Leta Dromantienė

Mykolas Romeris University, Lithuania,

dromante@mruni.eu

Kęstutis Štaras

Mykolas Romeris University, Lithuania
Vilnius Central Outpatient Clinic, Lithuania

kestutis.staras@pylimas.lt

Monika Ūselytė

Mykolas Romeris University, Lithuania

monika.uselyte@mruni.eu

JOURNAL OF MODERN SCIENCE TOM 4/27/2015, S. 227–250

Lithuanian Case Study of Prescribed Participation in Cultural Events: Attitude of Health Care Practitioners

Abstract

The aim of the paper is to explore how non-medical factors influence health and well-being, quality of life (QoL). Thus, cultural attendance takes a significant role on QoL because namely culture is an important domain for health and QoL simultaneously. To analyze the possible connection between culture and health, and, attendance of cultural events in case of social project Cultural Prescription presented in a paper as one of the important dimensions of QoL. The article provides the results of that social project from a perspective of Lithuanian health care practitioners. Continuing about QoL and state inputs to it, cultural policy domains are presented to create an overall picture of it and make conditions for connection of those two segments. Research results indicate its advantages and disadvantages, which identified by health care practitioners as intermediaries between project's organizers and those who receive prescriptions (patients).

Keywords: *cultural prescription, quality of life, health, culture*

Introduction

Residents satisfied with their health and quality of life are the great power to state's prosperity. QoL has been widely analyzed by different disciplines: psychology (Diener & Diener, 2002) analyses personal experience based quality of

life; economics (Krutilla & Reuveny, 2002, Servetkienė, 2013) allocate its biggest focus on the objective economic capacity related to living standards; from medical perspective (Boumol, 1993, Michalis, 2003, Butikis, 2009); sociology (Raphael, 1996, 1998, Veenhoven, 1988, 2000) dispute individual's well-being and their reliance to different levels of society welfare. Growing popularity of interdisciplinary studies has led to interdisciplinary of QoL studies (Stiglitz, Sen, Fitoussi, 2009). Significant political organizations: UNESCO, World Health Organization (WHO), Organization for Economic Co-operation and Development (OECD) pay attention to QoL studies in order to ensure the main goal for every state to improve and secure QoL and welfare for everyone (Scottish Social Research, 2005). To reach these goals, scientific analysis is necessary because QoL is extremely complex by its nature and in different circumstances mean different things. Thus, some of the most important elements agreed to be constant by the authors.

Multitude studies come to a common agreement that health play a key role in the QoL (WHO, 1995, Mikhail, 2003). Scholar's state that health is one of the main factors that affects people's QoL, as health itself is a resource for human daily life capacity. QoL notion is also supported by the fact, that one of the first QoL definitions established by WHO (1993) included health as a significant domain. Therefore, health is also included in Human Development Index. It is expected that investments in health improvement are investments in quality of public development and welfare simultaneously (Baklien, 2009). Consequently, one of the ways to improve QoL is an aspiration to improve health. There are many approaches how the state in general or social network organizations, in particular, can improve residents health. Culture is between those methods. Actually, in our modern society cultural usage for the health and QoL purpose increases rapidly (Raphael, 1999, Angus, 2002, Guetzkow, 2002, Smith, 2004, Hyyppa et. al., 2005, Daykin, 2011). Moreover, culture is not only a measure to reach better QoL, but it is also a component of QoL. Culture is acknowledged in many social spheres as a social power to influence the particular issue in a right direction, which had not spared the attention of researchers.

This paper argues the social point of view of possibilities to improve QoL and research approach of evaluation of social project from the point of health

care practitioners view, as intermediaries between project organizer's and receivers' (patients'), perspective in Lithuania. Actual research is relevant to apply gained results to familiar future projects. A paper presents the findings of the social project "Cultural prescription" that was successfully carried out in April-November 2013 in Vilnius when implementing the best practice of Turku, Finland (2011) in that field. That is an example how a culture was employed for health care by collaborating cultural and social network enterprises. Precisely, this social project reveals the case when culture enabled for improving patients health, welfare and QoL simultaneously.

In Lithuania, social project "Cultural prescription" was organized by public cultural institution "Mokytojų Namai" (Eng. Teacher's House) in Vilnius and dedicated to outpatient clinic "Centro poliklinika" (Vilnius) patients, who were suffering from chronic disease cancer, cardiovascular disease and mental health disorders (a predisposition to depression) to improve their QoL. The idea of that project was participants receiving invitation cards – "Cultural Prescription" – to a cultural event or institution besides their regular based prescription for medicine.

The paper presents an analysis of Lithuanian case of social project "Cultural Prescription" and its role on QoL proposed by health care practitioners who have been prescribing for patients' prescriptions of cultural attendance.

The aim of the research: to explore the importance of social engage cultural project "Cultural prescription" on QoL of patients suffering from chronic disease m the point of view of health care practitioners.

Methods of the research: analysis of scientific literature/data, qualitative research, semi-structured interview, qualitative content analysis of the data.

The concept of quality of life and health related quality of life (HRQOL)

For centuries researchers and thinkers from different disciplines have proposed their own definitions of QoL according to particular time normative, social, economic and political actualities as well as on different approaches and assumptions (Veenhoven, 2006). Regardless, only at the very beginning of the XX century, issue of QoL has become a matter of systematic empirical research and finally, independent theory (Vesan & Bizzotto, 2011). QoL theory

development presents two historical approaches: Scandinavian and American. Scandinavian sociologists and economists stressed on objective living conditions (Erikson, 1993, Uustilo, 1994) and considered that happiness, satisfaction needed for QoL may be reached in condition of well-developed welfare state rather than on people's satisfaction itself (Noll, 2004). While the American approach highlighted subjective well – being, happiness, life sa-tisfaction and QoL evaluation by every person individually (Combell, Converse, Rodgers, 1976, Vesan & Bizzotto, 2011). American approach stressed, that different person may be differently satisfied in equal circumstances that is why QoL is subjective itself.

Although American and Scandinavian approaches present substantially different position toward QoL, both approaches take an active position in the social science, and nowadays it becomes new interdisciplinary study subject. Thus, in 1993 social scientific QoL research becomes institutionalized with the founding of the International Society for QoL studies (ISOQOL) (Veenhoven, 2006). Growing volume of QoL studies and its demand had led to the spread of it to the majority of Europe and opened the gates for further analysis of QoL (Raplay, 2003). QoL becomes a popular topic on social science debates, which resulted that American (subjective), and Scandinavian (objective) approaches lost the links with researcher's geographical location, as it was at the beginning and were renamed to subjective and objective domains of QoL.

Even scholars identify different components of QoL, but some domains are agreed by all, such as physical, mental and social health, only notable, that for example WHO (1995) identify it as social health, while others named it as health and psychological climate or health and social connections (Stiglitz et. al., 2009)

QoL studies have shown that health is significant part of QoL (Bruno et. al., 2003) and no other domain of life none of the QoL have attracted such attention in relation to measure of QoL as health. This is a consequence of few related phenomenon:

- Beveridge Report[1], which connected health as significant domain for quality of life with postwar welfare state;
- World Health Organization (WHO) has defined health not only as absence of illness but in wider terms: health is state of complete physical,

mental and social well – being and not merely the absence of disease or infirmity (WHO, 2014);
- Health is accepted as a common value in most of the societies, and it may be easily damaged by physical impacts or diseases and scholars find importance to measure HRQoL in different disease or its treatment conditions.

Holistically, health is a most important domain of the QoL because health problems mostly interfere with person's usual social activities, as well as good health leads to economic prosperity and social welfare. Moreover, health is vital for the realization of capacity, as well as it is needed for loving, having and being. Also is highlighted, that even health is named as most important domain of QoL which leads to capacity to reach desired well – being, it is not enough to be in good health condition to have high QoL, thus health is not equal to overall QoL, but high QoL certainly includes health (Phillips, 2006).

However, the concept of HRQoL has evolved through the time and till the last decades of XX century encompassed information about the quality of the physical, mental, and social domains of the population or individual life. As it is also defined by Organization Healthy People (2014), "Health-related qua-lity of life (HRQoL) is a multi-dimensional concept that includes domains related to mental, emotional, physical, and social functioning" (Healthy People, 2014).

Moreover, one of the requirements of the WHO for member states is to take care of the citizen's health to create the conditions for personal healthy growth and development that is vital for individuals QoL. In this regard, is not a coincidence, that certain states include QoL improvement as a goal in their Health Care manual and multiannual programs. Additionally, may be argued that resembling calculus arise in distribute of resources between me-dical treatment and disease prevention services.

Due to holistic approach to HRQoL and QoL as a whole, could be said, that despite objective purpose of health care services, part of HRQoL in particular or QoL in general, are still improved through medical care. It is comprehensible, that person receiving health care also receive improvement for QoL. In this sense, QoL also depends on the remit of medicine and health care system

and services. In this order health care provides health and part of HRQoL, which, in fact, is an objectively measured health condition. This situation and priorities of health care and prevention services also have an impact on treatment choice of members of a medical community who makes decisions on treatment methods. In respect, medical practitioners are oriented and focused mostly on medical treatment that determined for improving health itself and neglected possible alternatives in more social or cultural activities, some supplementary activities began to emerge.

Culture, health and quality of life interrelations

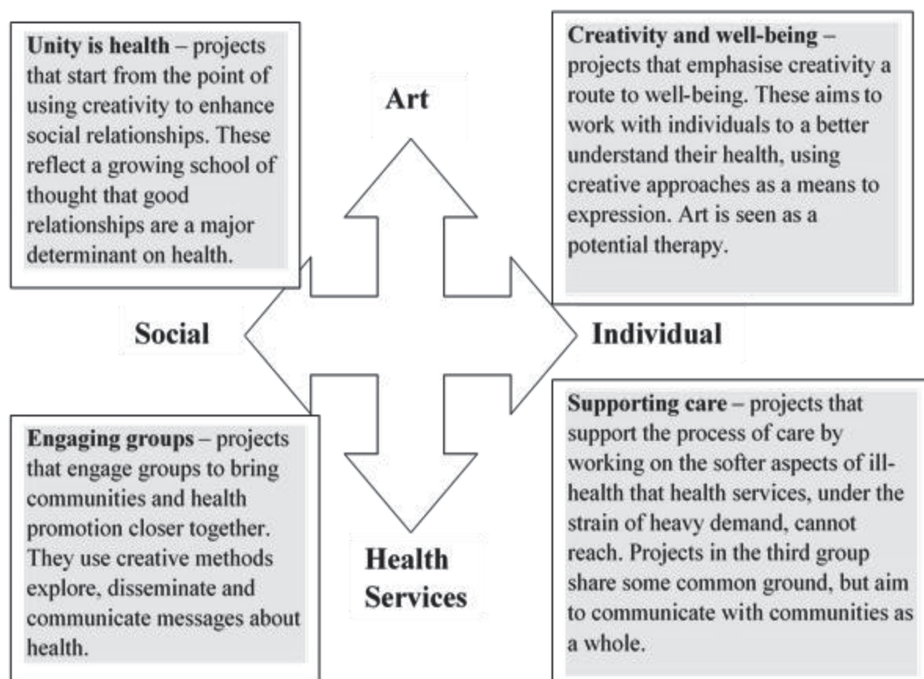
Culture itself is adopted as a harmless phenomenon. Moreover, cultural experience and impressions from the culture have physical, mental and social effects (Johansson, 2001). Sociologist identifies culture as spiritual value and engine of every society (Gaižutis, 1988). Considering an a linkage between QoL and culture the Canadian research (2010) outcomes state that culture enriches people's QoL and they value culture as an important part for it. Also Augustinsson (2011) added, that all kind of cultural experience helps people to express themselves in daily life regardless of objective living conditions, in this way culture is suggested to be understood as resource of human well – being which directly matters to QoL. Cuypers et al. (2011) notice, that even low-level cultural activity may have a protective effect on health during the time. Therefore, there is no coincidence that culture have to be accepted and understood as one of the most recent component of QoL, as far as cultural activity has a positive impact on QoL, culture needs be considered as one of determinant of it (Servetkienė 2013). Even if culture or attendance of cultural events presented as entertainment, culture by nature provides more social and individual values. At the individual level cultural experience improves mental health by relieving stress, anxiety and depression and its symptoms. Therefore, it stimulates positive feelings, experiences and minds (Cuypers et al, 2011). Culture can contribute to the human life and humanity improvement, individual self-esteem and happiness. This is all come through understanding of culture as an aesthetic phenomenon (Gaižutis, 1988). Culture also play

a role for improvement of health, social relationships, social participation and QoL in general and makes influence at the community level through reducing social isolation, and increasing social activities, supplementing social welfare. Certainly, in most cases researchers seek to share or dedicate their results with wider audience, also including health care practitioners. Unfortunately, health care practitioners are often skeptical about health related researches if they do not measure solid medical facts which actually implies, that non-traditional treatment activities or methods such as cultural or social initiatives frequently does not convince medics as an important or having value for objective health status, because, they rather rely on medicine technologies and laboratory tests (Phillips, 2006). An important note should be done, that despite this approach of medical practitioners, various activities been implemented, and researches conducted, which proved the great interest in the topic in scientific and social levels.

There has provided several population surveys that determined to evaluate possible influence of attending various kind of cultural events or visiting cultural institutions in European countries: in 2000 survey conducted by Department of Welfare and Social Statistics of Sweden (Konlaan et al, 2000); in 2005 by National Public Health Institute, Department of Health and Functional Capacity of city Turku in Finland; in 2009 joint Sweden, Norway and USA researchers group conducted longitudinal survey on attending cultural events and cancer related mortality. Results imply that attendance at cultural events is interacted with improved viability and better self – related health (Bygren, 2009). Scottish Government Social Research Institute in 2013 presented research on the evidence of cultural engagement and sports participation on health and QoL in Scotland. The main results reveal, that those, who participated in cultural activities or have attended cultural institutions or cultural events have reported one and a half times better subjective health than those who have not participated in cultural activities during the last twelve months. Albeit presented explorations only introduce with numerous of culture and QoL integral studies, but it evidences the matter that culture by nature is beneficial for health and human being in general. Is also acknow-ledged, that such impact is not straightforward if people are not attending cultural events. That

is why must be systematically sought for opportunities and social spaces how to empower culture to reach positive affection to community members as wide as possible.

Figure 1.
Key dimensions of art and health



Source: Made by Monika Ūselytė, 2014, based on Smith (2003).

Social policy actions that reduce barriers to leisure participation are important interventions for improvement of people's health. Cultural activity promotion should have a role in health promotion programs because they not only look after health risk factor's prevention but also regard leisure participation in social, cultural and religious activities as part of their concerns. Although there are a plethora of social engaged cultural projects, they are never the same because of human resources who implements and participate in projects. Unique background, assumptions, skills and intentions make every project different.

Comprehend this, scholars distinguished unifying social project aims: raising awareness of health issues and encouraging people to take responsibility for their health, personal development, acquisition of art and craft skills, social activity and participation, staff development for health professionals, health needs assessment, communication between consumers and the health and social care agencies, cross-sector partnership, common welfare at the society (Angus, 2002). In 2003, Angus presented Diamond visualization of key dimensions of social engaged cultural projects (see Figure 1).

The four axles present four types of cultural-engaged social projects. Top axle shows creative emphasis, and bottom axle presents focus on health directly by regular health care agenda. Left side presents projects focused on health through the social sphere and social health. Right side – projects, which focuses on individual perception (Angus, 2002). Following clockwise from the top axe the art – individual combination is a concern with methods in which the culture is intrinsically healthy activity and the extent to which such a view improves individual's capacity to be healthy. Further, individual health services focus on the way in which culture is understood as art therapy (therapeutic dimension) or also can support healthcare in meeting non-medical dimensions of health. At the end health services – social perspective in concerned on engagement groups who suffer health problems. Social – arts perspective stress, that health positively results from creative engagement between people. Assessing cultural prescription as social projects due to this Diamond covers three parts of it, bottom, where it is regular health care agenda, lefts side, where health is presented in social understanding and right side, where health is presented in individual manner, joining them consist projects effects models:

1) Individual + health services = nonmedical dimension on health;
2) Health services + social = engagement groups who suffer health problems.

The first pattern described as nonmedical activities due to increasing health in particular and QoL in general. As mentioned, the cultural prescription is not linked to therapy, but it is aimed to improve QoL through health. Therefore, reach engagement groups are crucial, due to cultural prescription aims

to improve QoL of those who suffer chronic diseases. Moreover, living with a chronic disease creates significant psychological difficulties for those who live with it, no matter which kind of chronic disease it would be. A daily illness may progress into depression and that further reduce daily function, relation with other people and social participation simultaneously, which leads to decreasing the quality of life (Lyracos, 2010). That is the emergency to support those people, and it was aimed to do with prescribing participation in cultural events. The study focuses on Lithuanian case, cultural engaged social initiatives addressing health and QoL are found throughout the world. Great Britain has more than decade experience of prescribing culture. These initiatives had started 2004 as cultural prescriptions, later in 2010 it recalled "Social Prescription" as it links patient to participate in particular social actions. The social prescription is already wider than cultural prescription and indicates a various range of initiatives for example cultural event, membership in social networks, volunteering clubs, etc. (Friedli et al, 2012). In Sweden, Region Skane in 2009-2011 it has been tried to prescribe culture as supplemented method to long term sick leave patient‘s rehabilitation. It proves, that cultural participation can be also used to promote personal and national capacity – participate in the labour market (Augustinsson, 2011). As German example reveals, a familiar initiative is also suitable for children and teenagers. In Germany in 2009–2013 has been implemented Theatrical Prescription. Children and adolescents who faced with difficulties in school or with peers could receive Theatre Prescription. In particular Lithuanian case "Cultural prescription" brought from Turku, Finland, where it was implemented in 2011 while Turku was European Capital of Culture. The purpose of culture year was to uncover the comprehensive role of culture for individuals and communities – well-being providing a valuable perspective.

Cultural prescription context in Lithuania

Culture and QoL interrelation is a quite new expression in Lithuania, and there is an apparent lack of scholar literature and statistics on this particular topic. Therefore, in Lithuania social engaged culture is still identified as art therapy. The situation began to change after 2009 when Vilnius, a capital of

Lithuania was a European Capital of Culture and the first time in Lithuania organized international conference on the interface of culture and health. The same year at the Parliament of Republic Lithuania (PRL) it was a discussion on Lithuanian cultural policy. Two main results should be mentioned: first, it was formed working group to prepare a document on cultural policy development possibilities and cooperative strategies with other sectors in social policy (health, social care). Second, made a distinction between the concepts of art therapy and socially engaged culture. Means that art therapy is left to medical treatments and culture for health and social aims assigned to non-medical pursuits. Further in 2010 PRL approved Change Guidelines for Lithuanian Cultural Policy (Valstybės Žinios, 2010, Nr 80-4152). In 2011 PRL approved inter-institutional action plan for culture policy change implementation 2012–2014 and aimed to consolidate culture as a strategic direction of state development. Therefore, was also aimed to increase cultural accessibility in Lithuania for all residents (Valstybės Žinios, 2011, Nr 134 – 6350). In parallel, 2012 Government of the Republic of Lithuania approved the National Progress Program 2014–2020, which determine Culture, Regional Development and Health for all as equal (horizontal) political priorities of the Republic of Lithuania. A culture was recognised at the political level as significant determinant to reach national growth for the first time in Lithuanian legislation history.

Therefore cooperation perspective is also important, because integration of culture and health care and social issues in public and political spheres of activities is a complicated process that requires for concentrated efforts in order to achieve best results. Inter-institution cooperation remains important from the year of 2008 when Lithuania State Audit Report highlighted the lack of this cooperation particularly between private and public sectors (Valstybinio Audito Ataskaita, 2008, 4 – 6350). The measures for implementation of this aim was provided by joint actions of Ministries of Cultural, Health Care and Social Security and Labour in 2013–2014 and accomplished social projects which would provide advantageous conditions to strengthen role of culture in health care and social security spheres in order to improve residents' QoL. Even if legislation aspects of culture for QoL engagement does not consolidate situ-

ation of culture in Lithuania, it made a foundation for creating intersectional and inter-institutional actions to achieve a recognised role of culture in a common goal, for the QoL of residents. Such actions are important because public health related concerns exist in Lithuania.

According to results of research on QoL (2012) conducted by the Statistical Department of Republic of Lithuania in 2012, one on five (21 percent) of Lithuanian residents assessed their health condition as bad or very bad in 2010. From 2007, this number had increased 17 percent. 31 percent of residents aged 16 and older stated as being suffering any chronic disease or long term (not less than six months) health disorders in 2010. This number cannot be agreed as eligible in the society, although reasons may vary and not necessary depend on health care system or services. Health care system selected domains shows, that general number of doctors as well as of family doctors in the year from 2008–2012, had maintain almost the same, which actually means the same number of doctors per head. In other words, according to the self-assessed health status of people went worse, but the accessibility of doctors or quotas, which is problematic in Lithuania remain the same. Residents health situation requires an alternative to medical prevention programmes or/ and social projects.

Methodology of empirical research of social project Cultural prescription

The research conducted on 18–31 October 2013 in four different departments of Outpatient Clinic "Centro Poliklinika" in city Vilnius where prescriptions for the attendance of cultural events were prescribed. The research was aimed to evaluate health care practitioners 'comprehension about prescribing culture and their experience in familiar practices. Respondents provided answers verbally during an interview. The empiric data was collected by applying a semi-structured interview method that induced a more relaxed communication atmosphere, better adjustment to the research environment, and provided information contributing to an in-depth discussion of the problem analysis. Five doctors and five nurses were selected by Gatekeeper method of sampling. Health care practitioners participated in the research were family doctors (n =

5) and nurses (n = 5), average of work experience 17 years. The focus during the interview was given to understanding of specific moment of prescribing culture, better understanding of respondents 'attitudes and comprehension on actual practise.

The data has been collected until a certain degree of theoretical "satiation" has been achieved.

Questionnaire contained twenty questions which were grouped in five blocks which covered questions on common information about informants; familiar experience, participation and participants in social project Cultural Prescription; possible influence on health and QoL; evaluation of the project; and health care practitioners role in the process of prescribing culture. Research has been conducted following the scientific research ethics: voluntary approach, goodwill, privacy and respect. To ensure confidentiality of respondents, their names have been replaced with number and letter that indicates participant and occupation (D = doctor, N = nurse). Results were processed using qualitative processing method distinguishing categories and subcategories. Inductive category approach was used. Data derived categories raises attention to the data, which also means information gained from the interviewees. In this case, then voice of health care practitioners are hoping to raise, this approach of categorization is agreed as most suitable to apply, because the actual content of the text is much richer than it could be predicted in advance. The qualitative content analysis presents wider understand to date and more information than only it's content (Hennink et al 2011).

Research outcomes. Analysis of the data obtained during the research revealed the following main categories: ***General perception*, *Experience and interest*, *Process, Outcomes, Concluding appraisals*** establishing health care practitioners experience in prescribing culture process, attitudes and related practise.

Participants of the research identified different perceptions of social project Culture Prescription. Three subcategories (Figure 2): *Art therapy, Entertainment, Charity distinguished.*

Figure 2.
Cultural Prescription perceptions in terms of Health care practitioners

Subcategory	Supporting statement
Art therapy	*1 – D: "<…> not unnecessarily various art therapies occur, so <…> Cultural Prescription also exist".*
Entertainment	*4 – D: "<…> it is beneficial for everyone to have fun sometimes".* *6 – D: "<…> culture cannot harm people <…>, it is good that this project exist". so exist".*
Charity	6 – D: "<…> something like a charitable <…>, well that came to us also". 3 – D: "<…> if social status is high, <…> they do not need for this charity". 2 – N: "<…> those who like attending <…> this charitable initiative makes them very happy <…>".

It was established, that health care practitioners equates cultural prescription to art therapy that itself is close to medical terminology and may be associated with health also. Moreover, as it was stated upwards, any cultural relation in Lithuania are related to art therapy because of being most known term as a term but not by its meaning. Therefore, as it noticed, health care practitioners not all the time can bring clarity to its explanation. Misunderstanding between the concepts, initiatives and activities exist because of the long term absence of clear definition what is art therapy and what is not (Brazauskaitė et al, 2012). This reflected in the informant's answers, which also shows, that understanding between the health care practitioners is not applicable. Despite the fact that definition does not reflect the same things, closer naming could be unknown. However, this assign deeper understanding of cultural events and health interrelation, because another understanding as entertainment and charity supports an idea, that health care practitioners do not recognise health and cultural event interaction as medically important. Association with entertainment informs us that because of access to the cultural event health care practitioners automatically ascribe it as entertainment without any medical willingness. An expression of charity also responds to cultural events and health interrelations acknowledgement. Thus, information was found as important due to present

how does the health care practitioners, who been prescribing cultural prescriptions by themselves perceived this project. Particularly because they also were a part of it. Is important to emphasize, that first category revealed three interpretations of the one phenomenon – culture prescription. Because this many causal indicators can be behind these different perceptions (Figure 3). Obtained direct or indirect experience, scientific knowledge or even absence of interest gained during lifetime may influence presumption of a phenomenon as well as disclose surrounding circumstances of health care practitioner's perception of Cultural Prescription.

Figure 3.
Health care practitioner's common experience and interest

Subcategory	Supporting statement
Direct/indirect experience	1 – N: "<...> ceramic therapy <…> I am going and participate there <...>". 10 – N: "<…> I had an internship at oncology institution <…> there are <…> relax therapies, music therapies, painting therapies, light therapy <…>. <…> but it was serious treatments, not projects <…>". D – 6: "<...> I have heard, Mental Health Centre had a project about clay <...> something with clay <...> and I participated in their exhibition <...>".
Scientific knowledge	7 – D: "I remember at the study times I had a course about art therapies". 7 – D: "<...> I remember at the study times I had a course about art therapies for mental disorder patients". 10 – N: "Had to take interest in the scientific literature, because I had to write internship assignments, and there was much to do on this topic".
Absence of interest	*9 – N: "<…> this is not work area of mine <…>".* 4 – N: "<...> I have nothing to comment <...> me or my patients with me we had never been participated in familiar initiatives". 9-N: "No, <...> there is no time for that. Somehow it is not my sphere <...>" 6 – D: "No <...>. Never needed. But basically it seems that maybe somehow it is not my area anyway".

Participants of the research identified a different status of experience: direct experience – indicate the practices, which had directly included interviewee into the process. The same as social project Cultural Prescription did. Indirect experience – knowledge about something in relation to culture and health occurs, but no personal link exists.

An absence of interests comprises provision that cultural events and health care are not spheres of family doctors or nurses. It was established that most often health care practitioners mentioned art therapies practises as direct experience of culture and health most relevant to the prescribed culture. In this order seems more meaningful, that health care practitioners who had direct experience tends to associate Cultural prescription with art therapy.

Health care practitioners also indicated Cultural Prescription as a first social project that they are involved as part of implementers team. Although they knew about familiar initiatives, they had limited experience of culture applications in their working environment. It was also established, that only a minority (n = 2) have encountered with scientific literature. It is interesting to note that interviewees who stated about scientific literature had less than ten years working practice, which also means that studies were graduated earlier. Time aspect is relevant to be mentioned because in Lithuanian context exist significant differences between the decades due to countries historical development as well as art therapies as a source of cultural engaged social projects.

Art therapy theory and method had reached Lithuania only in the eighties of last century and at that time it was psychologists' privilege and medical representatives from other spheres were not invited to related events, trainings or courses almost decade from inception of such activities.

Period, when art therapies were dedicated only to psychologist had also influenced the perception, that arts in particular or culture, in general, are matter of psychologist rather than someone else from the health care system, this approach remain till nowadays (Butkus, 2009). It stresses the importance of the research, to highlight health care practitioner's attitudes and perceptions because health care system is the one that needs to be convinced about the worth to join forces. Moreover, interviewees perception on Cultural prescription are varied as well as their experience and interest are various, which naturally concludes, that current state of knowledge influence the perception of the subject and process of its realization. It was established, that process may vary from fail to succeed and also can be neglected (Figure 4).

Figure 4.
Domains of Culture prescription's process

Subcategory	Supporting statement
Neglect	*8 – D: "<...> I did not prescribe, because last week I had many patients <...> it takes tame to explain, registered into computer <...> difficult to find time <...>". 1 – N: "<...> they don't say nothing about, they don't know. Then you (nurse) on your own are tired or unhappy or slimly a lot of work, <...> and patient stays without prescription". 4 – N: "<...> my patients did not know about this project <....>".* 6 – D: "<...> when serious chronic disease patients is already gone I notice that I did not had time or forgot to prescribe this prescription even I could. Our regimes are too high".
Fail	*6 – D: "Who refused said, do not want, will not go, I'm not interested". 6 – D: "<...> one who refused said, do not want, will not go, I'm not interested". 10 – N: "<...> happens that people says No, but only because one lives far away, outside Vilnius, but not because one does not want <...>". 2 – D: "<...> you offer for people, but one has chronicled back pain <...> and people refuse to go <...>".*
Succeed	1 – N: "<...> they are very happy about it <...>. We share good emotions".10 – N: "<...> happens that people come here again to thank <...>".

Prescribing Cultural prescription is more complex and liable process than it may seem. Complexity depends on both – patients and health care practitioners sides. Research revealed that health care practitioners neglected cultural prescriptions – conceptually appropriate patient came to owns doctor, not necessarily, one gets a Cultural Prescription.

Neglect occurs via the complexity of reasons. First established is a low level of project popularity between patients – it leads to an absence of patients recall about a possibility to get a cultural prescription, which, according to health care practitioners would be helpful. Also when a person is unaware of this project, it becomes more time consuming to answer all questions and explain all information. Second is the requirement of firmly scheduled health care and patient appointment. According to the research, this case is even more problematic if practitioner once had a practise when patient refused or it took too long to prescribe cultural prescription, practitioners enthusiasm about pro-

cess reduces. It was investigated, that absent of interest in cultural life, living location, late evening events also health condition are most popular reasons why patients refuse to take a cultural prescription. However, a solid number of cultural prescriptions were prescribed (3420 units) which evidence health care practitioners determination to this social projects and also their acceptance of it despite all mentioned encumbrances. Health care practitioner's efforts were necessary to reaching this number equally as they had to strive for every patient to get pleasure and benefits from this project. Research revealed, that health care practitioners had experienced positive emotions among their workloads and rush that indicate mutual outcomes, for practitioners and patients. Established emotional, social and financial subcategories that reflect findings (Figure 5).

Figure 5.
Distribution of Cultural Prescription outcome

Subcategory	Supporting statements
Emotional	1 – N: “*<...> they are really happy about it*”.
Social	*3 – D: “<...> finally meet same-minded people <...> communicate and be in society <...> is needful also for quality of life <...>”.*
Economic	2– D: “<...> appreciate that they can go for free, <...> and save money <...> they are very happy about it”.

Was established that prescribed culture play a role in patient's social life and increase their social welfare. According to the research emotional, social and economic factors consist prescribed culture outcomes. Succeed cases incurred practitioners good emotions because of being the one who could make patient pleased. Simultaneously patients provided positive emotions as received cultural prescription. Emotions are important to daily life because it allow people feel better in daily routine and easier to access social networks (Allardt‘s, 1993). Positive emotions release tension and open the way for freer communication. Moreover, relationships are important with those people or networks that can provide emotional or material support for people: patients, who received cultural prescription noticed health care practitioner friendly and favourable themselves and noticed relations as important. Thus,

health care practitioners play a significant role in chronic disease patient life because visiting is periodical. Good relationship and trust between health care practitioner and patient are important, not an event for good feelings, but also it may improve treatment circumstances and social life of patients. Besides, Lyracos (2010) highlighted, emotional experiences is like a starting point that allow culture to make a further influence. Social factor is equally important, because importance of being in society and communicating to other people are agreed indicators of quality of life between scholars (Allardt, 1993; Raphael, 1999; Angus, 2002; Guetzkow, 2002; Smith, 2004).

Established cultural prescription connection with economic factor linking possibility to save money for those people who were generally attending cultural events as well as for those who postpone their attendance due to a shortage of money. Cultural prescription plays role for improvement of health, social relationships, social participation and QoL in general and makes influence at community level through reducing social isolation, and increasing social connections also promotes interpersonal interactions (Cuypers et al, 2011). Taking into account, that cultural prescriptions make such positive influence, was important to evaluate and generalize this social project in general. To reach this, advantages and disadvantages (Figure 6) were aimed to gain information about what is done right and what may be improved in the future due to pursuit the best version of the project. Advantages and disadvantages were asked to identify only for cultural prescription as a social project by nature not its outcomes on patient's health or QoL.

Figure 6.
Cultural Prescription concluded appraisals

Subcategory	Supporting statements
Advantages	1 – N: "<...> that they can go two". 7 – D: "<...> allow participated for those, who don't actually want participate <...> labels are not stick there".
Disadvantages	1 – N: "<...> *cannot choose those concerts* <...> *limited choice* <...>" 2 – N: "<...> *that they have to go to pick up their ticket* 9 – N: "<...> *question of time should be considered* <...>".

It was established, that cultural prescription for two persons and the possi-

bility to participate in the cultural event as a regular participant are highlighted as significant advantages. Two tickets prescribed allow patient to take a company together which increase emotional and social ties between close persons. Participating in the cultural event as regular audience allow people to gain positive outcomes without belonging to a group of people, taking responsibilities as a group member and avoid stigmatizing (Guetzkow's, 2010). Therefore, enable less determined patients, who do not like participate in active initiatives also gain social project benefits. If person receives a cultural prescription then only project – related persons may know that patient participate in the cultural engaged social project. That means that this method of providing cultural benefits is more suitable for individuals who are not determined to take part in active cultural initiatives.

Limited repertoire, agency between health care institutions and cultural events and timing were established as disadvantages. List of possible cultural institutions or events did not respond to everyone who gave cultural prescription needs. Informants highlighted that prescribing direct tickets to cultural events could be more productive, especially for those, who received cultural prescription more than once. Thus, opposition to intermediaries is linked to time consuming to patients and health care practitioner simultaneously. Therefore, health care practitioners stressed, that type should be considered in advance.

Conclusion

Study present health care practitioner's attitude toward social engaged cultural project "Social Prescription" where chronically ill patients are receiving tickets to cultural events in order to improve their health, social welfare and quality of life. Although the current study poses some limitations, to the authors knowledge this is the first study examining the health care practitioners perspective of such social engaged cultural projects in Lithuania. The findings of this study suggest that health care practitioners do not deny benefits of attending culture, but also do not recognize it as capable to have medical significance. Moreover, investigated that the meaning health care practitioners gave to social project cultural prescription depends on their personal inte-rest in a subject as well as knowledge and experience. Thought organizational disad-

vantages and displeasure about occupied time founded, generally health care practitioners have a positive attitude toward this particular initiative for their patients. The study is meaningful because following the success of the project it runs one additional years with corrections based on research results due to make project run easier for health care practitioners. Also, the current study and project were presented at the stakeholder's conference where it made a discussion toward joining health care and cultural sectors forces for a common social welfare of the residents.

Literatura

Angus, J. (2002). *An Enquiry concerning Possible Methods for evaluation Arts for Health Projects. Bath*. UK: Community Health.

Angus, J. (2012). *A review of evaluation in community-based art for health activity in the UK*. Health development Agency.

Augustinsson, S. (2011). *Prescribed culture. Summary of resulting research.* Malmo: Region Skane.

Baklien, B. (2009, July). *Culture is Healthy.* „International Journal of Cultural Policy". 7(2), s. 235–257.

Bruno, D., Hubley, A., Hubley, Z. (2003). *Health and the quality of life*. Essays of the quality of life. vol. 19, s. 153–183.

Bygren, L.O., *et al*. (2009, January). *Attending cultural events and cancer mortality: A Swedish cohort study.* Arts & Health. 1(1), s. 64–73.

Cuypers, K., et al (2011, August). *Patterns of receptive and creative cultural activities and their association with perceived health, anxiety, depression and satisfaction with life among adults: the HUNT study, Norway.* „Journal of Epidemiology and Community Health". 66(8), s. 698–703.

Environics research group, (2010). *The Arts and the Quality of Life. The attitudes of Ontarians.* Canada: Ontario Arts Council, interactive web, retrieved from http://www.arts.on.ca/assetfactory.aspx?did=6235.

Gaižutis, A. (1998). *Sociology of art. Vilnius, Lithuania. Encyclopedia.*

Guetzkow, J. (2010). *How the arts impact communities: An introduction to the literature on art impact studies.* Priceton: Priceton University.

Healthy People 2020 Foundation Health Measure Report: Health-Related Quality of Life and Well-Being. (2010, April 7) Retrieved from healthy people webpage: http://www.healthypeople.gov/2020/.

Hennink, M., Hutter, I., Baley, A. (2011). *Qualitative research methods*. Los Angeles: Sage.

Hyyppa, M., et al (2011, January). *Leisure participation predicts survival population-based study in Finland*. „Health Promotion International". Oxford university press. 21(1), s. 5–12.

Johansson, S.E., Konlaan, B.B., Bygren, L.O. (2011, March). *Sustaining habits of attending cultural events and maintenance of health: longitudinal study*. „Health promotion international". Oxford university press. 16(3), s. 229–234.

Konlaan, B., Bygren, O.L., Johansson, S. E. (2000). *Visiting the cinema, concerts, museums or art exhibitions as determinant of survival: a Swedish fourteen-year cohort follow-up.*, „Public Health". s. 174–178.

Krutilla, K., Reuveny, R. (2002, January). *The quality of life in the dynamics of economic development. Oxford university press, Environment and Development Economics*, 01(2), s. 23–45.

Lietuvos Respublikos Kultūros ministro 2012 m. vasario 28 d. įsakymas Nr. ĮV-140 „Dėl kultūros specialistų kvalifikacijos tobulinimo projektų dalinio finansavimo iš 2012 metų valstybės biudžeto lėšų taisyklių, paraiškos, sutarties, sąmatos ir ataskaitų formų patvirtinimo".

Lietuvos Respublikos Seimo 2010 birželio 30 d. nutarimas Nr XI-977 „Dėl Lietuvos kultūros politikos kaitos gairių patvirtinimo". 2010, Valstybės Žinios, Nr 80-4152.

Lietuvos Respublikos Seimo nutarimo projektas Nr. XIIP- 1280 „Dėl Lietuvos sveikatos 2014–2023 metų programos patvirtinimo".

Lietuvos Respublikos Vyriausybės 2011 m. Spalio 27 d. nutarimas Nr 1269 „Dėl Lietuvos kultūros politikos kaitos gairių įgyvendinimo 2012–2014 metų tarpinstitucinio veiklos plano patvirtinimo". 2011, Valstybės žinios, Nr 134-6350.

Lyracos, G.N. (2010). *Role of dispositional optimism in Health related quality of life among health care professionals with musculoskeletal pain*. New York: Nova science.

Noll, H.H. (2004). *Social indicators and quality of life research: background, achievements and current trends. Genov, Nicolai, Ed.: Advances in Sociological Knowledge over Half a Century.*

Phillips, D. (2006). *Quality of life. Concept. Policy and practice*. London and New York: Routledge.

Raphael, D. (1996, May). *The quality of life profile – Adolescent version: Background, description, and initial validation*. Journal of Adolescent Health, 19(5), s. 366–375.

Raphael, D. (1999). *The quality of life project: a health promotion approach to understanding communities*, Great Britain, Oxford University Press.

Rapley, M. (2003). *Quality of life research: a critical introduction.* London: Sage publications.

Servetkienė, V. (2013). *Gyvenimo kokybės daugiadimensis vertinimas, identifikuojant kritines sritis.* Doctoral thesis. Vilnius, Mykolas Romeris University.

Stiglitz, J.E., Sen, A., Fitoussi, J.P. (2009). *Report by the Commission on the Measurement of Economic Performance and Social Progress.* Interactive. Retrieved from http://www.stiglitz-sen-fitoussi.fr/documents/rapport_anglais.pdf.

Valstybinio Audito Ataskaita (2008). Viešojo ir privataus sektoriaus bendradarbiavimas Vilnius: Lietuvos Respublikos Valstybės kontrolė, interactive webpage, retrieved from http://www.vkontrole.lt/failas.aspx?id=3046.

Veenhoven, R. (1996). *Happy life expectancy: a comprehensive measure of quality of life in nations*. „Social Indicators Research". 39, s. 1–58.

Veenhoven, R. (2000). *The Four qualities of life. Ordering concepts and measures of the qood life*. „Journal of the happiness studies". United Nations University press, 1, s. 1–39.

Vesan, P., Bizzotto, G. (2011). *Work and quality of life in new and growing jobs. Quality of life in Europe: Conseptual approaches and empirical definitions.* Empirical evidence. Interactive webpage, retrieved from http://www.walqing.eu/fileadmin/download/external_website/Newsletters___policy_briefs/WALQING_244597_WPaper2011.4_Del5.pdf.

Endnote

[1] In 1942 Great Britain published A Report on Social Insurance and Allied Services (Beveridge Report) which was the best – selling British book of the years of Second world war, which provided the foundations for the post war welfare state (Phillips, 2006).