



ARTS ON PRESCRIPTION

A POLICY BRIEF FOR HEALTH AND CULTURE MINISTRIES

Policy Brief
Arts on Prescription
in the Baltic Sea Region



The Problem

Mental ill-health has become the leading cause of long-term disability across the Baltic Sea Region. Mental disorders now account for a greater share of total disability than cardiovascular disease. Unlike many physical conditions, they are persistent rather than fatal, producing decades of reduced functioning, repeated healthcare use, and diminished participation in work, education, and social life.

Despite this burden, health systems continue to prioritise late-stage clinical treatment, while early and preventive interventions remain underfunded. The largest economic costs of mental ill-health fall outside the healthcare sector: productivity losses, sickness absence, and early exit from the labour market. A mismatch between population need and policy response persists across the region.

At the same time, cultural institutions such as museums, adult and youth education centres, and community arts organisations represent a substantial public resource that is underused in health and social policy. Connecting these two realities is both logical and achievable.

Arts on Prescription (AoP) is a structured approach that does exactly this. It offers community-based, non-clinical support for people experiencing mild to moderate mental distress, delivered through existing cultural infrastructure, with referrals from health and social services. It is not therapy. It complements clinical care rather than replacing it, and it activates cultural assets that are already publicly funded.

What Arts on Prescription Is

The Baltic AoP model brings together a referral channel — e.g. a GP, rehabilitation coordinator, social worker, school, or employment service — a link worker who assesses suitability and provides ongoing support, and a culture and arts facilitator who leads group-based activities. Participants of all ages experiencing mild to moderate mental health challenges are referred to a group of 10–12 people for 8–12 weeks, meeting between one to three times a week to participate in various arts and culture activities. Programmes should include at least three different art forms, spanning visual arts, music, theatre, dance, creative writing, and museum visits.

The key design principles are: no performance demands, a safe non-judgemental environment, voluntary participation, group-based structure, and professional facilitation. Participation is free of charge or very low cost to participants.

AoP is not a new concept. It was first developed in the UK in the early 1990s and has been extensively studied and promoted worldwide including by the World Health Organization. What is new is the systematic development, piloting, and evaluation of a model adapted specifically for the Baltic Sea Region.

What the Arts on Prescription in the Baltic Sea Region Project Has Produced

Between 2023 and 2025, the Interreg Baltic Sea Region-funded Arts on Prescription project ran 24 pilot programmes across five countries — Sweden, Denmark, Germany, Latvia, and Poland — with 13 partner organisations including municipalities, regions, universities, cultural institutions, and an intergovernmental

public health organisation. A total of 255 people completed the programmes across three rounds of piloting and were evaluated for mental health outcomes, implementation processes, and cost.

The project has produced: a generic programme concept (the Baltic AoP Model), a comprehensive online guide covering organisation, financing, facilitation, and evaluation (aop.ndphs.org), an evaluation framework, a resource data base with tools and training materials, and a find-a-mentor programme connecting experienced implementers with municipalities and regions beginning the process.

Partners from Sweden, Poland and Ukraine have developed an ongoing transnational network (ArtWell Net) supporting continued exchange on the Baltic AoP model and related interventions.

The generic programme concept, online guide and other resources are publicly available and are designed to make it easy to start up local tailor-made AoP programmes. Decision makers in the BSR do not need to start from scratch.

What the Evidence Shows

Across 24 pilot programmes in five countries, 255 people completed Arts on Prescription in the Baltic Sea Region between 2023 and 2025. The results were consistent and clear.

Among participants, anxiety symptoms fell by 30% and depression symptoms by 25% during the programme. Nearly three in four participants who started with low mental well-being improved by the end. Nine in ten said they would recommend AoP to others.

These findings are not unique to the project. Independent, controlled research from Sweden, the largest of its kind in the Nordic region, following 479 participants over 12 months, found that AoP produced significantly greater reductions in depression than conventional healthcare alone. A separate one-year follow-up study with 586 participants found that AoP produced twice the improvement in psychological resilience compared to conventional care.

What participants themselves describe is equally striking. They speak of finding a place to belong without being judged, of panic attacks that stopped, of reconnecting with other people after years of isolation, and of feeling hope for the future for the first time in a long time. Many describe a shift in how they relate to themselves, moving from self-criticism towards self-care, with a renewed sense of motivation, empowerment and control over their own lives. Independent qualitative research identifies these not as incidental benefits, but as the core mechanisms through which AoP works — belonging, absorption in creative activity, and the experience of succeeding at something in a safe environment.

The EU Commission's 2025 report *Culture and Health: Time to Act*, produced by Ministries of Culture and Health from across Europe, singles out the AoP Baltic Model as a leading example of what this field can achieve at scale.

Why Investing in Arts on Prescription Makes Sense

The question for decision makers is not whether AoP is expensive. It is whether the alternative is cheaper.

Mental ill-health is already one of the costliest challenges facing BSR societies — not primarily through healthcare spending, but through lost productivity, sickness absence, and early exit from the labour market. These costs fall on employers, social insurance systems, regions and municipalities, often for years at a time. AoP addresses the problem early, before it reaches that stage. A person who regains a sense of agency, social connection, and hope after a 8 to 12-week programme is less likely to spend the next two years cycling through GP appointments, medication trials, and sick leave. Prevention is always cheaper than prolonged treatment, even when prevention has a visible cost and treatment costs are diffuse and invisible.

AoP is also unusual among public health interventions in that the investment goes toward something tangible and reaches the local community. Funding AoP means paying professional artists and cultural facilitators for their work. It means filling empty slots in museum programmes, adult education centres, and community arts venues — institutions that were built with public money. AoP gives cultural infrastructure a measurable public health function. It does not create a new system; it makes better use of one that already exists.

This dual return — health outcomes and cultural sector value — means the investment can be shared. Health budgets, culture budgets, and municipal social welfare budgets all benefit from AoP. This is not a reason to let each sector wait for the others to act. It is an argument for joint financing, joint ownership, and joint accountability. Several EU Member States have already signed formal agreements between their ministries of health and culture precisely because they recognise that this kind of investment cannot be optimised by either sector acting alone.

For artists and cultural professionals, AoP creates sustained, meaningful employment in a sector where precarity is common. Facilitating AoP groups requires skill, training, and ongoing professional support — it is not a residual activity but a recognised professional role. Countries that invest in AoP are investing in a cultural workforce with a clear social purpose.

Finally, AoP reaches people who would otherwise go unreached. The people who benefit most are not gallery visitors or concert subscribers. They are people on sick leave, isolated older adults, long-term unemployed, young people at risk, new residents who have not yet found their place, etc. For them, AoP is often a first point of re-engagement with public life. The return on that investment is not easily measured in a spreadsheet — but it is real and lasting.

Where Does AoP Fit in the Health System?

Many BSR countries aim to organise mental health care according to a stepped-care model — a tiered person-centered cost-effective approach in which people receive the least intensive support appropriate to their needs, escalating to more intensive interventions only when necessary. The principle is sound and widely endorsed: not everyone experiencing mental distress needs a therapist, and scarce specialist resources should not be the default response to mild or moderate problems.

In practice, however, existing stepped care frameworks leave a significant gap at the lower end. The first steps typically consist of low-intensity interventions, such as self-help, online apps, brief sessions, or watchful waiting. The next step up is more intense treatment — counselling, structured psychological therapy, guided CBT, or medication managed by a GP or specialist. What

is missing is a middle tier: structured, community-based support that is more purposeful than self-help but does not require clinical infrastructure or a trained psychologist.

This gap is not a minor oversight. It is where the largest share of people with mental health problems actually sit — experiencing real distress, not yet at a clinical threshold, but with nowhere meaningful to go within the formal system. Many cycle through GP appointments without receiving anything beyond a prescription or a waiting list referral. Others simply go unsupported until their condition worsens.

AoP fits precisely in this missing tier. It is structured enough to be prescribed and evaluated. It is delivered in the community, outside clinical settings, at relatively low cost. It targets the population that falls through the cracks of existing stepped-care frameworks, and the evidence shows it works for them. Recognising AoP formally within stepped care systems would not require rebuilding those systems — it would mean adding a step that should always have been there.

Why This Requires Action from Both Health and Culture Ministries

AoP does not fit neatly within either sector's existing mandate — which is both its greatest implementation challenge and its greatest policy opportunity.

For health ministries, AoP offers a structured early intervention pathway that reduces pressure on primary care by diverting people with mild to moderate mental distress away from clinical consultations and toward community-based support. It targets a population that healthcare systems currently struggle to serve

cost-effectively, and it does so by using an evidence-based model with a validated programme concept, evaluation framework, and implementation guide.

For culture ministries, AoP provides cultural institutions with a clear and measurable public health function, strengthening their case for sustained public investment. Cultural infrastructure – such as museums, adult education centres, art and music schools, and libraries – becomes an active component of the health and social welfare system rather than a separate budget category. This integration makes cultural and artistic offerings more accessible and inclusive, broadens the institutions' outreach, and ultimately leads to increased revenue for the cultural sector.

The financing logic follows from this. AoP benefits flow across multiple sectors and levels of government: health systems gain from reduced primary and mental health care demand; cultural institutions benefit from sustained use of existing infrastructure; and labour and employment systems benefit from reduced sickness absence. Sustainable financing should reflect this, through blended models that combine national and local funding streams across health, culture, and social welfare budgets, with potential employer co-financing in countries where workplace wellbeing allowances exist.

Seven Policy Recommendations

1. Recognise AoP formally within mental health prevention and promotion strategies

Pilot evidence is sufficient. AoP should be designated as a structured component of mental health and wellbeing policy at national and regional levels, embedded within — not separated from — existing prevention strategies. Health ministries should task relevant public health bodies with coordinating implementation.

2. Establish national or regional Culture and Health strategies

The 2025 EU Open Method of Coordination (OMC) report calls on all Member States to develop such strategies. Several BSR countries have already begun this process; others have not. A formal Culture and Health strategy, jointly owned by health and culture ministries, provides the governance foundation for sustainable AoP implementation. It also signals to cultural institutions that their health-promoting role is recognised and will be resourced.

3. Integrate AoP into stepped care frameworks for mental health

Health ministries across the BSR should review their low-intensity interventions and stepped-care guidelines with a view to explicitly including community-based non-clinical interventions, such as AoP, as a recognised step between self-help and more intensive treatment. This would formalise AoP's role in the care pathway, create a legitimate referral route from primary care, social services, schools, employment agencies, and other public services relevant in the local context, and ensure that people with mild to moderate

mental health challenges receive meaningful support before their condition escalates.

4. Close the evidence gap by establishing national knowledge and resource centers

Several countries have already established national knowledge and resource centers for culture and health, which play a crucial role in providing decision-makers and professionals in both the health and culture sectors with the evidence and capacity building they need. Such institutions connect public health and cultural actors, and academia. They develop training programmes and guide programme evaluation – a crucial contribution to turning AoP and similar interventions from pilots into sustainable prevention interventions.

5. Secure sustainable cross-sectoral financing

Pilot projects must transition to sustainable funding. We recommend blended funding models that draw on multiple sectors – health, culture and social welfare – and combine both national and local funding streams. In countries with employer-paid wellness allowances, extending them to cover structured cultural health activities could provide an additional incentive and source of funding.

6. Invest in workforce capacity

The quality and safety of AoP depend on well-supported culture and arts facilitators and link workers whose roles are recognised as essential within community-based mental health support. Training frameworks must include mental health literacy, inclusive facilitation methods, group dynamics, and guidance on how to respond appropriately to acute situations that may arise during sessions.

Responsibility for providing this training should lie with national or regional knowledge and resource centres, public health institutes, and municipal or regional departments for social services, health and culture, as well as NGOs specialised in arts and/or health. It should not rest on individual facilitators or small organisations operating without institutional support.

7. Adopt common monitoring and evaluation standards

Without shared indicators across the BSR, the evidence base will remain fragmented. We recommend adopting a common set of outcome measures — including validated wellbeing scales, and where possible, service utilisation data — alongside the evaluation framework developed by the BSR project. Transnational cooperation on best practices and regional data sharing will build the evidence base needed for sustained political and financial commitment.

What Already Exists

Decision makers do not need to commission new development work. The following resources are already available through the AoP in the BSR project:

The online [Arts on Prescription Guide](#) provides practical guidance on organising, financing, facilitating, and evaluating AoP programmes, tested across eight pilot sites in five countries.

The [Evaluation Framework](#) includes tools for assessing mental health outcomes, implementation strategies, and intervention costs.

The [Find-a-Mentor Programme](#) connects municipalities and regions beginning implementation with experienced partners from across the BSR.

[ArtWell Net](#), an initiative developed from the AoP project, provides an ongoing transnational network for knowledge exchange as the field develops.

The [International Arts on Prescription Collaborative \(IAPC\)](#), convened by the National Academy of Social Prescribing in late 2025, connects AoP practitioners, researchers, and policymakers across more than 12 countries, providing a global platform for knowledge exchange and a shared international voice for the field.

Time to Act

Mental ill-health continues to place a growing burden on individuals, communities, and public systems across the Baltic Sea Region. Without earlier and more effective intervention, this burden will continue to increase — in rising demand for healthcare, prolonged sickness absence, and reduced participation in work, education, and social life. The gap in current systems is clear, and it is where the majority of people with mental health challenges are currently left without meaningful support.

The evidence is in. The tools exist. The EU mandate is clear. Participants in the AoP program in the Baltic Sea Region describe their experience using metaphors that go beyond clinical measures, such as discovering light after darkness, feeling a sense of belonging without judgment, and sailing together as if on a shared ship. These outcomes are not peripheral but central, embodying the very purpose of mental health policy.

The [BSR Mental Health Platform](#), funded by the Interreg Baltic Sea Region Programme 2021–2027, as well as the [ArtWell Network](#), funded by the Swedish Institute, will continue to promote these outcomes and refine these recommendations in dialogue with

decision-makers across the region. The infrastructure for sustained cross-sectoral cooperation is in place.

The question is therefore no longer whether Arts on Prescription should be implemented, but how quickly it can be integrated at scale.

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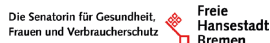
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