

Experience Is Not Always the Best Teacher: Lessons from the Certified Psychiatric Rehabilitation Practitioner Certification Program

Kenneth J. Gill

Department of Psychiatric Rehabilitation, University of Medicine and Dentistry of New Jersey, Scotch Plains, New Jersey, USA

This article examines the factors associated with successful attainment of the Certified Psychiatric Rehabilitation Practitioner (CPRP) credential. A brief overview of the development of the examination and its content validity is provided. Level and type of education, psychiatric rehabilitation experience, and letters of recommendations were examined. The first 1,054 applicants for this test-based credential were included in the study. Level of education and mental health-related education were found to be positively correlated with test score and the prediction of who passes the examination. Objectively scored letters of reference contributed a small, but significant percentage of the explained variance. Surprisingly, years of PsyR experience were not correlated with test outcomes. The findings highlight the importance of relevant educational experience for the certification of PsyR staff. Implications for test validity and the preparation of CPRPs are discussed.

Keywords: Certification; Psychiatric Rehabilitation Practitioners

The author serves as Vice President and Chair of the Test Oversight Committee of the Commission on Certification for Psychiatric Rehabilitation.

The author gratefully acknowledges the assistance of Jette Engstrom, Chief Staff Officer, Commission on Certification for Psychiatric Rehabilitation, United States Psychiatric Rehabilitation Association, 601 North Hammonds Ferry Rd, Suite A, Linthicum, MD 21090, USA.

Address correspondence to Kenneth J. Gill, UMDNJ-SHRP Department of Psychiatric Rehabilitation, 1776 Raritan Rd, Scotch Plains, NJ 07076, USA. E-mail: kgill@umdnj.edu

To encourage the highest practice standards among psychiatric rehabilitation service providers for persons with severe and persistent mental illness, the International Association of Psychosocial Rehabilitation Services (IAPRS), now the United States Psychiatric Rehabilitation Association (USPRA), established a registry of qualified practitioners in 1996 and a test-based certification program in 2001 (Henderson, 2001). Consistent with the purposes of all certification programs, these credentialing initiatives were designed to serve consumers of PsyR, the general public, state agencies and other regulators of PsyR by identifying who is competent to deliver services. At present (May 2005), more than 2,200 individuals are CPRPs. The CPRP is recognized in the mental health regulations of 13 states and one Canadian province.

The impetus for certification came from a number of sources, but in large part was based on the assumption that other existing credentials did not sufficiently reflect who was qualified to deliver this type of service (Pernell-Arnold, 1996). In fact, there is some sentiment that formal credentials from other mental health fields may interfere with the acquisition of the skills and attitudes helpful for PsyR. Anthony, Cohen, and Farkas (1990) for example, argued that "functional" professionals (skilled but uncredentialed persons) might be more effective PsyR practitioners. Anthony et al. (1990) and others have also suggested that level of preparation will not be related to competence. However, there has been little empirical support for this idea (e.g., Casper, 2001).

For example, Casper (2001) found that individuals with PsyR related education and degrees were more likely to express attitudes consistent with PsyR beliefs goals and attitudes. In fact, he found education was the strongest predictor of PsyR beliefs. In terms of experience, he found no relationship between PsyR beliefs, goals, and practices and the length of time working in mental health or PsyR. Gill, Pratt, and Barrett (1997) found that students and graduates of an associate's degree program specializing in PsyR were often rated as more skilled by their supervisors than experienced colleagues working in the same agencies. These findings support the utility of PsyR specific education, which has been the subject of a number of articles (Farkas & Anthony, 2001; Gill et al., 1997; Nemeč & Pratt, 2001). Indeed, both the *Rehabilitation Education* (Dell Orto, 2001) and *Psychiatric Rehabilitation Skills* (Gill, 2001) journals have devoted entire issues to this subject.

IAPSRS CREDENTIALING INITIATIVE—THE REGISTERED
PSYCHIATRIC REHABILITATION PRACTITIONER

The PsyR credentialing process began with the creation of the Registered Psychiatric Rehabilitation Practitioner (RPRP) in 1996. In large part, the IAPSRS credentialing initiative was designed to emphasize specific PsyR knowledge, skills, and attitudes without emphasizing formal education (Pernell-Arnold, 1996). In part, this was to insure the inclusion of both persons in recovery and those PsyR workers without advanced academic credentials. After much deliberation, it was determined that while education was to be considered, with specified levels of PsyR experience, the credentialing program would be open to people of all levels of educational background. Thus, an individual with extensive PsyR experience, but no higher education, could enter the registry and become an RPRP or later sit for the CPRP examination and have the opportunity to demonstrate their knowledge and skill. Those with more formal education would be eligible for certification with less experience.

To gather additional information in a cost-effective manner, formal written recommendations (references) that included an objective rating scale were required for both credentialing programs. Supervisors and colleagues with direct knowledge of the work of an applicant rated the extent to which an applicant demonstrates the knowledge and skills of PsyR in their everyday practice. Despite the potential bias inherent in collecting data from persons identified by the applicant, this was deemed the best practical means of collecting additional relevant data to qualify applications. These references paid an important part of the Registry process of RPRPs and APRPs Associate Psychiatric Rehabilitation Practitioners those with less than a bachelor's degree. To enter the Registry, one also had to complete essays based on the principles of PsyR, and provide four letters of reference. Two reviewers graded the essays and the reference letters had a scoring system as well. In the final analysis 80% of the score was based on the references and 20% on the essays. In addition, entry to the Registry required a specific amount of work experience and an agreement to abide by the IAPSRS Code of Ethics.

TEST-BASED CERTIFICATION—THE CERTIFIED PSYCHIATRIC REHABILITATION PRACTITIONER

Beginning in 2002, the Registry was replaced by a certification program based on a psychometrically sound instrument, the CPRP examination (IAPSRS, 2001). The examination was based on widely accepted principles of content validity and internal consistency outlined in federal regulations (*Uniform Guideline for Employee Selection Procedures*, US Department of Labor, 1978), the *Standards for Educational and Psychological Testing* (American Educational Research Association, 1999) and the standards of National Commission for Certifying Agencies (www.NOCA.org). Experience requirements, letters of reference, and adherence to the Code of Ethics were retained as certification criteria, although the number of references required was reduced to two.

CONTENT VALIDITY OF THE EXAMINATION

Content validity, in the context of a professional examination, allows a test developer to demonstrate that the examination correctly reflects the knowledge and skills necessary to function as a competent practitioner. To this end, Castle Worldwide and IAPSRS conducted a role delineation study (IAPSRS, 2001) to identify the knowledge and skills required for the field. Areas of knowledge and skills rated as sufficiently important, critical (their absence results in harm to the public or people served), and frequently needed by practitioners were included in the examination.

The development of the exam has been outlined in a number of reports and documents including the *Role Delineation of the Psychiatric Rehabilitation Practitioner* (IAPSRS, 2001) and reports by the lead psychometrician on the project, James Henderson (2001). Specifically, the content validity of the exam is documented in the report on the role delineation study (IAPSRS, 2001). Briefly, in 2000, 22 PsyR experts were convened to identify tasks, knowledge and skills essential to competence. The panel included experts from throughout the United States representing different PsyR approaches and models. More than 90 skills and knowledge areas were identified and grouped within seven broad performance domains that were found to be sufficiently important, used frequently and critical to competent practice. These seven domains

include: interpersonal competencies; professional role; community resources; assessment, planning, and outcomes; systems competencies; interventions; and diversity.

The next step in this process was a validation study. The work of the initial panel was shared with 248 PsyR professionals from the United States and Canada, 60% of whom were RPRP and 92% of whom were IAPSRs members (IAPSRs, 2001). The resulting final version of the examination consisted of 150 multiple-choice items written by PsyR subject matters experts according to the "blue print" outlined by the role delineation study. Based on those findings, the score on the CPRP examination and the resulting pass/fail became the operational definition of PsyR competence.

WHAT HAVE WE LEARNED SO FAR?

Over 1000 candidates for the CPRP credential have taken the examination at the time of this writing. The testing results of these candidates combined with information about their education and level of PsyR experience provides a rich source of information about the validity of the examination, about the workforce and about what predicts the attainment of certification. This article addresses some of these questions. This article seeks to address the following questions:

Is level of education related to examination score and or the ability to pass the examination? Level of education has been included as eligibility criteria for both the RPRP and the CPRP. One had to have bachelor's degree or higher to qualify as an RPRP. For the CPRP any level of education is permissible, but individuals with degrees have the advantage of needing fewer years of experience to qualify.

Is type of education related to examination score and or the ability to pass the examination? The RPRP and CPRP programs both give an eligibility advantage to individuals with related mental health degrees. As discussed above, studies suggest that PsyR specific degrees are related to indicators of PsyR competence (Gill et al., 1997; Casper, 2001). A small number of CPRP applicants have PsyR degrees and a much larger number have related degrees from other mental health disciplines.

Is amount of psychiatric rehabilitation experience related to examination score and or the ability to pass the examination?

Length of service in PsyR, part of the eligibility criteria for the CPRP and the earlier RPRP, has traditionally been considered an indicator of competence.

Do scored letters of reference relate to examination scores and or the ability to pass the examination? Letters of reference, which have a great deal of intuitive appeal, were weighed highly for the RPRP and are still required for the CPRP, although they are no longer a criterion. However, both empirical and anecdotal evidence suggest letters of reference are not helpful in their ability to distinguish qualified applicants from non-qualified applicants. That is because there are such an overwhelming number of very positive recommendations from references chosen by the applicants.

Does membership in IAPSRS (USPRA) relate to examination score and or the ability to pass the examination? The question of whether IAPSRS members have any advantage on the examination might suggest better preparation or bias against non-members. While there might be reason to believe the former, the latter should not be the case if the examination is content valid.

METHOD

Participants

The study examined archival CPRP testing data obtained from Commission on the Certification of Psychiatric Rehabilitation Practitioners. Test results and nonidentifying data on the characteristics of certification applicants from the fall of 2001 through the summer of 2004 ($n = 1,053$) were included in the sample. Some analyses included fewer participants due to missing data. Complete data was available on 998 individuals. Identifying information such as age, geographic location, and names remained confidential and were not included. However, information relating to the qualifications for eligibility: number of years' experience, level of education and type of education were included.

Compared with previous studies of the PsyR workforce (e.g., Basto, Pratt, Gill, & Barrett, 2000; Blankertz et al., 1996; Walko, Pratt, Siiter, & Ellison, 1993) the resulting sample is better educated and more experienced. Test applicants averaged 5.2 of years of experience in PsyR, with a good deal of variability ($SD = 5.7$) in a negatively skewed distribution of 1 to 27 years. Gender, an optional question, was provided by 567 applicants (62.2% women; 37.8%

TABLE 1. Sample characteristics

Variable	N	Percentage
IAPSRs Membership	867	82.4%
Gender (n = 567)		
Male	128	37.8%
Female	354	62.2%
Highest degree earned		
None	168	16.0%
Associate's	75	7.1%
Bachelor's	495	47.2%
Master's	288	27.5%
Doctoral	19	1.8%
Mental Health Degree	730	69%
Application Status		
Passed	803	76%
Failed	250	24%

Overall n = 1,053 for all analyses except for gender an optional question, n = 567.

men). The higher percentage of women is consistent with earlier findings. Three quarters of the applicants held a bachelor's or masters degree. Additional applicant information including educational level and the proportion of applicants with a mental health related degree (69%) is summarized in Table 1.

Instruments

Several equated versions of the CPRP examination were used as the operational dependent measure for this study. Specific dependent

TABLE 2. Domains of practice within psychiatric rehabilitation

Domain	Number of Items	KR-20
Interpersonal Competencies	31	.68
Professional Role	22	.49
Community Resources	18	.54
Assessment, Planning & Outcomes	25	.71
Systems Competencies	15	.60
Interventions	25	.69
Diversity	14	.60
Total Exam	150	.92

Based on May 2004 exam, n = 33.

¹ Kuder-Richardson-20 (KR-20) internal consistency statistic.

measures were the overall test score (0–150) or pass/fail (0,1) depending on the analysis. The examination is composed of 150 multiple choice questions with four possible answers each. The overall test has high internal consistency (KR–20, $r = .92$). Content validity has been reported on elsewhere (International Association of Psychosocial Rehabilitation Services, 2001). The number of items and internal consistency of the domains is included in Table 2.

Other data was drawn from a database maintained by IAPSR/USPRA regarding the applicant information. Applicant identifying information had been stripped prior to being made available for analysis.

RESULTS

Descriptive Statistics

Seventy six (76%) percent of the applicants in this sample passed the exam, with a mean score of 113.53 and a standard deviation of 15.57 for the overall sample. Applicant letters of references, scored on a scale of 1–20 averaged a score of 17.5 with a standard deviation of 2.6, details are summarized in Table 3.

Education and Type of Education

A one-way ANOVA was conducted to examine differences between the average test scores at each level of education. Means and standard deviations are reported in Table 4. Average test scores increased with higher levels of education ($F [4,1040] = 43.28$, $p < .001$).

Followup tests using the Student Newman-Kuels method were conducted. No significant differences were found between individuals without degrees and those with associate's degrees. Individuals with bachelor's degrees had significantly higher scores than individuals with associate's degrees. Master's prepared candidates

TABLE 3. Descriptive statistics on test scores and reference scores

	Mean	(S.D.)
Test score	113.53	15.57
Reference 1—score	17.39	2.90
Reference 2—score	17.62	2.28

TABLE 4. Test score descriptive statistics by educational level

	N	Mean	S.D.
No degree	168	103.29	17.74
Associate's level	75	106.81	15.29
Bachelor's level	495	113.33	14.38
Master's level	288	119.80	12.42
Doctoral level	19	127.84	7.43
Total	1045	113.29	15.58

$F(4,1040) = 43.28, p < .001, \eta = .14.$

Student-Newman Kuels follow-up test, Harmonic mean = 64.59 used due to unequal sample size. Mean square error = 209.02. The "no degree" group and associate's group are significantly different from the other three groups at $p < .05$.

scored higher than bachelor's prepared candidates. Doctoral degree recipients scored significant higher than individuals with master's degrees.

To study the impact of different types of education, a second factor was added, type of education (mental health-related degree vs. non- mental health related degree). Only associate's bachelor's, and master's degree applicants were included in this analysis reducing the overall sample to $n = 861$. For obvious reasons those without any degree ($n = 168$) were not included in this analysis. Those with doctoral degrees ($n = 19$) were also excluded since these individuals, who scored uniformly higher on the examination, all reported holding a mental health-related degree. A two-way ANOVA was conducted to assess the effect of educational level (associate's, bachelor's and master's levels) and type of education (mental health-related or not). A main effect for level of education was found ($F[2, 852] = 11.35, p < .001$). As reported above, average test scores increased with higher levels of education. A main effect for type of education (mental health degree vs. unrelated degree) was also found ($F[1, 852] = 10.85, p < .001$). Those with mental health related degrees scored higher than those with degrees in other areas. An interaction of level of education and type of education was also found ($F[2, 852] = 3.88, p = .02$). The interaction appears to be at the master's degree level where there is clearly a difference between those with and without mental health preparation. See Figure 1.

Examining Figure 1, individuals with a mental health degree ($M = 116.25$) score higher than individuals with unrelated degree

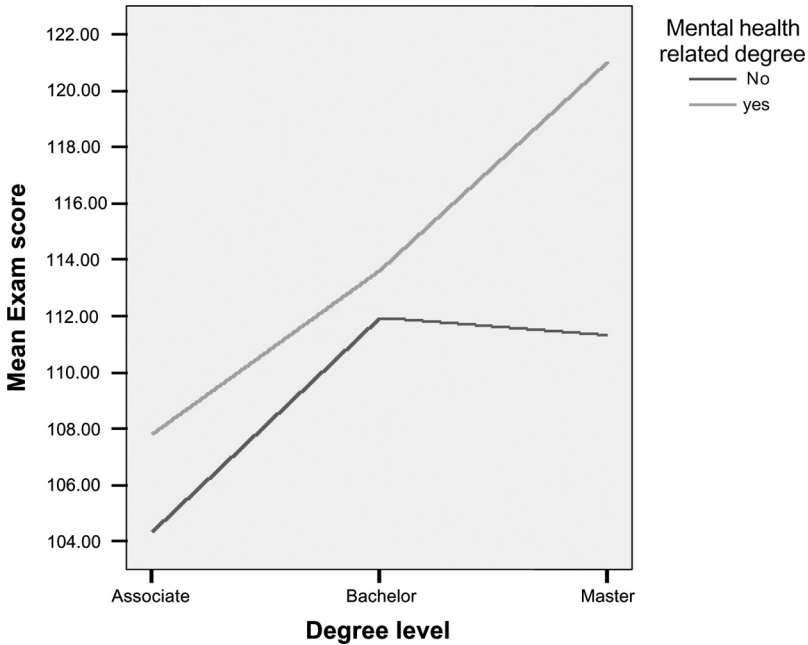


Figure 1. Effect of interaction of educational level and degree type on test scores.

($M = 110.70$), regardless of educational level. At the master's degree level, however, the difference becomes quite pronounced. A mental health degree is associated with a 2.5 point advantage at the associate's level, a 3.0 point advantage at the bachelor's level, but a very large 10.30 advantage at the master's level. Another way of looking at this interaction is that individuals with *nonmental health master's* degrees ($M = 111.32$) scored almost identically to *bachelor's* students with a non-mental health degree ($M = 111.95$). In fact, they scored slightly lower than *bachelor's* students with a mental health degree ($M = 113.96$). In contrast, those with a mental health-related master's degree have a much higher mean score of 121.69.

Consistent with the above findings, the proportion of individuals passing the exam was also related to educational level. Individuals at the lowest level of education were least likely to pass the exam. Only 52% of individuals with no degree passed the examination, whereas of those with the most education, at the doctoral

level, 100% passed (see Table 4). A mental health-related degree was also associated with passing the exam and receiving a higher score with 82% of the people with a mental health-related degree passing the exam, compared to 61% without such a degree ($\chi^2(1) = 57.18$ $p < .01$).

Years of Experience

Interestingly enough, years of experience was unrelated to the likelihood of passing the exam. It was also unrelated to exam score with $r(998) = .06$, $p < .05$. Although statistically significant, this is of little practical significance, accounting for much less than 1% of the variance.

Membership in IAPSRs

A total of 81.8% of nonmembers passed the exam, compared to 74.8% of IAPSRs members. This difference was not statistically significant ($\chi^2(1) = 3.32$, ns).

Predicting Who Passes and Who Fails

In order to predict who passes the exam, a discriminant function with the predictors of educational level (coded 1 to 5), mental health-related education (0 = no, 1 = yes), the two letters of reference scores and years of experiences was conducted. Using Wilk's stepwise method, a significant effect was found (Wilk's $\lambda = .871$, exact $F[1, 988] = 36.531$, $p < .001$). Years of experience did not contribute to discriminating between who passed the exam and who did not. For the associated canonical function, the canonical $r = .36$, accounting for about 13% of the variance. The overall classification rate of who passed and failed was 77.1% correct. Degree level was entered first, accounting for about 10% of the variance. Each of the additional variables added about 1% each. See Table 5.

Prediction of Test Scores

Similarly, a multiple regression model was developed to predict test scores using the same variables. All of the variables were

TABLE 5. Predictors contributing to the discriminant function

	Approximate Change in η^2	Standardized Canonical Discriminant Function Coefficients
Degree level	.10	.685
Related MH degree	.01	.260
Reference Score 1	.01	.266
Reference Score 2	.01	.273

TABLE 6. Factors in multiple regression model explaining test scores

	Beta	r	Partial r	Part r	p
Degree Level	.284	.377	.244	.226	.000
Related MH degree	.095	.279	.085	.076	.006
Reference 1	.119	.223	.122	.111	.000
Reference 2	.153	.231	.158	.143	.000

Multiple r (997) = .44, $p < .01$.

entered simultaneously and their unique contributions were assessed. Of the predictors in this model, the strongest was level of education; others included type of education and letters of reference scores. Years of experience did not contribute to the prediction of test scores (see Table 6).

DISCUSSION

The findings support the significant role that advanced, relevant education has in preparing individuals for competent PsyR practice. In addition, the finding also supports the utility of the input of those who have direct knowledge of a practitioner's work, as evidenced by the role of the scored references in predicting competence as measured by test scores. No support was found for the notion that experience, defined as years of paid work, is associated with competence. Also, IAPSRS members are not better prepared for the test, nor is there any evidence that the test is biased against non-members.

In one sense, the lack of effect of experience is an unexpected finding, considering the great value that is traditionally put on

experience anecdotally and in the folklore of the field. On the other hand, it is not a surprising finding at all, because part of the impetus behind the certification program is an implicit acknowledgement that experience does not equal competence, indeed, this is an underlying assumption of all credentialing modern credentialing efforts.

It is somewhat surprising that the references do relate to the probability of passing the examination as well as the examination score. Some of the more quantitatively oriented commissioners of the CPRP commission (including the author) were averse to using references as a criterion, given their overall halo or positive bias (Range, Menyhart, Walsh, Hardin., 1991). Yet, these scored recommendations do in fact predict a small amount of variance in test scores. Although the Commission on Certification of Psychiatric Rehabilitation no longer requires these references, only verification of employment, this finding does suggest that those completing the recommendations were taking the scale seriously and conscientiously completing it based on their observations.

Advanced education, particularly mental health-related education was found to be associated with a greater likelihood of passing the examination and higher test scores. In a sense, it would be erroneous to conclude that a higher degree in a mental health field is the most essential factor in passing the examination. Given that the test is content-valid, knowledge and skills of PsyR are the most important factors. Indeed, a slight majority of those individuals with no higher education who take the examination pass (52%).

An important consideration is the fact that there is a large self-selection bias being introduced by studying PsyR applicants. Only those professionals with a strong interest and inclination in the field bother to take the examination and acquire the credential. What it does suggest, however, is that advanced education for such individuals, especially those with mental health-related degrees is associated with competence. This is an important finding which supports the need for PsyR practitioners to pursue advanced, and in particular, *related* education in a mental health field. It also speaks to content and construct validity of the test. That is, if level of education were a sufficient predictor, the test would be measuring general reading or intellectual ability, academic achievement or some other non-specific factor. Instead, there is evidence it is measuring the specialized knowledge of PsyR.

REFERENCES

- American Educational Research Association (1999). *Standards for Educational and Psychological Testing*. Washington, DC: American Educational Research Association.
- Anthony, W., Cohen, M., & Farkas, M. (1990). *Psychiatric Rehabilitation*. Boston, MA: Boston University Center for Psychiatric Rehabilitation.
- Basto, P.M., Pratt, C.W., Gill, K.J., & Barrett, N.M. (2000). The organizational assimilation of consumer providers: A quantitative examination. *Psychiatric Rehabilitation Skills*, 4, 105–119.
- Blankertz, L. & Robinson, S. (1996). Who is the psychosocial rehabilitation worker? *Psychiatric Rehabilitation Journal*, 19(4), 3–12.
- Casper, E.S. (2001). Psychiatric rehabilitation degree-granting programs and practitioners' knowledge practice patterns. *Psychiatric Rehabilitation Skills*, 5(3), 534–547.
- Dell Orto, A. (Ed.). (2001). Psychiatric Rehabilitation Education (entire issue), *Rehabilitation Education*, 15, 119–199.
- Farkas, M. & Anthony, W.A. (2001). Overview of psychiatric rehabilitation education: Concepts of training and skill development. *Rehabilitation Education*, 15(2), 119–132.
- Gill, K.J. (Ed.). (2001). Special Issue: Psychiatric rehabilitation curriculum in higher education. *Psychiatric Rehabilitation Skills*, 5(3), 432–571.
- Gill, K.J., Pratt, C.W., & Barrett, N.M. (1997). Preparing psychiatric rehabilitation specialists through undergraduate education. *Community Mental Health Journal*, 33, 323–329.
- Henderson, J. (2001). "History" of psychiatric rehabilitation certification program. Retrieved from <http://www.uspra.org/certification/welcome/history.html>. Accessed May 11, 2005.
- Internal Association of Psychosocial Rehabilitation Services (IAPRSRS). (2001). *Role delineation report of the certified psychiatric rehabilitation practitioner*. Morrisville, NC: Columbia Assessment Services.
- Nemec, P. & Pratt, C.W. (2001). Graduate education in psychiatric rehabilitation. *Psychiatric Rehabilitation Skills*, 5, 477–494.
- Pernell-Arnold, A. (1996). Report of the IAPRSRS Certification subcommittee to the IAPRSRS Board, personal communication.
- Range, L.M., Menyert, A., Walsh, M.L., & Hardin, K.N. (1991). Letters of recommendation: Perspectives, recommendations, and ethics. *Professional Psychology: Research & Practice*, 22(5), 389–392.
- United States Department of Labor. (1978). *Uniform guidelines of employee selection procedures*. CFR, title 41, Chapter 60, part 60–3. Retrieved from http://www.dol.gov/dol/allcfr/Title_41/Part_60-3/toc.htm. Accessed May 11, 2005.
- Walko, S.E., Pratt, C.W., Siiter, R., & Ellison, K. (1993). Predicting staff retention in psychiatric rehabilitation. *Psychosocial Rehabilitation Journal*, 16(3), 150–153.