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## Emergence of the Universal Wellbeing Model: A journey from indigenous cultural responsiveness to international relevance and applicability

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### Abstract

A search began in 2008 to identify a theoretical wellbeing model with the capacity to underpin holistic student supports for a cohort of Indigenous and Pacific Island students in order to support their achievement, and equity aspirations. An initial literature review found evidence-based wellbeing definitions, and models related to higher education students to be highly variable. A long term programme of research was implemented to build a robust philosophical, theoretical, research, and use inspired practice base to measurably enhance the inclusion and holistic wellbeing of all students in higher education settings. Post a nationally funded investigation into the effectiveness of an indigenous model in praxis, a more robust model was sought and investigated with more ethnically and culturally diverse international students, staff, and holistic wellbeing-pastoral care practitioners. The methods selected to comprehensively answer the questions posed included a programme of themed literature review, theoretical model analysis and evaluation, plus use inspired theoretical and practice research. Findings from the second funded investigation led to the emergence, and creation of new, indigenously based but internationally responsive Universal Wellbeing Model (UWM), and new 'researchable' definition of wellbeing. The emerging UWM, and a new definition of wellbeing, were strongly contributed to by international participants' perspectives. The implications for the practice of higher education sector leaders, staff, professional wellbeing and pastoral care practitioners, and policy makers are far reaching. The UWM is capable of underpinning policy, planning, wellbeing and pastoral care practice, and supportive cross organisational systems in institutions seeking to measurably enhance wellbeing outcomes.

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# Introduction

## Rationale

The research journeys summarised in this paper were initiated with a 'use inspired' research project designed to support a cohort of socio-economically deprived Indigenous Māori and Pacific Island students enrolled in a higher education institution in South Auckland, New Zealand. The cohort of students were required to study to retain financial benefits from the government of the day, and while they initially appeared to be domestic students, the cohort included students from the sixteen Pacific Island nations who overtime exhibited needs more aligned to those of diverse international students. It quickly became apparent to staff/researchers supporting the cohort's holistic wellbeing, and achievements, that the institution's conventional student supports would not be adequate. Clear perspective differences existed between students in the new cohort, as well as with others in the institution, the former feeling compulsion to attend and the latter choosing to attend. The new cohort challenged staff/researcher's identities, expectations, and practices, staff/researchers also identified measurable differences in engagement, and aspirations.

The new cohort of students were found to have emerged from different ethnic, cultural, socio-economic circumstances, and life experiences; few of which were supportive of academic achievements, and future employment. The cohort students reported negative school experiences, were resistant to regulations, voiced experiences of racism, and resented the situation they found themselves in, namely being required to attend a government funded institution, and study an education programme. Outstanding for staff/researchers were the clear differences in ethnic, and cultural perspectives, priorities, knowledge bases, values held, and the ways of thinking demonstrated. While some staff/researchers initially came from similar communities to the cohort students their worldviews had changed overtime due to their education, experiences, and the diversity of those they needed to professionally support in practice.

Faced with a pressing need to provide a genuinely holistically supportive community for this cohort of students; the staff/researchers prioritised locating a theoretical model that could guide them to effectively support this cohort, related research, and practices. Initially thinking this search could be simple and short, this point came to be viewed as marking the initiation of the intensive and iterative long term theoretical development research journey this paper focusses on alongside the contributions international students made to this and woven alongside the outcomes of two nationally funded traditional research investigations.

The theoretical research journey initiated in 2008 sought to identify a theoretical wellbeing model capable of holistically responding to, and appropriately supporting Indigenous Māori, and diverse Pacific Island higher education students. It formed the impetus for an extended programme of wellbeing research conducted to implement a long-term vision to build a robust philosophical, theoretical, research, and use inspired practice base to measurably enhance the holistic wellbeing of all students in higher education settings. The researchers found that while many institutions, and countries publish aspirations to improve wellbeing, a review of national and international literature found few significant or sustained student and/or wellbeing research programmes. Wellbeing definitions, models, philosophies (if documented) and/or the presence of an evidence-

base related to higher education students, and staff/researchers that were found, were highly variable in their findings and often disconnected from literature and robust research.

Staff/researchers and those holding professional wellbeing or pastoral care support roles could find little in the available literature to support their practice, and especially service provisions for domestic and international students. Supporting the above aspirations and need for improved evidence-based understandings of wellbeing and pastoral care support was successive and increasingly demanding implementations of new Pastoral Care legislation by the New Zealand Government from 2005. This legislation amplified the need for measurable improvements to holistic wellbeing supports for domestic, and international higher education students plus staff, and confirmed the significance of the programme of comprehensive wellbeing research commenced. Developing an improved wellbeing model was recognised by the researchers as requiring a long-term, multi-phase, and diverse programme of research.

Locating, creating, and designing such a culturally responsive model from available research, which would be applicable to the dynamic, and COVID-19 impacted learning contexts of the day and diverse students and staff/researchers was a significant challenge. The process of developing such a wellbeing model included ongoing investigation, reflection, evaluation, and continuous improvements in practices, to ensure it remained relevant and effective in addressing the numerous holistic wellbeing needs of both domestic and international higher education students and staff it would need to support. The programme of research also required collaboration, and robust critiques by diverse students, staff/researchers, wellbeing, and pastoral care practitioners, and other stakeholders to clearly identify ethnic, and cultural knowledges, themes, and the wellbeing influencing variables that emerged.

The eventual emergence, and creation of the Universal Wellbeing Model (UWM) plus a new definition of wellbeing occurred through comparing, critiquing, synthesising, and applying the theoretical wellbeing models of others post publication, and when available, drawing on literature and practice-based research that investigated these models. Two research journeys were undertaken, the theoretical journey set out here, and alongside the traditional and practice focussed research investigations focussed on the effectiveness of two models located in practice that were nationally funded and have been published. Critical to the researchers was the emergence of a model that was inclusive, ethnically, and culturally responsive, and capable of supporting the wellbeing needs equitably of both diverse domestic and international students and staff in praxis.

## **Research Questions**

Three research questions were formulated and investigated through the research journeys:

- 1) what theoretical wellbeing models are there?
- 2) what literature supports these wellbeing models?
- 3) what models of wellbeing are supported by current literature, and research?

## **Literature**

The theoretical journey after identifying humanistic philosophies and theories as a basis for this research, the teaching staff/researchers, and wellbeing and pastoral care practitioners, whose

practice contexts were embedded in education, health, psychology, business, Indigenous and community development fields, located extensive anecdotal, professional, and research papers on wellbeing. Due to the extensive amount of the literature located they elected to implement meta-analyses of literature, then multiple iterative themed wellbeing literature review searches. Wellbeing Model literature that could qualify for inclusion in the themed reviews was required to meet one or more of the following criteria: i) an identified philosophical base; ii) the capacity to support wellbeing literacy through clear articulation of their model; iii) include sufficient information that it could be evaluated through research; iv) evaluate through a formal investigation processes, v) provide guidance to wellbeing or pastoral care practitioners; vi) be fit for purpose, in that it could be implemented in the above fields and with ethnically and culturally diverse youth, adult individuals, families, teams, organisations and communities. The themes emerging from these reviews are set out below.

### **Theme 1. Ethnic and Cultural Perspectives of Wellbeing**

From 1982, a range of wellbeing models emerged, designed for specific ethnic, and cultural groups; for example, Pere published the 'Te Wheke' (the Octopus) Model, which included eight cultural concepts for support and development to meet the specific wellbeing needs of New Zealand's Indigenous Māori people. In 2004, Love provided an expanded explanation of Te Wheke, its underpinning Indigenous philosophy, and worldview. While Love's work was supportive of the Te Wheke, no research into the model's effectiveness could be located. Also created at this time was the Fonofale Model of Pacific Health & Wellbeing (Pulotu-Endemann, 1984), and Whānau Ora Model (Whānau Ora Ministry for Community and Voluntary, 2009; Taranaki District Health Board, 2014; Savage et.al, 2020). The Whānau Ora Model (family life) sought to reframe wellbeing from a western, and individual challenge to an ethnic/cultural, family, and collective challenge. The Whānau Ora Model and its evaluation in praxis assumed an increased focus when political negotiations led to the establishment of a national Whānau Ora programme for New Zealand's Indigenous population.

Also appearing in the literature were models from ethnic, cultural, and professional groups that were designed for a specific or exclusive audiences. For example, Hassan (2015), published a paper on the Islamic Transcendental Wellbeing Model, which was underpinned by Islamic philosophies, the Koran, and focused specifically on the provision of counselling services for Malaysian Muslim women. The Kawa Model (Teoh & Iwama, 2015) was likewise designed to specifically support Occupational Therapists in improving the wellbeing of clients they were providing therapeutic services to. An Aboriginal Social and Emotional Wellbeing Model published by the Australian Mental Health Commission (2018), was also designed to exclusively serve this ethnic, and cultural community disadvantaged in western health, and wellbeing service provisions. Hinemoa Elder, an eminent youth forensic psychiatrist, also in 2017 set out two further models, Te Waka Oranga and Te Waka Kuaka, the first designed to establish partnership between those with an interest in supporting indigenous youth, and the second promoting the inclusion of ethnic, and cultural knowledge, and skills to improve the responsiveness of wellbeing supports being provided to youth receiving forensic services.

Shifting focus Lester, Cefai, Cavioni, Barnes & Cross (2020) advocated for the promotion of staff wellbeing, while Garvey, Anderson, Gall, Butler, Whop, Arley, Cunningham, Dickson, Cass,

Ratcliffe (2021) advocated for a better Care Model to support Aboriginal and Torres Strait Islander wellbeing. A strength of the latter two models was the open presentation of the philosophy, theory, and practice incorporated, as well as the possibilities they included for conducting evaluative research. In summary, all the above ethnic, cultural, and professionally focused models added to the diversity of dialogue on wellbeing and sought to be systemically transformative of wellbeing by voicing the perspectives of the disadvantaged, specific communities, and the previously unheard. These models could all also be critiqued as being exclusive or limited in nature, by advocating for differentiated service provisions, and practices that a) could only be provided by people of certain ethnic, cultural, religious, professional backgrounds and to b) specific communities or people. Debate about whether such models support inclusion, and equity or are politically motivated and ongoing.

## **Theme 2. Student Wellbeing**

From 2004 on, interest in student wellbeing and its measurement begins to emerge in the literature (Masters, 2004; Frailon, 2004; Soutter, Gilmore & O'Steen, 2010, Soutter, 2011). Soutter, Gilmore & O'Steen proposed a multi-dimensional conceptual framework that included: having, being, relating, thinking, feeling, striving concepts as indicators of a student's 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 be poor. In 2014, (Crawford, et.al) reported the implementation of four models designed to enhance student wellbeing in four Australian universities. In their search to identify best practices, two themes emerged: that of the importance of creating 'a culture of care' and 'a culture of self-development and growth.' A further finding by these researchers was that universities needed to create 'enabling spaces' where social interactions could support visioning, and mapping of an integrated wellbeing journey beyond programme achievement in their institutions. Hews, McNamara, and Nay (2022) endorse the above finding proposing higher education institutions begin to prioritise 'lifeload' over 'learning load' in this post pandemic period.

Also emerging amongst education based, and student wellbeing models are those developed by United States of America school counsellors such as 'Paces' (Nelson, Tarabochia & Koltz, 2015). Interestingly, their model excludes ethnicity, and culture as dimensions of interest. At this same period, the Ministry of Education in New Zealand in 2017 published 'Te Pakiaka Tangata Student Wellbeing for Success' and firmly embedded cultural, and ethnic identity as a wellbeing dimension in the models they advocated for, for both domestic and international students. This recent change in Ministry of Education perspective was viewed as dramatic change when the inclusion of a cultural and /or ethnicity dimension from a wellbeing model was rejected by New Zealand government in 1997 during development of a new Health and Physical Education curricula. Such 180-degree change in perspective flagged the extent of wellbeing model transformations overtime. Other education related wellbeing research has focused on evaluations of specific programmes designed to support wellbeing (Päivi, 2017). Research publications of this type have been found to be prolific, and usually 'one-offs' in nature. A final development in the Wellbeing model space has been creation of a model of, and introduction to the concept of Wellbeing Literacy (Oades, Jarden, Ozturk, Williams, Slemph, Huang, 2021); their research supports the

notion that a clear understanding of wellbeing is of value and should be an embedded and pursued as an objective with transformative value at all education levels.

### **Theme 3. Sciences Versus Humanities Perspectives**

A final theme emerging from the review of wellbeing model literature has been the clearly differentiated science, and humanities perspectives of wellbeing. For example, Seligman (2011) proposed the 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 all from a humanities base while Choudhury and Barman (2014, 2015), and Zaffar (2021) pursue notions of subjective and objective wellbeing from a science perspective. While the terms subjective, and objective wellbeing are never clearly defined or explained all these different models, and viewpoints have contributed overtime to evolutions in thinking and wellbeing model making. Unfortunately, all the above models named in this section struggled to meet more than one qualifier in the themed literature review criteria. In summary, none of the models discussed met all the themed literature criteria. Most literature underpinning the models presented appear to show fleeting interest in wellbeing, and no research or ongoing programmes of wellbeing research were associated with any of the models discussed.

Consensus was however emerging around the nature of wellbeing; all literature reviewed recognises the concept of wellbeing as multi-dimensional. While agreement on the dimensions and terminology is not reached in the literature, most wellbeing models recognised intellectual/cognitive, social, cultural/ethnic, emotional, spiritual, and physical dimensions. Another key contribution in the development of the models proposed from specific ethnic, cultural, and professional perspectives is advocacy for the use of narrative, or interactive dialoguing, such as Korero (for Māori) or Yarning (for Aboriginal) to establish common social understandings, accurate interpretations, and transformative meanings related to wellbeing. These different ethnic, and culturally based interactions focused on dialogue to establish the meaning of wellbeing aligned with the theoretical discussions of Bronfenbrenner (1979), and Vygotsky (1980). Despite being from diverse ethnic, and cultural bases, focussed social interactions are also practiced in diverse ethnic, and cultural communities under protocols, and guidance pertinent to those communities.

The search for models, research, and practices that could meet the complex wellbeing support needs of the initial cohort of Indigenous Māori and diverse international Pacific Island students led the researchers in three directions. Firstly, it led to an array of definitions, and models of wellbeing. The Ottawa Charter for Health Promotion (World Health Organisation, 1986) was a significant starting point, as it set out new parameters for the transformation of wellbeing, and health status internationally. The Charter provided a new macro and parts of a micro picture of the complex array of variables influencing health, and wellbeing outcomes.

For those working in higher education wellbeing, and pastoral care, the charter especially supported the need to identify the personally controllable variables influencing student wellbeing. The macro picture responsibilities of government, public health ministries, and policy makers emerged as beyond the influence of most domestic, and international students, staff, researchers, and wellbeing-pastoral care practitioners. For the first time multiple social, and environmental layers, at macro, and micro levels influencing higher education domestic, and international

students, staff/researchers, and wellbeing and pastoral care practitioners' challenges were unpacked and the adequacy of past simple 'cause and effect' approaches brought into question. To make the work of wellbeing, and pastoral care practitioners achievable, institutions began to focus their service provisions on improving wellbeing influencing variables their domestic, and international students could control. It was also at this point that the question of what variables influence wellbeing emerged as an important sub question.

The Ottawa Charter was underpinned by two theoretical models that explained the nature of human learning, change and development: the socio-ecological model of Urie Bronfenbrenner (1979), and the socio-cultural Model of Lev Vygotsky (1980). These models, and the Charter together were recognised internationally as providing accurate explanations of what was impacting health, and wellbeing status and in turn led to countries changing their health, and wellbeing policies, perspectives, and curricula to reflect the innovative ideas, concepts, and explanations included. New Zealand for example adopted an Indigenous Hauora (breath of life) concept, aligned to the Indigenously based holistic wellbeing model Whare Tapa Whā (the four-sided house) written about by Durie in 1994, in their national health, and physical education school curricula.

A key finding emerging in the 90's was also that despite notions of wellbeing having appeared in academic literature for over 40 years, there appeared to have been few robust attempts made to define the term itself. Ryff and Keyes (1995) noted, for example that 'the absence of theory-based formulations of well-being is puzzling given the abundant accounts of positive functioning in subfields' (such as psychology). Also emerging was support for the view that most wellbeing definitions came from clinical health/medical model or psychological perspectives. Those coming from psychological perspectives related to mood or affect (Hattie, Myers, & Sweeney, 2004), or tended to view well-being as being related to intellectual or emotional areas such as depression or positive self-attributes (Keyes, 1998; Ryff & Singer, 1996). Other researchers 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 tended to view wellbeing as the absence of diagnosed physical health conditions such as heart disease (Bolton, D. et.al, 2019).

Thus, definitions of wellbeing in the literature were found to be disparate, and highly influenced by the underpinning field, or discipline perspective. While several psychologically based papers focused on emotional or psychological factors, others emphasised physical health, happiness, or academic achievement as indicators of wellbeing. These findings highlighted the need for a more multi, inter, trans-disciplinary or holistic approach to the clearly complex concept of wellbeing, and for this approach to be shown through a clear definition and model underpinned by evidence. In 2010, 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". In 2017, WHO then revised the initial health advice they provided to schools and stated, "a school that constantly seeks to strengthen its capacity to promote healthy living, learning and working conditions" (p.19) is providing early intervention to reduce long term risk.

WHO was now urging schools (and the education sector) to consider making a commitment to enhancing the social, emotional, physical, and moral wellbeing of all members in their communities. The direction of change signalled by WHO prompted educational institutions to focus on: sharing practice problems related to wellbeing, active learning through inquiry, taking collective ownership, including an appropriate mix of partners, and having a sufficient commitment to implementation, effective governance and decision-making structures related to wellbeing (Education Review Office, 2016). In 2019, WHO drew further attention to the mental health risk factors that could be present in communities.

A second investigation direction pursued by the researchers led to wellbeing models emerging in the field of education. In 1999, the New Zealand Ministry of Education published a Health and Physical Education curricula that included the following conceptual framework (Table 1):

**Table 1**

Health and Physical Education Curricula Conceptual Framework

Dimension	Description
"Hauora"	A Māori philosophy of well-being 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 well-being; 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"

Further exploration of the indigenous Māori concept of Hauora (breath of life-wellbeing) led in turn to two indigenous Māori models being trialled by the researchers (Schofield, Walker, & Going, 2011 & Fielden, et.al. 2020a, 2020b); the first is Whare Tapa Whā (the four-sided house) described by Durie in 1994.

### **Nationally Funded Research Investigation 1**

The Whare Tapa Whā (the four-sided house) model was initially designed to support the ethnic, and cultural capabilities of non-Indigenous health workers supporting Indigenous Māori patients in health settings. Durie's model outlined the world view and wellbeing needs of Māori patients in relation to the following four dimensions: taha wairua (the spiritual side) taha hinengaro (the intellectual and emotional side), taha tinana (the physical side) and taha whanau (the family and social side). The researchers investigated providing support to the first cohort of new Indigenous Māori and international Pacific Island students using this model. Hence the support provided according to this model was found through a nationally funded investigation to be highly effective



overtime for the students in terms of improving their achievement levels, and retention and maintained these outcomes overtime (Schofield, Walker, & Going, 2011).

Serious critiques however emerged from Indigenous Māori and international Pacific Island students. Analyses of student feedback found for example, that while the Whare Tapa Whā model resonated with most domestic Indigenous Māori students, some Māori students voiced preferences for other wellbeing models underpinned by other Indigenous tribal groups. The Whare Tapa Whā model was also found to be less effective in recognising and meeting the needs of the international Pacific Island students, who came from sixteen different Pacific Island nations, and whose ethnic, cultural worldviews and priorities differed. The contributions and critique of the Indigenous and diverse Pacific Island students, during the first investigation were critical to identification of four major critiques of the Whare Tapa Whā model. Without these findings it is unlikely further developments in the wellbeing model that eventually emerged would have occurred.

The four critiques of the Whare Tapa Whā model were:

- 1) it was unclear who was ethnically, and culturally 'appropriate' to deliver student support underpinned by the Whare Tapa Whā Indigenous model, and attempts to clarify this concern with Indigenous advisors, and other stakeholders failed to resolve this matter, leaving some students and pastoral care and wellbeing practitioners feeling unsafe, and unconfident with the Whare Tapa Whā model.
- 2) the level of understanding of Whare Tapa Whā required by the pastoral care and wellbeing practitioners was unclear, as was guidance about how the different dimensions were to be interpreted; there was also an absence of evidence-based Whare Tapa Whā related materials, and resources available.
- 3) pastoral care and wellbeing practitioners using the Whare Tapa Whā model identified the lack of specificity and an ethnic and/or cultural dimension that could support them to be responsive to each student they supported as a major weakness in the model and
- 4) who the model was to support, and if it was genuinely inclusive of all students, ethnicities, and cultures was questioned. Some Māori students, and staff/researchers argued the model was exclusively by Māori, and therefore only for the use and benefit of Māori only, while others stated it was gifted to all by Durie via publication at a conference. Pacific Island students contributed the view that the model did not meet the diverse views of their Pacific Island nations and most thought the spiritual dimension should be changed to Christianity. The above findings provided the impetus for the search for a new model and the investigation that follows.

## **Nationally Funded Research Investigation 2**

As a result of the above critiques the staff/researchers continued their search for wellbeing models that could better support their practice and especially the diverse international students they supported. A second and more ancient, Indigenous Māori model of wellbeing; the Whare Tapa Rima (the five-sided home) by Moeau (1997) was located. Moeau's model included all four dimensions set out in Durie's model but also a new fifth and foundational dimension, whenua (cultural and ethnic identity); this new dimension which required pastoral care and wellbeing

practitioners to understand, and support the different ethnic, and culturally dimensions of each student and staff/researcher's member they served in their wellbeing practice. Māori, and Pacific Island Advisory groups consulted advocated for the staff/researchers to refer to the model, in English as 'the five-sided home,' as they regarded this terminology as more accurately reflecting the objective and capabilities of this model in the institutions in which it was implemented. The Whare Tapa Rima model if successfully delivered would transform the institution where it was implemented into a 'second home' for all and especially for international students.

A second nationally funded investigation into the provision of wellbeing and pastoral care support to international students and staff supported by the Whare Tapa Rima (five-sided home) model again showed diverse international student, and staff achievement and retention levels were significantly enhanced, and withdrawals ceased despite the investigation occurring over two COVID – 19 lockdowns. These outcomes were also maintained overtime due to the ongoing and holistically supportive community the model fostered (Fielden, Stevenson, Going, Grant, & Zagala, 2020a). Key reasons for the success of the Whare Tapa Rima model were that a) it consistently, and holistically supported domestic and international students, and staff b) it featured ongoing positive encouragement and feedback c) it created an inclusive, caring, and family home type community. Understandings, and implementation support for this model was further provided by Stevenson and Zagala (2021), who described the capacity of the model to contribute to equitable outcomes in higher education institutions. The contributions of the international students, staff/researchers, and wellbeing and pastoral care practitioners during this second investigation were again important to the identification of critiques of the second Whare Tapa Rima model evaluated.

The contributions and critique of the international students, staff/researchers, and wellbeing and pastoral care practitioners during the second investigation and with the Whare Tapa Rima model echoed some of those from the first investigation with one exception. Critique 1) remained, and it continued to be unclear who was ethnically and culturally 'appropriate' to deliver support underpinned by the Whare Tapa Rima Indigenous model, with students, staff/researchers and wellbeing and pastoral care practitioners continuing to feel unsafe and unconfident because of the debate, especially impacted were international teaching staff/researchers and wellbeing and pastoral care practitioners, some indicating they viewed the model as creating a barrier to service delivery with some of their clients. Critique 2) was also valid and there was again the absence of an evidence-based Whare Tapa Rima related materials, and resources to draw. The staff/researchers could find no other investigations of this model, so had to create their own resources. Critique 3) the third critique of the Whare Tapa Whā model was resolved by the Whare Tapa Rima model with its inclusion of whenua (ethnic-cultural) dimension as this supported holistic, inclusive, and individually responsive practice, about this all participants were positive. The specificity to support Wellbeing Practitioner practices however remained an issue. Critique 4) concerns about who the model was for, i.e., was it a, for and by Māori only model persisted during the second investigation again creating barriers to supporting diverse international and domestic students. Some wellbeing and pastoral care practitioners also held concerns for their own cultural safety. Resistance to having to learn another language after struggling to meet English requirements proved too difficult for some national and international students so many of the staff/researchers and wellbeing and pastoral care practitioners created bilingual or English

versions of the model. These challenges were time consuming, created stress, and often delayed student access to support for serious wellbeing/pastoral care, suicidal ideation, trauma, and other challenges being experienced.

Two summative findings emerging from the above investigation were that, students, staff/researchers and wellbeing and pastoral care practitioners a) viewed an evidence-based inclusive and internationally or universally applicable wellbeing model 'free from any specific ethnic or cultural' flavour' was still needed to support the quality of their practice with international students and staff, and b) a model supporting staff, researchers and wellbeing and pastoral care practitioners to be able to apply specific ethnic, and culturally diverse wellbeing models to support wellbeing literacy, alongside their alignment with diverse international students and staff was also viewed both desirable and still missing.

These and other findings in this section demonstrate staff/researcher, and wellbeing and pastoral care practitioners interest in the acquisition of intercultural and collaborative competencies discussed by Anand & Lui in 2019, plus the need for further opportunities where staff/researchers and wellbeing and pastoral care practitioners might safely develop understandings of their own ethnic and cultural identity along with the professional capabilities needed by those working in international education contexts (Tran & Nguyen, 2015). As Clifford and Montgomery (2017), note, the time has come for curriculum designers to design international students' programmes that adequately prepare students for local and global citizenship, but they also need to create programmes that build support capabilities to achieve such objectives for higher education staff/researchers and wellbeing and pastoral care practitioners. The summative findings of the second investigation provided the impetus for further theoretical investigations which led to the emergence of a new model of wellbeing.

## **Method**

### **Design**

The methods selected to answer the above questions over a fourteen-year period included:

- an iterative programme of meta, and themed literature review, theoretical model analysis and evaluation,
- two nationally funded mixed methods investigations of two different wellbeing models plus
- use inspired theoretical and practice research relating to both students, staff/researchers and wellbeing and pastoral care practitioners.

### **Participants**

Participants in the two nationally funded investigations were a) socio-economically challenged Indigenous Māori and international Pacific Island students from sixteen different nations, and staff/researchers (Schofield, Walker, & Going, 2011), and b) ethnically, and culturally diverse domestic, and international students, staff/researchers, and wellbeing and pastoral care practitioners (Fielden, Stevenson, Going, Grant, & Zagala, 2020a & 2020b). Below a summary of meta and themed literature review findings are set out alongside the contributions of international

students, staff/researchers, and wellbeing and pastoral care practitioners not yet detailed in published research papers.

### **Data analysis**

Data analysis methods conducted during the programme of research conducted included: meta and thematic analysis of literature and quantitative and qualitative data gathered via questionnaires, interviews, and focus groups. Theoretical models were analysed utilising thematic analysis and model component analysis, which evaluated the conceptual model, theory or theories, and various concepts and propositions underpinning the models examined (Niedderer, 2013).

## **Results**

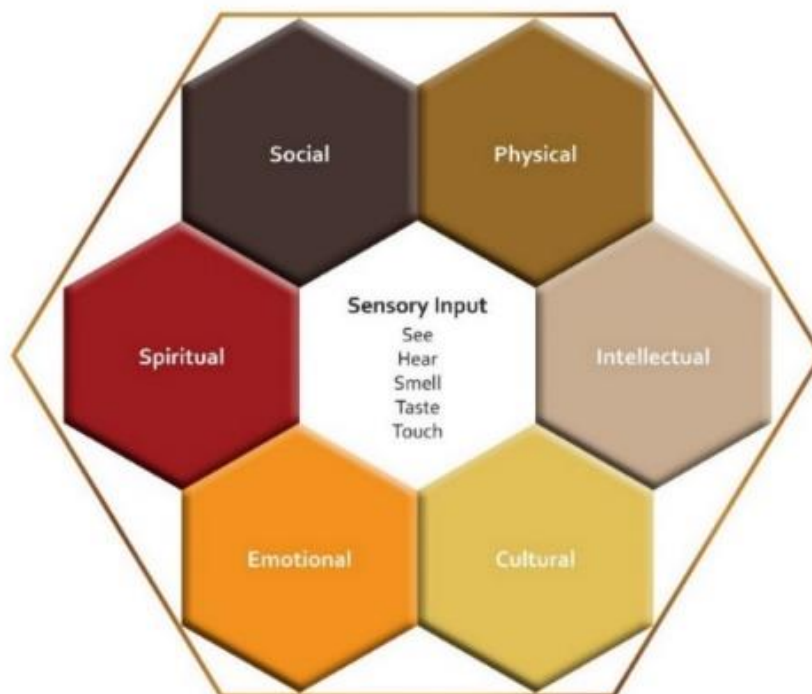
### **Research Output 1**

The key output emerging from the multiple investigations conducted is the emergence of the Universal Wellbeing Model (UWM), and a new definition of wellbeing. Both have been extensively contributed to by the programmes of research and especially the multiple international perspectives of students, staff/researchers and wellbeing and pastoral care practitioners that contributed to this research. The UWM (Figure 1) that has emerged is capable of underpinning practice, and the definition proposed is researchable.

### **Figure 1**

*The Universal Wellbeing Model (UWM) (Stevenson, 2022)*

*(Social, Physical, Intellectual, Cultural, Emotional & Spiritual = SPICES)*



The UWM has been designed to provide an explanation of how holistic wellbeing is influenced, and both the macro (dimensions) and micro (evidence-based variables) components that make up and influence the status of human wellbeing at any given point in time. The UWM is shown in a balanced hexagonal form, which appears frequently in nature and like a spice box used in kitchens across the world. The six human dimensions abbreviate to SPICES, like those we eat, flavours our interactive experiences, and impact our holistic wellbeing. Too much or too little of any Sensory Input, dimensions or variable will have an impact to us. The UWM also supports wellbeing literacy due to the clarity of its simple four component structure including: 5 Sensory Inputs, 6 Dimensions, 70 Variables and 5 Principles. Underpinned by indigenous views of wellbeing, the UWM is also holistic and draws on evidence from multiple disciplines and practice fields while being inclusive of a range of different ethnic and cultural wellbeing literacy perspectives and aids.

### **Component 1: Five Sensory Inputs**

Sensory Input is placed at the centre of the model, as the state of human wellbeing is influenced by multiple single, and multiple inputs from our senses, that is, what we see, hear, smell, taste, and touch during social, and interactive experiences. These social and interactive experiences occur at all the levels set out in Bronfenbrenner's Socio-ecological Theory (1979). That is, the learning we acquire will be sourced via social learning interactions: within us (intra-psychological), with others (inter-psychological, meso, level, and exo-level), and with items, materials, and inanimate objects in our wider environment throughout our lives. Interactive social learning experiences we encounter may be controllable or not; pleasant, and uplifting, have no impact, or be unpleasant (such as a car accident) or traumatic event.

Our wellbeing is influenced by the multiple 'Sensory Inputs' we encounter and then process, assign meaning eventually becoming new learning then outputted in our daily lives. New learning is often viewed as being linked or part of ourselves and manifested through one or a combination of our social, physical, intellectual, cultural, emotional, or spiritual dimensions. Vygotsky's Socio-cultural Theory (1980) sheds further light on how meaning and knowledge develop. He proposed that it is through our socio-cultural interactions that we interpret and give meaning to what we learn. Key micro social-cultural learning experiences Vygotsky discusses include scaffolding (being supported by a more able other), bridging gaps in zones of proximal development and social-cultural guidance. The latter, especially empowers people to structure and acquire the ethnic or culturally specific tools that assist us to learn, memorise, attend, and problem solve. As humans our survival or thriving depends on whether we learn and accurately interpret experiences we have and whether they are helpful or harmful to us, and our wellbeing. New learning in humans is rewarded by an increase in capability and proficiency in our world. International students are exposed to rich new Sensory Inputs when they travel and study in new contexts, for most this will serve to optimise and accelerate their learning and development.

### **Component 2: Six Wellbeing Dimensions**

The variables influencing Wellbeing have been organised under six dimensions that emerged from the multiple literature reviews conducted. The six dimensions: Social, Physical, Intellectual, Cultural, Emotional & Spiritual have been identified to support wellbeing literacy, identify how learning may be manifest through behaviours and provide focus areas for wellbeing supporting

practitioners and facilitators seeking to implement the UWM in praxis. Below is a summary of the parameters for the evidence-based variables included within each dimension.

**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 disease, financial means, physical safety, and other selected controllable physical human needs.

**I** Intellectual – our awareness, knowledge and skills are related to(i) our thinking styles, patterns, processes, and strategies (such as how we make decisions) and (ii) the 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, which informs the attitude with which the person approaches all interactive experiences in their life.

The six dimensions should be viewed as dynamic and fluid, influenced by interactive experiences, and social learning yet integrated, and interrelated. The state of each dimension can be enhanced, unaffected or harmed through social learning experiences and interpretations of these. Note the dimensions named are designed to support wellbeing literacy and should not be viewed as cognitively, socially, or psychological discrete as in for example Howard Gardner's Multiple Intelligences Model. Resulting behaviours exhibited or outputted will demonstrate the status of various wellbeing variables to various degrees and often be visible to a professional's trained eye.

### **Component 3: Seventy Wellbeing Variables**

The third component in the UWM are 70 evidence-based wellbeing-influencing variables, which focussed literature reviews and participant feedback in the investigations discussed have shown influence human wellbeing. The variables identified include for example, self-talk in the social domain. Vygotsky identified intra-psychological interactions within a person as one of the most significant social interaction contexts to influence human wellbeing. There are significant bodies of research on self-talk and its impact on human wellbeing available in and that cross various fields. Likewise, psychologists and physiologists have developed extensive bodies of research showing the clear relationship between adequate sleep, and physical wellbeing. Sleep is one of the wellbeing-influencing variables included at the micro level in the model and under the physical dimension. All variables identified below are likewise supported by significant bodies of research

that demonstrate their ability to influence human wellbeing. In Table 1 below the 70 variables are named.

**Table 2**

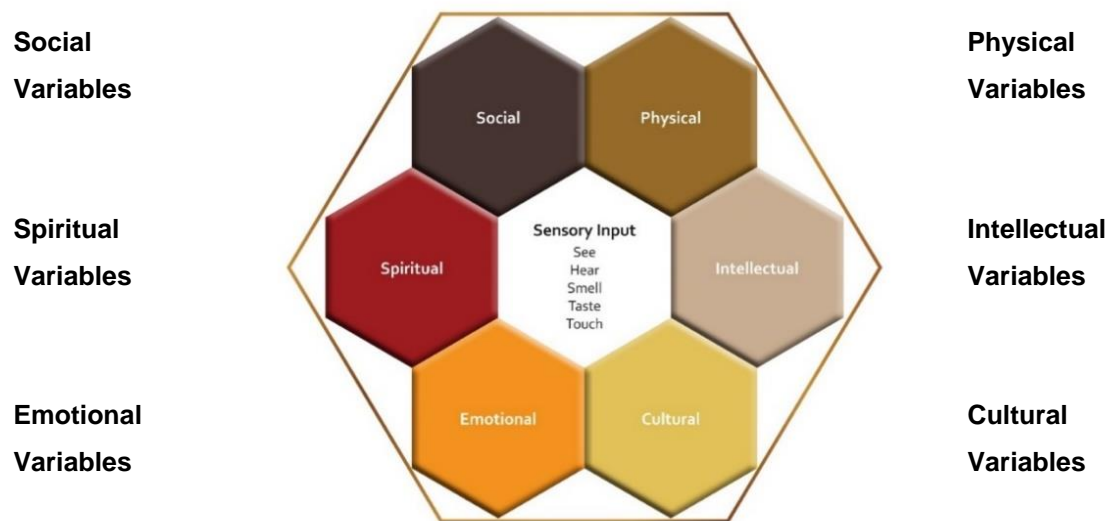
The Universal Wellbeing Variables

Social Domain	Intellectual Domain	Emotional Domain
1. Self Talk	29. Intellectual Safety	51. Emotion Recognition
2. Significant Others	30. Thinking Skills	52. Emotion Recognition in Others
3. Family	31. Problem Identification	53. Emotional Knowledge
4. Friends	32. Solution Finding	54. Emotional Regulation
5. Study/Workplace	33. Decision Making	55. Emotional Safety
6. Community	34. Achievement	56. Acceptance
7. Nationwide	35. Learning Activity	57. Emotional Growth
8. Global Context	36. Reading	58. Self Esteem
9. Social Safety	37. Writing	59. Validation
10. Social Acceptance	38. Maths-Numeracy	60. Love-Connection
11. Social Confidence	39. Comprehension	61. Social media-Internet
	40. Learning Challenges	62. Gambling
Physical Domain	Cultural Domain	Spiritual Domain
12. Sleep	41. Ethnic Identity (Genetic)	63. Belief System
13. Physical Safety	42. Ethnic Group Acceptance	64. Values System
14. Exercise	43. Ethnic Capabilities	65. Default Attitude
15. Hydration	44. Ethnic Safety	66. Intuition
16. Financial Security	45. Ethnic Confidence	67. Loci of Control
17. Physical Touch (Affection Sex)	46. Cultural Identity (Lifestyle Choice)	68. Resilience
18. Warmth	47. Cultural Group Acceptance	69. Unique Value
19. Prescribed Medicines	48. Cultural Capabilities	70. Life Value
20. Non-prescribed Medicines/Illegal Drugs	49. Cultural Safety	
21. Alcohol	50. Cultural Confidence	
22. Smoking		
23. Vaping		
24. Physical Disability		
25. Pain		
26. Dis-ease		
27. Housing		
28. Eating		

A second version of the Universal Wellbeing Model was later created which identified the location of the variables in the model, see Figure 2 below.

**Figure 2**

*Universal Wellbeing Model (UWM V2)* (Stevenson, 2022)



#### **Component 4: Five Principles**

Understandings of the UWM are guided by the following five principles mostly derived from Indigenous wellbeing models which have contributed to formation of this model and support inclusion and equity. They are, the UWM:

1. is holistic and supports outcomes greater than the sum of its parts.
2. is integrated, all dimensions are interwoven, interlinked and interdependent.
3. is designed to empower, appreciate, and support wellbeing enhancements.
4. can respond to diverse individuals and collective differences and needs.  
(for example: ethnicity, culture, beliefs, and gender) and
5. all dimensions are of equal importance and balanced development is supported.

While discussion of the literature and practice underpinning the selection of the seventy variables identified in Figure 2 is beyond the scope of this paper, the purposes for designing the UWM are important. The UWM has been designed to empower and support specifically youth, individuals, family, 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, b) explaining how our senses are the source materials through which we gain learnings about the various wellbeing variables c) explaining how learnings about wellbeing will manifest themselves as behaviours via one or more of the dimensions identified d) enhancing understandings of the diverse variables that impact human wellbeing and e) guiding how we interpret and understand wellbeing through the principles. Fields underpinning and implementing the UWM include those relating to business, community, education, health, Indigenous studies, psychology, and workplaces as well as areas that are the focus of the humanities and social science disciplines.



## **Research Outputs – 2**

### **UWM Underpinned Wellbeing Definition**

The research journey undertaken has led to a definition of wellbeing underpinned by the UWM as:

“a multi-dimensional concept impacted by sensory inputs derived from diverse social interactions. It is comprised of a social, physical, intellectual, cultural, emotional, and spiritual dimensions at a macro level and seventy variables shown by research to influence human functioning at a micro level and achieves coherence through five overarching principles.” (Stevenson et al.,2023).

### **Further Emerging UWM Underpinned Innovations**

Four innovations underpinned by the UWM have subsequently been developed, all of which are the result of the researchers’ long-term vision to contribute to enhancing holistic and inclusive human wellbeing for all. The four innovations developed, and being researched with Indigenous, domestic, and international students, staff, researchers, and wellbeing and pastoral care practitioners currently are set out below.

- Universal Wellbeing Evaluation Tool,
- Universal Wellbeing Evaluation, Enhancement Planning and Coaching system,
- Professional Wellbeing Practitioner Guidelines and
- Whole of Organisation/Community Universal Wellbeing Supporting System

## **Discussion**

This section of the paper discusses the findings and implications of the research. It provides an in-depth analysis of the data collected and presents a comprehensive interpretation of the results. This also explores the significance of the findings in relation to existing literature and identifies potential areas for further research.

### **International**

International education, since the 1919 establishment of the Institute of International Education in the United States of America, had been initiated to: promote goodwill, cooperation, and understandings between countries. International education provision in higher education has long required those providing wellbeing, and pastoral care support services in higher education to undertake “action or process(es) (Oxford University, 2023) to ‘internationalise’ their services; the new pre, during, and post COVID-19 environment, heightened, and made more extreme the many wellbeing needs of especially international students, teaching staff, researchers and the wellbeing and pastoral care practitioners’. The COVID-19 pandemic altered the international education landscape forever and created new challenges. New barriers, and access challenges to wellbeing, and pastoral care supports grew. For example, international students struggled to maintain contact with their families during COVID-19 lockdowns. Technological access, online education, inclusive teaching, and robust assessment were all identified by Shankey (2022), as challenges. Institutions also came under pressure to be responsive, and genuinely internationalise supports by designing products to meet the needs of diverse users, in multiple countries, or to design them so they can be easily modified, to achieve this goal” (Hayes, 2021).

Face to face meetings traditionally held to support the holistic wellbeing needs of international students and staff/researchers on campus became impossible due to lockdown and COVID-19 restrictions. Face to face support services, which were usually reserved for the most critical student wellbeing, and pastoral care support needs were disrupted, or often abandoned. Institutions did not have in place alternative wellbeing, and pastoral care support service systems, technological supports, or tech savvy staffing available to provide them as soon as learning shifted online. Institutions were faced for the first time with responding to the serious wellbeing concerns of international students' parents and family members. The usual wellbeing supports for domestic, and international students, teaching staff, researchers and wellbeing, and pastoral care practitioners were disrupted.

Domestic students were now also locked down, and away from their family homes, many began to need more or the same level of support as international students. International students were not only unable to go to their family homes or access traditional ethnic, and culturally appropriate supports, these students also experienced hearing harrowing stories of COVID-19 impacts on their families in other countries but were unable to travel to them or take actions to support them. These events demonstrate that the internationalising of higher education as envisioned by Brown and Jones (2007) has significant objectives yet to achieve, while De Wit and Altbach (2021) provide recommendations for a significant transformation in international education.

Both the theoretical and conventional investigations summarised were conducted before, during, and post New Zealand's first lockdowns reveal a new challenge in the provision of ethnically, and culturally appropriate wellbeing and pastoral care supports. When face to face contact was not permitted, wellbeing, and pastoral care practitioners were left with only one- or two-dimensional communication channels instead of the three-dimensional communications they usually utilise. This meant wellbeing and pastoral care practitioners were facing heightened, and more extreme wellbeing needs, with less information. At the same time digital resources, available on campus for these international students often closed or were not available or accessible in the residences where international students lived. Building effective relationships with international students and staff/researchers online, or by telephone became an urgent priority.

The above events during COVID-19, provided a rich and robust test of the wellbeing model(s) evaluated and utilised with international students, staff/researchers and wellbeing and pastoral care practitioners. It cannot be overstated that the findings contributed by international students, staff/researchers and their wellbeing and pastoral care practitioners during both investigations conducted, were critical in revealing serious weaknesses in the models investigated leading directly to the subsequent emergence and creation of the Universal Wellbeing Model (UWM).

## **Conclusion**

In conclusion two key outputs have to date emerged from the programme of research conducted; the Universal Wellbeing Model (Version 1 and 2, including the seventy wellbeing variables identified) and a new definition of wellbeing. Reflections on the research conducted to date has yielded three insights:

- i) the UWM aids wellbeing literacy and has been highly influenced by the contributions of international students, staff/researchers, and wellbeing and pastoral care practitioners,

- ii) implementation of the UWM and use of the wellbeing definition that have emerged are producing benefits such as clarity, specificity, and wellbeing literacy gains in practice settings.
- iii) contributions made by international students in investigations have significantly progressed the potential for the UWM to improve inclusion, and equity outcomes.

### **Practice-based Implications of the Research**

Three practice-based implications of this programme of research are:

- The objective of the programme of research to locate (or create) a wellbeing model, and definition capable of supporting diverse international students, teaching staff, researchers, and wellbeing and pastoral care practitioners to address diverse students' needs in praxis could not have been achieved without the robust evaluations by international students.
- The UWM incorporates provision for teaching, wellbeing, and pastoral care practitioners to use multiple ethnic, and cultural presentations of wellbeing; this ensures the safety, and confidence of those who provide wellbeing and pastoral care services and their students or clients. That is, there is no conflict in practitioners knowing and implementing the UWM and using 'other' ethnic or culturally based wellbeing resources to support relationship building and wellbeing literacy with their students or clients.
- Effective delivery of wellbeing, and pastoral care services in higher education institutions requires a close and aligned partnership between leadership and wellbeing and pastoral care practitioners.

In the words of Leask and Carroll (2011) it is time to move beyond wishing, and hoping for international students to experience engagement, and inclusion, and to utilise models, definitions, and practices, such as those included in this paper to realise such aspirations in praxis. Gao contributed to the above aspiration by proposing a lever in 2018 that if implemented could prompt action. Goa proposed a set indicator, and specific and measurable internationalisation indicators be adopted that could compare institutional performance across national boundaries, if actioned these measures may prompt implementation in the higher education sector and provide diverse international students with a level of 'consumer' information they currently do not have. Central to such measures must be support at all organisational levels for the holistic wellbeing of international students.

### **Limitations of the Research**

While pilot investigations into the effectiveness of the UWM, and wellbeing definition have been conducted, more comprehensive investigations of these outputs are currently in process, so do not currently inform and have limited what can be stated in this paper.

### **Further Research**

Investigations into the accuracy of the UWM as are accuracy, reliability, and validity studies into the subsequently developed Universal Wellbeing Evaluation Tool are also in progress. The author

welcomes contact from researchers and practitioners interested in practicing or research the model and definition reported.

## Conflict of Interest

The authors disclose that they have no actual or perceived conflicts of interest. The authors disclose that their institute received Ako Aotearoa funding that contributed to one of the investigations reported in this manuscript, otherwise the authors have not received any funding for the creation of this manuscript beyond resourcing for academic time. The authors have produced this manuscript without artificial intelligence support.

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