Complementary and alternative therapies are a mixed group of therapies considered low priority treatments on the basis of weak evidence of clinical effectiveness. These will only be provided under the NHS as part of an existing service, and where there is a commissioned pathway, when:

- The individual therapy used for a specific condition has been critically appraised and has been shown to have proven clinical effectiveness
- The training and practice of the therapist is regulated by a statutory regulatory body.

**Definition:**
Complementary and alternative therapies comprise a wide range of disciplines. We have adapted the classification used by the House of Lords Select committee, which divides these therapies into three groups:

- **Group 1** – those which are regarded as the principle disciplines:
  - Group 1a – with statutory regulatory control – osteopathy, chiropractic
  - Group 1b – acupuncture, herbal medicine and homeopathy

- **Group 2** – therapies used to complement conventional medicine without embracing diagnostic skills, e.g. massage, aromatherapy, hypnotherapy, reflexology and the Alexander Technique

- **Group 3** – therapies which are long established and rational in certain cultures, for example, ayurvedic medicine
  - Group 3b – others with no credible evidence such as crystal therapy and dowsing.

Whilst some evidence of effectiveness exists for therapies in Group 1, the clinical effectiveness of the majority of these therapies has not been proven with strong evidence as obtained through properly established scientific trials. Some NHS professionals use a selection of these therapies in their practice, for example, physiotherapists using manipulation or acupuncture, or GPs using homeopathy. With effective regulatory mechanisms in place for individual professionals and under NHS clinical governance arrangements, the use of such therapies is acceptable.
**Resource implications:**
This policy does not change current practice; therefore, the resource implications remain unchanged.

**Health Benefits:**
While some complementary treatments may give health benefits, these have proved difficult to quantify. A placebo effect can lead people (both patients and therapists) to conclude that a treatment is effective when it is not. This is true for new treatments in scientific medicine as well as for complementary and alternative medicine. This is why new scientific treatments are subject to experimental trials and the evidence of effectiveness is critically appraised. There is little good quality evidence comparing alternative therapies with other treatments, and this makes it particularly difficult to judge the health benefit of the therapy.

**Risks:**
In general, these are likely to be low, but should not be ignored. Adverse reactions to herbal medicines can be due to toxic compounds, interaction with conventional drug treatments, heavy metals or corticosteroids in the preparation as well as to the herbs themselves. Infections linked to acupuncture and the improper handling of needles or their reuse, without sterilisation, has included Hepatitis B and C, HIV, bacterial endocarditis and staphylococcal septicaemia. It is accepted that these are rare events, but they highlight the need for therapies to be used by properly trained and accredited professionals in a controlled environment.

**Regulatory framework:**
National developments such as the relatively recent creation of the General Osteopathy and General Chiropractic Councils will help establish accreditation and quality standards for professionals in Group 1a as defined by the House of Lords Report.

**Priority**
Due to low evidence of effectiveness, complimentary therapies will only be funded in exceptional circumstances and where they are incorporated into mainstream NHS practice.

**REFERENCES:**
Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy. Individual cases will be reviewed as per the CCG policy.

<table>
<thead>
<tr>
<th>Approved by (committee):</th>
<th>Health and Care Commissioning Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date approved:</td>
<td>August 2019</td>
</tr>
<tr>
<td>Produced by:</td>
<td></td>
</tr>
<tr>
<td>Updated by:</td>
<td>Clinical Effectiveness Manager</td>
</tr>
<tr>
<td>Review date:</td>
<td>August 2021</td>
</tr>
</tbody>
</table>