

Co-Designing a Social Prescribing Intervention for Carer-Employees: A Qualitative Exploration of Stakeholder Perspectives

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Abstract

Background

Carer-employees (CEs) balance unpaid caregiving responsibilities with paid employment, leading to intersecting emotional, financial, occupational, and social challenges. Although social prescribing (SP) has emerged as a promising approach to addressing the social determinants of health, few SP interventions have been specifically designed for CEs. This first phase of a multi-phase study seeks to explore the lived experiences, needs and challenges of CEs to inform the development of a SP intervention that can be piloted, refined and scaled across Canada.

Methods

A qualitative descriptive design was employed. Data collection occurred through semi-structured interviews with CEs and employers, and a multi-stakeholder co-design workshop involving CEs, employers, healthcare providers, community organizations, and researchers in Hamilton, Ontario. Reflective thematic analysis was conducted inductively using NVivo qualitative coding software.

Conclusion

As caregiving needs rise with Canada's aging population, co-designed SP interventions may offer a scalable strategy to improve caregiver well-being, sustain workforce participation, and advance more equitable and responsive systems of care.

1. INTRODUCTION

1.1 Background & Rationale

Carer employees (CEs) are individuals who manage unpaid caregiving responsibilities alongside paid employment. According to Statistics Canada, one in four individuals aged 15 or older identify as caregivers, with many of these individuals also participating in the labor workforce.¹ Balancing these dual responsibilities requires CEs to navigate competing demands across both their work and caregiving roles, often with limited time and resources. As a result, CEs can experience heightened stress, depression and anxiety alongside financial strain, workplace absenteeism and/or limited career progression.²⁻⁴ The gendered distribution of caregiving further compounds these impacts, placing women at a disproportionate risk of having to reduce work hours, take leave, and/or miss more days of paid work to attend to caregiving responsibilities.⁵ Beyond these immediate consequences on employment and health, caregiving responsibilities can also have long-term broader implications on physical health and overall quality of life.^{6,7}

As populations age and labor force participation among older adults increases, the number of individuals who will balance paid employment with unpaid caregiving is expected to significantly increase over the coming decades.^{2,8} When CEs reduce work hours, leave the workforce, or experience burnout, the consequences extend beyond individual well-being to also affect employers, healthcare systems, and the broader economy through productivity losses, including staff turnover, increased demand for formal care services, and reduced labour force participation.^{5,6,9} Supporting CEs is emerging as an important public health, workforce and economic priority, with implications not only for the wellbeing of caregivers, but also for employee retention and the sustainability of broader health and social care systems.

1.2 Current Approaches to Supporting CEs: Fragmentation Across Support Systems

Within organizations, a variety of carer-friendly workplace policies have emerged as an important and recommended strategy to support CEs. These usually include flexible work arrangements, employee assistance programs and supportive organizational environments, which have been associated with improved mental health outcomes.^{10,11} Other carer-friendly policies can encompass a range of initiatives including leave, compassionate care benefits, accommodations for family care responsibilities, compressed workweeks, internal support programs, job sharing and more. However, implementation remains inconsistent, and the availability of and access to supports can vary considerably across regions and communities.^{12,13} Outside of work settings, community-based resources such as respite care, peer support groups, and other social and recreational programs can help promote social connectedness, reduce carer distress, and improve overall wellbeing of caregivers.^{14,15} However, avenues of support for caregivers may often operate independently of each other with limited coordination across sectors. As such, the fragmentation across organizations and community support systems can make it difficult for individuals like CEs to identify, access and navigate appropriate resources. This fragmentation, coupled with other factors such as inflexible policies, restrictive eligibility criteria, wait times, and even complex application procedures, imposes an additional structural burden on a population already managing competing employment and caregiving responsibilities.¹⁶ Consequently, CEs are often required to determine what supports they are eligible for, where and how to access them, while simultaneously balancing working and caregiving responsibilities. As such, there is an imperative need to facilitate coordinated, timely and targeted navigation across organizational and community supports for CEs.

1.3 A Potential Solution: Social Prescribing

Social prescribing (SP) is a person-centred model of care that connects individuals, typically through structured referral pathways, with non-clinical supports and services tailored to their unique needs.^{17,18} For example, an individual experiencing burnout and social isolation may be referred to participate in a local museum activity or a gardening group to facilitate social connection. SP services can be accessed

at multiple entry points, such as through doctors, link workers, spiritual advisors and, in the case of CEs, even organizations.¹⁹

Within Canada, SP initiatives continue to be piloted, refined and expanded for various populations through organizations such as the *Canadian Institute for Social Prescribing (CISP)*.^{20–22} The *CISP* outlines five distinct stages of the SP pathway, namely *Enter, Connect, Attend, Follow-up, and Exit*.²³ The pathway is iterative rather than linear, allowing individuals to enter, re-enter or exit the pathway depending on their support needs. One may “enter” the pathway through self-referral or referral from a trusted source, and once engaged, they can be guided and “connected” to tailored support until needs are “attended” to.^{20–23} Additionally, the potential for ongoing “follow-up” enables monitoring of progress, addressing barriers to engagement, and modifying referrals as care needs evolve. This coordinated, structured, yet flexible approach allows for sustained, targeted engagement with community resources, allowing individuals to connect and be navigated to avenues of support that address various social determinants of health.^{20–23} Given that CEs experience interconnected challenges related to their dual roles, a person-centred and navigational model of care may help holistically address their support needs and improve health and wellbeing, especially as fragmentation across support systems persists for this population.

Despite growing interest in and application of SP, few initiatives have explored how SP could address the unique needs of individuals such as CEs, even though various workplace carer-friendly interventions have shown promise.²⁴ Some existing SP programs involving older adults and caregivers more broadly have demonstrated promising potential to improve well-being and economic outcomes.^{25–29} However, the literature examining SP programs for caregivers is heterogeneous, with significant variation in program approaches, referral pathways, and the extent to which programs involve carers and their care recipients in addressing various health and well-being needs.²⁵ This emerging evidence showcases the potential of SP while also highlighting the need to improve the understanding of how program design can be optimized and catered to caregiver populations. Very little is known about how SP may directly cater to the needs of CEs and connect them to diverse health, social and community resources needed to address the multidimensional challenges of managing paid employment alongside unpaid caregiving.

At McMaster University, researchers are collaborating with community and organizational partners to co-design, implement and evaluate a scalable social prescribing intervention for CEs in Hamilton, Canada. As part of the co-design process, the initial phase of the project involves interviews with stakeholders (including CEs and employers), complemented by a co-design workshop to better understand the current lived experiences, needs and challenges of CEs and ultimately to inform the development of an appropriate intervention. A co-design approach, by definition, involves an integrative, participatory approach that incorporates reflexivity and creativity through stakeholder involvement to identify challenges and explore solutions.³⁰ This approach was selected as a valuable approach to ensure that a future intervention is informed by the perspectives of those who will ultimately use, deliver and support the implementation of a successful SP intervention. The current study represents the first phase (Phase A) of the broader research project (Fig. 1).

1.4 Study Aims

The aim of the overarching research is to understand various stakeholder perspectives on the experiences, needs, and implementation priorities relevant to creating and piloting a social prescribing intervention for CEs. Specifically, the current study sought to identify perceived needs, barriers, facilitators, and program priorities from various stakeholder perspectives using interview and workshop data to inform the design of a future SP intervention that can be piloted, refined and scaled across Canada.

2. METHODS

2.1 Design & Theoretical Approach

This study used a qualitative descriptive approach. Ethical approval was obtained from the McMaster Research Ethics Board (MREB; Project #8113). Further, Social Innovation Theory was used to conceptualize the co-design process with directly with community members via semi-structured interviews and co-design workshops. This theory emphasizes how diverse stakeholders can share, develop and adapt ideas to support development and implementation of various health service development innovations.³¹

2.2 Advisory Committee

An interdisciplinary advisory committee consisting of field experts was established to support the project through its different phases. The advisory committee consisted of six individuals comprising researchers, project leads, evaluation specialists and other experts representing organizations such as the *Canadian Institute for Social Prescribing* and *Red Cross Canada*. The advisory committee met monthly with the research team to provide iterative guidance and advice on study design, recruitment strategies, data collection, interpretation of findings and intervention development.

2.3 Location and Context

Hamilton, Ontario, was selected as the geographic location of the research given the established community partnerships, stakeholder networks and implementation infrastructure, such as with the *Canadian Red Cross*.³² Both the research team and advisory committee agreed that it would be the most feasible location to facilitate recruitment and future implementation of a pilot SP intervention. Hamilton is a medium-sized city within Southern Ontario, comprised of 785,000 inhabitants with 65% of the overall population made up of working adults between the ages of 15 to 64.³³ Historically, the city comprised of a large working sector within the steel manufacturing industry and today is comprised of key sectors within health care and social assistance, retail trade and manufacturing.³³

2.4 Semi-Structured Interviews with CEs and Employers

2.4.1 Participants, Recruitment and Eligibility

A purposive sampling technique was employed to recruit participants with direct knowledge experience or knowledge about the intersection of paid employment and unpaid caregiving. Eligible CEs were adults who were aged 18 and over, who balanced paid employment (part-time, full-time, or employment within the last 12 months) alongside unpaid caregiving responsibilities for a family member, friend or loved one. Employers included supervisors, managers, HR personnel or other individuals in leadership positions who worked with one or more CEs in any capacity. All individuals had to be working or employed in Hamilton, Ontario.

Recruitment was conducted through email invitation to community and organizational partners and other professional networks within Hamilton, Ontario. Snowball sampling was also employed, as participants were encouraged to share study information with other eligible individuals within their existing networks. Participants were recruited through digital and print materials distributed via the Principal Investigator’s research program website, social media (Instagram, X, and LinkedIn), as well as professional and organizational networks. Interested individuals completed a screening form, and those meeting the eligibility criteria were contacted using the information provided. For semi-structured interviews, CEs and employers of CEs were recruited. The research team aimed to recruit a minimum of 6 CEs and 6 employers of CEs over a two-month period.

2.4.2 Data Collection

Semi-structured interviews were conducted between March and May 2026. Separate interview guides were developed for CEs and employers by the research team in consultation with project partners to ensure that the questions reflected the objectives of the larger project. Interview guides comprised open-ended questions related to caregiving, employment supports, and knowledge of accommodations, challenges, barriers to accessing resources, as well as implementation considerations and recommendations to better explore the role of social prescribing for CEs. Key interview questions for CEs and employers are presented in Table 1.

Interviews were conducted by two research assistants with prior experience in qualitative research, either virtually (via Zoom/Microsoft Teams) or in person, according to participant preference. These interviews lasted between 30–60 minutes and were audio-recorded with participant consent and then transcribed prior to analysis. Participants were asked for relevant demographic information and were provided with an honorarium of \$30.00 CAD for their time.

Table 1
Key Interview Questions for CEs and Employers

Participant Group	Key Interview Questions
CEs	1. Can you describe what a typical week looks like for you in relation to work and caregiving?
	2. What kinds of non-medical supports or community resources do you think could be helpful for CEs?
Employers	1. Can you tell me a little about your current role and responsibilities related to managing/supporting staff who are CEs?
	2. What types of support (formal or informal) do you offer to employees? Prompt: Workplace supports, community or social services, personal or family supports

2.5 Co-design Workshop

2.5.1 Participants, Recruitment and Eligibility

A purposive sampling technique was employed through email invitations to community and organizational partners and other professional networks within Hamilton, Ontario to take part in a half-day in-person co-design workshop. Participants were also encouraged to share study information with other eligible individuals within their existing networks. A range of stakeholders including CEs, employers of CEs, representatives from community-based organizations, healthcare providers, and researchers were invited to the co-creation workshop. Community stakeholders, CEs, employers, healthcare providers and researchers were eligible based on their relevant experience or knowledge of caregiving, employment, support provision, community programming, and/or social prescribing in Hamilton, Ontario. This ensured representation of lived, professional, and/or organizational expertise.

2.5.2 Data Collection

The co-design workshop was held on April 9, 2026, at McMaster University (Hamilton, Ontario). The half-day workshop brought together 23 CEs, employers, service providers, community/NGO/non-profit organizations, healthcare providers and researchers to collaboratively explore the lived experiences and challenges of CEs and appropriate ways to design and introduce a practical SP intervention. This workshop was facilitated by an expert in co-design from the McMaster Institute for Research in Aging and consisted of various large-group discussions, small breakout sessions and collaborative and interactive activities.

The co-design process involved moving from understanding the experiences and challenges of CEs to identifying barriers, generating potential solutions, and developing and refining intervention components and implementation priorities. During breakout sessions, participants worked in interdisciplinary groups of 4–5 individuals to brainstorm and develop ideas, diagrams, pathways, and potential intervention components related to CE experiences, identified barriers, and SP pathways. Groups subsequently

shared and discussed their ideas collectively to identify potential intervention and implementation priorities. This iterative process distinguished the workshop from stakeholder consultation by involving participants directly in generating and developing potential solutions instead of solely providing feedback on predetermined intervention components. Data generated through the co-design process included notes collected by a research assistant, participant worksheets, sticky notes, and visual diagrams, all of which were photographed, digitally scanned, and uploaded for analysis.

2.6 Data Analysis

Data included audio transcripts of interviews for interview analysis as well as notes, participant worksheets, sticky notes and visual diagrams from the workshop. Interviews were transcribed verbatim using built-in software of online interview platforms or through an AI audio transcription service, *TranscribeToText* (<https://transcribetotext.ai/>). After the first round of transcripts were generated, research assistants then revised the initial transcriptions to check for errors and cleaned up the data to ensure clarity and readability. Additionally, appropriate pseudonyms were used to maintain participants' anonymity.

Both interview and workshop data were analyzed using Braun and Clarke's reflexive thematic analysis approach.³⁴ This approach was used to provide flexibility through the process of identifying meaning across various stakeholder perspectives to inform future intervention development. Research Assistants (Ras) first familiarized themselves with the data through repeated reading of transcripts and workshop data. An inductive approach was then used to generate initial codes. Through this process, RAs sought to consider how their positionality and potential biases may have influenced the interpretation of data. Codes were then organized into appropriate themes, which were iteratively discussed, refined and reviewed with the research team and advisory committee through ongoing discussion and feedback. NVivo Version 14 was used to support data organization and coding across the co-design workshop and interview datasets. Interview and workshop data were analyzed separately, and data was then triangulated for the purposes of this paper and to address overall study objectives.

The interview data, collected as two separate sets of data (i.e., CE interviews and employer interviews), were first thematically coded separately by two Research Assistants. Once the initial codes were identified for each dataset, the datasets were then compared to determine whether there were overlapping themes and differences that could inform the co-design workshop including both CEs and employers. Dual role interviewees were first interviewed as CEs and then as employers, ensuring their perspectives could be compared alongside the CE and employer thematic codes. The majority of overlap surrounded issues around balancing work and care, where employers reflected more on opportunities for offering flexible work arrangements and other supports, as well as acknowledging that SP can extend support, while CEs primarily reflected on the precariousness of care and the need for workplace adaptability.

3. RESULTS

3.1 Overview

A total of 10 Hamiltonian interviewees were recruited for the CEs data, and six Hamiltonian interviewees were recruited for the employers' data. Two participants held dual roles as both CEs and employers of CEs and are therefore included in both participant groups. Participants were assigned pseudonyms according to their participant group: carer-employees were identified as CE1-CE8, employers as E1-E3 and E6, and participants who held dual roles as both carer-employees and employers were identified as P1-P2. The majority of CEs were women ($n = 7$), with participants ranging from 25 to 64 years of age. Most CEs were White ($n = 6$), followed by South Asian ($n = 3$), and East Asian ($n = 1$). Employment circumstances varied, with participants reporting full-time employment ($n = 4$), part-time employment ($n = 2$), self-employment ($n = 3$), and employment in the last 12 months ($n = 1$) (Table 2).

Employer participants were all White women ($n = 6$) working in full-time positions across diverse organizational settings (Table 3), including public sector, healthcare, non-profit, and private-sector organizations. As shown in Table 4, employers held leadership and professional roles, including human resources leadership, clinical management, caregiver support coordination, and business ownership.

The co-design workshop included 23 participants who were initially categorized according to their primary stakeholder role in the workshop, including CEs ($n = 3$), community/organizational representatives ($n = 13$), employer and organizational representatives ($n = 1$), researchers ($n = 5$), and healthcare providers ($n = 1$) (Table 5). During the workshop, a Menti polling activity provided participants with an opportunity to identify roles with which they identified, allowing participants to select more than one role. As shown in Table 6, 14 participants identified as CEs, reflecting their personal caregiving responsibilities outside of their professional role in the workshop. Other self-identified roles included employer of CEs ($n = 8$), service provider/community organization ($n = 10$), researcher ($n = 5$), and other ($n = 2$). As participants could select more than one role, categories were not mutually exclusive, and the n values do not sum to 23 in this specific case.

Table 2
Demographic Characteristics of CEs and their Care-recipients (n = 10).

Characteristic	Category	Participants, n (%)
Gender	Men	3 (30%)
	Women	7 (70%)
Age group (years)	25–34	1 (10%)
	35–44	4 (40%)
	45–54	4 (40%)
	55–64	1 (10%)
Ethnic background	White	6 (60%)
	South Asian	3 (30%)
	East Asian	1 (10%)
Employment status	Full-time	4 (40%)
	Part-time	2 (20%)
	Self-employed	3 (30%)
	Employed in the past 12 months	1 (10%)
Care-recipient group	Older adult (≥ 65 years)	3 (30%)
	Child with special needs	4 (40%)
	Adult family member with health/care needs	3 (30%)

Table 3
Demographic Characteristics of Employers (n = 6)

Characteristic	Category	n, (%)
Gender	Women	6 (100%)
Ethnic Background	White/Caucasian	6 (100%)
Employment Status	Full-time	6 (100%)
Age Group (years)	35–44	5 (83.3%)
	25–34	1 (16.7%)

Table 4
Professional Roles and Organizational Settings of Employer Participants

Participant	Professional Role	Organization/Sector
E1	Head of Human Resources	Federal public sector organization
E2	Clinical Manager	Healthcare organization
E3	Coordinator of Caregiver Support	Non-profit organization
P1	Owner	Coaching/consulting business
P2	Owner	Creative agency
E6	Owner	Therapeutic services agency for children and families

Table 5
Workshop Participants Characteristics (n = 23)

Stakeholder Group	n, (%)
CEs	3 (13%)
Community/organizational representatives	13 (56.5%)
Employer and organizational representative	1 (4.3%)
Researchers	5 (21.7%)
Healthcare providers	1 (4.3%)

Table 6
Workshop Participant Self-Identified Roles Based on Menti Poll (n = 23)

Self-identified Role*	n, (%)
Employer of CEs	8 (34.8%)
CEs	14 (60.9%)
Service provider/community organization	10 (43.5%)
Researcher	5 (21.7%)
Other	2 (8.7%)
*Participants could select more than one role; therefore, categories are not mutually exclusive and percentages do not sum to 100%	

The findings of this research address the study's aims of understanding stakeholder perspectives on the experiences and needs of CEs, as well as the barriers, facilitators, and implementation priorities relevant to developing a SP intervention. Across the three datasets, CEs described caregiving as an unpredictable

responsibility that intersects with employment, emotional well-being, financial circumstances, and social lives. Stakeholders also identified practical and structural factors that shape access to support, including limited time, work demands, financial costs, transportation, respite availability, and fragmented systems of care. These perspectives informed a range of priorities for a future SP intervention, including individualized support, accessible and flexible delivery, navigation, follow-up, and workplace integration. The following sections present these findings across the three datasets, beginning with section 3.2–3.4 which present CE perspectives on their experiences, needs, and challenges, as well as SP program recommendations. Section 3.5 entails employer perspectives on workplace supports, communication, flexibility, and opportunities for supporting CEs. Section 3.6 presents the co-design workshop findings, which bring together stakeholder perspectives to identify barriers, potential solutions, and priorities for the design and implementation of a future SP intervention.

3.2 Results from CEs’ Dataset: The Expansive Nature of Caregiving

3.2.1 Providing Diverse Forms of Care

Participants described caregiving as encompassing a broad range of responsibilities. Caregiving involved assisting with activities of daily living, providing emotional support, coordinating and attending healthcare appointments, managing finances and housing, arranging transportation, and organizing formal and informal care services. One CE explained, *“I manage money for her [care-recipient]...I do a lot of different, like, everything. She probably calls me 10 to 15 times a day if she's not physically here”* (CE5). In parallel, an interviewee stated, *“I am sort of also responsible for everything related to my husband's care... I take him to doctor's appointments...if he wants to go somewhere, I'm the chauffeur”* (CE4). Correspondingly, another CE communicated, *“I manage all her [care-recipient] finances. I do all her shopping. I help her with laundry and anything that requires organization, medication”* (CE3). All-in-all, these quotations illustrate caregiving as a multifaceted role requiring the coordination of practical, logistical, and emotional labour.

3.2.2 The Unpredictability of Care Demands

Participants characterized caregiving as unpredictable, with care demands fluctuating in response to changes in health status and unexpected events. One participant reflected, *“A typical week...it's unpredictable too...for the most part, I feel on edge”* (CE5). Reinforcing this, an interviewee mentioned:

“There's no such thing [as a typical week]. It's typical, with his point of presentation, like there can be weeks that run, like, normal, like, and what's normal for us is not normal for other people... we go through our routine with like, reasonable amounts of hiccups” (CE8).

Another participant elaborated that periods following a fall intensify caregiving demands, noting that:

“When she does injure herself, then obviously, there's kind of a lot more management required to kind of help her with rehabilitating that. And so...the time required to care for her just kind of increases”

exponentially" (CE1).

Thus, these quotes show that caregiving is marked by uncertainty, requiring constant adjustment to care needs.

3.2.3 Caregiving as Time-Intensive Labour

Participants defined caregiving as a time-intensive responsibility that affected how they allocated and managed their time across work, family, and personal life. One participant expressed, *"Sometimes we're in very intensive therapy... that can be like 20 hours a week... I have to, like, be there for all the behavioural therapy, all the speech therapy...the occupational therapy"* (CE8). Another CE stated, *"At least 40 [hours of care per week]...I would say it's a whole other job"* (CE4). Analogously, a participant reported, *"I feel I have to be...in two places at the same time...there are men and women in a household, they share the responsibilities. Right now, I'm doing two people's work"* (CE7). Therefore, these accounts provide evidence that CEs manage duties that require sustained time commitment and continual responsiveness.

3.3 Results from CEs' Dataset: The Costs of Caregiving

3.3.1 Employment Experiences

Participants disclosed significant employment impacts as a result of their caregiving roles. Interviewees described using vacation and personal leave, taking time away from work, resigning from employment, and experiencing challenges related to occupational flexibility. While flexible and remote work arrangements were described as helpful, participants identified gaps in caregiver-friendly policies. One participant indicated, *"I wish in my workplace, it didn't have to get to the point where I felt that I had to quit my job"* (CE3). Supporting this pattern, one CE who was unemployed at the time of the interview, but had been employed within the preceding 12 months, said:

"Part of the reason why I'm unemployed is because of...that difficulty in balancing. I was let go of my contract because they did not find me a good fit...what kind of fit is there for caregivers for a role?" (CE5).

Similarly, a CE explained, *"I've had to take leaves when...there's been, like, a very symptomatic time...I left a job at one point, and so I was off work for like two months... I've like hobbled things together"* (CE8).

Altogether, these quotes demonstrate that caregiving adversely affects CEs' employment experiences and highlight the need for greater organizational accommodations.

3.3.2 The Emotional Toll of Caregiving

Participants talked about caregiving as emotionally and psychologically demanding, emphasizing stress, anxiety, emotional exhaustion, and feelings of guilt. One CE caring for a family member with dementia shared, *"The biggest...hardest thing, is the emotional strain of this kind of disease...there's stress on you all the time, and I think that's been the hardest part"* (P1). Another CE illuminated the pressure of simultaneously managing work, business responsibilities, and caregiving, explaining, *"There's some days,*

weeks, months where my mental health is negatively impacted because there's so much pressure" (P2). Capturing this emotional toll, another interviewee stated, *"I don't feel psychologically safe... I'll get a call that my daughter has had a seizure. And the first time I got a call of that, I just, I was like in a freeze state"* (CE5). Hence, these quotes reveal that caregiving exerts a pervasive emotional burden on CEs.

3.3.3 Financial and Social Consequences

Participants spoke about financial pressures associated with caregiving, including out-of-pocket costs and concerns about long-term financial security. One participant reflected on the impact of caregiving on retirement planning, stating:

"We're in the years that we really need to make as much money as we can so that we can retire eventually, and so the stress... the financial stress of not being able to, like, make the money that we should be at this time" (P1).

Another participant reported, *"I'm kind of in the worst income bracket because we're not, we're not rich, like we don't have any family money... my biggest, like, all-day, every-day stress is money"* (CE8). Participants also described social consequences of caregiving such as strained or reduced social networks. One participant recounted the limited availability of others to share caregiving responsibilities, noting, *"Our siblings... they have their own jobs, and their own kids, and their own lives. So, their availability is kind of limited as well"* (CE6). Another interviewee conveyed:

"I wish sometimes that people would just check in on us and ask, like, if there's anything we need... we have nieces and nephews... and they'll sometimes play with her...but it's also more like, you know, reactive than proactive" (CE5).

Henceforth, caregiving shaped participants' economic security and social lives, creating additional pressures beyond their everyday caregiving roles.

3.4 Results from CEs' Dataset: Envisioning Accessible and Worthwhile SP Supports

3.4.1 Meaningful SP Interventions

CEs revealed that SP interventions should reflect caregivers' individual interests, preferences, and circumstances rather than adopting one standardized approach. Interviewees suggested including exercise groups, music therapy, reading groups, art therapy, gardening, pet therapy, and other recreational programs that foster caregiver connectedness. As an interviewee articulated:

"It [intervention] needs to be individualized and unique....so maybe it's music therapy, maybe it's pet therapy, maybe it's, you know, gardening, maybe it's Tai Chi, like, it could be many different things" (CE2).

Aligned with this perspective, another participant said, *"We want it [intervention] to be person-centered...so whether that's yoga or art or music or whatever, I think that part is highly individual"* (CE8).

One more CE expressed:

"I think anything that allows you to kind of leave the house, go to a new space, and just really be able to enjoy an activity with other people... that's kind of key to kind of recharging yourself and kind of repairing that mental health aspect" (CE1).

Therefore, these quotes indicate that participants envision SP interventions as flexible and meaningful for caregivers' diverse needs and interests.

3.4.2 Barriers to Participation in SP

Interviewees identified barriers to participating in an SP intervention such as time constraints, transportation, financial costs, work conflicts, and difficulty securing alternative caregiving supports. One CE echoed, *"Cost is, is potentially a barrier...location and sort of just working it into the regular routine of our, of our day, you know, finding the time... finding caregiving support" (CE4).* Another interviewee said,

"If I'm going to go on a nature walk, you know, or my wife is going to go on a nature walk, then ...who's going to handle [care-recipient] while we're doing that? And if we do it during the workday, well, then how do we get the time?" (CE6).

One more CE declared, *"There could be some transportation barriers... like convenient location from my home... as long as there's no conflict with timing" (CE5).* Together, these quotes suggest that reducing practical barriers will be essential to supporting participation in SP interventions among CEs.

3.4.3 Delivery Features Reflecting Caregivers' Realities

CEs discussed delivery features they believed would enhance the accessibility of SP interventions. These included flexible scheduling (e.g., evening or weekend sessions) and opportunities to include care recipients in programming. While virtual delivery via Zoom was considered a feasible option, participants emphasized the importance of offering in-person programming. One CE mentioned, *"It would be better if it was Zoom. But with that being said, I think one of my biggest kind of things is that sometimes I do really just want to step out of the house" (CE1).* Another participant stated, *"I would probably be more likely to take part in something that was in an evening... a weekend evening would be okay too" (CE3).* One more participant added:

"The ones that we've had the most success with, I think, are when the event is in person, but they provide...child care, or, you know, respite care... it's really nice if that service is provided at the event" (CE6).

All in all, these quotations highlight the need for SP interventions to be designed with caregiver accessibility in mind.

3.5 Results from Employers' Dataset

3.5.1 Balancing Well-being with Work Demands

Employers described supporting CEs within the context of maintaining organizational performance. While employers recognized the challenges faced by CEs, accommodations were generally discussed as mechanisms to help caregivers continue to meet professional expectations rather than to reduce those expectations. As one employer explained:

"It's hard to face that you're spread too thin and not able to focus your time and energy constraints to work. And so you endeavour that you ask for an accommodation...we offer accommodations, but that's with the expectation that people can still deliver work to the same extent possible." (E1)

Another employer similarly mentioned:

"If thinking long term with an employee, it's like, this is someone that is going to be with us for maybe a long time. And this is a stage of their life, right? We want to be able to support them through, and maybe it will help them even perform better right? Like if they're able to balance things in a way that works for them." (E2)

One more employer went on to explain:

"From an employer perspective, trusting your employee to manage their workload responsibilities, I think, is a big thing...There's only so much that you can plan for, but as much as you can, trying to plan around managing time and deliverables" (E3)

Overall, employers described balancing professional responsibilities with efforts to support CEs as they juggle caregiving.

3.5.2 Communication/Disclosure as a Gateway to Support

Employers identified ongoing communication between employees and supervisors as central to providing support. Participants described conversations as the primary mechanism for communicating caregiving needs and initiating appropriate accommodations. One employer expressed, *"There's not a formalized process, they [CEs] have a conversation with me. And then I direct and support them to that paperwork" (E2)*. Another employer backed up this notion and said:

"Most accommodations can be handled by conversation between the manager and the employee...some people are very private, and they don't disclose or talk about it, nor do we expect them to. But, you know, that in turn limits kind of our ability to take that extra step and based on specifically their needs or their situation" (E1).

Another employer added:

"Being transparent is important. It can be awkward to say, I'm a caregiver, but being transparent, it lets the folks you work with know where you're at, which I think is important, and then it really helps to normalize being a caregiver...so really, I think employees need to ask for help before that burnout occurs" (E3).

These quotations suggest that employers viewed open dialogue as a vital step in identifying caregiving needs and facilitating access to available work-setting supports.

3.5.3 Flexibility as the Primary Support Mechanism

Employers described flexibility as the primary strategy for supporting CEs. In place of standardized organizational policies, employers commonly provided informal arrangements like flexible work hours, hybrid or remote work, and modified schedules. One employer revealed adapting work arrangements for an employee whose partner required a transplant:

"We were saying, let's work around this, how can we manage this? So we gave her the resources, the computers, the phones, whatever, to be able to do the work wherever she was...we switched around our meets in-person... we did that for her, so she didn't have to go off on EI. We just did a workaround" (E6).

Another employer shared: *"We endeavor as much as possible for accommodations to be informal... so flexible hours and flexible schedules are the other thing that at least formally this organization has" (E1).* Correspondingly, one more employer conveyed:

"We definitely accommodate people to work in hybrid settings, work flexibly to meet the needs. Let's say you need to support a parent with the morning routine right...then we just shift hours a different way" (E2).

Thus, employers described flexible and individualized employment arrangements as the main mechanism for accommodating CEs.

3.5.4 Workplace Supports can be Extended via Social Prescribing

Employers viewed SP as a potential extension of organizational supports, facilitating connections to community-based resources. Participants established that CEs experience significant time constraints, which should be considered when designing and implementing SP initiatives. One employer declared:

"Working caregivers are starved for time... employers need to give employees the time...take a walk, go to a book club, go to meditation, go to yoga.. a paid 30 minutes just to focus on their wellness. And they can squeeze that in during their working day" (E1).

One more employer added:

"Mindfulness training... in workplaces, it could be art in workplaces... I always think anything that you can do to reduce the stress on the caregiver at work so that, they can get work done without all of that added stress" (P1).

Another employer asserted:

"I'm thinking from an entrepreneur perspective, but even an employee who works, remotely, where they could... go to like a co-working space, oh my god, that would be amazing. Where they could go to get out of

their space to work occasionally?...I feel like that... would be HUGE" (P2).

Therefore, these quotes distinguish that employers viewed SP as a crucial extension of occupational support that could promote caregiver well-being.

3.6 Results from the Co-Design Workshop

3.6.1 Lived Experiences of CEs

Workshop participants reported balancing paid employment and unpaid caregiving as intensive, emotionally taxing, and structurally unsupported. Caregiving was characterized as a "*delicate balancing act*," with participants describing experiences of burnout, stress, exhaustion, overwhelm, and ongoing time pressure. Discussants also conveyed feelings of guilt and being "*pulled*" in multiple directions while trying to meet work and caregiving responsibilities. Workshop attendees further recounted the hidden challenges of caregiving, such as stigma and uncertainty about disclosing their caregiving role to employers. Participants additionally accentuated broader system-level challenges, depicting CEs as "*holding up broken systems*" and navigating "*system limitations*."

3.6.2 Core Barriers Experienced by CEs

Participants identified financial constraints as the greatest barrier experienced by CEs, followed by employer-related factors (e.g., inflexibility, lack of awareness), family dynamics, awareness of available resources, care recipient conditions, and administrative burden. Discussants elaborated on these priorities across three interconnected domains. Structural barriers included fragmented systems, difficulties navigating available supports, and limited respite services. Worksite barriers revolved around stigma and bias, limited psychological safety, concerns about being perceived as less committed employees, and a lack of organizational accommodations and advocacy. Participants also noted social and relational barriers such as isolation, limited community support, gendered expectations surrounding caregiving, and misconceptions regarding who qualifies as a caregiver.

3.6.3 Consequences of Barriers on CEs

Workshop attendees shed light on the identified barriers as producing long-term effects. Specifically, career disruptions encompassed leaving the workforce, transitioning to lower-paying positions, and missing opportunities for career advancement. Participants went on to discuss psychosocial impacts such as isolation from peers and community, as well as changing and, at times, strained family relationships. Chronic time scarcity emerged as a recurring issue, with participants stating the continuous challenge of managing their dual roles. Discussions affirmed that caregiving responsibilities are layered among children, parents, and other family members, making caregiving highly unpredictable, with participants noting that "*every day is different*."

3.6.4 Solutions and Opportunities for Social Prescribing Design

Attendees emphasized the need for a centralized navigation system that would serve as a single-entry point where CEs could complete an intake based on their individual needs and be connected to tailored services, programs, financial supports, and community resources organized around the social determinants of health. To improve accessibility, participants proposed a distributed network of link workers embedded across healthcare, employment spaces, community organizations, libraries, schools, pharmacies, local businesses, faith-based workplaces, and existing services, with both community-based and virtual access points supported by digital tools, including AI-assisted navigation and chat functions.

Discussants also reinforced that SP programs should extend beyond referral by incorporating follow-up and continuity of care. Suggested approaches included maintaining a live file for each participant, monitoring service use, and identifying unmet needs over time. Integrating employment settings was identified as another key design priority, as participants recommended employer-led programs that provide conversation tools, workshops, and structured pathways to discuss caregiving needs with supervisors, while positioning caregiving as part of broader employee wellness initiatives. Across all proposed solutions, participants emphasized the importance of reducing stigma, shame, and isolation by creating supportive environments that proactively offer assistance, normalize caregiving within organizations and communities, and increase awareness of social prescribing through greater public visibility and outreach.

4. DISCUSSION & CONCLUSION

This study integrated the perspectives of CEs, employers, and other stakeholders such as service providers, community organization representatives, healthcare providers and researchers to help inform the future development of a co-designed SP intervention for CEs. The findings are discussed in order of their prominence and relevance across the datasets, beginning with the most crucial overarching and cross-cutting findings and progressing to more specific intervention-design considerations. The results of this research demonstrate that caregiving is configured by intersecting individual, organizational, and systemic factors. Participants delineated caregiving as a multifaceted form of labour that results in occupational, emotional, social, and financial consequences. While the adverse impacts of caregiving on mental health and employment have been previously documented, this study extends existing knowledge by showcasing how these challenges converge across systems and by identifying features of SP interventions that may respond to the needs of CEs.^{6, 35–37}

Across all three datasets, the influence of time scarcity on CEs' experiences and their ability to access support was highly prevalent. CEs communicated that caregiving is time-consuming, while workshop participants identified chronic time scarcity as both a consequence of caregiving and a barrier to accessing formal supports. Employers likewise recognized that CEs were starved for time and affirmed that the success of SP initiatives would depend on providing employees with protected time to participate. These findings align with scholarship detailing time poverty as a defining feature of unpaid caregiving, while expanding the literature by demonstrating that time constraints also influence the

feasibility of interventions intended to support CEs.^{38,39} For this population, time should therefore be considered a core intervention-design principle, and not just a barrier to participation. An SP pathway that requires CEs to repeatedly seek out services, coordinate referrals, or attend appointments may inadvertently add to the organizational and time demands that caregivers already experience. Designing SP to minimize these demands through streamlined access, flexible delivery, coordinated referrals, and continuity of support may reduce the time and effort required for CEs to engage with services. In this context, the value of SP may depend on the resources to which CEs are connected, and also on how efficiently and flexibly those connections can be made within the realities of unpaid caregivers.

A particularly noteworthy finding herein is the convergence across stakeholder groups regarding the unpredictable nature of caregiving. CEs reported that care demands fluctuate according to changing health conditions; employers acknowledged that caregiving needs emerge unexpectedly, and workshop discussants repeatedly characterized caregiving as difficult to predict. These results echo research by Hailu et al.⁴⁰ and Yong et al.⁴¹, which supports that caregiving is dynamic and that care responsibilities change over time.

The employer findings provide critical insight into how organizations recognize support for CEs. Employers viewed flexible work arrangements, modified schedules, and other informal accommodations as the primary means of supporting caregivers, consistent with evidence that flexibility in work settings can reduce work-family conflict and improve caregiver retention.^{42,43} Nonetheless, when considered alongside the experiences of CEs and workshop participants, flexibility emerged as necessary but insufficient. Although flexible work arrangements helped CEs in this research remain employed, they did not address broader organizational challenges, including limited caregiver awareness and the absence of formal caregiver-inclusive policies.

The findings further illustrate that caregiver-friendly organizations require supportive cultures in addition to flexible work arrangements. Employers considered disclosure as the main pathway for accommodations, whereas CEs described disclosure as a difficult decision influenced by concerns regarding stigma, career progression, and psychological safety. This divergence suggests that although disclosure is a personal decision for each CE, it can influence the extent to which employment supports are accessible. These results are comparable to earlier scholarly work showing that caregivers may be reluctant to disclose their caregiving responsibilities because of concerns about stigma in professional environments and being perceived as less committed employees, despite disclosure often being necessary to access caregiver-friendly arrangements.⁴⁴

This study showcases that caregiver burden is understood as a systems-level challenge. Mirroring previous research that associates unpaid caregiving with physical exhaustion, financial strain, and social isolation, participants emphasized that much of this burden arose from navigating fragmented health and social systems.^{45,46} Across the workshop and CE interviews, caregiving extended beyond direct care to include coordinating healthcare, managing finances, arranging transportation, navigating services, and advocating for care recipients while simultaneously trying to fulfill employment obligations. These

results are backed by published research, which showcases that unpaid care encompasses organizational, emotional, and administrative responsibilities.⁴⁷

In addition, this research better situates SP for CEs. Traditional SP models have focused on linking individuals from primary care to community resources.⁴⁸ However, workshop participants envisioned SP as a coordinated model that provides ongoing navigation, individualized guidance, and continuity of support across healthcare, work, and community settings. Participants also positioned employment sites as important partners in facilitating access to SP. By integrating organizations and positioning navigation as a core component of SP programs, these findings highlight the value of cross-sector collaboration in supporting CEs.

Participants signified that SP initiatives should be individualized, and that programs should be targeted to CEs' interests and circumstances. This finding aligns with the person-centered philosophy underpinning SP, which advocates connecting individuals with activities that are personally meaningful.^{49,50} However, participants broadened this principle by identifying a diverse range of interventions, including exercise groups, nature walks, gardening, Tai Chi, art and music therapy, pet therapy, and reading groups, emphasizing that no single activity would meet the needs of all caregivers. Instead, these activities were valued for promoting respite, social connection, and psychological well-being.

The findings further present that the effectiveness of SP depends on its accessibility. Simpson et al.⁵¹ & Sadio et al.⁵² have discussed barriers such as the urban concentration of services, transportation challenges, and service availability as prominent implementation considerations. Likewise, participants in this study spoke of time constraints, work commitments, transportation, financial costs, and limited respite as key barriers to participation in SP interventions. Therefore, these results enrich prior knowledge by distinguishing that accessibility should be considered a vital design feature of SP programs for CEs.

Overall, the findings of this study provide practical guidance for the co-design of a future SP intervention geared to the needs of CEs. Such an intervention should be person-centered, flexible, and responsive to the unpredictable nature of caregiving while recognizing that CEs navigate interconnected healthcare and community systems. Core design features should include tailored navigation, accessible and diverse referral pathways, ongoing follow-up, and employer partnerships that support communication, individualized accommodations, and participation without compromising employment responsibilities. SP interventions should also be designed to address practical barriers such as time constraints, transportation, financial costs, limited respite, and work demands while fostering opportunities for social connection, normalization of caregiving, and sustained engagement. These elements provide a foundation for developing and evaluating scalable SP interventions that improve accessibility, uptake, and long-term participation among CEs.

The scope of this research includes some limitations. Firstly, this research was conducted within a single Canadian city (Hamilton). Consequently, the findings reflect experiences situated within one geographical area and may not fully represent the experiences of CEs and employers in other Canadian provinces, rural settings, or jurisdictions with different healthcare systems, employment legislation, and caregiver supports. Nevertheless, qualitative research seeks to generate rich contextual understanding rather than statistical generalizability, and the inclusion of diverse stakeholder groups provides valuable insights that may inform intervention development in comparable contexts.⁵³ Second, although recruitment efforts sought to include participants from broad racial and ethnic backgrounds, most CEs and employers identified as White, limiting the representation of culturally and racially diverse perspectives. As such, the experiences of caregivers from racialized and ethnically diverse communities may be underrepresented. It is also important to note that the employer sample primarily consisted of individuals from smaller organizations, including self-employed employers, which may limit the applicability of these findings to larger organizations with more complex human resource structures. Finally, the sample did not include participants who identified as gender diverse, limiting understanding of how caregiving experiences and support needs may differ across gender identities.

Despite these limitations, there are multiple important implications of this research. From an organizational perspective, there needs to be a shift towards formal caregiver-inclusive strategies. For instance, developing clearer accommodation pathways, educating managers about caregiving responsibilities, strengthening leave provisions, and integrating caregiving considerations into organizational well-being initiatives. Normalizing caregiving within organizational policies may reduce stigma, encourage earlier disclosure, and support employee retention. Further, healthcare systems and community organizations should prioritize integrated approaches that improve coordination across services and reduce caregiver navigation demands. Enhancing partnerships among healthcare providers, community agencies, and SP providers may facilitate more seamless access to accommodations for CEs. At the policy level, caregiver support should be positioned as a cross-sector priority involving health systems, labour policies, and social infrastructure. Policy initiatives should consider expanding caregiver-inclusive employment standards, investing in navigation and respite services, and improving visibility of available resources. While these macro policy implications outline the required infrastructure needed to sustain effective SP for CEs and can be restructured through the development of SP programs, this does not imply that SP can alone mitigate the enabling conditions of poor support for CEs. Rather, this suggests that broader structural changes related to carer-inclusive workplace policies (e.g., leaves, flexible employment, job sharing) are needed to effectively respond to the needs of CEs that can be addressed through SP.

Moreover, future research should examine the experiences of CEs across more diverse geographical, cultural, racial, and gender groups to better understand how caregiving support needs vary across populations. Comparative research across provinces and organizational contexts would further advance understanding of how policy environments influence CEs' experiences and needs. Lastly, researchers should recruit a broader range of employers across industries, company sizes, and sectors to better

understand organizational readiness, perceived barriers, and facilitators to implementing caregiver-inclusive practices and integrating SP within workforce settings.

In conclusion, as caregiving continues to increase alongside Canada’s aging population, developing accessible, caregiver-informed interventions will be central to promoting caregiver well-being, bolstering workforce participation, and building more equitable and compassionate health and social systems. By informing the co-design of SP interventions, this research lays out the groundwork for scalable models of support that recognize CEs as a public health and workforce priority.

Abbreviations

- CEs
- Carer-employees
- CISP
- Canadian Institute for Social Prescribing
- EI
- Employment Insurance
- SP
- Social prescribing

Declarations

Declarations

Ethics approval and consent to participate:

ethical approval for this study was obtained from the McMaster Research Ethics Board (MREB; Project #8113). All participants provided informed consent to participate in the study. All research activities were conducted in accordance with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2, 2022), ensuring respect for persons, concern for welfare, and justice throughout the research process.

Consent for publication:

Not applicable. No individual participant data or identifiable information are presented in this manuscript.

Competing interests:

The authors declare that they have no competing interests.

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Author Contribution

AW contributed to the conceptualization of the study, writing, supervision, funding acquisition, and critical review and feedback on the manuscript. RS contributed to the writing, composition, revision, and development of the manuscript. ZK contributed to writing and revision of the manuscript. BC contributed to critical review, writing, revision, and feedback on the manuscript. SNS contributed to critical review and feedback on the manuscript. KM contributed to critical review and feedback on the manuscript. WF contributed to critical review and feedback on the manuscript. All authors reviewed and approved the final manuscript.

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Data Availability

Data is protected under MREB # 8113 due to confidentiality of participants.

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Figures

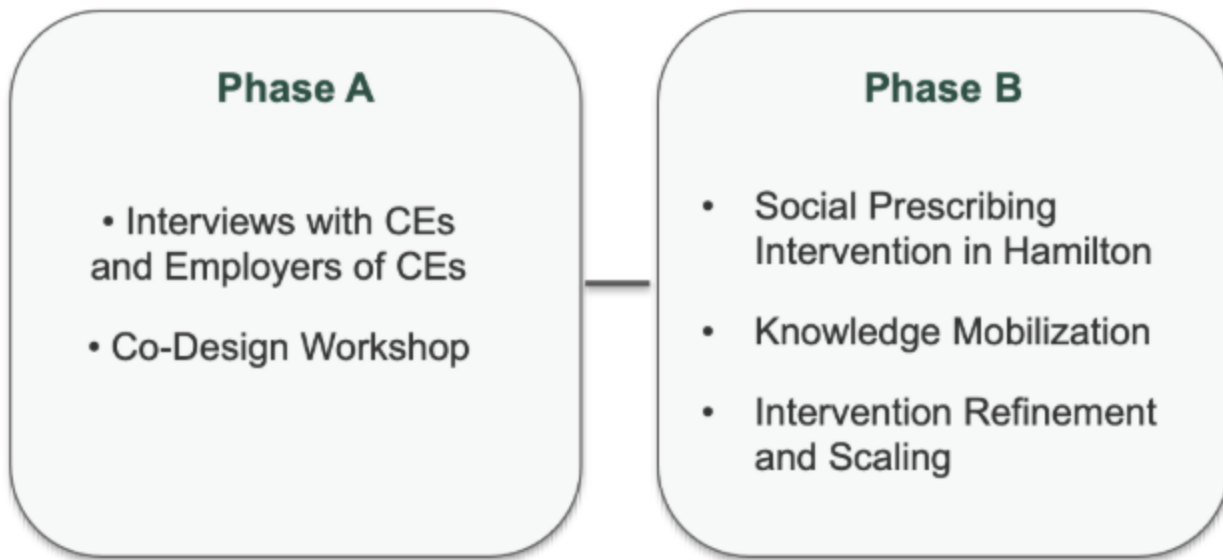


Figure 1

Overview of Study Phases