

Difficult *Conversations*

A practical sequence for sensitive conversations with refugee-background patients. Focused on creating the conditions for disclosure across multiple visits, not on a single ideal conversation.

Patients from refugee backgrounds may have experienced conflict, persecution, family separation, torture, sexual violence, or prolonged uncertainty. Many also come from contexts where mental illness, communicable disease, reproductive health, family violence, or child safety carry shame, fear, or stigma. Safe disclosure depends on trust, time, and language access — not on the practitioner's skill in asking a single question well.

The principle: disclosure across visits, not in a single conversation

Most difficult conversations in refugee health do not happen in one sitting. The practice's job is to create the conditions in which the patient eventually feels safe to raise a difficult issue, often after several routine encounters. The goal is not to ask the difficult question well; it is to be a place where the patient eventually feels safe to raise it.

Time <i>enough of it</i>	Sensitive issues rarely surface in a 15-minute consult. Plan longer or staged appointments where possible.
Relationship <i>over visits</i>	Continuity matters. Seeing the same GP or nurse over several visits creates the conditions for disclosure that a single appointment cannot.
Language <i>accurate and trusted</i>	An appropriate interpreter is essential. A sensitive conversation through an unsafe or unfamiliar interpreter often produces less, not more, disclosure.
Confidentiality <i>explained and demonstrated</i>	Patients need to understand what will and will not be shared, with whom, and why. This needs to be explained early, not at the moment of disclosure.

Steps for a difficult conversation

STEP 1 · PREPARE

- Book a longer appointment, or plan to use multiple visits
- Arrange a professional interpreter, considering gender preference where relevant
- Avoid using family members or community members for sensitive conversations
- Review the patient record and any prior notes
- If the patient is new, focus the first conversation on rapport, not disclosure

STEP 2 · SET THE SCENE

- Greet warmly and check the patient is comfortable
- Introduce the interpreter and explain their role and confidentiality obligations
- Briefly explain what the appointment will cover, and that the patient is in control of what they discuss
- Explain confidentiality in plain language: who sees the record, what will and won't be shared
- Acknowledge any prior visits or context

STEP 3 · START BROAD, NARROW GENTLY

- Open with general wellbeing questions ("How have things been since I last saw you?")
- Listen for cues: sleep, appetite, energy, family, work, mood
- Follow the patient's lead. If they introduce a topic, follow it
- If they don't, raise topics gently and as options, not interrogations
- Use "some people in your situation have..." phrasing, which can normalise disclosure without pressuring it

STEP 4 · RESPECT THE PACE

- If the patient deflects or changes topic, accept it. Don't push.
- Note what was raised and what was avoided
- Some patients will disclose immediately. Many will not. Both are normal
- Silence is often productive. Allow space
- Watch for signs of distress and pause if needed

STEP 5 · CLOSE SAFELY

- Summarise what was discussed and what was agreed
- Make sure the patient knows what happens next (referral, follow-up, results)
- Confirm the next appointment, ideally before they leave
- If the conversation raised difficult material, check the patient has support to go home to
- If immediate safety concerns are present, follow standard practice protocols and refer appropriately

STEP 6 · DOCUMENT AND DEBRIEF

- Document the discussion sensitively in the clinical record
- Record interpreter details
- Note any flags for future visits ("avoid discussing X in front of family member Y")
- If the conversation was difficult for you as the clinician, debrief with a colleague — refugee health work can carry vicarious load

TIP

Don't underestimate how much the patient is watching the practice between consultations. Whether reception treats them respectfully, whether the interpreter actually arrives, whether the GP returns to a topic at the next visit — these are the cues patients use to decide whether the practice is safe.

Specific topics

MENTAL HEALTH AND TRAUMA

The terms "depression", "anxiety", "trauma", "PTSD" may not map directly to how the patient experiences distress. Listen for sleep problems, pain, irritability, family conflict, worry, spiritual concerns, or difficulty managing daily life — these are often how trauma presents. Avoid pathologising terms early. Refer to QPASTT for specialist support where appropriate.

COMMUNICABLE DISEASE (TB, HIV, HEPATITIS)

Many patients carry significant fear and shame around communicable diseases, particularly HIV. Explain that screening is routine, confidential, and required for care planning, not for visa or government reporting. Some patients may have received conflicting information about confidentiality previously. Be patient with repeated clarification.

REPRODUCTIVE AND SEXUAL HEALTH

Cultural and religious considerations vary widely. Where possible, offer a clinician of the patient's preferred gender. Be specific about confidentiality in family-facing contexts. For patients with female genital cutting, ensure clinical sensitivity and appropriate referral; avoid making assumptions about how the patient feels about their experience.

FAMILY VIOLENCE

Refugee-background patients may have experienced family violence in their country of origin, during displacement, or in Australia. Cultural and family considerations affect disclosure. Where there are concerns, use established safe-enquiry techniques: ask alone, ask with care, document carefully, and link to specialist services.

CHILD SAFETY

Mandatory reporting obligations apply equally to refugee-background patients. Explain the obligation early in the relationship, not at the moment of concern. Where possible, work with the family rather than around them, while meeting reporting obligations.

A NOTE ON PACE AND CONTINUITY

The single most useful intervention in many difficult-conversation scenarios is not a particular technique, but continuity. A patient who sees the same GP three times will disclose things they would not disclose to three different GPs across three visits. Where possible, build continuity into the appointment booking workflow.

NEXT STEP

For complex mental health or trauma presentations, refer to QPASTT (Queensland Program of Assistance to Survivors of Torture and Trauma). For local refugee health nursing support, contact the Townsville Refugee Health Nurses. For ongoing professional development in this area, see **Appendix 14 (Cultural Readiness Assessment)** and the resource list at the back of the main toolkit.