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Editorial

Social prescribing in Canada: linking the Ottawa Charter for Health Promotion with health care's Quintuple Aim for a collaborative approach to health

Kate Mulligan, PhD (1); Kiffer G. Card, PhD (2); Sandra Allison, MD (3)

Abstract

Social prescribing offers a practical mechanism by which public health and health care systems can work together toward a future in which well-being is prioritized, health equity is addressed and people and communities thrive. The articles in this second part of the *Health Promotion and Chronic Disease Prevention in Canada* special issue on social prescribing explore how social prescribing in Canada supports action on two frameworks important to public health and health care communities: the Ottawa Charter for Health Promotion, which emphasizes building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services, and the Quintuple Aim for health care improvement, which focusses on improved population health, health equity, patient experience, care team well-being and reduced costs.

Keywords: *social prescribing; Ottawa Charter for Health Promotion; Quintuple Aim for health care improvement*

Highlights

- Social prescribing supports collaboration between public health and health care services by providing a mechanism for action on both the Ottawa Charter for Health Promotion and the Quintuple Aim for health care improvement.
- At the individual level, people develop personal skills (Ottawa Charter), and care experiences improve for participants, patients and health care workers (Quintuple Aim).
- At the community level, health service reorientation strengthens community action, builds supportive environments and reduces acute care costs by moving care upstream.
- At the population level, precision data on health and social care support prioritization and decision making for healthy public policy and health equity.

Introduction

Social prescribing continues to grow rapidly across Canada, complementing existing strengths and building capacity for improving how we address health promotion and chronic disease prevention in Canada. The first part of this special issue of *Health Promotion and Chronic Disease Prevention in Canada* (HPCDP) on social prescribing (published in June 2024) described the practice of social prescribing across settings, populations and interventions, with a focus on the role of communities and community organizations.

This second part speaks primarily to public health and health care communities, who are respectively guided by two crucial frameworks: the Ottawa Charter for Health Promotion[1] and the Quintuple Aim for health care improvement.[2] The Ottawa Charter, established by the World Health Organization in 1986, describes health promotion as a process of empowering people and communities to take more control over their health and its determinants. The Charter outlines five action areas for health promotion: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services. The Quintuple Aim, developed by the Institute for Healthcare Improvement, expands on the traditional triple aim for better health care (patient or participant experience, population health and reduced costs) by adding clinician or care team well-being and addressing health equity. The articles in this second part of our special social prescribing issue explore how social prescribing research, policies and practices in Canada align with these frameworks, as outlined here.

Develop personal skills (Ottawa Charter) and improve patient experience (Quintuple Aim)

Social prescribing is a strengths-based approach that supports people in exercising and developing personal skills, such as financial literacy, cooking skills, advocacy

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or leadership, that support self-determination—a health promotion approach rooted in individual and collective autonomy, competence, relatedness and beneficence.[3] These skills vary across populations, geographies and the life course, as demonstrated by Yu et al.'s qualitative analysis of the expressed social prescribing needs and priorities of older adults.[4] Increasingly, research shows that relationships built with social prescribing link workers—often peers from a shared community—are important to this skill development and are correlated with an improvement in experience.[5] The connection to a supportive community health worker helps to support and sustain people and distinguishes social prescribing from a less personalized approach focussed first and foremost on care or service navigation; link workers not only provide social referrals, but befriend participants and bear witness to their distress.[5]

Strengthen community action (Ottawa Charter) and address health equity (Quintuple Aim)

Social prescribing programs can help bridge the gap in health outcomes experienced by different populations, both by supporting communities in identifying and addressing their own health needs and by connecting patients with resources they may not have otherwise accessed.[6] Part I of our special issue on social prescribing includes examples of Afrocentric[7] and reconciliation-based[8] community development in social prescribing. In this issue, Kadowaki et al.'s mixed methods analysis demonstrates how social prescribing in British Columbia improved access to services for older adults, but also established a clear need for stronger and more stable resources for existing and new community programs.[9]

Reorient health services (Ottawa Charter) and reduce costs (Quintuple Aim)

Social prescribing provides a mechanism for meaningful collaboration between health care and community organizations on addressing health-related social needs.[10] It also demonstrably supports deprescribing, allows for more efficient upstream health spending by moving care upstream and reduces health care's environmental impacts by preventing unnecessary health care utilization.[11] Saluja and Dahrouge's contribution from the Access to Resources in the Community project in Ottawa provides detailed guidance for how to reorient services within health care settings,[12] while Lin and colleagues' commentary from BC's Fraser Health Authority demonstrates the value of long-term funding and strong support from within health care organizations to initiate and sustain community-partnered social prescribing.[13]

Create supportive environments (Ottawa Charter) and improve care team well-being (Quintuple Aim)

Social prescribing creates and supports connections to, and resources for, healthy social and physical places, such as community gardens and cultural centres, that foster a sense of belonging, social interaction and a connection to nature.[14] This impact extends to the well-being of strained health human resources, offering a sense of connection, purpose and belonging for clinicians.[15] The quantitative study by Turpin et al. of Youth Wellness Hubs in Ontario demonstrates the benefits of a service hub approach,[16] whereby multiple youth wellness services are most often provided in a single, community space, for coordination among multidisciplinary care teams and across clinical and nonclinical services.

Build healthy public policy (Ottawa Charter) and improve population health outcomes (Quintuple Aim)

Social prescribing can improve population health at scale by promoting healthy behaviours, social connections and access to community resources for all users of health and social services.[17] Crucially, it can inform healthy public policy priorities and decisions through precision data collection that helps to identify the community resources that participants need most.[18] Most social prescribing initiatives are well connected to policy development in their respective regions, as demonstrated by Mansell et al.'s policy brief[19] linking social prescribing evaluation and policy as guided by the Healthy Aging Asset Index in Alberta.

Conclusion

Social prescribing represents a significant step forward in achieving the goals outlined in both the Ottawa Charter and the Quintuple Aim. It fosters a holistic approach to health care, recognizing the interconnectedness of social, environmental and individual factors that influence health. By investing in social prescribing programs, public health and health care systems can move towards a future in which well-being is prioritized, health equity is addressed and both communities and health and social care workers thrive. As we strive for a healthier Canada, social prescribing offers a powerful and practical tool to navigate the path forward.

Conflicts of interest

KM, KGC, and SA were Guest Editors for this issue of the HPCDP Journal, but removed themselves from the editorial decision-making associated with this manuscript.

Statement

The content and views expressed in this article are those of the authors and do not necessarily reflect those of the Government of Canada.

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Original quantitative research

Leveraging integrated youth services for social prescribing: a case study of Youth Wellness Hubs Ontario

Aaron Turpin, PhD (1,2); Deb Chiodo, PhD (1); Maria Talotta (1); Jo Henderson, PhD (1,3)

This article has been peer reviewed.

Abstract

Introduction: Integrated youth services (IYS) presents a unique opportunity to adopt social prescribing (SP) strategies within the IYS service model by developing and leveraging a highly connected multidisciplinary network of clinical and community-based service providers to tackle health inequities and enhance service access and outcomes for youth. This paper outlines a case study of Youth Wellness Hubs Ontario (YWHO), Canada, a collective of youth-serving organizations integrated and networked, and operating as a learning health system implementing SP services. The main study objective was to document how YWHO hubs engage in social prescribing through service provision.

Methods: We adopted an embedded case study approach. Data were collected from youth (n = 6361) aged between 12 and 25 years who were seeking services at a YWHO hub. Descriptive analyses, including frequencies across categories, were generated from service data, including reason for visit, needs addressed and service provided.

Results: A comparative analysis of services requested and provided found that youth across visits to YWHO hubs were engaging with multiple services and service providers, with a wide range of health, mental health and social support needs being addressed.

Conclusion: YWHO implements SP services that aim to improve mental health resilience by supporting the vocational, educational and socialization needs of young people accessing IYS through YWHO hubs.

***Keywords:** social prescribing, integrated youth services, youth services, youth well-being*

Highlights

- IYS exemplifies an innovative approach to SP through the development of a closely connected network of interdisciplinary service providers.
- Youth engaged in IYS are likely to connect with multiple services concurrently as biopsychosocial needs are identified and addressed.
- The most common services provided by YWHO address mental health, educational and relationships needs, and are provided by mental health workers, care navigators and education or training support workers.

Introduction

Mental health service use among youth continues to be low,[1,2] while treatment for substance use has been found insufficient for meeting youths' needs.[3] Youth seeking services commonly experience multiple internalizing (e.g. depressive symptoms, anxiety, stress) and externalizing (e.g. inattention, substance use, hyperactivity) difficulties[3-6] that can lead to poor developmental outcomes if not fully addressed.[7] The need for quality integrated services addressing these health disparities concurrently is well documented,[2,5,8-11] yet service frameworks adopting this approach are largely absent from practice.[9]

Addressing this service gap, integrated youth services (IYS) is an innovative care approach that establishes multidisciplinary teams of professionals who work together to meet the co-occurring needs of youth and their families.[4,9,10] IYS establishes a shared vision of delivering youth services across an integrated network of providers,[9,11] thereby transcending the capacity of individual programs and leveraging the power of a collective network providing wholistic support and reducing fragmentation of care.[10-13] By enhancing connections to and between services, IYS supports timely and effective health and mental health care for youth,[2] thereby decreasing health disparities faced by this population.[7,8]

A core component of IYS includes leveraging the power of social prescribing (SP) practices for the purpose of enhancing service engagement for youth.[4,10] SP refers to activities that connect service users to

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person-centred health and mental health services in a community setting as part of an intervention.[14] These services aim to support individuals in addressing their own social and health needs through community connections[15] by facilitating referrals from clinical to nonclinical community services.[16] As IYS becomes more established across Canada,[4,9,11,13,17,18] the opportunity to expand and broaden SP in youth wellness services grows.[15] Local, regional and pan-Canadian IYS networks, such as YouthCan IMPACT,[13] are implementing models supporting appropriate and timely access to youth well-being services. While substantial evidence supporting the IYS model exists,[9-11] practice-based literature describing model components and service use is needed to facilitate replicability.[11] Supporting this need, our study adopted a case study methodology to explore how youth wellness hubs engage in social prescribing through service provision.

Integrated youth services and social prescribing

IYS networks in Canada adopt a service hub approach, whereby multiple youth wellness services are most often provided in a single, community space.[9,19,20] Hubs commonly address complex social, psychological and physical health needs by providing youth- and family-centred services delivered by integrated care teams using rapid, continuum-of-care approaches in a youth-friendly environment.[2,9] Core to the operation of these hubs are youth and family engagement in service design and delivery, efforts to increase community awareness of services, community network development, measurement-based care and program evaluation activities.[9] IYS implementation may differ, however, depending on hub context, emphasizing the active involvement of local partners in hub development, including youth, staff, families and external organizations.[9,11,12,21]

SP is a tool that complements mental health and primary care,[22] and is highly compatible with the IYS model, given that both share the goal of connecting youth to community-based social supports,[18] which often includes screening for needs and actively supporting access to services.[17] Moreover, a key pillar of SP in IYS is the notion of person-centredness, in which interventions are designed to empower individuals to improve their own health.[21] In addition, SP aligns with IYS because both facilitate strong relationships between practitioners by building on pre-existing network strengths, enhancing service tracking and increasing follow-through when working between services.[19] Evidence supports that challenges with social determinants of health (i.e. access to treatment, food security, employment, education, finances) are common among service-seeking youth,[22] and models of IYS provide service integrated pathways that address the full range of concerns with which youth are presenting.[9,16]

Reducing health disparities

Hubs address longstanding issues with system fragmentation by increasing youth access to several different services at once, while providing navigator-supported transitions to higher intensity or other external services if needed.[16] As multiple service providers become tightly bound within a network, youth benefit from interventions that are more responsive to their current needs.[4] IYS seeks to remove barriers that commonly prevent youth from accessing timely and appropriate services, such as a lack of trust and awareness.[12] It accomplishes this by fostering meaningful and ongoing relationships among providers and youth, as well as across the service landscape between organizations and professionals who serve youth.[23]

Research has shown that youth initiatives adopting IYS and SP approaches are successful at reducing health disparities. For example, the Assertive Community Treatment approach integrates rapid and stepped care approaches, including the use of community-based referrals, and has been shown to decrease psychosocial difficulties, as well as depressive and subclinical psychosis symptoms experienced by youth, while improving social interactions and quality of life.[24] Similarly, an integrated family-based treatment program for adolescents with substance use concerns presenting to community mental health centres included several social prescribing techniques, such as delivering several services at a single localized space and adopting a sequential approach to service provision.[6] A randomized controlled trial of the program found positive outcomes for youth substance use when compared to treatment as usual.[6] Finally, integrated behavioural health services using social prescribing techniques have been found to strengthen mental health literacy and commitment to serving youth among practitioners while enhancing practitioner self-efficacy and skill development.[8]

Research and service evaluation in the area of youth-focussed SP is needed to support continued implementation and evidence-based practice. Accordingly, we present a description of SP into a specific IYS model being implemented and evaluated in Ontario, Canada.

The case study: Youth Wellness Hubs Ontario

Youth Wellness Hubs Ontario (YWHO) is Ontario's provincial network of youth-serving hubs that provide integrated services co-designed with youth and families. Currently, there are 22 hub networks with YWHO hubs in 31 geographically diverse communities serving youth aged 12 to 25 years. YWHO networks address a continuum of youth needs related to mental health, substance use health, primary care, peer support, navigation, education, employment, housing, wellness activities and other community and social programming.[9] Available virtually and in person, YWHO hubs are local places where young people have low-barrier, walk-in access to an equity-focussed, high quality, integrated delivery model of support services. Each hub must offer evidence-based or evidence-generating mental health, substance use health, primary care, and social and community supports, though the specific services within each of these domains provided at each hub are determined by local service availability and through consultation and co-development with local youth and community members who form a governance table for the network.

Also consistent across all hubs is the implementation of youth wellness teams at each location to support enhanced service integration for the clinical service pathway (physical, mental and substance use health services). These teams include mental health and substance use clinicians; medical professionals such as nurse practitioners, primary care providers, and psychiatrists; peer support workers; care navigators; and youth wellness facilitators who support engagement and orientation to measurement-based care. YWHO service pathways comprise a continuum of care for youth, with varying levels of intensity, to facilitate tailoring of services to youth needs, self-reported goals for service, and preferences.

Reflecting the voices of youth and family members, YWHO services are available to youth without any required referrals, previous assessments or diagnoses. Youth can access services without an appointment (or with an appointment, if preferred), and convenient hours of service (including evenings and weekends) are offered. Youth are also able to move in and out of services with minimal barriers, to reflect their changing needs over the course of development. A full description of the YWHO model, values, and core components has been published elsewhere.[9]

Methods

Ethics approval

This project has undergone ethics review and approval by the Centre for Addictions and Mental Health Quality Projects Ethics Review (#QPER42).

Procedure

This project adopted an embedded case study approach[25] to profile a novel social prescribing strategy using service data from YWHO hubs. Case studies provide in-depth analyses using a single example of a social phenomenon to highlight more nuanced and novel characteristics,[25] which are often lost in studies employing multiple case samples. Embedded case studies differ from typical case studies in that researchers are actively engaged in organizational activities and are often a part of the organizational structure (for example, as staff members).[26] In our study, a descriptive analysis of cross-sectional quantitative service use data was conducted using a large sample of youth accessing YWHO. A comparison of reasons for engaging with YWHO and needs addressed during service provision provide insight into the challenges presented by youth, and how those were addressed in YWHO services. Further, descriptive analyses of services provided illuminate the modalities that were employed with youth.

Sample and recruitment

Participants included youth (n = 6361) aged 12 to 25 years receiving services from 14 hubs between April 2020 and March 2023.

Youth demographic and service data have been collected by YWHO sites since April 2020, and are a routine part of the measurement-based care process between staff and youth that occurs during service visits. At the beginning of a visit, youth are provided with a private space and a tablet programmed to administer measures that include questions regarding needs, goals, symptoms, functioning and demographics. The youth also review and complete a consent form for services that describes the integrated hub services available and the sharing of data among their circle of care. Youth are provided with supports for consent and measure completion as required, but measure completion is not required to access services. Upon completion of the service visit, service providers complete an electronic end-of-visit form, which includes questions about the interventions delivered, needs addressed and next steps in the plan of care. Measures of youths’ experiences and satisfaction with services are also electronically administered. Data are stored in a secure cloud platform, partitioned by site; hub staff can access their own hub’s data. Specific YWHO Provincial Office staff are able to access data across hubs.

Measures and analysis

Data from three variables were analyzed: “reason for visit,” “needs addressed” and “type of service provider” who delivered service. “Reason for visit” is a question completed by youth at the beginning of each visit before services are provided. Youth are asked to indicate the reason they are visiting the hub that day and are provided with several response categories relating to mental, physical, cultural and social needs. “Needs addressed” includes a matching list of needs that is completed by the service provider at the end of the visit to indicate which needs were addressed in session. “Type of service provider” asks service providers to indicate who was involved in service delivery, and is completed at the end of the visit.

For all variables, multiple responses are allowed. Frequencies for all response categories across each variable were tabulated for service data. Number of selections (n) and percentage of total visits (%) were calculated. Adding further nuance to service data, responses for reason for visit categories were stratified across age and gender demographic variables. This analysis was completed to provide additional information regarding which demographic subgroups were most represented within each service category. Reason for visit was selected because it is the only service variable that is youth-provided, and stratifying additional service variables was beyond the scope of this paper. Analysis was conducted using SPSS Statistics for Windows, version 27.0 (IBM Corp., Armonk, NY, US).

Results

Demographic statistics

Table 1 provides demographic characteristics of the youth in our sample. The sample is distributed similarly to the whole youth population in Canada.[27] Response categories for gender, sexual identity, disability status and housing status were collapsed into general categories to increase group size and maintain youth data confidentiality. (Appendix 1 contains a full list of collapsed demographic variables.) Of the sample, 31.8% of youth identified as girl or woman, 25.2% identified as boy or man, and 7.5% identified as trans or gender diverse. For the sexual identity category, 29.7% of youth identified as heterosexual and 19.6% as 2SLGBQI+. For a full list of demographic variables, see Table 1.

Missing data ranged from 4.2% (age) to 46.9% (employment status). Demographic data is not mandatory for youth to complete (i.e. they may skip providing data for specific demographic questions) but highly encouraged in order that their needs may be best understood. This is an intentional decision, as youth may not feel safe providing identity-based data. Further, response categories are not mutually exclusive, allowing youth to select more than one option per demographic question, in an effort to allow youth to use categories that are most reflective of how they identify. Consequently, counts and percentages for specific demographic and service variables may not be congruous with the sample size.

Services requested and provided

Table 2 summarizes findings from n = 6361 youth across 22 153 visits (M = 3.5 visits/youth) showing youth-reported, pre-service reason for visit and the service provider–reported, post-service needs addressed. Overall, youth were most likely to indicate “mental health” as a reason for visit (47.3%), followed by “school/education” (13.0%), “relationships” (13.0%), “physical health” (6.8%) and “food/nutrition” (5.6%). The remaining categories for reason for visit were less than 5.5%. For needs addressed, service providers noted “mental health” was the most common need (72.7%), followed by “school/education”

TABLE 1
Demographic characteristics of youth receiving IYS at YWHO hubs, April 2020 to March 2023

Variable	n (%)
Total number of visits	22 153
Total unique youth	6 361
Age (y)	
12–14	1204 (18.9)
15–17	2086 (32.7)
18–20	1445 (22.7)
21+	1414 (22.2)
Missing	269 (4.2)
Gender identity	
Boy/man	1606 (25.2)
Gender diverse	484 (7.5)
Girl/woman	2025 (31.8)
Not sure/questioning/other/prefer not to answer	214 (3.3)
Missing	2062 (32.4)
Sexual identity	
Heterosexual	1889 (29.7)
2SLGBTQI+	1247 (19.6)
Don't use labels/not sure/questioning/other/prefer not to answer	549 (8.6)
Missing	2868 (45.1)
Born in Canada	
Yes	3199 (50.3)
No	251 (3.9)
Do not know/do not want to answer	30 (0.5)
Missing	2900 (45.6)
Disability status	
Has a chronic illness	145 (34.7)
Has a disability	1351 (21.2)
No disability	1601 (25.2)
Not sure/do not want to answer	745 (11.7)
Missing	2048 (32.2)
Housing status	
Experiencing homelessness	92 (1.4)
Has housing	3370 (53.0)
Other/prefer not to answer	125 (1.9)
Missing	2779 (43.7)
Student status	
Is a student	2513 (39.5)
Is not a student	892 (14.0)
Missing	2957 (46.5)
Employment status	
Has employment	1289 (20.3)
Does not have employment	2086 (32.8)
Missing	2983 (46.9)

Abbreviations: IYS, integrated youth services; y, year; YWHO, Youth Wellness Hubs Ontario.

(13.7%), "relationships" (12.1%), "physical health" (8.3%), "substance use" (6.8%) and "employment" (5.7%). All other categories were less than 5.5%. Service providers were more likely than youth to select multiple response categories for needs addressed, which had an additional 6942 needs identified (29.5% higher than youth).

Tables 3 and 4 provide a stratification of reason for visit data across demographic categories for age and gender, respectively. Youth aged 15 to 17 years were the most represented age group in the top three categories, including "mental health," "school/education" and "relationships." Frequencies and percentages for other age groups were similar. Youth identifying as "girl/woman" had the highest number of visits for "mental health," "school/education" and "relationships," while youth identifying as "boy/man" had more visits for "mental health" than youth identifying as "gender diverse." Frequencies and percentages for all other categories were similar across gender groups.

Type of service provider

For frequencies of type of service provider (Table 5), the most common service provider was "mental health/substance use clinician/worker" (41.7%), followed by "care navigator/coordinator" (13.4%), "education/training support worker" (6.5%) and "measurement-based care facilitator" (5.7%). All other categories were less than 5%.

Discussion

The description of social prescribing within IYS has not been well documented and, in general, the literature lacks in-depth analyses of specific models implementing the SP approach. Using an embedded case study design, we sought to describe an innovative SP model presently being implemented within IYS in Ontario, while analyzing service use data to understand the complexity and intersection of youth needs while engaging in IYS. Our findings provide insight into youth service needs and service delivery while connecting with integrated service hubs.

With respect to the gender categories, about one-third of youth in the sample identified as girl/woman, reflecting existing research findings that girls and women are more likely to seek support for mental

TABLE 2
Frequencies of service requests compared to services provided across all visits (n = 22 153) to YWHO hubs from April 2020 to March 2023

Service	Reason for visit n (%)	Needs addressed n (%)
Mental health	10 475 (47.3)	16 098 (72.7)
School/education	2 873 (13.0)	3 039 (13.7)
Relationships	2 891 (13.0)	2 685 (12.1)
Physical health	1 506 (6.8)	1 838 (8.3)
Food/nutrition	1 242 (5.6)	1 171 (5.3)
Employment	1 099 (5.0)	1 274 (5.7)
Substance use	950 (4.3)	1 506 (6.8)
Peer support	893 (4.0)	953 (4.3)
Housing	842 (3.8)	804 (3.6)
Cultural	270 (1.2)	495 (2.2)
Total	23 041	29 863

Abbreviation: YWHO, Youth Wellness Hubs Ontario.

health and other services.[28,29] Transition-aged youth (18–25) represented the largest age group seeking services from YWHO, confirming similar findings across other international models of IYS and further supporting the elimination of typical barriers to help-seeking in this group of young adults.[4,22,23]

IYS models are designed to address the gaps (e.g. help-seeking barriers, fragmentation, age barriers) that exist in traditional youth mental health and substance use systems, and our data support that young people seeking mental health services will be better served and have improved access where mental health services are offered in integrated settings.

Youth in this sample selecting mental health as a reason for visit may use this response to indicate the need for several different services within the hub (e.g. group and individual counselling), and the "mental health" reason for visit may also overlap with similar needs, such as peer support, relationships and physical health. Given the association between mental health and the social determinants of health such as finances, employment, food security and housing,[22,30] these data highlight both the need for multidisciplinary professional care in youth services and the ability of YWHO to be responsive to SP needs. These findings also represent further evidence that youth are accessing several different services within hubs that are addressing a wider set of needs, following an SP approach.

TABLE 3
Reason for visit across age categories of youth visiting YWHO hubs from April 2020 to March 2023

Service	Age 12–14 y (n = 1204) n (%)	Age 15–17 y (n = 2086) n (%)	Age 18–20 y (n = 1445) n (%)	Age 21–25 y (n = 1414) n (%)
Mental health	1225 (5.5)	3155 (14.2)	2232 (10.1)	2092 (9.4)
School/education	361 (1.6)	946 (4.2)	423 (1.9)	302 (1.3)
Relationships	319 (1.4)	851 (3.8)	583 (2.6)	603 (2.7)
Food/nutrition	157 (1.0)	342 (1.5)	232 (1.0)	208 (1.0)
Employment	25 (< 1)	165 (1.0)	220 (1.0)	252 (1.1)
Substance use[a]	59	211	178	232
Peer support[a]	65	182	113	157
Housing[a]	67	161	169	147
Cultural[a]	11	32	29	68

Abbreviations: y, year; YWHO, Youth Wellness Hubs Ontario.

Note: Total visits n = 22 153.

[a] n for all categories is ≤ 1%.

"School/education" and "relationships" were the second most common reason for visit (13%) category. Youth are commonly using YWHO hubs as spaces to complete and access support for schoolwork, highlighting the multifunctionality of hubs and significance to youth as drop-in facilities. The prevalence of "relationships" in service data underscores the importance of interpersonal development for youth, peers and family within mental health services, and how these connections are integral to youth care. Social connection, or lack thereof, is considered a social determinant of health, with documented health consequences, including poor health and socioeconomic status.[31] SP services have been described as supporting connectedness and, by extension, mental well-being, health behaviours and physical health.[32,33] Integrated services are believed to provide youth with a safe space where various practitioners can address their wholistic needs without youth having to repeat their story multiple times.[34] In addition, youth can receive services without their peers knowing which services they are accessing.[35] YWHO has implemented an integrated data platform across its network of service providers that gathers and stores information about the needs, goals and preferences for services of the youth they serve. Service providers who are part of the circle of care for youth have access to their history and can provide personalized measurement-based care.

Finally, the types of service providers within networks at YWHO hubs highlight the importance of co-location of different service providers who are able to meet the varied needs and goals of youth presenting for service. The fact that care navigator/coordinator was the second most frequently requested service provider (13.4%) highlights the importance of multifunctional care as facilitated by staff who catalyze the SP process in YWHO hubs by navigating health systems, connecting with other providers, completing referrals and ensuring continuity of care. These workers provide youth with valuable supports, ensuring service connectivity and seamless accessibility between services by enhancing

TABLE 4
Reason for visit across gender categories of youth visiting YWHO hubs from April 2020 to March 2023

Service	Girl/woman (n = 2025) n (%)	Boy/man (n = 1606) n (%)	Gender diverse (n = 484) n (%)	Not sure/questioning/other/ prefer not to answer (n = 214) n (%)
Mental health	3443 (15.5)	1621 (7.3)	802 (3.6)	264 (1.2)
School/education	967 (4.4)	369 (1.6)	238 (1.1)	103 (< 1)
Relationships	1066 (4.8)	384 (1.7)	308 (1.4)	99 (< 1)
Food/nutrition	451 (2.0)	135 (1.0)	133 (< 1)	59 (< 1)
Employment	246 (1.1)	148 (1.0)	80 (< 1)	34 (<1)
Substance use[a]	189	207	84	27
Peer support	239 (1.1)	84 (< 1)	92 (< 1)	27 (< 1)
Housing[a]	228	103	169	147
Cultural[a]	48	33	42	8

Abbreviation: YWHO, Youth Wellness Hubs Ontario.

Note: Total visits n = 22 153.

[a] n for all categories is ≤ 1%.

communication between providers. Therefore, the role of care navigators and coordinators should be viewed as an essential component of SP and IYS. Similarly, other social support staff are also reflected in the data, and are key for IYS, including education/training, housing, income and employment workers, who together provide over 10% of services.

Strengths and limitations

Several strengths enhance the generalizability of this work. The sample size is considerably large for a study using youth data, as is the number of visits where data were provided. The sample includes representation from several communities, including 2SLGBTQI+ and gender diverse youth. Similarly, data were collected from across the province of Ontario, including large, medium and small population centres. We consider the self-report data to be a strength of this study, as youth voices are often neglected in similar research. This is the first large-scale youth dataset of its kind in Canada.

However, this study is not without limitations. Data from findings are descriptive, and therefore relationships between variables cannot be ascertained. The absence of inferential analyses prohibits the identification of causal and correlational interactions, and conjecture in the interpretation of findings requires further investigation using multivariate modelling to confirm. The dataset used in this study includes high rates of missing demographic, services provided and service provider data. This was due to the nature of the data collection—most questions provided to youth and staff are not mandatory, and therefore respondents may choose not to provide data for a variety of legitimate reasons (e.g. if a youth is not comfortable providing data, or not in a mental space conducive to providing data on a specific visit).

Similarly, staff may neglect to complete surveys, either because they have forgotten to complete data entry, or because they have not actually referred a youth to a service. Regardless, missing data may include responses that would alter the nature of findings, although it is not possible to ascertain whether this is the case here. Data validity could have been strengthened in this study by ensuring all variables were responded to by youth. This would ensure continuity across services requested and provided by integrating youth voices throughout.

TABLE 5
Frequencies of type of service provider across all visits (n = 22 153) to YWHO hubs from April 2020 to March 2023

Service	Visits n (%)
Mental health/substance use clinician/worker	9241 (41.7)
Care navigator/coordinator	2966 (13.4)
Education/training support worker	1454 (6.5)
Measurement-based care facilitator	1259 (5.7)
Peer support worker	1060 (4.8)
Housing, income, or other social support worker	625 (2.8)
Employment/individualized placement support worker	409 (1.8)
Missing	7546 (34.1)

Abbreviation: YWHO, Youth Wellness Hubs Ontario.

Conclusion

In-depth, descriptive accounts of SP in youth services are largely missing from the knowledge base, but are needed to provide detailed examples of the development, implementation and outcomes associated with related activities. A novel, innovative approach to SP adopted by YWHO embraces IYS as a method for timely and effective referrals across a multidisciplinary set of services addressing youth needs. In our study, a comparative analysis of service data revealed that staff serving youth were more likely to select multiple needs addressed after service delivery, supporting the notion that SP approaches in IYS connect youth to multiple services effectively. A high prevalence of transition-aged youth in the sample lends support to IYS addressing barriers to service access that are common among older youth. Data also show considerable overlap between clinical and nonclinical services, highlighting the need for coordination among multidisciplinary care teams. The diversity of service needs shown in this sample also highlights the importance of effective care navigation.

Overall, this study frames the case of YWHO as a model for youth SP that may be leveraged to guide other IYS and health service settings. Partners seeking to adopt IYS may consider a similar data collection approach to track service use and identify trends within youth service engagement. Implementation of an IYS system would be enhanced by developing interprofessional care teams to ensure seamless transitions between services addressing the wholistic health, mental health and social support needs of youth. Future research can contribute to the growing body of evidence for IYS by implementing inferential and longitudinal designs that seek to measure change over time across health and mental health outcomes for youth.

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Conflicts of interest

The authors declare there are no conflicts of interest.

Authors' contributions and statement

AT, DC: conceptualization, analysis.

AT, DC: writing—original draft.

MT, JH: writing—review and editing.

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Appendix 1

Demographic variables: collapsed categories

Name of the reported variable	Collapsed variables from the sample
Gender diverse	Trans woman; trans man; nonbinary; Two-Spirit; gender queer; gender fluid; androgynous
2SLGBTQI+	Gay; lesbian; bisexual; asexual; queer; pansexual; omnisexual; demisexual; Two-Spirit
Has a disability	Developmental disability; learning disability; physical disability; sensory disability; other
Has housing	Family home; own place; lives with friends; foster group home; supported housing; open custody; single room in someone else's house
Experiencing homelessness	Living in shelter; living on the street; couch surfing

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Original qualitative research

Social prescribing needs and priorities of older adults in Canada: a qualitative analysis

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This article has been peer reviewed.

Abstract

Introduction: Social prescribing (SP) is a holistic and collaborative approach to help individuals access community-based supports and services for their nonmedical social needs. The aim of this study was to assess the needs and priorities of Canadian older adults (aged 55 years and older), with a focus on optimizing SP programs for those who are systemically disadvantaged and socially marginalized.

Methods: Semistructured focus groups (N = 10 groups, 43 participants) were conducted online via Zoom with participants from across Canada. Data transcription and thematic analysis were completed in NVivo. Analyses were informed by self-determination theory.

Results: Our results suggest that older adults desire SP programs that respect their ability to maintain their autonomy and independence, aid and facilitate the development of connectedness and belonging, are built on a foundation of trust and relationship-building in interactions with providers and link workers, and prioritize the person and thus personalize SP to the unique needs of each individual.

Conclusion: SP programs should be informed by the values of older adults. As work is currently underway to formalize and scale SP in Canada, personalizing these programs to the unique circumstances, needs and priorities of participants should be a top priority.

Keywords: *social prescribing, qualitative research, older adults, social determinants of health, social needs*

Highlights

- Structurally disadvantaged and socially marginalized older adults want social prescribing (SP) programs that respect their autonomy and independence, boost their social connections with others and help them regain a sense of belonging in their community.
- Trust and a solid relationship with a link worker or health care provider are of utmost importance.
- Each older adult is unique, necessitating personalized supports and resources, particularly if they are structurally marginalized and socially disadvantaged.
- SP implementation in Canada should aim to meet older adults' needs for autonomy, relatedness and competency in order to be effective.

Introduction

Social prescribing as a holistic intervention

Social prescribing (SP) is a holistic approach to improving health and well-being by addressing participants' nonmedical, health-related social needs, such as poor social integration, housing and food insecurity and poor mental health.[1,2] It accomplishes this goal by providing a formal framework for health care providers and interprofessional community providers to refer clients to local, community-based, nonmedical services and supports that can address the client's personal well-being, interests and needs through a person-centred and collaborative approach. In doing so, SP creates strong integration between medical care and community care systems, while

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also empowering clients to engage with their community and actively participate in improving their own health.[3] Successful implementation of a SP program involves follow-ups to reduce barriers to access and ensure that supports were appropriate and beneficial to the client. Thorough program evaluation of SP interventions is also key to ensure they are meeting participants' needs.[4-6]

History and local adaptation of social prescribing programs

The idea and implementation of SP originated in England in the mid-1980s to early 1990s to direct patients to local nonclinical services. Since then, SP has gained traction in many countries.[7] In Canada, SP has also been gaining momentum, spurred by a growing body of evidence highlighting the importance of addressing social determinants of health for overall health and well-being.[8,9] The way that SP is implemented is context-dependent and may differ across jurisdictions. Such differences include the scale and scope of services offered and how health and social services are integrated.[7] Therefore, it is important to identify the needs of local program participants when scaling SP programs.

Social prescribing needs of older adults

Although social isolation and loneliness are detrimental to the well-being and health of all populations, they are an underappreciated risk for older adults in particular.[10,11] Older adults are more likely to experience risk factors that bidirectionally worsen social isolation and loneliness, such as chronic illness, loss of family members and living alone.[12] Evidence suggests social isolation is linked to major health risks as well, including premature mortality.[13] Older adults in marginalized, underserved populations are particularly impacted by the adverse effects of social isolation and loneliness on overall well-being and quality of life.[12,14]

In order to ensure that SP pathways, as well as the supports and services they link clients to, can provide benefit to those in greater need of the programs, it is crucial to understand the priorities of older adults who face structural disadvantages and social marginalization; in other words, older adults who may be limited in their privileges in the current system and social structure due to their race, gender, sexuality, age, disability, isolation and socioeconomic status.[15] Given the person-centred nature of SP, client participation in co-designing and co-production (i.e. development of service activities through mutual understanding and agreement of service users [older adults] and service providers [health care and community providers]) is an integral element of the sustainability of SP.[16]

Research on SP has demonstrated that it has the potential to aid older adults in meeting their health and well-being needs.[11,17] Bhatti et al. explored how SP facilitates positive outcomes in patients (aged 26–81 years) from 11 community health centres across Ontario, and found patients reported that engaging in SP satisfied their psychological needs for autonomy, competence and relatedness.[18] In their literature review, Rothe and Heiss identified the need for link workers that take an active and supportive role for individuals with psychosocial needs, and for some with physical or mental illness.[19]

Furthermore, most studies indicated the importance of referring participants to activities that meet personal preferences and identity needs. Wildman et al. interviewed participants (aged 40–74 years) living in a socioeconomically deprived area in North East England.[20] Although participants reported improvements in social connection and condition management, they also experienced difficulties related to multimorbidity, family circumstances and social, economic and cultural factors, outlining the importance of more complex SP interventions for those facing a multitude of social disadvantages and structural marginalization. The role of a strong and supportive relationship with an accessible link worker was particularly important for this study sample as well.

Study aims and objectives

Currently, there is limited research on the SP needs, attitudes and beliefs of older adults from diverse backgrounds.[21] This understanding plays an important role in introducing and advancing SP in Canada. Our study aimed to explore the unique needs and priorities of older adults who experience systemic disadvantage and social marginalization. The study specifically focussed on gathering insights into the following: (1) older adults' experiences with and interest in SP; (2) their comfort with their primary health care provider; (3) their comfort with other community providers; (4) qualities they would like in a link worker; and (5) barriers that may impede their participation.

Methods

Ethics approval

Study procedures were approved by the Research Ethics Board of Simon Fraser University (REB #30001382).

Theoretical framework

This study is informed by self-determination theory (SDT), which advances the idea that people who are enabled to self-determine their actions are more likely to experience greater well-being and motivation for change. The theory posits that self-determination requires the satisfaction of three psychological needs: (1) autonomy (i.e. a sense of control over one's behaviours, having choice and decision-making power in what is important); (2) competency (i.e. the ability to achieve what one sets out to do effectively and have influence on outcomes); and (3) relatedness (i.e. social connectedness and belonging, and feeling understood, cared for and valued by others).[22] SDT has previously been implemented in research into healthy aging among older adults[23] as well as in understanding and improving SP specifically.[18,24,25]

Participant recruitment and data collection

This qualitative study used semistructured focus groups and thematic analysis to explore older adults' attitudes toward and experiences with SP. A focus group is a specific form of interview that encourages engagement among participants, with the interviewer serving as a facilitator of discussion.[26] Focus groups were conducted via Zoom, lasted anywhere between 60 and 90 minutes, and included between 3 and 7 participants per group, alongside a facilitator. Facilitators (CY, SL) underwent training with lab colleagues in practice focus groups, prioritizing practising open facilitation skills and awareness of sensitive topics.

Focus group questions were designed with input from all authors, and are presented in Table 1. All focus groups were conducted in English.

TABLE 1
Focus group questions on social prescribing needs and priorities of older adults in Canada

	Questions
1.	Have you ever experienced anything like social prescribing before? For instance, have your doctors prescribed or referred you to anything for a nonmedical, health-related social need?
2.	Would you be interested and willing to participate in and follow through on social prescribing activities? What kinds would you be most interested in?
3.	How comfortable would you be to bring up your nonmedical, social needs to your primary health care provider?
4.	What's your experience been like with other community providers? Would you be comfortable receiving social prescriptions from community providers other than your primary health care provider?
5.	What qualities would make a good link worker to you?
6.	Are there any barriers that you might face in participating in social prescribing?

All participants gave informed consent. Older adults were recruited through a previously conducted online survey focussing on health care needs and utilization and SP attitudes among older adults (aged 55 years and older who resided in Canada). The online survey was promoted via paid advertisements on Facebook, Instagram, Twitter and Google Ads, and through frontline health care services, and all participants were enrolled in a prize draw for CAD 200 in cash. The online survey introduced participants to the idea of SP and outlined important differences in health and overall well-being outcomes by demographics and lived experience.

Eligibility was limited to older adults who experienced at least one of the following forms of social marginalization and structural disadvantage, with priority given to those who reported multiple forms: fair or poor health; disability; racialized group status, newcomer status or Indigenous identity; 2SLGBTQI+ identity; low household income (< CAD 30 000 per year); and social isolation or being homebound. Of note, these factors may disadvantage and marginalize individuals to differing degrees, and every participant in this study experienced at least one form.

After the email invitation, participants met via Zoom and participated in semistructured focus groups exploring experiences with and attitudes toward SP. Prior to the discussion, information about SP was presented to ensure participants understood what the intervention was and what it typically entailed. Data collection occurred via Zoom's video recording and audio transcription for cloud recordings features. Minor inaccuracies in the transcription were corrected by manually reviewing video recordings of the focus groups.

Data analysis

Data analysis was performed in NVivo Version 11,[27] used a thematic approach developed by Braun and Clarke[28] and applied SDT.[22] The thematic analysis process began with multiple readings of the transcripts to gain a comprehensive understanding of the data. Initial codes were created based on the patterns, insights and themes that emerged from the data. Codes were then organized into broader themes over multiple rounds of mapping and connecting initial codes. These broader themes were reviewed and refined through iterative processes of analysis until final themes were established. Data analysis was considered complete when theme and data saturation were achieved. Quotations from transcripts that highlighted salient points were selected for inclusion in the analysis.

Results

The demographic information of those who participated in the focus groups is provided in Table 2.

Thematic analysis of the results of these semistructured focus groups identified several key themes: (1) the importance of considering older adults' sense of autonomy and independence; (2) a sense of connectedness and belonging, trust and relationship-building with providers; and (3) the uniqueness of each individual's personal identity and how it shapes their needs, wants and barriers with respect to SP. These themes underlie our understanding of the five categories of discussion, namely:

(1) older adults' experiences with and interest in SP;

(2) their comfort with their primary health care provider;

(3) their comfort with other community providers;

(4) the qualities they would like in a link worker; and

(5) the barriers that may impede their participation.

Each of these categories is examined in greater depth below, and includes quotations from the focus group participants.

1. Older adults' experiences with and interest in SP

Older adults' experiences with and interest in SP varied widely. Very few knew about SP or had experience with it, whether formally or through practices with SP components. The ones who had experience or knowledge of it had often heard about nonmedical supports through various providers, such as doctors and community health workers, among others, for health-related challenges (e.g. post-surgery) but also life changes and transitions (e.g. loss of a spouse, divorce) and overall mental health and stress. SP-like interventions fell in the categories of social groups, health and wellness, community resources, and career and financial support. Notably, most SP experiences were not called SP, but were person-centred, nonmedical referrals, more broadly speaking. These results suggest there is a need to raise awareness about SP, and to formalize the concept of SP.

Willingness to participate in SP also varied widely among participants. Those uninterested in SP often mentioned their contentment and satisfaction with their current interpersonal connections and

TABLE 2
Older adult focus group participant demographics

Demographics	N	%*
Total	**43**	**100**
Age (y)		
55–59	13	30
60–69	20	47
70–79	7	16
80–89	3	7
Gender		
Male	11	26
Female	32	74
Region		
British Columbia	12	28
Alberta	4	9
Saskatchewan	2	5
Manitoba	4	9
Ontario	15	35
Quebec	3	7
New Brunswick	1	2
Nova Scotia	1	2
Newfoundland and Labrador	1	2
Ethnicity		
Racialized groups	21	48
Indigenous	7	
East Asian	5	
Latin American	3	
Middle Eastern	3	
Black African	1	
South Asian	1	
South East Asian	1	
White	22	51
Community		
Large urban centre	18	42
Medium city/town	3	7
Small city/town	10	23
Rural area	12	28
Income (CAD)		
< 10 000	2	5
10 000–19 999	16	37
20 000–29 999	5	12
30 000–39 999	6	14
40 000–49 999	4	9
50 000–99 999	5	12
> 100 000	3	7
NA	2	5
Employment		
Unemployed	34	79
Full-time	2	5
Part-time	7	16
Living alone		
Living alone	23	54
Living with others	20	47
Independence		
Independent	39	91
Cannot leave home without assistance	4	9
Disability		
Any disability	38	88
No disability	5	12

Abbreviations: CAD, Canadian dollars; NA, not available; y, years.

* Percentages are rounded and therefore may not add up to 100%.

communities (e.g. family ties, close friends and acquaintances) and preference for solitude. Importantly, underlying both reasons were two core factors: that their present state was both healthy and independent. If either of these two factors deteriorated, older adults often indicated they would consider SP then. Notably, healthiness and independence were not strongly age-dependent, as some individuals in their eighties perceived themselves to be physically and cognitively fit and capable:

> I'm feeling very thankful for my own good health because I really don't have major health problems, and I'm able to be very active physically and in the community. (Woman, aged 81, small city/town resident)

Of those interested in SP, categories of SP activities of interest included holistic health, wellness and fitness, arts and culture, education and personal development, social groups and community, and nature and outdoor activities. The diversity of SP activities of interest, some of which were even opposed (e.g. something online vs. something outside of home), suggest the need for a person-centred and individualized approach to SP. As one participant noted, "Each person is unique and their needs are unique" (woman, aged 64, rural area resident).

For those who wanted to participate in SP, a prominent theme that arose was the desire to keep active and engaged in mind and body and socially. These individuals expressed a strong need for social connection and companionship, often due a lack in current social networks or family ties. Some preferred connections with others with similar backgrounds or interests, while others were interested in diverse interactions, including intergenerational and animal companionship. The desire to "live life again" underscored their reasons for SP participation:

> Yes, I would be interested in participating and looking more for things where there is some human connection. We can live quite solitary lives, and it would be helpful to integrate back into a community. (Woman, aged 72, small city/town resident)

2. Comfort with primary health care providers

Primary health care providers and link workers play integral roles in the SP process, and thus the relationship between older adults and their providers and link workers is an essential factor to consider. Older adults were asked questions about their comfort level with their primary health care provider, as well as to identify the qualities most valued in a potential link worker. Individuals' comfort levels discussing nonmedical, health-related social needs with their health care providers varied significantly. In the focus groups, participants often discussed their overall relationship with their provider rather than specifically addressing whether they were comfortable discussing social needs with their health care provider. This highlights the importance of the overall client–provider relationship in shaping social prescribing processes.

Older adults with positive relationships cited genuine care, trust and good rapport as essential factors. Their health care providers did not stick only to the medical model but were willing to work outside of it, asking about emotions as well as life; the older adults felt like their health care provider genuinely cared and had good intentions, evidenced by not being in a rush, listening, following up and being personable. These relationships were long-lasting and built on a foundation of trust:

> I do trust my doctors. I'm lucky to have a really good family doctor and a really good pain doctor. My pain doctor especially isn't afraid to go

> outside of medical to, you know, like he recommended that mindfulness thing, and he's always searching for new ideas, that aren't necessarily involving taking drugs. (Woman, aged 69, small city/town resident)

Older adults with negative relationships with their health care providers indicated that the lack of those same factors (i.e. genuine care, trust and rapport) had a detrimental effect on their comfort level with their health care providers. Their health care providers often addressed solely medical concerns (e.g. renewing prescriptions), were dismissive of emotional concerns and didn't ask questions to probe for deeper, underlying issues. In these cases, there was no trust or connection between the older adult and their health care provider, potentially because the provider was too busy (e.g. one concern per visit, phone first); the provider did not seem to genuinely care (e.g. often gave up, seemed impersonal and intimidating, did not follow-up, lacked empathy); or the provider was forceful as an authority (i.e. someone "who knows best"):

> But there are signs that specifically say, please be advised that doctors can only help you for one question per visit per day. It's intimidating. And then we don't feel comfortable taking up space that you're not allowed. (Woman, aged 58, small city/town resident)

Even among individuals with positive relationships, some still felt uncomfortable discussing social needs because it was an unfamiliar topic to health care. This suggests the need to normalize such conversations. As one woman noted, "I have a regular doctor that I see at the clinic that I consider my doctor; but he's also very much under a time crunch and time pressure. And so he doesn't ask, and I don't tell" (woman, aged 55, large urban centre resident).

For other older adults, external factors also affected their relationships with their health care provider, such as not having a primary health care provider at all, having a provider who was entirely remote and thus would not be aware of community resources and support, and having only newly established a relationship with the provider. For older adults with new relationships, a common trend was that they had a long-standing relationship with their previous provider, who had retired, and now needed more time to build trust and connection with their new one.

Rural individuals either reported positive relationships due to their provider being personable and involved in their community, or negative ones, due to their provider being in their town on a short-term contract (e.g. 2 years): "We rotate through doctors so often in [rural areas] that I have a feeling that 2 years from now, I'm going to have a new doctor again. So I'd have to build a totally new relationship" (woman, aged 61, small city/town resident).

Some individuals felt that SP did not belong in the realm of the medical system at all, as health care providers and the medical system were already overburdened, but also because it wasn't their expertise.

These findings suggest the essential nature of a positive and strong relationship between older adults and providers before questions of SP can even be addressed. Without a positive relationship, introducing new and unfamiliar topics such as loneliness, rather than purely medical topics, will likely be unproductive.

3. Comfort with community providers

Older adults were generally more comfortable discussing nonmedical, health-related social needs with community providers instead of their primary health care providers. Comfort level depended on personal experience, and varied across a range of community providers (e.g. community mental health workers, social workers). Major reasons for comfort stemmed from personal experience, trust and familiarity, accessibility and availability, and perceived integration within the community.

Some concerns were raised regarding the professionalism and expertise of these community providers, given the diversity in professional training and backgrounds of potential SP providers. Some participants preferred that all community providers receive SP-specific formal training or accreditation and that community providers had a clear understanding of their practice boundaries, scope and limitations: "I would have no problem with the community providers so long as they were attuned at some educational level or experiential level to what my specific needs may be" (woman, aged 58, large urban centre resident).

Furthermore, some participants from rural areas lacked experience with community providers because in their rural communities there was a lack of community providers to be referred by, and resources to be referred to.

4. Qualities in link workers

Compared to topics of SP interest and provider relationships, there were clearer core qualities that participants wanted in a link worker. Every discussion touched on core qualities of care, empathy and good communication skills. They wanted to interact with a link worker who was nonjudgmental of the participant's concerns, was open-minded and who could genuinely care about the individual. Empathy could be demonstrated by a link worker being personable and demonstrating genuine curiosity, by being a good listener, by asking insightful questions and by being engaged in the conversation:

> I want to be heard. I want to be listened to. I want somebody who can check for understanding along the way, because I have that much more respect for the person who says, "Okay, this is what I've heard from you." I want a meaningful conversation that goes both ways to know that that person held space for me. That's meaningful. That puts me in a relaxed position where I go, "Oh, thankfully, I finally got somebody who's listening to me!" (Woman, aged 59, large urban centre resident)

Following empathy, creativity and knowledge about SP and referral resources and supports were also key criteria. Participants wanted a link worker who could think outside of the box, think beyond a set rubric or guideline and consider the unique needs of the person in front of them. They wanted a link worker who was connected to the community, who demonstrated competency and resourcefulness and who could understand the diverse needs older adults might bring to them. Ideally, the link worker would also be an expert in the field and have professional training and qualifications to meet this role seriously:

> They need to have a broad understanding of the community they live

> in or work in … which is sometimes not the community they live in. Be trained in delivery of that information in a nonjudgmental and broad-minded and sensitive way. Additionally, they must have training and ethics. (Woman, aged 66, rural area resident)

The focus group participants considered accessibility and availability to be crucial qualities in a link worker. Participants wanted a link worker who was easy to reach (e.g. responsive to calls or emails), with whom appointments were quick to schedule (i.e. not a long multi-week or -month wait time), and who were available for follow-up and a continued long-term relationship. They didn't want to reintroduce their story and meet someone new at every appointment, and would rather have a long-standing relationship with one link worker or a stable team of link workers.

> Most people don't want to wait a week and a half or six weeks for an appointment with a link worker. If somebody could call them back within the day, and then they could organize a longer appointment or longer stay, and they could, you know, realize you one way or another. But I think availability is, without that you got nothing. You drop the ball if you make people wait too long. (Woman, aged 70, small city/town resident)

Finally, link workers who prioritized a person-centred approach were essential. Participants wanted a link worker who was willing to try to understand their entire life circumstances, understand how they may have ended up where they are, and what unique needs they may have as a result. They wanted a link worker who equally respected their dignity and autonomy in personal decision-making. They did not want someone to tell them what to do or make assumptions about them without trying to understand first. Inevitably, a link worker who prioritizes a person-centred approach will also make efforts to prioritize individualized care.

> Just the understanding they are there to help us, not save us, not rescue us. I need to have options presented to me, and me to be free to decide where I go from there. And it's not a failure to me or to them if I don't like what's being proposed. (Man, aged 64, large urban centre resident)

For some individuals, this meant someone with similar life experiences, especially similar age, was preferred. Others, however, were satisfied with a link worker who demonstrated understanding, regardless of age or life experience. As one participant said, "I don't think it's entry level. I think it requires some depth" (woman, aged 64, rural area resident).

5. Barriers to participation

The primary barriers to participating in SP were transportation, accessibility and financial constraints. Lack of reliable public transportation, difficulties driving, long commutes and limited mobility were cited as barriers to accessing SP services, let alone the initial SP appointment: "I can only go as far as I walk. That's a huge barrier for me, like even just to make an appointment with the doctor is quite an experience, because I've got [to] arrange rides and all that kind of stuff" (woman, aged 66, rural area resident). Many individuals, being retired, found that the cost of many activities of interest could limit their participation, even with subsidization.

Service availability, particularly in rural locations, was a clear external barrier:

> Well, there's not much here. That where I live and in other areas outside of urban areas are kind of neglected when it comes to any kind of programs, because, well, this is no way to deliver them, because there isn't the population. (Woman, aged 69, small city/town resident)

Language barriers for those who were non-native English speakers or relied more on nonverbal communication styles (e.g. those with dementia), were also raised.

Older adults worried that there would be a lack of continuity of care in SP programs. They outlined the importance of care providers being reachable, open to follow-ups, and accessible, and of SP being provided in a manner as helpful to them and as reliable as possible:

> When a person is asking and reaching out for help, you grab them while they're willing to give it a chance. On the spot. Don't wait, because it may have been the only time they'll actually ask you for help. And in the meantime, you may just end up losing them. (Woman, aged 65, small city/town resident)

Rigid eligibility criteria for certain programs and services were another barrier to participation. For instance, cut-offs by age may not address the actual need and may limit older adults' ability to access services.

Participants with health issues or disabilities experienced difficulties due to all of the aforementioned barriers. However, some individuals with severe disabilities often cited specific barriers, such as the toll that continuously asking for help could take on their dignity, and the need for providers to understand and empathize with the unique day-to-day changes in their ability to take care of even the simplest of activities.

> There will be events here that I would love to go to, but I can't afford it. And I stopped asking for waivers because it's just too hard and embarrassing. You're kind of giving somebody else control over what you want to do. It's like asking permission and it's not a good feeling. (Man, aged 58, small city/town resident)

Further internal barriers, including their current isolation and subsequent sense of social anxiety, were also brought up as huge barriers in preventing them from seeking out SP options, even though they knew SP could help them. For example, feeling embarrassed and "othered" for needing SP services could be a significant barrier. As one participant expressed, "It might be difficult to reach out for help if your problem is embarrassing or not socially accepted" (woman, aged 61, rural area resident).

The stigma experienced by participants and the ageism among providers and link workers in the SP process were identified as barriers as well. Some participants felt that they had been put into a box, or fit into a template, in the minds of providers, causing providers to miss opportunities to connect and truly understand participants' life experiences, needs and desires:

> My experience with my doctor is, she's young, and she makes assumptions about what I'm like at my age,

> and she's completely wrong. She sees me as an old lady. And I am. But there's more to me than that. And I think for young people, that's all they see. They see the white hair, and they make assumptions about who I am and what I might like. I want somebody who would understand *my* interest, *my* capabilities, rather than lump me into a group with old people just because we're all old people. (Woman, aged 81, small city/town resident)

Finally, the constant need to self-advocate was brought up and outlined two major concerns: (1) those unable to self-advocate risk being overlooked and forgotten; and (2) for those who can, constant self-advocacy can be exhausting:

> The most patient people are most likely to fall between the cracks are the quietest and shyest, and I don't know what the system of SP is going to do here, but we have to overcome the reluctance people have because they simply don't feel comfortable talking to strangers or burdening people with their own issues. (Man, aged 78, rural area resident)

Discussion

Our study assessed the SP needs and priorities of socially marginalized and structurally disadvantaged Canadian older adults. A total of 10 focus groups were conducted with 3 to 7 participants each, for a total of 43 participants. The general goal of the focus groups was to identify older adults' current experience with SP, willingness to participate and interest in various SP activities, and comfort bringing up social needs to a primary health care provider or other community providers, and the qualities they would like to see in a link worker, as well as any barriers, real or perceived, they might face that would prevent them from participating in SP.

Although some participants knew of SP, many were unaware of the term, suggesting room for efforts to increase awareness of SP. Our findings reflect those of similar research indicating the need to promote awareness of SP. For example, although there is little research exploring public awareness of SP in Canada, research from England suggests that there is limited awareness among the public of what social prescribing entails, and indicates the relevance of awareness for uptake of SP; if individuals do not know what SP is, they are highly unlikely to participate.[29]

In asking about participants' comfort discussing social needs with their health care provider, discussions ultimately turned towards their overall relationship, indicating the importance of client–provider relationships if SP is to work. Even among older adults who felt they had a positive relationship with their health care provider, discussing social needs still felt like an uncomfortable and unfamiliar topic, suggesting the need to normalize conversations. This finding further suggests that the success of having a conversation about loneliness, rather than purely medical topics, is highly contingent on the personal relationship someone has with their health care provider, and the societal awareness of the concept at large. Our findings are aligned with those of a recent systematic review, which found that one of the key implementation factors for SP success among older adults was their relationships with health care providers and link workers. These researchers found that older adults who felt reassured, encouraged and comforted by their health care provider or link worker throughout the process were more likely to have positive experiences and outcomes in SP.[17]

Additionally, varying types of barriers and differences in personal identity were described that may foster or hinder participation, outlining the importance of a person-centred approach to SP. One potential solution to limiting the impact of barriers older adults may face is to continue to prioritize the co-designing backbone of SP.[16] This may be accomplished by including the opinions of older adults in every stage of the SP framework development in Canada, as well as co-designing each individual prescription to tailor it to the unique needs and priorities of each client.

Underlying these topics, the three themes of SDT—autonomy, relatedness and competency—were important for understanding why older adults had the feelings and opinions that they did. First, it was important that their autonomy was respected, such as through interactions with their primary health care providers in decision-making. Second, there was a strong desire to gain a sense of relatedness (i.e. connectedness and belonging) with their community but also with the providers and link workers who are part of the SP pathway in the form of trust, genuine care and empathy. Third, older adults wanted a sense of competency and influence over which SP programs they would participate in, the outcomes they might have and what SP might offer them.

Our study contributes to the field of SP by presenting views of Canadian older adults from multiple life circumstances who are structurally disadvantaged and socially marginalized. Future focus groups can explore more deeply the values identified in this study, and how SP can be curated to fit the personalized needs of each individual.

Strengths and limitations

Our study had several strengths. Firstly, the use of qualitative focus groups provided an opportunity for in-depth examination and exploration of participants' experiences and perspectives, which is often missed in quantitative data. The use of groups allowed for the inclusion of multiple voices, fostering rich discussion. The semistructured nature provided flexibility and adaptability, allowing the direction of the discussion to be influenced by the participants themselves, as the experts of their own experiences. This allowed emerging themes to be explored, such as the need to be proactive, as they were raised by participants. Finally, an online platform made it feasible to reach participants across Canada (including rural and urban participants), as well as those with mobility issues unable to attend an in-person session. This ensured a diverse and geographically representative sample.

However, our study also had several limitations. First, while efforts were made to include a diverse sample, we relied on a nonrepresentative, opt-in online recruitment method that may have introduced bias into our sample. Second, while we aimed to be inclusive, some participants may have been unable to participate due to our use of an online platform, which not all older adults may be comfortable using.[30] Third, themes unique to specific demographic groups could not be parsed out, given that each focus group was a mix of participants with multiple forms of experience.

However, additional focus groups were hosted for minority groups only, in order to identify potential minority-specific attitudes and thoughts toward SP. These additional interviews demonstrated that the underlying themes and comments were consistent across all groups, with some additional considerations brought forth: the need for cultural competency from providers and link workers; the unique barriers to newcomers, such as language to connect and communicate; and knowledge about resources available to newcomers in Canada.

In future research, focus groups consisting of specific demographic groups (e.g. those with mobility issues, Indigenous people, those with low income, etc.) would further inform the themes, but could not be undertaken in this study given the nature of the study and the available resources.

Conclusion

The aim of our study was to explore the perceptions structurally disadvantaged and socially marginalized older adults may hold regarding SP practices that integrate health and social care and well-being, and what they want from such processes. Our older adult focus group participants suggested they would experience a wide range of potential barriers in accessing social services and barriers in engaging with their providers, and indicated their interests in SP, highlighting the importance of a person-centred approach to SP programs. Furthermore, SP programs that prioritize bolstering older adults' sense of autonomy, relatedness and competency are integral to tailoring SP programs to the needs and priorities of older adults. We suggest that SP developers prioritize client participation in the co-designing and co-production of SP programs to ensure they meet the needs of the unique population whom they serve.

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Conflicts of interest

The authors declare there are no conflicts of interest.

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Authors' contributions and statement

CY: conceptualization, methodology, data curation, formal analysis, project administration, writing—original draft, writing—review and editing.

SL: data curation, project administration, writing—review and editing.

KGC: conceptualization, methodology, funding acquisition, supervision, writing—review and editing.

SB, PH, SH, KM, MN, MS, VW: conceptualization, methodology, writing—review and editing.

SA: writing—review and editing.

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Original mixed methods research

Building the capacity of older adults and community: findings from a developmental evaluation of United Way British Columbia's social prescribing programs for older adults

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Abstract

Introduction: Older adults with higher needs are ideal candidates for social prescribing interventions, given the complex and intersectoral nature of their needs. This article describes findings from a developmental evaluation of 19 social prescribing programs for older adults at risk of frailty.

Methods: An evaluation of the programs was conducted from 2020 to 2023. We used data from three components of the evaluation: (1) initial evaluation data collected in 2020 and 2021; (2) program profiles developed in 2022; and (3) co-creation sessions conducted in 2023.

Results: From startup until March 2023, the programs served a total of 2544 older adults. The community connectors identified factors at the individual, interpersonal, institutional, community and policy levels that contributed to the successful implementation and delivery of their programs (e.g. physician champions, communities of practice, strong pre-existing relationships with the health care system), as well as challenges (e.g. limited capacity of family physicians, lack of community resources). There was strong agreement among community connectors that successful social prescribing programs should include the following core elements: (1) making connections to needed community resources; (2) co-creation of a wellness plan with long-term clients or clients who require intensive supports; (3) ongoing follow-up and check-ins for clients with wellness plans; and (4) an assessment and triaging process for the prioritization of clients.

Conclusion: To leverage the full potential of social prescribing interventions, it is essential that programs engage with a range of health and social care providers, that community connectors are skilled and well supported, and that adequate investments are made in the nonprofit and voluntary sector.

Keywords: *social prescribing, seniors, evaluation, healthy aging*

Highlights

- From a developmental evaluation of 19 social prescribing programs for older adults, we report on essential social prescribing program components, and facilitators and challenges of program implementation and delivery.
- The key challenge reported by programs was engaging with family physicians, suggesting that programs can benefit from having physician champions and engaging with a broad range of health and social care providers to make referrals.
- The community connector position emerged as essential to the success of the social prescribing interventions.
- A strong nonprofit and voluntary sector is required to leverage the full potential of social prescribing.

Introduction

Social prescribing is a health promotion intervention designed to connect individuals with community resources to address their nonmedical needs. The intervention is considered to have originated in the United Kingdom, and examples of programs can be found across Europe, Asia, North America and Australia.[1] Social prescribing builds on current global health trends and priorities, including integrated care and care coordination, person-centred care, co-design and co-production, strengths-based approaches, asset-based community development, health promotion,

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self-determination theory and quadruple aim.[1]

There are two common pathways through which social prescribing interventions may take place: (1) direct referrals by a primary care provider to needed community resources (e.g. arts programs, exercise, nature) or (2) a referral to a community connector who works with the individual to identify and address unmet needs.[2] We use the term "community connector" throughout this article because it is the terminology used in British Columbia (BC), but these individuals are also commonly known as "link workers" or "navigators."

Social prescribing interventions using a community connector usually consists of three stages: (1) a primary care provider refers the individual to a community connector; (2) the community connector works with the individual to identify their needs and refer them to appropriate community resources; and (3) the individual engages with new community resources or activities.[3] Traditionally in social prescribing models, primary care providers are the source of referrals to community connectors; however, some models now target a wide range of health and social care providers for referrals.[3,4]

Older adults with higher care needs—such as those experiencing frailty, multiple chronic conditions, loneliness or poor nutrition—are ideal candidates for social prescribing interventions, given the often complex and intersectoral nature of their needs. In Canada, it has been estimated that over half of older adults are either frail (22%) or pre-frail (32%).[5] About one in five older adults also lacks social support.[6] Furthermore, between 17% and 33% of older Canadians are lonely at least some of the time, depending on age and gender (the prevalence of loneliness increased to 26%–42% during the pandemic).[7]

Two recent systematic reviews illustrate the current state of knowledge about social prescribing programs for older adults.[3,8] In the systematic review by Percival et al.,[3] seven articles were identified that met their inclusion criteria (i.e. a social prescribing intervention for older adults with quantitative outcome data). The social prescribing programs described in the articles relied on a range of health and social care providers for referrals, and community connectors referred clients to a variety of community resources (e.g. art programs, health promotion classes, social activities). The studies in the review most commonly reported on psychosocial outcomes, and consistently found improvements on mental well-being measures. Positive impacts were also observed for physical health outcomes in two studies. However, the findings on health care utilization were mixed.

A second, complementary systematic review was conducted by Grover et al.[8] and identified eight qualitative studies that met their inclusion criteria (i.e. studies of the experience, outcomes or processes of social prescribing programs from the perspective of older adults or service providers). Using a meta-aggregation approach, the authors synthesized the results into five findings: (1) personalized experiences (i.e. the need for person-centred approaches to support older adults living with chronic conditions); (2) providers and connectors (i.e. role of the general practitioners and community connectors in making older adults feel supported); (3) behaviour change (i.e. studies reported on successful motivators and behaviour change techniques such as increased self-confidence and building skills for long-term self-management); (4) environment (i.e. familiar and well-chosen places for activities contributed to the positive engagement of participants); and (5) outcomes (i.e. most of the articles reported on positive outcomes for older adults related to health, lifestyle and/or socialization).

To help build our knowledge on social prescribing programs for older adults within the Canadian context, in this article we describe findings from a developmental evaluation of 19 social prescribing programs for older adults at risk of frailty. These social prescribing programs were being implemented as a part of a series of demonstration projects called "Integrated Community-Based Programs for Older Adults with Higher Needs" that were funded by the Province of British Columbia. United Way British Columbia (United Way BC) was the backbone organization for the social prescribing programs, which were being implemented in 19 communities across BC by local community-based seniors' services. Since the completion of the successful demonstration project, United Way BC has been undertaking a phased approach to roll out social prescribing programs across the province, funded by the Province of BC, with the goal of having a community connector in place in each local health area by 2025/26.

Methods

This article reports on the findings of a developmental evaluation of the social prescribing programs conducted over the period 2020 to 2023 by an externally contracted group (Howegroup). As this was a program evaluation, it did not fall under the scope of research ethics board review.

Overview of social prescribing interventions

Using the Template for Intervention Description and Replication (TIDieR) checklist as a guide,[9] Table 1 describes key characteristics of the social prescribing interventions.

Evaluation methods

Originally, the intention was to conduct both developmental and summative evaluations of the programs using a mixed methods approach. However, the COVID-19 pandemic resulted in significant disruptions to the implementation of the social prescribing programs and the planned collection of longitudinal outcome data from program clients (i.e. delays in program start-up, challenges engaging with older adults, alteration of intended program activities, insufficient time for follow-up). While baseline outcome data were collected from an initial 504 clients, the evaluation was only able to obtain follow-up responses from 34 clients at the six-month follow-up. This resulted in significant data validity concerns. Further time and evaluation are required to determine the outcomes for individual older adults participating. As a result, this article focusses on the findings from the developmental evaluation components.

We draw on data that were collected from the programs' community connectors via three components of the evaluation: (1) initial evaluation data collected from community connectors in 2020 and 2021; (2) programs profiles developed in 2022; and (3) co-creation sessions conducted in 2023. Invitations were sent out by United Way BC asking the community connectors (n = 19) to participate in the various evaluation components. Each of these components are described in greater detail below.

TABLE 1
Description of 19 social prescribing programs for frail older adults, British Columbia, 2020 to 2023

Why	The purpose of the intervention was to support older adults at risk of frailty to play an active role in the management of their well-being and stay in their own home for longer.
What	Older adults accessed the social prescribing programs through referral from a health or social care provider, nonprofit or community organization or self-referral. Older adults were generally considered eligible for the intervention if they were experiencing poor physical/mental health, socially vulnerable or frequent users of acute or primary care. Social prescribing programs developed their own paper or online referral forms and referrals also occurred directly via the telephone, email, internal referrals and/or self-referral by older adults. The top referral sources identified by social prescribing programs were (1) primary care providers, (2) home and community care services, (3) hospital discharge planning, and (4) their own organization. Intake and meetings with clients took place either over the telephone or in person. The community connector listened to the older adult's needs and worked with them to develop a strengths-based wellness plan and make referrals to needed community resources. The most common types of resources community connectors made referrals to were physical activity, information and referral, and food security. The pathways for referrals to community resources varied based on the needs of the older adult and the organization or type of program the older adult was being referred to. For example, if referring the older adult to mental health services, a warm referral process would usually be required in which the community connector would connect directly with the service and possibly arrange an appointment for the older adult. However, in other cases, signposting referrals, in which the community connector provided the older adult with the contact information of an organization or program, was appropriate. Additional check-ins and follow-up were conducted as required.
Who provided	The social prescribing programs were delivered locally by a nonprofit, community-based seniors' service. These organizations included multiservice nonprofit organizations or neighbourhood houses (n = 11), immigrant and ethnocultural serving organizations (n = 3), senior-specific agencies (n = 3), a volunteer centre (n = 1), and a seniors' campus of care (n = 1). Approximately half (n = 8) of the organizations delivering the programs identified as large or extra-large nonprofit organizations. Most social prescribing programs had a full-time equivalent community connector. Most community connectors (74%) had five or more years of work experience and an undergraduate or graduate degree (79%). Community connectors had a range of backgrounds, including social work, nursing, public health, communications, etc. Some programs reported using volunteers or practicum students to augment their capacity.
How	The social prescribing intervention was provided to older adults one-on-one, though some community connectors also organized group activities. As the intervention was initially being implemented during the pandemic, intake and meetings with older adults needed to be conducted over telephone. Eventually, community connectors were able to conduct face-to-face meetings (usually either at their organization or the older adult's home); however, some community connectors continued to offer the option of telephone meetings.
Where	The social prescribing programs were implemented by community-based seniors' services located in 19 communities across British Columbia. The communities were diverse in terms of their geography and size. Fourteen of the communities identified as urban, while five identified as rural communities.
When and how much	The intensity of service delivery was dependent on the needs of the older adult. In some cases, the older adult only required signposting (i.e. providing an answer to a question; making a single referral) in which case programs usually did not conduct intake or record the older adult as a client. For older adults requiring the full social prescribing intervention, community connectors estimated that 60% were long-term clients who required three or more months of support.
Tailoring	As providing personalized services and referrals is a core element of social prescribing programs, interventions were tailored to meet the needs of individual older adults. The social prescribing programs were also tailored to meet the specific needs of their community and target audiences of older adults (e.g. immigrant older adults, rural residents), and to leverage organizational relationships and community resources. For example, some programs were able to provide interpretation services or services in multiple languages in order to support older adults who had limited English skills. Another example is within the Fraser Health region, where the programs were designed to be implemented in tandem with the health authority's CARES (Community Action and Resources Empowering Seniors) model.[10]
Modifications	The COVID-19 pandemic necessitated modifications to the intervention, particularly during the early stages of the pandemic, due to social distancing restrictions, the closure of many community spaces and pressing community needs. The most significant change that occurred was the implementation of the "Safe Seniors, Strong Communities" initiative that required the social prescribing programs to temporarily shift their activities to focus on providing urgently needed pandemic supports. The pandemic also made it necessary to offer social prescribing intake and meetings over the telephone instead of face-to-face, a practice that is continued by some programs today.
How well	During the early stages of the pandemic, it was not possible to implement and deliver the intervention as originally planned. Later, when it was possible for organizations to properly establish their social prescribing programs, it was apparent that variations had emerged due to the pandemic as well as the different contexts of organizations and communities. Three co-creation sessions were held in early 2023 to identify core features of the social prescribing programs and provide guidance for a future program operating manual.

After the pandemic began, an online COVID-19 check-in survey (n = 19) was conducted with program staff to determine how the social prescribing programs were being impacted. The survey included closed-ended questions about the extent to which the programs had shifted or been offered as planned due to the pandemic and whether the intake process had started. Participants also could provide additional written feedback via the survey. A focus group was also held with the community connectors in 2021 (n = 10) to explore the program implementation in more detail. Discussion questions were posed by the evaluators on program shifts due to the pandemic, service delivery strategies, and feedback on available support and suggestions for program improvements.

In 2022, after the social prescribing programs had been able to fully resume their regular activities, data were collected on each program from telephone interviews (n = 19) and an online survey (n = 18). The survey was used to collect basic information on the programs, including characteristics of the organization delivering the program (e.g. size, location), staffing information (e.g. education and experience of community connector) and referral sources (e.g. main sources of referrals to and from programs). The semistructured interviews were used to collect information on approaches to social prescribing, facilitators and limiting factors, areas requiring further support, successes and challenges, partnerships, and lessons learned.

The data from the interview and survey for each individual program were then combined into a program profile to provide a fulsome picture of the organization's social prescribing program characteristics, approach, and successes and challenges. The program profiles were collectively analyzed to identify program challenges and successes and potential program guidelines and best practices. Key findings from the program profiles were presented back to the community connectors at a community of practice meeting for validation and refinement. Due to staff turnover, one social prescribing program was able to provide only limited program profile data. A second program was unable to complete the online survey.

Finally, three co-creation focus group sessions were conducted with the community connectors in early 2023. Two of the sessions were conducted in person (with a virtual option for those unable to attend in person) and one was conducted fully online. The sessions built on the data collected via the program profiles and were held to develop consensus on social prescribing program design and delivery components, as well as to identify areas for future support. Feedback was collected from the community connectors via group discussions and supplemental polls, and the notes from the sessions were examined to identify key findings. The co-creation sessions were semistructured, with discussion prompts and questions posed by the facilitators (e.g. what are core vs. optional program elements; share examples of successful relationship-building in your community; possible community of practice formats and topics for meetings, etc.), but also provided flexibility for the discussions to evolve organically. Feedback was also collected from the community connectors via close-ended polls. The notes from the sessions were compiled into summaries for each session.

Discussions at co-creation session 1 focussed on the characteristics of program clients who benefit most, core program elements and desired training opportunities. Discussions at co-creation session 2 included further discussion and polls on the characteristics of program clients who benefit most and core program elements, as well as discussion of strategies to support program referrals. Discussions at co-creation session 3 focussed on the role of networks, communities of practice and strategies to support program referrals.

In this paper, we use the evaluation data from 2020 and 2021 to provide brief background context for the implementation process and challenges that occurred due to the pandemic. The primary focus of the paper is the program profile and co-creation session data that provide insights into the social prescribing program implementation and delivery when normal operations began to resume. Thematic analysis was used to identify themes and key findings from the program profiles and co-creation session. We use the social-ecological model (described in the next section) to structure these findings in the paper.

Social-ecological model

The social-ecological model has its origin in the work of Bronfenbrenner on human development.[11] Concern about individualistic approaches to health promotion interventions led researchers to examine the general ecological model as a model for health promotion. McLeroy et al.[12] developed a variation of Bronfenbrenner's model; theirs is referred to as the social-ecological model. The social-ecological model proposes a nested model consisting of five levels: intrapersonal (i.e. characteristics of the individual); interpersonal (i.e. formal and informal social support networks and systems); institutional (i.e. processes, norms, rules and regulations of institutions); community (i.e. relationships among organizations, institutions and networks); and public policy (i.e. laws and policies).[12] Compared to earlier ecological models, the social-ecological model more explicitly acknowledges the social environment, institutions and cultural contexts that influence the implementation of health promotion interventions and shape the health and well-being of individuals.[13]

Results

In the first section of the results, we provide an overview of the implementation of the social prescribing programs, including the impacts of the COVID-19 pandemic. In the second section of the results, based on the program profile and co-creation session data, we describe key factors at the five levels of the social-ecological model that influenced the implementation and delivery of the intervention. The "Who provided" section of Table 1 shows basic information on the community connectors who participated in the evaluation and their organizations.

Implementation of the social prescribing programs

The social prescribing programs were slated to be implemented on a rolling basis between summer 2019 and summer 2020. However, the COVID-19 pandemic caused significant disruption to the start-up of the programs due to closure of organizational locations, inability to meet face-to-face with older adults, reduced referral opportunities and changing support needs of older adults. In a check-in survey of the social prescribing programs conducted in fall 2020, only three programs reported they were offering services as planned or more effectively than originally planned; five programs reported they had not even been able to start offering social prescribing services.

While the programs had very limited success offering actual social prescribing services during their first year of operation, they played an important role in offering COVID-19 supports to vulnerable older adults. In partnership with the BC Ministry of Health, the Office of the Seniors Advocate and 211 British Columbia (a province-wide information and referral service), United Way BC coordinated a province-wide response to the pandemic called “Safe Seniors, Strong Communities.” Beginning in March 2020, the social prescribing programs, as well as other United Way BC Healthy Aging–funded initiatives, shifted their programming to focus on providing pandemic supports. As of March 2023, Safe Seniors, Strong Communities has provided 1 294 248 services (i.e. check-ins, grocery shopping and delivery, prepared meal delivery, prescription pick-up and drop-off, etc.) to 39 220 older adults.

Most of the social prescribing programs did not resume their intended social prescribing operations until 2021. During the first phase of the demonstration project (from the time the programs initially started up until March 2022), when the impacts of the COVID-19 pandemic were the most intense and programs were in the process of establishing themselves or resuming regular activities, the programs served a total of 1110 unique clients (average of 58 per program). Most of these clients were served in 2021/22 due to pandemic disruptions. In the second phase of the demonstration project (April 2022 to March 2023), when the programs were fully established, a total of 1434 unique clients were served (average of 75 per program).

Table 1 describes the approaches and implementation of the social prescribing programs. During the co-creation sessions, the core elements of social prescribing programs for frail older adults were discussed. In polls conducted at the session, there was consensus among most of the community connectors that the following four activities should be core program elements: (1) making connections to needed community resources for the older adult (100% agreement); (2) co-creating a wellness plan for clients requiring more intensive supports (i.e. long-term support lasting more than three months or intensive one-on-one short-term support; 74% agreement); (3) providing ongoing follow-up and check-ins for clients with wellness plans (74% agreement); and (4) establishing an assessment and triaging process for prioritizing clients if referrals exceed program capacity (68% agreement). Community connectors were ambivalent as to whether two additional activities should be core program elements: (1) assistance with health system navigation (58% agreement); and (2) reporting back to referring health care providers (32% agreement).

Facilitators and challenges of program implementation and delivery

Based on the data from the program profiles and co-creation sessions, we describe in the sections below key facilitators and challenges that influenced program implementation and delivery at the five levels of the social-ecological model. It is important to note that many of these factors are cross-cutting and span multiple levels of the model; therefore, while we have chosen to discuss them at a specific social-ecological level, most intersect with additional levels of the model. While there were a number of challenges that occurred specifically due to the pandemic, we have focussed on those challenges that would be relevant for a wide range of contexts.

Individual level

During the co-creation session discussions and polls, there was unanimous (100%) agreement among the community connectors that individuals with limited family and social support benefit the most from social prescribing. Additionally, the intervention was also deemed to be most beneficial for older adults who desire support and are motivated to participate (84% agreement) and older adults who are able to set goals and engage over time (84% agreement).

Interpersonal level

At the interpersonal level, relationships between the community connector and the older adults, health care system and other community resources emerged as essential. From the program profiles it was apparent that the experience, community knowledge and relationships of community connectors were key to the success of the programs. Community connectors reported leveraging their knowledge and pre-existing relationships with other nonprofit and health care organizations in their community in order to (1) offer their clients referrals to needed community resources; (2) address service gaps and develop new activities and services to meet the needs of older adults (e.g. educational talks, digital technology training, interpretation services); and (3) share information and resources to better support clients. A common challenge for the programs that struggled with getting their social prescribing service off the ground was inexperienced community connectors or staff turnover. In the co-creation sessions, the most recommended training topics to enhance community connector skills were trainings on how the health care system works, available health care and community resources, identifying mental health crises, motivational interviewing and boundary setting.

Institutional level

At the institutional level, the community connectors identified current and desired supports from United Way BC to support the social prescribing programs. Most community connectors identified in the program profiles the value of having a community of practice so they could connect with and learn from the challenges and successes of the other social prescribing programs. A formal community of practice exists for all programs and Fraser Health also operates a community of practice for the programs in their region (individuals from programs outside of the region are also able to attend some of their sessions that are not specific to Fraser Health). In the co-creation sessions, most community connectors voiced their preference that community of practice meetings occur monthly or bi-monthly, be chaired by a content expert and include regular open discussion time in addition to structured presentations and activities.

During the program profile interviews and co-creation sessions, community connectors also identified improved marketing and communication supports from United Way BC as potential facilitators for increasing referrals and strengthening programs’ credibility. In the co-creation sessions, community connectors emphasized the importance of communicating to potential clients that social prescribing programs offer services that are person-centred and strengths-based, and can help to enhance the independence and social connections of older adults. Furthermore, it is important to clearly explain the role of the community connector and types of support that can be offered.

When communicating with health care providers, community connectors emphasized clearly explaining what the program is (e.g. connects older adults to needed community resources), who the target audience is (e.g. older adults who need social connections and supports, underserved older adults) and the benefits of the program to older adults (e.g. alleviating loneliness, increasing quality of life and well-being, improving skills and confidence). The importance of establishing the credibility of social prescribing programs was emphasized by, for example, stating that these programs are funded by the Ministry of Health and affiliated with United Way BC. Community connectors also suggested developing a brochure that health care providers can give to an older adult during their appointment.

Community level

The main challenge for programs that emerged from the program profile data was building relationships with and getting referrals from the health care system (specifically family physicians). Often there was a lack of understanding among health care providers of what social prescribing was and who would be appropriate to refer to the programs. Some community connectors reported feeling they were not taken seriously when they tried to conduct outreach to family physicians' offices. While originally it was intended that the social prescribing programs would primarily target family physicians for referrals, in response to the challenges that were encountered, most programs pivoted to outreach to a wider range of health care providers. Often programs reported having more success conducting outreach to home health teams, community health centres, older adult mental health teams and hospital discharge teams.

From the program profile data, it was also apparent that the strength of social prescribing programs' relationships with the health care system varied significantly. Having a physician champion or a preexisting, close working relationship with the health care system assisted some programs in getting buy-in and referrals from health care providers. Generally, social prescribing programs within the Fraser Health region were the most successful at building relationships with health care providers, as they were implemented with the support of a physician champion as a part of the health authority's Community Action and Resources Empowering Seniors (CARES) model. Community connectors from this region commented on how the physician champion was able to provide them with credibility and open doors for them (some community connectors from outside of this health region even commented on how the physician champion was able to offer advice or help make connections for them).

Several Fraser Health programs were also working with health care partners to pilot social prescribing in assisted living facilities or acute care settings. Outside of the Fraser Health region, programs generally reported making progress building relationships with health care providers, but this was often slow, and it took more time to build relationships.

Policy level

Family physician shortages acted as a barrier to the intervention, as several community connectors observed that family physicians were overworked and lacked the capacity to engage with the social prescribing programs. It was also highlighted, particularly in the rural context, that a notable number of older adults do not have a family physician. For example, in a small rural community it was reported that one in five individuals did not have a family physician and for those with a family physician wait times were six or more weeks.

Despite the significant efforts of community connectors to make referrals for their clients, lack of community resources to which to refer clients emerged as a commonly reported challenge. This was particularly a concern in rural communities, with some community connectors suggesting social prescribing programs need the flexibility to create activities and services to fill gaps, in addition to pushing referrals. During the pandemic, the issue of the availability of community resources was intensified by the closure of many organizations and community spaces. While there were opportunities to refer older adults to online activities, not everyone has access to digital technology or sufficient digital literacy to make use of these opportunities. Furthermore, community connectors identified that even after more organizations and locations began to open up and offer in-person activities, some older adults remained hesitant to engage in person.

Some vulnerable older adults require significant social and emotional support to help them engage with community resources (e.g. providing transportation, accompanying them on outings into the community, interpretation), which can challenge the capacity of social prescribing programs. Several community connectors commented on the need to maintain boundaries and resist trying to fix problems that are outside of the scope of their program. Community connectors also identified that some clients have complex needs and require referrals for services that are not available or are at capacity in their community (e.g. social housing, mental health services, food security). While community connectors recognize they cannot solve all the problems of their clients, it is troubling to them when their clients have serious health-, housing- or poverty-related concerns they are unable to address.

Discussion

The findings from our developmental evaluation highlight the importance of planning for the implementation and delivery of social prescribing interventions at all levels of the social-ecological model. In particular, our study highlights the impact that higher level institutional-, community- and policy-level factors can have on the implementation of social prescribing programs.

The key challenge reported by community connectors was building relationships with family physicians to facilitate referrals, a challenge that spans the interpersonal, institutional, community and policy levels of the social-ecological model. Challenges receiving referrals from family physicians have similarly been reported in other studies due to lack of understanding of social prescribing programs and the lack of family physicians' time.[8,14] Indeed, gaining buy-in from family physicians and legitimizing social prescribing programs in the eyes of the health care system has been identified as a key step in successful social prescribing program implementation.[15] The most impactful strategy that emerged from our study for addressing this issue was cultivating a physician champion, a strategy that has also been identified in other research.[14] Additional recommended strategies from the literature to encourage the engagement of family physicians include regular education and information sessions, providing feedback letters on referrals, embedding social prescribers in physicians' offices and ensuring the referral process is brief and easy.[14,15]

Contrary to the literature, in our study when community connectors were polled, the majority did not identify reporting back to the referrer as a core program element. This perhaps is reflective of the context in BC and the perception that family physicians are overburdened and lack the capacity or interest to review such documents. A 2022 poll conducted by Angus Reid reported that 59% of British Columbians lack access to or find it difficult to access a family physician,[16] supporting that there is a need for social prescribing programs to engage with a broader range of health care providers. Many social prescribing programs reported greater success connecting with other health care providers (e.g. home and community care, mental health teams, hospital discharge teams) who may have a greater capacity for engagement due to the presence of team members such as case managers to facilitate referrals.

At the other end of the social prescribing process, some community connectors reported a lack of appropriate organizations and services to refer older adults to, representing a key community- and policy-level challenge. The need for a strong nonprofit and voluntary service sector to support social prescribing programs has previously been reported in the literature.[14,17-19] Hamilton-West et al.[17] caution there is the potential that social prescribing will increase the strain on nonprofit and voluntary services that are already struggling with capacity and downloading of responsibility from the health and social care systems.

As the social prescribing programs in BC were implemented during the COVID-19 pandemic, it is unclear to what extent gaps in community resources may have been due to pandemic closures versus inadequate capacity and investment in the nonprofit and voluntary sector. The agreement (68%) among community connectors that an assessment and triaging process for referrals should be a core program element indicates there are capacity concerns beyond the context of the pandemic. Furthermore, some community connectors reported older adults having significant unmet needs beyond the capacity of community resources to address, suggesting that gaps in capacity exist more broadly in major sectors such as health and housing. In rural communities, these gaps were observed to be especially acute.

At the interpersonal and community levels, the community connector role emerged as essential to the success of the social prescribing interventions. Programs with experienced community connectors who were knowledgeable about community assets and had pre-existing relationships with other organizations and providers in the community generally reported more success receiving and making referrals.

Furthermore, some community connectors reported going beyond just making referrals to offering additional supports for accessing resources (e.g. arranging transportation, accompanying on outings) and organizing or developing new community resources or activities to meet the needs of older adults in their community. This finding suggests that there is the potential for community connectors to play a broader role in supporting vulnerable older adults and contributing to capacity-building within their community. However, it also raises the possibility that community connectors might become overburdened if they are not adequately resourced and supported. In the United Kingdom, social prescribing approaches that incorporate community-asset building are being developed.[20,21] For example, in Rotherham, grant funding is available for both the social prescribing referral processes and the activities and programs to which the clients are being referred.[20]

At the institutional level, an important finding in our evaluation was the value of communities of practice and how community connectors benefit from the opportunity to share and engage in discussions with other community connectors. Community connectors in the United Kingdom have reported the benefits of shadowing others,[22] suggesting that one-on-one mentorship or support may also be beneficial for less experienced community connectors. Furthermore, previous research has warned about the potential stress and burnout that can occur when dealing with high-needs and complex clients;[15,22,23] therefore it is important that community connectors receive effective training and emotional supports. Tierney et al.[15] also note that when staff turnover occurs in the community connector position, it can take time to rebuild the community knowledge and relationships that were held by the previous individual.

Strengths and limitations

A key strength of this evaluation was the large number of social prescribing programs involved (n = 19), including programs implemented in rural communities. A second strength of the research was the multiple data collection points that spanned 2020 to 2023, which allowed for a more fulsome picture of the intervention to be developed. Furthermore, the evaluation adds to our knowledge on social prescribing programs for frail older adults, a vulnerable target population on which there has been only limited Canadian social prescribing research to-date.

There are several limitations of the research that should also be noted. First, due to the disruptions caused by the COVID-19 pandemic, it was not possible to evaluate the impacts of the social prescribing interventions on individual older adults. Second, due to staffing challenges, data collection from two programs for the program profiles were incomplete or limited. Third, as our data were collected in the province of BC primarily during the COVID-19 pandemic, some of the findings may not be generalizable to other contexts.

Conclusion

As populations around the globe age, there will be increased interest in interventions to support the nonmedical needs of frail older adults and older adults who are isolated or lack social supports. The developmental evaluation findings reported on in this article contribute to our understanding of social prescribing programs for older adults at multiple levels of the social-ecological model, including essential program components and facilitators, and challenges of program implementation and delivery. Key lessons that have emerged from this research include the benefits of social prescribing programs engaging with a broad range of health and social care providers who can make referrals, beyond just family physicians; the value of physician champions and communities of practice; the essential knowledge mobilization, capacity-building and relationship-building role of the community connector; and the importance of adequately investing in nonprofit and voluntary sectors in order to leverage the full potential of social prescribing.

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Conflicts of interest

Laura Kadowaki, Bobbi Symes and Kahir Lalji are employed by United Way British Columbia. Grace Park is a contracted regional medical director for community health services in Fraser Health. Wynona Giannasi, Jennifer Hystad and Elayne McIvor are independent consultants from the Howegroup who were contracted to conduct the evaluation of the social prescribing programs.

Authors' contributions and statement

LK, BS, KL, GP, WG, JH, EM: conceptualization.

WG, JH, EM: investigation, methodology, project administration.

WG, JH, EM, LK: formal analysis.

LK: writing—original draft.

LK, BS, KL, GP, WG, JH, EM: writing—review and editing.

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Evidence-informed policy brief

Utilizing the determinants of healthy aging to guide the choice of social prescriptions for older adults

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This article has been peer reviewed.

Executive summary

The age of Canada's population is increasing, necessitating innovative methods and tools for assessing the needs of older adults and identifying effective health and social prescriptions. In Alberta, a community-based, senior-serving organization undertook the development and piloting of the Healthy Aging Asset Index, an assessment tool and social prescribing guide for use by a variety of professionals within the community. Tool development was rooted in medical complexity assessment and social work practice, and adhered to the determinants of healthy aging established by Alberta's Healthy Aging Framework, which is based on the determinants of healthy aging published by the World Health Organization. Results from the pilot showed improvement in the functionality of older adults within the determinants over time, as they were supported in addressing areas of personal vulnerability. Adopting tools such as the Healthy Aging Asset Index can bring cohesiveness to the support that older adults receive across the care continuum and has the potential to shift the balance of care away from the health system and towards the community, thus improving the capacity of health systems and government to meet the needs of Canada's older adults.

Keywords: *healthy aging, seniors, older adults, community health, frailty, referral*

Highlights

- The Healthy Aging Asset Index (HAAI) is an assessment tool that can be used to guide social prescribing by a variety of professionals in the community.
- The determinants of healthy aging can be used to inform social prescriptions in different domains.
- The HAAI can support shifting care away from the health system and into the community, and improve the capacity of health systems.
- Further investment is needed to support the implementation of the HAAI and social prescribing pathways within community-based organizations.

Introduction

The age of the Canadian population is increasing, along with the need to understand the factors that affect the ability of older adults to age well in community.[1] Organizations must develop programs to respond to these factors. The world population is aging faster than ever before,[2] and the ability of health systems to provide care to the older adult population is limited. Frailty is one of those factors affecting the ability of older adults to age well in community. Frail older adults require holistic models of care to optimize patient-centred outcomes and improve quality of life.[3] In spite of this need, previous research has only examined how frailty could be screened for in medical contexts such as primary care, ambulatory care, assisted living, long-term care homes, acute care and critical care settings.[3] Community-based organizations that employ a strengths-based approach to increase resiliency in older adults are uniquely positioned to identify and respond to frailty through social prescribing programs; new practices and policies should be geared toward community solutions to address frailty in systems outside of medicine.

In Alberta, more than one million people will be aged 65 or older by 2035.[4] Older adults currently make up less than one-fifth of the population of Canada, yet they account for nearly half of all health care expenditures.[1] Many older adults live with some degree of frailty, and there is a link between frailty and chronic diseases, especially when considering socioeconomic status. In Ontario, the prevalence of having five or more chronic diseases is 11% among low-frailty, 26% among medium-frailty and 44% among high-frailty groups.[5] Increased frailty has been associated with lower neighbourhood-level income,[5] and research has shown that social factors can be a predictor of hospitalization.[6] These costs and challenges are adding pressure to health systems' post–COVID-19 response, including long wait times for emergency and surgical care, difficulty reaching health screening targets in primary care (i.e. pap

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smears, mammograms, prostate screening) and the provision of on-time primary care services for simple tasks, such as prescription refills.

Given the current dramatic demographic trends and the inability of health systems to respond to the care demands of an aging population, there is a need to do things differently. A potential solution is to identify frailty early and address the social and nonmedical needs of older adults in locations other than physician offices and primary care settings, underscoring the notion of the right provider, in the right place, at the right time—an approach that systems planners have been pursuing to improve service efficiency and effectiveness.[7] Providing care and addressing the needs of older adults living in the community can be complex, and appropriate tools and resources are required to support this goal, especially as the number of older adults living in the community increases due to demographic changes. Case complexity has been identified as a key contributor to increased health care use, and methods to identify those individuals who require targeted assessments to inform interdisciplinary interventions have been discussed in the literature.[8-12] Social prescribing has been defined as "a means for trusted individuals in clinical and community settings to identify that a person has nonmedical, health-related social needs and to subsequently connect them to nonclinical supports and services within the community by co-producing a social prescription—a nonmedical prescription, to improve health and well-being and to strengthen community connections."[13, p.9] Assessing complexity and risk in older adults can identify opportunities to build resilience through options such as social prescribing and help to reduce downstream medical effects.[8]

For social prescribing to effectively connect older individuals to nonclinical supports and services, there is a need for a shared comprehensive (social and clinical) assessment that focusses on strengths, resiliency and positive change, rather than on deficits, and that facilitates integration of the services provided by voluntary and community organizations in collaboration with primary care.[14] However, there is a lack of assessment tools that address social and clinical assessment needs for this population. This article describes the development of an assessment tool, the Healthy Aging Asset Index (HAAI), informed by the Healthy Aging Framework, and its potential use in community agencies to facilitate social prescriptions and address frailty.

Development of the Healthy Aging Asset Index

The HAAI was developed to facilitate a more in-depth, comprehensive assessment of older adults' risk factors for functional decline, as there is a lack of clarity regarding how to respond to older adults who present with complex health and social needs. Ideally, anyone serving older adults within the community, where over 92% of older adults live and take recreation,[15] could identify frailty and administer healthy aging assessment. An interprofessional team developed and sought feedback from a variety of stakeholders on the HAAI, which used common language to support early and efficient assessment and identification of clinical and social interventions. These interventions inform the development of personalized asset plans for healthy aging of older adults living in the community. Assessment and interventions are based on a social prescribing model embedded in an anti-oppressive, holistic approach to care.

Using this approach acknowledges that health concerns of older adults may be exacerbated by the social conditions in which they live that are beyond their control.[16] Assessment and planning are also based on the knowledge that older adults living in the community experience different levels of frailty—some are "minimally frail," many are "moderately frail" and a very few are "severely frail," categories established through use of the Clinical Frailty Scale.[17] Individualized plans can optimize social prescribing to address social and medical complexity and direct both clinical and social prescriptions, a type of integrated social prescribing approach that is currently used only in a very limited capacity in Canada.

We conducted a review of the literature related to complexity in older adults and other underserved populations living in community. This review of both scholarly and grey literature identified several tools that address population complexity indicators. None of the tools included a focus on strengths instead of deficits, and all tools lacked comprehensive social assessment components, both of which are increasingly called for in the literature.[18,19] Current approaches with older adults, such as anti-oppressive, person-centred social work practice, take a strengths-based approach that emphasizes the possibilities, capabilities and capacity of older adults. These strengths may be accumulated over years of life and optimized within a support network of family, friends and care providers. Identifying and working with what older adults bring to the care relationship fosters inclusion, validation and empowerment.[18]

Building on the example of an intake tool of an Edmonton-based nonprofit organization, the HAAI was developed to address polypharmacy, the occurrence of chronic conditions, and medical attachment, as well as a variety of social factors such as safety, economic stability and housing. It was critical, given that implementation occurred in the early days of the COVID-19 pandemic, that the tool could be used both in person and via a telehealth appointment, to facilitate ongoing support for older adults experiencing significant health care access barriers. In addition, the tool should be usable, understandable and reliable across health and social assessors. The resultant product included strengths-based language, focussed on a range of determinants of health, was easy to use, supported social prescribing and provided a quantitative score that could be incorporated into evaluation and reassessment plans.

The Healthy Aging Asset Index (HAAI) incorporates seven domains that align with the Healthy Aging Framework's determinants of healthy aging.[20] The Healthy Aging Framework (HAF) is a tool that can be used to articulate, organize and communicate the work of senior-serving organizations, and is based on the determinants of healthy aging (DOHA) established by the World Health Organization.[21] The DOHA are the domains of the framework under which all work is organized. Below the DOHA are service areas, followed by specific activities, outcomes and impacts. The HAF can be used for strategic planning, priority setting, evaluation within organizations and coordination across the sector. DOHA play an integral role in the adversity, challenges and vulnerabilities individuals face as they age.[16] The DOHA listed in the HAF were adapted to create the seven domains of the HAAI: physical health, personal well-being, mental health, social support, physical environment, safety and security, and social engagement.

Structuring the HAAI according to Alberta's HAF allows an assessor to easily identify areas in which an individual could benefit from social prescribing. This is accomplished through a series of questions for each of the DOHA; each determinant is scored out of a total of four points. For example, within the physical environment determinant, questions address housing, poverty and transportation: "Do you have a safe place to live, is it affordable, and do you want to continue to live there?"; "Is it hard to make ends meet each month with your current income?"; and "How do you normally get to appointments/shopping?" Based on the responses, the tool will suggest interventions such as assistance completing an affordable housing application, assistance to access financial benefits and assistance to find transportation options. Individuals seldom require assistance across all domains, but frequently require targeted intervention to achieve specific goals such as increased social engagement, safer living arrangements, improved financial security or mental health stability.

Domains are scored and then combined as a total for each determinant. Scores of zero in a domain indicate a low level of complexity without any evidence of a need to intervene. Low-scoring domains on the HAAI indicate areas of strength and resilience. In domains with scores of one and above, clinical and social prescriptions are triggered to address factors contributing to vulnerability. High-scoring domains indicate areas of vulnerability, and the suggested clinical and social interventions are intended to stabilize older adults at risk of experiencing advancing frailty living in the community. The total score for the HAAI quantifies the overall resilience or asset status of the individual. This method aligns with the scoring guidance used by other complexity tools.[22]

Having a tool to direct assessment and intervention is critical for the spread of the process to nonclinical personnel, as HAAI scoring provides guidance regarding possible social prescriptions to enhance resilience in particular domains.[19] An approach that optimizes the involvement of all professionals and addresses all determinants of health supports holistic care for older adults.[23] In addition, scores in individual domains can assist with prioritization of needs within the total wellness picture for the individual, recognizing that the priorities of the assessor may not align with those of the older adult and will need to be negotiated collaboratively.

Clinical prescribing activities align with standard medical care and include prescription optimization, connection with primary care, mental and physical health supports, allied health connection and chronic disease management. Social prescribing activities are focussed on individual needs that are not immediately identifiable as "clinical" or "health-related," though these social factors have a significant impact on the future health state and well-being of the individual.[23] Assessors collaborate with older adults to create an asset plan that is acceptable to the individual and aligns with their health and wellness goals. Specifically, the most effective social prescriptions are those that are supported by workers embedded in the community who have built connections with diverse voluntary, community and social resources.[14]

HAAI pilot methods

In the fall of 2019, funding was secured to pilot the HAAI with older adults who were identified as moderately frail. Older adults were screened using the Clinical Frailty Scale (CFS)[17] to identify a quality improvement group (those who scored between 4 and 6 on the CFS) for whom additional assessments with the HAAI were completed. Older adults were recruited from incoming calls to the seniors association; callers were asked to complete a frailty screen, adapted from the Clinical Frailty Scale, identifying those who were minimally or moderately frail. These individuals were offered a call from the community connectors (link workers) to facilitate additional assessment with the HAAI. The HAAI was used as a comprehensive geriatric assessment to identify areas of resilience and vulnerability for this moderately frail group of older adults. The assessment was completed on admission to the pilot, and then repeated at 3, 6 and 12 months, allowing for tracking of scores over time.

Older adults who were seen in person were also administered the Edmonton Frail Scale (EFS)[24] as a comparative measure. The EFS scores were used to provide frailty context from a validated scale for those individuals who were screened with the HAAI.[24] These data were limited due to the COVID-19 pandemic, making convergent validity determinations difficult. Formal content validity and interrater reliability processes were ongoing at the time of writing. During the pilot, administration of the tool by different types of professionals led to a depth of perspective during iterative tool development, and a more robust community and social services approach to implementation. Social workers were trained to administer both the CFS and HAAI to older adults living in the community via phone or in person, in essence working in a community connector role, which is well described in the social prescribing literature.[23] Connectors took the lead in providing navigation support, directed by the individual's primary care provider.

Using the HAAI led the connectors to recommend increasing numbers of interventions over the course of the pilot to facilitate asset development for the older adult. This allowed nonmedical professionals to support connection to a wide range of interventions, contributing to conversations that gave older adults the agency to determine which diverse preventive and empowering supports were right for them. This practice, facilitated by the HAAI, builds on the concept of social prescribing, which is a structured system of referring people to a range of clinical and nonclinical services and leveraging the community-based sector to support an individual's needs.

Results

Following the HAAI pilot's conclusion in 2022, a statistical analysis was completed to identify program and tool impacts on the functional level of participants. Data were available for 77 individuals aged 50 and older, across four time points from intake to final follow-up. The HAAI was used 210 times over the period of the pilot, as not all individuals completed the total number of follow-up assessments. The statistical analysis identified a need for standardization in category composition. Given that DOHA domains initially included two, three or four questions, completing comparative analysis between domains was difficult. When considering the effects of the HAAI program and the social prescriptions that were implemented, overall HAAI scores showed a statistically significant improvement after a 12-month period when controlling for age and gender.

However, more important to consider is the scoring and improvement for each of the specific DOHA domains, as social prescriptions are targeted to the domain rather than the total HAAI score. Scoring on the tool is optimally as low as possible; the pilot demonstrated the highest scores in physical health and social engagement, identifying these domains as most problematic for participating individuals. Domains that seemed less concerning for the majority of participants were safety and security and personal well-being, a finding that is also supported in the literature.[25]

Given the type of data and number of older adults assessed, it was determined that a regression model fitted to panel data with random effects was the most appropriate. Due diligence suggested that additional statistical models be run using standard ordinary least squares regression, ANOVA and panel data with fixed effects. Panel data regression is more appropriate than ANOVA in this case because it allows for missing values. Random effects were used rather than fixed effects in order to test the significance of client age and gender.

A statistically significant reduction in HAAI score was observed for clients at the 12-month assessment when compared to their intake score. In this analysis, the reduction is equal to a 4.1-point decrease (95% CI: 2.61-7.26; $p < 0.001$) in the total score when controlling for age and gender. Regression results for the overall HAAI score are presented below (Table 1). Time, age and gender together explain about 20% of the change in HAAI score within individuals, and just under 12% of the differences in HAAI score between individuals. When compared to the initial assessment, there was no significant change in the overall HAAI score at the 3-month or 6-month time points. When compared to women, men did not have a statistically significant different HAAI score. When compared to those aged 50 to 64 years, HAAI scores were not statistically different for those aged 65 to 74 years, but they were significantly lower (by 6.51 points; $p < 0.01$) for clients aged 75 years and older.

Analysis of pilot data also highlighted the domains that showed the most improvement over the course of the pilot, demonstrating statistically significant score improvements immediately in safety and security, 6-month improvements in personal well-being and physical environment, and 12-month improvements in mental health and social engagement. Physical health scores did not show significant improvement during the one-year pilot (Table 1). Declining social support scores are difficult to interpret, but may be related to launching the project at the onset of the COVID-19 pandemic.

Unlike traditional frailty or geriatric assessment tools, the HAAI pilot optimized the relational role of the community connector to ensure that the selected interventions aligned with the older adults' current goals and assets, placing the older adult in the centre of the process, and in control. The use of modern social work approaches, such as solutions-focussed coaching and motivational interviewing,[26] further enhances the HAAI not only as an assessment instrument, but as a collaborative tool that facilitates active partnership with clients. The HAAI goes beyond the immediate problem-solving model (i.e. treatment only), which is common in current frontline social work practice and outreach, to a practice philosophy that encourages greater relationship building and holistic and long-term wellness—a preventive approach for which many social work professionals have advocated.[10] Future research efforts will target potential measurements of how HAAI use influences overall health and what the impact is on health resource use. Combining analysis with other measures such as hospitalization length of stay, quality of life, movement to settings offering higher levels of care, or emergency visits may provide relevant data to support expansion and public funding of social prescribing programs.

Policy and program options

The HAAI, which was developed and intended for use across both the health and social sectors, expands the capacity of the health and community-based systems to identify older adults with complex needs seeking support, and clearly identifies

TABLE 1
Summary of HAAI regression fitted to panel data with random effects, decomposed by domain

Variable	Mental health (out of 12)	Personal well-being (out of 9)	Physical environment (out of 9)	Physical health (out of 12)	Safety & security (out of 6)	Social support (out of 9)	Social engagement (out of 9)
Time—initial	Reference	Reference	Reference	Reference	Reference	Reference	Reference
Time—3 months	−0.0798	−0.0987	−0.3304	0.2025	−0.3821***	0.3407*	0.2264
Time—6 months	−0.0862	−0.3292*	−0.4923**	0.1095	−0.5625***	0.2896	0.0515
Time—12 months	−0.4807*	−0.4945**	−0.8170***	−0.4639	−0.6382***	0.0533	−1.2147***
Gender—female	Reference	Reference	Reference	Reference	Reference	Reference	Reference
Gender—male	−0.4678	−0.0483	0.3332	0.1360	0.0708	0.3954	0.2673
Age—50–64 y	Reference	Reference	Reference	Reference	Reference	Reference	Reference
Age—65–74 y	−1.6795**	−0.1844	−0.8233	0.4291	−0.8358**	0.2233	−1.1505*
Age—75+ y	−1.9816***	−0.2394	−1.8825***	−0.4730	−0.9145**	0.0549	−1.0425*
Constant	3.5441***	1.0098***	3.1871***	4.7363***	1.6647***	1.1038***	4.1188***

Abbreviations: HAAI, Healthy Aging Asset Index; y, years.

*$p < 0.05$

**$p < 0.01$

***$p < 0.001$

potential options the older adult may have for resolving or addressing the issues that could, over time, contribute to increased frailty, increased societal cost and system pressures. Preventative, community-based care is an important priority for local, provincial and federal governments.

As stated earlier, most older adults (92%) reside in private dwellings[15] and require access to a network of community-based supports that will facilitate aging in place. Communities in turn require adequate funding for this network of supports, as well as a dedicated community connector or link worker to conduct comprehensive assessments using the HAAI. Though primary care clinicians recognize the impact that the DOHA have on older adults living in the community, they are ill-equipped to advise on resources within the community. Essential to the success of social prescribing models is knowledge of ever-changing community resources—expertise that cannot be expected of medical professionals and that social workers may not have capacity to keep up. The HAAI tool facilitates and organizes this knowledge for the link worker. The HAAI also provides an opportunity to link the DOHA domains with resource databases, such as the 211 information and referral service available in some provinces.

Ensuring that there is seamless access and communication between health clinics and link workers will facilitate simple referrals from clinicians to the social prescribing structures that are in place. The HAAI tool, when used in conjunction with a screening mechanism such as the CFS, offers a clear pathway for social prescription and the associated interventions to be implemented. These tools can be used to identify and address frailty in systems outside of medicine, recognizing that frailty exists on a continuum and can be mitigated with a variety of social and clinical interventions. Social prescribing needs to be clear, accessible and simple to assess for, or it will fall to the bottom of the priority list of clinicians, despite its value.

Optimization of community-based approaches to the support of older adults is essential for the overall health of our society, and the long-term affordability of care for this population. Placing value on social needs such as affordable housing, financial security and food security will allow older adults to live healthier lives and decrease their use of the health system. This preventative action (concentrating on social needs) will not just shift a burden from one system to another, but will be more efficient and economical, since individuals will be more easily able to access resources and supports that meet these needs before having to access the health system. For this shift from health care to community to occur successfully, government funding is integral to supporting the development of social prescribing models and to ensuring that the tools and processes are supported by current research. The HAAI is shown to improve the process of assessment and intervention, and use of the tool can further advance social prescribing approaches in the community. Increased advocacy from the health sector, alongside the community-based senior-serving (CBSS) sector, is critical to promoting use of the HAAI and the link worker role, as has been demonstrated in other jurisdictions.[23]

The HAAI also allows community-based organizations to evaluate the efficacy of interventions using a common framework. During the HAAI pilot, assessments were repeated 3, 6 and 12 months post–program intake, which allowed for analysis of the impact of the social and clinical prescribing triggered during the process. This information is useful for informing policy and program decisions at all levels of government. For example, in the pilot, scores were highest in the physical health domain, yet did not improve significantly over a 12-month period. This could mean that the intervention options in the physical health domain were not meeting individuals' needs, and that further funding in this area is required to develop new programs and services. Ideally, a larger implementation group would provide more robust data on which to base analysis, which in turn would support a greater understanding of the impact of prescribing on the trajectory of healthy aging.

Barriers to implementation

Leveraging CBSS organizations as resources in a social prescribing model can prevent older adults from moving up the tiers of care and cost. However, a shift from health care toward community presumes a readiness among CBSS organizations that does not necessarily exist; the need to advance research, improve cross-sector collaboration and build system-level capacity in this area is evident. A systematic review examining facilitators and barriers of implementing and delivering a social prescribing service in the UK found that organizational readiness was a key facilitator to a successful social prescribing program.[27] Organizations have to be "navigator ready," and there is a need for a collaborative multisector approach to project management.[27] In Alberta, it is recognized that the senior-serving sector is relatively uncoordinated, and organizations face challenges due to the lack of collaborative tools, streamlined referrals processes, sector leadership and common frameworks for action.[28] However, work is underway through Healthy Aging Alberta that can be leveraged to promote the adoption of tools like the HAAI.

Capacity limitations within CBSS organizations also restrict the full implementation of assessment tools like the HAAI. Frontline staff are overworked due to the increasing demand for services, as they lack sufficient funds for staff and programming. This results in difficulties recruiting and retaining staff and makes it challenging to engage in systematic change management processes. In the UK, temporary staff contracts and staff turnover were found to be barriers to social prescribing implementation.[27] When we shift care into community, more value must be placed on the importance of these frontline roles, as they facilitate relationship-based social interventions and have the potential to increase the positive impact on an individual's health and well-being. CBSS programs and staff must be supported to the same degree as clinical interventions provided through medical professionals.

Currently, there is neither a systemic nor a systematic approach to the delivery of nonmedical services in community, including assessment and intervention, to support this shift from health care to community care. A lack of consensus on the best tool for assessing frailty has been noted as a barrier to implementing frailty assessments in clinical settings, despite the tools being adaptable to different settings.[29] A systemic approach is crucial to the ongoing success and sustainability of a social prescribing model—one in which a link worker can make connections to necessary nonmedical services and assist social workers in meeting the needs of older adults. Assessment before social prescription was found to be one of three critical components for successful impact on the loneliness, health and well-being of older adults.[30]

Currently, social workers working within both medical services and community services are overwhelmed by growing caseloads of increasing complexity. Systematic efforts to address this challenge must include training of link workers, engagement of CBSS organizations and active recruitment of clinical partners to participate in graduated social prescribing pilots. Successfully demonstrating proof of concept within local community organizations should lead to more complex integration within health organizations, which would in turn reinforce the downstream health and financial impact of the model.

Conclusion

The process of developing and piloting a healthy aging assessment tool based on the DOHA provided us with valuable insights into how social prescribing could be streamlined and leveraged within a CBSS organization. Older adults living in the community often require targeted support, aimed at facilitating higher levels of function within one of these key determinants of health, and the HAAI not only guides assessment of aging but also provides possible prescriptions to address identified areas of vulnerability. Consistent use of a tool such as this, across areas of practice and with diverse professionals involved in the care of older adults, will streamline assessment, service delivery and data collection. Ideally, the data captured from widespread use of the HAAI would support governmental decision making within the senior-serving sector, inform program investments and ignite innovative approaches to service delivery.

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Conflicts of interest

All authors declare no conflicts of interest.

Authors' contributions and statement

BM: writing—original draft, project administration, writing—review and editing.

AS: conceptualization, methodology, project administration, writing—review and editing.

SM: writing—review and editing.

TO: conceptualization, methodology, project administration, writing—review and editing.

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Commentary

Integrating social prescribing in a Canadian regional health system to support healthy aging

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Introduction

Social prescribing (SP) is a rapidly growing health and social model of care. The concept of social prescribing is based on well-known clinical practices such as community referrals, integrated health and social care,[1] and navigator models.[2,3] Although SP began in the United Kingdom's mental health and social care field, there are many examples of different models of SP foci and pathways.[4] Here in Canada, SP is emerging at several provincial locations, with differences in its delivery reflecting the local context of people and places.

In British Columbia (BC), there are five regional health authorities, a First Nations health authority and a provincial health authority overseeing specialized services. Fraser Health is the largest of the five regional health authorities in BC. It employs 45 000 health workers, delivering hospital- and community-based health services to more than 1.9 million people in 20 diverse communities, including over 320 000 adults over 65 years of age.[5] Since 2019, Fraser Health has been partnering with United Way BC (UWBC) to support the integration of SP into practice for older adults.

We provide a summary of the experience of the Fraser Health team, who are integrating SP into practice, to inform other health organizations, policy makers, decision-makers and health care providers who may be beginning a similar process. We describe the development and structure of the BC social prescribing model, followed by a summary of the team's strategies to support SP model integration. We conclude this work with reflections on the strengths and challenges we encountered during the regional integration work.

Co-creating social prescribing in BC and the Fraser Health region

The SP model at Fraser Health was developed through a partnership with the provincial government, UWBC, other nonprofit community organizations, BC Divisions of Family Practices (representing primary care physicians in the province) and Fraser Health teams including the Patient and Family Advisory Council. The partnership began in 2019, when the BC Ministry of Health provided funding for a new program through UWBC.[6] At the time, Fraser Health had begun an initiative called "Community Actions and Resources Empowering Seniors" (CARES), which engages community-based primary care providers to identify, manage and develop care plans for older adults living with frailty, based on evidence that it can be delayed or prevented.[7] The initiative piloted the model of care in two local communities to spread the innovation throughout the region. A partnership between CARES and UWBC allowed Fraser Health community practitioners to further partner with local nonprofit organizations to create a new peer support role to help older adults navigate available services, called the "seniors community connector" (SCC).

Between 2019 and December 2023, there were 20 SCCs working throughout BC. The SCCs are staff hired by local community nonprofit organizations, although their position is funded by a BC Ministry of Health grant and managed through UWBC.[6] The SCCs share many common features with the community link workers in the UK SP model.[8] For example, they use a strengths-based approach to address unmet, nonmedical social needs; locate and connect older adults with community resources; and follow up over time.[8] The SCCs come from a variety of backgrounds and have a variety of training, such as social work and nursing, or experience in the nonprofit sector.

Highlights

- British Columbia (BC) has developed a province-wide social prescribing model supporting older adults through close partnerships between health care and community organizations.
- A regional health authority, Fraser Health, has a specific regional team focussing on integrating social prescribing into the health system through meaningful engagement and continuous co-creation with multisectoral partners, using strategies such as change management and Plan-Do-Study-Act cycles.
- Environmental and organizational support are big facilitators that have supported the continuation of the designated integration effort.
- Long-term funding and more partnerships between health care and community organizations will be critical to sustaining the social prescribing model in BC.

The SCCs from each catchment area receive referrals from health care providers, older people or their friends and

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families. Based on the older adult's needs and preferences, the SCC provides tailored support to facilitate access to community resources, which may range from food and nutrition support to physical activity and social engagement opportunities in the older adult's community. After the initial meeting, the older person and SCC set goals, co-create a wellness plan, and develop a follow-up plan together.

Integrating social prescribing into the health system

The role of the Fraser Health social prescribing team

At Fraser Health, a SP team evolved from the CARES initiative to support the integration of social prescribing into the regional health system. The Fraser Health SP team includes eight core team members who meet weekly to monitor project progress and discuss strategies. Two SP "change leads" are employed by Fraser Health to fully support the initiative. The aim of this role is to implement and facilitate organizational improvements through change management strategies. One lead has experience as a clinical nurse educator in community health and the other lead is a registered nurse who coordinated the CARES initiative. The two change leads are supported by six team members with already existing roles in Fraser Health's Home and Community Services regional team: a service operations director, a regional medical director, a clinical nurse specialist, a clinical nurse educator, a clinical social work educator and an occupational therapy clinical leader. The team also works with consultants from the Communications and System Optimization department within Fraser Health.

The SP team is critical to the integration of a complex model like social prescribing, as the team members act as implementation support practitioners (ISPs), which have been shown to be beneficial by implementation science studies.[9-11] An ISP is a "facilitator, coach, knowledge broker and technical assistance provider to support implementation of evidence-informed programs and practices … to sustain and scale research evidence for improved and equitable population outcomes."[11,p.2] At Fraser Health, the two change leads take on the role of ISP and co-create strategies with partners to integrate SP, apply ongoing quality improvement and support the sustainability of the program.[12]

Integrating new programs into practice involves multiple phases, such as the ISPs providing information on the program (knowledge mobilization) to service providers, and the providers adopting and sustaining the new intervention.[13] The SP team facilitates these phases and engages partners using the ISP core competencies derived from implementation science and quality improvement strategies, such as the Plan-Do-Study-Act (PDSA) cycle from improvement science.[14] Utilizing both types of strategies promotes engagement, fosters local ownership and helps refine strategies.[15]

Engagement process

The SP team's process of health care staff engagement using PDSA cycles and ISP competencies is summarized in Figure 1. Along with frontline care providers, the team engages other regional team members in Fraser Health to consider how the SP model can complement existing services in primary care, community health, public health and palliative care settings to support older adults' quality of life. To ensure a suitable and sustainable SP model in Fraser Health, the change leads engage SCCs regularly through monthly meetings that form communities of practice that aim to share insights and resources from the health care sector with the SCCs, hear the SCCs' insights, encourage peer support among the SCCs and co-create action plans to improve the health care–community partnerships. The SP team also partners with other nonprofit community organizations, universities, members of the public and national SP organizations, such as the Canadian Institute of Social Prescribing, to explore collaborations. For instance, some local BC universities have started to embed SP as a topic in health care students' curricula and encourage preceptorships in SP.

All materials shared and knowledge disseminated continue to be developed based on users' feedback (health care providers and SCCs) throughout the engagement process. The change leads facilitate communication between health care teams and the SCCs, provide tailored support and suggest ways for the two sectors to collaborate. For example, early in the engagement process, the Fraser Health SP team quickly realized that the health care system and community service organizations have different workflow and infrastructure systems. Health care providers often identify and request a specific type of community resource for patients and prefer a standardized referral process in which each step of the program is clearly defined. On the other hand, the SP model encourages holistic exploring of nonmedical needs and approaches, and the time and approach required to do this varies highly based on the individuals' needs and community resources. Brown et al.[16] also noted that "[t]he formalization of social prescribing within [the health system] … and the administrative activities that this is likely to bring with it … could endanger some of the existing advantages of [community work], such as its flexibility, informality and personal approach."[16,p.621]

Upon realizing the difference, the Fraser Health SP team quickly developed standardized ways to clarify the nature and scope of SP and took time to explain to both the health care and the community care providers the difference in expectations for components such as referral criteria, program scope and follow-up mechanisms, and offered recommendations to facilitate collaboration.

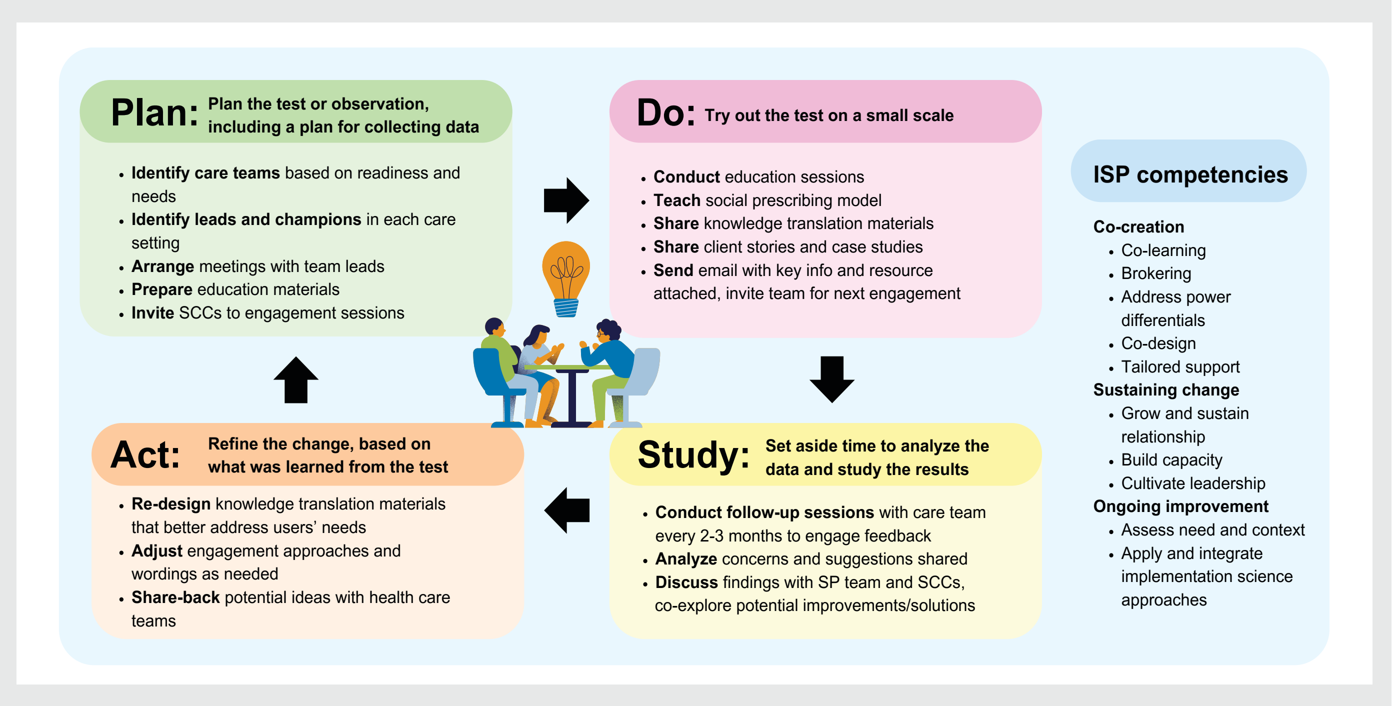
Reflections

In addition to engaging partners, the SP team constantly reflects on the integration journey and takes action to develop a more sustainable SP model in BC and Fraser Health. Between September 2019 and July 2023, the SP program in the Fraser Health region was introduced to at least 126 health care teams, and supported over 1000 older adults in the region. We are aware that for SP to support more people, sustainability and maturity of the model are critical. In this section, we reflect on our experience and learnings based on the eight domains suggested by the Program Sustainability Assessment Tool (PSAT),[17] which evaluates and aids sustainability planning for public health programs: environmental support, funding stability, partnerships, organizational capacity, program evaluation, program adaption, communications and strategic planning.

1. Environmental support

Like the rest of Canada, BC and the Fraser Health region have an aging population.[18,19] The BC Ministry of Health and other interested parties in the health care

FIGURE 1
Fraser Health social prescribing team engagement process



Plan: Plan the test or observation, including a plan for collecting data

- **Identify care teams** based on readiness and needs
- **Identify leads and champions** in each care setting
- **Arrange** meetings with team leads
- **Prepare** education materials
- **Invite** SCCs to engagement sessions

Do: Try out the test on a small scale

- **Conduct** education sessions
- **Teach** social prescribing model
- **Share** knowledge translation materials
- **Share** client stories and case studies
- **Send** email with key info and resource attached, invite team for next engagement

Study: Set aside time to analyze the data and study the results

- **Conduct follow-up sessions** with care team every 2-3 months to engage feedback
- **Analyze** concerns and suggestions shared
- **Discuss** findings with SP team and SCCs, co-explore potential improvements/solutions

Act: Refine the change, based on what was learned from the test

- **Re-design** knowledge translation materials that better address users' needs
- **Adjust** engagement approaches and wordings as needed
- **Share-back** potential ideas with health care teams

ISP competencies

Co-creation
- Co-learning
- Brokering
- Address power differentials
- Co-design
- Tailored support

Sustaining change
- Grow and sustain relationship
- Build capacity
- Cultivate leadership

Ongoing improvement
- Assess need and context
- Apply and integrate implementation science approaches

Abbreviations: ISP, implementation support practitioner; SCC, seniors community connector; SP, social prescribing.

industry have been exploring different ways to support interdisciplinary care and healthy aging. Within Fraser Health, there has also been an emphasis on enhancing the integration of a community services model with the traditional model focussed on acute care.[20] This health care trend and supportive environment have led to the integration and promotion of the SP model in the Fraser Health community. When we introduced the SP model to health care and community staff, leadership teams and the public in the past, we received positive feedback and enthusiasm, showing that this model is timely and aligns with people's needs. In the next phase, we will engage with municipalities to further explore (and hopefully integrate) the health–community partnership model.

2. Funding stability

Since the start of the program, the SP program has been funded as a demonstration project on a year-to-year basis by both the Ministry of Health and Fraser Health. The uncertainty of continuous funding had led to concerns from care providers in the community and within Fraser Health. The SP team continues to advocate for continuous funding, by highlighting program gaps in reports and in meetings with both health care and community decision makers. At the time of writing, the Ministry of Health and Fraser Health had released new funding to support the initiative, and the UWBC and Fraser Health team members are continuously brainstorming on how to optimally streamline health care and community infrastructures.

3. Partnerships

Partnerships with different health care teams and community organizations have been one of the biggest levers in SP integration. Partners have been supportive, leading to more opportunities to collaborate on a healthy aging environment, including leveraging existing resources. A barrier the SP team encountered is that SCCs in the community and health care providers do not have a mutual platform or standardized method and policy for information sharing, leading to difficulty in collaborative care planning and follow-up. The SP team continues to explore different ways to facilitate communication between health care staff and community organization staff.

4. Organizational capacity

Support from Fraser Health has been critical to sustaining the integrated SP model. The ease of accessing and partnering with other Fraser Health teams has led to better integration of services. For example, the team has support from the Fraser Health communications department to facilitate knowledge mobilization. The team also partners with the health authority's systems optimization and research teams for program evaluation.

5. Program evaluation

With support from fellow Fraser Health team members, the SP team is evaluating the program's impact on older adult health and health system utilization, such as emergency room utilization and hospital re-admission rate. We continue to partner with UWBC, local community organizations and Fraser Health team members to evaluate program capacity and sustainability. We also plan on evaluating the experience of older adults, family and care providers with social prescribing, via surveys.

6. Program adaption

The SP initiative in Fraser Health adapts rapidly based on feedback, new partnerships and health system needs. The SP team values and respects the readiness and capacity of each interested party and adjusts integration approaches through continuous engagement and PDSA cycles.

Our learnings also lead to discussion about whether more health authority staff should be hired or trained to specifically address more urgent nonmedical needs during care transition, in addition to the existing SP model. We aim to continue adapting the SP program based on routinely collected data, creating a “learning health system” in social prescribing.

7. Communications

Standardized messages and promotional materials greatly facilitate learning and adaption of the health care–community model. The SP team is partnering with the Fraser Health communications department and UWBC to build standardized materials for the SCCs, health care providers, and older adults and families. We have used methods such as social media campaigns, community sessions and conferences to increase community awareness, and hope to have more opportunities to showcase the social–health model on a larger scale.

8. Strategic planning

The Fraser Health 2020/21–2022/23 Service Plan highlighted the Authority’s priority of ensuring older adults access to timely and comprehensive care through increased partnership between community and health care.[20] This priority prompted a new initiative, Frailty Pathway, which includes the SP model and related collaborative initiatives to address frailty in Fraser Health. The initiative is leading to increased funding from the health authority and the formation of new partnerships in order to establish a comprehensive healthy aging care model that supports more older adults.

We are grateful for the collaboration of our partners, which allowed us to develop social prescribing in Fraser Health. Continued engagement with health care, community organization and academic institution partners and the willingness of all partners to co-create strategies have been the key element leading to our success to date. Although each system and community structure is unique, we believe our learnings and practical, evidence-informed strategies will inspire other health systems to embed social prescribing in their region.

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Conflicts of interest

ML is the social prescribing change lead and Frailty Pathway project lead employed by Fraser Health. GP is the regional medical director for Home and Community Services, contracted by Fraser Heath. MCA is a professor at The University of British Columbia, with no conflicts to declare.

Authors’ contributions and statement

ML, GP, MCA: conceptualization, formal analysis, methodology, visualization, writing—original draft, writing—review and editing.

ML, GP: project administration, resources.

The content and views expressed in this article are those of the authors and do not necessarily reflect those of the Government of Canada.

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At-a-glance

Guides for facilitating the implementation and evaluation of social prescribing: lessons from the "Access to Resources in the Community" model

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Abstract

Social prescribing (SP) embodies a comprehensive approach to addressing the social determinants of health. Access to Resources in the Community (ARC) is an innovative SP program offering bilingual services that involves a single point of entry for health and social needs and introduces practice changes to assist primary care providers in engaging patients, along with a nonclinical lay navigator who supports patients in accessing relevant community resources. The ARC team has created a SP toolkit offering practical guidance for setting up, implementing, monitoring the progress of and evaluating SP programs. The four ARC guides can be easily customized for application in diverse practice and research settings.

Keywords: *social prescribing, patient navigation, toolkit, navigator training*

Highlights

- We developed a set of guides for use in "Access to Resources in the Community" (ARC), one of the first social prescribing (SP) programs established and evaluated in Ontario, Canada.
- The four guides are: (1) PC Practice Set Up, (2) Navigator Training, (3) Navigation Processes and (4) Evaluation. The guides provide practical guidance for establishing, conducting and monitoring progress, and evaluating SP programs; they form the basis of a toolkit we created to support organizations and researchers in establishing and evaluating SP programs.
- The guides and toolkit are currently being adopted for the ARC/211-Ontario program that we are co-creating through a nonprofit research partnership with Community Connections, an innovative hub of 211 Ontario in Collingwood. The program will help generate evidence on the feasibility, effectiveness, impact on health inequities and cost-effectiveness of adapting and scaling up SP programs in Canada.

Introduction

The social determinants of health have a significant impact on the health of individuals.[1] Social prescribing (SP) consists of the identification of patients with unmet needs related to these determinants, commonly in primary care (PC), and the provision of support to help them access the needed resources. The structure of SP varies considerably across settings. In some programs, changes are introduced to the PC practice, such as establishing practice champions and referral mechanisms, to facilitate the identification and engagement of such individuals,[2,3] although many studies describing these programs do not mention any changes to practice.[4,5]

In some cases, the support offered to help individuals access resources may be as simple as sign-posting (providing information and/or promotional material) at the PC practice, which has less impact[6,7] than the more common structure in which a trained individual, often called a link worker, provides navigation services.[4,8,9] With some exceptions,[10] the link worker is an individual outside the PC practice who supports practices within a defined region.[2,4,11] The training and role of the link worker are often not well described;[12,13] in some studies, their role is principally described as that of identifying and connecting the individual to the service,[4] while in others it involves more intensive support. Some link workers' functions include a structured approach to identifying access barriers and helping individuals overcome them; the co-creation of personalized plans;[8] providing various levels of emotional support; advocacy; and forming strategies to build empowerment and self-efficacy.[2,8,14]

Some SP programs limit the target population to specific sociodemographic groups[12,15,16] or to individuals with specific needs,[9,17-19] while others target a broad population.[4] Studies have shown SP to have varying degrees of success, which is likely because

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a broad range of approaches are used, with different target populations and vast variability in the outcome measures.[3,4,10,20] There is evidence that more intensive support, continued patient engagement and structured referral processes are more likely to produce benefits.[2,17,21]

Access to Resources in the Community (ARC) SP model

Over the past decade, SP has been widely adopted across the United Kingdom and is rapidly expanding internationally.[22,23] Initiatives to promote SP are relatively new in Canada.[2,24] In partnership with patients, providers and health planners, our team developed ARC, an innovative, PC-based SP program offering bilingual services to improve equitable access to health and social resources. The ARC approach involves a single point of entry for health and social needs, introduces practice changes to assist PC providers to engage their patients in self-care for these needs, and provides the services of a nonclinical lay navigator who supports patients to access the appropriate community resources. The ARC SP model was demonstrated to be feasible and acceptable across different PC practice models in Ontario, Canada.[2]

We subsequently conducted a randomized controlled trial to compare the ARC navigation services to the existing online navigation services provided by 211 Ontario, a free, multilingual web and telephone information and referral service for health and social resources that is available around the clock in Ontario. In that trial, PC practices applied SP as usual, but patients were randomized to either the ARC navigation service or the 211 Ontario navigation system. We assessed patient and provider experience, access to needed resources and impact on health services in the two arms. These results are in preparation for publication.

ARC social prescribing guides and toolkit

There is a dearth of information and resources relating to practice changes and the training required for the link worker. The tools and guides available to support the implementation and practice of SP were mostly developed in the UK,[25-27] and more recently from the Alliance for Healthier Communities in Ontario.[28] The ARC team developed a set of guides for use in the ARC research program[29] that can provide practical guidance for establishing, conducting, monitoring the progress of and evaluating SP programs. These guides are the basis of the toolkit (https://www.arcnavigatorproject.com/sp-toolkit)[30] we created to support organizations and researchers in establishing SP programs; the four guides are: PC Practice Set Up, Navigator Training, Navigation Processes, and Evaluation.

Guide 1: PC Practice Set Up

The ARC team established simple processes for implementing SP in primary care that can readily be integrated without disrupting the practice workflow. This guide includes presentations on SP for recruitment and practice orientation to review study procedures; recommendations for practice changes to adopt social prescribing; and examples of the tools used.

Guide 2: Navigator Training

The navigator's role is broad. Navigators must establish a trusting relationship with the patients, elicit information about their social context and anticipated access barriers, understand their priorities and preferences, and help build the individual's self-efficacy. They offer informational, instrumental and emotional support to help patients overcome barriers and successfully access the needed resources. The ARC team developed a learner-centred, theoretically grounded, competency-based training program for individuals without a clinical background to acquire the competencies to carry out their role.[31] The training involves a total of 25 hours of self-paced education sessions, covering a set of 13 training modules supplemented with face-to-face workshops, and covers the need for ongoing mentorship from experienced navigators or program managers. Each module contains study material such as PowerPoint presentations, video recordings, handouts, peer-reviewed articles and additional learning resources.

Guide 3: Navigation Processes

In addition to providing patients with the support required to achieve access, the navigator also helps ensure the continuity of information across sectors by providing feedback to the PC provider about their patient's progress and resources accessed. This guide provides a step-by-step description of the ARC navigation processes and the corresponding tools that support navigators in their role, facilitate their work and help ensure fidelity to the established processes.

Guide 4: Evaluation

Ongoing monitoring of SP programs, especially at the earlier stages, is necessary to identify and mitigate issues relating to fidelity, processes in place, and other factors that can compromise the success of the program. The evaluation of SP programs allows the program administrators to assess whether the initiative has achieved its intended objectives. While these are often specific to each initiative, they will also contain common elements. The ARC SP evaluation guide provides some insight and tools from our work that may be adapted for use in other SP programs. That guide covers (1) rapid cycle evaluations, to assess the impact of SP on PC practice functioning; (2) patient surveys, to assess access and patient experience; and (3) provider surveys, to assess providers' level of satisfaction with various components of the SP program and their perception of the impact of SP on the health and well-being of their patients.

Scaling up SP: the ARC/211-Ontario SP program

The ARC team and the Collingwood Community Connection (CC) team, a regional initiative of 211 Ontario that has been piloting a SP program, have partnered to co-develop, implement and test a comprehensive SP model that builds on the two teams' assets and experience. The ARC/211-Ontario model will incorporate elements of the ARC approach that support practice engagement and delivering patient-centred, longitudinal services required for more socially complex individuals, and will leverage the CC's approach for regional SP programs, existing resources and technological innovations to enhance the structure and efficiency of the service delivery and facilitate the navigator's work.

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Conflicts of interest

The authors declare no conflicts of interest.

Authors' contributions and statement

SD: conceptualization, writing—review and editing.

KS: writing—original draft.

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Call for papers: Generating stronger evidence to inform policy and practice: natural experiments on built environments, health behaviours and chronic diseases

Guest editors: Dr. Stephanie Prince Ware (Public Health Agency of Canada), Dr. Gavin McCormack (University of Calgary)

HPCDP Journal Editors: Robert Geneau and Margaret de Groh (Public Health Agency of Canada)

Where we work, learn, play, eat and live has important implications for health. The built environment has been associated with the development of chronic disease, and with health behaviours often seen as critical pathways for this relationship.[1,2] Built environments refer to components of the physical environment that are human-made or human-modified and include structures and buildings, recreation facilities, green spaces and parks, transportation systems and community design.

Natural experiments are interventions that occur without a researcher's ability to manipulate the intervention or exposure to the intervention.[3,4] Natural experiments offer the opportunity to evaluate the effects of "naturally occurring" interventions such as changes to the built environment (e.g. creation of a new bike path, park improvements, infrastructure changes to schools or workplaces, construction of a new recreation facility or grocery store) on health behaviours and chronic disease risk. Natural experiments are often more practical for investigating the health impacts of environmental interventions when compared to traditional experimental studies (e.g. randomized controlled trials). Compared to cross-sectional studies, natural experiments provide a means to generate rigorous evidence to better establish causality, as well as to understand the implementation of interventions in "real-world" scenarios.

This special issue answers the 2017 Canadian Public Health Officer annual report's call to further evaluate the health impacts of community design features in Canada.[5] This special issue resonates with the expanding scholarly and policy-oriented interest in the utility of natural experiments as a critical tool in advancing the body of evidence and for informing interventions to improve public and population health.[6,7] Specifically, the objective of this special issue on natural experiments is to provide timely evidence to further understand the effectiveness of built environment interventions on health behaviours and chronic disease prevention in a Canadian context.

Health Promotion and Chronic Disease Prevention in Canada: Research, Policy and Practice is seeking relevant topical research articles that present new findings or synthesize/review existing evidence on natural experiments of the built environment (or related policies) that influence health behaviours with implications for chronic disease prevention in Canada.

Relevant topic areas include, but are not limited to:

- Built environments, including community or neighbourhoods, workplaces, schools, transportation infrastructure, home environments, recreation environments, parks, playgrounds, green spaces, public open spaces, natural environments and seniors' residences.
- All health-related behaviours, including physical activity, sedentary behaviour, sleep, food consumption, smoking and substance use.
- Chronic diseases and health-related outcomes, including body mass index, fitness, blood pressure, blood lipids, blood sugar, injuries, falls, mental health, stress, depression, anxiety, Alzheimer's disease, dementia, obesity, metabolic syndrome, cardiovascular disease, cancer, diabetes and lung disease.

International submissions will be considered if they include Canadian data, results (e.g. as part of multi-country studies or global comparisons) and/or evidence-based discussion of implications for community or population health in Canada.

Consult the Journal's website for information on article types and detailed submission guidelines for authors. Kindly refer to this call for papers in your cover letter.

All manuscripts should be submitted using the Journal's ScholarOne Manuscripts online system. Pre-submission inquiries and questions about suitability or scope can be directed to HPCDP.Journal-Revue.PSPMC@phac-aspc.gc.ca.

Submission deadline: November 30, 2024

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Corrigendum

Glossary of terms: A shared understanding of the common terms used to describe psychological trauma, version 3.0

This corrigendum is being published to acknowledge the contribution of Dr. Deborah Norris, which was omitted from the original version of the article:

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Before correction

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Other PHAC publications

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