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Health-Promoting UWEL Intervention: Giving Voice to New Zealand Teacher Aide Workplace Wellbeing and Practice Challenges

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ABSTRACT

The compulsory education sector in New Zealand faced post-COVID challenges in 2023, including teacher shortages, poor student behaviour and attendance, declining achievement, and record levels of inequitable outcomes for Māori, Pacific peoples, and students with disabilities, learning differences, or neurodivergent conditions. In response, the Ministry of Education implemented unprecedented strategies, including, funding Teacher Aide (TA) Professional Learning and Development (PLD). This study originated in dialogues with TAs about their workplace wellbeing and its impact on their practice. Examined is TA Universal Wellbeing across the New Zealand compulsory education sector and the influences on practice. Framed by health promotion, the researchers used a mixed-methods design and implemented a Universal Wellbeing Evaluation and Literacy (UWEL) intervention to investigate TA wellbeing. Underpinned by the Universal Wellbeing Model (UWM), the intervention combined the quantitative Universal Wellbeing Evaluation Tool (UWET) with structured and Socratic qualitative questions. Findings illuminate the state of TA workplace wellbeing and their professional practice realities. Both supports and impediments are revealed alongside inconsistencies in professional standards, culture, staff safety, and support provisions. The results identify a quarter of TAs require further workplace wellbeing supports to promote student achievement. While literature portrays accurately TAs as resilient, they are also often unsupported, insecure financially, and treated inequitably; this investigation finds they are an underestimated workforce that makes a significant contribution to student outcomes in New Zealand's compulsory education sector.

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Introduction

Aspirations and Challenges

Dialogues between facilitators and one hundred New Zealand (NZ) Teacher Aides (TAs) undertaking Ministry of Education (MoE)–funded Professional Learning and Development (PLD) programmes from June 2023 sparked this investigation. TAs expressed ambitious aspirations to professionalise educational support and improve student equity outcomes. As past prime minister, Peter Fraser indicated in 1939, his goal was that every person, whatever their level of academic ability, whether rich or poor, whether living in town or country, has a right, as a citizen, to a free education of the kind for which they are fitted best, and to the fullest extent of their powers (Te Ara Encyclopaedia of NZ, 2009, p. 3) [1]. The dialogues with TAs' echoed Fraser's aspirations while describing personal experiences of inadequate educational support and the need for more effective student-support practices.

The 2019 Wellbeing Budget showed official awareness of national concerns about poor wellbeing and committed to placing people's wellbeing at the heart of policy, and prioritising those under 24 years of age (p. B1.1). Over the preceding 12 years a total of 14 national poor wellbeing metrics became entrenched and declined in NZ: high rates of child and adult suicide; sexual and family violence; crime and addictions; chronic illness and mental-health problems; and low levels of home ownership, workplace wellbeing and productivity, educational engagement and achievement, and social cohesion. The Wellbeing Budget aspirations have not materialised.

Investigation Context

Teacher shortages, poor student behaviour, low attendance, and inequitable and low educational achievement for some groups are still challenges in NZ's compulsory education sector [2-5]. Although COVID-19 contributed to these problems, pre-COVID data show these negative trends were entrenched already and declining before COVID. Recently the MoE has implemented a range of strategies to reverse these trends.

Strategy 1: increase the number of Teacher Aides (TAs) supporting the compulsory education system. TA numbers have grown from 17,859 to over 20,000, according to data released under the Official Information Act in April [6,7]. In Australia there are more than 200,000 education and teacher aides [8]. Meanwhile, teacher numbers - 55,000 in 2018—have risen to about 74,104 (headcount) in state and state-integrated schools [5,9]. These data demonstrate (a) that TAs are a significant resource employed to

address increasingly complex student needs—learning difficulties, attendance and behaviour issues, neurodivergent conditions, disabilities, and wellbeing challenges—and (b) that TA numbers have not increased in step with student attendance, which rose from 46.1% to 65.9% in 2025 and continues to climb [7].

Strategy 2: which commenced in mid-2023, was for the MoE to fund PLD for TAs for the first time. While the ERO identified teacher stress and mental and physical health as challenges, the absence of attention to TAs wellbeing is notable. The distinct and complex front line role TAs play, and the inclusion of voices is missing from recent literature [3]. While TA burnout and wellbeing, received little attention historically, in recent times it has received even less [10]. No comprehensive investigation of the wellbeing of NZ's ~20,000 TAs and 200,000 Australian TAs has been conducted in the last ten years. As Norm Kelly, Deputy Mayor of Toronto, commented famously, "You cannot pour from an empty cup;" this raises the question: what are the wellbeing levels of NZ TAs.

Health Promotion and the UWEL Intervention

The UWEL intervention was designed to align with and extend the five-core health promotion action areas [11]. The Intervention aimed to improve TA wellbeing and programme completion rates, to the extent their new capabilities would increase TAs' capacity to enhance student attendance, and achievement levels [12]. All evidence-based UWEL intervention elements have emerged from a sixteen-year wellbeing research programme. The intervention is authentically holistic: it addresses and defines social, physical, intellectual, ethnic, cultural, emotional, and spiritual dimensions of human wellbeing. The intervention endorses the health promotion view of health as a fundamental human right, then advances health promotion practice through its comprehensive multi-disciplinary foundations and promotes collaborative engagement between schools, staff, TAs, students, families, and communities via a new overarching Universal Wellbeing Charter: A Framework for Global Primordial Prevention [13].

Although the UWEL intervention supports health as a right underpinned by psychological, medical, and health literature; the Universal Wellbeing Model (UWM) draws on a broader, more diverse body of evidence to support the right to Universal Wellbeing and the opportunity to achieve one's potential as well. The UWEL intervention supports seventy individually controllable Determinants of Universal Wellbeing (DoUW). This emphasis differs from public-health system orientations, which prioritise social and ecological determinants while overlooking dimensions such as ethnicity, culture, and spirituality. Because this investigation is situated in education rather than a clinical or public-health settings, implementation of the UWEL is aligned better and more appropriate to this setting. Furthermore, the UWEL theory of change empowers participants to make sustainable changes through professionally facilitated, relevant, and progressively scaffolded learning experiences that build Universal Wellbeing Literacy, i.e. awareness of what wellbeing is, how it is influenced, how it can be improved and maintained over time, and how it can be measured.

Literature Review

Defining Wellbeing

Literature on defining wellbeing and on teacher-aide (TA) wellbeing has informed this investigation. Since 2008, the researchers have identified over 1,000 definitions and nearly 500 wellbeing models; unfortunately, fewer than five percent of these are supported by any evidence base. Wellbeing related publications over the last 40 years have promoted diverse understandings of wellbeing, but few have made robust, evidence-based attempts to define the term itself. In 1995, Ryff and Keyes noted a puzzling absence of theory-based and evidence-based formulations of wellbeing despite large numbers of accounts of positive wellbeing in the literature [14]. XXX et al. detailed global perspectives and discussions of wellbeing over time, and noted recently three distinct evidence-based wellbeing paradigms have emerged, they are [15]:

- **Psychology, Medicine and Health Sciences Paradigm:** The most dominant paradigm is underpinned by evidence from the above fields. This paradigm focuses on the clinical diagnosis and treatment of poor mental health & wellbeing such as depression and psychosis, affecting approximately 25% of the population over their lifetimes. The PERMA model is cited commonly within this paradigm [16].
- **Multidisciplinary and authentically holistic paradigm:** This evidence-based paradigm focuses on the science of measurably realising human potential, thriving, and, or flourishing, along with the prevention of poor wellbeing; it is relevant to 100% of the population over the life course. The Universal Wellbeing Model exemplifies this paradigm [15].
- **Special-populations paradigm:** This evidence-based paradigm draws on multidisciplinary and holistic from specific population (e.g., Indigenous, religious, or professional). This paradigm supports wellbeing from that population's viewpoint by employing traditional beliefs, values, and knowledge. The population covered varies; Te Wheke – The Octopus (Pere, 1997) is a model in this paradigm [17].
- Some argue there is a fourth, potentially dangerous paradigm anecdotal and market-driven that is not underpinned by evidence yet is common in education, health, and business sectors and is amplified by social media. This approach is used often to promote products and services to targeted markets. Many parts of NZ's compulsory education sector have largely interpreted and implemented wellbeing in line with Paradigm 1, viewing wellbeing primarily as a clinical or public-health concern. Although this interpretation is relevant for some students, it overlooks a key function of a national education system: to empower students and prevent poor wellbeing through learning over the life span. In the Ottawa Charter (1948), the World Health Organization stated that wellbeing is not merely the absence of disease or infirmity but a holistic state integrating physical, mental, and social aspects, and that wellbeing "is a positive state encompassing physical, mental, and social dimensions, reflecting the ability of individuals and societies to thrive and contribute meaningfully to life" (pp. 1–2) [18].

In 2017 WHO defined mental wellbeing as a state in which every individual realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to their community—moving strongly toward Paradigm 2. Also, in 2017, WHO revised its advice to schools, stating that "a school that constantly seeks to strengthen its capacity to promote healthy living, learning and working conditions" (p.19) provides early intervention to reduce long-term risk, and urged schools to commit to enhancing the social, emotional, physical, and moral wellbeing of all [19]. This guidance leans toward Paradigm 2 while still supporting aspects of Paradigm 1. More recently, WHO described wellbeing as a positive state experienced by individuals and societies, a resource for daily life determined by social, economic, and environmental conditions, and incorporating quality of life and the ability of people and societies to contribute to the world with meaning and purpose [20]. WHO also advocates

for the equitable distribution of resources, overall thriving, and sustainability.

The above 2021 WHO guidance recognises five of the Universal Wellbeing Model (UWM) dimensions, including the spiritual via reference to "moral wellbeing," but it omits mention of the highly influential evidence-based ethnic and cultural dimensions in the UWM. Despite all the above, the WHO Glossary of Terms does not include an evidence-based definition of wellbeing [21]. After reviewing WHO's definitions and different models across the three evidence-based paradigms, the researchers selected Paradigm 2—the Universal Wellbeing Model—as the most suitable framework for this investigation due to it being inclusive, individually empowering, evidence-based, and testable. This investigation adopted the UWM's standardised definitions alongside Health Promotion principles [22].

Note: Researchers aligned with Paradigm 1 hyphenate well-being (an APA publishing convention) typically, whereas those aligned with Paradigms 2 and 3 use the unhyphenated wellbeing to reflect the holistic nature of the concept.

Teacher Aide Wellbeing

Like the WHO, the NZ MoE's applications of the wellbeing concept have over time shifted toward Paradigms 2 and 3, although their approach still appears dominated largely by a clinical-psychology perspective rather than a diverse multi-disciplinary and educationally oriented one. Between 1999 and 2025 the MoE also aligned with the special-populations Paradigm 3 by adopting the Hauora - Breath of Life model in the 1999 NZ Health and Physical Education curriculum [23]. Simultaneously included in this curriculum was also health promotion – a Paradigm 1 model. After the 2019 Wellbeing Budget, the MoE also incorporated wellbeing actions into the NZ National Education and Learning Priorities via an implementation statement and related wellbeing to COVID, ethnicity, and mental health and with objectives such as Learners at the Centre; Barrier-Free Education; and Quality Teaching and Leadership [24]. Although over 50% of the specified actions related to special populations, staff and student wellbeing were not included in system objectives and no definition of wellbeing was provided.

Further confusing understandings of wellbeing are discussions about the relationship between, for example, school attendance and wellbeing [25]. McGregor and Webber adopt an exclusively psychological, Paradigm 1 view of wellbeing when discussing absenteeism and suggest, simplistically, that only anxiety, belonging, bullying, motivation, and unfair treatment affect school attendance [25]. Such competing, shifting, and limited understandings of current evidence-based wellbeing paradigms appear to have captured compulsory education sector dialogues and are adding substantial expense to the system. Oades, described many five-point psychological models as 'psychological reductivism', indicating these are one of the biggest challenges to the global development of wellbeing science [26]. The use of public, mental-health, and clinical models could be a barrier to re-establishing and/or establishing an effective, evidence-based prevention-oriented, authentically holistic national school–community wellbeing support system.

Ward indicated in 2011 that TA literature along with debating their use, role, and value, describes TA relationships as "transactional: about what they do and what they know, but not about how they are" (p.5) [27]. TA voices are notably absent from most literature [28-30]. Publications before 2014 examined how to "use" TAs; after 2015 the focus becomes administrative, focused on what TAs do and do not do, as though numerous guides could address the complex, dynamic, and fast-moving environments TAs face in practice [30-34]. TA accounts of supporting the most complex student learning and wellbeing challenges while monitoring their relationships with teachers, many TAs find stifling and energy-sapping. The question emerges: if TAs experience in a workplace is not inclusive or equitable, is it reasonable to expect they can support achievement of the same with the students they support?

The Health Promoting UWEL Intervention

A sixteen-year wellbeing research programme conducted in NZ has investigated the capacity of different models to support health-promoting, pastoral-care, and wellbeing support systems in educational settings [12,35,36]. The research has focused on four questions: What is wellbeing, How is wellbeing influenced? How can wellbeing be improved and sustained over time? And How can wellbeing be measured? This research underpins the Universal Wellbeing Model (UWM), the Universal Wellbeing Evaluation Tool (UWET), and the UWEL intervention programme, and it informs the following evidence-based lay and research definitions of Universal Wellbeing used in this investigation: Universal Wellbeing (lay): the science of realising human potential.

Universal Wellbeing (research): a hierarchical, multidimensional concept impacted by sensory inputs derived from diverse social interactions. This comprises social, physical, intellectual, ethnic, cultural, emotional, and spiritual dimensions at a macro level, and seventy determinants shown by research to influence human functioning at a micro level. This achieves coherence through five overarching principles [22].

A detailed description of the UWEL intervention, sufficient to support replication, is provided in [12]. These researchers have shown they can create positive, caring, and empathetic learning environments with low dropout and high programme completion rates through holistic, health-promoting pastoral-care and wellbeing support systems [35]. These supports have been implemented both with individual students and across whole institutions to achieve programme completion rates between 87% and 98% consistently in contexts where national norms previously ranged from 30% to 60%. Hilliam and Williams Lister et al., and especially Cowie have all advocated for such "systems and interventions that reach out" (p. 321) [37-39]. Pacansky-Brock et al. call for equity-sensitive approaches that include ethnic and cultural wellbeing also [40].

Chung et al. reviewed 2,599 studies published between 2009 and 2021 and found that students experienced poorer mental health than the general population [41]. Like Katajavuori et al. they found that a psychological/mental-health paradigm limited researchers' ability to identify holistic, influential, and alternative variables [42]. Both groups shifted their focus toward seldom-investigated wellbeing approaches and more standardised, replicable intervention studies, acknowledging the limitations of psychology-only approaches in meeting diverse student needs. Even recent innovators in online wellbeing supports report limited success when implementing mental-health-focused approaches [43]. The absence of evidence-based, holistic, inclusive, standardised wellbeing interventions; new hypotheses; replicable intervention studies; and proactive, individually responsive wellbeing services has been revealed as problematic. Crawford et al. concluded only by shifting to an inclusive, health-promoting whole-student approaches that prioritise the holistic wellbeing of the most vulnerable in the

compulsory sector—will educational achievement and equity be improved [44]. Teacher aides would be an integral part of such compulsory school sector systems. The investigation that follows responds directly to the above findings, and gaps.

Theory of Change

Investigations into preventing low educational achievement, by addressing the drivers of poor wellbeing show promise. The attainment of Universal Wellbeing Literacy; that is, implementable understandings about what wellbeing is; what influences it; how to improve and sustain a positive level and how it can be measured are critical. Understandings have emerged that indicate an effective Universal Wellbeing Theory of Change must incorporate:

- Provision of personally relevant, transformative, and powerful applied learning about Universal Wellbeing one's own Universal Wellbeing profile, and how this can be improved [45].
- Recognition that survival-related wellbeing needs will take priority over all other needs and life demands; that is; impenetrability is in play [46].
- Development of empathetic identification of one's impact on the Universal Wellbeing of others, formal operations and enactment of empathy are possible through progressively scaffolded learning [47, 48]. The Universal Wellbeing Literacy – Theory of Change Steps are set out in set out below, the intervention applied focussed on steps 1 to 5 below [13].

Table 1: Universal Wellbeing Literacy - Theory of Change Steps

Method

A mixed method research design was selected for this investigation [49]. Quantitative data was gathered to answer the first question below using the UWET; this revealed Universal Wellbeing determinants, dimension, environmental settings and individual TA Universal Wellbeing risk level scores. Qualitative data was gathered through two open and three closed questions asked at Draft UWET Report back Meetings during the Intervention:

Quantitative

- What are TA Universal Wellbeing levels in the compulsory sector in NZ?

Qualitative

- What factors reduce the impact of your TA practice?
- What factors support the impact of your TA practice?
- Have you been threatened in your workplace?
- Have you been physically struck in your workplace?
- Would you like to have the option to pursue teacher education part-time?

Two further questions were also asked and have been reported in detail in XXX & YYY:
i.e [12]. what are your views on the UWM you learned about, and what was your experience of completing the UWET questionnaire?

Data Analysis

Quantitative data was cleaned and analysed independently using Cronbach Alpha [50]. Qualitative data was collected verbatim then analysed using thematic analysis and descriptive statistical analysis [51]. Finally, the five UWM principles and five core health promotion action areas were applied to findings to guide interpretations, synthesis and reporting of both the quantitative and qualitative data [13].

Participants

Participants were 100 randomly volunteering and consenting TAs from diverse ECE, Primary, Intermediate and High School settings in NZ, were enrolled in MoE approved online PLD courses and programmes. The participants were as described by Chung et al., largely mature, returning to education after a gap with family/other commitments, employed, and/or in caregiving roles [41]. Enrolees were funded by the MoE, their employing school, or private means. Completion of Year 11 or 12 schooling was the highest reported by the TAs.

Results Demographic Data Gender

The participant population was 94% female and 6% male; no participants identified with any other gender. The gender distribution reflected the national TA workforce profile.

Age

Table 2: Participants Ages

19 to 26 years	26 to 35 years	36 to 45 years	46 to 55 years	56 to 65 years	66 to 75 years
14%	12%	24%	36%	11%	3%

Ethnicity

Participants self-selected 48 ethnic descriptors of their own ethnicity, numbers of each are not provided to protect participant identification.

Programme Completion, Dropout and Withdrawal Rates

All participants were required to completed three courses to achieve programme certification over an 18-month period; 94% of participants completed the programmes they enrolled in, 6% withdrew, none dropped out (left without withdrawing formally or became uncontactable). TAs who withdrew from the programme identified reasons for this.

Quantitative

After the quantitative data was cleaned, it was analysed using Cronbach Alpha, the objective being to assess the internal consistency reliability of the UWET [50]. This measured the extent to which all 70 items DoUW in the tool are correlated, indicating they measure the same underlying construct i.e., Universal Wellbeing. The dataset included 100 participants responses to

the 70 core DoUW questions (Q1-Q70), and for each of the six theoretical dimensions. The Interpretation Benchmarks were: $\alpha \geq 0.9$: Excellent, $0.8 \leq \alpha < 0.9$: Good, $0.7 \leq \alpha < 0.8$: Acceptable, $0.6 \leq \alpha < 0.7$: Questionable, and $\alpha < 0.6$: Poor.

Table 3: Internal Consistency Reliability Levels of the UWET

Scale / Dimension	Number of Items	Cronbach's Alpha (α)	Reliability Interpretation
Full UWET Scale	70	0.94	Excellent
Social Dimension	11	0.87	Good
Physical Dimension	17	0.82	Good
Intellectual Dimension	18	0.89	Good
Cultural-Ethnic Dimension	10	0.91	Excellent
Emotional Dimension	12	0.88	Good
Spiritual Dimension	8	0.85	Good

Overall Scale Reliability ($\alpha = 0.94$): The exceptionally high alpha for the full 70-item scale indicates a superb internal consistency, confirming the UWET is a highly reliable and coherent instrument. t. Respondents are interpreting the items in a consistent manner, and the tool is stably measuring the complex, multi-faceted construct of Universal Wellbeing as defined. Based on the Cronbach's Alpha analysis and the UWET-Based UWEL Intervention, the following conclusions can be drawn: The UWET is a psychometrically sound instrument with demonstrated high internal consistency, this means that the scores it generates are stable and trustworthy. This supports research confidence in UWET reports and their capacity to generated valid data to respond to the first research question: 1. What are TA Universal Wellbeing levels in the compulsory sector in NZ?

Quantitative Data Analysis Findings

Total Teacher Aide Universal Wellbeing Levels

The TA Universal Wellbeing scores ranged from the highest to the lowest possible; 75% of TAs were in the highest positive level category, 23% were at a Moderate positive level and 2% were at the highest possible negative level. The TAs with a moderate positive level of Universal Wellbeing demonstrate a need for Universal Wellbeing supports and the 2% with the highest negative level are 'at risk' and their Universal Wellbeing needs were serious, urgent, and related to safety and or suicidal ideation.

Table 4: Total TA UWET Scores and Range

	High level of positive UW 86 to 172	Moderate Level of positive UW 173 to 258	Moderate Level of negative UW 173 to 258	High Level of negative UW 259 plus
TAs in this category	75	23	0	2
Lowest and most Positive UWET Score			Highest and most negative UWET score	
94			347	
Mean		Medium		Mode
154.6		146		146

Overall the twelve DoUWs most positively supporting the TAs Universal Wellbeing in order are: 1. Physical Safety at Home (Q13a), 2. Not Smoking (Q22), 3. Not Vaping (Q23), 4. Not Gambling, 5. Their Housing (Q27), 6. Physical Safety at Work (Q13b), 7. Not taking Non Prescribed or Illegal Drugs (Q20), 8. Physical Safety in Study (Q13c), 9. Reading (Q36), 10. Writing (Q37), 11. Warmth at Home (Q18a), and 12. Comprehension (Q39).

The twelve Determinants most negatively influencing Universal Wellbeing in order are: 1. Unique Valuing of Self (Q69), 2. Not Valuing Life (Q70), 3. Their Beliefs (Q63), 4. Loci of Control (Q67), 5. Values (Q64), 6. Sleep (Q12), 7. Self Esteem (Q58), 8. Disease (Q26), 9. Hydration (Q15), 10. Alcohol (Q21), 11. Exercise (Q14), and 12. Default Attitude (Q65).

Key Findings and Conclusion

Eight of the DoUW most positively supporting overall Universal Wellbeing were Physical, three were Intellectual and one was from the Emotional Dimension. Six of the DoUW most negatively influencing Universal Wellbeing were from the Spiritual Dimension, five were from the Physical dimension, and one was from the Emotional Dimension.

Analysis of Home, and Work Environmental Influences on Universal Wellbeing

Based on the dataset analysed (100 TA), the averaged environmental level scores for the whole population have been calculated mean scores for the 24 specific determinants across four domains. These reveal the environment most supporting TA Universal Wellbeing was their homes, and the environment least supporting Universal Wellbeing was Work being significantly more negative than Home. The Work environment score is concerningly high for those providing learning, ability, and behaviour support to students in schools.

Table 5: Home-Work-Study Environmental Score

Environment	Averaged TA Population Scores	High Positive Environmental Score 5 to 15	Moderate Environmental Score 16 to 28	Low Negative Environmental Score 29 to 40
Home	13.2			
Work	18.6			

The six Universal Wellbeing Determinants contributing most positively influencing Universal Wellbeing from the highest down were 1. Physical Safety at Home (Q13a), 2. Physical Safety at Work (Q13b), 3. Physical Safety at Study (Q13c); 4. Warmth at Home (Q18a), 5. Warmth at Work (18b), all from the Physical Dimensions then 6. Home Environment (Q5a). All Intellectual, Physical, Ethnic/Cultural, Emotional, and Spiritual Determinants had higher means (>2.3) and were therefore less positive.

The eight Universal Wellbeing Determinants contributing most negatively influencing Universal Wellbeing from the highest down were 1. Emotional Safety at Work (Q55b), 2. Validation at Work (Q59b), from the Emotional Dimension and 5. Intellectual Safety at Work (Q29b), 6. Achievement at Work (Q34b), 7. Learning Activity at Work(Q35b), in the Intellectual Dimension and 8. Emotional Safety at Home(Q55a).

Key Findings and Conclusion

Physical Safety was the most critical contributor to positive Universal Wellbeing, then Warmth at Home and Work and finally the Social environment at Home, and then at Work. A lack of Emotional Safety and Validation at Work had the most negative influences on Universal Wellbeing, followed by Emotional Safety and Validation in Study from the Emotional Dimension. Other determinants negatively influencing their Universal Wellbeing were Intellectual Safety, Achievement, Learning Activity at Work in the Intellectual Dimension and finally Emotional Safety at Home in the Emotional Dimension.

For this population of TAs, Home then Work provided the strongest Universal Wellbeing Supports from Physical and then Social Dimension perspectives. The environment most harmfully influencing Universal Wellbeing was Work, then Home, from Emotional and Intellectual Dimensions. These results indicate Universal Wellbeing Interventions that provide Emotional and Intellectual Wellbeing capabilities should be prioritised by schools to support TA's practice effectiveness. Especially lacking is the workplace capacity to provide Emotional Safety, Validation, Intellectual Safety, and Learning Activities in the workplace to TAs.

Table 6: Dimensional Averages: Most and Least Helpful Universal Wellbeing Dimensions

Dimension	Mean Dimensional Average	Ranking
Intellectual	1.733	1 (most helpful/least difficulties)
Ethnic-Cultural	1.822	2
Spiritual	1.85	3
Emotional	1.899	4
Physical	1.916	5
Social	2.145	6 (least helpful/most difficulties)

The Intellectual dimension (e.g., intellectual safety, problem identification and solving, decision making, learning achievements and challenges) showed the lowest mean score (1.733), meaning TAs reported this Dimension was most helpful and had the least difficulties for them followed by the Ethnic-Cultural, Spiritual, Emotional and then Physical Dimensions. The Social dimension (e.g., family, friends, home, work, study environments, social safety, acceptance, and confidence etc) showed the highest mean score (2.145), indicating the greatest level of difficulty or lowest wellbeing in this dimension. Thus, the Social Dimension appears to be the most challenging dimension for TAs. While these statistical analyses can provide general population trends, the TA UWET Profiles were diverse and showed there was a need for customised Universal Wellbeing learning and interventions.

Key Findings and Conclusion

These findings highlight that while the Intellectual along with the Ethnic-Cultural, and Spiritual Dimensions strengthened Universal Wellbeing most for the TA population, the Social, Physical and Emotional Dimensions emerge as particularly requiring greater attention in Health Promoting Universal Wellbeing based learning and Intervention programmes.

The statistical evidence confirms that the UWET is a robust engine for screening individual and group Universal Wellbeing to drive the Theory of Change outlined. The UWET is a reliable and authentic holistic measurement, that can empower practitioners to transition from vague or anecdotal understanding of wellbeing to a precise, actionable, and evidence-based one where they can check the effectiveness of their practice through post UWET administrations after learning and Intervention programmes to achieve improved outcomes.

Qualitative Data Findings

The themes below emerged from verbatim data collected and subjected to thematic analysis.

What factors reduce the impact of your TA practice?

Theme One – Holistic Safety

Workplace safety, especially physical, social, intellectual and emotional, was identified as the most critical practice impact; Provision of workplace orientations, inductions and health and safety practices were rarely reported. No TA reported receiving MoE abuse and neglect definitions and reporting guidelines. The lack of professional/appropriate management of safety incidents was widespread along with an expectation TAs should expect to experience threats, and assaults.

Themes Two Communication

Unprofessional and incomplete communication negatively impacted practice; being requested to work with students alone about whom they had no information was common. In many workplaces TAs were excluded from access to information critical to their practice/own safety, e.g. neurodiverse, and or violent student histories and then expected to practice effectively.

Theme Three - Exclusion

Many TAs practice was negatively impacted by exclusion from staffrooms, and workplace meetings; and reported feeling like second class citizens. Some indicated their role was to improve student equity outcomes but the schools they worked in did not treat staff fairly or model equitable treatment of TAs. The TAs reported their ability to practice effectively was often compromised by inequitable treatment by other staff.

Theme Four- Financial Insecurity

TAs reported their insecure, often hourly and temporary basis of employment made them vulnerable and reduced their ability form relationships and to practice effectively. Most were so fearful of being judged negatively and losing their employment, the TAs rarely reported difficulties, traumatising incidents, or support needs. The lack of being paid to attend practice related meetings was noted as a major impediment to their practice effectiveness.

What Factors Support the Impact of your TA Practice?
Theme Five- Professional Inclusion
Workplace settings where TAs were professionally included in meetings, planning, assessment and other aspects of student learning indicated they were able to practice more effectively. TAs reported being part of workplace teams gave them a safe, respected, and positive social, intellectual and emotion environment in which to work which increased their effectiveness and practice quality over time.

Theme Six- Professional Processes
TAs in settings where there was a fit for purpose, fair, and accessible quality management system practiced most effectively. In such settings TAs could locate processes and procedures, see expectations and practice standards they needed to meet; such settings were highly supportive of TA practice quality but rare. TAs also reported an increased sense of safety in these workplace settings.

Theme Seven – Professional Development and Progression
TAs reported an increment in their capabilities in settings where they were included in PLD and had progression opportunities; these markedly increased their practice contributions, workplace safety and satisfaction, it also motivated them to increase their practice quality. Gaining Teaching Council Limited Authority to Teach was an aspired to progression by TAs.

Theme Eight – Professional Support
TAs working in settings where there was holistic support for them to overcome challenges and difficulties in their roles improved their practice quality and student outcomes. Being accepted and recognised as worthy of support like other staff had positive impacts on TAs practice.
Descriptive statistics revealed the following responses by the participating TAs to the final three closed research questions:

Have you been Threatened in your Workplace?
Fifty seven percent of TAs reported being threatened at their workplace to the point they believed it impacted their Universal Wellbeing, interfering with, for example, movement around their school, sleep, eating, self-talk, relationships with others and ability to practice. Forty eight percent of threats were from students, six from other staff and two were from parents and one from a community member.

Have you been Physically Struck in your Workplace?
Twenty seven percent of the TAs reported being struck/assaulted in their workplace. Twenty-four were struck by students, and one by another staff member, parent and community member. Only one TA reported satisfaction with how school management addressed the assault upon them; the balance reported the event was minimised, brushed under the carpet and not formally addressed as an assault, and/or no health and safety processes were actioned. In most situations the assault occurred when no teacher was present. In some incidents the TA was placed back with the assailant a lone within a space with an hour and expected to carry own as though the event had not occurred. Some TAs left the settings where they had been assaulted and reported being traumatised by the event, lack of processes and support made available to them. Fear the incident would be blamed on them and lead to reduced hours or termination was common.

Would you Like to have the Option to Pursue Teacher Education Part-Time?
One hundred percent of the participating TAs wanted the option to be able to pursue teacher education while working as a TA. Many TAs have years of experience, special capabilities, often manage behaviour for teachers, and have responsibilities beyond MoE guidelines.

Conclusions
The above results conclude that TA Universal Wellbeing is positive for 75% of TAs, but 25% require additional supports, largely because of a negative workplace environment. PLD is needed to empower managing teachers and TAs with the understanding and capacity to support intellectual and emotional safety, design effective learning activities, and validate TA work.

The impressive 94% programme completion rate among TAs confirms the effectiveness of the health-promoting UWEL intervention. This outcome is surprising given (a) the high levels of fear and anxiety TAs experienced when returning to study after histories of unhappy school experiences, and (b) the 51% programme completion rate in a parallel programme that provided only reactive pastoral care supports. The UWEL intervention supported core health-promotion action areas also by creating a supportive environment, developing personal skills, and reorienting services toward the prevention of poor Universal Wellbeing. The findings have the potential to guide future wellbeing system policy developments in Australasia.

Application of the five Universal Wellbeing Model principles to both the quantitative and qualitative findings leads to the conclusion that the investigation did examine holistic Universal Wellbeing and demonstrated how DoUW are integrated, interlinked, and interdependent in practice [13]. All UWM dimensions contributed to the overall picture of TA Universal Wellbeing strengths and capabilities, and each also played a role in the potential and actual harms to Universal Wellbeing identified. The high TA programme completion rates endorse the conclusion that acquiring health-promoting Universal Wellbeing literacy was empowering and addressed the diverse Universal Wellbeing needs of TAs. Generalisation of the findings supports the following conclusions and urgent actions:

- Build an aligned, collaborative, and measurably effective evidence-based Universal Wellbeing onsite support system in schools for staff and students.
- Adopt leadership and management practices that address systemic inequities, exclusion, holistic unsafety, and unprofessional communication experienced by over 25% of TAs, which negatively impact their practice effectiveness.
- Consider offering part-time teacher education to TAs to further enhance their capacity to support achievement and staffing levels over time.

While adults are responsible for their own wellbeing, employers are legally responsible for workplace environments that harm staff. Recent research on teachers in Australia supports reducing the impact of work-related stressors and advocates for interventions that increase teachers' positive feelings and thoughts as much as those that reduce negative feelings and thoughts in the workplace [52].

Finally, this investigation reveals that public health and narrowly focused clinical-mental-health models are only partial solutions and can be barriers to establishing effective, prevention-oriented, and authentically holistic national onsite school–community wellbeing support systems.

The key limitation of this investigation was the absence of a post-PLD programme evaluation; such an evaluation could have provided further insights into the impact of UWEL on TA Universal Wellbeing, PLD undertaken, and student outcomes over

time. A key advantage of the investigation is that it supports the use of a second UWEL intervention with additional supports in the future (the UWELS intervention) investigations.

Future research should include diverse populations to test the universality of the UWM/UWET; populations experiencing survival-related wellbeing needs to better understand the relationship between wellbeing and impenetrability; and large-scale, randomized controlled trials with multi-ecological-level and primordial-prevention orientations.

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Authors' Contributions
XXX: Conceptualisation, Implementation, Analysis, write up, Editorial YYY: SUPERVISION, Editorial and Advisory
ZZZ: Quantitative and Qualitative Analysis, write up and Editorial

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