to mental health services. A cross-sectional online survey was conducted among ninety-six immigrant health professionals and allied health and care workers in the UK's health and social care sector. The mental well-being of study participants was measured using the Warwick-Edinburgh Well-being Scale (WEMWBS). Mood changes post-migration, use of mental health services and perceived effectiveness of these services were assessed using direct survey questions.

The majority of respondents reported average levels of mental well-being. A significant portion of the study participants experienced a decline in mental health post-migration. The study found a strong association between ethnicity and mental well-being, with certain ethnic groups reporting worse outcomes ($p=0.003$, $p<0.05$). Despite reported mental health concerns, only a few sought professional help from mental health services or support groups, and even fewer found these effective.

This study shows significant mental health challenges and poor service access faced by immigrant health professionals in the UK, exacerbated by changing migration policies. Addressing these challenges is vital for the affected individuals and ensuring a thriving, diverse UK healthcare workforce.

Keywords: Migration; Healthcare; Social Care; Mental Health; Policy

1. Introduction

As of 2020, an estimated 281 million people were considered migrants globally according to the International Organization for Migration (IOM) [1]. This represents individuals living in a country that is not their birthplace. Humans have been recorded as migrating for millennia; however, the current immigration rate has been the highest ever reported [2,3]. People have moved from one place to another for multiple reasons. Although this is mostly by choice, some are forced to relocate out of necessity like in the case of refugees [4]. The UK saw a record-high net migration of 606,000 in 2022 alone: reasons for immigration included humanitarian purposes, study (mostly in universities), and working in multiple sectors, especially the health and care sector [2]. According to the Home Office, 211,285 work visas were issued in 2023, including workers and their dependents. Of the visas provided, 101,570 were given to workers in the health and care sector that year [5].

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It is no secret that the NHS is under the most pressure it has been in its 76-year history with the highest patient backlog ever recorded, and extremely long waiting times which are exacerbated by the lack of staff; the NHS in England is estimated to be short of 12,000 hospital doctors and more than 50,000 nurses and midwives [6]. A similar story is seen in the care and nursing homes battling severe understaffing [7]. McCarey and Dayan found that staff shortages in nursing and the care industry were exacerbated after Brexit due to restrictions placed on EU nationals. On the other hand, healthcare staff numbers in EU countries remained broadly stable [8]. Making matters worse, a study involving 25 countries, including the UK, showed that the lack of staff in hospitals and nursing homes was compounded by COVID-19 leading to a reduced quality of care [9]. These shortages have led to the heavy reliance of the NHS and other healthcare organisations on foreign-trained professionals such as doctors, nurses, and carers; over a third of NHS doctors currently are from foreign countries while 27% of nurses are immigrants [10,11].

In the UK, immigration is highly unpopular among the residents with an estimated three-quarters of the population in favour of reduced migration into the country [12]. According to Blinder and Allen, the majority of the British public felt the cost of skilled workers (EU or non-EU migrants) outweighed the benefits gained. However, while most of the population was more favourable towards the migration of doctors and nurses (72%), they were almost split in half regarding care workers. Furthermore, over half of the population was against spousal reunification of these immigrants [12].

In recent years, especially following the "refugee crisis" in 2015, the topic of immigration has become a highly polarising one due to the increase in anti-immigration sentiments across North America and Western Europe, leading to governments concurrently implementing stricter laws regarding migration into these nations [13]. This results in increased insecurity among immigrants, including "skilled workers" like health and care professionals [14]. Internationally trained healthcare workers in the UK face multiple challenges relative to their UK-trained counterparts. This ranges from having to acclimatise to new working conditions and systems, to subconscious or conscious discrimination [15]. Combined with insecurity due to perceived hostility from their host country, this takes a mental toll on the individual [16]. Most recently, immigrant health workers have felt increased threats to safety during violent riots that broke out in the UK, following misinformation around the death of three children in England's Merseyside [17].

Historically, the driving force of migration included imbalances in the workforce and labour, wealth inequalities, and political conflicts; the purpose of immigration policy implementation is to guide or change the migratory patterns of foreigners to prevent out-of-control migration once a critical point is reached [18]. Public policy influences how immigrants adapt to life in their host country; the implementation of rules that isolate migrants from the rest of society tends to reduce their rate of assimilation into the new land [19]. A study conducted in the United States to assess the mental health of refugees and immigrants showed the presence of post-migration mental trauma compounded by discrimination and the stress of trying to fit in [20]. Although the NHS and social care sector need health and care workers, many foreign professionals are put off due to immigration bureaucracy [21].

The UK has six types of visas: work visas, student visas, family visas, tourist visas, business visas, and transit visas; the "skilled worker visa" (formerly the Tier-2 visa) encompasses health and care workers [22]. The constant changes in migration policies tend to affect workers already in the UK as well as those aspiring to migrate into the country. In December 2023, a "five-point plan" was announced to reduce immigration in the UK [23]. Some changes made that impact the lives of health and care workers include the inability of social care workers to bring their dependents to the UK with them, increasing the baseline salary for a sponsored skilled worker visa from £26,200 to £38,700, as well as the increment in the minimum salary required for a worker to sponsor their spouse or partner from £18,600 to £29,000 per year [23]. Although health and care visas are exempt from the £38,700 salary threshold, to be eligible for a skilled worker visa, some categories will not be able to sponsor their dependents and must therefore leave their families overseas [24].

According to the Home Office and Department of Health and Social Care, these restrictions were put in place due to the abuse of the old policy. They report that under the former policy, 130,000 dependents accompanied the 100,000 care workers who received the worker visa between 2022 and 2023. This number projected to increase in the following years informed the decision to change the immigration policy [25]. On the other hand, with the projected need for skilled care workers expected to rise by 25% in 2035, organisations like the Cavendish Coalition (a group of private care and nursing homes) question the decision which is expected to make recruiting exponentially more difficult [26]. Furthermore, Canning argued that forced family separation is a restriction on migrants' rights and places further pressure on an already struggling area in healthcare [27]. In addition, an often-overlooked aspect of bringing family along for healthcare workers is the stress on an individual trying to make enough money to take care of themselves and

their families; both spouses working enhances the household income and reduces poverty in an already underpaid job [28].

The International Organisation for Migration (IOM) re-echoes the need for more in-depth research in the area of migration policy and how it affects immigrants, to break the so-called 'receiving country perspective bias' [1]. Current literature reveals that there is indeed a psychological impact of migration on various migrant categories. However, there is a dearth of research on the perception of immigrant healthcare professionals regarding immigration policies in the UK and their effects on mental well-being. This study aims to explore the mental health experiences of immigrant healthcare professionals in the United Kingdom, using standardised assessment scales.

2. Materials and methods

2.1. Introduction

This methodology chapter outlines the research design and methods employed in this research. The study aims to investigate the mental health impacts of evolving migration policies on immigrant healthcare professionals, integrating both quantitative and qualitative analyses. The chapter begins with a detailed description of the research design, followed by an explanation of the sampling strategies, data collection methods, and analytical procedures. It also highlights the ethical considerations relevant to the study and addresses the steps taken to ensure reliability and validity in the research process. By employing a mixed-methods approach, this study seeks to provide a comprehensive understanding of the psychological experiences of immigrant healthcare professionals in the context of migration policy changes.

2.2. Study design

This study has been conducted using a cross-sectional study design. This has been chosen as a useful way to establish preliminary evidence of possible mental health effects of the ever-changing migration policies in the UK among the study population. This can help estimate the prevalence of mental health problems among this population and make recommendations for an advanced study. A cross-sectional approach is particularly suitable for this research for several reasons. First, it allows for the collection of data at a single point in time, providing a snapshot of the current mental health status of the participants with recent policy changes. This is essential for capturing the immediate effects of these changes on mental health. Secondly, the cross-sectional design is efficient and cost-effective, as it allows for the collection of huge amounts of data from a diverse group of participants without the need for prolonged follow-up. Thirdly, this approach enables the comparison of different variables, which includes demographic factors, professional experiences, and individual perceptions, to identify potential patterns and correlations within the data.

2.3. Study setting

The study was conducted online. The survey was disseminated among immigrant healthcare professionals across the UK. The survey was conducted within two months (May to July 2024).

2.4. Study population

The study covers a cross-section of health and social care workers, on migrant visas, working in the United Kingdom. To reach the target population of health professionals and other allied workers, regardless of whether they work in the NHS or the care sector, this study has recruited participants working in hospitals, community settings and the social care sector provided they fall into the categories that would be classified by the World Health Organization (WHO) as Health Professionals, Health Associate Professionals or Personal Care Workers [29]. The inclusion and exclusion criteria in this study are shown in Table 1.

Table 1 Summary of Inclusion and Exclusion Criteria

Inclusion criteria	**Exclusion criteria**
Non-British nationals working in the health and care sector	Those on volunteer roles.
They should be on health and social	Those with no right to stay in the UK.
care work visa or Indefinite Leave to Remain	
Participants should be aged 18 years and above.	

2.5. Sampling technique and sample size determination

The sample size has been calculated using Andrew Fisher's formula for the unknown population, shown below.[30]

$$\text{Necessary Sample Size} = \frac{(\text{Z-score})^2 \times \text{Std Dev} \times (1-\text{Std Dev})}{(\text{margin of error})^2}$$

Z score: 1.96, this is the Z score for a confidence level of 95%.

SD: Standard Deviation, set at 0.05

Margin of error: 10%

$(1.96)^2 \times 0.5(0.5)) / (0.1)^2$

$(3.8416 \times 0.25) / 0.01$

$0.9604 / 0.01 = 96$

Convenience sampling technique has been used in this study. Healthcare professionals have been recruited into the study by disseminating recruitment flyers and messages on online platforms for international health and social care workers on WhatsApp, Facebook, and Telegram. Referrals were also received from other recruits. This has been particularly useful in recruiting from under-represented professional groups. There are several reasons why convenience sampling has been used in this study, utilising the advantages highlighted in a previous paper [31]. One reason is that this research is exploratory, and the findings will provide initial insights and patterns that will inform future research, which is easily achieved by this sampling technique. The study population also share many characteristics that reduce variability in responses, hence using convenience sampling would provide vital insights into this near-homogenous group.

2.6. Data collection method

The research participants consented online, and the surveys were completed online using Google Forms. The survey was structured to be completed within 30 minutes. Each study participant was required to complete the survey once. The online access allowed a wider geographical coverage. It is easy to access for the respondents who can complete the survey at their convenience, thus improving participation rates. Another advantage of the online survey is its time efficiency; they have been distributed and completed much faster than traditional methods. Last but not least, this method has been eco-friendly, as avoiding paper-based surveys has positively contributed to environmental sustainability.

2.7. Data collection tool

In other to cover the qualitative/quantitative sections of the research, the survey was created with various components to enable accurate data capture. The qualitative data has been collected using the Warwick-Edinburgh Mental Well-being Scale (WEMWBS), a simple tool, validated among the UK population, and adapted for use in this study. "WEMWBS is a measure of mental well-being focusing entirely on positive aspects of mental health. As a short and psychometrically robust scale, with no ceiling effects in a population sample, it offers promise as a tool for monitoring mental well-being at a population level". (Tennant et al, 2007) [32]. The standardised questions were slightly adapted to help respondents report their perspectives on the subject matter. In a study that compared this tool to other mental health assessment tools among respondents in the UK, the WEMWBS tool was found to be less susceptible to social desirability bias [32]. It is therefore anticipated that the questions have allowed the participants to express their true opinions.

The quantitative sections include standard demographic questions covering age, sex, occupation, ethnicity and years of residency in the UK. The length of stay in the UK has been categorised similarly to the model used in the report from the University of Oxford's Migration Observatory, which reports worsening health with longer length of stay, an outcome that is tested in this work [33].

2.8. Quality assurance

Face validity has been used in this study, with feedback received from respondents to ascertain that the test measures what it is intended for. Internal consistency using Cronbach's Alpha has been the tool relied on for confirming the

reliability of this study. A previous work reports that the standardised Cronbach's alpha for the WEMWBS (used in this research) among the UK population is 0.91, which is above the recommended limit [32]. This assures that the survey tool is a reliable measure.

2.9. Data analysis

Data analysis was done using the SPSS software. Mental well-being was measured using a self-administered questionnaire on positive mental state, the 14-item Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS). The scoring range for each item on the scale is 1-5 and the total score ranges from 14 to a maximum of 70. The respondents were also divided into four groups based on their duration of stay in the UK; reflecting categories of people who had reached the leave-to-stay category before the 2024 Changes to Immigration Act Rules, and those who were unlikely to be qualified for leave-to-remain application at the time of these changes. The mental well-being of respondents was also categorised as high, average, and low well-being. Following standardization for the UK population, researchers categorise scores ranging from 60-70 as high mental well-being, scores 14-42 reflect low mental well-being and 43-59 are considered average [32]. The percentage of the study population which falls into the different categories was calculated. A chi-square test was thereafter used to compare the difference between these categories ($p<0.05$).

3. Results

3.1. Introduction

The results presented in this chapter are derived from a mix of quantitative and qualitative data, gathered through the online survey. The findings highlight the demographics of the sample population, as well as a comprehensive analysis of respondents' perception of the subject matter and their utilization of mental health support services, where indicated.

Table 2 Demographic and mental health data of the study population

	High mental well-being	Average mental well-being	Low mental well-being
Age			
18-24	1	5	1
25-34	7	40	20
35-44	1	10	2
45-54	0	5	1
55-64	0	2	0
			n = 95*
Gender			
Male	4	20	8
Female	5	42	16
			n = 95*
Race/ethnicity			
Black	2	41	11
Asian	7	16	13
White	0	2	0
Mixed or multiple	0	3	0
			n = 95*
Occupation			
Doctor/dentist	4	34	12
Nurse	1	6	1

HCA	0	1	3
Support worker	1	6	5
Other AHP**	3	15	3
			n = 95*

*1 respondent not included due to incomplete data for WEMWBS scoring; **Allied Health Professionals

3.2. Demographic distribution

The demographics of the study population are reflected in Table 2. Ninety-six respondents consented and took part in the survey. One respondent was excluded from the data shown due to incomplete responses to assess their mental well-being score, but their data provided useful information for other sections. The majority of the respondents were female (twice the number of males), predominantly aged 25 to 34 years.

Ethnically, the respondents were predominantly Black African and Caribbean (57.3%) and Asian (37.5%), with minimal representation from White and mixed ethnic groups. Notably, Nigerians, Indians, and Filipinos were the most represented nationalities, reflecting the high migration rates from these countries to the UK.[34]

3.3. Occupational Distribution

In this study, the majority of respondents were Medical Doctors or Dentists (53.1%), followed by Nurses and other Allied Health Professionals (30%), and Support or Care Workers (12.5%). The professional background of the respondents is crucial, as the demands and stresses associated with different healthcare roles can vary significantly, potentially affecting mental well-being differently. As discussed later, this cross-sectoral and inter-professional spread of respondents provides a unique opportunity to investigate this assumption.

3.4. Reported reason for migration

When asked about the reason behind their migration, the common reasons picked by respondents were career progression, finance, family and personal fulfilment, in that order, as shown in Fig 1. However, less than a third of the respondents were feeling 'strongly' optimistic about the future of working in the UK (30.2%).

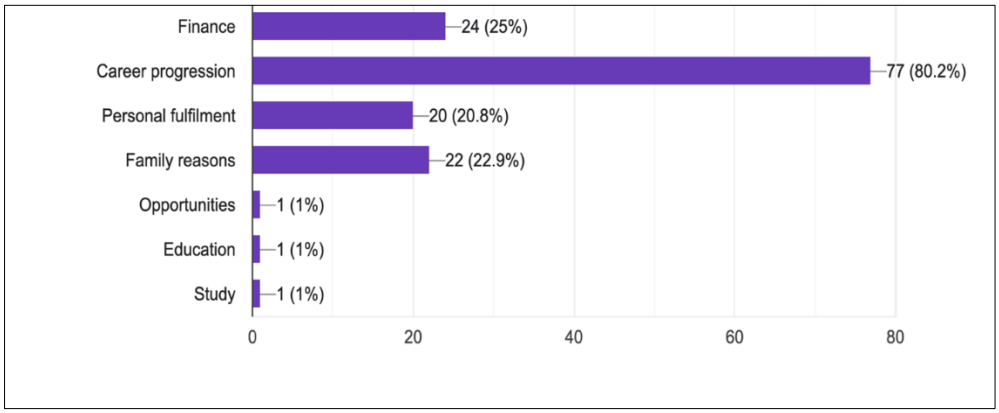

Figure 1 Respondents' reported reason for migration

Only one-fourth of the respondents felt financial incentive was the driving force behind their decision to move to the UK. This may be due to the opportunities for advanced training, and professional development available in the UK compared to many source countries. However, the pursuit of these opportunities often comes at a personal cost, including separation from family, which can adversely impact mental health. Twenty-three per cent (22/96) of the respondents seemed to be addressing this need, stating 'family reasons' as the reason for their migration to the UK.

Mental Well-being, Associations and Utilization of Services

Mental well-being and migration policies' Effect

The mental well-being of the respondents was evaluated using the WEMWBS score and reported adverse mood changes. Using the calculated WEMWBS score, the respondents were categorised into three shown below and displayed in Figure 2. *

Poor mental well-being (14-42): 22 (23.2%, n=95)

Average mental well-being (43-59): 64 (67.4%, n=95)

High mental well-being (60-70): 7 (7.4%, n=95)

*As stated previously, one respondent was excluded.

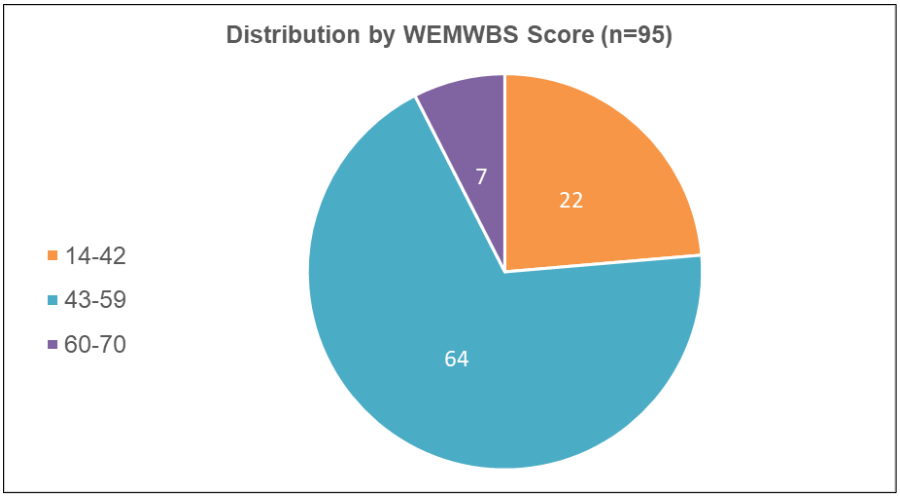

Figure 2 Respondents' Mental Wellbeing Scores

The respondents were asked whether or not they had experienced any negative change in their mental well-being and mood since migrating to the UK and whether migration policy changes affected their mental well-being. These perception questions were used to assess adverse mood change. More than half of the respondents reported an adverse change in their mental well-being since migrating to the UK (47/96) as shown in Figure 3. When the number of participants who were uncertain about this effect was added, there was a total of 65 respondents with possible mental well-being changes following migration. Of this number, 33 respondents felt that the adverse change in their mental well-being had worsened or been triggered by the uncertainties around the UK's migration policies (48%).

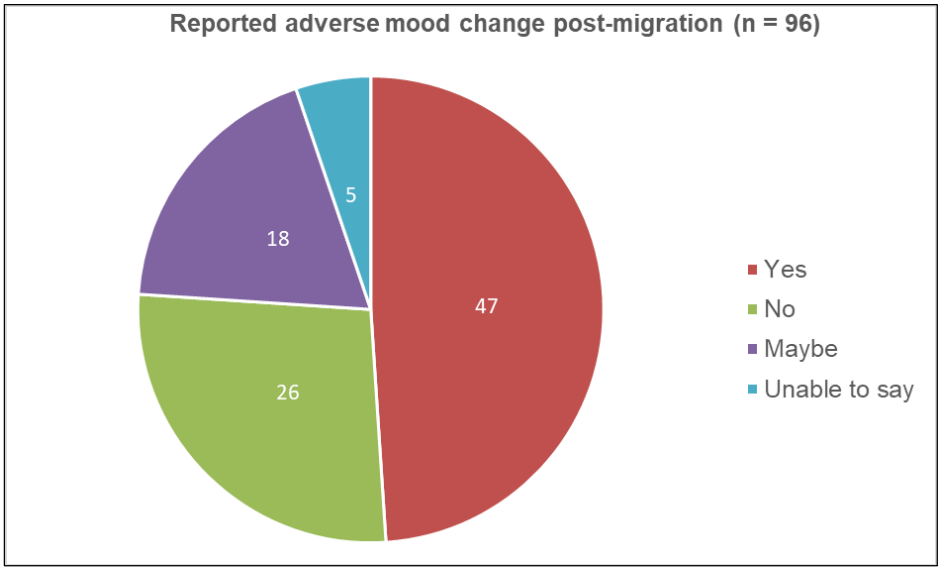

Figure 3 Frequency of Reported Adverse Mood Change Post-migration

These findings are concerning, suggesting that a significant proportion of immigrant healthcare professionals experience suboptimal mental health. The fact that only about a third of the respondents felt 'mostly' optimistic about their future, working in the UK (35.4%) further highlights the fragile mental state of many participants

"It is already a tough decision leaving your home country, but these policies, which are often not in favour of immigrants, make things even tougher. It is, therefore, a definite contributory factor to mental health deterioration among immigrant health professionals." (Comment from a respondent on migration policy changes and mental health)

As shown in Fig 3, the majority of the respondents have experienced some level of mental health impact post-migration.

3.5. Confounding factors associated with reported mental well-being

When tested for association, ethnicity had a statistically significant association with the WEMWBS score of the respondents, as shown in Table 3. The calculated Phi and Cramer's V were both >0.25 which indicates a very strong association [36]. Ethnicity did not however show any significant effect on reported mood changes following migration. On the other hand, age, gender, occupation and duration of stay did not have any statistically significant association with WEMWBS nor reported mood change in respondents when tested.

Table 3 Test of association between ethnicity & WEMWBS scores

	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	13.857[a]	6	0.031
Likelihood Ratio	15.245	6	0.018
Linear-by-Linear Association	0.202	1	0.653
N of Valid Cases	95		

The respondents were placed in 4 categories based on their responses to the question on their duration of stay in the UK as follows: <1 year, 1-2 years, >2 to < 5 years, and > 5 years. As shown in Fig 4, respondents who had spent less than a year in the UK had lower mental well-being scores (29%), compared to those who had spent longer. The percentage of those with calculated low WEMWBS scores in the other categories were 25% (1-2yrs), 21% (>2 to < 5 years) and 24% (> 5 years). This difference based on duration of stay was however not statistically significant.

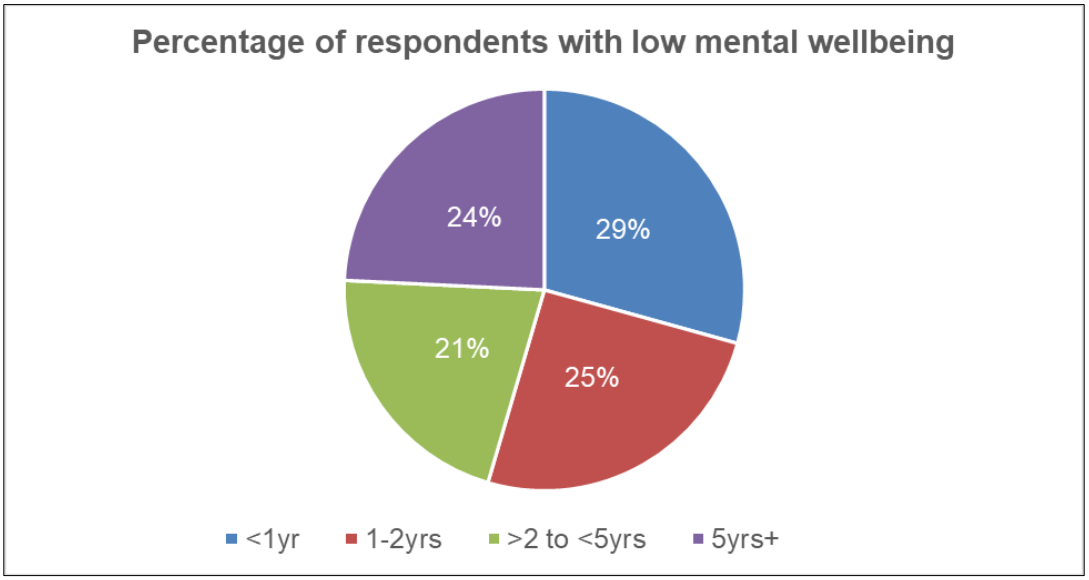

Figure 4 Distribution of Low Mental Well-being Individuals by Length of UK Stay

Similarly, the number of respondents reporting a definite adverse change in mood following migration was relatively higher in those who have lived for fewer years in the UK, when compared with those who had lived longer in the country. The number of respondents who stated 'Yes' to the question on adverse mood change post-migration was as follows: 22/41, 54% (:<1 year); 7/8, 88% (1-2yrs); 12/30, 40% (>2 to <5years); and 6/17, 35% (>5years). This correlation was not found to be statistically significant but might indicate the possibility of greater anxiety among those with uncertainties around their visa status compared to those who have or are closer to settled status. This sentiment is reflected in the comment of one respondent; *"It will be great for one to know they have a stable future. The policymakers aren't fair. They are just taking advantage of the migrants. Policies that weren't there before entry should not affect those in the country already."*

3.6. Respondents' utilization of mental health services

In terms of therapy, only 17 respondents had sought support from mental health services regarding their concerns, despite more than half of the respondents reporting an adverse change in their mood and mental well-being. It is important to note that 33 (38.8%) of the respondents were certain that the changes in their mental well-being had worsened with the uncertainties around the UK's migration policies. Therefore, less than half of the respondents who possibly needed mental health support were seeking this. Of the 17 respondents who had accessed some form of mental health support, 11 of them felt this support was effective.

"I sought counselling as a proactive approach as I saw other doctors burning out, but I did not feel I benefited from it." (Comment from a respondent on the effectiveness of mental health support)

4. Discussion

4.1. Introduction

This section explores the key findings of the study while highlighting the implications of these results within the broader context of existing literature. This section will also highlight some recommendations for policymakers, healthcare institutions, and support organizations. Lastly, the limitations of the study and future research suggestions will be discussed.

4.2. Mental wellbeing

The study addresses the principal research question by highlighting the perceived effects of recent changes in government migration policies on the mental well-being of UK healthcare workers. The findings indicate that more than half of the respondents reported an adverse change in their mental health since migrating, with nearly half of these attributing their poorer mental health state to the uncertainties surrounding UK migration policies. This shows how these policies are being perceived by the respondents. The objective of the perceived impact of recent migration policy changes was measured using frequency testing for one of the survey questions. The calculated frequency indicates that more than half of the respondents reported worsened mental well-being due to policy changes. This perceived impact makes the case for stable and supportive immigration policies to maintain the mental health of immigrant workers.

The first study objective of assessing mental well-being is achieved through the evaluation of the WEMWBS scores for the respondents. The majority of the respondents had average mental well-being but with a significant proportion of respondents experiencing poor mental well-being and a notable number linking their distress to migration policy uncertainties, this work provides a useful insight into the health state of this vital section of the UK's health workforce. This evaluation therefore highlights the varied mental health statuses among the study cohort.

Immigrant health professionals face the double barrel challenge of depreciating the mental well-being of the general UK workforce and challenges related to migration policy uncertainties and other migrant-specific challenges. Figures showed that the annual incidence of work-related mental health problems such as stress and anxiety reached about 760 per 100,000 [39]. Research has shown that an individual worker's security and emotional stability in a job often is influenced by wider happenings in society [40]. Therefore, constant changes in the policies and attitudes of government and employers towards immigrants may have an impact on individual workers, irrespective of their circumstances [40]. This might explain why the respondents in this study were affected by migration policy changes regardless of the specific profession and duration of stay in the UK.

Health professionals, by the very nature of their jobs, have been reported to experience significantly higher stress and negative mental well-being when compared to the rest of the working population [41]. Doctors and nurses are most severely affected in this category [40]. It is, therefore, necessary to highlight that the occupation of the respondents

might account for the bare average mental well-being scores of many of the respondents, although no significant interprofessional difference was seen in this study. Therefore, strategies to address the mental well-being of the study population must be targeted, first viewing them not just as immigrants, but also as a unique part of the UK workforce

4.3. Impact of Sociodemographic Factors on mental well-being & resilience

Ethnicity was the only significant demographic factor found to be associated with the self-reported mental health effects on immigrant healthcare professionals in the UK, with different ethnic groups exhibiting varying levels of mental health. The study found a statistically significant association between ethnicity and WEMWBS scores, indicating that ethnic background plays a crucial role in mental well-being among immigrant healthcare professionals. This finding aligns with research that highlights how racial and ethnic minorities often face additional stressors, including discrimination, cultural adjustment challenges, and social isolation, which can adversely affect mental health [42]. However, ethnicity did not show a significant effect on reported mood changes following migration, suggesting that while baseline mental well-being differs across ethnic groups, the specific impact of migration on mood may be influenced more by individual experiences and perceptions rather than ethnicity alone.

Black, Asian, and Minority Ethnic (BAME) individuals have been reported to be at higher risk of mental health disorders compared to the white population in the UK [43]. When analysed, researchers found that the rate of these mental health conditions in this BAME population differed significantly from the rates in their country of birth, suggesting that there might be specific challenges such as migration, racism and poverty that put this group at increased risk in the UK [16]. Considering these findings, it is important not to simply rule out the influence of ethnicity as found in this study as a matter of genetics. The broader socio-economic implications should be considered. A previous study found that settlement in the UK and high social capital were protective for the mental health of minority ethnic communities [44]. Therefore, policymakers need to ensure that there is a clear and consistent path to settlement for immigrant health professionals in the UK, as well as work towards removing barriers that hinder migrants' access to social capital regardless of their ethnicity.

Other specific cultural factors have been reported to affect the mental well-being of certain BAME groups. An example is how being unmarried or childless was found to be a major cause of mental distress among women of Asian backgrounds in the UK [45]. These problems might be exacerbated by the social isolation that several individuals face following migration and might contribute to the ethnic differences seen in this study. Therapists and those seeking to improve the mental resilience of immigrant health professionals should therefore be aware of these cultural sensitivities and provide appropriate strategies to tackle them.

Although, it has been highlighted in the previous section that doctors and nurses reportedly face the greatest stress, an important factor not directly considered in this study is the effect of working in the NHS vs the private sector. In 2001, a UK study of depression, coping and turnover among NHS and private sector staff caring for people with dementia found that levels of stress amongst healthcare workers in NHS community settings were much lower than in health workers in private care homes. They reported higher rates of staff turnover in the private sector homes and attributed this finding to a greater sense of community amongst NHS staff [46]. Those who identified as support or care workers (12.5% of the respondents) were likely to be working in the largely privately owned care sector, whereas hospital care still largely remains publicly funded in the UK (NHS) [40]. Therefore, it can be postulated that the protective advantage from the occupational status of support/care workers is lost from the stress of the more task-driven workplace environment typical of some private care outfits. Conversely, although NHS doctors and nurses have more stressful job roles, the community spirit in the NHS might help to counterbalance some of these effects.

4.4. Impact of Settlement Status on mental well-being & resilience

A previous study had shown that immigrants' physical and mental health status was poorer compared to the native population, regardless of their duration of stay or settlement status, due to discrimination issues [47]. Previous works have also reported that migrants tend to be happier and have more positive mental well-being following migration, although this tends to plateau or dip as they stay longer in the host country [48]. This current study's findings differ in that there were relatively more people with poorer mental well-being among those who had recently migrated to the UK. Several factors might contribute to this finding. The UK is currently facing several challenges that make it difficult for new immigrants to settle. These include housing shortages, the high cost of the few available accommodation, higher general cost of living and rising anti-immigration sentiments [49].

Although the challenges above are not peculiar to new immigrants, coupled with the added stress of acculturation and workplace adaptation, these new immigrants find themselves caught in a precarious situation. Organizations can therefore respond to these by enabling soft landing for new staff from abroad through the provision of more robust

accommodation support, financial packages to cushion against the cost-of-living crisis and peer support to help these individuals find their feet in the system and return more healthy and productive members of staff. Those who have lived longer in the UK, as well as those eligible for settled status in the UK (>5 years) do not appear to be faring much better, with only a small proportion of them in the high mental wellbeing category. Some studies have suggested that immigrants tend to have better subjective well-being post-migration due to the new opportunities to achieve better living conditions [50]. However, the degree to which these aspirations are achieved eventually affects the mental well-being of these immigrants [51]. Previous research has highlighted that job dissatisfaction, discrimination, poor social networks and extreme weather conditions also have an impact on their subjective well-being over time [51,52,53]. So, while on the one hand, well-educated immigrants like the participants in this study are assumed to be able to leverage their educational qualifications to achieve a good quality of life, the realities that they face often means that their aspirations may remain unfulfilled leading to poorer mental wellbeing [53]. It is therefore imperative that there be a more transparent recruitment and promotion system within the health and social care sector, where those with the right qualifications and skills are given the deserved recognition.

"The stress in filling out forms explaining every single change you make at work or purchase just because you are an immigrant is enormous"

(Comment from survey participant)

4.5. Therapy and Support

As reported in the previous chapter, this study shows that mental health support services were underutilised by the respondents, despite widespread mental wellbeing concerns. Even when accessed, an even smaller proportion found it effective. A previous UK study showed similar concerns, with a large proportion of the study participants unsatisfied with mental health services [54]. The concerns raised by the participants in that study included long waiting times, overreliance on pharmacological treatments and inadequate follow-up. The themes of long waiting times and UK health service burdens are well reported in other literature [55]. The situation is even worse when migrants are considered, as they are already faced with the additional challenge of understanding and navigating access to health services [56].

A lot of emphasis around the challenging access to mental health services among migrants in Europe has been on language barrier, stigma and social problems which are mostly true of refugees. These were some of the key findings of a systematic review [57]. These factors are unlikely to be a huge contributor to our study population, with a very high percentage being highly educated professionals (Doctors, Dentists, Nurses, etc.). Although stigma and perception bias cut across all social strata, professionals working in the UK have high English language requirements and thus are likely to be proficient enough to communicate with mental health professionals. Additionally, they do not have the same barriers that refugees and illegal migrants are likely to face. This highlights the importance of a tailored approach to care, as suggested by some scholars [54].

However, it is important to point out that targeted formal mental health services for immigrant health professionals might also be fraught with problems. It has been reported in previous literature that some mental health professionals and primary care practitioners have tended to avoid a service that uniquely provides care for migrants due to concerns around alleged malingering to claim benefits or rights to remain in the country [58,59]. Community organisations and other less formal services, including peer support groups, might therefore be a useful alternative for immigrant health professionals as they reduce the problem of access-related stigma, reduce the burden on NHS services, thus reducing waiting times and can inform more culturally appropriate and relevant support for immigrant health professionals [60,61].

4.6. Implications and Recommendations

The findings of this study have several crucial implications for policy and practice. Firstly, the number of respondents experiencing poor mental well-being highlights the need for targeted mental health support for immigrant healthcare professionals. Healthcare organisations and policymakers should consider implementing comprehensive mental health programs that are culturally sensitive and accessible to all employees, regardless of their background. At a time when staff retention is a huge challenge in the NHS and social care, investing in the mental well-being of all staff, particularly those recruited from overseas, is not only morally appropriate but also a financially prudent move in the long run [62].

Secondly, the association between ethnicity and mental well-being highlights the need for tailored interventions that address the unique challenges faced by different ethnic groups. This could include providing diversity training for staff, fostering inclusive workplace environments, increasing awareness of mental health support groups and services among staff recruited from abroad and ensuring that these mental health services are equipped to address the specific needs

of minority groups and immigrants. A previous study has highlighted that non-white doctors in NHS England had a lower one-year retention rate compared to their white counterparts [62]. There is, therefore, the need to review the one-size-fits-all mental support approach currently available to staff in some health and social care organisations.

Lastly, the highlighted impact of migration policies on mental health calls for a more humane approach to immigration. Policymakers should consider the mental health implications of immigration policies and strive to create a more stable and supportive environment for immigrant healthcare professionals. There are many ways that this could be achieved, including the provision of clearer information about immigration processes, reduction of the bureaucratic bottlenecks in the visa and migration process, and ensuring that migrants have access to reliable legal and social support.

4.7. Suggestions for Future Research

This study highlights the growing problem of migrant integration and, importantly, gives voice to the concerns of the immigrants themselves. Future studies could build on the findings of this research by employing alternative study designs such as longitudinal studies, recruiting larger sample sizes, and more diverse participant groups to provide a deeper understanding of the mental health impacts of migration policies.

4.8. Limitations of the Study

This study has not explored other confounders that may affect the mental health of the respondents, such as stress at work. While that might have been useful, the focus of this study has been to capture the perception of the respondents. Therefore, emphasis has been placed on what the respondents perceive to be the impact of the change in the UK's migration policies on their mental well-being. As written in the recommendation, further study to explore other possible confounders are needed to build on this study's findings.

Secondly, people have been excluded based on their visa or settlement status. People with no right to stay have been excluded as the questions might cause undue distress or a sense of threat. This study is looking specifically at how recent migration policy changes made by the UK government are affecting the mental well-being of those directly targeted. Illegal immigrants might be affected in one way or the other. However, this is not the focus of the study.

5. Conclusion

This study provides useful insights into the self-reported mental health effects of changing migration policies on immigrant healthcare professionals in the UK. The findings highlight the complex inter-relationship of demographic factors, occupational roles, migration experiences and mental wellbeing. The significant impact of migration policies on mental health highlights the need for a more supportive and inclusive approach to immigration. Government, policymakers and healthcare organisations must ensure the well-being of this essential workforce, and they can do so by addressing the unique challenges faced by immigrant healthcare professionals and providing targeted mental health support. Further research is needed to assess the effectiveness of any targeted support or intervention provided to these migrant groups to ensure that they continue to thrive and remain productive in the country.

Compliance with ethical standards

Disclosure of conflict of interest

This work was submitted as a MSc dissertation to Queen Mary University of London but there are no conflicts of interest regarding this research or the right to publish.

Statement of ethical approval

Ethical approval for this study was received from the Ethics Committee at Queen Mary University of London (Ref GHDE_2324_20).

Statement of informed consent

Informed consent was obtained online, from all the study participants.

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Data availability statement

Data supporting this study are accessible on the following link: DOI: 10.6084/m9.figshare.26863567.

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