**Recollections of managing the health of migrants in a blue-collar workplace.**

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It is estimated that 825,000 migrants work in the UK (ONS, 2016); of these 76.4% come from the European Union. Migrants though often highly skilled, work in ‘low skilled work’ such as process operative work in manufacturing, domestic services, hospitality, elementary construction and labouring roles (National Migration Observatory, 2015). It is generally understood that initially these documented economic migrants are healthy upon arrival (Rechel *et al.,* 2013). However, a combination of social and economic disadvantage including employment type, are confounding factors that specifically affect them (Robinson and Reeve, 2006). These aspects become determinants of health, which in the longer term have a negative outcome on health and wellbeing throughout the life-course (Marmot *et al.,* 2012) of migrants. The purpose of this article is to highlight a range of health factors that potentially affect such employees and to consider the role of the occupational health professional in managing these issues. It is written from the perspective of an OH nurse with experience of providing OH support for a predominantly migrant workforce.

Rechel and colleagues (2013) cite evidence indicating that occupational exposures are an important factor specifically affecting migrants’ health and wellbeing. The author’s own experience is that those working in blue-collar workplaces face particular challenges, which include physical, psychological and emotional injury at work. To illustrate with an example; language barriers affect personal relationships with colleagues, understanding of safety briefings, influence psychosocial workplace engagement negatively and can result in undetected bullying, where team leaders and managers speak a different language to their teams. Furthermore, migrants are often willing to do the work that others will not, rendering them vulnerable to a range of stresses (Weishaar, 2008), sometimes injury through taking risks to get the job done (HSE, 2007), and potential exploitation (Janta *et al*., 2011). Furthermore, employees working in low-skilled work often receive low pay with limited or no sick pay. This increases the likelihood that they will present for work even when they are not well enough to do so (Williams, 2013).

Though documented migrants tend to have good health at the point of arrival, when they become unwell, in the author’s experience, they don’t necessarily access healthcare services to address their health need, including sexual health. In England anyone can register with a GP and does not need to be ‘ordinarily resident’ to have access to a consultation without charge (NHS England, 2015). The recent Immigration Act (2014) affected who can access NHS healthcare and secondary services. For those living, working and paying taxes in the UK as residents, the NHS in England is available without charge at point of use. However, anecdotal evidence and a Kings Fund report (2015) suggests that migrants don’t always access these services as much as their UK counterparts. Cultural and language barriers may be a prime contributing factor (Hargreaves *et al.*, 2006). Additionally, a small-scale UK study identified that the experience of being a migrant in a waiting room can be intimidating (Franks *et al.,* 2007), especially for those experiencing mental health difficulties. Consequently migrants, who might also personally experience negative cultural attitudes to their mental ill health, are likely to avoid seeking help.

Employees who are not registered with a GP and who speak poor English have a number of innovative but not necessarily effective coping strategies. In the author’s observations of a large migrant workforce, self-medication using illicit drugs, alcohol, traditional remedies and remedies purchased from the Internet, as well as overdosing on analgesics and opioids, appeared to be common practice within the manufacturing site. Furthermore, the sharing of medication on the production line hospitalised one employee with the side effects of cardiac medication she would otherwise not have needed. An additional public health challenge observed in this particular setting is the practice of antibiotics being purchased abroad and returned to the UK. These antibiotics appeared to be medicating a range of ailments in some of the workforce, though the ailments did not necessarily appear to be microbial in nature. Obviously, side-effects notwithstanding, this practice is a potential contributor in the challenge of rising antimicrobial resistance across the globe (Kelesidis *et al.,* 2007; PHE, 2016). The other obvious concern is that these drugs, much like some of the cigarettes observed in that particular workplace, could be counterfeit and potentially harmful (Blackstone *et al.,* 2014; MHRA, 2015).

The author recollects that the local A&E units appeared to bear the brunt of the employees not registered with a GP. The use of emergency rooms seemed to result when ignored minor conditions or pain deteriorated to such an extent that the employee could no longer cope. Employees often reported that they would prefer to have minor health problems assessed and addressed in the country of origin, where they understood how the local health system operated, how to access it and where they spoke the language fluently in order to understand how to manage any condition.

Thus far this article has perhaps painted a rather negative light on migrant employees in low skilled work, yet they deserve greater understanding; for they provide deep insights into the bigger challenges that they have to overcome. Underuse of employees’ skills is recognised to be a contributory factor to stress; this has been observed in migrants, particularly those who previously worked as skilled or professional employees prior to migration (Reid, 2012). Furthermore, some appear to experience a loss of cultural and personal identity occasionally coupled with a loss of status (for example previously training and working in a role such as nurse or teacher), resulting in subsequent low self-worth or cultural bereavement. The loss of social and support networks can be challenging or isolating, particularly onerous when migrant employees become unwell or have young children or others to care for. Some employees may bear a double burden, in that they are required to do both paid work and also be the primary provider to the household chores and care giver to children and family members (Habib and Fathalla, 2012). Transition to life in the UK, can be challenging beyond cultural difference and language barriers. Some migrants report feeling isolation having left families behind to come to UK to work; they may develop negative coping strategies such as increased alcohol and tobacco use (Carballo et al. 2008).

In the author’s experience low-paid work and zero hours contracts means that some staff may hold more than one job to be certain that they can afford to survive. This potentially results in employees working one shift, before heading straight to another. Many of these employees will have travelled a distance to reach work. They travel because affordable housing isn’t always in the neighbourhood of their work. They sometimes skip meals because they want to make sure that their children eat or bills can be paid. Whilst a number of these factors apply to all employees in low-paid work, when coupled with aggravating factors such as an inability to communicate, loss of social capital, loss of identity, low self-worth or complex migration histories (e.g. escaping war or torture), it is argued that these employees are rendered extremely vulnerable. Employees may also experience feelings of helplessness or guilt when negative events (e.g. war) continue, when they are bereaved, or a natural disaster strikes in their home country (Raphaely and O’Moore, 2010).

Anecdotally, low-paid employees may be living in areas where there is increased crime. Anxiety may rise through fear of crime. Whilst working with a large migrant workforce there were three occasions where employees were assaulted, sustained serious head injuries and robbed in the town where they lived. Each sustained substantial injury, one was hospitalised and experienced complications, associated with that type of injury. A wider group experienced fear and anxiety. Furthermore, throughout July and August 2016, the UK media have reported an increase in hate crimes and crimes against migrants since the referendum result to leave the EU. Again this highlights additional vulnerabilities and stressors that affect the physical and mental wellbeing of migrant workers.

The aspects described above begin to highlight the extended challenge for managing good health and wellbeing of employees. Yet the consequence of these external factors and wider determinants on individual health is further compounded by the biggest of the public health challenges to be overcome in the UK, that of non-communicable diseases (Fenton, 2016). In an environment where work is predominantly sedentary and cultural normative behaviours include smoking tobacco, drinking strong caffeinated drinks or energy drinks, as well as eating carbohydrate and sugar-rich foods, the provision of opportunities to encourage lifestyle adaptions and behaviour change, might seem overwhelming for the occupational health professional.

In order to address the health of employees, in the broadest context, it is recommended that a psychosocial approach be adopted. This means taking a social history from the employee, thinking about how their thinking and behaviours might be influenced by social aspects and vice versa. Take time to build a rapport, use empathy, and develop understanding and insights into the challenges of their lives. This understanding can help the practitioner build a picture, which may be invaluable when doing health assessment but also develops a professional relationship of trust. In the author’s experience this approach also aided the cessation of human trafficking and slavery in one organisation.

Additional strategies for the OH advisor working with migrants in low-skilled work include the following;

**Communication**

* Be patient when communicating. Learn a few key words in the employee’s language such as hello, goodbye and thank you.
* Find out whether there are translation services available, to enable you to conduct the interview. Be aware that sometimes employees bring their children to communicate on their behalf; remember that many work sites aren’t safe places for children to be. Children might also inhibit or misinterpret what information the employee gives you.
* Ensure that if an employee brings a colleague from the workplace to translate on their behalf, that they are willing to openly discuss their health in front of them.
* Use leadership to make a business case for English for speakers of other languages (ESOL) courses; it assists safety briefings, retention and productivity (HSE, 2016)
* Try to avoid using Google Translate as this can lengthen consultations and leave both parties very confused.
* Arrange to have key documents translated into the key languages
* Be confident to refuse to undertake the assessment until suitable arrangements have been put in place to ensure that you and the employee understand each other.

**Assessment and referral**

* Equip yourself with a range of skills – advocacy, objectivity, empowering language, awareness, empathy and sensitivity.
* Acknowledge employees’ survival skills and resilience; focus on the positives rather than negatives. Acknowledge their cultural bereavement.
* Be aware of exposures from poor social environment e.g. aspergillus fungus in housing, or living in housing of multiple occupation.
* Be aware of environmental and occupational exposures from life before the UK.
* Develop deeper understanding of particular health issues affecting specific groups e.g. some eastern Europeans have increased thyroid cancers due to the Chernobyl incident, helminth infections such as hydatid disease are noted in the Middle East.
* Be aware that medication taken by the employee may not have been issued by a doctor or pharmacist.
* Be aware of the influence that culture, faith and religion may have on health beliefs; be sensitive to this.
* Signpost services e.g. cultural cafes and support networks
* Assist access to healthcare services; if necessary work with local GP’s and CCG’s to ensure that suitable services exist for your staff.
* Don’t expect migrant employees to have health literacy of things we take for granted e.g. smoking is harmful to health

**Working with employers**

* Influence management to invest in translators, ensure that key services such as EAPs are accessible and promoted in the key languages used on site.
* Provide culturally appropriate meals – do promote healthy eating and recognise when employees may fast for religious beliefs
* Don’t assume that all employees from the same country are a community or willing to assist
* Highlight behaviours that implicitly create difference or discriminate e.g. written recruitment opportunities or health and safety briefings, only offered in English language. By doing this you ensure that English speakers with low literacy also have opportunities afforded to them.

**Sources of information**

* The HSE webpage for migrant workers <http://www.hse.gov.uk/migrantworkers/index.htm>
* Migrant Help <http://www.migranthelpuk.org/>
* Unison provide leaflets in a range of languages about worker rights and responsibilities in UK <https://www.unison.org.uk/get-help/knowledge/vulnerable-workers/migrant-workers/>

Understandably, in the modern context of OH provision, this process can be difficult where time and communication are both limited and where the OH practitioner is not necessarily employed within the organisation. Furthermore, migrant populations can also be transient, creating a high turnover in the workforce, which as many OH practitioners know can be a symptom of organisational culture, or that better paid work is available elsewhere. In general be patient, observe workforce trends, avoid jumping to conclusions and use critical self-questioning to understand whether you are noticing specific behaviours or patterns. Act on your findings and talk to the employer, highlighting some of the specific challenges that migrant staff face. Give objective, evidenced, creative and low-cost solutions to help address the challenges and ensure continuing fitness to work.

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