

Report of the National Working Group on the Regulation of Complementary Therapists to the Minister for Health and Children

December 2005

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Foreword

Over the two years that the National Working Group on the Regulation of Complementary Therapists has been in existence, I have become increasingly aware of the level of commitment that exists within the complementary therapy sector for the greater development of the sector and for the elimination of areas of concern to them, such as variations in standards of education and training or codes of practice. It has been a source of great re-assurance and encouragement as regards these areas of concern to find, from the information submitted to the Working Group, that many professional associations are already at a high level of development.

What remains to be done is for all professional associations to reach these high standards through a process of unification and federation where necessary for different associations involved in the same therapy. Every therapist practising a complementary therapy should be a competent, qualified and registered member of a relevant professional association. This will ensure that the public will be able to access up-to-date sources of information and make an informed judgment as to what they can expect from a competent and registered practitioner.

It is frequently the case that the term “complementary therapist” is inaccurately applied, usually by the media, to an untrained and/or unregistered self-styled practitioner who has come to public notice through malpractice. A sham practitioner or rogue trader might be a more accurate description. With greater unification of the sector and availability of reliable, accessible sources of information for the public, it is hoped that such sad cases will become even more of a rarity.

On a more positive note, such sources of advice will make information on the many benefits of complementary therapies available to an even wider public. Appendix 3 of this report outlines examples of research, particularly research in the interesting and expanding area of integrated healthcare, where conventional medicine and complementary therapies interact and work in tandem and where the client or patient can avail of the benefits of the best of both sectors.

It has been my good fortune to have been involved in this process of development as Chairperson of the Working Group. I hope that recommendations 1 to 7 in Chapter 8 will be implemented without delay and that the stage will be reached, which is the culmination of these recommendations, where recommendation 8 can be attained. This is a stage where an overarching body, whether that is a Council or a Congress, will oversee issues in a unified and harmonised complementary sector. The public will be able to avail of the many benefits of complementary therapies in the knowledge that their therapist is qualified, competent and registered and that they, as a consumer, have full support, information and protection from the wider complementary sector.

There are many people to be acknowledged and thanked: the wider complementary sector who provided information and attended the consultative forum; the Department of Health and Children for their

support, especially William Beausang and the Secretariat, Anne Tighe and Ruth Dunne; Suzanne Campbell, who undertook research on behalf of the Working Group; and the members of the Working Group who have given generously of their knowledge, skills, expertise and, above all, time over the past two years. To them, many thanks for their commitment and hard work. At this time we remember particularly the important contribution of Working Group member Sally Quinlan of the Irish Society of Homeopaths who died in June 2005 and to whom this report is dedicated.

Teri Garvey
Chairperson of the National Working Group

November 2005

CHAPTER 1

General background to this report

It is widely accepted that there has been a large increase in the number of people using complementary therapies, here in Ireland and worldwide. This report will not cover in detail material already covered by the O’Sullivan report of 2002 (The Regulation of Practitioners of Complementary and Alternative Medicine in Ireland) regarding the use of complementary therapies and definitions of same. People unfamiliar with this report are recommended to read it. The report can be found at the following website address:

http://www.dohc.ie/publications/regulation_of_practitioners_of_complementary_and_alternative_medicine.html.

Consumer Choice and Information

The focus of this report is the regulation of complementary therapists and, as such, does not deal directly with the efficacy of such therapies.

It is for the consumer to make the choice of which therapy they intend to use. Whether they wish to consult a qualified therapist such as a homeopath or an acupuncturist, a healer, the seventh son of a seventh son, a person reputed to have a cure for a particular ailment or a person with a special skill with bones; the choice is theirs.

However, the public needs a reliable, current source of information regarding standards to be expected in relation to good practice. The public also needs to know where they can find a competent and qualified therapist; how they can check that this therapist is currently registered with an association for that therapy and what grievance procedures are available to them should difficulties arise.

Some professional associations currently provide such sources of information through websites, leaflets, information days, contact numbers and help lines. Others are less organised and need to be supported in developing this area of communication.

Use of the term “therapist”

Where the term “therapist” is used in this report, it is implicit in the term that the person is appropriately qualified and a currently registered member of a relevant professional association.

Reputable professional associations have codes of practice, grievance structures, disciplinary procedures and training standards. They have current registers of practitioners and continuing professional

development structures. They insist on members having insurance cover for their members and supply sources of information on their therapy and their members to the public.

Reputable therapists do not claim to cure, they do not impose conditions regarding conventional medicine, they abide by a code of ethics and good practice which they make available to a client on the first consultation, they do not seek to impose their personality or their personal judgment and they do not claim to be the sole authority.

What the term “therapist” does not cover in this report are the rogue traders and sham practitioners who may practise various mishmashes of therapies without any qualifications and without any on-going education or monitoring.

Such people exist in the complementary field, as in many other areas. Just as one would not entrust the design of an extension or the rewiring of a house to somebody sticking a leaflet through the letterbox with only a mobile phone number on it, so it would also be expected that the public would exercise as much care and responsibility in taking sensible, informed decisions with regard to their own health care.

Use of the term “Complementary”

The word “complementary” rather than “alternative” is used throughout the report. Use of the term “alternative” sets up an either/or position whereas, for most therapists, the ideal position would be the best use of both conventional and complementary systems. Reputable therapists would recommend consulting conventional medical practitioners where they think that is advisable and if it has not already been done thereby availing in particular of the diagnostic expertise of conventional medicine.

No reputable therapist would advise bypassing the use of modern diagnostic procedures such as scans, blood tests or x-rays where the need for these is evident. To quote one well-known proponent of complementary therapies, Dr David Reilly of the Glasgow Homeopathic Hospital “If you don’t believe drugs and surgery are important, try operating an emergency ward for thirty minutes without them.”

Research on Complementary Therapies

Research in the area of complementary therapies will be covered in Appendix 3 to this report but it is important to realise that research is increasing in this area. It is increasingly being supported by bodies such as the Foundation for Integrated Health in the United Kingdom with Government funding and in the United States arising from the White House Commission. Given our small population size, it is unlikely that there will be major research projects of the RCT (randomised controlled trial) type here but complementary therapy will benefit from the expansion of research available internationally. More research in Ireland needs to be encouraged, particularly quality of life and whole systems research.

Integrated Health Care

Of increasing interest and of great hope to the complementary sector is the fast-growing area of integrated/integrative medicine or integrated healthcare, where complementary therapies are available in a conventional healthcare setting and with conventional healthcare funding.

Many hospitals, health-centres, GP practices and health areas in Ireland have an involvement in this area. For this development to expand more widely it is essential that the flow of information between the

conventional and the complementary sectors is increased to educate more providers of conventional healthcare of the benefits, not least financial, of integrated medicine.

Complementary therapies have been used for some considerable time in the area of palliative care and there is considerable research from behavioural medicine studies in this area to show the benefits of therapies such as yoga, meditation, visualisation and hypnotherapy.

Such therapies have also been used in cardiac programmes for reduction of stress levels and reduction of cholesterol levels. Names such as Benson, Selye, Simonton, Spiegel, Ornish, Kabat Zinn are familiar to many from studies in psychoneuroimmunology or behavioural medicine. Increasingly, studies are being conducted on less severe conditions, particularly common chronic conditions which can remain intractable to conventional medical treatment.

The Glastonbury Health Centre and the St Margaret's Surgery studies (Russo 2000)¹ show how the use of complementary therapies in a conventional setting not only benefit the patients but can be self-funding initially and can cut future costs. The Glastonbury study was a project where over 600 patients were referred to a complementary service for chronic conditions relating to muscles and joints. The therapies used were acupuncture, herbal medicine, homeopathy, massage therapy and osteopathy.

Eighty-five percent of persons reported an improvement in their condition. Of even more interest if you are a fund manager or an economist, the figures showed that the project was self-funding. The improvement in well-being came at no extra cost. When the figures were compared for reduced referrals to secondary care, the team estimated the corresponding savings to be over £18,000. To quote Russo "This analysis demonstrates the potential for improving patient care and producing longer term cost savings at no extra cost to the health service."

The St Margaret's Surgery general practice project used homeopathy for certain chronic conditions; childhood eczema, sinusitis and chronic nasal catarrh. Ninety-five per cent of respondents were satisfied their condition improved. The number of GP consultations for a sample of the participants was compared for the year before treatment and for the year after treatment. The findings indicated a significant saving in consultation time. The most common outcome was where no consultations were needed with the GP in the year after treatment.

A conservative estimate of the total cost savings for the group selected, only 65% of the total group, was approximately £12,000. This was the cost of running the entire homeopathy service.

The conclusion here, as at Glastonbury, was that the use of complementary therapies can not only be self-funding but can cut future costs through a reduction in secondary referrals, drug use and GP consultations. This again has the benefit of reduced waiting lists and freeing up services for those in need of conventional treatment.

Whether it was the effects of massage on mother-baby interaction, the use of tai chi in preventing falls in elderly nursing home residents, the benefits of massage on recruitment and retention of staff in the oncology units in Hammersmith and Charing Cross Hospitals, or the benefits to staff morale in Glasgow Homeopathic Hospital allowing them to work more efficiently, reducing staff sickness and avoiding burnout; all these projects in integrated medicine or integrated health are good news for patients, staff and hospital and practice administrators.

¹ Integrated Healthcare: A Guide to Good Practice, Hazel Russo, The Foundation for Integrated Medicine 2000.

The outcome of a second research project at Christie NHS Trust Hospital in Manchester on the use and efficacy of a combination of three essential oils in counteracting the MRSA bug is eagerly awaited by health care officials who might never previously have considered the potential of complementary therapies. In December 2004, the hospital announced that initial research showed that essential oils may kill the MRSA bacteria. Researchers tested 40 essential oils against ten of the most dangerous bacteria and fungi. Two of the essential oils were found to kill the MRSA bug and E-coli instantly while one-third of the oils showed positive results over a longer period of time. New trials are underway involving around 100 patients.

Foundation for Integrated Health Award Scheme

The provision of a Foundation for Integrated Health award scheme for such projects in the United Kingdom has no doubt made some conventional healthcare providers more aware of the potential benefits to all concerned. On-going research on the benefits of complementary therapies for patients, carers, staff and administrators make it clear that the further development of complementary therapies and the better regulation of complementary therapists is something that cannot be overlooked by any health system.

The initiation of such an award system for integrated projects here in Ireland is something that would contribute enormously to bridging gaps between the complementary and conventional medical sectors and would help strengthen and expand projects that are currently underway here and could help to initiate further projects.

Primary Health Care

Conferences on health issues frequently refer to the importance of primary care, usually referring to the GPs as the “gate-keepers”. However, it could be said that the essence of primary care starts with the patient or person themselves being pro-active and dealing with health promotion. This fits with the central tenets of complementary therapies. They are person-centred and they have a holistic approach to managing health and promoting well-being. The focus is on staying well, on taking steps to maintain one’s immune system to minimise one’s chances of becoming ill and then to support the healing mechanisms of the body when illness strikes.

In this paradigm, primary care starts with the person themselves at home. It focuses on protecting the immune system, dissipating stress and practising good health habits in diet and exercise. At work, increasingly, employers are offering in-house complementary therapies to their staff for the same reasons.

In an integrated system the complementary therapist might be included in the primary care team. Such complementary care needs to be well organised by reputable therapy bodies and reputable, competent, well-qualified and monitored therapists. This leads us to the work of the National Working Group on the Regulation of Complementary Therapists.

Origins of the National Working Group on the Regulation of Complementary Therapists

In November 2002, the Minister for Health and Children announced the establishment of a National Working Group on the Regulation of Complementary Therapists to advise on future measures for strengthening the regulatory environment for complementary therapists. The establishment of this group had its origins in the concerns of the complementary therapy sector for the greater development and

harmonisation of the sector. Professional associations have developed for some therapies. Through the usually voluntary, hard work of many committed therapists, many of these associations have developed standards of qualification and continuing professional development; codes of ethics and good practice; systems of registration, monitoring and regulation; sources of information for consumers; and links with international bodies for the individual therapies.

However there are issues, which we shall return to throughout this report, of disparity in standards of educational qualifications and of confusion in the mind of the consumer as regards registration of therapists. Such disparity and confusion allows rogue practitioners to operate.

The situation may not be as bad as that described by Stone and Matthews (1996)². While acknowledging the creditable success of some well established therapy areas or therapies in Britain in organising themselves and their willingness to set their own houses in order, they go on to say “Beyond these well-established therapies the situation is too often a messy and dis-organised array of fragmentary legitimising bodies which must be a cause of considerable bewilderment to even the most determined and conscientious of consumers”.

However, there are many areas here in Ireland which need harmonisation and development and the complementary therapy sector was anxious to enlist the support of the Department of Health and Children for this reason. From their contacts with the Department of Health and Children, a consultative forum was organised in June 2001. To build on the discussions of that forum and a subsequent survey, the O’Sullivan Report was commissioned. This report recommended that a National Working Group on the Regulation of Complementary Therapists be set up to further progress the work done to date, to examine the practical steps involved in the better regulation of complementary therapists and to continue to develop the consultative process for stakeholders in the sector.

Composition of the National Working Group

The Working Group had its first meeting on May 28th, 2003 and comprised representatives of the main therapy groups as selected by the various groups for those therapies, a consumer representative, the Department of Health and Children, the Department of Education and Science and Ministerial nominees. A list of members of the Working Group can be found in Appendix 1.

In the composition of the group, a balance had to be struck between the need to facilitate focused and effective working, which constrained the size of the group, and the need to ensure appropriate representation with the required skills, knowledge and expertise.

Initially, therapists from the complementary sector expressed the fear that if a therapy did not have a representative on the Working Group it could be overlooked. It was made clear that, while a person’s own therapy background would inform their contributions to the work of the group, once functioning as a group each person was working for the benefit and development of the entire complementary sector.

Work of the Group

In its work, the group first considered the state of play of the different and differing associations for various therapies. It looked at background information on the number of associations for different therapies, the number of schools from which therapists are qualifying and the number of therapists in

² Complementary Medicine and The Law, Julie Stone and Joan Matthews, Oxford University Press 1996 reprinted 2003

practice. It also considered the level of communication and contact between the different organisations representing the same therapy.

What emerged was a spectrum of situations. At one end of the spectrum was a position where the therapy in question was represented by a single professional association with highly developed levels of initial qualification, with a code of ethics and good practice, with registration and on-going continuing professional development. At the other end of the spectrum was the example of a therapy represented by many associations with no common agreement on standards of qualification or practice. Regarding communication between the organisations, one source was quoted as saying “the situation is complex with much in-fighting”.

The professional associations for most therapies had a commitment to the best development of the complementary sector and had a strong focus on continually improving and harmonising their standards. The impetus for regulation of the sector and for the development of better standards, with resultant greater protection for the public, was coming from themselves. The lack of unity and confusion about standards and qualifications in some therapies were causes of concern to them. The variation in courses being offered and the lack of coherent, current sources of information for the public also caused concern.

These concerns were addressed by the Working Group and are reflected in the recommendations to the Tánaiste and Minister for Health and Children regarding facilitated work days and the provision of a comprehensive information booklet for the consumer.

Quality and Accountability

Two of the key principles in the 2001 Health Strategy³ were identified as quality and accountability. These fundamental principles are just as relevant to complementary therapy practitioners as they are to conventional health practitioners.

Action 106 of the Health Strategy on Quality and Fairness signalled the intention to enhance the regulation of complementary therapists as part of the comprehensive programme of reform envisaged for the regulation of health and social care professionals generally. Quality healthcare services need to be underpinned by the excellence of the skills, knowledge, expertise and high standards of professional conduct maintained by all those who offer healthcare services to the public. Protection of the public must be at the heart of effective regulation of any activity.

People’s trust in the standard of all care being provided must be copper-fastened by a guarantee of quality and accountability. They need to be properly informed so they can be confident that a practitioner providing a service is competent to do so. Therefore, they need the provision of reliable and up-to-date information which is crucial for them in making an informed choice about a therapist and a therapy.

Because the principles of quality and accountability relating to the education and training of therapists is so central to any development of common standards, the Working Group focused its attention on that area from early-2004. This was followed by the question of definition and categorisation of therapies and the question of professional associations.

³ Quality and Fairness — A Health System for You, Health Strategy, Department of Health and Children 2001

Consultation with the wider sector

As part of the on-going consultative process, the Working Group held a forum for the complementary sector and interested bodies in September 2004 to consult with them on outstanding issues of concern, to introduce the Working Group and to inform them of the work of the Group to date.

At this forum, the various therapy bodies were encouraged to begin the process of unifying and federating the different and differing therapy bodies for the same therapy. It was highlighted that differing bodies can unite and promote inclusivity while still preserving diversity. A federation of bodies for the same therapy is essential for cohesive strength in the sector and for greater success in developing the aims and goals for the therapy in question. Speakers from the Yoga Federation of Ireland discussed how the various yoga bodies had come together to federate as an umbrella organisation for the further development and promotion of yoga.

Importance of federating

Since then, and arising out of the efforts of the Working Group, most of the acupuncture groups have come together to form the Acupuncture Council of Ireland and the herbalism groups have done likewise as the National Herbal Council. Groups in the massage and aromatherapy areas are also in the process of federating.

Not every professional association may agree to join a federation of associations for that therapy. However, for greater harmonisation of standards, for clearer information and for greater protection of the public it is essential that such a process continues for all therapies. This should ultimately lead to an overarching, overseeing body for all federated therapies such as a Council for Complementary Therapies.

Greater unity among professional associations representing the same therapy is, as has been stated, essential. With competing rivalries, egos and political infighting among some professional associations, it may not always be an easy process. However, without such federation and harmonisation, progress in the development of common standards and sources of information will be delayed.

One member of the Working Group described the process which has already happened for their therapy. “It did not happen easily and it did not happen overnight. Everybody came together and agreed to step down from the platform and elect a new body for the therapy.” If egos and interests can be put aside in the interests of the bigger picture, if differing bodies can agree to “step down from the platform” and elect a representative body for that therapy then greater progress will be made.

Summary

The use of complementary therapies is increasing in Ireland and worldwide as is the area of integrated medicine where conventional medicine and complementary therapies form an integrated healthcare system in many conventional medical settings.

The Irish professional associations for complementary therapies are seeking to promote and develop their sector, particularly in the area of harmonisation of standards of practice and qualifications.

Through their interaction with the Department of Health and Children over a number of years, the National Working Group on the Regulation of Complementary Therapists was set up in 2003 to progress practical areas of regulation.

The Working Group addressed the areas of definition and categorisation, education and training, professional associations, unification of the sector and differing professional associations for the same therapy.

Over the life of the Working Group, associations for several therapies have come together to unite as one overall group for the therapy in question.

CHAPTER 2

Definition, Categorisation and Scope of Practice

Definition

In his report of 2002, Tim O’Sullivan stated “Complementary therapies are extremely varied and complex and are practised by a very wide range of practitioners so it would be very difficult to find a totally satisfactory and all-encompassing definition”.

The situation hasn’t changed since as regards a succinct definition covering all therapies. However, Zollman and Vickers (1999) and the Cochrane Collaboration offer two perspectives on definition which are worth considering. They both use the older term “complementary medicine” rather than “therapies”. The use of the word “therapies” includes the therapeutic aspect inherent in the word medicine but also allows for the promotion of well-being inherent in the philosophy of most, if not all, complementary therapies.

“Complementary Medicine refers to a group of therapeutic and diagnostic disciplines that exist largely outside the institutions where conventional health care is taught and provided.”

(Zollman and Vickers (editors), ABC of Complementary Medicine, Complementary Medicine in conventional practice, Bmj publishing group, 1999)

“Complementary and Alternative Medicine (CAM) is a broad domain of healing resources that encompasses all health systems, modalities and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period. CAM includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and well-being. Boundaries within CAM and between the CAM domain and that of the dominant system are not always sharp or fixed.”

(Cochrane Collaboration)

The range of therapies which may be considered complementary is vast. The task of this Working Group is to advise the Minister for Health and Children on the regulation of complementary therapists. There was no prior definition of what constitutes a complementary therapy or of which therapists, if any, would be excluded from consideration on the grounds of the therapy they practise. The focus was on the initial education and training of the therapists, their continuing professional development and also the area of professional associations for individual therapies. This orientation arose from the focus on protection of the public and on the quality and accountability of complementary therapists as described in the O’Sullivan report (2002).

The Working Group uses the term “complementary” rather than “alternative”. The client is the person who decides whether they will consult a conventional medical practitioner or a complementary practitioner. It is their choice to consult a complementary practitioner perhaps following, or alongside, a conventional medical treatment for some condition or to use a complementary therapy in the first place, i.e. as an alternative to conventional treatment. The decision as to which approach to take lies with the client. The decision to treat, however, lies with the complementary therapist and will be influenced by factors such as code of ethics and scope of practice which will be dealt with later in the report.

The focus of the Working Group’s concerns was the area of the professional standards of persons practising complementary therapies and not the question of the efficacy of one therapy over another. The group did consider the question of the definition of a complementary therapy and what follows is based on that consideration.

A complementary therapist is a practitioner of a healing philosophy or tradition that offers health-related advice and treatment that is considered to be of a different use, acceptance, study and understanding to mainstream western, conventionally practised medicine. A complementary therapist could be described as one who is trained in a coherent but non-conventional system of therapeutic intervention.

Complementary therapies comprise a vast range of practices. There are those which aim to achieve therapeutic benefit based primarily on the physiology of western medicine e.g. sports and therapeutic massage and western medical herbalists. There are also therapies which primarily rely on a modern western understanding of the mind-body connection and its influence on healing, e.g. hypnotherapy, re-birthing, neuro-linguistic programming. Other therapies originate from the medical systems of different cultures, based on what can be called vitalistic systems of medicine. Such therapies as Chinese medicine, shiatsu, ayurvedic and Tibetan medicine have physiologies, diagnoses and treatment parameters based on theories of the vital or life-force of the individual. Some therapies span two or more of these categories, e.g. re-birthing, amatsu, cranio-sacral therapy and kinesiology.

Complementary therapy theories generally use the word “holistic”. A central defining tenet of the theory and practice of a complementary therapy is that it works with the whole person; body, mind, emotions, spirit and energy within their socio-economic context. It sees the client as the integration of all these aspects. In treatment, the whole person is considered not just the presenting issue. Implicit in this is the theory that, with appropriate help, clients are capable of increasing well-being and, in many cases, freeing themselves from illness. By utilising such traditional systems and other energy-based systems of healing in this holistic, mind-body way the immune system is protected and well-being is promoted.

The defining aspects of a complementary therapy may be seen as the holistic approach to well-being which underpins all therapies and working with the client’s own energy and life force to promote self-healing.

Categorisation of therapies

A majority of the members of the Working Group favoured a two category system of categorisation based on the element of risk involved for the client. Such risks could be physical and/or psychological and depend both on the level of intervention and the level of invasiveness of the therapy. Risks in Category 1 would include such issues as puncturing of the skin, ingestion of products etc. Categorisation on the basis of risk arises out of practicality and is in keeping with the protection of the public remit of

the Working Group. The categorisation does not concern efficacy of a therapy or the body of knowledge and length of history of any particular therapy.

Category 1 therapies include acupuncture, herbalism, Traditional Chinese Medicine (TCM), aromatic medicine and homeopathy.

Category 2 includes all other therapies.

It is also recognised that the level of risk involved in any therapy may vary depending on particular aspects inherent to the therapy involved. For instance, while the herbal and acupuncture aspects of TCM cause it to be seen as a Category 1 therapy, other TCM elements such as Tai Chi and Qi Gong do not carry the same level of risk. The level of risk involved is also influenced by the condition of a client e.g. in aromatherapy, a pregnant client or one with a condition such as epilepsy would carry a greater level of risk. Similarly, mind-based therapies such as hypnotherapy, re-birthing and neuro linguistic programming can be seen as having an element of psychological risk related to the stability or fragility of the client's own psychological state.

It is very important that, where relevant, levels of risk should be categorised within therapies irrespective of the placement of the therapy in Category 1 or 2. This concerns therapies such as aromatherapy and therapeutic massage in particular. It should be covered in the therapist's initial education and training and maintained by continuing professional development. It is implicit throughout this report that any reference to a therapist is based on the assumption that the therapist is fully qualified for the level of treatment they are providing and that they are a member of a professional association relevant to the therapy they are practising.

It is imperative that the initial education and training of the therapist clearly distinguishes between the levels of risk involved in a therapy; whether they are intrinsic to the therapy itself or arise from a condition relevant to the client. It is also imperative that through continuing professional development of the therapist and membership of a relevant professional association that this knowledge of risk is maintained on an on-going basis. It is also taken as a given that any professional association will implement a code of ethics and good practice which ensures that practitioners are competent to practise the level of therapy offered by them. This competence should be monitored on an on-going basis by the professional association. Professional associations should also provide public information on their therapies including a complaints procedure.

Scope of Practice

Guidelines must be given to therapists (as mentioned already under the section on categorisation) when undergoing their initial education and training and later through continuing professional development as to the scope of practice for their therapy. In particular, guidelines on the limits to the scope of practice, on contraindications to treatment and on questions of diagnosis must be given.

As part of their code of ethics and good practice, all professional associations for complementary therapies should advise therapists to refer a client for conventional medical investigation if they have any doubts as to the seriousness of a condition, the presenting symptoms or any new symptoms which arise in the course of treatment. When to treat, when to refuse to treat or to refuse to continue to treat, and when to refer on for conventional medical procedures or to advise a client to seek conventional medical advice; these are all extremely important matters for any complementary therapist and are as essential for them as they are for any conventional practitioner.

As regards the question of diagnosis in complementary therapies, much hinges on what is meant by the use of the term. Conventional medical diagnosis consists of history taking, clinical examination and investigations as appropriate. In many therapies (e.g. reflexology, aromatherapy, reiki, etc.), therapists are very specifically advised not to diagnose medical conditions but therapists may carry out an assessment of a client. Other therapies may diagnose as part of their therapy (e.g. TCM, acupuncture, medical herbalism, etc.) but would have established diagnostic limits.

Conventional diagnosis is a function of conventional medicine; it is not necessarily a function of complementary therapies. Evaluation of a client is in accordance with the philosophy of healing of a therapy and in a manner appropriate to the treatment as, for instance, in homeopathy where finding the combination of symptoms and characteristics indicates the appropriate remedy. In TCM, diagnosis is done in terms of TCM diagnostic categories. Diagnostic tools include history taking, assessment of signs and symptoms as well as culturally particular diagnoses such as pulse and tongue diagnoses. Patients are referred for conventional medical diagnosis when the symptoms are severe and/or indicate a potentially serious condition or where, in less acute cases, clients do not respond to the complementary therapy in question or where new symptoms arise in the course of treatment.

Frequently clients approach a complementary therapist having previously obtained conventional medical diagnosis and treatment. Currently, and particularly where complementary therapists are not working in direct co-operation with conventional medical practitioners, there are no satisfactory routes of communication between both conventional and complementary practitioners.

Increasingly however, people are approaching complementary therapists with the knowledge, approval and indeed sometimes the recommendation of their medical practitioner. With expanding emphasis, both nationally and internationally, on integrated medicine where conventional and complementary practitioners work together and communicate with each other, the question of diagnosis will become less of an issue.

A feature of diagnosis which complementary practitioners feel is particular to their approach is the attention paid to the total physiological and psychological aspects of the individual. Complementary diagnostic systems are frequently concerned with “patterns of imbalance” in addition to a specific disease entity or a precise cause. This approach arises from the energistic or vitalistic aspects of many complementary therapies where patterns of disharmony provide the framework for treatment and where the treatment attempts to restore balance and harmony, vitality and the flow of energy to the client.

It is important to distinguish between aspects of assessment and diagnosis. Assessments are made prior to treatment by a complementary therapist. Arising out of an evaluation of the assessment, the therapist will be aware (because of their initial education and training, continuing professional development and therapy body membership) whether treatment can proceed or whether this particular case/condition is beyond the scope of practice of their therapy and level of qualification and needs to be referred to a conventional medical practitioner or a more qualified practitioner of their own therapy.

Summary

There is no one definition for complementary therapies. A definition of a complementary therapist that emerged from the Working Group is “A practitioner of a healing philosophy or tradition that offers health-related advice and treatment which is considered to be of a different use, acceptance, study and understanding to the mainstream western, conventionally practised medicine”.

A central defining tenet of the theory and practice of a complementary therapy is that it is holistic, i.e. working with the whole person; body, mind, emotions, spirit and energy.

Therapies were divided into two categories, based on the element of risk involved for the client.

Category 1 includes herbalism, acupuncture, aromatic medicine, homeopathy and Traditional Chinese Medicine (TCM).

Category 2 includes all other therapies.

The level of risk involved in any therapy may vary depending on particular aspects inherent to the therapy involved or the condition of the client.

Codes of ethics and good practice, which involve direction as to the scope of practice allowed and knowledge of risks involved, must be implemented by a professional association for its members as part of their original training and maintained by continuing professional development.

Complementary diagnosis, where it takes place, is based on the paradigm of the therapy in question and is not the same as conventional medical diagnosis.

CHAPTER 3

Education and Training

The Current state of play: Education and Training

At present there is an array of courses in the area of the initial and on-going education and training of complementary therapies. Courses vary widely and unacceptably in levels of quality even where a single therapy is in question. The variations cover aspects of course content; course duration; theoretical and, where applicable, practical components of courses; assessment procedures; qualifications and practical experience of course providers, tutors and trainers.

Course providers currently come from either professional associations or from commercial interests. Often there is little communication or agreement between both sectors. There is, at present, no one source of independent, external assessment, validation and accreditation which would provide for monitoring of educational programmes and of providers, tutors and examiners.

Concerns have been expressed by the professional associations and by members of the Working Group about:

- the number of therapists practising therapies on the basis of inadequate home study courses;
- courses not including practical aspects where these are integral elements to the proper practice of the therapy;
- courses taught by therapists whose own practical experience of the therapy is inadequate or non-existent.

The continuation of such a situation is untenable both for the professional associations in the complementary therapy sector and for the Department of Health and Children.

Matters relating to professional practice

As regards proper professional practice, concern has been expressed about people practising a therapy who are not members of any professional association relevant to that therapy. This gives rise to questions of continuing professional development and, not least, insurance.

As regards professional associations, in very many therapies there are differing associations at varying stages of development and expertise. Communication between these associations ranges from good to fragmented to hostile. Although many therapies are at very different stages of development in relation to a regulatory framework, there does seem to be a general consensus that a credible system of regulation is a desirable goal for their therapy.

The importance of a unified approach between professional associations, covering the same therapy in particular and for all therapies in general, cannot be underestimated in relation to matters of proper professional practice. These matters cover:

- initial education and training;
- registration with a professional association;
- on-going monitoring and clinical supervision, where relevant;
- ethical considerations, proper business practices, continuing professional development and grievance and disciplinary procedures.

Although this section deals in the main with education and training, it is not possible to separate entirely from that the question of professional associations. Input, advice and provision of educational programmes for instance will have to be informed by consultations with professional associations. But which associations? What associations could be used as arbiters of best practice?

A most urgent consideration for the professional associations is to seek a harmonisation and a unity between their varying associations, very particularly where those differing associations are dealing with the same therapy. This harmonisation and unity is essential to the development of robust systems of voluntary self-regulation.

Self-regulation is a process in which individual therapies develop their own education programmes, codes of ethics, statistics, research programmes and competency standards. This process will need the support of the Department of Health and Children to address areas of concern and to help existing registering bodies improve communication between themselves. The support could be in the form of forums for the sector in general and small-group symposia for single therapies with multiple associations. In the long-term, on-going support and development could come from an over-arching group such as a Complementary Therapies Council which would represent all the stakeholders in the sector.

Possible routes to independent external validation of education and training programmes

In October 2003, the National Qualifications Authority of Ireland (NQAI) launched a new framework of 10 levels of qualification which contains 15 award types. These range from basic literacy and education to doctoral level and cover all award types in the state in the education and training sectors.

The new framework is “the single nationally and internationally accepted entity through which all learning achievements may be measured and related to each other in a coherent way and which defines the relationship between all education and training awards.” The NQAI has also determined descriptors for these award types and has set out the overall standards of knowledge, skills and competences required for an award at each level within the framework.

A process of implementation is now underway which involves the Further and Higher Education and Training Awards Councils (FETAC and HETAC) establishing arrangements in consultation with stakeholders governing quality assurance procedures, standards for awards across various disciplines in the new framework, and procedures for validation of programmes leading to these awards.

It is HETAC or FETAC who will be the primary contact point for industry and providers regarding the content, standards and learning outcomes for particular awards. A flexible approach, rather than a prescriptive one, is to be adopted under which programme providers satisfy HETAC or FETAC that:

- their quality assurance procedures are satisfactory
- their programme is suitable for validation (staff, policies, processes, resources, and course structures are capable of achieving the learning outcomes and standards required within the framework for a particular award)
- their arrangements for assessment of learners are fair and consistent
- they implement the NQAI's policies for access, transfer and progression
- they have protection for learners.

As a result of the development of an extensive framework of qualifications, and because of the opportunity for course providers and professional associations to collaborate with HETAC and FETAC in the development and assessment of such courses, the way seems clear for the development of independently validated and accredited courses in complementary therapies.

It is obvious that HETAC and FETAC would need to consult closely with the professional associations for each therapy to be considered and for programmes and providers to be evaluated for course validation and accreditation. But the question still arises. With which therapy body, which professional association would HETAC or FETAC consult as arbiters of best practice and information on the course requirements for any therapy? If there are several associations for the same therapy how would one be selected for consultation on matters of course content? It is obvious that the multiple associations which represent the same therapy would first need to come together in some form of federation or umbrella body to facilitate effective consultation with HETAC or FETAC concerning that therapy and courses specific to it. In the interim period, HETAC and FETAC will consult the relevant sector as widely as possible.

A single, voluntary self-regulating body for each individual therapy would achieve a more focused and efficient approach to all matters related to that therapy and, in particular, to matters pertaining to external validation of education and training. It ought to be possible for an umbrella body or federation of associations to be formed which would preserve the diversity of the separate associations and promote inclusivity for the greater good of the therapy concerned.

Given the number of separate therapies which are likely to be seeking validation and accreditation of courses, logistically it would be advisable for various therapies to come together to agree on standard course modules which would be common to all therapies. This could include best practice, elements of running a business, codes of practice, professional ethics etc. at one level and common elements such as basic clinical sciences e.g. anatomy, physiology, etc. at another level where associations could agree on a common approach to these areas. This would also avoid duplication of work. Accompanying these common modules would be modules relevant to each specific therapy.

Continuing professional development is another area which would need a degree of consultation between providers, HETAC and FETAC and the professional associations. HETAC and FETAC could validate and accredit these areas, as they would with initial education and training courses, and the professional associations would deal with registration requirements, research, insurance, matters of ethical practice and disciplinary matters. The question of grand-parenting and of qualifications acquired outside the state is another area where consultation would be necessary between providers, HETAC and FETAC and the various professional associations.

Expertise and high standards are prevalent in many professional associations. This expertise ranges from initial education and training provision to continuing professional development programmes, which is a mandatory requirement in many associations for renewal of registration of members. Therefore, there is already a base for development in many therapies which will greatly facilitate future negotiations with HETAC and FETAC as regards validation and accreditation.

Providers in the statutory sector are obliged to have their programmes validated by FETAC or HETAC or another relevant awards body, apart from programmes of a leisure or recreational nature which are not intended to lead to an award under the Qualifications (Education and Training) Act 1999. Validation is optional in the private sector. Awards under the national framework of qualifications confer obvious advantages in terms of the national status and portability of awards, particularly in the context of emerging proposals from the European Commission relating to the development of a European Framework of Qualifications.

The National Qualifications Authority of Ireland provides a service, Qualifications Recognition — Ireland, which provides advice for individuals on the comparability of international awards made by bodies outside the State relative to the Irish system. Details are available at www.nqai.ie.

Many therapies already have policy documents and guideline reports available which should further facilitate the processes involved e.g. in homeopathy the European Council of Classical Homeopathy have developed guidelines for the accreditation of courses, for code of ethics, for continuing professional development, and for policy on research. Similarly WHO TCM have guidelines on training and exam standards for TCM.

This position is replicated in other therapies and should facilitate the development of a template of modules common to all courses and those which are specific to a single therapy but which have to be accepted and agreed on by differing associations within that single therapy. This would help with greater harmonisation within the professions especially with regard to education and training. It would also facilitate the transfer of credits system in keeping with the Bologna agreement as part of the international programme for lifelong learning.

Conventional Healthcare Practitioners and Education and Training

If conventional healthcare practitioners are practising complementary therapies it is essential that they are qualified to standards comparable to any practitioner in that therapy and comply with the requirements of an appropriate registering body for that therapy. While there may be prior knowledge of, and qualification in, basic clinical sciences and principles of conventional diagnosis, which may be accepted for credits in any education and training programme in the complementary therapy they wish to practise, it would also be important that any area which might have specific requirements for that therapy be complied with. For example, anatomy and physiology as it might relate to yoga rather than to conventional medicine etc.

Therapies not using independent external validation

For therapies where there is not, at present, any body of knowledge which can be taught, examined and evaluated, it is clear that the question of independent, external validation does not arise.

In the interests of safety and protection of the public, it is important that in such cases, an assessment of the level of risk involved in the practice of the therapy is considered with a view to providing the public

with a checklist or kite-mark of reference as regards dangers, standards, proper practices, etc. The public should be provided with a reliable source of information or consumer guide as to what they might expect from such a therapist and as to the professional association guidelines for the proper practice of that therapy.

Summary

Education and training courses for complementary therapists can vary widely and up to now there has been no co-ordinated system of external, independent validation and accreditation available.

The new ten level framework of qualifications from the NQAI now offers a route to independent validation of education and training courses for complementary therapies.

To evaluate such courses the training awards councils — HETAC and FETAC — will need to collaborate with the course providers and the professional associations or preferably an overall association or federation of associations for each therapy.

CHAPTER 4

Curriculum for complementary therapy courses

Some therapies have long-established and well-developed curricula. Through affiliations to international associations, these curricula are often linked into broader models, usually European. For other therapies, or indeed for other professional associations within the same therapy, levels of curricula may vary. With that in mind the Working Group considered what should form the essential elements in any therapy curriculum.

Curriculum template for any complementary therapy

The Working Group recommends that every course should include the following areas to an appropriate level related to the therapy being studied:

- Ethics and Code of Practice
- Scope of Practice including:
 - duty of care
 - contra indications
- Professional/practitioner development including:
 - professional conduct
 - communication skills
 - confidentiality
 - client relationships
 - psychological relationships
 - membership of related professional body national/international
 - awareness of reflective practice and CPD
 - business practices
 - record keeping
- Clinical practice including:
 - case history
 - questioning
 - assessment
 - diagnostic issues
 - contact

- pharmacology
 - developing trust
- Clinical supervision
- Referral
- Anatomy, physiology and pathology
- Nutrition
- First aid and basic requirements of health and safety
- Legal obligations of service providers including:
 - health and safety
 - equality
 - child protection
- Personal development
- Study skills and research
- History, philosophy, theory and practice of the particular therapy being studied

The aim of any training must be to establish basic competencies in the practitioner, competencies which are developed into skills through clinical supervision in initial training and which are developed and consolidated through continuing professional development. For those already practising, the concept of supportive grand-parenting and bridging can be used to facilitate those who may have extensive clinical and empirical experience but whose training standards may be lacking in other aspects. Bridging training may be required as part of grand-parenting, where it has been identified by the professional organisation that there are gaps in the practitioner's knowledge that need to be filled before they can become fully registered. The professional association would inform the applicant of what areas need further training and where this can be obtained. Normally a time frame of 2-3 years is given for this to be achieved, depending on the amount of training that is needed.

As with the initial training and accreditation of courses by HETAC or FETAC, under the new framework of qualifications there will be a process of accreditation of prior learning under which individuals may seek to have evidence of their learning assessed by reference to the requirements of awards in the new framework. This could involve producing a portfolio of work as evidence or sitting assessments or doing further modules to address gaps. It could be a combination of all of these which would eventually result in the person being given an award under the new framework.

Admission Criteria for Students

The question of admission criteria for students into any course providing a qualification to practise as a therapist, and the required background for course tutors, was also considered.

Concern was expressed about proposals in the United Kingdom to allow 16 to 18 year old students onto courses which would allow them to practise as therapists (as opposed to courses to gain knowledge of a therapy for their own interest such as an evening/weekend class or a longer PLC course aimed at the beauty/leisure industry). It was agreed that age 18 should be the minimum age for entry to a course. Many professional associations prefer age 21 and age 23 was suggested for mind-therapy courses where life-experience is extremely important.

Entry requirements for a professional training course should include the following:

- Leaving Certificate or equivalent as required by the professional association
- Proficiency in the English language
- A panel interview
- Two references and appropriate checks to gauge personal suitability.

It was also considered essential that assessing the personal suitability of a student should be on-going throughout the course and into a probationary period of practice as a therapist.

Requirements for Course Tutors

Some concern was expressed that tutors on courses are sometimes appointed as tutors on the basis of their having been a very good student on that course. They may not always have the desired degree of practical experience as a therapist.

The Working Group considers it essential that course tutors or trainers should:

- have a qualification in the therapy concerned
- have at least three to five years full-time experience as a therapist, with clinical supervision, where relevant, before starting as a trainer on their own
- undertake a course in teacher training or adult education.

The third component is seen as a necessary complement to their practical experience as a therapist and would ensure the right balance of theoretical as well as practical training on a therapy course.

Length of training and continuing professional development

Some therapy course providers have already applied to HETAC or FETAC for recognition and accreditation of courses. The areas of content, tutor qualifications etc. will be overseen by HETAC or FETAC in collaboration with the course providers and the wider sector.

For those therapies or professional associations not yet at this stage, the situation regarding course provision is very varied. The question of length of training, whether measured in years or hours, differs considerably between therapies and within therapies depending on the level to which the therapy is being studied.

The Working Group agrees that all training needs to have a mix of practical skills and theoretical knowledge and generally a minimum of two years training for any therapy, although very many therapies would have a much longer training period. See Appendix 6 for some examples from different therapies on course duration. This is a matter which the professional associations need to address and it can only be properly addressed when the various related bodies or associations for the same therapy unite together to agree common standards and harmonisation of requirements.

This highlights the need for the facilitated work-days for therapies as stated in the recommendations to the Tánaiste and Minister for Health and Children to progress these issues in collaboration, where relevant, with providers and the Further and Higher Education and Training Awards Councils.

Continuing Professional Development (CPD)

Skills based CPD is generally a requirement for professional associations. For some professional associations it is a requirement for annual entry on the register of therapists recognised by those associations. It can involve attendance at seminars, training days or AGMs; work as a guest lecturer, writing books on the area or articles for professional journals; peer review and discussion groups; clinical training; supervision or other approved activities.

When initial training courses by course providers, validated and accredited by HETAC or FETAC in collaboration with professional associations, have been developed and are underway it should be possible for CPD courses to follow the same formula. All the activities mentioned above carry a score, assigned by the relevant professional association, which goes towards making up the total score required by that association to fulfil CPD requirements for its members. Some associations have a passport-type document on which the scores for activities recognised for CPD points are entered and verified and which are then presented, usually annually, to the professional association for continued registration.

Summary

The Working Group has devised a template of modules which should form the essential elements in a therapy course curriculum.

The concept of grand-parenting and bridging can be used to facilitate therapists whose training standards may not be at the current level required by the professional association or who have not been formally assessed.

Admission criteria for acceptance of students into a course should include a minimum age of 18 and preferably older, particularly for the mind-therapy courses. Assessment of personal suitability should be on-going throughout the course and into a probationary period of practice as a therapist.

Course tutors should have a qualification in the therapy concerned, three to five years experience as a therapist in the therapy they are planning to teach and training in adult education or teacher training.

Therapy courses should generally be a minimum of two years full-time.

These recommendations are aimed at education and training for practice as therapists in the complementary health sector. Many, but not all of them, have relevance to programmes aimed at preparing students for employment in the beauty and leisure industries. This issue is dealt with in Chapter 6.

CHAPTER 5

Professional Associations

Many therapies have several associations representing the one therapy. Some of these may originate outside Ireland; others are affiliated to international associations. The communication and co-operation between these different associations can, as has been said previously, vary greatly. The problems posed by this fragmentation of the sector, and the question of what constitutes a professional association for a therapy, were considered at length by the Working Group.

Over the two years of the life of the Working Group and with the encouragement of the group, particularly at the 2004 forum, several professional associations have come together, or are in the process of coming together, as a federation of associations for their therapy to promote and develop knowledge of their therapy and excellence in practice.

For greater unity within the complementary therapy sector and within each individual therapy it is essential that the different groups for each therapy come together to agree common basic standards of practice, education and training, for greater strength as a lobbying body and as a source of information on their therapy. Without a common unified source of information on a therapy and the therapists practising it, and on what one might reasonably expect from the therapy and the therapist, the general public (the consumers) are at a loss as to how to make a judgment on what choice to make.

For greater protection and information it is essential that associations come together to harmonise their standards of education and training and the conditions of regulation of their members. For this to happen, the various associations will need the support of the Department of Health and Children. This could be in the form of support for, and organisation of, work days for the different therapies or groups of similar therapies to come together, with facilitation, to undertake this process of harmonisation and development. This is a recommendation to the Tánaiste and Minister for Health and Children from the Working Group.

As regards associations, it was pointed out that in many cases an association emerges initially from a training school and may or may not become independent of that school in time. For greater objectivity, especially in the area of setting standards, a professional association needs to be independent of a training provider and commercial interests. It is important that subtle commercial pressures do not enter into factors affecting what is best for that therapy and the consumer. It is also important to avoid conflicts of interest, described sometimes as individual empire building, which might prevent or delay federation of associations.

Crucial areas for associations to reach agreement on are questions of scope of practice, limits of competence and referrals to another practitioner whether conventional or complementary. It is part of

the code of ethics of almost all therapies that a therapist advise a client to seek conventional medical advice if they feel this is needed. In the majority of therapies, therapists would not continue to treat a client who refused to follow this advice.

Template for a professional association

The Working Group feels that a professional association for a therapy needs to have a written constitution and open, democratic election procedures with limits to office holding. An association should:

- advise on standards and criteria for the education and training of therapists and for the practice of the therapy
- maintain a current register of practitioners and provide for continuing professional development
- have a code of ethics and good practice and clear grievance procedures which allow for removal of a therapist from a register
- consider the interests of both the therapist and the consumer and provide sources of information for the public on their therapy
- represent the therapy at national and international level and consult with international bodies regarding new developments and research

Examples of codes of ethics and good practice, including grievance and disciplinary procedures, can be found at Appendices 7 and 8 in this report.

Summary

Some therapies are represented by one overall body or a federation of associations for that therapy involving most, if not all, associations for that therapy.

Over the life of the Working Group, and arising from the work of the group, several differing associations for the same therapy have come together to form one overall association to harmonise standards for that therapy. This has happened in the case of two major therapies.

Other therapies are represented by several different and differing associations. For greater development of these therapies, harmonisation of standards of education and training, codes of ethics and good practice and continuing professional development, all such associations need to be supported by the Department of Health and Children.

The Working Group recommends to the Tánaiste and Minister for Health and Children that a series of facilitated work-days be held for these associations to progress the issues. In connection with this aspect, the Working Group devised a template of elements needed in a professional association.

CHAPTER 6

The Consumer

An integral part of this report on the regulation of complementary therapists is the consumer or the client. Arising from the central issue of duty of care to the public, any discussion on regulation has to consider what might impinge on the consumer or the client. At present, as in many other countries, the area of complementary therapies, and in particular complementary therapists, is a confusing one for consumers.

Whether a therapist is properly trained or qualified, whether they are a member of a professional association, whether they are currently registered with that association, whether they undertake continuing professional development, whether they have insurance cover, are all areas where information can be lacking. In some cases there is a unified body for a therapy which can be a source of information on these areas but this situation does not exist for all therapies.

If there was a grouping or federation of associations for a therapy working as one overall registering body, with agreed standards regarding length of training, level of qualifications, codes of ethics and good practice, this would be a greater safeguard for the consumer and would provide a checklist by which clients could evaluate the suitability of a therapist.

For this reason, the Working Group is recommending to the Tánaiste and Minister for Health and Children that the Department of Health and Children assist and facilitate the various therapy associations for any one therapy to come together to federate for the better development of their therapy, for greater harmonisation of standards of education, training and good practice and as a source of information for the public.

It is also recommended that, following such a process for various therapies or therapy groupings such as mind therapies, body therapies and energy therapies, a comprehensive information booklet of current information, regularly updated, on therapy associations be developed to provide a good source of reliable consumer information. Such a booklet should be widely distributed.

The absence of good information at present is shown in several areas of confusion for the consumer. At the most basic level, titles can be used by groups which can be confusing and misleading. For example, “the National Association of . . .” or “the National Centre for . . .” implies some form of Government backing and approval or implies a more widespread existence than might be the case.

The use of the word “medical” in a description may cause consumers to think that there is conventional medical backing for, or involvement in, a therapy.

The use of the term complementary therapies in the beauty industry or the leisure/spa industry can also cause confusion and will be dealt with in a later paragraph.

Well-produced glossy brochures on courses in complementary therapies with impressive titles may give the impression of in-depth training courses. However, this can often be well-organised publicity material for courses which may be correspondence courses or courses which may not be of any great duration, may not have any depth of content or which do not involve practical experience or supervision. Such courses may not be recognised by professional associations.

In the absence of a comprehensive information booklet covering most therapies, a unified overall association for a therapy will be able to give information through websites or other material as to the courses which they accept as being of the required content and duration to meet their standards for that therapy. The difficulty for the consumer is that at present such unified associations do not exist for the majority of therapies and this highlights again the need for unification of associations and reliable objective information sources.

Information on qualification standards is also important where a therapist might practise multiple therapies which may or may not be related. Provided the therapist is properly qualified in each therapy they are practising, there may not be a problem for the client. A point which should be considered however is where something goes wrong in the practice of one of the therapies offered by the therapist. The client may wish to make a complaint against the therapist through the grievance procedures of the registering body for that particular therapy. If the therapist is not registered with that particular professional association (although they may be registered with an association or associations for the other therapies which they practise) the client may have no redress.

If a practitioner is a member of a properly constituted professional association of any complementary therapy, the insurance cover, code of ethics and practice and disciplinary/grievance procedures of that association should cover all the therapies that the practitioner has properly declared themselves to be practising and shown evidence of adequate training in. It should be inherent in the ethics that they will only practise what they are properly qualified in and that they will practise within the proper scope of practice; i.e. it would be malpractice to practise a therapy in which they are not properly qualified.

As well as difficulties for the consumer in assessing general areas such as standards of qualification and good practice, there are also areas specific to certain therapies which can be confusing or misleading. This is particularly important where there are different levels of the same therapy practised by therapists or where variations on one therapy are included in the repertoire of therapists from another discipline.

An example here would be homeopathy where fully qualified homeopaths generally practise classical homeopathy and where remedies are used in accordance with the original definitions of Samuel Hahnemann, originator of homeopathy. Other therapists use combination formulae or products known as complex homeopathy. These therapists may be qualified in a therapy other than homeopathy but may use homeopathic products. A consumer who has not got a source of information on homeopathy may not appreciate the difference or be in a position to decide for themselves which therapy would be the most suitable one for them.

A similar problem can arise in aromatherapy where there can be four different levels of practice:

- Holistic aromatherapy, the area most people would be familiar with;
- Aromatic medicine and psycho-aromatherapy, more widely practised in France and Germany than here;
- Aesthetic aromatherapy, mainly practised as an adjunct therapy to beauty therapy using ready blended products;

The qualification to practise aesthetic aromatherapy would not be accepted as sufficient to practise in healthcare. Without an accurate and reliable source of information on the therapy in question the consumer is not in a position to evaluate the qualifications or methods of the practitioner.

As with any therapist, whether with an independent validation of educational qualifications or not, it is incumbent on the consumer to check matters such as current membership of a professional association, insurance cover, proper practice, etc. A possible checklist for any consumer thinking of consulting a complementary therapist might include the following questions:

- Has research been done on this therapy?
- Are there books written on it and available to me?
- Is there at least strong suggestive evidence that it benefits the patient?
- Are there risks or side-effects?
- Could it interfere with my current treatment?
- Is there a national association of practitioners?
- Is the practitioner a member in good standing with a national association?
- Is the practitioner insured?
- What will the cost and duration of treatments be?
- Are there reputable international organisations for this therapy?
- Is there an available statement of the therapists' code of ethics and redress procedures?

Client/Therapist Charter

As in all aspects of life, the consumer has an obligation to check out the qualifications, level of practice covered and current registration of the therapist before commencing treatment.

When therapy associations have federated and can be a source of information for the consumer and when a comprehensive information booklet on the sector has been published, it will be a simpler process for the consumer to check out a therapist.

Until that time, and also as a matter of good practice, it would be very important and would offer greater protection to the consumer if every therapist had a therapist/client charter prominently displayed in their premises. It should also be available in a form to be given to the client at the first meeting which they can take away for further consultation.

Some professional associations currently have such a client/therapist charter but it is recommended that all associations and all therapists provide this. Such a charter should be a clear, concise, explicit and tangible statement defining good complementary practice as regards standards of qualification, membership of a professional association, code of ethics and good practice including grievance procedures, information on insurance cover, etc. It should involve a clear statement of the therapist's qualifications and current registration with a relevant therapy association with all required contact details for that association including, where available, a client help-line number.

Such a charter would delineate the importance of mutual trust between client and therapist, particularly in the area of a client's medical history and any medication currently being taken or treatment being followed. It would advise the client to consult with their GP if it is necessary to inform their GP of the therapy they are undergoing and any product being used in relation to the therapy. From the therapist's point of view, if any product is being supplied, the client should be informed in writing of the formulation of the product and be told of any possible side-effects or interactions with any other medicine.

As would be set out in the therapist's code of ethics relating to scope of practice, the charter would advise the client to avail of the appropriate care for their condition whether that is conventional medical care or another form of therapy for their condition if it is beyond the scope of practice for that therapist. It could also advise the client that if, in the opinion of the therapist, the client needs to be referred for conventional medical help, the therapist would not continue the therapy if the client refused to take that advice. This is the position of the majority of professional associations.

In the case of some therapies however, the therapist would continue to work with the client for a limited number of sessions, using those sessions to encourage the client to avail of conventional medical treatment. The therapist would then cease treatment if after those sessions the client continued to refuse to seek conventional medical advice.

In the case of many homeopaths, while strongly urging the client to avail of conventional medical advice, they would continue to treat if the client made the decision not to avail of this. In the words of the Irish Society of Homeopaths "The Society of Homeopaths supports the principle of the individual's right to choose in personal health matters. In addition, having regard to a duty of care, homeopathic practitioners will work within the bounds of their competence and within the law as it allows or otherwise attaches conditions to the freedom of the individual to make informed healthcare choices. This principle and understanding applies to appropriate referral for the diagnosis of disease as well as the provision of any subsequent conventional, complementary or alternative medical assistance."

Complementary therapies and the beauty industry

There is no restriction of use and no reservation of title of the term complementary therapy or complementary therapist. In many cases, therapists describe themselves by the therapy they practice; a herbalist, a homeopath, a massage therapist, an acupuncturist etc. and the term complementary therapist is used by others about them in a generic way. However, there has been increasing use of the terms complementary therapies and complementary therapist by the beauty industry along with the term holistic therapist.

Generally, the therapies in question here are massage, aromatherapy and reflexology. These may be perceived to be therapies of low risk although this risk level can depend on the client's state of health,

e.g. where a client has active cancer; or the risk level may be affected by the product involved, e.g. where undiluted essential oils are being used.

Generally, the public are using these therapies through the beauty/hotel/leisure/day spa industry for relaxation rather than to remedy a condition. However, there could be confusion regarding qualifications and the scope of practice covered by the level of qualification of the therapist involved. Serious concern would also arise where there is a level of invasiveness involved in the treatment such as cosmetic acupuncture or colonic hydrotherapy where the risk of injury or cross-infection may arise.

Some beauticians may have additional qualifications as a therapist which are recognised as full qualifications and may be registered by a professional association. Others may have done a module or several modules as part of an overall beautician training course but would not be recognised by professional associations to practise that therapy. The client may be paying full price for a service from a person without full qualifications.

The beauty industry has expanded greatly in recent years into the spa therapy area, where beauty therapies and complementary therapies are often combined. These can be located in hotel leisure centres, day spas or premises described as holistic centres. With this expansion and the increase in the range of therapies being offered, it is important that the consumer is aware of the different levels of qualifications involved. Distinctions need to be drawn between both industries.

With increasing integration between complementary practices and conventional medicine in GP practices and hospitals, use of the term integrated practitioner could be used by those involved in this area. However, this term would not cover the complementary therapist who does not have any involvement with the conventional medical sector.

In the absence of such delineation by title, the existence and easy accessibility of a register of fully qualified and currently registered therapists by a professional association for that therapy would be of assistance to the public in distinguishing between fully qualified therapists and those who may have had a cursory introduction to a therapy as part of an overall beautician course.

Consumers also need to be aware of the different levels of courses available which then might be used as a qualification by a self-styled, unregistered and unmonitored practitioner. There are night/weekend classes in many therapies which give a basic knowledge of a therapy sufficient perhaps for interest and self-use but not sufficient to practise as a therapist with the public.

For their own protection, the public should seek a qualification at a level recognised by a professional association as qualifying a therapist to offer treatment of pathological conditions needing remediation in line with the code of ethics and scope of practice of that professional association.

Summary

The area of protection of the public is integral to any question of regulation of complementary therapists. The public needs to be well-informed and to take personal responsibility and due care in this area as in any other area of their lives.

Where there are a number of professional associations for any one therapy, with differing standards of qualification and practice, the consumer needs a reliable, up-to-date source of information to guide them

towards the best choice of therapist for their needs. The Working Group recommends the publication of such a consumer guide by the Department of Health and Children.

Professional associations should provide a client/therapist charter for their members if it is not already in existence. This would provide clear information for the consumer as to what they could expect from the therapist and the therapy and would provide them with contact information for the professional association registering the therapist.

While beauty therapists may be very well qualified within the parameters of their own industry, and some may be fully qualified in a particular therapy, others may not have the full level of qualification which would be accepted by a professional association to practise in healthcare. The public needs to check the qualifications and registration of any therapist.

The Regulation of Complementary Therapists

There are two broad approaches to the area of regulation of professions.

1. **Statutory regulation** is a system whereby each individual member of a profession is recognised by a specified body as competent to practice within that profession under a formal mechanism that is provided for by law. Unlike systems of voluntary regulation, it is a legally binding process: all persons wishing to practise must be registered, and can be prosecuted for practising if not registered.
2. **Voluntary self-regulation** is a system where the profession itself self governs. Voluntary self-regulation, when administered by a single, professional body, is often thought to be enough to protect the client and to organise practitioners. Provided a profession has all the self-regulatory mechanisms in place, it can prove as effective as statutory registration.

The general thrust of public policy, here and in the EU, is towards minimising statutory regulation i.e. by law. The policy generally is only to regulate by statute when there is an overriding public interest for an activity to be regulated.

The trend internationally in the regulation of complementary therapists is away from statutory regulation and towards a robust system of voluntary self-regulation policed by one overall body for each therapy. For an overview of the regulatory position internationally please see Appendix 4.

It is clear there is no one common position worldwide or even Europe-wide. In Britain, the move towards statutory regulation of herbalists and acupuncturists is being delayed as government bodies await the outcome of two major reviews of statutory regulation of health-care workers.

This may be no bad thing as, according to Stone and Matthews⁴, statutory recognition to date has come at a high price, namely acceptance by the medical profession which they say “almost certainly necessitates a distancing from the more intuitive and esoteric underpinnings of holistic medicine”.

Stone and Matthews say that ethics, as in codes of practice, have been seen as encouraging optimum standards of behaviour whereas the law is usually concerned with enforcing minimum standards. They go on to say that ethics are central to statutory regulation and to voluntary self-regulation and that in organisational terms there may be very little difference between statutory regulation and voluntary self-regulation. It concludes “we must not rule out the fact that effective VSR may do a very good job of fulfilling all the regulatory requirements we have identified” and “It is our central contention that

⁴ Complementary Medicine and The Law, Julie Stone and Joan Matthews, Oxford University Press 1996 reprinted 2003

whether SSR or VSR is being pursued, a grounding in what it means to practise ethically is at the heart of either system of regulation. Ethics-led regulation provides the key to effective self-regulation.”

Regulation is sometimes proposed on the basis of perceived risk arising from a particular therapy. This position has its defects because while certain therapies do carry more obvious risks e.g. acupuncture needles or herbal medicines, less obvious risks also exist. Risks may arise from the therapy itself as mentioned above or they may arise from an inadequately trained practitioner or from lack of good practice on the part of the practitioner e.g. not referring on for a serious medical condition either at the commencement of treatment or arising during the course of treatment. Risks may arise from the client where there is a pre-existing condition or treatment has been undertaken which the client does not inform the therapist about.

The solution to such difficulties is a two part process of greater voluntary self-regulation in the complementary sector and greater information for, and personal responsibility on the part of, the public.

Protection of title, which is a feature of statutory registration, is sometimes referred to as a solution and this can be useful if a protected title is being used unlawfully by someone posing as a reputable therapist. In this case there is redress. Where it is of no use and where it is a much more common occurrence is where operators make up their own title. In the United Kingdom, where the title “osteopath” is protected by law, many operators use a similar sounding title e.g. “practitioner of osteopathic technique”. In such cases, provision of reliable information for the public on titles and associations will enable them to check out the difference between similar sounding therapies.

Having considered the area of regulation, the Working Group is recommending that statutory regulation should be considered for herbalists, TCM practitioners and acupuncturists. For herbalists, this is because of the issues involved in the use of herbal medicinal products by herbalists. The Working Group’s remit of the protection of the public is best served by statutory registration for herbalists. OTC, i.e. Over the Counter Herbal Products will be regulated by the Traditional Herbal Medicinal Products Directive. Herbalists using specialised herbal training, however, will be entitled to continue to use herbal medicines in individualised, complex prescriptions for their patients. Given the necessity of high training standards for herbalists and the increasing use of herbal medicinal products whereby there is increasing potential for interaction between allopathic and herbal medicinal products, it is recommended that a process of statutory regulation be put in place for herbalists. In the case of acupuncture, the risks arising from the invasive nature of treatment by needle demands a high degree of education and training and good practice.

Because these therapies are often seen as stand-alone systems with their own methods of diagnosis, they may be the primary point of call for a client, unlike other therapies where a client may have seen a GP first. As a primary point of call, it is essential that there is protection for the client in the form of greater regulation.

The process of how precisely these therapies would be regulated by statute will take more time and needs further examination by a single focus group to look solely at the issues involved. Such a group will benefit from the advanced work of the two UK bodies: the Acupuncture Regulatory Working Group and the Herbal Medicine Regulatory Working Group. There is no need to re-invent the wheel and the years of work done by expert groups in Britain could help to greatly shorten the life of a similar Irish Working Group.

For all other therapies, the Working Group is recommending the development of robust systems of voluntary self-regulation. This process is currently underway and has been for many years by many therapies and by many professional associations. Their concern is that such development is neither universal in the sector nor uniform even among associations for the same therapy. To bring about a situation where such voluntary self-regulation is both universal and uniform it is necessary that support be given to the sector to progress the level of development reached voluntarily by certain committed and hard working professional associations.

The precise nature of that support is clearly delineated in the recommendation to the Tánaiste and Minister for Health and Children that the Department of Health and Children offer facilitated work days to groups of professional associations for the same therapy or for groups of similar therapies to progress the issues which need to be harmonised. These could include issues of ethics and good practice, standards of externally validated education and training, the proper composition of a professional association or any other related matters. In addition, the adoption of a patient's charter, used at the initial point of contact between patient and therapist, constitutes another useful initiative.

Along with strong systems of voluntary self-regulation there needs to be a reliable and up-to-date source of information on therapies and professional associations for consumers. It is another recommendation of the Working Group that a booklet be published following the facilitated work days. Information on complementary therapies and complementary therapists tends frequently to come into the public domain via the media, most usually involving a rogue practitioner who is subsequently found not to have had appropriate qualifications and not to belong to the register of any professional association. With strong systems of self-regulation, a well developed sector of unified professional associations and a comprehensive information source for the public it is hoped that such sad cases will diminish if not vanish totally.

Summary

There are two broad approaches to the regulation of professions:

- Regulation by law or statutory regulation
- Voluntary self-regulation

The general thrust is towards minimising statutory regulation. The trend internationally in complementary therapies is towards a robust system of voluntary self-regulation by one overall body for each therapy.

The Working Group recommends setting up a single-focus group to consider the issues involved in the statutory regulation of TCM, herbalism and acupuncture.

The development of robust systems of voluntary self-regulation is recommended for all other therapies. This will need the active support of the Department of Health and Children.

CHAPTER 8

Recommendations of the National Working Group

The following are the recommendations of the group to the Minister for Health and Children:

1. Statutory regulation for herbalists/acupuncturists/Traditional Chinese Medicine practitioners. To achieve this, it is recommended that a small, single-focus working group be established without delay to consider the complex issues and various models involved in statutory regulation.
2. For all other groups, the development of a robust system of voluntary self-regulation is recommended.
3. Facilitated work-days for various therapy organisations to progress areas of development with a view to encouraging federation into one representative organisation for that therapy. This is a necessary first step before harmonisation of advice on education standards in collaboration, as appropriate, with providers and HETAC/FETAC.
4. A report on the state of the sector following these facilitated work days.
5. Publication of a comprehensive, up-to-date information booklet incorporating a client/therapist charter for the public following the publication of the report on the state of the sector.
6. Immediate setting up of a forum for dialogue between the complementary and conventional medical sectors.
7. The establishment of a National Annual Forum for the sector to continue the momentum arising from the work of the Working Group.
8. Following the facilitated work days and the report on the sector, the establishment of a working group on the single issue of the development of a Complementary Therapies Council which would oversee issues in the complementary therapies area.

Conclusion

Having looked at the areas of the complementary therapy sector which need remediation and development, the National Working Group has very specific reasons for making the eight particular recommendations to the Tánaiste and Minister for Health and Children.

Recommendation 1 arises from the importance of regulation for therapists practising therapies of a high risk category.

Recommendation 2 arises from the need to develop robust systems of voluntary self-regulation for therapists practising complementary therapies not covered by recommendation 1.

Recommendations 3, 4 and 5 arise from the need to support and assist therapy organisations to harmonise standards and to provide the public with reliable and current sources of information on properly qualified and registered complementary therapists.

Recommendation 6 arises both from the increasing expansion of integrated healthcare and from the importance of providing factual and accurate information on complementary therapies and therapists to the conventional medical sector. This needs to be at the initial level of undergraduate education, for GPs, consultants and hospital administrators and on a continuing basis.

This report is a stage in the process of development of the sector, not the end of the process.

Recommendations 7 and 8 arise from the need to continue that process, to maintain and build on the momentum of the collaboration and interaction of the Department of Health and Children with the complementary therapy sector over the last few years and to progress the work done by the Working Group over the last two years.

Some recommendations are concurrent, some consecutive. They are necessary, realistic, focused, phased and achievable in a reasonable time-frame. The implementation of all these recommendations will advance the development of the complementary sector and the knowledge of the general public. It should lead to a point where the sad cases which make the headlines — of rogue practitioners incorrectly described as complementary therapists — will be a welcome rarity and the consumer will no more go to an un-qualified, un-registered and un-monitored practitioner than they would to a barber to get their teeth pulled. The National Working Group looks forward to the speedy implementation of all these recommendations.

APPENDIX I

Working Group on the Regulation of Complementary Therapists

Membership

Chairperson Ms Teri Garvey	Department of Health and Children Ms Maeve O'Brien Replaced by Ms Caroline Kelly (April 2005)
Federation of Irish Complementary Therapy Associations Ms Catherine Dowling	Federation of Irish Complementary Therapy Associations Ms Josephine Lynch
Acupuncture Bodies Ms Noeleen Slattery, Lic.Ac.Dip Tuina. C.Ac.Nanjing	Irish Society of Homeopaths Ms Sally Quinlan Replaced by Ms Ursula Lynch (July 2005)
Irish Herbal Practitioners Association Dr Celine Leonard Ph.D.	Consumers Association of Ireland Ms Dorothy Gallagher
General Practitioner & Homeopathic Physician Dr Brian Kennedy	Practitioners from therapies with a psychological base Dr Sean Collins, Psychotherapist
Education Representative Ms Margaret Kelly Department of Education and Science	Ministerial Nominee Ms Phil O'Flynn, MA H.Dip Diploma in aromatherapy and reflexology
Ministerial Nominee Ms Frances Daly	Ministerial Nominee Ms Nicola Darrell, BSc(Hons), MIFA, MNIMH, MIMHO, MIMTA

APPENDIX II

National Working Group on the Regulation of Complementary Therapists

Terms of Reference

1. To examine and consider regulatory issues in Ireland and to present its findings and recommendations to the Minister for Health and Children.
2. To advise the Minister on the way forward in relation to regulation in Ireland, taking into account recent policy developments, the publication of the Health Strategy and the publication of a report on the regulation of practitioners of complementary and alternative medicine in Ireland.

Any registration scheme or schemes should take into account:—

- the categories of therapists to be covered;
 - the evidence base for each therapy;
 - the educational qualifications, training and experience of therapists;
 - the scope of practice involved;
 - the protection of the public and promotion of a quality service, including the efficacy of the therapies offered;
 - regulations governing alternative therapists in other countries; and
 - the current proposals for statutory registration of health and social care professionals in Ireland.
3. To coordinate further consultation and organise a further forum on a national or regional basis as appropriate.
 4. To assist and support individual therapies in developing or strengthening their systems of self-regulation.
 5. To coordinate the gathering and collation of statistics on complementary and alternative therapies in Ireland including the nature, number and scope of practice of such therapies and information on their representative/regulatory bodies.
 6. To gather, in cooperation with the individual therapies, information on the educational programmes currently being provided in educational institutions for complementary and alternative therapists, incorporating an assessment of such programmes by a body such as HETAC or FETAC in conjunction with the relevant professional bodies represented through the National Working Group.

7. To develop an agreed approach to continuing professional development (CPD) with the bodies representing the individual therapies.
8. To assist the proposed Health and Social Care Professionals Council in developing, for the benefit of complementary and alternative therapies that are considering applying for registration, some guidelines on the criteria governing such applications and on the requirements that they would have to meet.
9. To develop, in consultation with the Department of Health and Children, the Health Research Board and representative bodies, research on the efficacy/outcomes of CAM therapies and on the evidence base for each therapy.

APPENDIX III

Research on Complementary and Alternative Therapies

The rise in consumer use of complementary and alternative therapies has led to the need for further understanding of the effects of these therapies. We also need to know more about their application in public healthcare, their cost effectiveness, and to increase our knowledge of the basic mechanisms underlying them. The large increase in their popularity has also stimulated health services internationally, academics and the biomedical community's interest in researching their safety and efficacy. The UK and USA have established funded research bodies (the Foundation for Integrated Health and NCCAM) to award research grants and establish centres of learning. These agencies also act to co-ordinate trials, share information and improve the quality and rigour of the research being conducted. In recent years, this has produced a rise in the quality and quantity of research and has led to a wider evidence base for the efficacy of a number of CAM approaches and treatments.

Issues surrounding research

This evidence base of treatment effectiveness has become integral to effective clinical care across all traditions of medicine. Over the past twenty years practitioners of conventional medicine have made a marked shift from a reliance on experience (directly observed or as recorded by others) to a reliance on a more rigorous research to evaluate the effectiveness of treatments.

This development has also shaped research practices on how they are applied to complementary and alternative therapies. However, many people in the complementary community have pointed out that there are obvious differences between complementary and orthodox medicine and the way in which they work. Not only that, there are differences between researchers and research characteristics of traditional Western-centred ideas of medical research and scientific practice from other cultures and types of medicine. The former is more likely to think in terms of linear cause and effect and to identify the simplest possible causal models. The latter is more likely to think of an overall "system" which is complex and has multiple levels of relationship rather than a linear pattern.^[1]

This difference in approach and understanding of the two medical traditions has influenced the idea that Western concepts of levels of evidence and use of Randomised Controlled Trials as the basic standard of evidence of effectiveness of complementary and alternative therapies may not be suitable as a research model. Though, it may be that this methodology is better suited to some alternative and complementary therapies than others.

This is further complicated by evidence from the USA where studies have highlighted that many therapies are not used to prevent a specific problem or disease but are used to prevent illness or to promote a more general sense of health and wellbeing. Randomised Controlled Trials may still be used

to assess the effects of complementary and alternative therapies on general health and well-being but they are even more difficult to conduct as it may require long periods of study (10 to 20 years) and very large sample sizes. Even then the outcome may be very hard to define as additional lifestyle changes which often accompany adoption of a complementary therapy also come into force, e.g. giving up smoking, eating a healthier diet, etc. These can have a profound effect on a patient's well-being and so confuse which variables have promoted the change in well-being.^[2]

Another complication in applying conventional research models is taking into account the particular features of the healer-patient relationship which is central to some complementary therapies. This is not new to orthodox medicine either; the relationship between a psychotherapist and their patient, the skill or surgical procedure of a particular surgeon have been taken into account in assessing the success of an outcome. However, in some of the energy or touch therapies the effectiveness of the treatment is especially bound up with the relationship between healer and patient and the healer's "gift" is something that is not easily measurable.

All of the agencies involved in research point out that there is a need for more innovative designs in research and new ways of thinking to accommodate these issues. In future years it is clear that we will see changes in the way research is conducted on complementary and alternative therapies, using models and methodologies which can cater for the differences between often divergent approaches.

Randomised Controlled Trials

Taking into account the more orthodox medical approach, many randomised trials have been conducted on complementary and alternative therapies. The Cochrane Collaboration lists more than 4000 examples in its electronic library. Furthermore, a number of Cochrane Collaboration systematic reviews of worldwide research literature have identified the benefits of complementary therapies, related approaches and products for a small number of chronic conditions including:

- Low fat or modified fats for preventing heart disease
- Acupuncture for the management of lower back pain and chronic headache
- St John's Wort for treating mild to moderate depression
- Herbal and glucosamine therapy for treating osteoarthritis
- Nutritional supplements for several neurological conditions ^[3]

In addition to these Cochrane systematic reviews, an American National Institute of Health scientific review panel concluded that acupuncture is a plausible option for treating several conditions, including nausea associated with chemotherapy and anesthesia, acute dental pain, headaches, temporomandibular joint dysfunction, fibromyalgia, and depression.^[4]

All of the literature reviews point to the need for larger more rigorous studies and the need for comprehensive research to be carried out particularly in those areas of complementary therapy that are becoming more integrated and popular in mainstream medical care. There is an acknowledgement in the sector that as it moves towards a more integrated model, (particularly in the UK and the USA) that clear evidence of efficacy in practice in hospitals has both led to further integration of complementary therapies but also more opportunities for the evaluation of how they are working alongside orthodox medicine.

Studies of Use

In the UK, responses to the House of Lords Select Committee's recommendations on research have led to increased awareness of promoting high quality evaluations of how complementary and alternative practices are performing in integrated settings. In 2003, the Department of Health provided funding for research (£1.3 million for the first round of a research capacity building scheme, and £324,000 for three qualitative research projects on complementary and alternative therapies in the care of patients with cancer).^[5] These projects aim to contribute to a better understanding of the demand for therapies and their effects on patient-centred outcomes among patients with cancer. They are focussed upon those therapies as an adjunct to conventional forms of treatment and in palliative/supportive care.

Researching this use of complementary therapies in practice has also contributed to a rise in research funding; as the sector grows and patients express satisfaction with the therapies that they are using. It adds more impetus to examine how these therapies are creating successful outcomes. Cancer sufferers are some of the biggest users of complementary and alternative therapies. In February of this year, an important study conducted by the University of Manchester found that a third of cancer patients across Europe use complementary and alternative therapies.^[6] This marks a significant increase since the last review of 29 studies was undertaken in 1998.

The study found that usage rates varied from just under 15% of patients in Greece to a high of nearly three quarters in Italy. Following the publication of its findings, the lead researcher Dr Alex Molassiotis, a Reader in Cancer and Supportive Care at Manchester University's School of Nursing, Midwifery and Social Work said that:

'Irrespective of what health professionals believe, our findings show that patients are using and will continue to use CAM. This will necessitate a re-thinking of medical and healthcare education, and work towards integrating CAM therapies for which there is evidence of effectiveness into mainstream healthcare services.'

Nearly 1000 patients aged 17 to 91 were surveyed in 14 countries for the survey, which was carried out in conjunction with member countries of the European Oncology Nursing Society. Patients are using the therapies for an average of 27 months, with only 3% feeling that they have received no benefit from this. Most patients reported using CAM to increase their body's ability to fight the disease (50%), although only 22% reported subsequent benefits. However, although only 35% initially used CAM to improve their emotional well-being, 42% reported benefits in this area. Forty percent said they used CAM to improve their physical well-being.

This broad pattern of satisfaction with complementary therapies tracked outside controlled trial situations is common and also with many studies conducted in the U.K. In a study by the Royal London Homeopathic Hospital NHS Trust, patients were surveyed about the complementary and alternative therapies they received at the hospital. Of the 262 patients that said they were using conventional medication at the start of the survey, 29% stopped all conventional medication after receiving treatment at the hospital and 32% decreased their medication^[7]. Similarly, in the Glasgow Homeopathic Hospital, 46% of patients using complementary therapies reported a decrease in the use of conventional medication and 72% reported significant improvement to their state of overall well-being three months after discharge.^[8]

Cost Effectiveness

For health services, one of the attractions of research into integrative models is examining cost savings that complementary and alternative interventions can yield for health providers. Increasingly, this has become an important benchmark in evaluating health care projects and particularly integrated models of care. When complementary and alternative therapies work effectively in this environment, they produce savings in terms of reductions in visits to doctors, reductions in medication, reductions in referrals for further treatment in hospital (x-ray, ECG etc.) and/or the take up of beds in a hospital ward. To conclude, patients who experience benefits in health from complementary therapies tend to have less recourse to the more expensive health services such as GP visits, consultant referrals and medicines.

In a British/American study published in the British Medical Journal, acupuncture was assessed under randomised control trial conditions with an economic analysis of the outcome. Compared with controls, patients randomised to acupuncture used 15% less medication, made 25% fewer visits to GPs and took 15% fewer days off sick. The report concluded that “acupuncture leads to persisting, clinically relevant benefits for primary care patients with chronic headache, particularly migraine. It is relatively cost-effective compared with a number of other interventions provided by the NHS.”^[9]

The Glastonbury Health Centre Study is a good example of evaluation of complementary therapies in general practice with a focus on their cost effectiveness. The centre offered various complementary therapies to a range of patients visiting doctors at the facility. Taking into account the costs of providing the service, it was possible to establish that a group of 41 patients from the practice which had cost the NHS around £4,000 each for NHS treatment, when in the year after their treatment with complementary and alternative therapies their costs went down to just over £1,500, giving a saving of around £2,500 per patient. The overall saving in secondary referrals in the year of the treatments was over £18,000.^[10]

A Danish study which evaluated patients receiving acupuncture and other complementary treatments for acute angina pectoris outlined significant cost savings of US\$36,000 and US\$22,000 for surgical and non-surgical patients, respectively. These savings were mainly achieved by the reduction in the use of invasive treatment and a 95% reduction in in-hospital days.^[11] The report concluded that “Integrated rehabilitation was found to be cost effective, and added years to the lives of patients with severe angina pectoris”.

Acupuncture was also the focus of a study conducted by the University of Washington. Together with massage therapy and spinal manipulation its aim was to examine the best available evidence about the effectiveness, safety, and costs of the most popular complementary and alternative medical therapies used to treat back pain. They found massage to be the most cost effective for persistent back pain.^[12]

In a wide ranging study, the University of Arizona examined 56 economic evaluations of complementary and alternative therapies applied to a variety of conditions.^[13] The studies that met their particular conditions of quality methodology indicated several therapies that may be considered cost-effective compared to the usual clinical care for various conditions: acupuncture for migraine, manual therapy for neck pain, spa therapy for Parkinson’s, self-administered stress management for cancer patients undergoing chemotherapy, pre- and post-operative oral nutritional supplementation for lower gastrointestinal tract surgery, biofeedback for patients with “functional” disorders (e.g. irritable bowel syndrome), and guided imagery, relaxation therapy, and potassium-rich diet for cardiac patients.

It is clear that there are proven cost savings to be made for health service providers by allowing patients to avail of complementary therapies. Not all evaluations of complementary and alternative therapy

programmes denote this to be the case outright, but there is widespread acknowledgement of a need for further in depth understanding of how and why these positive outcomes are taking place.

Award winning projects

In the U.K., the use of complementary therapies in the field of community health care and preventive medicine has provided successful and award-winning models of projects which offer visible benefits to those who take part in them and to their health service providers. The Foundation for Integrated Health on a bi-annual basis awards the most effective or innovative programmes offering therapies to various types of patients and healthcare consumers.

In a joint project, the Royal Berkshire Hospital and the Chinese Internal Arts Association established a programme of Tai Chi exercises for the patients and staff at the elderly care unit resulting in patients reporting improved balance and muscle strength. A U.S. study conducted by the University of Atlanta also found the practice of Tai Chi by the elderly to have a favourable impact on the occurrence of falls.^[14]

Infant Massage taught to neo-natal mothers in a programme run by the Imperial School of Medicine in London was another award winning project of this kind. Research has shown that mothers with post natal depression who are taught infant massage suffer a reduction in depression and also have improved interactions with their infants^[15]. In another audit of a maternity aromatherapy service in a small Midlands maternity unit, offering aromatherapy services to expectant mothers showed to be effective in normalising childbirth and increasing satisfaction of mothers in respect of their labour experiences.^[16]

Another award winning project is the work carried out at the Derriford Hospital in Plymouth, where acupuncture is offered for pain relief in pregnancy and labour. They have treated over 5,000 women in Plymouth with antenatal problems — mostly morning sickness and backache but also a wide range of other conditions such as constipation, varicose veins, headaches and migraines, and pelvic pain needing admission to hospital. Complementary therapies have found a particular place with pregnant women as they are restricted in what pharmaceutical products they can take for health complications.

These interventions of complementary and alternative therapies at community level are becoming more common in the U.K. and research tracking their success in economic terms will increase as time goes on. While projects that demonstrate cost benefits of complementary and alternative therapies are easier to track in terms of how and where they benefit a health service, Peter Mackereth, lecturer in complementary therapies at the University of Salford points out that the outcome of patient well-being is still at the top of the list in terms of the desired effect of complementary therapies offered to patients at their cancer hospital. At Christies NHS Hospital Trust in Manchester the use of complementary medicines and therapies can have a profound effect in helping patients “comply with their chemotherapy” and “improve their experience” of care in the hospital.

Currently, Christies is involved in a potentially ground breaking project which is using essential oils in order to kill off the MRSA bug. While the research is at an early stage, lab trials have proved that essential oils are acting in the desired way on the MRSA. The trial is continuing in a laboratory environment and will proceed onto research with patients at a later stage.

Suzanne Campbell

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August 2005

References

1. The Geography of Thought, How Asians and Westerners think differently and Why, New York, Free Press 2003, Nesbitt
2. Complementary Medicine in the United States, The Committee on the Use of Complementary and Alternative Medicine by the American Public, The National Academies Press, 2004),
3. White House Commission on Complementary and Alternative Medicine Policy Report 2002
4. National Institute of Health, Office of the Director. NIH Consensus Statement: Acupuncture Volume 15 (5): November 3-5, 1997.
5. www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ComplementaryAndAlternativeMedicine
6. Annals of Oncology, publication date 3/01/2005
www.annonc.oupjournals.org <<http://www.annonc.oupjournals.org/>>
7. A review of inpatient care integrating complementary and orthodox medicine at Glasgow Homeopathic Hospital. The Academic Departments, Glasgow Homeopathic Hospital 1998
8. Patients' perspectives on using a complementary medicine approach to their health; A survey at the Royal London Homeopathic Hospital NHS Trust. F Sharples and R Van Haselen 1997
9. Acupuncture of chronic headache disorders in primary care: randomised controlled trial an economic analysis, AJ Vickers,1* RW Rees,2 CE Zollman,3 R McCarney,4 CM Smith,5 N Ellis,6 P Fisher,7 R Van Haselen,7 D Wonderling8 and R Grieve8. Health Technology Assessment 2004; Vol 8: number 48
10. Complementary Therapy in General Practice; An Evaluation of the Glastonbury Health Centre Complementary Medicine Service. Dione Hills, Dr. Roy Welford
11. Long-Term Effects of Integrated Rehabilitation in Patients with Advanced Angina Pectoris: A Nonrandomized Comparative Study (Denmark). Ballengaard, Borg, Karpatschof, Nyboe, Johannessen. Journal of Alternative and Complementary Medicine Oct 2004, Vol. 10, No. 5: 777-1783.
12. A review of the evidence for the effectiveness, safety, and cost of acupuncture, massage therapy, and spinal manipulation for back pain. Cherkin, Sherman, Deyo, Shekelle Group Health Cooperative and University of Washington, Seattle, Washington 98101, USA.
13. Is complementary and alternative medicine (CAM) cost-effective? a systematic review. Herman, Craig and Caspi. Program in Integrative Medicine, University of Arizona, Tucson, Arizona, USA. pherman@email.arizona.edu.
14. Reducing frailty and falls in older persons: an investigation of tai chi and computerized balance training. Wolf, Barnhart, Kutner, McNeely, Coogler, Xu, Atlanta FICSIT Group, Emory School of Medicine, Atlanta, Georgia. (American Geriatric Society 2003)
15. Infant massage improves mother-infant interaction for mothers with post-natal depression. Onozawa, Glover, Adams, Modi, Kumar, Journal of Affective Disorders 2001
16. Audit of an aromatherapy service in a maternity unit in Warwickshire. S Mousely Community Midwives Office, George Eliot Hospital, 1st Floor Maternity Unit, Heath End Rd, Nuneaton, Warks, CV10 7DJ, UK.

APPENDIX IV

International Regulation

The information below is supplementary to the 2002 O’Sullivan report which describes in detail how complementary and alternative therapies are regulated in each country. Detailed below is an update to the 2002 report and a description of recent legislative changes internationally.

Issues surrounding regulation

In the past few years, the rise in the use of complementary therapies, the improved quality of research on efficacy and successful models of integrated healthcare have prompted much analysis of the best way to regulate therapists in the sector. This has led to many countries conducting systematic reviews of their regulatory systems, with several publishing reports arising from the findings of advisory committees and working groups commissioned by governments. It has been a useful process internationally in helping countries gather facts on the issue and to set their regulation agenda.

In terms of regulation, there are unique challenges affecting complementary and alternative practitioners which have been noted by many of the advisory documents and government reports arising from this examination. Some of these challenges of regulating practitioners were identified in the 2002 report of the United States White House Commission on Complementary and Alternative Medicine Policy^[1]. They found the chief challenges to be:

- Disagreement surrounding the nature and scope of some professions
- Confusion and potential legal consequences arising from the overlap of approaches and techniques used by practitioners
- The variation in the views of practitioners about how much training is needed to attain regulation status in a given field

There are also those points recognised by the New Zealand Commission on Complementary and Alternative Health in terms of regulation of practitioners by statutory regulation.^[2]

- Statutory regulation can be seen as a means to gain legitimacy with consumers and biomedical practitioners, facilitate integration and access public health funds
- The costs of statutory regulation are not warranted for low risk modalities

Trends in Regulation

Many countries, including New Zealand, favour strong self-regulation with statutory regulation of those therapies that are understood to have potential risk to the consumer. The model of self-regulation is also

preferred in Canada, where the advantages of using the therapists themselves to self-govern have been examined by their health services.^[3]

- The therapists act as “gate-keepers” to the therapy, typically by establishing and enforcing entrance standards for the therapy.
- They establish standards of practice for the therapy providing guidance to their members on the performance of their duties.
- They establish continuing education or continuing competence requirements which members must follow to maintain their competence throughout their career.
- They administer a professional disciplinary process designed to protect the public from incompetent or unethical professionals. Members of the profession found to have engaged in unprofessional conduct or unskilled practise can face a range of sanctions from a directive to take remedial training to the expulsion from the profession in extremely serious cases.

Self-regulation through professional bodies seems to be a desirable option in many countries. This is particularly the case where the level of perceived risk to the consumer as one of the main forces driving the need to statutorily regulate some professions while leaving others to police themselves. Increasingly, organisations and professional associations of complementary therapists are formulating frameworks for self-regulatory possibilities. A 2005 report by the European Council for Classical Homeopathy (an NGO with participatory status with the Council of Europe)^[4] gives an example of agreed minimum criteria for voluntary self-regulation.

1. A single national professional body, where appropriate, established according to common high standards of education, registration and practice agreed across Europe.
2. Patient representation on all standard committees — particularly for complaints and professional conduct procedures.
3. An accreditation process for institutions providing education.
4. Continuing professional development required for all practitioners.
5. Professional indemnity insurance for all practitioners.
6. Code of ethics and practice.
7. Complaints and disciplinary procedures.

The reports published by Canada, New Zealand and the House of Lords recommendations in the UK all favour a degree of self-regulation combined with statutory regulation for certain therapies as a possible regulatory framework. In both the UK and New Zealand, recent legislation (The 2003 Health Practitioners Competence Assurance Act and the Health Act 1999) allow for the possibility of the therapy to become statutorily regulated without separate lengthy legislation having to be formed. All Government Advisory Groups reporting in the last seven years point out that statutory regulation is not suitable or necessary for all modalities. In most cases, solid self-regulation, preceded by a strong degree of uniformity in the sector, is seen as a useful way forward.

Europe

Following the 1997 Lannoye report, the Collins resolution^[5] was passed by the European Parliament in 1997 which called on the Commission to “launch a process of recognising non-conventional medicine” and to carry out a study of its effectiveness, areas of application, and legal models to which it was subject. Two years later the 1999 COST report^[6] (Cooperation in Science and Technology) was published. It identified two legal issues in relation to licensing therapies; licensing a therapist to practise complementary medicine and the reimbursement by social security systems of the costs for the client.

In relation to licensing, COST developed three categories of models of regulatory frameworks; the

- monopolistic systems where only the practice of modern, scientific medicine is recognised as lawful, with the exclusion of, and sanctions against, all other forms of healing and practitioners.
- tolerant systems where only the system based on modern, scientific medicine is recognised, although the practitioners of various forms of complementary medicines are tolerated, at least to some extent, by law.
- mixed systems where there are some monopolistic and some tolerant characteristics.

Ireland, Germany and Britain fell into the “tolerant” category while countries like France and Spain were seen as monopolistic and Denmark, Finland and Sweden were examples of mixed systems. Since the COST report and the Collins resolution, there have been no legislative procedures made concerning complementary and alternative medicine by the EU. Nuala Ahern, former MEP, led a working group on the sector in the last parliamentary session. Since the new term began in June 2004, the position regarding the basis on which the sector is regulated remains unchanged.

To this end, a Brussels based NGO, the European Forum for Complementary and Alternative Medicine (EFCAM) was formed in 2004 in response to the EU Commission’s call for single umbrella bodies to represent the various stakeholders sharing broad areas of interest and concern in the EU. Its aim is to represent the collective views and promote the interests of professional practitioners, patients and users of complementary and alternative medicine in Europe. Together with lobbying groups such as the European Public Health Alliance (EPHA), EFCAM hopes to keep the issue on the agenda.

The EPHA represents over 100 non-governmental and other not-for-profit organisations working in support of health in Europe. The platform was founded in 1994 in Brussels. Their aim is to create a permanent forum for exchange of views and information and to act as a point of reference for the EU institutions on policy and regulatory issues for CAM.

Updated status on regulation internationally

Denmark

The Danish parliament has passed a resolution to establish a register effective from June 2004 for CAM practitioners. The register is voluntary and practitioners will be self-regulated through their member associations. It includes practitioners who have well defined criteria for education and are members of an organisation for practitioners that will take on the necessary tasks for registration and maintaining the register. Politicians hope that the resolution will result in bridge building between alternative practitioners and healthcare practitioners. The register is voluntary and practitioners are self-regulated through their member associations^[8].

Italy

The Government of Northern Italy (Piedmont region) issued a new regional law in 2002 which legally recognises the practice of Complementary and Alternative Medicine^[9]. There is no national policy on CAM other than that in the Piedmont region.

Holland

Holland has regulated CAM therapies since 1993. The Individual Health Care Professions Act came into force in 1997. In relation to alternative practitioners, the focus has been on voluntary self-regulation and on the development of systems to ensure quality. A quality framework has been established for alternative practitioners. It includes 36 criteria developed in agreement with patient organisations, health insurers and the health inspectorate.

The areas covered include education, vocational training and continuing education; the register of qualified members; the application of alternative treatments; guidelines on practice organisation; codes of conduct; relationships with other health care providers; disciplinary rules and complaints procedures; and quality assurance. An independent research organisation is monitoring the progress which organisations are making in the implementation of this quality policy.

Norway

A new law for alternative therapies was enacted from 1 January 2004. The law lays out regulation for the legal practice of therapies by someone who is not a medical doctor.

The law states that the practitioner:

- must follow the same regulations for confidentiality as health care personnel.
- may not treat dangerous contagious diseases or serious diseases, but may treat when the purpose of the treatment exclusively is to palliate or reduce symptoms of, or consequences of, the disease or side-effects of treatment given, or when the purpose is to enhance the body's immune system or ability to heal itself.
- may treat serious diseases in co-operation or understanding with the patient's doctor and when the patient is over 18 years of age and has the ability to give consent.
- may treat serious diseases when the health care service can not offer the patient healing and can only offer palliative treatment.

In June 2004 a register for practitioners was also established by the Norwegian Government and is open to practitioners to join voluntarily. To qualify for registration they must be a member of a professional organisation that has been approved in accordance with the nine recommended points that the register requires for approving professional organisations. The register is run by the Bronnoysund Register in conjunction with the Directorate for Health and Social Affairs. The register is voluntary and the professions are self-regulated.

Belgium

In Belgium, before 29 August 1999, anyone who practised medicine — complementary or orthodox — without being enrolled with the Belgian General Medical Council was committing a criminal offence. Registered doctors have had clinical and diagnostic freedom to carry out whatever treatments they think fit. However, those who chose complementary medicine found themselves in conflict with their professional organisation, which requires them to treat patients 'taking all reasonable care given the

current state of scientific knowledge'. This discrimination led to Colla's Law, named after Minister Colla (29 April 1999).

Colla foresees the installation of four 'commissions' (homeopathy, acupuncture, osteopathy and chiropractic) and for the first time in Belgium, regulation concerning complementary and alternative therapies.

Work is now in progress to establish committees and procedures under the new legislation that will establish the legal right to practise under a new national register.

Portugal

In July 2003, the Portuguese Parliament voted in a new law that recognises the practice of acupuncture, homeopathy, osteopathy, naturopathy, pytotherapy and chiropractic. Under this law, the practice of these therapies will be controlled and accredited by the Health Ministry while the education and certification of qualifications will be controlled by the Ministry of Education.

Sweden

The Government has proposed the establishment of a register of complementary and alternative practitioners. Funding for the process was included in the budget of 2004.

UK regulation since 2000

In the United Kingdom, the House of Lords Science and Technology Committee report on complementary and alternative medicine, published in 2000, is the chief blueprint for regulatory policy. The inquiry was mounted because of the increased use of complementary and alternative therapies not only in the United Kingdom but across the developed world. This rise in its popularity and use raised several questions of substantial significance in relation to public health policy. The inquiry lasted for 15 months. It received more than 180 written submissions and took evidence from 46 different bodies. To understand its recommendations on regulation we must first look at the report's subdivision of therapies into three groups.

- *The first group* embraces what may be called the principal disciplines, two of which, osteopathy and chiropractic, are already regulated in their professional activity and education by Acts of Parliament. The others are acupuncture, herbal medicine and homeopathy. Each of these therapies claims to have an individual diagnostic approach and are seen as the 'Big 5'.
- *The second group* contains therapies, which are most often used to complement conventional medicine and do not purport to embrace diagnostic skills. It includes aromatherapy; the Alexander Technique; body work therapies (including massage); counselling; stress therapy; hypnotherapy; reflexology and probably shiatsu, meditation and healing.
- *The third group* embraces those other disciplines which purport to offer diagnostic information as well as treatment and which, in general, favour a philosophical approach and are indifferent to the scientific principles of conventional medicine, and through which various and disparate frameworks of disease causation and its management are proposed. These therapies can be split into two sub-groups: Group 3a includes long-established and traditional systems of healthcare such as Ayurvedic medicine and Traditional Chinese medicine. Group 3b covers other alternative disciplines which lack any credible evidence base such as crystal therapy, iridology, radionics, dowsing and kinesiology.

Group 1 includes the most organised professions and Group 2 contains those therapies that most clearly complement conventional medicine. While the question of efficacy was not included in their initial terms of reference, in the absence of a credible evidence base it was seen that Group 3 cannot be supported unless and until convincing research evidence of efficacy, based upon the results of well designed trials, can be produced.

Their chief recommendations were:

- In order to protect the public, professions with more than one regulatory body should make a concerted effort to bring their various bodies together and to develop a clear professional structure (para 5.12).
- Each of the therapies in Group 2 should organise themselves under a single professional body for each therapy. These bodies should be well promoted so that the public who access these therapies are aware of them. Each should comply with core professional principles, and relevant information about each body should be made known to medical practitioners and other healthcare professionals. Patients could then have a single, reliable point of reference for standards, and would be protected against the risk of poorly-trained practitioners and have redress for poor service (para 5.23).
- Acupuncture and herbal medicine are the two therapies which are at a stage where it would be of benefit to them and their patients if the practitioners strive for statutory regulation under the Health Act 1999, and it was recommended that they should do so. Statutory regulation may also be appropriate eventually for the non-medical homeopaths. Other professions must strive to come together under one voluntary self-regulating body with the appropriate features outlined in Box 5, and some may wish ultimately to aim to move towards regulation under the Health Act once they are unified with a single voice (paras 5.53 and 5.55).
- Each existing regulatory body in the healthcare professions should develop clear guidelines on competency and training for their members on the position they take in relation to their members' activities in well organised CAM disciplines; as well as guidelines on appropriate training courses and other relevant issues. In drawing up such guidelines, the conventional regulatory bodies should communicate with the relevant complementary regulatory bodies and the Foundation for Integrated Medicine to obtain advice on training and best practice and to encourage integrated practice (para 5.79).
- The report encourages the bodies representing medical and non-medical CAM therapists, particularly those in Groups 1 and 2, to collaborate more closely, especially on developing reliable public information sources. They recommended that if CAM is to be practised by any conventional healthcare practitioners, they should be trained to standards comparable to those set out for that particular therapy by the appropriate (single) CAM regulatory body (para 5.83).

Following on from these recommendations, between March and June 2004 the Department of Health began a period of consultation on proposals to proceed with the regulation of herbal medicine and acupuncture practitioners. Over 1000 copies of the consultation were distributed to interested individuals and organisations and a total 698 responses were received to the consultation. The majority of the responses indicated strong support for the introduction of statutory regulation, in order to ensure patient and public protection. Key areas of debate included the type and name of the proposed regulatory council, protected titles, collaborative regulation and the composition of the council.

The Department analysed the responses received and in February 2005 launched a report on the consultation titled “Statutory regulation of herbal medicine and acupuncture: Report on the consultation”. The Department of Health planned to publish draft legislation for further consultation in Autumn 2005.

However, pace on the statutory regulation of herbal medicine and acupuncture has slowed as a result of the UK Government’s current scrutiny of the entire area of statutory regulation. Since the enquiry into the deaths caused by Dr. Harold Shipman, two major reviews of statutory regulation of healthcare workers are now taking place as part of the Government’s response to the Shipman enquiry. At present there are nine different regulators in what is regarded by some as an unwieldy and time consuming process. This has resulted in the regulation of herbal medicine and acupuncture being put on hold until the Government reacts to the findings of these enquiries.

Many people who are expert in the field of complementary therapies in the UK and their regulation feel that voluntary regulation through a federal structure could be the way forward for most groups. This would mean the establishment of agreed umbrella organisations with bodies structured beneath them through each (or related) therapies, a route which is in line with the recommendations of the House of Lords report.

Also, further regulatory change is about to occur in the UK; regulation of health care workers such as social workers, domiciliary workers etc. allows for further registration and tracking of those who work with potentially vulnerable adults and children. This process has raised questions for the alternative and complementary sector in terms of registration. Could registration and a rigorous framework of voluntary regulation act just as effectively as statutory regulation? It is felt that for some groups, the economics of statutory regulation (and perhaps factors based on lack of perceived risk) could result in voluntary regulation being a more effective choice.

The Foundation for Integrated Health is currently examining these issues and looking at the various possibilities for non-statutory regulated therapies. It is felt that there are many issues to be examined such as incentive for practitioners to belong to a federated structure and quality assurance criteria but that voluntary self-regulation could be the most suitable way forward for many groups.

The Foundation receives Government funding to support the setting up of effective voluntary self-regulation schemes for therapies such as homeopathy, aromatherapy and reflexology. The Foundation’s focus is to help establish a single regulatory body for each of the main complementary health therapies and then to facilitate the development of robust forms of voluntary or statutory self-regulation.

United States

In the U.S.A., every state has its own licensing scheme, with different laws and regulations and courts and judicial documents that interpret these rules. The primary means by which states regulate health care practitioners are: (1) mandatory licensure, the most common; (2) title licensure, where a licence is needed to use a particular professional title; (3) registration, with the designated state agency; and (4) exemption from licensure requirements. In general, state regulatory boards establish educational and licensure requirements such as requiring the passing of a specific exam and minimum number of training hours.

Regulation for certain therapies is also moving faster than for others. For example, South Dakota passed a law in February of this year to regulate the state’s massage therapy profession. According to the American Massage Therapy Association (AMTA), South Dakota is now the 34th state to regulate massage

therapy. The first state to regulate massage therapy was Arkansas, which passed its law in 1951. Fifty-four years later, there are still 16 states with no specific regulation and in many states, massage is still regulated by individual town ordinances. This situation is one familiar to many complementary and alternative therapies in the U.S.A.

Minnesota is a state where there is almost unlimited freedom to practise a therapy. Unlicensed practitioners must inform clients of their education, experience and intended treatments, as well as possible side effects or known risks of the treatment. Clients must sign an informed consent form acknowledging the practitioner is unlicensed, that complaints may be filed with the Minnesota Department of Health if the treatment is unsatisfactory, and that they have the right to seek licensed care at any time. Requirements for practice are minimal, but practitioners are not exempted from liability for untoward outcomes.

In a contrasting example, Washington provides licensure, registration, or exemption for various categories of therapists, based on their education and the extent to which their profession prepares practitioners to assume responsibility for the total health care of clients. Regulations delineate standards of practice, the scope of practice allowable, education and training requirements for licensure, registration or exemption and required professional oversight. Four therapy groups (naturopaths, acupuncturists, massage therapists and chiropractors) are licensed and regulated.

While accepting the view that the U.S. has a multiplicity of regulatory and educational requirements for therapists, in order to facilitate future uniformity the Federation of State Medical Boards Special Committee for the Study of Unconventional Health Care Practises has begun to develop guidelines for the use of complementary therapies. These guidelines address training and education with a focus on the scientific basis of treatment methods. The American Board of Holistic Medicine has administered a board certification examination covering 13 areas of holistic medicine including nutritional medicine, environmental medicine, bio-molecular medicine, homeopathic medicine, manual medicine, ethno-medicine including acupuncture and conventional medicine.

Chiropractic is the most developed in terms of national standards for education and training in the U.S.A. of any complementary profession. Traditional Chinese acupuncture, therapeutic massage and naturopathic medicine have moved closer than other CAM professions to having national education and training standards. Because of this progression, these professions are appropriate candidates for conferences convened by the Department of Health and Human Services and other agencies where the leaders of the sector, conventional medicine, health professional groups, the public and other organisations will meet to facilitate the establishment of education and training guidelines. Establishing agreed levels of training, education and standards of continuing education and scope of practice is necessary if legal authority to practise a therapy is to be recognised in a wider context across the states.

As the U.S. regulatory framework is framed by its federal nature, one of the recommendations of the report of the White House Commission on Complementary and Alternative Medicine Policy is to establish a centralised office for the sector in order to facilitate policy formulation and implementation.

It was also a recommendation of the White House Commission on Complementary and Alternative Medicine Policy that the Department of Health and Human Services should assist the states in evaluating the impact of legislation enacted in various states in terms of regulation of practitioners and ensure accountability to the public, with periodic review. It was also recommended that the Secretary of Health

and Human Services, in collaboration with states, should assist CAM organisations that wish to develop consensus within the field of practice regarding standards of practice including education and training.^[1]

These conclusions could then be considered by states in terms of regulatory options such as registration licensure or exemption. In conclusion, it is evident that the United States is endeavoring to establish a more cohesive framework for regulation across the country and facilitate better communication, evaluation, and review of regulations between states, regulatory bodies and practitioners.

Canada

Canada, along with many other nations, is examining policy issues relating to the safety, efficacy, cost-effectiveness and regulation of complementary and alternative health care. In the next few years, the policy choices that will be made with respect to the recognition and regulation of complementary and alternative health care practitioners will have a great impact on the continuing development of complementary and alternative health care in Canada.^[13]

The predominant mode of regulation for health professions in Canada is self-regulation. Historically, this has been achieved after certain acceptance or recognition by the political and economic players and institutions in the health sector. Regulatory precursors to such self-regulation include direct government regulation through mechanisms such as the Acupuncture Committee in Alberta. Legislation in Canada has established three primary regulatory structures for the self-regulation of health professions.

The provinces and the territories have the constitutional jurisdiction to regulate health care professionals, including complementary and alternative practitioners. While the national health service (Health Canada) does not have a direct role in regulating health professionals, the significant impact of complementary and alternative health practices on the health system has necessitated policy analysis in this area.

The 2001 report commissioned by Health Canada recommended four primary themes for further regulation of the sector.^[14]

- The importance of government to remain cognisant of the consumer driven nature of complementary and alternative health care. The potential lack of an “evidence-based” approach should not necessarily be a barrier to regulation.
- Consideration of potential regulatory mechanisms should focus primarily on the identification of risk and the meaningful reduction of risk.
- Consider carefully the implications of championing complementary over alternative health care, or over-emphasising the concept of integration of Complementary and Alternative Health Care with conventional health care. Many practitioners worry that complete integration of Complementary and Alternative Health Care with conventional health care would lead to an undermining of the holistic nature of complementary therapies which is perceived by consumers to be of great value.
- Consider the pace and extent to which governments consider regulating CAM practitioners, given the dearth of evidence about harm done to the public because of the level of current professional regulation. Government should advocate for *appropriate regulation*, rather than over-regulation or under-regulation. In some cases, no regulation of practitioners of certain CAM modalities may be appropriate. Where some form of regulation is necessary, it cannot be assumed that the same type of regulation is necessary for all CAM modalities.

Australia

Regulation of practitioners in Australia is the responsibility of the various state governments. Currently, Victoria is the only Australian jurisdiction to formally regulate therapists, requiring practitioners who use the title “Acupuncturist”, “Chinese Herbal Medicine Practitioner”, and “Chinese Medicine Practitioner” to register with the Chinese Medicine Registration Board. However, all state jurisdictions have legislation (with varying requirements) for the registration of chiropractors and osteopaths. Most therapists are therefore subject only to varying forms of professional self-regulation.

However, the federal Government is getting involved in funding some groups of practitioners to explore avenues for self-regulation. Under A New Tax System (Goods and Services Tax) Act 1999, complementary and alternative practitioners had to satisfy the definition of being a recognised professional in order to continue to supply their services GST-free beyond 30 June 2003. To this end, the Australian Government has provided AUS\$500,000 to help professional associations form national professional registration systems for acupuncture, naturopathy and herbal medicine practitioners. The funding was spread between the following groups: National Herbalists Association of Australia; Australian Traditional Medicine Society Ltd; Australian Natural Therapists Association Ltd; Federation of Natural and Traditional Therapists; and Australian Acupuncture and Chinese Medicine Association Ltd.^[15]

New Zealand

New Zealand has taken a risk-based approach to the statutory regulation of health practitioners and to date has provided for the statutory regulation of two therapies; chiropractic and osteopathy. Other therapies are at various stages of self-regulation through a range of therapy-based professional bodies and/or through the multi-therapy body, the New Zealand Charter of Health Practitioners.

The 2003 Health Practitioners Competence Assurance Act stresses the importance of the health and safety of the public and an accountability regime for practitioners. Most importantly for the professions under discussion, it also provides an opportunity for additional complementary modalities to be covered under the act. Again, the risk-based approach is primary here and chiropractic and osteopathy were regulated under this Act as they were felt to have appropriate level of risk for consumers.

In 2004, the Ministerial Advisory Committee on Complementary and Alternative Health (MACCAH) published its report into the sector with advice to the Minister for Health on policy.^[2] The MACCAH report examined the issue of statutory regulation for therapies while favouring the risk-based approach. The report also notes that other countries are at a similar stage of considering statutory regulation but that no country has yet provided a best practice model for New Zealand.

For future policy, the report concludes that an increased level of regulation of practitioners is needed to effectively protect New Zealand consumers from the risks involved with complementary and alternative healthcare. On the basis of the information available to them, the report recommends that strong self-regulation through professional bodies is the best way to protect consumers and that a strong regulatory framework, including such elements as those set out in the House of Lords Report, is the most desirable basis for regulation.

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References

1. United States White House Commission on Complementary and Alternative Medicine Policy 2002
2. The Ministerial Advisory Committee on Complementary and Alternative Healthcare (MACCAH) Report 2004
www.newhealth.govt.nz/maccah
3. The Regulation of Complementary and Alternative Health Care Practitioners: Policy Considerations, a report commissioned by Health Canada Health Human Resource Strategies Division, 2001
4. European Council for Classical Homeopathy Recognition and Regulation of Homeopathy in Europe. March 2005 — draft
5. European Parliament, Report on Non-Conventional Medicine (Collins Resolution: Doc-En/PR/289/289543 PE216.066/fin) Strasbourg, European Parliament
6. COST Action B4 Unconventional Medicine. Final report of management committee 1993-1998 (EUR 18420 EN) Luxembourg, office for the publication of the European Communities
7. [www.ft.dk/Samling/20021/beslutningsforslag_oversigtsformat /B47.htm](http://www.ft.dk/Samling/20021/beslutningsforslag_oversigtsformat/B47.htm)
8. Legge Regionale 24 Ottobre 2002, n.25. Regalomentazione delle pratiche terapeutiche e dee line discip line non convenzionali
9. Lov am alternativ behandling av sykdom mv
10. www.eatcm.net European Association of Traditional Chinese Medicine
11. Project of law No.263/IX (for framing the base of Non-Conventional Medicines) and Project of law No.27/ IX *Legal procedures of the Non Conventional Therapies*
12. Regeringen proposition 2003/04:1. Budgetpropositionen for 2004. Forslag till statsbudget for 2004, finansplan, skattefragor och tillaggsbudget m.m
13. de Bruyn, T. 2000. *Taking stock: Policy issues associated with complementary and alternative health care.* A commissioned report for the Health Systems Division, Health Promotion and Programs Branch, Health Canada, March, 2000.
14. The Regulation of Complementary and Alternative Health Care Practitioners: Policy Considerations, a report commissioned by Health Canada Health Human Resource Strategies Division, 2001
15. Ethical and legal issues at the interface of complementary and conventional medicine. Ian McKerridge and John R McPhee Medical Journal of Australia 2004

APPENDIX V

Associations

In Ireland, the complementary and alternative therapy community is a very disparate one with a broad range of levels of expertise, training and level of association with other practitioners and/or international organisations. In comparison to some countries, Ireland is at a slightly earlier stage of forming solid frameworks of associations and federations with which to link, and in some cases govern, the sector.

In Ireland (as with many countries) it is frequently the case that alternative and complementary therapists practise on a part-time basis, are not registered with any association or group and work in a non-business orientated way. The basis of some therapies is the relationship between the therapist and the patient being healed; the economics of this transaction are not always as important.

At the other end of the scale are groupings of therapists in clinics or with large numbers of clients or referrals, therapists who practise on their own but on a full-time basis and who are active members of a single association which governs or lobbies for their particular discipline.

This variance is to be expected where the level of practice that individuals have is influenced by the amount of time they are prepared to dedicate to training, their commitment to continuing professional development and/or earning from their expertise. Some associations point out that most of their therapists only use their therapy on family or friends and don't charge for their therapy. Others, at the much more professionally organised end of the scale, have total reliance for income on their therapy and a high degree of involvement in one single therapy association.

Many therapists concentrate on one single therapy while others practise as many as 18 different therapies (the most identified in this study) and offer a very diverse range of treatments. With this broad range of differences in practice, one of the challenges for the complementary and alternative therapy community is providing organisational or regulating frameworks that are inclusive for everyone.

Methodology

For the purposes of this project, 63 groups were contacted by post or e-mail and more than 80 additional individuals and groups who had attended Department of Health and Children forums were also contacted by post. Each was asked for the following details:

- Background on their association, why and when it was established, its purpose and goals
- The number (and if possible) names of therapists that are members of the association
- A note on training; what are the qualifications acceptable for membership of your association and where these qualifications can be gained
- What other associations or groups of members are active in your therapy in Ireland?

- In terms of individuals we would like to hear from people who are practising single or multiple therapies, details of your qualifications, professional practice and membership of professional bodies (if any)
- We would also like to know the rates charged for treatments (if possible)

[The full query letter is included at the end of this appendix along with the survey results.]

The response to the questionnaire was mixed. Some groups did not make contact, despite follow up phone calls on three or more occasions. Some original contact details were inaccurate and so efforts were made to find someone in a group or association who would respond. Following this, the new contact often failed to reply. Some organisations' contact people were abroad and others did not receive the query letter in time from the former contact person.

Most organisations were reluctant to forward names to the study and nearly all omitted the costs of treatment. Some organisations responded with substantial information about their group but were reluctant to give membership numbers. When pushed, most submitted membership figures. It appears that the smaller groups were more reluctant to give membership figures as they felt that their membership size could result in them being left outside of future decision making processes. Some organisations gave great responses with a comprehensive breakdown of everything that was requested in the query letter.

In Ireland, level of association falls into the following groups:

1. Associations representing one therapy only who are part of two or more associations representing their therapy e.g. Kinesiology Association of Ireland representing the Association of Systematic Kinesiology in Ireland and Brain Gym Educational Kinesiology
2. Associations or registers established by a school and representing only those trained in a therapy at their particular school, e.g. The Irish Reflexology Institute
3. Associations that are pan-therapy and represent therapists who may also be a member of an association for their own therapy, e.g. Complementary Therapy Association of Ireland
4. Federations i.e. groups representing single therapy associations e.g. Yoga Federation of Ireland or the National Herbal Council, or groups representing associations encompassing many therapies e.g. FICTA.

In Ireland the associations in Group 1 are the most common. Single representative bodies for a therapy are unknown. There are four associations in Group 3 representing many therapies namely — Irish Association of Holistic Therapies, Association of Registered Complementary Health Therapists of Ireland, Complementary Therapy Association of Ireland and Association of Holistic Therapies. In Group 4 there are three federations representing associations for a particular therapy i.e. — Yoga Federation of Ireland, National Herbal Council and Federation of Irish Reflexology Professional Bodies.

From the research it follows that there are many factors affecting why therapists join particular bodies. Many therapists want to remain in contact with those in the same field as they often work on their own and in some cases are geographically isolated. The idea of community is fostered by therapy associations whose aims tend to fall into the same general terms:

- To promote communication and exchange of expertise between members

- To have an established code of ethics and training guidelines
- To promote the benefits of the therapy and to offer continuing professional development
- To offer newsletters and/or email communications of events and research to members
- To provide a directory or website of accredited practitioners to facilitate the public

Some practitioners become registered with the register or organisation that is based around their college or training association. Some therapists leave their initial association because of personal differences with those in charge of their original association.

One common situation that was mentioned frequently is the predicament of therapists who practise more than one therapy. Some of them are members of several associations while others have joined the pan-therapy associations which are The Association of Registered Complementary Health Therapists of Ireland (ARCHII), established in 1999 and the Complementary Therapy Association of Ireland (CTA), established in 2004.

The cost of joining and paying yearly membership to several associations is a factor in the establishment of these pan-therapy groups. To some therapists it is more attractive to pay one single membership fee each year and to have an involvement with one single association rather than pay for membership and have to attend meetings etc. of several associations. At present, these pan-therapy groups are at an early stage of development and are not affiliated to each other or to FICTA. However, both have plans to lobby on the part of their members for better recognition and influence on the process of regulation of therapists in Ireland.

The price of insurance premiums is also a driver for therapists seeking membership of organisations. One of the pan-therapy groups indicated that since they began to offer an insurance policy on their website, 75% of its membership queries are from people who are interested in joining the association to take up the insurance offer. Another therapist said that the reason he left an Irish association to go to an English pan-therapy group was because the insurance premium with the English group (Embody) was lower than his professional association here.

Amalgamation/Federation

There are quite large differences in the degree or openness to federation or amalgamation from groups across the complementary and alternative therapy community.

Most associations tend to operate on their own but have an awareness of others working in their sector. Many have a positive attitude to integration, amalgamation or federation of groups within their therapy. In opposition to this, some associations were formed by a group of therapists that has left another organisation and formed their own association. These groups tend to have negative attitudes to joining with the former association in any capacity.

In terms of associations which represent a single therapy, there were many reasons stated for reluctance to join several groups in their sector into one single association.

The main differences arise over accepted standards of training and education. This is a common difficulty in that some associations don't recognise the standards accepted by other groups in their field. Some felt that their association could not join with another as it was affiliated to a European body with a shared standard that was above those standards accepted by other associations in its field. For example, one

association's governing European body insists that all practitioners hold a primary degree which was not demanded by other associations representing the same field. Therefore this association felt that it was difficult to join with other Irish associations as it would lower the standard of their practitioners.

Likewise, some groups were subject to a U.K. standard and had difficulties accepting practitioners trained in Ireland under what they felt were lower standards.

However, there is an awareness generally that a more cohesive structure is desirable and more beneficial to therapists in the long term. Many felt that a federated structure of one umbrella association in each therapy with others affiliated to it is more attractive than a complete amalgamation of the present associations in their field.

Many groups who discussed this issue wish to stay autonomous; they felt that in a federated system the bigger groups can dictate to the smaller groups and drive policy their way. One therapy group reported that when trying to get a federation structure off the ground there were basic logistical issues such as the fact that representatives of other groups didn't always turn up to meetings to move the process along, and not all groups in their therapy were interested in a federated body. In short, in some cases there is an openness to a federated structure within their field, it is often simply a matter of needing the incentive to do so.

Some associations are open to amalgamation but feel that sometimes this is driven by a larger group or federation who is more dominant in their field. They are reluctant to become "swallowed" by a larger group already in existence, whose structure and membership would become the dominant framework of the new group. Broadly they would be amenable to amalgamation provided it was conducted on a basis of equality and that one single group (or more than one) would not take charge at the expense of others.

There is also overlap between associations and registers offered by schools; for example, the National Register of Reflexologists has twelve accredited schools on its register. One of these schools, The Natural Healing Centre in Cork, runs its own register of therapists (The National Healing Institute) which covers a range of therapies including reflexology. In some ways, it is understandable why therapists might be confused about the benefits of joining an association, or which one is the best choice to represent their interests. Many simply practise on their own and are happy to remain outside a group where they see no benefit to joining it. This idea of incentive is an important point to remember as a factor in future registration or regulation of therapists.

The following are the therapy associations in Ireland who have moved or are moving towards a degree of amalgamation/federation:

- Bio-energy Therapists Association is a member of FICTA and formed from two separate groups in 2003
- The IMTA have made attempts at bringing the other physical therapy groups together. In 2004, the Irish and International Aromatherapy Association joined with them and the IMTA is in talks with the Natural Healing Institute for possible joining up in the near future
- The Federation of Irish Reflexology Bodies comprises three groups [The Association of Irish Reflexologists, The Irish Reflexology Institute and the National Register of Reflexologists]
- Five of the herbal groups are working to form a herbal council, with a herbal register. At present, it is more of a steering group who are in the process of agreeing common standards, and a lobbying position. These groups are

- The Irish Medical Herbalists Association
- The Irish Association of Master and Medical Herbalists
- The Irish Register of Chinese and Herbal Medicine
- The Association of Chinese Herbalists in Ireland
- The Irish Herbal Association

There are two Herbal Associations who exist outside this process.

- The Yoga Federation of Ireland is an umbrella group with:
 - Yoga Therapy Ireland
 - Contemporary Yoga (Cork)
 - Yoga Fellowship of Northern Ireland
 - Galway Yoga Centre
 - Aurolab Project (Offaly)
 - ViniYoga Ireland is an Associate Member

Three other yoga associations operate outside of the Federation

In conclusion, while the community of therapists involved in complementary and alternative therapies is a disparate one, there are some moves to provide uniformity in terms of establishing single professional bodies. This process is going to be quicker in some therapy associations than in others, but this study found an increasing awareness of the benefits of working towards more cohesiveness within therapy groups.

Suzanne Campbell

Researcher to the National Working Group on the Regulation of Complementary Therapists

August 2005

Letter sent to associations and individuals in the complementary and alternative therapy community

On behalf of the National Working Group on the Regulation of Complementary Therapists, I am compiling statistics on the complementary and alternative therapy sector in Ireland.

To enable the group to carry out this function, we would like to hear from therapists and/or associations active in this field. The information we are seeking regarding associations is:

- Background on the association, why and when it was established, purpose etc.
- The number (and if possible) names of therapists that are members of the association — A note on training; what are the qualifications acceptable for membership of your association and where these qualifications can be gained.
- What other associations or groups of members are active in your therapy in Ireland? In terms of individuals we would like to hear from people who are practising single or multiple therapies, details of your qualifications, professional practice and membership of professional bodies (if any).

We would also like to know the rates charged for treatments. This information will remain confidential and the names, qualifications or rates for treatment will not be published in the report. The purpose of gathering these statistics is to collate an accurate picture of the complementary and alternative therapy sector in Ireland, and most importantly, to find how many individuals and associations are active in it. Relevant research on the efficacy of your therapy which you feel might be useful for the report can be sent my way, or any pointers which you feel are relevant to a description of what is happening in terms of new developments or projects in your area. I would appreciate it if you could send this information to me as soon as possible. The gathering of statistics for the report is to be completed in five weeks time so it is vital that people contact us soon.

Thanking you in advance.

Sincerely

Suzanne Campbell

Project Manager, National Working Group for the Regulation of Complementary Therapists.

List of Associations with notes on membership and educational standards

Federations

The Federation of Irish Complementary Therapy Associations	FICTA — 25 associations, 3 affiliated members			
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Pan-Therapy Groups

Irish Association of Holistic Therapies		Offers diploma awards in various therapies using City and Guilds qualifications and Irish Yoga Group qualifications.		300 members practising various therapy groups
Association of Registered Complementary Health Therapists of Ireland (ARCHII)			www.Complementarytherapists.org	
Complementary Therapy Association of Ireland (CTA) (est. 2004)	The CTA aims to affiliate with the British Complementary Medicine Association (BCMA)	Members are qualified in various therapies.		12 members
Association of Holistic Therapies		founded in 1986 to represent graduates from the College of Holistic Therapies which gives qualifications in several therapies. It has recently become ITEC registered and plans to offer ITEC courses	www.taht.ie	60 members

Associations

Acupuncture

The Acupuncture and Chinese Medicine Association*				170 members
The Association of Irish Acupuncturists*		Members must have completed a 3yr course with not less than 1250 training contact hours		115 members
Acupuncture Foundation Professional Association*				
The Professional Register of Traditional Chinese Medicine (PRTCM)				36 members

*[all three moving to amalgamation by end 2005, early 2006]

Amatsu

Amatsu Association of Ireland				
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Ayurvedic Medicine

Mary Daly				
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Bio-Energy

Bio-Energy Therapists Association; BETA		Therapists must have a diploma in Bio-Energy therapy		16 members
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Bio Testing and Therapy

Bio Testing and Therapy International		Offers basic course of 5 days and an advanced course of 5 days.		89 members, 20 associate members
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Bowen Therapy

Accredited Bowen Therapists of Ireland			www.bowenireland.com	32 members across 32 counties
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Cranio Sacral Therapy

Irish Association of Cranio Sacral Therapy		Training is provided by the Upledger Institute which is an international body.	www.upledgerireland.com	They have 500 therapists practising in Ireland
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Endorphin Release

Endorphin Release Clinics Ltd.	The only centre offering this therapy and training of therapists			
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Herbal Groups

The associations marked with an asterisk are affiliated to the National Herbal Council.

Professional Register of Traditional Chinese Herbal Medicine				8 members on its register of herbal medicine practitioners
Irish Register of Chinese Herbal Medicine*				
Irish Association of Master and Medical Herbalists*				
Association of Chinese Herbalists of Ireland*				
Irish Herbal Register*				
Irish Medical Herbalists Association*		Must be graduates of colleges accredited by the National Institute of Medical Herbalists with a minimum of three years training		12 members

Homeopaths

The Irish Society of Homeopaths		3 schools in Ireland teaching over a four year period, application made to HETAC for degree status		390 members
Institute of Complex Homeopathy				

Healing (multi-discipline)

The National Healing Institute (NHII)	Based at the National Healing Clinic and Training School in Cork.	Member training school of the British Complementary Medicine Association. Graduates can join the Institute's Association, National Register of Reflexologists or IMTA		113 members
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Indian Head Massage

Ayurvedic bodywork consortium				
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Kinesiology

Kinesiology Association of Ireland		Does not provide training, members must have 120 hours training from accredited courses		Professional members 86, others 30
Association of Systematic Kinesiology in Ireland		Affiliate to ASK in the UK, offer a two year part time diploma course		Professional members 32, student members 18, associate 14
Brain Gym Educational Kinesiology				13 practising members with qualifications gained over 360 hours
Professional Register of the Kinesiology College of Ireland PRKCI				

Manual Lymph Drainage

MLD Ireland		Registered therapists must have completed training in nursing, physiotherapy, physical therapy or massage therapy. Following this they must complete a basic course in MLD of 40 hours, followed by Therapy 1 (48 hours) and Therapy 2 and 3 (80 hours). Students are then certified as MLD therapists		16 full members
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Massage

Irish Massage Therapists Association				750 members, also includes aromatherapists
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Neuromuscular Therapy

Association of Neuromuscular Therapists (ANMT)		The association offers membership to graduates of the National Training Centre in Neuromuscular Therapy		892 members
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Mind Therapies

Irish Institute of Counseling and Hypnotherapy		Members undergo a three year part time diploma with external assessment from City and Guilds in the UK		70 members
Institute of Clinical Hypnotherapy & Psychotherapy		Offers training courses up to higher diploma level	www. hypnosiseire.com	284 members
Association for Neuro Linguistic Programming				20 members.
Neuro-Developmental Therapy Ireland	Neuro-Developmental Delay Therapy clinic was opened in the early 1990's			Circa 20 therapists are in part time or full time practice. Circa 400 professionals are trained to use the work within their own profession.
Association of Neuro-Developmental Therapy				

Naturopathy

The Association of Naturopathic Practitioners		Colleges in Cork, Limerick, Galway and Dublin. The College of Naturopathic Medicine has applied to HETAC for applying the award of Bachelors Degree to their Naturopathic programme		Over 100 members
Naturopathic Society of Ireland				50 members

Nutritional Therapy

Professional Body — the British Association for Nutritional Therapy		Diploma and Degree courses available in the UK, Irish Institute is a recognised teaching body for NT; awards a diploma in Nutritional Therapy in a 3 year part time course	Contact -Director of Irish Institute of Nutrition and Health. (IINH, www.iinh.net)	
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Physical Therapy

The Irish Association of Physical Therapy				120 members
Irish Institute of Physical Therapies				

Reiki

Reiki Association of Ireland	Some members do not have public practise and just practise for the benefit of family and friends.	Members must have completed Reiki 1 to join.	www.reikiassociationireland.com	100 members
Reiki Federation Ireland.				???(163) (F)????

Re-birthing Psychotherapy

Re-birthing Psychotherapy Association.		No training courses currently in Ireland which are of a sufficient length to qualify people for this association	www.rebirthing.ie	8 members
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Reflexology

Federation of Irish Reflexology Professional Bodies*				
The Association of Irish Reflexologists*		Members must have completed a course of at least 100 hrs teaching time spread over a 12 month period.		40 members
Irish Reflexologists Institute*		Members must have completed a course of at least 120 hours	www.reflexology.ie	1300 members with 20 accredited reflexology schools
National Register of Reflexologists				412 members, has 12 accredited schools
Association of Clinical Reflexologists				

* Those marked with an asterix have federated

Scenar

Scenar Practioners Society of Ireland			www.scenrtherapyireland.com	
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Seichem (now disbanded)

Irish Seichem Association				
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Shen

SHEN Association Ireland				12 members
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Shiatsu

Shiatsu Society of Ireland	Affiliated to the European Shiatsu Society	Three schools in Republic and one in Belfast. Three years part time professional course		33 professional members
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Tai-Chi

Tai-Chi Association.	Affiliated to the Irish Martial Arts Association			
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Tibetan Medicine

Tara Institute of Tibetan Medicine				
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Yoga

Irish Yoga Association.	Members of the European Union of Yoga (EUY)	Runs teacher training courses; 621 hours over four years.	www.iya.ie	214 members
Yoga Society Ireland. (F)		trains teachers and most membership comes from students they have trained.		250 members
Yoga Therapy Ireland & Yoga Federation of Ireland (F)	Umbrella group for five Yoga training organisations throughout Ireland	Standard training course is a minimum of two years with compulsory COPD Currently putting a proposal together for HETAC	www.yogatherapyireland.com	Over 600 members
Harmony Yoga Ireland*				

APPENDIX VI

Training Standards

1. Training standards agreed by the Herbal Council, now comprising 5 discrete registers and therefore the majority of trained herbalists in the State:

Accreditation & Training

The minimum requirements for membership in respect of the National Herbal Council are as follows:

The training curriculum for all traditions of Herbal Medicine must include the following:—

Human Sciences

250 Hours of lectures and study time in those aspects of normal Anatomy, Physiology and biochemistry that are essential to understanding the causes, mechanisms, diagnosis and clinical features of disease as understood by biomedicine.

Nutrition

80 hours of lectures and study time to comprehensively understand the foundations of nutrition and diet as a means for the maintenance of good health and treating disease. Included in this would be an understanding of the effects of food and diet on specific body systems and disease processes whilst underscoring the holistic aspects of this type of approach.

To provide a perspective on the possible interactions between foods, herb supplements and drugs, with an emphasis being placed on the safe limitations of their usage including nutrient/drug/herb and food interactions.

To allow the herbalist and related practitioners to use an understanding of nutrition as an essential part of their existing discipline.

Clinical Sciences

350 hours of lectures and study aimed at outlining the common diseases, their causes, mechanisms, clinical features and diagnosis.

Training and experience in case-history taking and physical examination.

Training to enable students to develop an understanding of the limits of their own medical capabilities and thereby enhance the skills of appropriate referral.

To provide practitioners with a foundation from which to compare and contrast this knowledge with their own approach to medicine and to communicate effectively with practitioners of conventional medicine.

Plant Chemistry and Pharmacology

80 hours of lectures and study time to ensure that herbal medicine practitioners are familiar with the main chemical constituents of the most common herbs, the effects they have on the human body, and their reactions with orthodox drugs.

Pharmacognosy and Dispensing

80 hours of lectures, study time to ensure the safety of herbal practice by enabling herbalists to evaluate quality control and quality-assurance processes for herbal medicines.

To ensure a good understanding of the processes by which herbal medicines are grown, harvested, stored and processed.

To enable herbalists to read and evaluate technical material published on herbal medicines in pharmacopoeias, monographs etc.

To teach the legal requirements relating to herbal practice.

To teach the necessary skills for the running of a herbal dispensary.

Practitioner Development and Ethics

40 hours of lectures, study time to enable practitioner self-development leading to effective communication (including listening and counselling skills, and empathy) within the therapeutic relationship, and within their professional lives as a whole, e.g. in liaising with GPs, etc.

To support the development of reflective practice — the practitioner as a life-long learner; and an understanding of how personal and psychological factors influence the therapeutic relationship.

To provide practitioners with the ethical, legal and professional foundations of good practice, enabling them to apply these principles appropriately.

Practitioner Research

80 hours of lectures and study time to enable practitioners of herbal medicine to develop an orientation towards continuous professional development, recognising that learning is a life-long process, and that part of this process is concerned with the ability to frame enquiry within the context of personal practice, reflecting and analysing in a systematic and critical way.

To introduce the principles and practice of research as a system and critical process of enquiry in the context of health care in general and herbal medicine in particular.

Tradition Specific Training

1,000 hours of lectures, study time and clinical training within the theoretical and practice framework of the specific herbal tradition such as Ayurvedic, Chinese, Tibetan and Western Herbal medicine.

Clinical Practice

450 hours under the supervision of an experienced herbal practitioner(s), including developing a herbal-medicine treatment strategy, dispensing herbal medicines, dispensary management, health and safety aspects and practitioner development issues.

2. Reiki Practitioner Module

Please note that the following recommendations presented by Reiki Federation Ireland are currently a work in progress and not the finalised recommendations.

The *Practitioner Module* will be presented to RFI members at the next AGM — 25th March 2006 for approval.

Reiki Practitioner Module

Reiki

Reiki is an ancient non-intrusive complementary therapy. As hands on healing energy technique, Reiki enhances the body's own innate natural ability to heal itself on all levels. Reiki complements conventional medicine. It has no major side effects or contraindications.

Recommended Supervised Minimum Training Hours: 100

The complete module for Reiki Practitioner would include:

- Reiki Level One
- Reiki Level Two
- Duty of Client Care
- Professional Conduct
- Clinical Practice
- Membership of Professional Body
- Anatomy & Physiology
- First Aid
- Business Awareness
- Continual Personal Development
- Review of Case Studies

Non Supervised — Student Hours

- Reiki Level One — 10 $\frac{1}{2}$ hours
- Reiki Level Two — 10 $\frac{1}{2}$ hours
- Case Studies — 20 Hours minimum

FIRST LEVEL REIKI TRAINING

- Definition of Reiki
- How Reiki actually works
- The benefits of Reiki
- History of Reiki
- The Reiki Principles
- Receiving First Level Reiki
- Meditation/visualization
- Teaching and practice of Reiki hand positions for self-healing, chair treatment, and lying on a plinth
- With regard to hand positions it must be emphasised to students that the genital and breast areas are not physically touched and that clients remain clothed while receiving Reiki
- Each student to practice giving and receiving Reiki
- Explanation of the energetic systems of the body including the aura, chakras and endocrine systems
- Teacher emphasize importance of using Reiki self healing every day
- Opportunities for students to share workshop experience
- Teachers must make students fully aware of the possible effects during and after a Reiki treatment
- The ethical use of Reiki in the student's life is emphasized
- Course manual to be given
- Certification of First Level Reiki to be given
- Brief introduction to the various levels of Reiki
- Suggested reading list
- Overview of RFI and information on joining RFI
- Teaching on the integration of Reiki energy and possible experiences following the Reiki One workshop
- Teaching of the importance of personal energy management, self care and well being while giving Reiki

SECOND LEVEL REIKI TRAINING

- Revision of all aspects of Level One in detail
- Receiving of Second Level Reiki
- Meditation/visualization
- Sharing of experiences
- Teaching and practice of Reiki hand position for self-healing, chair treatment, and lying on a plinth
- With regard to hand positions it must be emphasised to students that the genital and breast area is not physically touched and that clients remain clothed while receiving Reiki
- Each student to practice giving and receiving Reiki
- Sharing of feedback since first level workshop and the experience of using Reiki on self and family and friends
- Introduction to the Reiki Symbols
- Teaching the Reiki symbols and practice of them physically
- Explanation and practice of distant Reiki Healing and distant treatments
- Teacher emphasize importance of using Reiki self healing every day
- Opportunities for students to share workshop experience
- Teachers must make students fully aware of the possible effects during and after a Reiki treatment
- Course Manual to be given
- Second Level Certificate to be given
- Suggested reading list
- Teaching on the integration of Reiki energy following Reiki Two workshop
- If student is new to the Reiki Master/Teacher they must ensure that the First level Reiki Certificate is presented
- The ethical use of Reiki in the student's life is emphasised

Duty of Client Care

- Consultation Methods
- Boundaries
- Creating Client Consultation Forms
- Assessing Client Consultation Forms
- Greeting and briefing the client
- Client Record Keeping
- Consent to treatment — (to include gaining consent from legal guardian)
- Explaining the Treatment To Client
- Helping onto and off the Plinth
- Ensuring client's comfort — need to use supports, chest, head, knees etc.
- After Treatment Feedback and assessment
- Home Care Advise
- Referral Procedure — GP, Counsellor etc.
- Understanding the Holistic Approach
- Knowledge and understanding of other complementary therapies.
- Client confidentiality
- Developing trust

Professional Conduct

- Code of Ethics and Conduct
- Boundaries for the Practitioner
- Communication Skills — listening, feed back
- Confidentiality
- Working in Harmony/Respect and Professional Behaviour with other Complementary Therapists
- Working in Harmony/Respect and Professional Behaviour with Conventional Medical Practitioners
- Hygiene — personal, premises, plinth and equipment
- Professional appearance and conduct
- Never using 'hands on' technique over the genital and breast area
- Reiki is a fully clothed treatment
- Client relationships
- Diagnosis — The Reiki Practitioner must never diagnose

Clinical Practice

- Treatment Procedure
- Length of Treatment
- Course of Treatments
- Treatment procedure for babies, young children and elderly
- Knowledge of other holistic therapies and how they work
- Referral Procedure
- Full Treatments given by each student; observed, supervised and discussed
- Introduction to Case Studies
- Clinical Supervision — to avail of ongoing supervision as required
- Respect
- Non discrimination
- Non judgement
- Therapy Room preparation to include: Heating, Lighting, Atmosphere, Security, Outside interference, Appropriate Music
- Possible Reactions: people may experience an emotional release, detoxification symptoms, increased need for sleep, relaxation.
- Contraindications — Do not perform a Reiki Healing if the client or Reiki Practitioner is under the influence of alcohol or mind altering substances.
- Special Recommendations — To assess and make decisions as to the suitability of treating a client suffering with an Acute Mental Psychotic Episode at the specific treatment time with special regard for the safety of the client and Reiki Practitioner.
- While Reiki is not contra-indicated to any medication we advise that clients' medication may need to be reassessed by their GP as Reiki can enhance the clients' rate of recovery.

Anatomy & Physiology

Understanding of the structures being worked over and their function:

- The Cellular System
- The Skeletal System
- The Muscular System
- The Skin
- The Circulatory, Cardiovascular & Lymphatic Systems
- The Neurological System
- The Endocrine System
- The Respiratory System
- The Digestive System
- The Urinary System
- The Reproductive System
- The Nervous System

First Aid

We recommend a recognised First Aid Certificate

- Contents of First Aid Box
- Teaching on how to deal with First Aid emergencies in professional practice
- Necessity for an accident book and its contents
- Correct first aid procedures for the following:
 - Fainting
 - Burns/scalds
 - Epileptic fit
 - Bleeding
 - Hysteria
 - Heart attack
 - Unconsciousness
 - Twisted ankle
 - Asthma attack
 - Diabetic coma
 - Nose bleed
 - Insect sting
 - Hyperventilation
 - Migraine
 - Dizziness
 - Recovery position
- Knowing how to call for medical assistance
- Types of fire fighting equipment required in the workplace
- CPR

Business Awareness

- Data Protection Act
- Child Protection Act
- Health & Safety
- Fire Prevention & Fire Regulations
- Insurance
- Appropriate Legislation applicable to Reiki (e.g. local authority)
- Registering and establishing a Business
- Types of Business — Sole Trader, Partnership, Limited Company
- Home Visiting
- Tax Returns
- Legality of Keeping Accounts
- Bank Accounts
- VAT
- Marketing — Leaflets, Flyers, Health Shows, Interviews
- Advertising — Newspapers, Radio, Talks, Leaflets, Mail Shots, Word of Mouth
- Contract of Employment
- Presentation Skills
- Planning a talk,
- Costing & Pricing
- Room Preparation , atmosphere, temperature, lighting,
- Suitable Equipment
- Keeping Accounts- Including income, expenditure and VAT
- Scheduling appointments, telephone manner, Customer Service, Taking money and logging payments
- Communication Skills
- Security — Premises, confidential client records, equipment, stock, people

Membership of Professional Body

- Benefits
- Choosing a Professional Body
- Constitution
- Code of Ethics
- Grievance Procedure

Continual Personal Development

Further training in personal development as a Holistic Therapist

This may include:

- Further Holistic Training
- Personal study skills
- Knowledge and awareness of research in the complementary field
- Reiki share groups or workshops
- AGM's or events of Professional Bodies
- Workshops, Talks, Health Fairs
- Reading, Books, Videos, Audiotapes
- Selected events
- Further related educational training (computer skills, business skills, etc.)
- Avail of supervision made available by Reiki Master Teacher

Case Studies

- Consultation including thorough medical history and general lifestyle
- Client Consultation Form Review
- Client profile
- Evaluating and reviewing the Reiki treatment programme
- Recording client's feedback and experience as appropriate
- Effectiveness of treatment
- Details of how the therapist conducted the treatment
- Details of how the client felt during and after the treatment
- Details of home care advice given to client
- Overall conclusion of each case should be recorded
- Reflective Practice — students should reflect on their own professional practice and learning outcomes of the case study.

3. Craniosacral Therapy

PROFESSIONAL TRAINING PROGRAMME (OCTOBER, 2005)

TRAINING PROGRAMME

All course material is written by **Dr John Upledger DO., O.M.M.**, founder of CranioSacral Therapy (CST) and SomatoEmotional Release® (SER) and is subject to constant review. Current teaching formats are the result of development over a 20-year period. All Workshops are conducted by Upledger Institute Certified Instructors who are all practicing Healthcare Professionals and have completed intensive training programmes with the Institute.

To meet the standards and objectives of the Irish Government Legislation, practitioners' work must be verifiable. As part of the training programme there will be study groups for the practitioners. The practitioners will share their written case histories with the study group leader. This will help with each practitioner's understanding of the work and will show areas for further study. There will be a documentary system that requires signatures to show that the work has been completed.

CONTINUED PROFESSIONAL DEVELOPMENT (CPD)

Therapists are given many opportunities for on-going professional development.

- Become a Teaching Assistant at Upledger Institute Ireland Workshops
- Become a Certified Presenter of one-day Seminars
- Become a Certified Instructor for the Upledger Institute
- Attend official study groups, and become a leader of study groups
- Organise and participate in supervised intensive clinic treatment programmes

THE IRISH ASSOCIATION FOR CRANIOSACRAL THERAPY (IACST)

IACST exists to promote **Cranio Sacral Therapy**, for **YOU**. It obtains preferential insurance rates. IACST works with the Federation of Irish Complementary Therapists Association (FICTA). FICTA works with the government and represents the Practitioner professional body.

IACST represents YOUR professional interests.

www.iacst.com (Web) E-mail: michael.j.ward@usermail.com (Secretary)

NEW SYLLABUS — HOURS

CRANIOSACRAL THERAPY 1	28
Home Study CST 1	84
Practice Hours	70
Study Groups	28
Personal Therapy	20
Anatomy & Physiology & Pathology	50
A & P & P Module Home Study	100

Anatomy & Physiology can be taken with a school of your choice but it MUST be approved by the UPLEDGER INSTITUTE IRELAND. We can recommend the name of an Instructor nearest to where you live.

CRANIOSACRAL THERAPY 11	28
Home Study	84
Case Studies	32
Study Groups/Preceptorship	28
Personal Therapy	10
Professional Standards/Procedures	50
Professional Standards/Procedures Module Home Study	100

Before carrying out your practice of CST it is necessary to be covered by insurance. This can be done through the IACST which offers a discount rate for group insurance. For your own protection it is important to know that it is a LEGAL requirement, when working with a child under the age of 16 years, that a PARENT or GUARDIAN, MUST be present at ALL times.

TECHNIQUES EXAMINATION

At this point you are eligible to take the Upledger Techniques Examination. For information on this please contact the Upledger Institute Ireland. After successful completion of the Techniques Certification Programme, a practitioner is **CST-T. Cranio Sacral Therapist, Techniques Certified.**

SOMATOEMOTIONAL RELEASE 1	28
Home Study	84
Case Studies	16
Study Groups/Preceptorship	16
Personal Therapy	10

SER 1 is open to non-Upledger trained students who have studied CST with other organisations that wish to skip CS1 and CS11. Proof of substantial CST training in CS1 and CS11 is required, you would then be eligible to attend a special 4 day course that combines CS1 and CS11 review.

PAEDIATRICS	32
Home Study	96
Case Studies	10
Study Groups/Preceptorship	20
Clinical Supervision	20

To enable you to work with babies from birth to 4 years, it is a requirement to attend this course which can be taken after SER1.

SOMATOEMOTIONAL RELEASE 11	32
Home Study	96
Case Studies	16
Study Groups/Preceptorship	16
Personal Therapy	10
ADVANCED (ADV) 1	60
Home Study	120
Personal Intensives	10
Total hours (Excluding Paediatrics)	1226

DIPLOMATE CERTIFICATION

A second level of certification is available after attending SomatoEmotional Release®, SomatoEmotional Release® 11 and Advanced. For information on the Advanced seminar and Diplomat Certification, please contact the Upledger Institute Ireland.

After successful completion of the Diplomat Certification Programme, a practitioner is **CST-D. CranioSacral Therapist, Diplomat Certified.**

Note: The workshops involve continual assessment of the participants by the instructor and teaching assistants. For a participant's benefit, he/she may be asked to repeat a workshop (at a reduced rate) if it is felt that extra help is needed to fully grasp the concepts and techniques in the seminar.

GRANDPARENTING CLAUSE

From August 1st 2005, the 'new' syllabus applies for all training students. Those in active practice as CST/SER for 5 years and more, have reached Advanced 1 level, certifiable, will not be required to retake any Upledger course training already completed. Those mentioned practitioners will be required, in certain cases, to complete approved bridging courses e.g. a relevant module such as Anatomy, Physiology; module on professional practice and procedures.

There is a period of 2 years from August 1st 2005 when upgrading as appropriate will be completed (refer to IACST). Ongoing continued professional development (CPD is a requirement for all practitioners. CPD is built in to the Upledger training programme e.g. Training Assistant (T/A) or CST 1, CST11 etc. (refer to UI Ireland). Approved external CPD training is also accessible (refer to IACST).

APPENDIX VII

Codes of Ethics

1. Irish Institute of Counselling and Hypnotherapy

Introduction

The purpose of this document is to define the general code of ethics and practice for IICH members. This code is based upon a set of philosophical principles which are detailed later in this paper and which are drawn from the European charter defining documents.

Organisational and individual members are bound to adhere to the code of ethics and practice detailed in Appendix A. The IICH code of ethics and practice is a controlled document bound to the articles of association of the IICH.

Definitions

Therapist: a person offering a therapeutic service to a client within the IICH definition of counselling and hypnotherapy, who has the levels of skill and training specified by standards laid down by the IICH.

Client: a person, couple, family, group or organisation seeking help through a therapeutic relationship.

Therapeutic Relationship: an explicit agreed and formally contracted professional relationship between the therapist and client/s.

Philosophical Principles

The core values of the therapist are based upon respect for human rights, individual and cultural differences. These values underpin a set of attitudes and skills which have regard for the integrity, authority and autonomy of the client.

Respect is the unconditional acceptance of clients but not necessarily acceptance of all of the client's behaviour. Therapists have the responsibility to make themselves aware of individual and cultural differences.

Integrity means the right of the client to maintain their physical and emotional boundaries and the right to not be exploited in any way.

Authority recognises that the responsibility for entering into and out off the therapeutic relationship is vested in the client.

Autonomy realises the freedom of the client to express themselves, as they see fit, within their own model of actualization, with an unbiased attitude towards the client's beliefs and culture.

Privacy means that there must be no un-contracted observation of the therapeutic relationship, nor must there be allowed any inappropriate observation, interference or intrusion by a third party.

Confidentiality respects that any personal information shared between client and therapist during the therapeutic process remain undisclosed and that the therapist, further undertakes to maintain any written records pertaining to the therapeutic process in such a way as to prevent inappropriate disclosure to third parties.

Responsibility requires that the therapist ensure strict adherence to the philosophical principles outlined above and conduct themselves in a professional manner consistent with the IICH Code of Ethics and Practice as detailed in Appendix A.

Competence is the requirement of the therapist to ensure, at all times, that they maintain the highest quality of standards in their practice. Therapists should only provide services and use only those techniques for which they are qualified by dint of education, training or experience.

The IICH is determined that its members shall be aware of, and conduct themselves at all times, to the standards of the Code of Ethics and Practice. Deviations from the Code of Ethics and Practice notified to the IICH will be investigated as defined by the Disciplinary Procedure of the IICH. In cases where there exists an ethical conflict the therapist is bound to take a position that reflects the greatest good and least harm to the client and other third parties, with due respect to the common law of the State.

Members of the IICH are required to present any ethical conflicts they may encounter to their clinical supervisor and the sitting standards committee. In these presentations the privacy and confidential nature of the therapeutic relationship is required to be maintained and may only be discussed in the third party.

Appendix A

The Code of Ethics and Practice of the Irish Institute of Counselling and Hypnotherapy

1. To establish and maintain standards of competence and integrity among members.
2. To respect the client's model of the world and to avoid imposing the therapist's values on the client.
3. To maintain the confidentiality of the client at all times, except where doing so would endanger the life or health of the client.
4. To accept that clients possess within themselves the resources needed for change.
5. To take responsibility for maintaining a high standard of competence, pursuing on-going training and courses of study and to maintain regular contact with colleagues and supervisors for consultation.
6. To be aware of the limits of their own competence and skills and, where necessary, refer clients to more suitably qualified persons.
7. To take care not to misrepresent their qualifications or level of competence
8. To refrain from practice if their judgement is impaired due to drugs, illness, stress.
9. To establish a boundary between a therapeutic or working relationship and a personal relationship and, where necessary, to make this boundary clear to the client.
10. To use hypnosis for therapeutic and/or training purposes only, and disassociate themselves from the use of hypnosis for entertainment.

2. Irish Massage Therapist Association



CODE OF ETHICS AND PRACTICE IRISH MASSAGE THERAPIST ASSOCIATION

Code of Ethics and Practice

- This code applies to registered members of the I.M.T. A. Its purpose is to establish and maintain standards for the practice of massage therapy, and to inform and protect members of the public seeking massage therapy treatment.

1 THE DUTIES

These are the general principles that therapists need to observe in order to responsibly fulfil their calling. To ignore these would imply a lack of regard for the needs of the patient and the reputation of massage therapy and the Irish Massage Therapy Association.

- 1.1 In general, members should endeavour to act in such a manner as to: Inspire public trust and confidence, uphold and enhance the good standing and reputation of the massage therapy profession and above all safeguard the interests of the client.
- 1.2 Members' professional conduct towards their client is respectful of the dignity and integrity of the individual, as a whole person, their beliefs and values must be taken into account; empathy, care, trust and confidentiality are characteristics of a professional massage therapist.
- 1.3 A therapist should practice their profession with integrity and dignity.
- 1.4 The highest standards must be maintained in conduct, the care of the client and professional expertise.
- 1.5 The therapist owes loyalty to their client and should have regard for their wishes.

- 1.6 The therapist should not exploit their clients emotionally, physically, sexually or financially.
- 1.7 The therapist should neither claim nor guarantee to cure, nor should they prescribe medication.
- 1.8 Essential oils should not be introduced or prescribed by the therapies unless qualified to do so.
- 1.9 Members' certificates and fee scale should be clearly displayed.
- 1.10 If a client is currently receiving medical treatment for a specific condition liaison between practitioner and the clients medical professional is advised.

2 THE OBLIGATIONS

These are the restrictions and regulations, which the association must impose upon its members for legal and professional reasons.

THE THERAPIST IS REQUIRED

- 2.1 To comply with the law of the state or territory where the therapist practices.
- 2.2 To advise the Secretary of the Association immediately in the event of any police or governmental (including local government) inquiry into their practice.
- 2.3 To secure and maintain full indemnity insurance.
- 2.4 Not to treat or make a physical examination of a child under 16, except in the presence of a parent or guardian.
- 2.5 Not to disclose any information about a patient which comes to them through their professional relationship with the patient, except:
 - (a) Where required to do so by rule of law; or
 - (b) In an emergency or other dangerous situation where, in the opinion of the therapist, the information may assist in the prevention of possible injury to the client or to another person; or
 - (b) Where the client has consented to the nature and the extent of the disclosure.

3 CONDUCT

- 3.1 A therapist shall keep full records of all treatments of clients, including the following details;
 - (a) Name, address, telephone number and date of birth and contact no.
 - (b) Essential details of medical history.

(c) Dates of treatments.

(d) Details of treatments

3.2 On deciding to retire or move practice, a therapist must inform all clients of their intentions to do so and of any arrangements being made for the transfer of the practice to another therapist. It is recommended that records should be kept for a minimum of five years.

3.3 A therapist may not in public nor to a client disparage or speak disrespectfully of a fellow therapist.

3.4 Where a therapist has good reason to believe a fellow therapist has committed misconduct or has any complaint whatsoever about them a confidential report should be made to the Irish Massage Therapist Association and the therapist concerned will be informed by the Secretary.

GENERAL

3.4 Dress should be clean and appropriate for the professional practice of a Massage Therapist

3.5 Premises should be of a professional standard and should be kept, along with all equipment, in a serviceable and hygienic condition.

4 ADJUDICATION

The Executive Committee of the Association sitting as a professional purpose subcommittee shall advise upon conduct and adjudicate upon matters concerning the skill, competence, qualification and conduct of Massage Therapist on the register.

4.1 The executive committee shall make a ruling.

4.2 An appeal may be made to the committee, following which; the decision is final and binding.

Breach of Code of Ethics shall invalidate membership of the Irish Massage Therapist Association.

Amended August 2000.

3. ACUPUNCTURE FOUNDATION PROFESSIONAL SOCIETY

AFPA Code of Ethics

RULE ONE Members shall comply at all times with the The requirements of the Codes of Ethics and Practice. By accepting membership of the organisation, members agree to abide by all terms and conditions of membership, and agree to accept sanction in the event of a breach of the Codes.

RULE TWO Members shall at all times conduct themselves in an honourable manner in their relations with their patients, the public, and with other members of the Organisation.

RULE THREE No member may advertise or allow his or her name to be advertised in any way, except in the form laid down by the Organisation. See Advertising format.

RULE FOUR Members shall not give formal courses of instruction in any TCM therapy without the approval of the Organisation.

RULE FIVE It is required that members apply the foregoing Code to all their professional activities.

RULE SIX Infringement of the Ethical Code renders members liable to disciplinary action with subsequent loss of privileges and benefits of the Organisation.

RULE ONE

Members shall comply at all times with the requirements of the Code of Practice

They shall thoroughly familiarise themselves with the contents of the Codes of Ethics and of Practice and any amendments made to the codes, and ensure that their premises meet the required standards. Any member who requires advice or help in meeting the requirements of the Code of Practice is encouraged to contact the Council of the Organisation which will offer every possible assistance.

Local authority bye-laws in his or her area under Part V111 of the Local Government (Miscellaneous Provisions) Act; or any similar Local Authority Act; or

U.K. and N.I. Members

Members are reminded that under Part V111 of the Local Government (Miscellaneous Provisions) Act 1982 and the other Private Acts, Local Authorities in England and Wales are empowered to require the registration of acupuncturists and their premises, and to introduce bye-laws and inspection procedures to ensure the cleanliness of the practice and the sterility of instruments. Where such bye-laws are introduced, they will apply to all practitioners in the area concerned, regardless of when they established themselves in practice or what qualifications they possess.

RULE TWO

Members shall at all times conduct themselves in a professional and ethical manner in their relations with their patients, the public, and with other members of the Organisation.

A. Member's obligations to their patients

Member's obligations to their patients are governed by the contractual relationship between them. Members owe their patients a duty to act with reasonable care in accordance with the standards of professional skill expected of an Acupuncturist and TCM Professional.

Professional and private life are indivisible

The relationship between an acupuncturist and his patient is that of a professional with a client. The patient puts complete trust in a practitioner's integrity and it is the duty of the member not to abuse this trust in any way. Proper moral conduct must always be paramount in member's relations with patients. Members must act with consideration concerning fees and justification for treatment.

Members must take care when explaining the procedures and treatment which they propose to administer, and should recognise the patient's right to refuse treatment or ignore advice.

For the purposes of 'medical treatment' the consent of a parent or guardian in the case of a minor is a requirement.

The practitioner will only offer treatment to patients within the bounds of practitioner competence, and if a practitioner is in doubt as to whether their ability is sufficient to offer the best treatment to the client, that he consults with, or refers to a more senior colleague, or to a practitioner within a different health care profession if it is in the client's best interest to do so.

Members as practitioners will maintain a suitable dress code while treating clients.

It is the duty of the member if he or she is away from the practice for any length of time to ensure adequate arrangements are made to enable patients to receive treatment.

Members have an implicit duty, within the law, to keep all information concerning, and views formed about, patients entirely confidential between the member and the patient concerned.

The same level of confidence must be maintained by any person employed in the practice. This extends to all information concerning the client or patient.

Practitioners will keep confidential documents relating to clients locked at all times, and only release them to other healthcare professionals upon the receipt of written consent by the client.

Members are warned not to assume that details of a wife's or husband's case should be discussed with the other. The above ruling applies to all parties including next of kin and members should never allow a third person to be present unless it is with the express consent of the patient.

Disclosure of any confidential information to a third person is only in order when all the following requirements are met:

- Disclosure is in the patient's interest
- It is done with the patient's knowledge and consent except when the patient is not in a condition to give this and a third person is in a position to be responsible for the patient's interests.
- There is a real need for such information to be imparted, such as when a member considers a case should be referred to a colleague. The only exceptions to this principle of confidentiality are:
 - When the law requires the information to be divulged (see below, members obligations to the Public).

- When for reasons relating to the condition or treatment of a patient it is inappropriate to seek his consent, but is in the patient’s own interest that confidentiality should be broken.
- When the member reasonably considers that his or her duty to society at large take precedence.

Members must ensure that they keep clear and comprehensive records of the treatment they administer to patients (see also Code of Practice, Appendix C).

The use by a member of an illegal substance e.g. narcotics, or the misuse of or improper use of legal but addictive substance e.g. alcohol is considered to be a breach of the Code of Ethics.

B. Members Obligations to the Public

B.1 Disclosure of Information

If members receive requests for the disclosure of confidential information they should first refer the matter to the Organisation for advice. If a member is asked in a Court of Law to disclose information which he or she considers to be confidential, the member should ask the Court to take into consideration his or her reasons for not wishing to divulge the information requested, i.e. on the grounds of professional secrecy.

If the Court nevertheless overrules this contention and requires disclosure of the information, the member may be in contempt of Court by refusing to disclose it, but if he or she does refuse, the Council will not hold the member in breach of this Code of Ethics.

In cases where sensitive information is given to a practitioner, especially regarding activities of a possibly criminal nature, members are strongly advised to take legal action and to consult the Committee before deciding how best to proceed.

B.2 Use of the title ‘Doctor’

No member may use the title ‘Doctor’ either directly or indirectly in such a way to imply that he or she is a medical practitioner, or holds a doctorate unless that is the case.

C. Members Obligations to other practitioners

Though this Code of Ethics is of course applicable to members of the Organisation, in this section the term ‘practitioners’ includes all Complementary and Alternative Practitioners. It is against the interests of the Organisation to have distrust or disputes between practitioners. Members shall at all times conduct themselves in a professional manner in their relations with other practitioners.

C.1. Transfer of a patient

Action taken by a member to persuade the patient of another practitioner or of his principal (If he or she is employed as an assistant), or of a clinic in which he or she may be working, to patronise him or her is in all circumstances unethical and contravenes this Code of Ethics. In consequence it is advisable that members should apply a clear and proper procedure when exchanging or referring patients or dealing with the patients of other practitioners.

When a member treats a patient of another practitioner (referred by the other or not) due to holiday, illness, or any other reason, the member should consider himself or herself to be under an obligation to encourage the patient to return to the original practitioner as soon as the practitioner can accept them back for treatment, and to inform the original practitioner as to which patients have been treated and the treatment that has been given.

In the same way, when a patient attends a second practitioner because the original practitioner has for any reason neglected to refer them or give them advice on where to go, the obligation on the second practitioner still remains the same. An exception to this may be if the original practitioner indicates that he or she wishes otherwise.

Any such attempt would, in the view of the Organisation, amount to soliciting the patient to accept treatment when he or she had not specifically requested it and would therefore be constructed as unethical conduct.

Where a patient transfers to another practitioner for any reason, e.g. change of location; all possible help should be afforded to the second practitioner if requested.

If a patient chooses for personal reasons to transfer to another practitioner without the knowledge or recommendation of the original practitioner, it would be advisable as a matter of courtesy for the second practitioner to inform the original practitioner before making any further arrangements, so that any relevant information may be exchanged.

C.2 Denigration

No matter how justified a practitioner may feel in holding critical views of a colleague's competence or behaviour, it is unprofessional and would be considered unethical that he or she should communicate such an opinion to a third party.

Not only might such criticisms be considered unjustified or slanderous, but also it is contrary to good practice that the confidence of the public should be undermined because of personally held views.

A member, to whom criticisms of a colleague's competence are communicated, whether he or she be a member of the Organisation or not, should at all times act with discretion and should himself express no opinion. An exception to this is when a member needs to refer a complaint to the Organisation.

RULE THREE

No member may advertise or allow his or her name to be advertised in any way, except in the form laid down by the Council of the Organisation. See advertising format.

RULE FOUR

Members shall not give formal courses of instruction in a Chinese Medical Therapy without approval of the Committee of the Organisation.

The Council of the Organisation has no wish to impede the free flow of information between fully qualified practitioners of acupuncture. Nevertheless, at a time when the major professional organisations are making great efforts to standardise and improve the teaching of acupuncture in this country, it is undesirable that there should be an uncontrolled proliferation of courses, 'colleges', etc; the spread of which can only further confuse the general public as to the qualifications of acupuncturists practicing in Ireland.

Lecturing to medical and paramedical groups and the public, in order that they may better understand the work of the qualified acupuncturist, the scope of his or her services and overall role is perfectly acceptable. The permitted scope of such lecturing is largely a matter of common sense in interpreting these guidelines. However, such lectures should be strictly informational and should not be promoted or constructed as being 'training' in the theories or techniques of acupuncture, or any TCM therapy.

The training of an individual or individuals by a member in the techniques of acupuncture, herbalism or tuina without the express consent of the Committee of the Organisation is strictly forbidden. The only exceptions to this rule are:

- Where the training is done by a member under the auspices of a teaching establishment approved by the Organisation.
- Where the member is training other qualified practitioners of acupuncture and
 - The contents of the course have been vetted and approved by the the Organisation and
 - Completion of the courses does not lead to any qualifications, degrees, certificates; etc; apart from certificates of attendance, except where these have been approved by the Council of the Organisation.

In this section the word ‘training’ includes any lectures, demonstrations or study material given to individuals with the implication that the satisfactory completion of said work will enable them to refer to themselves as ‘Acupuncturist’s’, or lead them to believe that they will be qualified to practice acupuncture on the general public.

The above rules do not preclude the participation of students of acupuncture teaching establishments approved by the Organisation as observers, and in so far as they are qualified, as assistants in a member’s practice. Whenever acupuncture students are permitted to participate in the work of a member, the member must ensure that:

- The teaching establishment where the student studies has been consulted and permission obtained.
- The student is never allowed to perform any function, which he or she is not fully trained to carry out.
- Where case taking is observed or confidential information is discussed, the consent of the patient is always obtained before allowing the student access to this.

RULE FIVE

It is required that members apply the Codes to all their professional activities.

A. Membership of other Professional Organisations

Members of the Organisation may belong to other organisations whose ethical standards may differ from those of the organisation. Such members must accept that their dual membership does not give them any immunity from the consequences of contravening the regulations of the Organisation, whether contained in it’s Memorandum and Articles of Association, this Code of Ethics or any rules, memoranda, recommendations or advice issued by the Committee of the Organisation for the conduct of it’s members.

RULE SIX

Infringement of the Ethical Code renders members liable to disciplinary action with subsequent loss of privileges and benefits of the Organisation.

APPENDIX VIII

Disciplinary and Grievance Procedures

Irish Society of Homeopaths

ARBITRATION AND DISCIPLINARY PROCEDURES

31. Failure by a Full Member to observe the provisions of either these presents or the Code of Ethics of the Society or any other standards or regulations made by the Society may render them subject to arbitration and/or disciplinary procedures, upon receipt of a complaint against them.
64. The Committee shall appoint one of its members to be the Arbitrator who shall be responsible for the maintenance of standards within the Society and to investigate all complaints against Full Members.
65. Complaints received by the Society concerning Full Members shall be referred to the Arbitrator and the member concerned and the Registrar shall be notified without delay of the fact that a complaint has been made against them.
66. Enquiries into complaints must be made impartially by those involved and they shall conciliate, where possible, by frank discussion and exchange of letters. The Arbitrator shall endeavour to resolve the complaint where necessary in consultation with one other Committee member and/or specialist advisors. The results of investigations and mediations shall be made known in writing to both the complainant and the member involved, and a report made to the Committee.
67. Where conciliation has proved unsatisfactory or unacceptable to any of the parties involved, or to the Committee, the disciplinary procedure, referred to at Articles 68 to 77 shall be followed.

DISCIPLINARY PROCEDURES AND DUTIES OF THE CONVENOR

68. The Arbitrator shall appoint a Convenor who shall be a Registered Member to conduct the hearing. More than one Convenor may be appointed to hear different cases occurring at the same time.
69. The Convenor shall appoint a mutually agreeable Registered Member to be supportive of the homeopath who is subject to the disciplinary procedure and a Registered Member to represent the complainant, if so desired.
70. The Convenor shall notify all parties and invite them to appear at a hearing with or without representation and any witnesses on their behalf. The Convenor shall also seek from each party written statements of all allegations, evidence, or other relevant material they wish to be available

at the hearing. Copies of such documents shall be sent to each party at least twenty-one days before the hearing.

71. The Convenor shall arrange a time, date and place for the hearing, notify all parties at least twenty-one days beforehand and shall nominate and ensure the attendance of a panel of three Registered Members, who are not Committee members, and one other person who is neither a member of the Society nor a homeopath, with full voting rights in this instance.
72. Where the homeopath under investigation is a member of the Committee, the panel may suspend them on the basis of the written submissions, until a final decision is made.
73. The Convenor shall attend the hearing, as an observer, but may take no part in its decision.
74. The Convenor shall communicate in full confidentiality, within seven days, the decision of the hearing to the Committee members, for ratification at the next meeting. Upon ratification by the Committee the Convenor shall notify, in writing, within seven days, the decision of the Committee to the complainant and the member, giving the latter notice of their rights to appeal.

THE PANEL IN DISCIPLINARY HEARINGS

75. The panel, as convened, shall consider all written and oral evidence presented to it by all parties and witnesses attending the hearing.
76. The panel shall dismiss a case unless they consider beyond all reasonable doubt that the member has contravened or insufficiently observed any provisions of these presents or the Code of Ethics of the Society or any other regulations of the Society. In this instance, the panel shall impose a penalty on the member from the following categories: a warning; a demand to give a written undertaking not to re-offend; a reprimand, a suspension; an expulsion from membership. The panel may, in addition or as an alternative to the above penalties, recommend that a member should embark on a period of counselling or supervision or training which is relevant to the matter in hand.
77. The panel shall make its report to the Convenor within twenty-eight days of completion of the hearing.
78. The Committee shall have the discretion to reimburse any reasonable out of pocket expenses incurred for work undertaken in the course of a panel hearing.

APPEALS

79. A Full Member can, within twenty-eight days of the date of the notice of the decision of the Committee, give written notice of their intention to appeal to the Society. Such notice shall state therein the grounds for such an appeal.
80. An appeal may be made on the grounds that:
 - (a) there is evidence which was not available at the panel hearing; or
 - (b) there is evidence that procedures were not properly followed; or
 - (c) the appellant considers that he/she has been unjustly or unfairly treated in the adjudication process generally.

81. Within three calendar months of receipt by the Society of the notice of intention to appeal, an appeal hearing shall be convened by the Secretary of which at least twenty-one days notice in writing shall be given to all Registered Members of the Society.
82. An appeal meeting shall be held in camera, consisting of twelve Registered Members, of whom eight shall be a quorum, who are neither members of the Committee nor the panel, the appellant with or without representation and the Arbitrator with or without representation.
83. Both parties to the appeal may supply written evidence in advance to be sent with notice of the meeting and provide written and oral evidence to the appeal meeting and to call any witnesses on their behalf.
84. Upon completion of the evidence from both sides, the Registered Members to whom the case has been presented shall make their decision. A decision of at least three-quarters of those members shall be final. In the absence of such a majority, the appeal shall be upheld and the decision of the panel set aside.
85. Within seven days of the appeal decision, the Secretary shall notify the complainant and the member concerned and any suspension or expulsion shall commence fifteen clear days from the date of such notice. All outcomes of the arbitration and disciplinary procedure shall be made in writing to the Registrar by the Arbitrator, who shall keep a confidential copy.

