Pikes Peak Model for Training in Professional Geropsychology

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The aging of the population will increase demand for psychological services for older adults, which challenges the profession of psychology to provide those services. In response to that challenge, professional geropsychology has been developing over the past few decades to meet current and prepare for anticipated future demand. The development of a range of training opportunities is important to enable psychologists to work effectively with older adults. This article describes the Pikes Peak model for training in professional geropsychology. The model is an aspirational, competencies-based approach to training professional geropsychologists that allows for entry points at multiple levels of professional development.

Keywords: aging, older adults, doctoral programs, internships, postdoctoral training

The aging of the population at large and the corresponding aging of clients receiving psychological services have been recognized for some time (e.g., Knight, Kelly, & Gatz, 1992; Qualls, Segal, Norman, Niederehe, & Gallagher-Thompson, 2002). Workforce shortages for geriatric mental health care are predicted to be significant (Center for Health Workforce Studies, 2005; Halpain, Harris, McClure, & Jeste, 1999; Jeste et al., 1999). Multiple factors contribute to the quickly growing need for geriatric mental health services: the growing number of adults over 65 years old (He, Sengupta, Velkoff, & DeBarros, 2005); the aging of the baby boom cohort, which has higher rates of mental disorder than the current cohort of older adults (e.g., Koenig, George, & Schneider, 1994); rapid growth of the "oldest-old" population (those over 85 years old), with associated complex mental health needs related to chronic illness, dementia, and long-term care; and greater receptivity to mental health services among cohorts now entering older age (Gatz & Smyer, 2001; Jeste et al., 1999; Qualls et al., 2002). Qualls et al. (2002) found that 69% of respondents to a survey of American Psychological Association (APA) members reported some professional work with older adults, with only 3% devoting most of their professional time to older clients. The majority reported very little formal training in aging and felt they needed further training to work competently with older adults.

The past few decades have seen a growth in training programs to prepare psychologists for work with older adults, but there has not been a comprehensive model for

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such training. In this article, we report on the development of the Pikes Peak model for training in professional geropsychology. The Pikes Peak model is offered as an aspirational model for training programs and for individual psychologists and psychologists in training who may seek guidance in selecting programs or creating self-study programs on their own.

The Pikes Peak model takes the position that specific training in geropsychology is not needed by all psychologists who see older adult clients. Most practitioners will see some older adults who are similar to the younger adults in their practice and will do competent work with them. As issues become more complex and more specialized in their nature (e.g., potential presence of dementia, complications from comorbid medical problems, assessment of decision-making capacity, nursing home consultation), the need for geropsychology competence increases.

The Pikes Peak competencies and related training recommendations are geared toward the level of a newly licensed psychologist who plans to focus on work with older clients. Such a psychologist is likely not yet an expert but has basic competence to serve older adults and knows when expert consultation is needed. Such a geropsychologist knows enough about the field and related competencies to work within the limits of his or her competence.

In this article, we first provide a conceptual context for the delineation of a professional geropsychology training model at this time. We then describe the methods and outcomes of the Pikes Peak conference on training in professional geropsychology. The outcomes include the definition of attitude, knowledge, and skill competencies for geropsychology practice (see Appendix) and the core features of training recommended for psychologists to develop these competencies.

Conceptual Bases of Professional Geropsychology as a Focus of Specialized Training

What are some of the issues that define geropsychology as a practice area that requires specialized training? Psychological assessment and intervention with older adults and consultation to the care systems that serve them require some distinctive training beyond what may be offered in general adult clinical or counseling psychology training. Four broad aspects of professional geropsychology define the field as a distinctive practice area.

First, professional geropsychology has roots in life span developmental psychology, particularly development during adulthood and old age. This tradition emphasizes the importance of research designs that address developmental change over the adult years (e.g., the sequential designs embodied in the Seattle Longitudinal Study; Schaie, 2005). These designs can disentangle developmental change from historical time influences that affect everyone during the same time period as well as from differences between successive birth cohorts that influence the ways in which generational groups differ (e.g., the World War II generation, the Boomers, Generation X). The clinical application of life span psychology emphasizes the importance of understanding normal aging before attempting to work with older adults with psychological disorders (Knight, 2004).

Second, professional geropsychology requires knowledge of and skills relevant to late-life psychopathologies, including those with higher prevalence in later life, especially the dementias, and those with different presentations, etiologies, or treatment implications in older adults, including the distinction between early- and late-life onset of disorders (Gatz, Kasl-Godley, & Karel, 1996; Zarit & Zarit, 2007). Psychopathology shared with younger adults may present differently in later life (e.g., Alexopoulos et al., 2002; Sheikh, 2005; Sorocco & Ferrell, 2006), and risk factors may differ for early- versus late-onset conditions. Depression, anxiety, alcohol abuse, psychotic symptoms, and personality disorders may all have distinct features in older adults.

A third major aspect of professional practice in geropsychology is the common presence of chronic medical conditions in older adults. This fact makes understanding the interactions of physical and psychological symptoms of critical importance and also makes knowledge of the psychological effects of medications for physical disorders (as well as psychotropic medications) essential to professional practice with older adults. This tradition draws attention to the need for geropsychologists to understand the health psychology of late-life medical disorders (e.g., Aldwin, Park, & Spiro, 2007; Frazer, 1995; Haley, 1996) and the impact of both medical and psychological conditions on functional disability in older adults.

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A fourth source of specificity in work with older adults is the range of age-specific environmental contexts in which older adult clients are embedded, including family, residential, health care, and community systems that serve older adults. Geropsychologists must have a working knowledge of these various systems and interface with them as appropriate. How and when to include family members in geropsychological care is a critical issue with ethical and clinical implications (Qualls, 2000). An example of a specific environmental context where psychologists increasingly provide services is that of long-term care settings, such as nursing homes and assisted living facilities (e.g., Hyer & Intrieri, 2006; Lichtenberg et al., 1998; Molinari, 2000; Rosowsky, Casciani, & Arnold, 2008). In addition to being able to attend to the complex needs of frail older adults in long-term care, the psychologist working in the long-term care setting must be capable of training all levels of staff from nurses' aides to administrators, organizational consultation, and skilled work within interdisciplinary teams.

This brief overview outlines key conceptual foundations of professional geropsychology and illustrates why practice in the field may require some specialized training. It also illustrates important ways in which geropsychology as a practice area shares competencies with other practice areas like neuropsychology and health psychology. To date, geropsychology (like most of child clinical psychology) has existed as a concentration within clinical psychology and counseling psychology. Recently, there have been signs of training programs at internship and postdoctoral levels with strong concentrations in health psychology and neuropsychology developing foci in professional geropsychology.

Pikes Peak Model for Geropsychology Training

Methodology for the Development of the Pikes Peak Model

Three national training conferences on the preparation of psychologists to work with older adults have been held. Older Boulder I, which took place in Boulder, Colorado, in 1981, focused on the knowledge base in geropsychology and began the discussion of how this knowledge base could be taught to new geropsychologists (Santos & VandenBos, 1982). Older Boulder II, which met in Washington, DC, in 1992, continued this discussion, but with a greater focus on skills training and more attention to the various levels of clinical training (Knight, Teri, Wohlford, & Santos, 1995). The third conference, called the Pikes Peak conference, met in Colorado Springs, Colorado, in 2006 and focused on the development of a model for training professional geropsychologists.

The list of geropsychology attitude, knowledge, and skill competencies was developed through an iterative process during the Pikes Peak conference meeting and refined in ongoing discussions after the meeting on the conference electronic mailing list. Conference participants met in groups organized by competency domains and levels of training. Because each participant was a member of each type of group, cross-fertilization of ideas occurred across these thematic groups. Summaries of all groups' decisions were distributed each day to all participants. The meeting closed with a final plenary session in which all conferees had the opportunity to respond to an initial draft of the attitude, knowledge, and skill competencies list and of key principles related to training programs at all levels. After the meeting, the planning committee further refined the list of competencies, and it was circulated to the attendees via electronic mailing list for feedback. The list in the Appendix and the main recommendations of this article represent the outcome of this conference process. Note that the conference delegates did not produce a formal consensus statement but rather a "sense of the meeting" regarding key recommendations; we, as the authors of this article, take final responsibility for the geropsychology competencies list and training recommendations presented here.

Competencies for Training in Professional Geropsychology

The Pikes Peak model's focus on competencies in geropsychology is consistent with the movement toward competency-based education, training, and credentialing within professional psychology (Kaslow, 2004; Kaslow et al., 2004; Rodolfa et al., 2005). Thus, the Pikes Peak model was influenced by outcomes of the 2002 Competencies Conference: Future Directions in Education and Credentialing in Professional Psychology. In particular, the cube model conceptual framework that considers the development of both foundational and functional competencies across a psychologist's training career helped to inform the conference work on geropsychology competencies (Rodolfa et al., 2005).
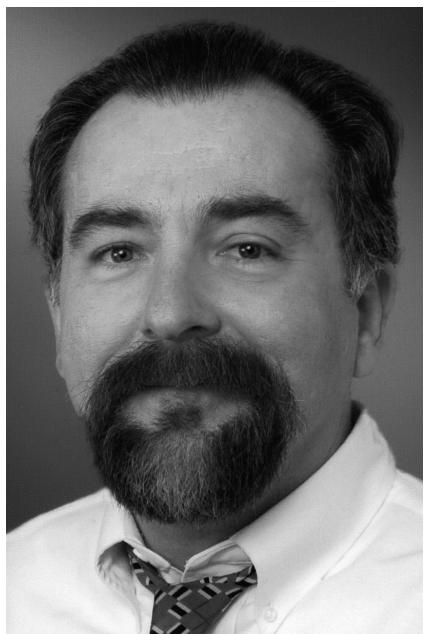
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The APA Guidelines for Psychological Practice With Older Adults (APA, 2004) provided the substantive starting point for the Pikes Peak model. The guidelines are organized around six categories: (a) attitudes; (b) general knowledge about adult development, aging, and older adults; (c) clinical issues; (d) assessment; (e) intervention, consultation, and other service provision; and (f) continuing education regarding practice with older adults. The guidelines give practitioners working with older adults a framework for thinking about the relevant attitudes, knowledge, and skills but do not speak specifically to the training pathways to acquire such skills. The Pikes Peak competencies build on the guidelines to provide additional detail, particularly regarding skills, framed as an outline of aspirational goals for training. The Pikes Peak competencies list is not intended to be a revision of the guidelines but a tool to be used specifically to enable programs and persons seeking training in geropsychology to plan and evaluate a course of training in the field.

The Pikes Peak model thus includes a summary of the attitude, knowledge, and skill competencies needed to become a competent geropsychologist. The Pikes Peak geropsychology competencies (see Appendix) are intended to be aspirational in nature and helpful for training programs and individual psychologists alike. They are geared toward the psychologist who plans to practice extensively with older adults, across a wide range of clinical needs and care settings.

Attitudes. Core attitudes for geropsychology practice were specified in the APA Guidelines for Psychological Practice With Older Adults (APA, 2004). They include practicing within one's scope of competence and recognizing how one's personal attitudes and beliefs about aging and older adults may affect one's work with them. Further, the Pikes Peak model emphasizes the central im-

portance for psychologists of being aware of individual diversity in all of its manifestations, including how gender, ethnicity, language, religion, socioeconomic status, sexual orientation, gender identity, disability status, and urban or rural residence interact with attitudes and beliefs about aging. The roots of geropsychology in life span developmental psychology suggested that a focus on the interactions between age and cohort and other aspects of individual diversity are critical for understanding the social context of an individual's experiences in late life.

Knowledge. The Pikes Peak model highlights four domains of knowledge.

1. The conceptual basis of professional geropsychology in life span developmental psychology leads to an emphasis on general knowledge about adult development, aging, and the older adult population (e.g., normal adult biological, psychological, emotional, and social development).
2. The interaction of life span development with increased neurological and health problems in later life leads to a focus on cognitive changes, functional changes, and specific presentations of psychopathology in later adulthood as foundations of clinical practice with older adults.
3. Both the normative changes with adult development and aging and the distinctive features of psychopathology in later life lead to a need for specialized knowledge regarding assessment methods and instruments suitable for assessing older adults.
4. Knowledge about developmental, cohort, contextual, and systemic issues, as well as of efficacy and effectiveness research, must inform psychological interventions with older adults.

Skills. The first skill domain specified in the Pikes Peak model is called professional geropsychology functioning, which describes the foundational competencies for professional geropsychology practice. According to Rodolfa et al. (2005), foundational competencies are "the building blocks of what psychologists do" (p. 350), and the competencies include reflective practice–self-assessment, scientific knowledge–methods, relationships, ethical–legal standards–policy, individual–cultural diversity, and interdisciplinary systems. A core foundational competency of the Pikes Peak model is respect for older adults and awareness of one's own ageist biases. Key methods used to combat ageist bias include acquiring an understanding of normative aging and experiential learning contacts with older adults who are exemplars of normative and successful aging. Other foundational geropsychology competencies include, but are not limited to, (a) understanding and applying aging-specific aspects of informed consent, confidentiality, capacity and competency, end-of-life decision making, and elder abuse and neglect; (b) applying understanding of cultural and individual diversity among older adults to assessment, intervention, and consultation; (c) working with multi- and interdisciplinary teams and other professionals; and (d) practicing appropriate documentation and billing for geropsychological services in compli-

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ance with federal and state laws and regulations (e.g., Medicare and Medicaid).

The Pikes Peak assessment skills domain addresses the special issues associated with the evaluation of older adults, who often have multiple comorbidities that challenge differential diagnosis, and also addresses developmental and disease-related changes in functional capacities and the multiple social contexts in which older adults can be found. Geropsychologists are able to tailor assessments to accommodate older adults' specific characteristics and contexts and use reliable and valid screening instruments to assess and diagnose common late-life clinical problems. They evaluate decision-making and functional capacities and risk issues, then communicate assessment results to various stakeholders with practical and clearly understandable recommendations.

Geropsychology intervention competencies include using evidence-based treatments for older adults when available; adapting individual, group, and family interventions to accommodate distinctive biopsychosocial functioning of the older adult; using common late-life interventions such as those addressing life review, grieving, caregiving, and end-of-life care; and using interventions to enhance the health of diverse older persons.

Because professional geropsychologists recognize that older adults can be found in multiple specialized contexts, consultation competencies are central to geropsychology practice. Geropsychologists are able, for example, to consult with families, other professionals, and a range of agencies and care systems; to participate in interprofessional geriatric care teams; to provide training to a variety of professional and nonprofessional audiences; and to design and participate in different models of aging services delivery.

Other competencies for psychologists include research–evaluation, supervision–teaching, and management–administration (Rodolfa et al., 2005). These latter competency domains, which are critical for the ongoing development and advancement of professional geropsychology, are considered advanced or leadership competencies for geropsychology and, as such, are not elaborated here as fundamental competencies for geropsychology practice.

Finally, again drawing on the recognition of the multiple specialized contexts in which older adults are served, the Pikes Peak model recognizes that psychologists who work with older adults should be competent to provide services across a range of possible clinical, community, or residential settings and be aware of special issues that arise in providing care in varied settings. The basic recommendation is that geropsychologists should be able to deliver services in at least two (and likely more) of the following settings: outpatient mental health services; outpatient primary care or medical settings; inpatient medical service; inpatient psychiatric service; long-term care settings including nursing homes, assisted living facilities, home care services, and day programs; rehabilitation settings; hospice; community-based programs; forensic settings; home; and research settings.

These competencies represent the aspirational goals for training in professional geropsychology. We next discuss the ways in which these competencies can be taught to persons wanting to become geropsychologists who are at different levels of training.

Development of Competencies Across Levels of Training

Core principles and features. A core principle of the Pikes Peak model is a commitment both to high standards of competence for psychological services to older adults and to inclusiveness in order to build the needed geropsychology workforce. To achieve the goal of training as many psychologists as possible to develop geropsychology competencies, training systems in geropsychology must be open for practitioners to enter at various points in training and career development, including postlicensure. Given the limitations of any one training program, it is probable that geropsychology training will involve multiple programs at different levels of training (e.g., graduate, internship, postdoctoral, and/or a range of postlicensure training options). For example, some psychologists might gain initial exposure to geropsychology in graduate school and pursue further internship training, whereas others will initially receive geropsychology training on internship. A few will seek specialized postdoctoral training. Others will design independent training programs postlicensure. To some extent, developing a personal plan for geropsychology training entails self-assessment of competencies by a trainee, with input from teachers, supervisors, and consultants.

The following six aspects of training in professional geropsychology are identified as key elements of a training program for a professional geropsychologist.
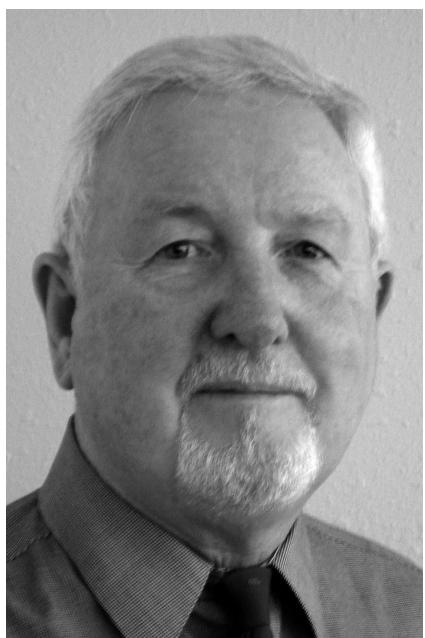
Michael Duffy

1. Normal aging is taught so that students have a basis for understanding abnormal aging experiences.
2. Bona fide professional geropsychologists using observational methods are employed as supervisors in geropsychology training programs so that students can develop appropriate skills in working with older adults.
3. Training in geropsychology includes facilitated experiences to gain self-awareness about one's responses to aging that vary by health status (e.g., frail as well as healthy aging), cultural and individual identities (e.g., wealthy or poor, rural or urban, ethnic identity, gender identity, sexual orientation, religious identity, disability status), and also diverse historical cohort experiences.
4. Experiential professional training with older adults is provided across a variety of settings. Trainees need experience in diverse settings (e.g., nursing homes, assisted living, primary care medical practice, hospitals, clients' homes).
5. Interprofessional team training is an essential part of professional geropsychology training. Trainees must learn about the knowledge base, scope of practice, and distinct professional work styles of other disciplines.
6. The distinct ethical and legal issues and practice standards that are part of practice with older adults are included in professional geropsychology training programs. Examples include late-life decision-making and functional capacities, advance care planning and surrogate decision making, communication with caregiving families in a manner that respects the confidentiality of the older client, and end-of-life care.

Development of Competencies Within Levels of Training

The Pikes Peak model provides recommendations for geropsychology training at graduate, internship, postdoctoral fellowship, and postlicensure levels. Although the specific goals and methods of geropsychology training differ somewhat across these developmental levels, level-specific recommendations all draw on the elements outlined above. These recommendations will be detailed in other publications and are aimed at helping training programs that wish to add or develop geropsychology concentrations. Although excellent models for geropsychology training exist at graduate, internship, and postdoctoral levels, postlicensure training models need continued elaboration. One outcome of the Pikes Peak conference was the establishment of the Council of Professional Geropsychology Training Programs, which serves as a forum for existing and new geropsychology programs at all levels of training to share resources, ideas, and mutual support.

Summary

In summary, the Pikes Peak model is intended to describe the competencies that psychologists aspire to attain for competent practice when engaging in specialized work with older adults. The Pikes Peak model is not intended to imply that all psychologists who work with older clients need to achieve all of the geropsychology competencies, because many older adults will be well-served by generalist psychologists working within the scope of their practice. The greater the presence of older adults in a psychologist's practice or the greater the specialized needs of specific older adults, the more relevant these specialized competencies are for psychological services for older clients.

Several themes thread throughout the model. We expect that the existing pattern of multiple entry points to training for specialized practice with older adults will continue. Training in the professional geropsychology competencies will involve both didactic and observed experiential education at all levels of training. The further along trainees are in their careers, the greater the reliance on self-assessment and self-direction in the training process. The model strongly emphasizes recognizing and countering one's own explicit or implicit ageism. Interdisciplinary collaboration and the influence of a range of social environments on older adults are also emphasized.

Global population aging, the greater proportion (as compared with earlier generations) of older adults with psychological disorders that will likely be evident when the Baby Boom generation reaches old age, and the increasing presence of older clients in psychologists' practices all support the proposition that professional geropsychology is a specialized area of psychological practice whose time has come. The Pikes Peak training model is intended to facilitate increased growth of resources and opportunities for high-quality training in geropsychology and, we hope, will inspire professional psychologists to expand their practices to include the underserved, professionally challenging, and personally rewarding population of older persons in need of psychological services.

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(*Appendix follows*)

Appendix

The Pikes Peak Model Competencies: Attitude, Knowledge, and Skill Competencies for Practice in Professional Geropsychology

I. Attitudes

1. Psychologists are encouraged to work with older adults within their scope of competence and to seek consultation or make appropriate referrals when indicated.

2. Psychologists are encouraged to recognize how their attitudes and beliefs about aging and about older individuals may be relevant to their assessment and treatment of older adults and to seek consultation or further education about these issues when indicated.

3. Psychologists are encouraged to expand their awareness of how individual diversity in all of its manifestations (including gender, age, cohort, ethnicity, language, religion, socioeconomic status, sexual orientation, gender identity, disability status, and urban or rural residence) interacts with attitudes and beliefs about aging, to use this awareness to inform their assessment and treatment of older adults, and to seek consultation or further education when indicated.

4. Psychologists are encouraged to increase their knowledge, understanding, and skills with respect to working with older adults through continuing education, training, supervision, and consultation.

II. Knowledge Base

A. Knowledge: General Knowledge About Adult Development, Aging, and the Older Adult Population

1. Theoretical models and research methodologies for understanding the processes of aging, including the life-span developmental perspective, conceptions of positive or successful aging, and methodological issues in conducting or evaluating research on aging

2. Demographics of aging, including where to obtain current knowledge on changes in population dynamics

3. Normal or "usual" aging, including the following:

- Biological and health-related aspects of aging and mind–body interactions
- Psychology of aging, including normative continuity and change in the domains of sensory processes, cognition, personality, and emotions
- Social dynamics of the aging process including issues such as work and retirement, friendships, roles, and family relationships

4. Awareness of diversity in the aging process, particularly how sociocultural factors such as gender, age, cohort, ethnicity, language, religion, socioeconomic status, sexual orientation, gender identity, disability status, and urban–rural residence may influence the experience and expression of health and of psychological problems in later life and how this knowledge may inform the assessment and treatment of older adults

B. Knowledge: Foundations of Clinical Practice With Older Adults

1. The neuroscience of aging, its applications to changes in cognition, and its implications for clinical interventions with older adults

2. Knowledge of the salience of functional changes in later adulthood, including resulting problems in daily living

3. Awareness of the concept of person–environment interaction and the implications of this concept for adaptation in late life

4. Psychopathology in middle and later adulthood, including differences in the prevalence, etiology, presentation, associated features, comorbidity, and course of mental disorders in older adults, as well as the health-related consequences of treated and untreated psychological disorders in late life

5. Knowledge of common acute, chronic, and terminal medical illnesses in late life

C. Knowledge: Foundations of Assessment of Older Adults

1. Theory and research informing psychological assessment of older adults, including the broad array of assessment domains, methods, and instruments that are psychometrically suitable for assessing older adults

2. Issues in the limits of using assessment instruments created for younger persons with older adults without adequate standardization

3. Knowledge of contextual issues in the assessment of older adults, including the system or environment in which the elder functions, and the impact on assessment process and outcomes

D. Knowledge: Foundations of Intervention, Consultation, and Other Service Provision

1. Theory, research, and practice of various methods of intervention with older adults, including current research evidence about their efficacy and effectiveness as applied to diverse groups within the older adult population

2. Health, illness, and pharmacology as related to assessment and treatment of late-life mental health problems, including awareness of medical or medication factors that may affect treatment outcomes (e.g., illness, medication side effects, polypharmacy)

3. Issues pertaining to the provision of services in the specific settings in which older adults typically live or seek treatment

4. Knowledge of aging services in the local community (e.g., day care, transportation, residential) and how to refer clients to these services

5. Prevention and health promotion services and their relevance for middle-aged and older adults at risk for mental disorders

6. Awareness of the broad array of potential clients (e.g., family members, other caregivers, health care professionals, and organizations) for psychological consultation and intervention and appropriate intervention strategies in these contexts

7. Models and methods of interdisciplinary collaboration, including an understanding of the varied components, roles, and contexts of interdisciplinary treatment of late-life mental disorders

8. Knowledge of ethical and legal standards related to psychological intervention with older adults and care systems, with particular attention to aging-specific issues of informed consent, confidentiality, substitute or end-of-life decision making and potential conflicts of interest, capacity and competency, and elder abuse and neglect

III. Skill Competencies[A1]

A. Skills: Professional Geropsychology Functioning (Foundational Competencies)

1. Understand and apply ethical and legal standards, with particular attention to aging-specific issues, such as informed consent, confidentiality, capacity and competency, end-of-life decision making, and elder abuse and neglect

2. Understand cultural and individual diversity as relevant to assessment, intervention, and consultation and apply to practice with diverse older adults

3. Address complex biopsychosocial issues among many older adults by collaborating with other disciplines in multi- and interdisciplinary teams

4. Practice self-reflection, self-assessment (e.g., self-awareness of ageist assumptions and biases, recognition of boundaries of competence and when and how to refer elsewhere)

5. Relate effectively and empathically with older adult clients, families, and other stakeholders in a range of professional roles and settings (e.g., senior center, hospital, long-term care)

6. Apply scientific knowledge to geropsychology practice and policy advocacy

7. Practice appropriate documentation, billing, and reimbursement procedures for geropsychological services in compliance with state and federal laws and regulations (especially regarding Medicare and Medicaid services), including assessment and documentation of medical necessity

8. Advocate for clients' needs and provide case management for needed services

B. Skills: Assessment

1. Conduct clinical assessment leading to *Diagnostic and Statistical Manual of Mental Disorders* diagnoses and other clinically relevant problems, formulation of treatment plans, and, specifically, differential diagnosis (common problems and issues include but are not limited to depression, anxiety, grief, delirium, dementia, medication effects, and physical disorders and their effects on functioning)

2. Use psychometrically sound screening instruments for cognition, psychopathology, and personality to inform treatment planning

3. Refer for neuropsychological, neurological, psychiatric, medical, or other evaluations as indicated

4. Use cognitive assessments and/or neuropsychological reports to clarify clinical issues and inform treatment planning[A2]

5. Evaluate decision-making and functional capacities (e.g., for managing finances, independent living, driving, making health care decisions)

6. Assess risk (e.g., suicidality, self-neglect, elder abuse)

7. Adapt instruments and tailor assessments to accommodate older adults' specific characteristics and contexts

8. Communicate assessment results to various stakeholders with relevant, practical, and clearly understandable recommendations, with appropriate consideration for confidentiality issues

C. Skills: Intervention

1. Apply individual, group, and family interventions to older adults using appropriate modifications to accommodate distinctive biopsychosocial functioning of older adults and distinct therapeutic relationship characteristics

2. Use available evidence-based treatments for older adults

3. Develop psychotherapeutic interventions based on empirical literature, theory, and clinical judgment when insufficient efficacy research is available on older adults

4. Be proficient in using commonly applied late-life interventions such as those focusing on life review, grief, end-of-life care, and caregiving

5. Use interventions to enhance the health of diverse older persons (e.g., chronic health problems, healthy aging, cognitive fitness)

6. Demonstrate ability to intervene in settings where older adults and their family members are often seen (e.g.,

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[A1] In preparing this document, the conference delegates acknowledged that skills in supervision–teaching, research–evaluation, and management–administration are also critical for geropsychology practice in many settings, as well as for the further development of professional geropsychology as a field. Although many geropsychologists will also have competencies in those skill domains, they are not considered to be core competencies for geropsychology practice. Rather, skills in supervision–teaching, research–evaluation, and management–administration are viewed as leadership skills to be encouraged through training, mentoring, and career development.

[A2] Some geropsychologists have also been trained as neuropsychologists and would thus be able to conduct neuropsychological evaluations within their scope of competence.

(Appendix continues)

health services, housing, community programs) with a range of strategies including those targeted at the individual, family, environment, and system

D. Skills: Consultation–Training

1. Consult to families, professionals, programs, health care facilities, legal systems, and other agencies and organizations that serve older adults

2. Provide training on geropsychological issues (e.g., in-services, workshops, community education) to different disciplines

3. Participate in interprofessional teams that serve older adults

4. Communicate psychological conceptualizations to medical and other professionals in a concise and useful manner

5. Implement strategies for systems analysis and change in organizations and facilities that serve older adults

6. Design and participate in different models of aging services delivery (e.g., integrated care)

7. Collaborate and coordinate with other agencies and professionals that serve older adults

8. Recognize and negotiate multiple roles in older adult consultation settings

E. Skills: Delivery of Services in Different Settings

Delivery of services in two or more different settings, including the following:
1. Outpatient mental health services
2. Outpatient primary care or medical settings
3. Inpatient medical service
4. Inpatient psychiatric service
5. Long-term care settings including nursing homes, assisted living facilities, home care, day programs
6. Rehabilitation settings
7. Hospice
8. Community-based programs
9. Forensic settings
10. Home-delivered psychological services
11. Research settings