**Understanding barriers faced by BAME communities**

**in accessing loneliness services**

 **A report for the British Red Cross and Co-op partnership**

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1. **Introduction**

A wide range of research has indicated that loneliness is an increasingly important issue. In the last few decades loneliness research has primarily focussed on older people with organisations such as Age UK predicting future rises in loneliness, as the proportion of the older population in the UK increases and as growing numbers of older people live alone (Davidson and Rossall 2014). However, it is increasingly becoming recognised that loneliness can affect people of all ages, and in their 2016 report the Co-op and the British Red Cross identified that loneliness can particularly affect people at major life transitions (including, for example, the onset of a health condition, bereavement, becoming a parent) (Kantar Public 2016). Other research has found that disabled people, carers, migrants and refugees, as well as young people can experience loneliness or social isolation at some stage or throughout their lifetime.

Academic research indicates a degree of variation in loneliness and social isolation among Black, Asian and Minority Ethnic (BAME) groups and again this has often focussed on loneliness in later life, suggesting that as members of the BAME population age they are more likely to experience health inequalities and utilise health services to a greater extent (Scheppers et al. 2006; Victor, Burholt, and Martin 2012). Social isolation and loneliness have negative associations with health across racial and ethnic groups, with loneliness impacting on physical health, and social isolation having a profound effect on mental health (Miyawaki 2015). Within the UK, people from BAME communities experience more health, social and economic inequalities compared to those from non-BAME communities (Jivraj and Simpson 2015). Inequalities may result in fewer opportunities for social participation, which increases the risk of becoming isolated throughout the lifecourse (Jivraj and Khan 2013). For some BAME groups language barriers are also a contributory factor and can have an impact when health is involved (Simkhada et al. 2015). The literature fails to address the diversity amongst sub-groups of BAME people and whether different dimensions of social isolation have varying effects across a wide range of ethnicities.

This report presents findings from a research project undertaken by the Centre for Loneliness Studies, University of Sheffield and commissioned by the British Red Cross and Co-op partnership which aimed to understand the barriers (and facilitators) faced by members of BAME communities in accessing loneliness services. As part of this study we aimed to identify ways in which service providers may improve referrals, and to contribute to and influence policy change more broadly in this area. The research emerged, in part, due to findings of an interim evaluation of the British Red Cross Community Connectors programme which indicated that service users did not always reflect the ethnic diversity of the localities within which they are based (ScHARR 2018). The study also builds on the findings from *Trapped in a Bubble* (Kantar Public 2016)which focussed on the triggers of loneliness amongst individuals. We hope that the findings presented in this report will help guide policy makers and practitioners to ensure that BAME communities are better enabled to benefit from service provision that can support those who are experiencing, or at risk of experiencing, loneliness.

Two additional connected pieces of research were commissioned by the British Red Cross and Co-op partnership at the same time: a qualitative study of the barriers to connection for people experiencing loneliness at key life transitions which was undertaken by the same research team at the University of Sheffield (Wigfield *et al.* 2019); and a quantitative study designed to explore more about the nature and experience of loneliness among BAME communities carried out by Runnymede (Haque *et al.* 2019).

***Lines of enquiry and research questions***

The study focussed on exploring five main research questions, each of which form key sections in this report:

1. What existing referral practices/ key referral routes are adopted by services?
2. What factors act as facilitators to involvement of BAME communities in loneliness services?
3. What factors act as barriers to involvement of BAME communities in loneliness services?
4. How can service providers ensure BAME communities can benefit from loneliness service provision?
5. What policy responses can facilitate more effective referral routes more broadly?
6. **Research Methods**

A six stage, qualitative study was undertaken, and the fieldwork for the study was carried out between September and November 2018. The research study draws on: interviews with 24 stakeholders who were representatives of service providers aiming to tackle social isolation and/or loneliness and/or support BAME communities; and interviews and a focus group with 22 people from BAME communities experiencing varying degrees of social isolation and/or loneliness and from various ethnic backgrounds (including Bangladeshi, Chinese, Iranian, Pakistani). They range in age from the mid 20s to the eldest at 87 and the majority (17/22) are female. Some of the individuals have health conditions and/or caring responsibilities, and whilst most live in the community, some are living in sheltered accommodation.

The six stages of the study are as follows:

***Stage 1: Rapid Literature Review*:** a small rapid literature review was carried out and included academic and grey literature to identify existing barriers to services. The contents of the literature review were used to help inform and guide the research tools and to help to identify where current referral practice may be inadvertently excluding people from BAME communities.

***Stage 2: Identification of three study sites:*** in discussion with the British Red Cross and Co-op partnership we identified three sites in which to carry out the research study: Islington: Oldham; and Newcastle. These localities were selected to represent a mix of areas where the British Red Cross and Co-op Community Connectors programme (a service aimed at reducing loneliness, provided to individuals by connecting them to other services, with the aim of delivering it primarily through volunteers) had experienced different levels of engagement from BAME communities.

*Islington* is located in north London and almost a third (32%) of the population is BAME, with some of the largest BAME communities being Black (13%), Asian (9%) and mixed race (6%) (ONS 2016). Islington’s Community Connector programme has been fairly successful in engaging with BAME communities; prior to commencing the fieldwork for this report one quarter of the Community Connector service users were recorded as being from a BAME community (British Red Cross internal service user statistics, 2018).

*Oldham* is located in Greater Manchester and 16 per cent of the population is BAME, with the largest BAME community being South Asian (13%) (ONS 2016). Like Islington, the Oldham Community Connector programme had experienced relative success in reaching the town’s BAME population; prior to commencing the fieldwork for this report 30 per cent of its services users were from a BAME community (British Red Cross internal service user statistics 2018).

*Newcastle* is located in the North-East and was selected because it has a lower BAME population and because the Community Connector programme had found it more difficult to engage with BAME communities. Just under one fifth of Newcastle’s population, according to the 2011 census, were BAME (19%), many of whom were Asian (ONS 2016), and prior to commencing the fieldwork for this study only eight per cent of the Community Connector service users were from a BAME community (British Red Cross internal service user statistics 2018).

***Stage 3: auditing and mapping review of existing services:***

To assess current service provision which offers potential benefit to participants affected by loneliness across three localities we carried out a desk-based scoping review of key documents and on-line resources in each area. The Campaign to End Loneliness framework which sets out the full range of interventions needed from stakeholders across the community, beyond the health and social care sector, to support older people experiencing, or at risk of experiencing, loneliness was used as a broad tool for identifying which services should be included and excluded from the search (<https://campaigntoendloneliness.org/guidance/>). As part of this review, we sought to identify and examine information on: the nature of the service; current referral processes; if the service involved a cost to the service user; who the referrers are (including self-referral); which groups of people are, and are not, accessing the services; any service outcome data; and identified gaps in provision. We included services which targeted all ages not just older people. A short template was devised to capture this information. In many cases the information that was required to complete the template was not available either in relevant documents or on-line. Where possible the research team contacted the individual services in an attempt to fill missing gaps in data but time and resource constraints meant that not all service providers could be contacted directly and, when they were contacted, staff themselves did not always have this information as it was not always collated and recorded. Gaps in data were particularly evident in relation to the types of service users and the outcomes of the service.

In total 245 services were mapped across the three localities: 87 in Islington; 121 in Oldham; and 37 in Newcastle. Following data cleansing 221 of these services were included in the analysis. Some of the organisations that have been removed were, for example, commissioners or Local Authority departments rather than individual service providers. It should, however, be noted that this exercise was carried out to provide a snapshot of key relevant services in each locality and additional services that have not been mapped will inevitably exist.

***Stage 4: Telephone interviews with key stakeholders in each locality:***

24 telephone interviews were carried out with stakeholders, eight in each of the three localities. The stakeholders selected for interview were identified in the mapping review (stage 3) and represented organisations that work with, and provide services for, local BAME community groups more broadly such as faith organisations, health providers and housing associations, alongside those which provide services aimed at alleviating loneliness. These interviews aimed to explore details about: the organisations; the loneliness services being offered; referral routes; users of services; as well as the stakeholder’s views on provision of services for BAME communities, barriers and facilitators to engagement; and examples of the kinds of strategies that are successful in engagement and referrals. Many of the stakeholders represented third sector organisations but some were also public sector or ALMOs (Arms Length Management Organisation). A summary of the kinds of services represented by the stakeholders interviewed is provided in Appendix 1.

***Stage 5: Focus groups and/or individual interviews with current Community Connector service users***

Eight current services users from BAME communities were interviewed across the three localities, comprising three individual interviews in Islington, one individual interview in Newcastle, and four individuals who participated in a focus group in Oldham. The interviews and the focus group aimed to gain insight into the participants’ experiences of referral pathways, why they chose to get involved in the service, as well as any identified opportunities and barriers they have experienced. It should be noted that despite being provided with links with individual community connectors in each locality the vulnerable nature of the service users being supported meant that arranging either interviews or focus groups was challenging. A summary of the key characteristics of the individuals who participated both the interviews and focus groups is provided in Appendix 1.

***Stage 6: Interviews with lonely BAME non-service users***

13 in-depth interviews with people from BAME communities who were identified as potentially being lonely and currently not accessing loneliness services were interviewed; five in Oldham and nine in Newcastle. The interviews explored the participants’ experiences of loneliness and any barriers to service use that they had experienced. A summary of the key characteristics of the individuals who participated in the interviews is provided in Appendix 1. We originally aimed to carry out 15 interviews across all three localities but unfortunately it was not possible to interview any appropriate individuals in Islington as the leads that were explored did not provide any relevant contacts. The tight timeframe, budget, and distance of the research team from the locality made this task more difficult.

***Recording and analysing data***

Where possible, and with the permission of the participants, all interviews/focus groups were audio-recorded and extensive written notes taken. All data were anonymised and analysed. As the data gathered were qualitative, a thematic technique was designed to capture a range of issues and any similarities/differences across respondents.

***Challenges of studying loneliness among BAME communities***

A number of challenges were encountered by the research team, when attempting to undertake the empirical research for this study. Firstly, it was difficult to identify and recruit appropriate people from BAME communities to be interviewed. Those lonely individuals accessing the existing Community Connectors programme were reported by the Community Connectors as experiencing a multitude of complex issues relating to social isolation and/or loneliness and therefore arranging interviews with them for research purposes was not always possible. Many of them were particularly vulnerable, for example experiencing mental ill-health and so arranging a research interview was not always deemed appropriate. Those individuals who were lonely but not currently accessing services were even more difficult to identify because there was no organisation or support service which the researchers could ask to identify them. Secondly, and linked to the previous point, it was not always easy to identify if an individual is lonely and therefore appropriate to interview until the interview had commenced. As many of these individuals are experiencing multiple challenges ethically we were not able to screen them out at the early stages of the interview. For most of the interviewees it had taken a lot of courage and determination to agree to be interviewed. Some would have been devastated had we used a screening question and then told them that they were not required because they did not meet our criteria. Thirdly, even if we had felt able to use a screening question to help identify appropriate individuals to interview, the findings of our interviews suggested that identifying if people are lonely through either a validated loneliness scale (such as the UCLA) and/or a single direct question asking if they are lonely would not work for various reasons: 1) the UCLA loneliness scale is only validated for self-completion and so to be confident in using this we would have had to circulate a self-completion survey prior to arranging the interview; 2) although the UCLA scale has been validated for use in some different languages many of the interviewees who speak English said they did not understand some of the terms used in the scale. In Oldham, for example, four of the five participants struggled to understand the UCLA scale questions. Four participants asked what the word ‘companionship’ meant, and three participants struggled to understand what the phrase ‘left out’ meant; 3) throughout the interviews the researchers asked interviewees if they were lonely using a variety of different questions and techniques (sometimes direct and sometimes indirect) and quite often individual responses were inconsistent. For example, in Newcastle one participant without prompting specifically about loneliness said that although she is not socially isolated in the sheltered accommodation she feels lonely, but on the UCLA scale her score was calculated to be five (not lonely). Some of the reasons for variation in responses relates to the type of question asked, some relates to a stigma associated with loneliness meaning that individuals are reluctant to admit to being lonely, and some of it reflects the way in which individuals can move in and out of feelings of loneliness – even within an the short spaces of an interview when they are recalling different aspects of their lives.

***Structure of the report***

The remainder of the report is divided into six sections, each of which addresses a separate research question or theme. Section three explores some of the existing literature and research around access to services for BAME communities and sections four to seven report on the findings of the empirical study. Section four looks at the existing referral practices/key referral routes that are adopted by services in the three localities; section five examines the factors that can act as barriers to involvement of BAME communities in loneliness services; section six explores the factors which can facilitate the involvement of BAME communities in loneliness services; and section seven provides some conclusions.

1. **Background insight into existing literature**

The research team carried out a summary rapid review of relevant literature which has explored the barriers and facilitators to BAME communities accessing services. The review certainly does not represent a comprehensive analysis of literature in this field, nor was it meant to. However, it does serve to help identify where current referral practice may be inadvertently excluding people from BAME communities which we then explore in more detail through the empirical study. There is scant literature which specifically considers access to loneliness services and therefore this review explores findings related to broader service participation, specifically for BAME communities who may be vulnerable to loneliness, for example through experiencing mental health or deprivation. Indeed existing literature refers to an under-utilisation of services among BAME communities across all sectors, including health and social care services (Bhattacharyya and Benbow 2012) and in community participation activities more generally (Bajekal *et al.* 2004).

Some key issues emerged from the literature which are outlined below and which are explored further in the empirical study: the role of informal networks and support; trust and ‘trusted’ organisations as service providers; culturally sensitive services, stigma and language; differential gender access to services.

***The role of informal networks for some BAME communities***

Participation in programmes generally, and those which aim to reduce loneliness and social isolation specifically, can vary enormously by ethnicity, but some evidence suggests that some BAME communities may be more likely to access informal rather than formal support. Research and programmes which have explored engagement of African Caribbean people in mental health (McLean *et al*. 2003) and loneliness services (Wigfield and Alden 2017), for example, found that informal social networks were of particular importance, with many community members relying on these, rather than on more formal services. Rochelle and Shardlow (2013) and Huang and Spurgeon (2006) similarly found a reliance on informal networks and lower likelihood of seeking formal services among Chinese communities across the UK and in Birmingham respectively.

Whilst some members of some BAME communities may access informal networks, research suggests they are less likely to use community services, apart from religious activities (Collins and Wrigley 2014). Some BAME communities are more likely to attend religious activities than white communities (Collins and Wrigley 2014) and McLean et al. (2003), during their research of an African Caribbean community, found that the religious activity, through attending Church, was particularly important. However, beyond participation in religious activity, BAME involvement in community activities is sometimes limited. For example, only six per cent of Chinese survey participants in Birmingham frequently got involved in community services (Huang and Spurgeon 2006). Though Huang and Spurgeon did not explore this in detail (due to the quantitative nature of the research), Chinese participants interviewed said they preferred to seek help through their own social networks.

***Trust and ‘trusted organisations’ as service providers.***

Issues of trust were also identified with regard to both organisations that work within communities and also in relation to trust between members of communities. Collins and Wrigley (2014) found there was a lack of trust among community members who come from different South Asian backgrounds. Meanwhile distrust of organisations offering services was a key finding in Campbell *et al’s* (2004) qualitative research of an African Caribbean community. Safe ‘trusted’ venues were viewed as important, where people may be more willing to attend an activity if it is based at a school, GP surgery or church, rather than a community centre (Collins and Wrigley 2014). Age Concern Coventry identified that offering outreach services where people already meet was an effective way of engaging BAME communities (Bhattacharyya and Benbow 2012). Mclean et al. (2003) found that informal support networks, such as church groups worked well as a means of encouraging BAME communities to try out services. The importance of ensuring flexibility, and the ability to adapt to local needs, was also viewed as important, as was ensuring regular contact (Collins and Wrigley 2014). A recurring theme in the literature appears to be the effectiveness of ensuring regular contact and suitable venues where people feel comfortable (Bhattacharyya and Benbow 2012; Collins and Wrigley 2014). Bhattacharyya and Benbow (2012) found that offering outreach in places where BAME communities go can also work well.

***Culturally sensitive services, stigma and language***

Much existing literature which considers services across sectors refers to the need to address language and culture when providing services (Butt and O’Neil 2004). Some evidence suggests organisations may inadvertently create barriers due to the language used to encourage people to get involved in services. For example Collins and Wrigley (2014) found that loneliness was not a term described in South Asian languages, and for this reason local health trainers adopted the term ‘confidence’. The literature also draws attention to the importance of how an intervention which aims to reduce loneliness is framed. For some, the term itself may hold a negative connotation, and prevent people accessing it due to pride or perceived stigma. Alongside this, some South Asian community members may not recognise the term loneliness, and therefore not access services as they may not perceive them being suitable for them. Campbell and McLean (2002) found that a sense of pride prevented some African Caribbean people seeking support through services. Stigma was also referred to by South Asian older people in Leeds, where the likelihood of accessing loneliness services was linked to how it was perceived by wider family networks (Wigfield and Alden 2017).

The Time to Shine programme in Leeds, which is aimed at people over 50, ran projects targeted towards specific BAME groups, including Chinese and Punjabi speakers. Feedback showed that many people across different BAME communities were reluctant to use services where it was perceived that staff and volunteers would not understand their cultural needs, or where they could not speak their first language (Wigfield and Alden 2017). A concern that organisations would not be sensitive to cultural needs was also identified by Malzer (2013) when looking at health and social care services. As well as language, some BAME communities have referred to religious observance, food consumption differences, and someone incorrectly pronouncing their name as examples of culturally insensitive services (Malzer 2013).

The perception of an organisation is also important. For example, McLean *et al.* (2003) looked at the perception of African Caribbean community members of local mental health services and found they used services less due to believing the organisation may lack an awareness of their culture, or that they may experience racism.

Collins and Wrigley’s (2014) research for the Joseph Rowntree Foundation (JRF) referred to the importance of ‘legitimacy’; this could refer to an organisation’s brand being trusted, but other useful ways to achieve this were through offering activities that provided some form of skill acquisition or qualification; this was particularly so for some BAME women. JRF also had some success through employing a local, trusted trainer, who was able to communicate in community languages. JRF felt that this shared ‘cultural bond’ enabled them gain trust, and encourage BAME groups to leave their home.

Age Concern Coventry (Bhattacharyya and Benbow 2012), carried out research which focused on improving awareness and take up of services among older Asian people, and as with JRF’s research, they found employing staff with cultural awareness, and the ability to speak community languages, were particularly effective; as well as ensuring information was available in different languages.

The identified centrality of cultural factors when engaging BAME communities in services highlights the importance of not treating members of the BAME population as an homogenous group, as unique customs, beliefs, behaviours and languages may have an impact. Alongside cultural traditions, people will also, of course, have a unique set of individual factors which may impact on their participation.

***Differential gendered access to services***

Some research has found that barriers to participation in services and activities can be gendered and can particularly adversely affect some women. For example, some research cites multiple family responsibilities as a barrier to engagement for women of some BAME communities who can struggle to get out into the community (Collins and Wrigley 2014; Malzer 2013). In one culture, women were not able to visit places where they might encounter males, unless a male chaperone accompanied them (Collins and Wrigley 2014). Asian women were also more likely to be reliant on men for transport (Malzer 2013).

The remainder of this report aims to provide a greater insight into barriers and facilitators to BAME communities accessing loneliness services through analysis of the findings of the empirical study.

**4. Existing referral practices/ key referral routes adopted by loneliness services**

To assess existing referral practices and key referral routes adopted by loneliness services we draw primarily on data generated from the mapping of loneliness services which was undertaken for Islington, Oldham and Newcastle, as well as the findings of the 24 interviews with representatives of service delivery organisations (eight in each locality). The organisations surveyed for both exercises included those which specifically aim to reduce social isolation and loneliness, and others which work with BAME communities in a more general sense. Where appropriate we also draw on some of the evidence presented by the interviews with lonely people from BAME communities. Before discussing the referral practices adopted, it is important to outline the kinds of services that are provided by the organisations mapped.

***Service provision to help prevent or reduce loneliness or social isolation***

The service provision mapping across the three localities was undertaken first and foremost with a view to finding out the range of services available. A BAME lens was also applied to consider: if there were any barriers in referral pathways; whether services were specifically targeted at BAME communities; whether there was information on service uptake from BAME communities; and whether there were any notable service gaps. As mentioned previously, in total 221 different services were included in the mapping exercise; 35 from Newcastle, 106 from Oldham, and 80 from Islington. The services covered the life-course, with Islington services including a number of children’s or early year centres which provided support for the whole family. Services that were mapped included those from statutory organisations, not-for-profit charitable organisations, and a range of volunteer led organisations. From the general analysis it is clear that many organisations have one primary focus, with a significant number providing multiple services aimed at preventing loneliness or reducing isolation.

Figure 1 illustrates that although about half the organisations (111) only provide one service, 60 provide two services, over 40 provide three or four services, and four organisations provide five or more services.

Figure 1: Number of services to reduce loneliness offered by organisation



The range of services offered varies (see figure 2). A significant number of organisations provide information, advice, advocacy services and signposting to other services, with a small number of organisations targeting support for people isolated through domestic violence. The majority of services offer direct support through group work, activities, therapies, lunch clubs or through listening and befriending services. Advocacy was a theme in both the befriending services and the information and advice services. A small number of organisations focussed more upon supporting communities and volunteers rather than directly supporting individuals who were lonely. Education and skill development appeared to be targeted at discrete groups such as youths, men, and people for whom English was not their first language.

Figure 2: Range of services to help reduce loneliness



It is worth noting that food was often a common theme to draw people together: either through the growing of food within the ‘hobbies’ or ‘community cohesion’ services; through cooking and buying of food in ‘group hobbies’ or ‘skill development’; or through sharing the eating experience and gaining nutrition through ‘lunch clubs, morning coffees, tea parties’. Food was often used as a vehicle to provide a secondary service such as information and advice, health promotion and skill development.

Interviews with individuals from various BAME groups, which are discussed later, reveal that loneliness is often not commonly understood or accepted as a phenomenon but attending skill development or information and advice sessions such as those provided by many of the organisations mapped is more usually understood and accepted. This is important in how services to prevent loneliness are promoted.

The services mapped are offered in a range of settings including social centres, museums, allotments, leisure facilities, and people’s own homes. There was one dedicated transport service, with a limited number of services offering tailored transport if required e.g. to lunch clubs or afternoon tea sessions. A lack of transport was one of the barriers to using services identified in the interviews with members of the BAME community, as explained in section 5.

***Intended target group of people for services to prevent loneliness***

Broad categories of intended service users have been developed from the mapping of service providers. Over 75 services were not specific in their intended target group, but were available to people across the age span, including faith-based services, physical activities, volunteering and web-based information services. Nearly 60 services were targeted specifically at older people including many lunch clubs and hobby groups. At the other end of the age spectrum there were nearly 30 different services for children and young families or for youths. This suggests a possible gap in services specifically designed to reduce loneliness for members of the adult population aged between around 25 and 50/55. There were also a range of services which were set up for use by people with a range of disabilities including physical disabilities (14), mental health (15), and learning disabilities (10). In Oldham there was a notable presence of services for people with autism, and in Islington there was a notable presence of services for people with anxiety related issues. There were a few services which explicitly targeted carers.

Some of the services were gender specific and an overview of these services can broadly be categorised into five types of support: Specifically for ‘vulnerable’ women (e.g. domestic violence, drugs); specifically for women from BAME communities; with a generic focus on women; with a generic focus on men; and children orientated. Twenty of the services can be classified as falling into these groups, eight for men only and 12 for women and girls. These were often associated with other target criteria such as older men (Men’s Sheds) or BAME women and girls (e.g. The Angelou Centre in Newcastle, the Indian Association in Oldham, and the West End Women and Girls Centre in Newcastle). There was one service (offered by Age UK) that supported (older) LGBT members of the community in Oldham.

Nearly 20 services were specifically set up to support members of predominantly BAME communities, with some of them open also to members who were not from BAME communities. Examples include religious and cultural groups such as the Muslim Welfare House in Islington, West End Refugee Service in Newcastle, and Fatima Women’s Association in Oldham. One service in particular was set up for members of BAME groups living with dementia in the European Islamic Centre in Oldham.

Some services did not sit easily in any of the broad categories described above. They include those for people who have experienced bereavement, people who are homeless, and for working professionals who are busy and short of time. There were some examples of inter-generational groups bringing together younger people and older people, including Good Gym (a national organisation with clubs in all three localities), and Magic Me (offering cocktails in care homes) and Grandmentors, both in Islington.

***Referral practices adopted by the services***

When thinking about the referral practice adopted by the services identified in all three localities it is evident from the data collected that a distinction needs to be made between strategies of *referral* and *engagement*. Where services operate through a referral strategy they often rely on other organisations to refer service users to them and, as explained in more detail shortly, this can be through a formal referral process or a more informal process. Where services operate an engagement strategy rather than rely on other organisations to refer service users to them, the service itself attempts to engage with and recruit appropriate individuals mainly through self-referrals and by using a variety of techniques such as advertising or outreach work (these are discussed in more detail later). Many of the stakeholders in all three localities, including those representing the British Red Cross Community Connectors programme, utilise a mixed approach, often obtaining referrals from a variety of different sources, as well as carrying out direct engagement with service users. Three broad types of referral practices have been identified from the interviews with the service providers: a mixed ad-hoc approach; referrals from other organisations only; self-referrals and direct engagement with services users.

*A mixed ad-hoc approach* *to referrals*

This approach appears to be adopted by many of the stakeholders interviewed. These organisations tend to rely on a mix of referrals from other agencies including predominantly local voluntary sector organisations, health care professionals, including GPs and community nurses through social prescribing, and local authorities. A few of the services (four) mentioned getting referrals from housing providers, employment agencies such as Jobcentre Plus, and pharmacies. All the services in this category also took self-referrals and thus were required to carry out some direct engagement and recruitment activity. As one stakeholder in Newcastle said: *‘Getting referrals is a combination of things, one size does not fit all’.* These service providers tend not to have a formal referral pathway with the organisations, but have established informal links with organisations in the locality, as one stakeholder explained *‘we have set up a few local conversations’*.

*Referrals from other organisations only*

A handful (three) of the stakeholders rely on referrals from other organisations only and do not accept self-referrals. These service providers tend to be those with more established, formal, referral routes and receive a regular flow of referrals without the need to undertake recruitment or engagement strategies.

*Self-referrals and direct engagement with services users*

A third group of providers rely heavily and sometimes exclusively on self-referrals and in these cases the organisations are required to devote extensive staff and volunteer time and resource into identifying and engaging with appropriate potential service users. A service provider in Islington summarised the extensive efforts needed to recruit and engage with potential service users:

*‘It is a question of going out and finding people as they do not come to us. So we have to advertise ourselves as much as possible. I have underestimated how much we need to advertise what we were doing in order to get referrals in’*

Some of the service providers have prioritisation criteria, which is often determined by the specific requirements of the funding source and these can include specific ethnicities; health conditions; geographical location.

***Challenges in the referral process***

The findings from the interviews with service providers highlight a number of challenges faced by them during the referral process. The challenges are experienced by service providers adopting all three referral categories (mentioned previously) but vary according to the category.

*A formal assessment processes can be off-putting*

As previously mentioned, a formal assessment process was adopted by three of the service providers and this was positively viewed by those organisations as it allowed for a regular flow of appropriate service users. However, some service providers which were not operating this formal referral method indicated that this process could create difficulties, particularly for some members of some BAME communities. They cited a general lack of knowledge about how services operate among potential service users and that this, together with the formality of the process means that sometimes some people from BAME communities had mentioned that they were sceptical about these kinds of services and their legitimacy or were worried that it might cost them financially (unless it was offered as part of the NHS), or that accessing the service might adversely affect their welfare benefit payments. This then can create barriers to them accepting the service. Some people from BAME communities were also reported by some of the service providers interviewed to be unlikely to use a service if there was a formal assessment process, as a stakeholder in Oldham explained: *‘…and if you’ve gotta have an assessment, puts people off. Fear it.’* This links to a fear of some public authorities such as social care which is picked up again in later in this section.

*Service users need a lot of support in the referral process*

Service providers adopting all three types of referrals pointed out that extensive support is often needed to support people from BAME communities from the initial point of identifying a need for support, to referring them to a service provider, to the individual actually receiving the support on offer. This appeared to apply to social prescribing as well as other forms of referrals. There were examples cited of where a GP may signpost/prescribe a service to a patient but that follow-up support is needed to ensure that the patient follows the referral through and gets the support that they need. In Newcastle one service provider talked about the difficulty of getting beyond the referral and breaking down the barriers to ensure that the service is accepted by the individual. Another explained that it often took numerous personal attempts at first point of contact before they were able to support the person being referred. Sometimes this is because the individual feels they do not need support, or because they are a carer for a family member or friend and do not feel they have time to get support for themselves, as one carers organisation in Newcastle reported: ‘*in my experience … carers will sometimes refuse the service being offered – often because they are too busy with everything and don’t have time, or they don’t want any extra support – they are managing’*.

Other research (Yeandle and Wigfield 2011) has identified this to be the case for many carers, regardless of ethnicity, and this links to the way in which carers often prioritise the health and well-being of the person they care for over their own, having little time to access support services for themselves. Indeed, depending on the amount and intensity of the caring provided, some carers are unable to access such services, even if they have the time, as they cannot leave the person they care for unattended. However, the pressure on some BAME individuals to undertake their caring roles is sometimes greater due to an expectation among some cultures that families should support each other, as a service provider in Newcastle had found: *‘Often BME communities don’t self-refer or attend because they are too busy looking after their own families to look after their own health’* . South Asian families being a particular example cited in the interviews, with the caring burden predominantly falling on women, as a service provider in Islington pointed out:

*‘I particularly think that there are groups of Asian women, who I know from my experience of working, who are locked into looking after their elders and cooking all day and providing for big families with not a lot of freedom.’*

Indeed there are a multitude of reasons which may prevent some BAME individuals accessing a service that they are referred for which are explored in more detail in section five. This is significant for organisations undertaking the referrals as it means that sufficient time, energy and resource is required to ensure that referrals translate into service use, a point which will be returned to later.

*Weak collaboration between service providers*

Although almost all of the stakeholders interviewed in all three localities referred to partnership relationships with other service providers in their localities, and sometimes beyond, the nature of the relationships are often not strong enough to allow for an effective and two way referral process. Indeed many of the service providers interviewed had only limited awareness of other services operating in the immediate vicinity. For example only half (4/8) service providers interviewed in Newcastle and a minority (2/8) in Oldham knew about the British Red Cross Community Connectors programme. It should, however, be pointed out that in Islington stakeholders had a better awareness of the programme with all except two of the service providers who were interviewed being aware of the British Red Cross Community Connectors. The greater levels of awareness among stakeholders of the Community Connectors programme in Islington in comparison to Newcastle and Oldham may be attributable to a better informed network in the former. One service provider in Islington said: *‘They [Community Connectors] have a real knack for knowing who to refer and getting to know them well and what we do’*. The Islington Community Connectors programme work with local organisations, primarily referring service users to them, and have attempted to improve knowledge of their presence in the local area by putting up posters and leaflets in libraries and GPs.

The Community Connectors in all three localities, when interviewed, did not feel that they had managed to develop particularly good partnership working with other organisations in their respective localities. One of the British Red Cross Community Connector service providers summarised this well:

*‘It is not really a relationship just the first port of call. We find organisations by looking at maps and picking up knowledge from other community services. They may say we do not offer that support but this centre does. We keep our eyes out for other stuff going on. We will take photos of posters in library windows and share these amongst our staff when we have not seen them before.’*

Some of the stakeholders interviewed suggested that they would like to develop closer links with other service providers but financial pressures mean that third sector organisations, in particular, are often required to compete for the same ever decreasing allocation of funding. Once funding has been secured they are then required to compete for a similar ‘pool’ of service users to meet the output and outcome targets required. Moreover, the organisations are often operating on a bare minimum of resources and so time to invest in collaborating with other similar organisations and developing relationships with them is scarce. Added to this, the often short term and uncertain funding streams mean that availability of local services is ever changing and it is difficult for organisations to keep a track of services operating in their area. As some of the stakeholders explained, there is usually a willingness to collaborate closely but the financial challenges and pressures make this increasingly difficult. Although these challenges affect many third sector organisations, they seem to have a particular impact on organisations which provide services specifically for members of BAME communities as they are often very small ‘below the radar’ organisations (MCabe *et al.* 2010), a term often applied to describe small voluntary organisations, community groups and more informal or semi-formal activities in the third sector which tend to have less access to finance and influence (MCabe and Philimore 2017).

The result of these challenges is that although organisations appear to be referring individuals to and from other service providers in each of the localities, these referral pathways are often based on ‘chance’ that a specific organisation is known, rather than each provider having comprehensive knowledge of local service provision. One provider in Islington mentioned that they have a database of other service provision in the area but this has relied on that organisation unilaterally developing the resource for themselves, while other organisations with less resource have been unable to do this. Many of the other organisations relied on individual staff and volunteer knowledge of other services or as a Newcastle service provider mentioned, a folder of appropriate leaflets relating to other existing service providers.

*Self-referrals often don’t reach the most lonely*

As mentioned earlier, many of the organisations relied on either a mix of self-referrals and referrals by organisations, or solely on self-referrals through engaging with the local community. When asked for further information about how individuals then find out about a particular service to self-refer to, many of those interviewed explained that word of mouth was the most common form taken. With friends and acquaintances telling their friends about particular services or activities that they themselves have used or are using and thus recommending the service. Many of the BAME service providers suggested that word of mouth was particularly relied on for their self-referrals as they are more likely to ‘trust’ a service that someone they know has used (further details on trust are explore in later in this section and in section five). A service provider in Newcastle explained:

‘*Generally posters and leaflets remain unseen and unread, and don’t always do the job Letters in the post are not read, understood ….a conversation [even if it is a phone call] gives a chance to explain what there is and get people involved. More time consuming but more productive’.*

However, this is a particularly problematic route of referral when attempting to reach lonely, isolated people. The very fact that people are lonely means they are unlikely to have many, if any, friends and are more at risk of being isolated and thus likely to have fewer acquaintances to inform them of the existence of appropriate services.

***What works well in referrals?***

Although many of the service providers interviewed identified a number of challenges encountered in the referral process, some mechanisms to overcome these challenges had been adopted and some examples of good practice emerged from the discussions.

*Working with local organisations that are trusted by individuals*

Trust has already briefly been mentioned and will be returned to again later (section five), and its presence clearly plays an important role in the referral process, thus confirming findings of research by Collins and Wrigley (2014) mentioned previously in section three. Some of the stakeholders pointed out that individuals are more likely to engage with a service if it is being offered by an organisation that they trust. As a service provider in Islington said:

*‘I would say that where people are going to a place where they are going for a specific purpose e.g. a GP or housing officer in the council, and those people recommend a social activity, there can be an extension of trust in that’*.

When talking about ‘trusted organisations’ a service provider in Newcastle said:

*‘organisations which are local and approachable and personal and therefore trusted are more likely to be effective in the referral process and in enabling people who are referred to take up the services. This is a particular key for people who are feeling lonely or isolated.’*

Local grass roots organisations with a long standing base in the locality were seen by some of the service providers as being trusted by potential BAME service users. Some service providers mentioned that if they themselves were not such an organisation they had developed strategies of connecting to ‘trusted’ organisations to help with referrals. This point is summarised well by a service provider in Newcastle:

*‘Work with grass roots organisations, may be other voluntary sector organisations or maybe public sector. Key is working with people who are trusted by the vulnerable communities’…*.*It was because they are local and approachable and personal and therefore trusted. This is key for people who are feeling lonely or isolated….because we plug ourselves into with grass roots organisations from the beginning – who are trusted, and open doors and signpost to* [our service].’

Other organisations which were mentioned as being ‘trusted’ organisations were those which had been recommended by friends and family (as mentioned earlier in this report). A service provider in Islington gave an example of how family recommendation can facilitate this trust:

*‘For example, like a grandchild who can take this* [information about a service] *into the family home as the trust is already there. Whereas if it is just an organisation that people have not heard of that may include the Council, by translating the leaflet into the language, it doesn't make it any more relatable…*…. *It is all about relationships’*

This ‘word of mouth’ information by friends and family in relation to which organisations can be trusted was seen as key by a service provider in Islington: *‘There is a lot of word of mouth in communities. Once you are trusted and know, people know that there is a good thing going and everyone starts flooding through the doors’.* An older female interviewee in Newcastle who was not currently accessing services but had done in the past also mentioned the importance of word of mouth from a trusted friend or family member: ‘*I mainly became aware [of the service] through family or a local friend who I trusted’*

Other organisations which were viewed as being trusted by the service providers were health providing organisations (including GP surgeries and pharmacies). Indeed a service provider in Newcastlementioned a particularly good example of how they had worked with local pharmacies for referrals.

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| **Good practice case study: Referrals through trusted organisations – Pharmacy referrals**A service in Newcastle deliberately targeted pharmacists (evidence had been provided by partner organisations that pharmacists were a good source of referrals because they were trusted people and were in contact with older people). This was seen as a good way to get in contact with older people who were not ill, not necessarily part of any existing service provision, and not considered vulnerable by social care. An 82 year old woman went into a local pharmacy for her regular prescription, and said, in passing, that she had been recently widowed, and she was finding it quite hard to work out where to go. The pharmacist, who she knew and trusted, gave her a leaflet for a dance programme. The woman then attended an event linked to the dance programme and said she had had loved the event. She said she had been attending for 10 weeks, twice a week with a dancer and because it came to her from somebody she knew, and that she trusted, she went along and participated. |

Large national charities (the British Red Cross and Age UK being two examples mentioned) were also perceived by the service providers as being ‘trusted’ by many potential BAME service users, as an Islington stakeholder mentioned:

‘*When it comes to the British Red Cross, they are a well trusted national institution which people understand and their greatest asset, on this sort of issue, which they do not necessary have a heritage with, is their campaigning resources and their ability to make arguments’.*

A Bangladeshi female interviewee living in Newcastle made similar comments about the British Red Cross and her trust in the organisation but had not used their services as she did not think they would be appropriate for her: ‘*I was aware of the British Red Cross from when I lived in Bangladesh, so I trusted the service, but had not thought that they would be appropriate for me when I moved to UK’.* This interviewee felt that the British Red Cross was essentially an overseas support agency rather than one which supported residents in the UK.

The British Red Cross Community Connectors programme was highlighted by the BAME service users in both Oldham and Newcastle as a service that had succeeded in this respect, with those who were accessing the programme, who were interviewed, emphasising that they felt they could trust both the individual Community Connector who was supporting them but also the British Red Cross as the organisation running the programme given it was a large, well known charity. They went on to point out that the personal service that was provided by the Community Connectors enabled them to develop a rapport with the Community Connector, that they felt they could talk to them in a safe, comfortable environment, which could be in their home or in a community venue, and that this meant they could trust the service provided. Because of this many of the Community Connector service users said they were able to talk to the Community Connector in a way that they not been able to do with anyone else before.

One example of this was provided by a female community connector service user in Newcastle. She said that she did not have ‘true’ parents to teach her things and the Community Connectors had been like second parents to her. They have given her confidence, and have helped her to *‘flush away’* all the negative things that had been affecting her. She said that the Community Connectors *‘really listened, and weren’t judgemental, they dealt with my issues and responded to me as a person’*

This level of trust in the British Red Cross Community Connector programme can be seen in the following case study example.

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| **Case example: trusting large well known charities**An interviewee currently living in Newcastle but originally from Bangladesh had recently accessed the British Red Cross Community Connectors programme. She is 44 and moved to the UK in 1986. She has lived alone for 14 years and has had a very complex background, with a traumatic history. She very obviously holds the British Red Cross in high regard. Religion plays an important part in her life, and the British Red Cross approach to religion and working across communities has been instrumental in her being able to approach and trust the Community Connectors programme. She was referred from Jobcentre Plus and the involvement of Jobcentre Plus and the Salvation Army have been critical to the interviewee gaining support and putting in place connections that have helped to overcome social isolation.  |

A service provider in Oldham, however, stressed that even these large ‘trusted’ organisations need to work further on gaining the trust of BAME communities: *‘Marketing and PR work is needed to help build trust and understanding of people like Red Cross as it and others are seen as White British groups’*

Interestingly local authority social care providers were suggested by some of the stakeholders and BAME residents interviewed as organisations which they were less likely to trust and were more wary of, and were feared for their potential to intervene in people’s lives.

It should be pointed out that the role of trusted locally based organisations in the referral process has been found in other research and is not necessarily specific to BAME communities. For example, the significance of trusted organisations providing referrals or services themselves and the particularly useful role of pharmacies has been found in other research in relation to uptake of services by carers (Yeandle and Wigfield 2011; Mooney and Wigfield 2015).

*Providing a ‘supported’ referral service*

As previously mentioned, one of the key challenges in referral practices highlighted by the service providers is the amount of support many of the most lonely and hard to reach need between referrals and take-up of services. Some organisations had dealt with this effectively by providing a supported referral service, what they referred to as a ‘hand-holding’ service through the referral process. A service provider in Islington, for example, explained the importance of a ‘hand-holding’ referral service to ensure that people feel effectively supported, are referred to the correct services, but most importantly that the referral is followed through:

 *‘We hand-hold them through. So we support the person. We refer through to the partner and check that the partner has contacted the person, then we check with the person that the help they get is the help they needed. If it isn't, then we will try to find someone else or we will chase up the original thing’.*

Whilst such a personalised and ‘supported’ referral service is deemed useful for many hard to reach, lonely and/or isolated individuals it can be particularly important for supporting people from BAME communities, particularly those who do not speak English and may lack the confidence to travel on public transport to services, or to attend a service which is located outside their immediate locality, or where the majority of other service users are White British. These issues are returned to and explored in more detail in section five.

*Recording referrals through a paper or online form*

To ensure that those in need are directed to the most appropriate services and to enable follow up of referrals to ensure that once referred individuals actually take up services it is important to keep accurate records of referrals. Many of the service providers did not necessarily have such a system but those which did found that it ensured that appropriate information was being collected, that the service users were appropriate for the service, and that the service user could be signposted elsewhere if that particular service was not appropriate. Some organisations mentioned resource constraints in implementing such a system including financial cost, time for staff to develop the form and process it, as well as time for other organisations who are referring to the service. Also the introduction of General Data Protection Regulation (GDPR) was cited as a further obstacle to the use of a referral form. However, it should be noted that although a formal referral form might be useful for service providers to track and ensure that the right sort of referrals are being provided, some service users (in particular BAME services users) can fear formal forms and assessments, as mentioned earlier.

*Social Media*

Some of the organisations which fall into the group of providers mentioned earlier which rely heavily, and sometimes exclusively, on self-referrals mentioned that the use of social media was starting to grow in importance and was enabling them to spread the word about services and reach people who may be lonely and do not have many, or any, face to face social contacts. Some organisations in Newcastle, for example, mentioned that Twitter was proving useful in engaging some BAME communities but they also mentioned a lack of time for staff members to spend on tweeting. A service provider in Oldham which works with African Caribbean people said that they have started, in recent years, to advertise through Facebook and that this has drawn in people from further afield such as Manchester, Rochdale and Salford.

**5. Barriers to involvement of BAME communities in loneliness services**

Some of the key challenges involved in the referral process have been discussed in the previous section but it is also important to look beyond the referral process when understanding accessibility and uptake of loneliness services to BAME communities. To examine the potential barriers faced by BAME communities in detail we draw primarily on the interviews and focus groups with the 21 people from BAME communities (eight of whom were involved in the British Red Cross Community Connectors programme and 13 of whom were not currently accessing any loneliness services), as well as the 24 stakeholder interviews. A number of key barriers emerged from analysis of the findings of this empirical research which are now discussed in turn.

***Lack of information and/or awareness***

As we saw in the previous section, service providers were often unaware of the other services operating in their locality and this lack of knowledge was also mentioned by the people from BAME communities who were interviewed.The majority of the 13 BAME residents who were not currently accessing loneliness services (all five of the Oldham participants and seven out of nine of the Newcastle participants) said that they were not aware of many services and activities in the locality, apart from the ones they were currently accessing. In Oldham, the interviewer mentioned some local services to the interviewees, including the British Red Cross Community Connectors programme, and many of them expressed interest in gettinginvolved but were unaware that they were available in the local community. When asked why they had not used a particular local service one participant said *‘Because nobody had told me. Sometimes, you don’t know things are happening.’* In Newcastle three of the participants had heard of the British Red Cross Community Connectors programme but had thought that it was not relevant or appropriate for them, but they could not really explain why. One of these, a 34 year old Bangladeshi female said that a Community Connector had approached her husband about her being referred to the service but he refused to use it. The interviewee did not appear to know much about this and was unable to elaborate further. One interviewee in Newcastle said that she had been living there for 40 years and still did not know what services and activities were available. Another individual in Newcastle explained that sometimes services existed but she did not know about them, even though they were *‘on the doorstep’*.

***Services may not be culturally sensitive***

Many of the service providers in all three localities mentioned that they thought that services were not necessarily culturally sensitive for some BAME communities and that this potentially acted as a barrier to their engagement with some services. When we explored what culturally sensitive meant in this context examples cited covered: the types of activities which were sometimes seen as focussing on White British culture such as knitting or bingo; services being offered by English only speaking staff and/or volunteers; traditional English food being served rather than a selection of foods from different countries; some services requiring participants to engage in activities which did not comply with their cultural norms. A service provider in Islington providing a friendship club for older people remarked on the importance of providing culturally sensitive services:

*‘Our co-ordinator is from Jamaica and she has some cultural insights. It is no good just sending e-mails, you have to turn up and consider different cultural approaches and she will be useful there…. Also thinking how we might adapt what we do to be a little more attractive. …the approach is very personalised.’*

The way in which this co-ordinator had ensured an effective culturally sensitive service is summarised in the following case study example.

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| **Case Study example: providing a culturally sensitive personalised service**The friendship club is Islington designed for older people offer a very personalised and very inclusive service which the interviewee who is an employee describes: ‘*We have taken down boundaries around traditional befriending and empowering people, putting them in charge of when, where and what they do. I think this is really important because each person is different and an individual. Like I said earlier, when we match people, if they have a particular culture and want to meet people in that culture we will try our best to find whatever people are looking for. We have not had a problem. We are very proud of the ethnic diversity of our senior members. We are still a small organisation. We were crunching our demographic information and I know for example, as London is a diverse city, we have 21% of our members from BME communities, possibly higher. We are just about to do some work in another area where there are 40% BME people. What we will be doing is making sure that we are reaching out and do better, making sure we reach out to that community.’* |

Another service provider in Oldham made similar comments *‘people don’t feel comfortable going places…they’re not culturally appropriate.’* By this the service provider was mainly referring to the fact that many of the potential service users did not speak English but services were often run by English only speaking staff.This service provider also cited examples ofknitting and bingo activities being offered which they felt were targeted at white older females but were not necessarily appropriate for older men, BAME women or indeed for younger white women. Another service provider, also in Oldham, pointed out that some cultural differences, if not taken into account when services are being delivered, mean that people feel uncomfortable and are unlikely to get involved, an example of South Asian women not being used to shaking hands with men was cited. Similar evidence to this was found in a study of South Asian women in West Yorkshire accessing support for entry to the labour market (Wigfield and Turner 2015).

The importance of culturally sensitive support was highlighted in Oldham among the British Red Cross Community Connector service users, who all stated that they had not come across any other similar culturally sensitive services before, despite exploring the options available. They cited the provision of culturally sensitive support as one of the reasons why they had accessed the service. When exploring what ‘culturally sensitive’ support referred to in this context the service users referred to the community connector being from the same ethnic background, speaking the same language, understanding them, and making them feel comfortable:

*‘Asian people can understand it better, because, with someone else, they don’t understand the culture. With [the Community Connector] she understands. There’s loads of people out there to help, just need to know the right people’*.

Some of the service providers who were providing friendship, buddying and befriending services were, however, keen to point out that for matching purposes it is important to note that culture is not the only consideration, and that having things is common is more important whether that be their ethnic background or an interest in a particular sport, or enjoyment of food.

***Funding arrangements and financial constraints***

Financial constraints were mentioned in the previous section as one of the challenges encountered by service providers in operating an effective referral process and these issues were also identified as a potential barrier to BAME communities accessing loneliness, as well as other services. Stakeholders in all three localities mentioned cuts to services and activities in recent times. Two of the BAME interviewees in Newcastle mentioned recent financial cuts had meant that many local services had closed down and they pointed to examples of the closure of a nursery and leisure centre. ‘*A lot of services are overstretched’*. A stakeholder in Oldham mirrored this sentiment: *‘we’re cash strapped services. There’s waiting times to see consultants, to see us, everything. There’s a cash strapped environment, it’s not therapeutic at all’.* Similarity in Islington the Community Connector service users appeared to access one main centre for activities and were very positive about the centre, although at the time of the interviews the centre’s future was under threat, and at least one of the participants was actively involved in campaigning for the centre’s future.

Linked to this, many service providers said that in the current financial climate many services are funded for specific purposes and target groups and so they cannot always include and involve groups or individuals who fall outside that criteria. An example was provided by an organisation in Newcastle of Sudanese refugees who had been identified as being lonely and therefore turning to crime but the brief of the organisation’s programme was quite tight and this meant that they could not support this group of lonely young people. Furthermore some of the service providers in Islington mentioned that services which they previously provided free of charge were now requiring a small fee from the service users, which many of those they were trying to engage with could not afford. One service provider in Islington also mentioned that financial hardship in the current economic climate was having a knock on effect on the pool of volunteers, with potential volunteers (who may themselves be lonely) facing an *‘economic barrier to them volunteering’.*

***Transport***

Much existing literature (for example Findlay 2003; Bolton 2012; Wethington and Pilemer 2014) has identified transport as a key barrier to people accessing loneliness and other more generalised services, particularly for older people and/or those with mobility issues. There was some discussion among the service providers about the importance of transport in getting lonely, isolated people to services, as a service provider is Islington said:

*‘Often, if you have got to get to a service, transport can be a big issue. If you have people who are house bound or have mobility issues it is a challenge, they are excluded. Anybody regardless of ethnic identity, an exclusion factor is their ability to get out.’*

Transport was also mentioned as a barrier specifically in relation to some lonely individuals from BAME communities but it must be stressed this was not a barrier to all*.* The challenges identified among some BAME communities in relation to transport relate to language, confidence, safety and availability.

*Language and transport*

Some of the service providers, indicated that transport could be particularly problematic for non-English speaking people. They explained that the most isolated and in need of support often have to rely on public transport which means that it is not always easy to access services which are provided outside their immediate locality. Other research has identified that long journeys on public transport are often difficult to make, and people do not always know when or where to get off the bus and this is particularly problematic if they do not speak English (Wigfield and Turner 2015). Research among socially isolated and lonely people in Leeds, for example, has found that when people are required to take more than one bus, or to access services in another locality, unless it is in the city or town centre, they are unlikely to turn up (Wigfield and Alden 2016). Similar issues relating to transportation and South Asian women’s access to employability services were found in research in West and South Yorkshire and sometimes this also links to a lack of confidence but can quite quickly be overcome by accompanying individuals for the first time (Wigfield and Turner 2015). This connects to the previous point mentioned in section four about the need for intensive support during the referral process.

However, it is important to note that although transportation is a key potential barrier it was pointed out by some of those interviewed it is not a barrier for all members of BAME communities. This is explained by a service provider in Islington:

*‘Transport issues are ones that are coming up more and more, with different professions. There is no difference in my experience for BME communities compared to White British. Many of the seniors I work with from BME communities will often go on the bus and some will drive and are good with trains. Language is not an issue I have dealt with since joining the service. We have seniors who are from the Democratic Republic of Conga, they will speak different languages like French and some English but they are still able to go out and engage in activities. They will get on well with people who do not share their first language.’*

A 75 year old BAME woman living in Islington reiterated this point stating that it was her health condition that prevented her from traveling on public transport rather than the fact that she was from an ethnic minority background: *‘It needs to be local as I can’t travel. I suffer from anxiety that makes travelling on public transport impossible’.*

*Confidence using transport*

Confidence to travel alone was also mentioned in relation to *walking* in places that are unknown by a service provider in Newcastle: *‘you have to have the skills to be confident to walk to places that are unknown’*. Another service provider mentioned geography and that some people from BAME communities who spend most of their time in their immediate neighbourhood do not always know how to physically get to certain places: ‘*they* [residents from BAME communities] *don’t always know when or where to get the bus from’*, this is picked up again later when we explore the way in which some people in BAME communities are living ‘ethnically homogenous’ lives.

*Safety and transport*

Fear for personal safety on public transport was also mentioned by one of those interviewed, with an example provided by a stakeholder in Newcastle of a person from a BAME community who had been spat at on a bus, and was then too afraid to access the service again.

Service providers in both Islington and Oldham had made a conscious effort to breakdown these transport barriers by providing transport when required and that was a key part of their service provision. A service provider in Oldham explained:

*‘Some people get a lift to our group, especially when they first join, because their orientation skills are poor, and it helps to not go alone. I pick up two people, and support workers often drive people here, especially when they first start coming’*

*Availability of transport*

Some service providers mentioned that the funding cuts and financial constraints in recent years had adversely affected their ability to provide transportation services. This is articulated by a service provider in Newcastle:

*‘funding appears to have been withdrawn that was previously available to support BME ladies in particular to access exercise. Another group that [we] picked up for the elderly was transferred because transport was withdrawn – they got a bit of everything, going out, making new friends, reducing being isolated, getting some time to enjoy themselves – all that appears to have been taken away in the last few years and isn’t now available as it was before ….. there was funding for transport where they were taking people to the gym or to swimming and things like that, but I do hear a lot of people from the community saying they would like to do things but they can’t get there because they haven’t got anybody to take them – and they say it was available five or ten years ago, why has it gone all of a sudden? They say they can’t do anything because they haven’t got the facilities or services to help them get to them.’*

***Language***

Language was perceived to be a barrier for some of those who were interviewed from BAME communities, particularly those who do not currently access loneliness services. Among the Newcastle interviewees, five of the nine participants who were not currently accessing services said they needed an interpreter to access services. One explained that this language barrier even extended to visiting the doctor: ‘*When I feel poorly I can’t go to see the doctor – we cannot understand each other. It can take a few days to arrange an interpreter.’* Another in Newcastle explained that they could not take the driving theory test because they could not read English*: ‘it’s a language barrier the driving theory test is not written in Bengali but in English only’*

Another said that traveling on public transport was virtually impossible for non-English speaking people, reinforcing the point made in the previous section about traveling on buses. A stakeholder in Islington made similar comments about language being a barrier for some service users from BAME communities:

*‘There have been a couple of people where language has been an issue because English is not their first language and they do not speak English. … it is difficult for us to work with them. We did have [a] lady who we did work with for a short period of time. It was tricky because she didn't speak English and I was having to converse with her daughters - one of two different daughters. I would ring and speak to a different daughter at different times and they were not aware of different conversations. It is better to be able to speak to the service user directly’*

A different stakeholder in Islington said that language barriers become particularly problematic as people age:

*‘Language is definitely an issue. I think for older people language becomes more of a problem when their hearing is going. Not only are they struggling with a second language but they are also struggling because they cannot hear very well. So for example, if you are a deaf elderly man and then add on that English is your second language then it is doubly difficult for him to communicate. Also the worry on top of that that you cannot speak English and the embarrassment and social anxiety around this. If English is your first language, you can say speak up but if not, asking people to repeat things adds an added anxiety that people may feel they are a foreigner.’*

Another stakeholder in Oldham explained that for them language was a barrier to providing support for lonely and isolated BAME individuals because they felt unable to establish the kinds of services that were wanted/needed because of communication and language issues: *‘[Its] No good putting it on if don’t want it! Especially with language and isolation’*

Another stakeholder in Oldham focussed on the older generation of some BAME communities and the language barriers:

*‘There’s different isolation in different communities. With Asian community, even living with extended families, cos their children etc talk in English, go out and see friends, parents are at home all day. And they’re isolated as cannot communicate in their language, cannot have a laugh with them, so feel lonely. So we provide a place for that – 22 women yesterday, had a laugh and went home’*

This suggests that providing tailored services for specific BAME groups in appropriate languages is important and indeed similar evidence has been found in Leeds when exploring the effectiveness of loneliness services to reach older people from BAME communities (Wigfield and Alden 2016). However, this raises issues about longer term sustainability, and this kind of support should perhaps provide a first step only for lonely people from BAME communities, with other support including provision of English language classes and support to access services involving a wider group of people provided once confidence levels have grown.

***Stigma***

Stigma was identified by both the service providers and interviewees from BAME communities as a contributing barrier to lonely people accessing both general services and those specifically for loneliness. Existing research has similarly found that a stigma attached to loneliness is one of the reasons why people, regardless of ethnicity, do not want to admit being lonely, or ask for, or accept support, and that this tends to be particularly evident amongst men (Lau and Gruen 1992; Wigfield and Alden 2016). Nevertheless, the findings from our interviews identify the presence of stigma associated with loneliness and seeking support for loneliness services which can also be specific to some BAME communities. These ethnicity specific stigmas relate to: the term ‘loneliness’; seeking help and accessing services; the role of the extended family. Each are now briefly explored.

*Terminology ‘Loneliness’*

One of the stigmas attached to loneliness relates to terminology and the word ‘lonely’. This was also found in research in Leeds and tends to be the case regardless of ethnicity. However, in some cultures the stigma attached to ‘lonely or loneliness’ may be even greater. A stakeholder inIslington referred to the way in which the term isolation in some communities is taboo and that if a project is to attract service users, terms such as loneliness and social isolation need to be avoided. This service provider explained that using alternative words such as ‘connect’ are more effective and have less of a stigma associated with them:

‘*It is a question of identifying what the community want and the language we use. The word connecting is perfect. If we are thinking of it from that angle the question becomes how we address this from the perspective of different cultures. In terms of the service being useful for people from BME communities, people just want to connect’.*

*Seeking help and accessing services*

Some of the BAME community members who were interviewed said that there was is not just a stigma attached to the term loneliness but to asking for help or support of any kind, as one of the British Red Cross Community Connector service users explained:

*‘there’s a stigma attached to asking for help…as an Asian person and a young woman, I was taught that you deal with problems yourself and no-one else need to know. After meeting [the Community Connector] I went for counselling as well…and I realised it does help’.*

This service user went onto explain the important role that the Community Connector had in helping her overcome this stigma in relation to seeking help and/or support:

‘[the community connector] *opened the door, saying ‘there’s this place, ring this person, kind of giving us the information to pass you down the right path’. ‘She showed me the way to go… and it’s not done in our culture’*

*Role of the extended family*

Others related the stigma in seeking support to the role of the extended family, pointing out that it can be exacerbated among some BAME communities where the role of the extended family is strong and valued, as there tends to be an assumption that individuals will not be lonely because the extended family are a source of support. Therefore individuals from these communities can be reluctant to admit feeling lonely for two main reasons: firstly they feel it suggests that their extended family has failed in its role in some way; and secondly they worry that it implies a weakness with them as individuals, how can they be lonely when they have a large family around them? This relates to the importance in the differences between social isolation and loneliness, which are often misunderstood. An individual can be surrounded by people, including members of the extended family and therefore not be socially isolated, but still be lonely. Talking about loneliness and the extended family a service provider in Oldham said: *‘…. they might have to explain they’ve just sat watching television all week, and they’re ashamed, don’t want to say that. So they wait for someone to come, but no-one will’.* Furthermore as another service provider suggested in Oldham some people from BAME communities who have a large extended family can feel even more lonely because they have a large family but they do not always connect with that family.

The stigma associated with loneliness among some BAME communities appeared to also be influenced by gender, perhaps more so than among White British residents. A service provider in Islington explained that of some men from particular BAME communities may find it very hard in terms of their status or cultural norms to admit that they are feeling lonely, depressed or unwell, with Somali men being mentioned as an example. Similarly, a lonely woman from a BAME community in Oldham mentioned that there was a particular stigma attached to South Asian women and girls accessing services for support, as there is a belief that they should not ask for help, although she said that this was starting to be overcome:

‘*There used to be a stigma about Asian women attending the centre, but that has been removed now, largely due to the efforts of the manager who went out locally knocking on doors to encourage Asian women to attend’.*

***Trust***

As mentioned in the previous section on referral practices, trust, or lack of it, can act as a barrier to people from BAME communities accessing both loneliness, as well as more generalised, services. A service provider in Newcastle gave an example of some members of the African Caribbean Community who had displayed signs of mistrust and were reported to be very suspicious of people coming into their community and ‘using them’, for example offering services to the community to meet specific targets for BAME participation. A service provider in Oldham reiterated the importance of trust: *‘Building up trust is a massive thing – I was invited to Friday prayers at mosque for Friday prayers, on first day they were very wary of me, by sixth day a lot more trust and some got into things’.*

It was widely agreed amongst those interviewed that ittakes time to develop trust between organisations offering services and the local community, as well as between the individual support workers and the service users. Another service provider in Newcastle explained: *‘It is a time consuming process’*. However, as previously mentioned, funding systems and financial constraints mean that there is not always sufficient time or resources to spend time building up trust with the local community as quite often commissioners expect new service provision to commence immediately.

***Perceived racism and hate crime***

Experiences of racism and/or hate crime were mentioned by a minority of the interviewees: by three of those from BAME communities living in Oldham; and by some of the service providers in Islington. None of the Newcastle interviewees explicitly mentioned any perceived racism. The three Oldham interviewees said they had experienced either racism or hate crime (due to their disability) when accessing local activities and/or services and that these experiences had meant they were reluctant to access services again: *‘I experienced racism a lot…. People posted abusive messages through the door. I felt very unwelcome, and was why I was so lonely and depressed when I lived here’* (the individual has since relocated). This quote suggests that experiences of racism have the potential to make people feel unwelcome which may adversely affect their sense of belonging to the place within which they live and could therefore exacerbate their feelings of loneliness (see Wigfield *et al.* 2019 for a more detailed discussion of sense of belonging to place). Some of the Islington service providers reported that some residents from BAME communities, particularly older ones who may have experienced racism in the past, feel that they cannot access services because of their previous experiences. Examples were cited of people from BAME communities who had felt excluded from a lunch club with predominantly White British attendees because they have memories of racist remarks in their earlier life and this then serves to exacerbate their experiences of social isolation and loneliness. One of the Islington service providers reported an example of a person from a BAME community who had been turned away from a national charity because she did not speak English and they could not support her:

*‘one of the charities who work in this space, a person who had looked for a befriending service for her mum, who has limited English as Spanish is her main language and was turned away. We find this racist… that we are living in multicultural London and services only cater for white British. We are uncomfortable with that. I will not name them but they are an influential charity and they get a lot of money. Maybe this is an isolated incident but when I heard that, it should be a problem. Inclusivity is a huge part and being personalised’.*

***Confidence***

Some service providers and BAME individuals pointed to a lack of confidence as a potential barrier to many lonely BAME residents accessing appropriate services. A lack of confidence in accessing services could be created by some of the previous barriers mentioned such as perceived racism and hate crime, a lack of trust, language barriers. However, it should be stressed that confidence was not explicitly mentioned frequently by the interviewees. A service provider in Newcastle said that a key barrier is:

*‘having the confidence to do something either on their own or with someone else supporting them to get involved initially – support and encouragement to go on the bus or attend for the first time when they are worried or scared, or unsure of what it is going to be like’.*

This was reiterated by a Pakistani resident in Oldham who pointed out:

 *‘this can be a key reason by BAME people might not access local services’… ‘Nervousness can be a problem too, if it’s something new to you. If I hadn’t been a youth worker before, I might not be here today. I could’ve made an excuse up. Wouldn’t have done this 30 years ago if asked, wouldn’t have had the confidence’*

Another service provider, when talking about barriers to socially isolated people generally accessing services said: *‘they need confidence building too as that, building self-esteem, helps overcome loneliness in the long run too’*.

A lack of confidence in accessing services is often common among lonely individuals regardless of their ethnicity, and can also be associated with age, as a stakeholder in Islington explained:

*‘Then there is the whole problem of communication. If you are elderly … and also are not confidence in going out and finding these places. I can see these groups may find it difficult to connect. This is about their age as well as their ethnicity.’*

A different service provider in Islington also mentioned the connection between confidence, loneliness, ability to access services and age: *‘Seniors in general, if they do have mobility issues, they may lack the confidence to go out on their own to different activities even if they do know what is going on.’*

Although confidence was not explicitly mentioned by many of the stakeholders or residents from BAME communities in each of the three localities, members of BAME communities appear to face particular barriers and challenges which we have discussed earlier such as language, culturally determined perceptions relating to stigma of loneliness, structural factors such as racism, which can have a further downward spiral effect on their confidence levels.

***Assumption around BAME family support***

Some BAME communities, for example those from Pakistan and Bangladesh have large extended families living close by and this has the potential to act as a buffer to loneliness but also a facilitator of loneliness and a barrier to them accessing services. Linked to the previous point about stigma in relation to the role of the extended family, interviewees in all three locations referred to a widely held perception by some that loneliness services are not needed for many BAME communities, as they have a wide network of family support which can act as protective factor to them becoming lonely. In Newcastle for example many of the interviewees from BAME communities said that they had regular contact with family (primarily because they lived with them) and some remarked that because they lived with their extended family the house was always full of guests. However, the participants reported that they had little contact with people outside their immediate family. The service providers also referred to these points, saying that even if individuals do have family support this does not mean that they are not lonely. The service providers were keen to point out that they themselves did not make these assumptions about family support and prevalence of loneliness.

Moreover, for some people from BAME communities, particularly some groups of South Asian women who are expected to adopt a caring role within the family, the presence of a wide family network might actually lead to greater levels of loneliness rather than mitigate against it. These women can potentially feel more lonely because they are expected to care for members of their family and therefore have limited ability to leave the home and interact with others. This is summarised by a service provider in Islington:

*‘I particularly think that there are groups of Asian women, who I know from my experience of working, who are locked into looking after their elders and cooking all day and providing for big families with not a lot of freedom and issues like not being able to speak English. Their opportunities for employment or training is poor. I worked with a woman who came into a children’s centre to the nursery with her children and over the years she became a part-time member of staff but she had to fight to get away from doing the chores. It was her mother-in-law not her husband who didn't want her to do more. She always talked about the issues for women in her community. So there are some issues for people who are not happy or not well but maybe would like to have more richness in their lives who are not getting seen.’*

A service provider in Oldham made a similar point: ‘*Also in some South Asian families younger people feel a duty to look after parents means older people see no-one the same age as them and can also feel lonely’.* Another service provider in Newcastle said that *‘some ladies tell their husbands that they are going shopping as if they say they are coming to a group they are not allowed to come’*.

***The existence of ethnically homogenous communities:***

From the interview findings it is clear that some residents from BAME communities are living in ethnically homogenous communities, what Cantle (2001) has referred to as parallel lives. To some extent this creates a sense of belonging and provides a source of support to some members of some BAME communities but for others this can lead to further isolation and loneliness and it can act as a barrier to them accessing services.

Examples were provided in each of the three localities of tight knit communities where support and social capital could be found from within, examples such as the Jewish community gathering at the synagogue or the Muslim community coming together at the mosque were provided. In Oldham, one interviewee, for example, stressed that one of the positive elements of the South Asian community was the strength of the social capital and the role of the extended family in helping avoid social isolation:

*‘[the] good thing about Asian communities, you help each other. All my brothers live on same street with me! But can leave key next door, no issue. Lady across the road, we invited her in when she forgot key and had to wait for husband - was 10 at night! Community gets together when there’s an issue’.*

Some explained that because of the close bond between people of the same ethnicity and faith they did not feel lonely or isolated, explaining that places of worship brought people together and encouraged interaction. A service provider in Islington explained the important role that religion can have:

*‘The church/Mosque is important. A lot of the BME groups are religious. For example, the Somali community will go to the Mosque and other communities to the church. Lots of our service users would go to the church…. I think if you have a religion it is a bit easier’.*

The role of the Mosque was viewed as a particularly important place for men to interact, as a service provider in Oldham pointed out: *‘BME men do often go to mosque five times a day, so gets them out and connected, if they’re religious. But other activities’*. A 60 year old Pakistani Male made a similar comment: *‘I only work three days a week, and rest of time is with my family or in mosque for prayer. But when there, I talk to people, about shopping, clothes, you know’*.

Some interviewees inferred a sense of belonging not only to people in community but to particular places such as places of worship, so even though they did not necessarily have social connections they had an attachment to place and this meant although they may be *alone* they were not *lonely (*see Wigfield *et al.* 2019 for a for a more detailed discussion*)*.

On the flip side of this there was concern expressed by one or two of the interviewees about the degree to which communities in Oldham seem to be segregated by ethnicity and in fact the interviewee who was cited above as mentioning the strength of the South Asian community also stated that they tend not to mix and integrate with others: *‘the issue I have with my own community sometimes – why don’t we go to other places?’.* Other examples were provided in the interviews where this notion of ethnically homogenous communities led to some people from BAME communities feeling isolated, and partly because of a lack of bridging social capital, they did not feel able to engage in activities or services which were dominated by participants from other ethnicities, faiths, or religions. A service provider in Newcastle discussed the lack of perceived familiarity that people from different ethnicities and backgrounds can have with each other and that this may then prevent groups being set up or people from both BAME and white British backgrounds being involved. An example was provided in Newcastle of an Asian connections business awards evening and the representation of people from BAME communities: there was a degree of separation at the tables between the people from BAME communities and those from non-BAME communities. Another example was provided by a service provider in Oldham who mentioned that one of the women’s organisations is perceived as a bit of a clique and for South Asian women only which can put others off from attending. Another stakeholder in Oldham explained that some services tend to be dominated by the same 10-15 white service users and that this needs to be broken down if a more diverse population of service users are to be attracted to the services/activities.

One way in which these barriers between different ethnic groups can be broken down is by encouraging more contact between them and indeed this approach has been adopted by some service providers. This can be explained in part by contact theory. [Intergroup contact hypothesis](http://www.in-mind.org/glossary/letter_i#Intergroup_Contact_Hypothesis)was first proposed by Allport (1954), who suggested that positive effects of intergroup contact occur. Since Allport formulated his contact hypothesis, intergroup contact has been seen as having an important role in reducing [prejudice](http://www.in-mind.org/glossary/letter_p#prejudice) and promoting more positive intergroup attitudes.  There were some examples from some of the service providers where these kinds of barriers were being broken down and where a mixed group of service users, in terms of ethnicity were being attracted:

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| **Good practice example: Islington- breaking down barriers between different ethnicities through a friendship service**  |
| *‘Treating people as individuals works well. We try to get as many people involved as possible because we believe that to get good matches we need lots of different people and to give them choice. One of the great things of doing this is that we do all sorts of matches across boundaries - socioeconomic, cultural, ethnic, and generational. We focus on what people have in common and not differences. We find that people just want to have a meaningful connection and that can often come in different ways. We do anonymised files for everyone and they get to read about the person and if they like the sound of them. Most the time people get on like a house on fire and in fact cultural diversity means that each side learns about the other’s culture. It is crossing divides and what we have in common. That is our approach and it seems to work well.’* |

Another service provider gave an example of how they had started to break down barriers by ethnicity by holding more general community cohesion events:

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| **Good practice example: Oldham breaking down barriers through community cohesion events** |
| *‘We recently held a Community cohesion event in a mosque, and 60 per cent of the people who attended were white, which was big for us. This helps build better communities and break down barriers. People said it broke stereotypes, and helped them feel more comfortable in their community. In the past it’s largely been Pakistani people that we have engaged with, so I hope this carries on’.*  |

1. **Facilitators for involvement of BAME communities in loneliness services**

Having explored some of the barriers seen to prevent people from BAME communities accessing services, particularly ones which specifically aim to tackle loneliness, we now explore some of the facilitators to their involvement in services which emerged from the findings of the interviews with both stakeholders and lonely individuals.

***Recruitment of a diverse range of volunteers and staff***

Many of those interviewed mentioned the importance of both staff and volunteers representing a diverse range of ethnicities if BAME communities are to be encouraged to engage with them. They reported that residents from BAME communities are more likely to feel that the service is appropriate for them if staff represent a range of ethnicities than if they are all White British. Some of the organisations in Newcastle mentioned the specific importance of recruiting volunteers to deliver services and the importance of matching volunteers to service users. One friendship based service provider interviewed suggested that in order to meet the needs of more diverse communities it is important to have volunteers who can be matched up with them. They stated that Muslim women, for example, are more likely to want to be matched with female volunteers from BAME communities rather than White British men. Another service provider in Newcastle, providing arts based support, reported that they are aware that their organisation needs to do more to recruit artists who represent BAME communities stating *‘that is the root to connecting more effectively with [BAME] groups’.*

A representative of a health based organisation in Newcastle said that they had recruited two members of staff of Bangladesh heritage and this was reported to work well. The staff had been successful in engaging with men from BAME communities, who seemed to be more accepting of the service when it was fronted by someone from a BAME community. The interviewee gave examples of going to the Hindu Temple to carry out diabetes awareness which was successful, but also mentioned the importance of the fact that one of the leaders of the Hindu temple was a doctor with an interest in diabetes.

In Islington service providers made similar comments saying that staff across the organisations need to represent the communities they are trying to engage with, with one saying: *‘looking at who is leading the groups [it’s important to] be more inclusive in terms of employees, employing people from all sorts of places.’* Having staff who are representative of the community enables people from BAME communities to identify with the service staff and thus can help to develop a sense of trust (see below for a more detailed discussion). Other service providers in all three localities also pointed out that it is important for service providers to tap into community leaders and not to assume that merely having a base in a locality will attract people to it; concerted effort needs to be made to make connections and build up trust, an issue which is explore further below.

***Engaging with, and creating trust, with the local community***

The importance of residents, particularly from BAME communities being able to trust service providers was examined in sections four and five, and it is therefore not surprising that developing trust between the local community and service providers is an important facilitator to engagement. Many of those who were interviewed suggested that this can be achieved by ensuring that services are embedded deeply in the local community, by having a physical base in the community but also through extensive networking with local community, and involving a diverse range of local community members and volunteers. The British Red Cross Community Connector programme was cited by a stakeholder in Newcastle as an example of how this can work well through a network of volunteers active in the community being proactive in terms of engagement. However, many of those interviewed were also realistic about the time it can take to develop and build up trust. A service provider in Newcastle explained that they had been trying to engage with the Czech Roma population but they had to gain their trust first as they were not used to accessing these kinds of services. Another service provider in Newcastle mentioned that they had successfully attempted to overcome some of these trust issues by holding ‘community conversations’ - an event in the community that people are invited to attend and that this had helped them engage and involve community members who they had not previously managed to reach.

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| **Good Practice example: Creating Trust through ‘Community Conversations’ in Newcastle** |
| The organisation successfully facilitated a series of conversations/brainstorming sessions to find out people’s interests, how they would like to work, who they would like to work with, what community groups already exist, who they could collaborate with. They used local authorities and their networks, and had a curtain raiser and choir at the beginning and end of the conversation. About 40 people came for a facilitated round table discussions to get information about possible future service provision. No professionals attended, these were all community members. This had worked well and built up trust, particularly when they had worked closely with the local authority to target the right kinds of organisations to recruit community members. |

In Islington another service provider said that they had created trust by providing fun activities for all communities to ensure a diverse representation:

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| **Good Practice example Islington: creating fun activities for all communities** |
| *‘I think one of the reasons why we are successful in the community is that we run a lot of fun days and events to try to bring that community together. The whole estate. On these days we may have four to six events per project. These happen each year and are full on. They really attract every ethnic community and I think it is because we are not a faith based or ethnic minority based labelled organisation. We are not the Council or housing association either. We are neutral, and we deliberately hold that neutral stance to be open to all communities. The thing with Islington, it is incredibly diverse and so has lots of different languages. We of course have different communities like the Somali and Bangladeshi community but it is very mixed. We have people from every background. So we do not target’.* |

Another service provider in Islington suggested that although single events such as those mentioned above can build up trust, one to one work with individuals is then needed as a follow up to embed that trust further:

*‘It is all about relationships. Some people do not have positive relationships at all and that is the course of isolation in the first place. Breaking this down and building relationships with people who have forgone any of those relationships and building them can be particularly difficult. In that sense you have got to persevere and in this sense we call people up again and again. We do not harass them but if they express some interest in attending in a couple of months, we will call them up and have very informal conversations, building the trust to work with us.’*

***A base in the heart of the community with associated outreach workers***

Interviews with the service providers suggest that having a base within the local community and/or providing outreach workers/volunteers who can go into the heart the community is essential to build up trust, spread awareness of services, and engage with local communities. Many of the service providers explained that this is true for many disadvantaged communities, including BAME populations. One provider in Islington explained how they have a base in a local GP practice once a week which works particularly well for engaging with people from BAME communities with health conditions. Another provider in Islington said that having a network of outreach workers from a local base is also essential and that this works best when they are local people that those who are being targeted can identify with: *‘These people become really approachable on the doorstep because they get people and get how they live, and live how they live’.* *There is a connection there’*. Service providers in Oldham made similar claims, with one mentioning that people who the outreach staff are targeting need to be able to identify and relate to them and this can include being able to speak the same language but also being of the same gender, as a focus group participant said: *‘she’s a woman too, and understands woman’s issues. If she’s a man, would never understand! She’s mother, understands.’* [The other participants all nodded in agreement].

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| **Good Practice example Islington: Outreach - reaching out to the community from within the community** |
| *‘We have a special outreach function which operates all year round but intensifies in the winter where we do door knocking, often targeted at the estates and the addresses where the council tells us older people live. We go out and have stands at supermarkets, supported by a local partner. We go and stand in pharmacies and talk to people as they come for their prescription. We talk to people at bus stops. We talk to people in pubs, betting shops, and paper shops. The approach of us being a community driven organisation rather than a service organisation, gives us the agency and credibility to be able to not wait for those big organisations to do this things because this is our community. We can make whatever connection we want as long as they are safeguarded and appropriate. A professional organisation but not overly professional. The people we hire to do this sort of work are hired on the basis of character and personality and playfulness and likeability as much as relevant professional experience.’* |

The Community Connector service users in Oldham similarly emphasised the importance of having an individual who they can identify with and trust. However, a word of caution applies here too. To some extent there appeared to be a dependence by the service users on the individual Community Connector in Oldham, particularly as a source of emotional and relationship support, akin to the issues sometimes raised by the role of befriender and befriending support. Many of these service users relied on the Community Connector as the main source of social connection. This was also found by Wigfield *et al*. (2019). Those interviewed in Oldham, in fact, suggested that more group gatherings, such as a focus group discussion, would be an additionally helpful tool to enable them to get to know other ‘like minded’ people and move beyond sole reliance on one individual. Indeed the British Red Cross Community Connector service users in Oldham were all planning to get involved in additional activities such as gardening and volunteering, as well as developing their own resilience strategies to help avoid social isolation and loneliness adversely affecting them. This perhaps highlights the importance of initial one to one support followed by support for individuals to enable them to create their own meaningful relationships which are sustainable beyond specifically funded projects and programmes.

***Services need to reflect the diversity of the community***

Some of the stakeholders who were interviewed in all three localities suggested that there was an absence of sufficient services to specifically support lonely and isolated people from BAME communities. Some of the more well established organisations were perceived to be ‘*very white’* and offering activities specifically for White British older people such as Bingo. Some organisations which had difficulty recruiting a diverse ethnic mix of services users suggested that as long as services continue to offer services that reflect a White British population they will have difficulty in recruiting people from BAME communities. One arts based organisation in Newcastle, for example, explained that one of the ways to make their services appealing to a diverse range of people is to create great dance pieces that reflect the diversity of their communities, this could be done by incorporating dances from different cultures but to do this they need to draw on the experiences of BAME communities. They explained that they had experienced difficulties doing this. They gave an example of a Bangladeshi community in North Tyneside which they had not yet been able to make connections with. Another service provider in Islington made similar comments, suggesting that if a service is based around food and cooking, it is important to ensure that recipes are chosen from different countries and that a diverse range of teachers are brought in to make sure that the service is appropriate for a diverse range of residents.

1. **Conclusions: Facilitating more effective referral routes for BAME communities accessing loneliness services**

**Mapping and identifying gaps in existing loneliness services**

This report has identified a number of existing services in Newcastle, Oldham, and Islington which are relevant to people from BAME communities of all ages, who may be lonely and experiencing social isolation. The services are provided by a range of organisations, including those from the statutory and third sector. A significant number of the organisations provide multiple services aimed at preventing loneliness or reducing isolation, offering support such as information, advice, advocacy services, and signposting to other services. The majority offer direct support through group work, activities, therapies, lunch clubs, or through listening and befriending services. Skills development activities, often based around food, appear to be a popular form of support for lonely and isolated people. Many of the services target specific groups of people, including a large proportion which focus on older people, and less so on younger people, but there is a possible gap in services specifically designed to reduce loneliness for members of the adult population aged between around 25 and 50/55, and very few loneliness services target carers. Some services were identified which target specific BAME communities.

***Recommendation 1:***

Service providers need to consider how they package and market loneliness services focusing on a skills development rather than a skills deficit approach. Loneliness services which target carers and adults aged 25-50/55 should be particularly encouraged to fill an existing gap in provision.

**Referral practices adopted by services: challenges and what works well**

Three broad types of referral practices were identified in this report: a mixed ad-hoc approach; referrals from other organisations only; and self-referrals and direct engagement with services users. Many of the service providers in all three localities, utilise a mixed approach to referrals, often obtaining them from a variety of different sources, as well as carrying out direct engagement with service users. A number of challenges in the referral process were identified, including: the potential off putting nature of a formal assessment process - particularly for people from some BAME communities; many BAME service users were identified as needing a lot of support in the referral process - from the initial point of identifying a need for support, to referring them to a service provider, to the individual actually receiving the support on offer; and weak collaboration between service providers - means that the nature of the relationships are often not strong enough to allow for an effective and two way referral process, with many services not aware of the full range of other services operating in their locality. Although these challenges affect many third sector organisations, they seem to have a particular impact on organisations which provide services specifically for BAME communities as they are often very small ‘below the radar’ organisations. Moreover, although self-referrals tend to be a popular form of recruitment, this approach often does not always reach the most lonely people, in most need, from BAME communities.

Nevertheless the report also found that certain activities and processes work well in loneliness service referrals for BAME communities, including:

* working with local organisations that are trusted by individuals, such as local grass roots organisations with a long standing base in the locality, or trusted’ organisations such as health providing organisations (including GP surgeries and pharmacies) and large well known national charities;
* providing a ‘supported’ referral service to ensure that people feel effectively supported, are referred to the correct services, but most importantly that the referral is followed through;
* recording referrals to ensure those in need are directed to the most appropriate services and to enable follow up of referrals to ensure that once referred individuals actually take up services; and
* using social media to spread the word about services and reach people who may be lonely and do not have many, or any, face to face social contacts.

***Recommendation 2:*** Loneliness service providers need to be supported to use the above strategies and need to build in sufficient time, resources, and appropriate training for staff and volunteers to implement them. Commissioners and funders need to be aware of the importance of these steps and to ensure sufficient funding is allocated to these activities, as well as the direct delivery of services.

**Barriers to involvement of BAME communities in loneliness services**

The report has identified a number of key barriers to BAME communities accessing loneliness services which include: a lack of information and/or awareness of services available; services may not be culturally sensitive; funding arrangements and financial constraints mean voluntary sector organisations can have difficulty providing the intensity of the support needed to identify, engage with and meet the needs of those most vulnerable, lonely and isolated; transportation to services due to issues with language, confidence, availability, and feeling unsafe. These barriers to involvement by BAME communities appeared to be particularly strong where individuals did not speak or understand English very well.

***Recommendation 3:*** It is important to provide tailored services for specific BAME groups in appropriate languages but, to ensure longer term sustainability, this needs to be accompanied by other support once confidence levels have grown, including provision of English language classes and support to access services involving a wider group of people. Offering culturally sensitive services by staff and volunteers who speak various community languages, and offering a range of activities and foods which are appropriate for different cultures are important aspects of any successful inclusive loneliness service.

Other particularly powerful barriers to BAME communities accessing loneliness services include: stigma - of loneliness and seeking support for loneliness services; trust which can take some time to develop; perceived racism and hate crime; a lack of confidence; assumptions around BAME family support which has the potential to act as a buffer to loneliness but also a facilitator of loneliness and a barrier to people accessing services; and the existence of ethnically homogenous communities where people may not mix much beyond outside their immediate community.

***Recommendation 4:*** It is important to facilitate contact between different BAME communities and between BAME and predominantly White British communities, as well as between service providers targeting different groups within communities. This can play an important role in reducing prejudice and promoting more positive intergroup attitudes where all people feel welcome.

**Facilitators for involvement of BAME communities in loneliness services**

Finally the report has identified a number of factors which can facilitate involvement of BAME communities in loneliness services, including: recruitment of a diverse range of volunteers and staff; engaging with, and creating trust with the local community; ensuring services for particular communities have a base in the heart of the community, with associated outreach workers; the importance of initial one to one support followed by support for individuals to enable them to create their own meaningful relationships which are sustainable beyond specifically funded projects and programmes; the need for services to reflect the diversity of the community which they aim to serve.

***Recommendation 5:*** future loneliness services hoping to reach BAME communities should recruit a diverse range of staff and volunteers, operate from a base within the local community with outreach workers, providing one-to-one support, and to enable individuals to become more resilient and create their own opportunities for meaningful relationships.

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