CLINICAL GEROPSYCHOLOGY NEWS

NEWSLETTER OF THE SECTION ON CLINICAL GEROPSYCHOLOGY
SECTION II OF DIVISION 12, AMERICAN PSYCHOLOGICAL ASSOCIATION

Volume 3, Number 2 December, 1996

■President's Column

Progress Report: A Lot is Happening - Hard Work in the Trenches is Starting to Pay Off

George Niederehe, Ph.D.

Recently, the APA Practice Directorate sought our Section's comments on a policy that is being implemented by the Medicare carrier companies in various states for reimbursement of psychiatric and psychological services to Medicare beneficiaries. I gathered and channeled back to APA comments from a number of members, many focusing on aspects of the policy that restrict coverage for psychotherapeutic treatment of dementia patients or nursing home residents. APA is attempting to meet with Health Care Financing Administration (HCFA) officials both about the objectionable aspects of this model policy and about adverse administrative actions taken by the carriers in implementing the Medicare program--such as long delays in processing claims, wholesale denials of coverage for services, and failures to clarify the rules and procedures that providers are expected to follow. Psychologists are engaged in an uphill struggle in pursuing these issues, as we attempt to defend services for the most impaired and vulnerable of older adults. The political terrain has been rendered especially difficult by highly publicized instances of fraud or exploitative (and probably incompetent) practice by some psychologists practicing in nursing home settings. Nonetheless, we should not overlook the positive aspect that Section II is gaining recognition as a voice of expertise in such matters, and we can anticipate further calls from APA and other quarters for involvement in these issues.

In fact, even while managed care and other changes in the health care delivery system are creating tremendous challenges, a number of new developments are underway in APA that suggest this is also a time of great promise and

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■Editor's Comment

Alexander I. Tröster, Ph.D.

As the year draws to a close, I wish to take the opportunity to wish all of you a very happy holiday season. As you will see from George Niederehe's columns, the Section has had a very productive, if challenging year, and had an active voice in representing you in the Division, as well as APA. Reviewing the last three years' newsletter issues also makes clear how the Section has continued to grow and prosper under excellent, visionary leadership.

The last three years have also seen this newsletter grow from infancy to adolescence. A tremendous gratitude is owed to the supporters of, and steady contributors to, the newsletter. I thank all of you for making my editorial duties a pleasure, and for working so hard to share meaningful information with your colleagues. It is with regret that I had to make the difficult decision to hand over the editorial reins.

Dr. Suzanne Norman has kindly agreed to serve as the new editor of the newsletter. I am certain that the Section's membership will join the Section's officers and I in welcoming Dr. Norman, and thanking her for her enthusiasm and efforts. Again, as in past issues, I remind all that the newsletter is there for <u>you</u>. Please continue to feel free to share your ideas and comments, and to help Dr. Norman oversee the newsletter's maturation to adulthood. As of 1997, please send your newsletter contributions to: **Suzanne Norman, Ph.D.**, Psychology Service (116B), VA Medical Center, Kansas City, MO 64128.■

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hope for significantly advancing clinical geropsychology as a professional field. Much of what is happening can be traced to longstanding efforts and hard work in which Section II members have played integral roles.

Perhaps most notably, in large part due to key Section II involvement at various junctures, APA now has an Ad Hoc Committee on Issues of the Older Adult (see related story page 5, column 2). Moreover, we have reason to hope that this will lead to establishing a standing committee on aging as a permanent part of APA's internal structure. This will give aging-related issues a recognition and some resources within APA that have been long sought, and will represent a major accomplishment for the field.

In another effort co-sponsored by Section II (along with Division 20), an APA Interdivisional Task Force has recently circulated its draft report on appropriate qualifications for practice in clinical and applied geropsychology. By the time you are reading this newsletter, you should also have received a copy of the Task Force report--on which you are invited to send comments to Peter Lichtenberg by January 10. The process undertaken by the Task Force may help to bring about some greater consensus within our field about the minimum sorts of training and supervised experience that psychologists should have as preparation for engaging in responsible practice with older adults. At the same time, preparations are underway to seek official APA recognition of clinical geropsychology as a professional proficiency area (again, see a related report page 5, column 1 for more details). If successful, this step can give our field significantly enhanced status within the structure of professional psychology, and pave the way for such subsequent developments as the credentialing of individual practitioners within the field.

With our Section II colleague, Norman Abeles, assuming the APA Presidency, aging will be given the spotlight and extraordinary opportunities within APA during the next year. For example, the 1997 convention in Chicago will prominently feature a 16-hour Presidential Mini-Convention on Aging (in addition to the program time regularly given to aging-related sessions) that will be worth planning to attend. Norm also plans other initiatives and will be in a strong position to move APA toward greater activity vis-a-vis aging.

All of these are very positive developments indicating that, as geropsychologists, we are finally beginning to get our professional

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■Report on APA Division 12 Board Activities

Barry Edelstein, Ph.D.

The Division 12 Board has been busy with many issues, some of which are probably of particular interest to Section II members. The last Board meeting was held in Tampa from October 12th through the 13th. The 1996 APA Convention was a great success and the planning for the 1997 Convention is well underway. We are all very proud that Norm Abeles, our outgoing Section II Secretary, is President of APA for 1997. Norm's theme for the 1997 APA convention will be "aging!" My understanding is that approximately 52 hours of the 1997 convention will be devoted to aging. This considerable time will be allotted to Norm's mini-convention on aging, Section II, and Division 20 activities.

Marty Seligman, who will be President of APA in 1998, has selected "prevention" as his theme for the 1998 convention. This is another area in which Section II members should have broad representation in the convention program. Now is the time to begin thinking about symposia and papers that address the theme of prevention among older adults.

The Division 12 Board voted to continue the Division 12 Task Force on Psychological Interventions, chaired by Dianne Chambless, for another two years. The scope of the original task force was expanded to include interventions for individuals across the lifespan. This effort complements Suzanne Johnson's task force that was charged with developing a series of journal articles addressing psychological interventions for individuals across the lifespan. Her task force is entitled "Task Force on Effective Psychosocial Interventions: A Lifetime Perspective." The "child section" of the Task Force report will be published in the Journal of Clinical Child Psychology.

Sheila Eyberg will chair a Division 12 Committee that will coordinate selection of Alan Kazdin's successor as Editor of *Clinical Psychology: Science and Practice* in two years. Now is the time to let Sheila know if you are interested in applying for the editorship. Sheila's mailing address is: Department of Clinical/Health Psychology, University of Florida, P.O. Box 100165 HSC, Gainesville, FL 32610-0165. Also, please consider *Clinical Psychology* as an outlet for your work. Alan would like to increase the percentage of published articles arising from submissions (as opposed to invited manuscripts).

APA will now assist Divisions and Sections in the development of WEB sites on the internet. Sections III and V already have WEB

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house in order. That we must do so was one of the strong messages that emerged from the 1992 national training conference on clinical aging.

In addition, in the previous newsletter, I presented several ideas for looking beyond ourselves and our professional affairs and making this Section a stronger force in addressing public issues in the world around us. Specifically, I mentioned possibilities of developing a public policy group, a speakers bureau, and a World Wide Web site or home page. Though I asked for feedback, relatively few members sent replies. Nonetheless, I am pleased to report that we have now formed an ad hoc Public Policy Committee whose initial task will be to report to the Board with recommendations about the key public policy issue (or issues) on which the Section might make a significant impact. Committee members include Susan Cooley, Charles Fogelman, Deborah Frazer, Manuel Miranda, Larry Rickards, and Erlene Rosowsky. Bob Knight, as the incoming President, has indicated he will continue to support further developments along these lines.

Though a number of members indicated interests in being involved as resources if a Speakers Bureau were developed, we have not had a volunteer willing to take on the task of organizing such an operation and Speakers Bureau efforts have been tabled for the time being. The Board believes this concept should probably be tied in with the Section's broader efforts to develop more Continuing Education opportunities. Nan Kramer, our Section II CE liaison, and Sara Qualls, the Division 20 CE Coordinator, have been working on a policy for collaboration between our organizations in future CE efforts.

The opinions offered by members following the last newsletter favored the notion of developing a Home Page, but discussions continue at this time about how (and by whom) this can be accomplished.

Our Section's program at this past APA convention included a Clinical Psychology Centennial Symposium on "Clinical Geropsychology: Past Development and Future Prospects," organized by Clifford Swensen, a symposium on "Clinical Geropsychology in Medical Settings-Challenges and Opportunities," organized by Bill Haley, and a lively conversation hour on prescription privileges in geropsychology (see related article, page 6). All these sessions were very informative and highly successful, and our Program Chair, Bob Knight, and the participants are to be commended. We also had a gratifying experience with the Section's new

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sites. Division 12 has a preliminary WEB site available through the APA home page.

Don Routh, 1997 President Elect of Division 12, is seeking suggestions for his Presidential initiative. He is entertaining the idea of creating a task force on the assessment of treatment outcome for the practicing clinician. This is another great area for Section 2 involvement, as we all know the need to identify instruments with psychometric properties appropriate for older adults.

Ed Craighead chaired a Division 12 committee that developed and submitted an application to CRSPPP to recognize clinical psychology as a specialty. The "clinical" application will be considered with applications from Health Psychology and Family Psychology. The application will hopefully come to the August, 1997 APA Council of Representatives meeting for a vote. I realize the notion of clinical psychology as a specialty, as opposed to a field, may appear a bit unusual. However, it does meet the qualifications for a specialty, as opposed to a proficiency, according to the CRSPPP criteria.

Ms. Lynn Peterson will assume the duties of Judy Wilson this spring, as Judy will be retiring. Ms. Peterson is based at the University of Colorado, which has committed space and phone support for the Division 12 Central Office.

Please let me know if there are issues you would like me to bring to the attention of the Division 12 Board at its mid-winter meeting in January.■

■*Taskforce on Effective Psychosocial Interventions: A Lifespan Perspective*

Forrest Scogin, Ph.D.

Forrest Scogin and Margaret Gatz are co-chairing Section II's contribution to the Taskforce on Effective Psychosocial Interventions: A Lifespan Perspective. Areas to be reviewed are depression, dementia, anxiety, sleep, caregiving, alcohol, and a particular therapy, life review. Reviews of literature in these areas were conducted by graduate students in a class lead by Dr. Gatz at the University of Southern California. The reviewers used the same criteria for "well-established" and "probably efficacious" treatments that were employed in similar reviews. The student documents have been reviewed by experts in each of the areas and suggestions for revision were made. A final report will be available soon.■

Clinical Geropsychology and the Prescription Privileges Issue

John Sexton, Antonette Zeiss, and Bob Knight

Introductory Note

Since APA has decided to pursue prescription privileges for psychologists, Section II, as an organization, is not able to oppose that position. However, questions have arisen at meetings and on the e-mail network regarding the impact of this development on older adults as consumers of the mental health services. It is possible that special consideration should be given to the elderly as a unique population. This could include suggestions that specific training is needed to prescribe for older adults or that psychologists should not prescribe for older adults, even if privileges are extended to prescribe for younger adults. This article is intended to spur further discussion and to initiate exploration of what position, if any, Section II ought to take on these issues.

The case in favor of prescribing psychologists serving older adults

Elderly Americans are poorly served with psychotropics. Perhaps more than any other group in America, they receive either too little or too much psychotropic intervention. Psychologists who prescribe could help ease this problem.

Over-prescribing of psychotropics to the elderly is widely believed to be common. It is estimated that at least 40% of nursing home patients receive psychotropics. The Florida legislature saw this problem and called for the systematic review of the use of major and minor tranquilizers, sedatives, hypnotics, and antidepressants in that state's elderly population. If one assumes that over-prescribing occurs because physicians working with older adults who have mental health problems either misdiagnose the problems or do not have other methods of intervention available to them (e.g., behavioral interventions, psychological therapies), then an enhanced role for psychologists may lead to more cautious prescribing of psychotropics.

The depressed elderly (and especially those who live in rural America) are under-served when a psychopharmacologic intervention is indicated. It is estimated that only 1 in 3 who meet the criteria for a major depressive disorder will seek treatment; and many would be aided by an antidepressant. If care is sought at a rural hospital, only 1 in 10 of these hospitals will have a psychiatrist on staff. According to the Bureau of health, 48 states report a shortage of psychiatrists. With fewer medical school graduating seniors choosing to work in psychiatry, and with the 'graying of America', the problem of the inappropriate use of psychotropics with the elderly will worsen.

Arguments against filling the need with psychologists who prescribe have holes in them. Those who believe one needs to go to medical school to be a safe and effective prescriber of medications should look at the expert quality of prescribing done by nurse practitioners and physician assistants. Creating a new type of psychologist called a "prescribing psychologist" may lead to a decline in collegiality with psychiatry, but not with other physicians. Surveys show that the majority of primary care physicians support the idea of some psychologists prescribing. Psychologists who prescribe are not likely to abandon psychotherapy for the 'quick fix', or to be dominated by the pharmaceutical industry. Ethical treatment will not be abandoned because one adds another treatment option to their armamentarium. Malpractice insurance will increase for those who prescribe, but not for others.

Psychologists who prescribe can reach the under-served, and can offer alternate interventions to the over-medicated. They can do so in close association with a physician who attends to the medical pathologies, leaving the mental health problems (which sometimes have a medical basis) to the 'full-service mental health specialist'. The prescribing psychologist not only assesses the mental health problem through psychometrics, but can add medication to the psychotherapy, and round out the care with life-style enhancement/health psychology interventions.

The case against prescribing psychologists working with older adults

Supporters of prescription privileges for psychologists need to be much more aware of problems regarding prescribing for older adults under current proposals. If prescription privileges are granted, they will be general and include the right to prescribe to any client. Thus, the special issues concerning prescribing for older adults need to be vigorously presented as part of intense debate about the wisdom of psychologists seeking the right to prescribe psychoactive medications.

Prescribing for older adults, particularly those with chronic or complex medical conditions, is an extremely complex task. Age brings gradual but important change in drug absorption rates and process, drug distribution, drug metabolism, and drug excretion (for extensive information on pharmacological and psychopharmacological treatment in the elderly, excellent reviews are available in Vestal & Cusack, 1990 and Shamoian, 1992). Physicians do obtain some special training in geriatric needs, although many general physicians are not as well trained as would be desirable. Lack of knowledge concerning special needs of the elderly can lead to iatrogenic problems and polypharmacy problems.

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Clinical geropsychologists will need to understand the pharmacodynamics and pharmacokinetics of medications, requiring extensive knowledge of physiology and pathophysiology. Knowledge of the full range of pharmaceutical agents, to understand the potential problems of drug-drug interactions in older adults on multiple medications for acute and/or chronic medical problems, is also essential for adequate care of older adults, for whom co-existing medical problems and multiple medications are the rule rather than the exception as is presumed to be true with young adults. Graduate training programs in psychology likely would be altered to accommodate the pressure to provide students with extensive training in pharmacology. The training required for prescribing to elderly would be far greater than that required for prescribing to healthy younger adults with psychological problems.

We will alienate members of other professional groups (not just psychiatrists, but also social workers, physician's assistants, masters' trained nurses, etc.). We need collaborative relationships with other professionals, not enmity and rivalry. Clinical geropsychologists can only function effectively as members of the interdisciplinary health care teams which have long been the dominant model of care in mental services for older adults and for geriatric primary care.

All psychologists prescribing to older adults would need competency, if not expertise, in clinical geropsychology, including differences in the presentation of DSM-IV diagnoses and other mental health issues, geropsychological assessment, differences in learning and cognition that can affect therapy, the most empirically-supported treatments for older adults, and so forth. Without this knowledge base, it is likely that prescribing psychologists would treat the elderly no better than do physicians without training or experience with older populations.

Psychology currently represents a particular approach to understanding and intervening with problems in psychological function. It is virtually certain that psychologists could learn to prescribe effectively since we are bright, dedicated people with a commitment to human welfare and an ability to work hard and long. It is also clear that medication can be an effective treatment modality, or even the most effective modality for some disorders, such as manic-depressive illness. Psychology does not deny the importance of biochemical and medical influences, but seeks to understand and utilize thoughts, actions, and feelings as a focus of treatment. This approach has been productive and has contributed enormously to the development of effective preventive and intervention programs.

Concluding comments

While much discussion of the prescription privileges issue has been framed in pro and con terms with regard to prescription privileges for all psychologists and clients, it is possible that clinical geropsychology could or should advocate for specific prescribing restrictions or requirements for older adult clients. It may well make sense for the limit to be phrased in terms of co-existing medical conditions, number of other medications taken, presence of dementing illness, residence of long-term care, and other age-related issues rather than chronological age, per se. The picture of those psychologists who are not competent to assess psychological disorders in the elderly then writing prescriptions is troubling.

Current training proposals related to prescribing psychologists are preceding with little or no input to date from clinical geropsychology. APA's discussion of this training covered three levels:

1. Content in psychopharmacology that psychologists should have. This level is probably not controversial for Section II, although additional geriatric content would be desirable.
2. Training needed to consult with a prescribing physician about medications. Such consultation is probably a common activity already for practice-oriented clinical geropsychologists, even though training does not support expertise in this area and it likely constitutes practicing beyond the current scope of licensure. In some sense, this lead could be thought of as bringing practice and law into conformance with (unsanctioned) practice by psychologist/primary care MD treatment teams.
3. Training for prescribing psychologists. This issue is the core of the controversy. It also potentially raises a number of issues regarding older adult clients over and above those involved in prescribing for young adult clients who are free from medical disorders and not taking over medications.

We invite responses from the membership of Section II regarding what action, if any, you would like to see Section II take and why. Responses will be summarized in a future newsletter. Previous discussions have been characterized by a preponderance of Section II members who are primarily researchers and professors and have largely opposed the idea of prescription privileges, especially without recognition of issues specific to older adults. Members who are practitioners, student members, and those favoring prescription privileges are especially encouraged to send in comments and responses.

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Student Award, and will continue to offer this $250 award again next year--perhaps linked with a student poster session.

As 1996 comes to a close, I'd like to extend special thanks to Al Kaszniak and Norm Abeles, whose terms on the Board of Directors are ending, for their long service to Section II. Al has served our Section very well in varied roles, this year as Past President very efficiently overseeing the nominations and elections process. For the past three years, Norm has very effectively handled the many tasks that fall to the Secretary, perhaps the most demanding of officer positions. Thank you, Al and Norm! We all owe you both a debt of gratitude.

In addition, this issue of *Clinical Geropsychology News* marks Alex Tröster's last as editor. The Board members all want to acknowledge what a superb job Alex has done in getting out informative and nicely organized newsletters over the initial years of this organization. Alex, we are extremely grateful for your services. We are also pleased to announce that Suzanne Norman of the Kansas City VA has graciously agreed to take on the Newsletter Editor responsibilities, and wish her every success in continuing and expanding the tradition of excellence that Alex has started.

Finally, let me thank you all for continuing to support this organization and for allowing me to serve as President this past year. We've come a long way in a relatively few years, and now we are beginning to see some payoff for a number of the efforts on which we have been toiling away. In 1997 Bob Knight will bring his extensive clinical experience and political savvy to the Section Presidency. If we can keep up the dedication and hard work that has characterized this organization to date, our prospects for even greater successes in the coming months look very bright.■

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Please send comments to: Bob Knight, Ph.D., Andrus Gerontology Center, USC, LOS ANGELES, CA 90089-0191; FAX: (213) 740-1871; E-MAIL: BKNIGHT@USC.EDU

Note: This article grows out of a Section II Conversation Hour at the 1996 APA Convention. John Sexton (Naval Medical Center, Portsmouth, Virginia), is a graduate of the DoD training program, and is a prescribing psychologist. He wrote in favor of prescription privileges. Antonette Zeiss (VAMC in Palo Alto) is president of AABT, and is opposed to prescription privileges. Bob Knight chaired the Conversation Hour and is president of Section II for 1997. He contributed the introductory and concluding portions of this article and served as its editor.■

■APA Advisory Committee Begins Work

George Niederehe, Ph.D.

This past summer, an Ad Hoc Committee on Issues of the Older Adult was established to advise the APA Central Office on how APA can improve its attention to issues of aging. The committee is chaired by M. Powell Lawton; other members include Michael Duffy, Margaret Gatz, Manuel Miranda, Denise Park, Michael Smyer, Barbara Yee, and Section II President-Elect Designate Steven Zarit. The committee began some preliminary discussions at the APA convention last summer, held an initial meeting in September, and plans to bring its primary recommendations before the Council of Representatives (C/R) meeting next February. Section II was instrumental in developing and advancing the motion that got the C/R to approve this committee for one year of operation and, upon becoming APA President-Elect, Norman Abeles was able to assure that it received the necessary funding. As stipulated in the enabling motion, both Section II and Division 20 leadership were consulted and had input in the committee member selection process.

The committee has decided to recommend that APA establish a standing (permanent) committee on aging. This development would help interconnect various aging-related activities and interest groups within APA, and give the gerontological community a stable place within the internal APA structure. Like all standing committees, this committee on aging would have to be "housed" somewhere within APA--according to the proposal, under the Public Interest Directorate, where the present ad hoc committee is staffed and where it would function alongside such parallel committees as those on Children, Youth and Families, Disabilities, and Ethnic Minorities. According to normal operating procedures, the motion introduced in February will likely receive full attention at the August 1997 C/R meeting.

The Ad Hoc Committee was also given several hours on next summer's APA convention program. This time will be used for a Presidential Forum on Aging, in which Norm Abeles and the next APA President-Elect Martin Seligman will participate. Various presentations will be made, as well as open comments taken from the floor, recommending issues that should be among APA's priorities on aging.■

■*Geropsychology Qualifications Task Force Presents Report*

George Niederehe, Ph.D.

By the time that this newsletter is published, Section II members should have received in the mail the draft report recently released for review and comment by the Interdivisional Task Force on Qualifications for Practice in Clinical and Applied Geropsychology. The report has been circulated to various APA boards, committees, divisions, and directorates, as well as to other organizations outside APA and to the Section II membership. The full text of the report has also been posted on the Division 20 home page (to be found at http://www.iog.wayne.edu/apadiv20/apadiv20.htm) and notices about accessing it there have been sent to multiple APA division newsletters. Established in 1994 as a collaborative initiative of Section II and Division 20, the Task Force is chaired by George Niederehe (for Section II) and Linda Teri (for Division 20). Other members include Michael Duffy, Barry Edelstein, Dolores Gallagher-Thompson, Margaret Gatz, Paula Hartman-Stein, Gregory Hinrichsen, Asenath LaRue, Peter Lichtenberg, and George Taylor. As noted in the draft itself, anyone who wishes to comment on the report should submit the comments in written form to Peter Lichtenberg by January 10. The Task Force will review the comments received and make any revisions required early in 1997.

The Task Force is also working on an application (termed a petition) to be submitted by March 1 to the APA Commission on Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP), asking that clinical geropsychology be officially recognized as a professional proficiency area. In recent meetings, both the Section II Board and the Division 20 Executive Committee have agreed that the two organizations will co-sponsor this application. Following this, notices will appear in several *APA Monitor* issues about the petition. Then, CRSPPP will consider it next October and, if they recommend approval, the APA Council of Representatives will vote on the petition in February 1998. If clinical geropsychology thereby becomes recognized as a proficiency, the APA College of Professional Psychology can then elect to offer certificates for individual practitioners in the area. This is now occurring with the first area recognized as a proficiency, substance abuse counseling. Undoubtedly, in this situation, the College would call upon the expertise in Section II and Division 20 for assistance in developing an examination process for certification applicants.■

■*Geropsychology Training at the Department of Veterans Affairs*

Victor Molinari, Ph.D.

The veteran population is aging at three times the rate of the general population. By the year 2000, 37% of all veterans (9 million) will be over the age of 65, and the number over the age of 85 is expected to increase to 474,000. Concomitantly, the demand for long-term care beds in the VA system is rising dramatically. The Department of Veterans Affairs is the single largest employer of psychologists in the United States, and the need for trained geropsychologists within the VA system is great. This need is not just for psychologists to address the emotional problems of older veterans on geropsychiatry and nursing home units, but in less traditional "geriatric" settings such as in PTSD clinics, neuropsychology labs, rehabilitation centers, and primary care settings.

Unfortunately, despite some attempts to expand training of clinical and counseling psychologists to work with older adults at the predoctoral level, efforts have woefully lagged the demand. Two Veterans Affairs Technical Advisory Groups (TAGs) have been formed in part to address training issues and to develop practice guidelines to assist non-geropsychologist VA staff members who will be working increasingly with older adult veterans. VA medical centers have also generated a number of geropsychology internship specialty slots (a perusal of the APPIC guide reveals that the vast majority of the geropsychology specialty internship slots are at VAs). In 1992, the VA began setting aside funds for geropsychology postdoctoral training. Forty-six psychologists have now completed fellowship programs, with ten others in training in the 1996-1997 year. The sites for postdoctoral training at the VA are located across the country in Brockton/West Roxbury, Cleveland, Gainesville, Knoxville (Iowa), Houston, Little Rock, Milwaukee, Palo Alto, Portland, San Antonio, and Seattle. It is hoped that the VA will soon augment its budget for the predoctoral and postdoctoral training of geropsychologists to bridge the ever-widening gap between service demand and service delivery.■

REMINDER ABOUT ADDRESS CHANGES

Please <u>DO NOT</u> send address changes to the newsletter editor. Address changes should be directed to: **Sara Honn Qualls**, Dept. of Psychology, University of Colorado at Colorado Springs, Colorado Springs, CO 80933-7150

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