Journal of Integrated Care

Social prescribing with link worker for dementia: a scoping review

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Received 4 April 2025
Revised 16 November 2025
Accepted 3 February 2026

Abstract

Purpose – Social prescribing supports people with complex needs to improve social, physical and mental well-being. While dementia is mentioned in UK social prescribing policy documents, there is no implementation guidance. People with dementia have complex health and social care needs, and support is available from community-based initiatives (third sector). Many people may struggle to access support, and social prescribing could have a role in bridging this gap. Evidence is needed to demonstrate benefits and identify additional training for link workers to address specific needs of people with dementia.

Design/methodology/approach – A systematic search was conducted of four academic databases and grey literature. Inclusion criteria included description of link worker and person-centred care planning.

Findings – 126 articles were identified and screened, leading to the selection of 6 articles. Quality appraisal found variable quality of reporting, with study types including survey, qualitative and mixed methods. Our analytic framework was derived from an international consensus study of social prescribing. Each theme was evidenced in our selected studies: referral route, link worker, person-centred care plan and access to resources. Evidence was limited on the role played by link workers. We noted an absence of discussion of how dementia-related impairments may require special training for link workers or additional resources.

Originality/value – In this first review of social prescribing for dementia, we found only a small number of studies. Our analysis has identified gaps in knowledge about social prescribing and, in particular, whether modifications are required in order to provide optimal support for people with dementia.

Keywords Social prescribing, Link worker, Community referral, Well-being coordinator, Social well-being, Dementia, Alzheimer's disease, Cognitive impairment, Neurodegenerative disease

Paper type Literature review

Plain language summary

Social prescribing has been described as a way to support people with "non-medical" health and well-being needs. A link worker supports the individual to access activities and resources in the community. We searched for publications about social prescribing for people with dementia. After searching four academic databases and also using web search engines, we found only six studies that describe people with dementia being supported by a link worker. The study types varied, including interviews with link workers and programme evaluations.

We summarised the studies using the following themes: how the individual was referred to the service, description of the link worker, development of a care plan to suit the individual and access to activities or social groups that meet the individual's needs and preferences. We identified further issues or variations which included the length of time that an individual could be supported by the service and the training or level of expertise of the link worker.

Journal of Integrated Care
Emerald Publishing Limited
e-ISSN: 2042-8685
p-ISSN: 1476-9018
DOI 10.1108/JICA-04-2025-0029

This review has highlighted the limited evidence on applying social prescribing to a particular group of people (people with dementia). We have summarised gaps in evidence about how services accommodate the specific impairments common to dementia. This summary of international evidence can help to plan services and also indicate where further research is required.

Introduction

Social prescribing can be described as a means of linking individuals from primary care to community resources (Calderón-Larrañaga *et al*., 2021). This is achieved with the help of a link worker, a lay health worker who can provide a vital connection between patient and service to ensure that support and care are appropriate and received promptly. This may range from helping patients gain access to exercise programmes or receive cooking classes, together with emotional support and assisting in decision-making (Husk *et al*., 2020; Calderón-Larrañaga *et al*., 2021). In particular, the link worker aims to specifically tailor their approach to the individual. This includes ongoing follow-up: it is not just providing the activity but the continued support that is a key component of social prescribing (Husk *et al*., 2020). The link worker role features in most, but not all, models of social prescribin, and a variety of staff or volunteers can take this role (World Health Organization Western Pacific Region, 2022). Thus, the non-medical or psychosocial needs of patients, which influence physical and/or mental health, may be identified and addressed (Tierney *et al*., 2020).

In the UK, social prescribing has become a fundamental component of the National Health Service (NHS) Long-Term Plan, with the provision of funding and resources having been allocated to support the integration of link workers across the nation. This is with a view to enhance personalised care, improve patient-valued outcomes and help reduce demand upon the markedly strained health system (Office for Health Improvement, 2022; Buck and Ewbank, 2020). Guidance in Canada also recommends social prescribing for older people (Canadian Institute for Social Prescribing, 2025).

The value and uptake of social prescribing has led to international interest, with more than 17 countries outside of the UK having implemented processes and/or link-type workers (Muhl *et al*., 2022). International uptake of social prescribing prompted a consensus study to establish a common understanding through the development of a framework for social prescribing. The framework consists of the following: referral route into the service, link worker, person-centred care plan and access to resources (Muhl *et al*., 2022). The link worker was deemed to be critical to guide optimal social prescribing across varied contexts and settings (Muhl *et al*., 2022). The lack of a standardised definition of social prescribing has been a weakness of previous reviews, and we have incorporated this consensus framework as a tool throughout our method. Social prescribing aims to improve individual well-being and autonomy while reducing health inequalities and health service costs (Morse *et al*., 2022).

Systematic reviews of social prescribing have covered mental health and physical health (Cooper *et al*., 2022; Husk *et al*., 2020). The review of social prescribing for mental health (Cooper *et al*., 2022) showed that 16 out of 17 studies reported statistically significant improvements in symptoms, well-being, quality of life and physical health outcomes. In an earlier review of similar systematic design, Napierala *et al*. (2021) also found that social prescribing was associated with varied improvements or positive outcomes in individuals with both mental health and physical health problems.

Globally, dementia affects more than 57 million people and contributes to 1.6 million deaths each year, with over 25 million disability-adjusted life years per annum (Li *et al*., 2022). Dementia prevalence in the UK is currently estimated as 900,000 and projected to rise to 1.6 million by 2040, due primarily to an ageing population. The disease accounts for excess disability and almost £35 billion in health and social care costs per year (Alzheimer's Society, 2022). In the UK, dementia is the second leading cause of disability-adjusted life years and represents a substantial 80% increase since the 1990s (Public Health England, 2014).

Life years lost to disability are an important measure of morbidity, particularly as this tends to associate with unmet needs. Unmet needs span across the biological, psychological and social domains of the biopsychosocial model or, in other words, person-centred care (Iliffe and Manthorpe, 2017).

The unmet needs of people with dementia include daytime activities, company and psychological distress. This may be due to a lack of awareness of community services and/or these provisions not matching the wishes of the individual (Janssen *et al*., 2020). Therefore, this offers potential for social prescribing to resolve an extensive and burdensome issue. For example, the results of a European multi-centre study comprising over 447 community-dwelling patients with dementia demonstrated that the prevalence of unmet needs exceeded 15% (Janssen *et al*., 2020). Notably, other research has shown that the rate of unmet needs of patients with dementia can be much higher, with a prevalence of 45–75% of one or more unmet needs (Minyo and Judge, 2022). This highlights deficits with provision of dementia care in the community setting and may indicate problems with integration of care across several providers (considering physical, mental and social aspects of care needs).

Delineating the needs of people with dementia, the Lancet Commission places great importance on both physical and mental health through social care and support. However, there is no clear guidance on how this may be implemented (Livingston *et al*., 2020). While many policy documents about social prescribing mention dementia as one condition that should benefit, there is little evidence that people with dementia are being supported by social prescribing currently (in the UK or elsewhere). Social prescribing relies on aspects of self-management or self-care, for example, where an individual is expected to control their own care plan and to take initiative in carrying out activities related to this plan. The impairments caused by dementia may be problematic for self-management – for example, cognition, memory and motivation (Baber *et al*., 2021).

A number of studies have explored the impact of targeting isolated unmet needs; for example, Camic *et al*. (2021) explored the impact of a heritage and arts-based intervention upon people with dementia and found some improvements in well-being scores; however, these failed to reach statistical significance relative to baseline. In a review of befriending interventions, Siette *et al*. (2017) conducted a meta-analysis and found significant improvements in patient-valued outcomes but no significant benefits upon quality of life, loneliness, self-confidence or general well-being. These studies describe social interventions; however, the intervention does not include a link worker or person-centred care plan and therefore should not be considered social prescribing. A study of implementation of social prescribing for dementia found many challenges, and there was no evidence presented about how many people with dementia actually accessed the service (Baker and Irving, 2016). Our assessment of the state of evidence on social prescribing for dementia was that it was at an early or formative stage, and therefore, a scoping review would be the best-suited method (Tricco *et al*., 2018; Arksey and O'Malley, 2005).

Our aim was to review the research on social prescribing for dementia, particularly because dementia is mentioned in social prescribing policy documents. Our starting assumption was that additional considerations or accommodations would be required to optimise social prescribing for people with dementia. Thus, we sought to conduct a systematic search and conduct a scoping review to consider the following research questions:

(1) Is there evidence that social prescribing has been used to support people with dementia?

(2) Is there evidence of gaps in provision – evidence that people with dementia are being excluded from social prescribing?

(3) How does social prescribing meet the complex needs of people with dementia?

We will apply common understanding of the social prescribing framework, as developed by Muhl *et al*. (2022), to address these questions with a narrative analysis of included studies.

Recent research and reviews have stated that the link worker (or similar role) is key to the concept or definition of social prescribing (see international review (Sonke *et al*., 2023)). Other models of social prescribing such as "signposting" or "direct referral" are also described (Husk *et al*., 2020); however, we decided that the scope of this review would be social prescribing with a link worker.

Method

Literature sources

A systematic search strategy was developed to identify relevant literature and ensure comprehensive coverage. Core search terms for the key concepts "social prescribing" were combined using the Boolean operator "AND" with core search terms for dementia. The following electronic databases were accessed: MEDLINE (1996–2023), EMBASE (1974–2023), CINAHL (1995–2023) and PsycINFO (2012–2023) (searches were conducted 14/06/2023 and updated 20/12/2024). The search strategies are shown in Table 1. We also searched systematic review databases and grey literature or expert stakeholder databases.

Selection of studies

A two-stage screening process was used. For the initial stage, the titles and abstracts were independently screened by two review authors. Abstracts that were deemed to be relevant were advanced to the second stage. Two review authors independently screened the full-text versions of potentially eligible studies for inclusion. Search results were imported into Endnote and deduplicated. Disagreements were resolved through discussion or consulting with a third review author. The process of study selection was recorded in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram.

Eligibility criteria

We applied the framework used in systematic reviews: patient, intervention, comparator, outcome and study design (PICOS); however, for this scoping review, we did not specify a comparator or outcome for inclusion or exclusion criteria:

Inclusion. Patient: studies involving people with dementia or mild cognitive impairment, studies where dementia is included with other conditions and studies involving carers of those with dementia.

Intervention: studies involve social prescribing with a link worker (or equivalent).

Study design: all quantitative and qualitative empirical studies. Furthermore, any pilot studies and protocol reports were also considered for inclusion.

Exclusion. Patient: We excluded alcohol-related dementia and learning-disability-related dementia from the scope. These groups follow distinct care pathways (addiction/dual-

Table 1. Search terms used in database searches

Search line	Search terms
1	(social prescri* or link work*).mp
2	(social prescri* or community referral).mp
3	(social prescri* or community referral or non-medical referral).mp
4	(social prescri* and primary health care).mp
5	(social prescri* and primary care).mp
6	(social prescri* or community referral or referral scheme).mp
7	(social prescri* or well-being coordinator)
8	(social prescri* or community connector)
9	(social prescri* or well-being coach)
10	1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 AND Dementia (exp)

diagnosis services; specialist LD teams), have different support needs and safeguarding considerations and use different outcome frameworks. Including them would have introduced substantial heterogeneity beyond our focus on social prescribing within mainstream primary care/memory-service pathways.

Intervention: creative or social interventions that do not include link worker (or similar role); interventions designed to reduce the onset of dementia (i.e. preventative).

Study design: non-empirical articles, including opinion pieces, editorials and educational.

Results

Our search retrieved 127 articles after deduplication (14/06/2023). Due to developments in this field, we updated the search, and this contributed a further two articles (20/12/2024). Screening of title and abstracts led to the exclusion of 99 articles. Reviewing the full texts, we included 6 articles and excluded 20 articles, see Figure 1. Two articles represented one study, with an interim as well as final evaluation. The majority of articles were excluded because they described a creativity or social activity but did not include the role of the link worker or it didn't involve a person-centred assessment or signposting process.

Quality appraisal

Table 2 provides a summary of the six articles selected for this review; the methodological quality of research was variable. The mixed-methods evaluation of the green social prescribing programme has been conducted at a national scale with an academic team and was published as a government report rather than an academic peer-reviewed article (Haywood *et al*. 2022, 2024). Of the remaining studies, the designs included a cross-sectional study (Giebel *et al*., 2021), a survey (Tucker *et al*., 2014) and two qualitative studies (Boughtwood *et al*., 2011; Di Lorito *et al*., 2025). There was marked inter-study heterogeneity across these seven studies, limiting comparisons of outcomes.

Findings are summarised according to the three review objectives: (1) use of social prescribing for people with dementia; (2) gaps in provision and evidence of exclusion and (3) how social prescribing meets the complex needs of people with dementia.

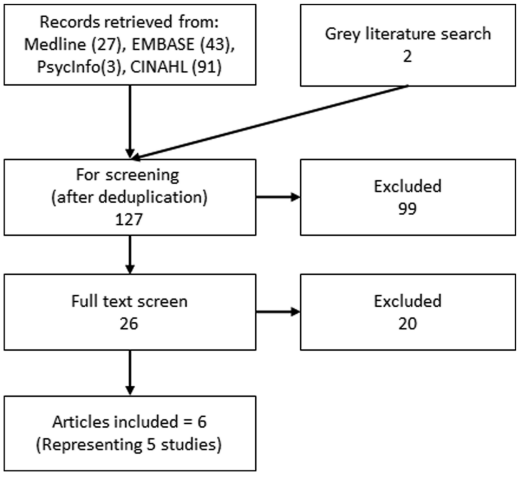

Figure 1. PRISMA flow diagram

Table 2. Summary description of studies

Date	First author	Study type	Recruitment, setting	Participants/ services	Intervention	Outcome
2011	Boughtwood	Qualitative	Dementia-specific healthcare	6	Link worker to access care services	Addressing stigma and fear of services
2014	Tucker	Survey of services	Community mental health teams	376 services	Outreach	Coordination with GPs, support and training for care home staff
2021	Giebel	Cross-sectional	Local community	36	Weekly social activities	Short Warwick–Edinburgh mental well-being scale for people with dementia and carers (combined)
2022	Haywood (interim report)	Mixed methods	Local community, 7 sites	943 link workers (not dementia specific)	Link worker enabling outdoor activities	Improvements in well-being, not dementia specific
2024	Haywood (final evaluation)	Mixed methods	Local community, 7 sites	8,339 people with mental health needs	Link worker enabling outdoor activities	No reporting of number of participants with dementia, or outcomes for this group specifically
2025	Di Lorito	Qualitative	National recruitment	24 social prescribers	Social prescribing	Qualitative interviews with social prescribers

Objective 1 – use of social prescribing to support people with dementia

Reported outcomes focused mainly on well-being or service coordination rather than clinical measures. Only one study described changes in well-being scores (Giebel *et al*., 2021), while others provided qualitative or process-based outcomes such as improved access to care or reduced stigma (Boughtwood *et al*., 2011; Tucker *et al*., 2014). None of the studies included standardised dementia-related or cognitive outcome measures.

Applying the international consensus study (Muhl *et al*., 2022) as a framework, we analysed evidence on the basis of whether interventions reported the following: referral route into the service, link worker, person-centred care plan and access to resources. Table 3 shows that evidence from across included studies was supportive of social prescribing for dementia, but there was a lack of evidence relating to an intervention which was fully consistent with the consensus definition. Two articles described interventions, which were not fully consistent with the consensus definition, describing a navigator role to improve access to health services (Boughtwood *et al*., 2011; Tucker *et al*., 2014).

Objective 2 – gaps in provision and evidence of exclusion

Two studies gave evidence of referral routes, with referrals being from a GP, self-referral and referrals from other services (e.g. memory clinic) (Giebel *et al*., 2021; Haywood *et al*., 2022, 2024). In the latter programme, the green social prescribing self-referral occurred more frequently than GP referral. However, this relates to all participants, and while dementia was prioritised within the programme aims, unfortunately, the evaluation did not collect data on how many participants had dementia (Haywood *et al*., 2024). In an interview study with social prescribers across many different services in England, they reported various referral routes and

Table 3. Analysis of included articles according to the framework from international consensus of social prescribing

Framework theme →	Boughtwood *et al.* (2011)	Tucker *et al.* (2014)	Giebel *et al.* (2021)	Haywood *et al.* (2022)	Haywood *et al.* (2024)	Di Lorito *et al.* (2025)
Referral route	Not stated	Not stated	✓ (GP, memory clinic)	✓ (self-referral, services, GP)	✓ (as 2022, dementia not isolated)	✓ (GP, self-referral)
Link worker role consistent with SP	✗ (health service navigator)	✗ (team outreach)	~ (specialist "dementia navigator")	~ (SP link workers, not dementia-specific)	~ (as 2022)	~ (self-identified SP; mixed roles)
Person-centred care plan	Not stated	✗ (liaison, no plan described)	~ (group sessions; limited personalisation)	~ (some personalisation; high referrals)	~ (as 2022)	✓ (needs identified; co-planning)
Access to resources or activities	Not stated	Not stated	✓ (Tai Chi, low-impact exercise, mindfulness)	✓ (nature-based activities)	✓ (as 2022)	✓ (varied local activities; transport negotiated)

identified differences in quality of information (Di Lorito *et al.*, 2025). Some social prescribers were based with GPs and could access further information from the patient's medical record. Where social prescribers were based in third-sector organisations, details of diagnosis may be limited. A further challenge identified by participants was that, in a first contact phone conversation, a patient may not engage with the service or respond that they "don't need anything" (Di Lorito *et al.*, 2025). This may be a particular problem for people with dementia, either because of lack of recall of the initial referral or due to apathy.

One of the most challenging aspects to summarise is the role of the link worker, where this is often poorly defined and various terms are used. In the study by Giebel *et al.*, this role is termed dementia care navigators (Giebel *et al.*, 2021). This may imply a more specialist role, rather than the generalist role of the social prescribing link worker. Link workers were also described in the green social prescribing programme (Haywood *et al.*, 2024). In the interview study of Di Lorito *et al.*, all participants self-identified as "social prescribers", but the occupation of some participants seems incongruent with this role (e.g. senior public health officer, consultant psychiatrist and head of service) (Di Lorito *et al.*, 2025).

Objective 3 – how social prescribing meets the complex needs of people with dementia

In terms of resources accessed, the study of Giebel *et al.* (2021) demonstrates that weekly sessions using a combination of low-impact exercises, Tai Chi and relaxation techniques are linked to improvements in well-being in patients with dementia over a three- and six-month period. The sample size (36) of the study was moderate, and there was no comparator group; thus, generalisability is limited (Giebel *et al.*, 2021). The evaluation of the national green social prescribing programme described many activities across seven distinct "test and learn" sites, all having some elements of physical activity and experience of greenspace (Haywood *et al.* 2022, 2024). In the interview study of social prescribers, participants reported looking online for evidence base and then giving recommendations to their clients (e.g. "top five" activities); they also mentioned the importance of getting to know local communities and negotiating access, for example, transport (Di Lorito *et al.*, 2025).

This scoping synthesis has identified services which fulfilled the criteria of the consensus definition of social prescribing. However, we have described diversity within the themes of this framework. Two further issues were found to be variable within the interview study of social prescribers: the length of time that social prescribing could continue and the lack of consistency of training of link workers in dementia care. Across the included studies, the needs of people with dementia were not described consistently. Memory problems and low motivation sometimes made engagement difficult (Di Lorito *et al*., 2025). Carer input was mentioned but rarely explained. Most services were time-limited, which sits uneasily with a progressive condition (Giebel *et al*., 2021; Haywood *et al*., 2024). This makes it hard to see how link workers tailor plans, keep people involved and help them use community resources.

Most social prescribing services were time-limited, creating a tension with a progressive, long-term condition. One interviewee argued that providing indefinite support would be a "disservice" because the social prescribing remit is to enable onwards engagement with community assets rather than offer ongoing case management; people could be re-referred if needed (Di Lorito *et al*., 2025). From a dementia perspective, this points to a potential mismatch between service design and the need for sustained support as cognition and motivation decline (Giebel *et al*., 2021; Haywood *et al*., 2024).

Some services described a "dementia champion" within the team of social prescribers, indicating that there was variable knowledge or training for link workers (Di Lorito *et al*., 2025). None of the included studies reported dementia severity or subtype. This limits interpretation of how social prescribing may meet the needs of people at different stages of dementia, or whether certain subtypes, such as Alzheimer's or vascular dementia, are better suited to this approach.

Discussion

From provisional searches, we anticipated a small and formative field of research. With this in mind, we applied a scoping review method with a broad approach to inclusion criteria, and we included grey literature evaluation ($n = 2$) as well as other articles of variable quality ($n = 4$). Considering the formative nature of the field, broad inclusion criteria were justified to give an exploratory summary of the current evidence.

Of the four studies of moderate-quality evidence, only one reported on people with dementia accessing an intervention that was a good fit to the international consensus definition of social prescribing with a link worker (Giebel *et al*., 2021). The interview study of social prescribers from various services across England indicated that people with dementia are accessing social prescribing; in practice, however, it remains unclear how many people are being supported (Di Lorito *et al*., 2025). One study that was excluded from this review reported social prescribing for older people; it did include two participants with cognitive impairment; however, a dementia diagnosis was not reported, nor was the service designed for people with dementia. Thus, it did not meet our inclusion criteria (Kim *et al*., 2021). It is noteworthy that there have been so few publications, considering the high demand for dementia services and that social prescribing has been shown to be effective for patients with mental health problems (Minyo and Judge, 2022; Shiells *et al*., 2020; Kerpershoek *et al*., 2018; Cooper *et al*., 2022).

Among the research analysed, a number of key evidence gaps emerged. First, definitions of link workers have been varied and are lacking standardisation. Secondly, person-centred care was emphasised with importance for optimising dementia outcomes across the literature, but there appeared uncertainty regarding how specific aspects of care and support could be personalised to address these individuals' unmet needs. The analysis of included articles indicates that social prescribing can be accessible and acceptable to people with dementia (objective 1). However, the small number of publications and small sample sizes within studies may imply that social prescribing remains an infrequent service or that there are gaps in services for dementia (objective 2). The internal validity of this scoping review is that the search strategy, selection criteria and analysis followed the themes of the international

consensus study of social prescribing (Muhl *et al*., 2022). However, the small number of studies retrieved by the search limited the depth of the analysis. In regard to external validity, the findings of this review are consistent with previous reviews on social prescribing; for example, Napierala *et al*. (2021) found positive effects on psychosocial well-being and quality of life with participants with mental and physical problems. The level of heterogeneity and poor quality of the evidence has also been noted previously, with two prior reviews identifying this problem (Bickerdike *et al*., 2017; Husk *et al*., 2019). Researching social prescribing may be challenging, and there is little consensus on appropriate outcome measures (Husk *et al*., 2019).

While we anticipated that multiple impairments caused by dementia (Broyles *et al*., 2023) may make the process of social prescribing difficult, only one study reported problems of impaired recall and motivation (Di Lorito *et al*., 2025). We anticipated that impairments in communication and cognition, as well as memory and motivation, could be barriers for the process of social prescribing, but neither stage of dementia nor specific subtypes were described within studies. Some articles described a diversity of resources and activities within the social prescribing intervention and also personalisation (particularly with support from the link worker role) (objective 3). However, we noted a lack of reporting of accommodations for the more challenging symptoms of later-stage dementia. Subtypes of dementia and stage of dementia progression were not reported in any included study, and this may imply that social prescribing is more suited to community-living, mild-moderate dementia rather than late-stage dementia.

The key strength of this review is the scoping design with the use of a systematic method for searching the international literature. The scoping method (Arksey and O'Malley, 2005; Tricco *et al*., 2018) enabled us to capture broader literature, and the systematic search gave confidence in describing gaps in evidence (see Appendix 1 for PRISMA-ScR checklist). Potential weaknesses of this review were due to the small number of included articles. We excluded many studies labelled as social prescribing, which nonetheless did not fit the criteria, as developed from the international consensus study (Muhl *et al*., 2022). This included articles that demonstrated some psychosocial improvements as a result of social interventions in patients living with dementia, but the link worker role was not evident (Camic *et al*., 2021; Siette *et al*., 2017). Moreover, there is a clear paucity of research investigating the effects of social prescribing in dementia and the roles and impact of link workers. This limited the depth of evidence exploration and evaluation, and thereby, some caution in interpreting the findings may be warranted. Against our three aims, social prescribing is being used with people with dementia, but reporting is thin; there are likely gaps where dementia-specific needs are missed, and current descriptions only partly show how link workers meet needs such as poor recall, apathy and the need for carer-led planning (Di Lorito *et al*., 2025; Giebel *et al*., 2021). Dementia-aware training, clearer roles for carers and options for longer follow-up may help.

Our findings should not be generalised to alcohol-related or learning-disability-related dementia. These groups are usually supported within addiction or specialist learning-disability services, and dedicated reviews are needed to explore how social prescribing may be adapted for these populations.

While future research is needed to address the current evidence gaps, social prescribing for dementia may not be feasible for a number of subgroups of people with dementia. This is due to the progressive nature of dementia with impairments including cognitive deficits that can impede both sensory and motor function (Broyles *et al*., 2023). Thereby, these individuals may not have the capacity to engage with social prescribing interventions. It is likely that this may be problematic for those with moderate- to advanced-stage dementia. However, social prescribing could be a viable treatment option for those with mild to moderate stages. This becomes particularly plausible in those who observe sufficient cognition and sensory and motor function as to permit safe participation in related interventions (Arvanitakis *et al*., 2019).

In light of the noted evidence gaps, it is clear that future research is greatly needed, including the clinical and patient-reported effectiveness of social prescribing. We note a programme of research has been established in England (Fox *et al*., 2024) and anticipate further work in this area. Future research should conform to the accepted definitions of social prescribing and assess efficacy across a large and diverse sample of people with dementia (Muhl *et al*., 2022). This research would allow us to understand which dementia groups may benefit from social prescribing, as well as what outcomes it can address. Moreover, research should also conduct economic evaluation to determine whether the use and upscaling of link workers to support social prescribing for dementia in the UK are feasible.

The main implications of this scoping review are for service design and clinical practice, with some tentative pointers for future policy. Social prescribing may be beneficial for people with dementia, and none of the included studies reported harms or safety concerns. Depending on the stage of dementia, an individual may have complex needs, difficulty communicating and behaviours that carers find challenging. However, the included studies did not specify the competencies required by link workers to address these issues or whether social prescribing may be inappropriate for some people at later stages of dementia. In practice, social prescribing services should ensure that link workers have access to dementia-specific training and clear pathways for referral back to dementia-specialist care when concerns arise. At a policy and commissioning level, these findings suggest that dementia-related competencies, supervision arrangements and routes back to specialist services could be made more explicit in social prescribing guidance and service specifications.

Conclusion

Social prescribing is an increasingly recognised approach to dementia care; however, this scoping review found a limited evidence base. The specification of the link worker role and the details of how person-centred care plans were developed were poorly described. Further research is required to give confidence in the effectiveness of social prescribing for dementia-specific quality of life or other outcomes. Services may need simple dementia-specific adjustments – for example, memory prompts and carer involvement in planning – and, where possible, follow-up that lasts beyond a short episode.

Declaration of contribution of authors

Neil Chadborn conceptualised the study and developed research questions, Ian Carmody developed search strategy and Ian Carmody and Alexandra Middleton conducted searches and screening, with input from Neil Chadborn. Ian Carmody and Neil Chadborn conducted analysis and structured the manuscript. Ian Carmody, Alexandra Middleton and Neil Chadborn drafted manuscript.

Acknowledgments

Neil Chadborn is the recipient of a post-doctoral fellowship from the National Institute for Health and Care Research (NIHR) Applied Research Collaboration East Midlands. This fellowship was part of an initiative funded by the NIHR and Alzheimer's Society to support post-doctoral capacity building in applied dementia research. The views expressed are those of the authors and not necessarily those of the Alzheimer's Society, NIHR, or the Department of Health and Social Care.

We gratefully acknowledge advice in developing a search strategy from Library Services, University of Nottingham and Chloe Turner, Information Specialist at University Hospitals of Derby and Burton NHS Trust.

Appendix

Table A1. Reporting checklist: PRISMA – extended scoping

Section	Item	
Title	1.	Title includes "scoping review"
Abstract	2. Structured summary	
Introduction	3. Rationale	Background literature which explores the research gap
	4. Objectives	Aim of review is stated as lack of link worker facilitation being the cause of limited efficacy of social prescribing for dementia patients
Methods	5. Protocol and registration	Scoping review; so we decided not to publish protocol, or register the review
	6. Eligibility criteria	Study selection and eligibility criteria are fully explained and justified
	7. Information sources	The databases searched are listed: CINAHL, MEDLINE, EMBASE and PsycInfo
	8. Search	Full search strategy for CINAHL, MEDLINE, EMBASE and PsycInfo databases are shown in the methods. Systematic review, grey literature and expert stakeholder databases were also searched
	9. Selection of sources	Full-text articles were reviewed against selection criteria based on international consensus study of social prescribing
	10. Data charting process	Table 1 describes the studies included and explores the evidence gaps
	11. Data items	Shown in Table 1 Summary description of studies in the results
	12. Critical appraisal	Data extraction included appraising validity and flaws in methods or reporting. Articles were not excluded on this basis, as they could still inform the scoping narrative review
	13. NA for scoping	
	14. Synthesis	Descriptive synthesis, comparing to framework derived from international consensus study of social prescribing
	15. NA for scoping	
	16. NA for scoping	
Results	17. Selection of sources	Screening, selection and eligibility are described in the methods and also visualised in a PRISMA flow diagram
	18. Characteristics	Study characteristics are shown in Table 2
	19. Critical appraisal	Quality of evidence is discussed and evidence gaps are explored in text
	20. Results of individual sources	Table 3 explores evidence gaps of individual sources
	21. Synthesis	Descriptive summary of articles in text
	22. NA for scoping	
	23. NA for scoping	
Discussion	24. Summary	Key messages from included studies and identification of evidence gaps
	25. Limitations	Validity, strengths and weaknesses and reasons for evidence gaps are discussed
	26. Conclusions	Key points for practice and policy and suggestions for future research is explored
Funding	27.	No external funding

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