NEW ZEALAND
CURRICULUM DESIGN INSTITUTE
Te Wānanga Hoahoa Matauranga Aotearoa

Research Underpinning the Universal Wellbeing Model (UWM)

Introduction

The UWM has been developed through a programme of themed literature review, and two nationally funded Ako Aotearoa best practice theoretical and applied practice research awards, one published in 2011 and one in 2020. The UWM was designed to i) explain the concept of wellbeing, ii) identify the key determinants of human wellbeing, and iii) support accurate evaluations of the wellbeing of youth, individuals, families, whānau and teams. The UWM underpins the Universal Wellbeing Evaluation Tool (UWET) which is administered during Universal Wellbeing Checks. Reports from these checks are actioned via Universal Wellbeing Enhancement Planning (UWEP) with Professional Wellbeing Facilitators who can provide related monitoring processes, education, risk management, advice giving, referrals and/or the implementation of universal wellbeing community implementation systems that individuals or groups may elect to establish.

The UWM also underpins Professional Wellbeing Facilitator education and accreditation programmes and Professional Wellbeing Facilitator practice and currency guidelines. This review summarises the journey, contexts and outcomes of research undertaken which led to the emergence of the UWM and the above wellbeing services and supports. Research outlined was and is part of a long-term vision to build a robust wellbeing philosophy, theory, research and practice bases from which to progress understandings of human wellbeing and the effectiveness of enhancement programmes overtime. While New Zealand and many other countries aspire to improve wellbeing, with a view to supporting achievement, inclusion, productivity, and equity; few long term and progressive wellbeing research programmes could be located.

The Journey

The Ottawa Charter for Health Promotion by the World Health Organisation in 1986 was a critical publication for many working in health, education, community, indigenous, and workplace research and practice related roles; it identified societal levels where influence could be exerted and changes might occur. The Charter also challenged the medical model cause and effect approaches of the day and advocated for health and wellbeing initiatives that were integrated and could meet the complex social, cultural, and multifactorial challenges set out. The Ottawa Charter was underpinned by two supportive theoretical models: the Socio-ecological Model of Urie Bronfenbrenner (1979) and the Socio-cultural Model of Lev Vygotsky (1980). The explanations these models gave along with the Charter impacted globally and to the extent that many countries changed their systems to reflect the new ideas and explanations they included, amongst them, was New Zealand. The socio-ecological and an indigenous Hauora (socially-culturally based) model of wellbeing were adopted in a new school health and physical education curriculum and intersected with a solution finding challenge faced by the researchers in 2008.

The challenge emerged when a new cohort of indigenous Māori and Pacific Island students entered an institution with the understanding their social welfare supports would be removed if they did not study. It quickly became apparent to staff that new approaches would be required

to support these students to achieve. Staff found the way the programmes and institution had been operating was often not responsive to these particular student's aspirations. Some students were hostile to the programmes, government funded institution, and their welfare system requirements. Staff found these students views were embedded in ethnically and culturally different expectations and world views and recognised they needed to provide a holistically supportive community for these students if they were to succeed. The search began for models, research, and practices that might assist the empowerment this special student cohort. Their search for models, research and practices that could meet the complex needs of their students led staff in three directions.

Firstly, it led to review of a high number of definitions and discussions of the concept and models of wellbeing from various standpoints. A surprising finding was that despite notions of wellbeing have appeared in academic literature for over 40 years, there were few evidence informed attempts made to define the term itself. Ryff and Keyes (1995) noted for example that 'the absence of theory-based formulations of wellbeing is puzzling given the abundant accounts of positive functioning in subfields (such as psychology). Definitions and research on wellbeing largely came from medical model based clinical health or psychological perspectives. Studies from psychological perspectives related to mood or affect (Hattie, Myers, & Sweeney, 2004) or tended to view wellbeing as being related to intellectual or emotional areas such as depression or positive self-attributes (Keyes, 1998; Ryff & Singer, 1996). Other studies related wellbeing to the degree to which a person demonstrated valued attributes such as academic achievement (Carr-Gregg, 2000b; Marks & Fleming, 1999; Rickwood, Boyle, Spears, & Scott, 2002; Whatman, 2000; Wyn, Cahill, Holdsworth, Rowling, & Carson, 2000). Those from clinical health backgrounds largely viewed wellbeing as an absence of diagnosed physical health conditions such as heart disease or similar.

The above definitions led to the need to establish definition and model selection and quality criteria if the researchers were to find definitions and models that could support their student wellbeing support challenge. They utilised the following questions to sift the definitions and models their literature search found:

1. Is the definition and /or model underpinned by philosophy?
2. Is the definition and /or model clear, is it an accurate explanation?
3. Is the definition and /or model supported by or evidence backed?
4. Is the definition and /or model supported by wellbeing practitioners?
5. Does the definition and /or model have the capacity to guide and support quality research?
6. Is the definition and /or model fit for our purposes?

The above criteria were largely met in 2010 by the World Health Organisation (WHO), defined mental wellbeing as "a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community". While this definition was limited to mental wellbeing only it provided a starting point for the researchers. In 2017, WHO then revised the health advice they provide to schools, they urged schools to make a commitment to enhancing the social, emotional, physical and moral wellbeing of all members of their school community and promoted the six ecologically orientated positive health promoting outcomes to support wellbeing: "*Engagement with health and education community leaders; Providing a safe and healthy environment; Curriculum teaching and learning; Access to health services; Policies and practices that intend to improve wellbeing and Improving the health of the school community" (p.19)*. In this statement the scope of wellbeing is extended to social, physical and moral wellbeing.

The direction of change advocated by WHO was for entire schools and communities to have a clear focus on shared practice problem(s, wellbeing); actively learn through inquiry; take collective ownership; include an appropriate mix of partners; have a sufficient commitment to

implementation and effective structure of governance and decision making relating to wellbeing. WHO also drew attention to the many mental risk factors that may be present in a working environment or community (WHO, 2019). The second direction pursued by the researchers led them wellbeing models emerging in education. In 1999, the New Zealand Ministry of Education published a Health and Physical Education curricula that included the following conceptual framework:

"Hauora – a Māori philosophy of wellbeing that includes the dimensions taha wairua, taha hinengaro, taha tinana, and taha whānau, each one influencing and supporting the others.

Attitudes and values – a positive, responsible attitude on the part of students to their own wellbeing; respect, care, and concern for other people and the environment; and a sense of social justice.
The **socio-ecological perspective** – a way of viewing and understanding the interrelationships that exist between the individual, others, and society.
Health promotion – a process that helps to develop and maintain supportive physical and emotional environments and that involves students in personal and collective action" (https://nzcurriculum.tki.org.nz/The-New-Zealand-Curriculum/Health-and-physical-education).

Exploration of the genesis of the concept of Hauora (breath of life) in turn led to two indigenous Māori models of hauora; the first was Whare Tapa Whā (the four-sided house) described by Durie in 1994. This model appeared to have been designed initially to support the development of Māori cultural capabilities of in non- Māori health workers supporting Māori patients in health settings. The model outlined the wellbeing needs of indigenous Māori patients as relating to four dimensions: taha wairua (spiritual side), taha hinengaro (intellectual and emotional side), taha tinana (physical side) and taha whanau (family and social side). The researchers noted it had been adopted in the curricula and educational settings so quickly implemented this model to support their cohort of Māori and Pacific Island students. The researchers quickly found that while Durie's model supported and resonated with Māori students and staff it was not successful in meeting the needs of the diverse Pacific Island students who's ethnic and cultural world views differed.

A second Māori model to support wellbeing was located; the Whare Tapa Rima Model (the five-sided house) by Moeau (1997) plus the Fonofale Model created by Fuimaono Karl Pulotu-Endemann in 1984. Moeau's model included all four dimensions set out in Durie's model but also included a new fifth dimension whenua (cultural and ethnic side); this new dimension supported staff awareness of their own ethnic and cultural perspectives as well as the unique ethnic and culturally needs of each student. Pulotu-Endemann's, Fonofale Model (family house) included the family as the foundation, four support posts of the physical, spiritual, mental and an 'other' dimension (which included: gender, sexuality and socio-economic status) these supported a thatched roof within a time, environment and context ecological frame. A nationally funded investigation of the outcomes of providing supports informed by these models (Schofield, Walker, & Going, 2011) showed them to be highly effective in practice. Student achievement levels were significantly enhanced and maintained overtime due to the ongoing and holistically supportive community the models fostered. Key success variables that emerged related to the holistic nature of the support provided plus the consistent and ongoing social connections and supportive community the models supported where the students studied.

Questions post this investigation lingered about the appropriateness and potential of the models to support more diverse people plus those delivering support services guided by them. Further analysis of the three models used found they were designed to: health enhance and improve health services for specific ethnic groups; employed to advocate for responsiveness to specific

ethnic/cultural groups, to develop empathy and the cultural competencies and understandings of 'others working with 'their people"; all were being utilised to promote political change in government health service delivery. Bearing in mind the researchers' initial challenge to support the ethnically and culturally diverse students they were prompted to in 2020 further evaluate the Whare Tapa Rima Model with an internationally diverse population. This investigation was nationally funded through a national best practice research grant (Fielden, Stevenson, Going, Grant, & Zagala). Moeau's, Whare Tapa Rima Model proved highly effective when staff implemented it with culturally and ethnically appropriate customisations.

Also emerging from this investigation were i) the challenge of utilising a model to support people when you are not from the ethnic or cultural group the model is derived from and ii) people accepting supports via a framework from another ethnic or cultural viewpoint and iii)the utilisation of models designed for other purposes and audiences. The first two challenges became barriers for some students and staff and the third raised issues for staff and their cultural safety performing such work and utilising such models. In 2021 Stevenson and Zagala further clarified the Whare Tapa Rima Model as customised and used in higher education to support others also seeking to improve achievement and equity in higher education institutions. The outcomes of the second national investigation prompted the researchers to view the models they had used to date as while helpful to inherently also include significant challenges. The researchers then embarked on their final search direction; an international review of wellbeing models.

Wellbeing Model Review

Having identified humanistic philosophies and theories at the base of their work, the researchers then located literally thousands of anecdotal, professional and research papers on wellbeing models. This finding led them to distil their findings through a themed wellbeing literature review search. Wellbeing model literature needed to meet one or more of the following: i) had an identified and declared philosophical base ii) had the capacity to support wellbeing literacy through being clearly articulated iii) had been or could be evaluated through research iv) could guide wellbeing practitioners v) was fit for purpose, that is, implementation with ethnically and culturally diverse youth, adult individuals, families/whānau or teams in order to enhance their wellbeing. Themes emerging from the literature reviewed are set out below.

Ethnic and Cultural Perspectives

From 1982 a range of wellbeing models emerged from specific ethnic or cultural groups; for example, 'Te Wheke', the Octopus Model by Pere, (it included eight cultural concepts for support to meet the specific wellbeing needs of New Zealand's indigenous Māori people). Love (2004) provided expanded explanations of this model its underpinning Māori worldview. While Love's work supported understandings of Te Wheke no formal evaluations of outcomes of the model could be located. Also created at this time was the Fonofale Model of Pacific Health & Wellbeing (Pulotu-Endemann, 1984), and Whānau Ora (family life) Model (Ministry for Community and Voluntary, 2009; Taranaki District Health Board, 2014; Ihi, Moana & Te Puni Kokiri, 2020). The Whānau Ora Model reframed wellbeing from a western and individual perspective to an ethnic/cultural, family/whānau, and collective one. The Whānau Ora Model underpinned a national Whānau Ora programme for New Zealand's Māori population and the model has been frequently evaluated as a public health programme. Also appearing in the literature then were models from other ethnic, cultural and professional groups designed often for a specific and exclusive audience. For example, Hassan (2015), published a paper on the Islamic Transcendental Wellbeing Model; it was underpinned by Islamic philosophies, the Koran, and focussed on and Islamic Model of wellbeing to guide provision of counselling services to Malaysian Muslim women.

Teoh and Iwama, Kawa Model (2015) was also designed to specifically support occupational therapists to improve the wellbeing of their client's. An Aboriginal Social and Emotional Wellbeing Model was published by the Australian Mental Health Commission (2018) this was also designed to exclusively serve this community who had been disadvantaged by western and medical model orientated health and wellbeing service provisions. In 2017, Hinemoa Elder an eminent youth forensic psychiatrist published two related models, Te Waka Oranga and Te Waka Kuaka, the first was designed to establishing partnerships between those with an interest in supporting Māori youth, and the second promoting the inclusion of cultural knowledge and skills to support improvements in the wellbeing of youth receiving forensic services. Shifting focus (Lester, Cefai, Cavioni, Barnes & Cross, 2020) advocated for the promotion of a staff wellbeing and (Garvey, Anderson, Gall, Butler, Whop, Arley, Cunningham, Dickson, Cass, Ratcliffe, 2021) a more culturally informed Care Model for Aboriginal and Torres Strait Islanders. A strength of these latter two models of the philosophy, theory, practice, and the support for evaluative research they included. In summary all the above ethnic, cultural and professionally focussed models added to the dialogue on wellbeing and sought to be systemically transformative of the wellbeing of those whose they advocated for; the disadvantaged, and previously unheard.

The above models could all be critiqued as being exclusive in nature, and advocating only for differentiated service provisions to be provided by people of certain ethnic, cultural, religious, or professional backgrounds, to specific others. In many situations this research has served to support change, increase empathy and bring about the inclusion of new and diverse voices. These models all inherently include the same challenges the research met in 2020 when faced with working with diverse others, a reality for most Professional Wellbeing Facilitators. New questions now emerged and questions such as can one cultural or ethnic group be only supported by others from that group, and would this be an acceptable scenario for those who work as heart surgeons? A clear challenge to be traversed is that of Professional Wellbeing Facilitators and those they work with being culturally safe when working with diverse people.

Student Wellbeing

Interest in student wellbeing and its measurement next begins to emerge in literature (Masters, 2004; ACER, 2005; Soutter, Gilmore & O'Steen, 2010, Soutter, 2011). Soutter, Gilmore & O'Steen for example proposed a Multi-dimensional Conceptual Framework which included: having, being, relating, thinking, feeling, striving concepts as indicative on students' wellbeing state. In 2008, Dunn, Iglewicz & Moutier proposed a 'Coping Reservoir' Model for medical student wellbeing, it supported the notion that medical student wellbeing was dependent on a store of coping skills and when they were adequate student wellbeing was positive and when the student had used or lacked coping capabilities their wellbeing would decline. In 2014, (Crawford, Lisciandro, Jones, Jaceglav, McCall, Bunn, Cameron, Westacott, Andersen) reported on implementation of four models of student wellbeing in four universities. Their search to identify best practice found two principles, that of creating i) 'a culture of care' and ii) 'a culture of self-development and growth'. A further insight gained was the need to create spaces where learning could support the visioning and mapping of an integrated wellbeing journey to achieve more than just programme completions.

Also emerging amongst education-based student wellbeing models are those developed by school counsellors such 'Paces' (Nelson, Tarabochia & Koltz, 2015). This model excluded ethnicity and culture as dimensions of interest while the New Zealand Ministry of Education in 2017 published 'Te Pakiaka Tangata Student Wellbeing for Success' and firmly embedded cultural and ethnic identity as a wellbeing dimension in models they publish. This latter change by the New Zealand Ministry of Education was dramatic when viewed against the rejection of a whenua (ethnic-cultural dimension) in1997. Other education context wellbeing research focussed on

evaluations of programmes designed to support wellbeing (Pesu, 2017), research in this area is prolific but usually one-off in nature. A recent contribution has been creation of a model of Wellbeing Literacy (Oades, Jarden, Ozturk, Williams, Slemp, Huang, 2021), developed by a diverse team of researchers this work flags a potentially valuable new direction. Wellbeing literacy (like academic literacy) supports literacy that is fit for an individual or collectives needs and therefore supports the provision of ethnic and cultural responsive wellbeing supports. These researchers also advocated for wellbeing being a pursued objective at all educational levels.

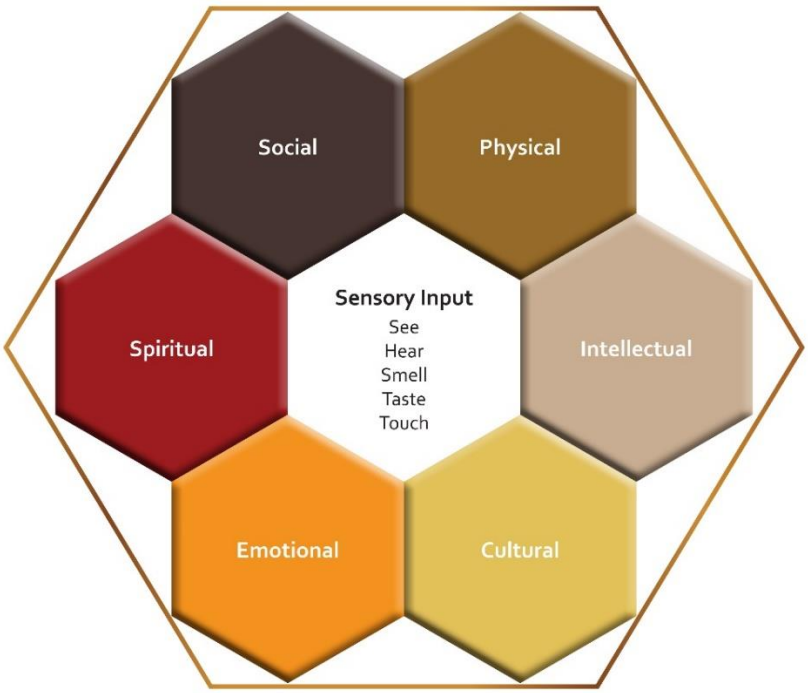
Sciences versus Humanities Perspectives

The final theme emerging from the review of wellbeing model literature has been that of the significantly different science and humanities perspectives displayed on wellbeing. Utilising a humanities perspective for example has been Seligman's (2011) Perma Model: A Scientific Theory of Happiness, Abraham & Sheeran (2015) a Health Belief Model, and Li, Hu & Chu (2021) a Mind Body Spirit Holistic Wellbeing Model while Choudhury and Barman (2014, 2015), and Zaffar (2021) pursued notions of subjective and objective wellbeing from a science perspective. While all these viewpoints contributed to discourse on wellbeing they all also struggled to meet more than one of the qualifier's set for this themed literature review. In summary, no models discussed meet all the themed literature criteria and qualifiers. Most papers showed little focus on the concept of wellbeing or even set out the definition of wellbeing used. There was however general consensus about the nature of wellbeing, all researchers viewed this concept as multi-dimensional and while they did not always agree on the dimensions most recognised intellectual/cognitive, social, cultural/ethnic, emotional, spiritual and physical dimensions. Another feature of the research reviewed from ethnic, cultural and professional perspectives was the utility of narrative, dialoguing, korero (for Māori), or yarning (for Aboriginal) to establish social understandings and interpretation accuracy about wellbeing dimensions and models. The above literature supports the view that ethnic and cultural wellbeing supports need to be negotiated at the outset and responsive to individual and collective differences.

The UWM has grown from a humanistic philosophy, a synthesis of the above themed literature review, theory and practice evaluating research plus tacit knowledge skills acquired through wellbeing enhancement programmes and practices to date. The key outcome of the above research has been the emergence of a new UWM. This UWM has as a consequence of its development process been designed to provide an explanation of both the macro (dimensions) and micro (evidence-based variables), determinants of wellbeing components that make up and influence the status of human wellbeing at any given point in time. Dimensions merged for example mind and emotions in Whare Tapa Rima are here distinguished due to the needs of Professional Wellbeing Facilitators in the contexts this work serves, they also however remain inextricably linked and integrated with the other dimensions that will be proposed. As understandings of wellbeing, (wellbeing literacy) have been found in practice to support and influence the wellbeing status of some individuals, and groups the clarity of presentation of the UWM was found to be critical.

The Universal Wellbeing Model (UWM)

(Social, Physical, Intellectual, Cultural, Emotional & Spiritual = SPICES)
The UWM is shown below in a balanced hexagon form similar to a honey comb or spice box utilised in kitchens in many countries. The six dimensions; in short form SPICES, (like those we eat), are sensed and flavour our socially interactive experiences and impact our wellbeing. Too much or too little of a component impacts us. Components of the UWM are now described.



(Stevenson, Gurung, & Zagala, 2022)

Component 1: Sensory Inputs

Sensory Input is shown at the centre of the model as the original source of human wellbeing, our wellbeing is influenced by incidents of single and multiple inputs from our senses, what we see, hear, smell, taste, and touch during interactions. These interactive social experiences occur at all the levels set out in Bronfenbrenner's Socio-ecological Theory (1979); that is, learning we acquire will be sourced via social interactions: within us (intra-psychological), with others (inter-psychological, meso, exo macro levels), and with items, materials and inanimate objects in our wider environment throughout our lives. Some of the interactive experiences we encounter, we will be able to control and others not, likewise some will be pleasant, have little impact, or be unpleasant or traumatic (such as a car accident).

Our wellbeing is influenced by our processing and the meanings we ascribe to the multiple 'Sensory Inputs' we encounter via one or a combination of our social, physical, intellectual, cultural, emotional, or spiritual dimensions. Vygotsky's Socio-cultural Theory (1980), explains how meaning and learning occur. He proposed that it is through our socio-cultural interactions and the meanings we give to what we experience that lead to what we know and can do. Our social-cultural learning experiences include being scaffolding (supported by a more able other), the bridging of gaps (zones of proximal development) and social-cultural guidance. The latter especially empowers people to structure and acquire culturally specific tools that assist us to

learn, memorise, attend, and problem solve. Our human survival or thriving will be impacted by what we learn and how accurately we interpret and process experiences we have and whether they are helpful or harmful to us and our wellbeing. New learnings are rewarded by increased mastery of our world.

Component 2: Wellbeing Domains

Micro determinants of wellbeing have been organised into six domains in the UWM; the social, physical, intellectual, cultural, emotional and spiritual. These domains are identified to support wellbeing literacy and provide focus areas for Professional Wellbeing Facilitators implementing the UWM. Below the scope of evidence-based variables within each domain is summarised.

S **Social** – social interactions within i) ourselves (intra-psychological), ii) with those around us (inter-psychological) closest to us (significant others), iii) in our family/whānau, and in iv) organisations, iwi, workplaces and our community context and with v) items, materials and inanimate objects in our wider environment.

P **Physical** – food, water, exercise, affection, warmth, sleep, fresh air, shelter, freedom from dis-ease, financial means, physical safety and other selected controllable physical human needs.

I **Intellectual** – our awareness, knowledge and skills related to i) our thinking styles, patterns, processes, and strategies (such as how we make decisions) and ii) learning styles, patterns, processes, and strategies we use to acquire new knowledge, skills and attitudes.

C **Cultural** – knowledge and skills that make up our ethnic and cultural intelligences and competencies plus their underpinning origins, ancestry/origin of i) our genetically determined ethnicity(ies) and ii) our selected cultural ways of interacting, existing and living in the various environments that make up our world.

E **Emotional** – all aspects making up and informing our emotional intelligence. It includes awareness of our emotional landscape and repertoire, emotion identification and impacts, expression of emotions, processing and what we can and cannot regulate.

S **Spiritual** – i) the beliefs held which may or may not be religious in nature and which inform and frame interactive experience, ii) the values held and what is valued and iii) a synthesis of the beliefs and values held, and which informs the attitude with which the person approaches all interactive experiences in their life.

The six dimensions are influenced by interactive experiences, yet integrated, inter-related and dynamic. The state of each dimension can be enhanced, unaffected or harmed through social learning experiences and interpretations of these.

Key features of the UWM are:
- it is holistic, and supports outcomes greater than the sum of its parts
- it is integrated, all dimensions are interwoven, interlinked and interdependent
- all dimensions are of equal importance and balanced development is supported
- it is designed to empower, appreciate, and support wellbeing enhancements
- it can respond to diverse individual and collect differences and needs

Component 3: Wellbeing Variables

The final components in the UWM are 70 key wellbeing influencing variables which research has shown influence human wellbeing, these variables are organised under the six overarching domains. An extensive body of research has shown a clear relationship between adequate sleep and physical wellbeing. Sleep is one variables included in the micro level in the model within the Physical domain. Likewise, there is a body of research showing the benefits of being able to regulate our emotions and how this can influence our wellbeing state; emotional regulation of the self is a variable is included under the Emotional domain.

The UWET discussed in the next section has been designed to evaluate the status of the 70 evidence-based variables included under the six identified domain areas in the UWM. The UWM has been designed to empower and support specifically youth, individuals, family, whānau and teams and those who work to support their wellbeing in a range of settings. The UWM achieves this by a) supporting the development of wellbeing literacy and b) providing insights that can lead to wellbeing enhancements and c) guidance of practice for those implementing the model (all via planned, provided and evaluated learning experiences). The most common field areas implementing the UWM include those relating to: education, psychology, health, community, and workplaces and areas that are the focus of the humanities and social science disciplines.

Associated Developments
Emerging from the UWM are four innovations, they are:

1) The Universal Wellbeing Evaluation Tool (UWET)

The UWET consists of 6 dimension sub scales (social, physical, intellectual, cultural, emotional & spiritual) and each includes questions designed to evaluate the status of 70 variables via a 5 point Likert scales. Responses selected demonstrate the status of the variable for the participant or group being administered the UWET. The UWET has been designed to optimise and accelerate accurate identification of the status of the evidence-based variables being evaluated. The evaluations reveal whether a variable is positive and well support, and to what degree, not impacting, neutral or yet to be considered or potentially harmful and to what degree. Accredited Professional Wellbeing Facilitators administer the UWET (also called Universal Wellbeing Check). Responses to questions are interpreted according to a pre-set formula and reported back to the participant or team. Options from that point depend on outcomes found.

2) Universal Wellbeing Enhancement Planning (UWEP)

After outcomes of a UWET are reported back individuals or teams receiving them are offered the opportunity to co-design and create a Universal Wellbeing Enhancement Plan (UWEP) with their Professional Wellbeing Facilitator. The UWEP identifies wellbeing variables that are well supported and reviews how this support and positive status can be maintained; supports further understandings of neutral or wellbeing variables not yet considered, and plans ways to address variables presenting challenges and possibly harming wellbeing. Strategies, supports and actions to be taken are recorded on the UWEP. Individuals or teams may also request the Professional Wellbeing Facilitator monitor implementation of their UWEP and/or educate, facilitate, risk manage, advise, or refer as needed. The objective of the UW-EP is to accelerate systematic enhancement(s) to a person, family, whānau or team's wellbeing over time.

3) Professional Wellbeing Facilitator Practice Guidelines (PWFPG)

The UWM underpins Professional Wellbeing Facilitator Practice Guidelines (PWFPG), these have been developed to support the practice of Professional Wellbeing Facilitators. Below the UWM is

shown with four practice responsibility areas noted; they are: Educate, Facilitate, Risk Manage, Advise and Refer.

Professional Wellbeing Facilitator Practice Guidelines

The objective of Professional Wellbeing Facilitators is to empower those they work with to optimise their wellbeing through the following practices:

Education – Wellbeing Facilitators will research and provide evidence-based knowledge, skills, and awareness of beliefs, values, and the attitudes they hold and about how to enhance their own and others holistic and integrated wellbeing
Facilitation – They are capable of creating powerful interactive learning experiences when needed to support the acquisition of wellbeing understandings and effective implementation of wellbeing enhancement planning.
Risk Management– Facilitators will identify holistic wellbeing risks for themselves and those they work, fully informing them of options to remove, mitigate, manage and minimise such risks if they occur.
Advice & Referrals – Wellbeing Facilitators use professional advice-giving practices and make referrals to other skilled people or services when in the best interests of those they are working with.

Professional Wellbeing Facilitators practice is underpinned by aligned humanistic education, social sciences, health sciences, and psychological philosophies, theories, research and practice. Key knowledge and skills held by such Facilitators include: communication, facilitation, planning, monitoring, risk management, advice giving, referral, and evaluation. Experienced Wellbeing Facilitators may also attain coordination, management, and leadership capabilities to further engage, and empower ownership by those they work with. Professional Wellbeing Facilitators undertake specific education and accreditation programmes, ongoing supervision, or membership in a Community of Practice and conferences or refreshers to retain their currency in relation to professional and ethical conduct, professional boundaries, reflective practice, evaluation, inclusion, diversity, equity, cultural responsiveness and empathetic communication.

4) Universal Wellbeing Community Implementation System (UWCIS)

Development of the Universal Wellbeing Model, Evaluation Tool, Wellbeing Enhancement Planning, and Practice Guidelines have led to the development of a community system that can be scaled up or down depending on the number of people involved and their specific needs. The community systems utilised during investigations in 2010 by Schofield, Walker, & Going and then again in 2020 by Fielden, Stevenson, Going, Grant, & Zagala provide successful prototypes for Universal Wellbeing Community Implementation Systems. For some communities, indigenous terminology may be preferred over community, for example pa or village.

Key features of a UWCIS whether in a higher education organisation, community or business setting of up to 1,000 individuals include:
Wellbeing Leader
5 Professional Wellbeing Facilitators
Staff who have understandings of the UWM
Participants

A sense of community is created through a planned programme which includes:
i) the Wellbeing Leader, plans, supports, manages, monitors and evaluates the system
ii) the Wellbeing Leader also supports and trains the Professional Wellbeing Facilitators
iii) the Professional Wellbeing Facilitators train staff and the participants on the UWM
iv) staff and participants undertake the UWET and may elect to follow a WEP co-designed with a Professional Wellbeing Facilitators
v) the Professional Wellbeing Facilitators provide education programme on variables challenging the community
vi) all members of the community and including staff and participants report wellbeing supports, challenges, risks and potential harm relating to any of the UWM components and variables as soon as possible as and when they occur to the Wellbeing Leader or a Professional Wellbeing Facilitator

The final learning loop required is that of ongoing monitoring and action by a member of the community if serious harms to wellbeing such as suicides in a community are to be prevented. Key components that support the success of a UWCIS are: respect for others, privacy, active participation, protection of what individuals or groups hold dear, benefit from the system plus seeing cross community progress in wellbeing variables over time. In high need communities the number of Professional Wellbeing Facilitators may need to double and ongoing cycles of learning experiences related to variables that challenge provided (for example on illegal drug taking, unwanted touching and so on). Wellbeing Leaders must not only be capable but also empowered to be prompt and effective in stopping behaviours such as bullying, sexism, racism and so on that cause harm to individual and collective wellbeing.

Key learnings

At all stages of development and from inception of the project in 2008 engagement with others has been critical, supporting, motivating and progressing overtime. Key to initial phases was the readiness of the individual students and as a group to patiently support and engage with staff as they moved into unknown ethnic and cultural worlds they had little understanding of. Over time identification of what was working, what was not, and why, led to ongoing honing of the

philosophy, values and theory underpinning our work and final form of the UWM. The two research investigations undertaken also brought into sharp focus what was valuable and significant and what was not.

Review and recent re-visiting of Bronfenbrenner, and Vygotsky's and Wenger-Trayner's (2020) views of social learning reveal synergies, and alignments, and collectively reveal a more comprehensive understanding of the nature and needs of those engaged in learning about wellbeing. The Universal Wellbeing Model shines light on the micro to macro components and requires those facilitating to 'consciously arrange spaces to support social, physical, intellectual, cultural, emotional and spiritual safety and wellbeing at multiple levels and in multiple ways.

The capabilities of employees, community members, educators, managers, administrators, researchers, leaders, and other stakeholders likewise require supportive micro level wellbeing support to increase their wellbeing literacy and skills. Key to such engagement is the building of a climate that is respectful, empathetic, inclusive and equitable across diverse peoples, disciplines, institutions and contexts.

Positive wellbeing adds value because it empowers people to be confident, and create communities that seem refreshed or new and where gains can be maintained and developed, sustained, evaluated and safely revised in new directions. The provision of safe places where people learn have added vitality and promoted and extended engagement in developing and implementing new understandings of wellbeing. As philosophy and values underpinned theory development, and theory underpinned and honed research and practice the value of the UWM began to be realised and revealed as valuable because it was transformative.

Conclusion

In conclusion, although safe spaces were not part of our original wellbeing philosophy, theory, research and practice parameters at the inception of this research and especially during the theory creation process, they are, as dissemination occurs becoming increasingly important to support ongoing reflection and dialogue. Two insights emerging are that i) support for and the development of wellbeing literacy and the UWM were valuable products and that ii) implementation of the UWM and further research overtime are producing further value in terms of achievement, inclusion, and equity only theorised about in the past. Perhaps most pressing is the need to facilitate a community dialogue around wellbeing literacy and a common definition or of wellbeing that might further enhancing individual and community wellbeing in practice. As Land stated (Meyer, Land & Baillie, 2010), significant new knowledge and skills need to be troubling in order for us to move, learn and change. Becoming more wellbeing literate may initially be troubling but it does progress toward learning and positive change.

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