

Art and Culture on Prescription in Italy

First national survey



Fondazione
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CCW - Cultural Welfare Center

Research Summary

April 2026

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1.

A field that exists, research that makes it visible

In Italy, thousands of people each year take part in artistic and cultural activities prescribed or recommended by doctors, psychologists and social workers. They take guided tours of museums, read aloud in libraries that serve as centres of care, and walk in parks with support groups. Until now, no one had measured this phenomenon on a national scale. This research does so for the first time.

The social prescription of art and culture is an approach whereby a doctor, psychologist or social worker directs a person towards artistic or cultural activities, either in addition to or as an alternative to pharmacological treatment. Visiting a museum, reading aloud in a group, taking part in theatre workshops, walking in natural surroundings: these activities are 'prescribed' because scientific research shows that they improve mental wellbeing, the quality of social relationships and, in many cases, physical health. Cultural welfare is the broader field within which this practice falls: it refers to the range of interventions in which art, culture and heritage are intentionally used as tools for healing and social inclusion.

The research – promoted by the CCW – Cultural Welfare Center together with the Fondazione Compagnia di San Paolo – was conducted in the summer of 2025 across three levels: a review of the scientific literature, a quantitative survey (918 valid questionnaires) and qualitative analysis (in-depth interviews and focus groups). It identified around 1,300 active participants in the field, of whom 918 responded to the questionnaire. The sample is divided into two groups: 617 Social Prescription Units (SPU, 67%) – organisations already carrying out activities on the prescription or recommendation of health or social care professionals – and 301 Cultural Welfare Units (CWU, 33%) – organisations active in the arts, culture and health sector, but not yet formally established on prescription; 97% intend to do so in the future.

This summary focuses on the overall data and, in particular, on the profile of SPUs.

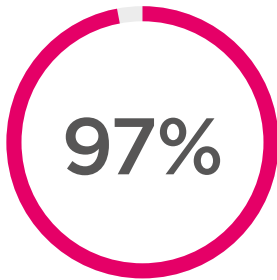


The five key figures

918

organisations surveyed that use art and culture for health and well-being

- Cultural institutions
- Healthcare bodies
- Social cooperatives
- Associations
- Individual professionals



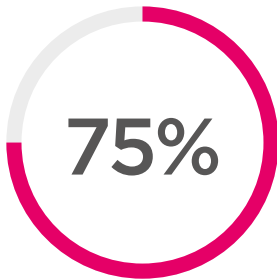
97%

completion rate

Those who start a cultural prescription see it through to the end



A result that many traditional healthcare interventions fail to achieve



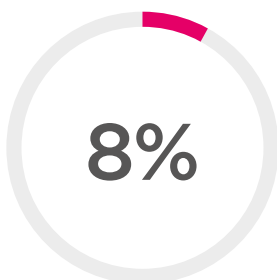
75%

of SPU pursue objectives to improve mental wellbeing and develop interpersonal skills

Social inclusion follows at 68%



The prescription acts first and foremost on the mind and relationships



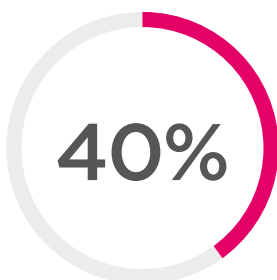
8%

of SPU identify the GP as the prescriber

This is the most surprising figure: the central figure in theoretical models is almost absent in Italian practice



The most frequent prescribers are psychologists (32%)



40%

of SPU pathways conclude without any structured follow-up

This is the critical point of the system



Benefits are achieved, but risk being lost without continuity



2.

Who they are and where they operate

The organisations surveyed are distributed in a highly skewed manner towards the Centre-North. The North-West and Centre macro-regions account for 39% and 27% of units respectively, compared to population shares of 27% and 20%. The South and Islands, with 34% of the population, host just 14% of the organisations surveyed.

MACRO-AREA	% ORGANISATIONS	% POPULATION	UNITS / 100,000 HABITANTS
North-West	39%	27.0%	2.22
North-East	20%	19.6%	1.62
Central	27%	19.8%	2.13
South	10%	22.8%	0.66
Islands	4%	10.8%	0.59

The distribution, as well as reflecting the actual prevalence of the phenomenon, also represents the ability to raise awareness. In the South, three enabling conditions are systematically lacking: a favourable regional regulatory framework, catalytic foundations and cross-sectoral links between culture and health.

Organisational profile of SPUs

The 617 SPUs present a structured and mature profile. 48% have a cultural/artistic identity, 22% a healthcare identity, and 14% a social identity. Their scale is significant: 58% have 10 or more staff members, compared to 10% of cultural-artistic non-profits recorded by Istat. As for longevity, 46% have been in existence for over 26 years, whilst 29% were established in the last three years: the sector is expanding. In-house healthcare expertise clearly distinguishes SPUs from CWUs: doctors are present in 31% of cases (vs 9%) and psychologists in 34% (vs 16%). 65% participate in national or international networks, used mainly for specialist training and technical exchange. Geographically, the Centre macro-region is the main laboratory for prescription activity, accounting for 30% of SPUs.



3.

What is done and how: prescription-based activities

The activities cover a wide range of artistic languages. At the top of the list are practices that focus on language, listening and movement in space: reading aloud (42%), educational activities in museums and heritage sites (35%), cultural or narrative walks (32%), theatre (29%), visual arts (27%), storytelling and writing (23%). 23% also offer artistic training: as well as promoting well-being, the prescription builds lasting skills. Almost all interventions are designed to suit the specific profile of the target group (72%) or individual beneficiaries (27%): only 5% follow a fixed format.

The objectives reveal the field's focus: mental wellbeing drives the activities of 54% of SPUs; relational objectives follow at 49%, and cultural and educational ones at 45%. The most frequently stated objectives are the improvement of mental wellbeing and the development of relational skills (both at 75%), social inclusion (68%), and the improvement of physical health (40%). The prescription of art and culture is primarily a tool for psychological care and for connecting people. This is because artistic and cultural activities operate on multiple levels simultaneously: they stimulate cognitive abilities, trigger emotions, build relationships and restore a sense of belonging and competence in people.

45% of organisations observe lasting benefits for health and well-being; 49% report a moderate impact, with benefits diminishing in the absence of continuity. The benefits of prescription require continuity of the programme and an active support network, and do not consolidate automatically.

Prescription takes place in cultural and community spaces: museums (37%), libraries (36%), natural environments (33%), and third sector venues (33%). Institutional healthcare settings are present but, in the minority, – hospitals 14%, care homes 11%, mental health centres 10%. 71% of SPUs offer free or low-cost activities; 60% tailor content, timing and methods.



4.

The people: beneficiaries, prescribers and link workers

Who benefits

The participants are predominantly adults (82%) and older people (49%), with a significant proportion in the 0–11 age group (47%). The most common approach is group work (54%). 96% of SPUs report that participants complete the programme, with dropout rates not exceeding ten people per year in 82% of cases. Young NEETs stand out as a key growth target: the cultural prescription approach has proved effective for this group precisely because it is not perceived as therapy – a lack of recognition that is a strength of the model. 61% of SPUs involve carers – family members or professionals – with documented effects: increased empathy in 56%, improved relationships with the person being cared for in 59%, and reduced anxiety and stress in 48%.

Who prescribes it

Prescriptions originate predominantly from the psychological, educational and social sectors: psychologists (32%), social workers (24%), teachers (24%), paediatricians (20%), psychiatrists (15%). The beneficiary's independent choice precedes referral by the GP: 12% versus 8%. The 8% figure for GPs does not signal a lack of interest but indicates that current models are not suited to their working environment. A GP manages an average of 1,500 patients; without the necessary infrastructure – platforms integrated into practice software, up-to-date directories of local resources – prescribing remains an unsustainable additional burden.

The link worker: a strategic role, still underutilised

The link worker – literally a 'liaison officer' – is the professional who coordinates the process: they receive the referral from the prescriber, meet the individual, assist them in choosing the cultural activity best suited to their profile and needs, follow them over time, and act as a bridge between the healthcare system and cultural organisations. They are considered essential by 86% of SPUs, but only 24% utilise them in a structured manner. The tasks assigned to them are: liaising between health, social and cultural services (73%), supporting the management of activities (58%), providing advice and guidance to beneficiaries (54%), and monitoring and evaluating outcomes (44%). There are two models: the endogenous model places the link worker within the healthcare system, integrated into existing institutional processes; the exogenous model

positions them in the third sector, as a neutral interface between the healthcare system and cultural organisations. In both cases, sustainability must be planned from the outset.

Training for link workers is still predominantly informal (33% learn on the job). The strongest recommendation is to incorporate the themes of social prescription into university curricula for medicine, nursing, social work and cultural heritage studies, as a cross-cutting theme – not as a standalone course.

5.

Processes, funding and critical issues

The art and culture prescription pathway is divided into four stages: entry (formal referral or self-referral), reception and co-design (the stage where mistrust and stigma are overcome), cultural action, and follow-up. The success of the entire cycle depends on the quality of the initial co-design: without listening and personalisation, the prescription risks becoming an imposed act. The critical point is the follow-up: 40% of SPU pathways conclude without any subsequent intervention, whilst only 14% include structured support. The absence of follow-up produces, in some cases, the ‘bubble effect’: benefits that remain confined within the structured pathway and do not transfer into everyday life. Designing the bridge to the community is an integral part of the work – not an add-on if resources are left over.

Monitoring is an established practice for 62% of SPUs: direct consultation with beneficiaries is the most common method (63%), followed by structured questionnaires (44%) and focus groups (39%). The results are used to verify expected outcomes (76%) and plan new activities (60%). The challenge is to transform internal monitoring into a policy issue for those who allocate resources.

The financial profile of SPUs shows a hybrid structure: vouchers or public incentives (30%), contributions from cultural bodies (28%), other types including voluntary work and the absence of structured funding (28%), donations or fundraising (20%), individual payment by the participant (19%). The most critical figure is that of the ‘other’ category (28%): this often corresponds to the absence of any structured funding. 19% of SPUs pass the cost on to the participant: a sign that the provision is not yet part of a universal welfare system.

If almost a third of the sector survives without secure funding, the sustainability of the system is more fragile than the completion rates of the programmes would suggest.



6.

Focus on the North-West: Piedmont, Valle d’Aosta and Liguria

The North-West emerges as one of the areas with the highest concentration of cultural welfare organisations in Italy: 116 organisations, of which 70 (60%) are active in social prescription. Piedmont dominates with 88.6% of the area’s SPUs, supported by an ecosystem of active foundations – starting with the Fondazione Compagnia di San Paolo – and a well-established tradition of innovation in the third sector.

INDICATOR	NORTH-WEST SPUs	NATIONAL AVERAGE
Completion rate	97%	96-97%
SPUs that assessed effectiveness	57%	62%
Psychologist as prescriber	39%	32%
GP as prescriber	10%	8%
SPUs with insufficient financial resources	94%*	-
Reaching 100+ beneficiaries (2024)	31%	20%

* Among organisations reporting insufficient resources – the highest concentration in the national sample.

The main activities in the North-West SPUs: museum and heritage education (41%), reading aloud (39%), painting and visual arts (33%), cultural walks (26%), theatre and dance (23%). The main objectives are mental wellbeing (59%), social interaction (57%), and cultural and educational objectives (54%). Three critical issues emerge clearly: the distance from the GP (only 10% of SPUs indicate the GP as the prescriber); the anomalous concentration of financial shortages (94% of those reporting insufficient resources cite financial resources as the main problem, in an area with numerous and active grant-making foundations); and the discontinuity of programmes (59% of programmes do not involve beneficiaries in the planning stage; a significant proportion have no structured follow-up).



Pilot projects and trials in Piedmont

In recent years, Piedmont has launched systemic social prescription trials that represent a significant step up from individual project activities, based on research and cross-sectoral co-design.

The Museo Ben-Essere project (ASL TO3) originated at the Oulx Health Centre and has expanded to include the Castello di Rivoli and the Reggia di Venaria: the museum serves as a cognitive and relational 'training ground' for people experiencing emotional fragility, combining aesthetic experience, movement and reflection. The SOMA research programme (Fondazione Medicina a Misura di Donna, AOU Città della Salute, University of Turin – Brain plasticity and behavioural changes, NOMA World) offers creative expression workshops – painting, photography, storytelling, movement – to restore quality of life for women who have experienced cancer: psychologists and neuroscientists from the University of Turin monitor the neurobiological activity of 50 women referred by oncologists; the creative output is presented in a participatory manner at the Gallerie d'Italia.

Ri-trovarsi in museo (Fondazione Molo) develops expertise for 'Alzheimer's-friendly' museums, for people with aphasia and dementia and their carers. These initiatives have also been made possible thanks to the recognition of the expertise demonstrated by the proposing bodies in the fields of Culture, Prevention and Care, by Fondazione Compagnia di San Paolo in the form of an unrestricted grant.

Turin is characterised by other systemic initiatives. Torino Social Prescription – a collaboration between the City Council, the Turin Local Health Authority (ASL) and the Lombroso16 Cultural Centre – builds new models of primary care by integrating clinical treatment and community resources for people experiencing emotional distress.

The Convoglio project (Fondazione Ufficio Pio) is a research-action project focused on combating loneliness: it activates neighbourhood networks by connecting people in isolation with cultural and community opportunities through liaison officers, in collaboration with the ASL Città di Torino and La Cultura dietro l'Angolo programme.

Other national programmes piloted in Piedmont include: Music & Motherhood (ISS-CCW-WHO), choral singing for mothers with postpartum depression, launched in 2023 with four health authorities; Archives and Health, piloted at the State Archives of Turin with over-65s with aphasia and their carers; Nati per Leggere, a prescriptive model already established in 14 regional hubs, the result of two decades of collaboration between the Region and the Fondazione Compagnia di San Paolo.

These examples demonstrate how social prescription can take various forms, adapting to the specific needs of individuals and contexts. A common element is the building of structural alliances between the healthcare system, cultural institutions and the third sector. The challenge is to consolidate these experiences, move beyond the experimental phase and integrate them into services in a systematic manner.



7.

For those who govern, fund and live in the field

This research answers the question of ‘whether’ the prescription of art and culture works. The answer is yes: it does, under the right conditions. The remaining open question is what those conditions are. The data point to four priority levers for intervention.

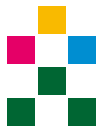
LEVER	WHAT IS REQUIRED
1 Recognition	Including cultural welfare organisations in Area Plans, Local Health Plans and Integrated Health Plans as partners in care, not merely as service providers.
2 Coordination	Using Community Centres (Ministerial Decree 77/2022) as a hub: protocols with local organisations, shared referral forms, dedicated contact persons.
3 Professionalisation	Defining a recognised professional profile for the link worker: certified interdisciplinary training programme, contractual status, explicit institutional mandate.
4 Funding	Extending regional vouchers to CWUs in transition; recognising cultural prescription within social and health funds; developing guidelines for reporting voluntary work as co-funding.

Priorities for those working in the field

- **Planning follow-up from the outset, not adding it later.** 40% of SPU pathways end without continuity: this is not a problem of resources, but of planning.
- **Using data that has already been produced.** 62% of SPUs carry out monitoring in a consolidated manner, but few transform that data into arguments for decision-makers.
- **Building horizontal exchanges between SPUs and CWUs.** SPUs have healthcare expertise; CWUs have replicability (68% vs 58%) and faster scaling.
- **Highlighting practices in Southern Italy.** 14% of the sample compared to 34% of the population: this does not reflect a lack of vitality, but rather a difficulty in gaining visibility through institutional channels.

Italian cultural welfare does not need to be invented. It needs to be recognised by funders, supported by policy makers, and made more robust by practitioners. This report is the starting point for all three conversations.





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