Exploring the psychological impact of working during the COVID-19 pandemic on UK Healthcare workers

By Leonie Royes

Thesis submitted in partial fulfilment of the requirements of Staffordshire University for the degree of Doctorate in Clinical Psychology

April 2024

Total word count: 18,489

THESIS PORTFOLIO: CANDIDATE DECLARATION

Title of degree programme	**Professional Doctorate in Clinical Psychology**
Candidate name	Leonie Royes
Registration number	21026387
Initial date of registration	September 2021

Declaration and signature of candidate
I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work.   I confirm that the decision to submit this thesis is my own.   I confirm that except where explicitly stated, the work has not been submitted for another academic award.   I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis.   Signed: Date: 25.04.24

Acknowledgements

Firstly, I would like to extend my gratitude to the participants who contributed to this thesis. Your courage and resilience in the face of adversity continue to inspire me. I hope that by honouring your experiences, they resonate with countless others.

I am incredibly thankful to Dr. Kim Gordon for her invaluable guidance, support and encouragement throughout this research and my clinical training. I also extend my appreciation to Dr. Sarah Vassalos and Dr. Kim Fisher for their mentorship and words of wisdom which have shaped my development during the clinical doctorate and research process.

My eternal gratitude goes to my parents for their unconditional support and belief in me to achieve my dreams. Your encouragement and the values you have instilled in me form the foundation of my accomplishments. None of this would have been possible without you.

To my incredible brothers, and cherished circle of friends and family, I am grateful for the moments of love and laughter which have provided me with strength throughout this journey. I also extend my appreciation to my incredible sisterhood, who have supported me from when this milestone felt like an impossible ambition.

To Eleni, I am so grateful to have had your support as we endured the highs and lows of clinical training together, you have no idea how much it has allowed me to persevere.

Lastly, I dedicate this research to my beloved Nan, Leonie Royes and late Grandad, Vernon Royes, whose sacrifices have paved the way for our family's achievements. It is my aspiration that my endeavours have contributed to honouring your legacy with pride.

I also dedicate this research in memory of the healthcare workers who sadly lost their lives during the COVID-19 pandemic. May their bravery, dedication and sacrifice serve as reminder of the impact they have made in the lives of others.

Table of contents

Thesis Abstract

This thesis explores the impact of the COVID-19 pandemic on the UK healthcare workforce, with a particular focus on Black mental health professionals. Awareness is drawn to this underrepresented demographic within research, providing clinical implications and recommendations to improve staff well-being initiatives for employees from racialised backgrounds.

Part 1 details a literature review which explores the experiences of UK healthcare workers (HCWs) and the psychological impact of working during the Covid-19 pandemic. Thirteen papers were reviewed, analysed and synthesised. Subsequent themes included prevalence of poor mental well-being and factors influencing poor mental well-being. Influencing factors of poor mental well-being were identified as (1) the stage of the pandemic; (2) fear of Covid-19; (3) occupational challenges; (4) organisational influences; and (5) resilience and coping. Findings are limited due to a lack of diverse samples which are not representative of the UK healthcare workforce. The review highlights a need for research to explore the psychological impact of at-risk HCW groups, including HCWs from racialised backgrounds.

Part 2 outlines empirical research exploring Black mental health professionals' (MHPs) experiences of their mental well-being during the COVID-19 pandemic. Thirteen Black MHPs were interviewed using a semi-structured format guided by grounded theory principles. The theory identifies participants conceptualised their experiences through salience with their ethnic identity. The COVID-19 pandemic and prominent Black Lives Matter (BLM) movement caused intersectional trauma which was heightened by stressors relating to health, workplace, racial and political stressors. These stressors exacerbated the social, cultural, and political context participants identified with. Participants highlighted a delayed recognition of and response to the deterioration of their mental well-being. This experience precipitated a transition in perspective, whereby the self is prioritised over occupation following the COVID-19 pandemic. The findings call for employee well-being initiatives to be informed by equality, diversity and inclusivity principles acknowledging the impact of health, political and racial issues which can be detrimental to staff well-being.

The executive summary provides a concise overview of the empirical paper.

Paper 1: Literature Review

**What was the psychological impact for UK Healthcare Workers
working throughout the Covid-19 pandemic? A Literature Review.**

Target journal: BMC Psychology

Word count: 7882

Due to academic assignment requirements, the following paper has
been prepared in accordance with APA 7 guidelines. The empirical
paper will be amended to the requirements of the journal *BMC
Psychology* for submission for publication. Author Guidelines are listed
in Appendix A

Abstract

This literature review aims to identify the experiences of UK healthcare workers (HCWs) and the psychological impact of working during the Covid-19 pandemic. The review explored factors which influenced psychological distress in this population, when many frontline workers were most at risk, and the implications for further research and organisational practice.

A narrative review was carried out systematically using the Staffordshire University database. Searches were restricted to UK-based research. Studies were evaluated in reference to pre-defined inclusion and exclusion criteria, resulting in 13 papers. Both qualitative and quantitative papers were evaluated using the Mixed Methods Appraisal Tool (MMAT) (Hong et al, 2018).

Included papers were analysed and synthesised. Subsequent themes included prevalence of poor mental well-being and factors influencing poor mental well-being. From this, influencing factors of poor mental well-being were identified (1) the stage of the pandemic; (2) fear of Covid-19; (3) occupational challenges; (4) organisational influences; and (5) resilience and coping.

Findings should be interpreted with caution due potential risk of publication bias, the self-selection recruitment processes utilised by most papers, and samples which are not representative of the UK healthcare workforce.

Working during the Covid-19 pandemic precipitated enduring psychological distress for many UK HCWs. Thus, findings should inform organisational implications to ensure HCWs psychological well-being is prioritised in the face of a pandemic through preventative measures. The literature review also highlights key research implications, calling for further research to explore the psychological impact of at-risk HCW groups.

Keywords: Healthcare workers, Covid-19, psychological impact, psychological distress

Introduction

Worldwide infectious outbreaks can result in enduring demands in healthcare workers' (HCWs) roles (Christian et al., 2014). Following the World Health Organisation (WHO) declaring coronavirus (COVID-19) a global pandemic in March 2020, HCWs were pivotal in reducing transmission and keeping populations safe (WHO, 2020). Subsequently, as with previous pandemics such as the severe acute respiratory syndrome outbreak (SARS), HCWs experienced drastic changes in their roles (Brooks et al., 2018; Temsah et al., 2021). HCWs were also at an increased risk of contracting the virus, with WHO (2021) estimating approximately 80,000 to 180,000 HCWs died from COVID-19 between January 2020 to May 2021. International comparisons show UK HCWs were at an increased risk of dying from Covid-19, citing shortage of personal protective equipment (PPE) as a potential cause (Amnesty International UK, 2021).

HCWs encountered a plethora of challenges resulting in concerns regarding their well-being and safety during the pandemic. Fears regarding access to appropriate PPE; being exposed to COVID-19; infecting family members and uncertainty in the workplace were prevalent (Shanafelt et al., 2020; Sunil et al., 2021). These stressors increased HCWs risk of developing mental health difficulties such as anxiety, depression, insomnia and stress (Liu et al., 2020). A Chinese-based study highlighted that HCWs' increased workloads exacerbated distress about becoming infected or transmitting COVID-19 to others (Liu et al., 2020). These findings are replicated throughout the literature exploring HCWs experiences of working throughout the pandemic, highlighting a relationship between working during this time and increased psychological distress (Shanafelt et al., 2020; Sunil et al., 2021; Verhoeven et al., 2020). Research has also highlighted that initiatives to reduce COVID-19 transmission such as self-isolation, social distancing and government enforced lockdowns caused feelings of loneliness and anxiety in HCWs (Greenberg et al., 2020; Shanafelt et al., 2020).

International systematic reviews of HCWs during pandemics such as SARS have identified occupational factors, fear of infection and social isolation as predictors of poor mental health (Brooks et al., 2018). Furthermore, HCWs are suspected to experience greater prevalence of psychological distress including post-traumatic stress disorder (PTSD) due to their role exposing them to infected patients or

infected family members (Kisely et al., 2020). International reviews highlight the enduring physical and psychological impact of working in healthcare during pandemics and an increased prevalence of stress, depression and anxiety in workforces (Ching et al., 2021). However, it is important to consider the experiences of UK-based HCWs due to variation in Covid-19 infection rates, government guidelines and national healthcare systems which international systemic reviews have not accounted for – thus limiting generalisability of their findings.

The literature review aims to understand the psychological impact UK HCWs experienced while working during the COVID-19 pandemic. Findings may inform policies of how to safeguard this workforce during and post-pandemic, whilst enabling healthcare organisations to prepare their workforce in the event of future infectious outbreaks (Frieden et al., 2021).

Methods

Scoping Searches

A scoping review of literature concerning HCWs' experiences of working during the Covid-19 pandemic was conducted to identify what reviews had been completed to date. The Staffordshire University Library Database (SULD) was utilised for these searches. Initially, searches targeted specific healthcare worker roles such as doctors, nurses, and healthcare support staff. However, these searches yielded low results. It was hypothesised that due to the recency of the Covid-19 pandemic, HCWs' experiences of working during this global health crisis was an emerging topic with limited research. At the time of the scoping searches, literature reviews had only explored HCWs experiences internationally. Thus, the literature review search focused on UK HCWs.

Search Strategy

The SULD was used to conduct the search of related literature. The following key search terms and Boolean operator 'AND' were used in the search, 'Covid-19 "' AND 'psychological impact' AND 'UK healthcare workers'.

Inclusion and Exclusion Criteria

Literature was eligible if it met the following criteria (1) study sample were clinical HCWs; (2) study assessed psychological impact either qualitatively or quantitatively;

(3) study was based in the UK; and (4) peer-reviewed articles. Studies were excluded on the basis they were (1) systematic reviews, editorials, theses or meta-analyses; (2) international studies; and (3) intervention papers.

Titles and abstracts were screened against the eligibility criteria by one reviewer. Where there were ambiguities, papers were included in the full-text screening to ensure relevant studies were not overlooked.

Publication Bias

The current review endeavoured to retrieve empirical papers of high quality (Tantra et al., 2019), thus papers which were not peer-reviewed were excluded. Although peer-reviewed papers are favourable, the risk of publication bias is debated (Haffar et al., 2019). Publication bias infers that studies which yield statistically significant and, therefore, favourable results are more likely to be published (DeVito & Goldacre, 2019; Nair, 2019). As a result, research findings should be interpreted with caution.

Data Extraction and Critical Appraisal Tool

The initial electronic database search retrieved 218 articles. Following this, titles and abstracts of the retrieved articles were assessed in line with the eligibility criteria. This resulted in 195 articles being excluded. The full texts of the remaining 22 were examined and a further nine papers were excluded, resulting in 13 papers being included in the literature review. Figure 1 depicts this process in detail through a Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) diagram (Page et al., 2021).

Full texts of eligible studies were screened, and data was extracted into a standardised table including information regarding the authors, year of publication, population, study design, key findings, methodological strengths limitations and MMAT score (see Table 1). To ascertain consistency of the critical appraisal across all papers, one critical appraisal tool was employed. The Mixed Methods Appraisal Tool (MMAT) (Hong et al., 2018) was utilised due to the research papers using different methodologies. Of the 13 papers included for review, eight papers used quantitative research methods, with the remaining five using qualitative methods. The MMAT assesses different research methodologies including qualitative, quantitative and non-randomized studies. For each methodology, reviewers are

instructed to rate the study by responding with 'Yes', 'No' or 'Can't tell' to each question. For this review, a numeric value was allocated to each response (*Yes = 2, No = 0, Can't tell = 1*), to allow comparison between studies (Appendix B, Appendix C).

Figure 1

PRISMA Flow Diagram (2021)
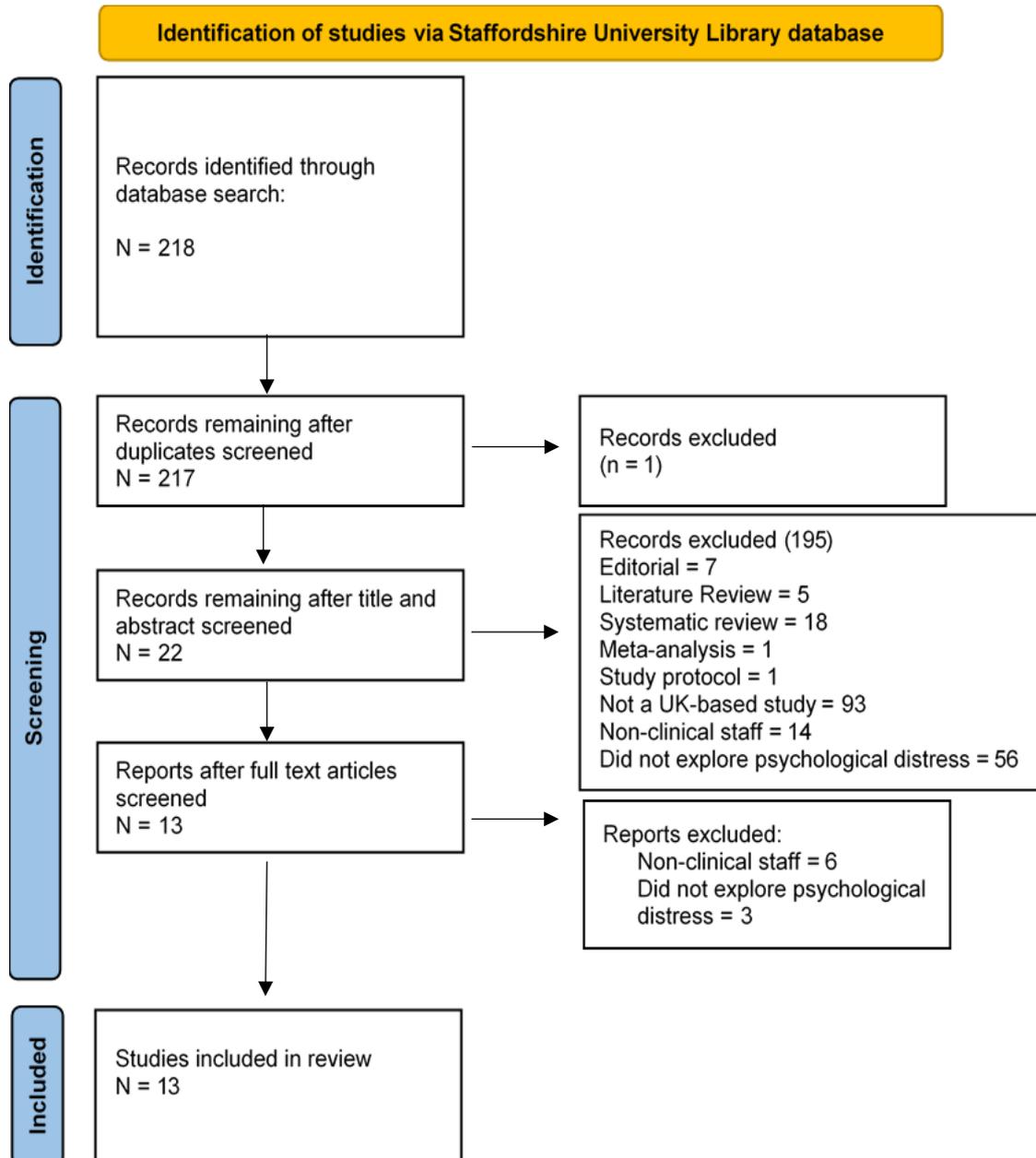
Table 1

Summary of included studies

	Author(s) & Year	Aim	Sample	Research Design	Key Findings	MMAT Score	Strengths	Limitations
1.	**Gilleen et al., 2021**	To examine mental health of UK HCWs and how this has been affected by Covid-19 pandemic	2773	Quantitative, cross-sectional design. Online survey	Increased prevalence of depression, anxiety and PTSD-related symptoms. Mental well-being had significantly worsened following COVID-19 pandemic. Fixed and controllable risk factors associated with high levels of psychiatric symptoms.	9	People encouraged to take part even if didn't feel negatively impacted. Large sample. Sample characteristics similar to NHS workforce. Validated mental health scales used.	Online survey requires self-selection which can limit representativeness. Sample characteristics similar to NHS workforce. Retrospective account of mental health before Covid-19. No baseline to compare well-being.
2.	**Wanigasooriya et al., 2020**	To identify the rates of symptoms of anxiety, depression and PTSD in UK HCWs.	2368	Quantitative cross-sectional study. Online questionnaire.	One third of HCW's reported clinically significant symptoms of anxiety and depression, a quarter reported PTSD symptoms. A history of mental health conditions	8	Participants recruited using different modalities e.g. email, newsletters and social media platforms. Large sample size of hospital staff.	Findings not generalizable to HCW who work from home or in the community. No follow-up to ascertain persistence of symptoms. Cross-sectional survey, causal inferences cannot be made. Conducted close to COVID-19 peak, which

					increased risk of symptoms. Adequate PPE and access to well-being support were negatively associated with reported symptoms.		Confounding variables including role, history of MH considered.	could have inflated scores.
3.	**Bennett et al., 2020**	To understand the experiences and concerns of frontline NHS workers caring for patients with Covid-19	54	Qualitative, online survey. Inductive thematic analysis	Trauma-related symptoms were a common experience for NHS workers including intrusive, traumatic thoughts/memories, emotional numbness.	10	Analysis was systematically reviewed by additional researcher. Reflective discussions were facilitated throughout . Adequate measure for safeguarding negative effects of participation. Themes supported by verbatim quotes.	Small sample obtained. Risk of sampling bias due to recruiting through social media. Increased number of doctors in comparison to other professions.
4.	**Petrella et al., 2021**	To assess HCW psychological well-being during the acute phase of the COVID-19 pandemic and use of support services.	1127	Quantitative, cross-sectional.	Deterioration of mental health reported by 47% of sample following start of Covid-19 pandemic. 84% of sample scored above the general population mean for psychological distress. At-risk populations of staff	7	Low attrition (17%). Some validated measures included in surveys. Confounders accounted for in analysis.	London-based study which limits generalisability of findings to other areas of UK. Female HCW overrepresented in sample (75%). No baseline, participant's retrospective account of mental health. Increased non-response bias as 9000 eligible but only 1127 completed.

					were young, female, staff and newly employed.			
5.	**Newman, Jeve & Majumder, 2022**	To understand the impact of working during pandemic on the psychological well-being of healthcare professionals.	395	Qualitative. Open-ended online survey. Content analysis.	Participants experienced difficulties such as hopelessness, worthlessness, self-harm and suicidal thoughts. Experiences of trauma-related symptoms reported including intrusive thoughts nightmares, flashbacks and panic attacks.	6	Recruited through multiple ways of advertising including social media and organisations. Large sample. Low likelihood of memory bias as conducted during first wave of pandemic.	Participants who answered minimum of one question included in analysis. Predominantly White, female sample. No acknowledgement of additional reviewers or reflexivity. Survey responses provide limited answers, cannot ask to clarify or questions.
6.	**Grailey, Lound & Brett, 2021**	To understand HCWs stressors, psychological safety and psychological distress during the Covid-19 pandemic.	49	Qualitative. Semi-structured interview. Thematic analysis.	Reports of psychological distress, feelings of burnout, anxiety, low mood and fear of Covid-19. HCWs observed psychological distress in colleagues.	10	Second researcher coded transcripts picked at random. Large sample, representative of workforce at hospitals recruited from.	Limited generalisability due to recruitment based in London. Reports of anxiety, burnout, low mood were not validated by diagnostic tool.

7.	Pink et al., 2021	To examine prevalence of psychological distress groups of front-line workers and analyse whether resilience levels moderated the psychological impact experienced.	12,989	Quantitative. Non-randomised.	HCWs reported lower levels of distress than other keyworkers and the general population group during first period of lockdown. NHS health care workers had higher stress immunity than other keyworkers and the general population. NHS staff had higher resilience than general population and other keyworkers but less than police, ambulance, fire and rescue.	9	Large sample size which is representative of Welsh population. Various ways of advertising research e.g. social media, news, paper versions for "hard-to-reach" groups.	Welsh-based study, cannot generalise to different parts of UK due to different Covid-19 infection rates and government guidelines to reduce transmission. No pre-Covid data available to compare distress levels.

8.	**Roberts et al., 2021**	To examine the rates of psychological distress during different stages of the Covid-19 pandemic in frontline doctors.	3079	Quantitative, longitudinal cohort survey. Online survey.	Prevalence of psychological distress significantly increased during the acceleration phase, and reached 23.7% for trauma symptoms during the peak phase. Recovery of distress rates was demonstrated in deceleration phase for most. Most significant predictors were familial safety, personal safety and established mental health conditions. One in four doctors met the clinical threshold, for trauma.	6	Large sample size. Established trend across pandemic phases – acknowledged impact of covid-19 activity on distress and trauma – can make comparisons. No significant difference in either the GHQ-12 or IES-R scores between those who dropped out and those who remained in the study	Reduced response rates for the peak and deceleration surveys. Reported rates of distress and trauma do not account for pre-existing psychiatric morbidity or historical predisposing factors. There is no pre-Covid baseline data to compare acceleration phase to.
9.	**McGlinchey et al., 2021**	To explore experiences of HCWs during the first wave of the Covid-19 pandemic.	10	Qualitative, telephone interviews. Interpretative Phenomenological Analysis.	Anxiety, hypervigilance and fear reported. Reduced social support, redeployment contributed to poor mental health. HCWs practiced acceptance, built resilience and sought positive coping strategies	9	All HCWs were in direct contact with patients. Peer-debriefing and reflexivity addressed. Interviewers were CBT therapists. Research team reflections pre-, post-interview conducted.	Small sample size, 70% female. Recruitment through social media and snowball sampling could cause selection bias. Interview schedule was not piloted. Telephone interviews. Sample was a Northern Irish work population which limits generalisability of findings.

						to manage difficult emotions.	Cross-examination of codes, reflective journals kept.	
10.	**Roberts et al., 2021**	To measure psychological distress experienced by doctors during the acceleration phase of COVID-19.	5440	Quantitative. Cross-sectional, online survey.	44.2% of participants reached study threshold for psychological distress during acceleration phase. Concentration, sleep, being under strain and day-to-day enjoyment of activities were negatively affected by GHQ scores. Reported concerns included the risk to families or loved ones due to their role.	6	Large sample size recruited which is representative of target population.	Data collection period fell during period where full lockdown began, the effect of this is not accounted for in this research. Risk of response bias due to online survey. Regional variation in COVID-19 activity was experienced during the survey period, meaning that participants' clinical experience is likely to vary by region. No pre-covid-19 baseline.

11.	Skelton et al., 2023	To assess the impact of working during Coivd-19 pandemic on burnout, role satisfaction and clinical practice for sonographers.	138	Quantitative cross-sectional, online survey.	92% of sonographers met threshold for burnout, 91% met threshold for disengagement. Significant relationship between burnout and psychological distress. Sonographers who reported a large, negative change in role satisfaction before and during the pandemic were more likely to have higher total burnout and distress scores. Mean CORE-10 score of 14.39 suggested mild psychological distress among respondents.	5	Participants provided with information of mental health support groups.	Recruitment through social media which requires self-selection. Evident missing data, not all participants completed all parts of questionnaire. Only 67% completed psychological distress measure. Not everyone answered demographics question, thus cannot infer whether sample is representative.

| 12 | Revythis et al., 2021 | To investigate junior and middle-grade doctors' physical and mental burnout during the COVID-19 pandemic. | 61 | Quantitative. Cross-sectional. | Moderate levels of emotional exhaustion, but high levels of personal satisfaction, a positive impact on doctors finances and very low levels of seeking support. Reports of change in workload and busier work days following Covid-19, particularly the second wave. No marked difference between roles. 57.3% identified that their responses to questions involving individual burnout components would be more favourable before the second wave. | 6 | Representative of NHS trust study was completed in. Explored experiences of trainee HCWs which is underrepresented within literature. Validated measure used. | Relatively small sample size. Retrospective reports of well-being prior to second wave of pandemic can be subjective and cannot infer causation. Completed within a single NHS trust, as Covid-19 rates varied throughout country the generalisability of these findings are limited. |
| 13 | Kabasinguzi et al., 2023 | To investigate mental health experiences and coping strategies of BAME care workers during the COVID-19 pandemic. | 15 | Qualitative, thematic analysis. Semi-structured interview. | Participants reported that COVID-19 pandemic had a negative impact on their mental health. Reported feelings of loneliness, social isolation after | 9 | Research explored an underrepresented demographic in literature, considered 'at-risk' population. Research conducted during pandemic. | Non-random sampling and snowball method used – not every care worker has an equal chance of being recruited. Findings limit generalisability due to care workers based in |

	work, depression anxiety and fear of Covid-19.	Interview guide based on literature review.	Luton. Only one coder used for transcripts.

Data synthesis and analysis

Elements of narrative synthesis as proposed by Popay et al. (2006) were incorporated to synthesise the data. Codes were developed from the research papers and grouped based on similarities including findings and study characteristics. These categories informed the overarching themes which produced two themes and five subthemes.

Results

Quality Assessment

The MMAT scores for each research article are depicted in Table 1. As a numeric value was allocated for each item on the critical appraisal tool, the maximum score possible was 10 (see Appendix B, Appendix C). As there is no guidance on the cut-off for a methodologically sound research paper, it is inferred that a higher score indicates increased research rigour across the appraisal criteria. The average MMAT score from the included research article was 7, with the highest score of 10 being obtained by two studies and the lowest score, 5, obtained by one study.

A common factor which reduced scores was that participants were not representative of the target population (Petrella et al., 2021; Revythis et al., 2021; Skelton et al., 2023). However, this factor also yielded increased appraisal scores in studies which recruited large sample sizes which were present in many of the quantitative studies. For example, Pink et al. (2021) recruited over 12,000 participants, which was guided by a minimum sample size within each Welsh local authority they recruited from, to ensure findings were generalisable to the Welsh population. Additionally, large sample sizes were also recruited within studies which explored specific clinical roles such as doctors, (Roberts et al., 2021; Roberts et al., 2021) and HCW roles (Gilleen et al., 2021; Wanigasooriya et al., 2020) suggesting increased generalisability of findings to individuals within these occupational roles. Although the qualitative MMAT appraisal tool does not assess the representativeness of samples, it should be acknowledged that studies had predominantly London-based, White British, female participants (Grailey et al., 2021; McGlinchey et al., 2021; Newman et al., 2022).

Quantitative studies which accrued large sample sizes were impacted by incomplete outcome data, reducing quality appraisal scores. Acceptable complete outcome data was set at a cut-off of 80% (Thomas et al., 2004; Zaza et al., 2000). Roberts et al.

(2021) had an attrition rate of 43.4% during the final follow-up measures, and although analysis determined that the incomplete data had no significant impact on the results, it is important to consider what factors could have influenced attrition rates, and whether these could have been mitigated. Skelton et al. (2023) received a low score of 4, which was influenced by the frequency of missing data. 67% of participants completed the psychological distress measure in this study, which was the measure of interest for this literature review. Additionally, not all participants completed demographic data, limiting the extent to which findings can be assessed for being representative of the target population. Petrella et al. (2021) had an attrition rate of 17% which is favourable considering the cut-off employed, however this research paper had advertised to 9000 eligible participants with only 1127 consenting and completing the research – potentially highlighting non-response bias within this study. Characteristics of non-participants were not analysed therefore it is difficult to ascertain whether non-response bias influenced findings (Prince, 2012).

Validity and reliability are important concepts to consider when designing qualitative research (Patton, 2015). Qualitative research papers were efficient at recording how findings were derived from the data by documenting how data was coded and analysed. Interpretations of data were substantiated by quotes. Three qualitative papers identified that a second reviewer was utilised when coding and analysing transcripts (Bennet et al., 2020; Grailey et al., 2021; McGlinchey et al, 2021). However, both Kabasinguzi et al. (2023) and Newman et al. (2022) did not identify whether a second reviewer had been used to verify accuracy of data interpretations. Additionally, these two studies did not declare a statement of reflexivity. Reflexive statements are important as they highlight potential researcher bias, which can influence interpretations of data. By including a reflexive statement, researchers can hinder credibility of their findings (Dodgson, 2019). Grailey et al. (2021) acknowledged that researchers had experience of working during the COVID-19 pandemic and incorporated triangulation strategies to manage the risk of researchers' preconceived perceptions influencing the analysis and interpretation of data. Similar strategies are also incorporated by McGlinchey et al. (2021) and Bennett et al. (2020) accruing increased quality appraisal scores, particularly when considering if findings were adequately derived from the data.

Various quantitative studies acknowledged potential confounding variables and how these were incorporated into analyses. Gilleen et al. (2021) considered confounders including a participant's occupational role, location, and experiences of bereavement during the COVID-19 pandemic and accounted for this in analysis. Wanigasooriya et al. (2020) also acknowledged a participant's occupational role and history of experiencing mental health difficulties. Petrella et al. (2021) employed a hierarchical regression to account for the impact of variables such as gender and age on experiences of psychological distress. Some studies also acknowledged that the geographical location of participants would also impact their experiences due to the varying Covid-19 infection rates (Pink et al., 2021; Roberts et al., 2021). However, Robert et al. (2021) identified that the reports of distress and trauma did not account for participant's experiences of mental health difficulties or historical predisposing factors – highlighting an oversight of confounding variables.

Demographic Characteristics

Most research papers (n=7) recruited participants in general HCWs roles. The remaining six papers focused on specific disciplines including care home workers (n=1), obstetric sonographers (n=1), doctors (n=3) and critical care and emergency department staff (n=1). Not all studies included participant demographics, which can be a limitation when assessing the representativeness and generalisability of findings.

Of the studies which did report demographics, it was found that female participants were overrepresented in most samples, apart from Kabasinguzi et al. (2023) where 53% of participants were female. Participants ranged in age from 25 – 54 with some studies recruiting participants who were above age 65. Ethnicity was not reported in most studies. In those that did, participants identifying as White accounted for the majority. Gilleen et al. (2021) acknowledges that the demographics highlighted may not indicate overrepresented samples and likens the sample demographics to that of the NHS workforce which is identified as predominantly White and female (Government Digital Service, 2020). One study explored participants who identify from racialised backgrounds (Kabasinguzi et al., 2023) and the sample included 86% of participants who identified as Black African.

A variety of sampling methods were demonstrated throughout the research papers. Opportunity sampling was predominantly used within clinical organisations and healthcare research networks to recruit HCWs both online and within employee spaces such as hospitals (Gilleen et al., 2021; Petrella et al., 2021; Revythis et al., 2021; Robert et al., 2021; Robert et al., 2021). Grailey et al. (2021) employed purposive sampling to recruit participants working in specific hospital departments to ensure all levels of seniority were represented. Two studies utilised snowball sampling: Bennett et al. (2020) recruited participants through two doctors with prominent social media following and Kabasinguzi et al. (2023) asked participants to recommend colleagues to interview. The remaining studies (n=5) disseminated research advertisements through social media, newsletters, and posters.

The MMAT does not indicate cut-offs for appropriate sample sizes of a target population. It could be inferred that a larger sample acquires a more representative group of the target population and therefore demonstrates research of high quality (Andrade, 2020). Bennett et al. (2020) acquired the largest sample size (n=54) within the qualitative research papers, whereas Roberts et al. (2021) recruited the largest sample within the quantitative papers (n=5440). McGlinchey et al. (2021) had the smallest sample size of qualitative research papers (n=10) and provided justification that due to the research being guided by Interpretative Phenomenological Analysis (IPA), a smaller sample size is more appropriate. Revythis et al. (2021) had the smallest sample size of the quantitative studies (n=61) which is acknowledged in the limitations of the study. However, as this review has highlighted that White, female participants were overrepresented in several samples, the representativeness of studies should not be inferred based on sample size alone.

Synthesis

To allow for synthesis of both quantitative and qualitative research, findings were transformed into descriptive format (Ryan, 2013). From this, codes were developed which later formed themes based on synthesising evidence from the included papers. These themes reflect the psychological impact experienced by HCWs working during the Covid-19 pandemic and the factors which influenced this.

Prevalence of poor mental well-being

Throughout the quantitative research papers, a variety of psychometric and self-report measures were utilised to assess HCWs' psychological well-being. Commonly used measures included the Generalized Anxiety Disorder scale (GAD-7), Patient Health Questionnaire (PHQ-9), Impact of Event Scale (IES-R) and Kessler Psychological Distress Scale (K10). Findings highlighted increased rates of HCWs reporting clinically significant symptoms for anxiety, depression and PTSD (Gilleen et al., 2021; Roberts et al., 2021; Wanigasooriya et al., 2020). Petrella et al., (2021) highlighted that 84% of HCWs score (M = 22) were above the general population mean (M = 14.5) – indicating an increased prevalence of psychological distress within this population. Measures of burnout also indicated that this was prevalent within junior and middle-grade doctors and sonographers (Revythis et al., 2021; Skelton et all., 2023). Contrastingly, research also indicated that HCWs reported lower levels of distress when compared with other keyworkers and the general population between June and July 2020, during the first period of lockdown in the UK (Pink et al., 2021).

Qualitative papers sought for present and retrospective accounts of HCWs psychological well-being during the pandemic, whereas symptomatic prevalence of mental well-being was measured in quantitative papers. Reports of symptoms associated with PTSD such as intrusive and traumatic thoughts were prevalent (Bennett et al., 2020; Grailey et al., 2021; Newman et al., 2022). Increased incidence of anxiety including panic attacks, hypervigilance and fear was also identified (Grailey et al., 2021; McGlinchey et al., 2021; Newman et al., 2022). Kabasinguzi et al. (2023) found participants identified the direct psychological impact of working during the pandemic had on their psychological well-being, citing difficulties such as stress and depression. These difficulties were attributed to the marked reduction in interactions with colleagues due to government guidelines on social distancing. HCWs also cited observing psychological distress in their colleagues (Grailey et al., 2021). Newman et al. (2022) identified that for some, psychological distress progressed in severity to thoughts of self-harm and suicidal ideation.

Factors influencing psychological impact

Stages of the Covid-19 pandemic

Papers which explored comparisons of psychological well-being before and during the Covid-19 pandemic highlighted a marked reduction in well-being. Gilleen et al. (2021) found that self-reported depression of 'high' severity was identified by 28% of HCWs whilst 33% experienced anxiety and 15% reported high posttraumatic stress disorder-related symptoms. Further, indicators of mental well-being had deteriorated significantly when compared with retrospective accounts of well-being prior to the pandemic. It was also highlighted that fluctuations in mental health were paralleled by different stages of the pandemic, with an increased number of HCWs (47%) reporting poor mental health during in comparison to before the pandemic (17%) (Petrella et al., 2021). These rates of distress were also found in research exploring specific healthcare roles. Roberts et al. (2021) explored doctors' levels of psychological distress during different 'phases' of the pandemic. During the acceleration phase (in which infection rates increased), rates of psychological distress and trauma significantly increased for doctors, with 44.2% reaching psychometric thresholds. This study also highlighted that from peak to deceleration phase (where infection rates reduced) psychological distress declined. Thus, highlighting an association between Covid-19 infection rates and psychological distress. This leads us to consider the personal, occupational and organisational challenges associated with increased Covid-19 infection rates, which could influence psychological distress experienced by HCWs.

Fear of Covid-19

HCWs reporting a fear of Covid-19 was common throughout the literature. Papers highlighted that fear related to contracting the virus and infecting patients or family members with the virus were predictors of distress (Grailey et al., 2021; McGlinchey et al., 2021) leading to PTSD in some HCWs (Roberts et al., 2021). Being aware of increased Covid-19 rates in colleagues heightened this fear which precipitated symptoms associated with anxiety (Kabasinguzi et al., 2023; McGlinchey et al., 2021). It was hypothesised that fear of Covid-19 was also exacerbated by patient mortality (Kabasinguzi et al., 2023). Fear of contracting Covid-19 led to physical exhaustion due to the extensive cleaning processes required to prevent the spread of infection (McGlinchey et al., 2021). Kabasinguzi et al. (2023) found that Black and

minority ethnic HCWs also experienced fears of contracting Covid-19. It could be hypothesised that such fears were perpetuated within this population due to the increased infection and mortality rates Covid-19 within this demographic (Bhatia, 2020; Chaudhry et al., 2020).

Occupational challenges

Factors associated with occupation were identified influencers of psychological distress throughout the literature. Wanigasooriya et al. (2020) identified doctor and nurse occupations were protective factors for anxiety and PTSD-related symptoms experienced working throughout the Covid-19 pandemic. Similarly, hospital-based research highlighted that staff members who were new to their role were more likely to experience increased levels of psychological distress and burnout (Petrella et al., 2021). Furthermore, Grailey et al. (2021) found that senior staff members were more likely to support colleagues and acquire their psychological distress. Thus, inferring potential vicarious trauma and highlighting further discrepancies in prevalence of distress. However, these findings are contested, as research has suggested that HCWs experienced psychological difficulties throughout the pandemic irrespective of their role or position of seniority (Newman et al., 2022).

The severity of psychological distress during the pandemic could have further been influenced by challenges such as occupational workload. Grailey et al. (2021) identified that HCWs' stressors were experienced across all disciplines, and this was associated with an increased workload and volume of acutely unwell patients. Such workload changes were also observed by doctors, with the second wave of the pandemic heightening workloads further (Revythis et al., 2021). HCWs in nursing homes also reported that the increase in workload alongside requirements to source, wear and change PPE was an additional stressor (Kabasinguzi et al., 2023). Positive correlations between increased workload and psychological distress such as anxiety, depression and PTSD-related symptoms have also been established in HCWs through studies that explored the role of healthcare worker burnout in psychological distress (Gilleen et al., 2021; Petrella et al., 2021).

Organisational influences

Government guidelines in response to Covid-19 infection rates saw significant changes in the way HCWs performed their duties, such as the need for all staff to

wear PPE (Kabasinguzi et al., 2023). However, with limited PPE provisions despite increased demands, staff were concerned regarding the insufficient resources and their own safety (Grailey et al., 2021; Newman et al., 2022). Some HCWs experienced pressure to work without such equipment – a challenge which was associated with increased depression (Gilleen et al., 2021). Thus, adequate provision of PPE was associated with a decrease in reported symptoms of psychological distress, reducing the likelihood of anxiety symptoms by 50% in some populations (Newman et al., 2022; Wanigasooriya et al., 2020). HCWs also reported barriers to using non-verbal cues and communicating with colleagues and patients because of PPE. These barriers prevented HCWs from carrying out their roles in a way that was familiar to them, causing distress (McGlinchey et al., 2021). McGlinchey et al. (2021) also highlighted that the availability of PPE was a prominent worry for HCWs, which led to feelings of "guilt" for using PPE. Grailey et al. (2021, p. 7) identified barriers to social interactions between colleagues due to wearing PPE, which reinforced feelings of isolation during a challenging time – this sense of isolation reduced when restrictions were less prominent in the workplace.

Due to the unpredictable nature of the Covid-19 pandemic, many healthcare organisations experienced significant changes in the workplace. Such changes led to short-staffed teams, increased workload, and exacerbated psychological distress for many HCWs (Grailey et al., 2021; McGlinchey et al., 2021). Redeployment was also associated with reduced well-being for staff (McGlinchey et al., 2021). These changes in occupational duties not only induced a sense of unfamiliarity in HCWs, but also increased social isolation due to working with unfamiliar people. This is hypothesised to have impacted HCWs mental health further (Grailey et al., 2021; McGlinchey et al., 2021). These negative influences on well-being are also demonstrated in individuals who were previously dissatisfied with their job before the Covid-19 pandemic and were at a higher risk of experiencing burnout and distress (Skelton et al., 2023).

Resilience and Coping

Many HCWs referred to a sense of resilience in the face of the Covid-19 pandemic (McGlinchey et al., 2021; Pink et al., 2021). When compared with other keyworkers such as the police and ambulance services, HCWs demonstrated higher stress immunity (Pink et al., 2021). It was hypothesised that such stress immunity was a

result of HCWs being able to maintain social interactions and financial security in their roles (Pink et al., 2021). Findings from Gilleen et al. (2021) suggested that increased resilience and the opportunity to share stress at work were significantly associated with having lower psychological distress in HCWs, highlighting potential protective factors such as resilience and social interaction against the psychological impact of working during the pandemic. The increased resilience in HCWs could be driven by the altruistic nature of their roles and a sense of reward for supporting others through challenging times – thus, reducing psychological distress (Pink et al., 2021). HCWs referred to their role as a "call to duty" (McGlinchey et al., 2021, p. 8) during the pandemic, which included acceptance of their job and encouraged adaptation to the challenges faced. Subsequently, many HCWs developed a positive mind-set and viewed the pandemic as an opportunity to learn within their roles – citing it as a traumatic but rewarding experience (McGlinchey et al., 2021; Bennett et al., 2020). However, resilience also coincided with worries regarding the long-term impact of the pandemic and how to maintain resilience throughout (McGlinchey et al., 2021).

Whilst practicing resilience, HCWs adopted an acceptance that the pandemic would cease eventually and focused on supporting their colleagues and service users (Grailey et al., 2021; Newman et al., 2022). This mind-set introduced various ways of coping in the face of the pandemic to manage psychological distress (Newman et al., 2022). HCWs cited many coping strategies including appreciating spending time with loved ones, engaging in hobbies, religious practices and trying to maintain a sense of normality (McGlinchey et al., 2021; Newman et al., 2022; Kabasinguzi et al., 2023). HCWs also shared that avoiding Covid-19 related information, such as the news, helped maintain a sense of normality whilst reducing anxiety. Following government guidelines provided reassurance that they were protecting their colleagues and patients (Kabasinguzi et al., 2023). Additionally, some maladaptive coping strategies were developed, such as increased alcohol consumption (McGlinchey et al., 2021; Newman et al., 2022). Overall, adopting a positive mind-set was an evident coping strategy, and although HCWs experienced distress throughout the pandemic, there was also a sense of pride in having a monumental role in supporting the nation through an unprecedented time (McGlinchey et al., 2021; Bennett et al., 2020; Newman et al., 2022).

Discussion

The aim of this literature review was to understand the psychological impact of working during the Covid-19 pandemic for UK HCWs. Following a synthesis of research findings, the prevalence of psychological distress experienced by HCWs during the pandemic has been evidenced. At the time of writing, this literature review is the first of its kind to explore UK HCWs experiences of working during the Covid-19 pandemic. This is a significant addition to the current evidence-base as Covid-19 infection rates and government guidelines were varied across the world, thus, reviews focusing on HCWs internationally may not have been generalisable to UK HCWs experiences.

HCWs experienced a negative psychological impact whilst working throughout the Covid-19 pandemic, with notable increases in the prevalence of symptoms related to anxiety, depression, PTSD and burnout (Gilleen et al., 2021; Roberts et al., 2021; Wanigassoriya et al., 2020). Literature exploring previous pandemics has also highlighted the enduring psychological impact HCWs experience during infectious outbreaks (Brooks et al., 2020; Maunder et al., 2003). It is evidenced that psychological distress occurs in response to the stage of a pandemic, where increased levels of distress are experienced when infection rates are at their peak and they reduce during deceleration of infection rates. This suggests that recovery from distress during a pandemic is possible (Roberts et al., 2021). Furthermore, evidence of recovery following psychological distress has been demonstrated in research based in Wuhan exploring frontline nurses' post-traumatic growth following the Covid-19 pandemic (Peng et al., 2021). It could be postulated that during stages of increased infection rates, a pandemic becomes more salient, which precipitates fear of infection and subsequent distress. Therefore, reduced infection rates lead to decreased salience, inferring a lower threat of infection which leads to recovery from distress.

Despite the challenges HCWs faced during the Covid-19 pandemic and the psychological distress experienced, this literature review has also demonstrated a sense of comradery adopted by many (McGlinchey et al., 2021; Bennett et al., 2020). HCWs practiced acceptance and an optimistic mind-set as a way of coping through the pandemic (McGlinchey et al., 2021; Bennett et al., 2020; Newman et al., 2022). Although differing coping strategies were employed throughout the workforce,

examples of resilience were prominent (McGlinchey et al., 2021; Pink et al., 2021). The impact of the altruistic nature of healthcare roles is hypothesised to have influenced examples of stress-immunity and resilience demonstrated by HCWs (Pink et al., 2021). It is postulated that altruism is a factor influencing post-traumatic growth observed in HCWs following a pandemic (Peng et al., 2021).

Several factors influencing the psychological distress experienced by HCWs have been identified. Challenges within the workplace have been cited as a primary cause of psychological distress, which has been evidenced in previous literature (Sunil et al., 2021). Immediate changes to HCWs normal way of working required many to adapt quickly to ensure the safety of themselves and the service users they cared for (Christian et al., 2014). This resulted in increased workload, changes to team working, the requirement of PPE and redeployment (Grailey et al., 2021; McGlinchey et al., 2021). Grailey et al. (2021) identified that this distress impacted all disciplines, regardless of seniority. Organisational influences also impacted HCWs well-being which impacted feelings of social isolation in the workplace (Grailey et al., 2021; McGlinchey et al., 2021). These changes significantly impacted well-being as social support was cited as an important coping mechanism for HCWs during working hours and in their personal lives (McGlinchey et al., 2021). These findings support previous literature exploring occupational factors associated with psychological distress in HCWs working during the SARS pandemic (Brooks et al., 2018).

Findings have mirrored those of previous international systematic reviews exploring HCWs' experience working throughout the SARS pandemic, with occupational factors, social isolation and fear of infection predictors of poor mental health in HCWs (Brooks et al., 2018). These findings highlight the enduring psychological impact of working in healthcare during pandemics, suggesting that the effects of working throughout a serious infectious outbreak are consistent throughout time and geographical locations.

Implications of findings

The literature review highlights a need for the provision of psychological support for HCWs regarding pandemics. This support is warranted as a preventative response to ensure staff well-being takes prominence in the face of a global health crisis. Support such as well-being drop-in centres have been proven effective during

previous pandemics, whereby workforces are provided with a mindful space to take a break (Maunder et al., 2003). However, practical measures such as social distancing and recruiting qualified group facilitators to support the provision of these centres should be considered. Support can also be provided through clear dissemination of communication, social support and coping strategy guidance – initiatives that are associated with increased resilience and posttraumatic growth (Palacio et al., 2019). As the importance of peer support has also been emphasised throughout the literature, the maintenance of positive peer relations should be fostered through organisational strategies such as well-being ambassadors, signposting of support services and encouraging self-care (Brooks et al., 2020; Walton et al., 2020). It is also important to consider the long-term psychological impact for HCWs who have worked though the Covid-19 pandemic and provide support in response to this. Tomlin et al. (2020) propose a phased model of psychosocial support for UK HCWs which reinforces the importance of longer-term organisational support following a pandemic. The model suggests initiatives such as incorporating reflective models into practice and the "watchful waiting" of HCWs, whereby those with subthreshold PTSD symptoms are closely monitored and offered follow-up support if they increase in severity (National Institute for Health and Care Excellence [NICE], 2018; Tomlin, et al., 2020). This approach is substantiated by research which highlights natural recovery of PTSD symptoms without formal intervention is common (Grey, 2009).

Future research should endeavour to explore the psychological impact experienced by HCWs from at-risk populations such as Black and minority ethnic groups as this population experienced increased mortality rates in comparison to the White British population during Covid-19 (Bambra et al., 2020; Bhatia, 2020; Chaudhry et al., 2020; Kirby, 2020; Office for National Statistics, 2020). Despite such risk factors there is limited research detailing this population's experiences during the pandemic. There is also a requirement for further longitudinal research studies exploring the long-term psychological impact of the pandemic for HCWs (Roberts et al., 2021). Most studies adopted a cross-sectional design, which limits the extent to which causal conclusions can be made (Wang & Cheng, 2020).

Strengths and limitations

This review was the first of its kind to explore UK based studies on HCWs experiences during the pandemic. Therefore, providing novel findings and implications, which are reflective of the UK HCW experience. Research exploring HCWs experiences of working during a pandemic is critical in informing healthcare organisations of the challenges employees face and aid development of preventative strategies to safeguard the well-being of staff in the event of future pandemics. The review's findings also support previous literature, which has explored HCWs' experiences in previous pandemics such as SARS and literature reviews exploring international HCWs experiences during the COVID-19 pandemic.

This review recognises key limitations in the methodology employed in the literature, therefore implications and recommendations should be considered with caution. Many quantitative papers did not include baseline measures of psychological distress before the pandemic. Thus, it is difficult to assess changes in mental well-being pre- and post-pandemic to infer causality (Hampton et al., 2013). Additionally, many studies relied on retrospective accounts of distress prior to the pandemic or during the pandemic. Such accounts could have been influenced by memory bias; this could lead to inaccurate estimations of distress or impact on mental health due to how the individual was feeling at the time of participation. Due to research taking place during the pandemic, there is also a lack of validated measures, which assess Covid-19 related issues. Studies mainly recruited through self-selection procedures such as social media, which could have encouraged individuals who had particularly negative experiences to take part in research. This may have caused an overrepresentation of HCWs who had experienced psychological distress. Many studies failed to acknowledge whether participants had pre-existing mental health difficulties, which could have been exacerbated by the pandemic. The oversight of potential confounding variables can lead us to question the validity of these findings.

When exploring psychological well-being within quantitative research, it is important to critically review how this is operationalised to ensure findings are reliable and objective (Bhandari, 2022). The quantitative research papers used validated measures to assess psychological distress, which supports the validity of research findings when making inferences of mental health prevalence (Hall et al., 2014). However, Grailey et al., (2021) advocates that qualitative research also provides

participants the opportunity to explore positive outcomes of the Covid-19 pandemic, which self-report measures do not acknowledge. This includes the sense of community and togetherness cited by HCWs as a favourable aspect of their role throughout an unprecedented time (McGlinchey et al., 2021; Bennett et al., 2020; Newman et al., 2022).

The literature review had one reviewer which is incongruent with MMAT guidelines that specifies using two reviewers to critically appraise research papers (Hong et al., 2018). Additionally, the review used one database to source research papers. This approach was taken as the database retrieved articles the researcher had access to, however, other potentially relevant research papers may have been overlooked. The review is also vulnerable to publication bias as grey literature was excluded. When considering the MMAT critical appraisal tool, there are limitations due to the categorical nature of assessment, which means that a research paper may meet criteria even if this has not been completed to a high quality – potentially inflating critical appraisal scores.

Conclusion

This literature review aimed to investigate and critically appraise research exploring the psychological impact UK HCWs experienced working during the Covid-19 pandemic. Subsequently, findings have highlighted that HCWs experienced detrimental effects on their mental well-being. Significant factors contributing to this included: the stage of the pandemic, fear of Covid-19, occupational challenges, organisational influences, resilience and coping.

It has also identified organisational implications which could safeguard HCWs psychological well-being in anticipation of future pandemics through preventative measures which can be practiced post-pandemic. This includes 'watchful waiting' of PTSD symptoms, well-being groups, clear guidance on self-care and support services – which should be endorsed by healthcare organisations to protect HCWs well-being. This review has highlighted a need for further research to explore the psychological impact of at-risk HCW groups which are underrepresented in the current literature regarding HCWs experiences during the COVID-19 pandemic.

References

Amnesty International UK (2020, July 13) *UK among highest COVID-19 health worker deaths in the world.* https://www.amnesty.org.uk/press-releases/uk-among-highest-covid-19-health-worker-deaths-world

Andrade, C. (2020). Sample Size and its Importance in Research. *Indian Journal of Psychological Medicine*, *42*(1), 102–103. https://doi.org/10.4103/ijpsym.ijpsym_504_19

Bambra, C., Riordan, R., Ford, J., & Matthews, F. (2020). The COVID-19 pandemic and health inequalities. *Journal of Epidemiology and Community Health*, *74*(11), 964–968. https://doi.org/10.1136/jech-2020-214401

Bennett, P., Noble, S., Johnston, S., Jones, D., & Hunter, R. (2020). COVID-19 confessions: a qualitative exploration of healthcare workers experiences of working with COVID-19. *BMJ Open*, *10*(12). https://doi.org/10.1136/bmjopen-2020-043949

Bhandari, P. (2022, December 02). *Operationalization | A Guide with Examples, Pros & Cons.* https://www.scribbr.com/dissertation/operationalization

Bhatia, M. (2020). COVID-19 and BAME group in the United Kingdom. *The International Journal of Community and Social Development*, *2*(2), 269–272. https://doi.org/10.1177/2516602620937878

Brooks, Samantha K., Webster, R. K., Smith, L. E., Woodland, L., Wessely, S., Greenberg, N., & Rubin, G. J. (2020). The psychological impact of quarantine and how to reduce it: rapid review of the evidence. *Lancet*, *395*(10227), 912–920. https://doi.org/10.1016/S0140-6736(20)30460-8

Brooks, Samantha Kelly, Dunn, R., Amlôt, R., Rubin, G. J., & Greenberg, N. (2018).
A systematic, thematic review of social and occupational factors associated
with psychological outcomes in healthcare employees during an infectious
disease outbreak. *Journal of Occupational and Environmental Medicine*, *60*(3),
248–257. https://doi.org/10.1097/JOM.0000000000001235

Chaudhry, F. B., Raza, S., Raja, K. Z., & Ahmad, U. (2020). COVID 19 and BAME
health care staff: Wrong place at the wrong time. *Journal of Global
Health*, *10*(2). https://doi.org/10.7189/jogh.10.020358

Ching, S. M., Ng, K. Y., Lee, K. W., Yee, A., Lim, P. Y., Ranita, H., Devaraj, N. K., Ooi,
P. B., & Cheong, A. T. (2021). Psychological distress among healthcare
providers during COVID-19 in Asia: Systematic review and meta-analysis. *PloS
One*, *16*(10), e0257983. https://doi.org/10.1371/journal.pone.0257983

DeVito, N. J., & Goldacre, B. (2019). Catalogue of bias: publication bias. *BMJ
Evidence-Based Medicine*, *24*(2), 53–54. https://doi.org/10.1136/bmjebm-2018-
111107

Dodgson, J. E. (2019). Reflexivity in qualitative research. Journal of Human
Lactation: Official Journal of International Lactation Consultant
Association, 35(2), 220–222. https://doi.org/10.1177/0890334419830990

Frieden, T. R., Buissonnière, M., & McClelland, A. (2021). The world must prepare
now for the next pandemic. *BMJ Global Health*, *6*(3).
https://doi.org/10.1136/bmjgh-2021-005184

Gilleen, J., Santaolalla, A., Valdearenas, L., Salice, C., & Fusté, M. (2021). Impact of the COVID-19 pandemic on the mental health and well-being of UK healthcare workers. *BJPsych Open*, *7*(3), e88. https://doi.org/10.1192/bjo.2021.42

Grailey, K., Lound, A., & Brett, S. (2021). Lived experiences of healthcare workers on the front line during the COVID-19 pandemic: a qualitative interview study. *BMJ Open*, *11*(12), e053680. https://doi.org/10.1136/bmjopen-2021-053680

Grey, N. (Ed.). (2009). A Casebook of Cognitive Therapy for Traumatic Stress Reactions. Routledge. https://doi.org/10.4324/9780203874318

Greenberg, N., Docherty, M., Gnanapragasam, S., & Wessely, S. (2020). Managing mental health challenges faced by healthcare workers during covid19 pandemic. *BMJ*, *368*. https://doi.org/10.1136/bmj.m121

Government Digital Service. (2020). *Ethnicity facts and figures: NHS Workforce*. Gov.uk. https://www.ethnicity-facts-figures.service.gov.uk/workforce-and-business/workforce-diversity/nhs-workforce/latest.

Haffar, S., Bazerbachi, F., & Murad, M. H. (2019). Peer review bias: A critical review. *Mayo Clinic Proceedings. Mayo Clinic*, *94*(4), 670–676. https://doi.org/10.1016/j.mayocp.2018.09.004

Hall, B. J., Puffer, E., Murray, L. K., Ismael, A., Bass, J. K., Sim, A., & Bolton, P. A. (2014). The importance of establishing reliability and validity of assessment instruments for mental health problems: An example from Somali children and adolescents living in three refugee camps in Ethiopia. *Psychological Injury and Law*, *7*(2), 153–164. https://doi.org/10.1007/s12207-014-9188-9

Hampton, C., Berkowitz, B., Nagy, K., (2013). *Developing baseline measures*.
Ctb.ku.edu. https://ctb.ku.edu/en/table-of-contents/assessment/assessing-
community-needs-and-resources/developing-baseline-measures/main

Hong, Q. N., Fàbregues, S., Bartlett, G., Boardman, F., Cargo, M., Dagenais, P.,
Gagnon, M.-P., Griffiths, F., Nicolau, B., O'Cathain, A., Rousseau, M.-C., Vedel,
I., & Pluye, P. (2018). The Mixed Methods Appraisal Tool (MMAT) version 2018
for information professionals and researchers. *Education for Information*, *34*(4),
285–291. https://doi.org/10.3233/EFI-180221

Kabasinguzi, I., Ali, N., & Ochepo, P. (2023). Mental health experiences and coping
strategies of BAME care workers who worked in nursing and residential care
homes during the COVID-19 pandemic in Luton, England. *BMC Public
Health*, *23*(1), 592. https://doi.org/10.1186/s12889-023-15423-2

Kirby, T. (2020). Evidence mounts on the disproportionate effect of COVID-19 on
ethnic minorities. *The Lancet. Respiratory Medicine*, *8*(6), 547–548.
https://doi.org/10.1016/s2213-2600(20)30228-9

Kisely, S., Warren, N., McMahon, L., Dalais, C., Henry, I., & Siskind, D. (2020).
Occurrence, prevention, and management of the psychological effects of
emerging virus outbreaks on healthcare workers: rapid review and meta-
analysis. *BMJ (Clinical Research Ed.)*, *369*, m1642.
https://doi.org/10.1136/bmj.m1642

Lamb, D., Gnanapragasam, S., Greenberg, N., Bhundia, R., Carr, E., Hotopf, M.,
Razavi, R., Raine, R., Cross, S., Dewar, A., Docherty, M., Dorrington, S., Hatch,
S., Wilson-Jones, C., Leightley, D., Madan, I., Marlow, S., McMullen, I., Rafferty,
A.-M., … Wessely, S. (2021). Psychosocial impact of the COVID-19 pandemic

on 4378 UK healthcare workers and ancillary staff: initial baseline data from a cohort study collected during the first wave of the pandemic. *Occupational and Environmental Medicine*, *78*(11), 801–808. https://doi.org/10.1136/oemed-2020-107276

Liu, Q., Luo, D., Haase, J. E., Guo, Q., Wang, X. Q., Liu, S., Xia, L., Liu, Z., Yang, J., & Yang, B. X. (2020). The experiences of health-care providers during the COVID-19 crisis in China: a qualitative study. *The Lancet. Global Health*, *8*(6), e790–e798. https://doi.org/10.1016/S2214-109X(20)30204-7

Liu, S., Yang, L., Zhang, C., Xiang, Y.-T., Liu, Z., Hu, S., & Zhang, B. (2020). Online mental health services in China during the COVID-19 outbreak. *The Lancet. Psychiatry*, *7*(4), e17–e18. https://doi.org/10.1016/S2215-0366(20)30077-8

Maunder, R., Hunter, J., Vincent, L., Bennett, J., Peladeau, N., Leszcz, M., Sadavoy, J., Verhaeghe, L. M., Steinberg, R., & Mazzulli, T. (2003). The immediate psychological and occupational impact of the 2003 SARS outbreak in a teaching hospital. *Journal de l'Association Medicale Canadienne [Canadian Medical Association Journal]*, *168*(10), 1245–1251. https://doi.org/10.1093/acprof:oso/9780198568193.003.0013

McGlinchey, E., Hitch, C., Butter, S., McCaughey, L., Berry, E., & Armour, C. (2021). Understanding the lived experiences of healthcare professionals during the COVID-19 pandemic: an interpretative phenomenological analysis. *European Journal of Psychotraumatology*, *12*(1), 1904700. https://doi.org/10.1080/20008198.2021.1904700

Nair, A. S. (2019). Publication bias - Importance of studies with negative results! *Indian Journal of Anaesthesia*, *63*(6), 505–507. https://doi.org/10.4103/ija.ija_142_19

National Institute for Health and Care Excellence (2018). *Post-Traumatic Stress Disorder NICE Guideline* [*NG116*]. London: National Institute for Health and Care Excellence

Newman, K. L., Jeve, Y., & Majumder, P. (2022). Experiences and emotional strain of NHS frontline workers during the peak of the COVID-19 pandemic. *The International Journal of Social Psychiatry*, *68*(4), 783–790. https://doi.org/10.1177/00207640211006153

Office for National Statistics. *Coronavirus and the social impacts on different ethnic groups in the UK: 2020* (2020, December). https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/coronavirusandthesocialimpactsondifferentethnicgroup sintheuk/2020 [Accessed May 2023]

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., … Moher, D. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ (Clinical Research Ed.), n71. https://doi.org/10.1136/bmj.n71

Patton, M. Q. (2015). *Qualitative research & evaluation methods: Integrating theory and practice* (4th ed.). SAGE Publications.

Peng, X., Zhao, H.-Z., Yang, Y., Rao, Z.-L., Hu, D.-Y., & He, Q. (2021). Post-traumatic growth level and its influencing factors among frontline nurses during the COVID-19 pandemic. *Frontiers in Psychiatry*, *12*, 632360. https://doi.org/10.3389/fpsyt.2021.632360

Petrella, A. R., Hughes, L., Fern, L. A., Monaghan, L., Hannon, B., Waters, A., & Taylor, R. M. (2021). Healthcare staff well-being and use of support services during COVID-19: a UK perspective. *General Psychiatry*, *34*(3), e100458. https://doi.org/10.1136/gpsych-2020-100458

Pink, J., Gray, N. S., O'Connor, C., Knowles, J. R., Simkiss, N. J., & Snowden, R. J. (2021). Psychological distress and resilience in first responders and health care workers during the COVID-19 pandemic. *Journal of Occupational and Organizational Psychology*, *94*(4), 789–807. https://doi.org/10.1111/joop.12364

Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., & Rodgers, M. (2006). *Guidance on the conduct of narrative synthesis in systematic reviews: a Product from the ESRC Methods Programme.* https://www.lancaster.ac.uk/media/lancaster-university/content-assets/documents/fhm/dhr/chir/NSsynthesisguidanceVersion1-April2006.pdf

Prince, M. (2012). Epidemiology. *Core Psychiatry*, 115–129. https://doi.org/10.1016/b978-0-7020-3397-1.00009-4

Revythis, A., Shah, S., Enyioma, S., Ghose, A., Patel, M., Karathanasi, A., Sanchez, E., & Boussios, S. (2021). The experience of a single NHS England trust on the impact of the COVID-19 pandemic on junior and middle-grade doctors: What is next? *International Journal of Environmental Research and Public Health*, *18*(19). https://doi.org/10.3390/ijerph181910413

Roberts, T., Daniels, J., Hulme, W., Hirst, R., Horner, D., Lyttle, M. D., Samuel, K., Graham, B., Reynard, C., Barrett, M., Foley, J., Cronin, J., Umana, E., Vinagre, J., Carlton, E., & collaborators of TERN, RAFT, PERUKI, ITERN, TRIC, and SATARN. (2021). Psychological distress during the acceleration phase of the COVID-19 pandemic: a survey of doctors practising in emergency medicine, anaesthesia and intensive care medicine in the UK and Ireland. *Emergency Medicine Journal: EMJ*, *38*(6), 450–459. https://doi.org/10.1136/emermed-2020-210438

Roberts, T., Daniels, J., Hulme, W., Hirst, R., Horner, D., Lyttle, M. D., Samuel, K., Graham, B., Reynard, C., Barrett, M., Foley, J., Cronin, J., Umana, E., Vinagre, J., Carlton, E., TheTrainee Emergency Research Network (TERN), Paediatric Emergency Research in the UK and Ireland (PERUKI), Research and Audit Federation of Trainees (RAFT), Irish Trainee Emergency Research Network (ITERN and Trainee Research in Intensive Care (TRIC)), Ireland Trainee Emergency Research Network (I-TERN) Collaborators, & Research and Audit Federation of Trainees (RAFT), Trainee Research in Intensive Care (TRIC) and Specialist Anaesthesia Trainee led Audit and Research Network (SATURN) Collaborators. (2021). Psychological distress and trauma in doctors providing frontline care during the COVID-19 pandemic in the United Kingdom and Ireland: a prospective longitudinal survey cohort study. *BMJ Open*, *11*(7), e049680. https://doi.org/10.1136/bmjopen-2021-049680

Ryan, R. (2013, June) *Cochrane Consumers and Communication Review Group. 'Cochrane Consumers and Communication Review Group: data synthesis and analysis'.* http://cccrg.cochrane.org

Shanafelt, T., Ripp, J., & Trockel, M. (2020). Understanding and addressing sources

    of anxiety among health care professionals during the COVID-19

    pandemic. *JAMA: The Journal of the American Medical Association*, *323*(21),

    2133–2134. https://doi.org/10.1001/jama.2020.5893

Skelton, E., Harrison, G., Rutherford, M., Ayers, S., & Malamateniou, C. (2023). UK

    obstetric sonographers' experiences of the COVID-19 pandemic: Burnout, role

    satisfaction and impact on clinical practice. *Ultrasound (Leeds, England)*, *31*(1),

    12–22. https://doi.org/10.1177/1742271X221091716

Sunil, R., Bhatt, M. T., Bhumika, T. V., Thomas, N., Puranik, A., Chaudhuri, S., &

    Shwethapriya, R. (2021). Weathering the storm: Psychological impact of

    COVID-19 pandemic on clinical and Nonclinical Healthcare Workers in

    India. *Indian Journal of Critical Care Medicine: Peer-Reviewed, Official*

    Publication of Indian Society of Critical Care Medicine, *25*(1), 16–20.

    https://doi.org/10.5005/jp-journals-10071-23702

Tantra, R. (2019). Peer-Review Publications. A Survival Guide for Research

    Scientists, 77–86. https://doi.org/10.1007/978-3-030-05435-9_7

Temsah, M.-H., Al Huzaimi, A., Alrabiaah, A., Alamro, N., Al-Sohime, F., Al-Eyadhy,

    A., Alhasan, K., Kari, J. A., Alhaboob, A., Alsalmi, A., AlMuhanna, W.,

    Almaghlouth, I., Aljamaan, F., Halwani, R., Saddik, B., Barry, M., Al-Zamil, F.,

    AlHadi, A. N., Al-Subaie, S., … Somily, A. M. (2021). Changes in healthcare

    workers' knowledge, attitudes, practices, and stress during the COVID-19

    pandemic. *Medicine*, *100*(18), e25825.

    https://doi.org/10.1097/MD.0000000000025825

Tomlin, J., Dalgleish-Warburton, B., & Lamph, G. (2020). Psychosocial support for healthcare workers during the COVID-19 pandemic. *Frontiers in Psychology*, *11*, 1960. https://doi.org/10.3389/fpsyg.2020.01960

Verhoeven, V., Tsakitzidis, G., Philips, H., & Van Royen, P. (2020). Impact of the COVID-19 pandemic on the core functions of primary care: will the cure be worse than the disease? A qualitative interview study in Flemish GPs. *BMJ Open*, *10*(6), e039674. https://doi.org/10.1136/bmjopen-2020-039674

Wanigasooriya, K., Palimar, P., Naumann, D. N., Ismail, K., Fellows, J. L., Logan, P., Thompson, C. V., Bermingham, H., Beggs, A. D., & Ismail, T. (2020). Mental health symptoms in a cohort of hospital healthcare workers following the first peak of the COVID-19 pandemic in the UK. *BJPsych Open*, *7*(1), e24. https://doi.org/10.1192/bjo.2020.150

Walton, M., Murray, E., & Christian, M. D. (2020). Mental health care for medical staff and affiliated healthcare workers during the COVID-19 pandemic. *European Heart Journal. Acute Cardiovascular Care*, *9*(3), 241–247. https://doi.org/10.1177/2048872620922795

Wang, X., & Cheng, Z. (2020). Cross-sectional studies: Strengths, weaknesses, and recommendations. *Chest*, *158*(1S), S65–S71. https://doi.org/10.1016/j.chest.2020.03.012

World Health Organisation (2020, March 11) *WHO Director-General's opening remarks at the media briefing on COVID-19 - 11 March 2020.* https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020

World Health Organisation (2021, October 20) *Health and Care Worker Deaths during COVID-19.* https://www.who.int/news/item/20-10-2021-health-and-care-worker-deaths-during-covid-19

Appendices Literature Review
Appendix A
Journal submission guidelines

Research article

Criteria

Research articles should report on original primary research or new experimental or computational methods, tests or procedures. Manuscripts reporting results of a clinical trial must conform to CONSORT 2010 guidelines. Authors of randomized controlled trials should submit a completed CONSORT checklist alongside their manuscript, available at www.consort-statement.org. Research articles may also report on systematic reviews of published research provided they adhere to the appropriate reporting guidelines which are detailed in our editorial policies. Please note that non-commissioned pooled analyses of selected published research and bibliometric analyses will not be considered. Studies reporting descriptive results from a single institution or region will only be considered if analogous data have not been previously published in a peer reviewed journal and the conclusions provide distinct insights that are of relevance to a regional or international audience.

BMC Psychology strongly supports open research, including transparency and openness in reporting. Further details of our Data availability policy can be found on the journal's About page.

BMC Psychology strongly encourages that all datasets on which the conclusions of the paper rely should be available to readers. We encourage authors to ensure that their datasets are either deposited in publicly available repositories (where available and appropriate) or presented in the main manuscript or additional supporting files whenever possible. Please see Springer Nature's data repository guidance. Where a widely established research community expectation for data archiving in public repositories exists, submission to a community-endorsed, public repository is mandatory. A list of data where deposition is required, with the appropriate repositories, can be found on the Editorial Policies Page.

Professionally produced Visual Abstracts
BMC Psychology will consider visual abstracts. As an author submitting to the journal, you may wish to make use of services provided at Springer Nature for high quality and affordable visual abstracts where you are entitled to a 20% discount. Click here to find out more about the service, and your discount will be automatically be applied when using this link.

Preparing your manuscript

The information below details the section headings that you should include in your manuscript and what information should be within each section.

Please note that your manuscript must include a 'Declarations' section including all of the subheadings (please see below for more information).

Title page

The title page should:

present a title that includes, if appropriate, the study design e.g.:

"A versus B in the treatment of C: a randomized controlled trial", "X is a risk factor for Y: a case control study", "What is the impact of factor X on subject Y: A systematic review"

or for non-clinical or non-research studies a description of what the article reports

list the full names and institutional addresses for all authors

if a collaboration group should be listed as an author, please list the Group name as an author. If you would like the names of the individual members of the Group to be searchable through their individual PubMed records, please include this information in the "Acknowledgements" section in accordance with the instructions below

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.

indicate the corresponding author

Abstract

The Abstract should not exceed 350 words. Please minimize the use of abbreviations and do not cite references in the abstract. Reports of randomized controlled trials should follow the CONSORT extension for abstracts. The abstract must include the following separate sections:

Background: the context and purpose of the study

Methods: how the study was performed and statistical tests used

Results: the main findings

Conclusions: brief summary and potential implications

Trial registration: If your article reports the results of a health care intervention on human participants, it must be registered in an appropriate registry and the registration number and date of registration should be stated in this section. If it was not registered prospectively (before enrollment of the first participant), you should include the words 'retrospectively registered'. See our editorial policies for more information on trial registration

Keywords

Three to ten keywords representing the main content of the article.

Background

The Background section should explain the background to the study, its aims, a summary of the existing literature and why this study was necessary or its contribution to the field.

Methods

The methods section should include:

the aim, design and setting of the study

the characteristics of participants or description of materials

a clear description of all processes, interventions and comparisons. Generic drug names should generally be used. When proprietary brands are used in research, include the brand names in parentheses

the type of statistical analysis used, including a power calculation if appropriate

Results

This should include the findings of the study including, if appropriate, results of statistical analysis which must be included either in the text or as tables and figures.

Discussion

This section should discuss the implications of the findings in context of existing research and highlight limitations of the study.

Conclusions

This should state clearly the main conclusions and provide an explanation of the importance and relevance of the study reported.

List of abbreviations

If abbreviations are used in the text they should be defined in the text at first use, and a list of abbreviations should be provided.

Declarations

All manuscripts must contain the following sections under the heading 'Declarations':

Ethics approval and consent to participate

Consent for publication

Availability of data and materials

Competing interests

Funding

Authors' contributions

Acknowledgements

Authors' information (optional)

Please see below for details on the information to be included in these sections.

If any of the sections are not relevant to your manuscript, please include the heading and write 'Not applicable' for that section.

Ethics approval and consent to participate

Manuscripts reporting studies involving human participants, human data or human tissue must:

include a statement on ethics approval and consent (even where the need for approval was waived)

include the name of the ethics committee that approved the study and the committee's reference number if appropriate

Studies involving animals must include a statement on ethics approval and for experimental studies involving client-owned animals, authors must also include a statement on informed consent from the client or owner.

See our editorial policies for more information.

If your manuscript does not report on or involve the use of any animal or human data or tissue, please state "Not applicable" in this section.

Consent for publication

If your manuscript contains any individual person's data in any form (including any individual details, images or videos), consent for publication must be obtained from that person, or in the case of children, their parent or legal guardian. All presentations of case reports must have consent for publication.

You can use your institutional consent form or our consent form if you prefer. You should not send the form to us on submission, but we may request to see a copy at any stage (including after publication).

See our editorial policies for more information on consent for publication.

If your manuscript does not contain data from any individual person, please state "Not applicable" in this section.

Availability of data and materials

All manuscripts must include an 'Availability of data and materials' statement. Data availability statements should include information on where data supporting the results reported in the article can be found including, where applicable, hyperlinks to

publicly archived datasets analysed or generated during the study. By data we mean the minimal dataset that would be necessary to interpret, replicate and build upon the findings reported in the article. We recognise it is not always possible to share research data publicly, for instance when individual privacy could be compromised, and in such instances data availability should still be stated in the manuscript along with any conditions for access.

Authors are also encouraged to preserve search strings on searchRxiv https://searchrxiv.org/, an archive to support researchers to report, store and share their searches consistently and to enable them to review and re-use existing searches. searchRxiv enables researchers to obtain a digital object identifier (DOI) for their search, allowing it to be cited.

Data availability statements can take one of the following forms (or a combination of more than one if required for multiple datasets):

The datasets generated and/or analysed during the current study are available in the [NAME] repository, [PERSISTENT WEB LINK TO DATASETS]

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

All data generated or analysed during this study are included in this published article [and its supplementary information files].

The datasets generated and/or analysed during the current study are not publicly available due [REASON WHY DATA ARE NOT PUBLIC] but are available from the corresponding author on reasonable request.

Data sharing is not applicable to this article as no datasets were generated or analysed during the current study.

The data that support the findings of this study are available from [third party name] but restrictions apply to the availability of these data, which were used under license for the current study, and so are not publicly available. Data are however available from the authors upon reasonable request and with permission of [third party name].

Not applicable. If your manuscript does not contain any data, please state 'Not applicable' in this section.

More examples of template data availability statements, which include examples of openly available and restricted access datasets, are available here.

BioMed Central strongly encourages the citation of any publicly available data on which the conclusions of the paper rely in the manuscript. Data citations should include a persistent identifier (such as a DOI) and should ideally be included in the reference list. Citations of datasets, when they appear in the reference list, should include the minimum information recommended by DataCite and follow journal style. Dataset identifiers including DOIs should be expressed as full URLs. For example:

Hao Z, AghaKouchak A, Nakhjiri N, Farahmand A. Global integrated drought monitoring and prediction system (GIDMaPS) data sets. figshare. 2014. http://dx.doi.org/10.6084/m9.figshare.853801

With the corresponding text in the Availability of data and materials statement:

The datasets generated during and/or analysed during the current study are available in the [NAME] repository, [PERSISTENT WEB LINK TO DATASETS].[Reference number]

If you wish to co-submit a data note describing your data to be published in BMC Research Notes, you can do so by visiting our submission portal. Data notes support open data and help authors to comply with funder policies on data sharing. Co-published data notes will be linked to the research article the data support (example).

Competing interests

All financial and non-financial competing interests must be declared in this section.

See our editorial policies for a full explanation of competing interests. If you are unsure whether you or any of your co-authors have a competing interest please contact the editorial office.

Please use the authors initials to refer to each authors' competing interests in this section.

If you do not have any competing interests, please state "The authors declare that they have no competing interests" in this section.

Funding

All sources of funding for the research reported should be declared. If the funder has a specific role in the conceptualization, design, data collection, analysis, decision to publish, or preparation of the manuscript, this should be declared.

Authors' contributions

The individual contributions of authors to the manuscript should be specified in this section. Guidance and criteria for authorship can be found in our editorial policies.

Please use initials to refer to each author's contribution in this section, for example: "FC analyzed and interpreted the patient data regarding the hematological disease and the transplant. RH performed the histological examination of the kidney, and was a major contributor in writing the manuscript. All authors read and approved the final manuscript."

Acknowledgements

Please acknowledge anyone who contributed towards the article who does not meet the criteria for authorship including anyone who provided professional writing services or materials.

Authors should obtain permission to acknowledge from all those mentioned in the Acknowledgements section.

See our editorial policies for a full explanation of acknowledgements and authorship criteria.

If you do not have anyone to acknowledge, please write "Not applicable" in this section.

Group authorship (for manuscripts involving a collaboration group): if you would like the names of the individual members of a collaboration Group to be searchable through their individual PubMed records, please ensure that the title of the collaboration Group is included on the title page and in the submission system and also include collaborating author names as the last paragraph of the "Acknowledgements" section. Please add authors in the format First Name, Middle initial(s) (optional), Last Name. You can add institution or country information for each author if you wish, but this should be consistent across all authors.

Please note that individual names may not be present in the PubMed record at the time a published article is initially included in PubMed as it takes PubMed additional time to code this information.

Authors' information

This section is optional.

You may choose to use this section to include any relevant information about the author(s) that may aid the reader's interpretation of the article, and understand the standpoint of the author(s). This may include details about the authors' qualifications, current positions they hold at institutions or societies, or any other relevant background information. Please refer to authors using their initials. Note this section should not be used to describe any competing interests.

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.

References

Examples of the Vancouver reference style are shown below.

See our editorial policies for author guidance on good citation practice

Web links and URLs: All web links and URLs, including links to the authors' own websites, should be given a reference number and included in the reference list rather than within the text of the manuscript. They should be provided in full,

including both the title of the site and the URL, as well as the date the site was accessed, in the following format: The Mouse Tumor Biology Database. http://tumor.informatics.jax.org/mtbwi/index.do. Accessed 20 May 2013. If an author or group of authors can clearly be associated with a web link, such as for weblogs, then they should be included in the reference

Appendix B
MMAT Critical Appraisal of Qualitative Literature

Qualitative	Bennett et al., 2020	Newman, Jeve & Majumder, 2022	Grailey, Lound & Brett, 2021	McGlinchey et al., 2021	Kabasinguzi et al., 2023
Is the qualitative approach appropriate to answer the research question?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
Are the qualitative data collection methods adequate to address the research question?	Yes (2)	Can't tell (1)	Yes (2)	Can't tell (1)	Yes (2)
Are the findings adequately derived from the data?	Yes (2)	Can't tell (1)	Yes (2)	Yes (2)	Can't tell (1)
Is the interpretation of results sufficiently substantiated by data?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
Is there coherence between qualitative data sources, collection, analysis and interpretation?	Yes (2)	No (0)	Yes (2)	Yes (2)	Yes (2)
MMAT Score	10	6	10	9	9

Appendix C
MMAT Critical Appraisal of Quantitative Literature

Quantitative – Non-randomised	Gilleen et al., 2021	Wanigasooriya et al., 2020	Petrella et al., 2020	Pink et al., 2021	Roberts et al., 2021	Roberts et al., 2021	Skelton et al., 2023	Revythis et al., 2021
Are the participant's representative of the target population?	Yes (2)	Yes (2)	No (0)	Yes (2)	Yes (2)	Yes (2)	Can't tell (1)	Can't tell (1)
Are measures appropriate regarding both the outcome and intervention (or exposure)?	Yes (2)	Yes (2)	Can't tell (1)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
Are there complete data?	Can't tell (1)	Can't tell (1)	Yes (2)	Can't tell (1)	No (0)	No (0)	No (0)	Can't tell (1)
Are the confounders accounted for in the design and analysis?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	No (0)	No (0)	No (0)	No (0)
During the study period, is the intervention administered (or exposure occurred) as intended?	Yes (2)	Can't tell (1)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
MMAT Score	**9**	**8**	**7**	**9**	**6**	**6**	**5**	**6**

Paper 2: Empirical Paper

"You think I should die for the NHS?": A grounded theory of Black mental health professionals' experience of mental well-being during the COVID-19 pandemic

Word count: 7884

Target journal: BMC Psychology

Due to academic assignment requirements, the following paper has been prepared in accordance with APA 7 guidelines. The empirical paper will be amended to the requirements of the journal *Psychology and Psychotherapy* for submission for publication. Author Guidelines are listed in Appendix A

Abstract

Background

The COVID-19 pandemic precipitated mental health difficulties experienced by healthcare workers in response to significant challenges within their occupation. However, the literature does not acknowledge the experience of Black Mental Health Professionals (MHPs) in particular. This study explored Black MHPs experiences of their mental well-being during the COVID-19 pandemic.

Method

Thirteen Black MHPs were recruited for the study. Semi-structured interviews focused on the impact of COVID-19 on mental well-being, including stressors experienced, coping, and how mental well-being was conceptualised. Data was analysed using a constructivist grounded theory approach.

Findings

Ethnic identity was salient for participants when conceptualising their experiences. The COVID-19 pandemic and Black Lives Matter movement caused an interplay of stressors relating to racial, health and workplace factors. These stressors exacerbated participants' social, cultural, and political context. Participants highlighted a delayed recognition and response to the deterioration of their mental well-being. This experience influenced a transition in perspective, whereby the self is re-prioritised following the COVID-19 pandemic.

Conclusion

The stressors identified highlight similarities with previous research exploring healthcare workers' experiences. However, there are nuances which are significant when considering the implementation of well-being initiatives for racialised staff members. The findings call for employee well-being initiatives to be informed by equality, diversity and inclusivity principles acknowledging the impact of health, political and racial issues which can be detrimental to staff well-being.

Keywords: Black mental health, Covid-19, mental well-being, inequality, allyship, EDI, staff well-being

Background

The impact of COVID-19 on healthcare workers

The coronavirus (COVID-19) pandemic significantly impacted health care workers (HCWs) worldwide, resulting in heightened workloads and risk of contracting the virus (Grailey et al., 2021; Revythis, et al., 2021; World Health Organisation, 2021). Additionally, the United Kingdom (UK) had an increased number of HCWs dying from the virus in comparison to other countries (Amnesty International UK, 2021; World Health Organisation, 2021). Subsequently, HCWs experienced a detrimental impact on their mental well-being (Lamb, 2021; Spoorthy et al., 2020).

Literature highlights that HCWs, including mental health professionals (MHPs), experienced psychological distress including low mood, anxiety, hopelessness and posttraumatic stress disorder (PTSD) during the COVID-19 pandemic (Bennett et al., 2020; Grailey et al., 2021; Newman et al., 2022; Vanhaecht, 2021). Risk factors for deteriorated mental well-being included poor working conditions, fear of contracting the virus and working on COVID-19 wards (Muller et al., 2020; Perego et al., 2023). Whereas protective factors included increased social support and perceived appreciation from the workplace (Perego et al., 2023).

Research by Soubra et al., (2023) highlighted that perceived support, isolation, and risk of COVID-19, influenced HCWs management of well-being. Similarly, Besirli et al., (2021) indicated a relationship between the coping strategies used by HCWs and mental well-being. Findings highlighted that an adaptive approach to coping reduced symptoms whereas maladaptive strategies such as substance misuse, and behavioural disengagement exacerbated symptoms.

Health and racial inequalities during COVID-19

Pre-existing health inequalities in the UK were exacerbated by the COVID-19 pandemic. Statistics highlighted increased infection and mortality rates in Black, Asian and Minority Ethnic ('BAME') individuals (Public Health England, 2020). It is important to highlight the implications of the term 'BAME' which overlooks the multidimensional experiences of racialised groups by assuming between-group homogeneity. The discontinuation of the use of 'BAME' in research is supported, with individuals from racialised backgrounds not identifying with the term (Khunti et al., 2020; Milner & Jumbe, 2020). Alternatives to 'BAME' have been posited within the

literature, for the purposes of this paper, the researcher will use an alternative to 'BAME' that fall under the classification of Black heritage, such as 'racialised' (DaCosta et al., 2021).

HCWs from racialised backgrounds were at a disproportionate risk of experiencing adverse effects of contracting COVID-19 (Kirby, 2020; Office for National Statistics, 2020). With workers from racialised backgrounds accounting for 20.7% of the NHS workforce, 63% of COVID-19-related deaths by April 2020 were racialised NHS workers, highlighting an overrepresentation of this demographic in COVID-19 mortality rates (Kirby, 2020; Kursumovic et al., 2020). Furthermore, the COVID-19 pandemic perpetuated mental health inequalities experienced by racialised individuals, with increased mental distress experienced in comparison to the White British population (Proto & Quintana-Domeque, 2020). Barriers to mental health services for Black individuals in the UK have been evidenced pre- and post-pandemic (Devonport et al.,2023; Mantovani et al., 2017; Smith et al., 2020) and research indicates that Black people had increased unmet mental health needs in comparison to White people during the COVID-19 pandemic (Thomeer et al., 2022).

Additionally, the Black community were also faced with a "pandemic on a pandemic" (Laurencin & Walker, 2020, p.10) following the murder of George Floyd (May 2020) and the prominence of the Black Lives Matter (BLM) movement which saw an increase in the recognition of depression and anxiety within the Black community related to experiences of racial trauma, and increased awareness of racial injustice (Comas-díaz et al., 2019; Thomeer et al., 2022). Ezell et al. (2021) refers to this as "intersectional trauma" (pp. 78) whereby health disparities and mental distress are a result of an accumulation of factors relating to an individual's cultural, political, and economic stressors which are salient with their ethnic or racial identity.

Despite the intersection of deteriorated mental health, health inequalities and racial trauma, Black people experienced less access to mental health services (Thomeer et al., 2022). A notable study by Kabasinguzi et al., (2023) highlighted symptoms such as anxiety and depression in racialised care workers, with religion and spirituality cited as significant coping strategies. The intersection of health and racial inequalities leads us to question how Black HCWs managed their mental well-being in response to stressors, in the context of the pandemic.

Addressing a gap in the literature

Despite calls for post-pandemic research to prioritise mental health needs of people from racialised backgrounds, participants from the Black community continue to be underrepresented within research (Cundiff, 2021; Roberts et al., 2020; Smith et al., 2020). Although the Black community experienced a plethora of health and racial inequalities during the COVID-19 pandemic (Kursumovic et al., 2020; Devonport et al.,2023; Kirby, 2020; Public Health England, 2020; Thomeer et al., 2022), there is limited research exploring Black HCWs experiences in response to this.

Research exploring Black MHPs' experiences during the COVID-19 pandemic are limited to US-based studies. Miu & Moore (2021) postulate that racialised MHPs were vulnerable to racial discrimination, burnout and racial trauma whilst working during the pandemic. However, these study findings have low generalisability, limiting the extent they can account for the experiences of UK-based Black MHPs.

Research Aims

Due to the increased risk Black HCWs experienced working throughout the COVID-19 pandemic, and inherent barriers to mental health services – this research aims to explore and understand experiences of mental well-being whilst working during this period, from the subjective experience of Black MHPs. This addresses a gap in the literature which fails to explore the experiences of an overrepresented demographic in COVID-19 mortality rates. The following research will explore and present an exploratory theory of Black MHPs experiences of their mental well-being throughout the COVID-19 pandemic.

This research aims to address the following questions:

1. What was the experience of Black MHPs and their mental well-being during the COVID-19 pandemic?

2. How do Black MHPs conceptualise the impact of working during a pandemic and their response to their mental well-being?

Methodology

Design

Grounded theory (GT) postulates that theory emerges from participants narratives of their experiences, which is analysed in an inductive and iterative process (Gill, 2020; Glaser & Strauss, 1967;). This study applied constructivist GT (CGT) to explore participants experiences (Charmaz, 2006). CGT acknowledges the existence of multiple realities where the researcher has a subjective view and co-constructs meaning with participants (Charmaz, 2000; Charmaz 2006). Thus, CGT aims to uncover an emerging theory which is relevant to culture, time, place, and situation. As CGT is a favourable methodology to employ when there is minimal understanding or no pre-existing theory about a phenomenon (Tweed & Priest, 2015) it was deemed the most appropriate method to address the research questions which required a theory generation technique regarding an under-represented population within the literature.

Epistemological Position

Social constructionism identifies that humans socially construct reality through shared meanings communicated through language and our knowledge about how the world is socially constructed (Burr & Dick, 2017; Glaser & Strauss, 1967). The researcher acknowledges their role in co-constructing meaning of participants' experience, rather than sourcing 'the truth' (Burr, 2015, p.223). Charmaz and Henwood (2008) highlight the importance of a social constructionist approach to CGT.app

Participants and Recruitment

Participants were Black MHPs, defined as those who work therapeutically with service users or trained in a psychological profession. Participants self-identified as Black or Black heritage, as defined by the UK Census (Office for National Statistics, 2022). Potential participants were excluded if they worked in non-client-based roles or had a clinically diagnosed mental health condition.

Thirteen participants were recruited through visual posters (Appendix B) which were disseminated on various social media platforms including Twitter, Instagram, LinkedIn, and Facebook. Individuals were instructed to contact the researcher by email and were provided with a participant information sheet (Appendix C) and

consent form (Appendix D) if they met the study eligibility criteria. Informed consent was obtained prior to interviews commencing. A purposive sample of 9 participants completed interviews between July 2023 – September 2023. A further 4 participants were recruited through theoretical sampling. Recruitment for the theoretical sample sought to uncover those from underrepresented groups within the purposive sample this included males and those who worked in inpatient environments. These interviews aimed to test categories, interpretations of data and the emerging theory. In line with a CGT framework, sampling ceased at data saturation whereby no new codes or categories were produced, and the pre-existing categories were established (Aldiabat & Navenec, 2018; Strauss, 2011). Participants demographic information is highlighted in Table 1.

Table 1

Participant demographic information

Gender	n
Male	1
Female	12
Age	**n**
25-34	11
35-44	1
45-54	1
Ethnicity	**n**
Black African	6
Black Caribbean	5
Mixed, White British and Black Caribbean	1
Mixed, Black African and Black Caribbean	1
Occupation	**n**
Assistant Psychologist	3
Clinical Psychologist	1

Forensic Mental Health Practitioner	1
Mental Healthcare Assistant	1
Mental Health Nurse	1
Occupational Therapy Assistant	1
Psychiatrist	1
Psychological Well-being Practitioner	4

Data Collection

Interviews were semi-structured and guided by a protocol (Appendix E) developed with experts by experience (*n*=2). Individuals who met inclusion criteria for the study but were unable due to have a pre-existing mental health condition were recruited as experts by experience. They were involved in the co-construction of interview protocol, recruitment poster design and debrief sheet design. Interview questions were then developed in an iterative process following each interview. Interviews were conducted via Microsoft Teams with an average duration of 48 minutes (*range 38 – 65 minutes*). Participants were informed of their right to withdraw and were encouraged to ask the researcher questions pre- and post-interview.

Emerging categories and themes across interviews were concurred with participants through the researcher's interactions with them. This included open discussions about which emerging categories resonated with their experiences and co-constructing the theoretical framework through shared reflections. Participants were provided with verbal and written debriefs (Appendix F) and invited to take part in a consultation of the emergent theory to uphold trustworthiness of data (Lindheim, 2022).

Data Analysis

Interviews were transcribed via Microsoft Teams before being manually amended for errors by the researcher. Interview recordings were deleted following transcription. Reliability measures included detailed memoing during data collection and analysis which captured the researcher's reflections and concurrent themes across interviews. The researcher engaged in data immersion by re-reading transcripts to

increase theoretical sensitivity (Birks & Mills, 2015; Tweed & Priest, 2015). Data analysis was guided by the CGT framework including initial, focused and theoretical coding (Charmaz, 2006). The coding process is depicted in Appendix G. Constant comparative analysis was employed throughout data analysis, whereby codes and categories were compared for similarities and differences to enhance abstract concepts which guided the theoretical framework (Charmaz, 2006; Tie et al., 2019). Data saturation was reached when the researcher could no longer identify new categories and pre-existing categories were established by interviews from the purposive sample (Birks & Mills, 2015).

Reflexivity

Researcher transparency when conducting research can enhance authenticity and credibility of findings (Maxwell, 2005; Reid, 2018), however social constructionism views reflexivity as valuing a researcher's subjectivity (Olmos-Vega et al., 2023). Within CGT, researchers should identify how their experiences may influence their interpretations of research participants experiences and theory development (Charmaz, 2006). The researcher is a 27-year-old Black, heterosexual, cis-gendered female who worked in a clinical role during the COVID-19 pandemic and was transparent about this during interactions with participants. Being aware of potential power differentials in the researcher-participant dyad, it was hoped that this transparency would encourage trust building and cultural sensitivity when interviewing participants, whereby a shared experience could foster a safe space and validation. Employing a social-constructionist approach acknowledged the potential shared experience which supported participants to conceptualise their experiences. Reflexivity strategies are highlighted in Figure 1.

Figure 1

Researcher reflexivity strategies
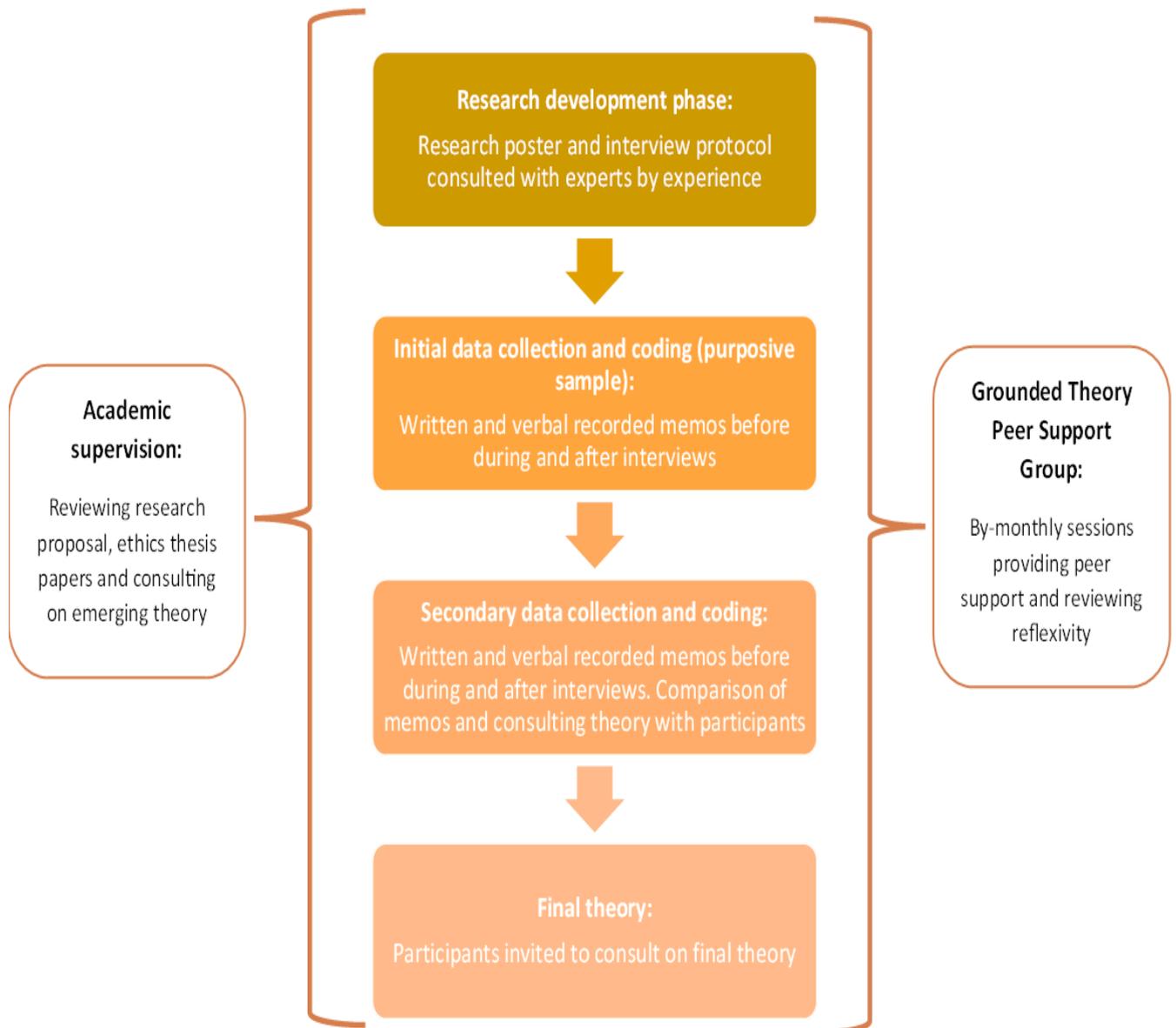
Theory consultation

In line with grounded theory best practice guidelines (Elliott & Lazenbatt, 2005), the researcher sought respondent validation (Maxwell, 2005) following the development of the emerging theory whereby participants were invited to consult on their interpretations and accuracy of the model (January – February 2024) (Lindheim, 2022). Participants identified with the foundation of the model, stressors and processes depicted. Respondents shared that the model highlighted experiences as a Black MHP over time and participants associated with a delayed response or

recognition of their mental well-being declining, contextualised by a post-Covid perspective.

Ethical considerations

Ethical approval was obtained by Staffordshire University's Research and Ethics Committee in February 2023 (Appendix H). Research design and procedures were explored with a research supervisor and guided by the British Psychological Society Code of Human Research Ethics (Oates et al., 2021). A risk assessment and management protocol was developed and adhered to throughout the course of the research process (Appendix I). At the beginning of the interviews, the discussion of potentially distressing experiences was brought to participant's attention. To uphold participant anonymity, pseudo-names are used when identifying participant quotes.

Findings

Theoretical model of Black MHPs experiences during the COVID-19 pandemic

The current study sought to develop a theoretical framework conceptualising the experiences of Black MHPs during the COVID-19 pandemic.

Table 2

Categories identified during coding process

Category	Sub-category
Experience as a Black Mental Health Professional: Social, Cultural & Political context	Cultural narratives of resilience
	Navigating racial stereotypes
	Experiencing systemic racism in the workplace
Stressors experienced during the COVID-19 pandemic	Racial & political: Black Lives Matter
	Racial & political: Lack of allyship
	Health: Vaccine Hesitancy
	Health: Risk of COVID-19

	Workplace: Implicit workplace expectations
	Workplace: Expectations of self as a mental health professional
Mental well-being decline	Delayed recognition
	Delayed response
Post-COVID perspective	Reprioritising self
	Restoring work-life balance

The categories (Table 2) informed the theoretical model (Figure 2). The foundation of the theoretical model identifies the social, political, and cultural context of Black MHPs and how this impacted their experiences during the COVID-19 pandemic. This salience with ethnic identity highlights how cultural narratives of resilience, navigating racial stereotypes, and systemic racism contributed to a perpetuating cycle which was exacerbated by the COVID-19 pandemic through a multitude of stressors. These stressors included health, workplace, racial and political factors. Subsequently, cultural narratives of resilience were reinforced in the workplace due to increased implicit workplace expectations, with many experiencing a conflict between their expectations of themselves as an MHP and their coping behaviours. Health and racial inequalities were reinforced through awareness of the adverse effects of COVID-19 for ethnic minorities and the emergence of the BLM movement. Colleagues displayed a lack of allyship in response to participants' expressing their experiences of these inequalities. Throughout this pandemic period, cultural narratives of resilience, showing stoicism in the face of adversity, implicitly influenced Black MHPs. The interaction of context and stressors led to a decline in mental well-being, which Black MHPs found difficult to acknowledge or respond to. This experience influenced a shift in perception of self-care. The results section that follows will present details of findings and the development of the theoretical model.

Figure 2

A theoretical model of categories depicting Black MHP's experiences during the COVID-19 pandemic
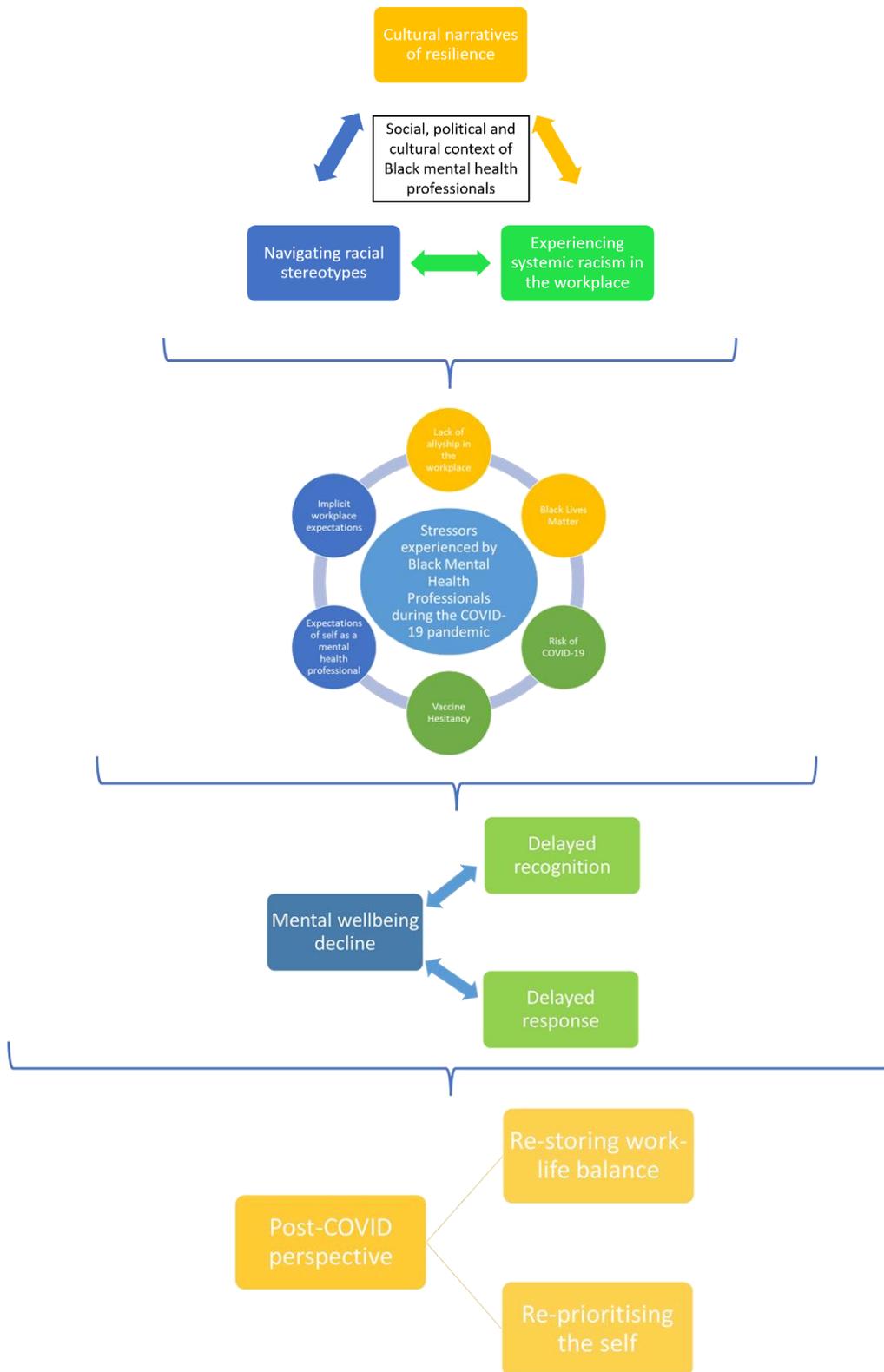
The social, cultural and political context of a Black mental health professional

Figure 3

Social, cultural and political context of a Black MHP

Cultural narratives of resilience

Participants considered their social, cultural and political context when conceptualising their experiences working during the COVID-19 pandemic (Figure 3). Participants reflected on cultural narratives which influenced a resilient approach to working. Many identified prioritising their job, with the importance of working hard embedded in generational discourse, with Naomi reflecting, "it's only natural for me to have those values for myself". This discourse perpetuated the idea that "we can't let ourselves down" (Amira).

Through prioritising their work, participants acknowledged that their own needs became redundant. This was attributed to cultural narratives of resilience and the expectation to accept workplace stressors to maintain a hard work ethic. Many reflected on past experiences of voicing concerns and how these had been invalidated. Participants also considered whether the workplace mirrored these expectations of resilience during the pandemic:

> I think it kind of comes from how I've grown up and the idea of not really having
>
> the space to complain or air our frustrations, it's like you get on and just do it. But

then also maybe that's also mirrored in the working environment that I'm also in as well (Mia).

I think culturally there's an expectation that you just you carry on and you get on and kind of, I think had I complained it would have just been minimised and I kind of felt like that to a degree was the workplace culture as well, so it was very much, you've just kind of got to get on with it (Jamilia).

Cultural narratives of resilience in the workplace also perpetuated beliefs of suppressing emotional distress. Participants highlighted that they could not communicate their distress to their managers:

There's always been this kind of expectation that we move on-we carry on like you don't really cry at work like you know, if you're going to breakdown leave it to at home [...] which is why it probably took me a little while to actually speak to my line manager about like this is everything that's going on at the moment and it feels too much (Jade).

Navigating racial stereotypes

Participants reflected on the racial stereotypes they encountered in the workplace, with some (Sade, Keisha) referring to the "strong Black woman" stereotype and its influence on their colleagues' expectations of them. Participants identified that this stereotype led to the impact of working during the pandemic on their well-being being disregarded by their colleagues.

I remember someone saying, "you're really resilient." I was like, what the hell does that mean? You know, why are you trying to suggest that kind of strong Black woman thing? [...] I just felt like nobody really checked in (Sade).

I'm just working so hard, you know, I try and just not complain. You know, there's

that kind of strong Black woman, kind of like mentality […] it can feel a little bit like

you've bitten off a bit more than you could (Keisha).

Participants highlighted that they did not feel equipped to "navigate" (Imani) racial stereotypes without causing ruptures or "rock the boat" (Jade). This caused distress for participants:

I was quite stressed out because. I felt because I had to learn how to navigate it

(Danielle).

Subsequently, participants avoided these conversations to maintain relationships with their colleagues and acknowledged that navigating stereotypes was "part of the job description" (Jamilia), an injustice which comes with being a Black MHP in the workplace:

I don't know what the answer is, but I think that as a Black woman [...] this is a

pressure that you're going to just going to have to learn how to how to cope with.

It's just not fair (Amira).

Experiencing systemic racism in the workplace

Many participants identified examples of systemic racism they experienced in the workplace. Participants acknowledged that they do not have the "same opportunities" (Danielle) as their White colleagues. Many reflected that this inequality caused them to work harder and fear making a mistake due to unfair retribution. Amira highlighted "I know that there's things that I'll never get away with and that's just because I'm Black".

We don't have the same opportunities as everyone else and we know that, you

know, to get that recognition, we've always got to work that little bit harder. So

maybe a part of that is you know that culture kind of aspect of it (Mia).

I was like, no, I don't want them to ever find a blemish. You can't find any fault in

me. […] that is what ended up happening at an extreme detriment, but for me it

was like as long as no one can say anything (Imani).

The subtle yet pervasive presence of systemic racism made it challenging for participants to confront their experiences of microaggressions and inequalities in the workplace, as they often felt unsafe. As Mia shared, "it's very hard to have honest conversations in the workplace, it just doesn't feel safe at times because it then [influences] how you're gonna be treated afterwards".

Systemic racism is insipid. It's very difficult to describe, but it's just like it's

festering, fermenting thing that is hidden behind, rising damp or something behind

the walls, and you could smell it, but you just can't quite see it (Keisha).

Stressors experienced by Black MHPs

Figure 4

Stressors experienced by Black MHP's during the COVID-19 pandemic
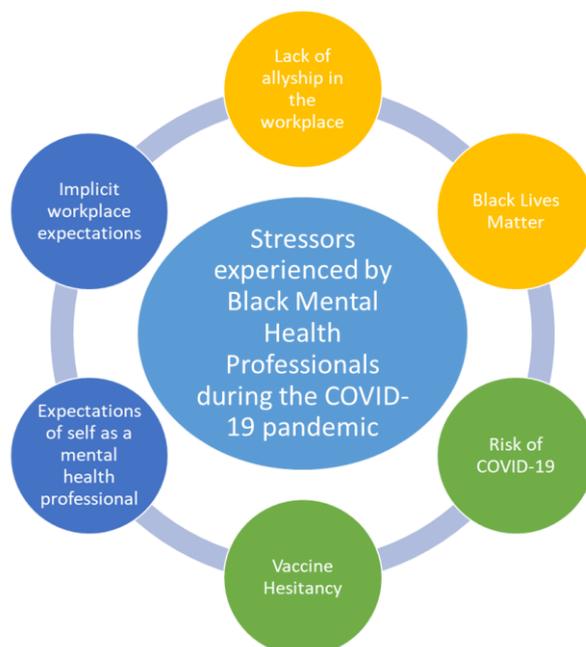
Racial and Political Stressors: Black Lives Matter (BLM)

Participants reflected on the BLM movement in 2020 and the racial trauma they experienced from being exposed to social media content and new reports of the killing of George Floyd on 25th May 2020 in the US. During a time of social isolation, participants found themselves immersed in an online revolution which was "challenging" (Imani). Participants spoke of their experiences watching Black people be "dehumanised" (Jade) through exposure of videos depicting police brutality, where it felt like they "couldn't really avoid hearing about Black people dying" (Danielle).

> I kept kind of coming across people, posting the videos and finding that really
>
> distressing cos I just kept thinking like that poor man's family have to keep seeing
>
> his murder everywhere. Like if I'm finding it really difficult, I couldn't imagine what
>
> it would be like to be somebody that actually knew that person (Amira).

Participants also highlighted their frustration at the responses to the BLM movement including performative allyship. Many felt that the BLM movement was treated as a novelty by their White peers and colleagues through social media trends such as posting black squares, which were perceived as "ingenuine" (Imani), invalidating the centuries of racial injustice already endured:

> I think in relation to the like BLM movement, I think mentally it was just very
>
> exhausting seeing it everywhere all the time, [...] especially when everyone was
>
> posted in the black squares and you think ohh, that's like, that's great. That'll help
>
> us in the long run (Aaliyah).

Racial and Political Stressors: Lack of allyship

Examples of performative allyship were also identified within the workplace. Strategies which were employed by managers to evoke awareness of the BLM movement, were perceived as ingenuine. Participants cited feeling "deflated" (Aaliyah) and "exhausted" (Keisha) highlighting that the movement and its wider impact was not taken as seriously within the workplace:

I think the most they did was a let's all wear black one day,[...] I think it kind of also showed, maybe just their lack of awareness to it or care for it, and also as an organisation I think if that's the only statement that you make about that, it doesn't go - it kind of just shows where their mindset is with that (Mia).

Participants also identified workplaces did not acknowledge the impact of the BLM movement for Black colleagues. Some participants attributed this to a lack of awareness, whereby colleagues "didn't know how to respond" (Danielle) whereas others felt that the movement was not deemed important enough to be acknowledged, and "didn't really give two monkeys about what was going on" (Imani) further questioning gestures of allyship by colleagues:

At work it [BLM] wasn't really acknowledged, so it wasn't something that came up in conversation. How tired I am because of this news. Do you know what I mean? But yet still it was impacting on how I felt for my day every day (Keisha).

Participants identified that they battled a physical pandemic in which they were at an increased risk of experiencing adverse effects, contextualised by a movement against racial injustice which sparked worldwide conversation. This perpetuated feelings of exhaustion and frustration as participants felt they had to "offload" (Jamilia) their experiences of racial trauma to their colleagues for them to understand their distress as they were "late to the game" (Jamilia).

[Black] People were feeling exhausted about the stress from the COVID bit, the stress of talking to those from non-BAME backgrounds about why it's scaring them a lot more […] then feeling exhausted that they're having to explain about why the BLM movement is important (Jade).

Health stressors: Risk of COVID-19

Participants acknowledged the significant risk of contracting COVID-19 was a constant stressor they experienced working throughout the pandemic. Many lived

with elder relatives who were physically vulnerable. Subsequently, participants experienced pressure to keep relatives safe:

The anxiety of, I've got asthma 'am I gonna get COVID' and then my Mum still going into work and she's coming home and also trying to be, cause I'm working with, you know, some patients who are, very scared and somewhat vulnerable as well (Imani).

Participants with underlying health conditions reflected on their experiences of not being taken seriously and feeling unsafe in the workplace, Jamilia reflected that "There was nowhere in the world I could go where I'd ever be safe." Increased COVID-19 mortality rates in the Black community were a prominent fear for many. Participants reflected that despite this "double whammy" (Jade), there was an expectation to continue providing a service, however many felt that this put their own health at risk in the process, "It's like, no, you can't be playing with my health like this. Like you think I should die for the NHS?" (Sade).

I remember it not being taken seriously, it was like, yeah, OK, but you've got a job to do, OK we can see that the stats are saying that this virus impacts you and your racial group particularly, but you've got a job to do (Amira).

Health stressors: Vaccine Hesitancy

In response to fears of contracting or transmitting COVID-19, participants identified with vaccine hesitancy and highlighted it was a "real source of stress" (Danielle) which precipitated as they battled with conflicting cultural and workplace expectations:

Part of me was thinking don't be what they think you are, which is an automatic anti-vaxxer because you're Black. […] within the Black community, that conflict and that pressure again to not take the vaccine. If you take the vaccine, you're almost like a sell-out (Amira).

Subsequently, participants reflected on their decision making, acknowledging there was a lack of information reassuring the Black community that the vaccine was safe. Keisha highlighted that deciding to take the vaccine felt "murky and panic driven". Some identified that because of workplace pressure, they had the vaccine which they now regret, as highlighted by Grace "I wouldn't have made that decision if I wasn't in that environment and felt pressured to do something [...] when I look back, I wish I never took the vaccine".

Workplace stressors: Implicit workplace expectations

Participants experienced an increased workload during the pandemic but did not receive increased workplace support. Many reflected on a lack of "psychological safety" (Sade), with implicit expectations to work above their competency and capacity, "My line manager turned 'round to me and said you're doing the most clinical hours within the service [...] I nearly reached 40 clinical hours in a week" (Grace).

Subsequently, participants stated that they were unable to request reducing their workload, and managers failed to acknowledge the impact of increased workloads, which were "bursting at the seams" (Grace).

> Because my caseload skyrocketed, but my contact with supervisors got reduced, my contact with my colleagues got massively reduced and I was just left doing all of these appointments, but then no one also said that I could cut back (Danielle).

Participants reflected on a sense of powerlessness as they reluctantly accepted increased workloads:

> Even though we were in a pandemic, and I get that targets are a thing, it just made it feel quite difficult to say actually "this is all a bit too much" when they are very aware of the situation (Jamilia).

By failing to acknowledge the risk of burnout, participants identified there was an implicit expectation to carry on working in the face of such stressors. Jade reflected on her manager's response to her concerns regarding the workload, "This is how it is at the moment; it sucks. But we got to continue on", further reinforcing the

expectation to accept an increased workload and subsequent stressors despite the impact on employee well-being.

Workplace stressors: Expectations of self as a mental health professional

Participants highlighted a pressure to continue in the face of adversity out of a sense of "duty first" (Amira). This responsibility perpetuated participants' resilience despite being aware of the workplace stressors they were experiencing, Naomi reflected that "putting myself at risk then probably wasn't in the forefront of my mind, the job always came first". Many acknowledged a lack of work-life balance as "there wasn't a life to balance" (Adeola). This resulted in their occupation becoming central to their lifestyle during the pandemic including working outside of working hours and not taking leave, Sade reflected "I can't really tell you much about what I was doing at that time other than I felt like I was just working. I feel like my brain is just gone, that was a horrible time".

Participants engaged in maladaptive coping strategies which were not in accordance with their expectations as a MHP, including increased alcohol consumption, poor sleep hygiene and comfort eating:

I massively noticed it [alcohol] impacted my sleep. It impacted how I felt the next day. Sometimes I'd wake up with that guilty drunk feeling, that wasn't really nice, and that probably contributed to why I was crying so much (Jamilia).

This was attributed to the absence of prosocial coping skills due to lockdown restrictions, "the lack of being able to go out socially, I think for me led more to kind of like the only joys was kind of eating or like getting my own snacks" (Danielle). Participants reflected on feeling "hypocritical" (Imani) as their coping skills were incongruent with the therapeutic advice, they were providing clients with. This challenged their expectations of themselves as MHPs:
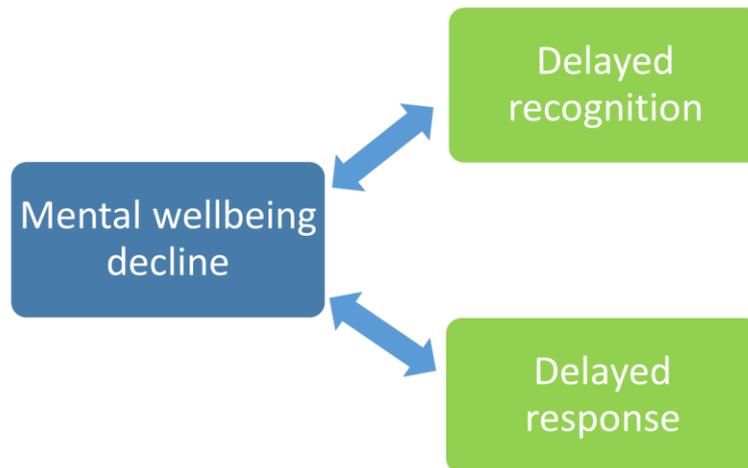
I remember sitting there telling people, if you wanna make sure that you're separating work from home, you need to stop being in your pyjamas - while sitting

in my pyjamas. You need to make sure that you have a separate space away from your bedroom - whilst I was lying in bed (Grace).

Mental well-being decline

Figure 5

The process of mental well-being declining

Delayed recognition

Participants acknowledged a delayed recognition of their declining mental health (Figure 5). Participants reflected on feelings of burnout such as "pulling from a well of nothing" (Jamilia) whilst being in "survival mode" (Mia). Grace reflected on how this burnout led to an impact on her emotional well-being, "It got to the point where I was pretty much in a sad state. I'd be crying all day. I'd be crying in between appointments".

Participants identified physical changes in response to stress which allowed them to recognise their mental well-being had deteriorated and realise the distress they were experiencing:

I didn't realise I was eating a lot less, and I did lose weight as well [...] I think that was my body's response to being really stressed out and I think it was like my mind took a while to catch up to like, like you're really anxious and you're not OK (Mia).

By working in "autopilot" (Jade) many overlooked the impact of working in a stress-inducing environment, acknowledging this in hindsight. Some reflected on the nature of their role and how caring for others masked their own changes in well-being:

> I think at the time I realised it was bad. Looking back, I realised just how bad it was and like I just felt it in my body like I felt really heavy. I felt really tired. I wasn't sleeping very well (Jamilia).

> We are so focused on helping others that we come second, not an intentionally destructive way, but in a 'I'm trying to help others and so if I'm trying to do that whilst the world seems to be on fire, I can't really be thinking about myself as well (Sade).

Delayed response

Others identified that even though they understood their mental well-being was declining they did not incorporate coping skills or respond to their mental well-being due to feeling "stuck" (Naomi) as "it was hard at the time to know what to do" (Keisha) despite being mental health professionals.

> I think a lot of it was looking back and going. Yeah, that did happen. And actually, yeah, that did cause me a lot of anxiety. But then you just kind of go well the next day I've got to move on cause I didn't have a choice (Sade).

Experiencing uncertainty in the pandemic left some participants feeling too overwhelmed to consider responding to their mental well-being, as Danielle highlights, "Was there any point where I thought about stopping or kind of slowing down? No". Consequently, pausing to respond to their needs did not feel like an option:

> I didn't really know what was gonna happen in terms of my work, how long are we gonna be in pandemic, how much longer can I realistically do this before I need

mental health support? I just felt like I had too much in my head and there wasn't space for me, and I think that makes me feel made me feel quite insane (Jamilia).

Post-COVID perspective

Figure 6

Black MHP's perspective of mental well-being following the pandemic
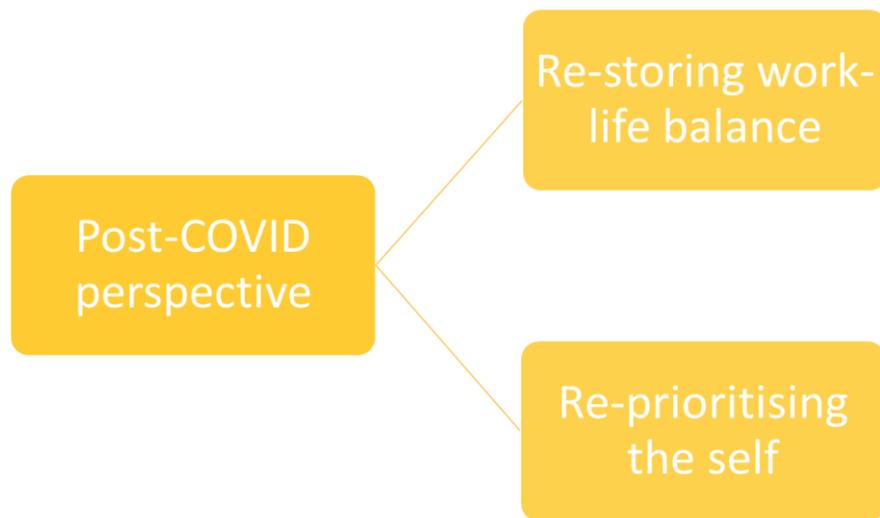
Re-prioritising the self

Participants identified a shift in perspective of how they view themselves and their work (Figure 6). Insight into managing mental well-being had improved for many participants, with some recognising this within their communities:

> Suddenly, mental health is no longer taboo in a church community or in the Black community to talk about because there is a reason we always tie it to COVID. It was the elephant in the room anyway, but nobody was bold enough to name it. But now I feel that that's changed a lot (Kwame).

Participants acknowledged that since the COVID-19 pandemic, they have re-prioritised their own needs and reflected on their mental well-being. This included increased insight of recognising when their mental well-being is deteriorating and how to proactively respond to this:

I'd never taken a sick leave until I got the tonsillitis, so since then I've taken sick leave when I need to take the sick leave. Since then it's very much kind of really paying attention to my body because I noticed those burnout signs before (Sade).

In reprioritising themselves, participants acknowledged how their occupation became secondary to their personal needs, with Danielle highlighting "COVID taught me that you have to look after your mental well-being when you're mentally well, like continue working on it."

Restoring work-life balance

Many participants identified that they have attempted to rectify the lack of work-life balance they experienced during the pandemic.

My priorities have changed now. I don't even want to work full time Monday to Friday. I want three days off at the weekend, whereas my priorities were work before now it's like it was always family as well, but now it's like, you know what I need that time for myself when 5:00 o'clock comes. I'm done (Naomi).

By recognising a relationship between lack of work-life balance and burnout, participants reflected on how they now give themselves "permission" (Jamilia) to put their needs first.

If someone cancels on me, I don't fill in that slot anymore. And I take that time to do whatever I wanna do - might even be to hoover or something but that makes me happy. Just giving myself permission to look after myself (Grace).

Subsequently, participants identified that they are actively restoring their work-life balance to support their mental well-being. Jamilia reflected on the notion of not sacrificing oneself for work "I try not to work as hard. It's just like a weird thing to say, but I just I can't come and die". In doing so, participants recognised an "attitude change" (Sade) where they reduced expectations of themselves in the workplace and preserved their self-value:

Actually, sometimes doing the minimum is better for me and looking after me in

the long run than trying to do above and beyond because at the end of day, even

though you're doing really well work, not many people appreciate it (Imani).

Participants identified the importance of "being more reflective" (Aaliyah, Mia),
"present" (Aaliyah) and re-evaluating their priorities:

Something that I try to do going forward in terms of like having that space to

reflect on how you're doing or how this role is for you it kind of lets you get back in

touch with yourself just to see where you are (Mia).

Through conceptualising this experience, participants identified a delayed
recognition and response to their mental well-being declining. Through reflection,
participants acknowledged a shift in perspective following the COVID-19 pandemic
which saw many re-prioritising themselves and restoring their work-life balance with
a proactive response to managing their mental well-being. Thus, suggesting a shift in
cultural narratives around resilience and seeing a move towards giving permission to
acknowledge one's own distress and respond to it effectively.

Discussion

The current study aimed to explore the experiences of Black MHPs mental well-
being working throughout the COVID-19 pandemic and how they conceptualise this
experience. The findings informed a theoretical framework depicting the factors
influencing Black MHPs experiences during the pandemic and how this influenced
their mental well-being. The framework postulates a shift in perspective following the
COVID-19 pandemic whereby Black MHPs re-prioritised their needs and placing less
significance of occupational demands.

Black MHPs conceptualised their experience through their social, cultural, and
political context. When recalling experiences of working during the pandemic, the
salience of ethnic identity has been highlighted in the literature (Gutman et al., 2024).
Participants identified the significance of cultural narratives of resilience, navigating
racial stereotypes and acknowledging systemic racism. The theory postulates that
the COVID-19 pandemic exacerbated this context. Participants identified the impact

of the BLM movement and subsequent experiences of racial trauma, whilst acknowledging their awareness of the adverse effects of COVID-19 on racialised groups, increased a lack of safety and distress. These findings support Laurencin and Walker's (2020) hypothesis of a "pandemic on a pandemic" (p.10) during the COVID-19 pandemic and intersectional trauma experienced by Black MHPs (Ezell et al., 2021). Additionally, findings identified the impact of racial trauma and burnout experienced in the workplace which is evidenced in Miu and Moore's (2021) study. Recent research by Gutman et al., (2024) supports this finding, revealing that staff from racialised backgrounds were significantly impacted by the BLM movement. Findings highlighted that many employees felt their experiences were not acknowledged by their workplace, resulting in feelings of resentment and isolation. The grounded theory disputes previous research findings which indicated no association between issues of racism and the political climate in 2020 on HCW well-being (Mercado et al., 2021). However, this contrast in findings could be explained by the lack of validated measures employed by Mercado et al., (2021).

The theory also indicated that Black MHPs experienced symptoms associated with anxiety and depression due to an increased workload and reduced work-life balance which is in line with the literature (Grailey et al., 2021; Revythis, et al., 2021). This was compounded by lack of organisational support and colleague allyship. Furthermore, participants experienced implicit workplace expectations and workloads which impacted their coping experiences and well-being – findings which are identified in the literature concerning healthcare workers (Greene et al., 2012; Soubra et al., 2023). Fears of contracting COVID-19 or infecting relatives are also reinforced by previous research findings (Grailey et al., 2021; Soubra et al., 2023). Despite the increased risk of COVID-19, Black MHPs acknowledged their vaccine hesitancy which is evidenced throughout the literature concerning COVID-19 vaccine uptake with Black individuals and HCWs (Roberston et al., 2021; Woolf et al., 2021). This has been attributed to factors including a lack of trust in healthcare services and a lack of ethnic diversity within vaccine studies, raising safety concerns of the vaccine for racialised individuals (Razai et al., 2021; Woolf et al., 2021).

Additionally, the grounded theory highlights that Black MHPs experienced unmet mental health needs during the pandemic as indicated by the literature (Kabasinguzi et al., 2023; Thomeer et al., 2022). Previous research has attributed barriers to

seeking mental health support, such as lack of access to services, however, the theory highlights alternative barriers including a delayed recognition and response to their mental well-being declining. The category exploring mental well-being decline is supported by Besirli et al., (2021) findings whereby behavioural disengagement was a maladaptive coping mechanism employed by HCWs in the COVID-19 pandemic. This involves reducing or ceasing attempts to deal with a stressor (Besirli et al.,2021; Carver et al., 1989; Newman et al., 2021). It is postulated that in the context of Black MHPs, this maladaptive coping is attributed to an exacerbation of cultural narratives of resilience, racial stereotypes and awareness of workplace inequalities which perpetuated stoicism. The stressors Black MHPs experienced further heightened this which led to a delayed recognition and response to mental well-being.

Clinical Implications

The grounded theory highlights the nuanced experience of Black MHPs during the COVID-19 pandemic, which contributed to intersectional trauma and exacerbated pre-existing inequalities. Thus, it is important to consider the clinical and occupational implications of these findings. The NHS People Plan (2020) was implemented to support HCWs during the COVID-19 pandemic, providing staff well-being support including specialist support services for racialised workers. However, the findings from the current study highlight that despite these efforts, Black MHPs did not feel supported in the workplace and identified examples of performative allyship (Kalina, 2020). Literature has highlighted that performative allyship can harm the well-being of marginalised groups (Estevean-Reina et al., 2021) which is acknowledged within the grounded theory. Therefore, the effectiveness of the NHS People Plan is questionable.

The clinical implications of this research highlight the importance of equality, diversity, and inclusivity (EDI) practices to inform workplace responses to managing staff well-being. Gutman et al. (2024) posit that organisational infrastructure should be guided by EDI and suggest evidence-based workplace strategies such as bespoke training on issues racialised staff experience in response to socio-political events which may impact their well-being and promoting inclusive language and awareness of ethnic diversity. However, change is dependent on a broader organisational acknowledgement of structural racism, and supportive allyship is

contingent on the authenticity and consistency of the act with the organisation's prior actions (Ponce de Leon et al., 2024).

The NHS workforce is diverse but not inclusive, as racialised staff members are more likely to experience discrimination in the workplace and are less likely to progress to leadership roles (NHS England, 2021; NHS England 2023). Therefore, an EDI initiative to re-shape the experience of racialised NHS workers should be supported by organisational changes which challenge structural racism and workplace policies (Naqvi et al., 2022). This organisational change could be developed by clinical psychologists who contributed to policy and decision making during the pandemic to uphold the health and safety of HCWs and the general population (Karekla et al., 2021). The findings from this research also highlight a need for clinical psychologists to consider how to individualize support in respect to staff identity and intersectionality. Their role in promoting EDI should ensure that all staff members, regardless of their identity, receive the support they need to thrive, particularly in the face of crises like the COVID-19 pandemic.

Thus, this research calls for staff well-being initiatives to acknowledge the significance of EDI when supporting staff members in the face of a health, social or political crisis – acknowledging that organisational changes which supports equitable work experiences and racialised employee mental well-being is essential in creating a sustainable change for the diverse NHS workforce.

Strengths and limitations

The research findings provide novel insight into a previously underrepresented demographic within the literature and answers calls for post-pandemic research to explore Black African, Caribbean and mixed heritage mental health. Furthermore, there is also a lack of research exploring retrospective accounts of the pandemic and the impact this has on current perspectives of mental health in HCWs. Retrospective accounts of the pandemic are significant as it allows professionals to reflect and conceptualise without being impacted by the potential trauma experienced during that time (Soubra et al., 2023).

However, there is a lack of diversity within the sample recruited. For instance, sample demographics highlighted an increased representation of Black females and professionals who were Band 4 or Band 5 in the NHS. However, this may reflect the

occupational workforce within the NHS (NHS England, 2023). This leads us to consider whether the findings are representative of other disciplines, questioning whether resilience and mental health insight differs with gender, professional grading and experience. The study findings are pertinent to UK-based Black MHPs and may be applicable to countries with public health care provision and similar demographics. These findings are not applicable to countries who do not have public health care provision as this context can impact organisational structure and service provision for MHPs.

Finally, it is important to consider whether the findings concerning Black MHPs' experiences are different to White MHPs as research highlights HCWs experienced similar stressors including fear of COVID-19 and infecting relatives, increased workload, lack of managerial support and behavioural disengagement (Grailey et al., 2021; Revythis, et al., 2021; Soubra et al., 2023). Due to the heterogeneity of experiences grouped within the 'BAME' term, future research should explore the experiences of other racialised groups to identify an individualised approach to supporting staff well-being.

Conclusion

Managing mental well-being throughout the COVID-19 pandemic was a complex experience for Black MHPs. With health, workplace and racial inequalities exacerbated by the precipitating risk conditions surrounding COVID-19 and associated stressors, many Black MHPs experienced a "pandemic on a pandemic" reinforcing their social, cultural, and political context. Such demands heightened cultural narratives of resilience which influenced a delayed recognition and response to declining mental well-being. Through conceptualising these experiences, Black MHPs acknowledge a shift in perspective, highlighting the importance of prioritising their needs over their occupation. Additionally, participants identified a lack of workplace support and allyship they experienced during the pandemic which heightened distress. The findings indicate a requirement for staff well-being initiatives to be informed by EDI principles when supporting racialised staff members in the face of a health, social, or political crisis.

References

Aldiabat, K., & Le Navenec, C.-L. (2018). Data saturation: The mysterious step in grounded theory method. *The Qualitative Report*. https://doi.org/10.46743/2160-3715/2018.2994

Amnesty International UK (2020, July 13) *UK among highest COVID-19 health worker deaths in the world*. https://www.amnesty.org.uk/press-releases/uk-among-highest-covid-19-health-worker-deaths-world

Andrews, T. (2012). *What is social constructionism?* Groundedtheoryreview.com. https://groundedtheoryreview.com/2012/06/01/what-is-social-constructionism/

Bambra, C., Riordan, R., Ford, J., & Matthews, F. (2020). The COVID-19 pandemic and health inequalities. *Journal of Epidemiology and Community Health*, jech-2020-214401. https://doi.org/10.1136/jech-2020-214401

Bennett, P., Noble, S., Johnston, S., Jones, D., & Hunter, R. (2020). COVID-19 confessions: a qualitative exploration of healthcare workers experiences of working with COVID-19. *BMJ Open*, *10*(12). https://doi.org/10.1136/bmjopen-2020-043949

Besirli, A., Erden, S. C., Atilgan, M., Varlihan, A., Habaci, M. F., Yeniceri, T., Isler, A. C., Gumus, M., Kizileroglu, S., Ozturk, G., Ozer, O. A., & Ozdemir, H. M. (2021). The relationship between anxiety and depression levels with perceived stress and coping strategies in health care workers during the COVID-19 pandemic. *SiSli Etfal Hastanesi Tip Bulteni / The Medical Bulletin of Sisli Hospital*, *55*(1), 1–11. https://doi.org/10.14744/semb.2020.57259

Birks, M., & Mills, J. (2015). *Grounded theory: a practical guide*. SAGE.

Burr, Viv. (2015). Social Constructionism. In *International Encyclopedia of the Social & Behavioral Sciences* (pp. 222–227). Elsevier.

Burr, Vivien, & Dick, P. (2017). *The Palgrave Handbook of Critical Social Psychology*. Palgrave Macmillan.

Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: a theoretically based approach. *Journal of Personality and Social Psychology*, *56*(2), 267–283. https://psycnet.apa.org/doi/10.1037/0022-3514.56.2.267

Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 509–535). Sage.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Sage.

Charmaz, K., & Henwood, K. (2008). Grounded Theory. The SAGE Handbook of Qualitative Research in Psychology, 240–260. https://doi.org/10.4135/9781848607927.n14

Chun Tie, Y., Birks, M., & Francis, K. (2019). Grounded theory research: A design framework for novice researchers. *SAGE Open Medicine*, *7*, 2050312118822927. https://doi.org/10.1177/2050312118822927

Comas-Díaz, L., Hall, G. N., & Neville, H. A. (2019). Racial trauma: Theory, research, and healing: Introduction to the special issue. *The American Psychologist*, *74*(1), 1–5. https://doi.org/10.1037/amp0000442

Cundiff, J. L. (2012). Is mainstream psychological research "womanless" and "raceless"? An updated analysis. *Sex Roles*, 67(3–4), 158–173. https://doi.org/10.1007/s11199-012-0141-7

Dacosta, C., Dixon-Smith, S., & Singh, G. (2021). *Beyond BAME: Rethinking the politics, construction, application and efficacy of ethnic categorization*. HERAG.

Devonport, T. J., Ward, G., Morrissey, H., Burt, C., Harris, J., Burt, S., Patel, R.,

  Manning, R., Paredes, R., & Nicholls, W. (2022). A systematic review of

  inequalities in the mental health experiences of Black African, Black

  Caribbean and Black-mixed UK populations: Implications for action. *Journal of*

  Racial and Ethnic Health Disparities, 10(4), 1669–1681.

  https://doi.org/10.1007/s40615-022-01352-0

Elliott, N. & Lazenbatt, A.(2005). How to recognise a 'quality' grounded theory

  research study. *Australian Journal of Advanced Nursing*, 22(3), 48–52.

England, N. H. S. (n.d.). *NHS England » New figures show NHS workforce most*

  diverse it has ever been. Nhs.uk. Retrieved 7 March 2024, from

  https://www.england.nhs.uk/2023/02/new-figures-show-nhs-workforce-most-

  diverse-it-has-ever-been/

Estevan-Reina, L., de Lemus, S., Megías, J. L., Kutlaca, M., Belmonte-García, M., &

  Becker, J. (2021). Allies against sexism: The impact of men's egalitarian

  versus paternalistic confrontation on women's empowerment and well-being.

  Sex Roles, 84(9–10), 536–553. https://doi.org/10.1007/s11199-020-01184-4

Ezell, J. M., Salari, S., Rooker, C., & Chase, E. C. (2021). Intersectional trauma:

  COVID-19, the psychosocial contract, and America's racialized public health

  lineage. *Traumatology*, 27(1), 78–85. https://doi.org/10.1037/trm0000302

Gill, M. J. (2020). How can I study who you are? Methodological approaches to

  identify work research. In A. Brown (Ed.), *The oxford handbook of identities in*

  organizations (pp. 295–310). Oxford University Press.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies*

  for qualitative research. Aldine Transaction.

Grailey, K., Lound, A., & Brett, S. (2021). Lived experiences of healthcare workers on the front line during the COVID-19 pandemic: a qualitative interview study. *BMJ Open*, 11(12), e053680. https://doi.org/10.1136/bmjopen-2021-053680

Greene, T., Harju-Seppänen, J., Adeniji, M., Steel, C., Grey, N., Brewin, C. R., Bloomfield, M. A., & Billings, J. (2021). Predictors and rates of PTSD, depression and anxiety in UK frontline health and social care workers during COVID-19. *European Journal of Psychotraumatology*, *12*(1). https://doi.org/10.1080/20008198.2021.1882781

Gutman, L. M., Younas, F., Perowne, R., & Hanrachtaigh, E. (2024). Lived experiences of diverse university staff during COVID-19: an examination of workplace wellbeing. Studies in Higher Education, 49(2), 251–268.

Kabasinguzi, I., Ali, N., & Ochepo, P. (2023). Mental health experiences and coping strategies of BAME care workers who worked in nursing and residential care homes during the COVID-19 pandemic in Luton, England. *BMC Public Health*, 23(1). https://doi.org/10.1186/s12889-023-15423-2

Kalina, P. (2020). Performative Allyship. *Technium Social Sciences Journal*, 11, 478–481. https://doi.org/10.47577/tssj.v11i1.1518

Karekla, M., Höfer, S., Plantade-Gipch, A., Neto, D. D., Schjødt, B., David, D., Schütz, C., Eleftheriou, A., Pappová, P. K., Lowet, K., McCracken, L., Sargautytė, R., Scharnhorst, J., & Hart, J. (2021). The role of psychologists in healthcare during the COVID-19 pandemic: Lessons learned and recommendations for the future. *European Journal of Psychology Open*, *80*(1–2), 5–17. https://doi.org/10.1024/2673-8627/a000003

Khunti, K., Routen, A., Pareek, M., Treweek, S., & Platt, L. (2020). The language of

ethnicity. *BMJ (Clinical Research Ed.)*, m4493.

https://doi.org/10.1136/bmj.m4493

Kirby, T. (2020). Evidence mounts on the disproportionate effect of COVID-19 on

ethnic minorities. *The Lancet. Respiratory Medicine*, *8*(6), 547–548.

https://doi.org/10.1016/S2213-2600(20)30228-9

Kursumovic, E., Lennane, S., & Cook, T. (2020, April 22). *Exclusive: deaths of NHS

staff from covid-19 analysed*. Health Service Journal.

https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-

analysed/7027471.article

Lamb, D., Gnanapragasam, S., Greenberg, N., Bhundia, R., Carr, E., Hotopf, M.,

Razavi, R., Raine, R., Cross, S., Dewar, A., Docherty, M., Dorrington, S.,

Hatch, S., Wilson-Jones, C., Leightley, D., Madan, I., Marlow, S., McMullen, I.,

Rafferty, A.-M., … Wessely, S. (2021). Psychosocial impact of the COVID-19

pandemic on 4378 UK healthcare workers and ancillary staff: initial baseline

data from a cohort study collected during the first wave of the pandemic.

Occupational and Environmental Medicine, *78*(11), 801–808.

https://doi.org/10.1136/oemed-2020-107276

Laurencin, C. T., & Walker, J. M. (2020). A pandemic on a pandemic: Racism and

COVID-19 in blacks. *Cell Systems*, *11*(1), 9–10.

https://doi.org/10.1016/j.cels.2020.07.002

Lindheim, T. (2022). Participant validation: A strategy to strengthen the

trustworthiness of your study and address ethical concerns. In *Researching

Values: Methodological Approaches for Understanding Values Work in*

Organisations and Leadership (pp. 225–239). Springer International
Publishing.

Mantovani, N., Pizzolati, M., & Edge, D. (2017). Exploring the relationship between
stigma and help-seeking for mental illness in African-descended faith
communities in the UK. *Health Expectations: An International Journal of Public
Participation in Health Care and Health Policy*, *20*(3), 373–384.
https://doi.org/10.1111/hex.12464

Maxwell, J. A. (2005). *Qualitative Research Design: An Interactive Approach*. Sage.

Mercado, M., Wachter, K., Schuster, R. C., Mathis, C. M., Johnson, E., Davis, O. I., &
Johnson-Agbakwu, C. E. (2022). A cross-sectional analysis of factors
associated with stress, burnout and turnover intention among healthcare
workers during the COVID-19 pandemic in the United States. *Health & Social
Care in the Community*, *30*(5). https://doi.org/10.1111/hsc.13712

Mills, J., Bonner, A., & Francis, K. (2006). The development of constructivist
grounded theory. *International Journal of Qualitative Methods*, *5*(1), 25–35.
https://doi.org/10.1177/160940690600500103

Milner, A., & Jumbe, S. (2020). Using the right words to address racial disparities in
COVID-19. *The Lancet Public Health*, 5(8), e419–e420.
https://doi.org/10.1016/s2468-2667(20)30162-6

Miu, A. S., & Moore, J. R. (2021). Behind the masks: Experiences of mental health
practitioners of color during the COVID-19 pandemic. *Academic Psychiatry*,
45(5), 539–544. https://doi.org/10.1007/s40596-021-01427-w

Muller, A. E., Hafstad, E. V., Himmels, J. P. W., Smedslund, G., Flottorp, S.,
Stensland, S. Ø., Stroobants, S., Van de Velde, S., & Vist, G. E. (2020). The
mental health impact of the covid-19 pandemic on healthcare workers, and

interventions to help them: A rapid systematic review. *Psychiatry Research*, 293, 113441. https://doi.org/10.1016/j.psychres.2020.113441

Naqvi, H., Williams, R. D., Chinembiri, O., & Rodger, S. (2022). Workforce and workplace racism in health systems: organisations are diverse but not inclusive. *The Lancet, 400*(10368), 2023–2026. https://doi.org/10.1016/s0140-6736(22)02395-9

National Health Service. (2020, July). *NHS People Plan*. England NHS. england.nhs.uk/wp-content/uploads/2020/07/We-Are-The-NHS-Action-For-All-Of-Us-FINAL-March-21.pdf

Newman, K. L., Jeve, Y., & Majumder, P. (2022). Experiences and emotional strain of NHS frontline workers during the peak of the COVID-19 pandemic. *The International Journal of Social Psychiatry*, *68*(4), 783–790. https://doi.org/10.1177/00207640211006153

NHS Digital. (2023, April 13). *NHS workforce*. Gov.uk. https://www.ethnicity-facts-figures.service.gov.uk/workforce-and-business/workforce-diversity/nhs-workforce/latest/

NHS England. (2023). Nhsstaffsurveys.com. https://www.nhsstaffsurveys.com/static/8c6442c8d92624a830e6656baf633c3f/NHS-Staff-Survey-2022-National-briefing.pdf

NHS England (2021). *Workforce Race Equality Standard.* https://www.england.nhs.uk/wp-content/uploads/2022/04/Workforce-Race-Equality-Standard-report-2021-.pdf

Oates, J., Carpenter, D., Fisher, M., Goodson, S., Hannah, B., Kwiatkowski, R., Prutton, K., Reeves, D., & Wainwright, T. (2021). *BPS Code of Human Research Ethics*. https://doi.org/10.53841/bpsrep.2021.inf180

Office for National Statistics. *Coronavirus and the social impacts on different ethnic groups in the UK: 2020* (2020, December). https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/coronavirusandthesocialimpactsondifferentethnicgroupsintheuk/2020 [Accessed February 2024]

Office for National Statistics. (2022). *Ethnic group variable: Census 2021.* https://www.ons.gov.uk/census/census2021dictionary/variablesbytopic/ethnicgroupnationalidentitylanguageandreligionvariablescensus2021/ethnicgroup

Olmos-Vega, F. M., Stalmeijer, R. E., Varpio, L., & Kahlke, R. (2022). A practical guide to reflexivity in qualitative research: AMEE Guide No. 149. *Medical Teacher*, 1–11. https://doi.org/10.1080/0142159X.2022.2057287

Perego, G., Cugnata, F., Brombin, C., Milano, F., Mazzetti, M., Taranto, P., Preti, E., Di Pierro, R., De Panfilis, C., Madeddu, F., & Di Mattei, V. E. (2023). Analysis of healthcare workers' mental health during the COVID-19 pandemic: Evidence from a three-wave longitudinal study. *Journal of Health Psychology*, 28(14), 1279–1292. https://doi.org/10.1177/13591053231168040

Ponce de Leon, R., Carter, J. T., & Rosette, A. S. (2024). Sincere solidarity or performative pretense? Evaluations of organizational allyship. *Organizational Behavior and Human Decision Processes*, *180*(104296), 104296. https://doi.org/10.1016/j.obhdp.2023.104296

Proto, E., & Quintana-Domeque, C. (2020). Covid-19 and mental health deterioration among bame groups in the UK. *SSRN Electronic Journal*. https://dx.doi.org/10.2139/ssrn.3660249

Public Health England. (2020, August). *Disparities in the risk and outcomes of COVID-19*. Gov.uk. https://assets.publishing.service.gov.uk/media/5f328354d3bf7f1b12a7023a/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf

Razai, M. S., Kankam, H. K. N., Majeed, A., Esmail, A., & Williams, D. R. (2021). Mitigating ethnic disparities in covid-19 and beyond. *BMJ (Clinical Research Ed.)*, m4921. https://doi.org/10.1136/bmj.m4921

Razai, M. S., Osama, T., McKechnie, D. G. J., & Majeed, A. (2021). Covid-19 vaccine hesitancy among ethnic minority groups. *BMJ (Clinical Research Ed.)*, n513. https://doi.org/10.1136/bmj.n513

Reid, A.-M., Brown, J. M., Smith, J. M., Cope, A. C., & Jamieson, S. (2018). Ethical dilemmas and reflexivity in qualitative research. *Perspectives on Medical Education*. https://doi.org/10.1007/S40037-018-0412-2

Revythis, A., Shah, S., Enyioma, S., Ghose, A., Patel, M., Karathanasi, A., Sanchez, E., & Boussios, S. (2021). The experience of a single NHS England trust on the impact of the COVID-19 pandemic on junior and middle-grade doctors: What is next? *International Journal of Environmental Research and Public Health*, *18*(19), 10413. https://doi.org/10.3390/ijerph181910413

Roberts, S. O., Bareket-Shavit, C., Dollins, F. A., Goldie, P. D., & Mortenson, E. (2020). Racial inequality in psychological research: Trends of the past and recommendations for the future. *Perspectives on Psychological Science: A Journal of the Association for Psychological Science*, *15*(6), 1295–1309. https://doi.org/10.1177/1745691620927709

Robertson, E., Reeve, K. S., Niedzwiedz, C. L., Moore, J., Blake, M., Green, M., Katikireddi, S. V., & Benzeval, M. J. (2021). Predictors of COVID-19 vaccine

hesitancy in the UK household longitudinal study. *Brain, Behavior, and Immunity*, *94*, 41–50. https://doi.org/10.1016/j.bbi.2021.03.008

Smith, K., Bhui, K., & Cipriani, A. (2020). COVID-19, mental health and ethnic minorities. *Evidence-Based Mental Health*, *23*(3), 89–90. https://doi.org/10.1136/ebmental-2020-300174

Soubra, K., Tamworth, C., Kamal, Z., Brook, C., Langdon, D., & Billings, J. (2023). Health and social care workers experiences of coping while working in the frontline during the COVID-19 pandemic: One year on. *PloS One*, *18*(4), e0284306. https://doi.org/10.1371/journal.pone.0284306

Spoorthy, M. S., Pratapa, S. K., & Mahant, S. (2020). Mental health problems faced by healthcare workers due to the COVID-19 pandemic–A review. *Asian Journal of Psychiatry*, *51*(102119), 102119. https://doi.org/10.1016/j.ajp.2020.102119

Strauss, A. L. (2011). *Qualitative Analysis for Social Scientists*. Cambridge University Press.

Thomeer, M. B., Moody, M. D., & Yahirun, J. (2022). Racial and ethnic disparities in mental health and mental health care during the COVID-19 pandemic. *Journal of Racial and Ethnic Health Disparities*, 10(2), 961–976. https://doi.org/10.1007/s40615-022-01284-9

Thomson, S. B. (2010). Sample size and grounded theory. *Journal of Administration and Governance*, *5*(1), 45–52. https://ssrn.com/abstract=3037218

Tweed, A., & Priest, H. (2015). *Grounded Theory*. In: Qualitative Research in Clinical and Health Psychology. Palgrave Macmillan, Basingstoke

Vanhaecht, K., Seys, D., Bruyneel, L., Cox, B., Kaesemans, G., Cloet, M., Van Den Broeck, K., Cools, O., De Witte, A., Lowet, K., Hellings, J., Bilsen, J.,

Lemmens, G., & Claes, S. (2021). COVID-19 is having a destructive impact on health-care workers' mental well-being. *International Journal for Quality in Health Care*, *33*(1). https://doi.org/10.1093/intqhc/mzaa158

Woolf, K., McManus, I. C., Martin, C. A., Nellums, L. B., Guyatt, A. L., Melbourne, C., Bryant, L., Gogoi, M., Wobi, F., Al-Oraibi, A., Hassan, O., Gupta, A., John, C., Tobin, M. D., Carr, S., Simpson, S., Gregary, B., Aujayeb, A., Zingwe, S., … Pareek, M. (2021). Ethnic differences in SARS-CoV-2 vaccine hesitancy in United Kingdom healthcare workers: Results from the UK-REACH prospective nationwide cohort study. *The Lancet Regional Health. Europe*, *9*(100180), 100180. https://doi.org/10.1016/j.lanepe.2021.100180

World Health Organisation (2021, October 20) *Health and Care Worker Deaths during COVID-19.* https://www.who.int/news/item/20-10-2021-health-and-care-worker-deaths-during-covid-19

Appendices Empirical Paper
Appendix A

Journal submission guidelines

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures/tables; supporting information.

Title Page

You may like to use this template for your title page. The title page should contain:

A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);

A short running title of less than 40 characters;

The full names of the authors;

The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;

Abstract;

Keywords;

Data availability statement (see Data Sharing and Data Accessibility Policy);

Acknowledgments.

Author Contributions

For all articles, the journal mandates the CRediT (Contribution Roles Taxonomy)—more information is available on our Author Services site.

Abstract

Please provide an abstract of up to 250 words. Articles containing original scientific research should include the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use the headings: Purpose, Methods, Results, Conclusions.

Keywords

Please provide appropriate keywords.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Practitioner Points

All articles must include Practitioner Points – these are 2-4 bullet point with the heading 'Practitioner Points'. They should briefly and clearly outline the relevance of your research to professional practice.

Main Text File

As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors.

Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx) or LaTex (.tex) format.

If submitting your manuscript file in LaTex format via Research Exchange, select the file designation "Main Document – LaTeX .tex File" on upload. When submitting a LaTex Main Document, you must also provide a PDF version of the manuscript for Peer Review. Please upload this file as "Main Document - LaTeX PDF." All supporting files that are referred to in the LaTex Main Document should be uploaded as a "LaTeX Supplementary File."

LaTex Guidelines for Post-Acceptance:

Please check that you have supplied the following files for typesetting post-acceptance:

PDF of the finalized source manuscript files compiled without any errors.

The LaTeX source code files (text, figure captions, and tables, preferably in a single file), BibTex files (if used), any associated packages/files along with all other files needed for compiling without any errors. This is particularly important if authors have used any LaTeX style or class files, bibliography files (.bbl, .bst. .blg) or packages apart from those used in the NJD LaTex Template class file.

Electronic graphics files for the illustrations in Encapsulated PostScript (EPS), PDF or TIFF format. Authors are requested not to create figures using LaTeX codes.

Your main document file should include:

A short informative title containing the major key words. The title should not contain abbreviations;

Abstract structured (intro/methods/results/conclusion);

Up to seven keywords;

Practitioner Points Authors will need to provide 2-4 bullet points, written with the practitioner in mind, that summarize the key messages of their paper to be published with their article;

Main body: formatted as introduction, materials & methods, results, discussion, conclusion;

References;

Tables (each table complete with title and footnotes);

Figure legends: Legends should be supplied as a complete list in the text. Figures should be uploaded as separate files (see below);

Statement of Contribution.

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.

As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors. Please do not mention the

authors' names or affiliations and always refer to any previous work in the third person.

The journal uses British/US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

References

This journal uses APA reference style; as the journal offers Free Format submission, however, this is for information only and you do not need to format the references in your article. This will instead be taken care of by the typesetter.

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Click here for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Supporting Information

Supporting information is information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.

Click here for Wiley's FAQs on supporting information.

Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

General Style Points

For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association. The following points provide general advice on formatting and style.

Language: Authors must avoid the use of sexist or any other discriminatory language.

Abbreviations: In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.

Units of measurement: Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.

Effect size: In normal circumstances, effect size should be incorporated.

Numbers: numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

Research participants needed for research on:
Black mental health professionals and their wellbeing during the Covid-19 pandemic

WHO'S IT FOR?

PEOPLE AGED 18 AND OVER

IF YOU IDENTIFY AS A BLACK PERSON OR PERSON OF BLACK HERITAGE

WORKED AS A MENTAL HEALTH PROFESSIONAL DURING THE COVID-19 PANDEMIC

YOU ARE INTERESTED IN SHARING YOUR EXPERIENCES

PLEASE GET IN TOUCH

Contact information:
Leonie Royes, Trainee Clinical Psychologist
r026387l@student.staffs.ac.uk

INFORMATION SHEET FOR PARTICIPANTS

Project Reference Number: SU_22_053

<u>Title of study</u>

Understanding Black mental health professionals' experiences of managing their mental well-being during the Covid-19 pandemic

<u>Invitation Paragraph</u>

I would like to invite you to participate in this research project which forms part of my Clinical Psychology Doctorate research. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

<u>What is the purpose of the study?</u>

The study aims to explore Black mental health professionals' experiences of coping during the Covid-19 pandemic. This includes experiences of mental health in response to being frontline workers during a pandemic and how these individual's coped (or not) in response to stressors which arose during this period.

<u>Why have I been invited to take part?</u>

You have been invited to take part as you identify as a mental health professional who worked during the Covid-19 pandemic supporting service users. For the purpose of this study, a mental health professional is someone who works in the mental health profession and provides therapeutic support to service users. It is also significant that you identify as being of Black heritage, which is the community we

are focusing this research on as this is a group which has historically been overlooked in research.

What will happen if I take part?

Your participation in the research study will involve an interview which will last approximately 30 minutes, however this can be longer or shorter depending on what you would like to say. You will be encouraged to talk about your experiences of working during the Covid-19 pandemic, the impact this had on your mental well-being and how you coped in response to these stressors.

Do I have to take part?

Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in anyway. Once you have read the information sheet, please contact us if you have any questions that will help you make a decision about taking part. If you decide to take part, we will ask you to sign a consent form and you will be given a copy of this consent form to keep.

What are the possible risks of taking part?

Recalling experiences of working during the Covid-19 pandemic and related stressors or difficulties which you encountered with your mental health can raise some distressing emotions or memories which can be difficult to manage. Following the completion of your participation, you will be provided with signposting to

appropriate services and charities which may be able to provide further support if you feel this is required.

What are the possible benefits of taking part?

Your participation is highly valued. As research developed by or including the Black community is lacking, understanding experiences of Black mental health professionals will provide a unique insight into how this work force managed working throughout unprecedented times in the face of a pandemic. Your participation could potentially influence further policies and guidance in how healthcare services can support Black employees more effectively and also raise valuable awareness of how the Covid-19 pandemic impacted the Black community.

Data handling and confidentiality

Your data will be processed in accordance with the data protection law and will comply with the General Data Protection Regulation 2016 (GDPR). Transcripts of the interviews will be anonymised to protect participant confidentially. This will be maintained through the written report of the study and any disseminations of findings. This data will only be shared within the research team.

Data Protection Statement

The data controller for this project will be Staffordshire University. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under the data protection law is a 'task in the public interest' You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you.

What if I change my mind about taking part?

You are free withdraw at any point of the study, without having to give a reason. Withdrawing from the study will not affect you in any way. You are able to withdraw your data from the study up within six weeks of the initial interview, after which withdrawal of your data will no longer be possible due to the data being anonymised and included in the final report of the thesis.

If you choose to withdraw from the study, please contact the principal investigator, Leonie Royes (e-mail: r026387l@student.staffs.ac.uk) we will not retain any information that you have provided us as a part of this study.

<u>What will happen to the results of the study?</u>

Study findings will be reported in an empirical paper supporting a Doctorate thesis. These results will also be disseminated to healthcare providers to inform how services can support Black mental health professionals in regards to managing mental well-being. There is the potential that the results may be published in a research journal which could be publicly available to view. However, all data will remain confidential and anonymised so that all names, locations and any other identifying information will be removed.

<u>Who should I contact for further information?</u>

If you have any questions or require more information about this study, please contact me using the following contact details:

Principal Investigator:

Leonie Royes – E-mail leonie.royes@student.staffs.ac.uk

Research supervisor:

Dr Kim Gordon – E-mail Kim.Gordon@staffs.ac.uk

<u>What if I have further questions, or if something goes wrong?</u>

If you feel that this study has impacted you in any way or if you wish to make a complaint about the conduct of the study you can contact the study supervisor or the Chair of the Staffordshire University Ethics Committee for further advice and information:

Dr Tim Horne, Chair of the Staffordshire University Ethic Committee Email: ethics@staffs.ac.uk

Thank you for reading this information sheet and for considering taking part in this research.

Appendix D
Participant Consent Form

Project Reference Number: SU_22_053

CONSENT FORM

Title of study: Understanding Black mental health professionals' experiences of managing their mental well-being during the Covid-19 pandemic

Name of Researcher: Leonie Royes (Trainee Clinical Psychologist)

Participation in this research is voluntary

I have read and understood the participant information sheet, or it has been read to me. I have been able to ask questions about the study and my questions have been answered to my satisfaction.	Yes/No
I consent voluntarily to be a participant in this study and understand that I can refuse to answer questions and that I can withdraw from the study at any time up until six weeks after the initial interview has taken place, without having to give a reason.	Yes/No
I agree to the interview being audio and video recorded.	Yes/No
I understand that the information I provide will be used for a research thesis conducted by Leonie Royes and that the information I provide will be anonymised.	Yes/No

I agree that my anonymised information can be quoted in research outputs.	Yes/No
I understand that any personal information that can identify me – such as my name, address, will be kept confidential and not shared with anyone other than the researcher and their academic supervisor.	Yes/No
I give permission for the information I have provided to be included in any public disseminations of the research, including journal article publications.	Yes/No

Please retain a copy of this consent form.

Participant name:

Signature: _____   Date _____

Interviewer name:

Signature:_____   Date _____

 For more information, please contact: Leonie Royes (Trainee Clinical Psychologist) r026387l@student.staffs.ac.uk

Appendix E
Interview Protocol

General introduction:

- Thank-you for taking part, background about myself and the research project, what I am hoping to aim from today's interview.

- Emphasise importance of own well-being when exploring questions, can take a break when needed, don't have to answer all questions, ensure free from distractions/interruptions, free to withdraw at any point, able to withdraw your data from the study up within six weeks of the initial interview

- Transcripts of the interviews will be anonymised to protect participant confidentially.

- Will be taking notes and reading from an interview protocol

Any questions before we begin?

Demographic information questions:

3. What gender do you identify as?

4. What is your age?

5. What is your ethnic and racial identity?

6. What is your current role and how long have worked within this role?

Interview Questions

1. Could you describe your role and how this was impacted by the COVID-19 pandemic?

2. Tell me about your experiences of supporting and helping others with their mental health during the COVID-19 pandemic.

3. Could you describe any stressors you experienced working during the COVID-19 pandemic?

4. Did these stressors impact your experiences in the workplace?

5. Did these stressors impact your mental well-being in anyway? If so, why and how?

6. Can you tell me about any expectations you experienced working during the pandemic as a Black Mental Health professional?

7. Could you tell me about what you think has influenced these expectations?

8. Were you able to identify or respond changes in your mental well-being? If so, how?

9. What did coping/managing mental well-being look like to you during the COVID-19 pandemic?

10. What does managing mental well-being look like to you following the COVID-19 pandemic

11. If you could summarise your experience of working during the COVID-19 pandemic as a Black mental health professional, how would you conceptualise/describe this?

12. Do you believe you are still experiencing effects on your mental well-being from working during the COVID-19 pandemic? If so, are you currently practicing any methods in response to this?

Follow-up questions to be asked after each participant's responses in order to engage them in a dialogue. At the end of the interview, the participants will be asked if they have anything to add.

Appendix F
Written participant debrief sheet

THANK-YOU FOR PARTICIPATING IN THE CURRENT RESEARCH STUDY

During the Covid-19 pandemic, Black, Asian and Minority Ethnic (BAME) workers in UK healthcare services were at an increased risk of experiencing adverse effects from Covid-19, including increased mortality rates (ONS, 2020). The current study aimed to explore Black mental health professional's experiences of managing their mental wellbeing during the Covid-19 pandemic

This topic of research is important to explore as the BAME population are traditionally referred to as a "hard to reach" group in health and mental health research due to studies encountering difficulties recruiting individual's from BAME backgrounds (Howe et al., 2006).

By sharing your experiences, you have been able to contribute to research on a demographic which is predominantly underepresented in the literature.

Contact information:
Leonie Royes, Trainee Clinical Psychologist
r026387l@student.staffs.ac.uk

Below are some organisations and charities which support Black mental health and healthcare workers in the UK and online resources if you would like support in relation to the topics discussed in this research project.

BMHM
Black Mental Health Matters
(bmhm.org)

NHS England

NHS Support for Employees - Staff mental health and wellbeing hubs
(https://www.england.nhs.uk/)

BAATN
The Black, African and Asian Therapy Network

The Black, African and Asian Therapy Network
(baatn.org.uk)

THANK-YOU AGAIN FOR YOUR PARTICIPATION

For further questions please contact:Leonie Royes, Trainee Clinical Psychologist

r026387l@student.staffs.ac.uk

Appendix G

Coding Decisions and Analysis

Example of transcript with coding
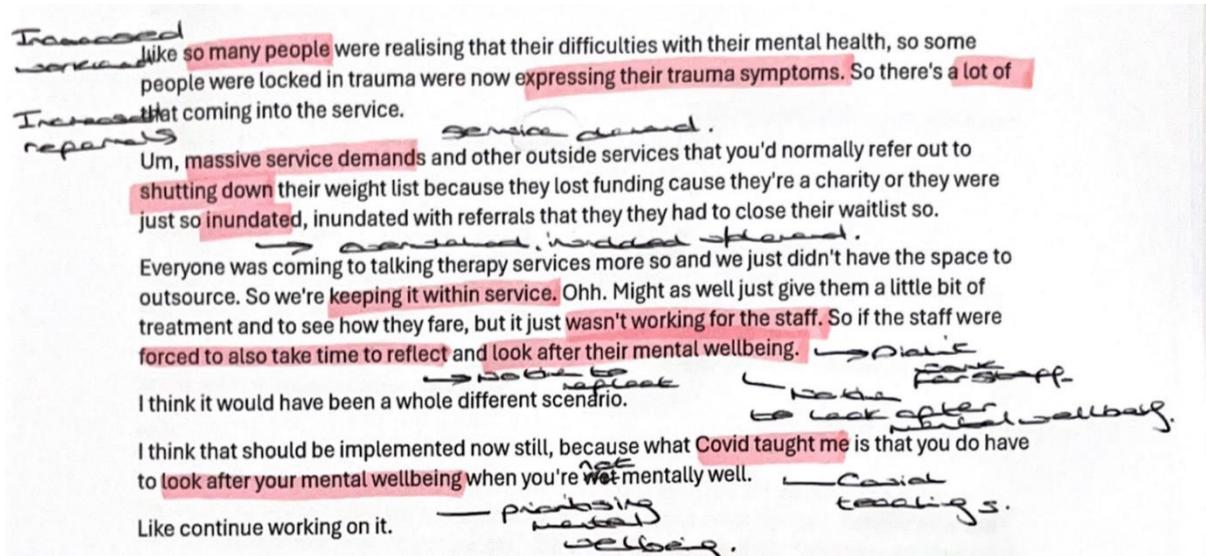
Initial codes:

- Increased workload
- Increased referrals
- Service demand
- Overwhelmed
- Inundated with demand
- Didn't work for staff
- No time to reflect
- No time for wellbeing
- Covid teachings
- Prioritising mental wellbeing

Example of initial coding

The initial stage of coding involved line-by-line analysis whereby important words, phrases or patterns were highlighted.

Initial code	Quote
Performative support	I think sometimes the performative feeling of things can leave you feeling quite deflated and Just that's like sense of. Here we go again and feeling quite low
BLM significant memory	I actually thinking about it the Black Lives Matter movement was like one of the biggest things that I remember. I think that was the time that I felt most deflated
BLM impact on mental wellbeing	I think it was definitely around the time of the protests and things that I'd say my mental wellbeing was at its lowest
Frustration with BLM awareness	"Why now?!", I really struggled with it happening at this particular time and because I was like this isn't ne
BLM most impact	That was the the summer or spring of Black Lives Matter and I think that had more of an impact than anything else to do this.
Not taken seriously (increased health risks)	I almost remember it not being taken seriously, it was almost like, yeah, OK, but you've got a job to do, so yeah, OK we can see that the stats are saying that this virus impacts you and your racial group particularly, but you've got a job to do.
Pressure to take the vaccine	I wouldn't have made that decision if I wasn't in that environment and felt pressured to do something about that pressure that I was feeling
Putting life on the line	I've got asthma. So I was like you lot are literally putting my life on the line and getting me to actually come in face to face
Fearful of COVID	We would have like nursing staff also go off sick, you would always kind of be fearful if COVID did come on our ward

Example of focused and theoretical coding
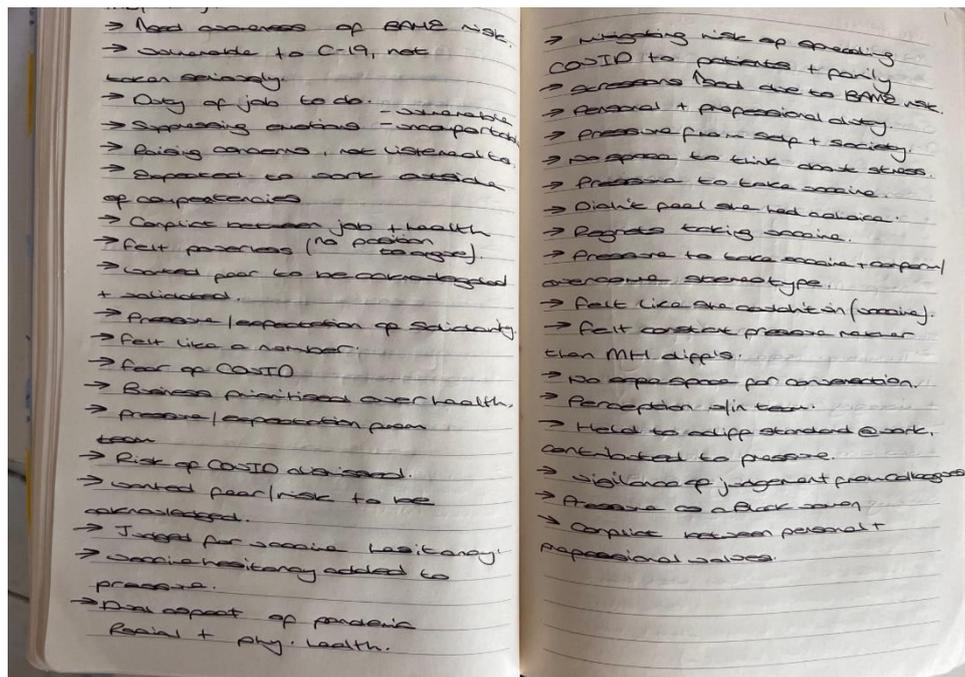
Focused coding sought to highlight abstract concepts from initial codes which led to categories beginning to develop. The notebook above highlights the focused codes which derived from this process. From this, initial codes were reduced to categories. This stage required using an excel spreadsheet to compare initial and focused codes, attempting to derive categories which were independent, and substantiated by codes.

Theoretical coding involved identifying the relationships between categories which followed the processes described by participants. This stage involved organising categories to form the theoretical framework. The researcher concurred with participants on the processes which formed their experiences during the interview stage to inform the theoretical coding.

Stages of developing categories

The following images highlight the development of categories throughout constant comparative analysis. As interviewing and data collection increases, subsequent categories are developed and established. The first image highlights the formative

categories which were postulated, the second image highlights how these categories are developed following further data collection.
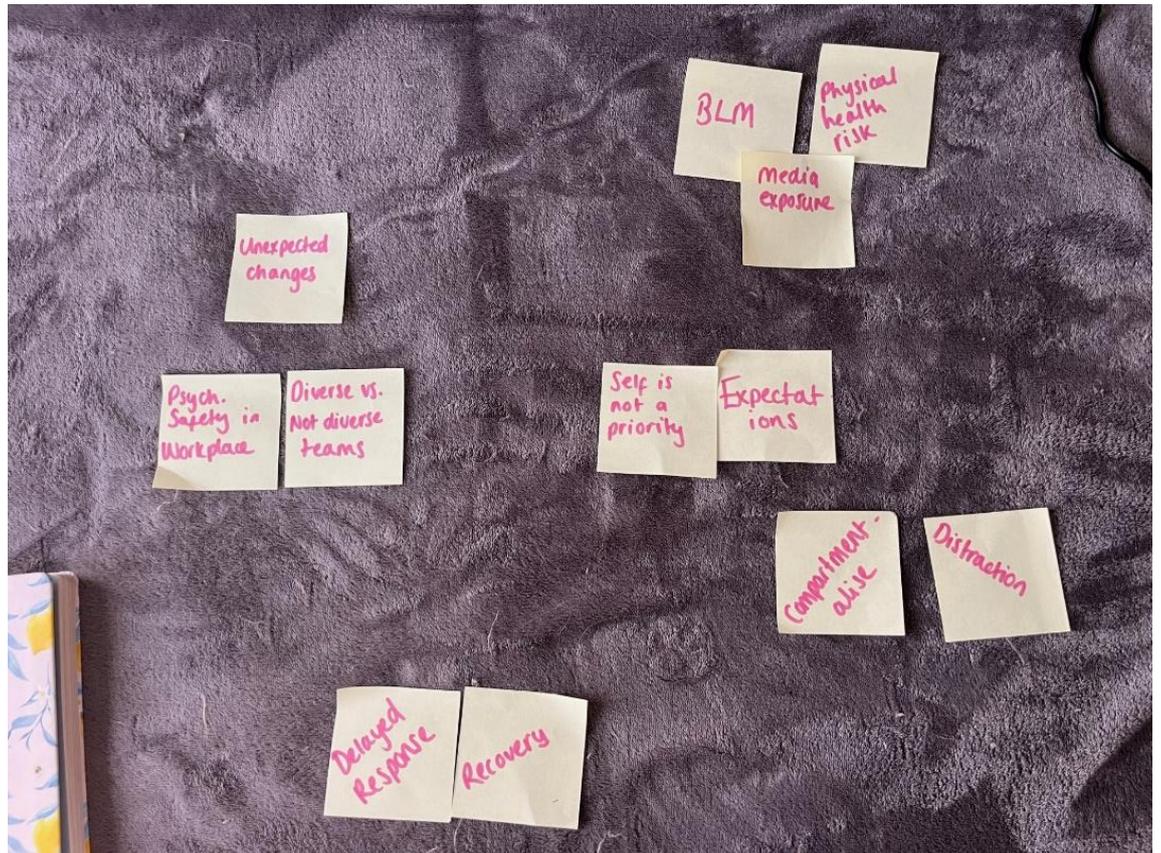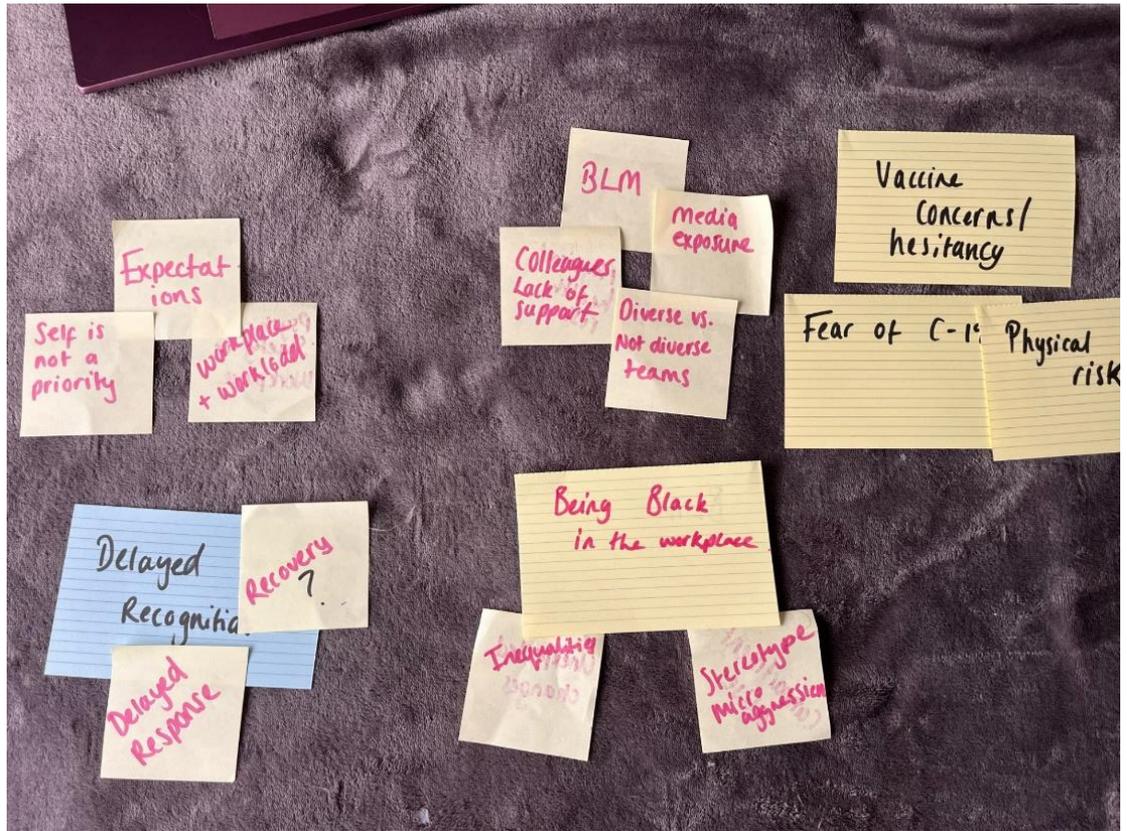
Example of memoing, reflecting on emerging theory and developing a theoretical framework

It seems that there are two main factors which characterise participants experiences of working throughout the pandemic. The BLM prominence and pandemic seem to occur in parallel whilst also interlinking in some parts e.g. hypervigilance of race at work, navigating conversations with colleagues and clients, experiencing microaggressions. I am beginning to reflect on whether a dual process is occurring, like the dual-process model, where COVID-19 and BLM is parallel, interlaced by participants awareness of workplace dynamics emerging or their awareness becoming more heightened as a result. Is this process maintained by cultural, workplace pressures to keep going and if so, do these pressures reinforce themselves because of their similarities e.g. mirror each other?
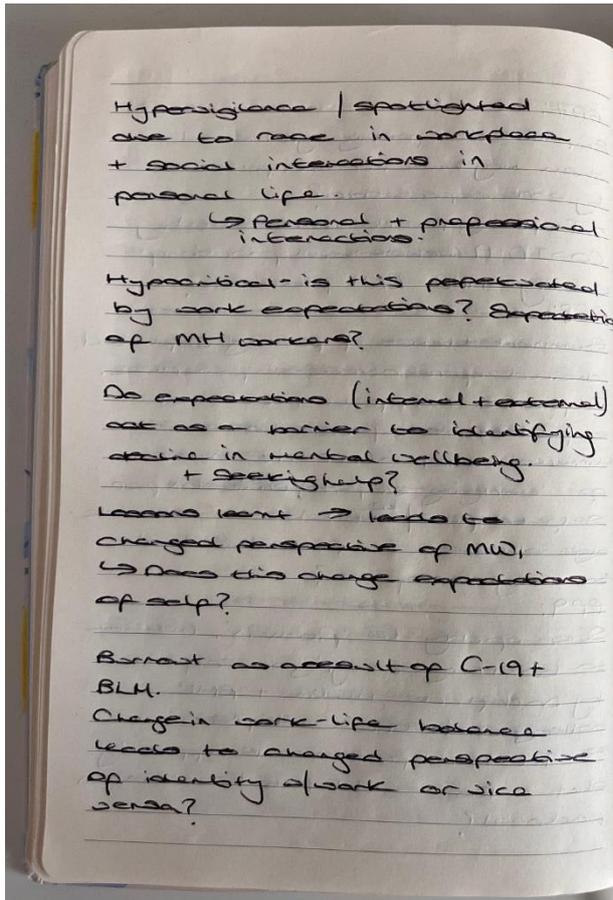
Hypervigilance/spotlighted due to race in workplace and social interactions in personal life – personal and professional interactions

Hypocritical – it this perpetuated by workplace expectations?
Expectations of mental health workers

Do expectations (internal or external) act as a barrier to identifying decline in mental wellbeing and seeking help?

Lessons learnt – leads to changed perspective of mental wellbeing – does this change expectations of self?

Burnout as a result of COVID-19 and BLM

Change in work-life balance leads to changed perspective of identity with work or vice versa?
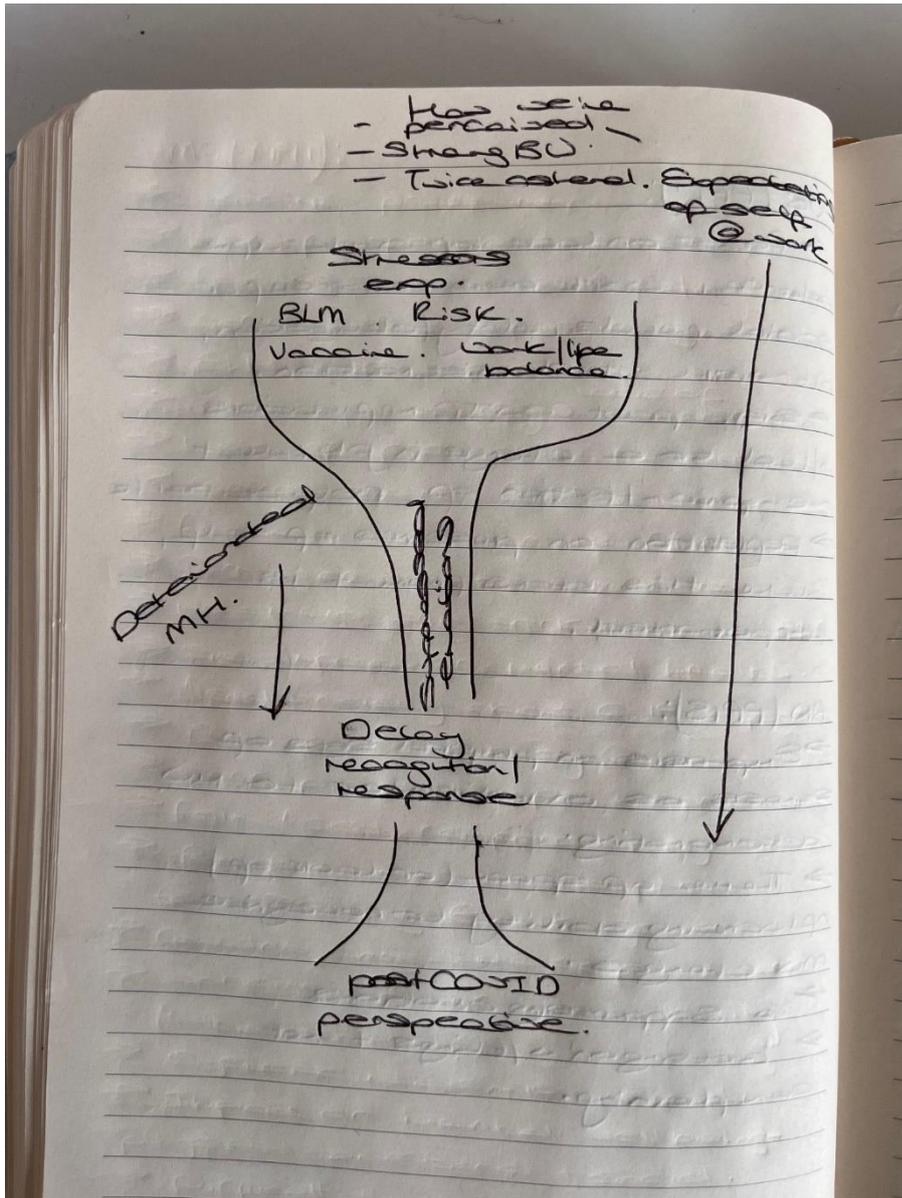
The following diagram highlights the outcome of theoretical coding whereby the relationship between categories were established and followed the processes described by participants. This stage involved organising categories to form the theoretical framework. The researcher concurred with participants on the processes which formed their experiences to inform the theoretical coding.

Appendix H

Ethical Approval Form

School of Health, Science and Wellbeing

ETHICAL APPROVAL FEEDBACK

Researcher name:	Leonie Royes
Title of Study:	SU_22_053 'Understanding Black mental health professionals' experiences of managing their mental wellbeing during the Covid-19 pandemic.'
Award Pathway:	PGR
Status of approval:	Approved

Your project **proposal has been approved** by the Ethics Panel and you may commence the implementation phase of your study. You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal. This approval is only valid for as long as you are registered as a student at the University.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics BlackBoard site.

The Ethics Committee wish you well with your research.

Signed: *[signature]*   Date: 08.02.2023

Dr Jade Elliott

Ethics Co-ordinator
Psychology
School of Health, Science and Wellbeing

Appendix I

Risk assessment and management protocol

Appendix VII: Risk Assessment **(University Research Ethics Committee)**

RESEARCH ETHICS RISK ASSESSMENT AND MANAGEMENT

Prior to completion, if there is any aspect of the risks or risk management process associated with your proposed research that you feel unsure about then it is **your responsibility** (as the researcher) to seek further guidance.

Identified Risks Identify the risks/hazards present	Likelihood High/Medium/Low	Potential Impact/Outcome Who might be harmed and how?	Risk Management/Mitigating Factors Evaluate the risks and decide on the precautions, e.g., Health & Safety
Travel risks to location of research project: • No travel required because it is an online study, interviews will be carried in home environments	Low	Researcher: • N/A	○ N/A
Mention of sensitive topics in the interview has potential to cause distress to participant.	Medium	Participant: • Psychological distress in relation to recalling potential trauma from experiences of working during the pandemic/the	• Clearly detail topic and content of questionnaires in information sheet • Participants will be encouraged to share experiences they

		impact it had on their wellbeing	feel comfortable with disclosing
			• If signs of distress present, participants will be asked if they wish to continue or choose to pause/end the interview
			• Verbal check-in to be provided following the interview recording ending
			• Participants will be signposted to relevant support services via. debrief sheet
Disclosure of information about poor practice	Medium	Immediate response may be required if disclosures about working environments, staffing/patients reported. This could include whistleblowing.	• Ensure all verbal and written information about research indicates possible researcher response to disclosure
			• Adhere to whistleblowing policies where necessary
Disclosure of unmet health or social care needs	Low	Immediate response may be required – including whistleblowing procedures	• Ensure all verbal and written information about research indicates the possibility of confidentiality breach if there is concern about the individual or others around them.
			• Ensure all verbal and written information about research

			indicates possible researcher response to disclosure
Research participant in danger of harm to self or others	Low	Immediate response may be required from service providers or emergency services	• Ensure all verbal and written information about research indicates the possibility of confidentiality breach if there is concern about the individual's risk to self or others • Ensure all verbal and written information about research indicates possible researcher response to indication of danger to self or others

Paper 3: Executive Summary

Understanding Black Mental Health Professionals' experiences of mental well-being during the COVID-19 pandemic

By Leonie Royes

Word count: 2723

What is an executive summary?

An executive summary provides an overview of a doctoral thesis research project. The aim of an executive summary is to present the research project and its findings in an understandable and concise way.

Who is the target audience?

- Mental health professionals, including Black mental health professionals (MHPs)
- Service managers and commissioners of mental health services
- Members of the public who wish to understand more about the impact of working throughout COVID-19 on the healthcare workforce

This summary has been read by relevant stakeholders in mental health services, Black MHPs, and members of the public who share an interest in understanding the impact of working throughout COVID-19 on the UK healthcare workforce.

Project Summary

- This research aimed to understand the experiences of Black MHPs and their mental well-being whilst working throughout the COVID-19 pandemic
- This research also explored how Black MHPs describe the impact of working during a pandemic and their response to their mental well-being
- A new theory of how Black MHPs mental well-being was significantly impacted whilst working during the COVID-19 pandemic was developed. This theory identifies the stressors they experienced whilst focusing on how their ethnic and racial identity influenced their responses to their mental well-being and experiences in the workplace during the pandemic.

Background Information

Healthcare workers during the COVID-19 pandemic experienced increased mental health difficulties due to pressures on healthcare services. Additionally, the COVID-19 pandemic significantly increased health inequalities experienced by individuals from racialised backgrounds. These health inequalities were particularly evident in the NHS workforce with employees from racialised backgrounds at a higher risk of dying from COVID-19. During this time, the Black population were exposed to racial trauma relating to the murder of George Floyd which increased awareness of the

Black Lives Matter movement. As a result, the Black community experienced multiple stressors relating to their health, racial and ethnic identity. Despite these inequalities, there is a lack of research exploring Black healthcare workers experiences during the COVID-19 pandemic.

The research project

What is Grounded Theory?

Grounded Theory is a qualitative research method which means that it aims to understand people's experiences and behaviour, rather than testing or measuring it with numbers. In Grounded Theory, the research aims to understand people's experiences (research participants) which contribute to developing a theory. The final theory represents the experiences of a group of people which the researcher has chosen to explore. This theory is then applied to others who have had similar experiences to the participants. For example, this research recruited participants who are Black MHPs, therefore, the theory aims to apply to Black MHPs experiences.

Aim

- To explore Black MHPs experiences of their mental well-being during the COVID-19 pandemic.
- To generate awareness of an underrepresented group in research regarding the COVID-19 pandemic.
- To develop a theory of Black MHPs experiences of their mental well-being throughout the COVID-19 pandemic.

Participants

Participants were MHPs who self-identified as Black or from Black heritage, this included people who were mental health nurses, clinical psychologists and psychiatrists.

Data collection & analysis

- People who were not participants during this research provided their opinions on the research recruitment poster and interview questions.
- Thirteen participants completed an individual interview which lasted around 1 hour.

- These interviews were transcribed, where participants answers were converted into written words.
- After each interview, the researcher analysed the transcripts for commonly occurring words and themes.
- This analysis informed how the researcher asked questions in the next set of interviews.
- Throughout this constant process, the researcher saw a theory begin to develop.
- The final theory was constructed and participants were invited to review whether this accurately represented their experiences.

Findings

A Grounded Theory of Black MHPs experiences of their mental well-being working during the COVID-19 pandemic

- All participants reflected on the relevance of their ethnic and racial identity
- Therefore, the Grounded Theory identifies that the social, political, and cultural context of Black MHPs impacted their experiences during the COVID-19 pandemic.
- This context relates to how cultural narratives of resilience, navigating racial stereotypes, and workplace inequalities contributed to an ongoing cycle which was increased by the COVID-19 pandemic through a number of stressors.
- These stressors included health, workplace, racial and political factors.
- Subsequently, cultural narratives of resilience were reinforced in the workplace due to increased workplace demands, with many experiencing a conflict between their expectations of themselves as a mental health professional and their coping behaviours.
- Health and racial inequalities were reinforced through awareness of the adverse effects of COVID-19 for ethnic minorities and the emergence of the BLM movement.
- Responses to these inequalities from peers and colleagues highlighted a lack of allyship and workplace support, reinforcing stereotypes of strength and inequality.

- The interaction of context and stressors led to a decline in mental well-being, forcing a change in perception of self-care.

The grounded theory is outlined below, the following section will explore each sub-section with quotes from participants to help illustrate the theory.

Figure 1

A theoretical model of categories highlighting Black MHP's experiences during the
COVID-19 pandemic
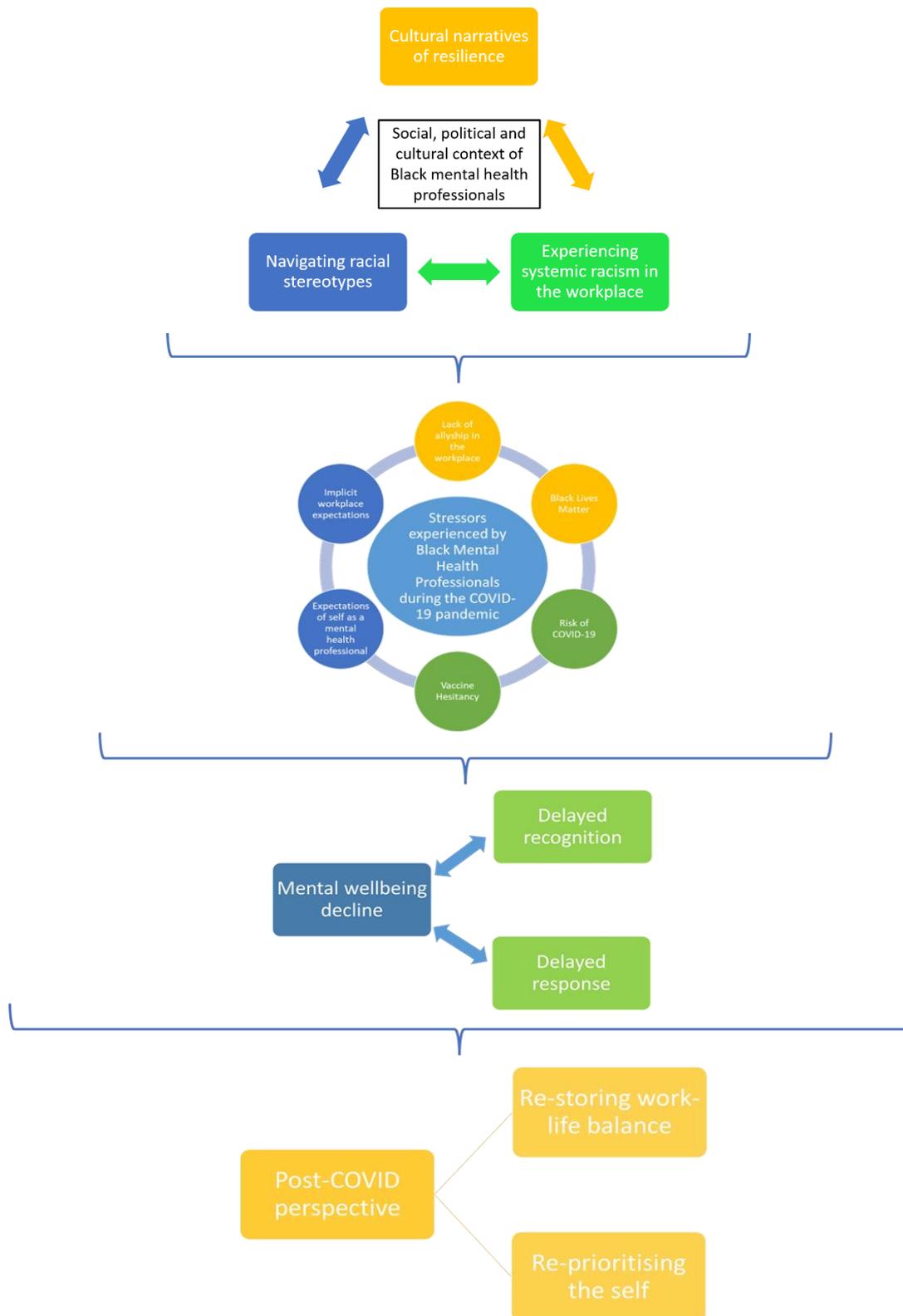
The social, cultural and political context of being a Black Mental Health professional

- Many participants related to the social, racial and political identity when talking about their experiences working during the COVID-19 pandemic.

- Participants identified how their racial and ethnic identity influenced their experiences with racial stereotypes, systemic racism in the workplace and cultural beliefs of resilience.

- This section of the model is referred to the social, cultural and political context of being a Black MHP. The arrows highlight how these factors influence each other.

Figure 2

The social, cultural and political context of being a Black mental health professionals

- Participants highlighted that they experience cultural norms and values which influence the idea of being resilient and working hard:

> *I think it kind of comes from how I've grown up and the idea of not really having the space to complain or air our frustrations, it's like you get on and just do it. But then also maybe that's also mirrored in the working environment that I'm also in as well*

- Participants also identified that they experience racial stereotypes which influences how people in the workplace view them:

> *I remember someone saying, "you're really resilient." I was like, what the hell does that mean? You know, why are you trying to suggest that kind of strong black woman thing? [...] I just felt like nobody really checked in…*

- Many also highlighted that they experience systemic racism in the workplace which means that they have to work harder than their colleagues to be recognised:

> *We don't have the same opportunities as everyone else and we know that, you know, to get that recognition, we've always got to work that little bit harder…*

Stressors experienced by Black MHPs

- Participants highlighted a number of stressors they experienced working throughout the pandemic, this included workplace, health, racial and political.
- Figure 3 shows how these factors are all linked and influenced each other.

Figure 3

Stressors experienced by Black mental health professionals during the COVID-19 pandemic
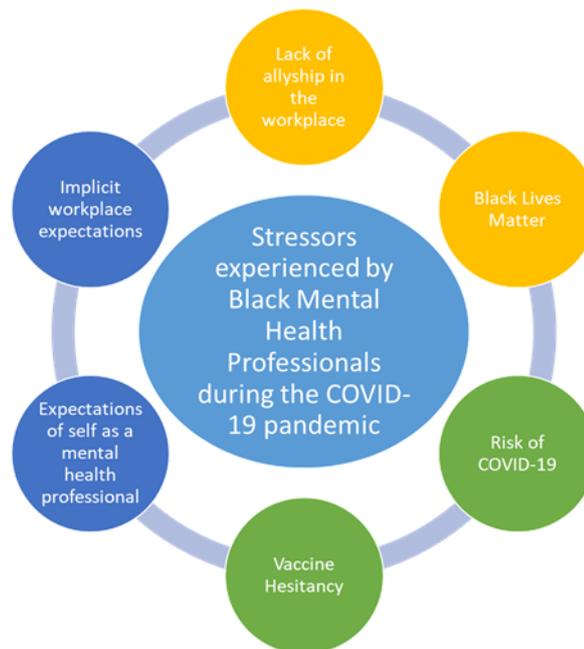
Racial and political stressors

- Black MHPs found the coverage of the murder of George Floyd distressing. Many highlighted that the response to the Black Lives Matter movement by their colleagues did not feel authentic. Black MHPs did not feel supported by colleagues or their workplace in response to the racial trauma they were experiencing, with acts of allyship perceived as ingenuinie. These factors impacted to their mental well-being.

> *I think in relation to the like BLM movement, I think mentally it was just very exhausting seeing it everywhere all the time…*

Health stressors

- Many participants identified the significant health risks they were exposed to working during the COVID-19 pandemic. Black MHPs identified that their health and increased risk of dying from COVID-19 was not taken seriously by their employers.

- Participants highlighted that they were sceptical about having the COVID-19 vaccine. This uncertainty caused stress for many, as they felt pressured to have the vaccine from their employers and colleagues.

You can't be playing with my health like this. Like you think I should die for the NHS?

I wouldn't have made that decision if I wasn't in that environment and felt pressured to do something [...] when I look back, I wish I never took the

Workplace stressors

- Black MHPs experienced increased expectations at work and felt that they could not ask for help from their managers or refuse to take on a higher workload as they were expected to carry on. Participants also felt that their expectations of themselves as MHPs had changed. They spoke of feeling hypocritical and guilty for not using coping skills which they were supporting their own clients to use.

It just made it feel quite difficult to say actually "this is all a bit too much" when they are very aware of the situation…

I remember sitting there telling people, if you wanna make sure that you're separating work from home, you need to stop being in your pyjamas - while sitting in my pyjamas. You need to make sure that you have a separate space away from your bedroom - whilst I was lying in bed…

Figure 5

The process of mental well-being declining
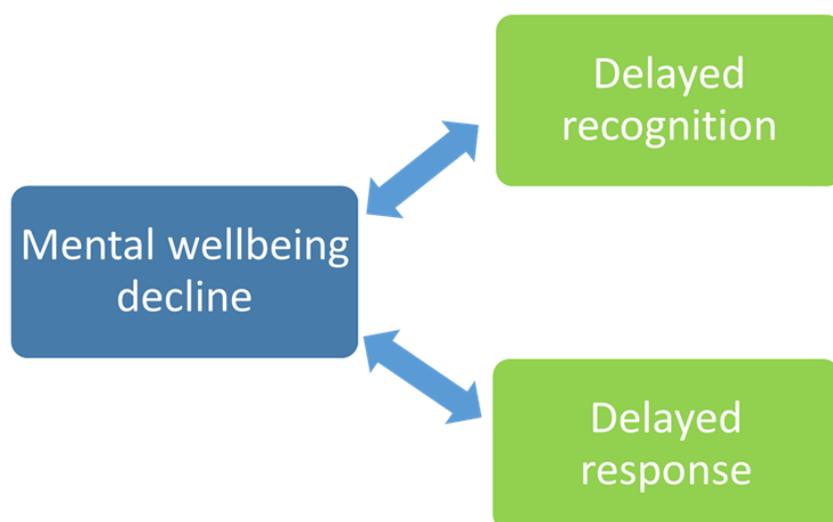
- Through talking about their experiences of working during the COVID-19 pandemic, participants realised that they had been experiencing stress and distress.

- Participants highlighted that they found it difficult to notice that their mental well-being was negatively impacted by the stressors they experienced. They also noted that they had a delayed response to the deterioration of their own mental well-being.

> *I think at the time I realised it was bad. Looking back, I realised just how bad it was and like I just felt it in my body like I felt really heavy…*

> *We are so focused on helping others that we come second, not an intentionally destructive way, but in a 'I'm trying to help others and so if I'm trying to do that whilst the world seems to be on fire, I can't really be thinking about myself as well*

Post-COVID perspective

Figure 6

Black MHP's perspective of mental well-being following the pandemic
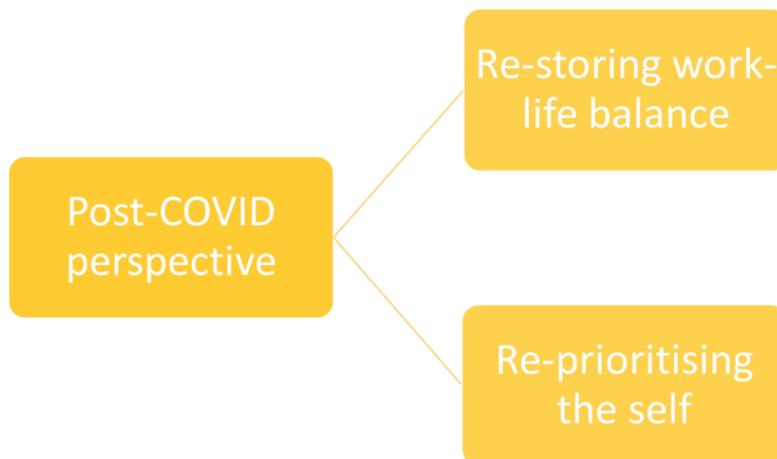
- Black MHPs identified that since the COVID-19 they have experienced a shift in how they view themselves and their work, this has been named as the 'Post-COVID perspective'.
- The Post-COVID perspective highlights how participants identified a transition in the awareness of their mental well-being and the importance of putting their needs (mental and physical) first.
- This included choosing to prioritise their own needs before their job demands, not working out of hours and understanding the consequences of not prioritising their mental well-being.

COVID taught me that you have to look after your mental well-being when you're mentally well, like continue working on it

I try not to work as hard. It's just like a weird thing to say, but I just-I can't come and die"

- This suggests a shift in the way different cultures think about cultural resilience and seeing a move towards giving permission to acknowledge when their mental well-being is impacted and responding to it effectively.

Discussion

- The research illustrates the multi-layered experience for Black MHPs working during the COVID-19 pandemic and the impact this had on their mental well-being.

- The findings also highlight how their social, cultural and political contexts (which was heightened by a number of stressors) contributed to a delayed recognition of and response to their mental well-being getting worse.

- Through reflecting on their experiences during the COVID-19 pandemic, Black MHPs identified a shift in perspective which sees many re-prioritising themselves and seeking to achieve a healthy work-life balance. This is different to the cultural beliefs of resilience. As a result, the research highlights a potential shift in cultural views around mental health, well-being and resilience.

- As there is a lack of research exploring the experiences of Black MHPs during the COVID-19 pandemic, the findings provide an overview on an underrepresented group within research.

- The findings supports conclusions from previous research which suggest that Black healthcare workers experienced a "pandemic on a pandemic" during the COVID-19 pandemic where they encountered and interaction of increased racial trauma and health inequalities which added to further distress.

- The findings also support research of healthcare workers during the COVID-19 pandemic who reported symptoms of anxiety and depression whilst experiencing a lack of support from employers and managers.

- Furthermore, findings mirror those from research suggesting that healthcare workers experienced a fear of being infected with COVID-19 and vaccine hesitancy.

- The delayed recognition and response to mental well-being declining has also been identified in the literature as an unhelpful coping strategy used by many healthcare workers during the COVID-19 pandemic.

Recommendations and dissemination of findings

- Service managers and commissioners should implement further equality, diversity and inclusivity (EDI) initiative to support employees from racialised backgrounds.
- Staff well-being initiatives should acknowledge the importance of EDI when supporting staff in the face of a health, political or social crisis.
- This research explores the experiences of those who identify as Black African, Caribbean or mixed heritage. This does not account for those from other racialised backgrounds. Therefore, it is recommended that future projects should endeavour to diversify the populations they research to influence literature which is representative of the UK healthcare workforce.
- Future research should explore the experiences of other racialised groups to identify an individualised approach to supporting staff well-being in the face of health, social and political stressors.
- The research findings will be shared with participants. A copy of the research thesis will be uploaded to EThOS which is an online library of doctoral thesis research projects. Finally, the research will also be submitted to an academic journal in the hopes of being published.

Limitations of research

- There is a lack of gender diversity within the sample of participants recruited which may limit the extent to which findings account for the experiences of Black male MHPs.
- As this is a UK-based research project, the findings are only applicable to UK-based Black MHPs and countries with public health care provision.
- Finally, it is important to consider whether the findings concerning Black MHPs' experiences are different to White MHPs as research highlights healthcare workers experienced similar stressors including fear of COVID-19 and infecting relatives, increased workload, lack of managerial support and unhelpful coping strategies.

Conclusion

Managing mental well-being throughout the COVID-19 pandemic was a difficult and complex experience for Black MHPs. With health, workplace and racial inequalities

heightened by the COVID-19 pandemic, Black MHPs experienced a 'pandemic on a pandemic' reinforcing their social, cultural, and political context. This reinforced pre-existing cultural narratives of resilience, which influenced a delayed recognition and response to declining mental well-being. Through identifying these experiences, Black MHPs acknowledge a shift in perspective, highlighting the importance of prioritising their needs over their occupation. Additionally, participants highlighted the lack of workplace support and allyship they had during the pandemic which heightened distress. The findings indicate a requirement for staff well-being initiatives to be informed by EDI principles when supporting racialised staff members in the face of a health, social, or political crisis.

Reading List

Kabasinguzi, I., Ali, N., & Ochepo, P. (2023). Mental health experiences and coping strategies of BAME care workers who worked in nursing and residential care homes during the COVID-19 pandemic in Luton, England. *BMC Public Health*, *23*(1), 592. https://doi.org/10.1186/s12889-023-15423-2

Kursumovic, E., Lennane, S., & Cook, T. (2020, April 22). *Exclusive: deaths of NHS staff from covid-19 analysed*. Health Service Journal. https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article

Laurencin, C. T., & Walker, J. M. (2020). A pandemic on a pandemic: Racism and COVID-19 in blacks. *Cell Systems*, *11*(1), 9–10. https://doi.org/10.1016/j.cels.2020.07.002

Miu, A. S., & Moore, J. R. (2021). Behind the masks: Experiences of mental health practitioners of color during the COVID-19 pandemic. *Academic Psychiatry: The Journal of the American Association of Directors of Psychiatric Residency*

Training and the Association for Academic Psychiatry, *45*(5), 539–544.

https://doi.org/10.1007/s40596-021-01427-w

Proto, E., & Quintana-Domeque, C. (2020). Covid-19 and mental health deterioration among bame groups in the UK. *SSRN Electronic Journal*. https://doi.org/10.2139/ssrn.3660249