Social Prescribing Webinar
Chat Q&A Summary

Thank you for your active participation in the Social Prescribing Webinar. Below is a structured summary of key questions raised in the chat, together with the main perspectives and clarifications shared by speakers and participants. Technical comments and logistical messages have been removed to focus on the substantive discussion.

1. The Role and Professional Identity of Link Workers

Q: What is a link worker? What professional background do they have?

A: Link workers are increasingly recognised as a distinct professional role, particularly in the UK and Ireland. They come from diverse backgrounds including nursing, occupational therapy, psychology, social care, mental health services, and community work. There is strong consensus on the need for formalised training, though no single educational background defines the role. The responsibility and complexity of the work justify it as a paid, skilled profession rather than a volunteer function.

Practitioner Reflection: The Connector Role in Practice

One participant highlighted that the connector is often, but certainly not always, a professional. In some cases, connectors may be trained volunteers.

In child and youth social prescribing in the United States, many programs engage trained volunteers—often medical students—who serve as connectors. In one program described, connectors included social workers, a pediatrician, a nurse, and a social work student, illustrating a multidisciplinary and flexible model.

Experience and research suggest that connectors should have a strong understanding of the community they serve, ideally being part of that community themselves. Lived experience can be particularly powerful. An example shared was Daz Dooler in the UK, who was once a recipient of social prescribing, credits it with saving his life, and now works as a social prescriber himself.

Regardless of professional background, it was emphasised that connectors must receive appropriate training to develop the knowledge and skills required for the role.

2. Where Should Social Prescribing Be Located?

Q: Should social prescribing be anchored in primary care, or can it operate outside the medical system?

A: Many participants emphasised the importance of strong links to primary care, especially for patients with complex medical needs. At the same time, social prescribing can successfully operate within community, voluntary, or local authority settings. The key is collaboration across sectors rather than strict institutional placement.

3. Relational Impact vs. Activity-Based Impact

Q: Are the positive effects mainly due to the activities themselves or the relationship with the link worker?

A: A strong theme in the discussion was that the relational component is central. Time, trust-building, and conversations focused on 'What matters to you?' were highlighted as key mechanisms of change. Several contributors suggested that the relational encounter itself can be therapeutic, sometimes even more impactful than the specific activity prescribed.

4. Social Prescribing and Vulnerable Patients

Q: Does social prescribing benefit very vulnerable patients? Is there a risk of neglecting somatic illness?

A: It was acknowledged that vulnerable patients often experience both social and severe somatic challenges. Participants stressed that social prescribing should complement—not replace—medical care. Close collaboration with primary care is essential to ensure medical needs remain appropriately addressed. Equity and accessibility must remain central considerations in implementation.

5. Digitalisation and AI

Q: Can digital tools replace link workers?

A: The prevailing view was that digital tools can support and facilitate social prescribing, but cannot replace the human, relational core of the work. Digital platforms may improve coordination and access, but trust-building and meaningful engagement require personal interaction.

6. Duration and Follow-Up

Q: How long does a social prescription last? When is someone discharged?

A: No single standard duration was defined. Interventions vary depending on individual needs and local models. The overarching goal discussed was empowerment—supporting individuals toward self-management, connection, and reduced dependency over time.

7. Definition and Conceptual Clarity

Q: Is there a shared understanding of what counts as social prescribing?

A: While core principles—person-centred, community-based, relational—are widely shared, interpretations vary across contexts. Participants highlighted the importance of avoiding over-medicalisation (e.g., treating loneliness strictly as a diagnosis) and instead focusing on broader personal goals and meaning.

8. International Perspectives

Q: How is social prescribing developing globally?

A: Examples were shared from multiple regions including the Western Pacific, Africa, India, and South America. Local cultural contexts, community structures, and family systems shape how social prescribing is implemented. The field is growing internationally, with increasing collaboration and knowledge exchange.

9. Training, Systems, and Multidisciplinary Collaboration

Q: Why was there no full consensus on educational background in the Delphi study?

A: While there was strong agreement on the need for structured training, participants recognised that the strength of social prescribing lies in its multidisciplinary nature. Effective implementation requires coordination between healthcare providers, municipalities, civil society, and community organisations.

We appreciate the rich discussion and diverse perspectives shared during the webinar. Social prescribing continues to evolve as both a concept and a practice, shaped by collaborative learning across countries and sectors.