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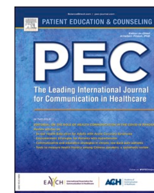

Communicating effectively with inclusion health populations: 2022 ICCH symposium

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ABSTRACT

Objective: To describe communication strategies for clinical practice that allow practitioners to work more effectively with marginalised population groups and to discuss how to incorporate these into medical practice.
Methods: Active practitioners working in inclusion health and people with lived experience of homelessness and the asylum-seeking process shared their perspectives in the symposium at the 2022 International Conference on Communication in Healthcare (ICCH) and a subsequent conference on empathy in healthcare. The views of attendees were sought.
Symposium Discussion: We describe the perspectives shared at the symposia under two main themes: communication needs in people experiencing homelessness and migrant populations, and trauma-informed practice.
Conclusions: People experiencing homelessness have more communication challenges compared to the general adult population. Migrant, refugee, and asylum-seeking populations also face the complexity of negotiating unfamiliar healthcare, legal and social systems with the added burden of language barriers. Trauma-informed practice provides a useful framework that can improve communication with these groups.

1. Introduction

At the 2022 International Conference on Communication in Healthcare (ICCH), a symposium was held to explore communication strategies that allow practitioners to work more effectively with socially excluded population groups and to discuss how to incorporate these into practice. The symposium was also presented at a subsequent conference on empathy in healthcare and the input of that audience was also considered in the preparation of this paper [1].

Inclusion health includes any population group that is marginalised and socially excluded. Marginalisation has been defined as, "the position of individuals, groups or populations outside of mainstream society"[2]. These groups can include people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery, but can also include other socially excluded groups [3]. Cheraghi-Sohi et al. found that marginalisation deprives people of a voice and influence on health policy which leads to gaps in health services to meet their needs. Additionally, there may be health impairment or personal contexts that lead to stigma or discrimination against individuals [4]. Communication with patients in inclusion healthcare requires a different approach to that usually adopted in mainstream practice. Whilst there are similarities in the communication issues facing all marginalised groups, it is important to remember that there are likely to be different lived experiences both between and within these groups. Healthcare providers must be sensitive to these differences while considering the common cultural and structural barriers that can interfere with effective communication. People experiencing homelessness have been shown to have more communication difficulties than the general population, creating significant barriers that prevent access to healthcare [5,6]. People who are asylum seekers, refugees or migrants may have additional language communication needs and may have experienced psychological trauma in their country of origin, on their journey and in their host country [7–10]. In mainstream practice, professionals are likely to encounter people from a range of these backgrounds. An empathic, culturally appropriate and

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trauma-informed approach provides a useful framework to enable practitioners to consult effectively with patients from marginalised groups [11,12].

2. Methods

Presenters for the symposium were selected to give an expert view on the two main themes: communication needs in people experiencing homelessness and migrant populations, and how trauma-informed practice can improve communication with these groups. The symposium was chaired by a UK-based inclusion health General Practitioner (GP) with experience in healthcare communication skills education. The panel was made up of a speech and language therapist working with rough sleepers and hostel dwellers; a GP working in an ethnically diverse area reducing health inequalities for those who seek asylum or are refugees, and an Inclusion Health GP and academic who delivers undergraduate and postgraduate teaching on the use of trauma-informed practice as well as using it in her practice. Experts by experience were represented on the panel by two local people – Derek Holliday who has lived with homelessness and Nesrine Labsi who has lived experience of the asylum process and who now works as an interpreter.

The symposium was delivered over 90 min. Each panellist spoke on their area of expertise, followed by the thoughts of the experts by experience. A discussion then took place with members of the audience, who shared examples from their practice.

3. Symposium discussion

3.1. Communication difficulties faced by people experiencing homelessness and migrant populations

In 2022, the National Institute for Health and Care Excellence (NICE) in the UK produced national guidance for health and care professionals working with people experiencing homelessness [13]. The guidance specifically highlighted the importance of using appropriate language and addressing individual communication needs.

The range of health and social challenges faced by people experiencing homelessness is considerable. Mental illness, autistic traits, brain injury, and care and prison experiences are over-represented in homeless populations in the UK [5, 14, 15]. Each of these conditions and circumstances are associated with communication difficulties [16–19] and may explain the higher rate of speech, language and communication needs amongst this population [5]. Pluck et al. hypothesised that acquired brain injury and developmental language disorder may account for differences in understanding and expression between people experiencing homelessness and those who have not been homeless from similar socio-economic backgrounds [20].

Whilst communication difficulties can be caused by brain injury, illness or neuro-developmental differences, social circumstances also play a role. In a systematic review conducted by Luchenski et al., it was found that people experiencing homelessness faced communication barriers related to language differences and feeling stigmatised when attempting to access healthcare [6]. Wen et al. explored whether people experiencing homelessness felt welcome or unwelcome in healthcare settings [21]. Participants commented that they felt discriminated against based on their housing situation and social class and this manifested as healthcare providers not listening and not wanting to talk to people experiencing homelessness who needed care. These experiences are of particular concern considering the extreme health inequalities experienced by homeless populations and the evidence that a third of deaths of people experiencing homelessness are from conditions amenable to treatment [15,22].

Derek has lived experience of homelessness and is now involved in educating medical students on the challenges facing marginalised populations. He joined the symposium to share his first-hand experiences of communicating with professionals. He recognised the discrimination and stigmatisation described above. This particularly had an impact on him when he sought support from the Benefits Agency in the UK. An aggressive and unwelcoming response contributed to him disengaging from care and sleeping rough for 2 years.

Considering the particular issues facing migrants, a 2018 UCL-Lancet Commission on Migration and health demonstrated the disproportionate health, social and economic burdens of forced migration [23]. In addition to any long-standing illness or disabilities, and increased rates of mental illness and complex health problems, asylum seekers and refugees often face discrimination and exclusion from healthcare in their country of settlement [23]. The loss of familiar culture and support networks, existing health profiles, disease prevalence in the country of origin, cultural health beliefs and values, the competing priorities of the asylum system and health policies in their country of settlement all impact the way that asylum seekers and refugees recognise, navigate and access healthcare [23–25]. Context, experience and culture have an impact on how patient-provider communication is interpreted [26]. Asylum seekers and refugees are a heterogeneous group - everyone's journey will have been different. However, they are all likely to have experienced trauma in multiple, different, and compounding ways [27, 28]. There may be trauma from the circumstances of having to leave their home country, and grief for who and what they have left behind or lost. Their journey can be dangerous, degrading, and often life-threatening. Trauma and stress can be further triggered by hostility and instability within the host country's asylum system [29,30]. Migrants can be unfairly labelled as "hard to reach" when it comes to patient-provider communication, leading to linguistic and cultural barriers not being adequately addressed [31]. In addition, racism and discrimination have been shown to lead to negative health outcomes during the pandemic and beyond [32]. Hostility in the media and negative political discourse and legislation towards asylum seekers and refugees, can further compound trauma and undermine practitioners' and individuals' understanding of entitlement [33–35]. Asylum seekers can face destitution and detention at various points in their journey. In 2019, it was found that 29% of destitute households in the UK were headed by a migrant to the UK, 10% of whom identified as an asylum seeker [36].

We know that health outcomes are improved by effective patient-provider communication [37] and effective communication in healthcare is a high priority for patients [38]. Examples of strategies that healthcare providers can use to support the communication needs of people experiencing homelessness were presented during the symposium and are summarised in Table 1.

3.2. Trauma-informed practice

3.2.1. What is psychologically trauma informed practice and why use it?

Psychologically Trauma Informed Practice (TIP) is defined as a model that is grounded in and directed by a complete understanding of how trauma exposure affects service user's neurological, biological, psychological, and social development. How this is enacted in clinical practice is based on the principles of safety, trustworthiness, choice, collaboration and empowerment [39]. The following examples of the use of TIP are based on the presenter's (AEW) experience of working for many years in a range of inclusion health settings and developing practical tips for using TIP in short clinical consultations. Professionals often feel paralysed or overwhelmed when considering how to work effectively in these settings, given the range of circumstances, health needs and complexities that can be encountered [40]. Using psychologically trauma-informed practice approaches helps address that - patients can respond productively, feel safe and function better in their contact with healthcare professionals [11]. The healthcare provider is more likely to have a better understanding of what might be going on with the patient so will waste less emotional energy getting angry, frustrated, or upset when consultations don't go well, or the patient does not do what is expected.

Table 1
Strategies to support communication with people experiencing homelessness.

Communication area	Strategy	Rationale
Verbal memory and attention	Reduce 'small talk'	Discarding unnecessary 'small talk' reduces verbal memory load so that a person can focus their attention on key matters in consultation.
Processing speed	Slow down	Speaking at a slower pace with pauses between sentences provides more time for a person to process and understand the information given in a consultation
Concentration and memory	Focus on one or two subjects	A person may feel overwhelmed by a long list of subjects, lose concentration and forget some aspects of the conversation
Attention, understanding and expression	Reduce distractions	A person may 'lose their train of thought' when distracted by interruptions, external noise etc. Consequently, they may not fully understand or ask all their questions in the consultation
Understanding and memory	Use pictures and keywords	These visual reminders can help a person sustain meaning or facts during a discussion. This can support their understanding of the subject and the expression of their views

TIP is a way of working with people with complex trauma that is therapeutic; however, it is not therapy nor is it time-consuming (often a fear healthcare providers have about psychologically orientated modalities). Most professionals are practising elements of TIP already - as patient-centred care; however, when a person's presentation at the health care reception desk or in the consultation room is complex or challenging, that's when the "wheels can come off" and professionals can resort to trying to over-control what happens or leak negative or judgemental responses.

What do we mean by "complex trauma"? This is the consequence of repeated traumatic events which affect a person's ability to function; sometimes in specific situations, permeating all of their life [41]. In these scenarios, the patient's mind can go into "survival mode" and it is important to reassure patients that this response is not a sign of mental illness [42]. A key factor to consider is that there is a "window of tolerance" for patients, where emotions are bearable. Moving out of this window can lead to hyper-arousal, manifesting as a patient who is upset, angry or impulsive. Alternatively, patients can become hypo-aroused, retreat to a position of dissociation to stay safe and seem not present or withdrawn [43]. In both cases, patients will be unable to engage effectively in a consultation. It can be useful to ask the question of yourself (as used in cognitive behavioural therapy) - "how does having a complex trauma background make a person think, feel and behave?". Using simple grounding techniques can help bring the patient back to their window of tolerance and can be helpful in consultations as well as something tangible for them to use in everyday life. This may be offering and focusing on a drink of water, focusing on their feet on the floor, or focusing on breathing for example.

3.2.2. When is it important to use trauma informed practice?

Trauma-informed practice provides a useful framework for all inclusion healthcare consultations. The following presentations in mainstream clinical practice should also alert a healthcare provider to the possibility of complex trauma:

- Mental health presentations.
- Social crises.
- Problem substance-use presentations.
- Repeated mental health concerns where resolution is challenging (for the patient and clinician).
- Feeling overwhelmed/very challenged by a patient's presentation (no matter the focus).
- Patients who are quick to exhibit negative emotions with any member of the practice team.
- Missingness from care- not doing what's expected, not managing to take up offers of support/treatment, or not managing preventative or health-promoting activity [44–46].

3.2.3. How to practice trauma informed practice

The environment in which care is delivered is important and should be given special attention for these patient groups. Waiting areas should be calm, and welcoming, signage positive, and should include a discrete space for people who find the waiting room difficult. A positive attitude of all staff towards all patients including receptionists is vital, for example, introducing themselves to all patients with "My name is. How can I help you today?". This needs to be backed up by non-verbal communication and the environment to ensure authenticity. It can be useful to add an alert to the patient's record so that when patients arrive for an appointment, they are offered a quiet space to wait. All healthcare staff must be aware of the legal definitions of different migrant groups (see Fig. 1), and the rights and entitlements of these different groups to healthcare, to avoid stereotyping, judgements, or unnecessary barriers to registering with a health service or making an appointment.

Appointment systems also play a role - particularly the timing of appointments, who gatekeeps them and how this is managed. Consideration should be given to how patients are followed up, who gets discharged and what policies are in place for patients who do not attend. Policies should be trauma-informed and include flexibility for those patients who may struggle to navigate traditional health systems. Individuals who are new to the country will need support in developing health literacy and empowerment in navigating the local healthcare system.

Attendees at both symposia raised the difficulties of dealing with these challenges in the limited time of clinical consultations. It is important to acknowledge that extra time is required in such consultations, especially if an interpreter is required. This may be made more achievable by booking appointments at the end of a clinic. Newly arrived asylum seekers are likely to have not received routine healthcare recently and time needs to be allowed to resolve any issues relating to this. Continuity in care can be helpful to build trust and avoid having to repeat traumatic history. All inclusion health populations need to be provided clear information about details such as timescales for referral and how to get to healthcare centres and hospitals. Difficulties with communication can have a "domino effect", obstructing what would normally be seen as basic tasks – booking a taxi, taking public transport, and attending appointments [47]. Access, digital literacy, or language

An asylum seeker is defined as:

A person who has left their country of origin and formally applied for asylum in another country but whose application has not yet been concluded.
Refugee Council 2020

When an asylum seeker's application has been concluded favourably, they are given refugee status.

A refugee is defined as:

A person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such a fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside of the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.
United Nations Convention 1951

Fig. 1. Definition of Asylum Seekers and Refugees:.

barriers may mean that the current consultation is the only opportunity a patient may have to clarify these details. Patient information in written formats should be organised, clear, and in positive language. For example, the content and appearance of information boards in waiting rooms should signal strongly what is important to that caregiving environment. The same principles should also apply to letters, texts or emails sent to patients. Any written posters or leaflets should be available in multiple languages.

It is helpful for healthcare providers to show interest in cultural differences and previous experiences in healthcare such as asking, "can you talk me through how you got help for your asthma in (*your country of origin*) and then we can discuss how that works here in (*current location*)?" Through cultural humility - "a process of openness, self-awareness, being egoless, and incorporating self-reflection and critique after willingly interacting with diverse individuals", there will be shared learning which will aid the consultation and understanding of expectations and presentations of illness [48]. It is also important to provide assurance of confidentiality and that information from healthcare will not be shared with government bodies or immigration authorities without the patient's consent. Other, transferable examples of how to apply the principles of TIP in consultations with inclusion health populations as presented at the symposium are summarised in Tables 2 and 3.

In the symposium, Derek described how a practitioner adopting a trauma-informed approach had increased his feelings of safety and helped to start his journey to recovery:

"Being asked 'How does this sound?' or 'Does that make sense?' helped me to feel involved in my care. It was such a change from just being asked 'What is wrong with you?'"

Table 2
An example of how to apply the principles of Trauma Informed Practice in consultations.

Collaborative care at ALL times
"I want to work at a pace you can cope with".
"I won't tell you what to do".
"What I'm thinking right now is this…. What do you think?"
Especially when the patient is not doing what you expect or has stymied an intervention (and you are feeling disappointed/frustrated/upset/rushed).
Actively signal authentic empathy- ALWAYS use clear verbal and non-verbal signalling, as described below, no matter what the patient may have initially said or if behaviours have been challenging:
"Good to see you, thanks for coming in. What can I do for you today?"
"I'm sorry. I'm thinking that must have been difficult for you" (when patients tell you about terrible/upsetting things that happen).
Managing disclosure
Detail is not important – don't feel the need to explore traumatic events in great detail.
"We know that if a lot of bad things have happened to people across their life and especially from childhood, that this has a major impact on them in terms of [mental health, problem substance use, physical health, as relevant]. I do not need to hear details unless you want to tell me. However, does that have relevance for you?"
or a simple **"What happened to you?"** [as opposed to 'What's wrong with you?']
Offer validation
"Thank you for telling me. I have some sense of how difficult that was for you. It helps me when trying to think through the best support we can offer."
Consider Safety
Ensure physical, emotional and social safety at each contact ask - **"Are you safe?"**
"It can be difficult to manage [*issue under discussion*] if you are not feeling safe, let us think about how we can help with improving that. What could you do with help with?" (it might be threats from a neighbour, current domestic abuse, struggling to stop using illicit substances).
Get consent
"If you feel comfortable doing so, I would like to make a brief record of this in your clinical record. What are you thinking?"
Strongly signal interest
Book follow up and actively discuss missed appointments.
Be very careful of verbal and nonverbal leakage (including psychological environments); body language and environment need to back up your words. This means that what you say, what your body says and what is around you ALL need to be positive and supportive, patients are sensitised to picking up mismatches and with a complex trauma background will more likely remember any negative aspects of what they experience.
Enact Self Care
Be reflective about what you can achieve for the person.
Use strategies to ensure you have a work/life balance.

Table 3
Specific adjustments for migrant, asylum seeker and refugee patients.

- Education and introduction evenings to help develop health literacy about the health system in the host country.
- Dedicated telephone numbers for interpreting needs.
- With consent, create social connections between newly arrived patients, either within the clinic population or by signposting to community groups.
- In areas with a large proportion of patients speaking a specific language, having dedicated drop-in clinics with an interpreter present who can assist with any paperwork or administration.

3.2.4. Working with Interpreters

At the symposium, Nesrine shared her experience as a multilingual housing support worker, who has lived experience of the asylum system and has worked as an interpreter for many years. She encouraged symposium participants to view the interpreter as a vital member of the healthcare team. Unless a patient is very confident in the language of their host country, she advised that an interpreter is needed, as consultations use a technical level of language that is not spoken every day. Details and nuance can be missed without an interpreter. Nesrine gave several recommended strategies for interpreted consultations. Whilst they are interpreting what the healthcare worker is saying, it is the interpreter who gives the information to the patient and who receives the first reaction. Consideration must be given to the care of the interpreter as it would to any team member. If possible, give the interpreter some warning if the consultation is likely to be upsetting or difficult and offer them the chance to debrief afterwards. Interpreters also need to be given some flexibility in the consultation to build trust between them and the patient. .

"I (the interpreter) need to build rapport and trust so that I can take the person with me and the doctor or nurse."

An interpreted consultation ideally needs to be at least a double appointment, as everything needs to be said twice and sometimes even longer as information needs to be couched in a way that can be both linguistically and culturally understood. .

"Sometimes people think the interpreter is speaking too long but we need to interpret culturally as well - to interpret English directly in many languages would come across as very harsh."

During the consultation, the healthcare provider should try to maintain eye contact with the patient, not the interpreter and be clear to the patient that confidentiality rules apply to the interpreter as well. If it is likely that the interpreter is part of the same local community, it may be better to offer remote telephone interpreting or to ask if the patient can speak another language or dialect - broadening the range of interpreters who could be used.

4. Conclusions

People experiencing homelessness are more likely to have communication needs, experience discrimination in accessing healthcare, and are more likely than the general population to have a condition or social circumstance that places them at risk of communication difficulties. Asylum seekers and refugees face the complexity of negotiating healthcare, and legal and social systems they may not understand, with the added burden of language barriers. Trauma-informed practice provides a practical framework that can improve communication between healthcare providers and patients in inclusion healthcare.

Practice Implications

Healthcare providers should be aware of the increased risk of communication difficulties and complex trauma in all inclusion health populations. Practitioners should also think about how they communicate with people from marginalised groups, focus on building positive respectful relationships and practice trauma-informed practice for the benefit of patients and practitioners. Communicating with people from marginalised groups requires healthcare providers to focus on building positive respectful relationships and practising trauma-informed practice for the benefit of patients and practitioners.

CRediT authorship contribution statement

All authors (AW, LA, AB, and AW) have made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data; have been involved in drafting the manuscript or revising it critically for important intellectual content; and have given final approval of the version to be published. We believe the manuscript represents honest work. Dr Andy Ward is a member of EACH and UK National Representative.

Declaration of Competing Interest

None of the authors contributing to this manuscript have any completing interests to declare.

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