Lifelong learning is a contested concept and, in practice, a range of models have emerged in Europe and beyond over the last few decades. Yet, although the ageing of the world’s population and the implications of demographic trends have been well documented, it is only comparatively recently that older people have come to merit some consideration when lifelong learning policies are being developed and to feature in educational policy documents at supra-national level and within individual countries. Indeed, it is now noticeable that, in many countries across the world, the United Nations Principles for Older People (1991) and the World Health Organization’s espousal of the concept of active ageing (2002) have been particularly influential in encouraging policy makers to accept that the provision of learning opportunities for older people is a vital ingredient in any recipe for healthy and productive ageing and for maintaining independence. A further example can be seen in the European Commission’s Lifelong Learning Programme 2007–13, designed to provide practical support for the implementation of adult learning policies across the member states of the European Union. It incorporated all kinds of adult learning within its Grundtvig strand and, for the first time, stated its intention to fund activities designed to address the challenges posed by ageing populations across Europe (EC 2007).

This move is timely, as governments in many countries seek to deal with economic crisis, skills shortages, escalating state benefit costs and an increasing number of pensioners in poverty by extending working life (Smeaton et al. 2009). There has also been a growing interest in changing concepts of retirement and in exploring what role learning can play in the lives of those no longer active in the labour market not just in respect of maintaining health, well-being and independence, but also in order to maintain and develop skills and competencies and as a dimension of social inclusion and participation in civic life. More controversially, it has often been claimed that participation in learning can promote empowerment, choice and personal development, although these terms are seldom well defined (Withnall 2010).

In spite of increasing recognition of the sheer diversity and potential of later life, what still seems to be missing from the debate is any real acknowledgement of what lifelong learning might mean in the lives of those older people who have some degree of physical disability or cognitive impairment, or both, and who are accordingly living in long-term residential care. Following Laslett (1989): this period is often gloomily designated the Fourth Age of descent into dependence, senility and death, in contrast to the Third Age of active leisure, although Laslett himself acknowledged that some Third Age activities can be maintained in the face of physical decline. More recently, Schuller and Watson (2009) have argued for a four-stage model
of the educational life course in which the age of 75+ marks the fourth stage. Acknowledging that this stage implies some degree of dependency, they rightly point out that the growing size of this age group poses particular challenges to the meaning and aims of lifelong learning. In particular, the prominence of older women also implies a gender dimension, although improvements in male life expectancy suggest that this aspect will become less prominent in future. It should also be pointed out, however, that many people over 75 years of age continue to lead healthy and busy lives and do not need assistance until much later in their lives, if at all. As with any other age group, there is considerable diversity in the processes of ageing and in how individuals respond.

What is of concern here is those older people who, for various reasons, have already entered long-term residential care. Institutional arrangements and titles tend to vary in different countries, but, in many places, what is often called ‘aged care’ has developed into big business. In the United Kingdom a care home is any home that is registered under the Care Standards Act 2000, including homes run by a local authority, voluntary organisation or those that are privately owned, and which offer personal care to those unable to cope at home, with some also providing full-time nursing care. A minority of homes provide specifically for those designated elderly mentally infirm (EMI). Currently, only 3 per cent of people over 65, 18 per cent of people over 80 and 28 per cent of people over 90 live in residential care (Audit Commission, 2008). However, just over half of residents in care homes aged over 65 are estimated to have some level of dementia, rising to 66.9 per cent of people in nursing homes and 79.9 per cent in EMI homes (PSSRU 2007). Depressive symptoms are also common. As life expectancy increases and the numbers of very old people grow, the need for some form of care is also forecast to increase. Indeed, within the UK, it is expected that over 1.7 million more adults will require some form of care or support in 20 years’ time (HM Government, 2009). Other countries are facing similar issues, although different solutions are being explored in Europe and beyond. Frequently, however, the emphasis is on how care should be funded, rather than on residents’ quality of life.

In respect of lifelong learning, Withnall (2010) has suggested that we adopt the term ‘longlife learning’ as a way of acknowledging the longevity of the population, the need to value individuality and diversity at any age and as a basis for exploring how learning activities could be understood and developed in respect of physically and mentally frail older people who require varying degrees of care and support in daily living. The notion of longlife learning will therefore underpin the ensuing debate; but a further consideration is how individual needs might be met in an institutional setting, where considerations of cost-effectiveness usually dictate the use of both time and available resources, including staff.

Ageing and the capacity to learn

Any discussion must begin from an appraisal of how the processes of ageing affects the ability to learn, since, as Jarvis (2010) points out, it is through the body that we communicate and learn. Whilst it is obviously not possible to review the vast amount of literature relating to the ageing body here, it is worth commenting on some of the more obvious age-related changes that take place. Physical aspects may include mobility problems as the structures that support movement undergo age-related changes, sometimes resulting in painful arthritis or osteoporosis and restricted movement. Degrees of visual disturbance may be caused by presbyopia (impaired near vision), age-related macular degeneration, cataracts or glaucoma, and there may be associated psychological difficulties, especially if other health problems are also present. It has been pointed out, however, that even those who are registered blind usually have some small degree of sight and can benefit from the provision of activities if their special requirements are taken into account. A degree of hearing loss is also considered to be a normal part of ageing, although it can range from slight to severe. If left undiagnosed, or if the older person does not acknowledge a hearing problem, difficulties in communication, isolation and depression may result, even though modern digital hearing aids can go some way to alleviating any problems (Withnall et al., 2004).
Structural and chemical changes in the brain as people grow older have fascinated researchers for many years. In spite of some evidence that the brain may shrink with increasing age, age-related changes in brain structure are not thought to have a major impact on intellectual abilities unless other more complex and abnormal changes in brain tissue associated with a range of dementias, Alzheimer’s disease in particular, appear to be present. Symptoms of dementia include gradual loss of memory, inability to concentrate, problems with language and communication, progressive difficulty in completing simple tasks and solving problems and sometimes mood swings and emotional reactions, as well as abnormal motor functions. Dementia may progress from mild to severe over a period of between five and 20 years, although people differ considerably regarding both their symptoms and the speed at which their illness progresses. Not all areas of the brain are simultaneously affected; for example, many people preserve a memory for music and singing. Alternatively, some people may experience mild cognitive impairment that does not develop into dementia, but causes the individual to experience problems with memory (Alzheimer’s Society, 2010).

Recently in the UK, the National Institute for Health and Clinical Excellence (NICE) has produced guidelines for the diagnosis, management and prevention of delirium, an acute confusional state that develops over a short time (but is usually only temporary), since being over the age of 65 appears to be one of the risk factors with which it is linked. It may appear as a result of the changes associated with admission to long-term care (NICE, 2010).

Even in the absence of the complex brain changes that characterise dementia, it does appear that ageing has some bearing on different components of memory, especially working memory, but this is not generally considered an indication of an inability to learn. Similarly, although some psychologists believe that fluid intelligence (the ability to carry out higher cognitive functions) declines as people pass their mid-60s, it is also thought that crystallised intelligence involving the skills, information and problem-solving strategies acquired across the life course continues to grow as people age. A further common perception is that people’s reactions slow down in later life and that this must affect their ability to learn. Reviewing the available evidence Withnall et al. (2004) stress the importance of considering an older person’s overall health status, since there are a number of illnesses such as chronic bronchitis or diabetes that may affect the efficiency of the central nervous system; and anxiety, depression and stress, common reactions to the presence of chronic illness, may exacerbate the situation.

Whitbourne (2001) has drawn attention to psychological issues in respect of admission to a long-term residential care facility. The danger of delirium has been mentioned above, but she comments further on the range of infirmity that individual residents may display and the problems of addressing their individual preferences in matters of daily living that may stem from physical factors or perhaps cultural background, including their ability to live comfortably in an institutional setting. There may also be some cultural differences between staff and residents, and she suggests that ‘differences in social class, ethnicity, age and experiences in the world outside the institution can interfere with their ability to establish a common ground as a basis for positive relationships’ (p. 387). Accordingly, Whitbourne draws on the competence-press model originally developed by Lawton and Nahemow (1973) for predicting how well people will adapt to living in an institutional setting. This model posits an ideal relationship between an individual resident’s physical and psychological competencies and the demands of the environment; if there is a complete mismatch, the resident may respond with negativity and display maladaptive behaviour.

A theoretical perspective

Let us now return to the issue of learning in long-term residential care. Owing to the comparative lack of interest in this aspect of learning, there have been virtually no attempts to develop any kind of theoretical perspective on this aspect of later life learning. An exception can be seen in the concept of integrative geragogy as a basic aspect of educational gerontology developed in a specifically German context by Maderer and Skiba (2006a) from earlier concepts of geragogy. They point out that geragogy itself cannot be easily
defined; in Germany, it appears to have emerged from three different schools of thought. These relate, first, to an educational position where geragogy is strongly connected to pedagogy and its main aim is to make older people aware of the ageing process in order to convince them of the need to recognise and make use of hidden opportunities. Second, another branch of discussion has focused on social geragogy with the suggestion that it should concentrate on analysis and critique of the socialisation process of older people and assist them in finding a fitting role. A third branch examined the relevance of a consideration of special sub-groups of older people with emerging connections between old age and frailty. It is this latter perspective that encouraged the authors, initially separately, to establish and refine the theoretical foundation of integrative geragogy. They base their arguments on the premise that, in the case of frail older people, learning may not be limited just to higher cognitive processes. Although their line of reasoning is complex and loses considerably in translation as there are no equivalent words in English for some of the German terms that they employ, they appear to be utilising an approach based in phenomenological anthropology. Put simply, each resident is more than just the recipient of care; whatever his/her level of functioning, he or she is a mixture of psychological and physical abilities and possesses a subjective biography linked into social relationships that are in turn influenced by emotional feelings, personal memories and interpretations of historical events. In this way, each resident plays a role in creating the environment of the care home and is central to any geragogical interventions (Maderer and Skiba, 2006b). According to the perspective of integrative geragogy, then, the overall aim of learning in residential care is to ensure that residents can maximise their individual abilities in different areas of their lives and are enabled to live as independently as possible even in the face of increasing physical or cognitive frailty. Learning may evolve from a combination of interventions designed to enhance the dimensions described above, together with appropriate social and medical care. Interventions may be individual or may take the form of various types of group work.

The authors go on to stress the importance of the role of care and nursing staff, relatives and the external community within a home and in any interventions. They also comment on environmental concerns, including the available space within a home and how it might be enriched. They seem less sure of their ground here and move to trying to justify their approach from economic, political, humanitarian and legal perspectives, as well as claiming a contribution to educational theory. Whilst their theoretical perspective is an original and useful input to an aspect of educational gerontology that has hitherto received little attention, it can be argued that the ‘integrative’ aspect of their approach is not well defined and the link that they attempt between theory and practice requires clearer definition, especially in respect of residents with advanced dementia or other intellectual disabilities that have a major impact on their daily lives.

**Developing a holistic approach to learning**

One of the problems with a geragogical approach is that different meanings have been ascribed to the term over time. It has previously been defined mainly in relation to teaching older people from the perspective of the provider and practitioner (Schuetz 1982; John 1988; Girton 1995) and has also been the subject of considerable academic debate as Maderer and Skiba (2006a) have shown. It has been less concerned with different types of frail older learners and their learning. It is therefore proposed that a more inclusive way of thinking about learning in long-term care would be to develop a holistic approach to learning. This basically involves the adoption of a systems approach in which the overall goal is, as above, to maximise each resident’s independence and well-being for as long as possible through learning. However, it also recognises that, within a care home, it is necessary to understand how the external environment, the prevailing philosophy of care and thus available resources, structures and processes and various people (residents, staff and visitors), interact within a particular physical environment in order for that goal to be attained. Since a care home is a dynamic entity constantly undergoing change in all these sub-systems and influenced by changing external factors, it can be seen as an open system.
If we consider the external environment in which a care home operates, this will be different in different countries, depending on any existing legislation. As an example, in the UK, the legal basis for inspections is the Health and Social Care Act 2008. The Care Quality Commission is responsible for the inspection of care homes; its guidance to providers to help meet regulations includes the necessity of ensuring that ‘people who use services get effective, safe and appropriate care, treatment and support that meets their individual needs’. In the same document, providers are advised to consider all aspects of service users’ welfare and well-being, including daytime activities (CQC, 2010). In Australia and some other countries, the appointment of an Activities Organiser within a care home is mandatory.

In addition to statutory requirements, the philosophy of care to which a home subscribes has a major impact on how it is organised and run, which resources are given priority and how staff and residents relate to each other. A further factor is whether the home is part of a larger group with its own imposed values and structures, or simply a small privately run institution. However, it appears that a growing international movement known as the Eden Alternative is having a measure of success in encouraging alternative ways of thinking about the ethos of care for the benefit of both residents and staff in a variety of care homes throughout the world. Founded in 1991 by an American geriatrician, its philosophy is based on combating ‘the three plagues’ of loneliness, helplessness and boredom that are said to afflict residents living in long-term care. Accordingly, the Eden philosophy is based on the notion that life can be fulfilling at any age. It proposes ten principles for creating an elder-centred community that stress relationships and continuing contact with younger people, plants and animals; loving companionship; the opportunity to give as well as receive care; spontaneity in daily life; placing decision-making authority in the hands of older people or their friends and relatives; and a recognition that the creation of such a community is an ongoing process that needs wise leadership. The approach requires a complete change to the culture of a care home in that it is necessary to develop a shared vision and to welcome other generations (and animals) in order for residents to participate in a variety of chosen activities. In this way, a home can become a thriving focal point for both individual and shared learning; staff roles may need to evolve or change in the course of time as they become not just carers or nurses but ‘life assistants’ (Burgess, 2009). Although evaluations of the Eden Alternative are still somewhat limited, Rosher and Robinson (2005) detected significant improvement in family satisfaction regarding their relatives’ quality of activities and general contentment amongst other benefits in their study completed at a large nursing home in the American Midwest.

A further example can be seen in the prevailing ethos of Sunrise Senior Living, an American organisation that now operates 365 homes in the USA, Canada, the UK and Germany. Sunrise recognises the need to respect residents’ dignity and individuality and employs Life Enrichment Managers, whose role is to work closely with individual residents and their relatives and friends to enhance residents’ enjoyment of their daily lives and to ensure that they are able to experience a sense of achievement in their chosen activities. However, the cost of living in a Sunrise facility appears to be notably higher than might be the case elsewhere (www.sunriseseniorliving.com).

In spite of these very positive philosophies, the internal physical environment of a care home has rarely been considered in relation to residents’ learning, although Eaton and Salari (2005) have drawn attention to the impact of physical surroundings in respect of seniors’ centres in the USA. Recently, Burton and Sheehan (forthcoming) conducted research into how individual design features can influence older people’s quality of life and well-being in a residential care setting in two different areas of the UK. Using an exploratory study of residents’ perceptions based on personal interviews and also making use of sets of photographs featuring variation in one particular design feature, they ascertained that, whilst views of nature and greenery were important, residents especially favoured open-plan layouts and practical, easily accessible design. The type of building most preferred was a single-storey design and, in communal rooms, home-like spaces, comfort, sunlight, grouped seating and tables for activities were generally seen as ideal. The researchers noted, however, from this and previous research, that it is often difficult to encourage people to think about their immediate physical environment and that they tend to adapt uncritically to
their surroundings over time. This suggests that more careful thought should be given at the outset to the design and location of care homes as an important facet of residents’ overall well-being and subsequent propensity to enjoy learning and other activities.

**The nature of learning in long-term care**

A holistic approach can provide a useful framework for thinking about how learning might take place in long-term care. The remaining aspect, or sub-system, is the residents themselves, the staff and relatives or other visitors. It has been seen that Maderer and Skiba (2006b) stressed the importance of seeing residents as more than just recipients of care; together with staff and visitors they are instrumental in helping to create the care home environment. However, this is a constantly changing population; some residents will decline or die, whilst others with varying interests and levels of ability are just moving into care. In turn, they introduce new groups of relatives and friends; staff leave and are replaced by others; visitors come and go.

Because the care home population is a shifting one, it is apparent that to develop one definition of learning in this setting is problematic. What can be said is that it will have a variety of meanings and practical applications for residents according to their background, personality, current level and type of dependency, and thus their abilities. A resident who is still reasonably active and has little in the way of physical, sensory or cognitive impairment can be encouraged to continue with existing hobbies and interests or to develop new ones and to continue to forge beneficial relationships with others. They are likely to remain in contact with and interested in, the wider world beyond the care home and this can be maintained through regular contact in ways envisaged within the Eden Alternative. Others whose mobility, sight or hearing has diminished may benefit from the same kind of opportunities, although more consideration might be needed in respect of the home’s environment, with more attention given to ergonomic issues. Aldridge (2009) has provided a rich variety of examples of innovative programmes devised with and for residents in a range of care homes in the UK, including the use of trained volunteer personal learning mentors to help develop an individual’s own interests and needs; and a series of reading groups in a Scottish care home, which provide both intellectual stimulation and a chance for residents and staff to learn from each other. There are many other examples from long-term care facilities in different countries across the world.

For residents who may be experiencing mild cognitive impairment or have some degree of dementia, perhaps in addition to physical or sensory problems, learning can still take place, but it will take different forms and require different approaches. An initial requirement might be to maintain some sense of continuity in residents’ lives. A useful starting point is the concept of ‘personhood’ (Kitwood, 1997), defined as being vested in relationships between carers and patients and implying recognition, respect and trust. Currently, further research to increase understanding and implementation of personhood approaches to dementia care is underway through a range of interdisciplinary projects, notably at the University of British Columbia in Canada, since it can provide the basis for a positive relationship between residents and those with whom they come into contact.

A further approach that has relevance is the Specialised Early Care for Alzheimer’s (SPECAL) method outlined by James (2008). Designed for use with people in the early stages of dementia, SPECAL recognises that, in spite of memory loss, recollection of past events and feelings are still intact and can be used to replace more recent information that has been lost. The resident (or client) is seen as the expert; it is important to enter his or her world and not to contradict or try to re-orientate them or ask questions that only lead to more confusion. SPECAL makes use of the idea of a ‘photograph’ from the past to create a present-day context in which the resident is enabled ‘to live much of their waking life in their favourite psychological place, an activity or interest that they have always loved, one that brings them alive, that promotes their feelings of self-worth’ (p. 133). In this way, as long as the resident is absorbed in their own recalled interests, they tend to remain calm and cease to be puzzled and distressed by their inability to
understand their current context. Memories from the past can be conjured up through ‘verbal ping-pong’, beginning from the introduction of words or phrases that might reflect the resident’s past interests. Adoption of this method means that carers, relatives or other visitors need to have a very good grasp of residents’ biographies and to be prepared to invest in conversations that may be in some ways counter-intuitive.

Although there is growing support for SPECAL among carers, the UK Alzheimer’s Society does not support its approach on the grounds that it is contrary both to principles embedded in the Mental Capacity Act (2005) and established best practice. It is said to take away choice and control from people suffering from dementia through its use of what amounts to deception (www.alzheimers.org.uk). Certainly, the method requires more debate regarding its ethics and an independent rigorous scientific evaluation as to its overall efficacy, but it appears to offer an interesting way to help residents reconnect with their past interests.

Meanwhile, a variety of other approaches to engaging people with dementia in learning and associated activities has been developed in different countries. For example, Zeisel (2009) emphasises the importance of creative activity to stimulate the brain and open pathways to better communication. Other examples include reminiscence work, music therapy, craft activities, learning to care for a pet or plant, gentle and progressive exercise and listening to the radio (but not watching television, which can sometimes cause further disorientation). For people in the advanced stages of dementia or suffering temporarily from delirium, learning can involve simple repetitive tasks that help the resident maintain a degree of functional independence. This might include the use of prompts and cues or various behavioural strategies that offer the resident the kind of cognitive stimulation required to learn how to carry out a task such as getting dressed. Positive reinforcement would also be needed to help maintain what has been learnt (Whitbourne 2001), although, in this situation, the resident is actually re-learning what was once known.

If we accept the concept of holistic learning and subscribe to very different ideas of learning that can be seen in long-term care, it is of course necessary to acknowledge that enabling learning in any form requires the active participation not only of individual residents, but also of care and nursing staff, relatives and other visitors. This implies the need for everyone who is involved with residents’ lives to subscribe to a vision that recognises the importance of learning however frail the resident may be. In addition, an important pre-requisite is for staff to be aware of each new resident’s biography and interests; relatives and friends have a role to play here as well as the older person. Above all, care and nursing staff need appropriate training, not just in delivering care, but in understanding what role different forms of learning can play in maintaining independence and encouraging well-being for as long as possible. Accordingly, as Neuberger (2008) has cogently argued, it is also important that caring is seen as an honourable, well-paid and well-trained profession, with real opportunities for career progression. In some countries, this is not always the case.

Conclusion

In view of demographic trends, it was suggested that the time has come to substitute the idea of ‘longlife learning’ for the more commonly used ‘lifelong learning’. Within this framework, it is necessary to begin to consider how learning can assist physically and/or mentally frail older people moving into long-term care to maintain their independence and well-being for as long as possible; and indeed, what meaning can be ascribed to learning in this context. The perspective offered by integrative geragogy points an interesting way forward, but it has been argued here that the use of a systems approach and the resulting concept of holistic learning can shift the emphasis from teaching to learning and help to identify the complexity of learning in the unique and dynamic setting of each long-term care home. As the population of very elderly people is set to increase, the issues raised here will doubtless come to attract more attention from educators of adults and learning theorists. All our futures are at stake.
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Lifelong learning in long-term care settings


