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Development of a tool to evaluate geropsychology knowledge and skill competencies

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ABSTRACT

Background: Workforce shortages to meet the mental health needs of the world's aging population are well documented. Within the field of professional geropsychology in the U.S.A., a national conference was convened in 2006 to delineate competencies for psychological practice with older adults and a training model for the field. The conference produced the Pikes Peak Model of Geropsychology Training. The Council of Professional Geropsychology Training Programs (CoPGTP) aimed to produce a competency evaluation tool to help individuals define training needs for and evaluate progress in development of the Pikes Peak professional geropsychology competencies.

Methods: A CoPGTP task force worked for one year to adapt the Pikes Peak Model geropsychology attitude, knowledge, and skill competencies into an evaluation tool for use by supervisors, students and professional psychologists at all levels of geropsychology training. The task force developed a competency rating tool, which included delineation of behavioral anchors for each of the Pikes Peak geropsychology knowledge and skill competencies and use of a developmental rating scale. Pilot testing was conducted, with 13 individuals providing feedback on the clarity and feasibility of the tool for evaluation of oneself or students.

Results: The Geropsychology Knowledge and Skills Assessment Tool, Version 1.1, is now posted on the CoPGTP website and is being used by geropsychology training programs in the U.S.A.

Conclusions: The evaluation tool has both strengths and limitations. We discuss future directions for its ongoing validation and professional use.

Key words: psychology, training, competence, geriatrics, assessment, professional practice

Introduction

While the field of geropsychology has grown in the U.S.A. and around the world, it must continue to grow in order for psychologists to meet the expanding need for geriatric mental and behavioral health care. To encourage and facilitate development of geropsychology practice and training opportunities, it is important to define competencies for professional psychology practice with older adults. The Pikes Peak Model of Geropsychology Training defines attitude, knowledge, and skill competencies for practice and makes recommendations for training (Knight *et al.*, 2009). The Council of Professional Geropsychology Training programs established a task force to create an evaluation tool based on the Pikes Peak competencies that could be used by training programs and individual psychologists to evaluate training needs and the development of competence in the field. This paper aims to introduce and describe development of the Pikes Peak Geropsychology Knowledge and Skill Assessment Tool.

The healthcare workforce in the U.S.A., and internationally, is unprepared to meet the health and mental health care needs of our aging population (Snowdon *et al.*, 1995; Center for Health Workforce Studies, 2005; LaMascus *et al.*, 2005; Fernández-Ballesteros *et al.*, 2007; Institute of Medicine, 2008; Shah, 2008). Across health care professions,

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there have been relatively few available training opportunities, professional interest in, or financial incentive for providing geriatric care. A critical challenge is both to increase the numbers of healthcare professionals working with older adults while simultaneously preparing professionals who have the competence to meet the specialized needs of an older clinical population.

In medicine, nursing, social work and psychiatry, efforts have been made to define knowledge and skill competencies for geriatric care to aid in the training and recognition of qualified geriatric healthcare professionals (American Association of Colleges of Nursing and The John A. Hartford Foundation Institute for Geriatric Nursing, 2000; Xakellis *et al.*, 2004; Lieff *et al.*, 2005; Damron-Rodriguez *et al.*, 2006). In psychology, published guidelines for geropsychological practice have been published (e.g. American Psychological Association, 2004), including efforts to identify competencies for psychological practice with older adults (e.g., Psychology Specialists Working with Older People, the British Psychological Society, 2006). Likewise, good geriatric care often entails interdisciplinary collaboration, and models of such care are important for training across disciplines (Seigler *et al.*, 1998; American Psychological Association, 2008a).

In the U.S.A. the past few decades have seen concerted efforts to define competencies for professional geropsychology practice and to foster training opportunities in the field. While a majority of American Psychological Association members surveyed in 1999 reported devoting some professional time to working with older adults (69%), the majority also reported having very little formal training in the field (Qualls *et al.*, 2002). Most reported on-the-job training (49%) or informal experience (76%). A small minority (3%) reported spending most of their professional time with older clients. More than half of respondents (58%) expressed the need for more training to work competently with older adults.

Psychologists in the U.S.A. who serve older adults are fortunate to have a growing research base and professional organizational homes to support practice in the field (e.g., APA Society of Clinical Geropsychology, APA Division of Adult Development and Aging, Psychologists in Long Term Care, Gerontological Society of America, Council of Professional Geropsychology Training Programs). Over the past three decades, geropsychologists have convened three conferences to define the scope of practice and models of training for the field. The "Older Boulder" conference, held in Boulder, Colorado in 1981, focused on graduate education in geropsychology. The "Older Boulder II" conference, held in Washington, DC in 1992, worked to define the knowledge base for professional geropsychology practice and outlined three levels of geropsychology competence: exposure, experience and expertise. Work following the 1992 conference ultimately led to the APA publication of *Guidelines for Psychological Practice with Older Adults* (American Psychological Association, 2004).

Despite this progress in defining the field of geropsychology in the U.S.A., there was still a sense that this developing specialty area within professional psychology lacked a formal training model. Questions remained about the core attitude, knowledge and skill competencies for a psychologist to be able to serve an older adult population ethically and competently, and what core aspects of training were needed to develop such geropsychology competence. In order to address these questions, two aging-related societies within the American Psychological Association (the Division of Adult Development and Aging, and the Society of Clinical Geropsychology) co-sponsored the National Conference on Training in Professional Geropsychology. This conference was held in Colorado Springs, Colorado, in June 2006. The conference produced the *Pikes Peak Model for Professional Geropsychology Training* (Knight *et al.*, 2009), named after the beautiful Pikes Peak mountain in Colorado Springs.

The Pikes Peak training model delineates attitude, knowledge and skill competencies for professional geropsychology practice, and makes recommendations for training at graduate, predoctoral internship, postdoctoral fellowship, and post-licensure levels of training (Hinrichsen *et al.*, in press; Karel *et al.*, in press; Qualls *et al.*, in press). The Pikes Peak model is aspirational and aims to assist training programs, as well as individual psychologists, to develop programs of study, and to facilitate the development of competence to work with older adults, their families and related care systems for as many psychologists as possible.

One unanticipated but exciting outcome of the Pikes Peak conference was the founding of the Council of Professional Geropsychology Training Programs (CoPGTP). Members of this training council represent training programs at graduate, internship, postdoctoral, or post-licensure levels, which offer training consistent with the Pikes Peak model. CoPGTP aims to share resources among existing programs, to facilitate the development of new programs, and to help individual psychologists identify training resources in the field (see http://www.uccs.edu/~cpgtp/).

CoPGTP has recognized that an important and useful resource for the field would be a competency evaluation tool that training programs and/or

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supervisors could use to evaluate the development of geropsychology competencies in their trainees. Individual psychologists could also use the tool to identify their own training needs in the field and seek out relevant training opportunities. Thus, CoPGTP established a Task Force on the Assessment of Geropsychology Competencies, to develop a geropsychology competency evaluation tool.

In the following sections we provide an overview of the Pikes Peak geropsycholgy competencies and describe the development of an evaluation tool to gauge these competencies. This instrument is a work-in-progress and CoPGTP has recently encouraged its use by training programs. We hope that it will be of benefit in its present form, but we also anticipate it will develop over time as we get feedback and learn more about its utility and validity. Furthermore, the rating scale format of this tool is one of many competency evaluation methods (Accreditation Council for Graduate Medical Education and American Board of Medical Specialties, 2000; American Psychological Association, 2008b) that may fruitfully be applied to the evaluation of geropsychology practice competencies in the future.

Pikes Peak professional geropsychology competencies

Methods

One goal of the 2006 Pikes Peak conference was to delineate the attitude, knowledge, and skill competencies for geropsychology practice. The conference brought together 49 organizational and at-large delegates, including professionals and students, all of whom had interests and expertise relevant to geropsychology service delivery, research, and/or training, for a 2.5 day working meeting (Knight *et al.*, 2009). A 16-member conference planning committee, co-chaired by Bob Knight, PhD, and Michele Karel, PhD, worked to raise funds, set the agenda, and invite delegate applications for the conference. Multiple professional organizations provided financial support and/or support by funding a delegate to attend the conference (see Knight *et al.*, 2009). The work done at the conference built upon previous efforts in defining competencies in the health professions more generally and professional psychology specifically, as well as previous efforts, as noted above, to define competencies for practice with older adults within psychology (American Psychological Association, 2004) and other geriatric health professions.

Consistent with other health care professions, professional psychology has moved towards competency-based education, training and credentialing (Kaslow *et al.*, 2004; Rodolfa *et al.*, 2005). Professional psychology in the U.S.A. has adapted a "Cube Model" conceptual framework for considering the development of both foundational and functional competencies across a psychologist's training career (Rodolfa *et al.*, 2005). Foundational competencies are the underlying "building blocks" informing all professional psychology activity, and comprise one axis of the "cube": (1) reflective practice – self-assessment, (2) scientific knowledge – methods, (3) relationships, (4) ethical – legal standards – policy, (5) individual – cultural diversity, and (6) interdisciplinary systems. Along another axis of the "cube" are the six functional competencies of psychological practice: (1) assessment – diagnosis – case conceptualization, (2) intervention, (3) consultation, (4) research – evaluation, (5) supervision – teaching, and (6) management – administration. The third axis represents stages of professional development over which psychologists develop competencies during the course of their careers: doctoral education, internship, postdoctoral training or residency, and continuing competency (i.e. life-long learning).

The cube model helped to inform the framework for the Pikes Peak geropsychology training conference. Conference delegates agreed that training in geropsychology entails the application of the foundational and functional competencies for psychology practice to the special needs of older adults. The Pikes Peak model emphasizes that geropsychology competencies are developed incrementally and can be acquired through multiple training pathways. Finally, like the cube model, which emphasizes the importance of the assessment of competence (including ongoing self-assessment), the Pikes Peak model depends, in part, on the presumption that psychologists are interested in reflecting on their individual competencies for providing care for older adults (Karel *et al.*, in press).

Conference delegates decided that, for a framework focused on geropsychology practice, the Pikes Peak model would emphasize the functional psychology competencies of assessment, intervention and consultation as adapted to work with older adults and geriatric care systems. The model does not specifically address the adaptation of professional psychology competencies in research, teaching/training and management/administration to the field of geropsychology.

The Pikes Peak competencies were developed through an iterative process that occurred before, during and after the 2006 conference in Colorado Springs. Prior to the conference, the planning committee distributed to all delegates a rough draft/outline of geropsychology attitude, knowledge and skill competencies, based on previous work in

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the field (e.g. American Psychological Association, 2004). During the conference, working groups that focused on competency domains (e.g. assessment, intervention) fleshed out and drafted language for the competencies. After the conference, the planning committee compiled all of the working group drafts and sent a combined competency draft document to all conference participants for their feedback. Input was integrated into the final list of the Pikes Peak competencies. Ultimately, Knight *et al.* (2009) take responsibility for the final list that was published in *American Psychologist* in 2009.

Results

The Pikes Peak attitude, knowledge and skill competencies are aspirational and considered important for proficient professional practice with older adults, especially when the psychologist works with older adults across a range of care settings or provides services to older adults with complex clinical problems. The competencies were developed with the newly trained, entry-level geropsychologist in mind, rather than a psychologist with years of developed expertise in the field. The new gero-competent psychologist would know enough about the field and his/her own competence to understand when expert consultation was necessary. This level of development was targeted in order to balance the joint objectives for facilitating training of psychologists to be ethical and competent providers of services to older adults while keeping the field as inclusive as possible. Required knowledge and skill competencies would vary to some extent across settings of care (e.g. nursing home versus outpatient private practice) and primary professional functions (e.g. assessment, psychotherapy, consultation) (Knight *et al.*, 2009; Karel *et al.*, in press).

The Pikes Peak competencies list can be found in the 2009 *American Psychologist* article by Knight and colleagues. Other helpful resources for illustration of the Pikes Peak competencies include the article by Karel and colleagues (in press) in *Training and Education in Professional Psychology* and the volume edited by Molinari (in press) on geropsychology competencies. Here, we provide a brief overview of the Pikes Peak attitude, knowledge and skill competencies.

Attitudes

Core attitudes important for psychological practice with older adults were defined in the *APA Guidelines for Psychological Practice with Older Adults* (American Psychological Association, 2004). They include awareness of one's scope of professional competence and seeking of supervision or consultation if unable to address the needs of an older client (or referring that client to another, competent provider). Similarly, the *Guidelines* emphasize the importance of continued development of competence through continuing education, training, supervision and consultation. A critical attitude is one of self-reflection regarding one's feelings, beliefs and possible stereotypes about aging and older adults, and how one's personal experiences and reactions may affect practice with this population.

Finally, the Pikes Peak model emphasizes awareness of individual diversity in all of its manifestations and, in particular, how attitudes and beliefs about gender, ethnicity, sexual orientation and other aspects of diversity interact with attitudes and beliefs about aging. An understanding of and appreciation for the interactions between age/cohort and other aspects of individual diversity, and one's personal responses to these aspects of diversity, enhance effective psychological assessment, intervention, and consultation with a diverse aging population.

Knowledge

The Pikes Peak model outlines the knowledge base for geropsychology practice across four domains, consistent with the APA *Guidelines* (2004): (i) general knowledge about adult development, aging and the older adult population (e.g. demographics; normal adult biological, psychological, emotional, and social development; wide diversity in the aging process); (ii) foundations of clinical practice with older adults (e.g., neuroscience of aging, functional changes, psychopathology in late life, common medical illnesses); (iii) foundations of assessment of older adults (e.g. assessment domains, methods, and instruments suitable for assessing older adults; contextual issues in assessment of older adults); and (iv) foundations of intervention, consultation and other service provision (e.g. efficacy and effectiveness of psychological interventions with older adults; models and methods of interdisciplinary collaboration; knowledge of aging services in the community).

Skills

The Pikes Peak model specifies geropsychology skills in four broad domains: (i) professional geropsychology functioning; (ii) assessment; (iii) intervention; and, (iv) consultation. Additionally, given that older adults may access care across a wide range of clinical, residential and community settings, the Pikes Peak model recommends that geropsychologists develop competency to work with older adults across diverse settings.

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Professional geropsychology functioning refers to adapting the foundational competencies of the cube model (e.g. ethical and legal issues, diversity) to work with older adults. The Pikes Peak model posed two additional foundational competencies for geropsychology practice: advocacy and care coordination, and the business of geropsychology practice (e.g. being a Medicare provider in the U.S.A.).

Competent geropsychology assessment includes the use of psychometrically sound assessment tools, differential diagnosis of common late-life conditions, evaluation of decision-making and functional capacities, assessment of late-life risk issues, and communication of assessment results with relevant and practical recommendations.

Intervention competencies are based upon core values including the use of evidence-based treatments when possible, therapeutic optimism, and interfacing with systems and providing care coordination as needed. These competencies also entail effective application and adaptation of psychological interventions to the special needs and care settings of older adults.

Geropsychology consultation includes the ability to: consult with families, other professionals and a range of agencies and care systems; provide training to professional and nonprofessional audiences; participate in interprofessional teams that serve older adults; design and participate in different models of aging services delivery; and collaborate and coordinate with other agencies that serve older adults (e.g. see *Blueprint for Change: Achieving Integrated Health Care for an Aging Population* (American Psychological Association, 2008a) at http://www.apa.org/pi/aging/blueprint.html).

Finally, the Pikes Peak training model highlights that geropsychologists often provide care to older adults across an array of clinical, community or residential settings and recommends that geropsychologists be able to provide competent care in at least two settings. Examples include inpatient or outpatient medical care settings, nursing homes, assisted living facilities, outpatient mental health clinics, rehabilitation settings, and home care.

Developing the Pikes Peak Competency Evaluation Tool

Methods

Task Force

While the Pikes Peak competencies represented a big step forward in defining the scope of professional geropsychology practice, the newly formed CoPGTP believed, as above, that it would help the field to have a tool that could be used to evaluate the development of those competencies prior to and during a course of training. The CoPGTP Task Force on the Assessment of Geropsychology Competencies was therefore formed, with the goal of exploring methods that could be used across training programs to evaluate development of the Pikes Peak geropsychology competencies, as well as to help post-licensure psychologists engage in a process of self-assessment of training needs in the field.

The task force included ten members: seven delegates from the Pikes Peak conference representing graduate, internship, postdoctoral and post-licensure training programs, as well as three student representatives (two graduate students and one postdoctoral fellow). Our goal was to develop a tool that would (i) address the Pikes Peak attitude, knowledge, and skill competencies; (ii) be useful for supervisor evaluation of trainees, for both formative and summative evaluation purposes; (iii) be useful for self-evaluation by learners; (iv) be useful across levels of training (rather than creating a separate tool for each level of training); and (v) be helpful in defining ongoing training needs and goals. While we considered a wide range of competency evaluation methods that might ultimately be useful for our field (e.g. case studies, objective structured clinical exams), we agreed to start with a fairly straightforward competency evaluation rating form. Such a tool would be easily shared across programs, distributed to interested practicing psychologists, and would allow for shared data collection.

Informing Resources

Our task force reviewed the outcome of multiple APA initiatives on the assessment of professional psychology competence (see overview at APA Education Directorate webpage at http://www.apa.org/ed/graduate/competency.html). The APA Task Force on Assessment of Competence produced several publications that outlined principles and recommendations for the assessment of competence (e.g. Kaslow *et al.*, 2007). The APA Board of Educational Affairs and the Council of Chairs of Training Councils (CCTC) convened the Assessment of Competency Benchmarks Work Group, which delineated essential elements and behavioral anchors for each professional psychology competency, at each of three levels of training (American Psychological Association, 2006). We contacted geropsychology training programs and asked them to share evaluation forms currently in use; tools submitted by nine programs were reviewed. We also reviewed professional competencies as defined and evaluated by other

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relevant professions, particularly efforts within Medicine to evaluate professional competence in residency programs (ACGME and ABMS, 2000). These resources helped to guide our thinking about competency assessment. As we decided to develop a competency evaluation rating form, our review of previous work emphasized to us the importance of defining operationally what is being evaluated (behavioral anchors) and to use a developmental rating scale (more below).

Delineating the competencies

Each of the Pikes Peak competency domains (e.g. assessment skills) is defined by three to eight specific competencies (see Knight *et al.*, 2009). Our task force further operationalized each of these competencies in order to define behavioral anchors for each one; that is, how would you know demonstration of that competency if you saw it, in oneself or another? We followed, in part, the model of the APA Competency Benchmarks project, where each of the cube model competency domains was broken down into specific competencies, which were then further defined by behavioral anchors.

The behavioral anchors serve to illustrate the specific competencies with examples of what specific knowledge or skill each competency requires; together, the anchors, weighted evenly, are believed to constitute that particular competency. Our task force was divided into working groups of two to three people representing varied levels of training to develop behavioral anchors for each of the 50 Pikes Peak knowledge and skill competencies. Behavioral anchors were developed based on the professional expertise and experience of task force members, as well as by consulting relevant research and clinical literature as indicated. Via email, each competency domain working group shared their drafts of behavioral anchors for each competency item with the entire task force. Through a process of monthly group teleconference discussion and iterative editing, we finalized behavioral anchors for each Pikes Peak competency.

For example, one of the geropsychology assessment skill competencies is to "Use psychometrically sound screening instruments for cognition, psychopathology, and personality to inform treatment planning." The following behavioral anchors were identified to operationalize that competency:

- utilize screening tools for mood, cognition, substance use, personality, and other clinical issues to guide and inform comprehensive assessment;
- evaluate age, educational, and cultural appropriateness of assessment instruments;
- consider reliability and validity data in using standardized instruments with older adults;
- assess older adult's ability to provide informed consent for psychological evaluation;
- recognize sensory impairments and make environmental modifications accordingly;
- consider the impact of medical conditions and medications on test performance; and
- make specific and appropriate recommendations, based on testing results, to inform treatment planning.

Clearly, this level of detail results in a very long evaluation tool. However, our task force agreed that, while the behavioral anchors help to clarify each of the Pikes Peak competencies, people using the tool are encouraged to rate development at the competency level rather than for each behavioral anchor. Thus, users of the tool would complete 50 ratings, one for each of the competencies, with ratings informed by the behavioral anchors for each knowledge and skill competency.

Of note, we did not include the Pikes Peak Attitude competencies to be rated separately on this evaluation tool. We struggled with the challenge of how to rate attitudes on this type of evaluation tool. The content of the attitude competencies is incorporated fairly well into the foundational skill items, and we specified the Pikes Peak attitudes in the introduction to the tool. This issue remains an open item for consideration as we continue to discuss how best to evaluate professional geropsychology competence.

Rating scale

Our goal was to use a developmental rating scale, one that could help supervisors and learners evaluate the extent to which each particular competency has been mastered as knowledge and skills are developed. Such a scale can be used across levels of training (e.g. graduate school practicum through postdoctoral fellowship), and ratings should generally reflect the level of development expected at that stage of training. We adapted a scale from the work of the Association of Directors of Psychology Training Clinics (ADPTC) and Council of Chairs of Training Councils (CCTC) to define and evaluate practicum level competencies (Hatcher and Lassiter, 2007). The anchors of the scale are: novice, intermediate, advanced, proficient, and expert. The scale is based on the work of Dreyfus and Dreyfus (1986), who describe the development of competence as a process whereby a learner becomes increasingly familiar with the analytic and action tasks of a particular field. Whereas a novice has difficulty recognizing patterns and needs specific guidance to aid performance, the performance of developing learners becomes increasingly integrated, efficient and automatic.

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Conceptual definitions of each anchor that were consistent with the original scale were provided, along with illustrations of each level of professional development through a case study (e.g. how someone with novice versus advanced competence would respond to the same case). We provided brief definitions of each rating scale anchor which were printed on each page of the evaluation tool, as follows:

> *Novice*: possesses entry-level skills; needs intensive supervision
> *Intermediate:* has a background of some exposure and experience; ongoing supervision is needed
> *Advanced*: has solid experience, handles typical situations well; requires supervision for unusual or complex situations
> *Proficient*: functions autonomously, knows limits of ability; seeks supervision or consultation as needed
> *Expert*: serves as resource consultant to others, is recognized as having expertise

For use in a psychology training program, this instrument would need to be adapted to define carefully what is expected for appropriate developmental progress, and to consider when a remediation plan is appropriate. The need for remediation would be defined differently according to the level of training and specific standards of each training program.

Introduction to the Tool

We provide a fairly detailed introduction to the evaluation tool in order to describe its purpose, the history of the Pikes Peak competencies and their aspirational intent, the applicability of geropsychology competence across practice settings, and instructions for using the tool. In this introduction, we clarify that, when the tool is used for evaluation in training/supervision settings, the evaluation should include the learner's perspective (self-assessment), observation of the learner's work, and regular supervision including case discussion. Psychologists and trainees conducting self-assessments can use the tool to evaluate their training and supervision needs in each competency domain.

Results

Due to the length of The Pikes Peak Geropsychology Knowledge and Skill Assessment Tool, we are not able to include it in this article. Please find the tool online at the CoPGTP website (http://www.uccs.edu/~cpgtp/), where it can be downloaded and printed. Note that the tool posted at the website, Version 1.1, includes revisions made based on feedback from the pilot administration, described below.

Piloting the Evaluation Tool

The task force solicited initial feedback about the clarity and feasibility of the evaluation tool from CoPGTP members who were asked to evaluate either a student or themselves, and then respond to a series of questions, via email, to provide feedback. Thirteen individuals completed the tool and provided formal feedback – six people from CoPGTP training programs who were not part of our task force, four task force members, and three students/colleagues of task force members. Four individuals used the tool to evaluate a student, five to evaluate themselves, two utilized it both ways, and two people provided general feedback without specifying how they had used the tool.

Individuals were asked about their general impressions of using the tool; whether the introduction was clear; whether the rating scale was helpful/understandable; whether the length was a problem; whether it adequately addressed the breadth/depth of geropsychology competencies; what the best uses of the tool might be; whether they expect to use it in the future and, if so, in what manner. We also invited any other feedback that individuals wished to share.

Most respondents perceived that the evaluation tool was worthwhile given its attention to depth and breadth of competencies for geropsychology practice, albeit rather lengthy. Several respondents shared their impression that the tool was too long for practical purposes, wondering whether people would use it in practice. Most reported that the introduction to the tool was clear, but several noted that it should be clarified that only each Pikes Peak competency item is to be rated, not every single behavioral specifier. Most reported that they liked the developmental rating scale and found it useful.

In addition to its length, a number of concerns were raised about the content and format of the evaluation tool. In terms of the developmental rating scale, several respondents questioned whether it was as useful in evaluating knowledge development as skill development. One person inquired whether the scale would work as well for early practicum-level training, where students might be novices in most areas. Others wondered if the "expert" rating was too "loaded," suggesting that only a handful of people nationally might be willing to use that term to describe themselves. Several respondents were concerned about how well the scale would capture development over time, within a single training rotation/experience.

Several respondents asked about how best to evaluate attitudes for geropsychology practice, which is an ongoing challenge for our task force. One respondent made the very helpful suggestion to include an evaluation summary page, summarizing

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strengths, areas for growth, and ongoing training goals in the field.

Discussion

The Pikes Peak Geropsychology Knowledge and Skill Assessment Tool was developed as a method to evaluate the Pikes Peak professional geropsychology practice competencies over time (Knight *et al.*, 2009). It allows supervisory evaluation of student progress, and psychologist self-evaluation of training needs in the geropsychology field, and can be used across levels of training and professional development. The evaluation tool is currently available at the CoPGTP website, and is starting to be used in geropsychology graduate, predoctoral internship, and postdoctoral fellowship programs in the U.S.A., as well as by some professional organizations providing geropsychology continuing education.

Strengths and benefits

Our experience and initial feedback suggest that training programs will find the tool useful, as it can promote a common platform across programs by providing a clearly operationalized structure to define and evaluate competencies in the field. Most geropsychology training programs are likely to have similar objectives to train students to assess and treat the psychological problems of older adults; the Pikes Peak model and evaluation tool may help to standardize the process and content of training.

For clinical supervisors, the tool has great utility for identifying a trainee's strengths and areas for growth at the beginning of a training period. This initial training-needs assessment can serve to guide supervisory intensity and methods, case assignment, assessment protocols, and additional training projects. Reassessment over the course of the training period allows the supervisor to determine which areas need continued attention in the trainee's development of geropsychology competence. Attainment of certain levels of specific competencies may also be identified as criteria for successful completion of a training rotation.

An additional important use for the tool is to help define needs for further training in the field and to highlight specific competencies which are not being adequately addressed by current programs. Further, the tool can be used for research and evaluation purposes, in defining geropsychology competence of varying groups, in determining an expected sequence of attaining the varied competencies, and in exploring which training formats are most successful in achieving competency aims. Perhaps most importantly, it can serve a public policy and advocacy purpose of providing evidence about how funded projects are accomplishing their proposed goals by producing competent geropsychologists to meet the workforce need for the growing older adult population.

Limitations and need for ongoing work

Our goal has been to facilitate the entry of as many people in the geropsychology field as possible, along with helping psychologists and students access training to enhance competence. It remains to be seen, however, whether the tool will be viewed by practitioners as helpful in professional development or restrictive to practice. Clearly there is a need to communicate our intent to promote geropsychology practice to the widest possible psychology audience. Further, although learning skills in self-reflection, "metacompetence," is a central component of the professional competencies movement in psychology (Barnett *et al.*, 2007), there are limitations to self-evaluation of competence (Eva and Regehr, 2005). That is, it is not clear to what extent professionals are able to evaluate their own competence accurately, with risks both of overestimating or underestimating their abilities. It remains to be seen whether the detailed evaluation tool presented here will optimize a psychologist's ability to reflect on his/her competence to work with older adults, and thus inform his/her training plan for the field.

Although the developmental rating scale was chosen to reduce bias inherent in other rating scales (e.g. "poor" to "excellent"), such a scale is only as valid as the data which inform the ratings. That is, supervisory evaluation requires comprehensive observation of a trainee's work across roles and settings (e.g. through co-therapy or videotaping therapy sessions, through observation of contributions to or feedback from interdisciplinary teams). Depending upon further feedback, we may need to clarify the anchors on the developmental rating scale, such as clarifying the definition of the term "expert".

It will be a challenge to incorporate this evaluation tool into the evaluation procedures of more generalist psychology training programs. Most graduate and internship programs offer training with diverse clinical populations, which may include "minor rotations" or electives in supervised geriatric settings. In the U.S.A., APA-accredited training programs must use competency evaluation tools to document development of broad competencies for professional psychology practice. The geropsychology evaluation tool would likely be used *in addition* to other required student evaluation tools within a particular program. Indeed, the

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tool may have utility in determining whether an individual supervisor is competent to supervise a geriatric rotation, especially when trainees' ratings of a geriatric rotation are consistently low. Finally, as discussed above, evaluating attitudes for working with older adults remains a challenge, and may be incorporated into future iterations of this tool.

Future directions

This report reflects the first credibility and feasibility assessment of the Pikes Peak Geropsychology Knowledge and Skill Assessment Tool. To evaluate utility of the tool further for self-evaluation purposes, CoPGTP developed a web-based version. Professional organizations of psychologists and graduate students likely to work with older adults were then contacted via email to request self-administration of the web-based tool along with identification of demographic, training, and clinical experience variables. We will be analyzing the data to describe psychologists working with older adults, to explore their self-rated geropsychology knowledge and skill competencies, and to examine the relationships between self-rated competencies and demographic variables, training background, years in the field, and professional work settings and functions.

Once we understand the ways in which the tool can be best utilized, an appropriate next step would be to link training resources to each competency. The identification of existing resources and development of new resources (e.g. books, websites, continuing education offerings, videos) for each competency would provide opportunities for comprehensive geropsychology training. Ultimately, this effort may translate into a hyperlink for each competency in the evaluation tool such that, as a learner completes the tool online and recognizes a need or desire for further training on a particular competency, a menu of training opportunities and resources would be provided.

As the field of geropsychology is increasingly recognized as an area of practice that requires some specialized training, this competency evaluation tool may help to identify both psychologists and training programs that are developing, or teaching, specific competencies for providing psychological services for older adults, their families, and related care systems. While formal credentials do not yet exist in the U.S.A., efforts to define and evaluation competencies for the field may assist in establishing such credentials. Finally, we hope that geropsychology competency initiatives in the U.S.A. will be linked with international efforts so that mental health training with older adults will be cross-fertilized with novel conceptual frameworks, cutting-edge methodologies, and refined culturally competent evaluation instruments.

Conclusion

The Pikes Peak Geropsychology Knowledge and Skill Competencies Assessment Tool will assist supervisors, supervisees and post-licensure psychologists in the evaluation process to identify areas for professional growth. The tool may also serve a heuristic role in generating more research in geropsychology competencies. The process of refining this scale will be iterative and reciprocal between the developers and those who use the instrument. Feedback drawn from both research and clinical applications, as well as new developments in professional psychology, will guide the revision process.

Defining and evaluating competencies for professional geropsychology practice is just one of many strategies that are needed to encourage increased training of psychologists and greater service provision in geriatric settings to meet the needs of our aging population. With the development of this instrument, psychologists who have been interested yet reticent about working with older adults due to competency concerns now may be able to understand more clearly their training challenges and how to overcome them in order to bridge the practice gap for this underserved population. Furthermore, awareness on a public policy level of the mental and behavioral health needs of older adults will be key to facilitating funding for training programs and creating incentives for the provision of a competent mental health service to older adults.

Conflict of interest

None.

Description of authors' roles

M. Karel co-chaired the Pikes Peak training conference and chaired the CoPGTP Task Force on the Assessment of Geropsychology Competencies. She took the lead on writing this paper. E. Emery and V. Molinari were delegates to the Pikes Peak training conference, members of the CoPGTP task force, and assisted with writing this paper. All authors contributed actively to iterative reviews of the geropsychology competencies and drafts of the evaluation tool presented here.

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