CLINICAL GEROPSYCHOLOGY NEWS

APA DIV. 12 SECTION II — MAY, 2000 Vol. 7, No. 2

President's Comments

A Bird's Eye View

Greg Hinrichsen, Ph.D.

I am putting the final touches on a summary of responsibilities associated with the role of each Section officer and committee chair -- what Toni Zeiss calls our "Procedures Manual." The number of tasks for which each officer and committee chair is responsible has grown over the years and we felt it was important to formally catalogue them. In reviewing the Procedures Manual, I was struck by the level of involvement and commitment to the Section by members of the clinical geropsychology community. One of the rewards and challenges of being president of the section is that one must keep on top of what's happening in the Section and more broadly in clinical geropsychology. I thought it might be useful to give a snapshot of how the Section formally operates and what officers, committees, and tasks forces do for the Section.

The Nuts and Bolts. Formally, the Section II board (along with most committee and task force chairs) meets twice a year (at the annual meeting of APA and the Gerontological Society of America). In the winter, board members have a telephone conference call. The sheer number of issues that need to be covered at these meetings has grown over the years. For example, on the one hour conference call that the board had recently, there were 24 items on the agenda. It has been difficult to keep our GSA and APA based meetings to less than three hours. In addition, the current, past, and future presidents of the Section have a monthly conference call to review issues of concern. So what do we talk about at these meetings?

Officer Activities. As you will see from the schedule of Section events in this issue of the Newsletter, Bill Haley (President-Elect and Program Committee Chair) has been busy setting up Section programming (at times, a daunting logistical task) which includes two innovative Section interest group meetings in geriatric neuropsychology and geropsychology in medical settings. As our new Section Secretary, Barry Edelstein is responsible for managing a large data base of information about Section membership, documenting board and memberships meetings, and soon will be producing a Section directory. For several years he has also coordinated the Section e-mail network. (In case you're not on the network, think about signing up. It's worth those extra e-mails you need to read.) Victor Molinari (Treasurer) keeps track of membership renewals (as well as issues gentle reminders to Section members who forget to renew), manages section finances, warns the board of financial shortfalls and urges us to be prudent when we've got a little extra money in the bank.

After a very successful year as Section President, Toni Zeiss is now responsible for managing the Section's election and providing wise guidance to myself and Bill Haley about emerging issues. By virtue of being the Section's past-past President, Steve Zarit is chair of the Awards and Recognition Committee, a vehicle through which we can honor the contributions of our own as well as identify APA committee positions (such as the APA Committee on Aging) where our members could best represent the interests of geropsychology. (Continues on p. 2)

President's Comments, (Continued from p. 1)

Student Involvement. I am particularly pleased with the work of our two Section Student Liaisons, Martha Crowther (MPH Postdoctoral Fellow, Univ. of Alabama) and Merla Arnold, R.N. (Doctoral Candidate in Counseling Psychology, Columbia Univ.). Martha and Merla have outreached to recruit student members to the Section, written a recent article about the Section for the American Psychological Association's Graduate Student Association (APAGS), started a student column in the Section newsletter, and crafted a soon to appear student section on the Section website. Merla has been working closely with me in updating the Section's *Directory of Predoctoral Internships with Clinical Geropsychology Training Opportunities and Postdoctoral Clinical Geropsychology Fellowships.* We plan to put it on the Section's website this summer.

Communication with the Membership. Speaking of the website, Becky Allen-Burge is the founder of the website and is in the process of updating and enlarging it. Becky's communication counterpart in the Section is Newsletter Editor Suzanne Norman. Suzanne has done a wonderful job of producing the Newsletter over the past three years and will finish her distinguished tenure at the end of this year. We are delighted that Michelle Gagnon (who recently took a position at Nova Southeastern University after working on a research study at the Philadelphia Geriatric Center) has agreed to take the editor's position starting in 2001. Michele Karel just started her role as Membership Chair and is updating and streamlining our membership application process as well as exploring new strategies to increase our membership.

Public Policy and Professional Affairs. As Public Policy Committee Chair, Margaret Norris and her committee have been working on ways to disseminate information about mental health and managed care to older adults. They have been trying to identify one or more organizations to distribute a brochure developed by the committee on this topic. Although Suzanne's role as Editor will end, she has agreed take the position of Continuing Education Liaison from Nan Kramer who will be retiring after her long tenure as CE liaison. Our thanks to Nan for her dedicated service.

There have been other efforts to influence the shape of mental health and aging within and outside of APA. Jiska Cohen-Mansfield has been our representative to the Coalition on Mental Health and Aging. The Coalition provides opportunities for professional, consumer and government organizations to work together toward improving the availability and quality of mental health prevention and treatment to older Americans and their families. The Coalition has conducted Senate Aging Committee and Capitol Hill briefings and convened a 1996 White House Conference on Aging pre-conference event on mental health and aging. Jiska will also represent us at a June Consensus Conference on Long Term Care that will focus on the problems and prospects for the delivery of quality mental health services in nursing homes. In an effort to establish a formal working relationship with our psychiatric counterpart in geropsychology, the American Association for Geriatric Psychiatry (AAGP), Dolores Gallagher-Thompson, Bill Haley, and Sara Qualls represent us on a Section II/AAGP Joint Task Force.

A long-standing Section commitment has been the Interdivisional Task Force on Qualifications in Clinical and Applied Geropsychology. This is has been a joint effort with Division 20 and is co-chaired by former Section President, George Niederehe. The Task Force was established following the 1992 conference on training in clinical geropsychology. The carefully crafted report from the Task Force, *Qualifications for Practice in Clinical Geropsychology*, will hopefully be re-reviewed soon by the APA Board of Directors then by the APA Council of Representatives. The Task Force was a catalyst for recognition by APA of Clinical Geropsychology as a proficiency. George has been a remarkably patient and persistent steward throughout this whole process. The most recent initiative in the professional arena, is the Treatment Guidelines Task Force composed of Forrest Scogin, Margaret Gatz, and Susan McCurry. They will represent the Section -- and with it the aging perspective -- on the second iteration of the Division 12 Task Force on Empirically-supported Treatments. Steve Rapp is working on a developing project to draw together APA divisions and other interested groups at the next APA convention to discuss ways in which we can collectively lobby APA to prioritize the concerns of psychologists who deliver services to the aged. Stand by for future developments.

And, of course, all of this could not be done without the support and good will of our membership.

APA Convention Program for Clinical Geropsychology

Bill Haley, Ph.D.

We have an exciting program planned for the 2000 APA Convention. In addition to the Presidential address and two symposia, we are scheduling two initial Interest Group meetings related to the symposia. Al Kaszniak [kaszniak@U.Arizona.EDU] will lead the Interest Group on "Geriatric neuropsychology", and Suzanne Norman [normans@XAVIER.XU.EDU] will lead the Interest Group on "Clinical Geropsychology in Medical Settings". We are hoping that the Interest Groups will be attractive not only to Section II members, but also to psychologists who are not yet members of the Section. We believe that the Interest Groups can provide a forum for sustained interaction in these very important areas in Clinical Geropsychology. If you are interested in helping the Interest Group leaders plan or publicize the meetings, please contact them via the email addresses shown.

We have also made plans to have a "Nite Out", a social activity for Section members. George Niederehe [gniedere@mail.nih.gov] will be organizing dinner out at a fun DC location. This should be well worth attending! Please contact George if you are interested in joining us.

Please note that our Business Meeting is scheduled for Tuesday morning and includes our Student Award Presentation, as well as an opportunity to provide input on the Section's plans. Feel free to take a look at the Section Web Page http://bama.ua.edu/~apapgero/apadiv12.htm "Conferences" page, or to contact me [whaley@chuma1.cas.usf.edu] for additional details.

FRIDAY, AUGUST 4

Division 12 Award Ceremony (9:00-10:50 AM). See APA Program for location.

SATURDAY, AUGUST 5

Section II Board of Directors Meeting (12:00-2:50 PM). Division 12 Hospitality Suite*. (This meeting is open only to Board members and others invited to conduct Board business).

Symposium: Preclinical Detection of Alzheimer's Disease: Contributions from Neuropsychology and Neuroimaging. (3-3:50 PM). Meeting Rooms 10 & 11, Washington Convention Center. Organizer: Alfred W. Kaszniak, Ph.D.

Interest Group Organizational Meeting: Geriatric Neuropsychology (4:30-6:30 PM). Division 12 Hospitality Suite. Organizer: Alfred W. Kaszniak, Ph.D.

Division 12 Social Hour (6:00-7:50 PM).See APA Program for location.

SUNDAY, AUGUST 6

Student breakfast and discussion: Student perspectives on Clinical Geropsychology: A conversation with Section II board members (7:30-9:30 AM), Division 12 Hospitality Suite*.

Coalition of Practice Divisions and Aging (12:00-2:00 PM), Division 12 Hospitality Suite*. (This meeting is open only to coalition members).

Presidential address, An interpersonal perspective on late life depression. (3-3:50 PM). Gregory Hinrichsen, Ph.D. See APA Program for location.

Symposium: Clinical Geropsychology in Medical Settings: Prevention, Assessment Intervention and Training (4-5:50 PM). Meeting Rm. 29, Washington Convention Center. Organizer: Suzanne Norman, Ph.D.

Interest Group Organizational Meeting: Clinical Geropsychology in Medical Settings (6-7:50 PM). Division 12 Hospitality Suite*. Organizer: Suzanne Norman, Ph.D.

TUESDAY, AUGUST 8

Business meeting: Division 12, Section II 9-9:50 AM. See APA Program for location.

*Please note, the location of the Division 12 Hospitality Suite will be unknown until the conference has begun! We will print up posters showing the location of the Hospitality Suite, and alert the Information Desk of the Convention Center to this location, on Friday August 4.

The Student Voice

Merla Arnold, R.N. Student Liaison-Clinical Geropsychology

Welcome to the new Student Section of the 12/II Newsletter - *The Student Voice*. The *Student Voice* is another effort of the Clinical Geropsychology Section to actively engage students. Although this column can reflect any issue of concern to students, we thought it would be useful to learn about students who are members of the Section. How did your interests in geropsychology develop? What are your professional goals and plans? What are the geropsychological issues that are of particular concern to you?

As a Student Liaison for the Section, I was invited to inaugurate this column by sharing with you the path that lead me to a professional focus on older adults. My interest in geropsychology joins different interests and a bit of serendipity. I have had longstanding interest in grief and how the health care community treats the dying and their families. This interest formed more than 20 years ago, when I grappled with the death of a friend's father. I read Kübler-Ross' work and I was moved by what she had to say about the experiences of the dying and their families. I continued to read. Several years later, during my nursing training (my first career was as a registered nurse), I had the opportunity to care for a terminally ill man. Cloistered at the end of the ward, family or staff rarely visited him, mirroring Kübler-Ross' description of the usual treatment of the dying. He felt frightened and alone. At one point, he took my hand and we sat silently together. It was a life changing moment. There was something exquisitely simple and transformative for both of us in that work with him. My rotation ended, life went on for me, and my nursing career developed.

Later in my nursing career, the primary focus of my work was to improve hospital systems. To enhance my skills, I took courses in organizational psychology and group dynamics at the Teachers College of Columbia University. It was there that I realized I wanted to be a psychologist. I found a mentor and my new home in psychology. I entered the Counseling program in 1994 and a new journey began.

For three years I have been working as a psychology extern, with an older adult population at Hillside Hospital's outpatient geriatric clinic. In September, I start a psychology internship at the Northport, Long Island Veterans Affairs Medical Center. At the Northport VA, I will work primarily with an older adult population and also expect nursing home and hospice placements. My dissertation examines the relationship among the constructs of attachment, death anxiety and attitudes toward old people. It also examines the interest of graduate psychology students to work with the older adult upon graduation. While my professional path has been a relatively long one, it takes the shape of a circle - from interest in loss and grief at the beginning of my nursing career to a psychological understanding of these issues in later life, at the beginning of my psychology career.

We want to hear your voice. What is the story of your interest in geropsychology? How have you come to this point in your career? What are your needs, concerns, questions, challenges, and interests? Please contact either Martha Crowther, Ph.D. or me, your Student Liaisons. You may contact Martha by e-mail at mcrowthe@gp.as.ua.edu. Contact me by writing to 13 Bennett Avenue, Huntington Station, New York, 11746 or by e-mail at ma159@columbia.edu.

Task Force Progress Report

George Niederehe, Ph.D.

The report of the Interdivisional Task Force on Qualifications for Practice in Clinical and Applied Geropsychology continues to wend its gradual way toward APA approval as a set of guidelines. Last December, the APA Board of Directors (B/D) reviewed the report, commended the Task Force for its work, but also returned the document for additional editing. Concerned that some of the report language seemed to be phrased more like standards than guidelines, the B/D asked the Task Force to clarify the intent and make the language more consistent with current expectations for guidelines. The issue of differentiating guidelines from standards has been a rather hot one within APA of late, and has affected the clearance of other sets of guidelines, as well. Working with several experts in guidelines development, the Task Force revised the language (not the content) of the report in a thorough manner, retitled the document "Training Guidelines for Practice in Clinical Psychology," and sent it back to the B/D for re-review. If that goes well when the B/D meets in June, the guidelines will then proceed to discussion by the Council of Representatives in August – the final step in the approval process. (Continues on p. 9)

Clinical Geropsychology Exchange

Clinical Psychology in New Zealand: Focus on Older Adults

Nancy A. Pachana, Ph.D.

People often think of New Zealand as a remote part of the world. This seems especially true if you are a geropsychologist living and working in this country! Having emigrated to New Zealand three years ago, after years of pre-and post-doctoral training in urban medical settings with fairly large numbers of geriatric specialists, I was amazed to come to New Zealand and find myself part of a distinct minority. Individuals with specialty training in the mental health needs of older adults are few and far between here, regardless of discipline. For example, there are approximately 20 geropsychiatrists, 35 geriatricians, 10 geropsychologists and 1 geriatric neuropsychologist (myself) working in New Zealand, which has a total population of 3.7 million people.

Although child and family therapy is a very well-established subspecialty within clinical psychology in New Zealand, geropsychology is still a relatively new subspecialty here. This is most likely due to three main factors:

1. The population of the country as a whole is quite small, with one main population center (the metropolitan Auckland area) which contains almost 40 percent of the country's population. In remaining areas, particularly the South Island, populations are small and scattered. Specialist health services then have less of a population to support them. In general, such services are less developed than, for example, in Australia (population: 18 million), and tend to be concentrated in a few urban centers which can support them. Specialist health professionals tend to be spread "thin and wide," limiting opportunities for consultation and collaboration.

2. Within New Zealand, there is a chronic shortage of clinical psychologists. Their numbers are so limited that psychologists often divide their time to work in several settings. Thus, it is often desirable to be a "jack-of-all trades" in the clinical marketplace. The lack of large hospital systems (as in the Veteran's hospital systems in Australia and the United States) also limits training opportunities for health professionals.

3. The traditional New Zealand clinical training model is generalist in orientation, with the only specialist emphasis during training on child and family therapeutic approaches. It is usually expected that specialist skills will be acquired on internship and beyond, in an apprenticeship framework rather than through programmatic learning. This has changed somewhat with the increasing profile of clinical neuropsychology in New Zealand. Both Australia and New Zealand training programs require training in child and family techniques. There is no such requirement (or even opportunity) for training specifically to work with older adults, despite the professional registration boards and societies in both countries mentioning the importance of developmental issues across the life span in clinical practice. In the UK, some specialist training in the assessment and treatment of older adults is required for registration as a clinical psychologist.

Geriatric specialties have received more attention with the increased focus on the "graying" of the New Zealand population. Just recently, the equivalent of US "board certification" in geriatric psychiatry was approved. Similarly, geriatric rotations have been added to most nursing courses. However, for many years specialization in geriatrics was not a popular choice within the allied health fields. Traditionally, work with older adults was thought of (and often funded under the national health care system) under the same category as developmental or intellectual disabilities (Disability Support Services). In fact, the mental health funding contracts in hospitals until 1999 only covered people until age 65. All older patients, with or without psychiatric problems, are cared for primarily in generalist geriatric services (despite vociferous lobbying from mental health professionals). This situation is set to change with the lifting of upper age restrictions, but the stereotype of mental health as an area that actively does not care for older adults may be very hard to overcome. Also, in many settings there is the misperception that psychiatric and neurological disorders rarely co-occur, or that somehow geriatric services should concern themselves only with dementias. Again, geriatric specialists are trying to educate both their colleagues as well as funding agencies about the need for adequate management of older adults. The World Health Organization's (1997) best-practice suggestion that the physical, cognitive and emotional needs of older adults should be managed in specialized comprehensive services is supported by New Zealand clinicians, but it has yet to be realized.

The fact that geropsychology is still a newly developing specialty here has many implications for clinical research, practice and training. In terms of research, relatively little work specifically focused on older adults is conducted. Only a few psychologists working in the six university psychology departments here concentrate on research with older adults. For a recent special double issue of the New Zealand Journal of Psychology that focused on aging issues (volume 28, numbers 1 and 2), recruitment of papers from within the country proved difficult. (Continues on p. 8)

By-Laws Changes for Section II

Antonette Zeiss, Ph.D.

Two By-Laws initiatives were presented to the membership of Section II in the last election, held last June, and both were approved overwhelmingly. My goal here is to give you a quick overview of these changes and their implications.

The first change was the creation of a new standing committee, the Committee on Awards and Recognition. The new By-Laws specify that the chair of this committee will be the person who has just completed a year as Past-President of Section II. and that other members of the committee also will be Past-Presidents of the section. Initially, the Board wanted to develop this committee to administer awards that we make internally. These awards are the annual Student Research award and the award for Professional Achievement that will be presented when the committee selects worthy recipients (Norm Abeles and George Niederehe were the first recipients of this award, last August at APA). In addition, the By-Laws were written such that the new committee also is charged with working to ensure broader recognition within APA for members of the Section. This includes things like nominating Section members for Division 12 and APA awards. It also includes developing mechanisms to track upcoming appointments to APA committees and Boards and identifying Section members who could be nominated and supported for those appointments. We enthusiastically encourage Section members to support this new committee by suggesting award and appointment nominations – suggesting yourself and/or other Section II members. Steve Zarit is the Chair of the committee this year, and I will be the Chair next year. Please contact us with your ideas.

The second change was designed to simplify review and acceptance of new members in the Section, in order to make new Members quickly feel welcomed. Previously, the whole Board had to vote on membership applications, and the Board meets only three times a year, so there was often a lengthy delay between application and acceptance. The By-Law approved last year specifies that applications will be reviewed by the Membership Committee, who are empowered to accept or reject the application, by majority vote of the committee members. If there are questions about an applicant, the Membership Committee can still refer the decision to the executive subcommittee of the Board of Directors. So far, this change is proceeding smoothly and the Board is pleased with the change.

Thanks for voting on these measures last year. We do not plan any By-Laws votes for this year's election, but I do encourage you to attend to the ballot for officers when it comes to you in June and to take the time to vote!

CALL FOR NOMINATIONS

Section II seeks nominations for the following offices:
PRESIDENT
DIVISION 12 REPRESENTATIVE

The person elected president will serve as President-elect from January to December, 2001, as President from January to December, 2002, and as Past-president for January to December, 2003. The Division 12 Representative will serve a term of 3 years, beginning January, 2001.

Please send nominations to Antonette Zeiss, VA Palo Alto health Care System (116B), 3801 Miranda Ave., Palo Alto, CA 94304 or by e-mail to Antonette.Zeiss@med.va.gov. Deadline is May 30. Self-nominations are welcomed, and you can nominate as many candidates as you would like.

President:_____

_____

Division 12 Representative: _____

_____

Notes from Coalition on Mental Health and Aging Meeting on 3/30/00

Weldon Bagwell, Ph.D.

Robert Bernstein from Bazelon Center for Mental Health Law introduced Mary Bayliss, an attorney, who described a new project sponsored by Bazelon that deals with People's access to Palliative Care. Undertreated pain is widely reported as a stressor for dying persons and is one of the main reasons for fear of death. Hospitals do not give enough pain medication and people suffer. This project will identify what barriers exist around end of life care and seek ways to bring them down. She wants to raise the coalition's awareness that this is a justice issue and that older patients, women, minorities, and disabled persons have the worst hurdles in getting end of life care. Nursing home do not resuscitate (dnr) orders are also an important end of life or death with dignity issue. This project is not about assisted suicide, but about better treatment at end of life. Many doctors fear losing their licenses for overmedicating dying patients. Morphine addiction should not be a factor when dealing with dying patients. The AMA recently sent a CD-ROM on Palliative Care to their members to teach doctors more on this issue. Hospice referrals would be more available if HCFA would be more flexible with its 6-month rule for terminal patients. Bazelon is seeking doctors who are plaintiffs in cases around drug prescribing or referrals in end of life cases. Part of this project will result in putting together a website on palliative care law.

The new ABC series, Wonderland, was discussed. NAMI and other mental health organizations who have joined together as the Mental Health Coalition Against Stigma in Hollywood are upset by the way this new primetime drama set in a criminal psychiatric hospital portrays mentally ill people. The group feels that this is the latest in a long line of movies and television show featuring plots and characters that connect mental illness with violence or depict people with mental illness as caricatures or stereotypes-subjects of humor or derision. In one episode of Wonderland, a man with schizophrenia who killed several people in Times Square commits suicide after being treated. The intensity of this scene causes NAMI to request that ABC provide warnings and referrals to suicide hotlines and acknowledge that this show depicts only a narrow part of the world of mental illness. Coalition members discussed whether the group should join in a letter writing campaign to ABC in support of NAMI's concerns.

Legislative Updates - In Idaho there is a petition by consumers regarded availability of mental heath care in nursing homes. Clinical social workers would not be reimbursed for services according to a new Idaho ruling in nursing homes, but are reimbursed in hospitals and rehabilitation Centers. This may go to HCFA to decide.

Older Adults with Mental Illness Self-Advocacy Coalition Building Project Update - This project is winding down and ends in April. It accomplished all of its objectives and provided training to 5 states and each state has applied for small grants and is eligible for technical assistance. Eight local sites were trained in coalition building. This program will be evaluated and a survey will be going out. A comprehensive 3-year grant is being developed to train coalitions in the rest of the country to establish a national network. A meeting, Older Consumers Forum II, will be held by this group in mid-May.

The Inspector General's office is doing a study of how states oversee the treatment of mentally ill persons in nursing facilities. This has been brought about by cases of patients with dementia becoming violent and injuring other patients. Five states will be surveyed. Special Care Units are needed to protect frail patients from others who may be violent or physically abusive. There seems to be confusion on the part of the feds regarding whether dementia is a mental illness or not.

The recent Report of the Surgeon General on Mental Health was discussed. Chapter 5 deals with Older Adults and Mental Health. The emphasis was upbeat with a view of aging as time for personal growth and stated that services work when they are available. Elimination of the stigma of mental illness was also emphasized.

Mental Health Courts - as experienced in Florida and Washington State were mentioned. Creation of this type of court stems from the growing numbers of incarcerated mentally ill persons who have no access to treatment. Only non-violent misdemeanors are brought to these courts and referral to treatment is made available. Would this type of court further stigmatize mentally ill persons and place them in a different system? This type of court was compared to "drug courts" from the past.

A written summary from the November 1999 Conference of the coalition was given out. Who to send this summary to and what to do next were discussed. Should it just go to coalition members as is or be repackaged and widely disseminated? It was decided that the ad hoc working group that planned the conference would meet one more time to discuss this issue further and make recommendations to the full coalition.

Clinical Geropsychology Exchange (Continued from p. 5)

Large areas of research interest remain unexamined, especially for older adults - particularly with respect to therapy outcome studies, normative data for tests for New Zealand populations, and incidence and prevalence studies. (For example, there is only one prevalence study of dementia in New Zealand: Campbell, McCosh, Reinken & Allen, 1983.) Declining government support for research in general exacerbates this situation, and little funding is earmarked for older adult populations.

In terms of clinical practice, specialists with knowledge of older adult practice are highly sought-after for consultation and are highly valued across disciplines, yet are under-employed in hospital settings. Government health care reforms in the past 10 years have worked toward dismantling purpose-built geriatric units, disbursing both their patients and staff, with the provision of psychological services being particularly hard-hit. Psychologists are under-represented on specialist geriatric units, with most such teams having only part-time or consulting psychologists available only a few days a week, at best. The situation is even more dire in terms of geriatric neuropsychology, a virtually unheard-of subspecialty in this country. The lack of a presence of psychologists in such settings results in few behavioral programs, virtually no ongoing psychotherapy and little psychological testing. Those few practicing geropsychologists find it difficult to consult over cases.

In a recent report by the New Zealand Faculty of Psychiatry of Old Age, both numbers of beds and psychiatrist levels are cited as low by international standards (Melding & Osman, 1998). Across all 11 catchment areas for the provision of services to older adults in New Zealand, there are 19 psychiatrists, 11 psychiatry trainees, 8.5 house surgeons, 152.2 registered nurses, 51.1 enrolled nurses, 32.8 care assistants, 7.6 clinical psychologists, 16.3 social workers, 12.3 occupational therapists, 5 OT aides and 2.25 physiotherapists (Melding & Osman, 1998). Patients are seen in inpatient, outpatient, liaison and day ward settings, but the majority of geriatric teams' patients are seen in the community, either at home or in nursing homes. Neuropsychological assessment and psychotherapy were among the greatest unmet geriatric patient needs throughout the country (Melding & Osman, 1998). These concerns are grave in light of the expected rise in the over 65 population in New Zealand from 11.5 percent currently to 15 percent by 2030.

With respect to clinical training of psychologists, the lack of available courses, placements or internships with a focus on assessment and treatment of older adults means that newly-trained psychologists here must often virtually train themselves in work with this population. There is only one course in New Zealand available to psychologists specifically in the psychology of later life; it is called Psychology of Aging and is taught by me as part of the graduate program in the School of Psychology at Massey University, in Palmerston North. The two medical schools in New Zealand, Auckland University and the University of Otago, offer some geriatric health care courses for allied medical professionals, psychiatrists and physicians who wish to specialize in the care of older adults. Some nursing programs do include a component on geriatric nursing. Post-doctoral opportunities are extremely rare for any type or specialty of psychology; none exist for clinical psychologists..

The smallness of the country facilitates informal networking; recently a group of psychologists working primarily with geriatric populations in Auckland has attempted a more formal organization. Such groups may in the future offer more support for those interested in specializing in geropsychology.

Cultural issues play a large part in the fabric of New Zealand society. The indigenous Maori people hold their elders (kaumatua) in very high esteem; they play a pivotal role in Maori political and cultural society. Although prevalence rates of mental illness among kaumatua are low (Durie et al., 1996), there are concerns that with the growth of the older Maori population sector, services may not be able to meet the needs of this group. Currently lower life expectancy rates of Maori translate into less persons over age 65 as a percentage of the population. However, the growth of this segment of the population is enormous. For example, in 1951, only one in 500 Maori reached age 85; by 2031 this figure will grow to one in 134 (Statistics New Zealand, 1995). There are few registered Maori clinical psychologists in New Zealand; virtually all of these work in Maori mental health services, and none work exclusively with older adults. Traditionally, older Maori adults are cared for by their extended families (whanau) and only rarely are seen in professional settings. One geropsychology colleague reported seeing no more than 3 or 4 older Maori individuals in 10 years of clinical practice. There are even fewer Maori psychology researchers, resulting in a wide gap between needs and service provision for all Maori, but particularly for older adults in this group.

Overall, working as a geropsychologist in New Zealand comes with many exciting challenges and almost daily rewards. I have come to know a number of highly committed professionals across several disciplines who actively pursue research and continued training in their field of geriatric health care. These individuals, often at great personal expense, travel overseas to conferences to maintain their professional knowledge and links with overseas colleagues.

(Continues on p. 9)

APA Division 12, Section II
Clinical Geropsychology
NEW MEMBER APPLICATION

Please complete the following information (print clearly or type):

Name : _____

Address: _____

_____

_____

Phone: _____ **FAX:** _____

e-mail: _____

Section II Membership Status *(Circle one):
(*Note: Divisional, Affiliate, and Associate members must be members of APA to join Section II.)

Divisional	**Affiliate**	**Associate**	**Student ****
Member or fellow of APA Division 12	Not a member Division 12	Associate member of APA	Must be enrolled as a graduate student or post-doc.

**Applicants for Student Member status must have their application endorsed by a faculty advisor who is a member of the American Psychological Association.

DUES
Divisional, Affiliate, Associate Dues are $15.00 (U.S.)
Student Dues are $5.00 (U.S.)
2000 Membership Dues enclosed $_____

Signature:_____ **Date:** _____
If student, Faculty name (print):_____
Faculty signature:_____ **Date:** _____

Please make your check (in U.S. dollars) payable to:
APA Division 12, Section II

Mail this form, along with your check to:

Michele J. Karel, Ph.D.
Section II Membership Chair
Psychology Service, 3-5-C
Brockton VAMC
940 Belmont St.
Brockton, MA 02301

Please complete the member information on the reverse side.

Name: _____

APA Status (check one): Fellow ___ Member ___ Associate ___ Student___

APA Division Affiliations: _____

Primary Professional Position and Institutional Affiliation:

_____

Date of Birth: _____ **Highest Degree/Date:** _____

(from) University/ Major Field _____

Current Employment Status: Full Time _____ Part Time ____ Not Employed ____

Primary Work Setting: University (Academic Dept.) _____ Medical School _____

Mental Health Center _____ Other Hospital _____ Private Practice _____

Other _____

Percentage of Time Spent In: Research _____ Clinical Service _____

Teaching _____ Clinical Training/Supervision _____

Administration _____ Other _____

Other Psychological and Gerontological Organizations to Which You Belong:

_____

Primary Areas of Interest Within Geropsychology:

_____

Would you be interested in serving on Section Committees? Please rank the following in order of your preference (1 = most preferred. If you prefer not to do committee work, leave blank):

_____ Membership **_____ Program**

_____ CE Committee **_____ Student Membership**

_____ Public Policy **_____ Newsletter**

Clinical Geropsychology Exchange (Continued from p.8)

I have been asked to participate in many projects, conferences and in-service training programs, and find that a small but growing number of professionals and students are attempting to specialize in geriatric mental health care.

At Massey University, we are attempting to form a Centre on Aging Studies, which could then attract Health Research Council funding (New Zealand's version of NIH) as a center of excellence. Possibly, post-doctoral opportunities could result from such a venture.

Many of my students in particular find this work exciting, and their enthusiasm is most infectious. One has gone on to gain a position in the Lottery Grants office, where she is well-placed to advocate for calls for research aimed at older adult issues. Overall, the continued growth and vitality of specialist geropsychology in New Zealand is promising.

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Melding, P. & Osman, N. (1998). The current status of old age psychiatry in New Zealand: A national survey of mental health services for older people in New Zealand. Auckland: Faculty of Psychiatry of Old Age – New Zealand.

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Task Force Progress Report (Continued from p. 4)

The revised Training Guidelines document has been posted on both the Section II and Division 20 websites.

For the past two years the APA College of Professional Psychology has had under consideration whether to develop a certificate in the now officially recognized proficiency of Clinical Geropsychology. The primary concerns of the board appear to be whether enough psychologists would seek such a credential to make its development financially feasible, and whether the certificate would lead to major benefits for the public. In 1999, Section II and Division 20 conducted a survey of practitioners' work with older adults, interest in geropsychological CE, and attitudes toward proficiency certificate. Michael Duffy, the Task Force's liaison to the College, will attend the next meeting of the College's Board of Small Governors in June to discuss the survey results and whether they may help inform the Colleges's decision about certificate development. Members with suggestions about how to present the case on the public benefit issue should contact Michael at 409-845-1848 or mduffy@zeus.tamu.edu.

Did you know...

- If you need to **change your address** for the newsletter please contact Barry Edelstein at e-mail: u21b4@wvnet.edu or by phone: (304) 293-2001, ext. 661.
- Stay connected with your colleagues in clinical geropsychology by joining our **e-mail network**. Simply send an e-mail to Barry Edelstein at u21b4@wvnet.edu (Be sure to include your name, e-mail address, and express your interest in joining the 12/2 e-mail network).
- Division 12, Section 2 has a **web-site**. Check it out at http://bama.ua.edu/~appgero/apadiv12.htm.
- Encourage your colleagues and students **to join Division 12, Section 2**. Contact Michele J. Karel, Ph.D., Psychology Service, 3-5-C, Brockton VAMC, 940 Belmont Street, Brockton, MA 02301; e-mail: Michele.Karel@med.va.gov; or phone: (508) 583-4500, ext. 3725 regarding membership.

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