CASCH

Canadian Alliance for
Social Connection and Health

RESEARCH REPORT

What is Needed to Promote the Uptake and Implementation of Social Prescribing?

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About CASCH

The Canadian Alliance for Social Connection and Health (CASCH) is a nation-wide initiative dedicated to combating loneliness and social isolation. By fostering collaboration among academic, community, and institutional partners, CASCH enhances research, policy, and practice through innovative knowledge mobilization. Our mission is to create a Canada where social health is a cornerstone of well-being, bridging efforts across sectors to build a more connected and inclusive society. Grounded in values of inclusivity, compassion, and integrity, we aim to inspire and empower collective action for meaningful change.

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The views in this report represent those of the authors informed by the perspectives shared from research participants.

Executive Summary

Social prescribing is a holistic healthcare approach that connects individuals with non-medical needs to community-based services, addressing social determinants such as isolation, housing, and financial insecurity that significantly impact health and wellbeing. Despite its benefits in improving mental health, reducing healthcare utilization, and fostering community integration, the uptake and implementation of social prescribing face numerous challenges across individual, organizational, systems, and societal levels.

This report explores what is needed to effectively integrate social prescribing into mainstream healthcare by exploring the barriers to social prescribing uptake and implementation and identifying the resources needed to overcome these barriers:

Barriers to Implementation included the following:

- Patients, particularly in rural or underserved areas, face challenges such as limited transportation options, service availability, and digital literacy. Recommendations include creating user-friendly websites with service directories, implementing a dedicated hotline, and developing ride-sharing programs tailored to patients' needs.
- A lack of coordination and communication among healthcare providers and social prescribing programs hampers efficiency. Solutions include integrating systems to enhance collaboration and ensure that all providers involved in a patient's care are informed of their progress and support engagements.
- Current services often do not meet patients' specific cultural, dietary, or financial needs. Recommendations focus on ensuring services are culturally safe and inclusive.

Resource needs required to overcome these barriers included:

- Comprehensive, standardized training is necessary for healthcare providers, community navigators, and community organizations to effectively implement social prescribing.
- Interactive and accessible educational resources, such as apps, websites, and social media outreach, are essential to improve patient understanding and engagement.
- The creation of standardized referral pathways and digital platforms can facilitate better coordination and communication among interested parties. AI-driven tools could help match patients with suitable programs based on their needs and preferences.
- Regularly updated databases reflecting the availability and capacity of community services, including AI capabilities, are recommended to enhance resource identification and address service gaps, particularly in underserved areas.
- Centralized portals for tracking patient progress and communication, alongside automated reminders and personalized follow-ups, would support patient engagement.

Recommendations

To support the effective uptake and implementation of social prescribing, a coordinated approach is needed, involving:

- Developing comprehensive training modules accessible across provinces, incorporating quick learning formats and practical demonstrations.
- Enhancing patient education through interactive platforms and digital outreach.
- Creating robust referral and follow-up systems that integrate healthcare and community resources.
- Expanding and dynamically mapping community services to ensure they meet the diverse needs of patients.

Conclusion

Addressing the barriers and resource gaps identified in this report is crucial for promoting the integration of social prescribing into healthcare systems. By implementing targeted recommendations, social prescribers can develop a more supportive infrastructure that aligns healthcare with the broader social context of patients' lives. This approach will reduce health inequalities, improve patient outcomes, and build a more resilient and connected healthcare system, ultimately maximizing the potential of social prescribing to enhance individual and community wellbeing.

Section 1.

Introduction

What is social prescribing?

Social prescribing is a holistic approach to healthcare that connects individuals with non-medical needs to community-based services and resources. It addresses the social, emotional, and practical issues that affect health and well-being, recognizing that many health conditions are influenced by social determinants such as isolation, housing, financial insecurity, and access to supportive networks. The process begins with screening patients to identify those with non-medical needs. Healthcare providers use routine clinical assessments, patient interviews, or standardized tools to uncover issues such as loneliness, stress, housing instability, or lack of social support. Once these needs are identified, the next step involves educating patients about how these factors may affect their health and well-being. This phase includes discussing the impact of social determinants on their condition, exploring their readiness to address these needs, and providing information on available resources and supports.

Patients are then connected with community navigators or link workers—professionals trained to support individuals in accessing appropriate non-medical services. These navigators help patients explore their needs more deeply and guide them through the process of accessing relevant services, serving as a bridge between clinical settings and community resources. To ensure the support is tailored to the patient's situation, the process includes mapping and identifying appropriate community services, such as social groups, exercise classes, financial advice, housing support, mental health resources, or other programs that contribute to overall well-being. Once suitable services have been identified, patients are directly referred or linked to these resources. This step may involve coordinating appointments, making introductions, or providing detailed information on how to access the services, ensuring that patients can easily navigate and engage with the prescribed supports.

After referral, follow-up is a crucial component of social prescribing to evaluate whether the prescribed supports are being utilized and are meeting the patient's needs. Healthcare providers check in with patients to address any barriers to engagement, provide ongoing encouragement, and make adjustments to the support plan as necessary. This ensures the plan remains effective and responsive to the patient’s changing circumstances, ultimately fostering a more holistic approach to health and well-being.

What are the benefits of Social Prescribing?

Social prescribing offers a range of benefits that extend beyond traditional healthcare by addressing the social, emotional, and practical factors that significantly influence health and wellbeing. One of the primary impacts of social prescribing is its ability to improve mental health outcomes, such as reducing symptoms of anxiety, depression, and stress, by connecting individuals with supportive community resources tailored to their needs. These non-medical interventions, which can include social clubs, exercise programs, arts activities, financial counseling, and peer support groups, empower individuals to take control of their health in a more holistic manner. By addressing social isolation and fostering meaningful connections,

social prescribing helps reduce loneliness, enhance social support networks, and promote a sense of belonging, all of which are critical components of mental and physical health.

Evidence supporting social prescribing shows that it not only benefits individuals but also has positive impacts on healthcare systems. Patients who engage in social prescribing are often less reliant on primary care services, resulting in a reduction in general practitioner visits, emergency room attendances, and overall healthcare utilization. This reduction in demand helps to alleviate pressure on healthcare providers, allowing them to focus on more complex medical cases. Additionally, social prescribing can contribute to cost savings for healthcare systems by addressing the root causes of frequent healthcare utilization and preventing the escalation of health issues that stem from social factors.

Furthermore, social prescribing enhances the role of community organizations and social services in supporting public health. By creating formal pathways between healthcare providers and community resources, social prescribing strengthens collaboration and fosters a more integrated approach to health and social care. This collaboration not only builds the capacity of community organizations to meet the needs of referred individuals but also enriches the healthcare provider's toolkit, enabling a more comprehensive approach to patient care.

Overall, social prescribing aligns healthcare delivery with the broader social context of patients' lives, providing a patient-centered model that is responsive to the complexities of individual health needs. By addressing the social determinants of health, social prescribing offers a promising avenue for improving health outcomes, reducing health inequalities, and fostering resilience within communities. As evidence of its effectiveness continues to grow, social prescribing is emerging as a valuable component of modern healthcare, offering a sustainable approach to enhancing individual and community wellbeing.

What are the Challenges to Promoting the Uptake and Implementation of Social Prescribing?

The uptake and implementation of social prescribing face multifaceted challenges at individual, organizational, systems, and societal levels, which have hindered its integration into mainstream healthcare. At the individual level, healthcare providers, community navigators, and community organizations often lack the training and resources needed to effectively engage in social prescribing. Healthcare providers may feel unprepared to screen for non-medical needs, educate patients, or confidently refer them to community resources due to inadequate training on the social determinants of health and the tools available to address them. Similarly, community navigators and link workers require specialized training to develop skills in patient engagement, needs assessment, and navigating local services, while community organizations need the capacity and expertise to handle increased referrals and deliver appropriate supports.

At the organizational level, the variability in the availability and quality of community resources poses a significant barrier. Inconsistent access to non-medical services, particularly in rural or underserved areas, makes it challenging for healthcare providers to consistently link patients to

appropriate supports. This variability can lead to unmet needs and frustration for both patients and providers. Community organizations often face capacity constraints, such as limited funding, staffing, or infrastructure, which can impede their ability to respond adequately to referrals and sustain long-term engagement with patients. Additionally, healthcare settings frequently lack the necessary infrastructure—such as standardized referral pathways, digital platforms, and data tracking systems—to support the coordination and follow-up required for effective social prescribing.

At the systems level, the absence of standardized processes for screening patients and linking them to suitable services further complicates the integration of social prescribing. There is a need for reliable and accessible tools that healthcare providers can use to identify social determinants of health affecting their patients, along with clear and efficient pathways for connecting patients to community navigators and services. Without these systems in place, care can become fragmented, and it becomes difficult to monitor patient outcomes and evaluate the impact of social prescribing interventions. Moreover, financial disincentives, such as the lack of clear reimbursement models for social prescribing activities, can limit the motivation for healthcare providers to engage in these practices.

Societally, cultural and organizational resistance within healthcare settings can impede the adoption of social prescribing. The traditional focus on biomedical models of care may lead to skepticism about the value of addressing social determinants of health through non-medical interventions. This resistance often stems from a lack of awareness or understanding of the evidence supporting social prescribing and its potential to complement conventional medical treatments. Overcoming these attitudinal barriers requires education and advocacy to shift mindsets and foster a culture that values holistic, patient-centered care.

To promote the uptake and ease the implementation of social prescribing, it is essential to address these challenges through an integrated framework that includes comprehensive training for all interested parties, development of standardized screening and referral processes, and the establishment of robust follow-up mechanisms. By investing in the necessary resources at the individual, organizational, systems, and societal levels, we can build a supportive infrastructure that facilitates collaboration between healthcare providers and community organizations, ensures the availability of high-quality resources, and ultimately maximizes the potential of social prescribing to improve health and wellbeing.

Section 2.

Aims & Methodology

The overall goal of this report is to promote the uptake and ease the implementation of social prescribing by identifying the resource needs of patients, community organizations, and healthcare providers.

To accomplish this goal, we conducted focus groups and key informant interviews with patients (n = 9), healthcare and social providers (n = 15). Our focus groups comprised adults ages 23-70 years old and of mixed genders (men = 9, women = 14 and non-binary = 1). 92% of the participants identified as straight while 8% identified as bisexual or queer. Participants came from various cultural backgrounds (African, Caribbean or Black, Chinese, Filipino, Indigenous, Latin America, West Asian and White). Approximately 71% of participants were born in Canada, while 28% were not and came from different cities across Canada. The interview guide and screening tool assessed participants' perceived barriers to social prescribing and identified the resource needs that might address these needs. The following areas were evaluated:

- **Training for Physicians and Healthcare Providers:** Evaluating the training needs of healthcare professionals to effectively screen for non-medical needs, educate patients, and refer them to appropriate community resources.
- **Training for Community Navigators/Link Workers:** Identifying the training requirements for community navigators and link workers.
- **Training for Community Organizations or Social Services**: Assessing the capacity-building needs of community organizations and social services to handle referrals, understand patient needs, and provide appropriate supports.
- **Screening Patients for Non-Medical Needs:** Exploring the tools and processes required for healthcare providers to consistently and accurately identify non-medical needs.
- **Educating Patients about Non-Medical Needs:** Understanding the resources needed to effectively educate patients about the impact of social determinants on their health and the benefits of engaging with prescribed supports.
- **Linking Patients to Community Navigators**: Identifying best practices and resources needed for healthcare providers to link patients efficiently to community navigators who can facilitate access to non-medical services.
- **Identifying Appropriate Services in the Community:** Evaluating the availability and accessibility of community resources and services that meet patient needs, with a focus on building comprehensive directories of local supports.
- **Linking Patients to Non-Medical Services:** Assessing the systems and pathways necessary for connecting patients to suitable non-medical services in their communities.
- **Following up on Patient’s Utilization of Prescribed Supports and Services:** Identifying the mechanisms needed for effective follow-up to ensure patients are engaging with the prescribed services and to assess the impact on their wellbeing.

Data from these interviews were thematically and descriptively analyzed in order to characterize (1) the salient barriers to the implementation of social prescribing and (2) the available and

Section 3.

Study Findings

What did participants see as the salient barriers to the implementation of social prescribing?

Patients and healthcare providers highlighted three key thematic challenges to the implementation of social prescribing: accessibility, process efficiency, and individual needs.

These themes underscore the challenges and potential solutions for improving the uptake and implementation of social prescribing by addressing the specific resource gaps identified.

Theme 1: Accessibility

Accessibility emerged as a major barrier for patients, particularly in terms of transportation and the availability of services. Patients noted that the lack of affordable public transit options, the absence of services in rural areas, and limited commuting options near where they live often prevent them from accessing social prescribing programs. Additionally, transportation costs and inflexible program schedules, such as offerings only during working hours, were seen as significant impediments to participation.

> *"What if they refer me to a program that's like super, far like, not on a bus street or something like that."*

> *"If it's a program that's like an art program that I would really like, but there's no financial assistance or something like that, or it's a program that only works like within work hours. And I have work so like, I won't even be able to attend."*

> *"Lack of transportation options can prevent patients from accessing prescribed social activities or community resources."*

To address these issues, participants suggested several solutions aimed at enhancing accessibility. These included the development of a hotline service similar to 811, where patients can call to receive information about available programs and services tailored to their needs. The creation of a user-friendly website featuring an interactive map with points indicating the location of nearby programs and transit options was also recommended. To mitigate the transportation barrier, the suggestion of a ride-sharing app specifically designed for patients needing transport to programs was proposed, facilitating shared rides for those in similar locations. Additionally, providing access to computers or internet services at healthcare facilities, particularly for older or low-income patients who may lack digital access or literacy, was highlighted as a crucial step toward improving accessibility.

Healthcare professionals also identified digital literacy as a barrier, particularly among older patients who are less willing to engage with digital platforms. A proposed solution was to ensure that these websites are accessible in public spaces like libraries, where staff can offer assistance to those needing help navigating these digital tools.

> *"One of the barriers should be, you know digital literacy, because a whole lot of people don't know how to navigate around these are digital online resources properly. And also, you know access to technology is also a problem that has to link with the digital literacy too."*

Theme 2: Process Efficiency

Process efficiency was another key theme, with a focus on improving collaboration among healthcare providers and social prescribing programs. The lack of a coordinated approach was seen as a barrier to providing holistic and continuous care for patients. Participants highlighted

the need for a more integrated system where all healthcare providers involved in a patient's care are kept informed of their progress and the various social supports they are accessing. By fostering collaboration and communication among professionals, social prescribing can be delivered in a more streamlined and effective manner, ensuring that patients receive consistent support throughout their healthcare journey.

> *"Our healthcare system is a little bit of a challenge, especially here in the lower mainland, because it's two health authorities. If both health authorities would have different perspectives on how to implement it [social prescribing], then it becomes a challenge, especially with the mobility of the people moving from one city to another, from a Fraser health region to Vancouver Coastal Health region. So, if both health authorities are united on how it will be properly implemented. Then that will be good as a part of their community health programs, because they are also expanding to community health programs."*

Patients also specified wanting to be directly involved in the social prescribing process. For example, rather than being seen as someone with an issue seeking treatment from their healthcare provider, patients want to be able to choose which program would best fit their individual needs. By fostering an inclusive and trusting relationship between healthcare providers and patients, it will allow for more patients to see through the social prescribing process and successfully complete programs.

> *"I think I'd want it to be like a collaborative type of process rather than you know the other one where I'm the one who fills it out, and there's no conversation."*

> *"I don't know how to put it. But we just hear a lot of feedback that people have experiences with doctors where they're kind of seen more as a problem to be solved rather than a human being to be connected with."*

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Theme 3: Individual Needs

Meeting individual needs was identified as a critical component of effective social prescribing, with patients expressing concerns that current services often do not align with their specific needs and preferences. For example, programs such as cooking classes that do not offer vegetarian or culturally relevant options may not be suitable for all participants. Furthermore, limitations in access to services for low-income patients or those lacking extended health coverage were noted as significant barriers.

> *"Language and cultural issues are very important. Because, for instance, if you don't have people that understand your culture or understand your language properly they*

> *won't how to navigate around your understanding. It can be very difficult to really understand what the person is talking about, especially when you are having the recommendations in person."*

Solutions to better meet individual needs included ensuring that social prescribing services are culturally safe and responsive, with reduced social stigma and inclusive practices. This could involve offering materials and services in multiple languages to accommodate diverse populations. Participants also recommended providing access to technology at places like libraries or healthcare offices, coupled with support for patients who may lack technological literacy, particularly older individuals. Furthermore, it was emphasized that patients prefer continuity in care, with one service provider accompanying them throughout the social prescribing process, as this builds trust and offers a more personalized approach.

> *"I think another challenge. And this is more kind of like specific to me is, I feel that whatever community service it is, is not culturally appropriate. Let's say I was meant to go to a group support thing with, you know a bunch of people. I think I'd be, and depending on what the topic is, or what the issue is. I think I'd be more comfortable being there with, you know, women, and these, you know, black people, and I'd be more comfortable going where I feel like these people that are like me."*

Participants also highlighted the need for social supports that extend beyond healthcare, such as recreation programs and housing supports, to fully address the social determinants of health. Concerns about the lack of trust in technology compared to in-person interactions were noted, with some patients expressing a preference for face-to-face workshops and direct communication with healthcare providers over digital platforms.

Overall, the focus groups revealed that addressing these key principles—accessibility, process efficiency, and individual needs—is essential for enhancing the uptake and implementation of social prescribing. By developing targeted resources and solutions, the gaps identified in these areas can be bridged, thereby improving the effectiveness and reach of social prescribing.


Sports

What resources exist and are needed to ease the implementation of social prescribing?

The focus groups with patients and healthcare providers identified several existing resources as well as critical gaps that need to be addressed to improve the uptake and implementation of social prescribing. These findings are organized across key components of the social prescribing process, highlighting the importance of developing targeted resources to support patients, healthcare providers, community navigators, and community organizations.

Training for Healthcare Providers

Patients emphasized the need for healthcare providers to have a general understanding of social prescribing to effectively introduce and explain the concept during appointments. Existing resources include some training models in social determinants of health and programs like the WHO social prescribing pilot project. However, there is a need for more comprehensive training that moves away from the traditional medical model and incorporates sensitivity to social issues such as health equity. Short, centralized training modules that provide quick, accessible information about social prescribing principles and processes are necessary to build confidence among both patients and providers. Moreover, healthcare providers require training on how to use virtual care tools to support health education and deliver services efficiently.

Professionals noted that while some training programs exist, such as the online social prescribing course offered in Eastern Canada, these are not universally accessible. There is a need for a standardized, incentivized online training module available across all provinces, with content that is adaptable to various health authorities. Additionally, time constraints were highlighted as a barrier, suggesting the value of quick learning videos with practical demonstrations. Incorporating training on cultural sensitivity and soft skills for explaining non-medical needs could further enhance the effectiveness of social prescribing initiatives

Example Resources for Training Healthcare Providers

- **The Alliance for Healthier Communities' Social Prescribing Online Course** (https://www.allianceon.org/Social-Prescribing-Online-Course) offers a series of equity-focused training modules designed for healthcare teams interested in implementing or improving their social prescribing process.
- **The Canadian Institute for Social Prescribing's Social Prescribing Initiatives Directory** (https://www.socialprescribing.ca/search) provides physicians and healthcare providers with foundational elements of social prescribing.
- **The World Health Organization's Social Prescribing Toolkit** (https://www.who.int/publications/i/item/9789290619765) allows healthcare providers to educate themselves on how to implement social prescribing at a community level.
- **Healthy Aging Core Alberta's Social Prescribing Partner Toolkit** (https://corealberta.ca/resources/social-prescribing-partner-toolkit) introduces social prescribing to healthcare providers, government entities, and community-based organizations/
- **Family Caregivers of BC's Caregiver Rx Project** (https://www.familycaregiversbc.ca/resources-for-health-care-providers/identify-and-refer-a-caregiver) offers strategies on how healthcare providers can build partnerships with family caregivers to help expedite evaluation and prevent errors in care.
- **The Government of Canada's Social Prescribing and Implementation toolkit (**https://www.canada.ca/en/public-health/services/reports-publications/health-promotion-chronic-disease-prevention-canada-research-policy-practice/vol-44-no-9-2024/guides-facilitating-implementation-evaluation-social-prescribing-lessons-access-resources-community-model.html) is helpful for healthcare providers to learn about the principles of social prescribing implementation.
- **The Centre for Effective Practice's Social Prescribing toolkit** (https://cep.health/clinical-products/social-prescribing/) is a guide on how to assess and prescribe different services.

Training for Community Navigators/Link Workers

Community navigators play a crucial role in guiding patients through the social prescribing process, yet there are varying criteria and training standards across different regions. Known resources include United Way's prescribing guidelines and the WHO social prescribing pilot project, but there is a clear need for formalized, standardized training programs to define the role of link workers more clearly. This includes training on the social determinants of health, community-specific knowledge, and the development of a structured framework for referrals and follow-ups. There is also a call for training modules that are specifically tailored to the communities in which navigators will work, ensuring that they are equipped to build trust and effectively support patients.

Example Resources for Training Community Navigators/Link Workers

- **The United Way's Healthy Aging Webpage** (https://uwbc.ca/program/healthy-aging/) provides a toolkit for.
- **The United Way's Community Connector Training** (https://uwbc-healthyaging.thinkific.com/courses/community-connector-training-2) is a course established for community navigators/link workers to learn equity based approaches to care and how to avoid frailty for healthy aging.
- **Healthy Aging CORE British Columbia's Social Prescribing Implantation Webpage** (https://uwbc.ca/program/healthy-aging/) offers a range of healthy aging programs that are designed to help British Columbians remain, active, connected and engaged in their existing communities.
- **Seniors' Community Connector document by Fraser Health** (https://www.fraserhealth.ca/Service-Directory/Services/home-and-community-care/seniors-community-connector) a resource that can aid in connecting older adults to community programs.
- **The Canadian Institute for Social Prescribing's Link Worker Webpage** (https://www.socialprescribing.ca/link-worker-competency-framework) explains the role of a link worker in social prescribing and the introduction of the competency framework.
- **The National Academy for Social Prescribing (NASP)'s Link Workers Webpage** (https://socialprescribingacademy.org.uk/how-we-can-support-you/social-prescribing-link-workers/) explains NASP's role in supporting Community Navigators/Link Workers in building a community network with the link worker community.

Training for Community and Social Service Providers

Community organizations are integral to the success of social prescribing, yet many operate in silos with limited coordination. Existing resources, such as the John Hopkins health navigator program and United Way training, provide some support, but there is a need for universal tools and aligned implementation processes across organizations. Professionals identified the need for a collaborative online system where community organizations can share knowledge, update on capacity and waitlists, and work in a uniform manner to deliver social prescribing services effectively.

Example Resources for Training Community and Social Service Providers

- **John Hopkins' Nurse Navigators** (https://gonaviance.com/nurse-navigator/) is a program where nurses connect oncology patients to care related care including survivorship.
- **Find a Service by Mosaic** (https://mosaicbc.org/find-a-service/) offers a database where individuals and organizations can find best services to meet their needs.
- **Supporting Voluntary and Community Organizations by NASP** (https://socialprescribingacademy.org.uk/how-we-can-support-you/voluntary-and-community-organisations/) the webpage is geared towards community organizations that are in need of social prescribing assistance where NASP offers networking opportunities and more.
- **Social Prescribing and Implementation Toolkit by Government of Canada** (https://www.canada.ca/en/public-health/services/reports-publications/health-promotion-chronic-disease-prevention-canada-research-policy-practice/vol-44-no-9-2024/guides-facilitating-implementation-evaluation-social-prescribing-lessons-access-resources-community-model.html) toolkit is helpful for organizations to learn about the basis of social prescribing, implementation, follow-up and monitoring of patient health throughout the overall social prescribing processes.

Screening Patients to Identify Non-Medical Needs

Current screening practices are often fragmented, relying on individualized approaches that may not capture the full range of patients' social needs. Available resources include standardized tools like the UCLA Loneliness Scale, but there is a need for a more integrated, accessible approach. Patients suggested the development of a questionnaire that can be completed online or with assistance, which would screen for interests, needs, and existing supports. A centralized system that allows healthcare providers to enter patient data and receive immediate feedback on appropriate referrals was also recommended.

Patients have expressed that their interactions with their healthcare providers often feel rushed, leaving them with the impression that they are seen as problems to be solved. A desire for open conversations with their healthcare providers where patients can discuss options directly with their provider would allow for feelings of greater sense of autonomy. During the focus groups, participants suggested implementing a checklist of symptoms to determine eligibility for social prescribing. Once eligibility has been determined an emphasis on having an open conversation with health care providers was highly desired. Finally, a self-referral option for social prescribing was suggested as a helpful solution for patients who may feel stigmatized when seeking assistance to access social prescribing programs.

Example Resources for Screening Patients to Identify Non-Medical Needs

- **The Health Equity Evidence Centre's guide on how to screen for social needs in primary care** (https://www.heec.co.uk/resource/social-needs-screening/) offers a practical guide on how primary care providers can screen for social needs.
- **The UCLA's Loneliness scale** (https://fetzer.org/sites/default/files/images/stories/pdf/selfmeasures/Self_Measures_for_Loneliness_and_Interpersonal_Problems_UCLA_LONELINESS.pdf) is a tool that assists with determining eligibility on which patients qualify for social prescribing programs.
- **The Patient Health Questionnaire by the Government of British Columbia** (https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/depression_patient_health_questionnaire.pdf) is one of the tools that can be used when assessing patients eligibility for social prescribing programs.
- **The CLEAR toolkit** (https://www.mcgill.ca/clear/files/clear/clear_toolkit_2015_-_english_1.pdf) is a methodology that goes through a step-by-step process on how healthcare workers can address the causes of poor social health.
- **The Social prescribing assessment tool** (https://socialprescribingqualification.org.uk/wp-content/uploads/2019/08/Social-Prescribing-Assessment-Tool.pdf) is a questionnaire that that poses key indicating questions on whether individuals require social prescribing.

Educating Patients about Non-Medical Needs

Patients and providers alike identified a gap in educational resources tailored to different learning styles and technological proficiencies. While some informational brochures and online resources exist, there is a demand for interactive, accessible platforms such as apps or websites that offer tutorials, simple explanations, and regularly updated information on social prescribing. Short, engaging videos and social media outreach, including the use of influencers, were suggested as ways to increase awareness and understanding, particularly among younger populations. Patients also expressed that after being educated on social prescribing having follow-up links with educational materials would be helpful to refer back to as sometimes in-person conversations can be overwhelming for some. There was also a need for healthcare providers to be able to clearly state the differences between social prescribing and medical prescriptions. A mix of in-person and online telehealth communications was overall preferred by patients

Example Resources for Educating Patients About Non-Medical Needs

- **Self Management BC** (https://www.selfmanagementbc.ca) is a resource where patients have access to coaches, online and in person programs for those with one or more conditions.
- **Social Prescribing by Healthy Aging Alberta and United Way** (https://calgaryunitedway.org/healthy-aging-alberta/social-prescribing/) is a resource that explains what social prescribing is and the different steps of the social prescribing process.
- **Social Prescribing Program by 211 British Columbia and United Way** (https://bc.211.ca/result/social-prescribing-program-79088468/) offers support for social prescribing programs after patients 55 years of age or older have been given a social prescription.
- **What is Social Prescribing by Canadian Institute on Social Prescribing** (https://www.socialprescribing.ca/about-social-prescribing) is a useful webpage that explains what social prescribing is using different learning styles (visuals, videos and written in plain text).

Linking Patients to Community Navigators

Effective linking of patients to community navigators requires clear communication and defined roles within the healthcare system. While some systems, like Pathways BC, provide a starting point, there is a need for greater integration and coordination. Patients expressed a desire to be actively involved in choosing their programs and understanding the process, highlighting the need for clear, accessible directories of services that include descriptions, eligibility criteria, and language options. Developing online booking portals and self-serve options could further empower patients and streamline the referral process.

Patients also expressed concerns regarding language barriers and feeling uncertain about meeting a link worker or community navigator. There was difficulty in whether they would be able to clearly understand the link workers' intentions or the purpose of the programs they are being referred to. Assistance with translation for patients where English is not their first language is necessary. With that, there was also mention of a need for active follow-ups throughout the social prescribing process once a referral has been given to meet with a link worker. Concerns were raised in the event that a patient is given a social prescription, but lacks the motivation to go through the process and attend the program. There were suggestions of having some type of encouragement so that patients who do require social prescribing programs can reap the benefits of it and feel better. Similarly, providers also reported some type of follow-up to be given to patients once referrals are given to link workers to ensure that patients are meeting with their link workers to select a program that best suits their needs and interests.

Example Resources for Linking Patients to Community Navigators

- **Referral database by Pathways BC** (https://pathwaysbc.ca/community) offers an online portal for physicians in BC are able to look up referral information and submit referrals online to streamline the referral process.
- **Seniors' Community Connector document by Fraser Health** (https://www.fraserhealth.ca/Service-Directory/Services/home-and-community-care/seniors-community-connector) discusses how to explain the process of social prescribing to patients and available social prescribing programs in their region.
- **Alberta Referral Directory by Alberta Health Services** (https://www.albertahealthservices.ca/info/page14282.aspx) is currently used in Alberta to streamline the referral process by having submissions and physician information online.
- **S.U.C.C.E.S.S. referral form by Healthy Aging CORE** (https://healthyagingcore.ca/files/25408) is a referral form for patients 55 years and older who require social prescribing.

Identifying Appropriate Services in the Community

Patients and providers noted the need for dynamic, regularly updated databases that accurately reflect the availability and capacity of community services. Existing resources like the United Way's 211 line and Pathways BC provide foundational support, but there is a need for more comprehensive tools that incorporate AI to match patients with the most suitable programs based on their unique needs and preferences. Ensuring that these services are inclusive, covering all age groups and social demographics, is essential for broadening the reach and effectiveness of social prescribing.

Example Resources for Identify Appropriate Services in the Community

- **8-1-1 Nurses Line by the Government of British Columbia** (https://www.healthlinkbc.ca/more/about-healthlink-bc/about-8-1-1) offers a direct connection with a health service navigator that can help patients find health information and services
- **Find Support BC** (https://findsupportbc.com) This is a resource where patients with disabilities can enter their information and be given a list of support resources that can help with their condition.
- **BC Health Service Locator App by the Government of British Columbia** (https://www.healthlinkbc.ca/bc-health-service-locator-app#:~:text=The%20BC%20Health%20Service%20Locator%20App%20helps%20you%20find%20walk,information%20from%20your%20mobile%20device) helps British Columbians find walk-in clinics, hospitals, emergency rooms, urgent care centres, immunization locations, pharmacies and laboratory services near them.

Linking Patients to Non-Medical Services

Linking patients to non-medical services is often hindered by logistical barriers such as transportation, financial constraints, and language needs. While some resources like the BC Nurse Line and MyHealthFinder provide initial guidance, there is a need for user-friendly, accessible websites that offer comprehensive information on available services, including virtual options to mitigate waitlists and physical barriers. Enhancing digital literacy among patients and ensuring that online platforms are simple and inclusive will help improve access and engagement with non-medical services.

Example Resources for Linking Patients to Non-Medical Services

- **MyHealthFinder by Office of Disease Prevention and Health Promotion** (https://odphp.health.gov/myhealthfinder) is a tool that educates patients on key health and lifestyle changes they may need to make to better support their pre-existing conditions.

Following Up on Patient's Engagement with Social Prescriptions

Follow-up is a critical component of social prescribing that is often under-resourced. Existing systems like Self-Management BC provide some continuity, but there is a need for a centralized portal where all involved healthcare providers, link workers, and patients can track progress and communicate effectively. Such a system would ensure a full-circle approach, maintaining engagement and encouraging patients to utilize the prescribed supports and services consistently.

Overall, these results underscore the importance of developing a comprehensive, coordinated infrastructure that addresses the identified resource gaps across all components of the social prescribing process. By providing the necessary training, tools, and systems, social prescribing can be more effectively integrated into healthcare practices, enhancing its potential to improve patient outcomes and wellbeing.

Example Resources for Following Up on Patient's Engagement

- **Care Connect by MCT Technology** (https://www.mcttechnology.com) is an online platform that is meant to administer health and child care by maintaining patient relationships, quick delivery of care, assists with retaining staff and delivery of payments on time.
- **Health Gateway App by Government of British Columbia** (https://www.healthgateway.gov.bc.ca). provides a way for British Columbians to access all their health records in British Columbia.

Section 4.

Discussion

The findings from our focus group interviews highlight the critical need for a coordinated and resource-rich infrastructure to support the uptake and implementation of social prescribing.

While organizations across Canada have made significant contributions by providing training resources, creating community networks, and advocating for social prescribing, the implementation of this approach remains fragmented and limited in scope. These organizations, along with other partners, play a pivotal role in addressing the barriers to social prescribing, but more comprehensive and targeted efforts are needed to translate policy into practice at the ground level.

This report serves as a guide for these leading organizations and others seeking to support on-the-ground efforts to expand social prescribing. By identifying the specific resource needs and gaps across various components of the social prescribing process, these findings offer actionable insights into how to build a more robust, integrated framework that can enhance the effectiveness and reach of social prescribing. The discussion below outlines the key areas where targeted support and resource development are essential, providing a roadmap for social prescribers to align their efforts and maximize the impact of social prescribing initiatives.

Individual Level Challenges and Needs

At the individual level, both patients and healthcare providers identified a clear need for comprehensive training and education. Patients feel more confident and engaged when their healthcare providers are well-informed and supportive of social prescribing. This underscores the importance of training healthcare providers on the social determinants of health and equipping them with the tools to effectively screen for non-medical needs and guide patients through the referral process. Current training offerings, such as those available in Eastern Canada, need to be expanded and standardized across provinces, incorporating modules on cultural sensitivity, virtual care, and the nuances of social prescribing.

Healthcare providers also highlighted the need for training that moves beyond the traditional medical model to include social health concepts and practical tools for integrating social prescribing into everyday practice. Quick learning modules, incentivized training programs, and the inclusion of real-world demonstrations could address time constraints and enhance provider engagement. Moreover, patients and providers expressed the need for simple, accessible educational resources that can help demystify social prescribing and clarify the differences between medical and social interventions.

Organizational Level Challenges and Needs

Organizationally, the variability in community resources and the siloed nature of community organizations present significant barriers to effective social prescribing. Consistent access to relevant, high-quality non-medical services is often lacking, particularly in rural or underserved

areas. This variability can lead to gaps in service delivery and undermine the effectiveness of social prescribing referrals. Community organizations require more robust capacity-building resources, including funding, staffing, and infrastructure support, to handle increased referrals and provide sustained engagement with patients.

The integration of social prescribing into healthcare settings also requires standardized referral pathways and digital platforms that facilitate communication and coordination among healthcare providers, community navigators, and patients. Existing resources, such as the WHO social prescribing pilot project and various regional programs, provide a foundation, but there is a need for a more comprehensive and unified approach that aligns training, tools, and processes across all parties involved.

Systems Level Challenges and Needs

At the systems level, the absence of standardized screening processes and referral pathways complicates the integration of social prescribing into mainstream healthcare. Reliable, accessible tools for identifying non-medical needs are crucial for ensuring that patients receive appropriate and timely referrals to community resources. Additionally, the lack of financial incentives and clear reimbursement models for social prescribing activities can discourage healthcare providers from engaging fully in this approach.

Developing a centralized, user-friendly portal that allows healthcare providers to screen patients, refer them to appropriate services, and track their progress could streamline the social prescribing process and enhance care continuity. Incorporating AI-driven tools to match patients with suitable programs based on their unique needs and preferences could further improve the efficiency and impact of social prescribing interventions.

Societal Level Challenges and Needs

Societal resistance to social prescribing, rooted in the dominance of biomedical models of care, also poses a challenge to its broader adoption. There is a need for ongoing education and advocacy to shift mindsets within healthcare settings and the broader community, promoting a more holistic, patient-centered approach that values the role of social determinants in health outcomes. Encouraging buy-in from healthcare providers through demonstrable evidence of the benefits of social prescribing, both for patients and healthcare systems, is essential to fostering a supportive culture for this approach.

Recommendations

To promote the effective uptake and implementation of social prescribing, a coordinated approach is needed to address the resource gaps identified in this report. Below are detailed recommendations that provide a structured framework for planners to support on-the-ground efforts.

Enhancing Training for All Professionals Involved

Enhancing training is critical to building capacity and ensuring consistency in social prescribing practices. Comprehensive, standardized training modules should be developed to address the social determinants of health, practical implementation skills, and cultural sensitivity. These modules must be accessible nationwide, incentivized through certification upon completion, and include diverse formats such as quick learning videos, role-playing scenarios, and real-world demonstrations. Clear job descriptions and formalized training programs should be established to equip community navigators with the skills necessary to engage patients, assess needs, and navigate local services effectively. Tailored training modules specific to the communities in which navigators work will ensure that support is customized to meet the unique needs of each population. Additionally, capacity-building resources, including training on coordinated care and data-sharing protocols, are essential for community organizations to enhance their ability to align with healthcare providers and effectively support referred individuals. These efforts will ensure that navigators are well-informed about local offerings and can guide patients to optimal care, fostering a more integrated and responsive approach to social prescribing.

Improving Patient Education and Engagement

Improving patient education and engagement is key to the success of social prescribing. Interactive and accessible platforms, such as apps or websites, should be developed to provide tutorials, simple explanations, and regularly updated information. These resources must cater to diverse learning styles and include content in multiple languages to ensure inclusivity. Social media and digital outreach methods, such as influencer-led campaigns, can be employed to raise awareness and understanding of social prescribing, particularly among younger populations. Additionally, healthcare providers should be equipped with tools to clearly explain the differences between medical and social prescriptions, ensuring patients fully understand the concept and benefits.

Strengthening Linkages and Referrals

Strengthening linkages and referrals is essential for streamlining the referral process and enhancing the patient experience. Standardized, user-friendly referral pathways and digital platforms should be developed to facilitate seamless communication and coordination among healthcare providers, community navigators, and patients. AI-driven tools can enhance this process by matching patients with suitable programs based on their unique needs and preferences. A centralized portal would further improve the system by enabling healthcare providers to screen patients, refer them to services, and track their progress, ensuring smooth transitions and comprehensive care.

Expanding and Mapping Community Resources

Expanding and mapping community resources is crucial to the success of social prescribing. Investments should be made in dynamic, regularly updated databases that accurately reflect the availability and capacity of community resources. Incorporating AI capabilities into these databases can assist in matching patients with the most appropriate services and identifying gaps in service provision, particularly in underserved areas. To ensure inclusivity, community resources must be accessible to all age groups and demographics, with special attention to addressing the needs of marginalized populations.

Enhancing Follow-Up Mechanisms

Enhancing follow-up mechanisms is vital for maintaining patient engagement and evaluating the impact of social prescribing. Robust follow-up systems should be established, such as centralized portals that allow healthcare providers, link workers, and patients to track progress and communicate effectively. These systems could mimic existing healthcare tracking systems, like hospital charting, to ensure all parties have access to up-to-date information. Automated reminders, such as email or phone follow-ups, can encourage patients to utilize prescribed supports and services. Assigning case workers or navigators to provide ongoing encouragement and address barriers to participation can further enhance follow-up efforts.

Conclusion

Promoting the uptake and implementation of social prescribing requires a concerted effort to address the resource gaps and barriers identified in this report. While organizations have made significant strides in supporting social prescribing initiatives, there remains a need for comprehensive training, enhanced patient education, streamlined referral processes, expanded community resources, and effective follow-up mechanisms.

By focusing on these areas, social prescribers can develop a more integrated and supportive infrastructure that aligns healthcare delivery with the broader social context of patients' lives. Implementing the recommendations outlined in this report will help to reduce health inequalities, improve patient outcomes, and build a more resilient and connected healthcare system, ultimately maximizing the potential of social prescribing to enhance individual and community wellbeing.

Learn more at www.casch.org

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