Canadian Institute for Social Prescribing

Canadian Red Cross

The Caregiver RX Initiative

Building a social prescribing pathway for caregivers in Canada

June 2026

Canadian Institute for Social Prescribing

The Canadian Institute for Social Prescribing (CISP) is an intersectoral collaboration initiative anchored by the Canadian Red Cross. CISP is a national hub focused on improving the health and well-being of Canadians by sharing, connecting, promoting, and celebrating social prescribing practices that connect the formal healthcare system with social and community supports. These practices address the social determinants of health, prioritize health equity, support community leadership, and promote collaboration.

Canadian Red Cross

The Canadian Red Cross has a mission to help people and communities in Canada and around the world in times of need and support them in strengthening their resilience. We are part of the largest humanitarian network in the world, the International Red Cross and Red Crescent Movement. This network includes the International Committee of the Red Cross (ICRC), the International Federation of Red Cross and Red Crescent Societies (Federation), and 192 National Red Cross and Red Crescent Societies dedicated to improving the situation of the most vulnerable people throughout the world.

Land Acknowledgement

We humbly acknowledge that our work takes place across vast and diverse lands through northern Turtle Island, the territories of countless Indigenous nations of First Nations, Métis, and Inuit peoples, who have cared for these lands, waters, and resources since time immemorial.

Throughout history and into today, Indigenous peoples have nurtured holistic approaches to health and well-being, understanding that being well encompasses physical, mental, emotional, and spiritual dimensions. Rooted in profound respect for the interconnectedness of all living beings, Indigenous practices recognize the inseparable link between human health, the health of the land, and the health of communities.

Despite the enduring impacts of colonization, including forced displacement, cultural suppression, and systemic inequities, Indigenous peoples continue to reclaim and revitalize their traditional knowledge systems and healing practices. We are inspired and guided by this resilience and determination as we strive to contribute to more connected and equitable communities.

As we work, learn, and live on this land, we are committed to fostering reconciliation, respect, and understanding. May we listen attentively to Indigenous voices, learn from their wisdom, and work collaboratively towards a future where all peoples can thrive.

Acknowledgements

We thank the Canadian Centre for Caregiving Excellence (CCCE), a program of the Azrieli Foundation, for financially supporting this initiative. We are grateful for our partnership with CCCE and thank them for all their work in advocating for social prescribing for caregivers in Canada. We also thank them for supporting ongoing programs across the country to advance this.

We also would like to thank our provincial implementation partners Family Caregivers British Columbia, Caregivers Alberta, Ontario Caregiver Organization, and Caregivers Nova Scotia, who headed the implementation in their corresponding provinces.

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EXECUTIVE SUMMARY

Canada is facing a caregiving crisis: Over 7.8 million people were caregivers as of the late 2010s, and roughly one in two Canadians will become a caregiver over their lifetime.

Caregivers are often family members and friends who provide unpaid care to loved ones – usually at a great personal cost. While this hidden workforce delivers significant value in unpaid care, the health and well-being of caregivers themselves often suffer. As a result, this increases the burden on caregivers and the healthcare system.

More than one-third of caregivers report experiencing serious distress or an inability to continue in their role. In the face of sleep deprivation and chronic stress, caregivers often prioritize the needs of others over their own health. This contributes to declines in their physical, social, emotional, and mental well-being. In some cases, caregivers experience severe health consequences and pass away before their care recipients.

Social Prescribing for Caregivers

In recent years, caregivers have been increasingly recognized as a priority population for social prescribing in Canada. This holistic, person-centred approach helps bridge siloed health and social systems. As a formal referral pathway, social prescribing allows healthcare providers to "prescribe" non-medical resources to address social determinants of health (SDOH), such as food security, housing support, or social connections.

Launching the Caregiver Rx Initiative

With support from the Canadian Centre for Caregiving Excellence, CISP launched the Caregiver Rx Initiative to co-design and evaluate a social prescribing pathway for caregivers across Canada. In collaboration with four provincial caregiver organizations, this two-year pilot initiative assessed how social prescribing can be effectively integrated into caregiver support systems.

The pilot focused on enhancing caregiver well-being, strengthening social networks, and improving access to meaningful resources. Across all provincial sites, social prescribing was recognized as a powerful approach to addressing the unique needs of caregivers.

Through the Caregiver Rx Initiative, we conducted a national evaluation that consisted of two main components: **Impact and Outcomes Evaluation** and **Process Evaluation**. The findings of these evaluations will help inform the adoption, spread, and scaling of future social prescribing initiatives for caregivers in Canada.

Findings

Impact and Outcomes Evaluation

OUTCOME 1

Caregivers' social, mental, and physical well-being improved & SDOH are supported.

ONTARIO
85% of caregivers reported improvement in mental well-being.

ALBERTA
50% of caregivers felt less stressed about their caregiving role.

BRITISH COLUMBIA
38% of caregivers reported taking more time for themselves.

OUTCOME 2

The community and social sectors have increased capacity to support the SDOH.

ONTARIO
142 social prescribing referrals on behalf of caregivers, linking them to community supports.

NOVA SCOTIA
97% of identified caregivers were served by Caregivers Nova Scotia – indicating substantial reach and delivery capacity.

ALBERTA
82% of partner organizations agreed that Caregivers Alberta increased caregivers' knowledge about available services – and increased partners' own knowledge of caregivers' needs.

BRITISH COLUMBIA
3.16 day average between referral and first contact, indicating a timely referral and follow-up process.

OUTCOME 3

When caregivers are appropriately supported in the community, there is a reduced reliance on clinical appointments, emergency care, and alternate levels of care.

ALBERTA
94% of caregivers felt they had a supportive network.

ONTARIO
50% of caregivers reported avoiding emergency department visits or hospitalizations for themselves.

BRITISH COLUMBIA
12% of caregivers reported needing fewer visits to their primary care provider following community-based support.

OUTCOME 4

Integration across health and community sectors is strengthened, leveraging each other's strengths to provide "the right care at the right place."

ALBERTA

212 referrals to Caregivers Alberta
from agencies with existing active partnerships.

BRITISH COLUMBIA

59% of caregivers
accessed services through referral pathways.

ONTARIO

35 service offerings or referral pathways
were established or utilized, indicating increased access to community-based supports.

NOVA SCOTIA

10 physicians and community partners
were involved in providing additional support and services for caregivers through Caregivers Nova Scotia.

OUTCOME 5

Caregivers' experiences of care are enhanced, and their capacity to navigate appropriate services is improved.

BRITISH COLUMBIA

88% of caregivers
reported an improved understanding of available resources and how to access them, following program participation.

ONTARIO

71% of caregivers
strongly agreed they felt seen and heard by the primary care provider who referred them to the program.

ALBERTA

63% of caregivers
agreed they developed relevant knowledge and skills through participation in the program.

NOVA SCOTIA

50% of caregivers
reported improved ability to navigate community supports using the caregiver survey.

Process Evaluation

Through roundtable discussions, we examined how social prescribing was implemented across the four provinces: Alberta, British Columbia, Nova Scotia, and Ontario. During site visits, our provincial partners identified the following enablers and barriers to social prescribing for caregivers.

Key Enablers of Social Prescribing

- Equitable access to caregiver support
- Virtual care
- Trauma-informed care
- Champions in the health and social systems
- Allied health professionals
- Community pharmacists
- Community paramedics
- Standardized training

System-Level Barriers to Caregiver Support

- Under-resourced and overextended health and social systems
- Fragmented health and social systems
- Long waitlists
- Staffing shortages
- Implications for caregivers and care recipients

Recommendations for Scaling Social Prescribing

Build Cross-Sectoral Integration Infrastructure

Integrating health and social systems should include referral platforms, co-sharing physical space, and data-sharing agreements. Investing in the electronic medical record (EMR) would also streamline the referral process, reduce siloed and fragmented systems, and increase the ease of social prescribing for the care team.

Standardize Education and Training Across Sectors

Governments, professional bodies, and health organizations should invest in standardized education and training for healthcare providers and allied health professionals. This should include caregiver identification, trauma-informed care, and the role of social prescribing.

Treat Caregiver Support as an Upstream Public Investment

Supporting caregivers before they reach a crisis improves health outcomes for both caregivers and their care recipients. As a result, policymakers and funders should recognize caregiver-focused social prescribing as a high-value, preventive public health investment.

Across all provincial sites, social prescribing was recognized as a powerful and unifying approach to addressing caregivers' non-clinical needs and alleviating caregivers' burden. By establishing structured referral pathways and fostering team-based care, the social prescribing pathway allows visible and invisible caregivers to be identified earlier and connected to much-needed community-based supports and services.

INTRODUCTION

Supporting the Health and Social Needs of Caregivers in Canada

Social Prescribing in Canada

In recent years, Canada has seen rapid growth and policy interest in social prescribing (SP) – an emerging approach to linking healthcare with social and community services. In every province, social prescribing initiatives are now underway, and healthcare leaders are recognizing this approach as a vital component of Canada's healthcare future. With health and social systems under pressure, this movement is being recognized as a way to relieve strained systems and improve health equity across the country.

More than 80% of health outcomes are driven by social factors like income, housing, and relationships.[1] As a formal referral pathway, social prescribing allows healthcare providers to "prescribe" non-medical resources in their community. This holistic, person-centred approach addresses the social determinants of health (SDOH) based on what matters to the individual. It also serves as a strategic way to address challenges like social isolation, food insecurity, or housing support alongside medical care. As a result, social prescribing allows healthcare providers to focus on their patients' health and well-being overall – rather than treating only medical illnesses.

The Caregiver Crisis

As of the late 2010s, about one in four Canadians – over 7.8 million people – was a caregiver, and roughly one in two Canadians will become a caregiver over their lifetime.[2] They are family members and friends who provide unpaid care to ill, disabled, or aging loved ones. Although this hidden workforce delivers significant value in unpaid care, it often comes at great personal cost.

More than one-third of unpaid caregivers report experiencing serious distress, including feelings of anger, depression, or an inability to continue in their role.[3] As they put the needs of their loved ones first, many caregivers experience social isolation and loneliness – and their physical health can also suffer. Caregivers often face sleep deprivation, chronic stress, and risk neglecting their own healthcare. Caregivers are increasingly recognized as a priority population for social prescribing in Canada.

1 Mulligan, K., Card, K. G., & Allison, S. (2024). Social prescribing in Canada: Health promotion in action, 50 years after the Lalonde report. *Health Promotion and Chronic Disease Prevention in Canada: Research, Policy and Practice,* 44(6), 241–243. https://doi.org/10.24095/hpcdp.44.6.01

2 Olesinski, O. (2022, November 7). Canadian Caregivers are at a Breaking Point. *Canadian Centre for Caregiving Excellence.* https://canadiancaregiving.org/canadian-caregivers-are-at-a-breaking-point/

3 CIHI. (2018). *Canadian Institute for Health Information. Unpaid caregiver challenges and supports.* Accessed February 3, 2026. https://www.cihi.ca/en/dementia-in-canada/unpaid-caregiver-challenges-and-supports

The Caregiver Rx Initiative

With support from the Canadian Centre for Caregiving Excellence (CCCE), CISP launched the Caregiver Rx Initiative – a pilot initiative in collaboration with four provincial caregiver organizations:

- Family Caregivers of British Columbia (FCBC)
- Caregivers Alberta
- Ontario Caregiver Organization (OCO)
- Caregivers Nova Scotia

Culminating in March 2026, the Caregiver Rx Initiative aimed to build and evaluate a social prescribing pathway for caregivers across Canada. The two-year pilot assessed how social prescribing can be effectively integrated into caregiver support systems to enhance caregiver well-being, strengthen social networks, and improve access to meaningful resources.

Through the Caregiver Rx Initiative, CISP partnered with the four provincial caregiver organizations to design, implement, and evaluate social prescribing pathways for caregivers in their respective provinces. Each of these partner organizations piloted a locally adapted social prescribing pathway for caregivers. Although grounded in a shared Theory of Change, the pathways were tailored to regional health system structures, referral mechanisms, and caregiver needs.

Over the two-year implementation period, each provincial organization aimed to achieve the following:

- Enhance caregiver well-being by addressing SDOH and connecting them to meaningful support.
- Strengthen collaboration between healthcare providers and community organizations to create sustainable referral pathways for caregivers.
- Enhance access to non-clinical services that support caregivers beyond traditional healthcare settings.

CISP journeyed alongside the provincial pilots to learn, gather insights, and explore how social prescribing can support caregivers at a system level. To ensure a national perspective, CISP was responsible for the following:

- Convening a national evaluation to assess collective learnings from the provincial pilots.
- Aggregating provincial findings to identify common themes, challenges, and best practices.
- Developing a shared understanding of the impact of social prescribing on caregivers and its role in strengthening caregiver support systems.

By bringing together findings from across the provinces, CISP helped tell a collective story on the impact of social prescribing on caregivers, communities, and health systems. The key insights discovered through the Caregiver Rx Initiative will help to inform the adoption and scaling of future social prescribing initiatives for caregivers across Canada.

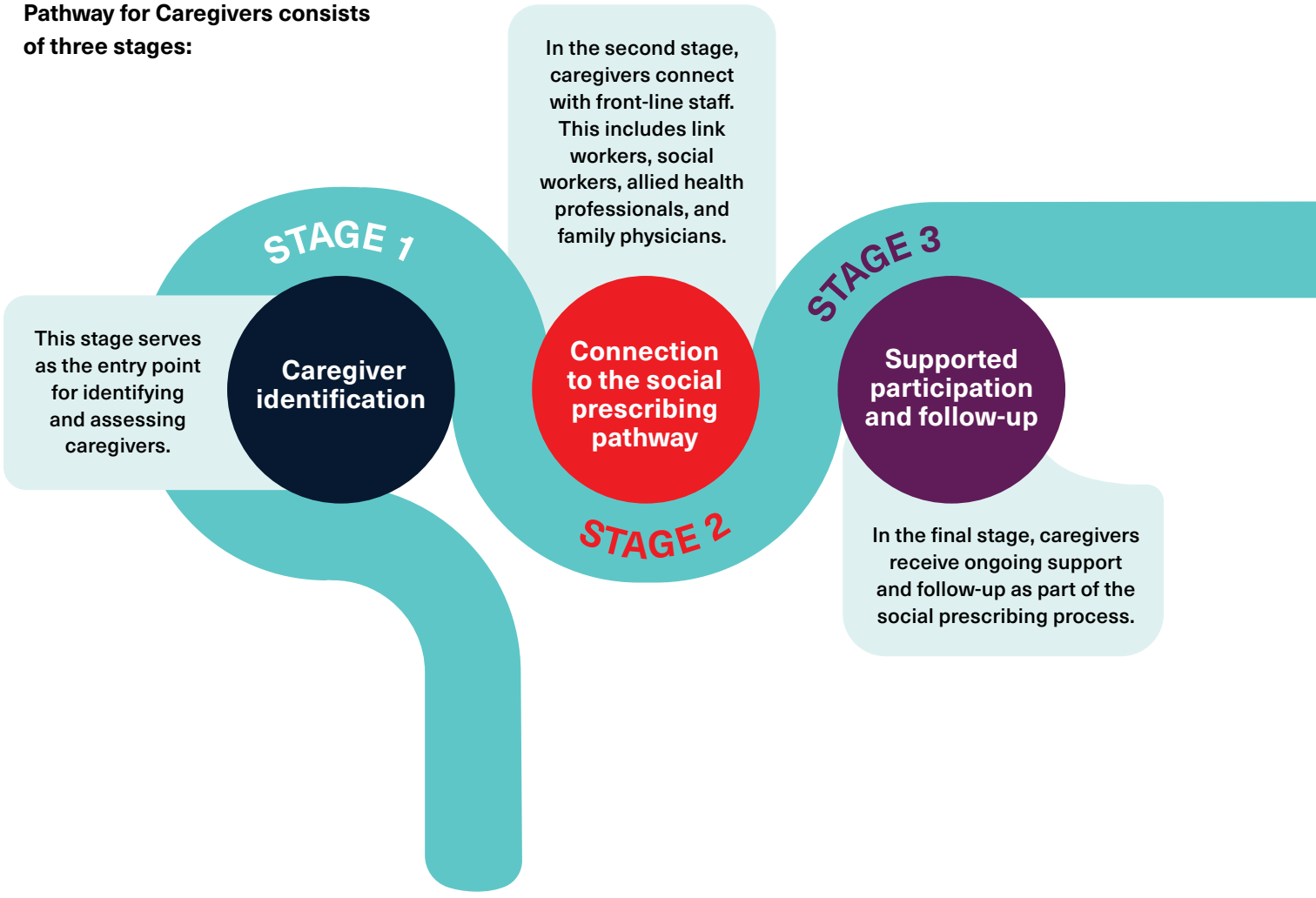
IMPLEMENTING SOCIAL PRESCRIBING FOR CAREGIVERS

In partnership with the four provincial caregiver organizations, CISP co-designed the national Social Prescribing Pathway for Caregivers and Theory of Change framework to meet the specific needs of caregivers in each region.

National Social Prescribing Pathway for Caregivers

Connecting caregivers with non-medical support, the national Social Prescribing Pathway for Caregivers is a collaborative effort that bridges healthcare, community resources, and individual needs to enhance well-being and health outcomes.

The national Social Prescribing Pathway for Caregivers consists of three stages:



STAGE 1
Caregiver Identification

Many caregivers who provide extensive care to others do not self-identify as caregivers. They view their role as a normal part of family expectations or as an extension of a relational role, such as a spouse, parent, or child**.** As a result, **caregivers often remain "invisible" within health and social systems** – despite their need to access essential supports themselves. Caregivers often engage with the health and social systems when they are already experiencing burnout or have reached a breaking point.

Through social prescribing pathways, caregivers can be identified through the following entry points:

- Self-referral
- Family physicians
- Allied health providers (e.g., pharmacist)
- Community professionals (e.g., link worker, paramedics)
- Social network referrals (e.g., friends and family)

Caregivers who are at risk of burnout or social isolation are more likely to engage in community, cultural, or informal spaces than walk into a medical clinic.

More specifically, faith-based organizations, community libraries, and community centres – where caregivers may already have established trust and relationships – provide access to the social prescription pathways. These spaces can help promote awareness among caregivers and access to community-based organizations and services.

STAGE 2
Connection to the Social Prescribing Pathway

Once caregivers are identified, they are triaged to community programs or social prescribing pathways. Through this process, caregivers engage with a dedicated link worker based on their unique needs.

Link workers are social professionals who provide dedicated, tailored, and co-creative support to help bridge the gap between health and social care.

Link workers are also referred to as community connectors, care coordinators, or wellness navigators. Other social professionals, such as the Canadian Red Cross paramedic teams and front-line staff, also play an important role in connecting caregivers to community-based resources.

Through social prescribing, caregivers are empowered to take the lead on their own health. Using a strength-based approach, link workers focus on *what matters to caregivers* – rather than *what is the matter with them*. This reframes help-seeking as a strength rather than a weakness or failure.

Link workers focus on confidence-building, system navigation, and emotional validation. By providing culturally sensitive care, link workers recognize caregivers' abilities, skills, resilience, and lived expertise. They also partner with caregivers to co-create personal goals.

STAGE 3
Supported Participation and Follow-up

After link workers connect caregivers to community-based resources, they initiate a comprehensive needs assessment within a few business days. This includes validated tools and other tools focused on SDOH to identify unique needs.

Here are some examples of social prescription services at Stage 3:

- One-on-one coaching for emotional wellness
- Group programs and peer support groups
- Education programs focused on building resilience and skills

For caregivers accessing the social prescribing pathway for the first time, responsiveness is the key to building trust.

Rapid outreach communicates legitimacy, reliability, and genuine care. If wait times are anticipated, administrative teams from community-based organizations proactively reach out to reassure caregivers. This approach helps prevent additional frustration and distress. It also keeps caregivers engaged while they wait for community-based resources or services.

As caregivers access community-based services and supports, **link workers play a vital role in providing follow-up, ongoing support, and progress monitoring.** This includes activating, mobilizing, and empowering individuals to take leadership in their own health and wellness, and contribute to building their communities.

On the Right Path

Overall, social prescribing aims to support caregivers earlier in their journey, raise awareness of available resources, and help prevent crises that could lead to emergency department or intensive care visits.

Through the Caregiver Rx Initiative, CISP worked with the four provincial caregiver organizations to develop pathways for each of their regions based on the national Social Prescribing Pathway for Caregivers. These provincial pathways share a common foundation with the original CISP pathway, while incorporating elements that adapt to unique regional contexts. They also address the specific needs of caregivers, programs, and provincial priorities.

Theory of Change for Caregivers

The national impact narrative of the Caregiver Rx Initiative is grounded in the Theory of Change (ToC) – guiding the implementation of caregiver-focused social prescribing. The ToC provides a structured framework to understand how social prescribing interventions can lead to meaningful caregiver outcomes. It also connects four critical input domains:

- Leveraging healthcare as a doorway to social care
- Collaboration and connection
- Community engagement and development
- Monitoring and learning towards the anticipated impacts

This process of adapting the ToC for caregivers was guided by ongoing consultation with caregiver implementation partners, incorporating insights from their expertise. As the provincial pilots progressed, the ToC underwent further refinement based on real-time learnings. This iterative approach ensured the ToC remained relevant, practical, and firmly grounded in implementation realities.

Caregivers Alberta
Meals on Wheels Partnership

A Timely Touchpoint

“Hello.”

The unexpected greeting startled the exhausted caregiver on the line. It was 4:15 p.m. on a Friday, so she was calling to leave a voicemail for the community resource about accessing support. Instead, she reached a real person who took the time to listen, understand her situation, and respond with care.

That single conversation became the gateway to a network of coordinated support.

First, the caregiver was referred to one-on-one coaching, where she could openly process the emotional toll of supporting her loved one. She was also welcomed into group programs to help reduce isolation. This allowed her to connect with others with similar experiences.

Through a community partnership, the caregiver was later connected to a Meals on Wheels program in Alberta that provides free meals for caregivers. This helped ease the daily stress of meal preparation and ensured the caregiver’s own nutritional needs were met.

This story illustrates how one timely touchpoint within the social prescribing pathway can cascade into multiple layers of support. A seemingly small act of support – such as answering the phone late on a Friday afternoon – can become the first step in restoring well-being, dignity, and stability for a caregiver at risk of burnout.

This social prescription addressed emotional, practical, and social needs in a coordinated and meaningful way.

NATIONAL COLLABORATIVE EVALUATION

Objectives

Through the Caregiver Rx Initiative, the national collaborative evaluation aimed to learn from provincial pilot sites to inform and equip the adoption, spreading, and scaling of future initiatives.

This evaluation had the following objectives:

- Inform about the impacts and process of SP implementation for caregivers.
- Build evidence for caregiver-focused SP initiatives.
  - » Assess the outcomes and impacts of integrating healthcare providers into the SP pathways for caregivers.
  - » Identify barriers and challenges, lessons learned, and existing gaps in the caregiver SP implementation process.
  - » Learn about stakeholder experiences.
- Support caregivers in their dual roles as both caregivers and patients.
  - » Engage healthcare providers and key stakeholders (e.g., the implementation team, community partners).

Evaluation Objectives

The national evaluation aimed to inform the adoption, spread, and scaling of future caregiver-focused social prescribing initiatives across Canada. Through the two main components of the national evaluation – **Impact and Outcomes Evaluation** and **Process Evaluation** – the Caregiver Rx Initiative aimed to achieve the following:

- Inform the caregiver implementation process by capturing provincial innovations, challenges, and factors that contribute to success.
- Measure the impact and outcomes of nationwide caregiver-focused initiatives.
- Contribute to a shared national narrative on the adaptation and delivery of caregiver-focused SP across diverse contexts.
- Support the advancement of future adoption and spreading through informing best practice recommendations.

Questions: Impact and Outcomes Evaluation

1. What is the impact of the Caregiver Rx initiative on Caregivers?
2. What is the impact of integrating healthcare providers and link workers/navigators into the SP pathway for unpaid caregivers across four provincial partners?

Questions: Process Evaluation

1. What are the insights gained from the Caregiver Rx Initiative implementation?
2. What are the lessons learned, challenges or barriers, enablers or facilitators of implementation of SP for caregivers?
3. What are the opportunities and support needed to scale and sustain caregiver-focused SP?

Pilot Population

The sample population for the national evaluation included caregivers accessing relevant non-clinical supports and services in the community through the link workers and/or navigators at each pilot site across the four provinces. In addition, the following individuals and groups were included in the evaluation to ensure a comprehensive overview:

- Healthcare providers
- Stakeholders from community organizations or partners
- Link workers or navigators
- The implementation team (e.g., caregiver support staff, manager, program staff)
- Family or friends, if actively involved in the referral process

Evaluation Approaches

Impact and Outcomes Evaluation

Based on the Theory of Change for caregivers, the following national priority outcomes were identified to measure the impact and outcomes of the Caregiver Rx Initiative:

Outcome 1: Caregivers' social, mental, and physical well-being improved & SDOH are supported.

Outcome 2: The community and social sectors have increased capacity to support the SDOH.

Outcome 3: When caregivers are appropriately supported in the community, there is a reduced reliance on clinical appointments, emergency care, and alternate levels of care.

Outcome 4: Integration across health and community sectors is strengthened, leveraging each other's strengths to provide "the right care at the right place."

Outcome 5: Caregivers' experiences of care are enhanced, and their capacity to navigate appropriate services is improved.

Process Evaluation: Site Visits

The Caregiver Rx Process Evaluation aimed to explore how social prescribing is being implemented for caregivers across four provinces in Canada, identify enablers and barriers, and capture place-based insights that inform a cohesive national strategy to caregiver-focused social prescribing.

The CISP evaluation team visited provincial partners and observed a range of community-based programs, including the following:

- Airdrie Public Library, Alta.
- Conversation Café, Alta.
- Art & crafts SP programs, Alta.
- Nature Prescription: Caregiver Walking Group, B.C.
- A transitional health facility, N.S.
- Canadian Red Cross office, Sault Ste. Marie, Ont.
- Community clinic, Hamilton, Ont.

Each province also hosted a partners' roundtable to convene implementation stakeholders and future potential partners:

- Primary Care Network
- Provincial Health Authorities
- Allied health professionals (e.g., occupational therapists)
- NGOs (e.g., Healthy Aging Alberta)
- Academic researchers
- Link workers and outreach workers
- Patient partners and caregivers

Impact and Outcomes Evaluation

Methods

Evaluation Approach

This evaluation used a mixed-methods comparative design to assess the implementation and impacts of social prescribing for caregivers in four Canadian jurisdictions: Alberta, British Columbia, Nova Scotia, and Ontario. The evaluation approach was also action-oriented and participatory. This emphasized practical relevance, local learning, and decision support for implementation partners.

Provincial partners retained autonomy to design indicators and data collection strategies aligned with their local contexts, capacities, and priorities. However, the provincial partners still contributed to a shared set of nationally defined outcomes. This design reflects the intent to generate a national impact narrative grounded in real-world implementation rather than controlled experimental comparison.

Indicators and Measures

Each province developed its own set of quantitative and qualitative indicators to assess progress toward the national outcomes. Although indicators were not standardized across provinces, they were mapped to the shared national outcomes to support synthesis.

Quantitative measures included validated tools, such as the Warwick–Edinburgh Mental Well-Being Scale and the Multidimensional Scale of Perceived Social Support. These tools were used alongside program-specific surveys, administrative data, and service utilization metrics.

Qualitative indicators captured caregiver, provider, and partner experiences through interviews, open-ended survey responses, case studies, and testimonials.

Data Collection

Data collection methods varied by province and reflected local evaluation designs. Across jurisdictions, data sources included the following:

- Caregiver surveys
- Stakeholder surveys
- Administrative program data
- Qualitative feedback collected through interviews, focus groups, and narrative submissions

Provincial partners were responsible for collecting and aggregating their own data. This information was then shared with the national evaluation team in anonymized and aggregated form. CISP also supplemented provincial data through additional interviews, site visits, and cross-provincial synthesis. This helped to identify gaps, triangulate findings, and strengthen interpretation.

Analysis and Synthesis

Quantitative data were summarized descriptively at the provincial level and synthesized narratively across jurisdictions. This process helped assess directional effects relative to each national outcome. No pooled statistical analyses were conducted, given the diversity of indicators and sample sizes.

Qualitative data were analyzed using an indexing and thematic analysis approach. This organized findings by outcome domain and identified recurring patterns, mechanisms, and contextual factors.

This mixed-methods, collaborative approach was designed to prioritize learning, relevance, and scalability. It also transparently documented variation, limitations, and contextual influences across provinces.

Results

OUTCOME 1

Caregivers' social, mental, and physical well-being improved & SDOH are supported.

Across the four provinces, quantitative and qualitative evidence indicate that social prescribing was associated with improvements in caregivers' mental well-being. There were also improvements in support for key social determinants of health. However, physical well-being outcomes were least consistently assessed and showed mixed results. This indicates that physical health may be less responsive to navigation-focused interventions in the short term or may require longer-term or more intensive supports.

The strongest and most consistent findings related to emotional well-being, stress reduction, validation, and perceived support.

Highlights

ONTARIO
85% of caregivers
reported improvement in mental well-being.

ALBERTA
50% of caregivers
felt less stressed about their caregiving role.

BRITISH COLUMBIA
38% of caregivers
reported taking more time for themselves.

OUTCOME 2

The community and social sectors have increased capacity to support the SDOH.

Across the four provinces, quantitative and qualitative evidence demonstrates that social prescribing initiatives contributed to measurable increases in community and social sector capacity to support caregivers' SDOH. While measurement approaches varied by province, the findings collectively point to a coherent and positive pattern of system strengthening.

Across jurisdictions, social prescribing functioned as a catalyst for system-level learning, coordination, and sustainability. Rather than solely increasing service volume, the initiatives contributed to qualitative improvements in how community and social sectors understand caregiver needs, collaborate across organizational boundaries, and deliver supports that address social determinants of health.

Highlights

ONTARIO
142 social prescribing referrals
on behalf of caregivers, linking them to community supports.

NOVA SCOTIA
97% of identified caregivers
were served by Caregivers Nova Scotia – indicating substantial reach and delivery capacity.

ALBERTA
82% of partner organizations agreed
that Caregivers Alberta increased caregivers' knowledge about available services – and increased partners' own knowledge of caregivers' needs.

BRITISH COLUMBIA
3.16 day average
between referral and first contact, indicating a timely referral and follow-up process.

OUTCOME 3

When caregivers are appropriately supported in the community, there is a reduced reliance on clinical appointments, emergency care, and alternate levels of care.

Taken together, the evidence indicates that **Outcome 3 is not yet demonstrated at a national level**. Direct measures of reduced reliance on clinical appointments, emergency care, and alternate levels of care were inconsistently collected, often based on small samples, and relied on caregiver self-report. Where health service utilization outcomes were measured, results suggest potential reductions in some contexts, particularly in Ontario. But results also show substantial proportions of caregivers reporting no change or uncertainty, especially for emergency and hospitalization outcomes.

At the same time, the evaluation provides strong evidence that enabling conditions for reduced system reliance were established across multiple provinces. For example, high levels of caregiver satisfaction with community-based supports and information – and widespread perceptions of having a supportive network – suggest that social prescribing strengthened non-clinical support pathways. These conditions are widely recognized as prerequisites for shifting care away from acute and primary care settings.[4,5]

Highlights

ALBERTA
94% of caregivers
felt they had a supportive network.

ONTARIO
50% of caregivers
reported avoiding emergency department visits or hospitalizations for themselves.

BRITISH COLUMBIA
12% of caregivers
reported needing fewer visits to their primary care provider following community-based support.

4 Mutoniwase E, Cheng Z, Cai X, Li Y. *Better State Support for Family Caregivers Linked to Lower Hospitalization Rates Among Older Adults Living With Dementia.* J Appl Gerontol. 2025 Aug 11:7334648251365673. doi: 10.1177/07334648251365673. Epub ahead of print. PMID: 40790898; PMCID: PMC12352608.

5 Nezafat Maldonado B, Bell W, Olivera J, Beyer F, Lambert M, Thomson R, Cookson R, Bambra C, Sowden S. *Social and policy interventions to reduce hospital admissions among socioeconomically disadvantaged groups in OECD countries with universal health care: a systematic review.* BMJ Public Health. 2025 Sep 23;3(2):e002592. doi: 10.1136/bmjph-2025-002592. PMID: 41001236; PMCID: PMC12458780.

OUTCOME 4

Integration across health and community sectors is strengthened, leveraging each other's strengths to provide "the right care at the right place."

Across the four provinces, quantitative evidence demonstrates substantial progress toward strengthening integration between health and community sectors. This includes consistent signals of expanded partnerships, active referral pathways, and high stakeholder confidence in collaborative processes. Qualitative data specific to this outcome were limited across jurisdictions. However, **the breadth and consistency of quantitative indicators provide a detailed picture of system-level integration and operational coordination.**

The consistency of positive signals supports the conclusion that social prescribing strengthened cross-sector relationships and improved the practical mechanics of coordinated care. This includes referral generation, follow-up, and partner confidence.

Highlights

ALBERTA
212 referrals to Caregivers Alberta
from agencies with existing active partnerships.

BRITISH COLUMBIA
59% of caregivers
accessed services through referral pathways.

ONTARIO
35 service offerings or referral pathways
were established or utilized, indicating increased access to community-based supports.

NOVA SCOTIA
10 physicians and community partners
were involved in providing additional support and services for caregivers through Caregivers Nova Scotia.

OUTCOME 5

Caregivers' experiences of care are enhanced, and their capacity to navigate appropriate services is improved.

Across the four provinces, quantitative and qualitative evidence indicate that **social prescribing strengthened caregivers' experiences of care.** It also improved their capacity to navigate community and health resources. Indicators across jurisdictions capture improvements in awareness of services, perceived access, navigation skills, satisfaction with referral processes, and relational aspects of care. Generally, there was a consistent positive direction across provinces, despite smaller samples for some caregiver-reported measures.

Highlights

BRITISH COLUMBIA
88% of caregivers
reported an improved understanding of available resources and how to access them, following program participation.

ONTARIO
71% of caregivers
strongly agreed they felt seen and heard by the primary care provider who referred them to the program.

ALBERTA
63% of caregivers
agreed they developed relevant knowledge and skills through participation in the program.

NOVA SCOTIA
50% of caregivers
reported improved ability to navigate community supports using the caregiver survey.

Discussion

This national evaluation examined how caregiver-focused social prescribing is associated with improvements in caregiver well-being and with system-level changes consistent with more integrated, community-oriented care. Across provinces, the evidence indicates a generally positive direction of effect on caregiver mental and emotional well-being, caregiver experience of care, navigation capacity, and cross-sector integration.

Evidence for reduced health system utilization was weaker and should be interpreted as preliminary. This is due to inconsistent measurement, small denominators for several indicators, and reliance on self-report.

Overall, the pattern is most consistent with social prescribing operating as an enabling intervention that achieves the following:

- Strengthens relational and informational continuity
- Improves access to community supports
- Stabilizes caregiver distress

However, downstream impacts on clinical utilization remain insufficiently demonstrated at a national level.

Summary of Evaluation Evidence Across Outcomes and Indicators

Outcome 1 concerned caregiver social, mental, and physical well-being and support for social determinants of health. Quantitative signals were strongest for mental well-being and stress-related outcomes.

Alberta reported improvements on the Short Warwick–Edinburgh scale among a majority of respondents with available paired data. The province also showed high staff and partner endorsement of program value.

British Columbia's baseline measures indicated moderate mental well-being and moderate perceived social support. However, caregiver-reported changes suggested modest improvements in social connectedness and self-care behaviours.

Ontario caregivers most consistently reported mental well-being improvement, with more mixed and variable responses for social and physical well-being. Qualitative evidence supported a mechanism centred on feeling heard, validated, and supported, alongside greater confidence and reduced anxiety.

Nova Scotia's qualitative responses highlighted high unmet need across emotional, physical, and financial domains. This contextualizes why short-term improvements may be constrained when caregiving intensity and structural barriers are substantial.

Outcome 2 addressed community and social sector capacity to support social determinants of health. Across jurisdictions, quantitative indicators suggest improved operational readiness and partnership functioning.

Alberta showed high partner satisfaction, perceived increases in knowledge about caregiver needs, and strong internal perceptions of readiness and learning supports.

British Columbia demonstrated efficient referral follow-up, with all referrals tracked and a short average time from referral to first contact. This indicates a responsive infrastructure.

Nova Scotia demonstrated broad service reach among identified caregivers. The province also reported strengthened partnerships and funding acquisition to expand services, consistent with capacity growth and sustainability.

Ontario expanded workforce capacity through training and link worker deployment. As a result, substantial numbers of caregivers were supported and referrals generated. Qualitative narratives suggest improved understanding of caregiver needs among practitioners and increased legitimacy and stability through diversified funding. Together, they support sustained sector capability.

Outcome 3 focused on reduced reliance on clinical appointments, emergency care, and alternate levels of care when caregivers are supported in the community. Direct utilization indicators were inconsistently collected, absent in some provinces, and often based on small samples.

Caregivers from Ontario reported comparatively stronger indications of avoided primary care visits and avoided emergency or hospitalization events for both caregivers and care recipients. But uncertainty and “no change” responses were common, which is expected for episodic outcomes and short observation windows.

British Columbia’s utilization-related indicators showed potential reductions but were based on very small denominators.

Alberta provided strong evidence for enabling conditions. This includes satisfaction with supports and information and perceived supportive networks. However, the province did not capture direct hospital utilization measures.

Outcome 4 examined whether integration across health and community sectors was strengthened to enable "the right care at the right place."

Indicators across Alberta, British Columbia, and Ontario converge on strong integration performance. This is reflected in established or sustained partnerships, bidirectional referrals, high partner satisfaction with collaboration and communication, and high ratings of referral pathway usability among providers.

British Columbia demonstrated both high partner satisfaction with the referral process and complete maintenance of identified partnerships, alongside evidence that a majority of caregivers accessed services through referral pathways.

Alberta reported numerous referrals exchanged through both new and existing partnerships. The province also formalized integration through memoranda of understanding.

Ontario reported multisectoral participation, partnership formation, and co-creation of services and pathways. Providers also reported that link workers enhanced navigation capability and caregiver support efforts.

Nova Scotia reported physician and partner engagement consistent with strengthened integration. However, fewer integration metrics were available, limiting cross-jurisdictional comparability.

Outcome 5 assessed the caregiver experience of care and navigation capacity. This outcome showed the most consistent positive pattern across provinces.

Alberta reported high proportions of caregivers indicating improved awareness of services, improved access, and meaningful gains in relevant knowledge and skills.

British Columbia caregivers frequently reported improved understanding of resources, easier access, and satisfaction with referral processes. The province also reported some sustained engagement with services at six months among a subset of participants.

Ontario caregiver ratings suggested improved relational quality of care. This includes feeling seen and heard by referring providers and perceiving link workers as effective in helping identify community supports.

Nova Scotia, despite limited survey participation, showed signals of improved navigation among respondents. Qualitative evidence from British Columbia adds interpretive depth, indicating that navigation support produced emotional benefits. This includes reduced isolation, validation, and small but meaningful improvements in daily functioning. This likely supports continued engagement with care and improved coping under persistent caregiving demands.

Ontario Caregiver Organization

The SCALE Program

Building Resilience in the Storm

After the death of her mother in 2020, a caregiver found herself navigating an overwhelming caregiving journey.

A few months after losing her mother, the caregiver's father declined rapidly and was later diagnosed with a rare and aggressive illness. This left the caregiver emotionally exhausted, and she did not know how she could manage caring for him while protecting her own well-being.

At this critical point, a representative from a social prescribing pilot in Ontario – the SCALE program – reached out to the caregiver. Previously delivered online, the program was piloted in-person in Elliot Lake to support caregiver awareness, learning, and empowerment.

Although the caregiver was hesitant to join group-based support at first, she later accepted the invitation. From the first session, she found solace in sharing her struggles with others in similar caregiving roles.

The program provided a strengths-based, supportive environment. It also challenged unrealistic expectations the caregiver had placed on herself. She describes the peer support as transformative: the empathy, guidance, and validation she received became essential to her coping and resilience.

Through the SCALE program, the caregiver also connected with other resources. This includes one-on-one coaching and community programs, such as Meals on Wheels. This network of support helped her navigate the complexities of caregiving while maintaining her own mental health. Inspired by her experience, she later helped establish a caregiver-led support group in Elliot Lake – creating a space for others to share and connect in person.

This story illustrates the cascading impact of social prescribing: connecting an individual caregiver to a structured program, building peer networks, and empowering participants to support others in the community.

The caregiver credits the Ontario Caregiver Organization, the SCALE program, and the dedication of social prescribing facilitators for providing the timely and holistic support that helped her through one of the most challenging periods of her life.

Process Evaluation

Methods

To examine the implementation of the Caregiver Rx Initiative, CISP engaged with provincial partners and community stakeholders through facilitated **roundtable discussions**. These semi-structured discussions explored implementation processes, captured key insights and lessons learned, and identified barriers and enablers related to social prescribing for caregivers.

In addition, CISP conducted **site visits** to gather real-time observational data on program implementation. These visits were conducted in collaboration with healthcare providers, link workers, community-based organizations, and caregivers to better understand on-the-ground practices and contextual factors influencing implementation.

Results

Defining Social Prescribing

Social prescription acts as a bridge between siloed health and social systems by identifying and supporting both visible and invisible caregivers. As a strengths-based approach, it helps caregivers rebuild identity beyond the caregiver role.

Social prescribing is empowerment-oriented rather than prescriptive. This helps ensure caregivers' strengths, goals, and aspirations guide the development of individualized action plans. Ultimately, it addresses caregivers' complex social, emotional, and mental health needs to improve whole-person quality of life.

Community is at the core of the social prescribing pathway. Through this pathway, caregivers receive non-clinical, relationship-based support from a coordinated network of health and social professionals, such as link workers, health providers, allied health professionals, and community partners. These professionals collaboratively connect caregivers with appropriate community services and resources, while recognizing that their needs are diverse and ever-changing.

To address the social determinants of health, community-based supports and services can range from website-based guidance to crisis intervention. This includes one-on-one coaching, system navigation to access external supports, group-based education programs, and peer support.

Together, these offerings strengthen resilience, reduce isolation, and provide flexible, responsive support that adapts to caregivers' complex and evolving needs.

Key Enablers of Social Prescribing

Social prescription acts as a bridge between the health and social systems. Through structural referral pathways, it can integrate these traditionally separate systems. As a result, social prescribing helps reduce duplication and enhance coordination to better support caregivers.

During site visits, the four provincial partners identified the following enablers of effective social prescribing.

Equitable Access to Caregiver Support

Caregivers who are most in need of services are often from marginalized communities. As a result, they usually do not get connected to appropriate support. Flexibility in program design and delivery options that meet caregivers "where they are at" are critical equity enablers. Caregivers facing time constraints and structural barriers – including transportation challenges, geographic isolation, and competing caregiver responsibilities – particularly need this flexibility.

Community-based services should be designed around caregiver capacity rather than provider convenience. For example, one care coordinator delivered an entire program through one-on-one phone conversations to accommodate a caregiver's schedule. In another instance, a group-based workshop was redesigned into individualized discussions to address the unique needs and circumstances of a caregiver. Findings show that rigid and standardized approaches risk excluding caregivers with the greatest need.

Virtual Care

Advancing equitable access requires intentional efforts to identify and remove structural barriers to care. **Virtual care has emerged as an important strategy to address challenges** related to transportation, geographic isolation in rural or remote regions, and competing caregiver responsibilities. However, service design must also account for differences in language, cultures, and health literacy. Technology should not be the only option for delivering health and social care, particularly for older caregivers and care recipients. This helps prevent technology-related stress that may compound existing caregiving burdens (e.g., limited use of email or video conferencing).

Trauma-Informed Care

Trauma-informed, relationship-centred practice emerged as a foundational way to effectively engage with caregivers – particularly those experiencing chronic stress, burnout, and cumulative trauma. Findings emphasize that social prescribing must be grounded in structural awareness and dignity, as well as respect. The intake process was identified as a meaningful intervention – with a warm, relational first contact supporting trust and engagement. More importantly, **how support is offered was found to be as critical as what is being offered.** Trauma-informed language and intake processes that prioritize consent, emotional safety, and flexibility are essential to meeting caregivers where they are.

Champions in the Health and Social Systems

Integrating champions within Canada's fragmented health and social systems is a key enabler of a functional social prescribing pathway. Champions include physicians, allied health professionals, social workers, and other providers delivering team-based care. **They each play a crucial role in bridging health and social systems through clear, trusted referral pathways.** Team-based models support caregivers without overburdening physicians with increased workloads in the health systems.

Social workers embedded within primary care teams can support physicians and allied health professionals by facilitating connections to coordinated community-based organizations. This helps ensure that caregivers' non-medical needs are addressed. Using social prescribing models, care coordinators bridge clinical care to broader community resources, increasing access to services for caregivers and care recipients.

Beyond supporting referrals, social prescribing leaders contribute to system-level integration by fostering cross-sector partnerships. This includes convening communities of practice that bring together leadership from community organizations, community health centres, and the medical community. Through this connection, they can share knowledge, tools, and resources, and collectively advocate for stronger supports for caregivers.

Allied Health Professionals

Alongside family physicians, allied health professionals (AHPs) such as nurses, physical therapists, and occupational therapists, serve as additional entry points into social prescribing pathways. **Team-based care fills the gaps of the system by identifying patients' non-medical needs.** This form of care also connects them to community-based supports and coordinating services that address SDOH, such as food security, transportation, and social isolation. As a result, AHPs help bridge the gap between clinical care and community resources.

The community outreach team at West Bedford Transitional Health in Nova Scotia works closely with caregivers and their care recipients as they transition out of West Bedford. They work with a network of healthcare and community service providers to co-create a care plan, including primary care, home support and nursing services. This also includes the Canadian Red Cross, Alzheimer Society of Canada, Caregivers Nova Scotia, and Community Health Teams, as well as food programs (i.e., Meals on Wheels).

Community Pharmacists

As frontline health professionals, pharmacists in Nova Scotia working in the community have developed trusted relationships with caregivers and their care recipients. By leveraging trusted relationships with community members, **pharmacists are well-positioned to act as a bridge to identify and connect caregivers to community support.** As a social prescribing partner, Caregivers Nova Scotia collaborates with pharmacists to identify and connect with caregivers who may benefit from social prescription. They also hand out a postcard with contact information, facilitating a timely connection to support services.

Community Paramedics

Working in the Community Response Centres in Nova Scotia, paramedics – who show up in uniform – are recognized as reputable community service agents at in-home assessments and follow-up visits. In their community paramedicine roles, **they are well-positioned to provide social prescription support by linking caregivers to community-based supports during urgent calls.** This includes home and community care, primary care teams, mental health services, and support for caregivers. They also collaborate with primary care providers, nurses, social workers, and community agencies to ensure referrals are acted upon and support is sustained over time.

Standardized Training

As an upstream approach, there is a need for standardized education and training for health providers and allied health professionals. This would help improve the identification and provision of services, especially for invisible caregivers within health and social systems.

Participants emphasized the need for allied health professionals (e.g., nurses, social workers, occupational therapists, physiotherapists, and pharmacists) to receive caregiver-related professional training and organizational orientation. This includes consistent, inclusive, and shared language to provide culturally sensitive care.

With standardized training, family physicians, allied health professionals, and social professionals are better equipped to recognize invisible caregivers. They can also intervene earlier, and reduce the risk of caregiver burnout and avoidable access to the emergency health system. This includes incorporating social prescribing training into onboarding and workflows to enable more proactive, preventive care. **In the case of staff turnover, continued education and training for onboarded care providers is crucial.** It also helps ensure awareness of current community programs and services for the referral process.

System-Level Barriers to Caregiver Support

Under-Resourced and Overextended Health and Social Systems

Canada's health and social systems are under-resourced and overextended. The healthcare system is experiencing significant strain due to rising healthcare costs, long wait lists, and workforce burnout. **These pressures significantly limit the system's capacity to deliver timely, coordinated, and patient-centred care to patients and their caregivers.** Limited resources, insufficient capacity, and unclear referral pathways discourage meaningful engagement between patients and health professionals.

The concept of the "ten-second handoff" illustrates the time constraints and workload pressures faced by providers, leaving few opportunities to identify caregiver needs or ensure continuity of care. In addition, the referral team or staff from the hospitals may lose confidence in community partnerships when referrals do not result in timely follow-up. Consequently, opportunities for identifying caregivers and connecting them to community supports through social prescribing pathways are frequently missed.

Fragmented Health and Social Systems

Within traditional healthcare models, roles and responsibilities among healthcare providers and allied health professionals are siloed. Patient care is also handed off from one professional to another with limited coordination. As a result, referral pathways between healthcare and social care are often inconsistent and weak, creating significant barriers to equitable caregiver support.

As patients transition from hospital to community settings, health and social systems are often not designed to provide seamless discharge support, as few roles span across health and community sectors. Hospital referrals contain insufficient or incomplete critical information, while home care and transition teams experience high turnover and low continuity of care. These factors further contribute to fragmented service delivery and delayed follow-up.

When systems fail to provide continuous and adequate support, the burden of care shifts disproportionately onto caregivers. Formal supports are often not initiated early enough or remain inaccessible following discharge. Consequently, caregivers are unprepared to fill gaps within a fragmented health and social system. These challenges highlight the need for stronger, system-wide collaboration between healthcare and community sectors – moving away from rigid role definitions toward a coordinated continuum of care.

Long Waitlists

Patients referred from hospitals or other health settings are frequently placed on waitlists of four weeks or longer without any interim contact from community services. This lack of communication between the health system and patients undermines trust in both the referral process and the broader social support system. **High-risk patients are especially vulnerable to falling through the cracks, increasing the likelihood of hospital admissions and readmissions.** Consequently, caregivers are left to provide continuous, 24/7 support without timely relief or adequate assistance.

Staffing Shortages

As a patient-centred approach, team-based care delivered by interdisciplinary teams supports coordinated, high-quality care. However, persistent staffing shortages across both health and social sectors continue to intensify these system-level pressures. Without adequate team support, frontline staff often carry a disproportionate workload and emotional burden.

At the community level, many community-based supports and services are also operating at or beyond capacity. Workforce gaps are frequently addressed with informal workarounds rather than sustainable, system-level solutions. **When the health and social systems rely on passionate individuals or champions to provide social prescription, staff turnover contributes to service instability.**

Implications for Caregivers and Care Recipients

Caregivers' well-being is closely linked to whether their loved ones receive adequate care. When care recipients have inadequate access to supports, especially during transitions from hospital to community settings, caregivers also experience heightened stress. This creates significant downstream impacts for both caregivers and care recipients.

Although caregivers may require support for themselves, they frequently prioritize the needs of care recipients over their own health. This contributes to declines in their physical, social, emotional, and mental well-being. Over time, poor health may reduce the caregiver's ability to provide support. In some cases, caregivers experience severe health consequences and pass away before their care recipients.

Timely Intervention Matters

These findings highlight the importance of proactively supporting caregivers and connecting them to services before reaching a crisis point. This helps protect caregiver health, improve care recipient outcomes, and reduce strain on the health system.

Caregivers Alberta
Community Programs Partnership

Becoming a Wife Again: A Caregiver's Journey

When I met my husband in 2014, I knew he had some health challenges. But we fell in love and hoped for many healthy years together. We married in 2018, never imagining how quickly things would change.

By early 2024, he was falling frequently, and his memory was slipping. After countless appointments and a hospitalization, I was exhausted – physically, emotionally, and mentally – trying to manage everything alone.

At the geriatric clinic, the doctor recognized that I, as my husband's caregiver, was struggling. She referred me to Caregivers Alberta, connecting me to one-on-one coaching and group [online] sessions with other caregivers.

While I didn't know it at the time, this referral is a perfect example of social prescribing in action: a healthcare professional linking me to community supports to improve my well-being. For the first time, someone focused on me – my well-being, my needs, my goals. I realized that to care for my husband, I needed to care for myself.

With these supports, I finally feel like I can be a wife again – not just my husband's caregiver.

We're able to age in place, stay together in our home, and avoid hospitalizations or long-term care, which also eases the cost to the healthcare system. My husband attends the CHOICE program and receives weekday home care, giving me a few hours of respite each week. The difference is life-changing.

Social prescribing isn't just about services; it's about healthcare professionals in every part of the system recognizing caregivers as essential partners in care. Programs like Caregivers Alberta remind us that it's OK to receive help – because sustainable caregiving benefits both the caregiver and the person they care for.

Discussion

Invisible caregivers carry a disproportionate share of responsibility, frequently without adequate recognition or support from healthcare providers. They also provide around-the-clock, unpaid, and often undervalued care. Without this support, many care recipients would be unable to remain in community settings. Therefore, caregivers should be recognized as health partners in care and consulted in the planning and treatment decisions for care recipients.

Consequently, the health and well-being of care recipients living in the community are closely tied to the health, capacity, quality, and sustainability of their caregivers. However, **caregivers often experience burnout and, in some cases, poorer health outcomes than those they support.** This is due to the fragmented and siloed health and social systems. **When caregivers do not receive timely mental, social, and emotional support, their health deteriorates.** This increases the burden on caregivers and the healthcare system.

Social prescribing helps bridge siloed health and social systems. Through the social prescribing pathways, both visible and invisible caregivers can be identified and receive support. As a strengths-based approach, **social prescribing affirms caregivers' identities beyond their caregiver roles and addresses non-clinical health needs that are often overlooked in traditional care models.** By strengthening caregiver well-being, social prescribing indirectly improves the quality of care provided to their care recipients.

Community lies at the core of social prescription. Through the social prescribing pathway, caregivers access non-clinical, relationship-based supports through multiple entry points. This includes self-referral, referral from family and friends, or health and social professionals to community programs and services. Integrated networks of healthcare and allied health professionals, including pharmacists and paramedics, collectively share responsibility for identifying, connecting, and supporting caregivers.

To advance and advocate for sustainable caregiver support, identifying cross-sectoral health and social champions emerged as a key enabler of effective social prescribing. **By leveraging champions across disciplines, social prescribing moves beyond relying on individual link workers or system navigators to an integrated social and healthcare system.** These interdisciplinary networks support earlier identification, stronger connections, and sustained follow-up with caregivers throughout their social prescribing journey.

Recommendations for Future Directions

Practice Level: Delivering Caregiver-Centred Social Prescribing

Focus on "*What Matters to You?*" Not "*What is the Matter with You?*"

Healthcare providers, allied health professionals, and community partners should adopt person-centred social prescribing approaches that prioritize caregivers' goals, values, and readiness for support. This approach shifts the focus from an "absence of disease" or deficit model to a whole-person quality of life approach, co-creating goals that reflect the caregivers.

Reframe Help-Seeking as a Strength

Caregiver messaging should explicitly reframe help-seeking as an act of resilience rather than weakness. Culturally responsive engagement strategies are needed to reach caregivers who view caregiving as a family or cultural obligation. These individuals may not self-identify as a caregiver who needs support.

Provide Flexible, Culturally Responsive Outreach

Some caregivers may think it is socially unacceptable to receive help in their role. Delivering culturally responsive outreach helps reduce isolation and strengthen connections. This is especially the case in rural and remote regions where bridging clinical care with community support is essential.

Avoid a One-Size-Fits-All Approach

Social prescription pathways must be adapted to caregivers' capacities, schedules, and their local context. For instance, rural and remote communities benefit from virtual options, while urban areas benefit from in-person connections. Support services and resources should be flexible and provide multiple delivery options, such as in-person, virtual, and phone-based.

Organizational Level: Strengthening Social Prescribing Pathways

Advance Family-Centred Model of Care

Social prescribing pathways should be embedded in community settings and supported by interdisciplinary health and social care teams. In a person-centred model of care, family members, including caregivers, are involved in care planning and decision-making. As caregivers often spend the most time with care recipients, a partnership between providers, patients, and family members supports more informed planning and decision-making.

Include Allied Health Professionals in Social Prescribing Pathway

Allied health professionals build stronger communities. Paramedics and pharmacists, for example, within the health and social care system, should be formally integrated into the social prescribing pathway as trusted referral partners. Shared accountability across disciplines supports earlier identification and connection, which is a paradigm shift from "I do my part" to "we carry this together."

Invest in Accessible Team-Based Care

When link workers are co-located within health teams and community spaces, it increases visibility, trust, and uptake of social prescription. When social and health professionals share physical space, team-based care is strengthened through care coordination and enhanced engagement.

Improve the Referral Process

Integrate and simplify referral processes within existing workflows and routine practices, including access points, intake procedures, and discharge planning. Standardize or share triage protocols between different organizations to better align client urgency with available resources. A streamlined referral process can reduce service delays and caregiver drop-offs.

System Level: Scaling

Build Cross-Sectoral Integration Infrastructure

Health and social systems should prioritize building cross-sectoral infrastructures. This includes referral platforms, co-sharing physical space, and data-sharing agreements to share knowledge-based resources, such as community asset maps. By investing in the electronic medical record (EMR), social prescription would be formally integrated into healthcare, accessible by other health providers, allied health providers, and link workers providing team-based care. An EMR would streamline the referral process, reduce siloed and fragmented systems, and increase the ease of social prescribing for the care team.

Standardize Education and Training Across Sectors

Governments, professional bodies, and health organizations should invest in standardized education and training for healthcare providers and allied health professionals. This should include caregiver identification, trauma-informed care, and the role of social prescribing. Ongoing professional development is essential to address staff turnover and ensure continuity of practice.

Treat Caregiver Support as an Upstream Public Investment

Policymakers and funders should recognize caregiver-focused social prescribing as a high-value, preventive public health investment. Supporting caregivers before they reach a crisis improves health outcomes for both caregivers and their care recipients. This also helps to reduce avoidable strain on health and social systems. Targeted investments should strengthen the social prescribing pathway – including caregiver identification and timely connection, appropriate services, and sustained follow-up and ongoing support. Sustaining social prescribing depends on well-resourced community-based organizations.

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At a system level, investing in social prescribing referral infrastructure and adequately resourcing community-based organizations can help alleviate pressures on under-resourced and overextended health and social systems. Caregiver-focused social prescribing directly advances the quintuple aim by achieving the following:

- Enhancing the experience of care
- Improving health outcomes for caregivers and care recipients
- Strengthening support for healthcare providers and care teams
- Advancing health equity by ensuring caregivers are visible, valued, and supported within integrated health and social systems
- Reducing per capita healthcare costs

Conclusion

Across all provincial sites, social prescribing was recognized as a powerful and unifying approach to addressing caregivers' non-clinical needs and alleviating caregivers' burden. By establishing structured referral pathways and fostering team-based care, the social prescribing pathway allows visible and invisible caregivers to be identified earlier and connected to much-needed community-based supports and services.

The Caregiver Rx Initiative illustrates how a social prescribing pathway that integrates healthcare providers, allied health professionals, link workers, and community organizations can collectively strengthen caregiver support and system navigation. As an upstream public health investment, social prescription shifts care delivery away from siloed responsibilities toward shared accountability. This improves caregiver experiences – while reducing pressure on under-resourced and overextended health and social systems.

Future caregiver-focused social prescribing initiatives would benefit from exploring system-level integration, including embedding referral pathways within routine clinical workflows and electronic medical records. Sustained investment in cross-sector infrastructure, standardized training, and adequately resourced community-based organizations will be essential to scale and sustain social prescribing across the country.

cisp Canadian Institute *for* Social Prescribing

Canadian Red Cross