Chapter One

What is wellbeing and how do we measure and evaluate it?

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Abstract

Wellbeing has many differing definitions, facets, concepts, and dimensions. It can mean different things to different audiences. While the lay term wellbeing may be considered to mean feeling happy and positive, psychologists may argue that the concept also comprises life satisfaction, purposefulness, and meaning, while in the health context, wellbeing may be considered the absence of symptoms of psychological distress, such as anxiety and depression. This lays the foundations for difficulty in how we communicate about wellbeing and how we measure and evaluate it, but we must, if we are to build an evidence-base for heritage interventions that can be used by service commissioners, providers, and policy makers. This chapter provides an overview of the theoretical foundations of *wellbeing*, as well as discussing what is meant by *mental health,* and explains the ways in which wellbeing can be quantified and measured, as well as discussing ways in which we may evaluate wellbeing through qualitative methods.

Keywords; wellbeing, evaluation, measurement, psychological theory

Introduction

Do we all (researchers, policy and decision makers, those experiencing mental health issues, and those working with them) mean the same thing when we refer to *wellbeing*? Whilst in its broadest use through popular literature and media this may refer to feeling happy or positive, *wellbeing* is increasingly measured and reported as the outcome of choice in health, psychology, social research, and epidemiology research (Dalingwater 2019; Karimi *et al* 2021; Patalay and Fitzsimmons 2018; Stampini *et al* 2021). In particular, it is used to evaluate interventions that aim to improve mental and physical health, ranging from psychological treatments to nature or heritage based interventions (for example, van Ageteren *et al* 2021; Britton *et al* 2020; Camic *et al* 2021; Rogerson *et al* 2020). However, wellbeing is a broadly applied term across these research fields and disciplines, and may be

capturing different aspects of wellbeing and mental (ill)health. Some psychologists have also argued that wellbeing encompasses more than these, possibly transient, emotions, and also encompasses deeper experiences of purpose in life and the ability to live in accordance with your values (van Agteren and Iasiello 2020; Seligman 2011). Indeed, it is often unclear what definitions are being applied and operationalised in research and evaluations, and it is therefore difficult to truly understand the evidence produced. This is further complicated because the concept of wellbeing, and how it can be operationalised and measured, may also be influenced by the approach of the researchers' discipline(s), and what is perceived as important to capture. This has the further effect of making the results of this disparate literature and evidence base difficult to synthesise and draw conclusions from (Linton *et al 2016*), and synthesising without this clarity and nuance provides too simplistic a view of wellbeing and claims made in terms of how it can be improved. For instance, systematic reviews exploring the impact of various interventions on wellbeing have found this field limited by the variation in use of measures, and use of *unvalidated* survey instruments (for example, Daykin *et al* 2018; Gascon *et al* 2017). Despite this, the findings from research or evaluations of interventions may still inform policy and practice in several fields, even though the evidence used to inform policy and services may be founded upon different definitions, concepts, and constructs, resulting in evidence that is considered comparable when this may not be the case (Carlquist *et al* 2017). Therefore, it is important for researchers in any field to be very clear about what they mean by, or are measuring when they evaluate changes in, wellbeing, as this will also link to the theoretical concepts upon which their definition of wellbeing is based. Whilst these may be different depending upon the aims and focus of the intervention, it is important to be transparent about the definitions used, and what it is that is being measured and there should be coherence between the two. As the policy focus in the UK increasingly includes a focus on wellbeing (Dalingwater 2019) we need to understand and be able to clearly show what is being measured, why, and what the changes observed really mean in practice.

This chapter therefore explores definitions of wellbeing in more depth, and provides an overview and explanation of the theoretical bases of wellbeing in psychology and allied professions and disciplines. We start with definitions within health research and we explore definitions of mental health here too, moving on to lay definitions, followed by psychological and sociological definitions. We then move on to demonstrate how we can operationalise and measure wellbeing in research, followed by what is involved in evaluation and the importance of transparency in our approaches. This will be useful to those who wish to assess the impact of their heritage and wellbeing projects or to critique the claims being

made by evaluations; to be clear about what is actually being measured and reported in order to use evidence appropriately in developing interventions.

Definitions and theoretical foundations of wellbeing

Health research and services

As discussed above, there has been an increase in research considering wellbeing in terms of both its influencers, and its measurement as an outcome in the health literature. From a theoretical perspective, there are two main conceptualisations that we discuss; wellbeing in the context of mental health as the absence of psychological distress and conflation with physical health.

Absence of psychological distress/ symptoms

The traditional biomedical model of mental health conceptualises wellbeing akin to mental health, and from the same lens as physical health - the opposite and absence of disease (Bourne 2010), without reference to the social and environmental determinants of health (Allen *et al* 2014). The approach to mental health within the National Health Service in England and Wales has, at times, reflected this. Although policy imperatives have shifted in recent years, with growing emphasis on community and social influences, and responses to health (for example through the embedding of social prescribing link workers in primary care; Aughterson *et al* 2020), dissonance remains between this policy and how it is enacted: "the notion that the absence of mental illness symptoms is insufficient to achieve good mental health and wellbeing is readily accepted (yet not always acted upon) in scientific, professional, and lay settings" (van Agteren and Iasiello 2020: 307). This is evidenced by the support for wellbeing offered online by the NHS, which appears to conflate wellbeing with mental health; specifically low mood, depression and anxiety (for example NHS 2021), when depression and anxiety are separate clinical diagnoses. Therefore, decreasing or removing these symptoms of poor mental health, such as sleep problems or negative thoughts, is taken as analogous to improved wellbeing, which may be an inappropriate conclusion to make.

Indeed, research suggests that while wellbeing is arguably separate from mental health, wellbeing may influence mental health (Keyes *et al* 2010), and that there is a possible protective relationship against developing symptoms of psychological distress (van Agteren and Iasiello 2020). It is therefore crucial that we develop our understanding of what the relationship is, what aspects of wellbeing are important in this relationship, and the ways in

which this might interact with mental health overall. Two points are important here though: sometimes it is assumed that wellbeing and mental health exist on the same continuum when this need not be the case; and that mental health and wellbeing seem to be used interchangeably in the literature, while they are arguably different concepts.

Before we discuss mental health further, it is perhaps important to explain what we mean by 'mental health problems' here, otherwise referred to as mental health disorders, mental ill-health, and mental illness. We recognise issues around stigma and medicalisation that can arise through the use of these latter terms, particularly when used by mental health professionals and academics, rather than those with lived experience. However, we also recognise that labelling severe and enduring mental ill-health as *problems* may not acknowledge the severity of experience and the impact on individuals, and perhaps here the term may itself be inappropriate, where mental ill-health or illness becomes more appropriate. Language is imperfect in this area, and beyond the scope of this chapter, but is discussed with great skill and clarity by Foulkes (2021). In this chapter we use the term *mental health problems,* in line with NICE terminology (NICE 2011).

How we define mental health is the focus of much research and debate; however, as influenced by medical approaches, mental health problems are referred to as *mental disorders*, and there are a number of sources of classification; such as the World Health Organisation's (WHO) ICD-11 Classification of Mental and Behavioural Disorders (ICD-11; WHO 2021), and the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Health Disorders (DSM 5; APA 2013). These references provide lists of symptoms that aid diagnosis. For instance, DSM 5 provides diagnostic criteria (including definitions and symptoms) for 157 disorders grouped into 20 diagnostic chapters. Of these, NICE (2011) identify a group of Common Mental Health Disorders (CMD). These include depression and anxiety disorders (including generalised anxiety disorder, panic disorder and specific phobias), obsessive-compulsive disorder (OCD), and Post-Traumatic Stress Disorder (PTSD). They are considered 'common' because they affect more people than other mental health disorders, and they may also be *co-morbid* (existing together). In the most recent Adult Psychiatric Morbidity Survey, 17% (1 in 6) of those surveyed in England met the criteria for a common mental disorder (McManus *et al* 2016). These CMDs may also be experienced as mild, moderate, or more severe depending on the number of symptoms experienced and the impact of these symptoms on daily life, and a person may experience different levels of severity at different times as symptoms and impact may fluctuate. As such, *common* does not mean insignificant.

Conflation with physical health

The health literature focusing on wellbeing more generally reflects the biomedical paradigm and again reflects assumptions of a widely shared meaning of wellbeing (Cameron *et al* 2006; Cronin de Chavez *et al* 2005). As such, given the assumptions made about wellbeing in the context of mental health from the biomedical perspective, there may be no surprise that wellbeing is often confused and conflated with physical health (Cameron *et al* 2006; Cronin de Chavez *et al* 2005; Wheeler *et al* 2012). There is also often an emphasis on the impact of physical ill-health on psychological wellbeing, with a lack of attention to the social determinants of health such as employment, occupational status or education level (Cronin de Chavez *et al* 2005), however this literature is starting to reflect the shift in policy focus, as discussed above, with an increasing focus upon the impact of other social interventions on wellbeing (Camic *et a*l 2021; Emerson *et al* 2021; Rogerson *et al* 2021).

Where wellbeing is used to encompass both physical and mental health, and in turn the lack of symptoms of physical or mental ill-health, this is a challenge to measurement; to progression of our understanding of the influencers and determinants of mental wellbeing; and for evaluating projects with an anticipated range of impacts. The problem with an under-defined concept of wellbeing is not confined to how to measure it, but also for developing effective interventions if there is not clarity around what it is that is being improved. For example, Cameron and colleagues found that effectiveness of interventions for community groups might be compromised where “they remain founded on assumed, conventional notions of health, and disconnected from the wider knowledge base identifying complexities of health conceptions” (Cameron *et al* 2006: 348i).

An aspect of this conflation with physical health is reflected in the use of generic health-related ‘quality of life (HRQoL) measurement instruments’ (Salvador-Carulla *et al* 2014). Quality of life is also a concept with a contested definition. It is broadly defined by the WHO as “an individual’s perception of their position in life in the context of the culture and value systems in which they live, and in relation to their *goals, expectations, standards and concerns*” (WHOQOL Group 1993, emphasis added). Thus, its measurement can potentially capture a positive, negative, or more complex ‘perception of position in life’ than the sole use of measurements of disease or disorder. However, many research instruments used to capture ‘quality of life’ focus on disorder and physical limitations (Huppert 2009). The WHO definition is reflected by the definition that Symon and colleagues use: ‘the extent to which hopes and ambitions are matched by experience’, (Symon *et al* 2003: 865) however, the

term ‘quality of life’ is used broadly in the literature, sometimes including definitions which overlap with wellbeing (Ngai and Ngu 2013), and sometimes with little definition. HRQoL instruments include the WHOQOL, which is a comprehensive measure and includes physical and psychological health, and social relationships. These are therefore more focused again on medical aspects of quality of life, “expressed as a combination of functional status, and symptoms related to disease” (Salvador-Carulla *et al* 2014: 55). These generic QoL measures have been critiqued for “not sufficiently captur[ing] wellbeing as the items that are included in their ‘emotional’ or ‘psychological’ wellbeing domains vary too much and are too narrow and therefore do not consistently assess the same concept” (van Agteren and Iasiello 2020). For example, in a comparison of two generic quality of life measures, these were found to have a low correlation for measuring quality of life, in patients with lower back pain, and were assessed to be “not interchangeable” (Eker *et al* 2007: 3) However, it has been argued that, despite the differences in meanings and approaches to wellbeing, as a concept it may in fact be useful for bringing together different sectors and to divert a focus from a purely ‘medical objective’ in the medical and health literature:

> “Wellbeing has come to the fore because of its potential to unite the objectives of the different sectors. Local authorities in England recognise ‘that an integrated approach to improving economic, social and environmental wellbeing is essential to improving health and reducing inequalities’ (Cronin de Chavez *et al* 2005: 71)

Therefore, wellbeing as a cross-sector common goal can serve to help sectors work together to innovate and develop interventions to improve lives, a key aim of those who develop community-based projects to support people experiencing poor mental health (Baxter and Fancourt 2020). However, in order to support claims for improvement of wellbeing, and subsequent improvement of mental health outcomes, it is important to be clear on what we are both measuring and claiming to improve.

Lay definitions of wellbeing and contribution to the debate

In the UK, wellbeing is also a key aspect of popular and public discourse (Carlisle and Hanlon 2007). In turn this reflects a shared meaning which appears to conflate wellbeing with *happiness* and an ongoing sense of feeling happy in our lives (Carlisle and Hanlon 2007; Rapley 2008). Whilst there is an increasing interest in popular psychology and self-help literature (Walker 2019) this focus on being well, and *achieving* happiness is also now constructed and communicated through popular social media platforms, such as Instagram (De Paola *et al* 2020).

Cameron *et al* (2006) suggest that lay understandings of wellbeing go beyond the biomedical model to encompass "feeling good in one's self, having time for yourself, self-respect, a positive outlook or confidence" (*ibid*: 350) but that in lay definitions this also encompasses social relationships, including friendships and family life.

There is also cultural context and shaping to lay definitions of wellbeing and therefore, when evaluating wellbeing changes as a result of an intervention, it is important to be aware of both these impacts on the intervention, and on what is being measured. For example, Kitayama and Park (2007) draw a distinction between the shaping context of Western culture and the centring of the self as independent, and the perception of self in Eastern culture as 'interdependent, interpersonally connected, and socially embedded' (*ibid*: 204). In turn, these, and other, societal norms and individual conceptions will drive an individual's perception of what it means to be happy, and in turn their assessment of it and wellbeing more broadly (Kitayama and Park 2007; McMahan and Estes 2011). This conceptualisation is further supported by the variety of responses to a survey on meanings of happiness, and the researchers having to first classify responses into what hypothetical question respondents appeared to be answering (Brkljačić *et al* 2020). Responses focused on "sources" of happiness – such as family, relationships and health – leading the researchers to argue that that the results showed "a potential misalignment between lay and theoretical conceptualizations of happiness" (*ibid*: 8) and that future measurements should consider social sources and aspects of happiness, such as relationships and social experiences.

Psychological understanding of, and approaches to, wellbeing

The psychological understanding of wellbeing occupies an interesting position in the literature in terms of the diversity of concepts within the discipline. Alongside 'set point'/homeostatic theories, which align with the biomedical model, we also see lay concepts of happiness reflected in the hedonic conceptualisation of wellbeing, while other conceptualisations speak more to feelings of purpose and satisfaction (perhaps in some ways reflecting concepts within quality-of-life approaches). Finally, there is also further debate to be had relating to whether wellbeing and psychological distress lie on the same continuum, or whether they are indeed separate, but interrelated concepts.

Set point/ homeostatic theory

One historically central approach to wellbeing within the psychology tradition, which reflects the biomedical model set out above, is that of 'set point theory' (also known as homeostatic or adaptation theory) as applied to wellbeing (Headey 2010). Proponents of this theory

suggest that we each have a “biologically determined brain state” (Rapley 2003: 191) that we will return to, despite events which might temporarily change our wellbeing level. This has been illustrated through popular research examples suggesting that people who had undergone life changing events such as amputation, or winning the lottery, returned after a period of time to their former, personal wellbeing set point (Headey 2010). Thus, whilst wellbeing levels might be modified by traumatic, or positive, life events that we experience, we will eventually return to our own, personality determined, wellbeing level, and further linked to ‘stable’ personality traits, such as extraversion (Headey 2010). As these are thought to be stable traits, it was argued that the events in individuals’ lives would be partly determined by these and would therefore also be predictable. Theorists in this field have developed this to suggest that genetic factors contribute to a large proportion of wellbeing, and our evaluation of it, and that therefore interventions and policy will have little impact (Headey 2010).

However, research has accumulated to contradict set-point theory, and to suggest that it is possible to change long term evaluations of wellbeing. This includes early evidence that there are certain events, such as the loss of a child, that permanently change wellbeing. There is also evidence that outlines how repeated periods of unemployment has a “scarring effect” which doesn’t adapt to other positive changes that have been documented as a result of, for example, getting married, or the positive impact of successful cosmetic surgery (Headey 2010: 10).

Hedonic approaches

There are two further approaches to conceptualising wellbeing in the discipline of psychology. The first, the *hedonic* approach, perhaps reflects more closely popular and lay conceptualisations: “Hedonic psychologists tend to take the view that wellbeing consists of subjective happiness. Hedonic psychology thus has the goal of research and intervention to maximise happiness and minimise misery” (Carlisle *et al* 2009: 1557). This perspective seeks to measure wellbeing in terms of three aspects, encompassing life satisfaction, presence of positive emotions, and the absence of negative emotions. The emphasis here is on happiness and emotions (affect), “positive affect, low negative affect and satisfaction with life” (Dodge *et al* 2012: 223).

However, there is a need to be cautious about conflating happiness with wellbeing. Although these might be regarded as synonymous in public and lay understanding of wellbeing (as discussed above), there is also some evidence (also discussed above), that these are not evaluated as the same thing by research participants, and that research participants further

distinguish between happiness and life satisfaction when asked. A further critique of these approaches is of the focus on positive emotions and equating this with wellbeing, as "it is normal, not pathological, to feel dissatisfied, disillusioned or depressed at times" (Carlisle *et al* 2009: 1558).

Eudemonic approaches

The second approach, termed *eudemonic*, rejects the conflation of happiness and positive emotions with wellbeing. Proponents of the eudemonic approach argue that "whilst some actions and outcomes may be pleasurable, they may not ultimately be good for people or able to promote wellness" (Carlisle *et al* 2009: 1557). This, for example, might include the pleasure that might come from drugs or alcohol in the short term, but which might be detrimental to mental and physical health in the long term. This approach also rejects that the presence of positive emotions/ absence of negative emotions constitutes wellbeing overall, arguing that functioning and 'living well' are instead better foundations for evaluating wellbeing. Therefore, this approach encompasses further constructs including those such as "autonomy, growth, self-acceptance, mastery and positive relatedness" (Carlisle *et al* 2009: 1557). This focus on functioning, and living well, and how this aligns with individual values as well as happiness is termed *psychological wellbeing*:

> "Common strands in the psychological wellbeing literature include self-acceptance, sense of purpose or fulfilment in life, sense of continued growth or feeling of interpersonal connectedness, happiness and subjective wellbeing" (Cronin de Chavez *et al* 2005: 73).

The emphasis here is on "positive psychological functioning and how to measure it" (Dodge *et al* 2012: 223). Further to this, Carol Ryff developed a model, which has six domains that reflect this eudemonic approach to what wellbeing is (Ryff and Keyes 1995). These domains, the components of wellbeing, are self-acceptance; autonomy, such as confidence to live life in accordance with your own values rather than external influences; environmental mastery – "the ability to manage one's life" (Abbott *et al* 2006: 2); personal growth, which encapsulates ability to develop in response to new experiences; purpose, capturing a sense of a purposeful and meaningful life; and positive relationships with others (Abbott *et al* 2006). Whilst this model clearly expands the definition of wellbeing beyond the experience of positive emotions and conceptualised *psychological* wellbeing, this approach has also been critiqued for lack of distinction in key concepts such as personal growth, purpose, self-acceptance and environmental mastery as these may be overlapping when trying to measure them (Springer *et al* 2006; van Dierendonck *et al* 2008).

Combining the hedonic and eudemonic approaches

Whilst these approaches have been historically developed separately, there is increasingly acknowledgement that wellbeing is multi-dimensional (Dodge *et al* 2012). Wellbeing may be better thought of as a combination of how people 'feel' (encompassing their individual wellbeing; hedonia) and what they are able to 'do' and achieve, along with how the life they are living aligns with their values and aims, rather than an absence of symptoms of psychological distress or negative emotions. One of the most well-known theories of wellbeing within this approach is the PERMA model, developed by Martin Seligman one of the leading proponents of positive psychology. Within this model, five domains impact on an individual's overall wellbeing: **P**ositive emotions, **E**ngagement, **R**elationships, **M**eaning and **A**ccomplishment. While happiness and positive emotions are an aspect of wellbeing, it is fleeting and transient in nature. More important perhaps are the experiences in our lives that allow us to feel fully engaged, allow us to experience positive and meaningful relationships, that give us meaning to life, and that we feel accomplished in completing. It is further argued that if a person can fully experience these five domains then this would lead to a state of 'flourishing' (Seligman 2011).

It is also increasingly clear in the recent research literature that the concept of *subjective* wellbeing (SWB; referring to the self-reported, positive aspects of mental health; Tennant *et al* 2007), also comprises both aspects: the 'hedonic' which includes happiness, pleasure, and enjoyment; and 'eudemonic', which encompasses purpose, meaning and fulfilment, suggesting that both the hedonic and eudemonic aspects are required for a state of positive wellbeing. This is because separately they may not lead to an overall positive state: for example, feelings such as happiness could be the result of an unhealthy coping strategy, as outlined above, and pursuing a life of meaning may not in and of itself lead to happiness or feeling contented (Huppert 2005).

Wellbeing and Mental Health

Where then, does this leave the relationship between wellbeing and mental health? Psychology theorists also have two different ways of looking at the relationship between mental wellbeing and mental health; the single and dual factor models.

The 'single factor' model, such as Huppert's mental health spectrum (Huppert 2009) states that mental wellbeing is at the opposite end of symptoms of psychological distress, and that therefore to improve population level mental health we need to shift population mental

wellbeing higher (van Agteren and Iasiello 2020). This will have the overall protective effect of moving a proportion of people away from the 'languishing' stage of the model, where they are at risk of deterioration into poor mental health.

In contrast to this, dual factor models such as those outlined by Keyes (The 'Complete State Model of Mental Health') suggest that it is possible to have differing levels of wellbeing even where experiencing symptoms of psychological distress and equally therefore that low wellbeing is not the same as symptoms of psychological distress (van Agteren and Iasiello 2020). Huppert, in outlining the single factor model above, argues that it is difficult to conceive of high wellbeing or 'flourishing' in people with (for example) major depressive disorder, however, as van Agteren and Iasiello argue, this is a matter of how both flourishing and any mental health problem or symptoms, and the relationship between the two, are defined and measured. It is therefore important that we are clear about the definitions of these concepts and constructs that we are including in designing interventions to support mental health, or recovery, why they are important, and how we are measuring them.

Critique of psychological approaches to wellbeing

There has been a shift, from material definitions of wellbeing (for example the use of Gross Domestic Product, or 'objective' measures such as income as proxy indicators) to the 'social indicator movement', and then to a more individualised focus of wellbeing and the quality of individual's lives, as encapsulated in these psychological, evaluative approaches to wellbeing (Rapley 2003). Rapley further distinguishes between a Scandinavian focus on social wellbeing, measured in terms of what he calls 'objective indicators' ("money, property, knowledge, psychic and physical energy" (Rapley 2003: 5), and American, a more subjective approach, and argues that the latter measures of our happiness are more influential in Western societies, reflecting the evidence above (Rapley 2003).

This further links to the lack of acknowledgement within these approaches of the cultural contexts of wellbeing, the different definitions of what might constitute wellbeing, particularly in locations and settings where individual evaluations of happiness and satisfaction are not elevated in the way that they are in North American, or Western societies. The North American location of much of this theorising and research means this has been shaped largely by North American culture and ideals, with the assumption that these are "universals" (Carlisle *et al* 2009: 1558). Awareness of cross-cultural definitions of what wellbeing is, or what is important and valued and trying to be achieved, is particularly important where we

are measuring the impacts of our interventions, or in adapting interventions from different settings to or from our own (Lomas 2020).

This criticism is further developed by researchers examining the individual nature of conceptualisation and measurement of wellbeing within psychology. Whilst the Ryff, PERMA and other models include elements that capture positive relationships with others, these approaches do not seek to capture other social and environmental influences of wellbeing or mental health, and how this interaction with social structures might shape individual evaluation of wellbeing (Cronin de Chavez *et al* 2005). This could include, for example, the constraints on ability to increase and maximise wellbeing in terms of access to resources and social capital (Deeming 2013; Nieminen *et al* 2010; Shields and Wheatley Price 2005). It may be that these reduce the power of heritage-based interventions to impact on participant wellbeing, or that these are factors that should be accounted for in the design of heritage based interventions. They might be particularly important when understanding how these might address the social and health inequalities that might also be faced by participants, and when trying to support mental wellbeing: "wellbeing is dependent on the justice of social conditions and therefore potentially related to social capital" (Cronin de Chavez *et al* 2005: 75).

Evaluating Wellbeing

As we have outlined, there are many ways in which wellbeing is conceptualised, and this impacts on how we measure wellbeing in evaluations. Heritage professionals and organisations working in this area have advocated for more and better evaluation (Darvill *et al* 2018; Heritage Lottery Fund n.d.), but rarely provide explicit instruction as to what it means to evaluate, what makes a *good* evaluation, and the importance of understanding the methods and tools associated with evaluation. The rigour of evaluation is essential to determine the impact, if any, that services and interventions have on wellbeing of those involved. Evaluations can take different forms, and often involve either quantitative methodologies (such as questionnaires), qualitative methodologies (such as interviews), or a mixed approach including both. Evaluation must also be robust and transparent and so it is important that recognised methods and analyses are employed.

Quantitative Evaluation

Quantitative evaluation broadly refers to methods that utilise empirical methods, such as experiments, to observe change and use numbers in order to measure this change.

Examples include Randomised Controlled Trials, Controlled Clinical Trials, as well as Before and After studies. The collation of quantitative data can be achieved through self-constructed surveys, in which we might develop a set of questions that we think are relevant to our projects and the changes we have witnessed in others. When self-constructed questionnaires are used, there is a risk of bias (in which we unconsciously or otherwise ask people about experiences we know, or think we know, change, thus confirming our own assumptions) or invalidity (we are not measuring what we think we are measuring). As a result, rigorous evaluations of psychosocial interventions use a pre-written questionnaire that measures a particular outcome we are interested in measuring, such as wellbeing, anxiety, and depression. These are known as validated scales, which means that the development of that scale has followed a rigorous process, and that it has been tested to ensure that it measures what it intends to measure (e.g. wellbeing) rather than something else (e.g. happiness or quality of life) and has been shown to do so reliably time after time. Boateng *et al* (2018) provide a very useful outline of the rigorous 9-step process that leads to validation, which includes item development (the development of individual questions) scale development (how each item contributes to the overall measurement of the construct), and scale evaluation (tests of validity and reliability). Only then are scales considered to be *valid.*

These measures are 'standardised', which means that the scores from these measures can be used to accurately compare different projects, services, and interventions to one another in order to demonstrate effectiveness (as long as we keep in mind the complexity of the projects involved). Some validated psychological measures can be completed by the participant, others need to be administered (and sometimes require training prior to being administered). Many of them also have rules about how to deal with missing data (i.e. when a participant misses a question). It is therefore important to note that if any aspect of the scale is changed, i.e. items are taken out of the scale, the wording is changed, the scale is changed, the language is changed (from English for example) or it is self-completed when it should be clinician completed, then the scale may no longer be valid and cannot claim to measure the outcome being evaluated. It also means that the data from an evaluation cannot be compared to the 'normative data' of the measure. Normative data provide the means from the general population for different age groups and genders and means that comparisons can be made. This is why it is essential that scales are seen as more than 'questionnaires' and that they must be used and analysed in their validated version with no changes made.

The choice of scale is also important as it speaks to the ways in which wellbeing is understood by the service providers. Scales to measure wellbeing have proliferated in recent

years, and this reflects theoretical and construct concerns. For example, the Ryff scale reflects Ryff's conceptualisation of wellbeing as based in the eudemonic theories outlined above, and comprises a 42-item scale across the six dimensions outlined above: autonomy; positive relations with others; environmental mastery; personal growth; purpose in life; and self-acceptance (although versions in use range from 120 items to 12) (Abbott *et al* 2006) The Warwick-Edinburgh Mental Wellbeing Score (WEMWBS) aims to capture both hedonic and eudemonic conceptualisations of subjective wellbeing discussed above (Tennant *et al* 2007). It is comprised in its full length of a 14-item Likert scale (5 possible responses, ranging through: None of the time; rarely; some of the time; often; all of the time). This scale also captures inter-personal relationships and 'positive functioning' (Tennant *et al* 2007). In common with the WEMWBS, the ONS4 questions used by the Office for National Statistics (ONS 2018) in the UK assesses these constructs (hedonic or evaluative, and eudemonic) separately. It employs a scale from 0 – 10 (where 0 equates to 'not at all' and 10 to 'completely) in answering a range of questions such as 'Overall, how satisfied are you with your life nowadays' and 'Overall, how happy are you with your life nowadays' and Overall, to what extent do you feel the things you do in your life are worthwhile?' The benefit of the inclusion of the ONS4 in the Annual Population Survey is the availability of comparative data. The Personal Wellbeing Score is based on these questions, and has recently been validated (Benson *et al* 2019).

We could keep presenting wellbeing scales, but the point we hope to make is that the scale selected must be suitable to the changes that can be realistically expected from the intervention, and expected changes should be based on understanding of the theory from which the service or projects operates and be transparent about this. Care should also be taken that the scale selected is appropriate and validated for the population it is to be used with. As outlined above, the concept of wellbeing may be differently defined according to cultural context, and language differences may also impact how scales are understood and completed (Taggart *et al* 2013). The WEMWBS is translated into several different languages, and validated in many of these (see Warwick Medical School 2021for a list of available translations).

Choosing the particular scale to use is only one of a number of decisions that need to be made in terms of evaluation. Another is the design of evaluation. *Gold standard* evaluation is considered to be achieved through a Randomised Controlled Trial (RCT). This is when people who fit a very specific set of criteria are randomly assigned to one of two (at a minimum)*conditions;* one that is the intervention (e.g. a heritage project) and another that is the control group. A control group means that a comparison can be made and a control

group is normally *treatment as usual* or a waiting list group. Having such a controlled set of variables means that any change can be said to be due to the intervention itself. Although gold standard, the practicalities of conducting RCTs are numerous. RCTs require large samples to allow statistical analysis to be conducted, often with numbers that might be difficult to cater for on heritage projects. Indeed, pilot trials would need to be conducted to ascertain an adequate sample size. We could also question the ethics of putting people, who might otherwise benefit from involvement, onto waiting lists if they are randomised to the control group, particularly as projects may not be consistently offered, and there may be no opportunity to be involved in the future. Given the impracticalities and, one may argue, the inappropriateness of adopting more medical types of evaluation on heritage projects, the importance of using validated scales becomes clearer. Using validated scales allows us to get a sense of change as we compare different studies to the normative data.

Qualitative evaluation

Qualitative methods focus on the analysis of words, and so evaluations from a qualitative perspective tend to focus on exploring with participants what (if anything) they feel has changed as a result of being involved in a project, and in what way. Qualitative research is often misunderstood as little more than anecdotes, but high quality qualitative research should be rigorous and transparent. It also requires the person conducting the work to be in a constant state of *reflexivity* to determine the extent to which they are analysing the experiences of the participants, rather than allowing their own thoughts and experiences to lead the interpretation.

Qualitative data are commonly collected through one-to-one interviews using a 'semi-structured' interview schedule, i.e. a set of questions with accompanying prompts that are used to guide the interview. It is important to note that the schedule is not a spoken questionnaire, but rather provides a road map to guide and facilitate the rich, in-depth data synonymous with qualitative research. Alternatively, focus groups may be used. Focus groups involve bringing a group of individuals together for a group discussion. Normally groups of people who have engaged with a service or project would be brought together, or perhaps those who have provided the service. Careful thought must be paid to the group composition in order to facilitate open discussion (i.e. service 'users' and providers in the same group may not be beneficial). As with interviews, focus groups would use a schedule to facilitate discussion.

It is in the analysis of qualitative data that attention is given to concepts of wellbeing. The most typical approach to analysing qualitative data is thematic analysis, in which patterns of interest are identified and are gradually developed into themes in an attempt to describe the data. It is in this analysis that theories of wellbeing would be used to guide the identification of themes, and would be used to support interpretation and conclusions drawn as to what changes for individuals through participation. For instance, an individual may talk about feeling that a project gave them something to get up for in the morning – thus arguably capturing aspects of purpose in the eudemonic concept of wellbeing. And it is in this careful interpretation – using definitions and models of wellbeing – through a rigorous method of analysis; in transparent reporting; and in the constant engagement in reflexivity, that results in findings of qualitative evaluations being fundamentally different to anecdotes or participant testimonials.

Conclusions

Wellbeing can have different meanings and definitions, which are linked to the term being employed in a lay, health or academic setting, and even across disciplines. This is further complicated when terms such as mental health are interchanged with wellbeing, and we hope this chapter has helped to outline the reasons behind this, and why caution needs to be exercised when discussing wellbeing and potential impacts on it through heritage-based interventions.

This chapter has discussed various conceptualisations of *wellbeing* and the underpinning theories for these, in particular the hedonic and eudemonic approaches and where these are combined as *flourishing* or *subjective wellbeing*, for example in the PERMA or WEMWBS scales. We have also considered competing models for the relationship between mental health and wellbeing – whether these occupy opposite ends of a continuum or are separate constructs wherein it is possible to have both mental health problems and high wellbeing.

A clear understanding of ‘wellbeing’ and its theoretical underpinnings should guide the selection of appropriate methods for measurement (where appropriate) and evaluation of interventions. The methods of evaluation may incorporate measurement using a validated scale as part of a questionnaire, or through qualitative techniques, or applied together to form a mixed methods approach. Although we have not been able to list all the available validated measures in this chapter, some examples and their relationships to the theoretical constructs outlined above have been given. In addition, we have not presented a complete guide to evaluation either, but encourage readers to fully explore options prior to undertaking evaluation.

Although there may not be a ‘one size fits all’ definition of wellbeing, there are some key areas about which it is important to be clear and transparent before making claims around an intervention’s impact on wellbeing, and what this means. When we are not clear about the terms we use, evidence becomes difficult to synthesise and employ, and it also becomes difficult to truly understand what it is that we are capturing in evaluation studies. For example, is wellbeing a reflection of happiness or positive emotions, purpose of and engagement with life, or a combination of these? Are we arguing that improving wellbeing will improve mental health, or protect against mental ill-health, and why? Each of these are aspects that need to be accounted for when evaluating interventions for wellbeing. By being clear about how wellbeing is conceptualised, the body of evidence for heritage projects will become stronger, and we can be more confident in the policy recommendations we make as a result.

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