

RESEARCH ARTICLE

Uniting generations: A research protocol examining the impacts of an intergenerational learning program on participants and organisations

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Abstract

Economic, health and social issues associated with the ageing population and the disconnect between the generations call for novel approaches to care services. Intergenerational programs are known to enhance engagement between generations, improve health and well-being and create a stronger sense of community. While the health and social benefits are well documented, little attention has been given to the operational aspects of intergenerational programs within care facilities. This paper describes the research protocol used to develop, implement and evaluate an intergenerational learning program for preschool-aged children and older people attending care services. The research focuses on five key areas: (a) impact on older people and children; (b) intergenerational learning; (c) workforce development; (d) socio-economic implications and costs; and (e) program fidelity and sustainability. Findings from this research are expected to contribute to building age-friendly communities through the development of practical operational guidelines for intergenerational learning programs to be implemented more broadly across Australia.

KEYWORDS

intergenerational relations, healthy aging, child care, learning, workforce

1 | INTRODUCTION

In response to the predicted social and economic impact of the ageing population and a growing disconnect between the generations, the World Health Organization (WHO) is advocating a global healthy ageing agenda and the creation of age-friendly cities through its Active Ageing Framework.¹

Intergenerational programs (IPs) directly address many of the key areas including social participation, respect and social inclusion, and lifelong learning.² IPs bring people from different generations together to participate in purposeful activities that are beneficial to all involved.³ Benefits include improved health and well-being among older people, reduced antisocial behaviour among children and young people, and

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creating a sense of community and a more inclusive society.⁴ Despite the recognised benefits, a number of barriers are yet to be overcome for IPs to be adopted more widely. Barriers include social policy constraints, rigid institutional structures and conventions, lack of industry knowledge and organisational capacity, staff reluctance and lack of training, lack of an intergenerational learning curriculum, and limited funding and resources.^{4,5}

To overcome these barriers, there is a need for robust research to demonstrate impact and develop evidence-based operational guidelines and policy recommendations that support the roll-out and long-term sustainability of effective programs.^{2,5} However, currently there is a lack of understanding around appropriate methods and measures to evaluate programs due to challenges such as issues with small sample sizes, conducting research with vulnerable populations (ie children and older adults with cognitive decline), and limited scale and time to demonstrate impact.⁶ In addition, much of the research tends to focus on measuring progress against targets⁵; however, research investigating intergenerational programs more broadly, such as the impact of on the workforce, carers, service providers and associated costs, is relatively scarce. This calls for a more holistic approach to evaluating the economic and social impact of intergenerational programs on participants and organisations.

1.1 | The Intergenerational Care Project

Preliminary research was conducted to explore the feasibility of introducing a formal IP in Australia. Through this research, two preferred models of care were identified: one model is a co-location model, where aged care and child-care centres are located on the same property; the other model is a visitation model, where the centres are located separately and people from one centre are transported to the other centre.⁷ Overall findings of the preliminary research demonstrated strong support for IPs and few legislative barriers that could not be overcome.^{8,9} Therefore, the key objective of the *Intergenerational Care Project* was to prepare, trial and evaluate an intergenerational program within two models of care.

The *Intergenerational Care Project* was conducted across four research sites in Australia and involved older people living with early stages of cognitive decline¹⁰ and children aged 3-5 years. The approach adopted for the project was consistent with WHO recommendations and addressed the key elements for success including the following: a collaborative approach that engages multiple stakeholders; a broad perspective to ensure initiatives are widely integrated into the community; and the presence of sound research evidence and evaluation processes.⁵

Practice Impact

This paper describes the protocol for a research project evaluating an intergenerational learning program in Australia. In doing so, it presents theoretical and practical insights with regard to the co-creation of intergenerational learning programs with organisations and participants, program implementation considerations including workforce training, and types of measures and tools used for evaluation.

This paper outlines the research protocol for the *Intergenerational Care Project*. In doing so, it presents theoretical and practical insights with regard to the co-creation of intergenerational programs with organisations and participants; program implementation considerations including workforce training; and a holistic approach to evaluation using multiple methods and tools.

1.2 | Development of the intergenerational learning program

There are different types of intergenerational program that can be broadly categorised according to the intensity of interaction. Level 1 involves activities that are conducted in the same physical space, but there is but no significant or purposeful interaction between generations. Level 2 is where interaction occurs, but it is often unidirectional; for example, children may visit a residential care facility, and do a performance. Level 3 is where young people and older people work together on a project, such as cooking meals for the homeless. Level 4, which is the highest level of interaction, is when a learning environment is shared to meet the learning goals of people from different age groups.¹¹ The *Intergenerational Care Project* is designed to meet the criteria for Level 4, as this high level of intergenerational exchange is most likely to produce the most benefit for all involved.^{3,12,13}

An intergenerational learning framework was developed through a systematic review of evidence about effective programs for children and older adults, as well as consultation with a selected group of stakeholders.¹⁴ The framework incorporates understandings about early learning and play from the Belonging, Being and Becoming: Early Years Learning Framework¹⁵; community development strategies¹⁶; and neuroscience from A Neurosequential Model of Education.¹⁷ The pedagogical concept is that both generations can learn from each other; thus, the role of the teacher and student is undertaken within both groups. The five

TABLE 1 Research sites and key characteristics

Research site	Model of IGC	Type of aged care	Type of childcare	Intergenerational learning program location	Cohorts
Site 1	Co-location: owned by the one organisation	Residential	Child day care centre	Common room located in residential care facility. Children walked a short distance within the same grounds	Intervention and matched control cohorts from the same organisation but childcare and residential care located at different premises
Site 2	Co-location: owned by the one organisation	Day respite: culturally diverse community	Child day care centre: culturally diverse community	Community hall located within the same premises as the childcare centre. Older people travelled to centre to participate in program and children walked across a playground	Intervention and matched control cohorts from the same organisation but childcare and respite care located at different premises
Site 3	Visitation: partnering childcare and aged care centres	Day respite	Child day care centre	Childcare centre. Older people travelled to childcare centre by mini-bus	Intervention cohorts
Site 4	Visitation: partnering childcare and aged care centres	Day respite	Child day care centre	Aged care centre. Children travelled to aged day care centre	Intervention cohorts

Abbreviation: IGC, intergenerational care.

principles of learning which underpin the program are as follows: (a) secure, respectful and reciprocal relationships; (b) partnerships; (c) high expectations and equity; (d) respect for diversity; and (e) ongoing learning and reflective practices.¹⁵

The intergenerational learning program (ILP) ran for 16 consecutive weeks where children and older people came together for 1 hour per week to participate in a range of learning activities. The intergenerational learning program was co-created by the workforce participants and researchers through a collaborative process drawing on theoretical frameworks from the literature. This allowed the program at each site to be tailored to suit the needs of the participants, the environment and the resources and equipment available. Activities such as games, music, singing, art/craft, gardening and reading were included in the learning program, and conducted in groups or pairs, to foster positive connections and build meaningful relationships between the generations.¹⁸

1.3 | Workforce training

Workforce training consisted of an orientation program that was developed in collaboration with consumer representatives and industry partners. The mandatory program was conducted at each research site separately and ran for a total of 6 hours. Workforce participants were involved in a series of interactive seminars to develop understandings around the theoretical frameworks, working with children and adults, building resilience and talking with children about death and dying (from parents and staff perspective). Workforce participants then worked collaboratively to plan and develop the learning activities for the first few sessions, which were linked with the principles and learning outcomes. This collaborative planning process continued throughout the duration of the 16-week program to allow for reflection and continual improvement to achieve positive outcomes for all.

2 | METHODS

2.1 | Research design

The research used a quasi-experimental/observational design. It was experimental in that it involved exposure of an intervention to participant groups, and the outcomes were compared with those of matched controls. It was also observational in that the researchers did not administer the intervention; rather, the intervention was co-constructed by partnering organisations and researchers and administered by workforce participants.

2.2 | Research sites

The study was conducted within four sites across South East Queensland and New South Wales and involved six organisations. Two research sites were co-location models where a childcare and aged care facility were located on the same grounds and owned by the one organisation. The other two research sites were visitation models where the childcare and aged care facilities were located separately and owned by different organisations. Sites were selected based on their ability to provide suitable locations and facilities, and willingness to participate in the research. The two visitation sites had intervention cohorts only, while the co-location sites had both intervention and control sites. The matched control sites were located at different premises to mitigate contamination. Matched control cohorts were only selected for the co-location sites as these organisations had both childcare and aged care centres located on other premises with matching characteristics.

Table 1 presents the research sites with corresponding key characteristics.

2.3 | Study population, sampling and recruitment

The study population consisted of three participant groups: child-parent dyads (children aged 3-5 years attending child day care and primary carer/parent); older person-carer dyad (older adults living with no dementia or early-to-mid-stage dementia attending aged care services, residential or day respite, and informal carer where appropriate); and workforce (aged care and childcare workers, managers and volunteers). Each participating organisation was responsible for selecting and recruiting study participants. Child-parent dyads and older person-carer dyads were selected based on three broad criteria: (a) attendance at the centre on the day(s) and time(s) that the program was conducted; (b) willingness to participate in the ILP and the research; and (c) suitability of child and older person, assessed as minimal risk to self and others based on health status and general behaviour. Workforce participants were selected based on employment with organisation and relevant childcare or aged care qualifications, familiarity with the child or older adult participants, and willingness to participate in the research program. Project funds were used to financially compensate organisations for the additional hours required by the workforce to participate.

2.3.1 | Sample size

Table 2 presents the sample size for each participant group at each research site at the time of recruitment.

In the intervention cohorts, 44 child-parent dyads and 39 older people were recruited. Nine of older people were in residential care, and the remaining attended day respite care. There were only a small number ($n = 7$) of informal carers recruited because the majority of older people were living with no, or very early stages of, dementia and did not require an informal carer. A total of 20 workers including managers, aged care and childcare workers and volunteers were recruited. All participants were required to attend the full 16-session program; however, it was understood that there would be some absenteeism given the vulnerability of the study population.

In the control cohorts, a total of 22 child-parent dyads and 25 older people were recruited. There were no informal carers in the control groups due to Site 1 being residential care and Site 2 had no older people living with dementia. The control groups were not exposed to the intervention.

2.3.2 | Program information sessions for participants

Selected participants attended an information session and were provided with a brochure and fact sheet outlining the details and requirements of their involvement. For those unable to attend the information session, a video recording was provided to the organisation to present to participants.

2.4 | Ethics

Ethical approval was granted through university and relevant participating organisations' ethics committees. Informed consent was obtained from all participants prior to commencing the program, and verbal consent was obtained prior to each session. Consent for video recordings and photographs taken during the sessions was also sought from participants and carers. Participants were required to indicate the level of consent from three options: Level 1: use of the video footage for research purposes; Level 2: use of images and video footage in dissemination of research findings, for example conferences and industry reports; and Level 3: use of images and video footage for marketing and communication purposes, for example media, brochures and website. Implied consent was obtained from control groups through the return of their completed surveys.

3 | PROGRAM EVALUATION

Given the complexity of the intervention, a range of quantitative and qualitative methods were used in the program evaluation to assess effectiveness, measure outcomes and understand process.¹⁹ Table 3 presents the key components of

TABLE 2 Sample size by participant group and research site at the time of recruitment

Intervention cohorts	Co-location model		Visitation model		Total
	Site 1	Site 2	Site 3	Site 4	
Child-parent dyad	11	16	11	6	44
Older people	9	15	9	6	39
Informal carer of older people	0	0	2	5	7
Workforce [†]	4	4	7	5	20
Total Intervention	24	35	29	22	110
Control cohorts	Site 1	Site 2			
Child-parent dyad	10	12	0	0	22
Older people	10	15	0	0	25
Informal carer of older people	0	0	0	0	0
Childcare workforce	4	6	0	0	10
Aged care workforce	4	1	0	0	5
Total control	28	34	0	0	62

[†]Workforce includes aged care and childcare workers, managers and volunteers.

TABLE 3 Evaluation framework components linked with objectives, indicators and data sources

Evaluation component	Objectives	Indicators	Data sources
Outcome evaluation			
Participant outcomes	1. To examine how an intergenerational learning program impacts on the health and well-being of participants.	Health Well-being Mood	Surveys Mood scales
Education outcomes	2. To examine the impact of an intergenerational learning program on engagement and program satisfaction.	Level of engagement Program satisfaction	Video ethnography Engagement Scale Leuven Scale Reflective journal (Program Reflections) Follow-up interviews with participants (children and older people)
Workforce outcomes	3. To examine the impact on workforce in terms of staff retention and career development	Job Stress Inventory Career development opportunities Program satisfaction	Reflective journal (Individual Practice) Job Stress Inventory (pre and post) Session satisfaction Reflective journal (Program Reflections) Workforce interviews (pre and post)
Economic evaluation			
Socio-economic outcomes	4. To examine the costs and benefits associated with implementing an intergenerational learning program	Cost analysis Willingness to pay Cost-benefit analysis	Surveys Cost data spreadsheet
Process evaluation			
Program fidelity and sustainability	5. To identify the core components of the program that are critical to its success, and other components that can be adapted to suit different contexts	Did we do as planned? Why/ why not? What would we do differently?	All

the evaluation framework linked with the stated objectives, indicators and data sources.

The evaluation framework consists of five key components, which are aligned with the five objectives:

Outcome evaluation (program effectiveness):

1. Participant health and well-being outcomes indicated by health and well-being.

2. Education outcomes indicated by level of engagement and program satisfaction.
3. Workforce outcomes indicated by Job Stress Inventory, career development opportunities and program satisfaction.

Economic evaluation:

4. Socio-economic outcomes indicated by costs, willingness to pay and cost-benefit analysis.

Process evaluation:

5. Program fidelity and sustainability were evaluated by assessing what was planned, what happened and what could be done better.

3.1 | Sources of data

This multimethod study incorporated multiple sources of data to evaluate the program from multiple perspectives. Table 4 presents a summary of the data sources with relevant participant groups.

3.1.1 | Surveys

Surveys were administered to each of the participant cohorts at two time points: pre and post. There were four different surveys:

Survey 1: Child-parent dyad (completed by the primary carer of the child).

Survey 2: Aged care recipient (completed by older person with assistance of informal carer if required).

Survey 3: Informal carer of older person.

Survey 4: Workforce (survey was embedded into the reflective journal for the intervention cohorts, but administered as a stand-alone survey for matched controls).

The surveys included a range of measures covering demographics, health and well-being, service use and service satisfaction.²⁰ Pre- and postsurveys were self-administered by hard copy and completed by intervention and control cohorts at the same time points. The workforce surveys include demographics and the Worker Job Stress Inventory.²¹ Table 5 presents the survey measures relevant to each participant group.

3.1.2 | Mood scales

Children and older people completed an adapted version of the Kunin Attitude Measure.²² The original measure asks participants to indicate their mood from a series of five face icons. This measure was adapted to only three faces to make

it suitable for young children and older people with cognitive decline.

3.1.3 | Video ethnography

Video ethnography was conducted to examine the inter-generational learning environment and observe patterns of engagement. Video recordings were obtained at three time points during the 16-session program: Session 1, Session 8 and Session 16. Three to four video cameras were used to record the entire 1-hour sessions; three cameras were set up around the outside of the room to provide 360-degree view of the space, and one camera was used to capture a close-up view of specific activities or interactions.

3.1.4 | Workforce reflective journals

Reflective journals were completed by the workforce after every session to capture the planning of the sessions and reflections around individual practice and the program activities. There were two types of journals: Individual Practice and Program Reflections.

The Individual Practice journal was completed by all workforce participants and contained four key components: Job Stress Inventory,²¹ which was completed prior to commencing the program and upon completion; and individual reflections, session satisfaction using the Kunin Attitude Measure²² and the Leuven Scale,²³ all of which were completed after every session.

The individual reflections used the Circles of Change Revisited (COCR) model.²⁴ This model explores how personal reflection, communication and transformational change can impact on practice. The four steps in the COCR process are as follows: Deconstruct: description of the phenomenon; Confront: clarification of perspectives about the phenomenon and challenge personal values and beliefs; Theorise: examination of characteristics of the phenomenon from different professional and theoretical perspectives; and Think otherwise: review of the dominant perspective. This process enabled workforce participants to describe what happened, critically assess what happened by challenging personal and professional assumptions and reflect on what could have been done better.²⁵

The Leuven Scale²³ measures observed levels of participant involvement and well-being and was completed for each individual participant relevant to their group (ie childcare workforce completed the scale for the children, and aged care workforce completed the scale for older people).

One Program Reflections journal was completed collaboratively by the participating workforce at each site following

TABLE 4 Summary of data sources by participant group

Data source	Intervention groups	Control groups
Surveys	Child-parent dyad, older people, informal carer	Child-parent dyad, older people, informal carer
Video ethnography	Children, older people	na
Participant Mood scales	Children, older people	na
Workforce reflective journal: Individual Practice (including Job Stress Inventory, practice reflections, session satisfaction, Leuven Scale)	Childcare and aged care workforce	Childcare and aged care workforce: Job Stress Inventory only
Workforce reflective journal: Program Reflections	Childcare and aged care workforce	na
Workforce interviews (pre and post)	Childcare and aged care workforce	na
Participant interviews (post only)	Children, older people	na
Mood scales (before and after every session)	Children, older people	na

Note: Job Stress Inventory²¹; Leuven Scale²³; Mood scales.²² na, not applicable

each of the 16 sessions. The journal required the workforce to describe each session in detail, including the program planning and delivery aspects such as preparation of the space and learning materials, the activities that were conducted during the sessions, what was successful and what could have been done differently.

3.1.5 | Interviews

Interviews were conducted with workforce participants before and after the intervention. Interviews were semi-structured, and focused on questions around what it is like to work in aged care/childcare; what the challenges and rewards are; why they chose that career and where they see themselves in 5-10 years; and how they feel about inter-generational programs. Combined with the reflective journals, these data are used to explore the impact that being involved in the ILP has on aged care and childcare workforce outcomes.

Group interviews were conducted with child and older adult participants at the completion of the 16-week program to explore their perceptions around their involvement in the ILP. The interviews with the children were conducted in small groups, and photographs and drawing materials were used to assist children to express their thoughts and opinions. Open-ended questions were asked, such as the following: ‘Tell me about your visits with the older adults’; ‘What is happening in these photos?’; ‘What do you remember about these times?’; and ‘Using this paper and pencils draw a picture of going/ being with older adults. Tell me about it.’

Interviews with older people were based on an open-ended survey and were conducted in groups or individually, which allowed older people to describe their experience in detail. Questions asked included the following: ‘Were you looking forward to the program?’; ‘What did you like about

the program; what didn't you like about the program; what could have made it better?'; ‘How did participating in the program make you feel?’; and ‘Would you like to take part in another program with children? Why/ why not?’

3.2 | Data analysis linked with evaluation components

As presented in Table 3, each component of the evaluation framework incorporated multiple sources of data. This section presents an overview of the data analysis procedures related to the five evaluation components.

3.2.1 | Participant health and well-being

The objective of the program evaluation was to examine the impact of an ILP on child and older adult participants with regard to level of engagement, health and well-being, mood and program satisfaction.

Statistical analyses were used to measure changes in primary outcomes from baseline to follow-up survey data and to compare intervention groups with matched controls (see Table 5 for key variables).

A thematic analysis of the follow-up group interviews was conducted to develop a deeper understanding of which aspects of the program the participants preferred and why, and how the program could be improved.

3.2.2 | Education outcomes

The objective of the education evaluation is to assess the learning outcomes including engagement, sense of identity, involvement, well-being, confidence and communication.¹⁵ Tools and methods used were video ethnography, Engagement

TABLE 5 Survey measures by participant group

Measures	Variable related to:			
	Child	Parent	Older people	Informal carer
Demographic				
Age	X	X	X	X
Sex	X	X	X	X
Relationship to carer/care recipient	X	X	X	X
Education		X	X	X
Marital status		X	X	X
Living arrangement		X	X	X
Employment status		X		X
Pension-concession card status		X	X	X
Health and well-being				
List of health conditions			X	X
Number of visits to health professional			X	
Quality of Life WHO-Five		X	X	X
Life Orientation Test-Revised		X		X
ASCOT			X	
KCSS Carer Stress				X
Service use/support				
Reason for care		X	X	X
Subsidy for care services		X		
Amount out of pocket		X		
Number of days in paid care	X		X	
Care program rating		X		
Time spent caring per week				X
Willingness to pay for intergenerational care ^a		X	X	X
Preference for intergenerational care ^a		X	X	X
Service satisfaction score		X	X	X
Program evaluation				
Perception of program's effect ^a		X		X

^aFollow-up survey only.

Scale, Leuven Scale, workforce reflective journals (individual practice) and participant follow-up interviews.

Video data were analysed in two ways. Firstly, the Engagement of a Person Living with Dementia Scale (EPWDS) was used to assess engagement using quantifiable measures, where the level of engagement is measured according to a 5-point scale across five dimensions of engagement: affective, visual, verbal, behavioural and social.²⁶ Secondly, a qualitative analysis was conducted using a multimodal visual transcribing process.²⁷ Still images of interactions between older people and children were obtained from the video clips that were supported with written commentaries which included observations of speech, gestures, facial expressions and movements. An analysis framework and preliminary coding system were developed based on initial coding of the data and consisted of five focus areas: type of activity; facilitator style;

environment; equipment and resources; and participant characteristics. The analysis framework was further developed to explore key focus areas and identify new emergent themes.

3.2.3 | Workforce outcomes

The workforce component examines the impact that being involved in ILP has on employee outcomes. It examines the sense of meaning and value that the program has/has not added to their job, the attraction of the opposite industry as a career choice and how this affects their retention and turnover outcomes. A mix of qualitative and quantitative methods was used including interviews, a reflective journal and a survey containing demographic and a Job Stress Inventory.²¹

3.2.4 | Economic outcomes

Cost information was sourced from participating organisations to assess the costs of implementing an ILP compared with their usual program. The cost information, along with primary outcome measures, was used to perform a cost-consequence analysis.²⁰

3.2.5 | Program fidelity and sustainability

Process evaluation was conducted using an adapted StaRI framework,²⁸ which is a program fidelity measurement tool that assesses the extent to which the intended process has been followed, the intended outcomes have been reached and the program continues to produce benefits to the end-users. The framework consists of five dimensions: design; training; delivering the intervention; monitoring the intervention receipt; and sustainability reporting implementation studies.²⁸ Evaluation of the program fidelity focuses on four key elements: 1. operational fidelity (the intervention is being implemented as intended); 2. theoretical fidelity (deciding the permissible level of innovation adaptability at outset); 3. end-user fidelity (the degree to which an intervention reaches end-users); and 4. sustained fidelity (the intervention being implemented is sustainable). For each dimension, core components that are required for the program to be effective are identified, and other components that may be adapted to different contexts are assessed.¹⁹

4 | DISCUSSION

This paper has described the research protocol for the *Intergenerational Care Project* to evaluate the implications of an intergenerational learning program. In doing so, it provides insights as to how other programs may wish to evaluate their programs and identifies a range of tools and measures that may be used for evaluation of participants as well as care workers, and measures for an economic evaluation. The final section of this paper discusses the implications of the research for key stakeholders and the contributions of the research findings.

4.1 | Implications for older people, children and the community

The global population is ageing, which means that the proportion of people over the age of 65 will continue to increase with potentially serious social and economic implications. Further, increasing numbers of older people wish to remain living in their communities⁵; however, with urban sprawl and family dispersion, older people often find themselves socially

isolated and living in urban environments that are not suited to their needs. Social isolation can have detrimental health consequences; for example, isolated older adults are at greater risk of being rehospitalised. In contrast, social participation has shown positive effects for health and quality-of-life outcomes such as reduced mortality, morbidity and hospitalisation and increased functional autonomy.¹² Social connection is at the heart of intergenerational programs as they focus on building high-quality connections, which are interactions that create a mutual heightened sense of positivity, and can develop into meaningful relationships over time.¹⁸ Social interactions such as conversations, sharing and participating in partner or group activities can elicit positive emotions that can alleviate stress and assist with coping skills.^{29,30} Findings from this research are expected to provide understanding as to how meaningful social engagement through an intergenerational learning program can improve older people's sense of well-being, which can enable them to remain living in the community longer, thereby reducing demand for costly high care services.^{4,13}

Social problems associated with young people are often caused by declining levels of inclusion in the community, lack of social cohesion at the local level, and a growing disconnect between the generations.¹³ Furthermore, animosity towards those who are different is nurtured through a lack of familiarity, and ignorance about the 'other' can foster stereotypes and prejudicial attitudes.³¹ However, regular contact with older people during childhood and adolescence can reduce negative attitudes towards ageing. Research on the life-course theory identifies the importance of adult support structures early in childhood to improve confidence and security, and lower incidences of antisocial behaviour.³² Therefore, IPs can benefit children and young people by providing access to adults at difficult times, reducing involvement in offending behaviour and drug use, improving school attendance and results; and improving personal resilience.^{4,13,32} Developing a strong sense of belonging and more positive attitudes towards ageing among young people can help to build a more inclusive community. Findings from this research are expected to provide understanding as to how developing meaningful relationships with older people through an intergenerational learning program can improve confidence and create positive attitudes towards older people.

4.2 | Implications for industry, practice and workforce

For the participating organisations, IPs are expected to be cost-effective since they can improve efficiency by taking advantage of economies of scale and scope by sharing resources such as infrastructure, support services, skilled labour and learning materials. They can also provide a competitive

advantage for organisations by providing new and innovative services that benefit their clients and families and break down institutional barriers and silos that segregate families and care services. In addition, IPs fulfil many of the requirements of the Aged Care Accreditation Standards, namely standards (a) Consumer dignity and choice; (b) Personal care and clinical care; (c) Services and supports for daily living; and (d) Organisation's service environment.³³ IPs also address the requirements for the National Quality Standards in early childhood education and care.³⁴ Furthermore, IPs can provide new career development opportunities for both the aged care and childcare workforce, which have been shown to increase staff retention and job satisfaction.³⁵ Findings from this research are expected to provide organisations with operational guidelines to develop, implement and evaluate intergenerational programs for the roll-out and long-term sustainability of effective programs. In addition, the findings are expected to inform the development of a recognised intergenerational practice qualification that will be offered to qualified aged care and childcare practitioners.

4.3 | Implications for policy

By improving the health and well-being of individuals and communities, IPs have the potential to provide economic benefits and cost savings for all levels of government. Financial support and social policy support are critical for the long-term sustainability of IPs; however, governments have demonstrated limited political and financial commitment.^{3,5} Findings from this research are expected to provide evidence-based recommendations to inform different levels of government how they can actively support and facilitate the roll-out of IPs more broadly within Australia. The recommendations will address financial and legislative barriers that inhibit the development and normalisation of such programs.

4.4 | Implications for research and evaluation of intergenerational programs

Findings from this research are expected to make recommendations and inform the development of appropriate methods, tools and measures for a holistic approach to evaluating intergenerational programs from multiple perspectives.

5 | CONCLUSIONS

This paper presents the research protocol for the Intergenerational Care Project: research evaluating an ILP in Australia. It provides theoretical and practical insights

with regard to the co-creation of an ILP with organisations and participants, program implementation considerations including workforce training, and types of measures and tools used for evaluation. The findings from this research are expected to contribute to developing age-friendly communities by informing the development of recommendations and guidelines for the operationalisation and evaluation of IPs designed to enhance engagement between the generations.

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CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

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