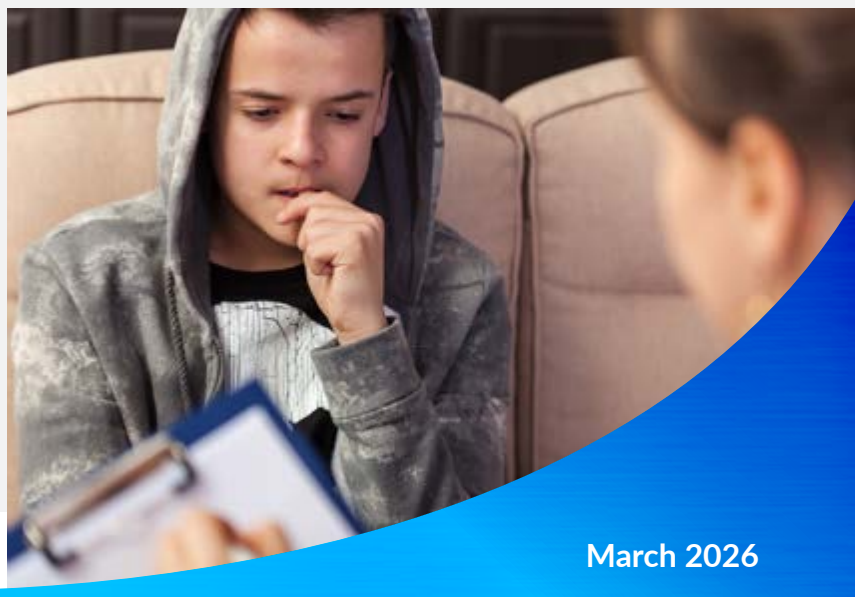
ROYAL COLLEGE OF PHYSICIANS OF IRELAND

Inclusion Health

An Education Framework for Postgraduate Medical Training



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Foreword

The Institute of Medicine (IOM) in the Royal College of Physicians of Ireland (RCPI) was founded in 2020 to promote education and training of post-graduate doctors in all of the medical specialties. One of the primary goals of the IOM is the development of novel, innovative resources that will be of benefit to our members, fellows and trainees and will directly improve patient care.

Following on from the successful publication of the Global Curriculum, which was one the first comprehensive curriculum for use across faculties in all post-graduate training bodies, the Institute of Medicine, in conjunction with Clinician Leads Prof Clíona Ní Cheallaigh and Dr Tara McGinty, are delighted to publish this document: **Inclusion Health: An Education Framework for Postgraduate Medical Training**. This is the first of its kind and, through funding from the NDTP and support from the Forum for Post-graduate Medical Education, provides a detailed, structured approach to educating post-graduate doctors on many aspects of Inclusion Medicine.

This document has been structured to equip medical post-graduate trainees with the skills required to deliver high-quality, person-centred, and equitable medical care to marginalised and socially excluded people who suffer disproportionately poor health outcomes and significantly reduced life expectancy. These include people experiencing homelessness, substance use disorders, forced migration and other social barriers to good health.

The framework is systematically organised into three interconnected sections that provide a holistic training structure. Each unit can be referenced independently of one another and provides a comprehensive guide for delivering optimal Inclusion Health.

Unit One focuses on interpersonal professional skills including crucial aspects of engagement and trust-building. This unit outlines core competencies required for effective communication, emphasising the adoption of trauma-informed approaches, enhancing cultural competence, and facilitating person-centred care.

Unit Two examines clinical skills in the specific context of Inclusion Health. It modifies traditional clinical procedures, such as history taking, physical examination, diagnosis, and treatment planning, to account for the unique vulnerabilities, common pathologies, and access issues relevant to marginalised patients. This unit ensures that clinical decisions are made not in isolation, but with full consideration of the patient's attitudes, social situation, and barriers that they may face.

Unit Three focuses on specific scenarios that are more common in people experiencing social exclusion This provides an opportunity for post-graduate trainees to educate themselves and prepare for working with marginalised patients.

On behalf of the IOM, we wish to thank the clinician leads and co-design partners for the considerable work that has gone into the development and publication of this comprehensive and detailed framework document. We believe that this framework will become an important tool for all trainees engaging with Inclusion Health patients and will lead to improved clinical care and outcomes for these marginalised and socially excluded populations.

Prof Edward McKone

Dean of the Institute of Medicine

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Project Overview

Overview

An Education Framework for Postgraduate Medical Education has been co-designed by the Royal College of Physicians of Ireland (RCPI), led by the Institute of Medicine (IOM), with support from HSE–NDTP Development Funding (2024). The framework was created with our co-design partners with specialist input from a broad group of healthcare professionals.

Project Goal

Inclusion Health is an approach to healthcare that recognises and aims to minimise the extreme health inequities faced by people experiencing social exclusion. Clinical excellence means delivering care that is not only clinically sound but also ethically grounded, socially responsive, and structurally aware. It recognises that high-quality treatment must reach those most at risk of exclusion - and that this requires more than technical competence. It demands a commitment to equity, person-centred communication, and cross-sector collaboration.

This framework is a practical and adaptive educational resource, grounded in the principle that Inclusion Health is a core competency across all areas of medicine, essential to achieving equitable health outcomes. It identifies the knowledge, skills, and attitudes doctors need to address health inequities and deliver safe, equitable care for people experiencing social exclusion. Developed through co-design and grounded in lived experience, it provides a structured, cross-specialty resource.

The framework is organised around Core Practice Topics that integrate clinical evidence with community perspectives, translating them into clear, practice-focused guidance that equips doctors and other healthcare professionals with actionable capabilities for everyday care. By embedding Inclusion Health principles into postgraduate medical education, the framework aims to reduce disparities and improve outcomes for patients experiencing social exclusion.

Project Leads

Prof Clíona Ní Cheallaigh and Dr Tara McGinty

Project Process

This project adopts a co-design approach, bringing together community representatives with lived experience, clinicians, and specialist professionals. Partner organisations included Safetynet Primary Care, Deep End Ireland, UISCE, MASI, AkiDwA, De Paul, EPIC, and TENI, working alongside the RCPI Inclusion Medicine Working Group. Through interviews, workshops, and expert consultation, the framework aims to reflect both the lived experiences of marginalisation and the clinical expertise required for safe, effective practice. This collaborative model is designed to ensure that the content is both patient-informed and clinically robust, supporting its practical application across postgraduate medical training.

Project Scope

Social exclusion is linked to delayed or limited access to appropriate healthcare, resulting in later presentations and more advanced disease, higher morbidity, and ultimately increased risk of premature mortality. These inequities are reinforced by stigma, discrimination, and systemic barriers, creating a pressing need for care that is clinically competent, culturally safe, and person-centred. Equitable outcomes require proportionate universalism. This framework focuses on the needs of people experiencing social exclusion due to homelessness, addiction, forced migration, state care and/or due to being Irish Travellers and Roma, and children and young people in state care as they represent those most at risk from the extremes of exclusion. Although these are distinct experiences, they impact on health and healthcare access in similar ways. Fundamentally, the framework is built on the shared principle that all patients should receive respectful, safe, and clinically competent care tailored to their circumstances.
The knowledge and skills developed in working with people who have experienced social exclusion can and should be employed in caring for all patients who may benefit from them.

Executive Summary

Introduction

Equity is a core standard of good medical practice and a clinical obligation that shapes care decisions and delivery, and improves patient outcomes. This Education Framework sets out the core interpersonal and clinical skills required by doctors to advance health equity for people experiencing social exclusion. It helps doctors recognise and respond to the health needs people may experience, providing practical education guidance to support consistent, safe and inclusive practice. The link between social exclusion and extreme health inequity underscores the need for policies and practices that better align social and healthcare priorities and objectives. Inclusion Health aims to identify and deliver on these mutual service goals across acute and community settings, thereby improving health outcomes (Montague, 2018; Luchenski et al., 2018). In this context, it affirms the crucial and distinct role doctors have in upholding dignity and fairness in care.

> **"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." (WHO, 2024)**

Why Inclusion Health Matters

Good professional practice delivers care that is safe, effective, and grounded in respect and compassion for patients. It obliges doctors to understand each patient as an individual and to recognise the wider determinants shaping their health and wellbeing (IMC, 2024).

Inclusion Health translates this duty into action by extending clinical reasoning beyond the presenting complaint to consider and address the effects of social context, including poverty, homelessness, addiction, limited health literacy, migration, and discrimination. These factors are most accurately and effectively engaged with as tangible clinical determinants shaping patients' presentation, diagnostic risk, treatment adherence, and health outcomes. People experiencing social exclusion are disproportionately affected by chronic illness and premature mortality and often require proportionately greater healthcare input (O'Connell, 2018; Aldridge et al., 2018). An Inclusion Health approach recognises this reality and supports clinicians to respond to social exclusion as a core component of equitable clinical care.

Every healthcare encounter can either deepen or diminish inequity. A dismissive exchange can fracture trust and compound community trauma; a respectful, patient-centred interaction can rebuild confidence in medicine – both in the system and individual clinicians. Doctors, therefore, hold a dual responsibility to people who are marginalised: to deliver effective clinical care and to actively build equity and trust. This can be addressed through the embedding of Inclusion Health principles in everyday practice.

> **"The right to health for all people means that everyone should have access to the health services they need, when and where they need them, without suffering financial hardship. No one should get sick and die just because they are poor, or because they cannot access the health services they need."**
>
> **(Dr Tedros Adhanom Ghebreyesus, WHO Director General, 2017)**

The Role of the Good Doctor

Doctors work within the same services and systems that shape patients' experiences of care. These are often complex and multilayered, yet they can also be fragmented, time-constrained, and difficult for patients to navigate – particularly when care pathways lack integration or continuity across services. Patients often arrive at moments of vulnerability, sharing personal histories and relying on doctors not only for treatment but for reassurance that the consultation is a safe, respectful space to disclose concerns and make decisions. Poor experiences leave a lasting impact: they influence whether individuals seek future care and shape how families and communities perceive the reliability and trustworthiness of health services. In this reality, clinicians can – often unconsciously or inadvertently – compound inequity through assumptions, tone, or omission. Attentive, person-centred care restores agency, rebuilds trust, and supports engagement with investigations and treatment. Care that explicitly affirms a patient's worth while addressing their health needs begins to repair past harms and interrupts cycles of mistrust and disengagement. The task, therefore, is to centre the patient – acknowledging systemic constraints while placing safety, dignity, and clarity at the heart of clinical practice.

Clinical excellence in Inclusion Health refers to delivering high-quality, evidence-based medical care that is also equitable, person-centred, and responsive to social vulnerability. It combines the standards of good clinical practice – accurate diagnosis, effective treatment,

safety, and professionalism - with a deep understanding of the social determinants of health, marginalisation, and barriers to access. In practical terms, it means:

- Listening actively to people whose voices may have been historically overlooked.
- Recognising how experiences of adversity and psychological trauma influence behaviour, and adapting clinicial encounters to ensure that patients feel safe and respected rather than judged and stigmatised.
- Incorporating social context (e.g. housing status, trauma history, literacy, migration experience) into clinical decision-making.
- Ensuring continuity of care, especially for people who may struggle to navigate fragmented systems.
- Prescribing and planning responsibly, with attention to feasibility (e.g. can the patient store medication safely? Can they attend follow-ups?).
- Collaborating across sectors - hospital, community, voluntary - to ensure care is coordinated and inclusive.
- Advocating for patients within systems that may not be designed with their needs in mind.

Clear, honest dialogue, careful listening, and genuine shared decision-making are consistently among the attributes patients value most. These practices are central to restoring agency where voices have been overlooked or dismissed (Steiner-Hofbauer et al., 2017; Schattner et al., 2004). Communication functions to align care with the person's lived realities, enabling social context to be meaningfully incorporated into assessment, diagnosis, and planning so that treatment is appropriate, feasible, and safe (IMC, 2024). Inclusion Health also depends on collaboration and leadership across teams, the hospital, and cross-sectorally. Coordinated care, responsible information exchange, and clear accountability are essential to delivering equitable services (IMC, 2024). Ethical practice ensures the patient is placed at the centre of decision-making, with clinical choices grounded in sound judgement, clear evidence, and the person's individual circumstances (Steiner-Hofbauer et al., 2017; IMC, 2024).

> This Education Framework supports the development of doctors who listen deeply, act consistently, and lead collaboratively. They treat context as part of diagnosis and compassion as part of competence. They advocate for fairness in care as a clinical responsibility. They aim to restore trust, enable participation, and ensure that medical care reaches people for whom it has too often been out of reach.

Clinical excellence in this context is not an abstract ideal, it is a responsibility to provide care that is structurally aware, person-centred, and capable of addressing the health impacts of marginalisation. Doctors can address health inequalities through specific, intentional actions across care, services, education, and public life. In direct care, they provide safe, person-

centred treatment with clear plans, reliable follow-up, and barrier-aware prescribing -ensuring that care is feasible and appropriate. Within services, they shape how clinics and pathways operate so they are welcoming, dependable, and accessible, e.g. flexible appointments, coordinated referrals, and trauma-informed environments. As educators, they help embed equity into practice through training students and colleagues in inclusive, reflective, and trauma-aware practice. As advocates within the system, they support patients in navigating referrals, entitlements, and care pathways, while also enabling colleagues to deliver equitable care through shared learning and leadership. Together, these actions translate the values of Inclusion Health into tangible practice.

Distinctiveness of the Framework

Inclusion Health initiatives seek to build collaborative models of healthcare design that bring together service users and providers, leveraging community insights to critique and enhance healthcare connectedness and provision (Marmot, 2017; Carroll et al., 2021). A central component of these initiatives is empowering community members to co-design healthcare solutions so that community-identified goals underscore service deliverables.

This framework translates co-designed insights into practical clinical guidance through a structured, multi-phase co-design methodology. Developed collaboratively with people who have lived experience of social exclusion, alongside clinicians and medical educators, it reflects real-world complexity and frontline clinical realities.

The process combined targeted scoping and evidence review with semi-structured interviews and facilitated co-design workshops, enabling the systematic identification of barriers to care and points of clinical risk. Reflexive thematic analysis was used to synthesise lived experience insights with specialist clinical input, ensuring that emerging priorities were translated into educationally usable and clinically actionable content. The resulting Core Practice Topics define the knowledge, skills, and professional attitudes required for doctors to engage safely, respectfully, and effectively with people experiencing social exclusion across settings and specialties. Ongoing collaboration between community organisations and the RCPI Inclusion Medicine Working Group ensured iterative validation, clinical credibility, and alignment with postgraduate training standards. This grounding in both lived experience and clinical governance makes the framework a methodologically robust, responsive, and practice-focused tool for improving care.

Principles That Guide the framework

The framework is built on interdependent principles that reflect the values and practices of Inclusion Health:

Equity: Care proportionate to need and responsive to social and structural context.

Safety: Recognition and mitigation of clinical risks associated with social exclusion.

Effectiveness: Person-centred, evidence-based care, that is adapted to real-world constraints and likely impact.

Dignity and Respect: Treating every person with inherent worth, compassion, and cultural humility.

Autonomy: Supporting informed decision-making and recognising the patient's right to choose, refuse, or question care.

Integration: Service continuity and coordination across hospital, community, rehabilitation, and voluntary sectors.

Trauma-Informed Practice: Recognising how trauma shapes engagement, behaviour, and pain perception, and responding accordingly.

Holistic Care: Addressing physical, psychological, and social wellbeing together within clinical decision-making.

How to Use This Framework

This framework is designed to support doctors in navigating clinical situations where exclusion, stigma, and systemic barriers contribute to inequitable outcomes, operating as a tool for reflection, learning, and action. The framework is organised into three units:

Unit One - Interpersonal Professional Skills

Focuses on the relational foundations of safe, equitable care. Supports doctors in building trust through transparency, reliability, and respect, especially with patients who have experienced exclusion or trauma. Covers trauma-informed communication, shared decision-making, accessible language, and continuity through responsive documentation.

Unit Two - Clinical Skills

Outlines an inclusive approach to core clinical competencies. Emphasises history-taking, examination, diagnosis, prescribing, and discharge planning that account for barriers to access and follow-up. Promotes psychological safety, diagnostic vigilance, and treatment plans aligned to the person's context and capacity.

Unit Three - Specific Scenarios:

Applies Inclusion Health principles to high-risk clinical contexts. Covers injecting-related complications, frailty in homelessness, infection risks, migration-linked presentations, women's health, and paediatric-to-adult transitions. Highlights trauma-informed communication, culturally safe care, and prescribing for access to reduce avoidable harm and exclusion.

Together, these units help doctors translate the principles of Inclusion Health into everyday clinical practice. This framework is built of self-contained units, and therefore there is overlap in content between sections.

Words and terms used in workshops by participants representing UISCE, a peer-led advocacy organisation, representing people who use drugs, promoting equality, human rights, and harm reduction. Their lived experiences of the health care system provide a foundation for the framework design.

Words and terms used in workshops by participants representing Pavee Point, representing members of the Travelling and Roma Communities. Their lived experiences of the health care system provide a foundation for the framework design.

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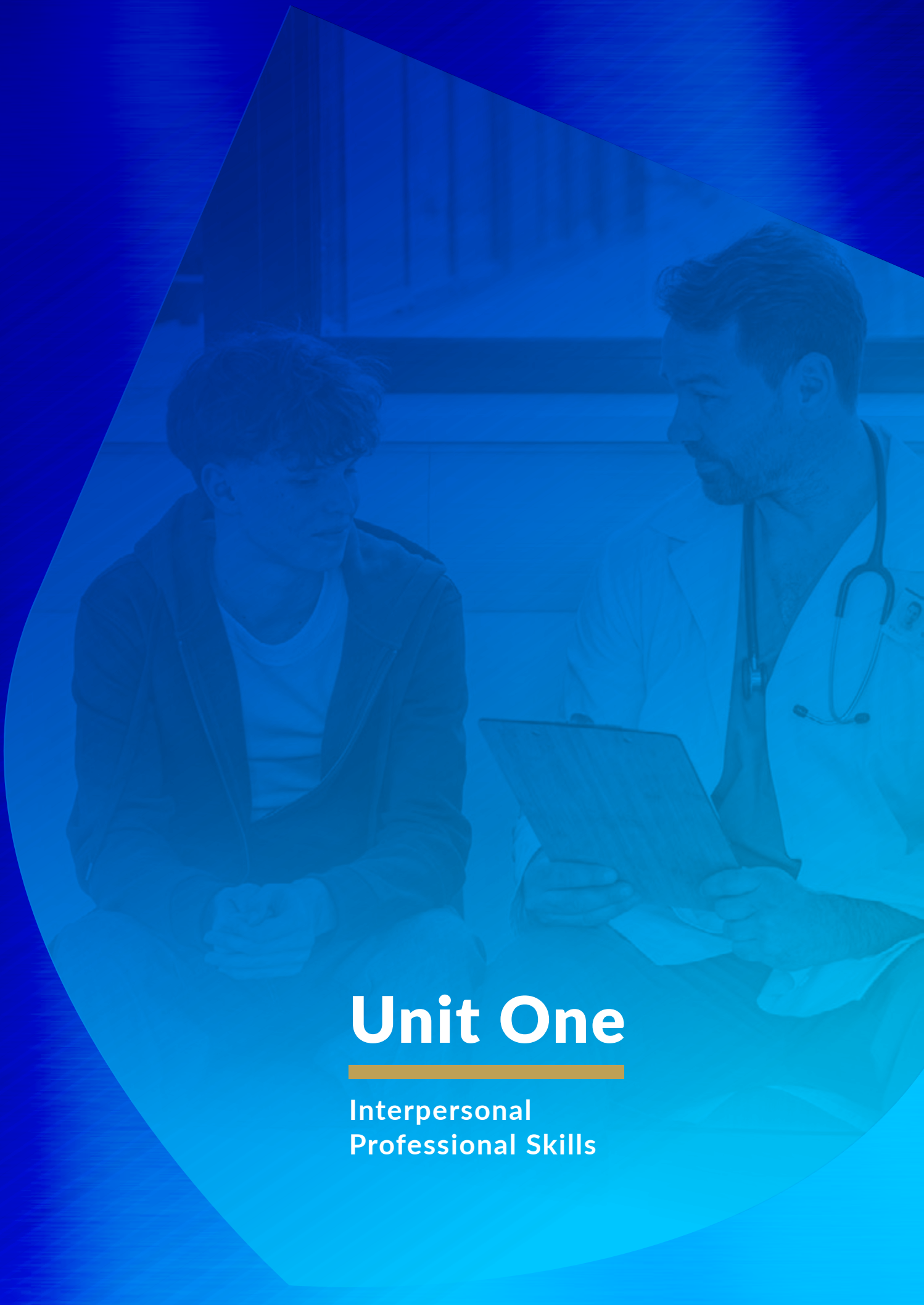

Unit One

Interpersonal Professional Skills

Unit One. Interpersonal Professional Skills

Unit One sets out the interpersonal professional skills required to deliver safe, equitable, and person-centred care for people who have experienced social exclusion. It focuses on how doctors build trust, communicate clearly and accessibly, recognise and respond to distress, and adapt clinical decisions to patients' lived circumstances, capacities, and priorities.

The Unit is organised around trauma-informed, culturally responsive, and inclusion-focused practice, framing communication and relationship-building as core components of clinical practice. It emphasises transparency, reliability, valid consent, shared decision-making, and aligning care with what is clinically safe and realistically achievable.

Its purpose is to strengthen psychological safety, reduce barriers to engagement, and support clinical decision-making that is both effective and grounded in the lived realities shaping patients' participation in healthcare.

Building Trust and Relationships

- Building a Therapeutic Relationship
- Communicate and Provide Care in a Trauma-Informed Way
- Understand Psychological Trauma and its Effects on Health and Behaviour
- Recognising and Responding to Patient Distress

This section examines how doctors establish and maintain trust in the clinical relationship and in the care being offered to people who have experienced social exclusion or psychological trauma, recognising that trust is often fragile and conditional. It emphasises the need for transparency, reliability, and trauma-informed communication as the basis for building trust in clinical encounters. The section explores how trauma shapes patients' health, behaviour, and engagement with care, and how this influences trust and participation in clinical interactions. It aims to equip doctors to recognise and respond to distress as relevant clinical information, using clear, compassionate communication to strengthen predictability, agency, and psychological safety, and to support continued participation in care. Together, these elements position relational skills as core clinical competencies in promoting patient safety and equity.

Building a Therapeutic Relationship

Keywords: therapeutic relationship, trust, trauma-informed care, transparency, empathy, validation, psychological safety, person-centred care

Overview

For many patients, their trust in healthcare cannot be taken for granted. People with experiences of trauma or stigma may associate medical settings with discomfort, judgement, or a loss of control, while those facing social exclusion often find services difficult to access or navigate. Doctors may, therefore, be perceived as intimidating or unapproachable authority figures, leading to understandable caution or defensiveness. In such circumstances, trust tends to be fragile and conditional, affecting disclosure, participation in treatment, and the likelihood of returning for care.

In this context, the doctor-patient relationship can either restore confidence in care or compound a sense of mistrust and exclusion. This relationship should be built through consistent follow-through, honesty, and respect for the patient's autonomy and experience. It relies not only on clinical expertise, but also on how care is delivered – integrating both cognitive and emotional elements of care (Di Blasi et al., 2001; Kelley et al., 2014). Cognitive care encompasses the informational and procedural elements of practice, such as accurate information gathering, clear explanations, patient education, and realistic expectations. Emotional care refers to the relational aspects of the interaction, including trust, empathy, and acceptance, which create a sense of psychological safety and interpersonal connection. When these elements of care are attended to, the therapeutic relationship becomes a stabilising, reliable anchor in healthcare.

Key Clinical Considerations

- **Recognise the conditional nature of trust:** Many patients' trust in healthcare, clinicians, and the system more broadly is shaped by past experiences of exclusion, discrimination, or neglect. Trust should not be assumed at first contact, but established through consistent, transparent, and reliable behaviour.
- **Acknowledge the impact of authority and power:** Patients who have experienced coercion, shame, discrimination, or dismissal may experience clinicians as authority figures and feel unsafe sharing openly. This can reflect both real healthcare power structures and their internalisation of past experiences, rather than a lack of motivation or interest in care.
- **Anticipate defensive or protective behaviours**: Behaviours such as guardedness, defensiveness, irritability, or non-attendance often represent self-protective attempts to stay emotionally or physically safe. These responses can indicate that trust has not yet been established and should prompt curiosity, not judgement.
- **Communicate with clarity and compassion:** Trauma-informed communication helps foster safety and predictability in clinical encounters. Use clear, respectful language, avoid jargon, explain what will happen next, and adjust the amount and pace of information to what the patient can realistically process and act on.
- **Demonstrate reliability and set realistic expectations:** Follow through on agreed actions wherever possible. If plans need to change, explain why and acknowledge how this may affect the patient's time, trust, hope, and practical arrangements. Avoid promising appointments, timelines, or availability you may not be able to guarantee; offer realistic alternatives and clear next steps instead.
- **Be explicit about confidentiality and roles:** Introduce yourself and any team members present. Explain confidentiality and its limits, who is involved in care, how information is recorded, and when it may need to be shared (e.g. safeguarding, risk to life).
- **Acknowledge and repair:** When misunderstandings, communication breakdowns, or errors occur, name them, apologise where appropriate, and clarify how they will be addressed. Even small acts of accountability demonstrate respect and can repair trust that might otherwise be lost.
- **Humanise the encounter**: Express empathy through attentive, active listening (e.g. allowing the patient to speak without interruption, reflecting back what you have heard, and checking you have understood correctly) and explicit acknowledgement of emotion.
- **Maintain a steady clinical presence:** Be mindful of open, non-threatening body language (e.g. unfolded arms, eye contact, seated when possible) and a steady, consistent presence — remaining engaged, unhurried, and present when conversations become challenging.

- **Create space for sensitive disclosure without pressure:** Explain why you are asking sensitive questions and only ask when the information is clinically relevant. Make it clear that the patient can decline to answer or return to the topic later. This reinforces agency and prevents disclosure from feeling forced or interrogative.
- **Apply trauma-informed principles consistently:** Approach the patient with a genuine interest in their perspective and the meaning behind their behaviour, rather than unexamined assumptions. Prioritise emotional and psychological safety, transparency, collaboration, and dependable follow-through — recognising that trust is built through consistent action rather than reassurance alone.

Why This Matters

For people affected by social exclusion or trauma, the quality of the clinical relationship often determines whether they feel comfortable or safe enough to access services, return for review, disclose concerns, or accept medical advice. Trust in the information shared, the advice offered, and the options given is essential for patients to engage with care, disclose personal information, and adhere to treatment or follow-up.

In these contexts, doctors function not only as individual care providers but as visible representatives of health and social systems that may have previously failed or marginalised the patient. Each act of honesty, respect, and compassion helps rebuild trust and restore a sense of safety and dignity in care (McKee et al., 2024). Over time, this enables patients to disclose sensitive information, ask questions without fear, and participate meaningfully in decisions about their care – improving diagnostic accuracy, continuity, and clinical outcomes.

Learning Tools

Tool	Purpose	Application
Vignette: Rebuilding Trust Through Relationship	To explore how trauma and previous negative experiences may shape a patient's response to care, and how communication can help restore trust.	Shannon is a 23-year-old woman with a mild-moderate learning difficulty that affects how she processes and retains information. She is currently experiencing homelessness and uses drugs. She presentsto the Emergency Department (ED) with a diabetic foot ulcer that is painful to examine. Her past experiences with authority figures in school left her feeling misunderstood and "always in trouble," and she becomes visibly tense during triage, avoiding eye contact with medical staff. When the examination is about to begin, she pulls her foot away and says, "You're not listening - doctors never do", appearing ready to disengage. **Reflective Prompt:** • What might she need to feel safe enough to participate in the examination? • How would you adjust your communication to support her engagement with the examination?

Further Resources

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Communicate and Provide Care in a Trauma-Informed Way

Keywords: trauma-informed communication, psychological trauma, trust-building, collaboration, patient choice, patient safety, peer support, cultural and historical context

Overview

Trauma-informed care (TIC) recognises that psychological trauma can alter people's health, stress responses, behaviours, and relationships, including their capacity for trust and their ability to regulate their emotions. It prioritises fostering physical and emotional safety, preventing re-traumatisation, and supporting patients to retain or regain a sense of control, dignity, and connection within care relationships (Hopper et al., 2010; Levenson, 2017).

Each clinical interaction is shaped by the experiences both patients and clinicians bring to it, influencing tone, trust, and interpretation on both sides. For many patients, past experiences of stigma, trauma, coercion, or exclusion — whether personal, witnessed, or shared within their community — affect how safe they feel, how much they disclose, and whether they choose to remain engaged in care. These patterns highlight the importance of a consistent, evidence-based approach to restoring safety and agency in clinical encounters. Trauma-informed care focuses on six guiding principles (SAMHSA, 2014):

- **Safety**: Ensuring physical and emotional safety for patients and staff.
- **Trustworthiness and Transparency:** Building trust through clear, honest communication and consistent behaviour.
- **Peer Support:** Valuing lived experience and mutual support as part of healing.
- **Collaboration and Mutuality:** Promoting shared decision-making and flattening power hierarchies in care relationships.
- **Empowerment, Voice, and Choice**: Supporting autonomy and recognising patients' strengths and preferences.
- **Cultural, Historical, and Gender Awareness:** Understanding how identity and past experiences shape engagement and care needs.

Key Clinical Considerations

- **Recognise trauma-related behaviours:** Trauma may present as heightened reactivity (e.g. irritability, aggression, hypervigilance), withdrawal or shutdown (e.g. avoidance, flat affect, or dissociation), or difficulty engaging with care (e.g. repeated leaving, declining examination, or missed appointments). These often reflect protective responses rather than disinterest or refusal of care.

- **Anticipate environmental and procedural triggers:** Triggers may include long waits without information, repeated questioning, refusal of requests (e.g. for food, privacy, or timing), sudden touch, exposing the body, certain positioning during examining, closed doors, crowded spaces, or clinicians' gender. Where possible, explain actions, offer choices, and adjust what you realistically can in the environment to help maintain a sense of safety and control.

- **Recognise emotional cost of questions, and ask only when necessary:** Disclosure about trauma, violence, or sensitive experiences can feel exposing, and may trigger shame, dissociation, or withdrawal. If patients choose not to answer questions, this is often a protective response. Ask about these areas only when it meaningfully informs diagnosis, treatment, risk assessment, or safeguarding. Explain why you are asking and explicitly affirm that the patient can pause, decline, or return to the conversation later (e.g. "I'm asking because it may affect your treatment and safety. If now isn't a good time, we can leave it or come back to it.").

- **Be aware of clinician and system influence:** Tone, pacing, interruptions, visible frustration, rushed interactions, or unexpected changes in plan can heighten distress or mistrust; consistent messaging, a respectful manner, and calm, steady communication – both verbal and non-verbal – can reduce perceived threat.

- **Communicate predictably and transparently:** Before examinations, procedures, or sensitive conversations, explain what will happen, why it matters, and what choices the patient has. Invite questions, pause to check understanding, and confirm consent throughout.

- **Acknowledge patient emotions:** Notice, name, and validate what the patient appears to feel, and, where possible, check your understanding (e.g. "Are you fed up of having to wait? I'm sorry – I know you had to wait for a long time").

- **Offer meaningful choice wherever possible:** Even small decisions (e.g. whether to sit or lie down, have the door remain open, or pause for a moment before continuing) can help restore a sense of control over what happens during healthcare interactions.

- **Use collaborative language:** Where appropriate, frame care as a partnership done with the patient (e.g. "Let's work on this together") rather than issuing directives (e.g. "You need to…").

- **Use grounding and pacing techniques:** When distress is visible, slow the interaction, reduce demands, speak steadily, offer breaks, and orient the patient to the present moment. Acknowledge emotional reactions without judgement.

- **Integrate peer or advocacy support:** Where available, involve trained peers, support workers, or patient advocates to provide emotional reassurance, support communication, and improve continuity and trust across care encounters and transitions.

- **Maintain professional boundaries and self-care:** Recognise when empathy fatigue, emotional burden, or over-involvement is emerging. Trauma-informed care includes safeguarding clinician wellbeing, supervision, and reflective practice as part of safe clinical care.

Why This Matters

Trauma-informed care is a core clinical skill that benefits both patients and clinical staff. Applied consistently, it can transform care from something done to patients into something undertaken with them, building relationships grounded in partnership. For doctors, it means examining assumptions, communicating intentions clearly, and responding to distress or guardedness with steady, responsive care. In the context of Inclusion Health, where trauma and exclusion frequently intersect, communicating and providing care in a trauma-informed way helps minimise distress and conflict, supports more collaborative interactions, improves diagnostic accuracy, and strengthens ongoing patient engagement with services.

Learning Tools

Tool	Purpose	Application
Vignette: Recognising and Responding to Trauma in Clinical Encounters	To illustrate how a patient's behaviour may reflect trauma responses, and how trauma-informed approaches can help stabilise the interaction.	Julie is a 35-year-old woman living with HIV who has experienced severe sexual abuse perpetrated by her father in childhood. She is currently homeless and using drugs. She presents to the Emergency Department (ED) with a femoral artery pseudoaneurysm. Staff report that she becomes verbally aggressive, refuses to answer questions, and turns away or withdraws when they try to take a history or bring her in for CT imaging. **Reflective Prompts:** • How might her past experiences and current circumstances be contributing to how she is responding in this encounter? • What safety, trust, or sense-of-control needs might be underlying her behaviour? • How could you apply trauma-informed principles to adapt your approach and help stabilise the interaction?

Further Resources

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Understand Psychological Trauma and its Effects on Health and Behaviour

Keywords: psychological trauma, Adverse Childhood Experiences (ACEs), trauma responses, emotional regulation, fight–flight–freeze–fawn responses, substance use, clinician response

Overview

Psychological trauma refers to the lasting emotional, cognitive, and physiological effects that follow exposure to events or circumstances perceived as threatening, overwhelming, or violating. Trauma may arise from a single event (e.g. assault, serious accident) or repeated exposure to adversity such as neglect, violence, coercion, or chronic deprivation. What determines its impact is not only what happened, but how it was experienced, including predictability, duration, interpersonal context, and the degree of safety or control available to the person at the time (SAMHSA, 2014).

Early psychological trauma is frequently linked to Adverse Childhood Experiences (ACEs), including abuse, neglect, and household instability. ACEs are strongly assosciated with long-term physical and mental health difficulties, including chronic illness, substance use, and mood disorders (CDC, 2025). Early trauma can deeply affect stress responses and emotional regulation, changing how people think, behave, and relate to others – including their sense of safety and trust. This can leave them struggling to maintain psychological balance and social stability (Lioce et al., 2020; McGarry et al., 2024), and may lead to behaviours such as hypervigilance, dissociation, or confrontation when they feel under pressure.

In healthcare, where loss of control and perceived threat are common, trauma-related responses from patients can easily be misunderstood. Behaviours often labelled as “non-compliance,” “aggression,” or “withdrawal” may instead reflect attempts to re-establish stability, safety, or dignity in situations that feel overwhelming or unpredictable. Understanding these responses as adaptive survival strategies allows clinicians to recognise more clearly what the patient needs to feel safe and respond accordingly, creating the foundation for more compassionate, person-centred care (The TS4TIC Toolkit).

Key Clinical Considerations

- **Recognise trauma patterns, not just trauma histories:** Trauma responses such as fight, flight, freeze, or appeasement (fawn response) may appear as restlessness, avoidance, irritability, emotional withdrawal, or rapid over-agreement. These behaviours often reflect attempts to maintain safety or control in situations that feel threatening, rather than intentional opposition.
- **Understand difficulties with emotional regulation:** People with trauma histories may struggle to manage stress when they feel scrutinised, powerless, or overwhelmed. Emotional outbursts or sudden shutdowns can often signal overload rather than defiance.
- **Acknowledge substance use as a coping strategy:** Alcohol or drug use, even within healthcare settings, may function as self-soothing or emotional regulation. Address immediate clinical safety first (e.g. risk of overdose, withdrawal, medical instability), then support safer alternatives and engagement.
- **Be mindful of clinician reactivity:** Feelings of frustration, defensiveness, urgency, or withdrawal may signal clinicians' own stress response is being activated. Notice it, pause where possible, reflect, and re-engage intentionally.
- **Use trauma-informed techniques to prevent escalation:** Slow the pace where feasible, maintain physical space, avoid sudden touch, and explain actions before proceeding. Predictable, steady communication helps reduce perceived threat.
- **Validate emotion before directing behaviour:** Acknowledge fear or frustration (e.g. "I can see this feels intense right now") before offering options or next steps. Validation can lower emotional arousal and support engagement.
- **Engage collaboration and choice at each step:** Offer clear options and manageable choices (e.g. "Would you prefer to sit here or in the chair?"). This reduces uncertainty and helps patients feel steadier and safer.
- **Model regulation:** Maintain calm, deliberate communication and body language, even when the patient's affect is heightened. Steadiness functions as a clinical tool that supports regulation within the interaction.

Why This Matters

People living with psychological trauma – particularly those with multiple ACEs – are more likely to develop chronic illness, mental health difficulties, and substance use disorders, yet they often face stigma or misinterpretation in healthcare settings. Understanding how trauma shapes behaviour is essential to providing safe and equitable care. When doctors recognise behaviours such as withdrawal, agitation, or guardedness as indicators of overwhelm or diminished sense of safety, their response can shift from managing the outward reaction to helping the patient feel more settled and able to engage. A trauma-informed approach focuses on restoring a sense of control and predictability during the encounter, thereby strengthening engagement and reducing the likelihood of escalation.

Learning Tools

Common Trauma-Related Response Patterns in Clinical Encounters

These describe how trauma responses may present in clinical encounters and should always be interpreted in context.

Response Type	What It Is	Common Cues
Emotional Dysregulation	Temporary loss of the ability to regulate emotional or physiological arousal in response to a perceived threat.	Rapid mood shifts, tearfulness, irritability, visible agitation, difficulty concentrating, appearing overwhelmed or angry.
Hyperarousal (Fight / Flight Response)	Activation of the sympathetic stress system, resulting in heightened vigilance or readiness to protect oneself through confrontation (fight) or withdrawal (flight).	Restlessness, pacing, raised voice, tense or defensive posture, scanning the environment, difficulty sustaining focus.
Hypoarousal / Dissociation (Freeze Response)	Sudden reduction in arousal, leading to immobility, detachment, or emotional numbing as a protective response.	Blank or distant expression, minimal speech, slowed reactions, limp or rigid posture, appearing "frozen" or disconnected.
Appeasement (Fawn Response)	Automatic effort to maintain safety through compliance, reassurance, or attempts to please a perceived authority or threat.	Excessive agreeableness, minimising distress ("I'm fine"), rapid compliance, nervous laughter, apologising frequently.
Suppression / Emotional Control	Conscious effort to remain composed in order to retain internal control during stress, distinct from appeasement in that it is self-directed rather than relational.	Controlled tone, limited affect, reduced eye contact, deflecting questions, restrained emotional expression.

Tool	Purpose	Example
Vignette: Recognising and Responding to Trauma in Patients and Clinicians	To illustrate how trauma-related distress may present in acute care.	John is a 75-year-old man who spent much of his childhood in an industrial school, where he experienced physical abuse and neglect. He presents to the Emergency Department (ED) with haematemesis. Nursing staff report that he is very quiet and withdrawn and gives only brief responses. They also have found a bottle of vodka in his pocket. When you speak with him, he avoids eye contact, answers with single words, and appears tense and unsure. **Reflective Prompts:** • What aspects of his history or current circumstances might be shaping how he is engaging with you now? • What adjustments to your communication or approach might help him feel safer and more able to participate in his care?
Vignette: Trauma Responses in Clinicians	To explore how a clinician's own history and stress responses may influence their reactions during challenging encounters.	Ciara is a doctor in her twenties. Throughout her childhood, her father was verbally and physically abusive toward her mother. On a busy evening shift, she is called to review a patient with moderate dementia who is shouting and threatening to hit nursing staff. As she approaches the bedside, she notices her breathing shorten slightly and her heart rate increase. **Reflective Prompts:** • What reactions might Ciara recognise in herself as she enters this situation, and how could these shape her initial response to the interaction? • How might pausing to recognise these reactions help her regulate her response and engage more purposefully with the patient?

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Recognising and Responding to Patient Distress

Keywords: emotional regulation, distress responses, trauma-informed care, communication, equity

Overview

Distress is a natural and adaptive human response to fear, uncertainty, or a perceived loss of control, and is therefore commonly encountered in clinical care. In healthcare settings, it is particularly prevalent among people who have experienced trauma or social exclusion, where prior harm, stigma, or disempowerment shape how safe the environment feels. Distress can present in many forms; reactions that appear oppositional, disengaged, or overly compliant often arise from underlying emotions such as fear, shame, confusion, or mistrust, and can represent efforts to regain control during an overwhelming situation.

Recognising this involves viewing moments of patient distress as meaningful communication to be explored and understood, rather than confrontations to be controlled. When doctors respond with emotionally attuned curiosity about what distress may signal, alongside steady and transparent communication about what is happening and why, this helps stabilise interactions, reduce perceived threat, and preserve partnership in care. The goal is to understand distress in its lived context, so that responses are proportionate, compassionate, and aligned with the patient's underlying needs and the requirements of safe healthcare delivery.

Key Clinical Considerations

- **Recognise diverse expressions of distress:** Distress may present as agitation, anger, aggression, sadness, withdrawal or silence, humour or deflection, avoidance, or rapid compliance. Each reflects different coping strategies and levels of perceived threat.
- **Move from behaviour to meaning:** Rather than responding only to how distress presents, consider what the behaviour may be signalling about unmet needs such as safety, dignity, predictability, or control. This supports more accurate judgement and helps tailor responses that stabilise the encounter.
- **Understand the physiology of distress:** When distress activates the stress response (fight, flight, freeze, or appeasement (fawn)), the body can shift into a survival-orientated state. This may reduce tolerance for uncertainty, increase vigilance, and make reasoning and verbal engagement more difficult.
- **Identify and minimise re-traumatisation during distress:** Rushed interactions, sudden changes, invasive procedures, or situations involving loss of control may re-evoke past experiences of powerlessness or violation. Where possible, explain what is happening and why, slow the pace, reduce unnecessary demands, and offer meaningful choices about timing, sequence, or approach.
- **Draw on patients' lived experience to guide your response:** Understand that patients are experts in their own experiences; ask what has helped or harmed in previous healthcare encounters and use this to inform communication, pacing, or approach in the moment.
- **Maintain perspective and emotional steadiness:** Acknowledge emotional or defensive behaviours without taking them personally, recognising that such reactions often reflect distress due to a situation, not personal disrespect. Maintain a calm tone, open posture, and measured pace; clinician steadiness helps contain heightened affect and stabilise the interaction.
- **Name and validate distress:** Briefly naming what you are noticing and inviting the patient to confirm or correct it (e.g. “This looks like it might feel really frustrating or frightening - am I getting that right?”) can signal that distress is seen and taken seriously, and create psychological space to support safer participation in the next step of care.
- **Collaborate to restore agency:** Where possible, frame the interaction around shared goals and offer meaningful choices (e.g. timing, sequence of steps, positioning). Inviting collaboration (e.g. “How would you like to approach this next part?”) helps shift the interaction from resistance to shared problem-solving, making it easier for patients to remain present, communicate concerns, and participate in care.
- **Frame distress as meaningful communication:** Understanding distress as a response to context, shaped by past experience, supports clearer clinical judgement, more stable interactions, and more effective engagement in the immediate encounter.

Why This Matters

Distress in clinical encounters is often a signal of fear, unmet needs, uncertainty, or emotional overwhelm. When doctors approach these moments as opportunities to understand the source of distress, they are better able to respond with insight and proportionate judgement. Applying trauma-informed care principles means responding to distress with clarity, transparency, and respect for autonomy, including explaining what will happen next, offering choices where possible, and avoiding sudden movements or changes that could heighten perceived threat. The aim is to meet patients where they are, acknowledge the legitimacy of their emotions, and create psychological safety that supports trust, engagement, and recovery.

Learning Tools

Common Expressions and Patterns of Patient Distress

These patterns are not diagnostic, but may indicate distress, perceived threat, or unmet safety needs and should always be interpreted in clinical context.

Verbal Expressions (what the patient says)	Physical Expressions (what the patient does)	Relational Expressions (how the patient relates to you)
• Anger or frustration: Raised voice, abrupt tone, swearing, critical or accusatory remarks that often signal fear, loss of control, or frustration with perceived powerlessness. • Withdrawal or silence: Minimal responses, avoidance of questions, or disengagement, often reflecting shame, anxiety, or emotional overwhelm. • Over-compliance: Rapid agreement or reluctance to express preferences ("whatever you think"), often masking fear of conflict or judgement, or a wish to avoid negative consequences.	• Hyperarousal: Restlessness, pacing, rapid breathing, clenched fists, or scanning the room, often signs of heightened alertness or perceived threat. • Hypoarousal/Dissociation: Flat affect, slowed movements, appearing "checked out" or detached as a protective response to stress. • Defensive posture: Crossing arms, turning away, or avoiding eye contact, often signalling discomfort, mistrust, or withdrawal.	• Apparent indifference: Emotional flatness or detachment, which may reflect self-protection rather than lack of concern. • Testing boundaries: Challenging tone, lateness, or inconsistent engagement that may reflect uncertainty about safety, prior experiences of mistrust, or a need to test whether the environment is predictable. • Emotional overwhelm: Visible distress, self-blame, or excessive apologising following feedback or perceived criticism.

Tool	Purpose	Example
Vignette: Distress, Perception, and Mutual Escalation	To illustrate how distress may arise and escalate within unequal systems of trust, and how clinician and patient perceptions can mutually shape communication during care.	John is an Irish Traveller who has experienced discrimination in school, when seeking employment, and in wider society. His reading ability is limited. He presents to the ED with a painful leg fracture and has difficulty reading the signs advising of long waiting times. While he waits, he sees another patient with chest pain being brought straight into resuscitation, while he is asked to remain in the waiting area for further assessment. Feeling overlooked, uncertain about how decisions are made, and fearful that he may not be treated, he approaches the doctor to question how much longer he will need to wait. The environment is busy, time-pressured, and decisions are being made rapidly to prioritise immediate clinical risk. The doctor, already fatigued from a challenging shift and a recent difficult interaction with a patient's relative, responds curtly and instructs John to sit down and wait his turn. John perceives this as dismissive and discriminatory and raises his voice. The doctor becomes increasingly defensive and anxious due to their own negative stereotypes about Travellers **Reflective Prompts** • What emotional, contextual, and historical factors may be shaping John's distress and behaviour? • How do you think this interaction would have been handled if John were not a member of the Traveller Community? • What trauma-informed strategies might help stabilise this encounter?

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Communication for Inclusion

Presenting Information to the Patient

Utilising Interpretation Services

Assessing and Addressing Health Literacy

This section focuses on how doctors communicate information in ways that support understanding, safety, and trust for people experiencing social exclusion. It frames communication as a core clinical skill and patient-safety function: the ability not only to explain clearly, but to adapt information so it can be understood, questioned, and used by patients with varying literacy levels, language needs, and lived experiences of trauma or exclusion. The section examines barriers to effective communication and highlights the clinical risks that arise when information is delivered but not understood. Practical, evidence-based approaches are presented, including structured checking for understanding, appropriate use of interpreters, and adaptation of information to patients' capacities and contexts. Together, these approaches support valid consent, clearer decision-making, and more reliable engagement with care.

Presenting Information to the Patient

Keywords: communication, shared decision-making, trauma-informed care, language barriers, person-centered care

Overview

Presenting information to patients is a core clinical task, yet for people experiencing social exclusion in Ireland, it is often complicated by barriers that affect whether information is understood, acted on, or feels safe to engage with. This includes people who are homeless, seeking international protection, from marginalised ethnic groups, or living with dual diagnoses such as intellectual disability, neurodiversity, or substance use. Lived experience accounts highlight common causes, including rushed consultations that limit time for explanation, complex or technical language that may make information difficult to grasp, and unspoken assumptions that patients have understood what has been communicated. These experiences often leave people feeling overwhelmed and excluded, unsure about what was discussed, what was decided, or what actions they should take following the appointment.

A sense of vulnerability, concern about how they might be perceived, and the implicit power dynamics of healthcare, combined in some cases with cultural norms that discourage interrupting or challenging authority figures, can inhibit patients from asking for clarification. Many patients describe feeling “like a burden”, masking uncertainty in ways that lead to unvoiced concerns, incomplete comprehension, and apparent agreement even when essential information is not understood. People with limited literacy or intellectual disability may not disclose difficulty with written information, and women, migrants, or people with trauma histories may hesitate to question plans presented with authority. In these contexts, non-disclosure is common. Language and interpretation needs also create additional complexity: misunderstanding can arise when interpreters are unavailable, when dialect or phrasing shifts meaning, or when stigma within a shared cultural background affects what can be safely conveyed.

Communication failures are a patient-safety risk. When information is not presented clearly or in a manner that supports accurate understanding, treatment plans may be misunderstood, consent may be given without full comprehension, and essential follow-up or monitoring can be disrupted.

Key Clinical Considerations

- **Anticipate barriers to understanding:**
  - Trauma, limited literacy, language differences, cognitive overload, and health anxiety can reduce a patient's ability to absorb and retain health information, particularly when consultations feel hurried or intimidating.
- **Check understanding actively:**
  - Nodding or passive agreement may mask confusion or fear of asking questions.
  - When offering written information, use gentle, action-based prompts such as "Would you like to go through this leaflet together?" or "Would a leaflet help?" to gauge literacy without direct questioning – inviting, rather than testing, comprehension.
  - Follow up with open-ended prompts such as "Would it help to go over that again?" or "What part feels unclear at this stage?" to confirm understanding in a supportive, non-judgmental manner.
- **Avoid assumptions about a person's literacy or health literacy:**
  - Begin by using neutral screening questions to gauge baseline understanding and to tailor how the information is shared. A lack of functional literacy is often a source of shame, and questions such as "how are you with reading?" or "do you find leaflets helpful?" may be perceived as less judgmental and may lead to disclosure of difficulties with written materials.
- **Acknowledge cultural and linguistic nuance:**
  - Cultural norms, dialect differences, gender dynamics, and the interpreter-patient relationship can all influence how information is conveyed and understood. Disclosure may be constrained not only by language but by stigma operating within the patient's own community or culture.

- **Identify where miscommunication poses clinical risk:**
  - Actively assess where misunderstanding is likely, e.g. when discussing consent, changing medication doses, explaining procedures, or outlining follow-up steps; errors in these areas often arise from unclear explanations or assumptions about understanding.
- **Adapt communication style to support comprehension:**
  - Use plain language, speak in short segments, and summarise key points.
  - Recognise that information may not be absorbed during the first explanation and use subsequent encounters to reinforce sharing of information.
  - Reinforce with repetition and apply the Teach Back Method ("To make sure I've explained that clearly, could you tell me how you'll take this medication?").
- **Use Interpreters appropriately and safely:**
  - Engage trained, professional interpreters where available.
  - Be mindful of the potential loss of nuance in questions and responses delivered through translation, e.g. the differences between the Romani and the Romanian language.
  - Anticipate risks such as dialect mismatch, cultural stigma, or interpreter bias, for example, a patient's discomfort discussing sensitive issues with someone from their own community, or gender dynamics when disclosing experiences such as sexual violence or female genital mutilation (FGM) through an interpreter of a different gender.
  - Avoid reliance on family members as interpreters for sensitive topics.
- **Co-create care plans rather than deliver instructions:**
  - Work with the patient to agree on goals and next steps.
  - Provide information in accessible formats (e.g. verbal explanation, easy-read materials, or pictorial aids).
  - Offer to revisit and clarify decisions at later points, recognising that understanding and readiness may change over time.
- **Normalise clarification as routine clinical safety practice:**
  - Encourage questions and signal that uncertainty is acceptable (e.g. "Many people find this confusing at first, would you like to go over it again?").

Why This Matters

Inclusive information-sharing is fundamental to effective clinical care, guiding how we listen, how we speak, and the moments we pause to clarify and confirm understanding. This involves presenting information in ways that patients can absorb, question, and apply to self-management. Trauma-informed communication supports this by providing predictability, genuine choice, and space for clarification without judgement. Applied to tasks such as explaining medication changes, seeking consent, or outlining follow-up, it creates encounters in which patients feel safe to express uncertainty and participate in decision-making. Early investment in clear, respectful information-sharing builds the foundation for a trusting clinical relationship and reduces preventable harm by supporting valid consent, clearer and safer treatment decisions, and reliable follow-up.

Learning Tools

Tool	Purpose	Application
Vignette: Supporting Accurate Understanding in Interpreter-Mediated Care	To illustrate how interpreter use and communication dynamics can influence patient understanding, comfort, and disclosure.	A woman seeking international protection presents with chronic abdominal pain. Her husband offers to interpret. During the consultation, she remains quiet, looks downward, and nods without asking questions. The clinician notices that the length and content of the husband's interpreted responses are inconsistent with the questions asked, with some responses markedly shorter or more general than expected, and that the woman's affect does not change when sensitive topics are raised. When the clinician pauses and gently explores alternative interpreter options, her husband hesitates, and the woman briefly glances up. **Reflective Prompts** • What factors in this situation might be shaping how the woman is engaging and what she feels able to say? • What steps could the doctor take to support accurate understanding and create space for the woman to participate safely in the consultation?
Suggested Phrasing: Supportive Language for Clarity and Comfort	To offer examples of neutral, supportive language that helps patients ask questions, express uncertainty, and revisit information.	**Normalising Clarification** • "We covered a lot today – would you like to look at any part of it again?" • "Many people find this confusing at first; would it help to go through it together?" • "Is there anything you'd like to add, question, or change before we decide next steps?" **Supporting Emotional Comfort** • "If what we are discussing becomes upsetting for you, we can always talk about things again at another time that is more comfortable for you." • "If you'd like a moment before we continue, just let me know – there's no rush." **Application:** communication workshops
Checklist: Core Communication Safety Checklist (Universal Clinical Communication Framework)	A framework to support safe, equitable, and accessible communication across all clinical encounters.	**Recognise** Identify when information may not be received as intended. • Look for verbal and non-verbal cues that indicate confusion, discomfort, masked uncertainty, or rapid agreement. • Note inconsistent responses, incomplete follow-up actions, or difficulty recounting prior plans. • Be attentive to silence, withdrawal, reliance on others, or avoidance of written or digital material.

Tool	Purpose	Application
		Clarify Check understanding in a natural, non-judgemental way • Pause and rephrase key information using plain, concrete language. • Use open prompts to invite the patient's perspective (e.g. "What feels clear so far?"). • Apply Teach Back (asking the person to explain in their own words to confirm understanding) or Chunk and Check (breaking information into small sections and checking understanding as you go) in a supportive, conversational manner.Address assumptions before proceeding to decisions or consent. **Adapt** Modify how information is delivered so it can be understood, retained, and used. • Break information into manageable steps and reinforce key points with repetition. • Provide accessible materials (easy-read, pictorial, or translated). • Adjust pace and allow time for questions or breaks. • Offer alternative communication modalities (spoken, written, or demonstrations). **Support** Create safety, choice, and shared control in communication. • Engage trained interpreters when language or dialect barriers exist. • Encourage patient choice and participation in decision-making. • Normalise clarification as a routine part of safe clinical communication. **Document** Ensure communication needs and adaptations are carried forward in care. • Record communication supports used (e.g. interpreter or written aids). • Note comprehension checks and remaining barriers for follow-up. • Share relevant learning points with the team to support continuity. **Application**: ward quick-reference tool or teaching poster

Further Resources

1. AkiDwA Cultural Competency and Awareness. Available at: https://akidwa.ie
2. AsIAm – Resource library. Available at: https://asiam.ie/advice-guidance/resource-library
3. Deep End GP Network Ireland – Resources. Available at: https://www.deepend.ie/resources
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Utilising Interpretation Services

Keywords: professional interpreting, language barriers, informed consent, cultural meaning, patient safety, legal and ethical obligations

Description of Issue

Clear and accessible communication is a core clinical safety requirement, particularly in encounters involving consent, diagnosis, and treatment planning. When patients do not speak English fluently, they face significant barriers to understanding their treatment, participating in decisions, and providing accurate histories. Receiving care without understanding what is happening, or being unable to express one's needs or concerns, can be deeply distressing and erode trust at the point of care.

For doctors, language barriers can compromise history-taking, delay diagnosis, and undermine informed consent – a fundamental requirement across all areas of care, particularly for invasive procedures. Yet, limited access to professional interpreters, especially in busy or out-of-hours services, often leads to reliance on family members, untrained staff, or unvalidated AI tools, and in some cases, no interpretation at all. These practices increase the risk of misunderstanding, breach confidentiality, and contribute to poorer patient outcomes. Crucially, there is both a clinical and a legal obligation to provide accessible, non-discriminatory healthcare. Failure to take reasonable steps to provide appropriate interpretation where a known language barrier limits equitable access to care may constitute unlawful racial discrimination under the Equal Status Acts. (HSE Social Inclusion Unit and Health Promoting Hospitals Network, 2009 Equal Status Act (2000).

Key Clinical Considerations

- **Identify language needs:**
  - Establish the patient's primary language and level of English at first contact and determine whether interpretation is required. Document this clearly to guide the care team.
- **Access appropriate services:**
  - Know which interpreter services are available within your organisation and how to access them when needed. Identify times (e.g. out-of-hours, emergency settings) where interpreter access may be limited and plan alternatives proactively. Anticipate potential delays, escalate where needed, and avoid unsafe substitutes where interpretation is clinically necessary.
- **Use interpreters to support meaning:**
  - Recognise that culture shapes how patients describe symptoms, express distress, and interpret clinical authority. Use interpreters to support cultural understanding – not only to translate language but to help clarify expectations, context, and meaning where relevant. This helps prevent misinterpretation, strengthens trust, and improves diagnostic and consent accuracy.
- **Allocate adequate time:**
  - Allow additional time for consultations involving interpreters; interpretation typically doubles discussion time. Rushed interpreted consultations significantly increases risk of misunderstanding, invalid consent, and unsafe care.
- **Identify the optimum communication mode:**
  - Choose telephone, video, or in-person interpreting based on clinical complexity, sensitivity, safeguarding needs, and patient preference. For highly sensitive, safeguarding-related, or emotionally complex encounters, in-person or high-quality video services are often preferable.
- **Prepare the Interpreter where feasible:**
  - Where possible, brief the interpreter on the consultation topic and preferred terminology to improve accuracy and conversation flow.
- **Communicate directly with the patient:**
  - Maintain eye contact and address the patient, not the interpreter. Use short, clear sentences and pause for translation.
- **Check for understanding:**
  - Repeatedly check your patient's understanding throughout the consultation to avoid misinterpretation. Attend to body language and interactional cues that may signal misunderstanding or discomfort.
- **Maintain confidentiality:**
  - Ensure interpreters understand confidentiality expectations. Avoid using family members or children for sensitive, safeguarding, or consent-related discussions. Be aware of cultural or gender dynamics that may silence patients when a familiar community interpreter is present.

Why This Matters

Working with interpreters is a complex clinical task that draws on specific communication skills, legal and ethical knowledge, and situational judgement, particularly where consent, safeguarding, or diagnostic uncertainty are present. Effective communication through an interpreter is more than the transfer of words between languages, it is an active clinical process requiring clinicians to choose appropriate modes of interpretation, structure the consultation differently, and actively manage accuracy, consent, and confidentiality throughout interpreted encounters. In Ireland, the absence of a single, formal regulatory framework for medical interpreters means that quality can vary significantly, and clinicians must remain vigilant about the risks such as miscommunication, invalid consent, and loss of patient trust. Accessible, professional interpreter services enhance patient trust, safeguard the integrity of clinical communication, and enable clinicians to deliver safe, equitable, and legally compliant care.

Learning Tools

Tool	Purpose	Application
Vignette: Interpreter Use, Cultural Meaning, and Safety	To demonstrate how reliance on untrained interpretation tools can undermine trust and compromise consent.	A Roma woman presents to the Emergency Department late on a Friday night and is diagnosed with COVID-19. She is sharing a single room with multiple family members. The treating team recommend the option of temporary isolation accommodation to reduce risk to her household and support her recovery, explaining that this is voluntary and intended to support both her safety and her family's, and that she can discuss alternatives if preferred. A taxi is arranged. The plan is explained using an automated translation tool (Google Translate), without clear discussion of alternatives, her preferences, or explicit consent. Although she nods, she appears tense and withdrawn. She is frightened that she is being taken away to an institution and may not be allowed to return to her family; these fears are influenced by stories within her community about previous institutional mistreatment. She gets into the taxi but, overwhelmed and unsure what is happening, jumps out at a traffic light. **Reflective Prompts** • What factors may have contributed to her anxiety, mistrust, and decision not to continue? • What changes to communication or interpreter use might have altered this outcome?

Further Resources

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Assessing and Addressing Health Literacy

Keywords: health literacy, general literacy and numeracy, trauma-informed communication, patient safety, informed consent, medication adherence, health equity

Overview

Health literacy refers to the ability to find, understand, and use health information to make informed decisions about care. It encompasses "people's knowledge, motivation and competences to access, understand, appraise, and apply health information in order to make judgements and take decisions in everyday life concerning healthcare, disease prevention and health promotion, to maintain or improve quality of life during the life course" (Sørensen et al., 2012).

Health literacy is distinct from general literacy and numeracy. A person may read and write well yet struggle to interpret medical terminology, follow explanations about risk, understand medication changes, or navigate complex care pathways. Conversely, limited general literacy or numeracy – common among people experiencing social exclusion due to disrupted education, poverty, undiagnosed learning disability, or structural disadvantage – can further constrain a person's use of health information safely and effectively.[1]

[1] Limited levels of literacy (reading and writing skills) and numeracy are common among people who experience social exclusion (Homeless Link, 2023), often reflecting broader structural disadvantages such as disrupted education, limited opportunities to upskill, or undiagnosed learning disabilities. The UK Centre for Homeless Impact (2024) highlights that poor literacy in the homeless population contributes not only to barriers in healthcare, but also to unemployment, social isolation, and enduring stigma.

Difficulties with either general or health literacy are often hidden in clinical encounters. Patients may not disclose challenges, and clinicians may miss subtle cues, particularly where patients nod in agreement, rely on others to interpret written material, or avoid paperwork.[2] These patterns frequently reflect intersecting emotional (shame, anxiety), cognitive (learning disability, neurodiversity), social-structural (exclusion, marginalisation), behavioural (masking, avoidance), and autonomy-related factors (reduced sense of control or confidence in healthcare settings). When unaddressed, this can contribute to unspoken confusion, unsafe assumptions, and preventable errors such as medication mismanagement, missed appointments, and disengagement from follow-up care. Behaviour labelled as "non-compliance" may therefore more accurately reflect systems that have not met people at their level of understanding.

In Ireland, healthcare processes often assume high levels of literacy, digital competence, familiarity with medical systems, and the ability to self-advocate. Increasing reliance on written forms, online portals, and digitally delivered information can further marginalise those without these skills.

Such inaccessibility undermines informed consent, adherence, and patient safety. Likewise, clinical communication may rely on terminology, concepts, or instructions that are unfamiliar or difficult to process, such as dosage changes, dietary guidance, or the purpose of allied health referrals.

These barriers can impede access and continuity of care and, in practice, limit their capacity to make informed decisions or contribute meaningfully to care planning. For example, a patient attending the Emergency Department for exacerbation of asthma may be discharged with a written emergency management plan and a tapering prescription for oral steroids. If the admitting team is not aware of the patient's literacy or numeracy needs, the plan may be difficult to follow, potentially leading to treatment error or reattendance.

[2] Estimating prevalence is difficult, as definitions and measures vary and often fail to distinguish between limited literacy, English as a second language, and poor digital literacy. In 2014, a report drawing on data from homelessness charity St Mungo's found that approximately 51% of people experiencing homelessness lacked basic literacy skills and 55% lacked basic numeracy skills (St Mungos 2014).

Key Clinical Considerations

- **Recognise variation in literacy and numeracy**
  - General literacy and numeracy, and digital literacy, vary widely across the population, with socially excluded groups disproportionately affected. These directly influence health literacy and can shape capacity for engagement and adherence, as well as health outcomes.
- **Identify cues of limited literacy**
  - Common indicators include administrative cues (missed appointments, incomplete forms, difficulty completing registration or consent paperwork), medication-related cues (confusion about prescriptions, incorrect medication use, repeated questions about dosage or timing), and system-navigation cues (difficulty progressing through referrals or investigations that require multiple steps, e.g. scheduling, attending, completing tests). These patterns may reflect limited general or health literacy, cognitive challenges, or executive dysfunction.
- **Recognise concealment strategies**
  - Patients often compensate for literacy or comprehension difficulties through masking behaviours, including avoidance (declining paperwork, not reading materials during the consultation), reliance on others (deferring to family, peers, or support workers to interpret written information, even when present in the consultation), and apparent agreement (nodding, giving minimal responses, or expressing rapid agreement to avoid scrutiny). These behaviours can obscure genuine misunderstanding, and should prompt sensitive, non-judgemental clarification.
- **Be aware of emotional and social barriers**
  - Shame, anxiety, or fear of judgment can prevent patients from disclosing confusion. Recognise that avoidance or passivity may reflect prior negative healthcare experiences.
- **Address digital barriers**
  - Identify and adapt for limited digital literacy. Where available, offer alternatives such as phone scheduling, printed summaries, or supported sign-up for online services.
- **Apply universal communication precautions**
  - Do not infer literacy or comprehension level from fluency, appearance, or occupation. Assume that all patients may benefit from plain language and structured checking for understanding.
- **Ask and check respectfully**
  - Ask patients about their comfort with written information in a non-judgemental way, (e.g. “How confident are you filling out forms by yourself?”; “How often do you have difficulty understanding written information your doctor gives you?”).
- **Use structured comprehension techniques**
  - Apply methods such as Teach Back (asking the patient to restate key information in their own words to confirm understanding) or Chunk and Check (breaking information into small sections and pausing after each to confirm comprehension, helping to reduce cognitive load and improving recall).

- **Communicate clearly and accessibly**
  - Avoid jargon, acronyms, and dense explanations. Focus on clear, manageable information units, supported by visual aids and purposeful repetition, and adjust pace to the patient's needs.
- **Clarify purpose and expectations**
  - Explain why each test, medication, or referral matters and what the patient can expect, including practical steps such as travel, forms, or digital sign-ins.
- **Simplify care plans**
  - Align treatment plans with the patient's capacity and context. Rationalise medication regimens, use pictorial or easy-read materials where appropriate, and arrange closer follow-up when comprehension is uncertain.
- **Normalise support and reinforce safety in asking for help**
  - Support a shame-free environment by explicitly normalising difficulty and inviting clarification. Language such as, "A lot of people find this confusing, let's go through it together," signals that checking understanding is routine clinical practice, not indicative of personal failing.
- **Link literacy to safe care planning**
  - Understand that low literacy and numeracy can affect adherence to treatment, safe medication use, and comprehension of health instructions – with implications for follow-up, consent, and patient safety.
- **Signpost and document**
  - Link patients to relevant community supports (e.g. advocates, disability services, or community navigators). Document identified literacy or access barriers, and the adaptations used, clearly in the care plan.

Why This Matters

Addressing health literacy is not just about simplifying information; it is about making care accessible, affirming, and navigable. Doctors have a professional duty to identify potential barriers, normalise clarification, and adapt both spoken and written communication to each patient's level of understanding. It is important that information is not omitted based on an assumption that it won't be understood; instead, a complete explanation should be given in a digestible way. Clear, collaborative care plans, supported by proactive adaptations and sensitive enquiry, support valid consent, clearer decision-making, and more reliable follow-through. Assessing and addressing health literacy, therefore, is not a peripheral communication skill but a core component of trauma-informed, rights-based, and person-centred practice. This ensures that all patients, regardless of background, literacy level, or cognitive profile, can understand their health needs and participate meaningfully in decisions about their care.

Learning Tools

Tool	Purpose	Application
Vignette: Hidden Comprehension Barriers	Illustrate how concealed literacy challenges may undermine engagement and treatment.	A man in his forties is attending a cardiology follow-up clinic. He has missed several previous appointments, and when asked about medication use, he gives brief answers and avoids looking at the prescription list. His chart shows that forms have been returned incomplete on multiple occasions. During the consultation, he nods quickly when instructions are given but does not ask questions. When handed a written information sheet, he hesitates before placing it into his pocket without reading it. **Reflective Prompts** • What cues in this interaction might suggest difficulty understanding written or spoken health information? • What steps could support clearer communication and reduce the risk of misunderstanding? **Application**: Multidisciplinary team reflection, case-based discussion, or communication skills workshop.
Vignette: Administrative and Systemic Barriers	Demonstrate how general literacy challenges intersect with financial and system navigation challenges.	A man with chronic illness attends clinic and reports that he has not taken his prescribed medication for the past month. When asked about this, he looks down and speaks quietly. He removes a folded medical card renewal form from his pocket; several sections are blank, and his signature is missing. He hesitates before handing it over, saying that he tried to fill it in but "wasn't sure what to put where". He adds that the pharmacy asked for payment he could not afford and that he left without the medication because he did not know how to proceed. **Reflective Prompts** • What barriers might be contributing to his lapse in medication use? • What practical supports could help him navigate the renewal process and continue treatment safely? **Application**: Multidisciplinary team reflection, case-based discussion, or communication skills workshop.
Suggested Phrasing: Exploring Literacy and Access Needs	Offer inclusive, non-judgemental questions that help clinicians identify literacy, language, and digital barriers.	**Examples:** • "Is English your first language?" • "Do you have any trouble reading or writing (in English)?" • "How do you prefer to get information – written down, talked through, or both?" • "Do you need a hand with any forms or paperwork?" • "Do you have access to the internet at home, and are you comfortable using it?" • "How confident are you filling out forms by yourself?" **Application**: Communication skills training, simulated consultations, or social inclusion workshops.

Tool	Purpose	Application
Suggested Phrasing: Normalising Clarification and Shared Understanding	Model relational language that normalises checking comprehension and invites patients to express uncertainty without shame.	**Examples:** • "We've covered a lot today; what would you find most helpful to go through again?" • "Would it help if we went through this together?" • "Would you like me to write that down more clearly or draw it?" • "A lot of people find this confusing; let's look at it together." • "Can you tell me in your own words what the next step is, so I can be sure I explained it well?" **Application**: Communication skills training, supervision sessions, or reflective practice discussions.
Checklist: Supporting Safe Communication Where Literacy or Numeracy May Be Limited	Apply core communication safety principles to situations where literacy, numeracy, or comprehension barriers may affect understanding, adherence, or safe decision-making.	**Recognise** Identify cues that suggest difficulty understanding written, spoken, or digital health information. • Missed appointments, incomplete forms, or difficulty completing registration/consent paperwork. • Uncertainty about medication names, doses, or timing. • Rapid agreement, minimal questions, or avoidance of written materials. • Reliance on family, peers, or support workers to interpret documents. • Difficulty navigating multi-step processes (e.g. referrals, investigations, or online portals). **Clarify** Confirm the patient's understanding before proceeding. • Restate key information in concrete, clear language. • Use open prompts (e.g. "What part would you like more detail on?"). • Apply Teach Back conversationally to confirm comprehension. • Explore whether written information, numbers, or digital tasks are difficult to use. **Adapt** Modify communication and care plans to support accurate understanding and safe use of information. • Break information into short segments; pause to confirm understanding. • Use accessible formats (e.g. easy-read, pictorial, colour-coded, or translated). • Adjust medication instructions using simple schedules or visual cues. • Explore and provide alternatives to digital tasks (e.g. printed summaries or phone scheduling) where feasible. • Support navigation of forms, instructions, or multi-step processes.

Tool	Purpose	Application
		Support Create a safe, non-judgemental environment that empowers patients to ask questions and participate. • Normalise clarification (e.g. "Many people find this confusing, let's look at it together"). • Facilitate practical help with paperwork when needed. • Involve family or support persons, with consent and where helpful. • Ensure the patient can access essential medication safely (e.g. bridging scripts or social worker support). **Document** Carry forward the necessary adaptations, so care remains consistent. • Record identified literacy or access barriers (with consent). • Note which strategies improved comprehension (e.g. Teach Back, easy-read, or working with an advocate). • Highlight follow-up steps or supports required. • Share relevant information with the MDT to prevent repeated barriers. **Application**: Clinic poster or ward handout.

Further Resources

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16. The Health Literacy Place. Chunk and check. Available at: https://www.healthliteracyplace.org.uk/toolkit/techniques/chunk-and-check/
17. The Health Literacy Place. Teach Back. Available at: https://www.healthliteracyplace.org.uk/toolkit/techniques/teach-back/

Appendices

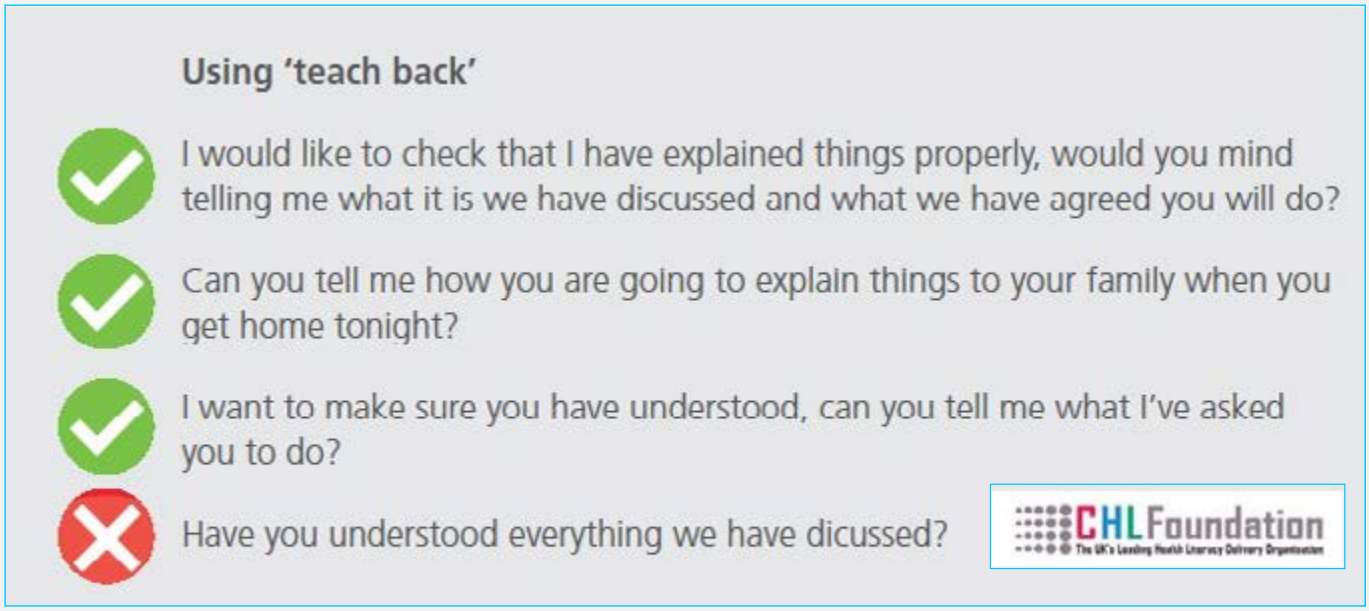
Table One. Dimensions of Health Literacy Applied to Three Health Domains

A highly cited systematic review and conceptual model of health literacy identified 12 dimensions of health literacy, which can be used to develop and target healthcare and public health interventions.

(Sørensen et al., 2012)

	Access/ obtain information relevant to health	Understand information relevant to health	Process/appraise information relevant to health	Apply/use information relevant to health
Health care	Ability to access information on medical or clinical issues.	Ability to understand medical information and derive meaning.	Ability to interpret and evaluate medical information.	Ability to make informed decisions on medical issues.
Disease prevention	Ability to access information on risk factors for health.	Ability to understand information on risk factors and derive meaning.	Ability to interpret and evaluate information on risk factors for health.	Ability to make informed decisions on risk factors for health.
Health promotion	Ability to update oneself on determinants of health in the social and physical environment.	Ability to understand information on determinants of health in the social and physical environment and derive meaning.	Ability to interpret and evaluate information on health determinants in the social and physical environment.	Ability to make informed decisions on health determinants in the social and physical environment.

Figure One. Teach Back Approach



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Person-Centred Care

Shared Decision Making

Culturally Safe and Trauma-Informed Care

This section explores how doctors deliver care grounded in the person's values, priorities, and lived circumstances, recognising person-centred practice as a core component of safe, equitable, and rights-based care. For people experiencing social exclusion, effective care depends not only on clinical expertise but on whether recommendations are feasible and acceptable within the realities of daily life. The section emphasises active listening, goal clarification, and collaborative planning so that investigations, treatment, and follow-up are clinically appropriate and realistically achievable, supporting engagement and reducing avoidable risk.

Shared Decision Making

Keywords: shared decision-making, patient priorities, feasibility, trust, self-determination, harm reduction, continuity of care

Overview

Shared decision-making is the process of aligning clinical recommendations and goals with the patient's values, priorities, and capacity to act. It does not mean agreeing to every patient request; rather, it involves a collaborative exploration of what matters to them, an explanation of clinical rationale, and the co-production of a plan that is both medically safe and practically achievable.

For patients experiencing social exclusion, competing priorities such as safety, withdrawal management, childcare, shelter, or legal obligations may take precedence over health concerns. Standard models of care, often built around assumptions of stable housing, transport, literacy, and GP access, may therefore feel unrealistic, rigid, or coercive. When plans do not reflect or respond to a patient's lived reality in this way, disengagement is more likely.

In practice, shared decision-making begins with understanding why the patient has presented, what they fear and value, and how they interpret their symptoms, before integrating these priorities into clinical assessment and the practical constraints shaping daily life. Clarifying symptom onset, functional baseline, patient priorities, and practical barriers allows investigations, treatment, and follow-up to be shaped in ways that are both clinically sound and realistically achievable. The process is grounded in openness, transparency about available options, and a respect for patient autonomy.

Key Clinical Considerations

- **Elicit concerns and patient priorities**
  - Use open, direct prompts to understand what matters most now (e.g. "What are you most worried about today?" or "What do you think might be happening?").
  - Explore practical and emotional pressures and constraints influencing engagement (e.g. pain, withdrawal, housing uncertainty, childcare, immigration worries, or safety fears).
  - Clarify what the patient sees as a meaningful outcome for this encounter (e.g. "What would feel like a good outcome today?"), recognising that this may differ from clinical goals.
- **Acknowledge and integrate patient priorities into care**
  - Explicitly recognise stated priorities and name their legitimacy to reduce shame, defensiveness, and disengagement (e.g. "It makes sense that withdrawal/housing/court is taking up a lot of your headspace right now.").
  - Where priorities limit capacity for full treatment, adopt a harm-reduction mindset: agree safe, achievable next steps rather than insisting on ideal plans that may not be followed.
  - Balance patient priorities with clinical risk by negotiating shared goals (e.g. "Let's figure out what we can safely manage today while keeping your other worries in mind.") and safety-net clearly.
- **Respect autonomy while maintaining clinical responsibility**
  - Where a patient has decision-making capacity, they may choose options that increase health risk (e.g. ongoing substance use, declining admission, or not engaging with follow-up).
  - The doctor's task is to explain clinical reasoning and risk clearly, check understanding, document capacity and the discussion, and continue to offer care (including harm-reduction options, symptom relief, and clear routes for re-engagement), rather than withdrawing support.
- **Clarify context, constraints, and capacity**
  - Establish the patient's symptom timeline, baseline function, and reason for attendance.
  - Identify feasibility constraints (e.g. no refrigeration for insulin, no transport, unstable housing, or daily competing demands).
  - Where the ability to make decisions or follow agreed plans may be affected by illness, distress, intoxication, cognitive impairment, coercion, or safeguarding concerns, address this explicitly, document clearly, and apply relevant statutory guidance.
- **Align plans with real-world feasibility**
  - Do not assume patients can follow standard instructions (e.g. bowel prep, dressings, or refrigeration of medications).
  - Adapt investigations, treatment plans, and follow-up to what is clinically safe and realistically achievable.
- **Make clinical reasoning transparent**
  - Explain options, risks, benefits, and trade-offs in grounded, non-technical language.
  - Be honest about uncertainties and limits of what services can provide.
  - Invite patients to shape the decision rather than simply agree with it.
- **Check understanding and agreement**
  - Confirm what the patient has understood, what they feel able to do, and where they anticipate difficulty and might need support.
  - Ask: "What part of this feels realistic?" / "What might get in the way?"
  - Agree on a shared, practical plan.

- **Use respectful, non-stigmatising language**
  - Avoid punitive framing of "non-compliance". Missed appointments or medication lapses may reflect instability rather than disinterest. Reframe as "interrupted care" and offer re-engagement, not judgement.
  - Validate concerns, uncertainty, and ambivalence, e.g. "I can see why this is worrying you," or "You've done a lot to manage this so far."
- **Explicitly acknowledge patient's concerns and severity of symptoms**
  - "I understand that you want to get X (e.g. your chest pain) sorted".
  - "While you're here, would it help if we involved our social work/advocacy team to look at practical supports?"
- **Plan flexibly, build contingency and safety-netting**
  - Recognise that engagement fluctuates; design follow-up that accommodates real-world barriers (e.g. flexible review options, drop-in services, peer accompaniment, outreach, or reminders), rather than relying solely on standard outpatient pathways.
  - When building explicit contingencies and re-engagement routes, explain what to monitor, when to seek help, where to go, and who to contact if circumstances change or the plan becomes unmanageable.
  - Frame this proactively as part of safe, supportive care (e.g. "If this doesn't work out as we hope, here's how we'll still make sure you're supported"), reducing fear of "failure" and supporting sustained engagement.
- **Consider harm reduction strategies**
  - Where abstinence or full adherence is not immediately achievable, adopt a harm reduction approach; agree on the safest next step rather than unrealistic targets.
  - Recognise and validate incremental progress (e.g. reduced use, safer injecting, or attending appointments).

Why This Matters

Shared decision-making improves clinical accuracy, strengthens trust, and enhances patient safety by ensuring that clinical plans reflect the realities of patients' lives. When doctors take time to understand a patient's priorities, context, and constraints, histories become clearer, diagnoses more accurate, and treatment adherence more achievable.

For people experiencing social marginalisation, health is often one priority among many - competing with immediate needs such as accommodation, food, safety, and withdrawal. When clinical plans overlook these realities, patients can feel judged, invalidated, or disengaged. The clinical task is to surface and recognise what matters to the patient, integrating these priorities into decision-making while retaining responsibility for ensuring care remains safe, evidence-based, realistic, and clinically appropriate. What may appear minor from a clinical perspective can be decisive for continuity of care. Plans grounded in feasibility, e.g. adapting timelines, supports, and follow-up, can enable patients to re-engage even after setbacks. This approach promotes dignity and helps ensure that treatment decisions remain fair and feasible, building a foundation for trusted and sustained engagement.

Learning Tools

Tool	Purpose	Application
Simulation: Shared Decision Making in Context	To provide a structured environment for practising shared decision-making with patients whose priorities, constraints, and lived circumstances shape what is feasible.	TS4TIC: Translational Simulation for Trauma Informed Care (accessible here: http://inclusionhealth.ie/?page_id=114)
Checklist Prompts: Shared Decision Making	To support doctors in aligning clinical plans with the patient's priorities, capacity, and lived context.	Use these quick prompts to ground shared decision-making in feasibility, clarity, and patient priorities. **Priorities** • Have I identified what matters most to the patient right now (e.g. fears, goals, or competing pressures)? **Feasibility** • Have I checked whether the proposed plan is realistically achievable given the patient's circumstances (housing, transport, withdrawal, caregiving, cost, or literacy)? **Options & Rationale** • Have I explained the clinical options, risks, and benefits clearly, and checked that the patient understands the reasoning behind them? **Agreement & Capacity** • Have I confirmed what the patient feels able to do, where they anticipate difficulty, and what supports might help? **Re-engagement Plan** • If this plan breaks down, is there a clear route for re-engagement (safety-netting, contacts, outreach, or alternative follow-up)?

Culturally Safe and Trauma-Informed Care

Keywords: cultural competence, cultural humility, structural competence, social exclusion

Overview

Cultural competence in healthcare is defined as "the trained ability to identify cross-cultural expressions of illness and health, and to thus counteract the marginalisation of patients by race, ethnicity, social class, religion, sexual orientation, or other markers of difference" (FNHA, 2016). Contemporary approaches extend this concept through cultural humility (an ongoing stance of self-reflection, openness, and partnership) and structural competence (which focuses on recognising upstream structural determinants that contribute to health inequities, including the "economic and political conditions producing and racialising inequalities in health") (FNHA, 2016, Metzl & Hansen, 2014, Metzl & Petty, 2017).

In practice, this involves recognising race and ethnicity as potential determinants of health and the cumulative and toxic effects of racism, discrimination, and exclusion on the health of people who are members of minority ethnic groups (FNHA, 2016, Neff et al., 2020). It is also important to recognise that cultural norms can vary among people of the same ethnicity.

Cultural norms and expectations must be understood and accounted for when discussing issues related to consent, family roles, and priorities for care and treatment decisions. The attitudes that healthcare professionals adopt when a patient makes a decision that differs from 'clinical norms' are crucial, and only by fostering mutual respect and working collaboratively can truly shared plans of care be developed.[4] Within an Inclusion Health context, this requires recognising that people from marginalised or excluded populations may experience healthcare differently due to cultural background, migration history, language barriers, or prior experiences of discrimination.

[4] As Hickson (2022) writes "Making culturally competent healthcare a priority reduces racial, economic, ethnic, and social disparities. The only way to treat all patients with compassion and dignity is by understanding their cultures and responding appropriately to their wishes and desires".

Key Clinical Considerations

- **Recognise culturally shaped communication patterns**
  - Do not assume shared communication norms. Politeness, indirect agreement, or deference may mask uncertainty or distress, while more direct communication styles may reflect cultural norms rather than hostility.
  - Distinguish apparent agreement from genuine understanding. Create explicit, psychologically safe opportunities for patients to question, disagree, or express concern, and normalise this openly (e.g. "It's okay if this doesn't feel right - we can talk it through.").
- **Be intentional about how information is shared and received**
  - Ask how the patient prefers to receive information (e.g. alone, with family present, or via interpreter).
  - Adjust pace, tone, and directness to align cultural communication preferences where appropriate, without compromising clarity or safety.
  - Invite the patient to describe the plan in their own words, focusing on meaning, not just wording.
  - Where interpreters are required, use trained professionals and consider issues of privacy, gender preference, trust, and safety.
- **Understanding Health Beliefs**
  - Explore how cultural and religious beliefs influence understanding of illness, consent, prognosis disclosure, treatment choices, and engagement with care (e.g. family-led decision-making).
  - Where appropriate and with consent, recognise the role of family, community, and social networks in shaping health decisions. Work with the patient to explain tests, diagnoses, and treatment plans in terms that are meaningful to them.
- **Practice self-awareness**
  - Remain alert to personal assumptions, cultural blind spots, and implicit biases that may influence clinical judgement or the doctor-patient relationship.
  - Reflect on how bias may influence tone, trust, diagnostic reasoning, and escalation decisions.
  - Where concerns about discriminatory care arise, address them sensitively and professionally.
- **Trauma and discrimination sensitivity**
  - Recognise when past trauma, racism, fear of authority, or institutional mistrust may shape engagement.
  - Proceed proportionately and avoid unnecessary repeated retelling of distressing history.
  - Where trauma significantly affects engagement or the pace of care, acknowledge this explicitly, document clearly, and seek senior or specialist support where appropriate.
- **Distinguish individual from system responsibility**
  - Distinguish between what can be addressed within the consultation (language, tone, privacy, pacing, interpreter use, validation of experiences of racism) and what requires organisational action (availability of interpreters, signage, staff training, safe complaint mechanisms).

  - Recognise when to escalate concerns about structural barriers or discriminatory practices, and when partnership with community or cultural organisations may support safer, more trusted care pathways.

- **Build trust through Cultural Humility**
  - Recognise how discrimination, exclusion, or prior negative experiences with healthcare may shape mistrust, and address this through consistency, respect, and cultural humility, acknowledging community context and lived experience where relevant.
- **Shared Decision-Making**
  - Incorporate cultural context into care planning while maintaining evidence-based standards. Involve family or community members where appropriate and with the patient's consent.

Why This Matters

Culturally competent and trauma-informed practice reduces miscommunication, diagnostic error, and mistrust by aligning clinical care with how patients understand illness, risk, and authority. For people who have experienced racism, migration-related trauma, or cultural marginalisation, routine clinical interactions such as undressing for an examination, being examined by a clinician of a particular gender, or being asked to repeat a traumatic history, may carry added layers of meaning and vulnerability.

Building trust in this context often requires adequate time and, where possible, continuity across encounters. Reviewing prior documentation, minimising repeated retelling of distressing histories, maintaining continuity with a known clinician, and ensuring appropriate information sharing across services all contribute to greater psychological safety. By combining cultural humility (ongoing self-reflection and openness to being taught by patients and communities) with structural competence (recognising and responding to the systems that produce inequity), doctors can create encounters that are safer, more respectful, and more effective.

Ultimately, healthcare professionals should seek to provide care that is culturally safe and centred on the patient's lived experience, recognising and actively addressing the power imbalances inherent in healthcare. This approach fosters environments free from racism and discrimination, where patients feel secure in accessing, engaging with, and remaining in care.

Learning Tools

Tool	Purpose	Application
Vignette: Risks of Using Family Members as Interpreters	To explore risks of using children or family members as interpreters and the impact on disclosure.	A Somali woman presents with lower abdominal pain. The only person accompanying her is her 12-year-old daughter, who is asked to interpret. During the consultation, the woman responds briefly, avoids eye contact, and does not describe gynaecological symptoms. Her daughter appears uncomfortable, hesitates during translation, and omits some details. Clinical review later reveals a pelvic infection that required earlier intervention. **Reflective Prompts** • What cues suggest that sensitive information may not be disclosed when a child interprets? • How could the doctor create a safer environment for accurate communication and disclosure? **Application**: simulation exercise or structured case discussion.
Vignette: Cultural Norms, Policy, and Trust in Critical Care	To examine how hospital policies and cultural norms may interact during critical care decision-making.	Martin is a 40-year-old Irish Traveller man with cirrhosis. He is in the Intensive Care Unit (ICU) with decompensated liver disease. The treating team has assessed his prognosis as very poor and is planning to withdraw care. A large number of family members are present at the ICU and wish to sit by his bedside, in line with their cultural traditions. The ICU policy states that only two family members may be present in the unit at a time. Martin's family members express that this is not in line with their community and cultural traditions, and in further discussion, become upset. This request is perceived by staff as disruptive behaviour, and security is called in line with the hospital's zero-tolerance policy, and the family is removed from the hospital. **Reflective Prompts** • How do health inequities manifest in this scenario? • How might this situation have been handled if the family were from a different cultural background? • What may be the impact of this experience on Martin's family and the wider community?
Suggested Phrasing: Professional Interpreter Use	Model how to sensitively explain the need for a professional interpreter.	• "Thank you for offering to interpret, but it's important we use a professional interpreter to make sure your mum feels comfortable and everything is translated correctly." • "This is a routine part of care - it helps protect your privacy and ensures we don't miss anything important." • "I'll arrange a professional interpreter now, so you don't have to translate for your mum." **Application**: communication skills training.

Tool	Purpose	Application
Suggested Phrasing: Exploring Cultural Background	To support clinicians in sensitively exploring cultural context and migration history without making assumptions.	**Questions**: What is your country of origin? What ethnic group(s) do you identify with? What language(s) do you speak? What is the main language spoken in your home? What language do you prefer speaking? Why and when did you come to Ireland? What challenges did you face when you arrived? What helped you and your family adjust? **Application**: roleplay or simulation in communication training.
Checklist: Cultural and Linguistic Safety Adaptation	To guide clinicians in recognising and addressing cultural, linguistic, and structural factors that influence communication and trust.	**Recognise** Identify when culture, language, or prior experiences may shape communication. • Notice hesitancy, limited disclosure, and apparent agreement without detail. • Look for reliance on family members, especially children, for interpretation. • Identify when trauma, migration history, or discrimination may affect comfort or trust. **Clarify** Check understanding and preferences without assumptions. • Ask how the patient prefers to receive information (language, interpreter, family presence). • Confirm understanding in clear, concrete terms. • Explore whether cultural norms influence decision-making, consent, or expectations. **Adapt** Modify communication and care planning in ways that respect cultural and linguistic needs. • Engage a professional interpreter; avoid using children to interpret.. • Speak directly to the patient, with the interpreter as a conduit rather than the focus of communication. • Adjust tone, pace, and directness in response to cultural communication norms. • Incorporate family roles when appropriate and with consent. • Plan examinations and procedures with gender, privacy, and cultural considerations in mind.

Tool	Purpose	Application
		Support Create conditions that allow patients to participate safely and fully. • Validate experiences of discrimination or exclusion when raised. • Minimise repeated retelling of traumatic migration or violence histories. • Offer continuity with a known clinician when possible. • Escalate structural or systemic barriers (e.g. interpreter availability, discriminatory practice **Document** Ensure adaptations are visible and inform ongoing care. • Record interpreter use or refusal. • Note cultural or linguistic preferences relevant to care. • Share information appropriately to reduce repeated traumatic disclosure. **Application**: handouts, wall posters, digital prompts.

Further Resources

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Holistic & Socially Informed Care

Integrated Care & Involvement of Support Services

Understanding Hygiene and Access to Facilities

This section focuses on how doctors integrate social context into clinical assessment, planning, and follow-up, recognising that for people experiencing social exclusion, safe care emerges from the interaction between clinical need and lived circumstances. It addresses two closely linked areas: the coordinated involvement of support services and the clinical implications of limited access to basic facilities such as hygiene, medication storage, and safe accommodation. The section supports doctors to identify social risks early, involve appropriate agencies, and adapt diagnostic, treatment, and discharge decisions to what is realistically achievable for each patient. By embedding social realities into routine clinical decision-making, this section highlights practice approaches that reduce preventable harm, improve continuity of care, and support plans that are clinically sound, feasible, and respectful of patients' circumstances.

Integrated Care & Involvement of Support Services

Keywords: integrated care, multidisciplinary care, inclusion health, support services, social work, advocacy, housing, transitions of care, safe discharge, continuity of care

Overview

For people experiencing social exclusion, safe and effective healthcare depends not only on clinical interventions but on the coordinated involvement of wider support services across acute care, transitions, and longer-term management. Several distinct but interrelated factors can undermine a person's ability to engage with care, including:

- Factors that disrupt treatment adherence and continuity: Such as unstable routines, active addiction, cognitive impairment, and poor mental health, which can interfere with taking medication as prescribed, attending appointments, or maintaining follow-up.
- Factors that limit recovery and stability after illness or hospitalisation: Including lack of secure accommodation, poverty, lack of reliable transport, or discharge to environments that cannot support convalescence, rehabilitation, or safe medication management.
- Factors that impede access to healthcare, entitlements, and support systems: Such as language or communication barriers, barriers related to immigration status, lack of identification, or difficulty navigating income, housing, and healthcare systems.

When these factors are present, they can compromise patients' ability to adhere to treatment plans, attend follow-up, and recover safely after acute illness or hospitalisation. In these contexts, services such as medical social work, addiction teams, public health nurses (PHNs), disability services, migrant health supports, housing officers, and community or voluntary organisations play a critical role in addressing non-medical barriers that directly affect clinical safety, continuity, and outcomes.

Depending on the risks identified, these services may contribute by:

- Stabilising treatment adherence and follow-up, through medication supervision, outreach reviews, appointment coordination, or addiction treatment continuity.
- Supporting recovery and safe discharge, by securing appropriate accommodation, facilitating access to income supports, arranging community nursing or rehabilitation input, and mitigating environmental risks.

- Facilitating access to care and entitlements, including assistance with documentation, interpretation, advocacy, and navigation of health, housing, and welfare systems.

With patient consent, these services may also provide collateral history that informs realistic care planning, particularly where family or informal supports are absent. For many patients experiencing social exclusion, these services can fulfil roles that, in other contexts, are often provided by family supports – such as coordinating appointments, reinforcing care plans, and maintaining continuity across services.

Transitions of care, such as hospital discharge, release from prison, or leaving detox or residential treatment, are periods of particularly high clinical risk. For people experiencing social exclusion, these transitions often occur without stable accommodation, continuity of medication, or clear follow-up arrangements. Without coordinated planning, rapid clinical or functional deterioration, treatment interruption, loss of engagement, or crisis re-presentation may occur, including relapse or overdose where substance use is a relevant factor. Integrated care is therefore not confined to the point of discharge; it should begin at admission or first clinical contact and requires early identification of both clinical and social needs, timely engagement of the appropriate support services, and clear accountability for follow-up across agencies.

Key Clinical Considerations

- **Screen for social needs early**
  - Use brief, routine prompts to identify social risks that may affect safety, treatment continuity, or recovery, across key domains:
    - Housing and safety: housing instability, unsafe discharge location, congregate or unsupported settings.
    - Income and entitlements: medical card or scheme eligibility, benefits disruption, medication affordability.
    - Health system access: GP registration, ability to attend appointments, transport barriers, fragmented service involvement.
    - Communication and capacity: health or digital literacy, language discordance, cognitive impairment, learning disability.
- **Know and use local resources**
  - Ensure awareness of, and access to, an up-to-date local directory of support services (e.g. medical social work, PHNs, addiction teams, housing officers, disability services, migrant health supports, NGO partners), including referral routes and eligibility criteria.
  - Know how to contact them in-hours and out-of-hours where relevant.
- **Recognise and use specialist expertise**
  - Treat support services as core partners who are essential for equity and safety in care.
  - Co-set goals with support services that are explicitly linked to clinical outcomes (e.g. medication continuity, opioid substitution therapy (OST) attendance, community nursing visits, safe accommodation).
  - Support services may play a key role in supporting the patient in adhering to their treatment plan post-discharge and in providing them with help in understanding and managing their condition.
- **Collaborate early – not only at discharge**
  - Involve social work/liaison psychiatry/public health nurses/addiction or advocacy teams at the start of care planning, not only at discharge.
  - Where appropriate and with consent, draw on support services to provide collateral history that informs realistic care planning.
- **Document to manage risk**
  - Record referrals made, consent to share information (and any limits), interagency communications, and agreed plans.
  - Ensure plans and contacts are visible in the record (e.g. problem list, discharge summary) and copied to relevant providers per policy.
  - Clear documentation supports continuity, clear consent, and accountability across services.
- **Distinguish immediate vs longer-term needs**
  - Acute/Immediate risks: overdose, withdrawal management, safeguarding concerns, loss of medication, unsafe discharge location.
  - Longer-term needs: housing applications, disability supports, income assistance, trauma therapy, chronic disease management, addiction treatment continuity.

Why This Matters

For people facing social exclusion, effective healthcare often depends on the timely and coordinated involvement of support services. Lived experience consistently highlights that when social work, housing, addiction, or advocacy services are involved early and appropriately, patients are more likely to remain engaged with care, understand next steps, and follow through with treatment plans – reducing self-discharge, missed follow-up, and confusion at transition points.

When referrals are delayed, communication between services is unclear, or advocacy input is absent, care becomes fragmented, follow-up is missed, and patients may re-present. Doctors, therefore, play a critical role in recognising both unmet clinical and social needs, obtaining consent to involve relevant services, and initiating timely referrals that align with the patient's real-world circumstances.

In practice, referral criteria, points of contact, and local pathways may be unclear, and competing clinical pressures can obscure opportunities for early engagement. Consequently, a proactive and structured approach to involving support services helps mitigate predictable risk, supports continuity across settings, and ensures that care plans are both clinically appropriate and realistically deliverable – strengthening safety, sustainability, and equity in care delivery.

Learning Tools

Tool	Purpose	Application
Vignette: Identifying Social Needs and Mobilising Supports Early	To highlight practicing early identification of social needs and timely activation of supports.	A man living with HIV and opioid dependence presents with a foot ulcer. He reports sleeping in different locations each night. He has recently missed multiple clinic appointments and is not linked with addiction support or medical social work. His medications are irregular, and he avoids questions about housing or follow-up. No support referrals are documented in the chart, and there is no identified plan for wound care, Opioid Substitute Treatment (OST) continuity, or safe discharge. **Reflective Prompts** • What social, logistical, or clinical risks are present that require early involvement of support services? • Which services should be engaged, and how would you obtain consent and initiate contact? **Application**: MDT review or outreach simulation to identify triggers for early social work/addiction/housing engagement and to rehearse warm handovers.

Tool	Purpose	Application
Suggested Phrasing: Introducing Support Services	To model consent-based, stigma-aware offers of support.	• "Would you like me to help connect you with someone who can support with housing/benefits/appointments?" • "Is it okay if I share your details with the social worker so we can plan together?" **Application**: Communication and advocacy training.
Checklist	Prompts for when and how to involve services.	**1. Identify Needs** What social, logistical, or clinical factors require support? • Housing instability, transport issues, or unsafe discharge options. • Addiction needs, medication continuity risks, safeguarding concerns • Disability, literacy/language barriers, or loss of entitlements. • Missed appointments or difficulty engaging with follow-up. **2. Mobilise the Right Supports** Who needs to be involved? • Social work, PHN, addiction services, housing officers, disability services. • Migrant health teams or advocacy organisations • NGO / community partners (with consent). • Confirm referral pathways and criteria. **3. Coordinate the Plan** How will services work together? • Agree roles and responsibilities (who leads what). • Use warm handovers (direct introductions, shared calls, MDT briefing). • Ensure safe transitions (bridging prescriptions, follow-up dates, contact points). • Align the clinical plan with what support services can provide. **4. Confirm & Communicate** Has a clear, shared plan been established? • Ensure a shared understanding of MDT roles and referral. pathways, including who coordinates housing or placement support. • Confirm the patient's wishes, consent, and preferred communication method. • Share key information with all involved services. • Record referrals, outcomes, and agreed follow-up. • Ensure the discharge summary clearly flags support needs. **Application**: Poster, electronic health record (EHR) checklist, or discharge tool.

Further Resources

1. HSE Social Inclusion Services Directory
2. Safetynet Primary Care: Health Advocacy Toolkit
3. Mental Health Reform – Interagency Practice Resources
4. Local NGO Partners: MQI, DePaul, Peter McVerry, AkiDwA, Pavee Point, AsIAm
5. Housing First & Case Management Pathways for Clinicians

Understanding Hygiene and Access to Facilities

Keywords: hygiene poverty, access to basic facilities, social exclusion, structural vulnerability, dignity-preserving care, infection risk, treatment feasibility, discharge safety, continuity of care, trauma-informed practice, interagency collaboration

Overview

People experiencing social exclusion (PESE) may have limited or no access to facilities required for basic hygiene, including washing themselves or their clothes, caring for wounds, catheters, or stomas, and storing personal or medical items safely (Whelan & Green, 2023). As a result, they may present with visibly poor hygiene, dishevelled or malodorous clothing, untreated wounds, or difficulty following care recommendations (e.g. medication use or wound care). Healthcare professionals may misinterpret these visible signs of unmet needs and instability as disengagement from care, apathy, deliberate self-neglect, or lack of personal responsibility.

In practice, poor hygiene often reflects structural and psychosocial barriers rather than individual choice. Structural causes include homelessness, overcrowded or temporary accommodation, limited access to water or sanitation facilities, inability to afford hygiene products, and lack of secure storage. Psychosocial and health-related contributors include depression, psychosis, substance dependence, cognitive impairment, trauma-related avoidance, and internalised or learned shame where repeated experiences of stigma or exclusion lead to withdrawal from self-care or healthcare encounters.

Poor hygiene has significant clinical consequences. It increases the risks of wound infection, infestations, catheter or stoma-associated infections, and delayed healing, and can limit safe self-management of chronic conditions. It can also obscure clinical signs (e.g. rashes, ulcers, injuries), leading to diagnostic delays. Patients may experience shame related to their appearance, anxiety about being judged by staff or other patients, or fear of embarrassment during examination, which can manifest as withdrawal from interactions with healthcare staff, irritability, leaving against medical advice, or refusing examinations.

Hygiene, therefore, represents both a clinical risk factor and a relational challenge. It directly influences patient, infection control, treatment feasibility, and discharge safety, while also shaping patient trust, engagement, and willingness to remain in care. Effective responses require clinicians to recognise hygiene-related presentations as potential markers of unmet need and vulnerability, and to adapt their assessment, communication, and care planning accordingly, avoiding reliance on unexamined assumptions about motivation or personal responsibility.

Key Clinical Considerations

- **Treat visible hygiene issues as clinical information**
  - Interpret patients' hygiene and appearance as clinical cues that may indicate unmet needs, instability, or barriers to treatment, rather than solely as indicators of motivation, engagement, or personal responsibility.
  - Use these cues to prompt further assessment of environmental, functional, and psychosocial factors that may affect safety, infection risk, or feasibility of care plans.
- **Recognise that hygiene barriers are usually multifactorial**
  - Consider common, often overlapping, contributors such as:
    - Environmental and structural factors:
      - Homelessness or insecure accommodation
      - Limited access to water, sanitation, or laundry facilities
      - Overcrowded or congregate living environments
      - Insecure storage for personal items, dressings, or medications
      - Poverty limiting access to hygiene products
    - Health and functional factors:
      - Reduced mobility, chronic pain, fatigue, or frailty
      - Cognitive impairment or learning disability
      - Chronic illness affecting self-care capacity
    - Psychological and social factors:
      - Depression, psychosis, substance dependence
      - Trauma-related avoidance of care or bodily exposure
      - Internalised shame or fear of judgement linked to prior healthcare experiences

- **Recognise clinical and safety implications**
  - Hygiene limitations directly increase risks including skin infections, infestations, delayed wound healing, and unsafe catheter or stoma care. Treat these risks as part of clinical assessment and planning, not solely as social concerns.
- **Adapt clinical plans to what is realistically achievable**
  - Consider that standard discharge plans (self-care instructions, daily dressing changes, outpatient appointments) may be unrealistic or unsafe without access to showers, clean dressings, or safe storage facilities.
  - Discuss constraints openly with the patient and, where appropriate, involve support services to identify feasible alternatives.
  - Consider approaches such as inpatient care, step-down facilities, community nursing, simplified regimes, or outreach supports.
- **Address immediate practical needs where possible**
  - Give time and resources to understanding the factors that have led to the patient's current situation. Where feasible, offer access to washing facilities, clean clothing, toiletries, wound cleaning, or referral to hygiene services.
  - Identify hygiene-related needs early and actively engage nursing staff, medical social work, or inclusion health teams to coordinate practical supports.
- **Maintain dignity and reduce shame**
  - Approach signs of poor hygiene with empathy, recognising them as often markers of disadvantage and exclusion rather than purely behavioural choices.
  - Recognise that embarrassment, avoidance, irritability, refusal of examination, or premature departure from care may represent protective responses to shame or anticipated judgement, rather than deliberate non-cooperation.
  - Use neutral, respectful verbal and body language. If a patient expresses embarrassment, acknowledge discomfort explicitly and reassure them that hygiene challenges are understood and not judged.
  - Take steps to preserve privacy and dignity during examinations and hygiene-related care.
- **Assess and document social circumstances**
  - Identify the patient's social circumstances (including accommodation, finances, dependents, and substance use) that may impact their medical care. Record this clearly to guide team decision-making and adapt plans to incorporate this information.
- **Plan through interagency support**
  - Utilise available interagency/integrated pathways to support the patient engaging in plans (e.g. step down or temporary accommodation).

Why This Matters

Limited access to hygiene facilities is often intertwined with conditions that impair health and self-management, such as chronic pain, reduced mobility, cognitive impairment, and unsafe accommodation. When a patient's appearance is misinterpreted as a personal failing rather than a marker of psychosocial and environmental constraint or disease burden, doctors may miss important diagnostic cues. Care plans that do not account for these realities, such as wound care requiring daily washing, medications needing refrigeration, or discharge instructions that presume access to laundry facilities, can result in patients facing avoidable barriers to engagement and adherence, resulting in delayed re-presentation, more advanced disease on arrival, and higher system-level costs.

Conversely, recognising hygiene limitations as clinically relevant enables doctors to adapt care plans, mobilise appropriate supports, and select safer management pathways. Approaches that preserve dignity, anticipate practical barriers, and integrate social and clinical planning improve patient engagement, reduce preventable complications, and support safer, more sustainable care for people experiencing social exclusion.

Learning Tools

Tool	Purpose	Example
Vignette: Safe Clinical Planning When Hygiene Barriers Are Present	To demonstrate a safe clinical approach when hygiene limitations directly affect medical decision-making.	A middle-aged man presents to the Emergency Department (ED) with urinary retention secondary to benign prostatic hypertrophy. On assessment, it is noted that he lives in tented accommodation without access to running water or sanitation facilities. Given his living circumstances, he is deemed unsuitable for the standard urology Trial Without Catheter (TWOC) clinic, which assumes a level of self-care and hygiene that he cannot maintain. The clinical team takes time to explore the broader social context, recognising that the patient is unlikely to manage a urinary catheter safely and may not receive or attend follow-up appointments. Without appropriate intervention, he is at high risk of re-presenting with complications and potentially requiring more intensive care. Following interdisciplinary discussion, the team agrees that inpatient management or placement in a step-down facility is the safest option. This would allow catheter monitoring, access to washing facilities, and reliable follow-up. A clear plan is documented, including roles for social work, Inclusion Health services, and the urology team, with a scheduled date for reassessment.

Tool	Purpose	Example
		Reflective Prompts • What elements of this approach helped prevent a high-risk discharge? • Which aspects of the decision-making relied on interagency collaboration?
Vignette: Dignity-Preserving Examination in the Context of Poor Hygiene	To explore practical communication and trauma-awareness within an examination.	Margaret is a 45-year-old woman with a background of adversity and trauma in childhood and adulthood. She is sleeping rough at present. She presents with leg cellulitis. When the doctor wants to examine her feet, Margaret gives non-verbal cues that she is worried about something. On questioning, she quietly discloses that she is ashamed of her unwashed feet and overgrown toenails. **Reflective Prompts** • How would you acknowledge and respond to her discomfort? • What practical steps could you take to maintain dignity while completing a clinically necessary examination?
Vignette: Shame, Public Exposure, and Risk of Disengagement	To consider how public exposure and lack of privacy during care can influence engagement in healthcare settings.	Stephen is a man in his forties who has experienced significant adversity, including childhood institutionalisation, violence, incarceration, homelessness, and longstanding stigma. He uses drugs. He presents to the Emergency Department (ED) with worsening infected chronic venous ulcers that are markedly malodorous. He does not have access to clean clothes or new dressings. While waiting to be seen, he overhears other patients commenting loudly about the odour, including, "It's like there's something dead in here". Staff appear aware but do not intervene. Stephen remains in the waiting area, but his body language changes; he appears unsettled and increasingly uncomfortable. The clinical team has not yet engaged with him. **Reflective Prompts** • How might Stephen react in this situation? • What alternatives does he realistically have to access care if he leaves? • If Stephen raises his concerns or experience with clinical staff, how should they respond?

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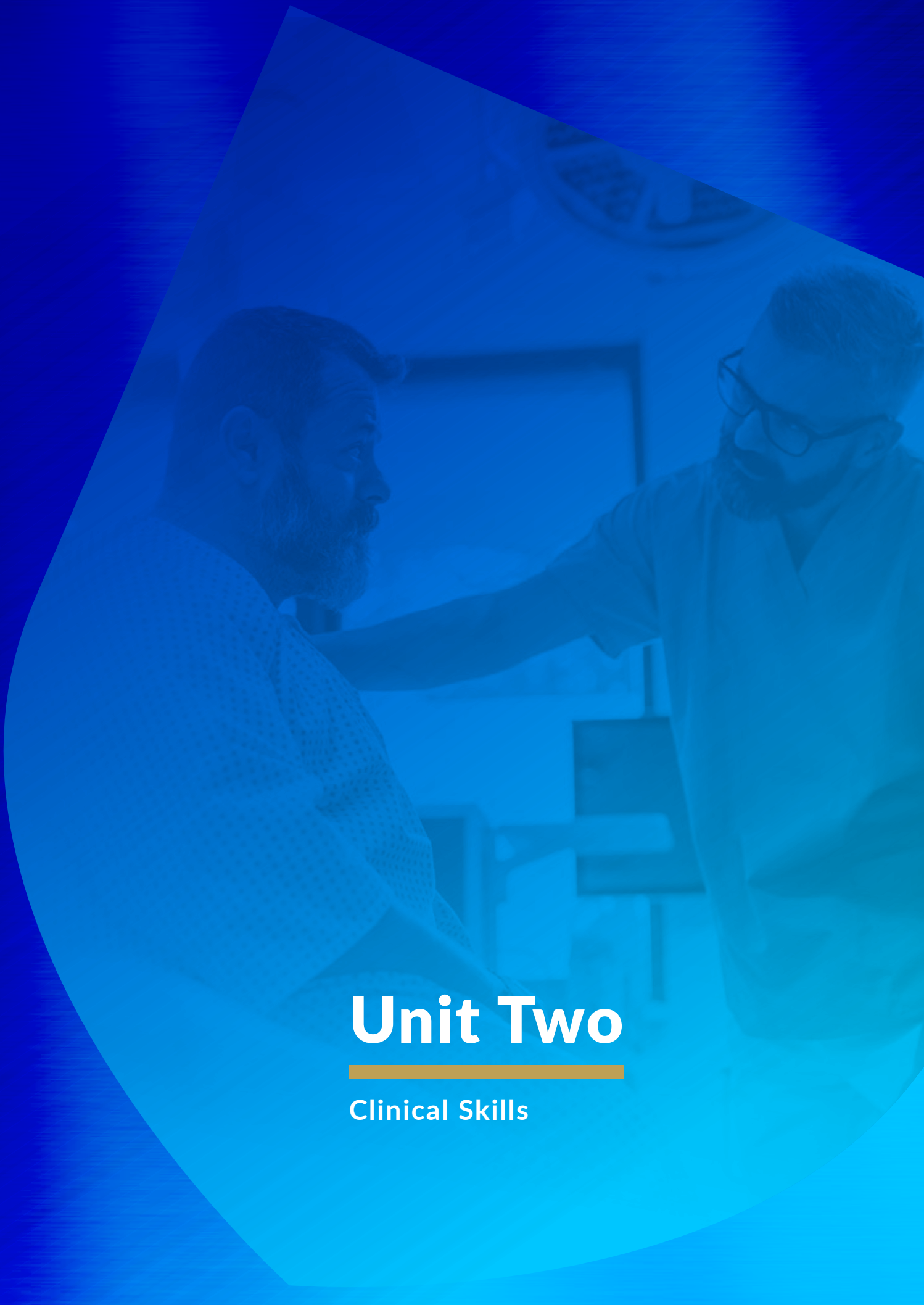

Unit Two

Clinical Skills

Unit Two. Clinical Skills

Unit Two focuses on core clinical skills required to deliver safe, equitable, and effective care for people experiencing social exclusion. It addresses how doctors take histories, perform examinations, make and test diagnoses, prescribe treatment, and plan discharge, with attention to the practical, social, and systemic factors that influence safety, feasibility, and continuity of care.

The Unit emphasises person-centred, trauma-informed and inclusion-aware practice across the care pathway. This includes taking histories and conducting examinations in ways that preserve dignity and psychological safety; maintaining diagnostic vigilance; recognising multimorbidity and early frailty; and making prescribing and treatment decisions that are workable within patients' lived circumstances and care environments. Its purpose is to help strengthen clinical judgement and patient safety by ensuring that assessment, diagnosis, treatment, and discharge decisions are both clinically appropriate and realistically achievable – reducing preventable harm and improving continuity for people at high risk of care fragmentation and disengagement.

History Taking

Taking a History in a Trauma-Informed Way

Taking a Social History in the Context of Inclusion Health

Taking a Sexual History

This section explores how effective history-taking builds trust between doctor and patient while laying the foundation of clinical reasoning, diagnosis, and treatment planning. When caring for people experiencing social exclusion, this process can present distinct challenges that require sensitivity, adaptability, and clinical judgement. A trauma-informed approach supports the gathering of accurate and relevant information while preserving psychological safety, transparency, and patient choice. The section outlines practical strategies for taking histories, managing sensitive disclosures, and framing questions in ways that respect dignity and minimise re-traumatisation. Together, these approaches ensure that history taking supports diagnostic accuracy, strengthens the therapeutic relationship, and upholds equitable, person-centred care.

Taking a History in a Trauma-Informed Way

Keywords: trauma-informed history-taking, trust, safety, consent, disclosure, collateral history, power dynamics

Overview

History-taking is often the patient's first meaningful interaction with their doctor. For people with experience of social exclusion, trauma, or discrimination, this encounter can evoke fear, hypervigilance, vulnerability, and a sense of losing control. Taking history in a trauma-informed way involves recognising that the way questions are asked can determine whether meaningful disclosure is possible and whether the encounter feels safe enough to continue. It is, therefore, not about avoiding sensitive or difficult topics; it is about how those topics are approached, i.e. gathering clinically relevant information while preserving dignity, offering choice, and creating a sense of psychological safety that allows patients to participate at a manageable pace.

Trauma can affect patients' ability to concentrate, remember, and recount events in sequence, particularly if questions feel rushed, interrogative, or impersonal. Patients may be reluctant to disclose information that they feel may result in them being judged. A key clinical risk is that important information may be lost when the patient shuts down, withholds information, or becomes overwhelmed. The relational quality of history-taking is, therefore, central to addressing these risks: preparing patients for the purpose of the conversation, offering choice about when and how sensitive issues are discussed, pacing the enquiry, monitoring for signs of distress or dissociation, and being transparent about confidentiality and mandatory reporting.

Key Clinical Considerations[5]

- **Anchor the encounter in trustworthiness and transparency**
  - Introduce yourself and your role prior to taking the history.
  - Explain why the history is needed, particularly if the patient has already repeated their story elsewhere.
  - Frame sensitive questions with purpose, signalling why they may be important to care – particularly if they relate to a topic that may be a cause of distress.
- **Demonstrate that you are not going to judge or shame the patient**
  - Verbal and non-verbal cues can be used to assure the patient that you will not judge or shame them.
- **Recognise how trauma shapes communication and adapt enquiry accordingly**
  - Expect that trauma may affect memory, attention, sequencing, and language.
  - Disclosure may be partial, delayed, or non-linear.
  - Interpret guardedness, irritability, minimal engagement, or limited eye contact as possible protective coping strategies rather than resistance or "non-compliance".
  - Be mindful of cultural, historical, gender-based, and institutional trauma that may affect trust, pace of disclosure, and willingness to engage.
- **Support safety, collaboration, and patient agency**
  - Use history-taking as an opportunity to collaborate, e.g. "I'm trying to figure out what is causing your symptoms, what do you think it might be?"; "What do you think I should know?"
  - Where possible, offer choice about when and where the history is taken, e.g. "are you okay to talk here on the ward, or would you prefer to go into a private room to answer some questions?"
  - Offer choice over timing and depth of sensitive areas when clinically safe, e.g. "we can discuss more about your diabetes later, if you'd prefer."
- **Be explicit about safety and confidentiality**
  - Before asking sensitive questions, clearly explain what will remain confidential and the circumstances under which information must be shared (e.g. child protection, immediate risk).
  - Be transparent about the consequences of disclosure, e.g. "I don't need to tell your hostel staff about anything you tell me, unless you agree. The exception would be if I thought someone might get seriously harmed or killed."
- **Recognise and respond to distress**
  - Watch for signs of dissociation, avoidance, tearfulness, silence, or agitation. If distress appears, pause and offer grounding, e.g. "Would you like a break?" / "Would you like someone you trust to sit in?"

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[5] These draw on the six principles of trauma-informed care to history-taking: Safety; Trustworthiness and Transparency; Peer Support; Collaboration and Mutuality; Empowerment, Voice and Choice; Cultural, Historical and Gender Awareness.

- **Offer peer support when appropriate**
  - Offer the patient to have someone with them that they may trust – this may be a peer support worker, a friend or family member, or a support worker or nurse from their accommodation or a service they attend.
- **Use culturally respectful language and be alert to identity-related barriers to disclosure**
  - Use non-judgemental, culturally appropriate terms when asking about drug or alcohol use, e.g. "what do you drink? How much would you have in a usual day or week?"; "do you use your groin to inject?"
  - Offer choice of gender of the person taking history, if possible and appropriate, e.g. women from certain communities or with certain experiences may prefer a female doctor.
  - Don't be afraid to ask/express curiosity, e.g. "I'm not sure what that means [referring to street name for a drug] – can you explain that to me?"
- **Collateral history proportionately and with consent**
  - If the patient cannot provide full information, e.g. due to memory gaps, confusion, substance use, ask for permission to contact trusted sources such as hostel staff, outreach teams, or family, e.g. "Would it be okay if I speak with someone from your support team to help plan your care safely?"
  - Keep collateral history requests focused on clinically relevant information.
- **Close the conversation safely**
  - Summarise key information shared and thank the patient for their openness. Check emotional wellbeing after difficult topics, e.g. "That was a lot to talk through – how are you feeling now?"; do not assume the conversation has "ended" psychologically once questioning stops.
  - Explain the next steps clearly, including what will happen, who is involved, and when the patient will hear more.

Why This Matters

When a history-taking encounter feels judgmental, intrusive, or overwhelming, patients may minimise symptoms, omit critical information, or disengage from care altogether. A trauma-informed approach mitigates this risk by prioritising predictability, transparency, and patient control during the encounter. Explaining why questions are being asked, pacing sensitive topics, offering choice, and responding appropriately to distress help patients remain engaged and able to think clearly. By maintaining predictability, shared control, and clear purpose throughout the history-taking process, doctors support patients to participate as active partners in the conversation. This results in fuller disclosure, clearer narratives, and more clinically reliable information. In turn, clinical reasoning is strengthened, management decisions are safer, and patients are more likely to remain engaged with ongoing care and follow-up.

Taking a Social History in the Context of Inclusion Health

Keywords: biopsychosocial model, social determinants of health, trauma-informed history-taking, stigma and shame, trust and rapport, cultural factors, substance use, housing insecurity

Overview

For people who have experienced exclusion, their social circumstances can directly shape the nature of their illness, their capacity to follow treatment plans, and their risk of deterioration. A core clinical risk is that care plans become unsafe, unrealistic, or inequitable because the doctor does not fully understand the patient's lived experience or environment. Taking a social history in Inclusion Health, therefore, focuses on systematically understanding the patient's biopsychosocial context (Williams et al, 2019), including housing stability and safety, access to food and hygiene, income and entitlements, substance use patterns, safety in accommodation, caregiving responsibilities, community supports, and relevant legal or immigration factors.[6] The purpose is to understand the patient's context so that diagnosis, treatment, and follow-up are not only safe but also realistically deliverable.

However, the process of social history-taking requires particular care. Formulaic or checklist-style questioning, while efficient, can heighten feelings of scrutiny, reinforce power imbalances, and elicit guarded or defensive responses in individuals who already feel exposed or unsafe. This risk is amplified when exploring sensitive areas such as accommodation, substance use, sexual health, or gender identity, where patients may previously have experienced judgement or discrimination. A skilled approach to social history-taking in Inclusion Health focuses on how questions are introduced, paced, and justified: explaining why sensitive topics are relevant to care, using neutral and non-presumptive language, sequencing questions to avoid premature judgement, checking regularly whether the patient is comfortable to continue, and pausing when distress or shutdown occurs. This creates conditions in which clinically relevant information can be shared safely and meaningfully.

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[6] The concept of the social history in medicine has its roots in the shift from a purely biomedical model of disease to the biopsychosocial model (Engel, 1977), which recognises that the interplay of biological, psychological, and social factors shapes illness and suffering. This shift has embedded the patient's broader lived experience and context into most clinical assessments, and social history taking is now a core element of patient-centred care and communication training. Travel and sexual history are often included but will not be considered in this section.

Key Clinical Considerations

- **Ensure privacy and safeguard confidentiality**
  - Seek a private space where sensitive issues (e.g. housing, trauma, or substance use) are not overheard.
  - Reassure patients about confidentiality to build trust.
  - Recognise that prolonged waiting can heighten distress and disengagement
- **Use clear, respectful, and accessible language**
  - Avoid jargon; use calm, direct, and respectful language.
  - Check comprehension routinely using non-judgemental prompts, and tailor communication accordingly. Do not assume low or high levels of literacy or health literacy. Recognise also that understanding may fluctuate with stress, illness, or fatigue.
- **Sequence questions to avoid premature judgement**
  - Prioritise understanding the presenting complaint fully before asking about social factors.
  - Avoid reflex associations (e.g. asking about smoking immediately after a cough), which can feel like blame.
  - Integrate lifestyle and social history questions framed as part of the clinical context of care.
- **Signpost the consultation and explain next steps**
  - Outline the structure of the encounter (e.g. "I'll ask some questions, then examine you, and then discuss a plan").
  - Check regularly for concerns or misunderstandings.
  - Use this approach to help reduce anxiety, especially for patients with negative past experiences in healthcare.
- **Frame questions without presumption; stay curious**
  - Avoid unexamined assumptions about housing, employment, or support systems.
  - Phrase questions neutrally to prevent reinforcing stigma or shame.
  - Maintain a stance of curiosity and openness, even when situations seem obvious.
- **Distinguish immediate risks from broader structural needs**
  - Identify what requires immediate action (e.g. unsafe discharge location, risk of overdose, or lack of medication) vs. longer-term needs (e.g. housing applications or addiction support).
- **Separate information-gathering from unsolicited advice**
  - Make the purpose of social history explicit; it is to understand context and constraints, not to assign blame or reach immediate judgements.
  - Be cautious of reflex advice-giving (e.g. immediately warning about alcohol or drug harms) before the patient's circumstances, priorities, and readiness are understood.
  - Offer advice when requested or when clinically appropriate, ideally with the patient's permission, and as part of a wider management plan.
- **Be mindful of the role of selective disclosure**
  - Some patients may be reluctant to disclose certain information; determine if it is relevant to their medical needs at this point in time, to avoid revisiting trauma and to build trust through patience.
  - Be aware that reluctance to share information on clinical questioning may reflect fear, stigma, past negative experiences, or safety concerns, and should not be assumed to indicate dishonesty.

Why This Matters

Taking a social history is central to understanding illness in context; however, when working with patients experiencing social exclusion, the process itself can either build or break trust. Complex trauma and living in a state of hypervigilance mean that even seemingly routine questions can trigger distress and disengagement. Often, a reluctance to answer may not be due to a desire to conceal information but rather due to the patient's inability to reach a psychological safe place to disclose what, on the surface, may seem like basic information. Conversely, attuned and purposefully structured social history-taking makes key contextual risks visible and clinically actionable, while reducing the likelihood of shame, defensiveness, or withdrawal. This allows essential information to be shared in a way that can meaningfully guide care, supports earlier identification of risk, enables treatment plans that patients can realistically follow, and prompts timely engagement of support services.

Learning Tools

Tool	Purpose	Application
Vignette Asking Social History Questions	To demonstrate how poorly timed or presumptive questions can disrupt trust, and how attuned sequencing preserves engagement.	A man presents with a persistent cough. Before exploring the symptom, the doctor immediately asks, "Do you smoke?" The patient stiffens and replies defensively. The consultation becomes strained, and further questioning yields minimal detail. Later, in a supervision session, the doctor replays the encounter and realises that the premature question felt accusatory. In a second consultation, using a different approach, they first take a full symptom history – onset, duration, sputum, red flags – before saying: "I'd like to understand the bigger picture of your day-to-day life. Would it be okay to ask a few questions about things like smoking, where you're living, and what support you have?" The patient remains engaged and volunteers more detail, including smoking history and difficulty managing symptoms at night in an overcrowded living situation. **Reflective Prompts** • How might the timing and sequencing of the questions influence the patient's willingness to engage? • What assumptions was the doctor at risk of making early in the consultation, and how did adjusting their approach change the interaction? **Application**: case-based teaching or simulation.

Tool	Purpose	Application
Suggested Phrasing: Safe Entry Points into Social History	To provide non-stigmatising, transparent ways of beginning social history.	• "I'll be asking questions, examining you, and then we'll plan together." • "I'll keep you updated as we go." **Application**: communication workshops.
Checklist: Sensitive and Purposeful Social History	A concise clinical guide to gather essential context while protecting dignity and psychological safety.	**1. Create Conditions for a Safe Conversation** • Aim for privacy and minimal interruption. • Briefly explain why social context helps clinical care. • Check if this is an acceptable moment to explore these areas. **2. Ask with Openness and Neutrality** • Where possible, let questions follow the patient's story rather than a rigid order. • Be mindful of premature early assumptions (e.g. linking symptoms to behaviour prematurely). • Acknowledge and build on relevant information already gathered by MDT colleagues; avoid unnecessary repetition. • Allow partial disclosure; do not rush or press for detail. **3. Explore Core Domains (as relevant to care)** • Living situation & safety: stability, hygiene access, where belongings and medication are kept. • Income/occupation: financial circumstances, entitlements, caregiving responsibilities. • Substance use: patterns, risks, withdrawal concerns (using a neutral tone). • Supports & relationships: who is involved in their daily life; who helps them. • Cultural or legal context: language needs, migration status, or documentation issues that may affect care delivery or follow-up. **4. Maintain Psychological Safety** • Normalise difficulty, e,g., "Many people find these topics hard, take your time." • Watch for changes in tone, avoidance, or defensiveness. • Reduce repeated trauma disclosure where possible by consulting existing records, acknowledging prior MDT input before proceeding. **5. Integrate Information into a Realistic Plan** • Differentiate immediate risks from broader structural needs. • Document relevant social context to guide the wider team. • With consent, involve appropriate support services early. **Application**: bedside teaching and clinic prompts.

Tool	Purpose	Application
Reflective Prompts	To support clinicians in examining how their own phrasing, timing, or assumptions influence disclosure and trust.	• "How might the timing or wording of my questions have affected trust in this consultation?" • "Did I assume the answer, or remain curious?" **Application**: reflection exercises or debrief sessions.

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Taking a Sexual History

Keywords: confidentiality, consent, identity, STI and blood-borne virus risk, sexual violence, exposure risk assessment, safeguarding, trauma-informed communication

Overview

Sexual health is an integral part of health and wellbeing. Understanding how to take a sexual history is therefore a core clinical skill that extends beyond identifying symptoms to include assessment of exposure risk, vulnerability to harm, ongoing risk, and opportunities for prevention, treatment, and safeguarding.

Concerns relating to sexual health often encompass physical, emotional, and social dimensions that are closely interrelated and must be considered together in clinical assessment (Brotto et al., 2025). Patients may experience embarrassment, shame, or fear when discussing sexual health issues, including fear of judgement, concerns about disclosure, or uncertainty about the implications of symptoms they may not fully understand. These responses may be intensified when patients anticipate personal, legal, or safeguarding consequences, or have prior experiences of stigma, trauma, or negative encounters with healthcare. Clinicians should adopt a non-judgemental approach, using direct questions and accurate anatomical terminology to support clarity and enable accurate assessment of symptoms, exposures, and risk. Clear explanation of the purpose of the consultation, alongside explicit discussion of confidentiality and its limits (including safeguarding obligations), should be provided at the outset.

Language, literacy, and cultural factors may affect understanding of symptoms, perceived risk, proposed investigations, and next steps in care, and should be actively considered throughout the consultation. Patients should be given adequate time to express their concerns and priorities. Where interpretation is required, professional interpreters must be used; it is not appropriate for intimate partners, family members, or acquaintances to translate during a sexual health assessment. Patients should be seen alone wherever possible to allow safe disclosure of sensitive issues, including experiences of coercion, violence, or exploitation.

Key Clinical Considerations

Clinical Orientation and Risk Awareness Considerations

- **Identify the issue:** Maintain awareness of common sexually transmitted infections, their modes of transmission, and typical and atypical presentations.
- **Consider medical background and medication interactions:** Take account of how chronic conditions and long-term medications may influence risk, presentation, or treatment choices.
- **Request Appropriate Investigations:** Understand which tests are indicated based on symptoms, exposure, and risk profile, and how to request them correctly.
- **Initiate Timely Treatment:**
  - Recognise that sexually transmitted infections require prompt diagnosis and management to prevent long-term sequelae and onward transmission.
  - Be familiar with first-line antimicrobial regimens and escalation pathways.
- **Remain alert to safeguarding indicators:** Maintain awareness of potential safeguarding concerns, including human trafficking, sexual exploitation, intimate partner violence, and female genital mutilation.

Structured Sexual History and Assessment Considerations

- **Clarify reason for attendance:** Why has the patient attended today?
  - Routine screening vs symptomatic presentation
  - Known contact of an infection
  - Consensual sexual encounter vs alleged assault
- **Assess symptoms systematically:** What changes or symptoms has the patient noticed?
  - Discharge (urethral, vaginal, rectal)
  - Dysuria
  - Pain (abdominal, pelvic, genital, dyspareunia)
  - Swelling, lumps, or lesions
  - Ulceration, rash, or other skin changes
  - Abnormal bleeding
  - Perianal symptoms
  - Any additional concerns raised by the patient
- **Assess Sexually Transmitted Infection (STI) Exposure Risk:**
  What potential exposures have occurred?
  - Number and gender of partners
  - Type of sexual contact (oral, vaginal, anal)
  - Timing and location of exposure
  - Condom use
  - Anatomical sites potentially exposed

- **Assess Pregnancy and contraception risk where relevant:** Is there a possibility of pregnancy?
  - Date of last menstrual period
  - Current contraception (barrier methods, long-acting reversible contraception (LARC), combined oral contraceptive pill (COCP), progesterone-only pill (POP), natural methods)
  - Risk of unintended pregnancy
  - Need for emergency contraception or referral to pregnancy support services
- **Assess HIV and blood-borne virus risk:** Is there prior or ongoing risk exposure?
  - Injecting drug use (including steroid use)
  - Tattoos or piercings (professional vs non-professional)
  - Sexual partners from higher-BBV-prevalence groups (e.g. gay, bisexual and other men who have sex with men; sex workers)
  - Blood transfusions or medical procedures in high-risk settings
- **Identify ongoing risk behaviours requiring intervention:** Are preventative or harm-reduction measures indicated?
  - Frequent, condomless sex
  - Previous post-exposure prophylaxis (PEP) use
  - Current eligibility for, or use of, pre-exposure prophylaxis (PrEP)
  - Vaccination status (e.g. HPV, HBV)
- **Explore other sexual health and wellbeing issues:** Are there additional issues affecting sexual function or quality of life?
  - Pain during sex (dyspareunia)
  - Sexual dysfunction (erectile dysfunction, anorgasmia, premature ejaculation)
  - Changes in sexual desire or satisfaction.

- **Assess safeguarding and safety issues:** Are they, or others, at risk of harm?
  - Intimate partner or gender-based violence
  - Sexual exploitation or coercion
  - Concerns involving young people
  - Female Genital Mutilation (FGM)
  - Human trafficking
- **Consider recreational drug use:** Is substance use relevant to risk or care planning?
  - Alcohol and recreational drugs
  - Injecting drug use, including performance-enhancing drugs
  - Chemsex or "slamming" practices
- **Conduct Examination where indicated:** Are there clinical signs requiring examination?
  - All patients should be offered a chaperone for intimate examination
  - Where possible, they should also have a choice over the gender of their provide
- **Arrange onward Referral where required:** Do they need further professional input?
  - Medical Social Work
  - An Garda Siochana
  - Sexual Assault Treatment Unit
  - Rape Crisis Centre
  - Patient's own GP for ongoing management

Why This Matters

Sexual health concerns can cause psychological distress and frequently intersect with experiences of trauma, coercion, stigma, or safeguarding risk. Patients presenting for sexual health assessment may therefore be clinically and emotionally vulnerable, and often require additional time, privacy, and sensitivity to support accurate disclosure and assessment.

Providing a structured, compassionate consultation, characterised by clear explanation, respect for autonomy, appropriate boundaries, and predictable processes, supports patient safety and clinical effectiveness. In practice, a trauma-informed approach involves explaining what will be asked and why, offering choice and control where possible, avoiding assumptions or moral framing, and responding calmly to distress or disclosure. These elements help reduce fear, support trust, and enable more complete and reliable history-taking, investigation, and referral.

A consultation that initially appears to be a "routine" screen may identify serious risk, exploitation, or harm, requiring immediate clinical or safeguarding actions. Clinicians must therefore be equipped to take a comprehensive sexual history, recognise safeguarding indicators, and respond appropriately. Skills in trauma-informed communication and effective use of professional interpreters are essential to this work and are addressed in other sections of this framework.

Further Resources

Resource	Focus	Link
British Association for Sexual Health and HIV (BASHH)	Guidance on sexual history-taking and STI management.	https://www.bashh.org/default.aspx
Health Service Executive (HSE)	National guidelines on the management of STIs.	
Rape Crisis Ireland (RCI)	Support and advocacy for survivors of sexual violence.	https://www.rapecrisisireland.ie/
Tusla – Child and Family Agency	Child welfare and protection reporting.	https://www.tusla.ie/
sexualwellbeing.ie	Patient education and sexual health information.	https://www.sexualwellbeing.ie/
Man2Man.ie	Sexual health information and support for men.	https://man2man.ie/
My Options	Freephone and webchat support for unplanned pregnancy.	https://www2.hse.ie/services/unplanned-pregnancy/support-services/my-options-freephone/

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Examinations

Perform A Trauma-Informed Examination

This section explores how doctors can perform physical examinations in a trauma-informed manner that upholds dignity, psychological safety, and trust. For patients affected by trauma, social exclusion, or violence, physical examination may evoke fear, shame, or loss of control. In such contexts, communication and consent are central to whether an examination can be conducted safely, tolerated by the patient, and produce reliable clinical findings. A trauma-informed approach therefore prioritises transparency, patient choice, and collaboration – clearly explaining each step, seeking explicit consent, and adapting the examination to the patient's comfort and capacity wherever clinically appropriate.

Perform A Trauma-Informed Examination

Keywords: Trauma-informed care, physical examination, consent, autonomy, psychological safety, re-traumatisation, power dynamics, safeguarding

Overview

Physical examination involves a combination of environmental cues (e.g. clinical settings, uniforms, closed doors), sensory stimuli (e.g. touch, smells, sounds, temperature), interpersonal processes (e.g. power dynamics, consent, tone of communication), and bodily exposure (e.g. undressing, positioning, intimate examination), which can be distressing for patients with histories of trauma, violence, coercion, or institutional harm. For people experiencing social exclusion, these risks may be compounded by prior negative healthcare encounters, loss of autonomy, or a power imbalance that is more acutely felt within clinical settings. Interactions that are perceived to remove control, limit choice, or resemble past custodial, medical, or interpersonal harm (e.g. rushed consent, enforced positioning, multiple observers, or unexplained touch) may precipitate fear, dissociation, withdrawal, or refusal, even when the examination is clinically routine.

A trauma-informed approach minimises the risks to patients and staff, balancing clinical necessity with psychological safety (Goldsten, et al, 2024). This approach does not avoid examination; rather, it supports examinations being conducted in ways that preserve safety and dignity, with consent treated as an ongoing process rather than a one-off event, and with patients given genuine choice and control (e.g. timing, pace, positioning, or the presence of a chaperone). It requires sensitivity to signs of distress or dissociation, and preparedness to pause or adapt the examination when needed. When conducted well, a trauma-informed approach enables thorough and reliable examination by ensuring the patient can tolerate and remain engaged in the process.

Key Clinical Considerations

- **Anchor the examination in transparency and consent**
  - Introduce yourself and your role prior to examining the patient.
  - Explain why you are doing particular elements of the examination (especially if the patient has already told another person about the same issue or if you've examined them before).
  - Explain the rationale for specific steps, particularly if they relate to a body part that may be a cause of shame.
- **Recognise trauma-related responses**
  - Emotions triggered by the expectation or experience of examination may present as anxiety, withdrawal, irritability, aggression (verbal or physical), refusal of examination, dissociation, or substance use. These behaviours often reflect fear or loss of control rather than defiance or non-cooperation.
- **• Anticipate and mitigate common examination triggers**
  - Recognise that distress may be triggered by exposure, hospital gowns, PPE, enclosed spaces, lying flat, rapid movements, or unexpected touch.
  - Modify positioning, sequencing, or environment where clinically safe (e.g. examining seated rather than supine, uncovering one area at a time).
- **• Acknowledge clinician impact**
  - Tone of voice, facial expression, body language, time pressure, gender of clinician, or medical hierarchy all influence safety and trust.
- **• Recognise and respond to distress or dissociation in real time**
  - Be alert to signs such as withdrawal, tearfulness, agitation, silence, immobility, or glazed affect.
  - If distress emerges, pause the examination, orient the patient, and offer options (e.g. a break, stopping, or resuming later).
- **• Support patient choice and empowerment**
  - Use examination as an opportunity to collaborate, e.g. "I'm trying to figure out what is going on, can you point to exactly where the pain is?"
  - Where possible, offer the patient choice about when and where the examination is done, e.g. "Are you okay to be examined now, or will I come back in a few minutes?"
  - Offer the patient choice over who is present during the physical examination.
  - Seek consent to each part of the examination, e.g. "Is it okay if I feel your tummy?"
- **Maintain privacy and environmental safety**
  - Consider the safety and privacy of the physical environment, e.g. offer to pull curtains.
  - Use calm tone, predictable movements, and clear verbal cues before touch.
- **Peer support opportunities**
  - Offer the patient to have someone with them that they may trust; this may be a peer support worker, a friend or family member, or a support worker or nurse from their accommodation or service they attend.

- **Awareness of cultural, historical and gender issues**
  - Recognise that cultural norms, prior institutional trauma, or gender-based violence may shape patients' comfort with touch or exposure.
  - Offer choice of gender of person doing physical examination if possible and appropriate, e.g. women from certain communities or with certain experiences may prefer a female doctor.
- **Close the examination deliberately and safely**
  - Signal clearly when the examination is complete.
  - Check how the patient is feeling and whether they need time before the next step of care.
  - Explain findings and next steps in plain language, reinforcing that the patient can raise concerns later if needed.

Why This Matters

Poorly conducted or rushed examinations can heighten patient distress to a point where they cannot tolerate further assessment, resulting in incomplete exams, unreliable findings, and reduced willingness to participate in future examinations. A trauma-informed physical examination is intended to maintain diagnostic quality by ensuring the patient can tolerate necessary clinical contact. By anticipating triggers, pacing the examination, and maintaining continuous consent, doctors can mitigate distress and create conditions in which a full, accurate, and safe assessment can proceed.

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Diagnosis

Avoid Diagnostic Overshadowing in Patients

Common Masked or Hidden Pathologies

Consider Common Comorbidities

This section explores how diagnosis may be influenced in the context of social exclusion, focusing on issues including diagnostic overshadowing, masked or late-presenting pathology, and unrecognised comorbidity. It outlines how factors like atypical presentation, fragmented information, and delayed presentation can influence clinical reasoning and contribute to missed or incomplete diagnosis. It highlights the importance of maintaining diagnostic breadth, recognising hidden or evolving disease, and considering co-existing conditions to support accurate and timely diagnosis.

Avoid Diagnostic Overshadowing in Patients

Keywords: diagnostic error, diagnostic overshadowing, cognitive bias, premature closure, stigma, atypical presentations

Overview

Diagnostic overshadowing is a recognised cognitive bias in which disproportionate emphasis is placed on a patient's social or medical background, leading doctors to misattribute new or acute symptoms to these pre-existing factors (The Joint Commission, 2022). This can result in missed, delayed, or incomplete diagnoses when alternative or coexisting medical causes are not adequately considered.

Patients experiencing social exclusion, including people with a history of substance use and homelessness, are particularly vulnerable to diagnostic overshadowing and having their symptoms minimised or reframed as behavioural rather than medical. Their presentations may be complex, non-linear, and shaped by trauma and inequitable access to care. For example, reduced consciousness may be prematurely attributed to intoxication, overlooking differentials such as hypoglycaemia, sepsis, stroke, or intracranial haemorrhage. Similarly, chest or abdominal pain may be dismissed as anxiety or withdrawal, delaying recognition of malignancy or infection. Antimicrobial resistance (AMR) may also be overshadowed when infections are misattributed to behavioural causes or assumed to be benign, delaying appropriate investigation and escalation.

This bias often occurs in high-pressure environments where atypical presentations are common, and doctors frequently rely on rapid, experience-based pattern recognition to make decisions under time constraints. While this can enhance efficiency, inappropriate use can increase the risk of diagnostic error by promoting premature closure and reducing sensitivity to atypical or complex presentations. This misattribution, such as perceiving pain as "drug-seeking" behaviour, can lead to under-investigation of acute pathologies, inadequate pain management, and missed opportunities for timely intervention. Repeated experiences of dismissal or minimisation of symptoms can also result in patient mistrust, reduce disclosure, and delay re-presentation.

Key Clinical Considerations

These clinical considerations relate primarily to patients with substance use histories, who are at increased risk of diagnostic overshadowing due to stigma, atypical presentations, and assumptions about their baseline health status.

- **Maintain Diagnostic Breadth**
  - Actively guard against diagnostic overshadowing by keeping alternative and co-existing explanations in view, particularly when symptoms persist, evolve, or do not respond as expected.
  - Check that the working diagnosis is not prematurely attributed to drug or alcohol use, actively consider alternative explanations; for example, reduced consciousness should prompt consideration of hypoglycaemia, sepsis, intracranial haemorrhage, or stroke alongside substance-related causes.
- **Use Structured Diagnostic Checkpoints**
  - Incorporate structured reassessment points during the patient's care journey.
  - If symptoms fail to respond to initial treatment or new signs emerge, revisit the diagnosis and expand the differential to avoid premature closure.
- **Guard against delayed or missed escalation**
  - If symptoms persist, worsen, or do not fit the assumed pattern of intoxication or withdrawal, actively revisit the working diagnosis and escalate investigation or referral (e.g. rapid cancer pathways, stroke codes, or sepsis protocols).
- **Use team-based decision making**
  - Engage multidisciplinary teams to challenge assumptions and broaden diagnostic perspectives, helping to reduce bias and improve diagnostic accuracy.
- **Use patient-centered communication**
  - Use respectful, non-judgmental language and validate patient concerns.
  - Avoid dismissive phrasing that may reinforce stigma or discourage disclosure; building trust improves history-taking, symptom reporting, and follow-up adherence.

Why This Matters

A trauma-informed, equity-aware, and systematic diagnostic approach is essential to prevent premature diagnostic closure, support timely escalation (e.g. stroke pathways, sepsis protocols, or cancer referrals), and maintain diagnostic accuracy in atypical or complex presentations. People experiencing social exclusion are at particular risk of diagnostic overshadowing, where new or evolving symptoms may be incorrectly attributed to existing labels (e.g. substance use, mental illness, or homelessness) rather than investigated as potentially separate pathology. Explicit awareness of diagnostic overshadowing strengthens clinical reasoning by maintaining broad differential diagnosis, improving handover clarity, and reducing bias in assessment and investigation.

References

1. The Joint Commission, (2022). Sentinel Event Alert 65: Diagnostic overshadowing among groups experiencing health disparities, 21 June 2022. Available at: https://digitalassets.jointcommission.org/api/public/content/e78449de170943209bfd9d0d04ee2365?v=2075367e

Common Masked or Hidden Pathologies

Keywords: atypical presentation, delayed diagnosis, hidden pathology, premature diagnostic closure, diagnostic vigilance, fragmented records, social exclusion

Overview

Patients experiencing social exclusion frequently present to emergency departments with complex, atypical, or late-stage illness. In this context, even common medical conditions may go unrecognised or be diagnosed late because clinical features are masked, presentations are non-linear, or baseline information is incomplete. These may include common but serious chronic conditions such as malignancy or advanced organ disease, as well as acute presentations including cerebrovascular or cardiovascular events, venous thromboembolism, seizures, arrhythmias, and syncope. Several interrelated factors may contribute to these diagnostic challenges:

- Clinician-related factors include the difficulty of interpreting symptoms that do not follow typical patterns and the risk of prematurely attributing new or evolving symptoms to existing conditions or behaviours. For example, reduced consciousness or neurological signs may be misinterpreted as intoxication, while chest pain may be attributed to anxiety or withdrawal, leading to missed diagnoses such as stroke or myocardial infarction.
- Patient-related factors include delayed help-seeking or limited symptom disclosure, where competing priorities - such as housing insecurity, financial stress, caregiving responsibilities, or substance dependence - may displace attention from emerging health concerns. A newly homeless individual may, for example, prioritise accessing shelter over reporting acute symptoms. Cultural beliefs, fear, and prior negative healthcare experiences may also influence when and how patients engage with care.
- Systemic factors include barriers such as limited access to interpretation services, restricted availability of diagnostic equipment, and reduced testing capacity outside regular service hours, and difficulties coordinating investigations for patients with unstable contact details or housing.

Together, these factors increase the likelihood that clinically significant pathology remains unrecognised until disease is advanced. Diagnostic processes may need to be adapted to account for fragmented records, barriers to investigation, and limited or delayed patient disclosure. Doctors should therefore maintain a high index of suspicion for both acute and chronic conditions, particularly when presentations are inconsistent.

Key Clinical Considerations

- **Recognise diagnostic barriers**
  - Recognise common contributors to delayed or missed diagnosis in patients experiencing social exclusion, including fragmented care, diagnostic overshadowing, and bias related to social circumstances, substance use, or mental illness, as well as atypical patterns of presentation.
- **Anticipate delayed presentation**
  - Expect that patients may present late in the disease course due to competing priorities, mistrust, or previous negative healthcare encounters.
  - Recognise that delayed presentation increases the risk of advanced malignancy, untreated infection, and irreversible functional decline.
- **Remain alert to atypical presentations**
  - Be aware that common medical conditions can present in atypical ways among individuals experiencing social exclusion. Common pathologies may present atypically due to malnutrition, early frailty, or chronic infection (e.g. reduced inflammatory responses or altered pain perception).
- **Maintain diagnostic openness**
  - Approach symptoms with an open and systematic clinical mindset. Avoid prematurely attributing symptoms to social circumstances, substance use, or baseline status in the absence of appropriate investigation and reassessment.
- **Coordinate timely diagnostics**
  - Ensure diagnostic tests are done in a timely manner and, where necessary, take additional steps to coordinate these tests, e.g. proactively liaising with radiology to secure investigation timing where missed appointments or early departure are likely.
- **Revisit histories when needed**
  - Re-assess history and symptoms when initial information is incomplete due to language barriers, reduced consciousness, distress, or environmental constraints.
- **Strengthen continuity and follow-up**
  - Recognise that people outside formal systems (“not on any service”) often lack safety nets for ongoing investigation.
  - Link patients with GPs, social inclusion teams, or community nursing services to maintain diagnostic momentum and prevent re-presentation.

Why This Matters

Timely and accurate diagnosis of acute medical conditions can be challenging within the context of social exclusion, requiring doctors to account for delayed presentation, atypical physiology, fragmented records, and reduced disclosure. When symptoms are prematurely attributed to physiological states (e.g. intoxication or withdrawal), psychological explanations (e.g. anxiety), or social assumptions about a patient's "baseline behaviour", clinical reasoning may narrow too early, leading to diagnostic closure before alternative causes are adequately explored. This increases the risk that serious acute or progressive illness, such as stroke, sepsis, cardiac disease, or malignancy, is missed or diagnosed late.

Recognising barriers to diagnosis and addressing them collaboratively, within the clinical team and in partnership with the patient, is essential to ensuring timely investigation and treatment. Maintaining diagnostic vigilance, revisiting histories, and using structured reassessment improve diagnostic accuracy and reduce preventable harm. Strengthening continuity between hospital-based care and community supports further ensures that investigation and treatment continue beyond the initial encounter, providing a critical safeguard for patients who might otherwise fall through system gaps.

Further Resources

1. Faugno, E., Galbraith, A.A., Walsh, K., Maglione, P.J., Farmer, J.R. and Ong, M.S. (2025) 'Experiences with diagnostic delay among underserved racial and ethnic patients: a systematic review of the qualitative literature', BMJ Quality & Safety, 34(3), pp. 190–200. DOI: 10.1136/bmjqs-2024-017506.

Consider Common Comorbidities

Keywords: multimorbidity, frailty, screening, chronic disease management, continuity of care, contingency planning

Overview

Multimorbidity is common among people experiencing social exclusion, yet it is frequently undocumented, underdiagnosed, or inconsistently managed. Fragmented engagement with healthcare services often results in incomplete medical records or the absence of formally confirmed diagnoses. As a result, some patients have unrecognised chronic conditions, while others struggle to engage with ongoing disease management once conditions are identified. These gaps compound over time, contributing to earlier frailty and poorer health outcomes.

For people experiencing social exclusion, multimorbidity often develops earlier and with greater severity and complexity. It frequently involves the co-occurrence of physical illness, mental or neurodevelopmental conditions, and alcohol and/or drug-use disorders ("trimorbidity") (Chilman et al, 2025). This can increase treatment burden, complicate coordination of care, and can mean that single-disease approaches are often insufficient. Clinical interactions, therefore, need to integrate assessment and planning across co-existing and interacting health needs as a routine standard of care. Common comorbidities span several domains that together characterise "trimorbidity", including:

- Physical health conditions, including chronic disease and infection (e.g. hypertension, asthma, cardiovascular disease, diabetes, chronic obstructive pulmonary disease, and infectious diseases such as HIV and hepatitis B/C). Neurological conditions (e.g. epilepsy, traumatic brain injury, or other central nervous system disorders) also carry physical and functional consequences that frequently intersect with mental health and substance-use challenges.
- Mental health and neurodevelopmental conditions, including depression, anxiety, psychotic disorders, and intellectual disability, which often co-occur with physical conditions and contribute to complex care needs. When unrecognised or undertreated, these conditions increase the risk of disengagement from care, crisis-driven presentations, and escalation of substance use as a means of coping or self-medication.
- Alcohol and/or drug-use disorders can mask clinical deterioration, interact with chronic disease, and disrupt engagement across services. This is associated with preventable complications, including liver disease, infectious transmission, overdose, and early frailty, and drives recurrent emergency attendance and excess mortality.

Across these domains, comorbidities are more likely to be overlooked or insufficiently supported due to intersecting environmental, practical, and system-level barriers. These include unstable or congregate housing; inability to store medications safely or manage complex regimens; inaccessible health communication; limited continuity of care; and reliance on episodic or crisis-driven healthcare contact. Without deliberate coordination, patients may be left to navigate multiple unlinked pathways, increasing the risk of fragmented care, treatment failure, and avoidable re-presentation.

Key Clinical Considerations

- **Verify diagnoses and records**
  - Patients experiencing social exclusion, such as those involved with multiple services (e.g. International Protection Accommodation Service (IPAS), migration services, drug treatment centres), may receive sporadic clinical reviews. This can lead to assumptions that certain diagnoses (e.g. COPD, mental illness, hypertension, diabetes, or epilepsy) are already documented elsewhere. In some cases, patients may be prescribed medications like inhalers based on a single consultation, without any follow-up. To ensure continuity of care:
    - Contact the patient's GP, if one is listed, or reach out to the last hospital they attended to obtain documentation of previous diagnoses and treatments.
    - Avoid assuming that the patient's current clinical presentation reflects their baseline health status, especially in the absence of prior medical records.
- **Recognise premature frailty and atypical presentations**
  - Homelessness, malnutrition, and chronic adversity can contribute to premature frailty, characterised by reduced physiological reserve, early functional decline, and increased vulnerability to acute stressors, even in younger adults. As a result, patients affected by social exclusion may develop chronic illnesses at a younger age than others in their cohort, present with atypical manifestations of illness, earlier functional impairment, or disproportionate deterioration in response to otherwise common conditions.
- **Plan for logistical barriers in treatment**
  - Managing common comorbidities in socially excluded populations presents unique logistical challenges. For example, individuals experiencing homelessness, whether sleeping rough or staying in temporary accommodation, may lack access to essential resources such as refrigeration for insulin storage. Others may have no secure place to keep their medications or may face stigma when taking treatments for conditions like HIV. Without appropriate support, many struggle to access medications in the community.
- **Mobilise support services early**
  - To support effective treatment planning:
    - Seek consent to engage Medical Social Work (MSW) early when initiating new therapies. They can assist with securing appropriate accommodation, applying for medical cards or the Long-Term Illness (LTI) scheme, and connecting patients with GPs.
    - Specialist Clinical Nurse Specialists (CNSs) can provide education and guidance, helping patients understand how to reconnect with hospital services if needed. This proactive approach can reduce the risk of treatment discontinuation and prevent crisis presentations.
- **Screen opportunistically**
  - Use clinical encounters as opportunities to screen for common chronic conditions such as hypertension, diabetes, COPD, and mental illness. Frame screening as routine and beneficial, linking findings to achievable next steps (e.g. follow-up, vaccination, or smoking cessation).
- **Plan for incomplete treatment courses**
  - Anticipate barriers to treatment completion, e.g. unstable housing, addiction, or fragmented care, by developing contingency plans. These may include simplified regimens, bridging prescriptions, or early involvement of support services to reduce treatment discontinuation and prevent emergency re-presentation.

Why This Matters

Multimorbidity is highly prevalent among socially excluded patients, yet diagnoses are often unverified, incomplete, or unmanaged due to fragmented records, disrupted care, and competing priorities. Clinical safety is strengthened when doctors actively confirm existing diagnoses, verify records across services, and use routine encounters to screen opportunistically for common conditions that may otherwise remain undetected. Because conditions interact and destabilise one another, particularly where mental illness or substance use is present, uncoordinated single-condition management can increase the risk of crisis presentations and diagnostic overshadowing.

Adapting treatment plans to real-world constraints improves feasibility and reduces treatment failure. Coordinating early with support services, simplifying regimens, and planning for incomplete adherence help prevent clinical deterioration, reduce avoidable re-presentations, and support continuity across care settings. Collectively, these approaches enable more reliable, equitable, and sustainable management of chronic illness in patients.

References

1. Chilman, N., Schofield, P., Laporte, D., Ronaldson, A. & DasMunshi, J., (2025). The prevalence of multimorbidity with mental and physical health for people who experience homelessness: a systematic review. European Journal of Public Health, 35(6), pp.1170–1177. DOI: 10.1093/eurpub/ckaf144. Available at: https://academic.oup.com/eurpub/advancearticle/doi/10.1093/eurpub/ckaf144/8242796

Treatment and Discharge Planning

- Appropriate Choices of Medication
- Further Resources
- Prescribing for Adherence
- Discharge Prescribing Practices to Ensure Access
- Discharge for Follow-Up Care
- Planning a Discharge to a Congregate Setting
- Chronic Disease Management

This section focuses on how doctors can deliver treatment and discharge plans that are clinically appropriate and realistically deliverable for patients experiencing social exclusion. It addresses prescribing decisions, medication reconciliation, and discharge planning as key patient safety points at which fragmented care, stigma, and practical constraints can lead to treatment interruption, duplication, or harm. The section emphasises trauma-informed, culturally respectful communication and pragmatic prescribing strategies that strengthen understanding, engagement, and adherence. Discharge is examined as a high-risk transition requiring early coordination across services, clear documentation, explicit responsibility for follow-up and prescribing, and effective safety-netting. These approaches aim to reduce preventable deterioration and re-presentation, strengthen continuity across care settings, and support more equitable outcomes for people at high risk of disengagement.

Appropriate Choices of Medication

Keywords: cost, access, patients' beliefs, safe storage, drug interactions, monitoring feasibility

Overview

Medication choice is shaped not only by clinical factors, such as diagnosis, allergies, and potential interactions, but also by the patient's social and practical circumstances. For people experiencing social exclusion, barriers to safe and effective prescribing commonly arise from:

- Practical factors, such as medication cost, pharmacy access, and the ability to store medicines safely.
- Personal factors, including cultural or religious beliefs, previous adverse experiences, and capacity to manage complex regimens.
- Clinical and system-related factors, such as interactions with illicit substances and the feasibility of ongoing monitoring or follow-up.

The primary clinical goal is to treat the condition a patient presents with; however, prescribing an effective medication does not ensure that treatment will be accessed, taken, or sustained. For patients experiencing social exclusion, failure to confirm that a medication can be accessed, afforded, or practically managed may result in the underlying condition remaining untreated despite appropriate clinical intent. Beyond access, prescribing decisions that do not account for a patient's beliefs, capacity, and living circumstances can lead to partial or episodic use, unsafe storage, or non-disclosure of relevant risks. These outcomes are often interpreted as non-adherence, when they more accurately reflect a mismatch between prescribing decisions and the patient's real-world context. When this mismatch is unrecognised, it introduces avoidable clinical risk, undermines safety, and increases the likelihood of disengagement from care.

The choice of medication should be adapted with consideration given to the patient's circumstances, and whether the treatment can be accessed, managed, monitored, and stored safely, recognising that the preferred treatment may not be the usual first-line treatment.

Key Clinical Considerations

- **Address Cost and Access Early:**
  - **Confirm entitlements:** Check medical card status and eligibility for schemes (e.g. General Medical Services (GMS), Long-Term Illness (LTI), or available hardship supports). Where a patient is not enrolled, involve social work to support applications.
  - **Avoid unaffordable prescribing:** Do not issue prescriptions without confirming the patient can realistically meet the costs.
  - **Prescribe within schemes:** Where possible, choose generics and reimbursable items on the List of Reimbursable Items provided by the Primary Care Reimbursement Services (PCRS). Consult pharmacies to assess if alternatives can be covered under hardship or LTI schemes.
  - **Leverage pharmacy support:** Engage trusted community or clinic pharmacies, who can confirm past treatments, card status, or arrange structured payments or dispensing (e.g. weekly dispensing or blister packing). Where patients are not known locally, clinicians or inclusion health staff should liaise with pharmacies to address barriers.
  - **Register eligible patients promptly:** Ensure LTI applications are completed by a registered doctor. Note that "Express LTI" (e.g. for epilepsy, diabetes mellitus, Parkinsonism) lasts two months only and cannot be assumed for multi-indication drugs. This can be applied for by the pharmacy if the patient hasn't been approved for LTI for their disease - this is done while the actual application (which is completed by the doctor) is being processed.
- **Recognise Beliefs and Preferences:**
  - Identify cultural, religious, or personal beliefs that may influence acceptance, use, or discontinuation of medicines (e.g. concerns about ingredients, perceived necessity or severity, prior adverse effects, or negative healthcare experiences).
  - Incorporate patient perspectives into shared decisions to help ensure treatment is acceptable, used as intended, and does not introduce avoidable risk.
- **Simplify Dosing Regimens:**
  - Avoid complex, multi-dosing, multiple medications, opting for once-daily or fixed-dose combinations where appropriate.
  - Consider long-acting medications such as injectable antipsychotics, long-acting contraception injections/IUDs, only where follow-up appointments or outpatient referrals are deemed feasible.
  - Clearly prescribe medications with indications, avoiding shorthand terms (e.g. "Take one tablet twice daily for seizures").
- **Plan for Safe Storage**
  - **Anticipate barriers:** Recognise that refrigeration or secure storage may be unavailable, particularly in shared, temporary, or unstable accommodation. Discuss feasible alternatives in advance (e.g. storage access via a keyworker, pharmacy, or clinic).
  - **Mitigate risks:** For controlled or psychoactive medicines, minimise risks of theft, coercion, misuse, or diversion by arranging daily or weekly dispensing where appropriate.
  - **Use trusted services:** For people sleeping rough with no facilities, explore safe storage options through drug treatment clinics or supportive pharmacies, ensuring good communication with Inclusion Health teams where available.
- **Account for Interactions with Illicit Drugs**
  - **Reconcile comprehensively:** Assess prescribed medicines alongside potential use of illicit substances when choosing treatment.
  - **Use collateral history carefully:** Recognise that patients, peers, or relatives may be the only source of reliable information before urine drug screen (UDS) results are available.

  - Build trust through confidentiality: Reassure patients that disclosures will remain confidential and will not be used to restrict access to treatment.

- **Minimise Monitoring Burden**
  - Avoid high-demand regimens: Where possible, choose medications that do not require frequent laboratory monitoring or clinic visits.
  - Support essential monitoring: If unavoidable, collaborate with outreach teams or community services to facilitate access and reduce the impact of hospital visits.
- **Account for service-level prescribing constraints**
  - Recognise service scope: Patients engaged with drug treatment services may have structured support for dispensing and monitoring, and in some cases prescribed medicines may be provided at no direct cost.
  - Understand service limitations: These services have limited capacity to initiate, prescribe, or monitor complex therapies outside their core remit (e.g. biologics for Inflammatory Bowel Disease (IBD)).
  - Align prescribing with deliverability: Do not assume that service engagement guarantees access to all treatments; prescribing decisions should reflect what can be realistically initiated, supported, and continued within the patient's current care setting.

Why This Matters

Open discussion about treatment allows clinicians to address concerns, provide clear education, and support shared decisions that align with a patient's values, preferences, and circumstances. This is particularly important when prescribing in the context of potential illicit drug interactions, where accurate disclosure is essential for safety. Patients are more likely to share relevant information when they do not feel stigmatised and when risks are explained transparently.

For example, patients receiving methadone may withhold information about illicit opioid or substance use if they fear their prescribed treatment will be delayed or withheld. Once their dose is confirmed and administered, patients often feel safer to disclose additional information, enabling more accurate assessment of interaction risk and safer prescribing decisions.

However, disclosure alone does not ensure safe or effective treatment. Even when clinical information is accurate, prescribing decisions that do not account for affordability, dispensing arrangements, storage constraints, monitoring burden, or service-level prescribing limits frequently result in partial use, unsafe handling, or treatment discontinuation. The clinical considerations outlined above are therefore essential safeguards, ensuring that prescribed treatments are not only clinically appropriate, but realistically deliverable, sustainable, and safe within the patient's living circumstances and care setting.

Please note: Information regarding Express LTI eligibility and duration is accurate as of December 2025 and may change in accordance with HSE policy.

Learning Tools

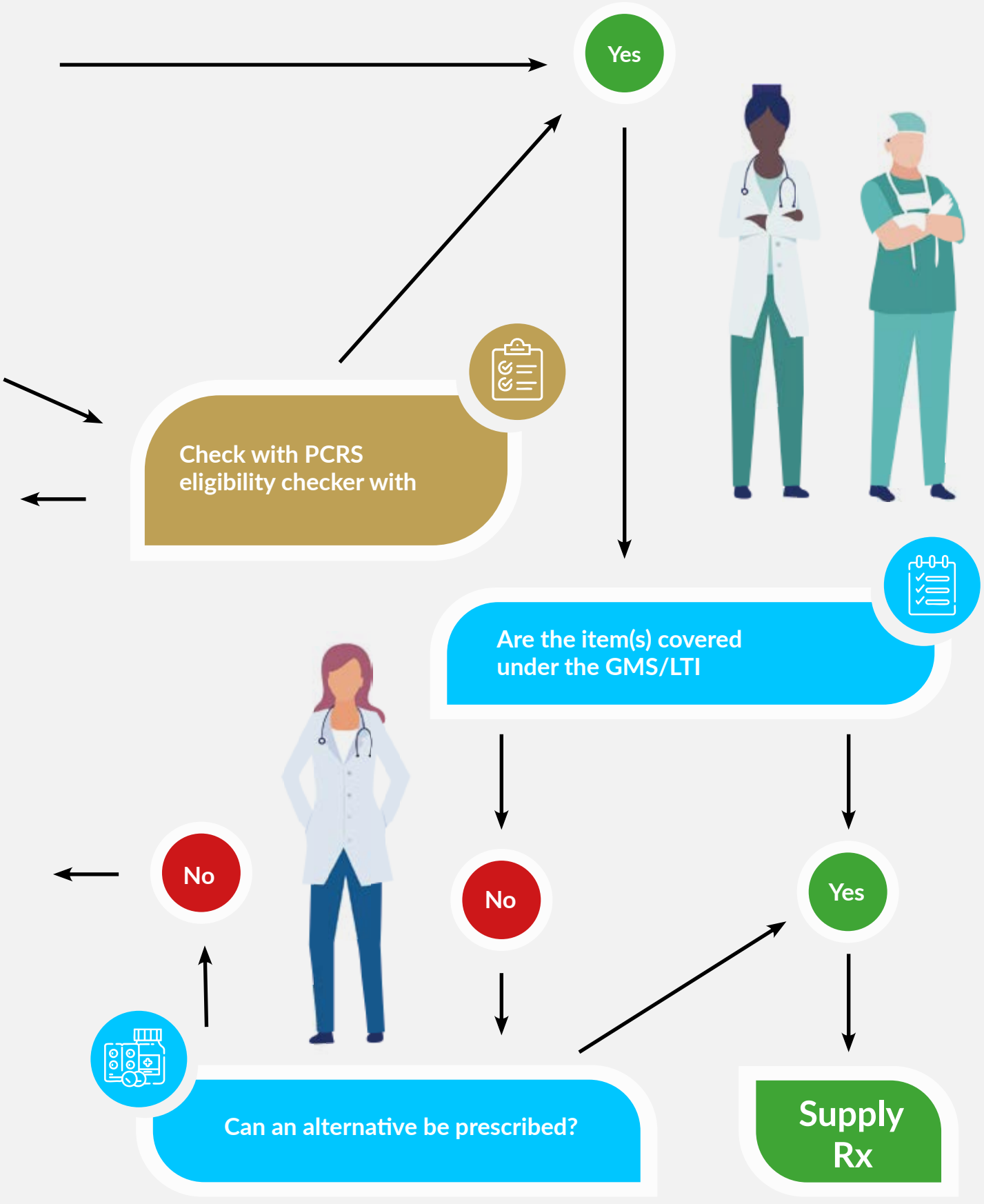
Tool	Purpose	Application
Flowchart: Medication Access & Affordability Check	To support clinicians in confirming whether a patient can realistically obtain, afford, and manage the prescribed medication before issuing the prescription.	Medication access guide: confirm scheme eligibility → consult pharmacy/social work → choose a feasible prescription → plan an achievable dispensing schedule. Application: Teaching, MDT induction, or integration into electronic prescribing prompts. Flowchart Below
Exploring Beliefs, Understanding, and Medication Safety	To sensitise clinicians to the impact of patient beliefs, prior experiences, and health literacy on medication use.	Peer experience: "I don't need you to dispense my Innohep, I have loads at home. I only take it when I feel my leg getting sore." This illustrates: • Misunderstanding of indication and risk, • Episodic or symptom-driven use based on personal interpretation, • The need for clear, respectful explanation that aligns clinical intent with patient understanding. **Application** Communication workshop or consultation-skills session.
Suggested Phrasing: Checking Understanding and Supporting Adherence	To provide concise, non-judgemental language that helps clinicians confirm comprehension, identify barriers, and support adherence.	**Confirm Purpose** • "What is this medication for, in your own words?" • "What have you been told about why you need this?" **Confirm Correct Use** • "How do you take this?" • "When do you usually take it?" • "Would you show me how you use it?"

Tool	Purpose	Application
		Explore Feasibility & Practical Barriers • "Will this fit into your routine?" • "Do you have somewhere safe to keep this?" • "Is getting to the pharmacy easy for you right now?" **Identify Concerns and Beliefs** • "Do you have any worries or past experiences with this medication?" • "Is anything making you unsure about taking it?" **Enhance Recall and Clarity** • "Would it help if I write the purpose clearly on the label?" • "Shall we go over the key points together once more?" **Non-Testing Teach-Back** • "Just so I know I explained it clearly, how will you take this when you're home?" **Application** Communication skills sessions, prescribing workshops, reflective supervision.

Figure One.
Access Pathways Flowchart

Further Resources

Health Services Executive (HSE), (2025), My Medicines List. Accessed here: HSE My Medicines List


Yes
Check with PCRS eligibility checker with
Are the item(s) covered under the GMS/LTI
No
No
Yes
Can an alternative be prescribed?
Supply Rx

Prescribing for Adherence

Keywords: medication adherence, prescribing feasibility, patient education, medication safety, supervised administration, continuity of care

Overview

Adherence refers to the extent to which a person takes medication as intended, including correct dose, timing/frequency, duration, and ancillary instructions (e.g. with/without food; avoid alcohol; separate from iron/calcium). Non-adherence is common and is associated with treatment failure and avoidable complications for patients, alongside increased re-presentation, emergency care use, and unplanned hospital admissions. For individuals experiencing social exclusion, additional barriers further increase the risk. These barriers can be grouped as follows:

- Regimen-related: complex dosing schedules, polypharmacy, or medication side-effects.
- Patient-related: mental health challenges, beliefs about illness or treatment, social isolation, substance use, and barriers to understanding or retaining health information.
- Contextual/practical: unstable housing, financial hardship, or frequent hospital admissions disrupting routines.
- System-related: stigma in healthcare settings (internalised and environmental), and poor continuity or fragmentation between providers.

While clinicians cannot control all determinants of adherence, they can adapt prescribing decisions, education, and support to maximise the likelihood that treatment can be started, continued, and used safely.

Key Clinical Considerations

- **Select appropriate medication**
  - Prioritise simple dosing regimens (e.g. once-daily, fixed-dose combinations).
  - Explore cost and access early (e.g. medical card status, affordability, pharmacy access).
- **Consider long-acting formulations where adherence is a significant risk**
  - Long-acting injectable medications (e.g. LAI antipsychotics) may be appropriate where daily oral adherence is unreliable.
  - Supervised administration can allow early identification of missed doses and reduce risks associated with unsafe storage or diversion.
  - For some patients, reduced dosing frequency may also lessen side-effect burden related to plasma level fluctuations.
  - Use only where follow-up arrangements and service capacity can reliably support administration and monitoring.
- **Provide clear, patient-centred education**
  - Check the patient's own understanding of their diagnosis and treatment purpose.
  - Use language appropriate to the patient, often clear and non-medical, to explain the condition, treatment purpose, potential side effects, and management strategies.
  - Confirm understanding using approaches such as Teach Back (e.g. ask the patient to explain the plan in their own words).
- **Provide clear, reinforced instructions**
  - Request pharmacists to add indication and dosing details on labels.
  - Ensure pharmacy counselling for device use (e.g. inhaler technique, tapering regimens).

- **Address polypharmacy**
  - Where possible, reduce unnecessary medicines and simplify treatment.
  - For complex regimens, consider arranging blister packs via pharmacy or encouraging patient/carer use of weekly trays to empower the patient to take control of their medication and understand their condition. Note that blister pack use should be individualised, recognising potential cost implications, pharmacy capacity constraints, regimen instability, and the risk of medication errors.
- **Ensure accurate reconciliation and safe discharge**
  - Confirm the patient's current medications directly with the patient and, where appropriate, with community pharmacies or clinics, recognising that multiple sources of supply may exist – particularly for patients receiving care across services or prescribed medicines with misuse potential.
- **Build trust and reduce barriers**
  - Communicate clearly and at an appropriate pace; rushed consultations and complex terminology are associated with incomplete understanding and reduced engagement.
  - Invest time early in rapport-building, especially at treatment initiation, to support disclosure of concerns and improve adherence over time.
- **Respond systematically when adherence is low**
  - Actively explore patient-identified reasons for missed or inconsistent use, including side effects, regimen complexity, and practical barriers.
  - Provide anticipatory guidance about common or transient side effects, including when they are expected to settle and when review is needed.
  - Explain or demonstrate administration techniques that reduce adverse effects (e.g. inhaler technique, taking medication with food or water, posture after dosing).
  - Where appropriate, consider alternative formulations or regimens that improve tolerability or feasibility (e.g. once-daily dosing, fixed-dose combinations, long-acting injectables).
- **Request supervised dosing when appropriate**
  - Where patients attend Drug Treatment Clinics, aligning prescribed medicines, where clinically appropriate, with existing supervised OST dosing arrangements when clinically indicated can support adherence and reduce diversion.

Why This Matters

Adherence is more likely when treatment regimens are straightforward, clearly explained, and aligned with the patient's capacity to manage them. For example, once-daily dosing or fixed-dose combinations reduce complexity, while the use of clear language and Teach Back techniques helps overcome health literacy barriers and prevent misunderstanding.

Additionally, pharmacies play a key role in supporting adherence. They can provide dispensing records and reinforce counselling on devices or complex regimens. Early communication between hospital teams and community pharmacies prevents missed doses at discharge and enables the timely addressing of concerns such as diversion or misuse. Adherence is most effectively supported when prescribing decisions, patient education, and systems of follow-up are aligned with how treatment will be used and supported in the patient's real-world context.

Learning Tools

Tool	Purpose	Application
Suggested Phrasing	To model language that builds trust by acknowledging circumstances and using trauma-informed communication.	• "I know you've had a long wait, thank you for bearing with us. I want to go through your medication so it works safely for you." • "Before we decide on the plan, can I check what you already know about this condition?" • "Would it be okay if we went over how you take this, just to make sure everything is clear?" **Application** Communication skills training, consultation roleplay, or reflective supervision.

Enhancing Safe Use Through Pharmacist-Led Reinforcement.	To prompt prescribers to use pharmacy-led education, especially for inhalers, injectables, tapering regimens, or medicines with complex instructions.	**Example/Application**
		• Add explicit counselling requests:
		  ◦ "Symbicort 200/6 - 2 puffs BD. Please demonstrate inhaler technique."
		  ◦ "Prednisolone taper - please reinforce schedule and side effects."
		• Pharmacists reinforce: inhaler technique, step-wise tapers, storage needs, safe administration.

Continuity Checklist.	Ensure safe transitions at discharge.	Discharge prescription clearly document changes: • "Bisoprolol 2.5mg OD (dose reduced)" • "Amlodipine 5mg (discontinued due to hypotension)."

Discharge Prescribing Practices to Ensure Access

Keywords: discharge prescribing, medicines reconciliation, duplicate prescribing, prescribing responsibility, continuity of care, medication access, discharge summary

Overview

Safe discharge prescribing is a critical point of vulnerability for people experiencing social exclusion. Inaccurate prescribing during admission or discharge, including omissions, incorrect dose changes, duplication, or drug interactions, is often driven by incomplete or poor medicines reconciliation on admission. Likewise, non-detailed or incomplete hospital discharge summaries and prescriptions can lead to medication errors. These risks are heightened for patients who obtain medication across multiple providers (e.g. GP, hospital, Opioid Substitution Treatment (OST) clinic, community pharmacy), do not have a consistent dispensing site, or are discharged to unstable accommodation.

Ireland has no national shared prescribing database. While OSTs (e.g. methadone) are recorded on the Central Treatment List (CTL), other medications – including psychotropics, antibiotics, antiretrovirals and analgesics – are not linked across services. This means a robust reconciliation at admission is essential, drawing on multiple sources, including, for example, the patient, caregivers, and community services, to establish an accurate medication history. Likewise, a detailed and accurate discharge summary and prescription are essential to ensure that patients continue, or are initiated on, safe, appropriate, and correctly prescribed treatments.

Key Clinical Considerations

- **Establish a complete medicines history**
  - Ask the patient directly what medicines they are taking, where they collect them, and which clinics or prescribers are involved.
  - Be alert to fragmented care (e.g. methadone from the OST clinic, antidepressants from the GP, inhalers from the pharmacy).
  - Consulting the patient first when verifying current medications is particularly important if they attend multiple pharmacies and/or clinics. While the information they provide will need to be confirmed, asking the patient offers valuable insight into their understanding of the treatment and condition.
- **Verify information with dispensing sites**
  - Cross-check doses and recent collections with community pharmacies, OST clinics and prescribers.
  - Use dispensing records where possible, as these often reflect the most accurate record of supply.
  - Confirm and document who will continue prescribing each medication after discharge.
  - A detailed reconciliation with the community pharmacy and/or clinic provides a more accurate picture of the patient's adherence and current medications.
  - If the patient cannot provide the name of their pharmacy, the Primary Care Reimbursement Service (PCRS) eligibility checker can help identify their GP, who can advise on where the patient collects their prescription. For OST patients, information on their treatment providers is maintained by the Central Treatment List (CTL).
- **Communicate and document medication changes clearly**
  - Record all amendments, discontinuations, or omissions on the discharge prescription, with rationale in the discharge summary.
  - Avoid unexplained omissions, which prompt clarification requests from pharmacies and delay treatment.
- **Clarify responsibility for ongoing prescribing**
  - If a Drug Treatment Clinic is responsible for prescribing and dispensing medication to a patient, there may be no need to issue a prescription to the patient (except where short-term cover is required, e.g. weekend discharge when the clinic is closed).
  - Where medicines will be dispensed by a community pharmacy, do not assume the prescription will be communicated to the GP; ensure a discharge summary is sent to confirm changes and maintain continuity of care.
- **Prevent duplicate prescribing**
  - Controlled or psychoactive medications should not be prescribed without confirming current supply through the OST clinic or community pharmacy.
  - Current ICT systems do not reliably flag duplicate prescribing, so proactive communication with community pharmacies, OST clinics, and hospital teams is essential.
  - Encourage system-level solutions such as shared prescribing databases, integrated discharge templates, and automated cross-check alerts. Where system integration remains limited, proactive communication between prescribers and pharmacies is essential.

- **Support safe deprescribing and rationalisation**
  - Review all medications for necessity, duplication and side-effect burden, especially in cases of polypharmacy.
  - Involve pharmacists, GPs or OST clinicians when deprescribing.
  - Clearly document any medication intentionally stopped and the reason, in the discharge summary.
- **Specify dispensing frequency based on risk**
  - Decide between daily, weekly or supervised dispensing according to risk factors such as suicidality, risk of diversion, unstable housing, or cognitive impairment, and record the rationale.
- **Plan for incomplete medication courses**
  - Anticipate that antibiotics or other time-sensitive medications may not be completed due to unstable living conditions, lack of storage or inconsistent follow-up.
  - Provide written contingency plans and consider Directly Observed Therapy (DOT), shorter prescription durations, or coordination with outreach or primary care.
- **Coordinate early with pharmacies and GPs**
  - Notify the dispensing site before discharge to allow ordering of non-stock or special-approval items.
  - For medicines requiring PCRS approval (e.g. High-Tech items), complete nomination and application forms early, where required, as approval may take 24-48 hours.
- **Manage risks with psychoactive medicines**
  - Do not issue prescriptions for controlled or psychoactive medicines without checking with other providers.
- **Plan for withdrawal prevention**
  - Assess and plan for withdrawal risks before discharge, including opioid, benzodiazepine or alcohol dependence.
  - Where withdrawal prevention is required, ensure appropriate medication (e.g. methadone, diazepam, chlordiazepoxide) is prescribed and accessible immediately post-discharge
  - Document agreed withdrawal management plans in the discharge summary and communicate to community teams.
- **Support transitions to independent management**
  - For young people leaving supported care (e.g. turning 18), notify the community pharmacy in advance so they can provide monitoring, education, and tailored support.
- **Adapt for health literacy and language needs**
  - Recognise when patients cannot interpret or act on changes due to limited literacy or language barriers.
  - Use plain language explanations, signpost changes clearly, and involve interpreters or advocates to ensure understanding.

Why This Matters

A timely and accurate discharge prescription is essential to continuity of care, particularly for patients who receive medicines from multiple providers or have limited capacity to resolve errors after leaving hospital. In this context, unclear prescribing responsibility, incomplete reconciliation, or poorly communicated changes can lead to duplication, interruption, or unsafe continuation of treatment.

A clear, detailed discharge summary is therefore a core patient safety intervention. By explicitly documenting medicines started, amended, or discontinued during admission, and communicating this information promptly to GPs, clinics, and pharmacies, clinicians establish shared accountability for prescribing, reduce ambiguity at transition points, and support safe continuation of care following discharge.

Learning Tools

Tool	Purpose	Example/Application
Vignette: Duplicate Supply Due to Incomplete Discharge Communication	To illustrate how incomplete discharge documentation can result in duplicate dispensing across services, with downstream safety risks.	A patient is discharged with a prescription for mirtazapine 45 mg and olanzapine 20 mg, which they collect as a one-month supply from a community pharmacy. The patient then continues attending a Drug Treatment Clinic, where these same medications are dispensed daily. When the Clinic later requests the discharge summary, it does not indicate that a prescription was issued on discharge. The duplication only comes to light when the Clinic's pharmacy contacts the community pharmacy to enquire about insulin adherence. **Reflective Prompts:** • Where did the breakdown in communication occur? • How could clearer discharge documentation have prevented duplicate supply?
Vignette: Misunderstood Dosing Instructions and Health Literacy Risk	To demonstrate how complex or poorly explained discharge prescriptions can lead to misunderstanding and unsafe use.	Following discharge, a patient is issued a prescription requiring gradual dose escalation over several weeks. The instructions are written in standard medical language and include multiple steps. During discharge, the plan is not verbally reviewed in detail, and no check of understanding is documented.

Tool	Purpose	Example/Application
Vignette: Misunderstood Dosing Instructions and Health Literacy Risk	To demonstrate how complex or poorly explained discharge prescriptions can lead to misunderstanding and unsafe use.	At home, the patient does not fully understand the instructions and feels uncomfortable contacting the hospital team for clarification. Instead, they ask a trusted community member to interpret the prescription. The advice given is well-intentioned but incorrect, and the medication is taken inconsistently, with doses missed on some days and doubled on others. Several days later, the patient presents again with worsening symptoms and adverse effects related to incorrect dosing. On review, it becomes clear that the patient did not understand the escalation schedule and was unaware that clarification or support was available after discharge. **Reflective Prompts:** • What assumptions were made about the patient's ability to interpret the prescription? • How could clearer labelling or counselling have reduced this risk? • What signals during discharge or early follow-up might suggest that instructions were not understood?
Checklist Prompt: Duplication Prevention	To support clinicians in identifying and preventing duplicate or unsafe co-prescribing across fragmented services.	Checklist Prompts • "Have I contacted the dispensing pharmacy to confirm recent supply?" • "Has the OST clinic confirmed current doses or supervised dispensing?" • "Have I clearly documented all changes with rationale?" • "Have all prescribers (GP/OST clinic/community team) been notified?" **Application** A brief prompt integrated into discharge workflows, digital checklists, or ward-round cards.
Glossary: Dispensing Scheme Terms in Ireland		• DPS: Drugs Payment Scheme • LTI: Long Term Illness Scheme • HT: Hi-tech Scheme • HX: Hardship Scheme • CN: Contraception Scheme • HRT Scheme • EU Scheme

Discharge for Follow-Up Care

Keywords: discharge planning, continuity of care, follow-up planning, safety-netting, integrated care, rehabilitation, communication, re-linkage

Overview

Discharge and other transitions of care represent a predictable point of clinical vulnerability, particularly for people experiencing social exclusion, as they involve a transfer of responsibility, a reduction in clinical oversight, and increased reliance on patient-led follow-up. Transitions such as discharge from hospital or outpatient care, release from custodial settings, completion of detoxification, or step-down from residential services are consistently associated with increased clinical risk.The risks that come with these transitions happen for several different, but related, reasons, including:

- Interruption of treatment or follow-up may lead to relapse, withdrawal, or deterioration of chronic disease.
- Loss of clinical monitoring or support can increase vulnerability to overdose, infection, and acute mental health crises.
- Breakdown in communication or continuity of care can contribute to missed appointments, medication errors, and avoidable readmission.

These risks are amplified where patients encounter structural barriers to continuity of care (such as unstable housing, lack of GP registration, or limited access to transport or communication), individual barriers affecting engagement or self-management (including limited health literacy, cognitive impairment, or active mental illness), and clinical factors that heighten vulnerability during care transitions (such as substance dependence or complex multimorbidity).

Standard discharge processes are typically designed around assumptions of stable accommodation, reliable contact details, and the capacity to self-manage medications and follow-up. For many patients experiencing social exclusion, these assumptions do not align with their lived reality. As a result, discharge plans may be technically complete but practically unworkable, leading to missed follow-up, medication errors, delayed treatment, avoidable readmission, and loss of continuity of care.

Alongside these constraints, interpersonal and patient-level factors further shape how discharge information is received and acted upon. Individuals facing barriers to understanding or engagement may appear to agree with plans while feeling overwhelmed or unable to act on them. Here, patients frequently report leaving care without a clear understanding of next steps, how to access prescribed treatments, or who is responsible for ongoing care. For those without stable accommodation, identification, or digital access, conventional follow-up systems may be inaccessible in practice.

In this context, discharge should not be treated as a single administrative handover of responsibility or information. Safe follow-up care requires that discharge planning begin early in the episode of care, with explicit attention to clinical risk, social context, and continuity of care across settings. Clear communication between hospital and community services, along with active patient involvement in planning, is essential to ensuring that discharge arrangements are both safe and realistically deliverable.

Key Clinical Considerations

- **Begin discharge planning early**
  - Anticipate discharge needs: Identify clinical, functional, and social factors likely to affect discharge (e.g. housing stability, transport, substance use, or cognitive impairment) and initiate planning early.
  - Screen and document structural barriers: Actively screen for unstable housing, lack of GP registration, limited health or digital literacy, language discordance, addiction, intellectual disability, or lack of phone/transport, and document these clearly to inform discharge decisions.
  - Adapt plans to real-world constraints: Ensure discharge arrangements account for practical barriers such as limited transport, unstable accommodation, inability to store medications or equipment, or absence of family support.
- **Co-design the plan with the patient and supports**
  - Involve the patient in goal-setting and agree on next steps. Include carers, keyworkers, case managers, or community advocates where appropriate.
- **Coordinate across services**
  - Discharge planning should also anticipate rehabilitation needs (e.g. physiotherapy, occupational therapy, speech and language therapy, or dietetics), ensuring referrals are made before discharge where clinically indicated.
  - Establish clear roles for follow-up, medication review, and community supports (GP, hospital team, OAT clinic, public health nurse, non-governmental organisation). Effective discharge relies on early engagement with primary care, public health nurses, addiction services, housing teams and NGOs, who often provide the only continuity once the patient leaves hospital.
  - Document who is responsible and ensure this is communicated to all parties.
- **Ensure medication safety and continuity**
  - Verify prescription accuracy, access, cost, and storage before discharge.
  - Communicate with pharmacies and GPs, especially for controlled drugs, methadone, high-tech items, or Primary Care Reimbursement Service (PCRS) applications.
  - Plan for withdrawal prevention if relevant (opioids, alcohol, benzodiazepines).
- **Tailor follow-up pathways**
  - Explore alternatives to standard Outpatient Department (OPD) (e.g. home visits, nurse-led clinics, peer accompaniment, or NGO-based follow-up).
  - Involve case managers or community advocates where available.
  - Ensure patients know where and when to attend, and how to get there.
  - Plan specifically for transitions into and out of rehabilitation services, ensuring treatment plans, medications and expectations are communicated clearly to both hospital and rehab teams.
- **Safety-net and plan for contingencies**
  - Provide clear guidance on red-flag symptoms, how to seek urgent care, and what to do if the plan fails.
  - Document escalation plans and communicate to the patient and receiving teams.

- **Close the loop**
  - Confirm that discharge information has been received and acknowledged by the GP, community team, or relevant service.
  - Where possible, check that follow-up has occurred or is scheduled.

Why This Matters

Effective discharge for people experiencing social exclusion requires attention at multiple levels: clear and accessible communication, clear and realistic planning, and active coordination across services to address gaps that fall outside standard discharge pathways. These considerations are particularly important where clinical complexity or life circumstances increase the likelihood of discharge failure, for example, in people managing chronic or relapsing conditions, navigating multiple follow-up appointments or services, or living with unstable housing, finances, or caregiving arrangements. When discharge planning is structured in this way, it reduces fragmentation at the point of transition, minimises avoidable readmission related to follow-up or medication failure, and supports safer recovery by maintaining continuity of care beyond the immediate episode.

A well-planned discharge supports the patient's understanding and capacity to act on information, including their diagnosis, medications, withdrawal or risk plans, and when and where to seek help. In parallel, it ensures the practical conditions for follow-up are in place, including access to prescribed medications, support for equipment or wound care needs, and safe re-linkage with GP care, addiction services, housing, or social supports where relevant.

Embedding principles of integrated care is essential: shared decision-making, a single clear plan, defined responsibility for prescribing and follow-up, and proactive communication with primary care, social services, rehabilitation teams, and voluntary organisations. For people experiencing exclusion, it ensures that the transition from hospital is not an endpoint but part of an integrated care journey.

Learning Tools

Tool	Purpose	Application
Vignette: Barriers to Safe Discharge	To highlight barriers to safe discharge and explore early identification of risks, coordination with GP/ outreach teams, and contingency planning.	A man experiencing rough sleeping completes IV antibiotics for cellulitis. He is deemed medically fit for discharge and is given a follow-up letter and standard Outpatient Department (OPD) instructions. However, he: • cannot read the discharge information, • has no phone, • is not registered with a GP, • has no fixed location to receive or attend OPD review, and • no community, GP, or outreach service is notified of his discharge. Three days later, he re-presents with fever and worsening symptoms. **Reflective Prompts** 1. Which parts of the discharge plan were unsafe or unworkable given the patient's circumstances? 2. Who should have been involved before discharge (GP, public health nurse (PHN), outreach, social work)? At what point should they have been engaged? 3. How could the follow-up plan and communication be adapted to match the patient's needs? **Application**: MDT simulation or case reflection
Vignette: Unrecognised Literacy Needs and Unclear Follow-Up	To highlight how unrecognised literacy needs, fragmented care, and unstable living circumstances can undermine discharge plans.	A man in his late fifties is admitted with an exacerbation of COPD. He lives in unstable private-rented accommodation and spends long periods staying with friends. His inhalers are often misplaced or stored in different locations. He has no regular GP and collects medications from different pharmacies depending on where he is staying. During the discharge conversation, he nods politely but asks no questions. He accepts the written plan, a new inhaler regimen, a short steroid taper, and instructions to follow up with a GP within a week, but does not look at it closely. Staff are busy, and no further checks are made. Four days later, he re-presents with worsening breathlessness. The new inhaler is still in its box, the steroid course has not been taken as intended, and he has not attended any follow-up. When asked, he says he "wasn't too sure about the plan" and "didn't want to bother anyone".

Tool	Purpose	Application
Vignette: Unrecognised Literacy Needs and Unclear Follow-Up	To highlight how unrecognised literacy needs, fragmented care, and unstable living circumstances can undermine discharge plans.	**Reflective Prompts** 1. What cues during the discharge process or social history might have signalled that the plan was not understood? 2. Which members of the wider care network might have been activated before discharge? 3. How could the discharge plan have been adapted to match his needs? **Application**: MDT simulation or case reflection
Suggested Phrasing	Support patient-centred, accessible communication at discharge.	"Is there someone you trust who can help you go through this later?" "Would it be easier if I wrote this down step by step?" **Application**: communication skills training or ward-based education.
Suggested Phrasing	Model integrated communication.	"Before you leave, I'll call your GP so they know your plan and can review your medication this week."
Checklist: Discharge Risks	Ensure consistent recognition of discharge risks and system supports.	**1. Follow-Up Arrangements** • Confirm that a realistic follow-up plan exists (location, timing, who is responsible). • Check whether the patient can attend (housing stability, transport). **2. Clinical and Social Supports** • Identify whether GP registration, outreach contact, PHN involvement, or NGO/keyworker support is in place. • Involve case managers where available (hospital or NGO). **3. Communication and Documentation** • Ensure the GP/receiving service has been notified of discharge plans. • Clarify who is responsible for ongoing review or prescribing. **4. Patient Comprehension** • Confirm the patient understands the plan (diagnosis, medication changes, red flags) in accessible language. • Adapt communication to literacy/language needs. **Application**: discharge toolkit or hospital protocol checklist.

Further Resources

1. HSE Discharge Planning National Guidelines
2. Safetynet Primary Care – Inclusion Health Discharge Toolkit
3. NALA: Plain English and Health Literacy Guidance
4. HSE Social Inclusion Services Contact List
5. Local NGO and Outreach Partnerships (e.g. Merchants Quay, DePaul, Peter McVerry Trust)

Planning a Discharge to a Congregate Setting

Keywords: congregate settings, discharge transitions, shared responsibility, infection risk, medication safety, confidentiality, continuity of care

Overview

Planning a discharge to a congregate or institutional setting, e.g. hostels, direct provision centres, prisons, or residential rehabilitation facilities, presents distinct clinical challenges that differ from discharge to private accommodation. These settings are characterised by shared environments, variable on-site clinical capacity, and shared responsibility for ongoing care, all of which can alter the feasibility and safety of standard discharge plans.

The challenges of discharging someone to congregate settings stem from several overlapping factors.Environmental factors include shared sleeping, washing, and dining facilities, which increase the risk of infectious transmission. In communal settings, this may include bacterial infections such as Clostridioides difficile (C. diff), necessitating anticipatory infection prevention and contingency planning at the point of discharge. Operational constraints may affect medication storage, supervised dispensing, wound care, or access to refrigeration and equipment. Organisational factors include variable on-site clinical capacity, unclear responsibility for monitoring, and reliance on external services for follow-up. In parallel, social and relational factors, such as lack of autonomy, stigma, or limited trust in institutions, may further affect engagement with care.

Many congregate settings are not designed to support recovery from acute illness, disability, or complex treatment regimens without additional coordination and input from multidisciplinary teams, including medical, nursing, allied health, and social care professionals. To ensure safety and continuity, discharge to a congregate setting must be planned collaboratively across hospital, community, and housing sectors from an early stage. Integration with nursing, rehabilitation, addiction, and outreach services helps ensure that treatment plans are feasible, risks are anticipated, and continuity of care is maintained after discharge.

Key Clinical Considerations

- **Assess the post-discharge environment**
  - Where feasible, confirm where the patient will stay post-discharge and identify risks related to infection exposure, mobility, privacy, or limited medication storage.
- **Coordinate with facility staff**
  - Liaise with key workers, nurses, or support staff to confirm follow-up arrangements and the facility's capacity to support medication administration, wound care, follow-up, or monitoring.
- **Protect confidentiality**
  - Maintain privacy in shared settings, and limit disclosure to the minimum information necessary for safe care.
- **Plan for continuity**
  - Link with community nursing, addiction, or outreach teams to ensure treatment and monitoring continue safely after discharge.
- **Document clearly and accessibly**
  - Provide accessible discharge information for both the patient and facility, including medications, next steps, escalation pathways, and emergency contacts, in formats accessible to both patients and staff.

Why This Matters

Transitions to congregate settings carry heightened risk due to shared environments, variable on-site supports, and fragmented responsibility for ongoing care. Without clear, explicit coordination, patients may experience treatment interruption, infection exposure, medication errors and discontinuity, or loss of follow-up shortly after discharge. Anticipating these risks and planning collaboratively across hospital, community, and facility-based services supports safer transitions. An integrated care approach – defined by shared planning, clear ownership of follow-up and prescribing, and proportionate information sharing – helps ensure that discharge plans remain feasible, confidential, and continuous once the patient enters a congregate setting. Clear communication and early linkage with appropriate supports reduce preventable harm and help ensure that care plans remain deliverable and equitable in congregate settings.

Learning Tools

Tool	Purpose	Application
Vignette: Discharge to a Hostel Without Coordinated Planning	To illustrate the consequences of inadequate vs. integrated discharge planning when the destination is a congregate setting.	Michael is a 62-year-old man staying in an emergency hostel. He is admitted with a leg ulcer and cellulitis and completes a course of IV antibiotics. He is discharged late in the evening with a dressing plan, written instructions, and an outpatient appointment for review. When asked at discharge whether he can manage the plan, he nods but appears hesitant. On arrival at the hostel, he finds it difficult to keep the dressing clean and dry and is unsure where to store his supplies. No contact was made with hostel staff or community nursing services prior to discharge. The staff are not aware of his treatment needs, and Michael struggles to read the instructions. He re-presents three days later with fever and a worsening wound. **Reflection Prompts** • Which early steps pre-discharge could have helped prevent his re-presentation? • How might the discharge plan need to be adapted for someone in these circumstances?
Checklist Prompt: Safe Discharge to Congregate Settings	To consider and explore core safety considerations when discharging a patient to a congregate or shared setting.	**1. Destination Confirmed** To consider and explore core safety considerations when discharging a patient to a congregate or shared setting. • Exact facility identified • Environmental risks considered (infection control, storage, privacy, mobility) **2. Clinical Needs Addressed** • Wound/catheter care feasible? • Dressing supplies required? • Community nursing or outreach is arranged if needed **3. Medication Safety Considered** • Safe storage available? • Clear instructions provided in accessible language • Facility staff aware of any supervised or time-sensitive medications **4. Communication Completed** • Keyworker/staff contacted • Follow-up arrangements shared • Confidentiality preserved (minimum necessary information)

Tool	Purpose	Application
Checklist Prompt: Safe Discharge to Congregate Settings	To consider and explore core safety considerations when discharging a patient to a congregate or shared setting.	**5. Patient Understanding Checked** • Can describe the plan (in their own words) • Knows where/when follow-up occurs • Knows who to contact if symptoms worsen
Suggested Phrasing	Support collaborative tone	"Can we check the facilities where you'll be staying, so we can plan your care safely and link in with the staff there?"

Chronic Disease Management

Keywords: chronic disease, continuity of care, self-management, access to care, health equity, multimorbidity, person-centred care

Overview

Chronic disease management involves the ongoing identification, monitoring, and treatment of long-term conditions over time. For people experiencing social exclusion, this is clinically more complex (Goodridge, et al, 2019) as many of the conditions under which care is typically delivered – regular attendance, continuity with a single provider, stable living arrangements, and capacity for self-management – are often absent or disrupted.

Where care is disrupted by instability of living circumstances, mental health or substance use-related barriers to engagement, and limitations in understanding or navigating health information, chronic conditions are more likely to remain undiagnosed, undertreated, or excluded from routine monitoring and prevention programmes. They frequently present late in the disease trajectory or during acute deterioration, limiting opportunities for early intervention, optimisation of treatment, and prevention of complications.

Conventional chronic disease management models assume that patients can prioritise health over competing demands such as securing housing, income, or safety; that they have the means and availability to attend scheduled appointments; and that they can understand, retain, and act on potentially complex health information. These assumptions do not accurately reflect the lived reality of many patients, who often face competing priorities, stigma, and systemic barriers that disrupt the continuity of care.

A person-centred approach to chronic disease management in this context requires flexible, accessible models of care that adapt to the patient's lived circumstances. The aim is to stabilise long-term conditions, reduce preventable deterioration and crisis presentations, and support achievable self-management of day-to-day treatment, monitoring, and engagement with care, in the context of intersecting clinical, social, and structural barriers.

Key Clinical Considerations

- **Screen opportunistically, proportionately, and with consent**
  - Use appropriate clinical encounters to assess for common, high-impact conditions that may otherwise go undiagnosed and are likely to benefit from early identification.
  - Establish a baseline problem list and initiate, restart, or rationalise treatment where safe, rather than defaulting to delayed outpatient referral.
  - Where investigations or follow-up cannot be completed, document barriers explicitly and agree on a concrete re-contact or re-assessment plan.
- **Simplify Treatment**
  - Rationalise medication where clinically possible, reducing polypharmacy and prioritising once-daily regimens, fixed-dose combinations, or long-acting injectables.
  - Align monitoring with existing touchpoints (e.g. OST clinics, housing support, outreach teams), with explicit agreement on roles, escalation pathways, and documentation, to reduce reliance on frequent attendances.
  - Provide an easy-read medication list, synchronise repeat prescriptions, and consider blister packs or similar aids to support adherence.
- **Adopt Trauma-Informed Care**
  - Acknowledge prior negative experiences; use non-judgemental language and avoid punitive framing around “compliance”.
  - Offer choices and pacing; allow a support person; minimise non-urgent invasive steps.
- **Prioritise Relationship-Building**
  - Aim for continuity with a named clinician or service where feasible, and ensure consistent messaging across teams.
  - Set small, shared goals (e.g. “use preventer inhaler daily”) and schedule brief, frequent check-ins (phone/outreach) when possible.
  - Share a concise care summary so plans are visible across services.
- **Link with Support Services**
  - Coordinate with addiction services, housing or outreach teams, community nursing, and NGOs to reinforce care plans and reduce the risk of disengagement between visits.
  - Involve peer support/health navigators for appointment accompaniment and troubleshooting.

Why This Matters

People experiencing social exclusion carry a disproportionate burden of chronic disease (e.g. COPD, diabetes, cardiovascular disease), yet diagnosis, treatment, and ongoing support are often disrupted by barriers to access, continuity, and engagement. When care plans do not fully align with these realities, disease control may deteriorate, leading to preventable complications, frequent hospitalisation, and early mortality. Fragmented monitoring and disrupted follow-up further increase risk, with deterioration often recognised only at the point of crisis. Patients have described disengagement associated with fragmented appointments, unclear medication instructions, and clinical language that can frames difficulty as "non-compliance" rather than reflecting access or system constraints.

Embedding flexible, patient-centred approaches across key domains – including treatment optimisation (e.g. simplified or long-acting regimens), access and detection (e.g. proportionate opportunistic screening), and continuity mechanisms (e.g. outreach-based monitoring) - supports earlier detection, improved clinical stability, and reduced unplanned admissions. Adapting chronic disease management to prioritise clarity of information, feasibility of care plans, and continuity over time strengthens patient safety while supporting more equitable care delivery.

Learning Tools

Tool	Purpose	Example
Vignette: Managing Chronic Disease in the Context of Instability	To illustrate how competing priorities and structural constraints can disrupt chronic disease management.	Sarah is a 38-year-old woman living in emergency accommodation with long-standing type 1 diabetes.She presents for her third admission with diabetic ketoacidosis (DKA) in two months. Staff have noted repeated missed follow-ups. Wh en speaking with her, Sarah explains that her accommodation changes frequently, she has limited access to refrigeration, and she often misses appointments because they conflict with supervised access visits for her children. She knows her diabetes is "out of control" but feels overwhelmed by the number of services involved. **Reflection Prompts** • What adaptations to monitoring, medication, and follow-up could make her care plan feasible? • Who else (services, supports) should be involved early to create continuity? **Application**: case-based discussion or MDT problem-solving session.

Tool	Purpose	Example
Suggested Phrasing: Grounding Chronic Disease Conversations	To support patient-centred conversations that validate competing priorities.	**Exploring Feasibility** • "It sounds like managing this is a big ask right now. Can we talk about what feels manageable for you?" • "Which part of the plan worries you most?" **Setting Shared Goals** • "What is most important for you right now?" • "If we were to focus on one change this week, what would feel realistic?" • "Would it help to break this into smaller steps?" **Checking** Understanding and Barriers • "What might get in the way of this plan when you leave today?" • "Is there anyone you trust who could support you with this?" **Application**: role-play or communication workshops.
Checklist: Chronic Disease Safety and Feasibility Check	To ensure multimorbidity management considers social and practical barriers.	**1. Medicine & Monitoring Access** • Can the patient reliably obtain their medications? • Is safe storage (e.g. refrigerataion, controlled substances) possible? • Are scheduled tests or reviews realistically accessible? **2. Medication Feasibility** • Is the regimen simplified (dose frequency, combinations, long-acting options) • Has the patient been given a clear or easy-read medication list? **3. Monitoring & Follow-Up** • Are investigations aligned with existing touchpoints (OST, PHN, NGO, housing supports)? • Is there a named clinician/service responsible for follow-up? **4. Support Network Engagement** • Have relevant services been involved (addiction, community nursing, outreach, peer support)? **5. Relationship & Goal-Setting** • Have competing priorities been acknowledged without judgement? • Have you agreed together on one achievable goal for now? **Application**: chronic disease clinic bundle or adapted checklist.

Further Resources

1. HSE National Framework for the Integrated Care of Chronic Disease
2. DeepEnd GP Ireland: Managing Multimorbidity in Disadvantaged Patients
3. SAOL and UISCE: Supporting Women and People Who Use Drugs with Long-Term Conditions
4. Safetynet Primary Care: Outreach and Community Management Resources
5. World Health Organization: Guidelines on Equitable Chronic Disease Care

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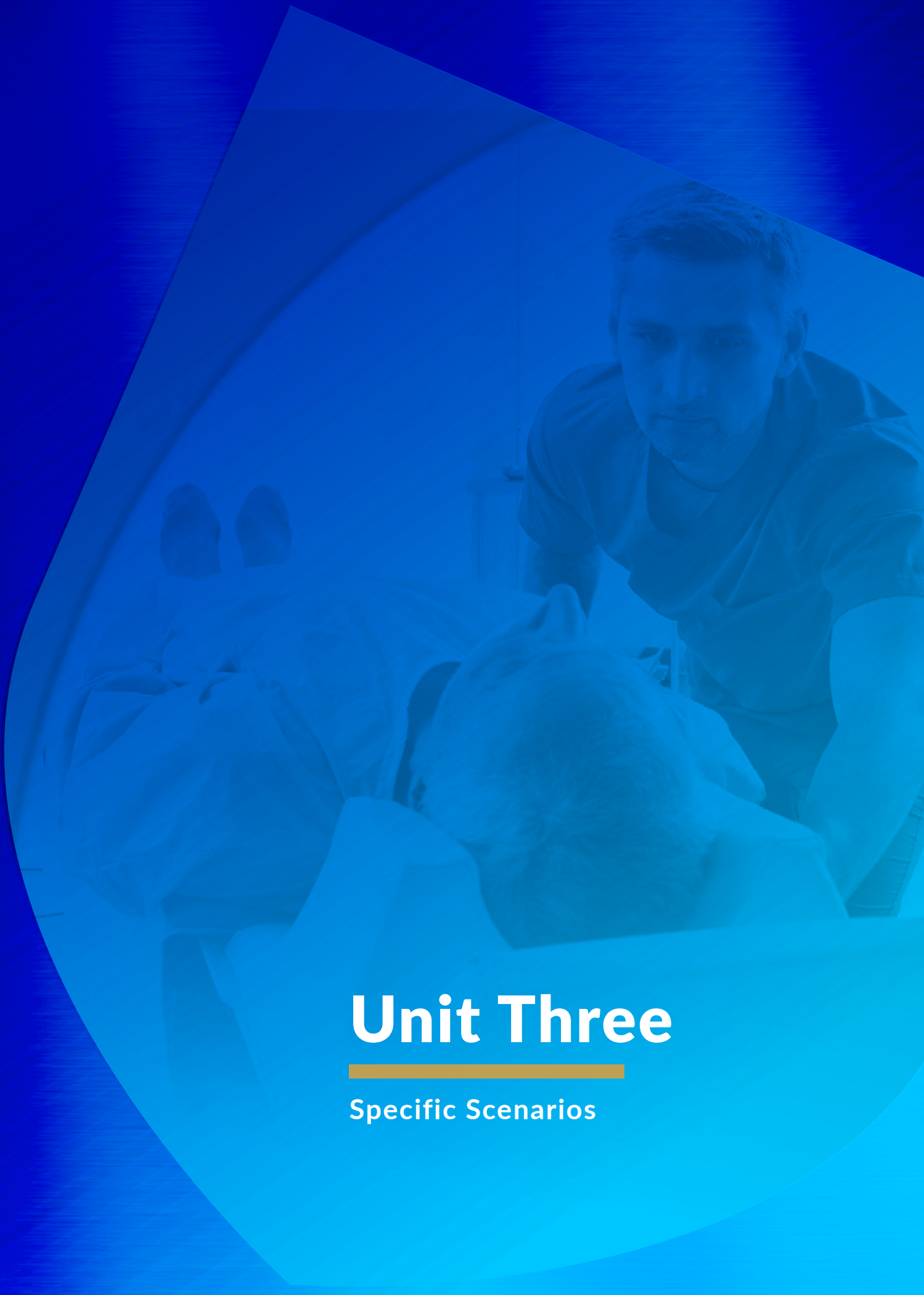

Unit Three

Specific Scenarios

Unit Three. Specific Scenarios

Unit Three addresses clinical scenarios in which social exclusion, stigma, and system fragmentation can increase the risk of delayed diagnosis, treatment interruption, and preventable harm. It translates Inclusion Health principles into clinical practice across a range of contexts, including care for people who use drugs, pain assessment and management, early frailty and functional decline, infectious diseases, women's health, and safeguarding. This unit emphasises diagnostic vigilance, trauma-informed and culturally responsive communication, and the adaptation of investigation, prescribing, and follow-up to patients' lived circumstances, capacity, and access constraints. Particular attention is given to presentations in which symptoms may be masked or misattributed; to clinical encounters shaped by stigma, fear, or prior harm; and to transitions of care in which continuity is most vulnerable. The aim is to strengthen clinical judgement and patient safety through earlier recognition of risk, accurate and fair assessment, and coordinated responses across services, supporting equity while reducing preventable morbidity and mortality.

Working with People Who Use Drugs

Recognising and Managing Medical Complications of Injecting Drug Use

Using POCUS to Support Complex Venous Access

Access to Opiate Substitution Treatment (OST) (or Opiate Agonist Therapy (OAT)) as Inpatients

This section explores the recognition and management of medical complications that may arise in the context of injecting drug use, with attention to early identification, safe procedural care, and continuity of treatment during hospital admission. It outlines a range of potential complications, including infection, vascular injury, overdose, and complex venous access, and notes how delayed presentation or fragmented care may increase clinical risk. The section also highlights practical aspects of care, such as the use of point-of-care ultrasound (POCUS) to support safer venous access and the verification and continuation of Opiate Substitution Treatment (OST/OAT) in inpatient settings. It aims to support a coordinated clinical approach that promotes patient safety, continuity of care, and appropriate follow-up.

Recognising and Managing Medical Complications of Injecting Drug Use

Keywords: injecting drug use, injecting-related complications, infection and sepsis, vascular injury, harm reduction, diagnostic vigilance, multidisciplinary care

Overview

People who inject drugs face a high burden of medical complications arising from repeated injecting, unsafe techniques, and non-sterile equipment. These complications range from local infections (cellulitis, abscesses, thrombophlebitis) to systemic and life-threatening illnesses (sepsis, endocarditis), as well as vascular injury (collapsed veins, thrombosis), often presenting late and with atypical features.

Although injecting-related complications are common and often severe, they are frequently under-recognised or inconsistently managed in healthcare settings. This can reflect a combination of diagnostic overshadowing and premature diagnostic closure, whereby symptoms may be attributed solely to injecting drug use. As a result, superimposed infection, vascular injury, or systemic illness may not be adequately assessed or investigated. Under-recognition is further compounded by variations in clinicians' familiarity with the full range of injecting-related complications, particularly those involving deep venous or groin injection sites. Stigma within healthcare encounters can inadvertently reinforce these patterns by discouraging thorough examination, investigation, or escalation of care.

Delays in care also arise from structural barriers, including homelessness, lack of a safe place to rest, dress wounds, store medications, or attend follow-up appointments, which undermine recovery even when treatment is initiated. Interpersonal barriers also add to risk: loss of dignity and privacy (for example, staff discussing patients openly in waiting areas or using insensitive language), fear of judgement, and prior negative encounters discourage both timely presentation and early disclosure of symptoms.

Co-existing mental illness, addiction, and chronic disease further complicate management by affecting pain perception, communication, adherence, and the feasibility of prolonged treatment or monitoring, increasing the risk of avoidable harm, delayed resolution, and recurrent hospitalisation.

Key Clinical Considerations

- **Recognise and assess injecting-related complications early**
  - Screen for common complications: abscesses, thrombophlebitis, sepsis, endocarditis and vascular injury.
  - Ask directly about pain, swelling, redness and fever in patients who inject drugs.
  - Maintain a high index of suspicion and avoid premature diagnostic closure (e.g. framing pain or fever solely as drug-seeking or withdrawal without assessment).
- **Use trauma-informed assessment to support disclosure and examination**
  - Use respectful, neutral language (e.g. "missed appointment" instead of "non-compliant").
  - Acknowledge prior healthcare experiences and clarify how current care is aiming to be different.
  - Offer choices where feasible and demonstrate empathy through active listening and open body language.
- **Adapt Treatment Goals to Readiness and Capacity**
  - Collaboratively agree on safer next steps, even if full adherence or abstinence isn't realistic, while maintaining clear clinical thresholds for investigation, escalation, and treatment.
  - Acknowledge progress (e.g. attending earlier, keeping wounds clean, using sterile needles).
  - Offer Opioid Substitution Therapy (OST), wound care packs, or clinically appropriate point-of-care antibiotic strategies where feasible.
- **Leverage peer and outreach support to strengthen engagement**
  - Involve peer workers and outreach teams to support early presentation, wound care, safer injecting practices, and follow-up.
  - Recognise that trust built outside hospital settings can enable earlier disclosure and reduce progression to severe infection.
- **Coordinate Multidisciplinary Care**
  - Involve addiction specialists, infection specialists e.g. Infectious Diseases or Clinical Microbiology, and mental health services where relevant, during hospital assessment and treatment.
  - Document risk factors, care needs, and agreed plans clearly in notes and handovers.
  - Use multidisciplinary team (MDT) discussions to plan investigations, pain management, and infection control in a holistic way.
- **Plan for Continuity of Care Post-Discharge**
  - Engage community supports, peer workers, and outreach teams to improve adherence and follow-up.
  - Refer to harm reduction or addiction services before discharge.
  - Share discharge summaries and care plans with relevant community providers to reduce service fragmentation.

Table: Common Medical Complications Associated with Injecting Drug Use

This table highlights common complications to prompt clinical vigilance; presentations may be atypical and overlapping.

Category	Key Complications
Infectious	• Soft tissue infection, abscess, and septic thrombophlebitis (including femoral/groin sites) • Blood-borne viral infections: HIV, hepatitis B and C • Bacterial and fungal endocarditis • Osteomyelitis and septic arthritis • Sepsis • Less common but severe infections: tetanus, botulism, necrotising fasciitis
Vascular	• Deep and superficial venous thrombosis (DVT, SVT), including iliofemoral disease • Chronic venous insufficiency • Arterial embolism or vasospasm causing limb ischaemia • Arterial injury and pseudoaneurysm formation
Toxic / Drug-Related	• Overdose (opioids and non-opioids), including risk of hypoxia and aspiration

Why This Matters

Injecting-related complications are a leading cause of morbidity and mortality among people who use drugs. Delayed recognition or inadequate management often results in preventable hospitalisations and death. These failures arise from interacting cognitive and structural factors, including stigma within healthcare encounters. In some cases, this may contribute to diagnostic overshadowing and premature diagnostic closure, delaying appropriate investigation, treatment, and escalation of care. The downstream consequences can include progression to advanced infection, organ damage, or death, contributing to avoidable harm and health inequalities.

A trauma-informed, harm-reduction approach supports patient engagement, treatment adherence, and improved clinical outcomes. Integrating medical care with peer and community support acknowledges patients' lived experience and helps reduce barriers to effective treatment. Alongside acute medical management, harm-reduction approaches such as sterile injecting equipment provision, education on safer injecting sites, naloxone access, and linkage with addiction services, can help reduce recurrent injury and prevent avoidable morbidity.

Learning Tools

Tool	Purpose	Example
Vignette: Trauma-Informed vs. Stigmatising Practice	To contrast how clinician behaviour affects disclosure, diagnostic accuracy, and patient engagement when complications of injecting arise.	Sarah is a 34-year-old woman who injects heroin in her lower limbs. She attends the Emergency Department (ED) with severe calf pain, fever, and difficulty walking. Her last visit to the hospital was distressing - a clinician openly questioned her pain, commented on "another abscess" and appeared impatient examining her. Feeling judged, she delayed seeking help this time until the pain became unbearable. Today, Sarah avoids eye contact, keeps her trousers pulled down only part-way, and apologises repeatedly for "wasting time." She describes "a lump that keeps getting bigger," but hesitates to say more. **A trauma-informed clinician:** • acknowledges that previous healthcare encounters may have been difficult, • asks permission before examining, • uses neutral, non-stigmatising language ("injecting equipment," "injecting sites"), • validates her reason for attending ("You've done the right thing coming in early"), and • explains what investigations are needed and why. Feeling safer, Sarah discloses that she has had difficulty accessing sterile equipment this week and has been injecting into the groin. Point-of-care ultrasound reveals a deep abscess with associated thrombophlebitis. She agrees to treatment and accepts linkage to harm-reduction and OST supports before discharge. **Reflective Prompts:** • Did any assumptions about Sarah's drug use influence the diagnostic reasoning, urgency of assessment, or interpretation of her symptoms? • Which aspects of the communication helped (or could have helped) Sarah feel safe enough to disclose her injecting practices early? **Application**: simulation or case-based discussion
Suggested Phrasing	To encourage safe, open discussion of complications.	• "Can you tell me about any changes or pain around your injecting sites?" • "Have you noticed any swelling or redness?" • "Which veins have you had difficulty accessing?" **Application**: communication workshops

Tool	Purpose	Example
Checklist Prompt	To support rapid recognition of injecting-related complications and standardise escalation in high-risk presentations.	• Spreading erythema, fluctuance, limb swelling • Groin pain or swelling (possible femoral abscess/ pseudoaneurysm) • Severe or rapidly worsening pain • Fever or rigours • Hypotension or tachycardia • New confusion or agitation • Suspected endocarditis (murmur, embolic signs, persistent bacteraemia) • Signs of limb ischaemia (cold, pale, pulseless limb) • Suspected DVT or septic thrombophlebitis **Action** • Document clearly → escalate to senior clinician → involve ID/General Medicine → consider imaging early. **Application** Ward poster, ED triage prompt, handover checklist.
Reflective Prompt	Build clinician self-awareness and reduce bias	• "Am I making assumptions about this patient's drug use or adherence?" • "How can I create a safer space for discussing injecting complications?" **Application**: reflective practice sessions

Further Resources

1. EuroNPUD, Safer Injecting and infection prevention resources. Available at: https://www.euronpud.net/course/safer-injecting/
2. Rich, K.M. and Solomon, D.A. (2023) 'Medical complications of injection drug use — Part I', NEJM Evidence, NEJM Evid 2023;2(2). DOI: 10.1056/EVIDra2200292
3. Rich, K.M. and Solomon, D.A. (2023) 'Medical complications of injection drug use — Part II', NEJM Evidence, NEJM Evid 2023;2(3). DOI: 10.1056/EVIDra2300019

Using POCUS to Support Complex Venous Access

Keywords: POCUS, complex venous access, injecting drug use, procedural safety, harm reduction, trauma-informed care

Overview

Venous access is often complex in patients with a history of injecting drug use, particularly people with prolonged or high-frequency use. Repeated vascular injury can result in collapsed or scarred peripheral veins and local tissue damage, often compounded by prior traumatic experiences related to needling or other invasive procedures. These factors can lead to repeated failed cannulation attempts, procedural pain, and distress, contributing to avoidance of healthcare. In some cases, loss of peripheral venous access also leads individuals to inject drugs into higher-risk sites such as the groin or neck, compounding the risk of serious infection and vascular injury.

Point-of-Care Ultrasound (POCUS) offers an evidence-based approach to support safer venous access in these situations. Its early use can reduce failed attempts at finding veins, prevent harm, and demonstrate attention to patients' bodily autonomy and lived experience. Integrating POCUS into care also helps to build trust and alleviate fear during clinical encounters, particularly among patients who may have previously encountered stigma, pain, or dismissal in healthcare settings.

Key Clinical Considerations

- **Recognise the Impact of Complex Access**
  - Understand that repeated failed cannulation attempts can be painful and distressing.
  - Acknowledge how such experiences may retraumatise individuals with previous negative healthcare encounters.
- **Use POCUS as a Standard Harm-Reduction Tool**
  - Use POCUS as an early harm-reduction tool when difficult access is anticipated, rather than only after multiple failed and painful attempts.
  - Normalise the use of ultrasound in these contexts to reduce repeated failed attempts and avoid escalation to higher-risk venous access practices.
- **Communicate with Respect and Transparency**
  - Respect patients' knowledge of their own veins (e.g. "This one usually works", "The back of the leg/arm should be easier"), including inviting them to identify potential access sites where appropriate.
  - Explain procedures clearly, use trauma-informed language and tone, and check for consent.
- **Engage Additional Support where Needed**
  - Involve addiction services, peer advocates, or outreach workers to enhance patient comfort and continuity of care, where possible.
  - Recognise that trusted relationships can support patient comfort and follow-up.

Why This Matters

Poor venous access is a common barrier to timely and safe care for people who inject drugs. Repeated failed cannulation attempts or dismissive encounters can cause pain, distress, and avoidance of healthcare altogether. People with lived experience describe valuing moments where clinicians acknowledged their knowledge of their own bodies, such as being invited to indicate where access might be easiest, which helped restore dignity and a sense of partnership in care.

POCUS offers a simple but powerful intervention to reduce harm, improve success rates, and demonstrate that patient safety and comfort are being prioritised. By supporting safer access, it also builds trust and supports ongoing engagement with healthcare. The use of ultrasound and vein-finding technology is already standard practice in harm reduction settings, such as the Medically Supervised Injecting Facility (MSIF), where it significantly reduces missed attempts, pain, and frustration for patients. Staff report higher success rates and safer experiences, and clients feel more respected and confident engaging with care. The same principle can be applied in hospital and community healthcare settings, where complex venous access is common.

Learning Tools

Tool	Purpose	Example
Vignette: Trauma and Venous Access	**Purpose** To illustrate how trauma, stigma, and repeated failed procedures can escalate distress during venous access.	A patient attends a clinic for an STI panel. She has a history of injecting drug use, and repeated vascular injury has resulted in severely damaged peripheral veins. Blood sampling proves difficult. The patient discloses past trauma related to being touched by men and becomes visibly anxious during venepuncture. After a second unsuccessful attempt, she begins to hyperventilate and experiences a panic response. A case worker is called to support her. Later, the patient reflects that clinicians often underestimate how invasive IV procedures can be for people who use drugs, particularly when past trauma is present. She recalls perceiving staff frustration during the attempts, which increased her anxiety and reinforced her desire "not to cause trouble." **Reflective Prompts** • What signals of distress were present during the encounter, and how might they have been recognised earlier? • How could anticipatory use of POCUS or changes in communication have altered the patient's experience and clinical outcome?
Vignette: Dignity and Missed Opportunities for Harm Reduction	**Purpose** To demonstrate how dismissive responses to complex venous access can undermine dignity and reduce trust in care.	A woman attends a Sexual Assault Trauma Unit for assessment. She has a history of injecting drug use and reports longstanding difficulty with venous access. During attempts at blood sampling, a male clinician expresses frustration to a colleague, referring to the procedure as disruptive to his workflow. The patient witnesses this exchange and becomes withdrawn. She later describes feeling dismissed and devalued, noting that her difficulties were treated as an inconvenience rather than a clinical issue. Reflecting on the encounter, she identifies that use of POCUS could have spared both her distress and the doctor's frustration. **Reflective Prompts** • How might clinician attitudes and informal communication influence the patient's perceptions of safety and respect? • In what ways could early use of POCUS function as both a clinical and trauma-informed intervention in this scenario?
Suggested Phrasing	Normalise patient involvement and offer reassurance	• "Would it be helpful if I used ultrasound to avoid multiple attempts?" • "Is there a spot that usually works for you?" • "You know your body best - can you show me where you've had success before?" **Application**: communication workshops or bedside teaching.

Further Resources

1. EuroNPUD, Safer Injecting and infection prevention resources. Available at: https://www.euronpud.net/course/safer-injecting/

Access to Opiate Substitution Treatment (OST) (or Opiate Agonist Therapy (OAT)) as Inpatients

Keywords: Opiate Substitution Treatment (OST), Opiate Agonist Therapy (OAT), opioid withdrawal, dose verification, opioid dosing, continuity of care, safe discharge

Inpatients receiving Opiate Substitution Treatment (OST, also termed Opiate Agonist Therapy, OAT) are at high risk if continuity of dosing is disrupted. Delays in confirming or administering OST can precipitate acute withdrawal, which is associated with distress, agitation, impaired concentration, and an increased risk of premature self-discharge before assessment or treatment is completed. Withdrawal symptoms may also interfere with effective clinical review, history-taking, and examination, particularly in acute or time-pressured settings.

People with lived experience describe leaving the hospital while awaiting admission or investigation once withdrawal symptoms begin, prioritising rapid access to their usual OST clinic over continued hospital care. Patients also report distress and mistrust when their prescribed OST is questioned or delayed, particularly when they feel their accounts are not taken seriously. These experiences help explain why disengagement may occur even when serious medical concerns are present.

In addition to withdrawal-related risks, inadvertent duplication of opioid dosing during admission - such as administering OST in the context of recent heroin or other opioid use - can result in life-threatening toxicity. Safe inpatient management therefore requires accurate verification of treatment status and careful clinical assessment to balance the risks of withdrawal against overdose.

To ensure safe prescribing, the patient's community pharmacy or OST clinic should be contacted immediately to verify the current dose and regimen. Using the Clinical Opiate Withdrawal Scale (COWS) assessment alongside any Urine Drug Screen (UDS) will facilitate the clinician to judge if there are concerns regarding recent heroin or other opiate use. Hospitals should have clear local protocols on OST prescribing during admissions, aligned with the National Clinical Guidelines for OST, which provide standardised direction on managing missed doses, treatment gaps, and safe continuation of therapy.

Key Clinical Considerations

- Verify OST status immediately
  - Contact the Central Treatment List) to confirm whether the patient is on OST and where they receive it.
  - Follow-up with the dispensing pharmacy or clinic to verify details before prescribing.
  - Confirm dosing and treatment details e.g. maintenance dose of methadone/buprenorphine.
- When did they last attend the pharmacy and take a supervised dose? Was the dose the same as their maintenance, or were there any amendments to it? If so why, e.g. were they deemed drug or alcohol affected?
- Were they dispensed any takeaway doses? If so, for how many days?
- Are they prescribed any other medications? If so, record details such as dose and quantity prescribed.
- Do they have any other information such as contact details of other pharmacies or clinic that the patient attends?
- Offer the verified dose safely.
- Only administer the confirmed dose once pharmacy/clinic verification, COWS Assessment, and UDS results raise no concerns.
- For accuracy and to reduce risk to the patient never rely solely on the patient's report of their dose unless all external sources are unavailable (e.g. out of hours).
- Manage missed doses cautiously.

Methadone:

- If <3 days missed → maintenance dose can generally be continued.
- If >3 days missed → halve the dose and titrate upwards (no more than +20ml over 7 days).

Buprenorphine:

- If < 5 days missed à maintenance dose can generally be continued.
- Use caution if short-acting opioids (e.g. heroin) have been used in the last 6 hours - risk of precipitated withdrawal.

Respond Appropriately Out of Hours

- If clinic/pharmacy confirmation is not possible, follow local hospital procedures.
- Where clinically safe, consider splitting the estimated maintenance dose into two administrations 12 hours apart until confirmation is available.

Plan for Safe Discharge

- Always contact the patient's OST provider (clinic or pharmacy) on discharge, regardless of whether the day's dose was given in hospital.
- Confirm how the patient will access their next dose (e.g. clinic opening hours, transport feasibility).
- Ensure all details are documented in the discharge summary/prescription and communicated to the dispensing service.

Why This Matters

Preventing opioid withdrawal during hospital admission is essential to maintaining patient safety and engagement with care. Timely verification and administration of OST, particularly while community pharmacies and clinics remain open, is therefore critical. At discharge, continuity of OST must be ensured on the same day to prevent missed doses and destabilisation. Clear communication with the dispensing clinic or pharmacy reduces treatment interruption, unnecessary suffering, and relapse risk, while consistent, respectful recognition of verified treatment needs supports trust, retention, and continuity within the care pathway.

Learning Tools

COWS Score for Opiate Withdrawal

Further Reading:

1. Health Service Executive (HSE) (2016) Clinical guidelines for opioid substitution treatment. Dublin: Health Service Executive. Available at: https://www2.healthservice.hse.ie/files/124/

Frailty and Functional Decline in the Context of Social Exclusion

Identification of Frailty and Functional Decline

Responding and Referring for Frailty and Functional Decline

Age-Related Considerations, Preventative Strategies, and Ageing Well

This section examines the early emergence and accelerated progression of frailty and functional decline in people experiencing social exclusion, particularly homelessness, where age-related vulnerability often appears earlier and is shaped by cumulative health, environmental, and social adversity. It focuses on recognising frailty beyond chronological age, avoiding misattributing functional vulnerability to non-engagement or behavioural difficulties, and responding proactively before decline becomes entrenched. The section emphasises context-appropriate assessment, trauma-informed communication, and timely referral to multidisciplinary and community supports, alongside preventative and outreach-based approaches to ageing well.

Identification of Frailty and Functional Decline

Keywords: frailty, homelessness, early recognition, functional decline, diagnostic overshadowing, cognitive impairment, social frailty

Overview

Frailty is common among people experiencing homelessness and often presents at a younger age, with patterns more typically seen in older adults. This reflects the cumulative effects social exclusion and unstable living conditions (e.g. homelessness, isolation, lack of support), health-related vulnerabilities (e.g. substance use, mental illness, chronic disease), and systemic barriers to care (e.g. poor access to primary care, fragmented services, delayed diagnosis).

In this context, falls often represent an early and clinically important manifestation of frailty and functional decline, arising from the interaction of comorbidities such as neuropathy, epilepsy, or substance use with environmental hazards and unstable living conditions. This highlights the need for assessment of both medical contributors and the physical environment, with referral to occupational therapy or physiotherapy where appropriate.

Recognising frailty early enables doctors to tailor clinical management, avoid misattribution of symptoms (e.g. to substance use or behavioural causes), and initiate timely interventions (Cronin, et al, 2025). These may include adapting treatment plans to account for reduced physiological reserve and lower tolerance for clinical stressors, initiating rehabilitation or falls prevention strategies, and engaging multidisciplinary teams to support functional stability and social needs.

Key Clinical Considerations

- **Avoid Age-Based Assumptions**
  - Avoid applying age-based assumptions; recognise that physiological vulnerability may be disproportionate to chronological age.
  - Recognise that frailty may present decades earlier than expected for chronological age in people experiencing homelessness.
- **Identify Clinical Red Flags**
  - Be alert to overt indicators of frailty and functional decline. These red flags typically reflect established frailty and should prompt immediate assessment and intervention, and may require multidisciplinary input. Key signs include: falls or near-falls; poor mobility or balance; loss of muscle mass and strength; incontinence; cognitive slowing or confusion.
- **Avoid Diagnostic Overshadowing**
  - Avoid attributing signs of frailty, such as fatigue, falls, or cognitive change, solely to substance use (e.g. alcohol or drug-related effects). Consider alternative or coexisting medical causes, including early frailty, nutritional deficiencies, or neurological conditions.
- **Identify Less Visible Frailty**
  - Pre-frailty may present subtly and progressively, making it harder to detect without active clinical assessment. It reflects an early stage of decline that is potentially reversible with timely intervention. Be attentive to:
    - Use of long-term mobility aids (e.g. crutches or walking frames)
    - Slower gait speed or reduced grip strength
    - Unintentional weight loss
    - Mild fatigue or reduced physical activity
    - Difficulty managing daily tasks or medications
- **Consider Psychosocial Dimensions**
  - Consider the vulnerability arising from limited social support, isolation, and unmet social needs, which can compound physical decline and increase the risk of adverse outcomes ("social frailty").
  - Consider the clustering of cognitive impairment, poor functional ability, and frailty, and assess cognition alongside frailty where concerns arise.
- **Distinguish between Cognitive Decline and Delirium**
  - Recognise that dementia-like presentations can occur earlier in people experiencing homelessness due to cumulative disadvantage.
  - Be alert to acute confusion, disorientation, or fluctuating attention, which may signal delirium rather than intoxication or behavioural disturbance.
  - Seek collateral history from staff, family, or outreach teams to clarify baseline cognition and onset of change, and maintain a low threshold for assessing and treating delirium as a medical emergency.
- **Recognise Higher-Risk Sub-populations**
  - Consider sub-populations with potentially higher frailty risk, such as women experiencing homelessness, individuals with high levels of substance use, or those with prolonged histories of homelessness.
  - Undertake proactive and regular frailty surveillance during consultations where appropriate.

Why This Matters

Without early recognition, symptoms of frailty may be overlooked, misattributed, or masked by comorbidities, leading to avoidable deterioration. Screening for frailty can be integrated into the routine assessment of patients experiencing homelessness who show signs of functional decline or poor physical performance, due to high prevalence and association with health vulnerabilities. Early identification can help shift care from crisis response to planned, preventative management.

Learning Tools

Frailty assessment in people experiencing social exclusion requires careful clinical judgement, with frailty assessment tools and measures extrapolated from geriatric care. Nevertheless, structured tools can support earlier recognition, shared clinical language, and multidisciplinary decision-making when used thoughtfully and in combination with clinical judgement. Employing more than one tool may help provide a multidimensional view of frailty, encompassing physical, cognitive, psychological, and social domains.

Tool	Purpose	Example
Frailty Scales	Support structured, multidimensional clinical judgement about frailty	• Clinical Frailty Scale (CFS) for multidimensional assessment (functional, cognitive, psychosocial).
Physical Measures	Detect early functional decline	• Fried Frailty Criteria or SHARE-FI (physical focus). • Hand-grip dynamometry as a quick proxy for strength/frailty.
Comprehensive Tools	Broaden assessment to include psychological and social vulnerability alongside physical health	• Tilburg Frailty Indicator (physical, psychological, social elements). • Comprehensive Geriatric Assessment for complex needs.

References

1. Cronin, T., Healy, D., McCarthy, N., Smith, S.M. & Travers, J., (2025). 'Prevalence and risk factors of frailty in people experiencing homelessness: a systematic review and metaanalysis'. The Journal of Frailty & Aging, 14(2), p.100029. DOI: 10.1016/j.tjfa.2025.100029

Responding and Referring for Frailty and Functional Decline

Keywords:frailty, pre-frailty, functional decline, referral pathways, integrated care, homelessness

Overview

Frailty and functional decline often develop earlier, progress more rapidly, and present less clearly in people experiencing social exclusion than in the general population (Mantell et al, 2023). Rather than emerging primarily through gradual age-related processes, frailty and functional decline in this context often arise from the cumulative interaction of stressors. Key contributing factors include chronic and poorly controlled physical illness, malnutrition, substance use, repeated acute illness or injury, and prolonged exposure to environmental instability. These clinical risks are further compounded by structural conditions, including limited access to nutritious food, the lack of safe spaces for rest and recovery, exposure to cold or damp environments, and extended periods of immobility or inactivity. Together, these pressures accelerate loss of physiological reserve and reduce the capacity to recover from illness or injury.

Functional vulnerability may be misinterpreted as behavioural difficulty, acute intoxication, or “non-engagement”. In practice, indicators commonly labelled as poor engagement, such as missed appointments, difficulty adhering to care plans, or inconsistent follow-up, may reflect reduced stamina, cognitive overload, or limited capacity to manage complex demands rather than unwillingness or lack of motivation. As a result, frailty in socially excluded populations may be under-recognised or misattributed.

In addition, clinical responses and referral pathways that are designed around assumptions of stable housing, consistent self-care capacity, or reliable outpatient follow-up may be poorly matched to the realities of social exclusion, limiting the effectiveness of otherwise appropriate care.

Key Clinical Considerations

- **Recognise frailty beyond age-based assumptions**
  - Frailty and functional vulnerability should be considered even in younger patients where there is evidence of repeated illness, falls, poor recovery, or declining capacity.
- **Use supportive, engagement-preserving language**
  - When communicating with people who are homeless, frame discussions in terms of building strength and resilience, rather than addressing frailty – as this can be more palatable, especially for younger or non-geriatric groups.
  - Support active participation by identifying concrete, manageable actions, eliciting what the person believes will help (e.g. "Which part of the plan feels manageable for you to start with?"), and co-setting goals that are realistic within their daily environment.
- **Address modifiable contributors to decline**
  - Identify and address contributors that commonly accelerate decline in this context (e.g. nutrition and hydration, inactivity, poorly controlled chronic disease, substance use, polypharmacy, or repeated acute illness).
  - Integrate preventative interventions into the care plan (e.g. vaccination, falls assessment, or smoking cessation) and ensure timely onward referral to allied health, community teams, or GP follow-up. Collaborate with dietitians or community nutrition supports where available.
- **Refer appropriately**
  - Refer or seek advice from geriatric services regarding frailty management, recognising that frailty assessment is not limited by chronological age.
  - Engage the multidisciplinary and primary care teams early (physiotherapy, occupational therapy, dietetics, addiction services) to design intervention plans tailored to the patient's living circumstances.
- **Integrate holistic supports**
  - Consider holistic interventions addressing physical, psychological, and social needs, particularly where these intersect with functional recovery.
- **Plan for recovery and follow-up**
  - Incorporate social and community supports into discharge planning, such as nursing follow-up, allied health input, social work, and housing support.
  - Ensure the plan explicitly addresses environmental risks (e.g. no access to cooking, mobility barriers, unsafe accommodation), reduced resilience, and limited social networks, to reduce the likelihood of deterioration or readmission.
- **Link to social and housing supports**
  - Align recovery planning with available community and social care networks, ensuring discharge arrangements consider mobility, nutrition, and self-care capacity.

Why This Matters

In people experiencing homelessness, pre-frailty and functional vulnerability may progress more rapidly, meaning that delayed recognition can quickly lead to established impairment and loss of independence. Planning for recovery in this context often requires integration of clinical and social supports. Discharge plans that do not address environmental risks, reduced physiological reserve, or limited capacity for self-care may inadvertently increase the likelihood of deterioration or readmission. Where available, linkage with community health, allied health, social care, and housing supports can help stabilise function and reduce preventable decline.

Frailty is a dynamic and potentially reversible condition, particularly when recognised at a pre-frailty stage. Timely, context-appropriate referral can alter the clinical trajectory, preserve independence, and reduce recurrent hospitalisation in people experiencing homelessness. A proactive, structured approach across the frailty continuum supports clinically realistic recovery aligned with the patient's circumstances and goals. Without adaptation to these realities, opportunities for early intervention are missed, potentially reinforcing cycles of deterioration and readmission.

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Age-Related Considerations, Preventative Strategies, and Ageing Well

Keywords: premature ageing, prevention, chronic disease, outreach care, harm reduction, screening, inclusion health, older homelessness

Overview

In Ireland, people experiencing homelessness face significantly reduced life expectancy, with the median age at death recorded at 42 years for men and 36.5 years for women in 2020. This contrasts starkly with the general population, where the median age at death was approximately 82 years (Kelleher et al, 2020). Drug and alcohol-related causes were the leading contributors to death among people experiencing homelessness, accounting for over one-third (37%) of all deaths recorded. This report also highlights that nearly 90% of those who died had a known history of mental health or substance use issues, underscoring the complex psychosocial challenges faced by this population. Many deaths among people experiencing homelessness are attributable to conditions considered amenable to timely care, including cardiovascular disease, cancer, infections, and chronic respiratory illnesses – highlighting persistent gaps in access and missed opportunities for prevention and early intervention (Aldridge et al., 2019; Fondation Abbé Pierre & FEANTSA, 2021).

In addition, demographic shifts mean more older adults are now entering homelessness, bringing distinct age-related risks and care needs. This group faces elevated risks associated with age-related comorbidities, including frailty, cognitive decline, chronic disease, and functional impairments, which are often exacerbated by prolonged exposure to unstable housing and limited access to preventive and primary care. Effective prevention and healthy ageing in people experiencing homelessness require outreach-delivered screening, opportunistic vaccination and chronic disease management during unscheduled encounters, and flexible care pathways that adapt to unstable housing, limited follow-up capacity, and competing health priorities.

Key Clinical Considerations

- **Integrate Opportunistic Prevention**
  - Use routine and unscheduled clinical encounters to offer proportionate, clinically indicated preventive interventions (e.g. vaccination for pneumococcus, influenza, HPV, Mpox), particularly where future attendance is uncertain.
- **Adapt Screening Approaches**
  - Offer screening in line with national cancer screening programmes, using clinical judgement to consider flexibility around age thresholds where life expectancy, risk profile, or access barriers differ from the general population. Consider mobile or outreach-based models for populations unlikely to attend routine appointments.
- **Access to Sexual Health Services**
  - Consider access in the community to services such as PrEP and sexual health services.
- **Support Harm Reduction**
  - Consider proactive naloxone prescribing, in collaboration with addiction services, for patients at risk of opioid overdose.
  - Where feasible, support training for patients and peers to recognise overdose risk and respond appropriately.
- **Deliver Outreach Models for Chronic Conditions**
  - Provide outreach-enabled testing and treatment for HCV, HIV, and other chronic conditions where standard clinic attendance is unlikely
- **Ongoing Support**
  - Identify a realistic point of ongoing clinical support or advice (e.g. named clinician, GP, homeless health service, specialist nurse, or addiction team) to reduce fragmentation of care and support continuity across services and transitions.

Why This Matters

Ageing within homelessness occurs under conditions of cumulative disadvantage, where preventable diseases often progress unchecked due to service inaccessibility. As a result, clinicians are more likely to encounter patients with advanced illness, multimorbidity, and functional vulnerability at younger ages, with fewer opportunities for planned prevention. Embedding prevention, harm reduction, and outreach-based chronic disease management into routine encounters supports timely intervention and more equitable health outcomes. Tailoring age-related care to the realities of homelessness supports proportionate clinical decision-making, preserves dignity and autonomy, and promotes healthier ageing even in the context of ongoing social instability.

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Transitions in Care

Transition from Paediatric to Adult Services

This section examines the transition from paediatric to adult healthcare as a high-risk period for adolescents, particularly those affected by social exclusion, trauma, neurodiversity, chronic illness, or limited family support. It highlights how gaps in handover, mismatched service thresholds, and assumptions about health literacy and autonomy can result in treatment disruption, medication risk, and loss to follow-up at a developmentally sensitive stage. The section emphasises ensuring continuity of clinical and psychosocial information, anticipating eligibility or entitlement changes, and coordinating across paediatric, adult, primary care, and relevant support services to preserve engagement and safety through transition.

Transition from Paediatric to Adult Services

Keywords: adolescent medicine, transition planning, continuity of care, equity, communication, neurodiversity, trauma-informed care

Overview

The transition from paediatric to adult healthcare represents a predictable point of clinical vulnerability, particularly for young people experiencing social exclusion, as it involves a transfer of responsibility, eligibility, and care coordination at a stage of ongoing developmental, psychological, and social change. Adolescents in state care, with unstable housing or limited family support, and those living with chronic illness, neurodiversity, or mental health difficulties, are especially vulnerable to fragmented care, disengagement, and delayed diagnosis. This can drive service discontinuity and poorer outcomes.

Gaps in communication and mismatched eligibility between child and adult services lead to treatment interruption, duplication, or complete loss to follow-up. Young people may also lose entitlements, key workers, or access to age-specific services, while being expected to "take over" their care without sufficient capacity, preparation, or support. Incomplete transfer of medical, social, and psychological information further increases the risk of missed diagnoses, treatment lapses, and inappropriate prescribing at a critical developmental stage.

Standard transition models often assume stable families, consistent care teams, and high health literacy – conditions which often do not present among socially excluded young people. Those leaving state care, living without family supports, or with unrecognised needs such as neurodivergence, trauma, or Adverse Childhood Experiences (ACEs) require explicit, structured preparation and continuity planning. A trauma-informed approach is particularly important: young people with histories of care or trauma benefit from slower pacing, consistent relationships, and clear reassurance that support will not be withdrawn as they enter adult services.

Key Clinical Considerations

- **Begin transition planning early**
  - Initiate discussions in early adolescence (ideally by age 14-16) and set shared, documented goals.
  - For young people with backgrounds of social adversity or instability, planning is often most effective when led by a trusted clinician familiar with the potential complexities of their physical and psychosocial needs.
- **Tailor communication to developmental and cultural needs**
  - Young people may have limited understanding of adult services or expectations of autonomy. Provide clear, age-appropriate explanations of how adult services operate and what will change during transition. Adapt communication for literacy level, neurodiversity, and cultural context.
- **Involve the young person directly**
  - Respect preferences about timing, support, and involvement of trusted adults.
  - Encourage questions and create a safe space for uncertainty or ambivalence about transition.
- **Coordinate care across services**
  - Ensure transition includes transfer of relevant social, educational, and psychological information, not solely medical records.
  - Use multidisciplinary approaches to involve key agencies where relevant (e.g. Tusla, schools, GPs).
  - Anticipate and address eligibility gaps between services to reduce the risk of treatment interruption or loss to follow-up.
- **Anticipate risks of exclusion and instability**
  - Screen for risks such as mental health deterioration, substance use, or housing instability.
  - Establish contingency and re-engagement plans in collaboration with community or outreach services.

Why This Matters

Effective transition is not a single handover but a phased, planned process requiring structured preparation, clear communication, and active collaboration between paediatric and adult teams. When this process is poorly managed or absent, young people are at increased risk of loss to follow-up, treatment interruption, and delayed recognition of emerging physical or mental health needs, and commonly describe feeling abandoned or unprepared to manage complex health and social demands.

Conversely, gradual preparation – supported by repeated conversations, shared decision-making, and clear signposting – helps maintain continuity of care, supports medication safety, and sustains medical, psychological, and social supports during the move to adult services. Here, lived experience feedback emphasises the importance of clarity about what will change, what will stay the same, and who will remain involved in care, alongside emotional support expressed through predictable communication and the opportunity to voice concerns without judgement.

The involvement of trusted adults or community workers, such as key workers, advocates, or support staff already known to the young person, can provide continuity across services, support understanding of new expectations, and help sustain engagement during the transition period. A structured, person-centred transition process is, therefore, critical to reducing risk, supporting continuity, and building lifelong engagement with healthcare.

Learning Tools

Tool	Purpose	Example
Vignette: Transition to Adult Services	To highlight how gaps in preparation, communication, and psychosocial support increase risk during transition for socially excluded adolescents.	Amira is a 15-year-old in state care with type 1 diabetes and ADHD. She has moved foster placements several times and often misses appointments when placements change. During a routine review, the paediatric team raises the need to begin transition planning. When asked about adult services, Amira shrugs. She has never attended an adult clinic and worries she will "have to manage everything alone". Her keyworker notes that she struggles to read clinic letters and frequently relies on staff to explain them. **The clinician identifies:** • No medical or transition summary has been prepared. • The receiving adult service has not been identified. • Her ADHD medication is managed within paediatric services, and continuity of prescribing may be lost without a planned link to adult care. • No assessment has been made of her readiness for self-management. The team arranges an MDT meeting with Tusla, the GP, school supports, and the adult diabetes service. A step-wise plan is agreed: early introduction to the adult clinic, paired visits with a trusted adult, simplified written materials, and a shared transition summary visible to all services. **Reflection Prompts:** • What key elements of a safe transition were missing at the time this issue was first identified? • How could communication be adapted to support her autonomy without overwhelming her? **Application**: case for simulation or case discussion.

Tool	Purpose	Example
Suggested Phrasing	Model communication that supports autonomy and engagement.	• "What are you most unsure or worried about when moving to adult services?" • "Who would you like us to involve in planning this next steap?" **Application**: communication workshop or reflective exercise.
Checklist: Transition Planning Prompts	To provide a structured, high-level set of prompts ensuring that medical, psychosocial, developmental, and social needs are addressed during transition planning. (Adapted from SteppingUp.ie and the TIER Network).	**Supports & Communication** • Who are the young person's current supports (family, foster carers, keyworkers, school staff)? • Have preferences for communication (language, literacy, neurodiversity needs) been established? **Self-Management Capacity** • Can the young person manage medications, appointments, and early warning signs? • What skills require coaching before transfer? **Education, Training & Daily Living** • Are there school, vocational, or daily-living needs relevant to health planning? • Are routines or instability impacting engagement (placement moves, transport, digital access)? **Entitlements & Eligibility** • Which entitlements or services will change at 18 (e.g. disability supports or foster care supports)? • Has a plan been made to avoid gaps in care or prescribing? **Follow-Up & Continuity** • Has the receiving adult service been identified? • Is there a named contact? • Are roles and responsibilities across teams clearly documented? **Application**: clinical teaching tool.

Additional Tools:

- Effective transition involves considering the adolescents' psychosocial as well as medical needs. A good psychosocial history is key. A useful tool is the HEEADSSS Assessment, which facilitates open communication as well as encouraging autonomy.
- Motivational Interviewing is an evidence-based, person-centred approach that has been shown to improve treatment adherence and self-management in adolescents with chronic disease. By using collaborative, non-judgemental communication to elicit patients' own goals, values, and readiness for change, it can strengthen engagement, supports autonomy, and facilitates realistic, sustainable behaviour change.

Further Resources

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7. Empowering People in Care (EPIC). Available at: https://www.epiconline.ie/
8. UK NICE Guidelines on Transition (NG43)
9. AsIAm – Supports for neurodivergent young people in transitions. Available at: https://asiam.ie/
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Pain: Perception and Tolerance

- Understanding Pain Tolerance in People Who Use Drugs
- Fair and Accurate Pain Assessment for People Who Use Drugs
- Recognising Pain as a Valid Symptom in People Who Use Drugs
- Delivering Respectful and Individualised Pain Management for People Who Use Drugs

This section examines how pain is perceived, expressed, assessed, and managed in people who use drugs, recognising the influence of trauma, stigma, and social exclusion on both patient experience and clinical decision-making. It highlights how pain may be under-recognised or misinterpreted when presentations do not align with expected patterns of distress, and how diagnostic overshadowing and bias can contribute to delayed investigation, inadequate pain relief, and disengagement from care. The section emphasises the importance of trauma-informed understanding of pain presentation, fair and accurate assessment that goes beyond verbal report alone, and recognition of pain as a legitimate clinical symptom regardless of substance-use history. By promoting respectful, individualised approaches to assessment and management, it supports safer diagnosis, appropriate treatment, and sustained engagement in care for patients at heightened risk of harm.

Understanding Pain Tolerance in People Who Use Drugs

Keywords: pain assessment, trauma-adapted presentation, substance use, stigma, diagnostic overshadowing, functional impact

Overview

People who use drugs, particularly those with a history of opioid use, may experience and express pain in ways that differ from conventional clinical expectations. Pain presentation in this context is often shaped by complex trauma, long-term substance use, and survival adaptations such as emotional detachment, dissociation, or reduced interoceptive awareness, which can blunt or delay the conscious experience and expression of pain.

Under-reporting of pain in this context is commonly shaped by prior negative healthcare experiences, including fear of dismissal or being labelled as seeking medication inappropriately. These experiences influence how willing patients feel to disclose pain, particularly when they anticipate scepticism or judgement. At the same time, clinician and system-level factors, including assumptions about opioid tolerance, concern about triggering substance use, and prior documentation that frames patients as “manipulative” or “drug-seeking”, can shape how pain is explored, discussed, and managed during clinical encounters. Together, these dynamics may discourage full disclosure and bias subsequent clinical interpretation of pain severity. These assessment challenges are further compounded by intersecting forms of social exclusion, such as homelessness, racism, or xenophobia, which influence both how pain is expressed by patients and how it is perceived and acted upon by clinicians.

As a result, low visible distress may not equate to low pain severity. Pain-related pathology may be masked by emotional numbing, disengagement, or trauma-adapted coping strategies, increasing the risk of under-assessment or missed diagnosis. Recognising these presentations as trauma-adapted responses reframes the assessment task, prompting clinicians to maintain appropriate vigilance, validate the patient’s experience, and avoid premature diagnostic reassurance. Pain should therefore be assessed holistically, incorporating functional impact, observed behaviour, physiological findings, and the patient’s sense of psychological safety alongside reported pain intensity.

Key Clinical Considerations

- **Recognise trauma-adapted behaviours**

· Identify substance or trauma-related behaviours (e.g. emotional detachment, blunted affect, or declining analgesia) that may suppress overt pain expression, recognising that avoidance of pain medication may reflect fear of stigma, concern over relapse, or discomfort with reduced alertness or autonomy, rather than low pain severity.

· Recognise that calmness, withdrawal, or disengagement during assessment may reflect protective responses shaped by prior healthcare experiences, rather than an absence of pain.

- **Assess function**

· Ask about changes in sleep, movement, and ability to manage daily tasks, considering functional deterioration as an indicator of pain severity even when verbal reporting is minimal.

- **Avoid sole reliance on verbal or visible pain cues**

· Be aware that assumptions about opioid tolerance, including methadone use, or prior documentation describing "drug-seeking" behaviour may bias pain assessment and contribute to under-treatment or delayed investigation.

· Where possible, anchor assessment to functional impact, physiological findings, and clinical risk, rather than affect alone.

- **Acknowledge intersectional stigma**

· Recognise that people who use drugs may also face racism, gender bias, or mental health-related stigma, all of which can shape how pain is interpreted and increase the risk of under-assessment.

Why This Matters

People who use drugs often encounter stigma and scepticism around pain reporting within healthcare settings, which can shape how pain is disclosed, discussed, and interpreted. Over time, these experiences may reduce patients' willingness to describe symptoms fully, seek timely review, or engage in ongoing assessment and treatment. In addition, pain may be expressed in ways that differ from conventional clinical expectations due to the influence of trauma, cultural norms, or substance-related adaptation. This can include minimisation of symptoms, limited verbal description, reluctance to request analgesia, or a mismatch between observed distress and underlying pathology. Without attention to these patterns, pain severity may be underestimated and serious clinical conditions recognised later than is optimal.

Inclusion-Health-informed, trauma-aware pain assessment supports safer and more accurate clinical decision-making by prioritising functional impact, physiological indicators, and the patient's sense of psychological safety alongside reported pain intensity. When patients feel believed, understood, and not judged, they are more likely to disclose concerns, participate in assessment, and re-engage with care. This approach improves diagnostic accuracy, supports appropriate treatment, and strengthens trust within the clinical relationship.

Learning Tools

Tool	Purpose	Application
Vignette: Missed Pain Due to Trauma-Adapted Presentation	To illustrate how trauma responses, stigma, and clinician assumptions can mask severe pathology and delay diagnosis.	Maria is a 39-year-old woman who uses heroin. She presents to the ED with abdominal pain that "comes and goes." Her vital signs are borderline abnormal, but she sits quietly, avoids eye contact, and answers in short sentences. She declines analgesia when first offered, saying she "doesn't want to be a bother." Because she appears calm and reports only "moderate" pain, the clinician attributes the presentation to opioid tolerance and delays imaging. Four hours later, her pain escalates rapidly; a CT confirms a perforated intra-abdominal abscess requiring emergency surgery. Maria later explains she did not want to be labelled "drug-seeking," and that calmness helps her cope when she is scared. **Reflective Prompts** • What cues in Maria's presentation were misinterpreted as low risk, and what alternative indicators should have guided assessment? • How did assumptions about opioid tolerance and pain behaviour contribute to delayed investigation in this case?
Suggested Phrasing: Trauma-Informed Pain Enquiry	To offer concise, non-judgemental phrasing that elicits clinically meaningful information.	• "How is this pain affecting your day-to-day life?" • "Is there a spot that usually hurts more?" • "Are you able to sleep or move around as usual?"
Prompt List/ Checklist	To support pain assessment when distress is not obvious.	• Is the patient calm, withdrawn, or declining analgesia, despite a concerning presentation? • Has their function changed – walking, sleeping, daily tasks – even if they minimise the pain? • Are vital signs or clinical findings (e.g. fever, tachycardia, or hypotension) inconsistent with their verbal report? • Is there a risk factor that should heighten suspicion? (e.g. injecting drug use, trauma history, immunosuppression, or recurrent infection).

Fair and Accurate Pain Assessment for People Who Use Drugs

Keywords: substance use, pain assessment, stigma, diagnostic bias, clinical judgement, addiction

Overview

People with a history of opioid or other substance use may experience challenges in having pain assessed accurately within clinical settings, particularly where concerns about inappropriate analgesic use ("drug-seeking") shape clinical interpretation of symptoms. In such contexts, pain may be discounted, insufficiently investigated, or attributed to withdrawal or psychological causes. This risk is heightened when presentations are non-specific or overlap with withdrawal features such as nausea, anxiety, or sweating, increasing the likelihood of under-assessment and delayed recognition of clinically significant pathology.

Long-term opioid exposure can alter pain perception, tolerance, and expression, affecting how pain is both experienced and communicated. Some individuals may tolerate substantial pain with limited outward distress, while others minimise or withhold symptoms. In this context, pain may be communicated less through verbal reporting and more through functional or physiological change, such as reduced mobility, altered posture, changes in sleep or appetite, deterioration in self-care, or repeated unscheduled attendance. As a result, conventional cues used to gauge pain severity or urgency can be unreliable.

When pain is interpreted primarily through the lens of withdrawal, psychological distress, or prior substance use in the absence of adequate diagnostic evaluation, underlying pathology may be recognised later in its course, increasing the risk of infection, progression, and the need for more complex intervention.

In parallel, people with histories of substance use are often highly attuned to stigma within healthcare encounters and may adapt their communication as a protective response. This can include delayed re-presentation or reduced engagement with follow-up, which can make it more difficult for clinicians to accurately assess pain severity or identify its cause, particularly when affect and reported distress appear incongruent with clinical findings.

Key Clinical Considerations

- **Recognise altered pain expression**
  - Understand that both altered tolerance and fear of stigma may influence how patients express, describe, or withhold pain, and attend to functional change and physiological cues when verbal reporting is limited.
- **Distinguish pain from withdrawal**
  - Use clinical reasoning to differentiate between opioid withdrawal and acute or chronic pain, recognising that both can occur simultaneously, and that pain should not be attributed to withdrawal without appropriate clinical assessment.
- **Avoid assumptions**
  - Apply consistent clinical standards to all patients. Avoid dismissing pain complaints based on appearance, history, or previous non-attendance, and ensure clinical causes are considered and investigated where indicated before behavioural explanations are prioritised.
- **Communicate transparently**
  - Be clear about treatment plans and limitations. Avoid vague reassurance or defensive responses; explain what is being prescribed, why, and what the patient can expect next, and involve them in decisions about pain management where possible.

Why This Matters

Fair and accurate pain assessment in people with a history of substance use requires a holistic approach in which pain is evaluated beyond verbal report alone. This can include assessment of functional impact, observed behaviours, physiological change, and the patient's level of psychological safety within the clinical encounter. Within this context, assessment must be underpinned by clinical rigour and respectful, transparent communication. Rigour involves systematic assessment, careful differentiation between pain and withdrawal, and timely investigation where indicated. Respect is reflected in clear explanations of clinical reasoning, inclusion of the patient in discussions about pain management, and acknowledgement of their uncertainty and concerns where present.

When used appropriately, a history of drug use can inform clinical assessment by highlighting altered pain tolerance, withdrawal risk, infection risk, or medication interactions. Fair and accurate pain assessment, therefore, directly supports safer diagnostic and prescribing decisions by promoting timely investigation, appropriate differentiation between pain and withdrawal, and clearer decision-making under uncertainty. It also supports dignity and trust by validating patients' accounts of pain. When these elements are in place, patients are more likely to re-present as symptoms evolve, engage in shared decision-making, and participate with assessment and treatment over time.

Learning Tools

Tool	Purpose	Example
Vignette: Bias in Pain Assessment	To illustrate how premature assumptions about "drug-seeking" behaviour can obscure serious pathology and delay care.	Michael is a man in his forties who attends the Emergency Department (ED) with severe back pain. He is on methadone and has previously presented with musculoskeletal discomfort. During the assessment, the clinician registers his drug history early and forms a working assumption that the pain is routine or low risk. Michael is reassured that it is "likely muscular" and is discharged with advice to use simple analgesia. Over the next two days, his pain worsens and new concerning symptoms appear. Feeling unsure whether he will be taken seriously, Michael delays returning until the situation becomes urgent. When he re-presents, he is found to have a serious underlying problem requiring immediate intervention. Later, Michael explains that he hesitated to come back because he felt disbelieved at the first visit and assumed the team "thought it was just because of the methadone". **Reflective Prompts** • What assumptions may have influenced the initial assessment, and how might they have shaped clinical decision-making? • What communication approaches might have helped Michael feel safe to return earlier?
Suggested Phrasing	To model language that validates pain and supports shared assessment.	• "I want to make sure we manage your pain properly – can you tell me how it's affecting you?" • "I understand you're on methadone – do you think this pain feels different or familiar?"
Reflective Prompt	To help in examining assumptions.	• "Am I making assumptions based on this patient's drug history or appearance?" • "Have I ruled out clinical causes before considering behavioural explanations?" • "Would I respond differently if this patient had no history of substance use?"

Recognising Pain as a Valid Symptom in People Who Use Drugs

Keywords: pain assessment, diagnostic overshadowing, opioid tolerance, withdrawal overlap, observational indicators, non-stigmatising language, multimodal analgesia, equity

Overview

Pain should be recognised and treated as a valid symptom, regardless of a patient's history of substance use or social exclusion. However, people who use drugs frequently report that their pain is dismissed or misattributed to non-physical or behavioural causes, including recurrent patterns of clinical misattribution such as:

- **Psychological explanations:** attributing pain solely to anxiety, psychosocial distress, mental illness or emotional instability rather than recognising it as a potential symptom of serious underlying physical pathology.
- **Physiological assumptions:** dismissing ongoing pain as part of substance withdrawal or as a consequence of opioid use, without assessing for co-existing illness or injury.
- **Behavioural or moral interpretations**: framing distress and attempts to seek help as "drug-seeking" or "attention-seeking," rather than as predictable responses to untreated pain.

Pain may also be measured against an inappropriately normalised baseline, where frequent attendance, chronic pain or long-standing illness may lead to decreased clinical concern. In parallel, some patients normalise ongoing pain, minimise symptoms, or delay presentation due to prior experiences of dismissal. Lived experience accounts highlight pain being minimised, under-assessed, or reframed as substance withdrawal or psychological distress, often requiring patients to self-advocate to be believed. These dynamics increase the risk of pain being under-investigated, poorly treated, or not re-evaluated if it evolves. This can result in missed or delayed diagnosis of serious conditions such as deep tissue infection, acute abdominal surgical emergencies, fracture, or malignancy. Ultimately, this may lead to patient harm or contribute to loss of trust that discourages timely re-presentation.

Key Clinical Considerations

- **Investigate pain**
  - Treat pain reports seriously and apply the same investigative and diagnostic process as for any other patient, including escalation where symptoms persist or evolve.
- **Challenge stigmatising labels**
  - Be aware of how labels such as "addict," "drug-seeker", "non-compliant," or "frequent attender" may unconsciously bias clinical decision-making.
- **Address diagnostic overshadowing**
  - Avoid attributing pain solely to addiction, withdrawal, or behavioural causes without ruling out underlying pathology.
  - Do not assume chronic drug use explains new or changing symptoms.
  - Reassess and escalate investigation if symptoms persist or worsen despite initial management.
- **Validate patient concerns**
  - Encourage open discussion and validate the significance of symptoms, even when descriptions may be vague or inconsistent.
  - Explain what investigations or monitoring will be done, helping to build trust and reduce perceptions of dismissal.
- **Add observational indicators when verbal report is limited**
  - In conjunction with the patient's self-report, consider non-verbal signs such as guarding, grimacing, reduced range of motion, protective postures, altered gait, or vital-sign changes. Cross-check these indicators with collateral information from peers, support workers, or outreach staff, where appropriate and consented.
  - However, avoid being falsely reassured by an absence of non-verbal pain indicators.
- **Safety-netting and follow-up**
  - Provide clear return criteria (e.g., if "red flag" symptoms occur, such as severe or worsening pain, fever, or new weakness). This may also need to be communicated to support workers or outreach staff.
  - Arrange realistic review plans, including coordinated imaging, liaison with existing services familiar to the patient or community follow-up, as appropriate.- Arrange realistic review plans, including coordinated imaging, liaison with existing services familiar to the patient or community follow-up, as appropriate.

Why This Matters

When pain is not recognised as a legitimate clinical symptom, opportunities for timely diagnosis and treatment may be missed, particularly in people with complex health and social needs. Diagnostic overshadowing when pain is attributed primarily to substance use, withdrawal, or behavioural factors, can narrow clinical reasoning and delay escalation when symptoms persist or evolve. Recognising pain as a valid symptom at the point of presentation supports clinical safety by keeping diagnostic differentials open, prompting appropriate investigation, and encouraging re-assessment over time. It also supports dignity by acknowledging patients' concerns as clinically meaningful, trust by demonstrating responsiveness and transparency, and ongoing engagement by making it more likely that patients will return promptly if symptoms worsen. In practice, this requires combining structured enquiry with observational indicators of pain, managing withdrawal alongside analgesia where relevant, and using multimodal pain management strategies to address symptom relief while investigating and treating the underlying cause.

Learning Tools

Tool	Purpose	Example
Vignette: When Pain is Discounted	To illustrate how premature attribution of pain to withdrawal or substance-related behaviour can result in missed or late recognition of serious pathology.	Joe, a 46-year-old man on long-term OST (Methadone) presents repeatedly to the Emergency Department (ED) with worsening abdominal pain, nausea, and reduced appetite. He appears distressed and requests analgesia early in each encounter. Notes from previous visits include descriptors such as "drug-seeking," "withdrawal symptoms," and "constipation." These assumptions dominate the clinical picture. Therefore, limited history taking, physical examination and investigations (blood tests only) are performed and the differential remains narrow. Consequently, his persistent symptoms and functional decline are not integrated into decision-making. He re-presents two days later, tachycardic, pale, and intermittently confused. Senior review broadens the assessment, leading to imaging that identifies advanced, disseminated malignancy requiring urgent admission. Reflection highlights how premature cognitive closure and stigma contributed to delayed diagnosis. **Reflective Prompts:** How can structured approaches to pain assessment help prevent diagnostic overshadowing? **Application:** MDT case discussion or simulation focusing on safeguarding diagnostic vigilance in patients with complex needs.
Suggested Phrasing	To promote validation and curiosity.	• "Thanks for telling me - I want to understand more about this pain." • "I know this has been going on a while. What's changed recently that made you decide to come to hospital?" • "I know pain can be hard to describe. What worries you most about it today?"
Reflective Prompts	To support diagnostic decision-making.	• "Have I ruled out a serious physical pathology such as infection, injury, or malignancy before assuming a behavioural cause or substance withdrawal?" • "Am I underestimating this person's symptoms because of their history, previous medical record entries, or the way that they communicate?" • "What might this patient need from me to feel believed and safe to return if the pain worsens?"

Learning Tools

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Delivering Respectful and Individualised Pain Management for People Who Use Drugs

Keywords: pain management, trauma-informed care, harm reduction, opioid substitution treatment (OST), shared decision-making, continuity of care

Overview

Delivering respectful and individualised pain management for people who use drugs requires clinical competence alongside clear, transparent communication and collaborative, trauma-aware care planning. This involves recognising patients as reliable informants about their own pain and using substance-use history and prior clinical experience to inform – rather than substitute for – careful assessment. Clinical interactions should be consistent, fair and explanatory. Individualised pain management requires adapting care to the patient's clinical presentation, considering their treatment history, concurrent OST, potential opioid tolerance, risk of opioid induced hyperalgesia, psychosocial supports and living situation. Individualised care works alongside standardised protocols, using them as a foundation while allowing appropriate flexibility to address factors such as altered analgesic requirements, withdrawal risk and barriers to follow-up.

Many people with substance-use histories describe healthcare encounters characterised by stigma, delayed recognition of pain or inadequate analgesia. All patients should be treated with empathy and reassurance that their pain will be managed. People who use drugs are often frightened of withdrawing and have had previous negative experiences with health care providers who may not have an adequate understanding of addiction. Diversion and misuse of drugs prescribed for pain is a potential risk but should not prevent adequate analgesia. Inadequate pain management will not only hamper recovery but increases the risk of relapse of illicit drug use.

The cumulative effect of past experiences can shape expectations of care and influence how patients communicate pain and participate in decision-making. Repeated exclusion from discussions about treatment can lead patients to minimise concerns, defer to clinicians without clarity or disengage from meaningful dialogue; this results in pain management that is not safe, effective or individualised. Effective pain management recognises patient knowledge of their own bodies as a valuable source of clinical information.

Key Clinical Considerations

- **Communicate Transparently**
  - Explain and record pain management plans clearly, including the rationale for each selected treatment, expected benefits, potential adverse effects and limitations. Discuss and clearly plan for de-escalation, weaning or cessation as pain improves.
  - Be mindful that a language barrier or varying levels of health literacy may hamper patients' ability to understand pain management plans. Use clear, accessible language and clarify understanding. Printed, plain language materials and interpretation services may be helpful.
- **Clarify Prescribing Rationale**
  - Recognise that pain is a highly subjective sensory and emotional experience; all treatment decisions should therefore reflect this.
  - Perform a thorough and holistic assessment to determine type of pain experienced (e.g. nociceptive versus neuropathic), this influences what medications should be used as part of a multimodal analgesic regime. Always discuss the purpose of, and evidence for, selected pharmacological and non-pharmacological treatments with patients.
  - Acknowledge that acute pain, cancer-related pain and chronic non-cancer pain are separate entities and require different prescribing approaches, particularly regarding opioids. Be mindful of existing opioid tolerance, incomplete cross tolerance, OST and potential for withdrawal symptoms when adjusting opioid dosing.
  - A patient on OST will not derive analgesia from their maintenance dose. OST should be continued alongside appropriate multimodal analgesia.
- **Engage in Shared Decision-Making**
  - Ask about what treatments have worked/not worked before and prior experiences of poorly managed pain or withdrawal.
  - Elicit what the patient is comfortable with, and what concerns they may have regarding pain control, access to treatment and medication safety. Early involvement of the patient's OST prescriber, OST dispensing service/community pharmacy, GP and support workers is key.
- **Elicit Patient Experience**
  - Acknowledge past experiences and prioritise psychological safety by allowing time for questions and discussion. Offer choice where evidence-based, practical and safe. Be aware that past dismissal or perceived mistreatment by healthcare staff may affect how a person engages with pain management plans.
- **Tailor to Context**
  - Review and adapt pain management plans together over time. Schedule appropriate follow-up to ensure that this occurs. Analgesic requirements may change as acute illness resolves or as opioid tolerance and OST dosing stabilise.
  - Involve specialist services (e.g. Pain Medicine and Addiction Psychiatry), if pain is difficult to manage or advice regarding increasing or splitting OST dosing to aid pain management is required.
  - Recognise that as part of a harm minimisation approach, careful prescribing/dispensing of opioid medications, particularly on discharge, may be necessary. The rationale for this should always be explained to the patient without judgement.

Why This Matters

Delivering respectful and individualised pain management requires communication and relationship-building. Clinical encounters should be structured around dialogue that clarifies what has been effective or ineffective in the past, explores patient preferences and concerns, and sets clear expectations regarding symptom monitoring, escalation, and review. A respectful conversation about pain, including treatment options, side effects, and what will happen if things don't improve, supports understanding, adherence, and ongoing engagement with care. Even when prescribing limitations exist (e.g. avoiding certain opioids), clear explanation, transparency, and empathy can preserve trust and engagement. Clinicians who are clear, compassionate, and collaborative send a strong message: "Your experience matters."

Patients who use drugs frequently report receiving inadequate analgesia, often related to uncertainty about how OST interacts with acute pain management. Clinical safety depends on clinicians' understanding of the pharmacology of OST, the need for additional short-acting opioids when clinically indicated, and the risks of abrupt interruption. Equally, timely access to a patient's prescribed OST during hospital admission is critical to preventing withdrawal, maintaining stability, and supporting engagement with care. Close communication between hospitals and community OST clinics ensures continuity, reduces delays, and safeguards both patient safety and trust.

Learning Tools

Tool	Purpose	Example
Vignette	To demonstrate how inadequate explanation of pain management in the context of OST can undermine safety.	Martha, a 38-year-old woman on OST (Methadone), presents to the ED with acute facial pain due to a dental abscess. She is prescribed an antibiotic and a short course of simple analgesia (an NSAID and Paracetamol). The purpose of, and mechanism of action of these medications, is not explained to Martha. She has a low level of literacy and cannot read the product information included with the medications. Martha is focused on her recovery from heroin addiction. Due to fear of relapse and uncertainty regarding the contents of these medications, she elects to not take either the antibiotic or analgesia. Martha re-presents five days later with worsening pain and infection. She is distressed at this presentation. She explains that due to severe pain she bought "street Methadone" two days previously. She feels like she has "failed" in her recovery journey and is concerned regarding risk of repeated relapse. Martha is reviewed by a different doctor at this visit. They acknowledge her concerns and explain how appropriate multimodal analgesia for acute pain can be safely managed alongside Methadone. The plan is made explicit: what will be prescribed, what each medication is intended to treat, what potential symptoms/adverse effects to monitor for and when to return for review. The doctor asks what has worked for Martha in the past and explores her preferences; they explain to her that poorly controlled pain increases the risk of relapse into substance misuse. Martha agrees to the plan. The doctor assesses her understanding using the "Teach Back" method and links with her OST treatment centre to provide support to her post-relapse.

Tool	Purpose	Example
Vignette	To demonstrate how inadequate explanation of pain management in the context of OST can undermine safety.	**Reflective Prompts:** • How might assumptions about the patient, substance use or OST have shaped the initial clinical encounter? • How might we create an environment where the patient feels safe to disclose their concerns, treatment priorities and level of understanding of the proposed plan for analgesia, without shame or fear of judgement? • How might we demonstrate transparency and safeguard shared decision-making regarding what is and is not safe, effective and appropriate when discussing analgesic options with patients? **Application**: Simulation, MDT teaching, or communication workshop. Practice the "teach back" method with a colleague
Suggested Phrasing	To support respectful and inclusive pain planning.	• "Here's what I'm thinking; how does that sound to you?" • "Are there treatments that have worked or not worked for you in the past?" • "I want to be upfront - we may not be able to give X medication, but let's talk through what we can do."
Prompt List	To support trauma-informed shared planning.	• "Have I explained the plan in a way that makes sense to the patient?" • "Have I offered choice where possible?" • "Have I asked about what's worked for them before?"

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High-Risk and Under-Recognised Conditions in Social Exclusion

Referral and Investigation for Cancer

Managing Uncommon Presentations and Tropical Infectious Diseases

Infections in the Context of Social Exclusion

People experiencing social exclusion face a disproportionate burden of serious illness that is more likely to be missed, diagnosed late, or inadequately followed up due to delayed presentation, atypical or masked symptoms, fragmented care, and barriers to investigation and follow-up. This section examines conditions where inequity in detection and escalation is a driver of harm, including cancer, infectious disease, and migration-related or tropical conditions. It emphasises the need for a higher index of suspicion, lower threshold and timely investigation when risk is elevated, alongside diagnostic pathways that account for barriers to attendance, preparation, communication, and follow-up. This section aims to support earlier recognition and safer escalation practices by highlighting the role of culturally responsive communication, structured reassessment, and coordinated referral.

Referral and Investigation for Cancer

Keywords: cancer diagnosis, late-stage presentation, diagnostic delay, screening access, referral pathways, health inequities, multimorbidity, continuity of care

Overview

Challenges in cancer diagnosis and treatment among people experiencing social exclusion are well established. Individuals facing social deprivation often have lower awareness of cancer symptoms, reduced participation in screening programmes, and are more likely to receive a later-stage diagnosis for certain cancers (Scott & Hoskin, 2024). Additionally, comorbidities frequently associated with social exclusion – such as HIV, viral hepatitis, smoking, and alcohol dependency – can increase the risk of developing specific cancers. Vaccination uptake, including for HPV and HBV, also tends to be lower among people experiencing marginalisation, further exacerbating their already elevated risk of developing related cancers. Barriers to diagnosis and screening may include the following:

- **Delayed or obscured recognition of cancer-related symptoms:** Constitutional warning signs such as weight loss, fatigue, or gastrointestinal disturbance may be attributed to competing clinical or social explanations (e.g. stress, malnutrition, substance use, concurrent illness), particularly in the presence of non-specific or advanced presentations. Atypical or advanced presentations, compounded by language barriers and premature diagnostic closure (e.g. attributing nausea and vomiting to alcohol, or attributing weight loss to malnutrition), further increase the risk of diagnoses not being picked up.
- **Difficulties accessing screening, diagnostic testing (scopes, imaging, biopsy), and outpatient follow-up:** Practical challenges such as unstable housing, changes in address, unreliable phone access, and language barriers/literacy, can prevent patients from receiving or understanding appointments. Additional barriers include denial or misunderstanding of the importance of appointments, practicalities of pre-appointment requirements (e.g. 'bowel prep'), addiction, or recurrent hospitalisations with competing health issues.
- **Systemic Challenges within healthcare pathways:** Healthcare pathways may lack the flexibility required to accommodate the realities of socially excluded patients, particularly in relation to scheduling, preparation requirements, and re-engagement after missed attendance.

Key Clinical Considerations

- **Recognise Elevated Risk**
  - Recognise that patients experiencing social exclusion are at increased risk of late-stage cancer presentation due to reduced symptom awareness, limited access to screening, and barriers to timely healthcare.
- **Avoid Premature Assumptions**
  - Avoid premature diagnostic closure by maintaining malignancy within the differential when symptoms are non-specific, recurrent, or discordant with presumed social or behavioural explanations, and reassessing if symptoms persist or worsen.
- **Integrate Preventive Care**
  - Where clinically appropriate, use patient encounters to address preventative care (e.g. screening eligibility, vaccination status, or lifestyle modifications), while explicitly reassuring patients that preventive discussions will not delay or diminish assessment of the presenting concern. Be mindful that unsolicited or blunt discussion of lifestyle modification may be perceived as judgement; such conversations should be introduced selectively and framed in a supportive, non-assumptive manner.
- **Deliver Targeted Education**
  - Provide targeted, clinically relevant information when risk factors are identified (e.g. HIV, smoking history), focusing on symptoms that should prompt re-presentation or re-assessment rather than general cancer awareness.

Why This Matters

Delayed cancer diagnosis is strongly associated with poorer clinical outcomes, including increased morbidity, reduced treatment options, and higher mortality. Socioeconomic disadvantage contributes to higher cancer incidence, later-stage diagnoses, and increased mortality from cancers that are both preventable and detectable through screening (Bourgeois et al., 2024), reflecting barriers to timely assessment, investigation, and follow-up. For clinicians, this translates into a heightened risk of diagnostic delay when symptoms are non-specific, access to screening is disrupted, or follow-up is unreliable. Improving the timeliness and appropriateness of referral, investigation, and re-assessment in patients experiencing social exclusion is therefore essential to reducing morbidity and mortality and achieving more equitable health outcomes.

Learning Tools

- NIAC (National Immunisation Advisory Committee) guidelines for vaccination in Ireland - https://www.hiqa.ie/areas-we-work/national-immunisation-advisory-committee/immunisation-guidelines-ireland

Further Resources

1. Scott, E.C.S. and Hoskin, P.J. (2024) 'Health inequalities in cancer care: a literature review of pathways to diagnosis in the United Kingdom', eClinicalMedicine, 76, 102864. DOI: 10.1016/j.eclinm.2024.102864. Available at: https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(24)00443-7/fulltext
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Managing Uncommon Presentations and Tropical Infectious Diseases

Keywords: tropical infectious diseases, imported infections, travel and exposure history, diagnostic delay, cultural and communication barriers, specialist referral pathways

Overview

People with a history of migration, including refugees and people seeking asylum, are disproportionately represented among those experiencing social exclusion in Ireland. Within this group, the incidence of tropical and neglected infectious diseases is notably higher. These may include tuberculosis, HIV, hepatitis B and C, malaria, leishmaniasis, schistosomiasis, strongyloidiasis, brucellosis, Chagas disease, viral haemorrhagic fevers, and gastrointestinal infections such as cholera, amoebiasis, and typhoid. These conditions may present acutely or chronically and can be diagnostically challenging, particularly when symptoms are non-specific, overlap with more common conditions, or emerge long after exposure. Missed or delayed diagnosis may arise from a combination of clinical, patient-related, and system-level factors, including:

- **Clinical factors:** Tropical and imported infections may fall outside the routine diagnostic experience of many clinicians, increasing the risk of delayed recognition and making management more challenging. Time pressures and competing demands may also affect the ability to take detailed histories, including travel and exposure information, or to conduct comprehensive physical examinations. Reliance on incomplete or assumed travel histories can result in missed consideration of endemic exposures, including in patients who appear locally based but have previously travelled or lived abroad.
- **Patient factors**: Individuals may be reluctant to disclose symptoms due to concerns about stigma, deportation, or mistrust in healthcare systems. Differences in literacy, education, and language can also affect how symptoms are understood and communicated. Cultural nuances may further complicate interpretation, for example, in some regions, a single term may be used to describe multiple symptoms or conditions.

- **Systemic factors:** Diagnostic tools for tropical diseases may not be readily available in all healthcare settings, and delays can occur due to unfamiliarity with testing protocols or limited laboratory capacity. Access to appropriate treatments may be restricted, and communication barriers can arise when translation services are unavailable or insufficient.

Improving clinical awareness, strengthening diagnostic pathways, and providing culturally responsive care are essential to addressing these challenges and ensuring appropriate investigation and management. Lived experience highlights that some migrants may preferentially seek advice or treatment within their own communities or from family abroad, reflecting both accessibility barriers and lower levels of trust in healthcare systems. Building confidence in care processes, through clear explanation and consistent follow-through, is therefore central to improving engagement and outcomes.

Key Clinical Considerations

- **Elicit Relevant History**
  - Understand the importance of a thorough travel and exposure history. This includes establishing the countries and regions that people of migrant status and people seeking asylum might have passed through before arriving in Ireland. Noting that patients may not perceive this as "foreign travel" and may not volunteer it unless specifically asked.
  - Avoid omitting a detailed travel history of countries entered when migrating to Ireland (e.g. a febrile patient may not have originally come from a malaria endemic region but may have travelled through one).
- **Identify Endemic Disease Risks**
  - Be aware of the tropical diseases that are endemic in different regions around the world, particularly in countries with high rates of migration to Ireland.
- **Use Trusted Clinical Resources**
  - Be familiar with reliable online resources for additional guidance on investigation and treatment in cases where a tropical disease is suspected.
- **Acknowledge Cultural Contexts**
  - Recognise how cultural differences shape health understanding and ensure you explain your working diagnosis and planned tests clearly to your patient. This is especially important in conditions such as HIV, where patients may not be aware that it is a manageable chronic illness rather than a terminal disease.
- **Conduct Detailed Histories and Exams**
  - Elicit a structured travel and exposure history in patients with unexplained, recurrent, or atypical symptoms, including transit countries and periods of residence outside Ireland.
- **Provide Communication Supports**
  - Arrange interpretation services where required and allow time for a thorough history and physical exam.
- **Seek Specialist Input**
  - Consult specialist services or reliable online resources where diagnostic uncertainty exists.
- **Tailor Care**
  - Where feasible, clinicians may need to adapt follow-up and investigation planning to reduce practical barriers to engagement, in collaboration with local services or support structures. This might involve providing taxi vouchers for patients without means of transport; offering later appointment times for those travelling long distances to attend clinics; adapting treatments and investigations, where possible, to respect religious and cultural occasions (e.g. fasting periods, prayer).
- **Offer Preventive Travel Health Advice**
  - Provide travel advice around safety measures, prophylaxis, and vaccination for individuals travelling to regions with endemic tropical diseases.

Why This Matters

Tropical and neglected infectious diseases contribute to a higher burden of illness in some migrant populations, reflecting global patterns of disease prevalence, migration routes, and prior access to healthcare. These conditions may present with non-specific or atypical features, increasing the risk of delayed recognition in routine clinical practice. Missed or late diagnosis can result in prolonged morbidity, preventable complications, delayed treatment initiation, and, in some cases, risks to public health through missed opportunities for infection control, contact tracing, or timely specialist involvement.

Maintaining clinical awareness of tropical and imported infections supports earlier inclusion of relevant differentials, appropriate investigation, and safer clinical decision-making and management. In practice, this relies on structured travel and exposure history-taking, recognition of diagnostic uncertainty, and appropriate use of specialist services or trusted clinical resources. Attention to communication, interpretation support, and cultural context further enables accurate history-taking and informed consent for investigation and treatment.

By strengthening clinicians' capacity to recognise and manage uncommon presentations and tropical infectious diseases, these clinical considerations reduce avoidable diagnostic delay, support appropriate infection control measures, and promote access to timely, evidence-based care for migrant populations experiencing social exclusion.

Learning Tools

Tool	Purpose	Example
Vignette: Missed Exposure History in Febrile Illness	To illustrate how unfamiliarity with tropical pathogens and incomplete travel histories can delay diagnosis and treatment.	A 38-year-old male working in Ireland and originally from Oman presents to the emergency department with fevers, fatigue, and knee pain. He recently spent two weeks visiting relatives in Oman, but took appropriate precautions against vector-borne illnesses and does not report consumption of unpasteurised cow's milk. He is admitted for investigation. Initial blood cultures identify a pathogen unfamiliar to the microbiology laboratory, identified on the MALDI-TOF as Ochrobactrum species, a genus similar to Brucella species. The patient's history is revisited, and on further questioning, he reports consumption of unpasteurised camel's milk, a potential source of brucellosis. The diagnosis is confirmed in an external laboratory, and treatment is initiated. **Reflective Prompts** • What opportunities for earlier diagnosis were missed in the initial history, and why?

Tool	Purpose	Example
Vignette: Re-assessment Reveals Missed Chronic Infection	To demonstrate the importance of revisiting diagnoses when initial assessment is limited or symptoms persist.	A 52-year-old male living in a hostel is admitted with reduced level of consciousness and alcohol intoxication. He is drowsy on presentation, so history and physical examination are limited. He has consolidation on his chest x-ray and is treated for presumed aspiration pneumonia. On re-assessment the following day, he is more alert. Further history reveals a six-month history of productive cough, weight loss, and night sweats. He has been treated for "pneumonia" in two other hospitals in recent months. Early morning sputum samples are sent, and pulmonary tuberculosis is confirmed on GeneXpert and culture. **Reflective Prompts** 1. What aspects of history-taking were limited or missed during the initial assessment? 2. How might earlier consideration of exposure history or symptom chronicity have altered the diagnostic pathway?

Resources

1. European Centre for Disease Prevention and Control (ECDC), Surveillance Atlas of Infectious Diseases. Available at: https://www.ecdc.europa.eu/en/surveillance-atlas-infectious-diseases https://www.ecdc.europa.eu/en/surveillanceatlasinfectiousdiseases
2. Centers for Disease Control and Prevention (CDC), 2025. CDC Yellow Book 2026: Health Information for International Travel.
3. ProMed International Society for Infectious Diseases – 24/7 early warning system for infectious diseases worldwide. Available at: https://www.promedmail.org

Infections in the Context of Social Exclusion

Keywords: Atypical infection presentation, diagnostic masking, structural vulnerability, immune dysfunction, delayed escalation of care, low-threshold investigation, recurrent infection

Overview

People experiencing social exclusion face a disproportionate burden of infectious diseases and are more likely to experience delayed diagnosis, incomplete treatment, and higher mortality (Ayorinde, A., et al, 2023). This vulnerability arises from a convergence of structural conditions, barriers to healthcare access, behavioural and environmental exposures, and host-related immunological factors.

- **Structural conditions** such as overcrowded accommodation, sleeping rough, or living in temporary shelters facilitate rapid transmission of respiratory, gastrointestinal, and skin infections. A lack of access to clean water, sanitation, and secure storage for wound-care or hygiene supplies increases the risk of cellulitis, infected ulcers, infestations, and delayed wound healing.
- **Barriers to healthcare access** further compound these risks. Access to care may be limited by practical barriers (e.g. transportation costs, lack of documentation) and relational barriers (e.g. fear of judgement or prior negative healthcare encounters). For many, healthcare is only accessed at a crisis point, resulting in more advanced disease on presentation and limited opportunity for early intervention or screening.
- **Behavioural and environmental risk exposures**, including injecting drug use, high-risk sexual activity, or unsafe living conditions, raise the incidence of blood-borne viruses (e.g. hepatitis B/C, HIV), endocarditis, abscesses, STIs, aspiration pneumonia, and recurrent soft tissue infections. Frequent hospital admissions, institutional stays, and antibiotic exposure also contribute to higher prevalence of multidrug-resistant organisms.
- **Physiological factors** such as malnutrition, chronic stress, liver disease, HIV, immunosuppression, and inadequate vaccination impair immune function and blunt inflammatory responses. In conditions like cirrhosis, neutrophil dysfunction and altered inflammatory markers (e.g. unreliable CRP or SIRS response) can mask early signs of sepsis, leading to delayed escalation and poorer outcomes.

Together, these elements create a clinical context in which infection may have an atypical presentation, progress rapidly, and be misattributed to behavioural issues or withdrawal. Early recognition requires doctors to approach infection in socially excluded populations with a higher index of suspicion, awareness of masked presentations, and adaptable diagnostic and treatment pathways.

Key Clinical Considerations

- **Recognise Common Presentations**
  - Be familiar with infections commonly seen in this population – TB, HIV, hepatitis B/C, skin and soft tissue infections, aspiration pneumonia, STIs, infective endocarditis, and osteomyelitis.
- **Consider Antimicrobial Resistance**
  - Recognise that rates of antimicrobial resistance may be higher in those experiencing social exclusion. For example, higher rates of community-acquired MRSA have been described among socioeconomically disadvantaged communities in North America (Dembski et al., 2025).
- **Prioritise Comprehensive Assessment**
  - Understand the importance of detailed history taking and thorough physical examination in assessing for infection-related illness in patients, recognising that there may be signs and symptoms present that patients will not disclose on initial assessment.
  - Pay particular attention to the more likely infections associated with the patient's specific demographic (e.g. blood-borne viruses in individuals who inject drugs, tuberculosis in those who have been incarcerated).
- **Identify Masked Symptoms**
  - Recognise that signs and symptoms of infection may be masked or overlooked by concurrent non-infectious medical conditions (such as symptoms relating to substance withdrawal or intoxication, mental health conditions, side effects of medications, or concurrent non-communicable diseases).
- **Consider Co-Pathology and Disease Clustering**
  - Multiple infections frequently co-exist (e.g. HIV and TB; HCV and infective endocarditis). Remain open to secondary diagnoses if the clinical course does not improve as expected.
- **Investigate Systematically**
  - Initiate appropriate investigation for infectious diseases based on clinical presentation, history and risk factors. This also includes screening for asymptomatic infectious diseases, such as bloodborne viruses and latent TB. This may involve revisiting the history and exam on multiple occasions and at an appropriate time (for example, returning to a patient who was initially intoxicated at the time of initial assessment).
- **Communicate Transparently**
  - Communicate to the patient the working diagnosis, investigations and treatment plan on an ongoing basis while assessing for infection. Communicating clearly can encourage patient engagement with the diagnostic process and help overcome barriers to investigation and treatment (e.g. challenges around IV access, discharging against medical advice, hesitancy around treatment).
- **Advocate for Timely Care**
  - Advocate to ensure diagnostic tests and treatments are provided in a timely manner. This requires clear and, sometimes, repeated communication with colleagues from other disciplines and with patients.

Why This Matters

Diagnosing infections in socially excluded individuals can be complex. Enhancing clinician awareness of these challenges and strategies to address them is essential for delivering timely, appropriate, and equitable care. Infections in people experiencing social exclusion are often missed, diagnosed late or poorly followed up. Atypical presentations, impaired immunity, comorbidities and system barriers increase the risk of untreated sepsis, TB, endocarditis and recurrent cellulitis. A structured, low-threshold, and clinically vigilant approach - incorporating reassessment, early investigation, clear explanation, and coordination - improves patient safety and reduces avoidable deterioration.

Learning Tools

Tool	Purpose	Example
Vignette: Diagnosing and Communicating Infection	Diagnose and communicate infections in the context of social exclusion.	A 36-year-old man experiencing homelessness is admitted with Staphylococcus aureus bacteraemia and left knee pain, raising concern for septic arthritis. Timely orthopaedic review is clinically important. During admission, the orthopaedic team have twice attended the ward to review him, but the patient was not present at the bedside at those times. He smokes and reports finding it difficult to remain on the ward for prolonged periods without clear information about when reviews will occur. Recognising the risk of delayed assessment, you liaise directly with the orthopaedic team to agree a specific, realistic review time, or explore whether clinic review would be more feasible. You then communicate this clearly to the patient, explaining why the review matters and what to expect, and work with nursing staff to support his availability at the agreed time. Where appropriate, you coordinate transport or escort to clinic to ensure assessment proceeds. This approach supports timely diagnosis while adapting care delivery to the patient's circumstances, reducing avoidable delay and missed review.

Tool	Purpose	Example
Vignette: Re-assessment Reveals Missed Chronic Infection	To demonstrate the importance of revisiting diagnoses when initial assessment is limited or symptoms persist.	A 52-year-old male living in a hostel is admitted with reduced level of consciousness and alcohol intoxication. He is drowsy on presentation, so history and physical examination are limited. He has consolidation on his chest x-ray and is treated for presumed aspiration pneumonia. On re-assessment the following day, he is more alert. Further history reveals a six-month history of productive cough, weight loss, and night sweats. He has been treated for "pneumonia" in two other hospitals in recent months. Early morning sputum samples are sent, and pulmonary tuberculosis is confirmed on GeneXpert and culture. **Reflective Prompts** 1. What aspects of history-taking were limited or missed during the initial assessment? 2. How might earlier consideration of exposure history or symptom chronicity have altered the diagnostic pathway?

Resources

1. Ayorinde, A., Ghosh, I., Ali, I., Zahair, I., Olarewaju, O., Singh, M., Meehan, E., Anjorin, S., Barr, B., McCarthy, N. and Oyebode, O., 2023. 'Health inequalities in infectious diseases: a systematic overview of reviews.' BMJ Open, 13(3), e067429. DOI: 10.1136/bmjopen2022067429
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Women's Health

Culturally Responsive and Trauma-Informed Women's Health Care

Recognition and Management of Common Women's Health Conditions

Female Genital Mutilation (FGM)

This section provides an overview of key aspects of women's health in the context of social exclusion, with a focus on culturally responsive and trauma-informed care. It outlines how past experiences, cultural context, communication differences, and practical barriers may influence engagement with healthcare, disclosure of relevant history, and participation in examinations or treatment. The section also addresses the recognition and initial management of common women's health conditions across clinical settings. In addition, it highlights clinical and communication considerations relevant to Female Genital Mutilation (FGM).

Culturally Responsive and Trauma-Informed Women's Health Care

Keywords: Trauma-informed care, cultural responsiveness, psychological safety, trust and disclosure, gender-based violence, consent and autonomy, professional interpretation, continuity of care

Women experiencing social exclusion are often exposed to disproportionately high levels of physical or sexual violence and/or control throughout their life. They may also have significant grief, trauma and shame associated with separation from children or disrupted family lives. Sexual and reproductive healthcare can also be particularly challenging, where examinations, disclosure of histories, or male clinicians can trigger feelings of exposure, loss of control, or re-traumatisation. Cultural expectations, language differences, reliance on untrained interpreters, and the absence of female staff can further inhibit disclosure or delay help-seeking.

Key Clinical Considerations

- **Identify layered risks and intersectional vulnerability:** Recognise how gender, migration, poverty, ethnicity, caregiving roles, legal insecurity, homelessness, disability, and past trauma intersect to shape risk, communication, and engagement with care.
- **Recognise trauma-related communication patterns:** Disclosure may be delayed, fragmented, or withheld. Patients may dissociate, minimise concerns, avoid examination, fail to attend appointments, or present with flat affect. These often reflect fear, shame, or conditioned protectiveness rather than disengagement.
- **Anticipate environmental and interpersonal triggers:** Lack of privacy, rushed or unexpected examinations, closed doors, sudden touch, male clinicians, or medical equipment can trigger distress or withdrawal.
- **Be alert to communication barriers:** Some women may nod or appear to understand but may not fully grasp the information due to language barriers or reluctance to ask for clarification, often influenced by cultural norms that discourage questioning or expressing uncertainty, or fear of appearing uninformed. Understanding should be confirmed, not assumed.
- **Ensure privacy and psychologically safe settings:** Avoid conducting sensitive consultations in shared or open spaces. Where possible, use a quiet, private room and ensure interruptions are minimised.
- **Offer choice and control throughout care:** Explain the purpose, steps, and duration of sensitive examinations. Ask for consent at each stage and reassure patients that they can pause or stop at any time.
- **Use trained professional interpreters proactively:** Arrange professional interpreters (in-person, phone, or video) where language barriers are present. Confirm language, dialect, and, where appropriate, gender or cultural preference. Avoid reliance on family members or children for interpretation, as this can raise confidentiality, safeguarding, and accuracy concerns.
- **Respond appropriately to distress or trauma cues:** If freezing, dissociation, withdrawal, or agitation is observed, pause, acknowledge sensitively, offer breaks, adjust positioning or environment, and restore predictability before proceeding.
- **Document sensitively:** Record trauma disclosures or safeguarding concerns objectively and factually, avoiding any stigmatising or judgemental language.

Why This Matters

To support safe and sustained engagement in healthcare, care must be both culturally responsive and trauma-informed; these are complementary elements of person-centred practice, especially for women whose experiences of trauma, inequality, or exclusion shape how they access and experience care.

- Culturally responsive care acknowledges how identity, belief systems, and social context influence healthcare experiences. Through clear, respectful, and non-judgmental communication, it supports women to participate in decision-making and ensures awareness of entitlements such as free maternity care, contraception schemes, fertility treatment, and menopause services. It requires clinicians to remain curious rather than assumptive, adapting care in ways that respect cultural practices while maintaining clinical best practices.
- Trauma-informed care focuses on how past or ongoing trauma shapes a person's sense of safety, control, and ability to engage with treatment. It recognises that experiences such as sexual violence, forced migration, FGM, trafficking, or domestic abuse can profoundly affect how women perceive healthcare environments, examinations, and authority figures. It prioritises emotional and physical safety, offers choice wherever possible, and avoids practices that may re-trigger fear or a sense of loss of control. Trauma-informed care considers not only what is asked, but how, when, by whom, and in what setting, ensuring women can engage in healthcare in conditions that prioritise safety and minimise the risk of further harm.

Learning Tools

- MyChild – HSE https://www2.hse.ie/my-child/
- Roma Daja – Supporting Roma Women During and After Pregnancy https://www.hse.ie/eng/services/mhml/roma-health/roma-daja-supporting-roma-women-during-and-after-pregnancy/roma-daja-supporting-women-during-and-after-pregnancy.html
- Getting IVF, ICSI, IUI – HSE https://www2.hse.ie/pregnancy-birth/trying-for-a-baby/your-fertility/getting-ivf-icsi-iui-hse/

Recognition and Management of Common Women's Health Conditions

Keywords: diagnostic delay, barriers to engagement, obstetrics & gynaecology, non-specialist management, safety-netting, fragmented care pathways

Overview

Common women's health conditions are frequently encountered across healthcare settings, often outside specialist Obstetrics and Gynaecology (O&G) services. Conditions such as endometriosis, menopause-related symptoms, amenorrhoea, genitourinary presentations, and issues relating to pregnancy and contraception can present with non-specific or overlapping features that complicate recognition and management, particularly where social exclusion is present. In these contexts, diagnostic complexity, competing clinical priorities, and fragmented care pathways may contribute to delayed or incomplete assessment and management, leading to prolonged symptoms, preventable complications, and avoidable harm.

From a patient perspective, lived experience accounts highlight that fear for a child's safety or custody, alongside stigma or prior negative healthcare encounters, may lead some women to withhold relevant information (e.g. history of Female Genital Mutilation (FGM) or substance use), further complicating assessment and engagement with care. Additionally, the perception of being referred to a specialist can lead to the misunderstanding that the referring doctor cannot treat the presenting complaint, rather than being an additional supportive step. This could be an opportunity to further build trust through shared decision-making on referrals.

Supporting specialists in areas other than O&G to recognise presentations that carry diagnostic risk, access basic care pathways, and initiate simple investigation and symptomatic management while awaiting specialist review may help resolve the issue or address symptoms in the interim.

Key Clinical Considerations

- **Recognise common presentations carrying diagnostic risk:** Be alert to common women's health presentations (e.g. pelvic pain, menstrual disturbance, abnormal bleeding, contraceptive concerns, genitourinary symptoms) that may be under-recognised or under-reported, particularly where social exclusion is present.
- **Take a sensitive and complete history:** Elicit relevant gynaecological, sexual, and reproductive history in a respectful and non-assumptive manner. Recognise that fear, shame, safeguarding concerns, or past trauma may lead to delayed or partial disclosure.
- **Consider barriers to engagement and follow-up:** Be mindful that unstable housing, stigma, substance use, or caring responsibilities may affect attendance, waiting-room behaviour, or ability to remain in care. These factors should inform how safety-netting and follow-up are planned.
- **Provide initial management within scope:** Where within scope, initiate basic investigations and simple, evidence-based symptomatic management while arranging referral, rather than deferring all care pending specialist review.
- **Use referral as a supportive step:** Frame referral to specialist services as an additional layer of care rather than a transfer of responsibility, and involve the patient in shared decision-making around timing, expectations, and interim management.
- **Ensure clear safety-netting:** Provide clear advice on red flags, expected symptom progression, and when and how to seek further care if symptoms worsen or fail to improve.
- **Use available guidance and pathways:** Use local and national clinical guidelines and referral pathways to support decision-making in common women's health presentations, particularly when working outside obstetrics and gynaecology.

Learning Tools

Tool	Purpose	Example
Vignette	To recognise and manage common women's health conditions.	Gráinne is 23 years old, presenting to the Emergency Department with a one-day history of severe left iliac fossa (LIF) pain. She is living in emergency accommodation and is experiencing addiction. She smokes crack cocaine and injects opioids. She otherwise has no relevant history. She is vitally stable, her bloods are unremarkable, and urine hCG is negative. She is not in the waiting room when called on three occassions and, therefore, other patients are seen first. She later informs you that she left the waiting room a number of times because her clothes were unclean and she had a malodourous leg wound, and she felt too embarrassed to sit with the other patients. The ED is very busy (an approximately 4-hour wait). There is only one SHO seeing patients and one midwife triaging. The staff are frustrated that Grainne was difficult to locate. Given her normal vitals, and normal clinical examination and bloods, she is discharged with paracetamol. Stronger analgesia was not provided due to her history of intravenous drug use and presumption of "drug-seeking behaviour". Eight hours later, she re-presents by ambulance with persistent stabbing LIF pain and low-grade fever. Pelvic ultrasound shows left-sided ovarian torsion. She undergoes surgery; the ovary is necrotic and not salvageable, and she has a salpingo-oophorectomy. She is discharged on post-operative day 2. **Reflection Prompts** • Was this clinical course inevitable, or were there factors in the history that may have led to this delayed diagnosis? • How might assessment, analgesia, or imaging decisions have differed if Gráinne were not homeless or did not use drugs?
Vignette	To recognise and manage common women's health conditions.	Christina is a 33-year-old woman from Dublin who has been rough sleeping in the city centre for three years. She grew up in the care system, left school aged 14, and has had two babies taken straight into care after delivery. She has smoked heavily for 16 years and has not received vaccinations since childhood. She has never had cervical screening. She has been experiencing intermenstrual bleeding and post-coital bleeding for eight months. She mentions this to her GP, who performs a speculum examination. The cervix appears inflamed and ulcerated, and there is a craggy mass protruding from the external os. She is referred urgently to gynaecological-oncology services. She undergoes biopsy and staging MRI and is diagnosed with Stage IVb cervical cancer. She undergoes palliative chemoradiotherapy but, due to poor baseline and compromised immune system, she suffers from frequent respiratory tract infections and dies of respiratory sepsis aged 34.

Tool	Purpose	Example
Vignette	Recognise and manage common women's health conditions	**Reflection Prompts** • What might be the reason Christina is less likely to engage with CervicalCheck compared with national averages in her demographic? • What populations are less likely to receive HPV vaccination and why? • Along with smoking, what are other risk factors for malignant transformation of HPV-infected cells in the cervix? • If HPV vaccination uptake improves, what additional benefits may follow for patients with similar life circumstances?

Why This Matters

Delayed recognition and under-treatment of common women's health conditions can result in avoidable harm, particularly where social exclusion or other structural barriers to care affect access, continuity, or follow-up. Supporting non-specialist clinicians to maintain appropriate diagnostic thresholds, initiate initial management within scope, and use referral pathways transparently helps reduce delay, improve symptom control while awaiting specialist care, and strengthen trust and engagement over time. In addition, improving the accessibility of clinical guidance, alongside patient information developed with meaningful patient input and provided in appropriate formats and languages, may support timelier assessment and more consistent access to appropriate care.

Further Resources

1. HSE Land courses: Practical management of substance misuse issues in pregnancy

Female Genital Mutilation (FGM)

Keywords: Trauma-informed care, culturally responsive practice, sensitive communication, informed consent, psychological safety, obstetric and gynaecological implications, specialist referral, professional interpreting

Female genital mutilation (FGM) is associated with a range of acute and long-term physical, reproductive, and psychological health consequences, which may present across healthcare settings, including primary care, emergency care, gynaecology, and maternity services.

Clinicians may encounter FGM incidentally during assessment or in the context of related symptoms, screening, pregnancy, or childbirth. Addressing FGM in healthcare settings requires a careful, clinically-grounded approach that integrates awareness of potential anatomical and physiological effects with sensitivity to the potential psychological trauma it may cause, alongside a clear understanding of the cultural contexts in which FGM occurs. It is also important that practitioners are aware of countries with high prevalence, so they can provide culturally appropriate and responsive care.

Fear of judgement, misunderstanding, or blame can significantly influence how care is experienced and whether patients feel able to engage, disclose concerns, or attend follow-up. Trauma-informed, person-centred communication is essential in this context, recognising FGM as a potential source of enduring physical and psychological trauma that can be re-activated during discussion, examination, or investigation. Care should therefore prioritise psychological safety, clear explanation, informed consent, and patient-led pacing, underpinned by non-judgemental listening, cultural humility, and respect for autonomy, to support disclosure, engagement, and safe clinical decision-making without assumption or coercion.

Key Clinical Considerations

- **Recognise FGM as a relevant clinical consideration:** FGM can have implications for gynaecological, obstetric, urological, sexual, and psychological health, including during puberty, pregnancy, childbirth, and cervical screening. Recognition should be guided by clinical context and sensitive history-taking rather than assumption.
- **Take a sensitive, non-assumptive history:** When clinically relevant, enquire about FGM in a respectful and non-judgemental manner, explaining why the information is being sought. Recognise that disclosure may be delayed, and may be influenced by fear, prior trauma, or concerns about judgement or consequences.
- **Avoid unnecessary or distressing examinations:** Where examination may cause pain or distress, consider alternative assessment approaches or deferral, particularly when the immediate clinical risk is low.
- **Use trained professional interpreters:** Arrange professional interpretation where language barriers exist, particularly for sensitive discussions, consent, or explanation of findings. Avoid reliance on family members or informal interpreters.
- **Explain findings, decisions, and next steps clearly:** Ensure patients understand what was done, what was found, and what will happen next, including the purpose of referrals or follow-up. Clear explanation supports informed consent, reduces anxiety, and helps maintain trust and engagement with care.
- **Recognise potential obstetric and gynaecological implications:** FGM may affect cervical screening, pregnancy assessment, labour, and delivery. Early identification allows timely referral to appropriate specialist services where needed.
- **Know when and how to seek specialist input:** Seek advice or refer to specialist services (e.g. obstetrics and gynaecology, specialist FGM services) when clinical uncertainty exists, complex care is required, or the patient requests further support.
- **Document sensitively and accurately:** Record relevant information factually and respectfully. Documentation should support continuity of care, patient safety, and appropriate follow-up.

Learning Tools

Tool	Purpose	Example
Vignette	To illustrate how communication, consent, interpretation, and explanation influence safety, trust, and ongoing engagement with care when FGM is encountered in routine clinical settings.	Fatmata is a 29-year-old Sudanese who arrived in Ireland four months ago as asylum seeker. At her first GP appointment in Dublin, she is encouraged to attend for cervical screening, having never had a smear test previously. During the examination, she notices that the GP registrar appears surprised and uncertain but does not provide explanation or reassurance. The examination is prolonged and painful. When it ends, she is told she can go home, without clarification of findings or next steps. English is not Fatmata's first language, and a professional interpreter was not arranged. A few days later, she receives a letter from a 'maternity hospital for a smear appointment'. She does not understand why a second appointment has been arranged so soon after her initial visit. Given the pain, confusion, and lack of explanation during her first experience, she feels fearful and anxious about attending another clinician for the same procedure. **Reflection Prompts** • What could the GP registrar have done differently to ensure Fatmata understood what was happening and what the next steps were? • What might be the future consequences of this experience for Fatmata? • Was a referral to a 'maternity hospital for a smear appointment' the most appropriate next step?
Vignette	To explore clinical decision-making around deferring intimate examination in pregnancy when FGM is present.	Alaya is a 24 year-old woman who has recently arrived in Ireland as an applicant for international protection. She presents to the emergency department of her local maternity hospital with early pregnancy bleeding. Transabdominal ultrasound confirms a viable intrauterine pregnancy. The obstetrics SHO reviewing her is hesitant to proceed with speculum examination as Alaya, after giving informed consent for the examination, appears extremely distressed by the prospect. On external examination, partial infibulation is evident, and the examination is likely to be extremely painful. Given the bleeding has stopped, and there is a viable intrauterine pregnancy seen on transabdominal ultrasound, she is able to reassure Alaya and discharge her with safety net advice without performing the potentially re-traumatising examination. **Reflection Prompts** • How might a history of FGM influence assessment and decision-making in early pregnancy presentations? • What specific interventions should be considered following this disclosure? • Is there any further care required for Alaya?

Why This Matters

Where FGM is present, failures in communication, consent, or explanation can lead to avoidable distress, disengagement from care, and missed opportunities for timely assessment or follow-up. Embedding trauma-informed, person-centred approaches into routine clinical practice supports safer decision-making, continuity of care, and sustained engagement with healthcare services.

Further Resources

1. HSELand courses: Female Genital Mutilation (FGM) education for Healthcare Professionals
2. Health Service Executive (HSE) & Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland (RCPI), (2019). Management of Female Genital Mutilation (FGM): National Clinical Guideline. Available at: https://www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/clinical-guidelines/management-of-female-genital-mutilation-2019-.pdf
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4. Health Service Executive (HSE), Domestic, Sexual and Gender Based Violence (DSGBV) Training. Available at: https://healthservice.hse.ie/staff/training-and-development/domestic-sexual-and-gender-based-violence-dsgbv-training/

Legal and Safeguarding Issues

Responding to Sexual and Intimate Partner Violence

Consent for Teenagers in Care

This section explores the legal, safeguarding, and ethical dimensions of caring for patients affected by sexual violence, intimate partner abuse, trafficking, and child protection concerns. It emphasises trauma-informed, culturally sensitive responses that prioritise patient safety, autonomy, and dignity - especially in contexts where disclosure may be difficult or where patients face barriers such as homelessness or addiction. Clinicians are guided to recognise signs of abuse, provide private consultation time, use trained interpreters, and understand the limits of specialist services. The section also highlights the importance of interagency collaboration in responding effectively to complex legal and social issues.

Responding to Sexual and Intimate Partner Violence

Keywords: trauma-informed care, sensitive enquiry, psychological safety, safeguarding, referral pathways, non-judgemental response

Overview

Sexual violence and intimate partner violence, whether physical, sexual, emotional, or psychological, are significant health concerns that often remain undisclosed in clinical settings. Disclosure is often inhibited by a range of factors, including:

- Psychosocial factors: shame/stigma, fear of blame or disbelief, safety concerns (coercive control, immigration status, or child custody), financial dependence, cultural norms, and language barriers).
- Clinical/system factors: lack of privacy, presence of partners/family, time-pressured encounters, inconsistent professional interpretation, uncertainty about confidentiality/reporting, fragmented pathways, and prior negative healthcare experiences.

Sexual violence may occur as a single assault or as part of an ongoing pattern of intimate partner abuse, with different implications for health, safety, and support needs. A trauma-informed, supportive clinical response, characterised by calm, non-judgemental communication, validation of the person's experience, attention to privacy and choice, use of professional interpretation where needed, clear explanation of options, and collaborative, pace-sensitive decision-making, helps create psychological safety. This, in turn, enables disclosure and facilitates timely access to appropriate care and specialist support.

Key Clinical Considerations

- **Recognise sexual and intimate partner violence:** Sexual violence and intimate partner violence may present as isolated incidents or ongoing patterns of physical, sexual, emotional, or psychological harm, and may be undisclosed unless sensitively explored.
- **Create conditions that support disclosure:** Fear of judgement, disbelief, repercussions, or loss of control commonly inhibit disclosure. A calm, supportive, non-judgemental approach and a private setting help create psychological safety for patients to share concerns.
- **Ask sensitively and respond appropriately:** Where indicated, ask about sexual or intimate partner violence using clear, non-leading language. If disclosure occurs, listen without interruption, acknowledge what has been shared, and be mindful of expressions of shock, blame, or pressure to act.
- **Assess immediate safety and safeguarding needs:** Where concerns are identified, consider whether there is immediate risk to the patient or dependants. Follow local safeguarding procedures when indicated, explaining processes and limits of confidentiality clearly.
- **Use professional interpretation where required:** Arrange trained professional interpreters for sensitive discussions or consent when language barriers exist. Do not rely on partners, family members, or informal interpreters.
- **Know referral pathways and supports:** Be familiar with local and national pathways for specialist support, and facilitate timely referral or supported linkage where appropriate.
- **Document:** Record disclosures, clinical findings, and agreed actions factually and sensitively. Record relevant safety concerns and follow-up plans in a way that supports continuity of care.

Learning Tools

Tool	Purpose	Example
Vignette	To support clinicians to recognise, respond to, and refer appropriately when sexual or intimate partner violence is disclosed or suspected.	Lucy is a 24-year-old woman who phones her GP requesting an urgent appointment, stating that she has been raped. The administrative team promptly arranges for the GP to speak with her directly, and a brief history is taken. Twelve hours previously, she had been out celebrating a friend's birthday. She became separated from her friends, met a group of tourists in a club and returned to their apartment for an afterparty. Soon after arriving, Lucy felt uncomfortable, and she decided to leave. One of the men forced her into a bedroom and held her down. He removed her shorts and underwear and forced his penis into her vagina. The GP discusses care options with Lucy and links her with a rape crisis 24-hour helpline. Lucy chooses to disclose the assault to An Garda Síochána, who arrange for her to attend the local Sexual Assault Treatment Unit (SATU). Within three hours, Lucy is assessed at the SATU, where she meets a support worker from the affiliated Rape Crisis Centre. Forensic swabs, samples and clothing are collected. Lucy was offered emergency contraception and other relevant healthcare and was provided with replacement clothing and follow-up appointments.

Tool	Purpose	Example
Vignette		**Reflection Prompts** • What alternative care options need to be considered if Lucy declines to attend SATU? • What supports are available if someone discloses sexual violence a long time after the acute incident?
Vignette	To respond to and care for patients experiencing sexual and intimate partner violence.	Marta is a 29-year-old primiparous woman attending the antenatal clinic for her booking visit with the midwife. She is from Poland and has been living in Dublin for ten years. She speaks intermediate English, and after initially greeting her, the midwife decides a Polish interpreter is not necessary. During the booking assessment, they have effective communication, and an appropriate medical history is taken. When asked routine domestic violence screening questions, Marta seems taken aback and uncomfortable. She nods her head to indicate she feels safe in her current relationship and shakes her head quickly when asked if she has ever been abused by her current partner. The midwife, who is very experienced, has a sense that Marta is potentially not being truthful about her answers to the domestic violence questions. She decides to ring a Polish interpreter to clarify a few elements of the medication and social history. When they repeated the domestic violence questions, Marta, appearing more relaxed speaking Polish, became tearful and disclosed that her partner monitors her social media and withholds her debit card. Since becoming pregnant, he frequently pinches her and pretends to choke her, and he often makes jokes to undermine how she will be a parent. **Reflective Prompts** • How should the team use this knowledge to enhance Marta's care for the remainder of the pregnancy (recognise, respond, refer)? • What child safeguarding issues may need to be considered?

Further Resources

1. Health Service Executive (HSE), Sexual Assault Treatment Units (SATU). Available at: https://www2.hse.ie/services/satu/

2. Health Service Executive (HSE), Domestic, Sexual and Gender-Based Violence (DSGBV) Programme Module 1–4. Available at: https://healthservice.hse.ie/staff/training-and-development/domestic-sexual-and-gender-based-violence-dsgbv-training/

3. Webster, J., Lawlor, S., Kavanagh, D., Breen, A., Sheil, O., McCarthy, A.M., O'Brien Green, S., Kirby, F. & Leahy, M., (2024). National Clinical Practice Guideline: Screening and Management of Domestic Violence in Pregnancy and the Early Postnatal Period. National Women and Infants Health Programme & Institute of Obstetricians and Gynaecologists. Available at: https://www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/clinical-guidelines/screening-and-management-of-domestic-violence-in-pregnancy-and-the-early-postnatal-period-2024-.pdf

4. Always Here Campaign, Always Here. Available at: https://www.alwayshere.ie/

Understanding Human Trafficking and Exploitation

Keywords: human trafficking, exploitation, complex trauma, gendered vulnerability, clinical indicators, disclosure barriers, safeguarding pathways, professional interpretation

Overview

Women impacted by trafficking often present with complex trauma and unmet health needs. Clinicians should be trained to identify signs of trafficking, respond sensitively, and coordinate safeguarding interventions appropriately. Across 2013-2022 in Ireland, women accounted for 67% of identified human trafficking victims (men 33%) (IHREC, 2023). The gendered pattern is particularly pronounced in trafficking for sexual exploitation: in 2023, 96% of those identified as trafficked for sexual exploitation were women and girls.Human Trafficking (also referred to as modern slavery) is a criminal offence and a human rights violation. According to the Palermo Protocol, human trafficking must have three distinct elements:

1. The Act of recruitment, transportation, transfer, harbouring or receipt of persons which must be done by;
2. The Means, characterised by the threat or use of force or other forms of coercion, abduction, fraud, deception, abuse of power or of a position of vulnerability or the giving or receiving of payments, and it must be for;
3. The Purpose of Exploitation, i.e. sexual exploitation, labour exploitation, forced begging, forced criminality, exploitation for surrogacy, forced marriage, illegal adoption or organ removal.

Although trafficking can affect anyone, trafficked individuals are likely to have had pre-trafficking vulnerabilities (including poverty, homelessness, experiences of war/community violence, domestic violence, adverse childhood events, disabilities, and learning difficulties). Global data shows that most trafficked people and survivors of human trafficking access healthcare during the period they are trafficked, primarily through emergency departments, however more than half are not identified as trafficked by healthcare practitioners. Trafficked individuals may live for years under the control of their traffickers, and the impact on their physical and mental health can be profound and enduring.

Women trafficked for commercial sex often access sexual and reproductive health services whilst trafficked (WHO, 2023). Physical and medical indicators that may suggest a person is being trafficked include signs across several clinical domains:

- Injury and assault-related indicators: unexplained or inconsistent injuries, delayed presentation of serious illness or trauma, recurrent bruising, or findings suggestive of physical or sexual assault.
- Evidence of restraint or control: ligature marks, scars consistent with physical restraint, injuries in various stages of healing, or signs of being monitored or controlled by another person.
- Neglect-related health indicators: untreated chronic medical conditions, malnutrition, dehydration, poor hygiene, or lack of preventive health care.
- Sexual and reproductive health indicators: multiple or recurrent STIs, chronic pelvic pain, or repeated presentations related to sexual exploitation.
- Substance-related indicators: patterns of addiction or substance dependence.
- Psychological and trauma-related indicators: PTSD symptoms, depression, anxiety, dissociation, hypervigilance, fearfulness, or other forms of psychological distress.[8]

There are many reasons why a trafficked person may not disclose information to healthcare providers. These can include psychosocial and coercive-control factors (e.g. fear for their own or family members' safety, emotional dependence, shame, or manipulation through intimate or romantic relationships), and structural and system barriers (e.g. distrust of authorities, fear of incarceration or deportation, language barriers, lack of privacy, or not recognising themselves as a victim of trafficking).

[8]Reported tactics used by traffickers to avoid detection include:

- Not allowing the trafficked individual access to their passport/ identification documents or money.
- Not allowing the trafficked individual to use the same healthcare provider more than once/ presenting to healthcare services far from their home address to ensure a lack of local connection.
- Socially and physically isolating the trafficked individual and moving their location frequently.
- In the case of labour exploitation, the individual will often be made to work in businesses that take cash only payments and are mobile, easy to open/ close or involve seasonal work.
- The trafficker may act as the translator for the trafficked individual and/or refuse to leave during healthcare consultations.

Key Clinical Considerations

- **Recognise trafficking as a clinical safeguarding concern:** Be aware that people affected by human trafficking may present across healthcare settings with complex trauma, unmet health needs, or indicators of exploitation, often without disclosing their circumstances.
- **Create conditions that support safe engagement:** Where possible, conduct consultations privately with the patient to enable safe disclosure. Recognise that fear, coercion, distrust of authorities, language barriers, or concern for personal or family safety, may inhibit disclosure. A calm, private, non-judgemental approach and use of professional interpreters can support engagement without requiring disclosure.
- **Know safeguarding pathways and act proportionately:** Be familiar with local safeguarding procedures and referral pathways. Where concerns arise, seek specialist advice and follow appropriate protocols, balancing patient safety, consent, and legal obligations.
- **Document carefully and support continuity of care:** Record concerns, findings, and actions factually and sensitively, avoiding assumptions or labels. Documentation should support continuity of care and appropriate safeguarding follow-up.

Why This Matters

Human trafficking and exploitation are associated with significant physical, psychological, and reproductive harm, yet often go unrecognised in healthcare settings. Clinicians are frequently among the few who may encounter affected individuals during periods of exploitation. Strengthening awareness, sensitive recognition, and proportionate safeguarding responses is therefore critical to patient safety, continuity of care, and meaningful harm reduction.

Further Resources

1. Health Service Executive (HSE), Human Trafficking Training Programme. Available at: https://healthservice.hse.ie/staff/training-and-development/national-social-inclusion-office-training-programmes/human-trafficking-training-programme/
2. World Health Organization (WHO) Regional Office for Europe, (2023). Addressing human trafficking through health systems: a scoping review. Copenhagen: WHO Regional Office for Europe. Available at: https://iris.who.int/handle/10665/366280
3. Health Service Executive (HSE), Human Trafficking. Available at: https://www2.hse.ie/services/human-trafficking/
4. Blue Blindfold Campaign, Blue Blindfold: Know the signs of human trafficking. Available at: https://www.blueblindfold.ie/

Learning Tools

Clinical Vignette

Purpose: To explore missed safeguarding opportunities in the context of language barriers, third-party control, and system constraints.

Alisha is a 26-year-old woman who presents to the Emergency Department (ED) of a large tertiary hospital on a Saturday evening with severe lower abdominal pain. She is originally from Nigeria and is accompanied by her husband, who acts as an informal interpreter. Alisha appears visibly distressed and in pain throughout the assessment. The address provided is approximately 2.5 hours' drive from the hospital. Her husband explains that they were in the city shopping when Alisha became unable to walk due to pain and attended the ED for assessment.

The treating clinician attempts to access a professional interpreter, but none are available at short notice. History-taking proceeds via the husband, though the information relayed is limited and non-specific. Following examination and initial assessment, Alisha is diagnosed and empirically treated for HSV-2. A genital swab is taken, along with STI and blood-borne virus screening. She is discharged with a referral to the sexual health service for follow-up.

One week later, Alisha's blood results are returned and she has tested positive for HIV and is viremic. Attempts to contact Alisha are unsuccessful: the phone number on record is not in use, no GP is listed, and the address provided does not appear to exist.

Reflective Prompts

- What safeguarding indicators are present in this case, and at what points might they have been explored further?
- How might language barriers and third-party interpretation affect disclosure, consent, and safety?
- What actions or services could be considered at the point of presentation, and once follow-up contact fails?

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3. Irish Human Rights and Equality Commission (IHREC), (2023). Trafficking in human beings in Ireland: Second evaluation of the implementation of the EU Anti-Trafficking Directive: A Digest (ISBN 978-1-913492-16-8). Dublin: Irish Human Rights and Equality Commission. Available at: https://www.ihrec.ie/app/uploads/2023/09/Trafficking-in-Human-Beings-in-Ireland-Digest_FA_web-Final.pdf

Consent for Teenagers in Care

Keywords: consent, capacity, child protection, trauma-informed care, adolescents in state care, decision-making, safeguarding, rights-based practice

Overview

Teenagers in the care of the State, whether in foster placements, residential units, or under special care orders, have the right to participate meaningfully in healthcare decisions affecting them. However, clinicians may lack clarity on how to assess their capacity, navigate consent, or appropriately involve social workers and guardians without undermining the autonomy or rights of the young person.

Many young people in State care have histories of trauma, disrupted attachments, or institutional placements, which can affect trust, engagement, and understanding in healthcare. They may struggle to trust clinicians, maintain engagement, or process complex information, so consent discussions must be sensitive to mistrust or avoidance, recognising these as consequences of lived experience rather than disinterest. Informed consent should be rooted in the developmental capacity of the young person, a clear explanation, confidentiality (and its limits), and respect for their voice. Clinicians should use clear, jargon-free language, confirm patient understanding in a non-judgemental way, and give an explanation of confidentiality – specifying what information is private, and the circumstances under which it must be shared with Tusla for safeguarding.

Even where legal authority rests with adults or the State, young people should be offered meaningful choice and agency, with assent sought wherever possible. Consent practice in Ireland is shaped by a legal framework spanning medical, welfare, and mental health contexts. Capacity and best interests are assessed under the HSE National Consent Policy; Tusla holds statutory responsibility under the Child Care Acts; and the Mental Health Act applies additional safeguards. Clinicians must establish the young person's legal status (voluntary care, care order, or special care), confirm who holds decision-making authority, and document this clearly. Where uncertainty exists, advice should be sought from social workers, legal services, or ethics support to ensure lawful, rights-based practice.

Key Clinical Considerations

- **Assess maturity and understanding**
  - Use developmentally appropriate, accessible language.
  - Check comprehension by inviting the young person to explain back in their own words, avoiding assumptions or shame.
- **Clarify legal status**
  - Establish whether the young person is in voluntary care, under a care order, or has a guardian ad litem.
  - Document legal status and who holds decision-making authority clearly in the record.
- **Support decision-making**
  - Engage the young person directly in discussions about their care, regardless of age or legal status.
  - Involve social workers and care staff to support communication and advocacy, without overriding the young person's voice.
- **Recognise trauma and mistrust**
  - Use trauma-informed approaches to create a safe and respectful environment.
  - Allow time, use plain language, and validate concerns to support trust and engagement.

Why This Matters

Young people in State care often face systemic barriers to exercising autonomy and participating in their care. Studies and advocacy reports (e.g. EPIC, Tusla reviews) highlight that these adolescents are frequently excluded from decision-making or presented with care plans as fixed and non-negotiable, thereby undermining their agency.

This can lead to disengagement, non-adherence, or refusal of care. In some cases, clinicians assume that adult or statutory consent overrides the decision of a competent adolescent, while in others, young people are expected to make complex decisions without adequate explanation, support, or safeguarding. A rights-based, developmentally appropriate approach to consent ensures that young people are provided with clear information, supported in expressing their views, and respected as active participants in their care. This enhances engagement, builds trust, and aligns with legal and ethical standards in adolescent healthcare.

Learning Tools

Tool	Purpose	Example
Vignette	Practise capacity assessment, legal status clarification, and trauma-informed consent in care settings.	A 15-year-old in a residential unit requests contraception. Run through: confirm legal status/ decision authority, private discussion with the young person, capacity assessment using teach-back, agreed plan, and documentation. **Application**: simulation or ethics case discussion
Suggested Phrasing	Model clear, respectful, developmentally appropriate consent dialogue.	"This is your health, and your views matter. Can we go through the options together and you tell me what makes sense?" "What would help this feel clearer or safer for you?" "Would you like some time alone to talk, and is there someone you'd like involved?" **Application**: communication workshop or bedside coaching
Checklist	Standardise safe practice across legal, ethical, and clinical domains.	Legal status verified; who holds decision authority; capacity elements checked (understand/retain/weigh/ communicate); confidentiality & limits explained; assent sought; involvement plan (SW/guardian/advocate); decision & documentation completed; escalation if disagreement/uncertainty. **Application**: clinic/ward template
Consent Discussion Guide	Provide a plain-language tool to support understanding and shared decisions.	Rights and confidentiality explained; what consent means; choices, risks, and benefits; questions to consider; space for notes/preferences and who the young person wants present. **Application**: co-designed handout or EHR smart phrase for teaching/clinic

Further Resources

1. National Consent Policy (HSE) – with guidance on children and young people
2. Tusla Information on Care Orders and Legal Status
3. EPIC: Youth Advocacy and Participation Resources
4. Children's Rights Alliance – Legal Explainers for Healthcare and Education
5. RCPI and ICGP Guidance on Adolescent Confidentiality and Consent

Glossary

1. **Co-Design**: Co-design is a collaborative process that brings consumers, carers, families, and health workers together to improve services. It seeks to establish an equal and reciprocal relationship between stakeholders, enabling them to design and deliver services in partnership (Agency for Clinical Innovation, 2019). Within healthcare, it is a participatory approach that actively involves stakeholders, particularly service users, in the design, development, and improvement of services and resources.
2. **Health Inequities**: Health inequities are systematic differences in the health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work, and age. Inequity describes inequalities in health outcomes that are preventable, due to social factors, and unfair, arising from systematic disadvantage (Heaslip, Thompson et al. 2022).
3. **Health Literacy:** Health literacy is the ability to access, understand, appraise, and use health information and services in order to make informed decisions about health and healthcare (National Adult Literacy Agency, 2024).
4. **Inclusion Health:** Inclusion health is a service, research, and policy agenda that aims to prevent and redress health and social inequities among the most vulnerable and excluded populations (Luchenski et al., 2018).
5. **Person-First Language:** Person-first language is a way to emphasise the person and view the disorder, disease, condition, or disability as only one part of the whole person – describing what the person "has" rather than what the person "is" (National Institutes of Health, 2025).
6. **Psychological Trauma:** Psychological trauma occurs when an individual experiences an event or series of events perceived as overwhelmingly threatening, distressing, or harmful (e.g. violence, abuse, disaster) (Perrotta, 2019). Trauma may result from a single event (acute) or repeated or prolonged exposure (chronic or complex).
7. **Simulation Training:** Simulation training is an educational approach that uses controlled environments to replicate potential real-world scenarios healthcare providers might face. This method enhances decision-making skills, responsiveness, and the practical application of theoretical knowledge in a safe and supportive setting.
8. **Social Determinants of Health:** The Social Determinants of Health (SDH) are the non-medical factors influencing health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems (World Health Organisation, 2024).
9. **Social Determinants of Health-Related Behaviours:** Health-related behaviours include patterns such as diet, tobacco use, alcohol or drug use, physical activity, sexual health

behaviours, and engagement with healthcare (e.g. screening, vaccination, medication adherence, and primary care use). Social determinants - such as access to healthy food, education, adverse childhood experiences, and exposure to trauma - strongly influence these behaviours and shape health outcomes.

10. **Social Exclusion:** Social Exclusion is the cumulative marginalisation of people from production (unemployment), from consumption (income poverty), from social networks (community, family, and neighbours), from decision making and from an adequate quality of life (Government of Ireland, 2020). In the context of healthcare provision, social exclusion refers to the systematic disadvantage and discrimination experienced by people based on their social status, identity, or other characteristics, resulting in reduced access to healthcare and social services.
11. **Social Inclusion:** Social Inclusion is achieved when people have access to sufficient income, resources, and services to enable them to play an active part in their communities and participate in activities that are considered the norm for people in society generally (Government of Ireland, 2020).
12. **Trauma-Informed Care:** Trauma-informed care is an approach that recognises the widespread impact of trauma and integrates this understanding into all aspects of care. It emphasises safety, trust, collaboration, empowerment, and avoidance of re-traumatisation. Within Inclusion Health, it recognises that repeated trauma and stigma can significantly shape behaviour, engagement, and healthcare experiences.

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