Pikes Peak Geropsychology Knowledge and Skill Assessment Tool
Council of Professional Geropsychology Training Programs
Version 1.0 © 2008

Purpose

This evaluation tool is for learners who are working to develop knowledge and skills for providing optimal care to older adults, their families, and related care systems. Psychology trainees, their supervisors, and practicing psychologists may use this tool to evaluate progress in developing geropsychology competencies, and to help define ongoing learning goals and training needs.

Pikes Peak Competencies

Competencies for professional geropsychology practice were delineated during the 2006 National Conference on Training in Professional Geropsychology. Taken together, the competencies are aspirational, rather than "required" of any particular psychologist. Even the most accomplished geropsychologist will have relative strengths and weaknesses across the spectrum of competencies for geropsychology. The conference produced the Pikes Peak Model for Geropsychology Training (Knight et al., 2008), and created the Council of Professional Geropsychology Training Programs (CoPGTP). CoPGTP developed this competency evaluation tool for learners and supervisors to have a measure by which to gauge competence in serving older adults[1]. For the purposes of this evaluation tool, each Pikes Peak geropsychology knowledge and skill competency is specified by behaviorally descriptive items, and can be rated along a continuum from Novice to Expert. Some redundancy is inherent in this measure. The intent is to evaluate both the learner's knowledge base and skill set separately for the same domains, as the awareness of information and ability or experience in applying it may differ.

Geropsychology practice

Geropsychologists provide assessment, intervention, consultation, and other professional services across a wide range of medical, mental health, residential, community, and other care settings with a population of demographically and socioculturally diverse older adults. The Pikes Peak competencies are applicable across varied geriatric care settings and populations. It is recognized also that each work area or training setting may call for the development of particular competencies, not all of which may be addressed in this document. Both the APA Guidelines for Psychological Practice with Older Adults (APA, 2004) and the Pikes Peak Model highlight core attitudes for practice with older adults. Although this tool does not evaluate attitudes explicitly, the knowledge and skill competencies reflect core geropsychology practice attitudes, including: recognition of scope of competence, self-awareness of attitudes and beliefs about aging and older adults, appreciation of diversity among older adults, and commitment to continuing education.

Using the Competency Evaluation Tool

This tool is intended to be used both by supervisors to assess trainees, and by psychologists to assess their own knowledge and skills. Supervisors in geropsychology training programs may choose to evaluate the domains relevant to the goals of their program. Evaluation should include the learner's perspective (self-assessment), observation of the learner's work (e.g., direct observation, audiotape, videotape, co-therapy), as well as regular supervision involving case discussion. Psychologists and trainees conducting self-assessments can use the tool to evaluate their training and supervision needs in each area. The tool also can gauge a learner's progress over time.

The learner can be rated on each Pikes Peak knowledge domain and skill competency as Novice (N), Intermediate (I), Advanced (A), Proficient (P), or Expert (E), as described below. Each Pikes Peak competency (highlighted in light gray in the chart below) is delineated by several specifiers (indicated by letters a., b., c., etc. in the chart). The specifiers are designed to help define the knowledge domain or skill competency and **do not need to be rated separately**. However, the specifiers can be rated individually if that level of assessment is desired.

Rating Scale Anchors

This rating scale assumes that professional competence is developed over time, as learners develop knowledge and skills with ongoing education, training, and supervision. The anchors, then, reflect developmental levels of competence, from Novice through Expert. The scale is adapted from previous efforts, as summarized by Hatcher and Lassiter (2007). Because the scale reflects development of competence, the same scale can be used at different levels of training. For example, graduate practica students would be expected to perform at Novice through Advanced levels, while Postdoctoral Fellows in Geropsychology would be expected to perform from Intermediate to Expert levels. Development of knowledge and skills may differ significantly across domains, depending upon previous training experiences.

To illustrate use of the scale, we provide a brief vignette and how an individual at each level might approach the case.

Vignette: *A 78-year-old Irish-American man is referred to the mental health clinic by his primary care physician because his daughter-in-law complained that, in recent months, he has become depressed and forgetful and is no longer involved in his hobbies. He has several chronic medical problems including mild diabetes and hypertension. His Korean-American wife of 52 years is angry that he is not completing his household chores. His three adult children have varied levels of involvement in his life, with one daughter and one son living nearby. He comes to the clinic for an initial evaluation.*

Novice (N): Possesses entry-level skills; needs intensive supervision

Novices have limited knowledge and understanding of case conceptualization and intervention skills, and the processes and techniques of implementing them. Novices do not yet recognize consistent patterns of behavior relevant for diagnosis and care planning and do not differentiate well between important and unimportant details.

Example: The learner is able to identify salient symptoms, but does not appreciate possible contributions of medical, neurological, and family system factors to the older adult's presentation, and does not know how to formulate differential diagnosis questions.

Intermediate (I): Has a background of some exposure and experience; ongoing supervision is needed

Experience has been gained through practice, supervision, and instruction. The learner is able to recognize important recurring issues and select appropriate strategies. Generalization of skills is limited and support is needed to guide performance.

Example: The learner recognizes multiple possible contributions to the older adult's presentation, is able to collect history from the patient (and his daughter-in-law, with his permission), administer depression and cognitive screening tools, and consult with supervisor to discuss possible implications and to plan further evaluation. Learner may not appreciate complex, late life family and cultural systems issues affecting patient's coping.

Advanced (A): Has solid experience, handles typical situations well; requires supervision for unusual or complex situations

Knowledge of the competency domain is more integrated, including application of appropriate research literature. The learner is more fluent in the ability to recognize patterns and select appropriate strategies to guide diagnosis and treatment

Example: The learner is able to integrate multiple sources of information (e.g., behavioral observation, cognitive testing data, medical records, collateral reports) and complex history (medical, psychiatric, family, occupational, and cultural context) to rule out possibility of early dementia plus depression, and make recommendations to the primary care provider and family about further assessment and treatment options. Learner consults with supervisor about local resources for older adults, and how best to handle issues around wife's difficulty coping with patient's changes, related marital conflict, family dynamics, culture, and treatment planning.

Proficient (P): Functions autonomously, knows limits of ability; seeks supervision or consultation as needed

Proficiency is demonstrated in perceiving situations as wholes and not only summations of parts, including an appreciation of longer term implications of current situation. The psychologist has a perspective on which of the many existing attributes and aspects in the present situation are important ones, and has developed a nuanced understanding of the clinical situation.

Example: Learner is able to integrate information, as above, collaborate with family and medical (e.g., psychiatrist, neurologist) and social service providers for ongoing assessment and intervention for the patient and family (e.g., psychoeducation, couple's therapy, explore community support options). Learner functions as a full member of an interdisciplinary team to address the biopsychosocial needs of the client and his family, and is able to assume a leadership role.

Expert (E): Serves as resource or consultant to others, is recognized as having expertise

With significant background of experience, the geropsychologist is able to focus in on the essentials of the problem quickly and efficiently. Analytical problem solving is used to consider unfamiliar situations, or when initial impressions do not bear out.

Example: Learner is frequently contacted by other psychologists in her community to provide consultation regarding care of older adults with dementia. Learner is able to use the above case as a teaching example for the need to provide a thorough biopsychosocial assessment in geriatric care, to implement an interdisciplinary team plan, and to be knowledgeable about geriatric resources in the community.

NOTE: Ratings are only needed where the anchors are provided (highlighted in light gray). Specifiers (indicated by letters a., b., c., etc in the chart) are designed to help define the knowledge domain or skill competency and do not need to be rated separately, unless that level of assessment is desired.

I. General Knowledge about Adult Development, Aging and the Older Adult Population

A. The psychologist/trainee has ***KNOWLEDGE*** OF:

	N	I	A	P	E
1. Models of Aging					
a. Development as a life-long process encompassing early to late life, and encompassing both gains and losses over the lifespan					
b. Different theories of late-life development and adaptation					
c. Biopsychosocial perspective for understanding an individual's physical and psychological development within the sociocultural context					
d. Concept of, and variables associated with, positive or successful aging					
e. Relevant research on adult development and aging, including methodological considerations in cross-sectional and longitudinal research.					
2. Demographics	**N**	**I**	**A**	**P**	**E**
a. Demographic trends of the aging population, including gender, racial, ethnic, and socioeconomic heterogeneity					
b. Resources to remain updated on the demographics of aging, including internet sites for: U.S. Census, Centers for Disease Control and Prevention, Social Security Administration, Bureau of Labor Statistics, National Institutes of Health, World Health Organization.					
3. Normal Aging – Biological, Psychological, Social Aspects	**N**	**I**	**A**	**P**	**E**
a. Physical changes in later life					
b. Normal aging as distinct from disease, regarding both physical and mental health					
c. Interactions among physical changes, health behaviors, stress, personality, and mental health in older adults					
d. Aging-related changes in sensory processes including vision, hearing, touch, taste, and smell					
e. Aging-related changes in sexual functioning					
f. Aging-related changes in cognitive processes, including attention, memory, executive functioning, language, and intellectual functions					
g. Aging-related changes in personality					
h. Aging-related changes in emotional expression and coping mechanisms					
i. Factors that influence vocational satisfaction, job performance, leisure activities, retirement satisfaction, and volunteer participation					
j. Family dynamics and role changes in aging families					
k. Changing social networks in late life, and value of close friendships in later life					
4. Diversity in Aging Experience	**N**	**I**	**A**	**P**	**E**
a. The diversity of the older adult population, and that age alone is a poor predictor of an individual's functioning					
b. The unique experience of each individual - based on demographic, sociocultural, and life experiences - and that multiple factors interact over the lifespan to influence an older individual's patterns of behavior					
c. Historical influences affecting particular cohorts					

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II. Foundations of Professional Geropsychology Practice

A. Knowledge base – The psychologist/trainee has *KNOWLEDGE* OF:

1. Neuroscience of aging	N	I	A	P	E
a. The parameters of cognitive changes in normal aging, including their basis in age-related changes in the brain.					
b. Factors that influence levels of cognitive performance in older adults (e.g., genetics, socioeconomic status, cohort effects, health status, mood, medications/ substances)					
c. Common types of dementia in terms of onset, etiology, risk factors, clinical course, associated behavioral features, and medical management of these disorders					
d. Characteristics and causes of mild cognitive impairment and reversible cognitive impairment, including delirium, and the pathway to their management or reversal					
e. Clinical interventions which target behavioral features and psychological problems in individuals with cognitive disorders and their caregivers					
2. Functional Changes	**N**	**I**	**A**	**P**	**E**
a. Relationships between age, environment and functional level					
b. Definition and assessment of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)					
c. Relationship between functional abilities and decisions older adults make with regard to employment, healthcare, relationships, lifestyle and leisure activities, and living environment					
d. Relationship between functional ability and psychopathology in older adults, including how functional ability of older persons affects family members					
e. Strategies commonly used by older adults to cope with functional limitations					
3. Person–Environment Interaction and Adaptation	**N**	**I**	**A**	**P**	**E**
a. Interaction of an elder's abilities and needs with the demands and opportunities provided by various living and treatment environments (e.g., private homes, assisted living facilitates, nursing facilities)					
b. Impact of aging stereotypes on an older individual's functional status and self-efficacy					
c. Importance and complexities around issues of maintaining optimal independence and optimal safety, particularly when medical conditions and cognitive disorders impair the elder's functioning					
d. Ethical and legal issues which arise in the context of markedly impaired functional status and decision making capacity					
e. Situations and signs that suggest risk for abuse and neglect					
4. Psychopathology	**N**	**I**	**A**	**P**	**E**
a. Biopsychosocial etiological models, applied within a lifespan developmental and cohort relevant context, for major psychological disorders affecting older adults					
b. Differential presentation, associated features, age of onset, and course of common psychological disorders and syndromes in older adults (e.g., anxiety, depression, dementia, etc.)					
c. Variations in presentations of psychopathology in later life due to cohort, cognitive, medical and pharmacological issues, including life long mental illness and late onset mental illness					
d. Under-recognized aspects of psychopathology in late life which affect functional impairment and safety (e.g., suicide risk, substance use, complicated grief)					

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e. Interaction of common mental illnesses with the more common medical illnesses and medications and implications involved for assessment and treatment	
f. Psychosocial, psychotherapeutic and psychopharmacological approaches to treating psychological disorders in older adults, as well as the health-related consequences of not treating and side effects of the possible treatments	
5. Medical Illness	**N I A P E**
a. Common medical and neurological problems (e.g. cardio- and cerebro-vascular disorders), syndromes (e.g. falls, incontinence), and substances or medications (e.g. alcohol, benzodiazepines, narcotics, over-the-counter remedies) associated with psychopathology in older adults	
b. Multiple pathways of interaction between medical illness and psychopathology in late life	
c. Common medical tests (e.g. thyroid function, urinalysis, CT/ MRI) relevant to differentiating medical and psychological illness in late life	
d. Relationships between chronic pain, functioning, and mental health in older adults (e.g. relationship of depression to pain)	
6. End of Life Issues	**N I A P E**
a. Physical, cognitive, emotional, and spiritual components of advanced illness and the dying process	
b. Diversity in ethnic, cultural, and spiritual beliefs and rituals involved in death and the dying process	
c. Models of hospice and palliative care	
d. Impact of advanced illness, caregiving, dying and death on family members	
e. Differences between normal grief reactions and complicated grief	
B. Professional Geropsychology Functioning – Foundational <u>SKILLS</u> -- The psychologist/trainee is *<u>ABLE TO</u>*:	
1. Apply Ethical and Legal Standards by identifying, analyzing, and addressing:	**N I A P E**
Identify complex ethical and legal issues that arise in the care of older adults, analyze them accurately, and proactively address them, including:	
a. Tension between sometimes competing goals of promoting autonomy and protecting safety of at-risk older adults	
b. Decision making capacity and strategies for optimizing older adults' participation in informed consent regarding a wide range of medical, residential, financial, and other life decisions	
c. Surrogate decision-making as indicated regarding a wide range of medical, residential, financial, end of life, and other life decisions	
d. State and organizational laws and policies covering elder abuse, advance directives, conservatorship, guardianship, multiple relationships, and confidentiality	
2. Address Cultural and Individual Diversity with older adults, families, communities, and systems/providers by being able to:	**N I A P E**
a. Recognize gender, age, cohort, ethnic/racial, cultural, linguistic, socioeconomic, religious, disability, sexual orientation, gender identity, and urban/rural residence variations in the aging process	
b. Articulate integrative conceptualizations of multiple aspects of diversity influencing older clients, psychologists, and systems of care	

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c. Adapt professional behavior in a culturally sensitive manner, as appropriate to the needs of the older client	
d. Work effectively with diverse providers, staff, and students in care settings serving older adults	
e. Demonstrate self-awareness and ability to recognize differences between the clinician's and the patient's values, attitudes, assumptions, hopes and fears related to aging, caregiving, illness, disability, social supports, medical care, dying, grief	
f. Initiate consultation with appropriate sources as needed to address specific diversity issues	
3. Recognize Importance of Teams **N I A P E**	
a. Understand the theory and science of geriatric team building	
b. Value the role that other providers play in the assessment and treatment of older clients	
c. Demonstrate awareness, appreciation, and respect for team experiences, values, and discipline-specific conceptual models	
d. Understand the importance of teamwork in geriatric settings to address the varied bio-psycho-social needs of older adults	
4. Practice Self-Reflection **N I A P E**	
a. Demonstrate awareness of personal biases, assumptions, stereotypes, and potential discomfort in working with older adults, particularly those of backgrounds divergent from the psychologist	
b. Monitor internal thoughts and feelings that may influence professional behavior, and adjust behavior accordingly in order to focus on needs of the patient, family, and treatment team	
c. Demonstrate accurate self-evaluation of knowledge and skill competencies related to work with diverse older adults, including those with particular diagnoses, or in particular care settings	
d. Initiate consultation with or referral to appropriate providers when uncertain about one's own competence	
e. Seek continuing education, training, supervision, and consultation to enhance geropsychology competencies related to practice	
5. Relate Effectively and Empathically **N I A P E**	
a. Use rapport and empathy in verbal and nonverbal behaviors to facilitate interactions with older adults, families, and care teams	
b. Form effective working alliance with wide range of older clients, families, colleagues, and other stakeholders	
c. Communicate new knowledge to patients and families, adjusting language and complexity of concepts based on the patient and family's level of sensory and cognitive capabilities, educational background, knowledge, values, and developmental stage	
d. Demonstrate awareness, appreciation, and respect for older patient, family, and team experiences, values, and conceptual models	
e. Demonstrate appreciation of client and organizational strengths, as well as deficits and challenges, and capitalize on strengths in planning interventions	
f. Tolerate and understand interpersonal conflict and differences within or between older patients, families, and team members, and negotiate conflict effectively	

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6. Apply Scientific Knowledge	N	I	A	P	E
a. Demonstrate awareness of scientific knowledge base in adult development and aging; biomedical, psychological, and social gerontology; and geriatric health and mental health care; Incorporate this knowledge into geriatric health and mental health practice					
b. Apply review of available scientific literature to case conceptualization, treatment planning, and intervention					
c. Acknowledge strengths and limitations of knowledge base in application to individual case					
d. Demonstrate ability to cite scientific evidence on aging to support professional activities in academic, clinical and policy settings					
7. Practice Appropriate Business of Geropsychology	**N**	**I**	**A**	**P**	**E**
a. Demonstrate awareness of Medicare, Medicaid, and other insurance coverage for diagnostic conditions and health and mental health care services					
b. Demonstrate appropriate diagnostic and procedure coding for psychological services rendered					
c. Demonstrate medical record documentation that is consistent with Medicare, Medicaid, HIPAA, and other federal, state, or local or organizational regulations, including appropriate documentation of medical necessity for services					
d. Remain updated on policy and regulatory changes that affect practice, such as through professional newsletters and e-mail forums					
e. Demonstrate understanding of quality indicators for the care of older adults with mental disorders					
8. Advocate and Provide Care Coordination	**N**	**I**	**A**	**P**	**E**
a. Demonstrate awareness of potential individual and psychosocial barriers to the ability of older adults to access and utilize health, mental health, or community services					
b. Collaborate with patients, families, and other organizational and community providers to improve older adults' access to needed health care, residential, transportation, social, or community services					
c. Advocate for clients' needs in interdisciplinary and organizational environments when appropriate					

III. Assessment

A. Knowledge base -- The psychologist/trainee has ***KNOWLEDGE*** OF:

1. Geropsychology Assessment Methods	N	I	A	P	E
a. Current research and literature relevant to understanding theory and current trends in geropsychology assessment					
b. Assessment measures or techniques which have been developed, normed, validated and determined to be psychometrically suitable for use with older adults					
c. Importance of a comprehensive interdisciplinary assessment approach (e.g. including other health professionals' evaluations of medical or social issues)					
d. Multi-method approach to assessing older adults (including cognitive, psychological, personality, and behavioral assessments, drawn from self-report, interviews, and observational methods)					

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e. Importance of integrating collateral information from family, friends, and caregivers, with appropriate consent, especially when cognitive impairment is suspected	
f. Need for baseline and repeated-measures assessments in order to understand complex diagnostic problems	
g. Assessment of domains unique to older adults (e.g., potential elder abuse)	
2. Limitations of Assessment Methods	**N I A P E**
a. Criterion and age requirements, as well as specific standard normative data, for testing instruments	
b. Limitations of testing instruments, including those validated in older samples, for assessing diverse older adults	
3. Contextual Issues in Geropsychology Assessment	**N I A P E**
a. The range of potential individual factors that may affect assessment performance (e.g., medications, substance use, medical conditions, cultural, educational, language background)	
b. The potential impact of the assessment environment on test performance (e.g., noise, lighting, distractions)	
c. The older person's environmental context and resources in deriving recommendations from assessment data	
B. SKILLS – The psychologist/trainee is *ABLE TO*:	
1. Conduct Clinical Assessment and Differential Diagnosis	**N I A P E**
a. Distinguish between signs of normal aging versus pathology in making diagnoses	
b. Consider base rates, risk factors, and distinct symptom presentations of psychological disorders in older adults when making diagnoses	
c. Conduct differential diagnosis (e.g., dementia versus depression), including consideration of co-morbid medical issues that may influence an older adult's presentation	
d. Identify subsyndromal disorders and implications for treatment	
e. Assess older adult's motivation for treatment	
f. Utilize biopsychosocial case conceptualization based on clinical evaluation to inform initial treatment plan or recommendations	
2. Utilize Screening Instruments	**N I A P E**
a. Utilize screening tools for mood, cognition, substance use, personality, and other clinical issues to guide and inform comprehensive assessment	
b. Evaluate age, educational, and cultural appropriateness of assessment instruments	
c. Consider reliability and validity data in using standardized instruments with older adults	
d. Assess older adult's ability to provide informed consent for psychological evaluation	
e. Recognize sensory impairments and makes environmental modifications accordingly	
f. Consider impact of medical conditions and medications on test performance	
g. Make specific and appropriate recommendations, based on testing results, to inform treatment planning	
3. Refer for Other Evaluations as Indicated	**N I A P E**
a. Acknowledge personal level of expertise regarding geriatric assessment and know when to refer or consult with other health care professionals	
b. Utilize screening data to inform need for more comprehensive, multidisciplinary	

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assessment						
c. Recognize when a medical evaluation is indicated to rule out underlying medical or pharmacological causes of presenting symptoms						
4. Utilize Cognitive Assessments	**N**	**I**	**A**	**P**	**E**
a. Integrate knowledge of normal and pathological aging, including age related changes in cognitive abilities, into geropsychological evaluations						
b. Interpret meaning and implications of cognitive testing data or reports for case conceptualization						
c. Demonstrate ability to translate cognitive testing results into practical conclusions and recommendations for patients, families, and other care providers						
5. Evaluate Decision Making and Functional Capacity	**N**	**I**	**A**	**P**	**E**
a. Evaluate older adults' understanding, appreciation, reasoning, and choice abilities with regards to capacity for decision making						
b. Utilize clinically specific assessment tools designed to aid evaluation of decision making and other functional capacities						
c. Integrate testing results with information from clinical interview with older adult and collateral sources, including behavioral observations and interviews with family members, to formulate impressions and recommendations						
d. Collaborate with professionals from other disciplines to assess specific functional capacities (e.g., independent living, driving)						
e. Appreciate legal and clinical contexts of capacity/competence evaluations (e.g., need for guardianship, loss of right to drive)						
6. Assess Risk	**N**	**I**	**A**	**P**	**E**
a. Identify risk factors for harm to self or others						
b. Screen and comprehensively assesses suicide risk						
c. Screen and assesses capacity for self-care including ADL's and IADL's						
d. Screen and assesses risk of elder abuse in emotional, physical, sexual, financial, and neglect domains						
7. Communicate Assessment Results and Recommendations	**N**	**I**	**A**	**P**	**E**
a. Communicate results within the confines of federal, state, local, and institutional privacy and confidentiality rules and regulations						
b. Translate assessment results into practical recommendations for patient, family, and team, providing written recommendations and relevant psychoeducational materials understandable to stakeholders						
c. Provide recommendations to other providers to assure that treatment plans are informed by assessment results						

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IV. Intervention

A. Knowledge – The psychologist/trainee has *KNOWLEDGE* OF:

1. Theory, Research, and Practice	N	I	A	P	E
a. Broad research findings regarding the effectiveness of psychological interventions with older adults (e.g., application of behavioral, cognitive, interpersonal, psychodynamic, family, environmental, psychoeducational, group interventions)					
b. Specialized interventions in working with older adults and how they evolve from and are consistent with theory in life span development (e.g., reminiscence therapy, validation techniques, behavioral interventions for disruptive behavior)					
c. Modifications of therapeutic techniques to address common aging changes (e.g., sensory difficulties, cognitive impairment), care setting (e.g., community, hospital, nursing home), education, and cultural background					
2. Health, Illness, and Pharmacology	**N**	**I**	**A**	**P**	**E**
a. The complexity and interplay of common late life medical problems, sensory changes and their impact on treatment approaches					
b. The possible impact of medications and procedures for medical and psychiatric problems, including detrimental side effects, on symptom presentation, mental status, and treatment effectiveness in older adults					
c. The frequent comorbidity between chronic medical and psychiatric problems, and need to address both medical and mental health issues					
d. The importance of setting realistic treatment goals (neither too high nor too low) for older adults with severe, chronic medical and psychiatric problems (e.g., remission of symptoms or maintenance of current functioning rather than cure)					
3. Specific Settings	**N**	**I**	**A**	**P**	**E**
a. The varied preferences older adults have in discussing emotional problems with family, primary care providers, spiritual advisors and, thus, the importance of allying with others, with appropriate consent, to assure proper psychological care is rendered					
b. The salience and presentation of ethical issues when employing interventions across varied care settings (e.g. confidentiality in context of team treatment planning; privacy constraints in institutional settings)					
c. Adaptations of interventions appropriate to particular settings (e.g., focus on staff education and behavioral, environmental interventions in long-term care settings)					
4. Aging Services	**N**	**I**	**A**	**P**	**E**
a. Specific referral sources including facilities (e.g., day care, residential), transportation, legal/safety (e.g., protective services), health, multicultural, caregiver, and other support services					
b. Referral processes and procedures to local community resources (e.g., via phone, Internet)					
c. Follow-up mechanism(s) regarding referrals					
5. Ethical and Legal Standards	**N**	**I**	**A**	**P**	**E**
a. Informed consent procedures for services to older adults, and challenges to some older adults' capacity to provide informed consent					
b. Indications for and role of surrogate decision makers in health and mental health treatment of older adults					
c. Older client's right to confidentiality and to be informed of limits of confidentiality					

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d. State and organizational laws and policies covering elder abuse, advance directives, conservatorship, guardianship, restraints, multiple relationships, and confidentiality					
B. SKILLS – The psychologist/trainee is *ABLE TO*:					
1. Apply Individual, Group, and Family interventions	**N**	**I**	**A**	**P**	**E**
a. Prioritize treatment goals as appropriate, taking into account multiple problem areas					
b. Integrate relevant treatment modalities					
c. Modify evidence-based and clinically informed intervention strategies to accommodate chronic and acute medical problems, sensory impairments, mobility limitations, cognitive abilities, generational and cultural factors, late-life developmental issues and possible client-therapist age differences					
d. Provide psychoeducation as needed to help the older adult client understand the therapeutic process					
2. Base Interventions on Empirical Research, Theory, and Clinical Judgment	**N**	**I**	**A**	**P**	**E**
a. Articulate theoretical case conceptualization and empirical support guiding choice of intervention strategies					
b. Describe the integration or adaptation of various strategies to meet the needs of particular older clients					
c. Measure the effectiveness of intervention					
d. Make appropriate adjustments to treatment based on client response					
3. Use Available Evidence-based Treatments for Older Adults	**N**	**I**	**A**	**P**	**E**
a. Choose evidence-based treatment for older adult clients based on diagnosis and other relevant client characteristics					
b. Choose and implement intervention strategies based on available evidence for effectiveness with older adults					
c. Measure the effectiveness of intervention					
d. Make appropriate adjustments to treatment based on client response					
4. Use Late Life Interventions -- Provide effective, evidence-based interventions for particular issues affecting older adults, including:	**N**	**I**	**A**	**P**	**E**
a. For older adults with dementia (and other disabling illnesses) and their family caregivers					
b. For patients and families facing advanced illness, dying, and death					
c. For adjustment difficulties secondary to bereavement					
d. Inclusion of reminiscence and life review into psychotherapeutic interventions					
e. Psychoeducation for patients and families regarding normal aging and a range of medical and mental health concerns					
f. Group interventions for a range of aging-related health, mental health, and adjustment concerns					
g. For older adults adjusting to age-related changes in relationships and sexuality					
5. Use Health-Enhancing Interventions	**N**	**I**	**A**	**P**	**E**
a. Determine which aspects of physical, mental and behavioral health can be improved in older clients via available psychological interventions					
b. Prioritize health issues to be addressed when multiple targets are possible					
c. Effectively intervene regarding health issues as part of overall mental health treatment plan, recognizing close link between medical and mental health and related disability in older adults					
d. Monitor impact of intervention on health behaviors and evaluates outcomes					

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6. Intervene across Settings	N	I	A	P	E
a. Intervene in common geriatric settings (e.g., home, community centers, nursing homes, assisted living facilities, retirement communities, medical clinics, medical and psychiatric hospitals)					
b. Intervene at the level appropriate to older adult client's needs, ranging from individual to family, systemic, and environmental contexts					
c. Modify interventions to adapt to the setting's particular environmental and social characteristics					

V. Consultation

A. Knowledge Base – The psychologist/trainee has *KNOWLEDGE* OF:

1. Prevention and Health Promotion	N	I	A	P	E
a. Incidence and prevalence rates of health problems in the older adult population					
b. How to partner with family and local community resources for health promotion					
c. Strategies for community-based training/education for promoting preventive interventions					
2. Diverse Clientele and Contexts	**N**	**I**	**A**	**P**	**E**
a. Multiple levels of geropsychological intervention/consultation, including individuals, families, healthcare professionals, organizations, and community leaders					
b. Systems-based consultative and intervention models and their use with appropriate modifications in different geriatric settings					
c. Strategies and methods for collaboration to address individual- and organizational-based needs					
3. Interdisciplinary Collaboration	**N**	**I**	**A**	**P**	**E**
a. The distinction between types of treatment teams (e.g., multidisciplinary and interdisciplinary)					
b. The roles, and potential contributions, of a wide range of healthcare professionals in the assessment and treatment of older adult with mental disorders					
c. How team composition and functioning may differ across settings of care					

B. SKILLS – The psychologist/trainee is *ABLE TO*:

1. Provide Geropsychological Consultation	N	I	A	P	E
a. Recognize situations in which geropsychological consultation is appropriate					
b. Demonstrate ability to clarify and refine a referral question					
c. Demonstrate ability to gather information necessary to answer referral question					
d. Advocate for quality care for older adults with their families, professionals, programs, health care facilities, legal systems, and other agencies or organizations					
2. Provide Training	**N**	**I**	**A**	**P**	**E**
a. Assess learning needs of trainees related to varying levels of training and amount of experience within and across disciplines					
b. Define learning goals and objectives as a basis for developing educational sessions					
c. Provide clear, concise education that is appropriate for the level and learning needs of the trainees					
3. Participate in Interprofessional Teams	**N**	**I**	**A**	**P**	**E**
a. Work with professionals in other disciplines to incorporate geropsychological information into team treatment planning and implementation					

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b.	Communicate psychological conceptualizations clearly and respectfully to other providers					
c.	Appreciate and integrate feedback from interdisciplinary team members into case conceptualizations					
d.	Work to build consensus on treatment plans and goals of care, to invite various perspectives, and to negotiate conflict constructively					
e.	Demonstrate ability to work with diverse team structures (e.g., hierarchical, lateral, virtual) and team members (e.g., including the ethics board, chaplains, and families in palliative care teams)					
4. Communicate Geropsychological Conceptualizations		**N**	**I**	**A**	**P**	**E**
a.	Provide clear and concise written communication of geropsychological conceptualizations and recommendations					
b.	Provide clear and concise oral communication of geropsychological conceptualizations and recommendations					
c.	Uses appropriate language and level of detail for the target audience of the communication					
5. Implement Organizational Change		**N**	**I**	**A**	**P**	**E**
a.	Conduct needs assessment for service delivery within the setting or program that serves older adults					
b.	Develop policies and procedures for service delivery that involve all appropriate disciplines and staff members					
c.	Evaluate effectiveness of service delivery model or program					
6. Participate in a Variety of Models of Aging Services Delivery		**N**	**I**	**A**	**P**	**E**
a.	Differentiate goals and models of care in long-term, rehabilitation, acute, primary, home, assisted living, hospice, and other care settings					
b.	Appreciate a variety of models of geriatric mental health care , including integrated mental health services in primary care, specialty consultation, and home- or community-based services					
c.	Demonstrate awareness of strengths and constraints of various care models					
d.	Demonstrate flexibility in professional roles to adapt to the realities of work in a variety of aging or healthcare delivery systems					
7. Collaborate and Coordinate with Other Agencies and Professionals		**N**	**I**	**A**	**P**	**E**
a.	Work with team members to create smooth and efficient transitions across health care settings for older adults and their families					
b.	Demonstrate respect for confidentiality and informed consent, as well as continuity of care, in coordinating with family members, other professionals, and agencies regarding care of an older client					
c.	Establish working relationships with local and national agencies and organizations, such as Elder Services, Alzheimer's Association, and Hospice					
8. Recognize and Negotiate Multiple Roles		**N**	**I**	**A**	**P**	**E**
a.	Identify the client and explicate the expectations of the relationship at the outset of the consultation					
b.	Advocate on behalf of the well-being of older adults within each professional role, including when the individual or group of older adults is not the direct client					
c.	Discuss potential conflicts of interest with colleagues and teams as indicated					
d.	Discuss financial arrangements with all stakeholders					

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Summary

It may help learners and/or supervisors to summarize the geropsychology knowledge and skill strengths, and areas for growth, based on this assessment. Areas for growth may then be linked to further goals for education and training.

Strengths: Knowledge and skill domains in which the learner feels most confident and competent in geropsychology practice

Areas for Growth: Knowledge and skill domains in which the learner wishes to develop further competency

Education and Training Goals (within a practicum, internship rotation, fellowship, or post-licensure program of self-study)

[1]Development of this evaluation tool was informed by several important previous efforts, including the APA policies on multicultural and evidence-based practice, extensive work on the assessment of competencies for professional psychology practice, competencies for geriatric and palliative care, and evaluation tools that have been used by geropsychology internship and fellowship programs. An abbreviated reference list follows:

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