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Skin in the Game: The Professionalisation of Lived Experience Roles in Mental Health

Abstract

The lived experience workforce has moved from being a grassroots support and activist movement to become the fastest growing workforce within mental health. As lived experience work becomes assimilated within mainstream mental health service delivery it faces mounting pressure to become more professionalised. Professionalisation has evoked both optimism and fear, with diverging views within the lived experience workforce. In this paper, an assessment of the existing professionalisation of the lived experience workforce is undertaken by drawing on theoretical positions and indices of what constitutes a profession. The arguments for and against professionalisation are explored to identify the risks, benefits, and considerations for the lived experience workforce. The drive for professionalisation has largely occurred due to the clinically focused mental health systems’ valuing of professional identity. The argument in favour of professionalisation is driven by a need for credibility within the views of that system, as well as greater regulation of the workforce. However, tensions are acknowledged with concerns that professionalisation to appeal to the clinically focused system may lead to erosion of the values and uniqueness of lived experience work and nullify its effectiveness as an alternative and complementary role. Given mental health nurses are increasingly colleagues and often line managers of lived experience workers, it is important at this stage of lived experience workforce development that mental health nurses understand and are able to advocate for lived experience roles as a distinct professional discipline to help avoid the risks of co-option to more dominant clinical practice.

Keywords: lived experience workforce; mental health; peer workers; professionalisation; inter-disciplinary practice.
PROFESSIONALISATION OF LIVED EXPERIENCE ROLES IN MENTAL HEALTH

Introduction

Lived experience (LE) roles in mental health, also known as peer roles, are distinguished from clinical roles by the use of lived expertise and experiential knowledge gained through experiences of diagnosis, service use and personal recovery from mental health challenges for the purpose of helping others and contributing to system change (Gagne, Finch et al. 2018). Lived experience roles increasingly refer to both consumer and carer roles (Byrne 2019). In the context of this paper, ‘professionalisation’ is defined as a process by which an occupation defines itself as a profession, by establishing appropriate qualifications, regulatory associations and demarcation from being perceived as unqualified (Abbott 2014).

This paper aims to identify and critically review diverging perspectives concerning the professionalisation of the lived experience or peer workforce. An assessment of the current lived experience workforce is taken to ascertain the current position of lived experience work in relation to classification as a profession. This is achieved by drawing on theoretical positions on indices of a profession and then examining specific measures of a profession within health settings (Jensen 2015). The paper then critically reviews the arguments for and against professionalisation and concludes by discussing clinical implications and the future of the lived experience workforce.

Background

The lived experience workforce refers to a range of roles that can be delineated based on direct service provision, or peer support, with individuals and groups through to more indirect service provision within leadership and management roles in mental health (Jacobson, Trojanowski et al. 2012). Personal experience is fundamental to lived experience
work. However, personal experience is not enough. Lived experience work encompasses a range of skills, values and theoretical propositions that provide a framework that distinguishes lived experience work as different from traditional mental health roles. Repper and Carter further define lived experience roles as working from “A wellness model that focuses on strengths and recovery…. rather than an illness model, which places more emphasis on symptoms and problems of individuals.”(2011). Personal recovery in mental health is markedly different from clinical recovery, in that the focus is not on eliminating symptoms but a process of moving towards regaining hope, autonomy, personal control, and meaning (Leamy, Bird et al. 2011).

Lived experience can be conceptualised as a relationship-based practice underpinned by recovery-orientated practice, person-centred approaches, and trauma-informed care (Beales and Wilson 2015). Lived experience work translates to practice that is empowering for consumers and honours individual choice and potential (Mead and MacNeil 2006, Croft, Wang et al. 2016). This emergent and increasingly formalised workforce is differentiated from more informal, unpaid peer support that occurs organically and mutually as people in similar experiences provide support to one another within the community (Naslund, Grande et al. 2014). Lived experience work (LEW) is not limited to the mental health sector and occurs in physical health and chronic disease management, such as diabetes and hepatitis C (Fisher, Ballesteros et al. 2015, MacLellan, Surey et al. 2015). However, our focus here is exclusively on paid LE roles within mental health.

Earliest accounts of lived experience work have been traced back to the 18th Century, when previous patients began to be employed as staff. These ‘ex-patients’ were reputed to be “Gentle, honest, and humane and less likely to abuse or mistreat the inmates [sic].” (Davidson, Rakfeldt et al. 2011). However, it was not until the consumer movement emerged, as part of the broader human rights movement during the 1960s, that lived experience work
began to develop in a more purposeful way, in response to harmful and often inhuman mental health treatment (Ostrow and Adams 2012). Although the consumer movement was the driving force for lived experience work, the impact of deinstitutionalisation and the move to a model of community care had a significant impact as individuals were sent back to the community, with often inadequate support (Newton, Rosen et al. 2000). More contemporary models of lived experience work emerged in the 1980s; however, this work still occurred on the fringes of mental health service delivery, rather than central to service provision (Davidson, Rakfeldt et al. 2011). It was not until lived experience work moved into mainstream service delivery in the last 30 years that roles started to be incorporated within the broader mental health workforce (Gillard, Foster et al. 2017).

The lived experience workforce within mental health has expanded globally, and LE workers in Australia are now employed in a range of services, including public health and the non-government sector (Stratford, Halpin et al. 2017). However, this growth does not reflect equal growth in shared understanding of lived experience work. Lived experience roles have grown in an ad hoc fashion and diversity of understanding from clinical workers, managers and funders about the uniqueness and difference of the work has proven to be challenging in clarifying the role and bringing credibility to the workforce (Jacobson, Trojanowski et al. 2012). The lack of clarity compounds the difficulties faced by an already marginalised workforce and hinders the ongoing evolution of a workforce often viewed with ambivalence by mental health professionals (Hurley, Cashin et al. 2016).

Victoria 2021). With increasing priority given to implementing and growing the lived experience workforce in Australia, it is critical that lived experience work is appropriately understood to ensure ongoing development protects the authenticity of the roles and focuses on best practice.

**Reasons for the Growth in the Lived Experience workforce**

The evidence for lived experience work in mental health services internationally shows benefits for consumers (individuals accessing mental health support), organisations, colleagues and lived experience workers (Beales and Wilson 2015). For consumers, access to lived experience workers has reduced hospital admissions and length of hospital stay; increased empowerment, hope and independence; reduced social isolation through strengthening access to social networks and increased consumer satisfaction (Solomon 2004, Davidson, Bellamy et al. 2012, Chinman, George et al. 2014, Beales and Wilson 2015, Gillard, Foster et al. 2017, Jackson and Fong 2017). Notably, no studies show that lived experience work has an adverse impact on those accessing support (Cyr, Mckee et al. 2016).

Benefits for colleagues and organisations employing lived experience workers have included an increased understanding and focus on recovery-oriented practice and improved outcomes and relationship with consumers (Bailie and Tickle 2015, Byrne, Happell et al. 2016, Gillard, Foster et al. 2017). Findings suggest substantial financial benefits of employing lived experience workers (Trachtenberg, Parsonage et al. 2013, Jackson and Fong 2017). Lived experience workers also benefit from increased personal growth, valued role status, and positive impacts of employment (Bailie and Tickle 2015, Vandewalle, Debyser et al. 2016). Moreover, evidence reveals that consumers often prefer to receive support from people in lived experience roles, with high levels of dissatisfaction with the traditional services provided indicating that mental health services require new approaches, including lived experience work, to deliver effective services (Dixon, Holoshitz et al. 2016).
This dissatisfaction from consumers speaks to an identified need for system change and alternatives to address long-standing access barriers to mental health care (Mendoza 2013, State of Victoria 2021). In developed countries, the estimated percentage of individuals who need mental health care but do not receive treatment ranges from 44% to 70% (World Health Organization 2014). The reasons for this lack of access to support are complex and multi-faceted but include negative experiences with traditional services and an absence of alternatives (Andrade, Alonso et al. 2014). Recognition of personal recovery and the recovery reform agenda has moved policies, plans and service provision goals away from previous ideas of inevitable long-term chronicity and towards promoting social inclusion and citizenship through community-based supports, including lived experience-based support.

Despite the evidence attesting to the benefits of lived experience work, several challenges exist. The evidence for lived experience work does not go uncontested, and theorists have questioned the validity of research evidence. While some studies had positive and convincing findings concerning the efficacy of lived experience roles, other studies have identified no differences between the outcomes for consumers accessing lived experience work as opposed to traditional mental health professionals (Lloyd-Evans, Mayo-Wilson et al. 2014). Although, as indicated in the National Mental Health Commission (2014) report, this research largely ignores social and recovery-based outcomes. However, within industry, particularly governmental policy, the value of lived experience work in mental health is generally well accepted (Gordon and Bradstreet 2015).

Research brings insights into the challenges organisations face in the employment of lived experience workers, and the challenges for lived experience workers within mainstream service delivery (Wolf, Lawrence et al. 2010, Faulkner and Basset 2012). Research on the effective integration of lived experience workers has also highlighted best practice (Byrne, Roennfeldt et al. 2018). Many of the best practice outcomes can be promoted by strategies
that create greater understanding and consequently status for lived experience roles. Strategies include the need for specific policies and practice that promote role clarity (Jacobson, Trojanowski et al. 2012), the value of training and qualifications within the lived experience workforce (Wolf 2014), and specific lived experience supervision (Davis 2015).

The growing interest in lived experience as a profession has arisen in part as a response to embedding the lived experience workforce within mainstream services. However, professionalisation has given rise to fears of co-option and losing the authenticity of lived experience if lived experience workers are influenced by the dominant medical model (Davidson, Chinman et al. 1999, Byrne, Happell et al. 2016). As the lived experience workforce evolves, it is essential to be grounded in the consumer movement's history and consumer/survivor culture in providing the foundation and values of lived experience work within a civil rights and social justice framework. Additional concerns centre around the potential for increased power imbalance between lived experience workers and consumers when roles are increasingly professionalised (Resnick, Armstrong et al. 2004).

What makes a Profession?

A profession has been defined as:

A disciplined group of individuals who adhere to ethical standards and who hold themselves out as, and are accepted by the public as possessing special knowledge and skills in a widely recognised body of learning derived from research, education and training at a high level, and who are prepared to apply this knowledge and exercise these skills in the interest of others (Australian Council of Professions 2003).

Therefore, a profession is an occupation that possesses qualities that have been attained by increasing training or raising the required qualifications to give professional character or status to establish itself as a profession (Evetts 2011). Professional character denotes qualities
of behaviour and practice that abides by an agreed code or set of guidelines. Professionalism has further been extended to imply integrity and serving the public good within the profession (Evetts 2011).

Building on this definition, Fawkes considers a profession as possessing five qualities: commitment to social values; clear entry route (involving education and qualifications); the body of knowledge and ideals of best practice; and a professional body and codes of conduct with a commitment to ethical practice (Fawkes 2014). These indices are also reflected in early accounts of a profession needing specialist knowledge (Carr-Saunders and Wilson 1933). The gatekeeper function of a profession is significant, and a distinguishing feature of a profession is the requirement of a collective body which regulates admission and upholds standards (Flood 2019).

Jensen developed a set of indices for professionalisation in health and further contends that health professionals' commonalities allow for the grouping of professionals and placement on a continuum of professionalisation that permits methodical comparisons (2015). An overview of Jensen’s typology of the professionalisation process is provided in table 1. This continuum begins with informal collaboration and requires a range of activities through to specialisation. Notably, this process is not linear. Jensen’s method for objectively describing health care professions on a continuum allows disciplines to be measured within a professionalisation process. Professions are described as ‘emerging’ through to a level of maturity where they have branched into specialisations. Using events on the professionalisation process, health professions can be identified and classified based on their level of attainment of events required for professional status.

(Insert Table 1)
Lived Experience Work in Mental Health: An Emerging Profession

It is suggested that the degree of professionalisation of lived experience work may be gauged by identifying the progress of attainment of the requisite activities along this continuum. These events are described below in relation to the lived experience workforce.

From Informal to Formalised Collaboration

The professionalisation process begins with informal collaboration of people with shared knowledge and skills to greater formalised collaboration, often in the form of a national association. The lived experience workforce has evolved from localised collectives to establish national and international networks and conferences. However, despite calls for a national peak representing the lived experience workforce, at present, there is not a regulatory body or a governing peak agency in Australia. State workforce peaks provide avenues for collaboration but do not have a formal regulatory role (https://qlewn.com.au/).

Authorised Practice

In Australia and internationally, there is currently no registration or licencing requirement for lived experience work. However, guidelines and standards of practice for the employment of lived experience practice are being developed (Chinman, George et al. 2014). Specifically, in Australia, the National Mental Health Commission is in the process of establishing guidelines for the development of the Lived Experience (Peer) Workforce which are expected to set out principles for the employment of lived experience workers as well as establishing benchmarks for lived experience practice. Several State frameworks and guidelines for lived experience/peer workforce development are already available (Gallagher and Halpin 2014, WAAMH 2014, LEWP 2018, NSW Mental Health Commission 2018, Byrne, Wang et al. 2019, Mental Health Council of Tasmania 2019, Queensland Health
Without governmental regulations and structures of accountability, these guidelines are not able to be enforced and remain as recommendations for the workforce.

**Standardised Qualifications and Regulated Education**

As the lived experience workforce has become more embedded within mainstream mental health service delivery, there have been efforts to increase standardised qualifications. Current training in Australia is at a Certificate IV level, and critics believe it is insufficient to consolidate knowledge needed to practice lived experience work effectively and greater technical training is needed (Gagne, Finch et al. 2018).

There is no set examination for lived experience work and or benchmark to establish competency (Myrick and del Vecchio 2016). This contributes to variability in employment with inconsistent position descriptions and ambiguity regarding the tasks of lived experience workers and variability regarding the training and requirements for the workforce (Cronise, Teixeira et al. 2016).

**Educational Uniformity**

Training is vital in evolving an identity as a professional group and developing agreed norms and values (Clarke, Martin et al. 2015). Currently, Australia, New Zealand, the UK and the US all have nationally accredited training with a curriculum based on core content including interpersonal skills, use of personal story, appropriate self-disclosure, recovery principles, use of language, and trauma-informed practice (Gillard, Edwards et al. 2013, Hurley, Cashin et al. 2016, Gagne, Finch et al. 2018, Kaine 2018). Credentialling and certification processes in the US have attempted to establish uniformity in provision of services and also meet funding requirements for reimbursement of services (Chinman, George et al. 2014).

**Educational Identity**
The lived experience workforce have developed several distinct models of practice including Intentional Peer Support (Mead 2003), Clubhouses (Mowbray, Collins et al. 2005) and Crisis Centres (Lyons, Hopley et al. 2009). These models have cemented lived experience roles within a range of services in mental health. Lived experience academics are employed in diverse disciplines including nursing, psychology, psychiatry, social work and management to provide a distinctive lived experience perspective (Happell, Wynaden et al. 2015, Banfield, Randall et al. 2018, Jones, Atterbury et al. 2021); however, lived experience is still not recognised as its own discipline.

**Consolidated Beliefs**

There has been a push to establish an International Charter for Peer Work to develop consensus on a common, core set of guiding principles and values (Stratford, Halpin et al. 2017). Authors claim this charter will pave the way for developing effective, culturally responsive forms of peer support. Further, it is suggested the charter will assist in ensuring lived experience work continues to have integrity to its founding values in a civil rights and social justice framework, and with responsiveness to local cultural worldviews. As yet, this has not eventuated.

**Enlarged Influence**

Lived experience work has influence within the mental health sector and has been instrumental in shaping policy reforms towards the recovery agenda. However, the lack of clarity and consensus of requirements for lived experience roles, lack of autonomy as a discipline and limited avenues for disseminating ideas, all contribute to lived experience roles still being considered an optional add-on, rather than integral to service delivery.

**Enhanced Communication**
Expanding lived experience work is further impacted by the lack of specialised lived experience journals and funding, reducing research and publication opportunities. These factors highlight the professional marginalisation of lived experience work as always existing as an adjunct to other disciplines (Happell and Roper 2006, Ashby, Gray et al. 2015).

**Specialisation**

Lived experience has not achieved diversification of roles at all levels, with roles predominantly being entry-level positions with few opportunities for career mobility. Although lived experience leadership roles now exist within Australia’s service delivery, they are considered the exception rather than standard practice (Scholz, Gordon et al. 2017).

**Overall Assessment of Professionalisation**

In assessing the level of professionalisation, the lived experience workforce has achieved steps towards establishing standardised education, creating a distinct identity and has formidable influence regarding policy and service delivery. However, without an established governing body, has not achieved autonomy to make decisions regarding its own workforce. Subsequently, the lived experience workforce is fighting for external validation and recognition as a profession. Hence, the lived experience workforce could be described as having a liminal occupational identity that has not reached the level of recognition and formalisation offered by professionalism (Simpson, Oster et al. 2018).

**An argument for and against professionalisation**

As previously noted, there is considerable variation in the employment and understanding of lived experience roles. Greater structure and formalisation of roles are arguably needed to hold organisations to account and support effective employment of lived experience workers. In ascribing a liminal professional status to lived experience workers, Simpson and colleagues have detailed the interlaced the evolution of utilising lived
PROFESSIONALISATION OF LIVED EXPERIENCE ROLES IN MENTAL HEALTH

experience and the formalisation of training, and engagement within diverse work environments (2018). This highlights that the transition to professional status for lived experience workers requires redefining of personal and occupational identity (Clarke, Martin et al. 2015). They argue, the difficulties of the in-between state of not being considered credible as a profession, could be eased through greater professionalisation (Simpson, Oster et al. 2018). The negative impacts of professional liminality have also been identified within role ambiguity and identity construction during role transitions, and research has argued for the need for collective identity to provide a stronger identity as a discipline (Beech 2011, Nissim and De Vries 2014).

There is a risk that clinicians and management take the view that the only contribution lived experience workers can make is their individual experience of mental health challenge (Ehrlich, Slattery et al. 2019). Recognised skills and knowledge beyond the use of personal story is one way that professionalisation would is one way to give lived experience workers a more valued status and external validation within organisations and systems of power. Health professions, including mental health, work within a system of medical dominance and medical power, established in part through the autonomy and professional power of economic and administrative influence, and collective associations (Kerry, 1992). Professionalisation may not only affirm the value of lived expertise, but it could also provide a platform to continue building an ever-stronger evidence base for lived experience work through standardised practice, leading to increased funding (Faulkner and Kalathil 2012). Greater recognition and status as a profession is also considered by some to attract better training, generating more employment opportunities, professional development and broader support for lived experience work (Tench and Yeomans 2017). Professionalisation and increased credibility could also guard against the lived experience workforce being used as a form of cheap labour (Simpson, Oster et al. 2018). In due course, the argument for professionalisation
claim that greater status and value of lived experience work as a profession, lead to greater possibilities for social change from within 'the system'.

Drawbacks to professionalisation are argued to include potential restrictions on political action, with demands for uniformity and registration to a governing body seen as an instrument to moderate the service reform agenda of lived experience work (Beales and Wilson 2015). Professionalisation could also exclude those who have not attained the entry requirements of the profession. Some people who have experienced disruptions in their education due to periods of hospitalisation or significant distress may not have completed their schooling but have still obtained great lived experience skills, in what has been described as a ‘sneaky degree’ (Scholz, Bocking et al. 2018). Likewise, people with low literacy or English as a second language may find formal education a barrier. There is an identified need for multiple pathways to be preserved to allow people who have the skills but lack the formal schooling to continue to participate in the workforce (Byrne, Wang et al. 2019, Queensland Health 2019). There is also tension regarding who is included in the governing body and who will decide what is best or ethical practice for the profession (Fawkes, 2017). An alternative to professionalisation is proposed as united action and unionisation by lived experience workers, and the creation of practice guidelines that enshrine the values of lived experience work (Beales and Wilson 2015). Concerns are also acknowledged in undermining the value of lived experience work as unique from mental health clinicians (Simpson, Oster et al. 2018). The authenticity of lived experience work lies in its distinction from clinical work, recognising the inherent strengths and vulnerabilities of lived experience work and the work of clinicians, and to the respected role of both. Some researchers have warned that it is imperative that lived experience work not become encumbered by professionalisation and entangled in bureaucracy, identifying the risk of
replicating clinical roles and restoring the conditions in which the need for lived experience roles arose (White 2009).

Debate surrounding professionalisation highlights the unique concerns of work that is fundamentally centred on personal experience and relationships trying to find credibility within a system that prioritises formalised knowledge (El Enany, Currie et al. 2013). The lack of recognition of life experience and informal learning is a caution against indiscriminately embracing the highly structured and regulated practice. Ultimately, professionalisation could be the result of attempting to solve the ‘wrong’ problem. Instead of trying to address the need for professionalisation, perhaps the focus should shift to how we shape the work environment to greater value and acknowledge lived expertise as a knowledge base and subsequently lived experience roles.

Clinical Implications and The Future of Lived Experience Work

In weighing up the argument for professionalisation, while there are resistance and counter-arguments to professionalisation, the strongly held belief is that the forces of professionalism are already in action (Simpson, Oster et al. 2018). Lived experience work is an emerging but increasingly embedded workforce within mental health service delivery. Presently, lived experience work is at a tipping point where its future development and policy structures are intersecting with broader reforms in disability and mental health, potentially leading to new understanding and acknowledgement of the value of lived experience work (State of Victoria 2021). It is critical ongoing development of a governing body and autonomy within their own discipline is led by lived experience workers, and proactively supported by leaders and allies within multi-disciplinary teams. As lived experience roles continue to evolve, there is perhaps an inevitability of greater professionalisation of roles in order to continue to address power imbalances and medical dominance within mental health
(El Enany, Currie et al. 2013). Yet, the push towards professionalisation is fraught with concerns of co-option and difficulties in the transition from a mostly activist practice. Mental health nurses and other colleagues have a role in advocating for policy and practice that upholds authentic practice and mechanisms of support based on lived experience values and principles. Progress needs to consider the historical and political roots of lived experience work. Lived experience work will continue to define and redefine itself and fight for valued status as it moves towards greater autonomy as a distinct and integral discipline within mental health. With support from mental health nurses and others, ideally, lived experience work will be embedded as an essential and equally respected element of the multi-disciplinary mental health system.

**Afterword**

As lived experience academics, the authors have provided an understanding of the issue of professionalisation from an insider perspective. This paper did not seek to land at a definitive position to pursue or resist professionalisation; rather illuminate the complexity of the issues and add to a timely debate. Professionalisation and a dedicated union have enabled many workforces to advocate for training, fair pay and working conditions, recognition of their expertise, and the development of tertiary education programs and opportunities for specialisations. The professionalisation of the lived experience workforce may provide a valuable opportunity to flag the importance of the lived experience workforce as another equally important workforce deserving of the same opportunities. However, there remains the risk of co-option and fear that there will be the loss of the potential to disrupt or dismantle traditional services in joining the ranks of mental health professionals. The lived experience workforce must be unrelenting in the integrity of the lived experience perspective and principles. Once the horse has bolted, it is too hard to get it back in the stable. These issues are far too important to discard because it feels onerous or inevitable. If there are open and
transparent discussions about the potential benefits and risks of professionalisation, the lived experience workforce and allies can advocate for how they wish to pursue it. If it isn't discussed at all, they may have no option.


PROFESSIONALISATION OF LIVED EXPERIENCE ROLES IN MENTAL HEALTH


Queensland Health (2019). Queensland Health Mental Health Framework Peer Workforce Support & Development 2019


Trachtenberg, M., M. Parsonage, G. Shepherd and J. Boardman (2013). "Peer support in mental health care: is it good value for money?".


### Table 1:

*The Continuum of Professionalisation of Health Professions*

<table>
<thead>
<tr>
<th>Event</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informal Collaboration</td>
<td>Assembly of a group of people with common skills or knowledge</td>
</tr>
<tr>
<td>Formalised Collaboration</td>
<td>Formation of a professional association (often national)</td>
</tr>
<tr>
<td>Authorised Practice</td>
<td>Passage of governmentally sponsored licensure or registration</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Standardised Qualifications</td>
<td>Administration of professional examinations</td>
</tr>
<tr>
<td>Educational Identity</td>
<td>Establishment of distinctive programs for professional education</td>
</tr>
<tr>
<td>Educational Uniformity</td>
<td>Standardisation of the process for professional education</td>
</tr>
<tr>
<td>Consolidated Beliefs</td>
<td>Establishment of a professional code of ethics, values, and philosophies</td>
</tr>
<tr>
<td>Enhanced Communication</td>
<td>Publication of a professional journal</td>
</tr>
<tr>
<td>Regulated Education</td>
<td>Accreditation of educational process</td>
</tr>
<tr>
<td>Enlarged Influence</td>
<td>Expansion of practice scope</td>
</tr>
<tr>
<td>Intensified Training</td>
<td>Expansion of education to accommodate the growth of practice scope</td>
</tr>
<tr>
<td>Specialisation</td>
<td>The division into multiple and more restricted professions</td>
</tr>
</tbody>
</table>