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REVIEW ARTICLE

A three-stage model of engagement with dementia social care services among minority ethnic communities in the United Kingdom: implications for policy and practice

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Abstract

INTRODUCTION: By 2050, 27% of UK's older population will be from minority ethnic (ME) groups, yet engagement with dementia-related social care remains low. This meta-synthesis aims to develop a conceptual understanding of ME families' attitudes toward social care services.

METHODS: A meta-synthesis of 25 UK-based studies was conducted following Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines. Using Thomas and Harden's line-of-argument approach, thematic constructs were synthesized to explain ME families' engagement with home-based, day care, respite, and residential care.

RESULTS: Three overarching stages of engagement were identified – rejection, conditional acceptance, and acceptance – representing linear and non-linear, dynamic trajectories shaped by cultural and religious obligations, stigma, gendered expectations, mistrust, and structural and systemic barriers.

CONCLUSION: Early interventions should combine culturally congruent care with ongoing stigma reduction and trust building. A key policy lever is to embed culturally competent dementia navigators with local social care services to bridge families and providers, normalize help-seeking and promote equitable, person-centered dementia care.

KEYWORDS

attitudes, conditional acceptance, dementia, engagement, minority ethnic people, rejection, rejection, social care services, UK

Highlights

- Examines minority ethnic communities' attitudes toward dementia-related social care services in the UK.
- Proposes a novel three-stage engagement model: rejection, conditional acceptance, and acceptance of social care services.

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- Describes linear as well as non-linear pathways of engagement with social care.
- Identifies key barriers including cultural and religious norms, stigma, gendered roles, and structural challenges.
- Highlights the critical role of culturally and religiously tailored care in facilitating dementia social service engagement.

1 | INTRODUCTION

By 2050, approximately 27% of the UK's older population will come from minority ethnic (ME) groups, with an estimated 400,000 ME individuals expected to be living with dementia.¹ Dementia, characterized by deterioration in cognitive function and accompanied by changes in mood, behavior, and social relationships, significantly affects quality of life for both people with dementia and their caregivers. As dementia progresses, caregiving responsibilities increase, placing considerable physical, emotional, and financial burdens on families, often increasing caregiver stress and burnout.²⁻⁴

Social care services play a crucial role in supporting people with dementia and their families. These include domiciliary (home-based) care, respite care, day care centers, and residential or nursing care homes.⁵⁻⁹ Yet uptake and engagement with dementia-related social care among ME communities remain low. In the UK, eligibility and access are set out by the Care Act 2014 and are largely means-tested.^{10,11} Despite this policy framework, evidence on ME uptake and engagement with social care is limited, with available data showing only a modest increase in residential care home occupancy from 0.62% in 2011 to 0.95% in 2021.¹²

Existing reviews and studies of dementia social care – predominantly from Australia and the USA – identify individual, community, structural, and systemic influences on access and use but provide limited evidence specific to ME people with dementia and their caregivers and did not discuss intersectionality in their findings.⁵⁻⁸ Specifically on ME populations, two recent reviews examined their experience in dementia care homes; however, the aggregation of the reviews' findings across Western countries and focus on a single type of social care limit their applicability to the UK context and to the broader spectrum of social care.^{13,14}

To strengthen understanding of help-seeking and dementia-related service access and use, theoretical frameworks have been applied. Such frameworks provide organized approaches to synthesizing evidence, identifying barriers, and informing policy and interventions. Examples include the Andersen's Behavioral Model,^{6,8} Integrated theoretical model,¹⁵ Health Care Access Barrier Model,¹⁶ Cultural Determinants of Help Seeking,¹⁷ and the Intrapersonal–Interpersonal Model.¹⁸ While these frameworks capture important demographic and contextual influences, they tend to conceptualize health attitudes and behaviors as a linear sequence – from symptom recognition to help seeking and then service use – placing less emphasis on non-linearity trajectories of behaviors or intersectionality of the phenomenon.

While UK research on dementia in ME communities is growing, a critical gap remains in understanding the specific use of formal social care services. Existing studies have identified multilevel barriers – including stigma, language, limited dementia knowledge, and structural inequalities – that contribute to delayed service use and increased family burden.¹⁹⁻²³ At the same time, emerging evidence points to shifting cultural norms and stressors among British-born ME individuals, which in some cases foster greater acceptance of external support and services.²⁴⁻²⁸ However, no review has systematically integrated this evidence to provide a comprehensive intersectional understanding of the barriers and facilitators shaping dementia social care engagement. Specifically, research has not examined service use across the four main domains of social care provision: home-based/domiciliary, day care, respite, and residential care.

While individual studies are beginning to shed light on caregiving experiences within these communities, there remains no systematic synthesis of this evidence to capture their attitudes toward, and experiences of, social care. This review bridges that gap through a qualitative meta-synthesis, consolidating dispersed UK evidence to generate new theoretical insight and inform culturally responsive, targeted policy and practice. In doing so, we extend existing theoretical frameworks by developing a conceptual model of engagement with dementia social care in the UK, highlighting barriers and facilitators, and identifying priority issues to guide culturally responsive practice and policy.

Specifically, our synthesis addresses three key research questions:

1. What are the attitudes of minority ethnic individuals toward dementia-related social care services in the UK?
2. What factors influence these attitudes?
3. How can services be improved to better support ME individuals living with dementia and their caregivers?

2 | METHODS

2.1 | Study design

We conducted a systematic literature review to provide a comprehensive and unbiased assessment of studies involving ME populations in the context of formal dementia care services.²⁹ The review adhered to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines.^{29,30}

2.2 | Search strategy

The search strategy was developed by the lead reviewer (JNWL) with librarian support to identify all studies relevant to minority ethnicity and dementia social care services in the UK. This was then refined through manual checking of those studies using the inclusion criteria. The search was conducted without a study design filter in order to retrieve studies using all methodologies: systematic reviews, qualitative studies, quantitative studies, mixed methods studies, case studies, and service evaluations. No time limit was applied to the search to capture all dementia studies involving ME populations as this area of research is still emerging (see online supplementary material for the full search strategy).

The search was performed on the EBSCOhost research platform, and the following databases were searched: APA PsycInfo, CINAHL Ultimate, MEDLINE with Full Text, Psychology and Behavioral Sciences Collection, SocINDEX with Full Text. The search was initially conducted in November 2024 and updated in February 2025. In addition to the database searches, we hand-searched the references lists of all relevant reviews that were returned in the search to identify any additional papers for inclusion. Search results were imported directly from EBSCOhost to Endnotes, where duplicates were removed.

Search terms combined dementia-related keywords with terms related to ethnicity, adult social care, and UK context using Boolean operators. Search domains included:

- Dementia-related terms: dementia, Alzheimer's disease, cognitive impairment, memory loss
- Ethnicity-related terms: minority ethnic groups, Black and minority ethnic "BAME," Black and minority ethnic "BME," Black, South Asian, Indian, Chinese, Bangladeshi, Pakistani, African, Caribbean, cultural diversity
- Social care services: day care centres, domiciliary care, home-based care, respite, residential care homes, nursing homes, long-term care
- UK context: United Kingdom, UK, England, Wales, Scotland, Northern Ireland
- Attitudes, experience, perception, knowledge, belief, opinion

2.3 | Inclusion and exclusion criteria

Studies were included if they:

- Focused on ME groups living in the UK;
- Explored attitudes toward social care services (day care, respite, domiciliary care, residential care homes, nursing homes, long-term care);
- Examined factors influencing access and utilization of social care services;
- Included perspectives from people with dementia, family members, caregivers, or care staff;
- Reported qualitative data; and
- Were published in English

Excluded studies were those that:

- Focused on non-UK settings or non-ME populations;
- Did not address attitudes or experiences of formal social care services; and
- Were quantitative studies.

Eleven reviews on dementia were manually searched to identify UK-based studies focusing on ME people with duplicates removed.^{13, 14, 19, 21, 31-37}

2.4 | Screening and charting of data

Using the eligibility criteria, MK and RA did the initial screening of titles and abstracts for relevance, resulted in 43 studies and their full texts downloaded online. Authors were assigned studies to perform the second stage, independent screening. They met and agreed on a list of 25 studies that met the inclusion criteria. The PRISMA flow diagram summarizes the study screening process (Figure 1).

The 25 included studies were distributed between the authors for data extraction (JNWL – 11, MK – 7, and RA – 7). Data were charted using a data extraction sheet designed by JNWL. The following information was extracted: publication date, aim of study, study design, geographical study site, social characteristics (ethnicity, gender, age, role/status, relationship to person with dementia, religion, and generational/immigration status), types of social care services reported, application of a theoretical framework and/or intersectionality lens, and qualitative data (verbatim quotes) on attitudes and/or experiences of social care. The team met to discuss the data, and any ambiguities were cross-checked with the original studies.

2.5 | Quality appraisal

All the studies employed a qualitative study design, and their methodological quality was assessed using the Critical Appraisal Skills Programme qualitative checklist.³⁸ Eighteen studies were rated high quality, six high-moderate, and one moderate; all were retained to maximize data extraction relevant to the review questions.

2.6 | Data synthesis

Data synthesis followed a thematic approach informed by Thomas and Harden's line-of-argument methodology.³⁹ First-order constructs, representing participants' attitudes, behaviors, and lived experiences, were identified through line-by-line coding using the original terms or concepts reported in the studies. These first-order constructs were then compared and transferred across studies to generate second-order constructs, which reflect the researchers' interpretations of participants' accounts. Building on these, third-order constructs were developed to capture overarching themes that interpretatively

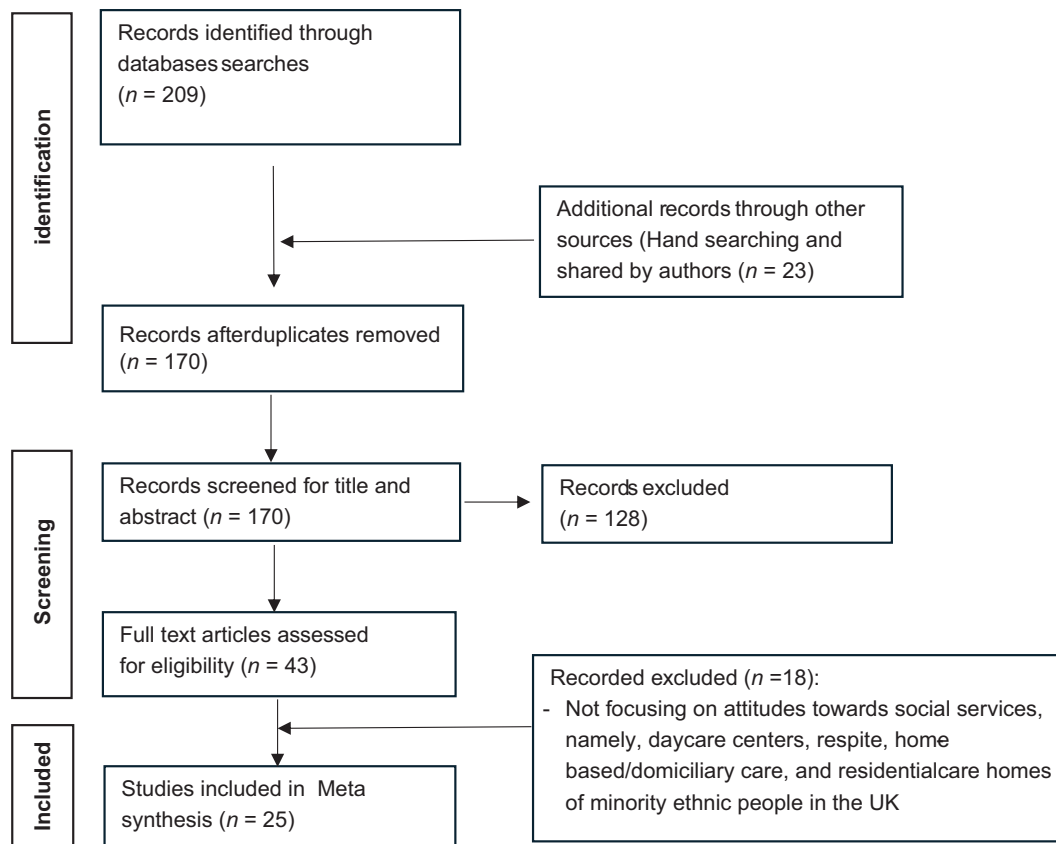


FIGURE 1 Preferred Reporting Items for Systematic Reviews and Meta-Analyses flow diagram.

describe the processes influencing ME communities' engagement with formal social care services. Finally, a line-of-argument synthesis was produced to interpret the relationships between these overarching themes, offering an integrated explanation of how ME communities in the UK engage with dementia-related social care.

JNWL performed line-by-line coding to generate initial codes related to attitudes and influencing factors toward dementia care services. All data were coded; even if they appeared only once across the studies, the principles of data saturation were not applied. The codes were then grouped into descriptive themes, followed by the development of higher-order analytical themes. Reflexivity was maintained throughout the synthesis process to enhance rigor. The descriptive and analytical themes were presented, discussed, and agreed in a team meeting with all authors.

3 | RESULTS

The included studies were published between 2003 and 2025; one took place in Scotland, a third in London, five in the Midlands, and the remainder spread across Portsmouth, Bristol, and northern England. Most studies centered on the UK's largest ME populations, namely, South Asian (Indian, Pakistani, and Bangladeshi) and Black Caribbean groups. Two studies included Chinese participants, and two involved Black African participants, despite their substantial population sizes

nationally. One study also featured Polish carers. Seven studies specifically focused on a single ethnic group: one on Indian (Sikh) carers, three on Bangladeshi carers, and three on Pakistani participants. Overall, South Asian communities were more frequently represented than Black communities.

None of the studies specifically set out to examine attitudes toward dementia social care services, but the topic has consistently emerged as a finding. In addition, none of the studies used a behavioral theoretical framework to guide their investigation, nor did they examine the influence of intersectionality (Table 1).

3.1 | Overall line of argument

Three third-order constructs – rejection, conditional acceptance, and acceptance – were identified following the translation of the information on attitudes toward social care services in the included studies. These constructs were integrated to form a line of argument that explains the social processes shaping attitudes toward social services for dementia, culminating into a three-stage engagement model. Figure 2 shows the interconnections between these three third-order constructs. The themes describing attitudes of ME people toward dementia-related social care services are presented in Table 2. Below, these are discussed in detail, organized according to the three stages of engagement.

TABLE 1 Characteristics of included studies.

Author(s), year	Title of paper	Aim of study	Methods	Study location(s), Total participants	Characteristics of study population—ethnicity, gender, age, relationship, number
Armstrong et al. ⁴⁰	Trust and inclusion during the Covid-19 pandemic: Perspectives from Black and South Asian people living with dementia and their carers in the UK	To explore the impact of Covid-19 on trust and inclusion for Black and South Asian individuals with dementia and their carers	Qualitative design with semi-structured interviews and thematic analysis	Greater London No. of participants: 15	Ethnicity: Black Caribbean ($n = 7$), South Asian ($n = 8$) Gender: People with dementia (2 female, 2 male); carers (10 female, 1 male) Age: People with dementia (66 to 88); carers (29 to 85) Relationship: Not reported UK born: $n = 4$
Atcha ⁴¹	Access to dementia diagnosis and support in a diverse South Asian community: A qualitative study	To explore how members of the South Asian community understand dementia and mental illness, and how cultural perceptions influence help seeking, stigma, and access to dementia-related services	Qualitative study using semi-structured interviews and focus groups, analyzed thematically	Blackburn with Darwen, Northwest	Ethnicity: South Asian ($n = 21$) Gender: People with dementia (2 female, 2 male); carers (majority female) Age: Not reported Relationship: Spouses, adult children UK born: Not reported Total participants: 30 participants
Baghirathan et al. ⁴²	A grounded theory analysis of the experiences of carers for people living with dementia from three BAME communities: Balancing the need for support against fears of being diminished	To explore the experiences of carers from South Asian, African Caribbean, and Chinese communities in the UK, focusing on their interactions with dementia-specific care services and their reluctance to access such services.	A grounded theory approach, involving semi-structured interviews, focus group	Bristol	Ethnicity: South Asian ($n = 47$), Chinese ($n = 31$), African Caribbean ($n = 25$) Gender: Female ($n = 78$), male ($n = 25$) Age: Not reported Relationship: Family carers, volunteers, staff UK-born: Not reported Total participants: 103 participants
Bartlett et al. ⁴³	Improving access to social farms for people with dementia, including people from India, Bangladesh, and Pakistan	To explore the accessibility of social farms in England for people living with dementia, particularly from Indian, Bangladeshi, and Pakistani backgrounds	Mixed-methods study using a concurrent transformative design	England	Ethnicity: White British ($n = 8$), South Asian ($n = 6$) Gender: Predominantly women (exact number not specified) Age: Not reported Relationship: Family carers, volunteers UK born: ($n = 8$) Total participants: 46 participants
Beattie et al. ⁴⁴	They Don't Quite Fit the Way We Organize Our Services" Results from a UK Field Study of marginalized groups and dementia care	To examine accessibility of dementia services for two marginalized groups (people under 65 and minority ethnic communities) and explore systemic barriers	Qualitative field study with semi-structured interviews with professionals and paid carers, using purposive and snowball sampling	Bristol	Ethnicity: African-Caribbean, South Asian. Gender: Not reported Age: < 65 (young-onset) Relationship: Not reported UK-born: Not reported Number: 61 participants

(Continues)

TABLE 1 (Continued)

Author(s), year	Title of paper	Aim of study	Methods	Study location(s), Total participants	Characteristics of study population—ethnicity, gender, age, relationship, number
Bowes and Wilkinson ⁴⁵	"We didn't know it would get that bad": South Asian experiences of dementia and the service response	To examine some views and experiences of dementia among older South Asian people, as well as their families and carers, and to explore central issues of service support	Qualitative study using semi-structured interviews	Urban areas in Scotland (Glasgow and Edinburgh)	Ethnicity: Pakistani and Indian families Gender: People with dementia (3 female, 1 male); carers (spouses and adult children) Age: Older adults (range not specified) Relationship: Spouses, adult children UK-born: Not reported Total participants: 4 case study families + 11 professionals
Carter et al. ⁴⁶	Equality of opportunity for timely dementia diagnosis (EQUATED): a qualitative study of how people from minoritized ethnic groups experience the early symptoms of dementia and seek help	To explore the pathways that influence the timing of dementia diagnosis among people from minoritized ethnic groups living in an ethnically diverse urban area of the UK, focusing on cultural and social factors affecting help-seeking behavior	Qualitative study using semi-structured interviews and reflexive thematic analysis	East London	Ethnicity: Bangladeshi (n = 17), Black African/Caribbean (n = 7) Gender: Carers (20 female, 10 male); professionals (13 female, 3 male); paid carers and interpreters (mixed) Age: Mean = 72 Relationship: Not reported UK Born: Not reported Total participants: 56 participants + 21 professionals/interpreters
Herat-Gunaratne et al. ⁴⁷	"In the Bengali Vocabulary, There Is No Such Word as Care Home": Caring Experiences of UK Bangladeshi and Indian Family Carers of People Living with Dementia at Home	To explore experiences of South Asian carers of people with dementia receiving health or social care in the United Kingdom	A qualitative research design using semi-structured interviews and thematic analysis	London and Bradford	Ethnicity: Bangladeshi (n = 4), Indian (n = 6) Gender: Female (n = 5), male (n = 5) Age: Mean 49.4 (range: 32 to 69) Relationship: Daughters (n = 3), sons (n = 4), spouses (n = 3) UK-born: (n = 5) Total participants: 10
Hossain and Khan ⁴⁸	Dementia in the Bangladeshi diaspora in England: A qualitative study of the myths and stigmas about dementia	To explore Bangladeshi family carers' knowledge and experiences of dementia in England	Qualitative design with semi-structured interviews and thematic analysis	London and Portsmouth	Ethnicity: Bangladeshi (n = 6) Gender: Female (n = 3), male (n = 3) Age: Mean 44.16 (range: 23 to 64) Relationship: Daughters (n = 1), wives (n = 1), sons (n = 3) UK Born: Not reported Total participants: 6
Hossain and Khan ⁴⁹	Barriers to access and ways to improve dementia services for a minority ethnic group in England	To examine the barriers to health care service use in the Bangladeshi community living in the United Kingdom	Qualitative study using focus groups and semi-structured interviews analyzed via thematic analysis	Portsmouth and London	Ethnicity: Bangladeshi (n = 27) Gender: Female (n = 15), male (n = 12) Age: Adults (18+) Relationship: Spouses, children, grandchildren UK Born: Not reported Total participants: 27

(Continues)

TABLE 1 (Continued)

Author(s), year	Title of paper	Aim of study	Methods	Study location(s), Total participants	Characteristics of study population—ethnicity, gender, age, relationship, number
Hossain et al. ⁵⁰	From detection to preparing for the end-of-life: A qualitative exploration of the South Asian family carers' experiences of the journey with dementia	To explore the experiences of carers of people of South Asian origin with dementia in the UK from first signs to end-of-life care	Qualitative study using semi-structured interviews and thematic analysis	West Midlands	Ethnicity: Pakistani ($n = 11$), Indian ($n = 5$) Gender: Not reported Age: Not reported Relationship: Daughters ($n = 5$), sons ($n = 4$), spouses ($n = 4$) UK Born: Not reported Total participants: 16
Hussain et al. ⁵¹	Cultural Myths, Superstitions, and Stigma Surrounding Dementia in a UK Bangladeshi Community	To explore cultural myths, superstitions, and stigma surrounding dementia in the UK Bangladeshi community, focusing on the experiences of people with dementia, their caregivers, and service providers	Qualitative research using semi-structured interviews and thematic analysis	England	Ethnicity: Bangladeshi ($n = 10$) Gender: Male ($n = 6$), female ($n = 4$) Age: Range = 55 to 85 Relationship: Not reported UK Born: Not reported Total participants: 10
James et al. ⁵²	Equity in care and support provision for people affected by dementia: experiences of people from UK South Asian and White British backgrounds	To explore the care and support received and wanted by United Kingdom (UK) South Asian and White British people affected by dementia and whether access to it is equitable	Qualitative study using semi-structured interviews and reflexive thematic analysis	London and Leicester	Ethnicity: South Asian ($n = 37$), White British ($n = 25$) Gender: People with dementia (8 female, 5 male); carers (16 female, 8 male) Age: People with dementia (mean = 75); carers (mean = 60.5) Relationship: Not reported UK Born: Not reported Total participants: 62
Jutlla ⁵³	The impact of migration experiences and migration identities on the experiences of services and caring for a family member with dementia for Sikhs living in Wolverhampton, UK	To explore how migration experiences and life histories influence perceptions and experiences of caring for a family member with dementia among Sikhs in Wolverhampton, UK, and their access to health and social care services	Qualitative study using narrative interviews and constructivist grounded theory analysis	Wolverhampton	Ethnicity: Sikh ($n = 12$) Gender: Female ($n = 9$), male ($n = 3$) Age: Range = 44 to 83 (mean ~60) Relationship: Spousal ($n = 5$), intergenerational ($n = 7$) UK Born: ($n = 3$) Total participants: 12
Jutlla and Moreland ⁵⁴	The personalization of dementia services and existential realities: understanding Sikh carers caring for an older person with dementia in Wolverhampton	The paper conceptualizes some of the ways in which different migration experiences and the realities of daily life influence the perceptions, experiences, and patterns of care among migrant Sikh carers in Wolverhampton caring for an older person with dementia	A qualitative study using biographical narrative interviews, thematic analysis	Wolverhampton, UK (West Midlands)	Ethnicity: Sikh ($n = 5$) Gender: Female ($n = 2$), male ($n = 3$) Age: Not reported Relationship: Spouses ($n = 2$), daughters-in-law ($n = 2$), sons ($n = 1$) UK Born: ($n = 1$) Total participants: 5

(Continues)

TABLE 1 (Continued)

Author(s), year	Title of paper	Aim of study	Methods	Study location(s), Total participants	Characteristics of study population—ethnicity, gender, age, relationship, number
Kevern et al. ⁵⁵	Religious Influences on the Experience of Family Carers of People with Dementia in a British Pakistani Muslim Community	To explore the role of religious beliefs, practices, and community networks in dementia care among British Pakistani Muslim carers	Qualitative study using semi-structured interviews and thematic analysis	Midlands and North of England	Ethnicity: British Pakistani Muslim ($n = 7$) Gender: Female ($n = 4$), male ($n = 3$) Age: Mean = 43 (range: 25 to 60) Relationship: Children ($n = 3$), grandchildren ($n = 3$), spouse ($n = 1$) UK Born: Not reported Total participants: 7
La Fontaine et al. ⁵⁶	Understanding dementia amongst people in minority ethnic and cultural groups	To explore perceptions of aging, dementia, and associated mental health difficulties among British South Asians of Punjabi Indian origin	A focus-group study with thematic analysis	Birmingham	Ethnicity: BAME, British South Asian ($n = 49$) Gender: Female ($n = 30$), male ($n = 19$) Age: Range = 17 to 61 Relationship: Mixed (family carers included) UK Born: Not reported Total participants: 49
Lawrence et al. ²⁶	Attitudes and support needs of Black Caribbean, south Asian and White British carers of people with dementia in the UK	To explore the caregiving attitudes, experiences, and needs of family carers of people with dementia from the three largest ethnic groups in the UK	Semi-structured interviews	London boroughs of Lambeth, Southwark, Lewisham, and Croydon	Ethnicity: Black Caribbean ($n = 10$), South Asian ($n = 10$), White British ($n = 12$) Gender: Female ($n = 25$), male ($n = 7$) Age: Range = 33 to 87 Relationship: Spouses ($n = 11$), children ($n = 18$), friends ($n = 3$) UK Born: Black Caribbean ($n = 4$), South Asian ($n = 2$), White British ($n = 12$) Total participants: 32
Mackenzie ²⁰	Stigma and dementia East European and South Asian family carers negotiating stigma in the UK	To identify the support needs of family carers from Eastern European and South Asian communities living in a northern England city	Qualitative study using semi-structured interviews, support group observations, and thematic analysis	Northern England	Ethnicity: Pakistani ($n = 11$), Indian ($n = 5$), Polish ($n = 4$), Ukrainian ($n = 1$) Gender: Female ($n = 12$), male ($n = 9$) Age: Not reported Relationship: Spouses ($n = 7$), daughters ($n = 8$), other relatives ($n = 6$) UK Born: Not reported Total participants: 21
Mukadam et al. ⁵⁷	Why do ethnic elders present later to UK dementia services? A qualitative study	To explore barriers and facilitators of help-seeking for dementia among minority ethnic (ME) and indigenous carers in the UK, comparing pathways to diagnosis	Semi-structured interviews and thematic analysis	Inner-city London	Ethnicity: White UK ($n = 4$), South Asian ($n = 5$), Black African/Caribbean ($n = 5$) Gender: Female ($n = 13$), male ($n = 5$) Age: Mean = 57 (range: 27 to 85) Relationship: Spouses ($n = 9$), children ($n = 6$) UK born: Black Caribbean ($n = 1$), Bangladesh ($n = 1$) Total participants: 18

(Continues)

TABLE 1 (Continued)

Author(s), year	Title of paper	Aim of study	Methods	Study location(s), Total participants	Characteristics of study population—ethnicity, gender, age, relationship, number
Nair et al. ⁵⁸	Experiences of Carers and People with Dementia from Ethnic Minority Groups Managing Eating and Drinking at Home in the United Kingdom	To explore how cultural identities and values influence South Asian carers' experiences, negotiation of the caring role, and interactions with formal services	A qualitative research design using semi-structured interviews and thematic analysis	Greater London area	Ethnicity: South Asian, Black Caribbean, Chinese, Mixed Chinese/White, North African Gender: Carers (8 female, 4 male); people with dementia (3 female, 2 male) Age: Carers = 55.25; people with dementia = 75.6 Relationship: Not reported UK Born: Not reported Total participants: 17
Nazir and Kevern ⁵⁹	Understanding and Awareness of Dementia in the Pakistani-Origin Community of Stoke-on-Trent, UK: A Scenario-Based Interview Study	To explore dementia awareness, cultural barriers, and help-seeking behaviors in the Pakistani-origin community	Qualitative study using scenario-based semi-structured interviews and thematic analysis	Stoke-on-Trent	Ethnicity: Pakistani-origin (n = 11) Gender: Female (n = 7), male (n = 4) Age: Range = 20 to 78 Relationship: Not reported UK Born: (n = 4) Total participants: 11
Regan ⁶⁰	Ethnic minority, young onset, rare dementia type, depression: A case study of a Muslim male accessing UK dementia health and social care services	To generate an understanding of the experiences and motivations of Mr. Q, a Pakistani, Muslim service user accessing UK dementia health and social care services	A qualitative case study using semi-structured interviews, clinical observations, informal discussions, and service provider interviews	West Midlands	Ethnicity: Pakistani Muslim (n = 1) Gender: 1 male Age: 56 years Relationship: Person with dementia UK born: Not reported Total participants: 1
Van den Heuvel et al. ⁶¹	Perspectives of Minority Ethnic Caregivers of People with Dementia Interviewed as Part of the IDEAL Program	To explore the experiences of dementia caregivers from Black Caribbean, Black African, and South Asian communities in England, focusing on motivations, consequences, and cultural contexts of caregiving	An exploratory descriptive qualitative (EDQ) approach using semi-structured interviews; thematic analysis was conducted using Braun and Clarke's model	England	Ethnicity: Black Caribbean/African (n = 10), South Asian (n = 8) Gender: Female (n = 17), male (n = 1) Age: 50+ (range: 30 to 79) Relationship: Daughters (n = 13), spouses (n = 3) UK-born: Not reported Total participants: 18
Zakir Hossain et al. ⁶²	Traditional Gender Roles and Effects of Dementia Caregiving within a South Asian Ethnic Group in England	To examine caring for a family member with dementia from a gender role perspective	Focus groups and semi-structured interviews	Portsmouth and London	Ethnicity: Bangladeshi (n = 27) Gender: Female (n = 14), male (n = 13) Age: Range = 37 to 76 Relationship: Spouses (n = 4), children (n = 18), daughters-in-law (n = 5) UK-born: (n = 5) Total participants: 27

3.2 | Stage 1: Rejection of social care

Rejection of formal dementia care was a conscious choice rather than due to lack of awareness, especially among South Asian and Black carers. Multiple interrelated factors shaped this rejection:

3.2.1 | Cultural and religious obligations

Strong cultural norms and religious beliefs consistently influenced preferences for family- and home-based care.^{26, 42, 47, 49, 55, 58, 61, 62} Caregiving was viewed as a moral duty embedded within cultural

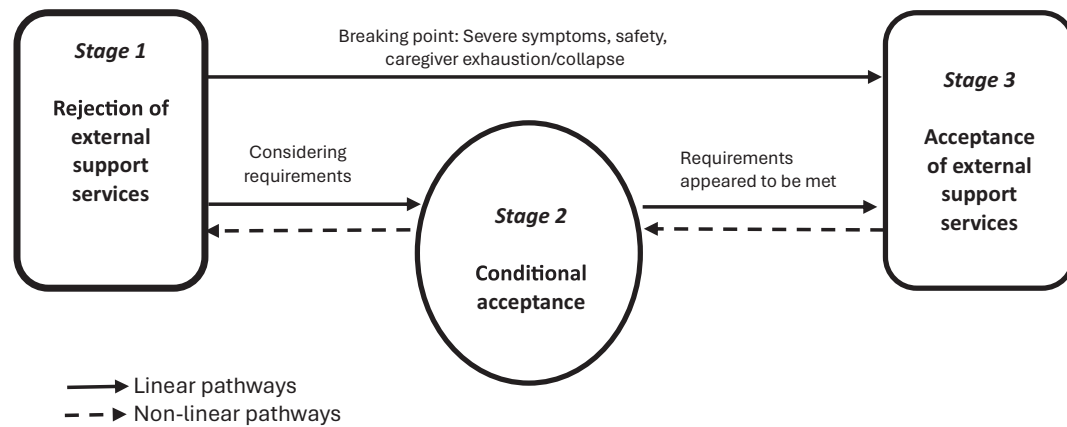


FIGURE 2 A three-stage model of dementia social care engagement in United Kingdom minority ethnic communities.

TABLE 2 Constructs explaining attitudes toward social care services among UK minority ethnic communities.

Subthemes (first-order constructs)	Themes (second-order constructs) (number of studies)	Overarching themes (third-order constructs)
Familial duty as moral and religious obligation	Cultural and religious obligations (n = 18)	Rejection
Intergenerational reciprocity		
Dementia is not a medical condition, a source of embarrassment	Stigma and shame (n = 15)	
Care homes as taboo		
Fear of social judgment (izzat/honor, abandonment, heartless)		
Mismatched cultural/religious provisions (halal, gender care, language)	Structural barriers (n = 14)	
Negative past experiences (neglect in hospitals/care homes)		
Wellbeing of loved ones will deteriorate in care home	Negative perceptions of care home's service and function (n = 13)	
Care homes are for end of life, palliative care		
Women as primary caregivers	Gendered expectations (n = 9)	
Male reluctance to outsource care		
Felt privilege, pride in caregiving and self-reliance	Dignity and pride (n = 6)	Conditional acceptance
Matched ethnicity and/or language formal carers	Culturally appropriate/sensitive Services (n = 12)	
Religious accommodations (halal, gender norms and care practices)		
Training, good standard of care over ethnicity and religion	Quality of care (n = 5)	
Dementia not a medical condition	Awareness of condition and support services (n = 8)	
Awareness of available resources		
Knowledge of purpose of social care services for dementia		
Trust in institutions (National Health Service, local authority, care homes)	Trust/confidence in social care (n = 2)	Acceptance
Financial/operational barriers and inflexible service	Structural flexibility (n = 4)	
Severe symptoms (aggression, incontinence)	Crisis-driven and safety (breaking points) (n = 4)	
Caregiver exhaustion		
Safety		
Approval from faith leader (Imam)	Religious endorsement (n = 2)	
UK-born caregivers more open	Generational shifts (n = 2)	
Social services as last resort when family cannot help	Exhaustion of family support (n = 2)	
Personal hygiene care	Specific tasks (domiciliary/home-based care) (n = 2)	
Cooking and cleaning		

identity, often perceived as incompatible with external support for both South Asian and Black Caribbean carers. For instance, participants expressed sentiments such as “*Children must care for parents*” and “*It’s my responsibility*.”⁶² Intergenerational reciprocity further reinforced this expectation, framing caregiving as repayment for parental investment.⁴⁷ Religious teachings, particularly within Muslim communities, echoed and reinforced these values: “*The Quran says don’t say ‘Uff’ to your parents*.”⁵⁵ Black Caribbean carers also viewed caregiving as a cultural obligation: “*It is in our culture. We care for each other until the very end. When people do go into care homes, into hospital, it is at the very last*.”⁴²

3.2.2 | Stigma and shame

Dementia was often stigmatized as “madness” or a taboo, leading families to conceal the condition and avoid social services to protect family honor (izzat).^{46, 51} Care homes were widely rejected, associated with abandonment and moral failure and often labeled “pogol ghor” (madhouses).⁴⁹ Fear of social judgment was a strong deterrent: “What will the community say? That man is abandoning his parents.”^{41, 43, 46, 48, 51, 56, 62, 63} These fears of shame and social censure were powerful deterrents.

3.2.3 | Structural barriers

Perceptions that care homes fail to meet religious and cultural needs – such as halal food, gender-appropriate care, and language accessibility – combined with previous negative experiences of institutional care, eroded trust in formal services.^{42, 48–51} Reports of neglect and poor hygiene further discouraged use.⁶²

3.2.4 | Negative perceptions of care homes

Care homes were seen as unfamiliar, isolating environments accelerating decline in people with dementia.^{42, 47} They were often associated with end-of-life care, contributing to family reluctance.

3.2.5 | Gendered expectations

Caregiving responsibilities disproportionately fell on women – wives, daughters, daughters-in-law – due to cultural and religious norms.^{55, 58} Male involvement was limited, and female carers reported significant emotional strain, isolation, and relationship stress.^{26, 54} Some families shared caregiving tasks among siblings,⁵⁰ but gendered norms largely prevailed.

3.2.6 | Dignity and pride

Caring for elders was linked to notions of dignity, pride, and self-reliance: “*It is a privilege and rewarding to care for mum*,” illustrating emotional investment in family care.^{40, 47, 63} Some in the Caribbean community concealed relatives’ nursing home placement to protect dignity.⁴²

3.3 | Stage 2: Conditional acceptance of social care

Families demonstrated openness to formal care when certain conditions were met:

3.3.1 | Culturally appropriate services

Carers in 10 studies emphasized the importance of culturally and linguistically appropriate care, including carers from the same community, halal food, culturally sensitive activities, and respect for religious observance.^{48–51, 56, 62} Another facilitator to accepting external support was same-gendered formal carers, particularly for Muslim male individuals with dementia. One participant lamented about a female social carer who did not know the way to wash her father and that a male Muslim carer would know the appropriate way.⁶² Some participants also expressed the need for culturally and linguistically accessible information; one study recommended multilingual printed materials and audio resources to better meet the needs of minority ethnic communities.⁴⁴

3.3.2 | Quality of care

In five studies, quality was prioritized over ethnic or religious concordance as reported by Bangladeshi and Pakistani Muslim families who used home-based care.^{26, 42, 47, 52, 60} A Bangladeshi daughter said, “*If it’s a Black, White, Asian person, it really doesn’t matter, as long as they do the caring properly, my parents won’t have any problems either*.”⁴⁷ Another Bangladeshi carer expressed: “*As long as the carers are doing the job properly, it doesn’t matter whether they’re Christian, Muslim, Buddhist*.”⁴² A Pakistani participant extended good quality of care to companionship and understanding.⁵²

3.3.3 | Awareness of services

Limited knowledge about dementia and available resources was a barrier; increasing awareness helped foster engagement: “*I had to educate my family that dementia is a medical condition*.”⁵⁷

3.3.4 | Trust and confidence

While families generally expressed trust in HS clinicians for diagnosis and treatment, as well as confidence in the local authority's vetting of carers for social care services, the perception that such services were only accessible in time of crisis situations appeared to limit early engagement with social support.⁴⁴ Trust in social services, particularly residential care homes, was also due to concerns about poor quality of care, leading to families to avoid the option of care homes.⁴⁰ In addition, some carers reported heightened fear about the risks of COVID-19 infection within care home settings, reinforcing their reluctance to consider residential care.

3.3.5 | Structural flexibility

Families expressed the need for more flexible, affordable, and accessible care packages.^{42, 44, 45, 62} One carer noted that the number of incontinence pads provided by the council as part of home-based care was insufficient to meet daily needs.⁶² Financial barriers were also highlighted, such as the experience of a Black Caribbean carer who, after a lengthy search for a culturally appropriate day care center, found the service unaffordable.⁴² Providers also confirmed the issue with funding affecting adequacy of service provision.⁴⁴ Additional challenges included language barriers, long delays in application process, and culturally insensitive care provision.⁶² These structural constraints often left families in a stage of conditional acceptance, where available care was acknowledged but experienced as inadequate.

3.4 | Stage 3: Acceptance of social care

Acceptance of social care was typically crisis-driven, occurring when family care became unsustainable or safety was compromised:

3.4.1 | Crisis and safety concerns

Families often accessed formal care reluctantly at advanced dementia stages: "After 10 years, we finally asked for help, we could not do it anymore."²⁶ Safety concerns could override stigma: "What good is izzat if Mama burns the house down?" (Bangladeshi daughter).⁵⁵ Triggered by crises and burnouts, four families skipped conditional acceptance to accept social services.

Healthcare professionals noted families often tried to manage privately until situations became unmanageable: "They only seek help when they're falling off the rails. The family will try to manage behind closed doors first"⁴⁴ and "The family tend to keep it amongst themselves and only when the problems start to become unmanageable at home ... they present to the services ... due to the advanced dementia with behavioural problems."⁴¹

3.4.2 | Religious endorsement

Although the evidence is limited to two studies involving Pakistani and Bangladeshi carers, support from faith leaders was reported as legitimizing the use of formal care, providing moral reassurance to the carers. For example, "The Mufti (imam) who witnessed the aggressive and violent behaviour of my mum said that we are permitted to seek expert support."⁵⁵ Such religious validation provided families with moral reassurance to pursue formal care without compromising their religious-based obligations.⁵¹

3.4.3 | Generational shifts

In two studies, UK-born South Asian carers showed greater openness to formal services, especially when culturally competent.^{26, 46, 64}

3.4.4 | Exhaustion of familial support

Social care was often considered a last resort, sought only after family assistance was exhausted: "If my siblings don't help, then I will seek social services."⁵⁹

3.4.5 | Specific tasks (personal hygiene care and house chores)

Some carers engaged social care services specifically for personal hygiene support at home.^{52, 53} For example, a Muslim daughter explained that her mother preferred a formal carer for hygiene needs, remarking, "Mum would prefer if somebody else was helping with personal care than me." Similarly, a Caribbean carer sought formal support for his wife's hygiene care out of desperation for help. Beyond personal care, others described the need for social services to assist with domestic tasks such as cooking and housekeeping.⁵² However, even when families accepted home-based care, their engagement was often accompanied by caution. Many carers reported feeling the need to remain present or closely monitor formal carers during visits, reflecting ongoing concerns about the quality and appropriateness of the support provided.

3.5 | Trajectories of engagement: linear and nonlinear pathways

Linear as well as non-linear pathways are observed in the social care engagement model (Figure 2).

3.5.1 | Linear pathways

Linear pathways were observed in instances where a crisis precipitated a sudden shift from rejection to full acceptance of services. In these cases, families initially resisted formal support but engaged only when the demands of family care became untenable. Such crisis-driven decisions often reflected an absence of gradual negotiation or conditional acceptance, highlighting the reactive rather than proactive nature of social care uptake. As one care explained: “*We didn't seek help until the violent behaviours started.*”⁴¹ Other crises that are triggers included fire hazards, hygiene-related incidents such as defecation in appropriate places, and caregiver burnout. These accounts were particularly noted among Indian, Bangladeshi, Pakistani, and Black Caribbean carers.

In addition, a gradual progression – from rejection to conditional acceptance, and in some cases to fuller acceptance of social care support when specific conditions were met – was reported. ME families often sought additional support at the home only when circumstances demanded it. As a Black carer explained: “*You don't want to bring in outside agencies unless you have to... and when you can't deal with it, we'll go to outside agencies who will help us deal with it. That's where we're coming from.*”⁵⁷

3.5.2 | Non-linear pathways

In contrast to linear trajectories of engagement, non-linear pathways were also identified, characterized by oscillation between uptake and rejection, as well as withdrawal following poor experiences or resistance from the person with dementia. In some cases, this resulted in unsustainable service use as reflected in carers' accounts: “*... this was my first experience of having so many carers... but my mum told the formal carer to go home*” (Indian carer), and a Bangladeshi Muslim carer said, “*... it's very difficult. She basically refused their assistance because they did not do the job right. So, whilst we appreciate the compliment, it also creates another job...*”⁴⁷

Another example of non-linear trajectory-involved parallel pathways, where family members disagreed over the use of social care service, with some members endorsing engagement and others resisting and preferring family care. A Caribbean carer explained her objection to her brothers' proposal to place their mother in a care home: “*They said, 'Put her in a home.' I said, 'How can I put her in a home where she doesn't speak the language, there's her food, the TV channels she is familiar with? It would just push her back... She would just lie there and cry.*”⁴²

3.6 | Evidence of engagement by social care modalities and ethnicity

Table 3 summarizes the extent to which the 25 included studies reported evidence on the service modalities and the ethnicity of families across the three stages. Evidence of *Stage 1: Rejection* of formal dementia social care appeared universally in all the studies, reflecting

the strong cultural and religious emphasis on family-based caregiving among ME communities in the UK. *Stage 2: Conditional acceptance* was evident in 14 studies (56%), where families cautiously engaged with external services only when specific cultural, religious, or quality-related conditions were met. *Stage 3: Acceptance* appeared in eight studies (32%), typically at crisis points such as caregivers' exhaustion or safety concerns, or when external services received endorsement from faith leaders or professional figures (doctors). These distributions illustrate that while rejection remains the norm, engagement with social care services tends to occur gradually and reactively rather than proactively.

Ethnic patterns with this three-stage framework highlight both shared and distinctive pathways, influenced by intersecting characteristics. South Asian families (Pakistani, Bangladeshi, Sikh [Indian]) dominated the evidence base, featuring in 18 of the 25 studies. Within this broad category, Bangladeshi and Pakistani carers appear to be more likely to progress toward acceptance, often through home-based or task-specific services legitimized by faith leaders or crisis need, whereas Indian/Sikh carers tended to remain within conditional engagement, seeking culturally congruent support. Black Caribbean families shared similar reject patterns but displayed distinctive narratives of self-reliance and crisis-triggered help seeking, while Chinese participants were represented only in one study – mainly rejected services due to limited awareness and language barriers. These findings emphasize that progression across stages is contingent not only on cultural values but also on intersecting factors such as faith identity, gender, and migration history, shaping how families negotiate care responsibilities and formal social care support.

4 | DISCUSSION

This synthesis aimed to develop a conceptual understanding of attitudes of ME people toward social care services for dementia in the UK. The line of argument illustrates that ME families' decisions about formal dementia social care are shaped by the interaction of cultural norms, trust in social services, and crisis events. Families overcome resistance due to duty and stigma to accept social care only when fit and/or endorsed by faith leaders. Their journeys often appear linear – moving from rejection to conditional acceptance and finally to acceptance of formal dementia care, and from rejection to acceptance.⁵⁷ However, non-linear pathways were also identified, where oscillations, setbacks or reversal occur from acceptance to rejection because services were inadequate or refused by the person with dementia.⁴⁷ Parallel pathways were also observed where divergent attitudes within families, such as disagreements between siblings over residential care versus family care, created parallel and often conflicting journeys.⁴² Crises, culturally sensitive services, and changing social and cultural norms act as tipping points to the acceptance of social care. Therefore, while the overall trajectory may seem progressive, the underlying movement is dynamic and contingent rather than a smooth, linear progression.

TABLE 3 Evidence supporting social care service engagement model by UK minority ethnic communities.

Ethnicity used to refer to participants in studies	Study reference	Rejection	Conditional acceptance	Acceptance	Modality of social care services discussed
South Asian	Bowes and Wilkinson ⁴⁵	✓	✓		Day care center
	McKenzie ²⁰	✓			Home-based care
	Z. Hossain et al. ⁵⁰	✓	✓		Home-based care
	James et al. ⁵²	✓	✓		Home-based care
	La Fontaine et al. ⁵⁶	✓			Social care services in general
	Atcha ⁴¹	✓	✓		Home-based care
	Beattie et al. ⁴⁴	✓	✓		Systemic/structural barriers faced in engaging with social care
	Baghirathan et al. ⁴²	✓			Respite
	Baghirathan et al. ⁴²			✓	Home-based care
Bangladeshi	Hossain et al. ⁶²	✓			Home-based care
	Hossain et al. ⁴⁹	✓	✓	✓	Home-based care, residential care homes
	Hossain and Khan ⁴⁸	✓			Home-based care
	Hussain et al. ⁵¹	✓			Residential care home
	Herat-Gunaratne et al. ⁴⁷	✓	✓	✓	Home-based care, Residential care home, Day care center
Pakistani	Regan ⁶⁰	✓	✓	✓	Home-based care
	Kevern et al. ⁵⁵	✓	✓		Home-based care
	Nazir and Kevern ⁵⁹	✓	✓	✓	Social care services, residential care home
Indian including Sikh	Juttla and Moorland ⁵⁴	✓			Home-based care
	Juttla (2014)	✓	✓		Day care center, home-based care
	Herat-Gunaratne et al. ⁴⁷	✓	✓	✓	Home-based care, residential care home, day care center
	Nair et al. ⁵⁸	✓			Residential care home, home-based care
Black Caribbean	Baghirathan et al. ⁴²	✓	✓	✓	Daycare center, home-based care
	Lawrence et al. ²⁶	✓	✓		Home-based care, social care services
	Mukadam et al. ⁵⁷	✓	✓		Social services
Black, and BME (Black and Minority Ethnic)	Juttla and Moorland ⁵⁴	✓			Home-based care
	Armstrong et al. ⁴⁰	✓			Residential care, home-based care
	Bartlett et al. ⁴³	✓	✓	✓	Social services
	Carter et al. ⁴⁶	✓	✓		Home-based care
	Victor et al. ¹	✓	✓		Home-based care
Chinese	Baghirathan et al. ⁴²	✓			Health and social care services

By integrating fragmented UK qualitative evidence, this synthesis contributes a conceptual model that extends existing international frameworks on help seeking and service utilization. Like established theoretical frameworks, such as Andersen's Behavioral Model of Health Services Use, our model recognizes the influence of predisposing (e.g., cultural norms) and enabling (e.g., culturally sensitive services) factors, shared by families living outside the UK as reported in previous studies.^{6–8,65} However, our model makes a distinct departure by its central emphasis on the non-linearity and dynamism of the engagement process. It captures the reality of setbacks, negotiations, and parallel decisions that characterize the lived experience of ME families navigating dementia care, offering a more nuanced and applicable theoretical tool for this context.

In this model, at the rejection stage, refusal of social care services is underpinned by strong familial caregiving norms, religious obligations, stigma, and mistrust of institutional care. These findings echo existing literature on collectivist cultures such as Chinese people where caregiving is a moral duty that traditionally remains within the family.^{28,66,67} The gendered nature of caregiving responsibilities, with women disproportionately burdened, is also consistent with previous research in the United States and Australia.^{6,8,65} Our findings therefore can be generalized to families caring for people with dementia and ME populations living in other Western countries.

Conditional acceptance emerges as a critical negotiated stage, where families cautiously engage with social care services provided their cultural and religious needs are respected. The importance of culturally congruent care providers, religious accommodations, and assurance of quality care underpins this engagement and actionable areas for service design improvements. This stage represents a delicate balance between cultural preservation and practical caregiving needs.

Acceptance is often reactive and crisis-driven, occurring only when caregiving demands overwhelm families or when endorsed by trusted faith leaders. This crisis-driven help-seeking pattern reflects systemic gaps in early intervention and preventative support, aligning with prior evidence on delayed dementia care engagement in ME populations.^{52,56,57,68} Such delays may contribute to worse outcomes for both people living with dementia and their caregivers.

It is crucial to acknowledge that transitions across these stages in our model are not shaped by culture alone. Although the included studies did not examine the intersectionality of dementia caregiving, we found within the data that characteristics such as gender, ethnicity, migration history, and religion intersected to amplify or mitigate caregiving burdens and openness to formal social care. For example, we found that South Asian women who migrated through marriage were often assigned rigid caregiving roles as daughters-in-law and were more likely to reject external support due to cultural norms and limited knowledge of health systems. In contrast, UK-born female carers (daughters and daughters-in-law), socialized within both cultural and British normative contexts, were more likely to view social care as a legitimate resource to reduce their burden. This greater familiarity with services enabled them to navigate and engage with providers more proactively. This intersectional lens needs further investigation as this perspective is vital for understanding the het-

erogeneity of experiences within ME communities and for tailoring support effectively.

4.1 | Policy and practice implications

Beyond broad calls for cultural tailoring, our synthesis identified specific, testable levers for intervention: provision of language-matched dementia navigators embedded in local pathways; routine integration of faith leaders into outreach strategies; flexible care packages that allow task-specific support (e.g., hygiene, food preparation); and gender-concordant staffing protocols. These mechanisms are amenable to evaluation using implementation framework such as Reach, Effectiveness/Efficacy, Adoption, Implementation, Maintenance⁶⁹ and Consolidated Framework for Implementation Research⁷⁰ which can guide assessment of reach, adoption, and sustainability across diverse service providers.

4.2 | Conceptual contributions

Conceptually, our synthesis challenges service providers to transcend superficial cultural competence toward an intersectional, relational approach. This approach acknowledges the complex interaction of culture, gender, socioeconomic status, religion, and migration history in shaping social care attitudes and decision-making. Embracing such complexity is essential for equitable dementia care delivery in an ever increasingly multicultural society.

4.3 | Strengths and limitations

This review synthesizes a broad range of qualitative evidence and proposed a novel conceptual framework for understanding dementia care attitudes in UK ME populations. It is the first review examining attitudes of ME people toward dementia social care in the UK and covering a broad range of formal community social services. Nevertheless, several limitations warrant consideration. The included studies did not explicitly examine utilization of social care for dementia and focused mostly on South Asian and Black Caribbean groups. Other ME groups such as the Black African and Chinese perspectives are notably under-represented in the evidence base. Thus, our findings should not be over-generalized across all ME communities.

The included studies were also biased toward urban, English-speaking participants and toward caregivers rather than people with dementia. Furthermore, despite clear cultural and religious distinctions within the South Asian subgroups, some studies presented Pakistani, Bangladeshi, and Indian participants as a homogenous category. Our synthesis highlighted emerging differences in caregiving attitudes toward social care among these groups; however, further work is required to explore intra-South Asian and wider ME variations in religious framing, migration histories, and acculturation processes.

This study extends existing theoretical frameworks on help seeking and dementia-related social care use by evidencing the non-linear nature of engagement pathways. Families often oscillated between conditional use and withdrawal following negative experiences and exhibited internal disagreement over the appropriateness of formal care, creating parallel or disrupted trajectories of engagement. Such patterns underscore that social care uptake is rarely sequential or uniform but dynamically shaped by shifting family, cultural, and structural factors. Future research should investigate these patterns longitudinally to better understand how families navigate transitions across care stages.

While this review did not explicitly examine period effects, the findings suggest that engagement with social care has evolved alongside major policy and societal shifts. The included studies, spanning 2003–2024, encompass the implementation of the Care Act 2014, the austerity period, the COVID-19 pandemic, and health and social care reforms. Participants described delays in application processing, poor service quality, financial constraints, and persistent lack of cultural appropriate provision. Pandemic experiences in particular amplified fears of institutional care and reinforced avoidance of residential care. Together, these observations indicate that engagement with social care is context-dependent and responsive to broader policy, funding, and public health environments. Future research should systematically examine how such period effects impact the thresholds between rejection, conditional acceptance, and full acceptance within the three-stage model.

5 | CONCLUSION

Improving dementia social care uptake for ME communities requires culturally nuanced, gender-sensitive, and structurally flexible services delivered through trusted institutions and community networks. Proactive engagement and early support are critical to prevent crisis-driven service uptake. By embracing the complex interplay of cultural values, religious beliefs, and systemic factors, policymakers and providers can better meet the needs of diverse families affected by dementia ([Supporting Information](#)).

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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