

# “Do-Live-Well”: A Canadian framework for promoting occupation, health, and well-being

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« Vivez-Bien-Votre Vie » : un cadre de référence canadien pour promouvoir l'occupation, la santé et le bien-être

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**Key words:** Activity; Health promotion; Models; Theoretical; Wellness.

**Mots clés :** activité; bien-être; modèles; promotion de la santé; théoriques.

## Abstract

**Background.** Occupational therapists can bring a unique and valuable perspective to the national dialogue on health promotion. Current approaches have a narrow focus on diet and exercise; a broader focus on occupation has the potential to enrich understanding regarding forces that contribute to health and well-being. **Purpose.** A new “Do-Live-Well” framework will be presented that is grounded in evidence regarding the links between what people do every day and their health and well-being. **Key Issues.** Elements of the framework include eight different dimensions of experience and five key activity patterns that impact health and well-being outcomes. Personal and social forces that shape activity engagement also affect the links to health and well-being. **Implications.** The framework is designed to facilitate individual reflection, community advocacy, and system-level dialogue about the impact of day-to-day occupations on the health and well-being of Canadians.

## Abrégé

**Description.** Les ergothérapeutes ont une perspective unique et utile qui peut contribuer à enrichir le dialogue national sur la promotion de la santé. Les approches actuelles mettent souvent un accent plutôt étroit sur le régime alimentaire et l'exercice physique; toutefois, une approche accordant une plus grande attention à l'occupation est susceptible de nous aider à mieux comprendre les facteurs qui contribuent à la santé et au bien-être. **But.** Un nouveau cadre de référence, « Vivez-Bien-Votre Vie », sera présenté; ce cadre est fondé sur des données probantes mettant en lumière les liens qui existent entre ce que les gens font tous les jours et leur santé et bien-être. **Questions clés.** Ce cadre est composé de huit dimensions différentes de l'expérience et de cinq dimensions principales liées à l'utilisation du temps, toutes ayant un impact sur la santé et le bien-être. Les facteurs personnels et sociaux qui façonnent la participation à des activités ont également un impact sur les liens avec la santé et le bien-être. **Conséquences.** Le cadre est conçu pour faciliter la réflexion individuelle, la défense d'intérêts communautaires et le dialogue à l'échelle du système sur l'impact des occupations quotidiennes sur la santé et le bien-être de tous les Canadiens.

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A health care system—even the best health care system in the world—will be only one of the ingredients that determine whether your life will be long or short, healthy or sick, full of fulfillment, or empty with despair.

—Roy Romanow (2004, p. 5)

The above quote by the Honorable Roy Romanow (2004) was designed to challenge health care leaders and policy makers to broaden their perspective regarding the future of health care in Canada. It moves away from the traditional emphasis on biomedical treatment to suggest broader social forces that shape whether Canadians live long, happy, and productive lives. Principles of the social determinants of health are rooted in clear evidence that health care plays only a small part in outcomes related to morbidity, mortality, and quality of life (Raphael, Curry-Stevens, & Bryant, 2010). Existing frameworks, such as the World Health Organization's (2002) Active Ageing Policy Framework, and health promotion frameworks, such as the Ottawa Charter for Health Promotion (World Health Organization, 1986), build on this perspective by highlighting the need for ongoing participation and engagement in all aspects of life for physical, social, and mental well-being throughout the life span. This perspective represents a new era of health promotion that is congruent with the values of occupational therapy. For example, there is an emphasis on health and quality of life rather than illness, and on employment and education rather than hospitalization.

Occupational therapists have an important perspective to bring to the national dialogue regarding the health and well-being of Canadians. Although existing health promotion frameworks address social determinants of health and begin to highlight the importance of participation and engagement, (e.g., Secretariat for Intersectoral Healthy Living Network, Federal/Provincial/Territorial Healthy Living Task Group, & Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security, 2005). there has been a tendency to focus narrowly on diet and exercise (Nettleton, 2006). The recognition of the link is missing between day-to-day experiences and health and well-being. However, concepts such as occupational engagement, activity patterns, community participation, time use, and meaningful activities are core elements of the theoretical and practical basis of the profession and are rooted in empirical evidence regarding the links to health and well-being at all stages of life (Reitz, 1992; Polatajko, Backman, et al., 2007; Polatajko, Davis, et al., 2007). There is a growing body of literature in occupational therapy that supports the health-promoting potential of occupation (see Clark et al., 1997, 2009; Scaffa, Van Slyke, & Brownson, 2008; Thibeault & Hébert, 2006; Trentham, Cockburn, & Shin, 2007). To build awareness among the general population and to contribute to the field of public health and health promotion, occupational therapists should communicate their core values as well as evidence-based data regarding the links between occupation and health in ways that can be taken up by the general public. An occupation-focused framework is needed to guide

development of interventions and policies that will foster the health and abilities of Canadians of all ages and abilities.

The purpose of this paper is to present a Canadian framework that depicts the relationship between what people do every day and their health and well-being. The framework, developed in both official languages, is based on public health and occupational therapy principles, with a focus on health promotion.

## Development of the Do-Live-Well Framework

Development of the framework was based on a three-step process of (a) reviewing existing models of occupation, health, and well-being; (b) critically appraising the theoretical and empirical literature to identify evidence-based links between occupation and health; and (c) gathering input from stakeholders in public health/health promotion, occupational therapy, and the general public regarding key concepts and messages within the framework. Principles of knowledge translation guided development from initial inquiry and identification of knowledge gaps through to development of the final framework (Graham et al., 2006). Information was progressively synthesized and refined to develop a framework that was grounded in research evidence as well as in the perspective of knowledge users. In addition, these sources informed development of the framework using language to be shared and understood across perspectives, thereby ultimately supporting the process of knowledge translation.

## Review of Existing Models of Occupation, Health, and Well-Being

The first step involved review of and critical reflection on models and measures both within and outside of occupational therapy that characterize and/or explore the links between occupation, health, and well-being. Principles and concepts were retrieved from seven key occupational therapy sources: (a) the Canadian Model of Occupational Performance and Engagement (Polatajko, Townsend, & Craik, 2007), (b) the Canadian Occupational Performance Measure (Law et al., 2005), (c) the Person-Environment-Occupation model (Law et al., 1996), (d) Wilcock's (2006) text titled *An Occupational Perspective of Health*, (e) Hammell's (2009) critical appraisal of occupational categories, (f) the work of numerous researchers on life balance edited by Matuska and Christiansen (2009), and (g) the work by Krupa and colleagues (2010) titled *Action Over Inertia*. In addition, we reviewed several related documents outside of the occupational therapy literature, including the International Classification of Functioning, Disability, and Health (World Health Organization, 2007); the Canadian General Social Survey of Time Use (Statistics Canada, 2010); and the Canadian Index of Wellbeing (2012). These sources influenced many aspects of framework development, including definition of key concepts, classification of ideas, explication of

assumptions about occupation and health, and the relationships between the key concepts and ideas.

### Critical Appraisal of the Theoretical and Empirical Literature

In the second step of development, empirical evidence was gathered from the literature regarding the links between the identified dimensions of occupation and their association with health and well-being. Principles of scoping review methodology (Arksey & O'Malley, 2005) were followed to examine the extent, range, and nature of publications about each key concept in the model from a range of sources, including databases within health, education, and psychology. Research literature, both quantitative and qualitative, was reviewed to explore whether the ideas were supported, how they were examined in different fields of study, and with what populations. The focus was on health and well-being outcomes with a general population rather than individuals with a disability, considering children through to older adults. Evidence was gathered regarding the definitions of the concepts, the health and wellness impact of each, and theoretical understanding of the mechanisms of action of the dimension. In accordance with scoping review principles, the focus was to summarize the empirical data and note any gaps in the existing literature, rather than conduct a detailed, systematic review of the evidence. Specific details of each scoping review are beyond the scope of this paper, but key evidence-based examples identified in this review process will be highlighted.

### Stakeholder Consultation

The third step in the process of framework development involved consulting with stakeholders from across Canada about the emerging ideas, including interpretation of the ideas in both official languages. Key stakeholders were (a) members of the general public who represented groups that have experienced disruptions in their activity patterns (e.g., seniors advocacy groups, new immigrants, high-risk youth, injured workers, members of the disability community), (b) advocates and policy makers from the health promotion/public health community (including local service providers as well as representatives from the Public Health Agency of Canada), and (c) researchers/leaders from the occupational therapy and occupational science community. The process of consultation occurred at various stages in the process. Individual and focus group interviews were conducted at an early stage with 41 stakeholders (22 from the general public, 4 from public health, 15 from occupational therapy) to gather their input about the content of the framework and suggestions for knowledge translation. Transcripts from the interviews and focus groups were reviewed to identify key themes and to identify opportunities and challenges for translating the framework in the context of public health. Findings from this stage of the process are outlined in an earlier paper (Moll, Gewurtz, Krupa, & Law, 2013). As the framework evolved, drafts have been presented to

occupational therapists as well as other service providers and service users across Canada to obtain further feedback and guide revisions of the framework and the key messages in both official languages. The framework outlined in this paper represents a synthesis of findings from this additional consultation process.

### The Do-Live-Well Framework

The title of the framework "Do-Live-Well" (see Figures 1 [English] and 2 [French]) was chosen to capture messages about the important links between occupation, health, and well-being. The fundamental message is that "what you do every day matters" to health and well-being. It is designed to be a positive message that presents choices and opportunities for "living well." This health promotion message has relevance for individuals, groups, and communities, from children through to older adults. The ultimate goal of the framework is to guide the development of tools that engage and empower Canadians to reflect on how they use their time and to promote opportunities for healthy occupational engagement.

The term *doing* was chosen as the central concept instead of activity or occupation. Although some concerns have been expressed in occupational therapy about the term *doing*, which appears to privilege action and outcomes over the experience of "being" (Hammell, 2009; Wilcock, 2006), our initial stakeholder consultation found that *doing* was more accessible to the general public and circumvents stereotypical images of physical activity and employment (Moll et al., 2013). *Doing*, as conceptualized within this model, encompasses a broad range of occupations, including ones that may be associated with spiritual reflection or connecting with others, as well as traditional perceptions of being active.

There are four main sections in the framework: (a) dimensions of experience, (b) activity patterns, (c) health and well-being outcomes, and (d) forces influencing activity engagement. Each section represents a building block for the overall "Do-Live-Well" message. Key concepts within each section of the framework will be outlined, with evidence from the literature provided to support inclusion in the model. Due to space limitations, evidence-based examples have been selected to illustrate key points from the scoping reviews for each concept and are summarized in Tables 1 and 2.

### Dimensions of Experience

The first part of the framework focuses on *dimensions of experience*. This approach is consistent with the argument made by Jonsson (2008) for the importance of classifying occupations based on how people experience them. The dimensions focus on experiences related to health and well-being that could be linked to participation in a range of occupations. The dimensions are designed to capture broad categories of everyday experience that are diverse yet distinct, understandable, meaningful, and evidence based. The eight categories presented here

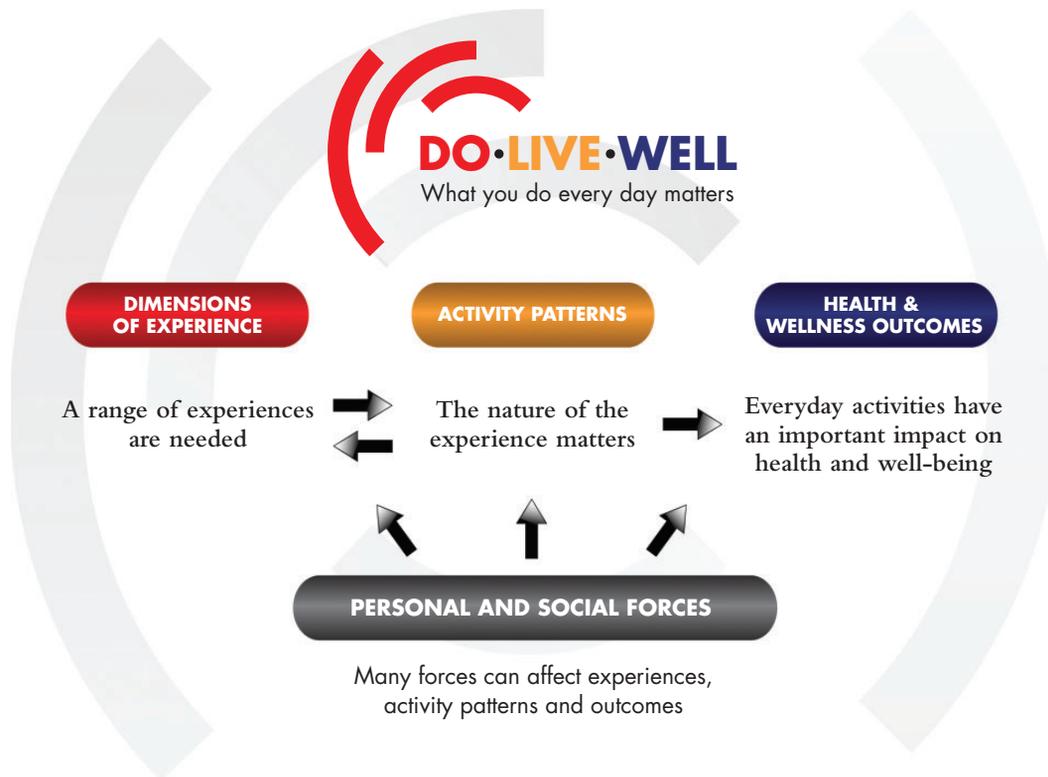


Figure 1. "Do-Live-Well": A Canadian framework for promoting occupation, health, and well-being.



Figure 2. « Vivez-Bien-Votre Vie » : un cadre de référence canadien pour promouvoir l'occupation, la santé et le bien-être.

Table 1  
Empirical Support for Dimensions of Experience

Dimensions of experience	Empirical links with health and well-being
Activating your body, mind, and senses	<ul style="list-style-type: none"> <li>• Regular engagement in physical activity is linked to reduced risk of premature death, heart disease, stroke, high blood pressure, certain types of cancer, osteoporosis, type 2 diabetes, and obesity as well as improvements in fitness, strength, and mental health (Warburton, Charlesworth, Ivey, Nettlefold, &amp; Bredin, 2010).</li> <li>• Participation in cognitively stimulating activities, such as computer-based training, memory, attention, and relaxation training, as well as productive engagement in a range of intellectually stimulating leisure and social activities have been shown to reduce risk of cognitive decline in later life (Depp, Harmell, &amp; Vahia, 2012; Valenzuela &amp; Sachdev, 2009).</li> <li>• Listening to music can lead to significant reductions in anxiety, reduce subjective experiences of pain, and help to regulate physiological responses, such as metabolism, energy balance, injury recovery, and immune system activity (Nilsson, 2008; Yamasaki et al., 2012).</li> </ul>
Connecting with others	<ul style="list-style-type: none"> <li>• People who are socially integrated and experience supportive and rewarding relationships have better mental health, higher levels of subjective well-being, and lower rates of morbidity and mortality (Holt-Lundstad, Smith, &amp; Layton, 2010).</li> <li>• Belonging, connectedness, and interdependence fostered through engaging in occupations is positively correlated with well-being (Suh &amp; Koo, 2008).</li> </ul>
Contributing to community and society	<ul style="list-style-type: none"> <li>• Volunteering is linked to lower mortality rates, greater functional ability, lower rates of depression, and higher self-reported health and well-being among older adults (Gottlieb &amp; Gillespie, 2008; Grimm, Spring, &amp; Dietz, 2007; Onyx &amp; Warburton, 2003).</li> <li>• Volunteering can also provide a sense of empowerment, perceived control, and optimism, which in turn promotes well-being among individuals of all ages (Mellor et al., 2008).</li> <li>• Providing instrumental or emotional support to others is associated with lower mortality rates and better health as long as the demands are not excessive and there are adequate supports and resources to initiate and sustain involvement (Brown, Nesse, Vinokur, &amp; Smith, 2003; Poulin, Brown, Dillard, &amp; Smith, 2012).</li> </ul>
Taking care of yourself	<ul style="list-style-type: none"> <li>• Maintaining a proper diet, engaging in regular exercise, and avoiding smoking and excessive alcohol use could add up to 9.8 years to one's life expectancy, as well as adding life to one's years through improved health and quality of life (Manuel et al., 2012).</li> <li>• Self-care through restorative activities, such as yoga, mindfulness, meditation, and spending time in nature, can have a significant positive impact on mental or emotional health and life satisfaction (Keng, Smoski, &amp; Robins, 2011; Köhn, Persson Lundholm, Bryngelsson, Anderzén-Carlsson, &amp; Westerdahl, 2013).</li> </ul>
Building security/prosperity	<ul style="list-style-type: none"> <li>• Engaging in productive, meaningful, and paid activities provides individuals with an avenue for achieving both economic and social security and assists in preventing the ill effects of poverty (McKee-Ryan, Song, Wanberg, &amp; Kinicki, 2005).</li> </ul>
Developing and expressing identity	<ul style="list-style-type: none"> <li>• Sports for young adults who form an "athlete" identity leads to lower health-risk behaviours and improved mental well-being (Miller &amp; Hoffman, 2009).</li> <li>• Cultural/community activities for adults with urban American Indian heritage is linked to benefits in nurturing identity, belongingness, spiritual renewal, and mental health (Iwasaki, Byrd, &amp; Onda, 2011).</li> </ul>
Developing capabilities and potential	<ul style="list-style-type: none"> <li>• After-school programs for youth based on evidence-based skill-building principles can lead to significant gains in personal, social, and academic performance, including increased feelings of self-confidence and reduced problem behaviours (Durlak &amp; Weissberg, 2007).</li> <li>• Continuing education is linked to improved self-efficacy among adults, including increased confidence to try new activities, take on more active roles, and regain control over their lives (Hammond, 2004).</li> </ul>
Experiencing pleasure and joy	<ul style="list-style-type: none"> <li>• Engaging in enjoyable leisure activities can lead to a greater positive affective state (e.g., well-being, vigour, and calm) for adults and seniors, including increased life satisfaction and life engagement, lower blood pressure, lower total cortisol, lower waist circumference, lower body mass index, and perceptions of better physical function (Pressman et al., 2009).</li> </ul>

have evolved over time, and although they are intended to be discrete, they are interrelated. A description of each of the categories is described below with empirical examples supporting links to health for each dimension outlined in Table 1.

The first dimension of experience involves *activating the physical body and also one's mind and senses* (vision, hearing, smell, taste, and touch). Activities associated with activation can take many forms, from physical exercise (activating one's

body) to completing crossword puzzles (activating one's mind) to listening to music (activating one's senses). Some activities may involve multiple sources of activation, such as taking dance lessons with a partner or walking in nature (activation of one's body, mind, and senses) (Bratman, Hamilton, & Daily, 2012). The intensity and nature of activation may vary from one type of experience to the next. Currently, much emphasis in the public health literature is placed on physical activity as

a key contributor to health, but this dimension recognizes the value and importance of other forms of active engagement as well that may be cognitive or sensory in nature (van Oostrom et al., 2012).

The second dimension, *connecting with others*, as conceptualized within the framework, involves an emotional attachment, affiliation, and sense of reciprocity within a social group (Cohen, 2004). The experience of connecting can include proximal to distal levels of involvement according to different goals (basic needs oriented, socially oriented, task oriented, altruistically oriented, and society oriented) and could be performed for oneself, with others, or for others (Levasseur, Richard, Gauvin, & Raymond, 2010). Connecting may take many forms (face-to-face versus virtual) and involve a range of “others” (family, friends, neighbours, coworkers, acquaintances, and even animals). The intensity and duration of the connection can be quite varied in addition to the nature of the connection itself (e.g., competitive, collegial, supportive); the quality as well as quantity of social interactions is predictive of health and well-being (Cohen, 2004).

The third dimension, *contributing to community and society*, involves imparting socially valued human capacities or resources (e.g., time, money, information) toward the good of social groups or aggregates of people who are organized around common interests, needs, or institutions (e.g., community organizations, schools, municipalities). Examples are paid or volunteer work, parenting, caregiving, and civic engagement (e.g., participation in advocacy initiatives). Participation in schooling can also be considered a contribution when the education and training prepares individuals to contribute through other social roles and activities (Hammond, 2004). Part of the mechanism of action may be the positive impact of altruism, not only on the recipient but the provider as well (Brown, Nesse, Vinokur, & Smith, 2003; Poulin, Brown, Dillard, & Smith, 2012). The community recipient of this contribution could be at a local level (e.g., family, neighbourhood) or a broader provincial, national, or international level.

The fourth dimension, *taking care of oneself*, involves attending to personal physical, psychosocial, and spiritual needs. Self-care may include a range of activities, such as exercising, eating well, taking vitamins, spending time with loved ones, and taking time to relax and rejuvenate. A population-based survey conducted in Sweden found that the most commonly reported strategies used to promote or maintain psychological well-being included physical exercise, spending time with family and friends, relaxing, and engaging in pleasurable activities (Hansson, Hilleras, & Forsell, 2005). For individuals with a chronic illness, self-care may also involve actively managing one’s medical condition and health care as well as associated changes in one’s life as a result of the condition (Lorig & Holman, 2003).

Another important dimension of experience, the fifth, is the concept of *building prosperity and security*. Prosperity is defined as a condition of being successful or thriving and is often associated with economic well-being, security, and social

status (Merriam-Webster, n.d.). Although often linked to paid work and earning an income, building prosperity captures the broader process of achieving financial and social security, which has been established as a key social determinant of health (Commission on Social Determinants of Health, 2008). Income, labour market, housing, and food security, for example, are important indicators of well-being, not only at an individual level but also at a community and population level (Sharpe, 2011). Examples of occupations that contribute toward this dimension of experience include engagement in paid employment, planning and managing finances, household management, and investing in stable housing and safe neighbourhoods.

The sixth dimension of experience relates to *developing and expressing identity*. Identity is the sense we have of ourselves as distinct beings. While identities are complex with multiple characteristics and elements, humans experience their identities as “whole” or integrated, recognizable to themselves and by other people (Christiansen, 1999). Engagement in activities is fundamental to the evolution of an identity. It is through “doing” that identities develop and evolve (Laliberte-Rudman, 2002; Unruh, 2004). Interests, preferences, values, personal strengths, and other characteristics of identity fuel engagement in preferred activities and, through the outcomes of these human experiences, a sense of coherence and continuity in meaning and purpose (Christiansen, 1999). This mechanism is believed to be one way that identity is linked to activity and ultimately to health and well-being.

The seventh dimension, *developing capabilities and potential*, involves developing skills, knowledge, abilities, aptitudes, and capacities. It involves challenging oneself, setting goals, and striving towards one’s potential or ideal self. Thus, this dimension is a future orientation comprising hope, skill building, personal growth, motivation, and development. Wilcock (2006) refers to the concept of “becoming” and argues that through doing, humans become what they have the capacity to be, and that becoming is a process of transformation and self-actualization related to realizing potential. Developing capabilities, learning new skills, and realizing potential are concepts that can be applied across the life span as a mechanism for promoting health and well-being (Hammond, 2004).

The final dimension, the eighth, involves *experiencing pleasure and joy*. While both are linked to feelings of happiness, pleasure is associated with experiences of enjoyment and amusement, while joy captures deep feelings of contentment. Occupations have the potential to trigger these positive emotions. Fredrickson (2001), for example, argues that “experiences of positive affects can prompt individuals to engage with their environments and partake in activities, many of which are adaptive for the individual, its species, or both” (p. 221). Enjoyable activities may counteract the negative impact of stress and facilitate a person’s recovery by replenishing damaged or depleted resources (Lazarus, Kanner, & Folkman, 1980).

It is important to note that discrete occupations may cross more than one dimension of experience. Taking a course, for example, may involve developing capabilities and potential as well as

Table 2  
Empirical Support for Key Activity Pattern Continuums

Activity pattern	Empirical links with health and well-being
Engagement	<ul style="list-style-type: none"> <li>• Time spent in “flow” is linked to happiness and personal growth and development (Nakamura &amp; Csikszentmihalyi, 2009).</li> <li>• Disengaged youth are at a greater risk of poor health, mental health difficulties, and social problems (Australian Research Alliance for Children and Youth, 2008).</li> </ul>
Meaning	<ul style="list-style-type: none"> <li>• Investing too much emotional energy can lead to issues such as compassion fatigue or burnout (Gallagher, 2013).</li> <li>• Older adults who create personal meaning despite loss of social roles have higher rates of resilience and life satisfaction (Krause &amp; Shaw, 2003; Wong, 1989).</li> <li>• Loss of meaning in adulthood has been linked to mental ill health (Wong, 1989).</li> </ul>
Balance	<ul style="list-style-type: none"> <li>• Subjective occupational balance is linked to lower perceived stress (Larivière, Levasseur, &amp; Boisvert, 2013; Matuska, 2012; Sheldon, Cummins, &amp; Kamble, 2010); higher subjective well-being (Matuska, 2012; Sheldon et al., 2010); better perceived health (Forhan &amp; Backman, 2010); and improved quality of life (Larivière et al., 2013).</li> <li>• Work–life imbalance is associated with stress, diminished quality of life, and increased risk of physical and mental health problems (Duxbury &amp; Higgins, 2009).</li> </ul>
Control/ choice	<ul style="list-style-type: none"> <li>• Choice and control over activity patterns is linked to self-efficacy, self-esteem, motivation to participate, and empowerment (Bandura, 1982).</li> <li>• Among working adults, perceived lack of choice and control in combination with high work demands is associated with health conditions, such as depression, anxiety, apathy, distress, burnout, exhaustion, low self-esteem, drug use, and coronary disease (Leka &amp; Jain, 2010; Vezina, Bourbonnais, Brisson, &amp; Trudel, 2004).</li> </ul>
Routine	<ul style="list-style-type: none"> <li>• In adolescents, stability provided through regular family routines is correlated with increased social competence and self-esteem, decreased mental illness, and improved educational outcomes (Koome, Hocking, &amp; Sutton 2012).</li> <li>• Habits and routines can also contribute to enhanced periods of creativity and innovation by freeing people from the work of attending to repetitive concerns of their daily lives (Hasselkus, 2011).</li> <li>• Disruption to regular bodily rhythms for eating and sleeping (e.g., through shift work) can have a negative impact on physical and/or mental health (Jacobson, Martell, &amp; Dimidjian, 2001).</li> </ul>

activating one’s mind, connecting with others, developing one’s identity, and even experiencing pleasure. Looking after small children or an aging parent may involve contributing to community and society as well as activating one’s body and connecting with others. Another key consideration is variation in the extent to which each dimension of experience is present in people’s lives. Working adults, for example, may spend a lot of their time building prosperity and security and contributing to society but may spend less time taking care of themselves or experiencing pleasure and joy (Duxbury & Higgins, 2009). In contrast, an older adult transitioning to retirement may experience a shift in how he or she develops and expresses his or her identity and contributes to community and society, thereby prompting new ways of connecting with others and activating his or her body, mind, and senses (Thomas, 2011). Life transitions and activity disruptions may call attention to changes in the extent to which important dimensions of experience contribute to health and well-being.

### Activity Patterns

The second part of the overall framework, *activity patterns*, considers not only the nature of what people do but how they engage in day-to-day activities over time and space (Krupa et al., 2010). Theoretical and empirical evidence led to identification of five key concepts related to characteristics of activity patterns that shape optimal health and well-being. Each of these concepts reflects a continuum of activity patterns that need to be considered. Optimal patterns lead to health benefits, whereas patterns on either end of

the continuum are linked to potential health risks. A description of each of the concepts will be provided with empirical examples supporting links to health and well-being outlined in Table 2.

**Engagement.** Engagement refers to the process of initiating and sustaining participation in particular activity patterns. There may be variation in the nature, intensity, and extent of engagement; it is not an end point but, rather, a process and continuum (Polatajko, Davis, et al., 2007). Theories about flow and about mindfulness inform our understanding of the nature of engagement. Flow theory, as outlined by Csikszentmihalyi, Abuhamed, and Nakamura (2005), profiles the experience of being so engaged in an activity that one does not realize that time is passing. According to flow theory, optimal engagement involves confidence in ability to perform and occurs when the challenges involved in the task present a good match with one’s abilities to perform the task. Closely related to the concept and practice of flow is mindfulness. Mindfulness is defined as a “process of attending to the immediate world, through sensory attunement, cognitive awareness and active engagement,” or being “present” when engaging in an activity (Elliot, 2011, p. 372). Unlike flow, mindfulness can be experienced through seemingly mundane and ordinary day-to-day activities, where time may be perceived as passing slowly rather than quickly and the outcome may be a feeling of peace or an emotional release rather than feeling energized (Wright, Sadlo, & Stew, 2006). Theories about both mindfulness and flow experiences contribute to our understanding of the health-promoting impact of active engagement.

**Meaning.** A second important characteristic of activity patterns is the extent to which they hold meaning for the individuals or groups engaging in them. Meaning is often conceptualized as an internal, subjective process, informed by one's personal values and unique history (Hasselkus, 2011). Although meaning is typically perceived as an internal process, it is also public and socially constituted; sources of meaning may be shaped by the community and culture in which people live (Kantartzis & Molineux, 2011). For example, a Westernized viewpoint might emphasize the value of future-oriented, individualistic activities that focus on gaining independence, whereas an Eastern philosophy might emphasize the value of activity patterns that are collective, interdependent, and focused on the here and now (Iwama, 2006). In addition to cultural beliefs, social norms related to developmental ages and stages may shape the personal meaning attached to particular activity patterns (Davis & Polatajko, 2010). For example, playing electric guitar in a heavy metal band may be considered more relevant to youth, whereas playing the card game of bridge may be associated more with older adults. It is important not to stereotype but simply to be aware how the meaning of particular activities is shaped by the social systems within which they are embedded. Meaning is purportedly derived from participation in activity, and in turn, patterns of activity may be shaped by the meaning that they hold for individuals and communities (Hasselkus, 2011).

**Balance.** Occupational balance and associated concepts of lifestyle balance (Christiansen & Matuska, 2006), role balance (Marks & MacDermid, 1996), and occupational integrity (Pentland & McColl, 2008) provide another lens for understanding activity patterns. Occupational balance is defined as a person's perception of having the right amount and the right variations in occupations (Wagman, Håkansson, & Björklund, 2012). It involves consideration of the nature and type of involvement and overall patterns of time use and may be examined objectively (through time allocation/use) or subjectively (self-perception of time use and balance) (Sheldon, Cummins, & Kamble, 2010; Veenhoven, 2009). Matuska (2012) has developed a life balance model that has been validated with several populations. Perceived life balance, according to the model, occurs when a person's everyday activities matches his or her desired patterns and when time spent in activities enable him or her to (a) meet basic instrumental needs necessary for sustained biological health and physical safety; (b) have rewarding and self-affirming relationships; (c) feel engaged, challenged, and competent; and (d) create meaning and a positive personal identity. The concept of balance appears frequently in the organizational psychology literature with the concept of work-life balance used to explain how workers are able to manage time at work versus home (Duxbury & Higgins, 2009).

**Control/choice.** The extent to which individuals perceive a sense of choice over their activity patterns is another key force to consider. Choice and a sense of control over "what to do and how to do it" are reported to be essential prerequisites for health and well-being (Polatajko, Molke, et al., 2007). People gain a sense of control over their lives by "choosing,

shaping and orchestrating their daily occupations" (Hammell, 2004, p. 300). It is an active process, involving autonomous and self-directed individuals (or communities) who make conscious decisions about opportunities to take charge of their lives and shape their future (Kantartzis & Molineux, 2011). This process has been described as "authoring one's life" or creating personal and social identity through occupation (Hammell, 2004). Choices are often culturally defined within acceptable traditions and rituals (Christiansen & Townsend, 2010). Ideas about the importance of control, autonomy, and empowerment, for example, are typically tied to values within Western society and a neoliberal focus on productivity and independence (Kantartzis & Molineux, 2011). In collectivist societies, the emphasis might be on shared rather than individual goals and values, with social relationships guiding activity duration and quality. While the specific expressions of autonomy, choice, and control may vary by social and cultural context, declarations of universal human rights have identified choice and access in important human activities, such as work, education, and leisure, as a basic human freedom (United Nations General Assembly, 1948).

**Routine.** Routines are regular, repetitive, predictable patterns of behaviour or time use, including habits, rituals, and the rhythms of life (Christiansen & Townsend, 2010). Since they reflect what is familiar and situate us within our culture, routines can be a source of stability (Hasselkus, 2011). In understanding the nature and impact of routines, Ludwig (1998) recommends considering the point at which they intersect the following continuums: flexible-rigid, minimal-extensive, autonomy-dependence, enjoy-dislike, work-leisure, and people oriented-task oriented. Habits, or actions reflecting one's values and beliefs, are established over time through routines that organize one's daily life, provide familiarity and predictability, and enable adaptation to demands of the environment (Kielhofner, 1977). Life transitions (e.g., starting a new school, onset of disability, children moving out of the home, retirement) may necessitate change in established routines. Ideally, routines should be flexible and autonomous (Ludwig, 1998). Lack of resources and opportunities may interfere with establishing predictable routines and lead to activity patterns that may appear to be random and unpredictable (Polatajko, Molke, et al., 2007). As they have the potential to promote health, it is important to reflect on the characteristics of routines, the personal and social context, and how they match the unique needs of the individual.

## Health and Well-Being Outcomes

The third part of the framework focuses on outcomes related to *health and well-being*. As outlined by the World Health Organization (1948), health is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (p. 100). A broad vision is adopted in this framework, moving beyond illness and disability to a range of health and wellness outcomes that consider not

only physical and mental health but social, emotional, and spiritual well-being. As outlined in Table 1, empirical evidence for each dimension of experience highlights the range of potential outcomes, from reduced risk of chronic disease to improved mental health and life satisfaction. These outcomes may be realized for individuals and/or communities.

One outcome that is congruent with the framework is that of “flourishing,” which is defined as living “within an optimal range of human functioning,” associated with “goodness, generativity, growth and resilience” (Fredrickson & Losada, 2005, p. 678). Flourishing is a concept developed by the positive psychology movement and is contrasted with the concept of languishing, or living a life that feels hollow and empty (Keyes, 2002). These concepts capture the potential of occupational engagement in a way that moves beyond traditional ideas about prevention of disease and disability and more toward Seligman’s (2012) view of happiness and well-being that involves an engaged and meaningful life.

It should be noted that the framework focuses on dimensions of experience and activity patterns that can lead to positive outcomes; however, it also acknowledged that the outcomes of day-to-day activities or occupations are not always positive. It has been argued that occupations may have “multiple effects on individuals, collectives, social structures and environments in complex, nonlinear ways” (Kiepek, Phelan, & Magalhães, 2013, p. 8). For example, connecting with others through participation in gang activities, expressing one’s identity through public graffiti, building prosperity through human trafficking, or experiencing pleasure through drug use illustrates the complexity of health and well-being outcomes. Health and well-being outcomes are multilayered and shaped by societal discourses. The framework is designed to promote reflection and capture some of the forces that contribute to positive outcomes while acknowledging that negative outcomes are also possible and need to be further understood and developed.

### Forces That Affect Activity Engagement

The final part of the framework focuses on contextual forces that affect what people do on a day-to-day basis. Activity patterns are dynamic, influenced by a range of complex, confounding, and potentially conflicting forces (Whiteford, Klomp, & Wright-St Clair, 2005). There are many potential determinants of participation, from demographic characteristics of individuals to social forces in the physical, institutional, or sociocultural environment.

Individual characteristics, such as age, socioeconomic status, gender, health, disability, culture, and ethnicity, may shape the kinds of things that people do on a day-to-day basis (Law, 2002). These individual characteristics may also affect access to services. For example, limited literacy or health problems may restrict opportunities for building prosperity and security and for developing capabilities and potential (van Brakel et al., 2006). Individual limitations may also restrict control or choice in dimensions of activity engagement. Furthermore, stigma and discrimination based

on age, gender, cultural background, or health condition could restrict options for meaningful participation (van Brakel et al., 2006). Individual forces may be complex and even conflicting at times, with variable impact from one person or group to the next.

Social forces can also have a significant impact on participation. According to a 2009 report from the Canadian Senate, 50% of population health outcomes are attributable to social and economic determinants, with an additional 10% related to the physical or built environment (Keon & Pépin, 2009). Institutional forces, such as affordability, location, and eligibility requirements, can shape accessibility. Barriers related to cost and availability of resources, for example, often deter or prevent optimal participation (Raphael et al., 2010). Lack of accessible transportation, limited accommodation for those with a disability, an unwelcoming environment, and restrictive or rigid rules for participation can also be a significant barrier to optimal activity engagement (Law, 2002). Consequently, individuals may become isolated and unable to access community supports or meaningful activity opportunities.

At a system level, political investment in opportunities for participation may be shaped by beliefs about their value to constituents. For example, funding for community centres, after-school programs, and workplace wellness initiatives depend upon recognition of the importance that these initiatives may ultimately have for the health and well-being of seniors, children, and working adults, respectively. Recognition of the direct links between exercise and health is one example of the ways in which knowledge translation and advocacy initiatives at a system level have facilitated a focus on physical activity projects (Provincial Health Services Authority, 2014).

This section of the framework is critical because it moves away from the typical focus of many health promotion frameworks on changing the individual. Instead, it highlights that individual reflection and lifestyle change is inadequate without the necessary availability of opportunities and community supports. It is not enough to say that a person should improve his or her patterns of engagement; promotion of healthy activity patterns must include recognition of the broader context within which activity patterns are embedded. Age-friendly communities are one example of a public health initiative that begins to address environmental barriers to participation (see Trentham et al., 2007). Initiatives in British Columbia related to creating healthy built environments and healthy community design also reflect progressive ideas about how to promote community participation for citizens of all ages (see Provincial Health Services Authority, 2014).

### Application of the Framework

The purpose of the framework is to prompt reflection and discussion about the ways in which everyday activities impact the health and well-being of Canadians of all ages and abilities. It is designed to be not prescriptive but, rather, a springboard for discussion and reflection on activity

patterns and the broad range of choices or options that are possible. It is not a model of practice or a tool to address acute illness or disability. It is a health promotion framework that is designed to engage and empower individuals and communities to reflect on patterns of activity engagement and explore opportunities for people to use their time in ways that will promote health and well-being.

At an individual level, the framework could be used to develop tools that prompt reflection on patterns of time use and increase understanding of the opportunities and challenges for participation as well as the risks and benefits of particular activity patterns. During times of transition, when activity patterns are disrupted or changing, the framework could guide discussion about the impact on health and well-being. For example, individuals entering or leaving the job market might struggle with changes in their experience of contributing to society, connecting with others, or building prosperity. Similarly, other transitions, such as the onset of an illness or impairment, could lead to changes in experiences of expressing one's identity, taking care of oneself, or developing one's capacities or potential. In these situations, the language of the framework might help to identify dimensions of experience that may be missing or disrupted in a way that has a negative impact on health. There is no universal pattern that is relevant for all people; however, some configurations of activity patterns are more likely than others to promote health and well-being. It might also be useful to examine the extent to which activity patterns are perceived as engaging, meaningful, and balanced and the extent to which there is a perception of choice or control over change. The concepts related to activity patterns capture a potential continuum (e.g., meaningful versus meaningless, balanced versus unbalanced), and each person is unique in terms of their perceptions of current versus desired placement on each continuum. Finally, the framework could validate the range of health-promoting activities in which people already engage and help individuals and groups articulate the importance and contributions of various dimensions of time use. It is important to note that the framework has not yet been translated into tools for clinical practice, although this is one of the potential future directions of the project.

At a community level, the framework could be used as an advocacy tool for development of social and physical environments and opportunities that provide Canadians with equitable access to activities that promote their health and well-being. For example, among high-risk youth, the evidence behind the concepts in the framework support the need for youth to have opportunities for participating in a range of meaningful, socially relevant health-promoting activities. In long-term care homes, where there is a risk for occupational deprivation, the evidence-based concepts in the framework could be used to advocate for a range of activity options and to create health-promoting patterns of engaging the bodies, minds, and senses of residents. In the case of people who are very socially marginalized, the framework offers a range of

possible avenues to enable well-being and to enable processes of meaningful connections to communities and meaningful social roles.

As a national framework, the hope is to inspire partnerships with policy makers and service providers to think more broadly about the things that people do every day and how to foster health through activity and activity patterns. For example, an occupational lens on initiatives to prevent obesity in children could prompt movement beyond a focus on diet and exercise to promoting a range of experiences that would activate not only the bodies of the target group but their minds and senses as well, in a way that promotes experiencing pleasure and joy. Instead of focusing solely on promoting 30 min of exercise a day, the messages should inspire people to engage in a range of activities that are meaningful and relevant and that could be incorporated into their daily routine. Dialogue about creating healthy communities could incorporate concepts from the Do-Live-Well framework to validate the importance of facilitating a range of experiences, from expressing one's identity to connecting with others and experiencing pleasure and joy. It is a way of inserting an occupational lens into policy discussions about public health and community development.

## Conclusion

The proposed framework is a work in progress and will evolve over time as the concepts continue to be developed and translated for different audiences. One of the challenges of creating a framework is that the process of categorization is not neutral and is often shaped by the temporal and social context (Hammell, 2004). Dickie (2009) argues that "the construct of occupation might very well defy efforts to reduce it to a single definition or set of categories" (p. 9). The framework presented here was based on a review of the theoretical and empirical literature, both within and outside the profession, as well as through ongoing reflection about how to capture meaningful "dimensions of experience" that are supported by theoretical and empirical evidence. It extends the current health promotion discourse to consider the health and well-being outcomes derived from engaging in a broad range of physical, mental, social, cognitive, and productive activities. The focus on experiences derived from what people do every day offers an occupational perspective that is missing from existing health promotion frameworks in a way that resonates with the general public. Additional research exploring key concepts and relationships in the framework will strengthen the ideas that are presented as well as scholarly debate about the key ideas. As stakeholders continue to be engaged in the process, messages will continue to be refined and translated in a way that will clearly resonate within our profession, with policy makers, and with the Canadian public. Ultimately, the goal is to open a dialogue about how to "Do-Live-Well" regardless of our age, culture, or ability.

## Key Messages

- Specific types of activity experiences can promote health and well-being.
- Patterns of activity engagement affect the extent to which positive health and well-being outcomes are met.
- Personal and social forces may affect whether people are able to engage in health-promoting activity patterns and experiences.

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