Decision on whether accreditation is in the public interest

Complementary and Natural Healthcare Council (CNHC)

February 2023

professional standards authority

About the Professional Standards Authority

The Professional Standards Authority for Health and Social Care promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and voluntary registration of people working in health and care. We are an independent body, accountable to the UK Parliament.

We oversee the work of 10 statutory bodies that regulate health professionals in the UK and social workers in England. We review the regulators' performance and audit and scrutinise their decisions about whether people on their registers are fit to practise.

We also set standards for organisations holding voluntary registers for people in unregulated health and care occupations and accredit those organisations that meet our standards.

To encourage improvement we share good practice and knowledge, conduct research and introduce new ideas including our concept of right-touch regulation. We monitor policy developments in the UK and internationally and provide advice to governments and others on matters relating to people working in health and care. We also undertake some international commissions to extend our understanding of regulation and to promote safety in the mobility of the health and care workforce.

Our organisational values are: integrity, transparency, respect, fairness and teamwork. We strive to ensure that our values are at the core of our work. More information about our work and the approach we take is available at www.professionalstandards.org.uk

Contents

1. The Accreditation process

How we assess organisations against Standard One ('public interest test')

1.1 The Professional Standards Authority accredits registers of people working in health and social care occupations not regulated by law. To be accredited, organisations holding such registers must prove they meet our *Standards for Accredited Registers*[1] (the Standards). Once accredited, we check that Registers continue to meet our Standards.

1.2 There are eight Standards. Registers must meet Standard One before we can assess against how the register meets the remaining Standards. Standard One checks eligibility under our legislation, and if accreditation is in the public interest.

1.3 Organisations may apply for a preliminary assessment against Standard One before submitting a full application.

1.4 Following its introduction in July 2021, we have been assessing currently Accredited Registers against Standard One. Some of these decisions are made by the Accreditation Team, but if the decision is more complex it is made by an Accreditation Panel. These decisions are published. The evidence considered by the Accreditation Panel includes the organisation's application, a desk-based review of relevant sources of evidence about the benefits and risks of the role(s) registered, and responses received through our 'Share your experience' public consultation.

1.5 If the Panel decides that the activities of registrants fall within the definition of healthcare, and that overall, the benefits of the services of practitioners outweigh the risks then it will determine that Standard One is met. The Accreditation Panel can also issue Conditions if it does not think Standard One is fully met, and/or Recommendations aimed at promoting good practice.

1.6 More about how we assess against Standard One can be found in our *Supplementary Guidance for Standard One*[2].

2. About the CNHC

About the organisation – Complementary and Natural Healthcare Council (CNHC)

2.1 This section of the report provides information about the register and the roles it covers.

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[1] https://www.professionalstandards.org.uk/docs/default-source/publications/standards/standards-for-accredited-registers.pdf?sfvrsn=e2577e20_6

[2] https://www.professionalstandards.org.uk/docs/default-source/accredited-registers/standards-for-accredited-registers/accredited-registers-supplementary-guidance-for-standard-one.pdf?sfvrsn=3e5f4920_6

Date first Accredited	23 September 2013
Type of Organisation	Private Limited Company
Overview of Governance	There is a CNHC Board, which the Chief Executive and Registrar, Profession Specific Boards (PSB) Advisory, and Independent case examiners and disciplinary panel members report in to.
Overview of the aims of the register	To protect the public by providing an independent UK register of complementary healthcare practitioners.
Register Website	www.cnhc.org.uk
UK countries in which Register operates	England, Northern Ireland, Scotland, Wales
Role(s) covered	• Alexander Technique teacher • Aromatherapist • Bowen Therapist • Colonic Hydrotherapist • Complementary Therapist • Craniosacral Therapist • Hypnotherapist • Massage Therapist • Micro-systems acupuncturist • Naturopath • Nutritional Therapist • Reflexologist • Reiki Therapist • Shiatsu Therapist • Sports Massage Therapist • Sports Therapist.
Number of registrants	As at 1 January 2023 the total number of registrants was 6,453.
Main practice settings	NHS secondary care, often as volunteers; private clinics.
About the patients and service users	Research[3] suggests that more women than men use complementary therapies, and that the vast majority self-refer.

[3] https://www.bristol.ac.uk/primaryhealthcare/news/2018/national-cam-survey.html

Inherent risks of the practice

2.2 This section uses the criteria developed as part of the Authority's Right Touch Assurance tool[4] to give an overview of the work of CNHC registrants.

Risk criteria	Complementary therapists
1. Scale of risk associated with complementary therapists. *a. What do complementary therapists do?* *b. How many complementary therapists are there?* *c. Where do complementary therapists work?* *d. Size of actual/potential service user group*	a. Complementary therapy may also be referred to as complementary and alternative medicine (CAM). These are broad terms, for treatment that generally falls outside of mainstream healthcare. CAM can apply in both statutory and non-statutory professional registration, for example osteopathy and chiropractic. There are a wide range of treatments that may be considered under the broad term of CAM. The CNHC describes its registrants as offering complementary therapies, rather than alternative. b. We did not find data about the total number of complementary therapists within the UK. It would be difficult to ascertain this number, because of the lack of single definition about CAM. There are reports to suggest an increase in use of CAM in England (2018 survey, as referenced in d. below). c. Complementary therapists often work in private clinics or otherwise independently but may also work within primary or secondary care setting. Of the 766 adults surveyed in England who had seen a CAM practitioner, 21% had been referred through either a GP or NHS professional, and 70% had self-referred although it should be noted the study included osteopathy and chiropractic (Sharp et al, 2018). d. Within England, use of practitioner-led CAM rose from 12% of the population in 2005 to 16% of the population in 2015 (Sharp et al, 2018). Across the UK, in methodologically sound surveys, average one-year prevalence of use of CAM was 26.3% and the average lifetime prevalence was 51.8% (Posadzki et al, 2013). These studies indicate widespread use of CAM across the UK, although the lack of consistent definitions of CAM and inclusion of chiropractic and osteopathy in some of the studies reviewed means that caution should be taken when interpreting implications for the users of CNHC registrants.

[4] https://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/right-touch-assurance---a-methodology-for-assessing-and-assuring-occupational-risk-of-harm91c118f761926971a151ff000072e7a6.pdf?sfvrsn=f537120_14

2. Means of assurance	For CAM practitioners registered with the CHNC, the standards and codes it requires and accreditation by the Authority will be the main forms of assurance. None of the equipment used by registrants are regulated by the Medicines and Healthcare products Regulatory Agency (MHRA) or other regulators.
3. About the sector in which complementary therapists operate	Complementary therapists work in a range of settings, but it appears will most commonly see people who have self-referred, either due to health reasons or to support broader wellbeing. This means that complementary therapists may work in their own homes or their clients, in private clinics, or other private settings. They may also work as part of secondary care services, such as hospitals or hospices, sometimes as volunteers. Osteopathy and chiropractic are often described as complementary therapies. Registration with the General Osteopathic Council and General Chiropractic Council respectively is required by law to practise in these roles in the UK.
4. Risk perception • *Need for public confidence complementary therapists?* • *Need for assurance for employers or other stakeholders?*	The CAM survey (Sharp et al, 2018) noted that concern about practitioners' professional regulation or qualifications was more common in social grades A and B (i.e. higher and intermediate managerial, administrative, and professional occupations). This may be due to greater awareness of the regulatory landscape at this level anyway, and so does not necessarily mean that people from other socioeconomic backgrounds would not expect practitioners to have some form of regulation. Quantitative research undertaken by the Authority in March 2020[5] found that overall, patients using complementary therapy treatments saw themselves as capable consumers exercising their choice, with some exceptions. The Authority's public consultation undertaken as part of a strategic review of the programme in 2020-21 found support for taking greater account of evidence of effectiveness of the practices registered in accreditation decisions[6], particularly from patient groups. Some CAM services are available on the NHS. The National Institute of Clinical Excellence (NICE) and Scottish Intercollegiate Guidelines Network (SIGN) recommend the use of CAM in a limited number of

[5] https://www.professionalstandards.org.uk/docs/default-source/accredited-registers/reports/accredited-registers-research-how-the-public-perceive-concepts-of-efficacy.pdf?sfvrsn=9c924920_4

[6] https://www.professionalstandards.org.uk/publications/detail/the-future-shape-of-the-accredited-registers-programme---consultation-report

	circumstances. Person-centred approaches to care, which are now well established in NHS services across the UK, can involve social prescribing and supporting use of self-management, which CAMS may help with.

3. Share your experience

3.1 As part of our assessments, we seek feedback from service users, the public, professional and representative organisations, employers and others on their experience of a Register.

3.2 We did not receive any responses to our invitation to share experience on about the CNHC's Standard One assessment.

4. Outcome

4.1 The Accreditation Panel met on 8 December 2022 to consider the CNHC's application for a preliminary assessment against Standard One ('public interest test'). Overall, the Accreditation Panel determined Standard One was met, with a Condition.

4.2 The Condition issued by the Panel was:

- Condition 1: The CNHC should strengthen its checks of whether registrants are advertising responsibly. It should introduce a clearer process for handling breaches of its requirements for advertising. This should include:
  a) Being clear about how it acts on concerns identified through its own checks of registrants' websites.
  b) Setting out clear routes for how concerns identified through its own checks, or raised by others, will be considered. This should include criteria for when they are reported to other agencies such as the Advertising Standards Authority, and when they are serious enough to constitute a breach of the CNHC's Codes.
  c) Being able to demonstrate progress with reducing the proportion of registrants where there are concerns about advertising.
  d) Reviewing how its standards for responsible advertising could be embedded more clearly within the core curricula for the roles registered. The CNHC should provide a report with recommendations it identifies for strengthening this aspect of practice within the core curricula, and how these could be achieved through its training bodies ('verifying organisations').

4.3 This must be completed within six months of publishing this report.

5. Assessment against the Standards

Standard 1: Eligibility and 'public interest test'

5.1 This section of the report summarises the key considerations in reaching this conclusion for each part of Standard One.

Standard 1a: Eligibility under our legislation

5.2 The Authority's powers of accreditation are set out in Section 25E of the National Health Service Reform and Health Care Professions Act 2002[7]. Standard 1a considers whether a Register is eligible for accreditation, on the basis of whether the role(s) it registers can be considered to provide health and care services and are not required by law to be registered with a statutory body to practise in the UK.

5.3 Complementary therapy may also be referred to as complementary and alternative medicine (CAM). These are broad terms, for treatment that generally falls outside of mainstream healthcare. CAM can apply in both statutory and non-statutory professional registration, for example chiropractic is regulated by the General Chiropractic Council. None of the eighteen roles registered by the CNHC require registration with a statutory body.

5.4 The practices offered by registrants fall under the definition of complementary therapies. Use of complementary therapies to improve health and wellbeing is recognised by UK Government health departments, and by the NHS. The CNHC was set up with the support of UK Government in 2008.

5.5 The Accreditation Panel concluded that Standard 1a was met for the CNHC.

Standard 1b: Public interest considerations

5.6 Under Standard 1b, we consider whether it is likely to be in the best interests of patients, service users and the public to accredit a register, with consideration of the types of activities practised by its registrants. This involves consideration of the overall balance of the benefits and risks of the activities.

5.7 An important contextual point for our assessment of whether the CNHC meets Standard 1b is the role of the Advertising Standards Authority (ASA). The ASA administers the UK Code of Non-Broadcast Advertising and Direct & Promotional Marketing and the UK Code of Broadcast Advertising (the Advertising Codes), which are written by the Committees of Advertising Practice (CAP). Whilst our *Standards for Accredited Registers* include consideration of whether an Accredited Register is promoting responsible advertising by its registrants, the ASA is the UK's independent regulator of advertising across all media. As noted in the report, the CNHC has sought advice from CAP's Copy Advice Team on the use, in advertising, of descriptions of the therapies its registrants offer.

5.8 The CAP Copy Advice team provides bespoke, non-binding guidance on the likely compliance of claims in non-broadcast advertising with the Advertising Codes, taking into account previous ASA rulings. Rulings are only available for cases where the ASA has received complaints. The CAP Copy Advice team does not, and would never, provide a definitive view on the evidence base for the effectiveness of therapies. While it can provide

[7] Roles that are required to be enrolled with a statutory register to practise in the UK are set out in Section 25E (2) of the National Health Service Reform and Health Care Professions Act 2002, available at: National Health Service Reform and Health Care Professions Act 2002 (legislation.gov.uk)

advice on the types of evidence that the ASA is likely to expect to support claims in advertising and offer a view where evidence falls clearly below the standard required, it does not seek input from external experts to review evidence[8]. Within our assessment we have therefore considered both CAP guidance and any relevant ASA rulings relating to a therapy, and the evidence that the CNHC has provided, to come to our own conclusions about whether Standard 1b is met overall.

5.9 Factors considered by the Accreditation Panel are discussed below.

i. Evidence that the activities carried out by registrants are likely to be beneficial

5.10 In 2000, the Select Committee on Science and Technology published its Sixth Report, covering the use and regulation of CAM. Although two decades on, this remains a useful reference point for the context of the development of the CNHC. The report notes for example that whilst there may be limited evidence for the efficacy of many complementary therapies, much of the inherent risks can be mitigated through training. It also highlighted the benefits of establishing a voluntary self-regulatory body to establish the training standards, as well as promoting other areas of good practice such as in ethics and professional indemnity insurance.

5.11 Before looking at the individual benefits of each therapy registered by the CNHC, it is also important to consider the broad benefits that people may get from complementary therapy in general. Some of these benefits are likely to underpin more than one therapy. For example, a range of complementary therapies are used in palliative care, which may bring comfort and other perceived benefits to people at the end of their lives. Others may find the holistic approach that often underpins complementary therapy practice to enhance physical, emotional and/or mental health.

5.12 Whilst recognising the benefits that people may derive from complementary therapies, the Accreditation Panel agreed that evidence of effectiveness is limited. It considered some of the key benefits identified for each of the roles registered with the CNHC. These are summarised below.

Alexander Technique Teaching

5.13 CAP's guidance accepts that regular, long-term Alexander Technique lessons can benefit sufferers of persistent or recurrent back pain by reducing pain and improving associated activity, chronic uncomplicated neck pain, control of balance, improved posture, and a sense of well-being. NICE have also recently published an updated Guideline NG71 for Parkinson's Disease in Adults which recommends to 'consider the Alexander Technique for people with Parkinson's disease who are experiencing balance or motor function problems'.

Aromatherapy

5.14 The CNHC provided evidence of the potential benefits of aromatherapy and/or massage for patients with cancer in terms of psychological

wellbeing, and reduction in anxiety and some physical symptoms. This is referred to in the NICE Guidance on Cancer Services (Manual), which refers to two systematic reviews indicating similar findings. Macmillan notes a lack of evidence but notes that many people find aromatherapy a relaxing and enjoyable experience[9].

Bowen Therapy

5.15 The CNHC provided evidence to show that Bowen Therapy can be effective for non-specific lumbar spine pain syndromes (Kopczyńska et al, 2018). One study also showed improved outcomes including for mental health in women breast cancer survivors with Lymphedema (Argenbright et al, 2016).

Colon hydrotherapy

5.16 The CNHC describes the benefits of colon hydrotherapy as 'facilitating the management of occasional constipation. It can also provide a sensation of overall well-being and often inspires people to consider a healthier diet and lifestyle'. During our assessment, we reviewed evidence of a study (Garzia et al, 2019) in which colon hydrotherapy performance prior to a colonoscopy was helped as a mechanical stool evacuation technique, and in improved mucosal visualization (relating to the mucous membrane of different segments of the colon).

Craniosacral therapy (CST)

5.17 The CNHC provided evidence suggesting that CST can help alleviate pregnancy-related pelvic pain (Liddle and Pennick, 2015) and for alleviating migraine symptoms (Thuridur et al, 2013). However, the ASA says neither it nor the Committee of Advertising Practice (CAP) 'has seen evidence that CST can improve health or that it can treat or alleviate medical conditions or their associated symptoms.'[10] This means that those advertising CST for these purposes would need to hold robust evidence of the benefits.

Healing

5.18 The CNHC provided evidence for spiritual healing reducing anxiety and the perception of muscle tension in cardiovascular inpatients (Carneiro et al, 2017). In a separate study on hospitalised patients, benefits of muscle relaxation, reduced anxiety and depression and decreased muscle tension were also found to contribute to raised perceptions of wellness in those receiving spiritual healing (Carneiro et al, 2017).

Hypnotherapy

5.19 The CNHC's published information about what hypnotherapy can help with matches the conditions listed by the ASA[11]: relieve anxiety and aid sleep and help with: bedwetting, confidence, eating problems (but not disorders) and minor skin conditions (e.g. those exacerbated by stress). *NICE guideline CG61 (1.2.3.1) - Irritable bowel syndrome in adults: diagnosis and*

[9] https://www.macmillan.org.uk/cancer-information-and-support/treatment/coping-with-treatment/complementary-therapies/herb-and-plant-extracts
[10] Health: Craniosacral Therapy - ASA | CAP
[11] https://www.asa.org.uk/advice-online/health-hypnotherapy.html

management[12] (2017) includes that 'referral for psychological interventions (cognitive behavioural therapy [CBT], hypnotherapy and/or psychological therapy) should be considered for people with IBS who do not respond to pharmacological treatments after 12 months and who develop a continuing symptom profile (described as refractory IBS).'

5.20 The CNHC also provided evidence of the benefits of hypnotherapy as part of a study on the benefits of complementary therapy use during labour (Smith et al, 2006). The study concluded that the 'data available suggest hypnosis reduces the need for pharmacological pain relief in labour, reduces the requirements for drugs to augment labour; and increases the incidence of spontaneous vaginal birth.'

Kinesiology

5.21 The CNHC provided a randomised controlled trial (RCT) that indicated benefits for people with chronic low back pain (Eardley et al, 2013). The researchers concluded however that a larger, definitive study would be beneficial for better understanding the mechanisms involved in professional kinesiology practice.

Massage Therapy

5.22 The description of the benefits of massage therapy agreed by the CNHC and the ASA is: 'Massage may be found to bring relief from everyday aches, reduce stress, increase relaxation, address feelings of anxiety and tension, and aid general wellness. It can also be used in support of other therapies to assist in the rehabilitation of muscular injuries.' The ASA's guidance on massage and body work[13] states that claims that massage can help with relieving everyday stress, helping relaxation, aiding sleep and promoting a sense of well-being are likely to be acceptable. The CNHC provided evidence in support of this type of use, including massage for short-term benefits for patients with cancer in terms of psychological well-being.

Microsystems acupuncture

5.23 In 2016 NICE Clinical Guidelines withdrew support for acupuncture treatment for back pain. This remains the case in the NICE guideline for Low back pain and sciatica in over 16s [NG59] that was updated in December 2020. In 2021, NICE published an updated Clinical Guideline on Chronic pain (primary and secondary) in over 16s[14]. Recommendation 1.2.5 is to 'consider a single course of acupuncture or dry needling' but with certain stipulations, such as that it is delivered in a community setting, and by a band 7 (equivalent or lower) healthcare professional with appropriate training. This is based on the findings that while there was evidence for short-term (up to three months) benefits, there was not enough evidence to

[12] https://www.nice.org.uk/guidance/cg61/chapter/Recommendations
[13] https://www.asa.org.uk/advice-online/therapies-massage-and-body-work.html
[14] https://www.nice.org.uk/guidance/ng193/resources/chronic-pain-primary-and-secondary-in-over-16s-assessment-of-all-chronic-pain-and-management-of-chronic-primary-pain-pdf-66142080468421

determine longer-term benefits. A recommendation was also issued for further research on repeat courses of acupuncture for chronic primary pain.

Naturopathy

5.24 The ASA's guidance on naturopathy[15] is that claims of a healthy lifestyle are likely to be acceptable, including references to the benefits associated with healthy eating, sleeping well, and taking exercise. The CNHC also provided evidence for naturopathy being effective in treating 'cardiovascular disease, musculoskeletal pain, type 2 diabetes, polycystic ovary syndrome, depression, anxiety, and a range of complex chronic conditions' (Myers et al, 2019).

Nutritional therapy

5.25 Evidence provided by the CNHC included a study at the University of Worcester (Harris and Benbow, 2021) which suggested that nutritional therapy can be effective in reducing client symptoms and improving health and activity. The CNHC also provided evidence supporting use of nutritional therapy to support weight loss published by the Centre for Nutrition Education and Lifestyle Management (Miles and Barrow, 2018). Both studies made a link between the relationship and support offered by the nutritional therapist, and positive health outcomes.

Reflexology

5.26 The ASA's guidance on reflexology[16] states that claims that 'many people find the hands-on nature of the therapy relaxing are likely to be acceptable as are claims that the therapy can improve mood, aid sleep and promote a sense of wellbeing.' As with massage therapy, NICE Guidance on Cancer Services (Manual) recommends use of reflexology for cancer patients to promote wellbeing and help alleviate anxiety. The CNHC also provided a study into reflexology for constipation, which showed some effectiveness, but which concluded that further RCTs and longer-term studies were required.

Reiki

5.27 The CNHC provided two studies demonstrating the potential benefits of Reiki. One of these (McManus, 2017) looked at the existing peer-reviewed clinical studies available in the English language to determine whether there is evidence for Reiki providing more than just a placebo effect. The review found 'reasonably strong' evidence for Reiki being more effective than a placebo. Some of the studies indicated that these benefits may derive from the time and attention of the practitioner rather than the nature of the 'biofield energy' therapy approach itself. However, one study (Billot et al, 2019) also indicated potential benefits of receiving Reiki for those at the end of their lives.

Shiatsu therapy

5.28 The CNHC provided evidence of the benefits on wellbeing for palliative and cancer care patients in NHS settings (Browne et al, 2018). This found

[15] Health: Naturopathy - ASA | CAP
[16] https://www.asa.org.uk/advice-online/health-reflexology.html

improvements in wellbeing, in particular for anxiety, stress management and pain scores. Patients stated that 'being listened to' and 'being heard' were important factors when describing how Shiatsu had helped. A second study provided showed some improvements in health-related quality of life of people with secondary progressive multiple sclerosis. These studies help show how patients with serious conditions can gain particular benefit from shiatsu in terms of wellbeing, as well as the population more broadly.

Sports massage therapy

5.29 The CNHC provided studies from 2008 and 2015 in support of the benefits for sports massage on recovery, performance and improved muscle efficiency post-exercise. However, these need to be set against a more recent systematic review and meta-analysis of the effects of massage on measures of sporting and recovery that included the COCHRANE database. This did not find evidence that sports massage improves performance directly, but that it may improve flexibility and Delayed Onset Muscle Soreness (DOMS) (Davis et al, 2020). The study highlights challenges with defining the benefits from sports massage due to lack of common definition of what the practice involves. This appears to be the largest review available currently. There also appears to be uncertain evidence of the benefits of advanced forms of massage, including Deep Transverse Frictions and Trigger point (Loew et al, 2014), which may be used in the treatment of 'tennis elbow' (lateral epicondylitis).

Sports therapy

5.30 The CNHC states that sports therapy as practised by its registrants has three main modalities: sports massage (as above), physical therapy and rehabilitation exercises. The CNHC provided evidence looking at the content, duration and adjustment of physical therapy for the rehabilitation of ambulation in spinal cord injury (Franz et al, 2017). There is also evidence that the approaches used in sports therapy can have therapeutic and preventative health benefits for people of a range of ages. For example, The *UK Chief Medical Officers' Physical Activity Guidelines*[17] emphasises the positive relationship between physical activity and health for all age groups.

Yoga therapy

5.31 The CNHC provided evidence for the benefits of improved psychological outcomes for young people undergoing cancer treatment. It also provided a study that concluded 'We found moderate-quality evidence that yoga probably leads to small improvements in quality of life and symptoms in people with asthma.'

5.32 The Accreditation Panel agreed that there are potential benefits to health and wellbeing of all of the practices registered with the CNHC. However, evidence in support of this is stronger in some areas than others. It is also notable that our Standard One assessment approach focuses on evidence for benefits, rather than disbenefits. While there may be robust evidence for

17 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/832868/uk-chief-medical-officers-physical-activity-guidelines.pdf

the benefits of a therapy in one context, this did not mean that service users would find it universally beneficial. This highlighted the importance of registrants describing the potential benefits of practices in a clear and responsible way, which is considered under sections ii) and iii) below.

5.33 Some of the research we reviewed also raised a question about whether the benefits people derived from therapies was due to the specific therapy itself, or from other aspects such as focused contact during end-of-life care. The Accreditation Panel agreed that for the purposes of our assessment, this did not have a significant bearing since it is not the Authority's role to assess efficacy.

ii. Evidence that any harms or risks likely to arise from the activities are justifiable and appropriately mitigated by the register's requirements for registration.

5.34 The CHNC has identified a number of risks in relation to the practices of its registrants, and how it mitigates these. These broadly aligned with those we identified through our review of the evidence provided to support the benefits of different therapies.

5.35 Some of these risks are over-arching, such as practitioners not being safe and competent to practise, or not establishing and maintaining appropriate boundaries with service users. These are mostly addressed through the CNHC's *Code of Conduct, Ethics and Performance*[18]. The CNHC also requires that practitioners take account of known contraindications for their therapy and provided a detailed list of these during the assessment. A key mitigation is that the National Occupational Standards (NOS), which the CNHC's standards for education and training of registrants are based on, include the relevant contraindications.

5.36 The CNHC also identifies risks in relation to specific therapies. This includes that practitioners who practise colonic hydrotherapy or microsystems acupuncture do not have the necessary knowledge and skills to identify and avoid risk of infection from the use of equipment.

5.37 The risk of misleading advertising is also identified by the CNHC. Mitigations for this include its *Advertising Standards Guidance,* and requirements for responsible advertising as part of business practice as set out in its *Code of Conduct, Ethics and Performance*. Misleading advertising may act as a proxy for identifying where practitioners could be likely to offer treatments as alternative, rather than complementary to conventional medicine. The risk of harm to service users includes financial harm, and of being deterred from seeking appropriate medical treatment for serious conditions. Our findings from Section iii) below indicate that the current approach to registrant advertising is not robust enough to mitigate these risks.

5.38 We also noted from our checks of registrant websites that some are offering services to children. Our recent pilot of criminal records checks[19] indicates that practitioners working directly with children are likely to be eligible for higher level criminal records checks, with a check of the Children's Barred List; and that Accredited Registers are able to access these checks. The

[18] Available at: https://www.cnhc.org.uk/code-conduct-registrants#gsc.tab=0
[19] Accredited Healthcare Registers | Safeguarding pilot (professionalstandards.org.uk)

Authority has recently consulted on whether to introduce a requirement in this area, in future[20]. The CNHC's *Code of Conduct, Ethics and Performance* includes requirements relating to safeguarding for children and vulnerable adults. We suggest that in the meantime to any changes to the Authority's *Standards for Accredited Registers* in this area, the CNHC considers whether this might be appropriate for its registrants.

5.39 We also noted that the risk matrix did not include any specific reference to allergies to nutritional supplements, and/or products used by aromatherapists or massage therapists. We suggest that this could be incorporated within existing risks relating to appropriate skills and knowledge.

iii. Commitment to ensuring that the treatments and services are offered in a way that does not make unproven claims or in any other way mislead the public

5.40 The CNHC has worked with the ASA's Copy Advice Team to develop descriptions of the therapies that are likely to be acceptable to the CAP. The information provided on the CNHC's website matches this wording.

5.41 We did not identify inconsistencies with the ASA's guidance for any of the therapies, with the exception as outlined at (i) of hypnotherapy for IBS. However, since we believe the adoption of this as a NICE recommendation is likely to form robust clinical evidence acceptable to the ASA, we do not see a contradiction. The information on the CNHC's website is generally clear and sets out clear information about the therapies. The CNHC also published research in relation to the therapies on its website here: https://www.cnhc.org.uk/research.

5.42 The CNHC publishes specific guidance on advertising: https://www.cnhc.org.uk/uploads/asset/file/34/Advertising-guidance.pdf and Guidance on the Cancer Act https://www.cnhc.org.uk/uploads/asset/file/31/CNHC-Guidance-on-The-Cancer-Act-1939-v2.pdf.

5.43 During our assessment, we checked a random sample of registrants across all therapies, representing approximately 1% of the total registrant base. We checked at least four registrants from each therapy.

5.44 Our checks of registrant websites found that approximately half appeared to deviate from the messaging that was developed by the CHNC and appeared to depart from the ASA's guidance. Although the nature of the concerns varied, some were significant such as suggesting that a therapy could 'help with' conditions such as cancer, which is in contravention of the Cancer Act 1939. Others included offering therapies for children and adults with conditions such arthritis, Attention Deficit Hyperactivity Disorder, long Covid, and to diagnose autism in children.

5.45 In response to these concerns, the CNHC followed up with individuals where concerns had been flagged. This resulted in some registrants making changes to their websites. At the time of the Accreditation Panel meeting, the CNHC was considering the administrative removal of two registrants

[20] PSA consultation | Safeguarding consultation about Accredited Registers accessing criminal record checks (professionalstandards.org.uk)

who had not complied with its requests to change the information on their websites.

5.46 The Accreditation Panel agreed that the monitoring suggested that the issue of misleading advertising was potentially widespread amongst the CNHC's registrant base.

5.47 Although it is the role of the ASA to set standards for advertising, the CNHC sets its own requirements for responsible advertising. It is expected that registrants comply with these as a condition of registration. The Accreditation Panel determined that the CNHC should have a stronger role in ensuring that registrants meet this requirement. As noted above, this is in part because advertising may be an indicator of offering treatments as an alternative to conventional medicine for serious conditions. The role of the CNHC is to protect the public through setting appropriate standards for its registrants. It is reasonable to expect it to check whether registrants are meeting all aspects of its *Codes*, including advertising.

5.48 The CNHC's approach to handling complaints about registrants' advertising has been to only take action if there is a ruling on a registrant by Trading Standards, and not to otherwise accept complaints about advertising. Although this had previously been acceptable to the Authority, the introduction of Standard One in July 2021 places clearer requirements on Accredited Registers to ensuring that the treatments and services are offered in a way that does not make unproven claims or in any other way mislead the public. This is broader than advertising; but advertising is a key indicator of actual practice.

5.49 The Accreditation Panel noted that although the CNHC had taken action to address concerns when highlighted by the Authority during the period of assessment, it was not clear whether this was an embedded process. Although the CNHC provided evidence of its own monthly monitoring of registrant websites, it is unclear whether this has led to improvements. It was not clear how the requirements in its *Codes* on advertising would translate into disciplinary procedures for serious or persistent cases. The Accreditation Panel noted that administrative erasure was being considered as an option for the most serious cases, as an alternative to a disciplinary hearing. This option could be needed if the CNHC's engagement with registrants to first provide support and guidance in terms of the necessary changes to their websites had not proven successful. The Accreditation Panel was concerned nevertheless that administrative erasure could deny registrants in this situation the right to a fair hearing and prevent publication of findings.

5.50 The Accreditation Panel also considered whether requirements for responsible advertising were sufficiently embedded within the training requirements for the roles registered by the CNHC. The CNHC accepts qualifications meet the National Occupational Standards (NOS) and its own core curricula for these disciplines. The core curricula include some generic competencies, such as procedures for record keeping in accordance with legal and professional requirements; but does not reference advertising. The Accreditation Panel suggested including advertising in the curricula could help equip registrants with the skills needed to meet the CNHC's requirements. However, we recognise this may take time to achieve, and would need engagement with training providers to deliver.

5.51 The Condition issued by the Accreditation Panel was:

> Condition 1: The CNHC should strengthen its checks of whether registrants are advertising responsibly and introduce clearer routes to how it handles these. This should include:
>
> a) Being clear about how it acts on concerns identified through its own checks of registrants' websites.
>
> b) Setting out clear routes for how concerns identified through its own checks, or raised by others, will be considered. This should include criteria for when they are reported to other agencies such as the Advertising Standards Authority, and when they are serious enough to constitute a breach of the CNHC's Codes.
>
> c) Being able to demonstrate progress with reducing the number of registrants where there are concerns about advertising.
>
> d) Reviewing how its standards for responsible advertising could be embedded more clearly within the core curricula for the roles registered. The CNHC should provide a report with recommendations it identifies for strengthening this aspect of practice within the core curricula, and how these could be achieved through its training bodies ('verifying organisations').

5.52 This must be completed within six months of publishing this report.

6. Impact assessment (including equalities)

6.1 The Authority is required to carry out an assessment of the impact of accreditation on service users before accreditation is granted. This impact assessment included an equalities impact assessment as part of the consideration of our duty under the Equality Act 2010. Once accredited, the impact assessment is reviewed as part of a Register's annual renewal, and at any point if there are concerns or significant changes in the external environment in the meantime.

6.2 The impact assessment for the CHNC is published here: [insert hyperlink]

6.3 The Accreditation Panel acknowledged that consideration also needs to be given to the benefits that different groups may derive from complementary therapies. Research by the Richmond Group[21] has shown there is a higher proportion of people from a lower socioeconomic background people living with multiple conditions. Some patients within this group use complementary therapies to help manage their conditions.

6.4 In 2010 the International Journal of Clinical Practice found that within England, women were significantly more likely than men to use complementary therapies. Since the CNHC has also highlighted that over 80% of its registrants are female, any decisions relating to accreditation are likely to affect women more than men.

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21 https://richmondgroupofcharities.org.uk/sites/default/files/final_just_one_thing_after_another_report_-_singles.pdf

6.5 A BBC documentary[22] from July 2022 highlighted the risks of sexual assault from unregistered massage therapists working in people's own homes. Using an Accredited Register such as the CNHC to find a therapist could help reduce this risk by having mechanisms to address concerns about practitioners.

6.6 The Accreditation Panel considered the potential impacts of requiring the CNHC to take a more robust approach to checking whether registrants are making unproven claims or otherwise misleading the public. This could include increased costs for the CNHC in terms of its complaints handling and deter people from registering. It was notable that a significant proportion of registrants and service users appeared to be female and would therefore be affected to a greater extent. However, it determined that the overriding consideration was the need to ensure that members of the public can have confidence that the CNHC's registrants are offering services in a responsible way. This is in line with the stated aims of the CNHC, and of the Accredited Register programme.

[22] https://www.bbc.co.uk/mediacentre/2022/calls-for-reform-after-massage-app-sex-abuse

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