

Conceptualising social wellbeing using an international Group Concept Mapping study

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Abstract: Physical, mental and social components of wellbeing are known to be important to health. However, in health research and practice much of the focus has been on physical and mental wellbeing with less attention paid to social components, which we assert detrimentally affects the development of health policies and practices. A systematic measure of wellbeing, which captures both mental (internal) and social (external) wellbeing is needed to offer a richer, nuanced, and more complex multi-dimensional account of wellbeing. We report on using Group Concept Mapping (GCM) to define a social conception of wellbeing. The aim was to capture the complex multi-dimensional aspects of the ‘social resources’ that people access, and the ‘social worlds’ they inhabit. We highlight why it is necessary to separate and promote different components of wellbeing simultaneously, and why a multi-dimensional definition of social wellbeing is needed. We discuss the importance of promoting social wellbeing in health and social care settings, with reference to social prescribing. The paper demonstrates how a theoretically coherent and workable conception of social wellbeing may support scale development i.e., the South Wales Social Wellbeing Scale (SWSWBS). It is anticipated that such a tool would measure the quality of respondents’ overall experience of social wellbeing via the external social resources they possess, their perceived ability to engage in and enjoy the social world in which they live, and, as a result, their capacity for human functioning and flourishing.

Keywords: wellbeing; consensus; social world; Group Concept Mapping; human flourishing

1. Introduction

The World Health Organization defines health as “*a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity*” (WHO 1948). Central to this definition are the three conceptualisations of wellbeing; physical, mental and social. However, there is no consensus regarding the definition and theoretical basis for wellbeing, and how these different components of wellbeing relate (Deci & Ryan 2008; Dodge et al. 2012).

A general definition of wellbeing refers to what helps people’s lives go better for them (Fletcher 2015; 2016; Galvin 2018). From this definition, certain *types* of wellbeing can be conceptualised by referring to two distinct but related domains. Firstly, wellbeing can be conceptualised in relation to *internal* mental and emotional states, which is a central aspect of what is often referred to as subjective wellbeing (Tennant et al. 2007; Eid & Larsen 2008). In this case, internal wellbeing is concerned with people’s individual feelings, their emotions, and/or their thoughts. Secondly, wellbeing can be conceptualised in relation to *external* social environments and the ability of an individual to access and enjoy social resources (Hill-Dixon, Solley & Bynon 2018; Smith, 2019; Williams et al. 2019). The main theoretical assumption of this paper is that promoting both conceptions of wellbeing i.e. internal and external, across health

and social care settings, is essential to understand how wellbeing may be enhanced across populations and guide professional assessment, intervention and evaluation. For example, in social prescribing services the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS), a 14-item tool, is the most common tool used by professionals to measure wellbeing. The development of a social wellbeing tool to complement WEMWBS would produce a multidimensional assessment of wellbeing. By enhancing peoples' internal mental and external social wellbeing, we argue that individuals are in a better position to flourish and function well in their environments and produce good health outcomes so that their lives go better for them.

Drawing from the work of Martha Nussbaum (1992; 2000; 2011), we start by defining social wellbeing broadly, as the capability individuals have to socially engage with their environments, conducive to their flourishing, and human functioning. However, it is also important to conceptualise what this social engagement means exactly in order to systematically measure social wellbeing in complex and multi-dimensional ways. It is widely acknowledged that the multi-faceted nature of the concept of wellbeing, lacks specific definition and a theoretical basis, which poses challenges in measuring wellbeing (Pollard & Lee 2003; Dodge et al. 2012). Subsequently, many measures to assess subjective wellbeing exist, with their utility varying depending on the discipline (e.g. in clinical psychology and health economics) and the context within which they are applied (Linton et al. 2016; Eid & Larson 2008). A thematic review of 99 self-report measures of wellbeing identified six broad dimensions of wellbeing that may be assessed using these tools; mental, social, physical, spiritual, activities and functioning and personal circumstances (Linton et al. 2016). The majority of these tools were multi-dimensional and the most commonly included measures were of mental wellbeing, especially when these tools were used for health research, policies, and practices. Measures of social wellbeing tended to be incorporated into existing tools measuring multiple dimensions of wellbeing. The Social Well-being Scale (Keyes 1998), a 50-item scale, measuring social wellbeing across five theoretically substantiated dimensions, was the only tool identified as measuring the concept of social wellbeing in isolation. However, despite substantial changes and developments to the social world in the past 20 years, the Social Well-being Scale has not been updated since 1998 (Linton et al. 2016). Given the global policy and practice influence of the social determinants of health model in addressing health inequality (Dahlgren & Whitehead 1991; Marmot et al. 2020), particularly in the context of the COVID-19 global pandemic (Bambra et al. 2020), it is necessary to explore the concept of social wellbeing in this new context, to provide a uni-dimensional tool that can support those working with communities to address health issues related to their social world. Such a tool could be used in conjunction with existing tools to assess mental wellbeing, i.e. The Warwick Edinburgh Mental Wellbeing Scale (WEMWBS; Tenant et al 2007).

Responding, the present study aims to develop the concept of social wellbeing and subsequently develop a tool which specifically measures social wellbeing to support front-line workers in addressing health inequalities and complement their assessment of mental wellbeing in order to produce a multidimensional assessment of wellbeing. Measuring social wellbeing has been well researched, insofar as mechanisms for assessing the level of engagement with social resources within communities have been variously developed and implemented (Williams et al, 2019; Haslam and Haslam, 2019; Haslam et al, 2019; D'Ambrosio, 2018; Hill-Dixon et al 2018; White and Blakemore 2016; Bruni, 2015; White 2015; Lee et al 2015; Atkinson, 2013). Subsequently, social wellbeing has often been related to notions of social connection, focussing on the capabilities individuals and social groups have to access social resources (Alkire and Deneulin, 2009; Nussbaum, 1992; 2000; 2011). However, the contention here is that a further dimension to measuring social well-being also needs developing. That is, concerning how

individuals variously *interpret* their social world as related to what they understand as their *own* social environment and including the relative importance, access and enjoyment of their 'social world' as reflected in these interpretations. It is this latter dimension which the study here is especially focussed on, allowing practitioners to measure social wellbeing reflecting these individual interpretations, anticipating that these measurements can then be tailored to individual service users' needs and perceptions. This work has been undertaken within the field of social prescribing, but we anticipate that the findings will be relevant to other disciplines in health and social care.

2. Background/setting

This study builds upon the work of the Wales School for Social Prescribing Research (www.wsspr.wales). Social prescribing is a means of "connecting citizens to community support to better manage their health and wellbeing" (Rees et al. 2019, p. 30). It involves a pathway in which a link worker, also referred to as a community connector, social prescriber or wellbeing advisor, works with an individual to co-produce goals, and connects them with resources, groups and assets in their local community (Kimberlee 2015; Husk et al. 2016; Carnes et al. 2017; Husk et al. 2019). The most commonly expressed aim of social prescribing is to help bring about an improved state of wellbeing (Rempel et al. 2017), specifically mental, social and physical wellbeing. Evaluations of social prescribing commonly use measures of mental wellbeing, most frequently the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS; Tennant et al. 2007; Rempel et al. 2017), but lack measures of social wellbeing and so undermines the robustness of the evaluation. Social prescribing evaluations often report dissonance between qualitative and quantitative outcomes (Carnes et al. 2017; Bickerdike et al. 2017; Pescheny et al. 2019). The lack of appropriate outcome tools for social prescribing, specifically focusing on social wellbeing may explain this. A systematic multi-dimensional measure of wellbeing, which captures both mental (internal) and social (external) wellbeing is required to give a rounded, robust and rigorous evaluation of social prescribing interventions. This would also offer a richer, more complex and nuanced multi-dimensional account of wellbeing.

This paper reports on the development of the concept of social wellbeing with a view to promoting and supporting the achievement of good health outcomes. The principal method used to develop the concept is Group Concept Mapping (GCM) (Kane & Trochim 2007). GCM was used to systematically understand the concept of social wellbeing and its role in promoting good health outcomes for various populations. The main research question that was addressed using GCM is, 'How may a social conception of wellbeing be coherently defined in order to capture the complex and multi-dimensional aspects of the social resources and the various 'social worlds' people inhabit?'

3. Methods

3.1 Design

The study used an integrated mixed-method design (Caracelli & Greene 1993) to explore how people conceptualise and interpret their social world. Group concept mapping (GCM) is a structured methodology used to generate consensus among a diverse group of stakeholders (Kane & Trochim 2007). It systematically integrates qualitative components of a study through the processes of idea generation, with quantitative components through the representation of those ideas in visual maps and other reports. These may then be used to generate a conceptual framework for the subject of inquiry, in this case social wellbeing. A conceptual framework

developed from using GCM can then be used to develop measurement tools (e.g. Wallace et al. 2018, Pontin et al. 2019; Dunlop et al. 2020) and frameworks for planning and evaluation (e.g. Macdiarmid et al. 2011; Schell et al. 2013).

There are three distinct stages of data collection when using GCM: brainstorming, sorting and rating. This is followed by structured data analysis and interpretation of the findings by the researchers and a stakeholder group (Kane & Trochim 2007). Using Group Wisdom™ software, all stages of the study were conducted remotely online. This helped to facilitate the recruitment and participation of a geographically diverse sample, which was of particular concern as the data collection period coincided with the United Kingdom COVID-19 pandemic restrictions on movement and face-to-face social interaction (Carroll et al. 2020). Consequently, the study was conducted on-line between June and September 2020.

3.2 Ethical approval

Ethical approval was granted by the authors' institutional faculty ethics committee (Reference: 200607LR).

3.3 Participants

Potential participants were contacted via gatekeeper organisations who were members of the Wales Social Prescribing Research Network, the Welsh Council for Voluntary Action and the Wales School for Social Prescribing Research. The gatekeeper organisations shared the study invitation amongst their networks via email and social media. A prospective purposive heterogenetic sampling strategy was used to identify a maximum variation of participants, including academics, social prescribing practitioners, healthcare professionals, and members of the public (Kane & Trochim 2007, p. 36; Patton 2002, p. 267). One-hundred and fifty-eight ($n=158$) people expressed an interest in participating, and ninety-six ($n=96$) returned a completed consent form via email. Of those, ninety-three ($n=93$) were enrolled onto the Group Wisdom™ software and three ($n=3$) joined a study advisory group to help steer the project to a satisfactory and meaningful fruition. The study advisory group membership comprised of researchers, social prescribing digital software solutions, healthcare professionals, social prescribers, third sector representatives and members of the public. There were representative of the social prescribing community. The advisory group were consulted at each stage of the GCM study to review findings and support interpretation.

3.4 Group concept mapping procedure

The three stages of the GCM study were facilitator-led and comprised individual 20-30-minute online exercises over an eight-week period. Study participants were emailed written instructions and guidance on how to access the online study site, engage with the project, and gain real time/asynchronous access to the facilitator if required. One participant completed all three phases of the study verbally via telephone due to visual impairment and was supported by a member of the research team to do this. Participants were asked to complete five demographic questions upon their first entry to the software, enquiring about gender, age, country, disability and type of area the lived in. The five demographic questions were used to organise the analysis of the qualitative data. The study steering group developed a focus prompt for the brainstorming exercise and identified the three rating scales for the latter activities. Participants read the focus prompt and completed it in their own words. They could generate as many statements as they wished, and these statements were used as the basis for the next two phases of GCM activity –

sorting and rating. The agreed focus prompt for the brainstorming exercise was:

“When I think of the things that have made up my social world over the last year, I include...”

To help clarify the intended focus of the study, further guidance was given to participants about the broad meaning of the social world:

Rather than focusing on your feelings and thoughts about yourself, we want you to think about your social world. By social world we mean things that you have or own, and other things that help you do what you want to do in your everyday life, so that you can be the person you want to be. It also covers when you’re inside and outside of your home.

The brainstorming stage was open for three weeks (July-August 2020) for participants to generate as many statements as they wanted, in response to the focus prompt. Statements generated in brainstorming were cleaned by the study steering group, the process of which is described in the Results section. The sorting phase started in August 2020 and was open for two weeks. Using the Group Wisdom™ online sorting screen, participants sorted the list of statements into groups that made sense to them, and they labelled each of their groups of statements using a term that made sense to them. After the sorting phase was completed, the rating phase started in September 2020 and was open for three weeks. Participants rated each of the statements (n=125) on three 5-point Likert scales, one each for *importance*, *access* and *enjoyment*.

3.5 Data analysis

The GCM data were reviewed, cleaned and accepted by the study team. The analysis was primarily conducted by the first author and supported by the study team. Four data analysis steps were completed using the online software (<https://groupwisdom.com/>):

1. responses to demographic questions were analysed using descriptive statistics.
2. a similarity matrix was created using data from the sorting stage to identify statements that were commonly sorted together. Kane and Trochim (2007, p93) describe the matrix as a ‘single sorter binary square’ data matrix that is developed for all sorters (participants) in a cumulative fashion and results in the total similarity matrix. A similarity cut-off can be used where results are difficult to interpret or outliers exist (Kane & Rosas, 2018). However, the data in this similarity matrix was easily interpreted, and therefore a similarity cut-off was not required.
3. multidimensional-scaling analysis of the similarity matrix produced a statement point map (Figure 1). It is described as ‘a general technique that represents any similarity or dissimilarity matrix as distances between the original items in the matrix’ (Kane and Trochim, 2007, p93).
4. Ward’s algorithm was used to create cluster maps with cluster labels, cluster rating maps, pattern match reports and go-zone reports using hierarchical cluster analysis. Cluster maps with labels and pattern match reports are described below. A cluster rating map demonstrated the average rating values each for importance, access and enjoyment. Multiple go-zone graphs were created, which allowed the researchers to compare statements across two rating scales, importance and access. The average of each statement was plotted in an X-Y graph, dividing the cluster contents into 4 quadrants which were above or below the mean value.

4. Results

4.1 Participant demographics

Of the n=93 participants recruited n=78 completed the participants questions. The majority of participants described themselves as female (71.8%; n=56). All age groups were represented from 19 years to 90 years (M=49 years). Most participants lived in Wales (73.1%, n=57), but there was representation from other countries including England (15.4%, n=12), Republic of Ireland (1.3%; n=1), United States of America (2.6%; n=2), Australia (2.6%; n=2), Spain (2.6%; n=2), Switzerland (1.3%; n=1) and Portugal (1.3%; n=1). The majority of participants identified as having no disability (77.3%; n=58). The remaining participants reported social/communication impairment (1.3%; n=1), long-standing illness or health conditions (1.3%; n=1), mental health conditions (10.7%; n=8), learning difficulties (1.3%; n=1), physical impairments/mobility issues (2.6%; n=2), two or more impairments/disabling medical conditions or other conditions not listed (1.3%; n=1). Finally, participants were asked to describe the type of area in which they lived. There was an even distribution between the type of location described, between city (24.7%; n=19), town (28.6%; n=22), village (20.8%; n=16), rural (19.5%; n=15) and other (6.5%; n=5, including seaside location, suburbs of a city, outskirts of a city, small town in rural location).

4.2 Developing the concept

The participants generated an initial list of 363 statements in the brainstorming exercise in response to the prompt “When I think of the things that have made up my social world over the last year, I include...”. The ‘Key Words in Context’ (KWIC; Kane & Rosas 2018) method was used to clean the statement list in order to make the study more manageable. This involved synthesising statements with similar meaning; removing statements that were redundant or irrelevant, and removing duplicates after compound statements were split. This left 207 remaining statements.

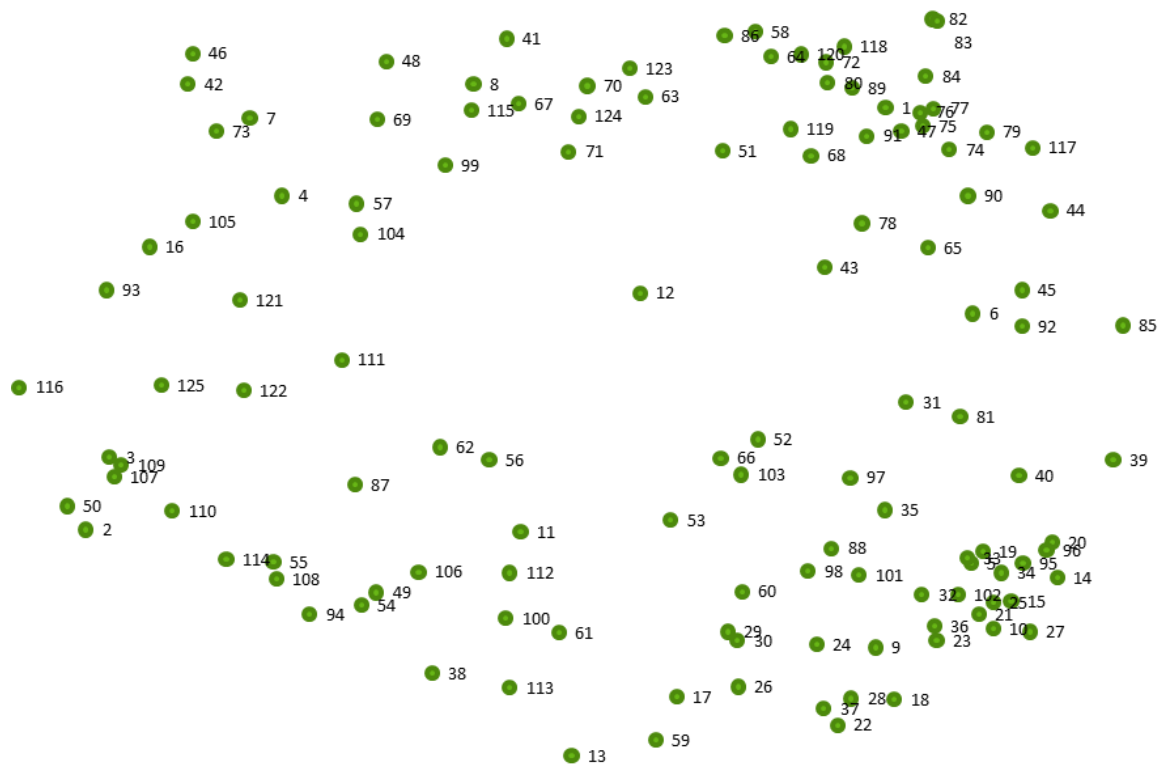
A code word was assigned to each of the 207 statements, and statements that were tagged with the same code word were reviewed by the study steering group and synthesised into a statement that shared a similar sentiment. At this point, the statements that were identified in the literature review and not generated by participants (n=9) were added to the list. The final statement list of 125 statements was reviewed by the research team and the advisory board. Examples of the final statements can be viewed in Table 1.

Table 1. Example statements generated from brainstorming.

| Statement No. | Statement |
|---------------|---|
| 19 | Going out with family and friends to restaurants, cafes and bars |
| 37 | Supporting family members, e.g. taking them shopping every week |
| 81 | Greeting people I meet when exercising and feeling part of an unofficial club when others say hello |
| 115 | Thinking about what I really want from my employment, work life balance |
| 121 | The ability to use government services, e.g. health, community |

The GCM software was used to generate a point map that placed all 125 statements on an X-Y axis using data from the sorting stage (Figure 1). The dataset had a final stress value of 0.2478. Stress value is considered to be similar to reliability, with an acceptable range of 0.205-0.365 (Kane & Trochim, 2007).

Figure 1. Computer generated point map of 125 statements. Each numbered point corresponds to the relevant statement number.



A series of cluster maps were produced from the software generated point map. After reviewing the various cluster permutations, the study steering group agreed on a six-cluster model for social wellbeing (Figure 2). Statements were placed within clusters depending on the information generated by participants when they sorted the statements into groups. The six clusters identified were; ‘everyday life, activities and pastimes’ [1], ‘family and friends’ [2], ‘connecting with others and supporting needs’ [3], ‘community involvement’ [4], ‘engaging with and reflecting on the wider world’ [5] and ‘self-growth and security’ [6].

The conceptual relationship between the clusters is indicated by the distance that exists between them, so the closer the clusters are to each other, the stronger the relationship they have between them. Cluster labels were generated by participants and reviewed by the research team to ensure a good fit between the label and the statements that were included within each cluster. Table 2 details the distribution of statements across the six clusters; ‘everyday life, activities and pastimes’ [1] has the most statements (n=29) and ‘self-growth and security’ [6] has the least (n=12). Examples of statements placed within each cluster can be seen in Table 3. Bridging values are used to indicate how closely statements are related to others which have been placed in the same cluster. Low bridging values indicate that statements were consistently sorted together and high bridging values indicate that statements may have been sorted within a range of other clusters. Statements with low bridging values represent anchor statements within a cluster. Bridging values for clusters and two anchor statements can be found in Table 3.

Figure 2. Cluster map with labels from the participant sorting exercise. The numbers indicate the statement.

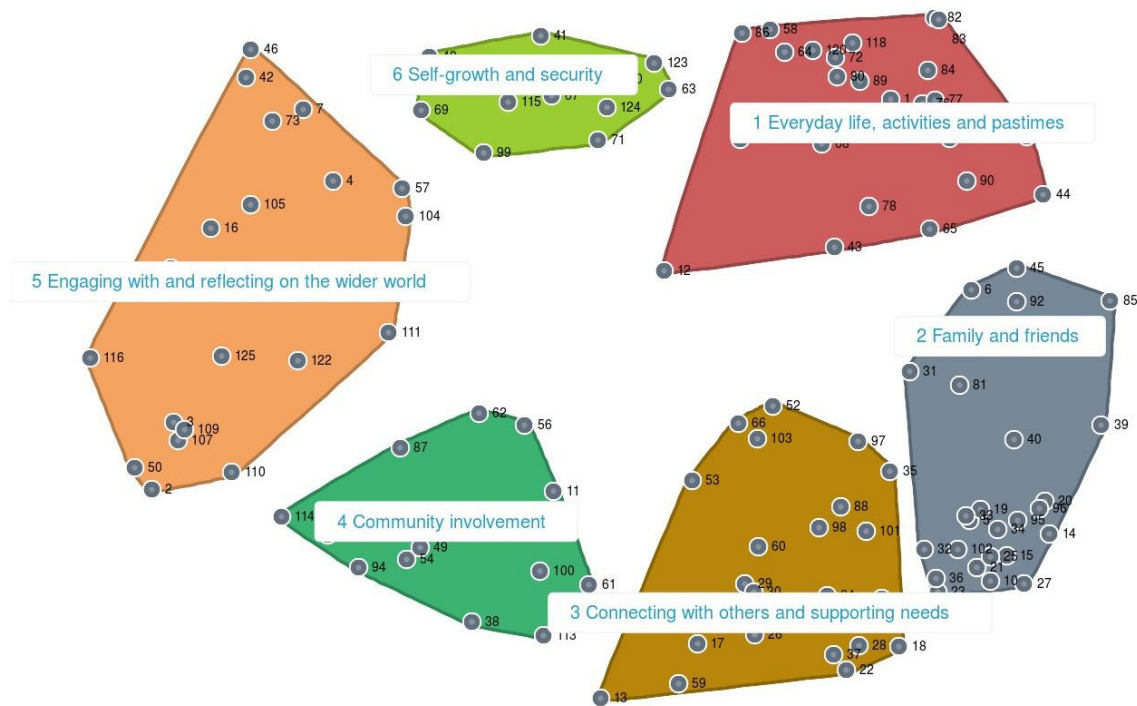


Table 2. Number of statements per cluster and average rating for each cluster on scales of importance, access and enjoyment.

| | Everyday life, activities and pastimes | Family and friends | Connecting with others and supporting needs | Community involvement | Engaging with and reflecting on the wider world | Self-growth and security |
|---|--|--------------------|---|-----------------------|---|--------------------------|
| Number of statements | 29 | 25 | 22 | 16 | 21 | 12 |
| Average importance rating of cluster | 3.50 | 3.44 | 3.02 | 2.97 | 2.87 | 3.61 |
| Average access rating of cluster | 3.48 | 3.08 | 2.72 | 2.73 | 2.97 | 3.61 |
| Average enjoyment rating of cluster | 3.78 | 3.84 | 3.26 | 3.30 | 2.39 | 3.66 |

The cluster that was rated the most important ($M=3.61$) and most accessible ($M=3.61$) was the ‘self-growth and security’ [6] cluster. ‘Family and friends’ [2] was rated as the most enjoyable cluster ($M=3.84$). Conversely, the least important cluster ($M=2.87$) was ‘engaging with and reflecting on the wider world’ [6], the least accessible cluster ($M=2.72$) was ‘connecting with others and supporting needs’ [3] and the least enjoyable cluster ($M=2.39$) was ‘engaging with and reflecting on the wider world’ [5].

Table 3. Example statements from each cluster.

| No. | Cluster | Bridging value |
|---|--|----------------|
| 1 – Everyday life, activities and pastimes (n=29) | | 0.21 |
| 1 | Relaxing and creative activities by myself, e.g. sewing, painting, knitting, writing, photography, reading, doing jigsaw puzzles | 0.08 |
| 75 | Enjoying the sunshine | 0.09 |
| 2 – Family and friends (n=25) | | 0.16 |
| 32 | Reconnecting with old friends and letting go of others | 0.00 |
| 36 | Sharing with friends, e.g. my writing for discussion or recipes | 0.00 |
| 3 – Connecting with others and supporting needs (n=22) | | 0.18 |
| 9 | A large network of friends | 0.07 |
| 60 | Getting to know the neighbours and chatting to them outside our houses | 0.09 |
| 4 – Community involvement (n=16) | | 0.41 |
| 61 | Seeing neighbours and offering them support | 0.27 |
| 56 | Using local businesses – cafés, pubs, bookshops, record stores, DIY stores | 0.29 |
| 5 – Engaging with and reflecting on the wider world (n=14) | | 0.68 |
| 111 | Continuing to work after retirement age – inputting my experience and mentoring others during this difficult time | 0.43 |
| 104 | Using more technology, e.g. computer, mobile phone | 0.47 |
| 6 – Self growth and security (n=12) | | 0.36 |
| 123 | Being able to make worthwhile plans for myself and my future | 0.22 |
| 124 | Being able to put into practice worthwhile plans for myself and my future | 0.22 |

All cluster average ratings for the three rating scales; importance, access and enjoyment can be found in table 2. These ratings can be further understood using a relative Pattern Match (Figure 3) which compares ratings of different concepts to establish a trend (Kamat 2019). This indicated the general consistency between the importance-access ratings ($r=0.86$) and importance-enjoyment ratings ($r=0.84$) but showed a weaker relationship between access and enjoyment ($r=0.48$). Discrepancies for access and enjoyment were identified in clusters 2, 3 and 4, which had high ratings of enjoyment and importance, but lower ratings of access. For the top-ten statements rated as highest on importance, access and enjoyment eight were derived from the ‘everyday life, activities and pastimes’ [1] cluster, one from ‘self-growth and security’ [6] and one from ‘engaging with and reflecting on the wider world’ [5]. Alternatively, for the top-ten statements rated as highest on importance and enjoyment, but lowest on access seven were derived from ‘family and friends’ [2], and others were drawn from ‘everyday life, activities and pastimes’ [1] ($n=2$) and ‘connecting with others and supporting needs’ [3] ($n=1$).

Figure 3. Relative pattern match report comparing cluster ratings for importance, enjoyment and access.



5. Discussion

This paper reports on the development of the concept of social wellbeing with a view to promoting and supporting the achievement of good health outcomes across Wales and elsewhere. The principal method was Group Concept Mapping (GCM; Kane & Trochim 2007). We have used GCM to identify how a range of participants, including health and social care practitioners, service-users and their representatives, conceptualise their social world. GCM is used here to systematically understand the concept of social wellbeing and its role in promoting good health outcomes.

By using the GCM method, we have been able to tease out the various components of the concept of social wellbeing and describe their multi-dimensional relationships. The clusters identified within the concept represent a variety of components of social wellbeing, ranging from everyday activities, interactions with others (family and friends), supporting others, being involved with our community, engagement and reflection, and self-growth and security. These components mirror well-established research on what is essential for facilitating social well-being as related to the capacity for social connection (Williams et al, 2019; Haslam and Haslam, 2019; Haslam et al, 2019; D’Ambrosio, 2018; Hill-Dixon et al 2018; White and Blakemore 2016; Bruni, 2015; White 2015; Lee et al 2015; Atkinson, 2013). However, in addition the analysis provided using the Group Wisdom™ software allowed us to explore individual interpretations of ‘the social world’ people inhabit, identifying those clusters that were considered by respondents to be most important, accessible and enjoyable, along with their opposites. Self-growth and security

and interacting with others (family and friends) feature highly in those clusters that are considered to be important, accessible and enjoyable, while engagement and reflection, and connecting with others least so. By giving this added nuance to how individuals variously interpret their 'social world' and relate this to their own social environment, the study here builds on and develops other research on social wellbeing (examples referenced above) which has tended to focus on the more general abilities individuals and groups have to access social resources within their communities.

We anticipate that the concept developed and reported in this paper will allow us to develop a tool, the South Wales Social Wellbeing Scale (SWSWBS), to measure social wellbeing that addresses the multi-dimensional relationships involved in the concept. Using the data generated in the present study, the SWSWBS will be co-produced with an advisory group. Items will be selected based on participant ratings of importance, access and enjoyment, in addition to considering the bridging value to ensure representation of all components of social well-being, as determined by this study. Iterative pilot testing of the tool will be necessary during item selection, followed by testing and validation.

The SWSWBS will measure the quality of an individual's experience of the external social resources they possess, their perceived ability to engage in and enjoy the social world in which they live, and subsequently their capacity for human functioning and flourishing. These components will constitute their overall experience of social wellbeing and may be used by health and social care practitioners when working with service users and their representatives. It is anticipated that using the SWSWBS will provide opportunities to access these external social resources through various social institutional practices, such as health, education, employment, income, housing, community assets, the 'outside' and natural environment, and engaging in other inclusive and empowering social networks.

Consistent with the idea of promoting both conceptions of wellbeing i.e. internal and external, we hypothesise that the SWSWBS could be used to complement the use of Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS; Tennant et al. 2007) by health and social care practitioners with service-users. The WEMWBS is a widely used and respected tool for measuring and evaluating the impact of policy and practice on the wellbeing of participants (Rempel et al. 2017; Stewart-Brown et al. 2009). When using the WEMWBS with service users, practitioners can explore with respondents their experiences over the previous two weeks by focusing on what respondents feel and think about themselves. In this case, the WEMWBS focuses on the internal definition of wellbeing. In contrast, rather than focussing on the internal mental states of mind/emotion of respondents as WEMWBS does, the aim of SWSWBS is to focus on respondents' experiences of the external 'social world' with which they are able to engage and enjoy to a greater or lesser extent. Using the SWSWBS in conjunction with the WEMWBS could provide a holistic overview of wellbeing to inform practice and support development of the social prescribing evidence base. It is anticipated that a much richer, more complex, and multi-dimensional account of wellbeing using the SWSWBS and the WEMWBS to measure and evaluate mental and social aspects of wellbeing may be generated than if using each scale alone would permit.

6. Limitations

There are some limitations to the study, not least that it was conducted during the COVID-19 pandemic which may have caused respondents to re-consider and reflect on their everyday life in a new light. We were mindful of this as we reviewed and synthesised the statements prior to the sorting phase, and we took steps to ameliorate any obvious references to the pandemic.

Although we took steps to recruit a broad international range of participants and were successful in including participants from the UK and abroad, and from the major constituencies involved in social prescribing, it's fair to say that our sample is over representative of women, living in Wales without a disability. In addition, we did not ask participants about their occupation. Finally, although 93 participants returned their consent form, not all participants completed the participant questions and all of the GCM stages. Despite this, the statement ratings were consistent across all demographic groups. This gives us confidence that the concept of social wellbeing as developed in the present study will provide a basis for developing a tool to measure social wellbeing, which in turn should complement the existing evidence-based tools available to social prescribers to help people maintain their wellbeing.

7. Conclusion

The study reported here demonstrates how consensus methods have been used to conceptualise social wellbeing and identify clusters within the concept. This conceptualisation of social wellbeing may be used to develop a corresponding measurement tool, for use by health and social care practitioners and evaluators. Using the GCM findings to develop an evidence-based tool may enhance knowledge about the impact of interventions on the distinct components of wellbeing.

Conflict of interest statement

The authors report no conflicts of interest.

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