AN ADMINISTRATOR'S GUIDE FOR ANIMAL FACILITATED THERAPY PROGRAMS IN FEDERAL HEALTH CARE FACILITIES

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The opinions or assertions contained herein are the private views of the author and are not to be construed as official or as reflecting the views of the Department of the Army or the Department of Defense.

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Animal facilitated therapy has positively impacted upon a wide variety of both in-patient and outpatient medical treatment programs. This study outlines a variety of issues and answers surrounding the inclusion of animals into health care organizations and their respective treatment programs. It also details a pilot program and proposed guidelines for Texas.

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AN ADMINISTRATOR'S GUIDE FOR ANIMAL FACILITATED THERAPY PROGRAMS IN FEDERAL HEALTH CARE FACILITIES

INTRODUCTION

The current trends in health care delivery indicate that supporting the outpatient is becoming a significant factor in controlling the demand for limited medical resources. The use of animal facilitated therapy starts in the outpatient setting, and can continue through inpatient care and into the post-illness period. While the use of animals can assist a therapy program, it should only be done with forethought and effective interdisciplinary cooperation, if long-term benefits are the goal.

Animal Facilitated Therapy (AFT) can take multiple forms, and these forms have not yet been fully explored. Animals can provide distractions, security, companionship, neutral means for communications, nonjudgemental love, stress reduction, and a host of other benefits and aids to the medical therapist; the limits of use have not been reached. The animal can be a full time pet, a visiting animal, a tactile stimulus, a visual environment, or an animal in the wild. These benefits, or the forms of involvement, are by no means inclusive. The examples and limits provided herein are reflective of the space available, not the applications possible.

Besides for guiding the administrator through the decision process for AFT, the purpose of this pamphlet is to provide the health care team alternative therapy methods, adjunctive therapies to the methodologies already in use, or just insight into already existing relationships that should be considered in therapy regimens for animal owners. The effectiveness of this program will be dependent upon the concern and cooperation of the local interdisciplinary team. It is critical to understand that animal facilitated

therapy is not a panacea, nor is it applicable to all situations; AFT must be tailored to the patient's needs as well as the therapist's/interdisciplinary team's abilities.

AN ADMINISTRATOR'S GUIDE FOR THE USE OF ANIMAL FACILITATED THERAPY PROGRAMS IN FEDERAL HEALTH CARE FACILITIES

CHAPTER ONE

INTRODUCTION TO ANIMAL FACILITATED HEALTH CARE SERVICES

A. INTRODUCTION:

A "new" health care service has begun to appear in the journals, yet many are finding that it has already been in use for thousands of years. Todays health care professionals are beginning to discover and recognize the meaning and significance of the human/companion animal bond. This bond plays a weakly defined role in maintaining and improving human mental, physical, emotional, and social health, as well as the general well-being of the patient (1). In response to this recognition, various health care delivery teams have developed basic principals concerning use of human/companion animal partnership programs. These principals have been designed to communicate the value of animals to people and people to animals, and have promoted positive interaction between the two. The programs have demonstrated the benefits of animals in therapy for the handicapped, aged, troubled, and lonely. The programs have also informed the participants about their responsibility as animal owners, and provided health care professionals with another methodology to assist in family and individual diagnostic, sociodynamic and therapeutic processes. This study is designed to demonstrate the rationale applicability of these proven programs (1-47) to the health care delivery system, especially when considering the administrative hurdles and concerns.

B. OVERVIEW OF SITUATION:

University of Minnesota studies (2) indicate that more than 50 percent of households in the United States have companion animals. Most people accept the idea that pets are beneficial, but the nature of the benefits and the need for further development of potential advantages have been inadequately explored. There is little evidence from epidemiologic studies or other scientific sources on when, where, for whom, and under what circumstances pets are or are not beneficial. Because of the therapeutic influence of pets on their owner's mental state and the dependence of a large proportion of the population on their relationships with their pets, the nature of these relationships deserves thorough study. The interaction of humans and animals in the environment has extensive health and financial implications. Removal of animal feces from city streets, prevention and treatment of zoonotic diseases of people, socialization between individuals, reduced mortality following hospitalization of pet owners, and the feeding, training, and care of small and large animals are examples of such implications. The effects of human-animal interaction on community, family, and animal health has extensive impact upon the home, the political environment, and the health care delivery systems.

C. AFFECTS ON DEPENDENT CHILDREN:

Multiple surveys have showed that about 99.2% of the respondents felt that children should have pets (2,26,28). Researchers like Carithers (3) strongly supported children having pets, as benefiting both development and

mental health, as long ago as 1958, but there was a lack of scientific data on the role pets play in the psychosocial maturation of children. The University of Minnesota (4) has been conducting a project to study the emotional relationships of several different groups of youths to their pets. The youths compared included high school students, adolescent patients in psychiatric hospitals, and youths in state correctional facilities. In this Minnesota study, these adolescents were asked questions regarding how they felt about their pets, their degree of attachment to their pets, how they might have felt about losing their pets if they did, and the importance they assign to having a pet for children while growing up. Preliminary indications seemed to reveal significant differences between delinquent and nondelinquent groups in regards to having lost their special pet. A very significant finding was the great depth of feelings expressed by each group for their pets and the importance the adolescents gave to their pets regardless of their status. Wolfe (5) also found that pets provided consolation, reduced stress, and facilitated adaption to traumatic events. The role of pets in the psychosocial development of adolescents, as shown by these studies, becomes a concern to the family and health care providers dealing with adolescent stress or development in todays highly mobile family/community situation.

Susan P. Stephenson, in an article on Child Welfare (6), explored novel approaches to therapy with latency age children (approximately 9 to 12 years). One of these was the use of pets. Primary advantages were that the animal can be cuddled, can be talked to but cannot talk back or be critical, and can aid in the therapist's communication with the child. In a review of

children and companion animals, published in Child Care and Health Development (7), Alisdair MacDonald felt that although little research has been done on the bond between children and animals, there was sufficient evidence to support the use of pets in a therapy situation. With the "baby boom" population being about 30 years old, the young, upwardly mobile families with young children are of primary concern when addressing the quality of life and the health care delivery systems that must be developed to effectively meet the needs of today's changing life styles.

Boris M. Levinson, Ph.D., has conducted many studies in the field of human/animal bonding and interaction, and has provided some key observations of importance to the family and the health care community. In an article published in Psychological Reports (8), Dr. Levinson provided a brief review of myths and folklore which used animals as a vehicle to depict ethical values, then focused on the role of companion animals in personality development. Not only were animals considered to contribute to a life style of nurturance and companionship, but they also were found to foster the development of such traits as empathy, self-control, self-esteem, and autonomy. Levinson explained that the greatest impact occurred in childhood and old age (taking the position that the process of personality development continues throughout life). He found the area of animal/human interaction neglected by researchers and suggested some hypotheses for empirical study that apply to both the mobile family and the health care delivery system. In an article titled, "Pets, Child Development and Mental Illness" (9), Dr. Levinson discussed the interrelationship between child development, emotional

disturbance, and the presence of a pet. Levinson felt that a pet became an influential factor in the child's life after the child was six months old, a time when the child begins to differentiate himself from the external environment. Throughout childhood, a pet influenced learning processes, emotional development, and interpersonal relationships; these factors alone provide many family implications. Levinson also explained that the pet helped the child deal with tension arising inside and outside the home, and elaborated on how the therapist could utilize pets in the office and home situations. The pet provided direct benefit to the child and gave the enlightened therapist insight into the child's problems and course of treatment.

In addressing, "Pets: A Special Technique in Child Psychotherapy," published in Mental Hygiene (10), Dr. Levinson took the position that with some children, pets must be incorporated into the treatment plan. This was particularly true in dealing with autistic children, where the animal strengthened their contact with reality. Specific recommendations were made for the type of pet that may be best suited for children with different types of emotional problems. For example, children who have difficulty in relating socially to peers seemed to benefit most from contact with larger animals. Significant case studies have been reported in recent conferences (2,42) concerning the exceptional improvements in autistic teenagers when animal facilitated therapy was used. In another Psychological Report article (11), Dr. Levinson enumerated the benefits of using animals in therapy with children, and went into a detailed comparison between pet therapy and play

therapy. He concluded that animals elicit a wider range of responses from the child because they elicit love and reaction in a way that is totally different from inanimate objects. With the trauma associated with the high mobility of today's family, these socialization processes appear extremely important.

D. AFFECTS ON RETIRED POPULATIONS:

Dr. Levinson has addressed "Pets and Old Age" in an article published in Mental Hygiene (12). He felt that pets, in varying ways, could alleviate problems confronting the older and retired person. This included providing affection and an affectional outlet as well as increasing physical activity and contact with others; the pet also reassured the person of their worth. Levinson recommended immediate replacement in the event of the pet's death. The impact of these concepts on the treatment of the elderly has multiple implications, especially considering the ever increasing life spans of today's patients.

Dr. Leo Bustad, who presided over Washington State University's veterinary health education program from 1973 to 1983, is regarded internationally as one of the top authorities on the use of animals as a therapeutic tool to benefit the aged. He has written a thoughtful discussion of the physical, psychological, and social problems faced by the elderly in a text titled, Animals, Aging and Aged (13). In this book, he discussed how animals have contributed to understanding the aging process, to improving geriatric medicine, and to providing companionship and assistance to the elderly. "The greatest problem confronting the elderly is not their physical ailments, but the loneliness and rejection they may experience," he explained, "By providing love and companionship, animals can give the elderly a purpose

and meaning in their lives at a time when they are often alienated from society." In Bustad's book, studies were cited showing how animals can help the elderly maintain their independence, prompt them to take better care of themselves, and encourage social contact. He also presented, for the first time in the scientific arena, evaluative tools for choosing the appropriate pet. Dr. Bustad devoted two chapters to a discussion of the contributions animal life-span studies have made in understanding the aging process. He told how such studies have indicated that changes in life-style may reduce the effects of many chronic degenerative diseases, including cancer, coronary heart disease, and chronic brain disorders. These factors make the human/companion animal relationship critical to the treatment of retired and elderly patients.

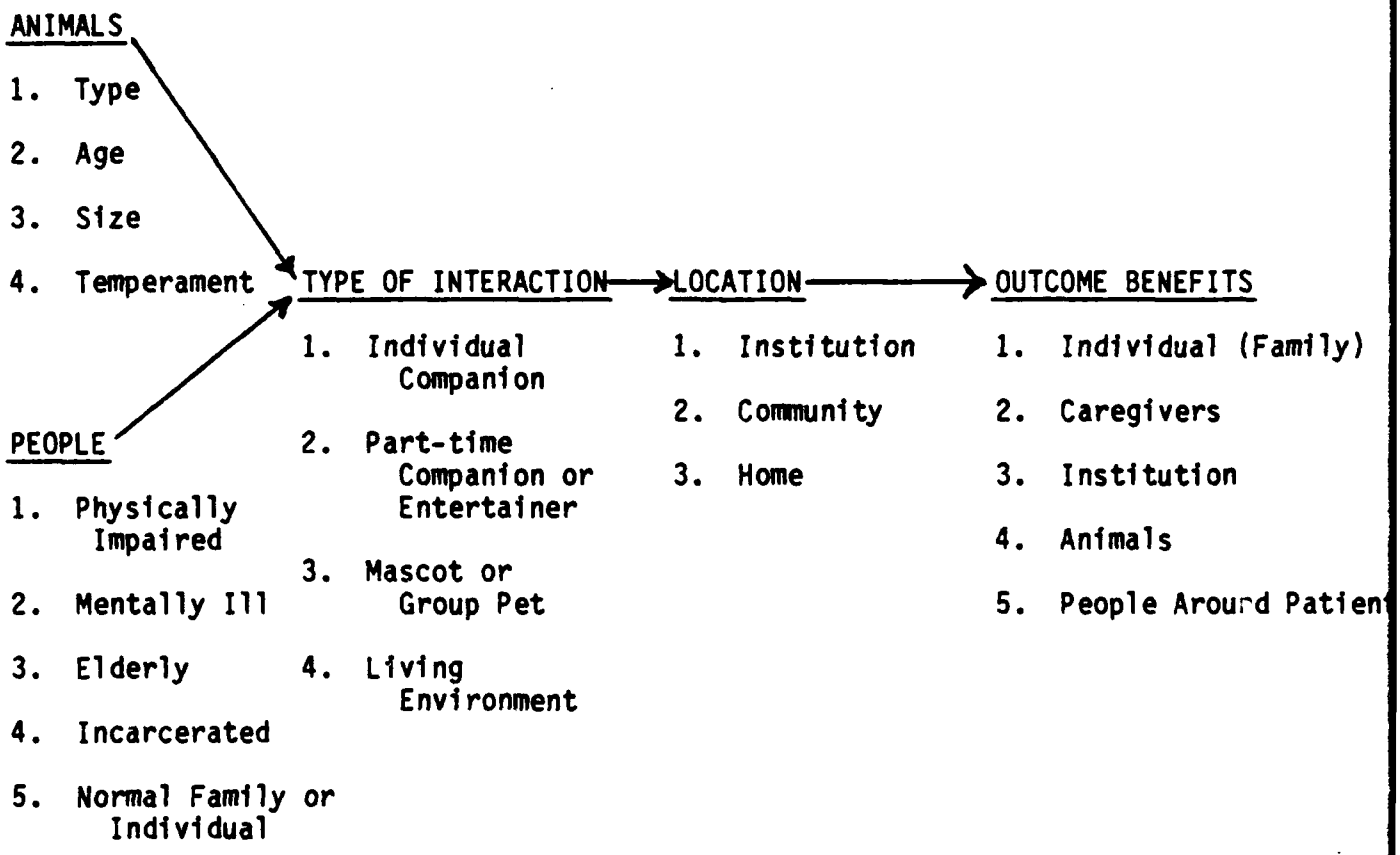
E. ANIMALS IN THERAPY:

Dr. M. J. McCulloch has addressed in lecture (14) a strong statement for the use of pets in combating depression, loneliness, isolation, feelings of hopelessness, and low self-esteem related to medical problems. McCulloch used case histories and research data to support his position. In one study, the support provided by a pet was rated as equal to that provided by spouse or by employment. This has many implications for the separations experienced by military or upwardly mobile families. Dr. McCulloch provided extensive guidelines to be followed when including a pet in the therapeutic procedure and developed a model for Animal Facilitated Therapy (AFT), with an illustration of the concept as shown in Figure 1.

Figure 1.

ANIMAL FACILITATED THERAPY MODEL

Michael J. McCulloch, M.D.



Recent research by Friedmann, Katcher, and Meislich (15), and by Gundy (16), has indicated that the pet ownership can be beneficial to people's health. Proposed benefits of pet ownership included reduction of anxiety as well as decreased feelings of loneliness and depression. In their study of patients hospitalized for coronary heart disease, 50 of 53 pet owners were alive one year after hospitalization compared with 17 of the 30 non-pet owners. The association of pet ownership with survival was independent of the patient's health status. While pet ownership may provide health benefits, it may also present difficulties for sick and/or hospitalized owners. To explore pet related problems associated with hospitalization, Friedmann, Katcher, and Meislich (15) surveyed 100 patients about their pet ownership status. Pet owners were asked about care for and contact with their pets during hospitalization. Pets usually were cared for by other family members or friends. Difficulties in placing pets usually did not affect hospitalization, however, hospitalized patients demonstrated concern about their pets. A majority of pet owners maintained daily contact with their pets by either speaking with the pet's caretaker or speaking directly to the pet by telephone. Evidence suggested that pets remained both major sources of support and concern for their hospitalized owners. Owners required frequent reassurance about their pet's welfare during hospitalization, but pets continued to provide a sense of being needed and an impetus for quick recovery for their hospitalized owners.

A two-year longitudinal study of the impact of cats on a geriatric ward was conducted by Bricket (17). The primary contact was the cats' lying on the

patients' laps, where they were hugged, stroked and talked to by the patients. The majority of the staff reacted positively toward the cats and felt that they provided entertainment, a source of comfort and affection, enhanced responsibility and self-esteem, and served as a catalyst for social interaction between patients. In another study, Fields (18) reported a comparison on the effects of placing dogs in nursing home wards and with residents of apartments within the same nursing home complex. In both situations the introduction of the dog increased peer interaction and brought about an improved life style. In reviewing statistical data on nursing homes, the Corsons (19) discussed the psychological impact of entering and living in the nursing home environment, which was often characterized by loneliness, depression, and mental and/or physical deterioration. The Corsons took the position that the positive nonverbal cues that patients receive from pets could counteract the negative nonverbal cues they frequently got from other people, breaking a vicious cycle and providing a turning point for improving the patients' emotional well-being.

Katcher, Friedmann, Beck and Lynch (20) were able to demonstrate that dialogue with pet dogs, in which the animals were both talked to and petted, lowered blood pressure below resting levels, while talking to human beings uniformly raised blood pressure. Study of children in a home environment also revealed that the presence of a dog alone, without overt interaction, resulted in lower blood pressure, both when the children were resting and when they were reading aloud. In another series of investigations, they measured blood pressure and heart rate while people looked at tropical fish. The fish were a

part of the visual environment, and did not have the capacity for the interaction possessed by dogs. The experiments began with a period of equilibration in which subjects were seated opposite a blank wall. When subjects were placed in front of the fish tank with instructions to do nothing but watch the fish, both systolic and diastolic blood pressure fell. The largest reductions in blood pressure were observed in subjects with elevated blood pressure. Reductions observed when people watched tropical fish were similar to those reported with the more cumbersome procedures of biofeedback and meditation. The results of the experiments described here suggest that the living environment can have an important influence on stress and blood pressure. When this information is applied to the military member responding to alerts or other military missions, the interaction of military family members with companion animals, and other parts of their living environments, may be able to make an important contribution to their quality of life, health, and sense of well being.

F. PETS ROLE IN CHILD ADVOCACY PROGRAMS:

Hutton and Herts (21) conducted a pilot study in 1980, based on the assumption that the companion animal is an integral part of the dynamics of family life and could therefore act as a diagnostic indicator of "abuse" within families. Free ranging interviews were used to obtain primary data on pet-owners known to the local humane society representatives as animal abusers. Utilizing the names and addresses provided by the primary source, a wide range of secondary sources was used to gather information relating to

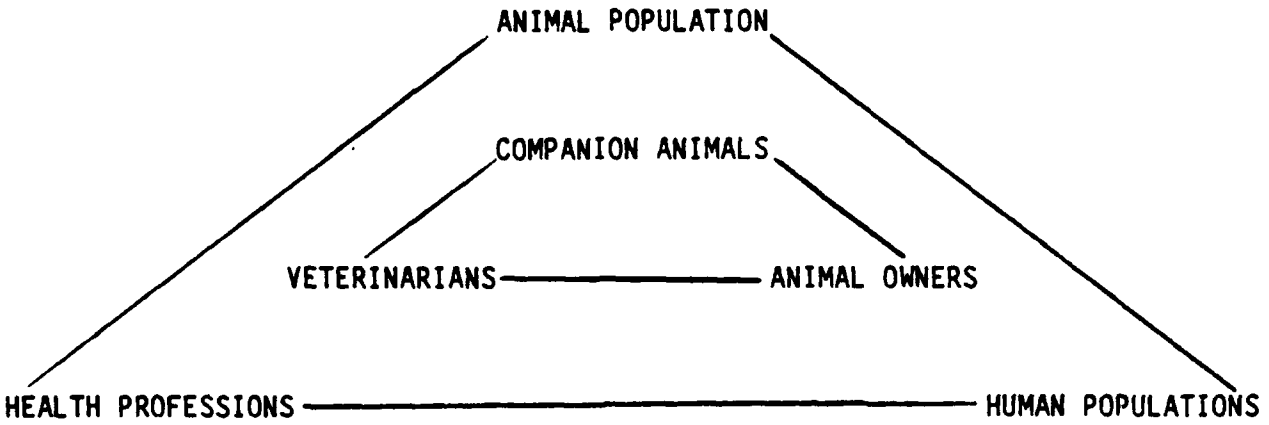
these families (including personal, family, and business networks, as well as direct and indirect interviewing). The two sets of data were then analyzed to see if subjects were known to local agencies (Social Services or Probation) and whether the descriptions of the abuse were similar in a general picture of the family. In this pilot study sample, over 80% were known to the social services, 50% to probation, and only 6% were not know to either agency. The Hutton and Herts study indicated a potential multi-disciplinary addition to the diagnostic tools of the military or community child advocacy program.

SUMMARY

The seeing-eye dog has been proven essential in animal facilitated therapy for the visually impaired. The hearing-ear dog, a more recent adjunct to animal facilitated therapy, has shown to be invaluable for many deaf persons. Equine therapy (riding) has become an accepted method of facilitating socialization and physical function in many physically/mentally challenged children and adults (22) (23). The caring heart dog has not yet been universally accepted as essential in animal facilitated therapy, yet research by Corson (24) shows an important role in fulfilling two basic psychological needs -- the need to love and be loved and the need to feel that we are worthwhile to ourselves and others. Dr. James L. Lynch has also examined this relationship and concluded that the essence of the bond is companionship, and that the nonverbal communication involved is very effective (25). The relationship between the health and allied professions and the human and animal populations has been depicted in the Greek Delta Triangle (Figure 2), and represents the complex interdependence of those relationships (25).

Figure 2.

HUMAN-ANIMAL INTERDEPENDENCE RELATIONSHIPS



The companion animal becomes extremely important to the health care provider when considering the highly mobile family, especially when stressed by military life, the social development of dependent children during relocations, and the related human/companion animal bonds formed within the family partnership. As progressive health care providers and professionals, this therapeutic and diagnostic tool, the companion animal, can no longer be ignored or discounted when providing holistic medical health care services.

CHAPTER 2

THE IMPORTANCE OF THE FAMILY PET WITHIN DoD

A. BACKGROUND:

The Department of Defense (DoD) human/companion animal bond family survey was developed to evaluate four factors: a cross section of American pet owners, the mobile military family group, the pet's role in the quality of life of service members, and the pet's role in community health. The baseline concepts were developed from Dr. Ann Cain's 1977 62-family survey titled, "A Study of Pets in the Family System" (26). The DOD survey questions were developed from the subjective responses to the Cain study, then expanded based on the professional health care experience of the DoD veterinarians, social workers, and psychiatry officers at the U.S. Army Health Services Command. Collaboration between Dr. Cain and Dr. Catanzaro helped refine the questionnaire into the final 32 question, computer-ready format.

To properly analyze the mobile Department of Defense family's opinions of human/companion animal bond factors, 1500 copies of the ten-page, 32-question survey were distributed to 63 DoD installations in August 1982; 961 surveys were returned (64%). The effects of human/animal interaction on community, family, and animal health has extensive impact upon the DoD member, the DoD installations, and the DoD health care delivery system. Results showed significant sociological and psychological factors that influence the quality of life of the mobile DoD member and the family. These factors would be expected to similarly influence upwardly mobile civilian families.

B. RESULTS:

The respondents reflect a varied cross-section of the American population. The average person completing the survey was: The father-34.9%, the mother-53.9%, an other adult-9.4%, and a child-1.7%. The economic status included: 59.7% enlisted personnel (average income $1100/mo), 3% warrant officers (average income $1500/mo), and 37% officer (average income $2000/mo). Of the respondents, 93.3% had pets while growing up: 710 had dogs, 448 had cats, 227 had birds, 150 had rodents, 176 had rabbits, 239 had fish, 95 had reptiles, and 88 had other type animals for pets. Of the respondents surveyed: 99% felt children should have pets, 66.0% visit their veterinarian two or more times per year per pet, and 66.3% use a civilian veterinarian as well as the DoD veterinarian. It was reported that 34.5% usually celebrate their pet's birthday. When asked about display of their pet's picture, 53% displayed pictures at home and 10.1% displayed pictures at their job site.

When asked about reasons for selecting their companion animals, respondents rated, in order of priorities, their reasons as follows:

Table 1. Reasons for Selecting the Family Companion Animal(s)

WHY DID YOU SELECT YOUR PET	WHAT WERE THE CONSIDERATIONS
1. Pleasure	1. Species
2. Companionship	2. Breed
3. Protection	3. Temperament
4. To teach children something	4. Sex of animal
5. Rescue an abandoned animal	5. Adult size
6. Replacement of person or pet	6. Appearance when young
7. Gift	7. Children wanted it
8. Breeding	8. Age
9. Stress relief	9. Appearance when grown
10. Sport	10. Ease of care
11. Pressure of friend	11. Economic to keep

Realizing that the companion animal is less important to some persons, questions were included in the survey to attempt to quantify the reasons. Respondents that did not have a pet (51 of the 961) were asked to rate their reasons, from the most important to the least important. Their answers are shown below:

Table 2. Reasons DoD Families State For Not Having Pets

1. Housing limitations (51.6%)
2. Inconvenience
3. Too much time required for care
4. Allergies or other health reasons
5. Too much responsibility
6. Recently lost pet, have not decided on replacement
7. Currently looking for a pet
8. Too expensive
9. Do not like pets
10. Behavior undesirable
11. Death too difficult

Respondents were also asked what they disliked about pets in their neighborhood. While 266 respondents stated "Nothing, I enjoy them," and 98 stated "Nothing, I'm indifferent," the remainder provided the following responses, rated from most disliked to least disliked:

Table 3. Reasons For Disliking Pets in the Neighborhood

1. Free roaming (61.6%)
2. Leave body waste/trash in other than owner's yard
3. Noise
4. Destruction of property
5. Danger of injury
6. Behavior with other animals
7. Behavior with people in neighborhood
8. Odor

In trying to determine why people thought children should have pets, as in 843 of the survey respondents, the survey asked what the respondent felt was gained by the child by associating with a pet. In order of most importance to least, the responses were: learning responsibility, companionship, pleasure, respect for life, gentleness, education in life processes, nothing. In evaluating the changes associated with bringing a pet into a household, the survey addressed family interaction changes. The factors and changes included:

Table 4. Family Changes Observed When an Animal Was Added To the Household

INCREASE	FACTOR	DECREASE
8.0%	Arguing	9.2%
59.3%	Affection expressed around pet	0.7%
6.8%	Travel and freedom	39.3%
70.1%	Happiness and fun	1.4%
63.5%	Responsibility	0.7%
51.7%	Time together as family (w/pet involved)	1.3%

In evaluating the expectations of pet owners, the survey asked the respondents to compare problems anticipated with what actually occurred. The following is a summary of problem areas:

Table 5. Comparison of Anticipated Animal Problems to Actual Experience

MORE PROBLEMS THAN EXPECTED	PROBLEM AREA	LESS PROBLEMS THAN EXPECTED
15.1%	Housebreaking	31.5%
17.8%	Discipline	27.0%
6.4%	Feeding	23.7%
10.6%	Behavior w/in family group	22.3%
11.9%	Location/Space/Territory	19.7%
18.1%	Grooming	17.1%
14.5%	Cleaning	16.7%

In attempting to evaluate why people used certain veterinarians, the reasons for selecting the military veterinarian versus the civilian veterinarian were compared. The comparison of the factors, listed in order of importance to the respondents, indicate two separate sets of values, as shown below:

Table 6. Reasons for Selecting/Patronizing Specific Veterinarians

CIVILIAN VETERINARIAN	REASON	MILITARY VETERINARIAN
1	Range/Scope of Services	10
2	Professional Skills of Veterinarian	3
3	Availability of After-hours Service	12
4	Convenience to Residence	2
5	Appointment Hours	5
6	Personality of the Veterinarian	4
7	Telephone Assistance	8
8	Cost of Services	1
9	Personality of the Staff	7
10	Veterinary Specialities on the Staff	11
11	Facility Appearance	14
12	House Call Service Availability	13
13	Knowledge of DoD Unique Problems	9
14	Parking	6

When asked what they would do if their pet became seriously ill, the difference in trust of the military versus civilian veterinarian became very evident; 53.1% would do whatever the DoD veterinarian recommended, but only 16.4% would do whatever the civilian veterinarian recommended. Other responses included: 27.1% would do whatever was needed if pet could be returned to normal health, 24.9% would do whatever was needed for the pet as long as the pet could live without pain or suffering, and 6% stated they would have the veterinarian put the pet to sleep if the cure exceeded a certain

dollar value (52.3% of these owners would spend $200-$250 before putting their pet to sleep). Economic considerations were further evaluated by asking how much did owners spend annually, per pet, for other than pet food. While 8.0% reported $200 or more per year, 28% stated they spent between 0-$30/year, 29.0% spent $40-$70/year, 22.0% spent $80-$110/year, and 12.0% spent $120-$190/year.

While independent subjective review of the surveys reflected 42% of the pets had "people-type" names, 28% had been named after "things or physical traits" and 30% were given "animal-type" names, the owners reported the following methods for selecting their pet's name: 23.4% after physical characteristics; 11.7% after TV show, movie, cartoon, or book character; 9.0% after a person; 7.7% after a previous pet; 6.2% after an object or place; and the balance as "other reasons."

When asked directly to evaluate how important their pet was to their family, 50.3% reported "extremely important," 33.8% reported "very important," 12.5% reported "important," and 3.3% reported "moderate to no importance." To better evaluate the importance of the companion animal, respondents were asked to rate the importance of their pet to them, in specific situations, on a line scale from "great" to "some" to "none," with the following results:

Table 7. Family's Perception(s) on the Importance of the Pet

SITUATION	GREAT IMPORTANCE	NO IMPORTANCE
At all times	75.4%	1.7%
Temporary absence of spouse	73.1%	6.7%
Free time/relaxation	71.5%	2.8%
Childhood period	69.6%	9.7%
Sad, lonely, depressed	68.4%	5.1%
Marriage w/o children	58.6%	25.5%
Temporary absence of children	53.2%	17.5%
During illness/after death of other	52.0%	13.2%
During crisis/separation/divorce	50.3%	16.3%
During moves or relocations	48.2%	17.5%
Teenage period	44.4%	16.1%
Unemployment	35.6%	31.4%

Besides questions concerning the importance of the pet to the family, other questions were posed to evaluate the respondents anthropomorphic tendencies. When asked how the companion animal fit into the family, 68.2% stated the pet had full family member status, 30.0% had friend status, and 1.9% of the pets were considered a possession/owned property. Later in the survey, the question was rephrased and the respondent was asked if the pet was afforded "people" status in the family. A line scale was used and the respondents were asked to rate the status from "always" thru "usually" and "sometimes" to "never." The survey indicated 70.4% felt their pet was

"usually" to "always" afforded "people" status (with 29.1% stating always), while only 3% stated they never gave their pet "people" status.

Many traits or attributes are credited to the companion animal during daily conversations, so the survey asked specifically what special characteristics did the pet display within the family. Again, responses were placed on a line scale from "great" thru "some" to "none," with the following extremes noted:

Table 8. Characteristics Observed in Family Companion Animals

GREAT DISPLAY OF TRAIT	CHARACTERISTIC	NO DISPLAY OF TRAIT
89.3%	Greet you upon coming home	1.5%
76.9%	Pet understands when you talked to him/her	0.8%
72.9%	Communicates to you	1.4%
59.6%	Demands for attention	2.3%
59.2%	Understands/sensitive to your moods	4.2%
49.7%	Stays close when you're anxious/ upset	10.8%
44.9%	Sleeps w/family member	34.8%
22.5%	Mimics your emotions	23.5%
11.8%	Hides or withdraws when you are anxious/upset	46.7%
10.6%	Expresses feelings that you cannot/do not	50.8%
3.8%	Develops illness when family tension high	74.9%

In evaluating the responsiveness of the companion animal within the family, respondents reported usually quick positive responses about 98% of the time for father or mother, and 90% for children. Realizing negative interactions occur, the question was rephrased and only about 26% reported usually quick negative responses to the father or mother, and about 31% toward the children. There was no significant difference between father and mother, or male child versus female child, in the pet's response. About one half the pets never showed a negative response to adults or children. Less than 1% of the animals never showed a positive response to an adult and less than 4% never showed a positive response to a child.

As with the Ann Cain study, pet owners were asked about who gets the most recognition in the family; the pet was slightly below (10%) the adults and children. When asked who gave the most recognition, the pet rated 5% above the children but 10% below the adults. Expanding on this theme, a question was posed concerning the pet's response when other family members were demonstrating affection; 78.0% of the pets wanted active involvement, while 6.8% never responded at all. The crisis or high anxiety family period was also questioned, and 59.1% of the pets usually wanted interaction with the family, with 8.0% remaining independent. The companion animal response to a new addition in the family group was surveyed; contrary to the stories of jealousy that we hear, 38.2% showed positive behavior changes, while only 16.3% showed negative behavior changes and 45.5% showed no change. Ann Cain also tested Bowen's theory of triangulating (27), that is, when tension between two persons exceeds a certain level, a third party is brought into the system to dissipate the intensity of the tension; this DoD survey showed while only 13.0% always see it occurring in the family group toward the pet, 47.7%

reported that it occurred with their pet sometimes to always. Also, 38.5% of the respondents reported that it never occurred with their pet.

Although the upwardly mobile civilian family move frequently in their first 10 years, it is by choice. The DoD community has a unique challenge with government-directed family relocations, often on short notice. The survey asked the respondents to predict what they were planning to do with their companion animal(s) when being moved/relocated:

Table 9. Family Intentions For Their Companion Animal at Relocation.

MOVE WITHIN COUNTRY	ACTION	OVERSEAS MOVE
59.8%	Take with you to new home	22.0%
12.2%	Ship to new home	27.3%
3.1%	Give away	5.9%
1.6%	Give to humane society	1.4%
1.5%	Turn-in for adoption	2.8%
1.1%	Sell	1.4%
1.1%	Turn in for veterinary disposal	1.0%
1.0%	Release to farm/woodland	0.7%
0.9%	Abandon	0.8%

Civilian and DoD families have common emotional stresses when a pet becomes lost, dies, or is killed. The respondents of this family survey reported that 94.4% of the families felt an important to extreme loss (with 58.8% feeling an extreme loss) and only 0.1% felt no loss. Another question dealt with the disposal method preferred for deceased companion animals, and the respcndents reported as follows:

Table 10. Family Preferences in Disposition of the Remains of a Lost Pet

FAMILIES SELECTION	METHOD OF DISPOSITION
37.1%	Bury in marked graves, but not pet cemetry
24.8%	Take to veterinarian/humane society for disposal
13.5%	Bury, but not anywhere special
11.5%	Bury with full ceremony in pet cemetry
2.6%	Let someone else do it
1.6%	Dispose of by standard waste removal services

C. SUMMARY:

In comparing the results of the DoD survey with the Cain study, certain relationships between the civilian and DoD communities become evident. Department of Defense families had a greater contact with pets while growing up. When considering the reasons for having a pet, both civilian and DoD families placed pleasure and companionship as the first two reasons, but then a divergency occurred. Department of Defense families placed protection as the third most important reason, possibly due to the temporary separation of the spouse common in DoD communities. the Cain study showed 7% of the respondents considered pets extremely important, compared to 50.4% in the DoD survey. This increased importance was also reflected for DoD families in all the subcategories, for instance: The most important time in the Cain study was when they were sad, lonely, or depressed (26%), compared to it ranking fifth (at 68.4%) in the DoD family; the first four DoD categories, at all times (11% Cain vs 75.4% DoD), temporary absence of spouse (6% vs 73.2% DoD),

free time/relaxation (none in Cain survey vs 71.4% DoD) and childhood period (6% Cain vs 69.6% DoD) probably reflect the family differences in a mobile society. The lack of importance during unemployment may be attributable to the lack of that threat in the DoD community. There was also a significant difference between the status afforded the pet; the Cain study reflected 36% afforded the pet person status, while the DoD study showed 71.7% considered the companion animal as a person.

In comparing the results of this DoD family survey to the recent Psychology Today survey, August 1984 (28), certain differences between the civilian family and DoD family should be noted. While the majority (62.7%) of the DoD respondents earned less than $20,000 per year, the Psychology Today respondents reflected the majority (74%) earned $20,000 or more per year. The DoD respondent was more likely to have had a pet while growing up and was more likely to believe children should have pets; the top three reasons for children having pets were the same, although they varied in rank of importance. There was a significant consideration in evaluating the importance of pets to the two survey populations, and that was the separation factor common to DoD families. While the Psychology Today survey reflected "lonely or depressed" as a particularly significant reason for animal companionship, the DoD family rated it as fifth (still 68.4%), after: at all times (75.4%), temporary absence of spouse (73.1%), free time/relaxation (71.5%), and childhood period (69.6%). The Psychology Today survey showed 16% treated their pets strictly as animals, compared to only 1.9% of the DoD families; 25% of the Psychology Today survey looked upon their animals as

human family members, compared to 29.1% of the DoD families. While the respondents in the Psychology Today survey reflected a great female influence (83% of the respondents), only about half of DoD survey respondents were women. The income and sex were two factors that varied between the surveys, and education was a third major variance. The Psychology Today respondents reflected 50% were college graduates, compared to 37% of the DoD respondents. These three factors, as well as the mobility of the DoD family, must be considered significant when comparing the populations.

While the family importance of the companion animal appeared significantly greater in the mobile DoD community when compared to the civilian community of the Cain or Psychology Today studies, the responses by the family's companion animal in family situations were very similar in both community settings. These initial subjective evaluations, based on the DoD survey, will require further investigations by multidisciplinary health care professional teams before valid conclusions can be stated objectively.

CHAPTER 3

FORENSIC/LEGAL CONCERNS and THE SPECTRUM OF ANIMALS AVAILABLE

A. INTRODUCTION

Like any new health care delivery program, animal facilitated health care has a few critics. The objections are based in both law and prejudice; often the laws are as much in error as the prejudice. The simple truth of the matter is that in promulgating the laws, most all states had not considered the positive effects of animals in health care delivery programs. The military community has not been much different, although sovereign immunity decreased liability concerns.

The doctrine of sovereign immunity meant that one could not sue the federal government for the torts of its employees. The injured party had to petition Congress directly by means of a private bill of relief, if he wished compensation. In 1946, Congress passed the Federal Tort Claims Act (FTCA) which was a comprehensive waiver of sovereign immunity. One of the purposes of the Act was to reduce the large number of private bills before Congress, since the legislative branch of the government is not a good forum for resolving these individual petitions involving complex problems of law and fact. The private bill of relief still exists, but it is used only when one cannot recover under the Act.

The FTCA allows the payment of money damages for injury, loss of property, or for personal injury or death, if caused by a wrongful or negligent act of an employee of the United States acting within the scope of his employment,

where the United States, if a private person, would be liable according to the law of the place where the act occurred. All claims under the FTCA must be first presented to an administrative agency for payment. If this procedure does not produce a settlement, an action may be filed in federal court. These cases are tried by judge alone, since Congress did not authorize a jury.

Most of the cases under the FTCA are suits against the federal government for the negligence of its employees. The employee is rarely sued individually because the federal government provides an easily accessible source of funds. Further, the Act states that a judgment under the Act, for or against the United States, constitutes a complete bar to any private action by the plaintiff against the government employee whose conduct occasioned suit against the United States. Case law holds that if the United States is held liable under the FTCA, it has no right of indemnity against the errant employee.

But what is the danger or hazards of an Animal Facilitated Therapy (AFT) program, and what has been the experience of agencies using AFT? What actions have states taken in response to the AFT programs? The University of Minnesota's CENSHARE (2) conducted studies to identify significant changes in laws and regulations which prohibit pets in nursing homes. In 1981, eight states prohibited all animals from nursing homes, but this decreased to only two such states by 1983. Fewer states, four, required a previous health certificate while more states, 14 were concerned with having a currently healthy animal. Thirteen states still prohibit all animals except by special permission or exemption. Ten states prohibit pets in patient rooms and nine

states prohibit specific animals, such as birds, turtles or wild animals. Although all states use general food sanitation laws to prohibit pets in food preparation areas, only 15 prohibit animals in medication and treatment areas. Laws and regulations in 33 states either do not address the issue of pets in nursing homes or do not prohibit animals except in food areas.

While the data in Tables 10, 11, 12, and 13 reveal a wide range of differences in restrictions among the states, it is interesting to note that none of the state health officials, in either 1981 or 1983, reported any problems of injuries or illnesses associated with pets in nursing homes. Results described in chapter one reflect the benefits of animals in health care facilities, and emphasize the need for rational guidelines based on actual epidemiological evidence.

TABLE 10. REGULATED AREAS FOR ANIMALS (per CENSHARE)

PROHIBITED AREA(s)	STATES NUMBER 1981	STATES NUMBER 1983	STATES PERCENT 1981	STATES PERCENT 1983
Food Preparation	50	50	100	100
Food Service	50	50	100	100
No Prohibited Areas Except Food	--	32	--	64
Medication and Treatment	16	15	32	30
Linen and Storage	16	14	32	28
Residents/Patients Rooms	11	10	22	20
Other Areas	10	8	20	16

TABLE 11. EXTENT OF REGULATION OF ANIMALS (per CENSHARE)

ANIMAL PROHIBITIONS	STATES NUMBER 1981	1983	PERCENT 1981	1983
All Animals from Nursing Homes	8a	2	16	4
All Animals Except by Special Permission	13	13	26	26
All Animals in Specific Areas	50	50	100	100
Specific Animals in All Areas	9	10	18	20

*a. Some exceptions were reported by six of the eight.

TABLE 12. TYPES OF ANIMALS SPECIFICALLY PROHIBITED (per CENSHARE)

PROHIBITED ANIMALS	STATES NUMBER 1981	1983	PERCENT 1981	1983
Birds	1	1	2	2
Domestic Turtles	1	1	2	4
Wild Animals	4	6	8	12
All Animals Except Fish	4	2	8	4

TABLE 13. REQUIREMENTS FOR ANIMALS PRIOR TO ENTERING FACILITY (per CENSHARE)

PRE-ENTRANCE REQUIREMENT	STATES NUMBER 1981	1983	PERCENT 1981	1983
Immunizations	13	14	26	28
Healthy Animal	10	14	20	28
Health Certificate	6	4	12	8
Appropriate Behavior	4	6	8	12

B. FORENSIC/LEGAL CONCERNS:

1. NEGLIGENCE

Any plaintiff who alleges negligent conduct on the part of a defendant must prove four elements in order to win his case: (1) the presence of a duty recognized by law, owed by defendant to plaintiff; (2) conduct on the part of defendant which violated this duty; (3) actual harm sustained by plaintiff; and (4) a causal relationship between this conduct and the harm sustained by plaintiff.

The standard of conduct, or duty, owed by defendant to plaintiff is generally stated to be that of a reasonable man in the same or similar situation as the defendant finds himself to be in at the time of the act in question. This is not necessarily what other people have actually done in the same circumstance, but what a hypothetical person would do--without demanding that hindsight be used to see what the "best" conduct would be under the circumstances.

This duty owed to the plaintiff by the defendant may vary depending upon the relationship between the parties. For instance, a doctor has a very limited duty to protect those who are in his office without his consent, such as a thief, from the hazards which exist there, but those who are in his office with the express or implied consent of the doctor may expect to be warned of hazards which are known to the doctor but would not be obvious to one unfamiliar with his office. A defendant doctor who gave the plaintiff an appointment but did not warn him when he arrived of the newly waxed floor in the reception office would therefore have violated his duty to the plaintiff.

The desired result of tort law as applied to negligence cases is to restore an injured plaintiff to his status before the injury, if possible, by compensating him for his loss by means of a monetary damage award. Given this basic policy, one can see why a causal relationship between the injury and the negligent conduct is required and why some actual harm must be alleged, before a plaintiff may take a defendant into court because a duty owed the plaintiff by the defendant was violated. Because of the difficulties of proving the breach of duty and causation of a specific injury in some negligence cases, particularly in medical malpractice suits when the plaintiff is unconscious, the doctrine of res ipsa locquitur has developed whereby circumstantial evidence may be used to prove these elements.

The general rule is that the doctrine of res ipsa loquitur is only used when the general experience of mankind shows that the result would not be expected without negligence. The modern view is that the doctrine is used if experts testify that the injury would not have occurred without someone's negligence. See Fricke, The Use of Expert Evidence in Res Ipsa Loquitur Cases (1959) 5 Vill, L, Rev 59.

2. CONSENT TO MEDICAL PROCEDURES

As has been shown in the cases dealing with negligence, the act or omission to act, with resultant injury, can be generally classified as accidental or unintentional in nature. Different principles of law leading to different consequences are found in those cases involving intentional torts; examples of this classification of torts are assault, battery, false imprisonment, invasion of privacy, mutilation of a dead body, and

misrepresentation. Intent to do injury is not a requirement in cases of that type; intentional conduct or purposeful action directed at invading the rights of the plaintiff, regardless of the purity of the motivation, is what gives rise to these causes of action. Hence, if one intends to touch another and does so without the other's express or implied consent, this constitutes a battery, even though there was no intent to injure.

The cases in this section deal with the necessity of and requirements for an informed consent by the patient for treatment and certain diagnostic procedures. If there is no consent, the question of whether to treat this as a negligent or intentional tort is debated at some length by various courts.

In sum, the patient's right of self-decision is the measure of the physician's duty to reveal. That right can be effectively exercised only if the patient possesses adequate information to enable an intelligent choice. The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is whatever information is material to the decision. Thus the test for determining whether a potential peril must be divulged is its materiality to the patient's decision (Canterbury V. Spence, supra, 464 F.2d 772, 786.)

There must be a causal relationship between the physician's failure to inform and the injury to the plaintiff. Such causal connection arises only if it is established that, had revelation been made, consent to treatment would not have been given. The patient-plaintiff may testify on this subject but the issue extends beyond his credibility. Since at the time of trial the uncommunicated hazard has materialized, it would be surprising if the patient-plaintiff did not claim that he had been informed of the dangers he would have

declined treatment. Subjectively he may believe so, with 20/20 vision of hindsight, but it is generally doubted that justice will be served by placing the physician in jeopardy of the patient's bitterness and disillusionment. Thus an objective test is preferable; i.e., what would a prudent person in the patient's position have decided if adequately informed of all significant perils.

The burden of going forward with evidence of nondisclosure rests on the plaintiff. Once such evidence has been produced, then the burden of going forward with evidence pertaining to justification for failure to disclose shifts to the physician. Whenever appropriate, the court should instruct the jury on the defenses available to a doctor who has failed to make the disclosure required by law. Thus, a medical doctor need not make disclosure of risks when the patient requests that he not be so informed. (See discussion of waiver: Hagman, The Medical Patient's Right to Know, supra, 17 U.C.L.A., L. Rev. 758, 785.). Such a disclosure need not be made if the procedure is simple and the danger remote and commonly appreciated to be remote. A disclosure need not be made beyond that required within the medical community when a doctor can prove by a preponderance of the evidence he relied upon facts which would demonstrate to a reasonable man the disclosure would have so seriously upset the patient that the patient would not have been able to dispassionately weigh the risks of refusing to undergo the recommended treatment (e.g., see discussion of informing the dying patient: Hagman, The Medical Patient's Right to Know, supra, 17 J.C.L.A., L. Rev. 758,778). Any defense, of course, must be consistent with what has been termed the "fiducial qualities" of the physician-patient relationship.

The courts have correctly pointed out in repeated opinions that a plaintiff has no right to recover in a battery case unless he can establish that he would not have consented to the procedure if he had been informed of the possible consequences. The courts have also required that such a refusal must be reasonable, i.e., that a prudent person in the patient's position would have declined treatment if adequately informed of all significant perils. At least one court has held that there is no liability on the part of the physician for battery if his attempts to explain the nature of the proposed operation are prevented by the patient's insistance upon remaining ignorant of the risks involved in the proposed operation (Putensen V. Clay Adams Incorporated, 12 Cal. App. 3d 1062, 91 Cal. Rptr. 319 (1970)). The Maryland Court of Special Appeals has held that the Maryland statute which governs medical consents by minors preempts the rights of the parent. The Code, Art. 43, s 135, provides that "a minor shall have the same capacity to consent to medical treatment as an adult," if one or more of the following apply:

"(1) The minor has attained the age of eighteen (18) years;

(2) The minor is married or the parent of the child;

(3) The minor seeks treatment or advice concerning venereal disease, pregnancy or contraception not amounting to sterilization;

(4) In the judgment of a physician treating a minor, the obtaining of consent of any other person would result in such delay of treatment as would adversely affect the life or health of the minor;

(5) The minor seeks treatment or advice concerning any form of drug abuse. . . ."

Because the right to consent is specifically granted to the minor in the above situations, it is automatically denied the parent. Although there are not many decisions directly on point, the majority of courts that have spoken on the subject seem to indicate that a competent adult may refuse medical treatment even though his life is in immediate danger. An exception to this rule was found in Raleigh Fitkin-Paul Morgan Memorial Hospital V. Anderson, 42 N.J. 421, 201 A. 2d 537 (1964), cert. denied 377 U.S. 985 (1964) where the New Jersey Supreme Court ordered blood transfusions to save the life of a mother and her unborn child.

3. CORPORATE NEGLIGENCE

The hospital may be liable for injuries due to negligence on the part of the hospital itself. Under this theory the hospital can be sued not only for injuries to patients, but also for injuries to visitors to the hospital and hospital employees. The question of the hospital being liable for the acts of its employees under the doctrine of respondeat superior underwent drastic reconsideration with the Supreme Court of Illinois opinion in the Darling V. Charleston Community Memorial Hospital action (33 Ill. 2d 326, 211 N.E. 2d 253, cert. denied, 383 U.S. 946 (1966)).

In 1970 the Joint Commission on Accreditation of Hospitals revised its objective to that of "setting optimal achievable standards" in place of the pre-Darling goal of establishing "minimum standards of quality of patient care." It might be difficult for a court to justify using "optimal achievable

standards" in setting the legal standard of reasonable conduct for a hospital. Three recent cases dealing with issue raised in Darling v. Charleston Community Memorial Hospital have split on the question of the degree of responsibility that a hospital has regarding restrictions upon physicians who practice in their facilities. In Mitchell County Hospital Authority v. Joiner, 229 Ga. 140, 189 S.E. 2d 412 (1972), it was held that a hospital authority had the duty and authority to limit the practice of a physician to areas of medicine in which the physician was competent. The fact that the doctor in question possessed a valid license from the state to practice medicine was held not to be a defense available to the hospital authority and the fact that the doctor held this license was not prima facie evidence of his competency to practice medicine. To the same effect is the holding in Purcell v. Zimbelman 18 Ariz. App. 75, 500 P. 2d 335 (1972) wherein a hospital was held liable for its failure to restrict the activities of a physician who negligently performed an operation. Testimony as to four prior malpractice suits filed against the physician, two of which involved the same type of operation, was allowed into evidence on the theory that the prior lawsuits demonstrated that the hospital had actual or constructive knowledge that the physician was not skilled with reference to the particular type of operation in question. It appears that current military credentialling doctrine has responded to these findings. However, a contrary result was reached in the case of Hull v. North Valley Hospital, 498 p. 2d 136 (Mont. 1972). In that case, doctors who served on the medical committee of the hospital did not incur any liability on the part of the hospital when they

failed to restrict the scope of medical procedures which could be performed by a doctor using the facilities of the hospital. The theory behind the Court's holding was that the medical committee itself could not have limited the function of the physician and that the only step they could have taken would have been to file a complaint with the State Medical Board. Moreover, the Court based its decision on an erroneous interpretation of the Darling case and spoke in terms of the hospital not being liable under the doctrine of respondeat superior. However, Darling was not a respondeat superior case but rather imposed independent liability on the hospital based on its duty to restrict and control physicians who practiced medicine at the facility

4. RESPONDEAT SUPERIOR

There are some traces of the concept of vicarious liability in the early law, but the principle of respondeat superior did not really develop until the industrial revolution. This doctrine makes the master, or employer, liable for the torts of his servant, or employee, that are committed within the scope of his employment. Although these acts are usually negligent torts, if the employee is acting within the scope of his employment, the employer may be held liable for intentional torts. Originally, the policy behind the employer being held liable was that since he received the profits from the toil of his employees, he should shoulder the losses occasioned by the work of his employees. Today the policy emphasis seems to have shifted to a concept of risk allocation; that is, the employer is in a better position to pay for the injury, especially in light of the fact that losses are usually covered by

insurance which he deducts as a normal business expense. It should be noted that the plaintiff may also sue the employee, but this action is often a hollow one since employees are frequently unable to pay the judgment against them.

Generally, when a hospital assigns its nurses to assist a surgeon in the operating room and surrenders to him the direction and control of the nurses, the nurses become servants of the operating surgeon insofar as their services relate to work so controlled and directed by the surgeon, and the hospital is no longer liable for torts committed in such controlled and directed work. The question as to whether a hospital or physician will be vicariously charged with the negligence of certain hospital employees under the "borrowed servant" rule has been examined by many courts in cases involving employees other than hospital medical or nursing staffs. In Synnott v. Midway Hospital, 287 Minn. 270 (1970), 178 N.W. 2d 211, a hospital patient was burned while being x-rayed by an x-ray technician employed by the hospital but under the direction of the plaintiff's treating orthopedic surgeon. The appellate court noted portions of the trial transcript covering the oral testimony of the technician as to the operation and control of the x-ray equipment at the time of the injury. The technician had testified that plaintiff's physician assisted her in aligning the machine, ordered additional film to be taken, verbally assisted in positioning the x-ray apparatus for successive films, and instructed her when to enter and leave the examination room. In granting the defendant hospital a new trial due to the trial court's error in imputing negligence to the hospital as a matter of law, the court held that with a sufficient showing

of evidence as to the control and direction over the hospital employee by the physician, liability for the employee's negligence may be imputed to the doctor in charge. Vicarious liability was also imposed on a physician who had another doctor look after his practice while the first physician was on vacation. The second doctor was paid $5.00 per day to look after his fellow physician's patients and the court ruled that this was sufficient to create an agency relationship and apply vicarious liability on the first doctor (Moulton v. Huckleberry, 150 Or. 538, 46 P. 2d 589 (1935)).

5. STRICT LIABILITY, BREACH OF WARRANTY, & CONTRACTS TO CURE

The concepts of strict liability, breach of warranty, and contracts to cure are each distinct theories of liability, but have a unifying element not found in either negligence or intentional torts. The point of similarity is that liability in these instances may be found even in the absence of fault or blameworthy conduct on the part of the defendant.

Litigation which bases a cause of action upon strict liability of a manufacturer for a defect in his product or upon warranties made by the manufacturer has been of growing importance in the hospital law area. This activity, particularly in the breach of warranty area, has been influenced by the Uniform Commercial Code (UCC) and by other state statutes (particularly those relating to the liability of whole blood providers for damages caused by a blood transfusion recipient's contracting of hepatitis).

Whether or not the UCC applies to hospitals which procure hepatitis-infected blood and administer it to patients is a matter for state courts and legislatures to decide. If the UCC does apply, its expressed and implied

warranty sections come into play. An expressed warranty is essentially a statement or promise by the manufacturer that the product will do what he says it will do. An implied warranty is a "statement" which arises soley due to the acts of the manufacturer; offering a product for sale when the public knows that the product is meant for a particular purpose implies that the item may be safely used for that purpose. The UCC also sets forth conditions under which these warranties may be disclaimed (disavowed by the manufacturer), but another section of the UCC permits the courts to find certain disclaimers unconscionable and therefore void as a matter of public policy.

The legal theory behind strict liability is that whether or not the manufacturer of a product has breached a duty to the user is irrelevant; rather, the mere fact that the user was injured by a defect in the product entitles him to damages. It is no defense that the manufacturer did all that was reasonable, or even possible, to guard against defects. The policy basis for this approach is that if the defect cannot be prevented, it is better to place the cost of the injury upon the manufacturer (who can adjust his price to spread the cost among all users) than upon the one who chanced to be injured by the defective product. While a cause of action based upon strict liability and one based upon warranties may appear to be essentially indistinguishable, the results of each of these can be quite different.

Cases involving contracts to cure or to obtain a specific result also require no finding of fault. If a health care provider contracts or promises to cure a patient, then he can be held liable if for any reason the cure is not affected.

6. LIABILITY OF ARMY MEDICAL PERSONNEL FOR MALPRACTICE

Everyone is expected to behave with ordinary care to their fellows. The absence of such care is termed "negligence," which is a basis for civil liability. "Malpractice" is the branch of negligence law applicable to professionals, such as doctors and lawyers, who are expected to bring an appropriate level of skill, advice, and treatment to their clients and patients.

Medical malpractice concerns negligent acts or omissions by medical personnel that cause personal injury to others. In military medical malpractice, the most common form of lawsuit is against the United States under the provisions of the Federal Tort Claims Act (28 U.S.C. 1346b). Most frequently the suit is against the United States alone and involves no individual defendants. The reason is obvious. The ability of the government to pay judgments, regardless of the amount, is greater than any individual or group of individuals. The government is thus a desirable target for plaintiffs and their lawyers. The FTCA is not, however, applicable for claims arising in foreign countries.

Whether government medical personnel (physicians, dentists, nurses, and ancillary personnel) can be individually liable, that is, can be responsible to pay a judgment from their personal finances, is a difficult question. At the present time, the courts have reached no unanimous opinion as to individual liability. One U.S. Circuit Court of Appeals has held that a military physician can be individually liable if there is a finding of negligence. Likewise, there are courts that have held the military physician immune from suit, regardless of negligence. The state of the law at this

time, therefore, is that the possibility of individual liability does exist. It is important to note, however, that to date no military or civilian medical practitioner employed by the federal government has had to pay a judgment based on individual liability. A military physician in residency at a civilian hospital is likewise subject to possible malpractice liability and, depending on the particular circumstances, may be covered by the hospital's insurance, considered a military source of medical care for U.S. Government liability purposes, or neither.

There are limitations as to who may bring suit. This limitation refers to the so-called Feres Doctrine established by the Supreme Court of the United States in 1950, to the effect that active duty military personnel may not recover damages from the government for the alleged malpractice (Feres v. United States, 340 U.S. 135). Under this doctrine, active duty military personnel may not sue either the government or the individual. The class of eligible claiments is consequently limited to civilian dependents of military personnel, retired military personnel (for treatment after retirement) and their dependents, and other civilians who might obtain medical care from a military source.

7. DAMAGES

The amount of money the plaintiff will receive as damages will depend upon the degree of his injury. Generally, damages can be divided into two basic categories, compensatory and punitive. Compensatory damages are those damages awarded by the courts for the purpose of "making the injured party whole." Although not strict legal terminology, attorneys commonly refer to

compensatory damages as either "special" or "general." Special damages are normally those which are the particular result of the injury suffered by the plaintiff; for instance, hospital and medical expenses, loss of income, and property damage. General damages are those less specific damages which the law itself presumes to be the natural consequence of the injury, as for example, mental or physical pain and suffering, future loss of earnings, loss of consortium, or physical impairment due to the injury.

Punitive, or exemplary, damages are awarded in cases where there has been malicious conduct on the part of the defendant. In most instances, the conduct has been intentional, but some cases have awarded punitive damages for gross negligence. This type of award evolved through a policy determination by the courts that in certain instances the individual should be punished for his wrongful conduct. In almost every situation, some compensatory damages have been awarded before any punitive damages are given. When awarded, punitive damages are frequently much greater than the amount of compensatory damages.

The questions of contribution and indemnity also arise in the awarding of damages. Contribution distributes the loss among the tortfeasors by requiring each to pay his share of the award. Indemnity requires one tortfeasor to pay the other the entire amount of the loss he has sustained. For example, an employer may be held liable under the doctrine of respondeat superior, and then bring an action under indemnity against the errant employee. It should be noted that the law varies greatly fron state to state in this area, and it is difficult to apply any general rule as to when contribution or indemnity will be allowed.

8. RELEASE AND IMMUNITIES

Both release and immunity are defenses which allow the defendant to avoid liability even though his tortious conduct has caused an injury. A release is the giving up of a claim by the person to whom it exists. In this sense it is a contract and must be supported by consideration. In cases of charitable immunity and governmental immunity, the law has allowed a defendant who would otherwise be held pecuniarily liable to be immune due to an overriding public policy. A common issue arising under the Tort Claims Act, as to which Courts of Appeals are in conflict, makes it appropriate to consider three cases in one opinion.

The Feres case: The District Court dismissed an action by the executrix of Feres against the United States to recover for death caused by negligence. Decedent perished by fire in the barracks at Pine Camp, New York, while on active duty in service of the United States. Negligence was alleged in quartering him in barracks known or which should have been known to be unsafe because of a defective heating plant, and in failing to maintain an adequate fire watch. The Court of Appeals, Second Circuit, affirmed.

The Jefferson case: Plaintiff, while in the Army, was required to undergo an abdominal operation. About eight months later, in the course of another operation after plaintiff was discharged, a towel 30 inches long by 18 inches wide, marked "Medical Department U.S. Army," was discovered and removed from his stomach. The complaint alleged that it was negligently left there by the Army surgeon. The District Court, being doubtful of the law, refused without prejudice the government's pre-trial motion to dismiss the complaint. After

trial, finding negligence as a fact, Judge Chesnut carefully reexamined the issue of law and concluded that the Act does not charge the United States with liability in this type of case. The Court of Appeals, Fourth Circuit, affirmed.

The Griggs case: The District Court dismissed the complaint of Griggs' executrix, which alleged that while on active duty he met death because of negligent and unskillful medical treatment by Army surgeons. The Court of Appeals, Tenth Circuit, reversed and, one judge dissenting, held that the complaint stated a cause of action under the Act.

The common fact underlying the three cases is that each claimant, while on active duty and not on furlough, sustained injury due to negligence of others in the armed forces. The only issue of law raised is whether the Tort Claims Act extends its remedy to one sustaining "incident to the service" what under other circumstances would be an actionable wrong. There are few guiding materials of statutory construction. No committee reports or floor debates disclosed what effect the statute was designed to have on the problem, or that it even was in mind. Under these circumstances, no conclusion can be above challenge, but if the Act is misinterpreted, at least Congress possesses a ready remedy.

The Act does confer district court jurisdiction generally over claims for money damages against the United States founded on negligence (28 USCA: 1346 (2) (b), FCA title 28, s 1346 (2) (b)). The law (FTCA) does contemplate that the government will sometimes respond for negligence of military personnel, for it defines "employee of the government" to include "members of the

military or naval forces of the United States," and provides that "acting within the scope of his office or employment, in the case of a member of the military or naval forces of the United States, means acting in line of duty." (28 USCA, Sec 2671, FCA Title 28, Sec 2671). Its exceptions might also imply inclusion of claims. 28 USCA, Sec 2680 (j), FCA Title 28, Sec 2680 (j) excepts "any claim arising out of the combatant activities of the military or naval forces, or the Coast Guard, during time of war" (emphasis supplied), from which it infers an allowance of claims arising from noncombat activites in peace. Section 2680 (k) excludes "any claim arising in a foreign country." Significance also has been attributed in these cases, to the fact that 18 tort claims bills were introduced in Congress between 1925 and 1935 and all but two expressly denied recovery to members of the armed forces; but the bill enacted as the present Tort Claims Act, from its introduction, made no exception.

The Tort Claims Act was not an isolated and spontaneous flash of Congressional generosity. It marked the culmination of a long effort to mitigate unjust consequences of sovereign immunity from suit. While the political theory that the King could do no wrong was repudiated in America, a legal doctrine derived from it that the Crown is immune from any suit to which it has not consented was invoked on behalf of the Republic and applied by our courts as vigorously as it had been on behalf of the Crown. As the federal government expanded its activities, its agents caused a multiplying number of remediless wrongs--wrongs which would have been actionable if inflicted by an individual or a corporation but remediless solely because their perpetrator was an officer or employee of the goverment. Relief was often sought and

sometimes granted through private bills in Congress, the number of which steadily increased as government activity increased. The volume of these private bills, the inadequacy of congressional machinery for determination of facts, the importunities to which claimants subjected members of Congress, and the capricious results, led to a strong demand that claims for tort wrongs be submitted to adjudication. Congress already had waived immunity and made the government answerable for breaches of its contracts and certain other types of claims. At last, in connection with the Reorganization Act, it waived immunity and transferred the burden of examining tort claims to the courts. The primary purpose of the Act was to extend a remedy to those who had been without; if it incidentally benefited those already well provided for, it appears to have been unintentional. Congress was suffering from no plague of private bills on the behalf of military and naval personnel, because a comprehensive system of relief had been authorized for them and their dependents by statute.

Looking to the detail of the Act, it is true that it provides, broadly, that the District Court "shall have exclusive jurisdiction of civil actions on claims against the United States, for money damages. . . ." This confers jurisdiction to render judgment upon all such claims, but it does not say that all claims must be allowed. Jurisdiction is necessary to deny a claim on its merits as matter of law as much as to adjudge that liability exists. The military has interpreted this language to mean all it says, but no more. Jurisdiction of the defendant now exists where the defendant was immune from suit before; it remains for courts, in exercise of their jurisdiction, to determine whether any claim is recognizable in law. For this purpose, the Act

goes on to prescribe the test of allowable claims, which is, "The United States shall be liable. . . in the same manner and to the same extent as a private individual under like circumstances. . . ." with certain exceptions not material here (28 USCA, Sec 2674, FCA title 28, Sec 2674).

This is not the creation of new causes of action but acceptance of liability under circumstances that would bring private liability into existence. This embodies the same idea that its English equivalent enacted in 1947 (Crown Proceedings Act 1947; 10 & 11 Geo VI, ch 44, p 863), expressed, "Where any person has a claim against the Crown after the commencement of this Act, and, if this Act had not been passed, the claim might have been enforced, subject to the grant. . . .", of consent to be sued, the claim may now be enforced without specific consent. One obvious shortcoming in these claims is that plaintiffs can point to no liability of a "private individual" even remotely analogous to that which they are asserting against the United States. American law has never permitted a soldier to recover for negligence, against either his superior officers or the government he is serving. Nor is there any liablility "under like circumstances," for no private individual has power to conscript or mobilize a private army with such authorities over persons as the government vests in echelons of command. The nearest parallel, even if "private individual" was considered a state, would be the relationship between the states and their militia. But given the benefit of this comparison, claimants cite no state which has permitted members of its militia to maintain tort actions for injuries suffered in the service, and in at least one state the contrary has been held to be the case.

In the usual civilian doctor and patient relationship, there is of course

a liability for malpractice. And a landlord would undoubtedly be held liable if an injury occurred to a tenant as the result of a negligently maintained heating plant. But the liability assumed by the government here is that created by "all the circumstances," not that which a few of the circumstances might create. There was no parallel liability before and no new one has been created by this Act. Its effect is to waive immunity from recognized causes of action and was not to visit the government with novel and unprecedented liabilities.

It is not without significance as to whether the Act should be construed to apply to service-connected injuries that it makes ". . . the law of the place where the act or omission occurred" govern any consequent liability (28 USCA, Sec 1346 (2) (b), FCA Title 28, Sec 1346 (2) (b)). This provision recognizes and assimilates into federal law the rules of substantive law of the several states among which divergencies are notorious. This perhaps is fair enough when the claimant is not on duty or is free to choose his own habitat and thereby limit the jurisdiction in which it will be possible for federal activities to cause him injury. That his tort claims should be governed by the law of the location where he has elected to be is just as fair when the defendant is the government as when the defendant is a private individual. But a soldier on active duty has no such choice and must serve any place or, under modern conditions, any number of places in quick succession in the 48 States, the Canal Zone, or Alaska, or Hawaii, or any other Territory of the United States. That the geography of an injury should select the law to be applied to his tort claims makes no sense. The fact that most states have abolished the common-law action for damages between employer

and employee and superseded it with workmen's compensation statutes which provide, in most instances, the sole basis of liability attests to the desire to expedite tort actions. Absent this, or where such statues are inapplicable, states have differing provisions as to limitations of liability and different doctrines as to assumption of risk, fellow servant rules, and contributory or comparative negligence. It would hardly be a rational plan of providing for those disabled in service by others in service to leave them dependent upon geographic considerations over which they have no control and to laws which fluctuate in existence and value.

The relationship between the government and members of its armed forces is "distinctively federal in character," as this Court recognized in United States v. Standard Oil Co., 332 US 301, 91 L ed 2067, 67 S Ct 1604, wherin the government unsuccessfully sought to recover for losses incurred by virtue of injuries to a soldier. The considerations which lead to that decision apply with even greater force to this case: ". . .To whatever extent state law may apply to govern the relations between soldiers or others in the armed forces and persons outside them or nonfederal governmental agencies, the scope, nature, legal incidents and consequences of the relation between persons in service and the government are fundamentally derived from federal sources and governed by federal authority." No federal law recognizes a recovery such as claimants seek. The Military Personnel Claims Act, 31 USCA, Section 223 (b), JFCA title 31, Section 223 (b) (now superseded by 28 USCA, Section 2672), permitted recovery in some circumstances, but it specifically excluded claims of military personnel "incident to their service."

This Court, in deciding claims for wrongs incident to service under the

Tort Claims Act, cannot escape attributing some bearing upon it to enactments by Congress which provide systems of simple, certain, and uniform compensation for injuries or death of those in armed services. We might say that the claimant may (a) enjoy both types of recovery, or (b) elect which to pursue, thereby waiving the other, or (c) pursue both, crediting the larger liability with the proceeds of the smaller; or (d) that the compensation and pension remedy excludes the tort remedy. There is as much statutory authority for one as for another of these conclusions. If Congress had contemplated that this Tort Act would be held to apply in cases of this kind, it is difficult to see why it should have omitted any provision to adjust these two types of remedy to each other. The absence of any such adjustment is persuasive that there was no awareness that the Act might be interpreted to permit recovery for injuries incident to military service.

A soldier is at peculiar disadvantages in litigation. Lack of time and money, the difficulty if not impossibility of procuring witnesses, are only a few of the factors working to this disadvantage. And the few cases charging superior officers or the government with neglect or misconduct which have been brought, have either been suits by widows or surviving dependents, or have been brought after the individual was discharged. The compensation system, which normally requires no litigation, is not negligible. The recoveries compare favorably with those provided by most workmen's compensation statutes. In the Jefferson case, the District Court considered actual and prospective payments by the Veterans Administration as diminution of the verdict. Plaintiff received $31,947 in addition. In the Griggs case, the widow, in the two-year period after her husband's death, received payments in

excess of $2,100. In addition, she received $2,695, representing the six-months' death gratuity under the Act of December 17, 1919, as amended, 41 Stat 367, ch 6 Dec 17, 1943, 57 Stat 599, ch 343, 10 USCA, Section 903, FCA Title 10, Section 903. It is estimated that her total future pension payments will aggregate $18,000. Thus the widow will receive an amount in excess of $22,000 from government gratuities, whereas she sought and could seek under state law only $15,000, the maximum permitted by Illinois for death.

In Foster v. Day & Zimmerman, Inc., 502 F. 2d 867 (8th Cir. 1974), an ROTC cadet was seriously injured at summer camp when a grenade exploded in his hand during a training exercise. The District Court for the Southern District of Iowa held that the manufacturer and assembler were strictly liable to the cadet, and the jury awarded $151,800 in damages. On appeal, the Eighth Circuit rejected the defendants' argument that they did not place the grenade in the stream of commmerce since they manufactured it exclusively for the government. The court also rejected defendants' contention that they sold a service rather than a product since they merely assembled raw materials in accordance with government specifications. Finally, the court concluded that the incident to service bar of Feres was inapplicable even though the government had agreed to indemnify defendants for this type of damages.

The government is not liable under the Federal Tort Claims Act for injuries to servicemen where the injuries arise out of or are in the course of activity incident to service. Without exception, the relationship of military personnel to the government has been governed exclusively by federal law. We do not think that Congress, in drafting this Act, created a new cause of action dependent on local law for service-connected injuries or

death due to negligence. We cannot impute to Congress such a radical departure from established law in the absence of express Congressional command. Accordingly, the judgments in the Feres and Jefferson cases are affirmed and that in the Griggs case is reversed.

C. POLICY OF DEPARTMENT OF ARMY AND DEPARTMENT OF JUSTICE CONCERNING MALPRACTICE SUITS

Malpractice claims can be one of three types. They can be against the United States only, against the United States and medical personnel jointly, or against medical personnel only. The type of action or claim will dictate how the matter is to be handled and who will pay any judgment or settlement.

For medical treatment other than in foreign countries, if a claimant decides to proceed against the United States, he must begin by filing an administrative claim under the Federal Tort Claims Act. The claim will be investigated under applicable regulations and processed by the U.S. Army Claims Service. If it is determined to settle the claim, the settlement will be paid with government funds. If the claim is denied and the claimant then sues the United States under the Federal Tort Claims Act, any resulting judgment will be paid by the General Accounting Office with government funds.

If the claimant sues the United States and medical personnel jointly, and there is a resulting joint judgment, it will be paid in total by the General Accounting Office from public funds, under present Department of Justice policy. It is possible for the United States to have a defense while the individual does not. For example, in unusual situations, the United States

could defend on the Statue of Limitations for the FTCA, while the individual could not.

If medical personnel are sued alone, or if the United States succeeds in a separate defense, there is a possibility for sole personal liability. As far as can be determined, to date no Federal civilian or military medical personnel have been required to pay a malpractice judgment. Should a judgment be rendered against an individual in the future. he or his insurance company, if any, would likely be responsible for payment. Reimbursement for any such payment not covered by insurance could be sought through private relief legislation. The Surgeon General and The Judge Advocate General would assist to the fullest extent of their ability in processing such legislation.

The reasons why medical personnel are sued alone when the government with its ability to pay judgments of any amount is available as a defendant are not clear. Some suits may be premised on individual feelings of malice by the claimant against the medical personnel. Others may be based on a lack of knowledge that the government can be sued. There may be other less apparent reasons. Nonetheless, medical defendants are faced with potential personal liabilities.

If Army medical personnel are sued alone or jointly with the U.S. for alleged malpractice in the performance of their regularly assigned duties, they may, upon request, be represented by the U.S. Attorney. If the defendants are insured, however, the insurance company has a financial interest in the outcome and will want to protect that interest. Accordingly, the insurance carrier will be expected to provide legal representation. Finally, the defendants may employ private counsel to represent them. There

is no provision for reimbursing the fees of private counsel in such cases.

Regardless of who represents individual defendants, they are entitled to advice and assistance from the lawyers in the Tort Branch, Litigation Division, Office of The Judge Advocate General, and the doctor-lawyers in the Armed Forces Institute of Pathology.

D. POLICY OF DEPARTMENT OF ARMY CONCERNING MALPRACTICE INSURANCE

The Department of the Army considers the question whether military medical personnel should buy medical malpractice insurance to be one for each individual to decide on the basis of his own circumstances. There is no reimbursement by the U.S. for payment of premiums. Only after the results of more cases are known will a stronger recommendation, pro or con, concerning insurance be possible.

In favor of purchasing malpractice insurance is the basic consideration of the peace of mind which is afforded by complete protection against malpractice liability. Each should decide whether to buy insurance based on his own personal circumstances. These circumstances include the potential risk of exposure in his specialty or practice versus the availability of insurance against such risk at a price he can afford for the relative peace of mind the insurance would provide.

Factors against the purchase of malpractice insurance are initially its cost and availability. As the amount of malpractice litigation is rising dramatically in the United States, the cost for insurance against such claims increases. Moreover, there are locations where insurance is unavailable. Another factor weighing against the purchase of insurance is the fact that the

third party interest as represented by the financial responsibility of the private insurance company. This separates the individual from the government defense. Another possible objection to malpractice insurance is the so-called "target" effect, which basically means that, if an individual is capable of paying a settlement by way of insurance, he becomes a more attractive target for suit. And, finally, the most persuasive objection to malpractice insurance is the fact that in the overwhelming percentage of cases, the United States is named a defendant and covers any adverse judgment, thus becoming an insurer for the individual physician.

From the foregoing, it is believed that the scales are tipped against military medical personnel buying malpractice insurance.

E. OTHER FEDERAL LEGISLATION

Originally only government physicians employed by the Veterans Administration and the Public Health Service had statutory immunity from suit in their individual capacities. There were four bills introduced in Congress that would in one way or another afford protection to military physicians. Congressman Gonzales had submitted H. R. 3954 which brings military physicians under the same immunity enjoyed by the Veterans Administration and the Public Health Service physicians. Congressman Chapel had introduced H. R. 387. This was the so-called "omnibus" bill giving all federal employees immunity from suit. In the Senate, two broader bills which address the problem of malpractice in the civilian community as a whole had been introduced; they would have provided an umbrella under which the military physician could practice also. The Inouye-Kennedy Bill, S. 215, would have established a

system comparable to Workmen's Compensation, avoiding court litigation to pay damages incurred by an individual undergoing medical treatment. Senator Nelson had introduced S. 188 which provided a combination of private malpractice insurance and governmental coverage, with the government paying damages incurred over a fixed amount. The Gonzales Bill was passed, and is now called the Gonzales Act. It directly relieved the military physician from the considerable uncertainty under which he previously worked. The other legislation was still pending at the time of this publication.

F. STATE LEGAL CONCERNS

Data from Tables 10, 11, and 12 compares state regulations that prohibit in health care facilities: all animals (decrease from 16% to 4%), specific animals in all areas (20%), or all animals except by special permission (26%). Some states only have provisions for intervention on receipt of complaints or upon observation of a problem during periodic inspections by the oversight agency. Looking at Table 10, it appears that at least 64% of the states depend upon the responsibility and accountability of health care administrators to regulate the presence of pets, rather than by prescribing "how to" regulations.

Only one state specifically prohibits turtles, which often are sources of salmonellosis; only six states prohibit wild animals which may pose greater risk than domestic animals. This appears to indicate that in most states the responsibility for taking rational precautions for health and safety is vested in the health care administrator; the administrators judgment and ability to obtain informed assistance, from physician and veterinarians as

needed, can be fit to individual circumstances and situations.

These same principals of individualized planning and evaluation can be applied to assure reasonable health and behavorial characteristics of an animal if a veterinarian is involved in the decision and placement process. The veterinarian should be involved in the selection of the species, breed, sex of animal, insuring appropriate characteristics, health care plans, feeding programs; and monitoring the systems, for the staff and patients. With only six states mentioning animal behavior, the human/animal relationships require an interdisciplinary health care team evaluation process to insure the program is forensically safe and medically appropiate. Most health certificate examinations do not detect the zoonotic diseases, such as: Psittacosis, rabies, toxoplasmosis, leptospirosis, or salmonellosis, which all may be transmitted to man during a "silent" incubation period in the animal. The misleading health certification program needs to be in addition to a routine monitoring program for the animals.

Another concern is that of mechanical damage or injury, whether it be a bite, scratch, or just tripping over the animal. There is a real concern about allergies to certain type animals, as well as the health hazard associated with animal waste. In his research, Phil Arkow remarks that in over 67,000 hours of patient exposure to dogs, neither injuries nor diseases occurred (29). In her long-term pilot dog study, researcher Susan Robb found that risks were not nearly as common as opponents of animal facilitated therapy would suggest and that stringent precautions may not be necessary (30). While these concerns are certainly valid considerations, and they can pose a potential problem in an institutional setting, the record shows the

problems simply did not materialize and the fears proved to be groundless. These must be considered possible problems by any administrator; they are not however, probable problems.

Abuse, particularly by patients who may have a grudge against the health care facility, society, family, or even other patients, might appear a potential problem. Research studies indicate, however, that although this could occur, it simply has not and there is some evidence that peer pressure (concern for the animal) can act as an effective deterrent if there is a potentially abusive patient in the population. Perhaps the strongest indicator comes from Lima State Hospital for the criminally insane, where 175 animals of various species have been included in the program. It would appear if any population would or could abuse the animals, it would be of this type. In fact, the animals have acted as a calming factor on the prisoners, and no abuse has occurred (31).

A final consideration is animal burnout, especially with the canine. These dogs are working as therapists and just like the human staff, they can experience stress if they do not have ample time to relax. Phil Arkow reported on this phenomena and suggested a relatively easy solution: Staff members took the dog home on occasion for a welcome change of pace (29).

G. A RISK MANAGEMENT APPROACH TO FORENSIC/LEGAL CONCERNS

The value and need for many of the present regulations, specifying apparently ineffective and burdensome requirements and restrictions for animals, as applied to all health care facilities and modalities in a given state, appears questionable at best; many are currently under revision in the

more progressive states. Based on the regulatory variables, R.K. Anderson (2) has advocated that each health care facility needs to develop an individual plan with defined purposes and objectives, such as:

1. To permit entry of animals based on sound epidemiological data and outcome criteria;

2. To provide rational precautions for the health and safety of people without unduly limiting the benefit of animals;

3. To allow the staff and appropriate consultants to be involved in developing any plan for animals in the facility, as well as in implementation and evaluation of such plans;

4. To insure such plans consider the desires of the patients and staff who wish to be away from animals, as well as those that want the association and companionship;

5. To consider the choice of animals based on normal species and breed behavior, health needs of the animal, and the purposes and objectives for the presence of animals;

6. To insure the staff members have time to take care of the animal when the patients are not able;

7. To insure that the animal will not be neglected, abused by the patients, or be stressed from having too many masters.

A good administrative program for developing an effective risk management program is to initiate or improve upon a practical three point defense. The best defense against malpractice liability is to insure that proper treatment is recorded daily. The physician that keeps good records and maintains a good rapport with his patients is not a likely target. Time and

again, defense of military malpractice suits has been frustrated by illegible or incomplete medical records. Commonly, the progress notes are weak or even absent for days at a time. These notes are essential to show that the treatment rendered was in accordance with the accepted medical standards and are essential in refreshing the treating physician's memory prior to testifying at any trial. Every physician who signs an order or is called on consultation should be identified by printed name if his signature is scribbled. Charts must be carefully reviewed for proper documentation before being closed. Without good records to contradict the plaintiff's alleged malpractice, it is impossible to properly defend the lawsuit.

The second good defense is good rapport with the patient. As indicated above, some malpractice suits may be initiated as punitive action against the system or a doctor. When things go wrong, that is the time to give extra consideration and time to the patient and family. If there is a true grievance, and the possibility of a malpractice suit is recognized, the chief of the service should be notified immediately. All records, x-rays, slides and other documentation should be reviewed and preserved. If death is involved, an autopsy should be requested. AFIP should be notified prior to the autopsy if possible. Also, the case should be discussed with the local claims judge advocate to determine what further steps are necessary.

Thirdly, the risks attendant to medical and surgical treatment must be carefully explained to all patients, spouses, parents sponsors, and guardians, as may be appropriate under the circumstances. A full record of such advice should be maintained by the physician and annotated in the medical records.

Evaluations of programs should involve end results or objectives/goals - not "how to" regulations -- and encourage more flexible, innovative methods that most effectively achieve the objectives of the health care facility. Administrators must provide leadership in developing a plan for admitting and monitoring the health and behavior of visiting animals, and should have veterinarians as advisors in insuring that appropriate animals meet the specific needs of the patient(s). The plan for promoting and monitoring the health and behavior of resident animals as a continuing health maintenance program must include veterinary medical leadership.

In any liability or forensic medical situation, the established policies are always reviewed first for failure to take the precautions of a reasonable nature. Some key elements that should be addressed in local directives are provided in Appendix H.

D. GENERAL CONSIDERATIONS IN THE SPECTRUM OF ANIMALS AVAILABLE

The first step in the selection of an appropriate animal (or animals) is to determine if there are any legal restrictions or requirements (housing, for example) that must be met before an animal can be introduced into a health care facility. As mentioned earlier, most states do not prohibit animals; even if a state does have such a restriction, the facility may be able to obtain a waiver. It is also recommended to check with municipal authorities for specific requirements (e.g., licensure of animals). An institution is also advised to check its' insurance coverage to be certain there are not animal-prohibitive clauses in the policy.

A few animals simply "walk in off the street," and become valuable and loved mascots. Some institutions elect to adopt an animal companion based upon successful experience with a visitation program. Others follow a careful evaluation of staff and patient preferences before deciding upon which animal is right for them. Regardless of the system utilized, a few factors are basic to the consideration of any animal for a health care delivery program:

1. Health history and vaccination status;
2. Tractability and behavior characteristics;
3. Appropriateness of animal to patient(s);
4. Operative legal status.

To date, there are no precise evaluation tools which determine which type of animal works best in a given situation; animal facilitated health care delivery is still part of the "art" of medicine. However, an extremely informative publication offers detailed guidelines to aid an institution in its selection of animal(s) and program(s). The title, "Guidelines: Animals in Nursing Homes," is misleading, in that the principals are applicable to virtually any health care delivery setting. To facilitate the reader's access to these guidelines, the detailed recommendations have been revised to encompass most military health care delivery settings and are incorporated into this study (32).

It has been discussed why the animal selection should be based on staff and patient preferences, availability of space (both social and physical), type of patient population, care and cost considerations, type of program expected (objectives of the program), and of course, the operative legal statutes. As a general rule of thumb, the types of animals that require the

most care and planning also offer the most potential for personal bonding and therapeutic application.

The animal(s) can be available to the health care provider in basically three modalities: As occasional visitors, as individual companion animals or pets, or as group mascots. An important consideration in the selection of which modality is best is determining where the patient(s) spend most of the time. If the target patient population is confined to a single institution, and the patients congregate in a large activity or recreation area for most of the day, group mascots might be the best choice; on the other hand, in the outpatient adolescent clinic, the personal animal, whether owned or visiting, becomes the most likely choice (32).

If individual companion animals are the choice, the selection process is easier due to the reduction of personalities and variables. Essentially, it depends upon (1) the patient's preference, (2) the ability of the patient to provide adequate care, (3) the possibility of accommodation in the living quarters available, (4) the veterinarians evaluation, and (5) the health care delivery professional's opinion. If the patient has a family or a roommate, the needs and wishes of those parties must be honored in the selection. Whereas, if the animal is to be a group mascot, it must be agreeable to not only the patients, but to the staff as well; the need for positive staff support for such a program cannot be overstated. Lee, et al, states that without full participation and cooperation, the chances of unsuccessful placement are high; the staff must possess the knowledge to plan a placement well, the energy and enthusiasm to make the placement work, and the commitment to care for an animal properly (32).

E. TYPES OF ANIMALS AVAILABLE

Numerous species are successfully used in health care facilities and health care delivery programs; this discussion will attempt to address the more common species currently in use, but should not be considered a full selection. As an example, dolphins have been used successfully in the socialization of autistic teenagers (2), but since a salt water aquarium is not usually available, the dolphin will not be addressed. A brief description of the possible choices, with advantages, disadvantages, cost considerations, and potential therapy benefits will be provided herein. This information is not intended to be a complete and total guide, but rather a quick summary and easy to use reference. Usually the best place to obtain information on the needs of an animal is the breeder, a specialized pet store, the humane society, or from your consulting veterinarian (or a combination of the four). Costs should only be considered for an overview of the possibilities, since they vary widely with the locale, the particular animal selected, and the source of the animal. Animals being turned into the humane society by their owners are generally the best choices, since they are inexpensive and a full health and personality history can be readily obtained. Any of the following animals may be found at a modern, progressive humane shelter, although the selection may not be as great as in a specialty pet store.

Aquariums

The colorful, tranquil, low maintenance aquarium may provide entertain ment, diversion, creative stimulus, and visual stimulation. It lacks tactile interaction, appears boring to some, and has limited potential for affection, companionship, or bonding, since the fish cannot be handled. The therapeutic

potential has been repeatedly proven; watching fish reduces stress and lowers elevated blood pressures. Some therapists report that eye contact can be made by meeting a patient's eyes through the aquarium. The largest size tank affordable (a 10-gallon tank will hold about 15 small fish) is best, and needs a filter, thermostat, heater, gravel, plants, decorative shells or ceramics, cover, fish net, siphon, and water conditioner; this set-up would cost approximately $75. The care requirements for an aquarium are minimal: daily feeding (overfeeding can be a problem), general checks on aquarium functions, and infrequent cleaning.

Vivarium

A vivarium is similar to an aquarium except that it houses small reptiles or amphibians; as such, it is unusual, educational, and requires little maintenance. The vivarium may provide entertainment, visual stimulation, educational enhancement, possible occupational therapy in habitat construction or breeding, and mental diversions. Again, like the aquarium, tactile stimulation, and the associated love, affection and bonding, is very limited; this is due to the special handling requirements as well as the negative reactions often seen with handling reptile-type creatures (fun to watch, but never hold). The history of their therapeutic potential goes back to the first recorded human/animal bond program in the United States (circa 1945), at Pawlings Army-Air Force Hospital. They found that recuperating trauma patients responded well to similar species found in the woods nearby; a turtle provided support and entertainment in a tubercular ward even though the patient who received the pet had an initial aversion to it. A large tank with sand, wood, rocks, shells, and sometimes even a small pond, is needed; the

needs vary with the species used, and the cost is generally less than $50. The care is minimal, since many species do not even require daily feeding; there are local health statutes that may prohibit certain species. A vivarium may be an excellent choice for a chronic patient that needs a low-cost and low-maintenance pet, and can build or care for a vivarium as a personal project.

Small Caged Mammals

Rats, mice, gerbils, and hamsters are active, furry, and offer some tactile interaction and entertainment at a low cost. These animals may provide diversions, some companionship, limited opportunity to express love and affection, and even offspring, if you want them; the rat is the exception in this group, as they often become very attached and affectionate pets, sitting on their owner's shoulder for hours. These mammals generally do not offer great one-on-one interaction like dogs or cats, and if they are not properly socialized, may bite; except for the rat, these will not provide an extensive opportunity for companionship, love, affection, or bonding. The therapeutic potential is based on the distraction of furry things scurring around, the tactile stimulation associated with handling the socialized animal, and the high trainability of the rat. These little creatures need more room than the vivarium inhabitants; a 10 gallon tank will house four mice, one hamster, or two gerbils, or a 20-gallon aquarium will make comfortable quarters for one rat. Also needed are bedding materials, exercise wheel, waterer, a tightly fitting cover, daily feedings with a commercial feed, and twice-a-week cage cleaning/scrubbing to prevent odors; again the

cost is minimal, generally less than $50. For a patient that really wishes for a dog or cat, but cannot house or care for such a large and demanding animal, a rat might be a perfect companion, assuming that the patient has no negative perceptions of them.

Rabbits and Guinea Pigs

Rabbits and guinea pigs, though still caged, offer more opportunity for interaction than the smaller mammals, as they are generally calm and can be handled easier; rabbits in particular can become companions just like a dog or cat. To achieve a companion animal status, they require more socialization efforts by the owner than do cats or dogs; they also have shorter life spans, do not provide much incentive for exercise or excitement, and cannot be readily "shared" in a group setting. The therapeutic potential has been realized with children, pet visitation programs, and has proven greatly beneficial to mentally deficient adults, as in the Lima State Hospital programs discussed earlier. The companionship, and opportunity to express love and affection, greatly facilitates therapy programs; and the occupational therapy possibilities increase with the construction of a rabbit hutch or development of a breeding program. A 20-gallon tank will house one guinea pig, and needs bedding and a water bottle; an exercise wheel would not be used by this docile animal, and there is no lid requirement since they don't jump. A rabbit hutch should be constructed of corrosion-resistant wire, be two feet wide, two feet deep, and four feet long, and contain a wooden nesting box that is totally enclosed except for the top half of one side. This size hutch will comfortably house two females and one male. Bedding material,

commercial feed, and a water bottle will be required; and a removable tray underneath the wire floor makes cleaning easier. Total cost should be less than $50, with guinea pigs being slightly less expensive than rabbits. Care requirements include daily feeding, fresh water, and socialization; bedding should be changed every other day, and the cage cleaned weekly. Rabbits can be taught to use a litter box if the pet is out of the cage often; just place fresh droppings into a low, easily accessible litter box and acquaint the rabbit to the box on frequent occasions; they usually learn quickly. A piece of hardwood is recommended for chewing, and a mineral block is needed by rabbits; both species require routine grooming. As both species are relatively docile companions, are pretty and soft, and can be kept in a minimal space, they make excellent individual pets for the less active patient; the animal should be handled frequently, but gently.

Caged Birds

There are two types of birds that make suitable therapy animals: The finch-type (which includes the canary) and the psittacine (which include parrot-types, parakeets, lovebirds, and cockatiels). These birds are colorful, vocal, entertaining, and the psittacine types can be hand trained to do tricks and talk; many finch types, if given ample cage space and good health, breed readily. The major disadvantages are the extreme care required in handling, the limited physical interaction available, the shorter life spans of some species, and the messy cage area (scattered seeds, etc). The therapeutic potential for psittacines is high, and for finch types moderate; budgerigars (parakeets) have proven of great value at Lima State Hospital and

in programs conducted by Mugford, et al (33). A cage 24 inches by 20 inches by 14 inches will house eight finches comfortably; large birds need a cage where they can fully spread their wings. Perches, gravel, seed, occasional fresh greens, liquid vitamins, food and water containers, a detachable bird bath, and possibly a small nesting box will be required; toys, mirrors, ladder, cuttlebone, etc., are also recommended. The cost for the bird varies greatly, from about $35 for a full canary set-up, with bird, to $100 for a cockatiel and cage, and proceeding up to the four-digit prices when buying the large parrot-types. Breeders that have hand-fed the newborns report greater sociability and easier taming when the birds mature. These pets make excellent in-room pets since they require so little space, and cannot only be seen by the bed-bound patient, but also can provide companionship and auditory distractions. Patients allergic to dogs or cats would be good candidates for birds; the cockatiel seems the best choice since they are larger, easier to tame, more affectionate, and usually faithful companions. Although they do not reach the verbal fluency of parrots, they do learn to talk and are very pretty companions.

Cats and Dogs

Cats and dogs have maximum therapeutic value and are excellent companions for most patients; but all require careful matching to the therapy program goals, and require the most care and supervision. The selection criteria is provided in the appendices, as well as the placement considerations. In general, the cat will probably require less care and supervision than a dog, and no special housing is necessary, unless an outdoor run for the dog is considered essential. It has been found that therapy animals have better health histories when restricted to the patients environment and not allowed

to roam free in the outdoors. Costs vary with species and source of the animal, as well as the type program adopted. The consulting veterinarian will be of the greatest assistance in establishing the expected budget and care needs.

Other Possibilities

There has been some benefits achieved with the use of wild bird feeders, outside fish ponds, and when allowed by zoning and space, small farm animals. In the small farm animal category, the African pygmy goat has proven to be a delightful species; many zoos are overpopulated with them today, but keep them becuase of the children that come to pet and play with these affectionate, friendly, playful animals. They can be paper-trained, and trained to ride in the car; since they are small (about 24 inches high), a pair can be housed relatively easy. The pygmy goat needs a large dog house and a fenced-in and sheltered location; they are hardy, but dampness can cause problems. Fresh water and a commercial goat chow is needed for proper nutrition, although they do graze enough to keep most lawns from needing mowing (if free from pesticides). The cost is about $100 each, unless you can convince a local zoo to donate their extras as a publicity program.

Whatever the animal selected, the proper care and maintenance of the animal will greatly assist in the success of the program. The consulting veterinarian, along with the health care delivery staff, must monitor the care given to the therapy animal as well as the care given to the patients; the interrelationships and interdependencies associated in the human/animal bond are greatly variable, and never fully predictable.

CHAPTER 4

THE PRE-SURVEY PROGRAM

INTRODUCTION

The pre-survey program is simply the systematic methodology utilized to assess the need for animal facilitated therapy, or animal facilitated socialization, or just plain animal-patient companionship. It is not the time to get hung-up in terminology and catchy phrases; it is the time to seriously assess the needs of the patients and the objectives of the health care delivery program being supported. In the broadest sense, the term therapy can apply to any activity that improves, slows, or eliminates a debilitating or undesirable condition in an individual. One person's therapy can be another person's problem. For example, a professional chef in a struggling new restaurant could worry and fret to the point of burnout; a few hours gardening might be a therapeutic diversion. Conversely, a professional landscaper could work to exhaustion trying to impress an influential client; and a few hours of gourmet cooking could give him just the break he needed. These forms of therapeutic diversion are common to all; we usually make no attempt to quantify the benefit received, we just know they make us feel better. In the strictest sense, the term therapy is restricted to the specific treatment of a condition (or disease); the implication is that benefits can be measured, and given certain conditions, are applicable to other individuals who are plagued by the same disease.

Animal Facilitated Therapy (AFT) programs, generally speaking, have fallen

traditionally into the broadest definition of the term therapy; but in the past few years, health care delivery programs utilizing animals have been quantified and replicated, with precise benefits to the patients being measured and assessed. The formal assessment of any AFT program is the biggest challenge facing the discipline today, and if it is to be recognized as a valid therapeutic modality, must be shown to be a valid, replicatable, and creditable treatment.

The biggest obstacle to formally assessing any AFT program is the nature of the treatment; one unique entity interacting with another, with only one of those entities being able to verbally assess the mental or physical benefits to the health care provider. Even holding certain factors constant, like breed, size, temperament, traits, etc., strong personality differences exist. A second problem is the interactive effect on a large confined population. An almost universal comment about AFT is that it makes the facility seem more like home, in a sense that the atmosphere is more congenial, more relaxed, more interesting, or less sterile. If AFT impacts upon a single individual, whether it be patient or provider, there is a spill-over affect on the rest of the population. The point is that apathy, lethargy, depression, and other symptoms that point to poor emotional health are contagious, particularly in an isolated and confined population. By improving these conditions for a few individuals, there is a good possibility of carry-over to the entire population (34).

Still another difficulty is improvement itself. Psychiatrist Michael McCulloch has asked: "How do we measure the smile on an old woman's face when

she picks up an animal?"(35). We can measure the number of smiles within a given period of time and compare it to a previously observed baseline standard, but what value can be assigned to a behavior that occurs for the first time in many weeks, months, or even years?

The fact remains that most formal research is based upon statistical analysis of the differences between a baseline condition (standard population) and the same condition after treatment. The effectiveness is determined based on the degree of deviation from chance toward improvement. A person that speaks after months of silence is medically seen as a much greater improvement than that of a person that just speaks more than before but this can be easily lost in routine statistical compilations. There is a certain skepticism that accompanies the anecdotal accounts of patient improvement, yet the full implication of the potential benefits of AFT have, to date, been reported in this manner. For example, Robert Andrysco reported about a patient that was delusional, paranoid, and violent; with AFT she made a virtual complete recovery. In his words, "she was our miracle." Andrysco's study yielded impressive results, but the subjective accounts of patient reactions more fully illustrate the incredible potential of this therapy.

A final consideration is the long-range effects that might be lost if the staff do not know what to look for in the patients. Andrysco says: "It's not enough to simply walk a dog through a patient population; you have to know what to expect and what to look for." As with his "miracle" patient, when the patient was first introduced to the animal, she knew it was brought in to kill her; the experienced therapist, Andrysco, was able to proceed slowly and

reinitiate the contact between patient and dog that led to the recovery. A less informed staff member would have immediately withdrawn the animal, and rightly so, considering the precautions recommended about patients that have adverse reactions to animals. For those administrators that wish to embark upon this exciting new program, remember the AFT adage:

> No one formally evaluates occupational and art therapy. They are accepted methods that we take for granted will improve the lives of certain patients. Animal facilitated therapy is similar, in that it should be instigated in the same fashion. Assessment of benefits should begin only after the novelty has worn off and the program is well established. All personnel in the health care delivery professions have their own internal guidelines, the parameters that they themselves use to determine if a given patient is improving or not. Keep notes, mark your files and the patient's chart; later, when all the excitement has calmed, take a good look.

THE PRE-SURVEY PROCEDURES

With the basic understanding of why a health care facility would want to assess the possibilities of various animal facilitated therapy programs for use by its staff, the basic administrative procedures can be detailed.

A. Initial Contact with the Administration.

The first step for the person(s) interested in introducing pets into a federal health care facility, whether that person is a staff member, a patient, or an outside source, is to meet with the administration. In the initial oral or written communication with the administrator (to arrange a meeting time), the contact person should indicate that informational materials will be sent for review prior to the meeting. The references in Appendices A,

G, and J are an excellent review of the current thinking and research on the role of animals in health care and will provide the administrator with a good overview of the possible benefits of visiting or resident animals in his or her facility. The contact person should be prepared at the meeting to answer questions about the materials and to review step-by-step the procedures outlined in this Guide for evaluation, recommendation , and possible animal placement in the federal facility.

B. Administrative Decision.

After reviewing the informational materials, most administrators are enthusiastic and willing to cooperate. Should the administrator decline to proceed with the evaluation, the contact person should offer to discuss the proposal again at a future date and leave the informational materials as a courtesy for his or her later consideration. If the administrator agrees to proceed, a time should be agreed upon for meeting with the staff in order to begin the evaluation. It is helpful if the administrator appoints one staff person to be a liaison in the evaluative process.

C. Staff Preferences.

The full participation and cooperation of the entire staff (nurses, aides, and housekeeping and custodial personnel) will be necessary if any animal placement is to succeed. Without staff involvement, the chances of unsuccessful placement are high. The staff of the institution must possess the knowledge to plan a placement well, the energy and enthusiasm to make the placement work, and the commitment to care for an animal properly.

1. Slide/Tape Show. It is helpful to arrange separate meetings for the

nursing staff, day and night-shift employees. These meetings should begin with an explanation that there is some interest in allowing pets in their facility, but a decision will be made only after the views of staff and patients have been considered. Then those present can be shown a brief slide/tape show. The narrated slide presentation should discuss all of the ways pets can be made available to health care providers and patients. For information on available slides and tapes, contact the Delta Society, (206) 226-7357, or write them at 212 Wells Ave So., Suite C, Renton, WA 98055. After viewing the slide show, the employees can give a more informed opinion on pets in their facility.

2. Distribution of Pet Preferences Form. After presenting the slide show, distribute the Pet Preferences Form (Appendix B). Explain that complete anonymity is maintained for all respondents. Since staff members cannot be identified by the form they fill out, they can feel free to express their honest opinions about possible uses of pets in health care. Ideally, the forms should be collected at this time; however, they can be returned to a designated place by a certain date for pick up.

3. Interviews with Individual Staff Members. Members of the health care delivery staff will probably have different perceptions of the advantages and disadvantages of allowing pets in the facility or using them to facilitate therapy. Often, persons with greater responsibilities and administrative duties perceive more problems and benefits since they see a larger picture of the institution. It is essential that these persons be contacted on an individual basis and interviewed in more detail than the Pet Preferences Form

allows. Using the back page of the Pet Preferences Form as the starting point of the interview, try to elicit some detailed response to the listed categories.

For each management area (e.g., housekeeping, nursing, maintenance), work with the health care facility liaison person to identify key people or opinion leaders. Meet with these individuals to discuss the benefits, problems and care of animals as envisioned by people in their area. Take detailed notes during the interview.

D. Institutional Data.

1. Health Care Facility Characteristics Inventory. The purpose of this brief form (Appendix C) is to summarize information about the facility, its patients and staff that is considered relevant to animal placement. The form should be given to the administrator as soon as the initial decision to proceed has been made. Some of the facility's characteristics that might influence the choice of animal are patient density (degree of crowding), ward segregation, and patients mental and physical capabilities. Similarly, some of the staff characteristics influencing animal choice are number of staff, time, comments, and responsibilities. These variables, along with the other evaluative data gathered, will provide the basis for the recommendations.

2. Physical Space Assessment. Another aspect in evaluating a facility for animal placement is to appraise the physical layout for its assets and liabilities. If a floor map of the institution is not available, sketch one. On the floor map note such things as traffic patterns, size of rooms, number of people per room, and open areas and restricted area, both inside and

outside. Some facilities can accommodate an exercise run, whereas others have room for only a cage or aquarium, depending upon the physical space available and the patient density. Indicate potential locations for pets or pet shelters on the map.

3. Social Space Assessment. An appraisal of the social space or social behavior of a facility is a subjective judgment. An observer, quietly and unobtrusively, should try to record the flow of social activity throughout the entire day. Note where the patients tend to congregate; the quantity and quality of interaction between the patients, staff, and visitors; whether or not there are social isolates; and whether or not there are any "social turfs" or areas staked out by patients or staff that one needs permission to access. It may be assumed that an animal will provide, in varying degrees, visual, tactile, auditory, olfactory, and social stimulation. The observer thus needs to view the social scene with the thought of how an animal might best fit in as a stimulus, not as an impediment. Working with one or two other people, the observer can share the responsibility so that together they observe one complete day in the facility--morning, afternoon, and evening. The physical and social space appraisals give specific information about each particular institution and are important pieces to the puzzle that fit together for the final recommendations.

4. Rules and Regulations. An important consideration is the rules or regulations governing the presence of animals in institutions. These rules may originate from federal, state, or local governments, or local commanders,

administrators, or committees. If rules must be written for the facility under study, the Appendix H models will be helpful.

E. Evaluations.

1. Interpretation of Pet Preferences Form. The information on this form can help provide answers to four basic questions:

-What suggestions do staff and patients have about making pets available in your facility?

-Which ways of having pets available in your health care facility are most favored by staff and residents?

-What particular species of pets are preferred by staff and patients?

-What benefits or problems do staff and patients anticipate?

2. Interpretation of Interview Data.

a. Patients. The interview is designed to provide information concerning the patients background with pets, pet preferences, and approval or disapproval of the many different ways of having pets available in the facility. In summarizing the personal pet preference of the patients, it is important not to overlook the comments given by those interviewed. These comments may suggest potential advantages or disadvantages of particular types of pets and be very useful in planning. A general summary of pet preferences can be made by using the worksheet in Appendix F.

b. Staff. Interviews with key staff members or administrators of the facility may provide considerable insight into the potential problems and benefits of allowing pets into the facility. Some of the questions which might be explored include: (1) Which patients or staff have particularly

strong positive or negative feelings about pets? (2) What types of problems or benefits concerning pets can be anticipated for different functional areas in the facility? (3) Are some locations more suitable than others for pets? (4) Which patients or staff in the facility would be capable of caring for an animal? (5) What concerns would staff members have if a pet were introduced into the facility? The best strategy for recording what is said in these interviews is to take careful notes. Later, the notes can be summarized by grouping the comments into general categories such as problems with pets, benefits of pets, suitable pet locations, and management of the pet(s).

3. Interpretation of Institutional and Observational Data. The Health Care Facility Characteristics Inventory is designed to provide an overview of the facility in terms of space, staffing, patients, and past pet history. In reviewing the completed form, keep the following types of questions in mind:

(1) For the size of the facility, are staffing levels adequate? Is staff turnover a problem? (Too few staff or a high turnover rate for a facility may suggest that pet care by staff should be minimal or care should be managed by patients or outside volunteers.)

(2) Are the patients generally mobile and in reasonable health, or do a large percentage require basic assistance and care? (The mobility and health of the patients may impact on the type, size, and location of a pet in the facility. For example, if patients are generally bed ridden and receive skilled nursing care, they will need someone to bring animals to them and oversee interaction. If mobile, patients can seek out animals and possibly provide animal care for them.)

(3) Do patients have private or shared living space? (Shared space will require agreement between patients of the room in which a pet might be placed. Hospice rooms may also provide opportunities for pet locations.)

(4) Which staff or administrators may have involvement in a pet placement? (They will have to be interviewed.)

(5) If past pet placements were unsuccessful, why? Has the situation changed?

Data resulting from review of the physical and social space within the facility are most useful in narrowing pet choices and potential pet locations. Space considerations alone may limit the type of animal selected for placement. Lack of any area suitable for an outdoor kennel run or for walking, for instance, will make selection of a dog for placement impractical. A high degree of crowding in a facility may restrict space for stationary pet cages or aquariums. Facilities with large outdoor areas may consider farm animals or fish ponds, in addition to more traditional indoor pets. State or other regulations must be considered, in order to identify the "real" space available for an animal, eliminating all restricted areas such as kitchens or dining rooms. Zoning regulations may limit the types of outside animals that could be considered.

Social patterns within the facility may suggest ways of integrating pets into the flow of activities and events. Each facility will undoubtedly have a sequence of activities at regular times throughout the day and night (rising, breakfast, baths, social hour, lunch, activities). These activities and the range of times at which they occur will vary considerably for each facility.

Those spaces where patients congregate daily or spend time individually may also be appropriate for interactions with pets (e.g., recreational or visiting space). If most patients spend a large portion of the day in private or shared rooms or visiting such rooms, the most effective way of including pets may be by pet assignment to particular rooms. If lounge areas are heavily used, pets in aquariums or cages may become part of the areaís flow of activities. In warm climates, outdoor space may also be well utilized for group interaction or solitary activities. The key consideration in placing pets is to locate the pet, both spatially and socially, out of the mainstream of the health care facility.

CHAPTER 5

THE OPTIONS FOR THE INPATIENT PROGRAMS

It is well recognized that pets have a positive influence on health, but the studies do not specifically tell us how they exert this effect. It must be by virtue of what they do for people. Some of those effects are unique to animals; others are shared with humans. There are a least nine recognized ways that companion animals can increase their owners' health and resistance to disease (37). At a minimum, the companion animals do the following:

1. They provide companionship.
2. They give us something to care for.
3. They provide pleasurable activites.
4. They are a source of constancy in our changing lives.
5. They make us feel safer.
6. They return us to play and laughter.
7. They are a stimulus to exercise.
8. They comfort with touch.
9. They are pleasurable to watch.

Realizing these nine benefits, and having conducted the presurvey program as outlined in Chapter 4, the evaluative data can be summarized and considered for the different treatment programs. All recommendations from consultants or the survey team should be in writing, and provided the administrator for deliberation prior to the decision process.

A. The Budget

The cost of animal facilitated therapy programs is relatively small compared to the potential benefits. The Lima State Hospital currently uses over 175 animals for a cost less than $600 a year (31). Although staff and patients are usually willing to contribute to the care of the furry therapists, it is recommended that a formal allotment in the institution's budget be developed. It is, after all, a therapeutic activity, and the initial investment can be kept to a minimum by methods noted in Chapter 3. Upkeep will vary greatly, depending upon the circumstances, but here are some estimated annual costs to include food, grooming, and veterinary supplies (military veterinary medical sevices should be available for free):

-Large dog: $500 - $700

-Large bird: $150 - $400

-Cat: $150 - $200

-Rabbits or guinea pigs: $75 - $150

-Small caged mammals: $50 - $100

-Vivarium: $25 - $75

-Small fresh water fish: $10 - $25

Additionally, within the budget development, funds should be allotted for conferences, reference materials, and if possible, training sessions. Conferences provide not only the current status of applicable research projects and forums for discussion of therapy results, but can often act as a springboard for new and more exciting uses of animal facilitated therapy. Supervisory personnel should be the ones to attend these national and

international interdisciplinary conferences, rather than the staff aides handling the animals on a daily basis; there are separate conferences on training or handling of animals that the staff can attend in the local community. Information concerning all aspects of the human/animal bond and the related environmental considerations is kept available by an interdisciplinary clearing house and professional organization called the Delta Society, 212 Wells Avenue S, Suite C, Renton, WA 98055.

B. The Alternatives.

No Animal

After thoroughly considering all of the information gathered, the evaluator may reach the conclusion that animals are not appropriate in a particular facility. Reasons for this conclusion should be explained in written recommendations and discussed with the administrator. With the administrator's permission, the recommendations should also be discussed with key staff and patients. Some reasons for this recommendation might include: Space too crowded for animal, majority of staff/patients opposed, no one to provide care of animal, majority of patients too confused to seek out pet, or no volunteers/staff available to bring pets to patients.

Visiting Animals

1. Types of Programs.

a. Volunteers visiting with animal(s). One of the most flexible and successful programs involves bringing animals into the facility to visit on a regular schedule. The animals provide entertainment and diversion, sensory

stimulation and an opportunity for reminiscence. The animals can be kept away from those patients with allergies or phobias or from those who object to the presence of animals in health care facilities. Care is not a problem since the animal is only in the facility for a brief time. This approach also makes it possible for patients to choose from a wide variety of species--dogs, cats, guinea pigs, rats, even a cockatiel or well-behaved ferret. Patients who are nonambulatory or confused and could not otherwise approach an animal have one brought to them and are assisted in properly holding it on a one-to-one basis --something a busy staff might not be able to do.

The success of the program hinges on: (1) establishing a regular visiting schedule; (2) providing training for volunteers; and (3) selecting suitable animals. A regular schedule is important since many patients look forward to the visits and are disappointed if *no one* comes. The wards also need to know what to anticipate in scheduling activities or working with individual patients. Training sessions for volunteers are recommended for several reasons. First, volunteers can be informed about visitation procedures that have been approved by the facility; thus minimizing inconvenience to wards and their patients. Second, volunteers can be educated on what to expect and how to work with persons with a variety of disabilities. A good approach is to have experienced nurses from the local institutions talk to volunteers about the most successful way to interact with residents in their facilities. If a local college or television station is willing, these presentations might be videotaped so they will be available for new

volunteers. This orientation will relieve some anxieties and make volunteers more comfortable and successful.

The selection of suitable animals is equally important. Many programs use puppies, kittens, and other animals from the local shelter. Certainly young animals are irresistable; they are also unpredictable and have an unknown health background. Some veterinarians have expressed the concern that such animals present a risk, however slight, of being a reservoir of rabies. However, to date, no instance where a health problem has resulted from such visits has been published.

The more successful visiting animal program have elected to use animals that are owned by members of the local community and have a known temperament and health history. Volunteers who do not own an animal are referred to local people willing to lend an animal. In some cases where the animal is home alone all day while its owner works, an outing with a volunteer to a health care facility also benefits the animal. As the weeks of visiting go by, the patient and staff come to know the individual animal by name, learn its history, and form a friendship with the animal. As friendships and confidence develop, volunteers are encouraged to visit individual patients so that a closer, more personal relationship can develop.

b. Traveling Zoo. Community volunteers may enjoy organizing a "traveling zoo" for three or four health care facilities. The "zoo" animals would be rotated monthly among the facilities. Each month when the new animals are brought into the facility, the volunteers would present a brief, entertaining program to residents and staff to introduce the animals. The animals cage would be kept in a lounge or day room public area. Food and cleaning supplies

would come with the animals. Examples of the "zoo" animals would be small mammals (rats, mice, gerbils, guinea pigs, hamsters), hermit crabs, snakes, tarantulas, chameleons/lizards, turtles/tortoises.

The staff of the health care facility would be responsible for feeding the animal(s) and cleaning the cage. The cost of cages, animals, food, and supplies might come from a fee to each facility in the program, from service club donations, or from fund-raising events. A local pet store might donate or loan some animals. Attached to each cage should be sheets of paper laminated in plastic that describe the animal, its habits, and proper handling. The printing should be large enough to allow patients with vision difficulties to read the descriptions. A detailed feeding and care schedule should also be attached. Once each week a volunteer should check to ascertain that proper care is being given.

2. Procedures.

The volunteer coordinator or a reliable volunteer at the facility might take the lead in organizing the visiting animal program. That person would do the following:

a. Circulate a sign-up sheet to obtain names of volunteers. Possible sources include volunteer bureau, 4-H, Scouts, senior citizen and youth groups, church groups, humane society.

b. Familiarize volunteers with basic procedures in the program through a manual, training meeting, and/or videotape.

c. Select one volunteer to coordinate all other volunteers for each health care facility.

d. Obtain from the administrator or chief nurse of the health care facility suggestions on the best time to visit and a list of patients who seek or would benefit from visits with animals. The list should include patients names, room numbers, animal preferences, and comments about disabilities and temperament.

e. Provide each volunteer with a list of approved animals that can be borrowed if the volunteer does not have access to a suitable animal. The list should contain the owner's name and telephone number (the owner should have available a handout on the procedure for borrowing his/her animal; remind volunteers to treat the animals with care and to get to know them before the first visit). These animals can be identified through local veterinarians, humane societies, or dog and cat fancier groups.

f. Make a list of all volunteers for each facility and circulate it among the volunteers to facilitate car pooling.

g. Have all volunteers meet at a central location on a regular basis (e.g., first and third Saturday at 9 a.m.) and go together. Eventually some volunteers may establish their individual schedules for visits at least twice each month to particular residents.

h. Let the patient administrator know ahead of time when you are coming so patients can be encouraged to gather in the day room or lounge.

i. For special events, organize a farm day when small farm animals can be brought by 4-H or FFA students to visit outside, perhaps in conjunction with a picnic. Or ask a 4-H or a local dog or cat fancier group to come and give an obedience demonstration or even mini pet show.

j. Remember these common sense requirements:

-Select an animal that is clean and in good health, has all required immunizations, and is temperamentally suitable and predictable (friendly, calm, under control).

-Keep the animal on a leash and/or transport in an appropriate cage.

-Familiarize the animal with the facility by making one trip before visits begin.

-Exercise the animal before the visit and take materials to promptly clean up any accidents.

-Keep the animal out of food preparation and serving areas.

-Know which people in the facility dislike or are allergic to animals and avoid them.

-Report to the nurse on duty any scratches or injuries that result.

-Report to the coordinator even the smallest problems so they can be resolved immediately.

-Tell the persons being visited and the coordinator if a volunteer can no longer come so that patients are not disappointed by "no shows."

-Enjoy getting to know the patients; be regular in the visits.

Resident Animal

Choosing a resident animal involves a long term commitment on the part of the members of the health care facility (staff, residents, and administrators) to the animal. For this reason, there should be a strong consensus among members of the staff that an animal is wanted before any final decision is made. It is also very desirable to take a cautious approach in selecting and placing the resident animal. If a reasonable trial period can be agreed upon by members of the staff and the individual(s) from whom the animal is

obtained, wrong choices can be corrected without long-term consequences. During the trial period, problems arising (such as misbehavior or improper animal care) may also be caught earlier and easily corrected if special attention is given to the placement process. Local experts or interested animal owners in the community may be of considerable help in this process.

1. Types of Models. There are many ways for an animal to be included as a resident of a health care facility, some of which may be more appropriate to a particular situation than others. One common approach is to assign a particular animal to one individual in the facility; this approach often involves restriction of the animal to the individual ward. Care for the animal may or may not be managed by an individual. Staff or patients may be given responsibility for the animal's care. An individual in good health who is able to care for the animal may enjoy and benefit from the activity in terms of reality orientation, daily scheduling, or physical movement and exercise. By its nature, this type of approach to keeping a resident animal lends itself well to becoming part of the overall therapy provided to an individual. If an animal is to be used in a therapeutic approach, the therapist should be referred to the work of Corson and others on animal facilitated therapy (see reference in Appendix J). Simple companionship, of course, may also be an equally acceptable reason for trying this approach, especially where human attention is more difficult to provide (e.g., small staff, immobile residents, etc.). Some health care facilities are considering letting a patient bring his/her own animal when being admitted, if the animal is suitable.

The mascot model is another means of keeping resident animals which are

most appropriate to group situations. In this approach, the animal is typically assigned to a small group of individuals whose living space (a room, a ward, or a lounge) often forms a set territory for the animal. Mascots may be free roaming within the territory or restricted via a cage to a particular location. Some mascot animals roam freely among all patients in a facility, but usually show a preference to certain individuals or groups. Care may be provided by an individual (either staff, patient, or volunteer) or by sharing responsibility within a group. An animal in a facility may be either a staff or a patient mascot. The mascot's main purpose may be to provide companionship or visual stimuli to those in its territory. Other functions a mascot might fulfill include facilitating conversation among groups, tactile stimulation, or entertainment. A third possibility for managing a resident animal is where a staff member brings a temperamentally suitable pet to the ward during his/her shift on a daily basis. This is similar to a visiting program, but since the animal is regularly brought to the facility/ward, a pseudo-resident status is developed. For the staff pet to be used effectively, the animal should be actively introduced to patients on a regular schedule. For instance, an animal may have a sequence of rooms to visit or set locations for being visited or staying during the day. The staff pet has the advantages of familiarity, regular interactions with certain patients or staff, and more active staff involvement with the pet. Daily care and feeding are not problems since these are provided by the animal's owner.

2. Species. Dogs, cats, birds, fish, small mammals, and many other types of animals have been successful residents in health care facilities and other institutions. Choosing the best species as a resident animal is a critical

decision. Some of the key considerations should include the level of care able to be provided (by either the staff or patients), the physical space available for an animal (shelter, exercise, feeding, grooming, etc.), the ability of patients to handle different types of pets (mobility, strength, motor control, awareness), the attitudes of patients and staff toward different types of animals, and the resources available for care of the animal. Information contained in the placement section of this report will be useful in gaining an understanding of the characteristics of different species and their environmental requirements. A visiting program, if one is available, may help to give the staff and patients experience with particular types of animals prior to selecting a permanent resident animal.

C. Placement, The Administrative Decision

After careful consideration of the recommendations concerning animal placement, as well as many other factors in the facility, the administrator makes a decision to proceed or not with a placement. The administrator should have access to the preference sheets and written consultant reports to aid him/her in making the decision. The decision may be made solely by the administrator or may, at his/her discretion, be made in a group setting where many individuals share in the process. If a decision is made to introduce animals, the next step depends upon whether a visiting or resident animal is desired. Whether a visiting program is chosen, or a resident animal program is chosen, the animal should be selected, trained, and placed using the information and procedures in this chapter.

CHAPTER 6

OUTPATIENT PROGRAMS

Once Animal Facilitated Therapy (AFT) is accepted as a viable method of improving communication, patient morale, or another aspect of health care delivery, the possibilities of how the animal(s) could be used are limited only by the staff's ability to be creative in employing the animal. The purpose of this chapter is to provide a few field-proven alternatives to assist the creative health care provider develop a progressive concept of possible options for outpatient treatment programs.

Physical Activity and Exercise

It has come to light in recent years that a brisk walk provides as much as 90 percent of the benefits of the more stressful and regimented jogging or running programs (38). Walking has the additional benefit of requiring very little preparation while allowing spontaneous group involvement. The companion canine facilitates this activity by making the walk not only have a purpose and meaning, but also adds companionship and enjoyment, especially in single-person households. The dog can also add an urgency when the biological demands dictate, which usually adds motivation to the owner to maintain a regular regimen. The walking program (without a companion animal) for senior citizens, or physically challenged patients, can be tedious and add to a feeling of aimless wandering; with a dog, the walk can never be considered aimless or tedious, especially when the dog starts chasing the neighborhood cat. The increase in community communications that result from these

companion animal excursions can be considered an intangible by-product; that by-product provides an unmeasurable but important benefit to both the patient and the community.

In conjunction with the veterinarian, a greater personal responsibility can be added to the walking program by addressing the health of the pet. If the dog is getting too fat, because of inadequate exercise, the patient could be inspired to increase his/her own exercise program for the benefit of his/her furry friend.

Other exercises occur that are often an overlooked therapy, such as petting an animal. While stroking a pet has proven soothing, and can reduce the signs of stress, it also causes the arthritic hand to move beyond the small rotation of a TV knob. The shoulder activity associated with caring for a caged bird is another example of applied exercise necessities being used in long-term therapy regimens (39). These exercises increase the need for locomotion, and the frequency, but allows it to occur at the patient's pace, while secondarily supporting the feelings of being needed and maintaining their dignity.

Speech Therapy

It has been well accepted that the presence of a companion animal can prompt an otherwise noncommunicative person to speak. It seems that animals can reach through the self-imposed muteness and often break the silence with only the nonjudgmental love that is exchanged. But this nonjudgmental love goes beyond the mute patient for the creative health care provider or therapist. Stroke victims often have difficulty recovering full speech, yet

an animal will listen intently to the patient's attempts, often responding to sounds that another person would not understand. The pet provides positive reinforcement to the tedious and frustrating recovery process; a reinforcement that is rewarding and filled with love, two important reasons for the patient to continue the rehabilitation (37).

The secondary activities of a companion animal in response to exercise activities can reinforce the need to do that activity, such as the cat that loves to watch the owner playing the piano, or the dog that likes to visit the friends of the owner. Even the bird that sings back to the owner's voice makes the owner get involved in the exercise of singing at cage-side. Pets are often willing participants to therapy or exercise programs where they're only allowed to observe.

Patients' Needs

Reminiscence, or reviewing one's life, is an important aspect of working with the elderly or terminally ill; yet it is a very private vent that is seldom shared with the health care provider. The pet is a tool that can trigger reminiscence, while serving as an anchor to force the patient into returning to the reality of today, to take care of the animal's needs.

The use of animals, even fish, to reduce anxiety and stress, has been proven to be effective (37). The soothing experience with animals may calm the patient enough to allow the therapist, aide, or chaplain an opportunity to discuss the troubles of the patient. Again, patients seldom equate the animal with therapy, and will talk freely with the pet while sorting out their own feelings. The animal is attentive to the tones of need, and the patient can

practice vocalizing the real problems, without fear of judgmental rejection or misunderstanding.

Beyond the reconstructive or corrective therapy lies the quality of health care; what the dignity of the patient needs in the therapy program. It is at this level that the companion animal generally far surpasses most efforts of the health care provider. The useless feeling of a patient that is institutionalized, or just barely ambulatory, can lead to depressions that can be manifested as anger, anorexia, fear, or a host of other abherant behaviors. The need to care for an animal often circumvents these feelings of uselessness and adds purpose to the patientis life. Similarly, the companion animal at home often makes the inpatient strive to become an outpatient, and to keep that outpatient status, in order to allow the human/animal bond to be maintained (40).

Occupational Therapy

Exercise, personal fulfillment, or social catalyst, whichever the reason, the use of an animal is limitless. The sensual spectrum of sights, sounds, smells, and touch provided by animals can provide adjunctive stimuli for the alert therapist. Yet the petting, playing, watching, and interacting that provides hours of therapeutic activity is often lost or discounted as leisure or entertainment. The health care provider can utilize any of these factors to facilitate the therapy program(s). Consider the use of guide dogs, hearing dogs, signal or service animals, that could provide patients with psychosocial or physical assistance vital to independent living; what better way to conduct therapy with dignity?

The occupational therapy possibilities go beyond animal care and maintenance skills. Obedience training, grooming, professional walking services, animal breeding, or pet sitting are only a few of the first mentioned occupati al activities. The opportunities extend further, into cage building, habitat reconstruction for the bird watcher, knitting coats, or building beds for the animals of others. The making of paraphernalia to resell to pet owners, such as collars, wall hangings, scratching posts, catnip toys (to include growing catnip), bird cage covers, or a host of similar activities, can become a secondary or even primary income source, as well as an augmentation of the occupational therapy program.

Stimulus To Creativity

The individual interests of the patients will be as variable as the types of pets, but the past may not be the therapy key. Corson reported patients that after 20 years of withdrawn and uncommunicative behavior, and with the introduction of a dog, became artistic (19). They started drawing and painting pictures of dogs, and even painted murals on walls. The presence of an animal could be used as a stimulus for creative pursuits.

Animal scrapbooks are a type of creative stimulus often overlooked. These books can be shared and they may provide stimulus to other patients (34). Often family activities can be stimulated around the family pet, whether it be something for the animal, or as a joint project about the animal, as in a montage or scrapbook.

Continuing Education

The companion animal can cause a quest for knowledge. Sometimes it is

manifested in library visits and is just reading for general knowledge. With some animals, like the cat, the literature is filled with myths and folklore that stimulates the mind. Simple questions like where the breed originated can open many avenues of discussion and expose many inner feelings with the patient that is outwardly neutral. Often, "researching" about a pet could even become a good topic for group discussion sessions.

On the other side of the issue is the guests that can be brought in to educate the patient, to establish new relationships; breeders or kennel clubs often like to share their interests with others. Sometimes local community groups will have visitation programs, or ask house-bound patients to be pet sitters, thus expanding the patient's contact with others as well as their responsibility to other persons.

The patient that gains a significant knowledge level could even be used to aid 4-H or Scouting activities. A feeling of worth could be available from helping the youth of their community. Involvement in pet shows, as a participant, a judge, or as an organizer/worker can add to the daily activities of a patient; causing that special event to occur increases the feelings of self-worth and personal esteem.

Developing Outpatient Program Objectives

Regardless of the specific benefits of an outpatient program, the critical element is the planning, and determining what is to be achieved. Vital to the success and longevity of any program is determining objectives that (1) meet the needs of the community supported and (2) can be implemented by the health care facility staff. These objectives (or goals) can be addressed at the initial informational meeting and attendees should be encouraged to address

objectives as an issue requiring the highest degree of definition and understanding. Let's assume that the initial health care delivery program to be augmented with Animal Facilitated Therapy will be primarily a social adjustment program for teenagers. The objectives might be stated as:

1. To place (if legally permissible) an animal mascot with as many teenagers as could accommodate pets.

a. If not permissable (due to parents, housing, or legal restrictions) to have individualized pets, to arrange for regular and innovative pet visitation programs. This could even be a pet sitting or pet walking service set-up for teenagers to operate; it would provide a method for increasing self-worth (not to mention the potential profit motive) and self esteem, as well as establishing a daily companion animal contact.

b. To work to alter current limitations so that more teenagers can have the opportunity to experience a pet.

2. To provide support for teenagers that already have a companion animal. This might include offering financial assistance via pet food coupons, discount veterinary services, training/obedience classes, or similar actions to support the teenager's pet "stewardship" role.

3. Placement of carefully selected companion animals that have been matched to the teenagers needs; this is an ownership program rather than a temporary mascot program.

4. Having teenagers learn to train specialty pets (such as hearing and signal dogs) for those who would need such an animal, and developing an appropriate placement and follow-up program to assess the benefits derived from the teenager's efforts.

5. Developing a referral service for teenagers who have problems with a companion animal.

Several ancillary concepts and interest areas have been identified that have therapeutic health care program possibilities (41,42). A few ideas that illustrate the wide spectrum of possibilities are listed below:

1. Establishment of an animal loan service to make selected therapy animals available to foster homes.

2. Implementation of a wallet or purse card for persons who live alone to carry with them; if involved in an accident, it will notify authorities that their animals need immediate care.

3. Revision of health care forms to include questions concerning care of pets in the absence of the owner (like upon admission). This can develop into an outpatient occupational therapy support program for inpatients.

4. Development of an emergency care plan to provide for animals displaced by personal or local disasters.

5. Transportation to veterinarian's offices of animals, and possibly the owners, belonging to people of limited mobility.

6. Political action to lobby for changes in legislation to permit animals in health care facilities and in government-sponsored housing.

7. Design a window sticker to alert rescuers to types and locations of companion animals in case of fire.

8. Development of a program to train animals to assist the handicapped in various ways (fetching glasses, turning on lights, hearing for the deaf, etc.), or establishing a resoure file to identify where such animals can be obtained.

9. Placement of a trained animal on a pilot basis with selected emotionally disturbed individuals. Staff members would conduct home visitations regularly to help solve problems.

10. Establishment of a telephone 'hot line' to answer outpatient questions about pet-owner problems.

11. Animal mediation of bereavement or stress by companionship and distraction; this could include a patient-pet visitation team in support of a hospice program or nursing home.

12. Development of a traveling "zoo" program, where five or six vivariums or small mammal display tanks (each with different species of animals) are rotated between area nursing homes; responsibilities for rotation and training of the nursing home care givers could become an outpatient therapy for selected patients.

CHAPTER 7

PET MEDIATION OF THE GRIEF PROCESS

The impact of the grief process within health care delivery has often been a complicating factor to effective patient care. It is a dynamic, cyclic, and often unpredictable sequence of events that beset the patient, the family, the medical staff, and others in the health care environment. The more traditional social worker or psychologist usually advocates letting the patient or family "work through" these intense feelings, but the number of patients in active therapy indicates that this is not always possible. The use of a pet to mediate within the grief process has multiple applications, such as: A neutral communication topic, a distractor, an anchor on the reality of today, an object to nonjudgmentally give and take love, a security factor, a friend and companion, or a host of other roles that can facilitate the "letting go" of the past that is associated with the grief resolution process.

The steps in the grief process were initially popularized with the writings of Dr. Kubler-Ross: denial, anger, guilt, depression, acceptance, resolution. These steps have been applied in many forms to multiple types of stress and grief situations. For the sake of this discussion, the "grief process" will be discussed within the scope of the four stages of grief, as shown below:

1. Anticipatory Grief Stage--that period from initial exposure to the potential problem or potential situation to the point of actual future occurrence.

2. Crisis Grief Stage--when the stress event occurs, when the potential

problem or situation becomes a reality and it is no longer a "future issue."

3. Crucible Grief Stage--that period following the crisis when emotions are sorted, and roles are redefined, so that the person can start putting their life back together.

4. Resolution Stage--this period can go days, months, or even years, while the person is developing themself into an independent entity that is capable of interaction, without reversion to a previous step of the grief process.

While the grief process has been identified mostly with the stress of death, dying, and the associated bereavement, it must be realized that grief occurs with the stress of divorce, unexpected unemployment, runaway children, or even bad grades in school. The grief process is applicable to any stressful situation where the person wishes something else could, would, or should happen. There are numerous texts and references on stress and grief, so these topics will not be developed further. The role that an animal can play in stress and/or grief situations will be the concern of the remainder of this discussion.

A pet, be it a dog, cat, bird, fish, or any other creature, often assumes a significant role in the human/animal bond. The concerned owner often anthropomorphizes the pet, but that is not at issue here. What is significant to note is that most "ownerships" actually evolve into "stewardships," where the animal's welfare becomes far more important than that of an "owned" possession. This stewardship relationship is the key factor that allows the pet to mediate in the grief process. The pet is generally given family or person status, as shown by the 1982 Department of Defense family study (44) and reverified by the 1984 Psychology Today survey (45).

The stages, or categories, of the grief process can be expanded to include the more typical key emotions that require mediation, and the key persons often associated with the nontherapeutic process of working through the steps of grief (denial, anger, guilt, depression, acceptance, resolution). Table 14 reflects the stages, emotions, and key persons in tabular form to facilitate further discussion.

TABLE 14

GRIEF IS A PROCESS, NOT A SINGLE FEELING;
A PROCESS OF "LETTING GO" WITHIN THE LIFE PROCESS

ANTICIPATORY GRIEF STAGE	CRISIS GRIEF STAGE	CRUCIBLE GRIEF STAGE	RECONSTRUCTION STAGE
DEATH (EVENT) IS EXPECTED	DEATH (EVENT) OCCURS	AFTER THE FUNERAL (EVENT)	RETURN TO SELF SENSES
EMOTIONS: DENIAL W/HOPE HOPE W/LONG RANGE SPIRITUAL PLAN ANGER &/OR GUILT WITHDRAWAL AND SOCIAL DEATH AS REHEARSAL OVER-COMPENSATIONS BECOME SMOTHERING BECOME DISTANT	EMOTIONS: SHOCK NUMBNESS DISORIENTATION DISBELIEF	EMOTIONS: PAIN & FEAR BLAME AND ANGER GUILT REMINISCENCE NEED TO DEAL WITH EMOTIONAL REALITIES DEVELOP NEW ROLES FOR FAMILY MEMBERS	EMOTIONS: ORIENTATION TO PRESENT NEW INTERESTS SELF-GROWTH GETTING STUCK SIGNS: 2 WEEKS OF INSOMNIA INCREASE WT LOSS INCREASE ALCOHOL INCREASE IN DESTRUCTIVES
KEY PLAYERS: FAMILY MINISTRY	KEY PLAYERS: HEALTH CARE PROVIDER FUNERAL DIRECTOR	KEY PLAYERS: SOCIAL COUNSELLORS MINISTRY	KEY PLAYERS: THE PERSON THEMSELF SIGNIFICANT OTHERS

The role of the pet becomes more evident when the key emotions reflected in Table 14 are considered individually. The hope associated with anticipatory grief can be safely discussed with the pet. Although the companion animal cannot express approval or disapproval, the talking to a pet provides a nonjudgmental receiver of emotions. The need to "talk it through" thereby becomes nonthreatening, and often the person solves the problem in the process of verbalizing the emotions to the pet. The companion animal provides a closeness, a nonjudgmental love and devotion, that is reassuring yet still requires attention in the reality of today. The cat purring on your lap, the dog licking your hand, or even the bird that sings back to your talking; each requires care and feeding on a daily basis. The grieving person must momentarily subjugate personal desires to another, but that subjugation is a part of the stewardship that retains the link to the reality of daily living.

The animal(s) in our environment provides a point of communication that is neutral, so that other persons may readily open conversations without dredging up a point that has yet to be worked through. What can you say to a grieving person that is safe? A comment about the pet may open the conversation into an area that the person wishes to discuss, such as a comment about the beautiful color of the fish in the aquarium may result in the person agreeing but adding the comment, "I wish my color was as good." This is the opening to start discussing the real problems and concerns, yet it isn't perceived as an invasion since the person grieving opened the discussion. A wild bird feeder outside a patient's window offers the same opportunities to safely open a discussion, possibly about the types of birds seen, and allows the patient to expand the subject. It also provides the visitor that doesn't know what to say a safe area of discussion.

The animal can provide many things to a person that is grieving, and the importance will vary with the person, and the stage of grief. For instance, in the crisis grief stage, the warm companionship may be all that's important, yet the need for attention and play can be significant during the resolution stage. It is well acknowledged that the person which is coming out of the resolution stage isn't of the same mind that entered the grief process. There is a change, in the mind, sometimes in emotions, and some even say, in the soul. Regardless of the change, that recovering person is accepted by the pet, whereas distancing often occurs between past friendships. The companion animal reinforces the worth of the individual, especially if the stewardship relationship has been strong. Table 15 shows some of the more significant contributions a pet can make during the grief process.

TABLE 15

POTENTIAL ROLES OF ANIMALS IN THE GRIEF PROCESS

Companionship

Nonjudgmental Love

Security/Safety

Neutral Communication Point

Stress Reduction

Triangulation (3rd party role)

Reality Anchor During Reminisence

Potential Distractions (e.g., exercise)

Intangible Distractions (e.g., mood)

Mandatory Distractions (e.g., feeding/care)

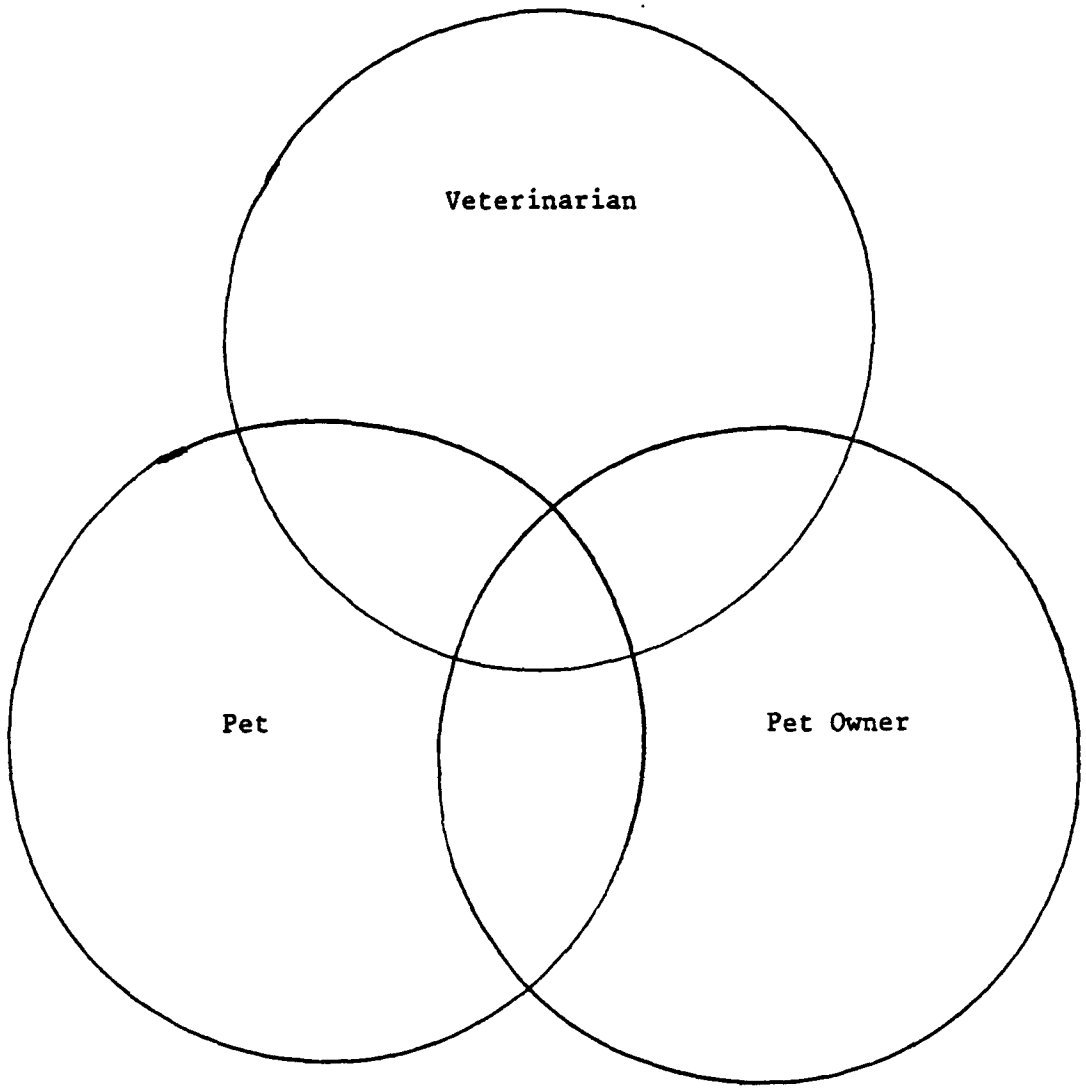
Stability of Environment

Animal mediation of the grief process is not for everyone, nor is it a panacea for all persons with pets. While research has proven that pets can reduce stress, it is not necessarily a permanent remedy. The type of stress, and character of the individual, will determine the degree of animal mediation.

It is the responsibility of every health care provider to realize that animals can reduce or soften the stress in many cases. The use of animals to facilitate care, counseling, or recovery is just one more tool in the arsenal of the contemporary health care professional. The role of the companion animal in mediating stress reactions is one such facilitation that needs consideration in today's fast paced, throw-away society.

TABLE 16

Dynamics of veterinarian - pet - pet owner interaction paradigm



Animal Offers:
* Companionship
* Protection
* Sensual Stimulation
* Economic Return
* Motor Release
* Bridge to Relationships (Human)
* Services

Human Offers:
* Physical Care
* Spatial Association
* Protection
* Sensual Stimulation
* Motor Responses
* Health Care

CHAPTER 8

THE ON-GOING EVALUATION

It is important to establish within the initial project objectives a method or methods for measuring the progress of the Animal Facilitated Therapy (AFT) program(s). These objectives can be measured in many forms, from positive feed-back from the families to NO negative feed-back from the families; or they could be very simple like to provide companionship, to facilitate interactions, or to provide sensory stimulation. It could be measured in specific actions, like when an autistic child progresses to the point that he/she will cross a strange room to pet their companion animal, when previously they would not even venture into a strange room. The objectives/goals measures need to be considered at the outset, to prevent ignoring minor changes, or developing a sliding scale of parameters. It is important to maintain uniformity in the evaluation method and the evaluators involvement with the therapy. Follow-up on animals placed with patients is critical on a weekly basis initially, extending to biweekly, and then monthly as the human/animal bond develops. Visiting animal programs should be periodically re-examined for effectiveness; it is best to use an impartial but informed, pre-briefed evaluator for these evaluations, since the new eyes will usually see the things the staff take for granted. The chief goals/objectives for any AFT follow-up evaluation are to determine how well the animal is being integrated into daily activities (socially, behaviorally, and physically) and how effective has the animal been in facilitating the achievement of the original placement goals or objectives.

Resident Animals

The initial period of placement for a resident animal may be critical to a good adaptation. Even the most carefully chosen and suitable animal may develop physical or behavioral problems in adapting to a specific health care program environment. Dr. Leo Bustad, President of the Delta Society and respected expert on people/pet partnership programs, has repeatedly reported that often, regardless of the expertise and screening, multiple animals have had to be placed with a specific patient to find the compatible pair; he often uses the example of placing six dogs into the same household before the appropriate chemistry occurred between animal and patient to form the needed therapist partnership.

Creating a predictable environment for the animals, as well as giving prompt attention to any emerging problems, can facilitate the transition. That is why the frequent visitations following placement. A patient may not have the expertise to identify the signs of an emerging problem, but the trained (and impartial) evaluator would not only identify the signs, but also initiate the preventative actions so the problem would never really occur. The guidance of an individual knowledgeable about animal behavior or the particular animal (the consulting veterinarian, an animal trainer, a breeder, a trained humane society representative, or even a well-informed animal owner) will be very useful in monitoring placements and training evaluators. It should be remembered that "too much, too soon" can be very stressful for some animals; an animal should be introduced to the home and allowed to become familiar with the new territory at a pace comfortable to that particular animal.

The animal placement evaluator(s) should brief the administrator, staff, and patients as applicable, concerning: The acceptance of the animal(s) by patients and/or staff, the quality and quantity of interactions with the animal, and any problems which have developed since placement. A typical schedule might utilize the evaluator one morning per week for small scale programs, or full time in large programs, or might even require multiple evaluators for complex, diversified, or interdisciplinary AFT programs.

During the visit to a resident animal's location, the animal should be evaluated for health, nutrition, and well-being. The evaluator should see if the care and feeding schedules proposed are being followed, and make recommendations if they are not. Similarily, if there are any people-based problems (patient or family group), such as animal abuse or jealousy, they need to be solved promptly; in fact, there should be a solution decided upon by the group involved before the evaluator departs the premises. Minor problems can often be solved on the spot, and an after-action report provided the administrator, staff, or patient. Others require consultation with the staff, the administrator, or the patient-family group. If for some reason the animal(s) is not adapting well, or there are unsolvable people-based problems, the evaluator should discuss with the administrator, the outside consultant, and the staff practitioners, the discontinuing of the program, the removal of the animal, or an alternative course of AFT action.

Visiting Animals

Monitoring the effectiveness of an animal visitation program is far more difficult than the resident animal program. The visiting animal does not have the constant health care reinforcement, and can change between visits if the

schedule does not provide an appropriate frequency of exposure. Also, often the visitations do not occur concurrent with a staff member being present, which allows for a double standard of behavior, by both the animal and the volunteer that is handling the animal. The evaluator must consider the volunteer when looking at any visitation program, as well as the management of the program, the staff and patient reactions, and the achieving of the objectives/goals.

Criteria for evaluation of volunteers can include: Regularity in visitations, reliability in keeping scheduled appointments, quality of interactions with patients, cooperation with staff, control and care of the animal, and/or participation in team meetings for patient evaluations. Criteria for evaluation of the management of a program can include: Ability to accommodate scheduled visitations and requests for visits, success in establishing mutually agreeable rules and objectives, communications between visitors and staff, effective handling of behavioral problems as they develop, and the ability to respond to changing situations while maintaining an acceptable quality of care in the patient care delivery system. Criteria for the evaluation of the visiting animal can include: Suitability of temperament, behavior exhibited during visitations, development of rapport with patients, enjoyment of visit, and health status. In evaluating the reactions of the staff and patients, flexibility is essential, but criteria that may be applied includes: Support and involvement of the staff in the program, number of requested visits by the patients, the number of referrals by the staff, the desire by patients for continuation of the program, the

perceived satisfaction of the patients, and the satisfaction (personally and professionally) by staff members with the program.

Conclusion

A good AFT program has no conclusion; it only has some satisfied participants that share their existence with an animal friend. When the health care facility has achieved the initial goals/objectives of the Animal Facilitated Therapy program, the program can be recycled, or it can be enlarged, or it can even be curtailed; whatever the final decision, the health care facility should share the final results with the interdisciplinary health care community.

If these guidelines have encouraged one administrator to become an advocate of Animal Facilitated Therapy, or has provided some health care delivery system an alternative to reach a previously unreachable patient, then they have provided the practical tools needed in today's complex health care delivery system. The result can be a genuine patient/animal partnership, with an improvement in the quality of life for thousands of patients, and an enrichment in the lives of the people and animals involved.

There are no shortcuts to the establishment or operation of effective programs; they all demand careful planning, implementation, evaluation, and general administrative oversight. The outcome is worth the effort; for the volunteers, staff, and health care professionals, it is often the first hand experience of joy, delight, tears, reminiscence, and quiet contentment that comes from the renewal of our bond with living, responsive, furred, feathered, and finned companions who share our space, our time, and our love.

APPENDIX A

PLACEMENT OF ANIMALS WITH THE ELDERLY: BENEFITS AND STRATEGIES

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INTRODUCTION

Many elderly people have discovered that animal companions satisfy some of their greatest needs. Pets restore order to their lives; provide a more secure grab of reality; and link their owners to a community of caring, concern, sacrifice and intense emotional relationships. When older people withdraw from active participation in daily human affairs, the nonhuman environment in general, and animals in particular, can become increasingly important. Animals have boundless capacity for acceptance, adoration, attention, forgiveness, and unconditional love. Although the potential for significant benefits to a great variety of people exists through association with companion animals, the potential seems greatest in the elderly, for whom the bond with animal companions is perhaps stronger and more profound than at any other age. Unfortunately, however, very little data exists on measurable effects of animal companionship on people, including the elderly, even though people have been associated with animals for thousands of years (see Bustad, 1980). Strategies for current programs can be developed based on what data is available, as well as on experiences at Washington State University and many other locations. Such strategies will be suggested in this paper and those of

others at this conference. We will begin by summarizing the magnitude of the problem demographically.

DEMOGRAPHIC TRENDS FOR THE ELDERLY

On the basis of current projections, the present population of people over 65 years old in the United States will have more than doubled by the year 2030. Butler predicts that in 50 years, we will have over 50 million people in this age group, or about 17% of the total population (Butler, 1980). It is within the realm of possibility that with advances in research and development, as well as significant improvements in health care, the percentage of people over 65 could go as high as 30.

About one-fifth of our population over 65 years old is now over 80 years old (4.5 million persons). By the turn of the century it is predicted that those over 80 will total 6 million persons (Siegel, 1980). The large increase has important ramifications. From 1920 to 1960 the ratio of the number of persons over 65 to the number of working age persons (18-64) doubled, In 1976 the ratio was 18 elderly per 100 persons of working age. This ratio is expected to increase to 20 per 100 by 1990, and possibly 26 by 2020.

One related concern is that these demographic changes mean that an increasingly greater share of the health budget, effort, and resources will go to fulfill the needs of the elderly. Not only will there be a proportionately larger number of elderly, but there will be an upward shift in the age of the elderly. And the demand for health care rises with age within the older age span. The net result is that the costs of health care will be increased remarkably, and they will be borne by relatively fewer people. This portends

badly unless cost-saving strategies are developed. In this regard, studies need to be conducted to determine if animal companions can contribute to reducing the costs of health care. There are suggestions that companion animals may permit the elderly to live independently in their own homes longer and experience better health (Katcher, 1980) or reduce their dependence on drugs (Corson, 1980).

As we consider animals and the elderly, we also need to consider where the people live and their degree of independence. Ten years ago, about one-third of the age group 65 or over lived in the central city, while about one-fourth lived in rural areas. This has probably not changed greatly (Siegel, 1980). It is estimated that 5% of the population that is over 65 resides in institutions (Siegel, 1980). As the proportion of the older age group increases, the number of elderly institutionalized will probably increase (Brehm, 1980). This may well increase morbidity and mortality, as well as decrease life satisfaction, although the degree and quality of animal association in each situation could modify this.

Some observations on social changes in the elderly indicated that involuntary relocation to better housing did not seem to significantly improve their health and longevity (Kasl, et al, 1980). No mention was made of whether animals were involved in the relocation (e.g., were they left behind?), even though it is possible that animals could affect health and well-being following involuntary or voluntary relocation.

REVIEW OF THE LITERATURE

The relative newness of the idea of carefully studying the relationship between animals and the elderly is evident from a review of the literature. It is not often that one can, by purchasing six volumes, have the significant articles on a subject or bibliographies which list the important articles. However, this is the case with studies on animals assisting the elderly. The six volumes which we would recommend and from which most of the review information is taken are as follows:

1. R. S. Anderson, ed, Pet Animals in Society. McMilan, New York, 1975.
2. L. K. Bustad, Animals, Aging and the Aged. University of Minnesota Press, Minneapolis, 1980.
3. S. A. and E. O. Corson, eds. Ethology and Nonverbal Communication in Mental Health, Pergamon Press, New York, 1980.
4. B. Fogle, ed. Interrelations Between People and Animals. Charles C. Thomas, Springfield, Illinois, 1981.
5. B. Levinson. Pets and Human Development. Charles C. Thomas, Springfield, Illinois, 1972.
6. "Veterinary Medical Practice: Pet Loss and Human Emotion." Archives of the Foundation of Thanatology, Vol. 9, No. 2, 1981.

A seventh volume will be added to the list with the publication of the Proceedings of the International Conference on the Human/Companion Animal Bond (the Proceedings of this meeting).

Articles discussing the effects of animals on the elderly can be divided into two basic groups: Those concerned with the noninstitutionalized elderly

and those focusing on the institutionalized elderly, primarily those in nursing homes.

NONINSTITUTIONALIZED ELDERLY

In the first category, a review of articles concerned with the noninstitutionalized elderly must necessarily be broad. Several articles make significant comments about the adult population generally that can apply in some measure to the elderly. On the one hand, we have articles which deal with an adult population that is normal and reasonably healthy. Another group of articles deals with an adult population that is experiencing mental or physical illnesses that are in some measure debilitating.

Studies are beginning to emphasize the importance of examining the relationship between animal companions and the normal, well-adjusted segment of our population. Dr. Aaron Katchen, in his article, "Interactions Between People and Their Pets: Form and Function" (Fogle, 1981) encourages us to look at pets not as substitutes for human contact but, perhaps, as entities that offer a different kind of relationship, one that supplements and augments human relationships. He lists a series of "somethings" that pets offer which can appeal to a wide spectrum of the adult population. According to Dr. Katcher, pets offer us something to decrease loneliness, which is a serious disease today (Lynch, 1977; Bustad, 1980) as well as something to care for, to keep us busy, to touch and fondle, to watch (perhaps in idle play), something that makes us feel safe, and something that provides stimulus for exercise. He indicates the possible significance of work now underway to measure the physiological effects of pets, for example, the drop in blood pressure when

people pet their animals. These studies, as well as a closer look at the "somethings" mentioned above, can provide us with critical data on the effect that pets can have on the elderly population, as well as the younger adult population.

Irene Mortenson Burnside, a gerontological nurse and author, provides valuable insight into the general needs of the elderly, which certainly affect the relationship that they have with pets. In the section, "Young Old Age Through Old Old Age" in Psychosocial Caring Throughout the Lifespan, Irene Burnside describes the basic characteristics of the elderly and some of their most important needs, needs which to some extent could be met through the relationship with an animal companion. She also explains that when we talk about the elderly we must recognize some very basic differences exist among those that are 45-65, 65-80, and 80 and above. We should not speak of the elderly as though they can be stereotyped and characterized as one group.

Some of the areas that she focuses on where pets might have a positive effect are the loneliness and emotional isolation which the elderly may experience, a feeling of being locked in one's self and unable to obtain warmth and comfort from others. Mrs. Burnside also points out the impact of relocation shock and its resultant stress when the elderly are moved from home to home, room to room, or home to institution. (Could animals reduce this stress?) Life review is an important aspect of working with the elderly; encouraging reminiscence is an effective tool. (Animals can trigger reminiscences.) Therapeutic touch is also extremely important. Nonverbal communication can decrease the elderly's sensory deprivation. The sensory loss, immobility, living alone, and loss of significant others experienced by

the elderly may increase the need for touching. (Touching animals, as well as being touched, could be therapeutic.) Ashley Montagu, in "Touching: The Human Significance of the Skin", reviews some fascinating data with animals showing the importance of touching and gentling. Mrs. Burnside reviews the very important steps which one must undergo in terminating relationships with the elderly. This could be especially important in instances when persons bring pets on regular visits to the elderly and then discontinue these visits.

The Aged Person and the Nursing Process (Yurick, et al., 1980) provides a comprehensive, well-referenced textbook on the "application of the nursing process as the organizing framework for nurses' efforts directed toward aged people as they experience variations in health status within the realm of 'normal." Dr. Susan Robb, in her chapter, "Resources in the Environment of the Aged," describes the potential of pets as *significant others for elderly* people and encourages nurses to cooperate in pet therapy programs. Barbara Spier perceptively includes animals in her list of significant others in her "Guide for Assessing Developmental Tasks, Self-Concept, and Coping Mechanisms" in the same volume. Ms. Spier agrees with Dr. Robb that pets can help the elderly feel cared about and needed. One of the several very sensitive pictures in the book showing animals with the elderly occurs in Dr. Ann Yurick's chapter, "Sensory Experiences of the Elderly Person." The photo demonstrates the value of animals in enhancing tactile sensitivity.

In, "The Broken Heart: The Medical Consequences of Loneliness", James Lynch recalled that as early as 1929 it was found that the canine heart beat and blood pressure slowed dramatically in response to petting. Since this

early observation, Katcher, Lynch and coworkers have performed studies extending these findings. It is noteworthy that the comforting effects of touch or even visual contact can be measured physiologically. We can speculate on the reasons for this. In 1959, J. I. Lacey proposed the hypothesis that cardiac deceleration may be associated with attention to an external task and intake of information from the environment (Lacey, 1959). Lacey's hypothesis was developed on the basis of his observations of the patient-therapist interaction during psychotherapy.

Recent advances in telemetry techniques have resulted in interesting studies on mother/child and people/animal interactions. Hong and associates (1977) reviewed some of the studies of sensory stimuli on heart rate. They also conducted a study on telemetered heart rates of children during play sessions with their mothers. They found that submissive status and warm affect of the child and dominant status and warm affect of the mother were associated with low heart rate in the child. The onset of smiling was associated with cardiac deceleration in most situations.

Two studies have focused specifically on the noninstitutionalized elderly segment of the population and their relationship to pets. One of the first to call attention to this area was Dr. Boris Levinson in his article, "Pets and Old Age." He pointed out that the elderly often suffer from a loss of relatives and withdraw from active participation in human affairs. Objects and animals which provided security in early life may assume greater importance in their later life. The animals may indeed be an anchor for good mental health. He also explains the fragile defense structures of the elderly and the reversal of roles which they experience. In this reversal, pets can

be important allies since the pets depend on the owner and offer a measure of security to them. Pets can help the elderly adapt to their change in status and accept their new role. Pets do not offer competition and can lead them to new interests and out into the environment to walk and to talk with others. Pets can also be important love objects and can be loved without fear of rejection. Levinson points out that the loss of a pet can be a great tragedy and a reminder of one's own death. This subject is covered in great depth in the Foundation of Thanatology series on "Pet Loss and Human Emotion."

The classic summary of the potential benefit of pets for the elderly is given by Dr. Levinson, "A pet can provide, in boundless measure, love and unqualified approval. Many elderly and lonely people have discovered that pets satisfy vital emotional needs. They find that they can hold onto the world of reality, of cares, of human toil and sacrifice, and of intense emotional relationships by caring for an animal. Their concepts of themselves as worthwhile persons can be restored, even enhanced, by the assurance that the pets they care for love them in return" (Levinson, 1969).

Roger Mugford and M. G. M'Comisky made a significant contribution to the literature on pets and the elderly by presenting the results of an evaluation both before and after the introduction of pets into the lives of selected elderly people. In their article, "Some Recent Work on the Psychotherapeutic Value of Cage Birds With Old People," they begin by explaining that old age often involves a loss of intimate human companions. Loneliness, a feeling of desertion by and disengagement from the wider society, can result. For this reason, they wanted to explore the role of animal companions in the everyday life of the elderly and the effects of pets on social attitudes and mental and

physical health. For their study, they selected 75- to 81-year-old pensioners who lived alone and divided them into experimental groups and a control group. The subjects were interviewed both before and five months after the introduction of the buderigars (budgies) and begonias. The control group received nothing except monthly visits from a social worker, as did the other groups. They discovered the group which received the budgies showed improvement in their attitudes toward people and in their attitudes to their own psychological health. Many formed an intimate attachment to the birds which extended far beyond the test period. The birds served as a "social lubricant" in increasing their owners' communication with others.

Information that can be relevant to the elderly who are ill is given in Dr. Michael McCulloch's article, "The Pet as Prosthesis: Defining Criteria for the Adjunctive Use of Companion Animals in the Treatment of Medically Ill Depressed Outpatients." He points out that physical deterioration and the losses which occur in old age can increase the likelihood of depression. His study, however, does not focus on the elderly. For the depressed, pets are important in helping them maintain a sense of humor and in providing valuable conpanionship. Dr. McCulloch lists a series of ten instances when pets might be especially helpful:

1. Chronic disability or illness
2. Depression
3. A previous relationship with pets
4. Role reversal
5. Negative dependency
6. Loneliness and isolation

7. Helplessness
8. Low self esteem
9. Hopelessness
10. Absence of humor

He offers some very significant precautions which should be observed. When pets are introduced to the medically ill, depressed patient, those involved in the prescription should:

1. Be aware of the increased vulnerability to the loss of a pet.
2. Tailor the prescription of the pet to the individual.
3. Coordinate the use of prescription pets with other therapy methods.
4. Identify situations that are inappropriate for prescription pets.
5. Be aware of the importance of timing.

He also voices a concern common among scientists active in the field of Animal Facilitated Therapy: "If pets are to be prescribed for human ailments, they should be subject to the same scientific indications as are surgical procedures, drug therapy, and other forms of medical and psychiatric treatment."

INSTITUTIONALIZED ELDERLY

A much larger body of literature deals with the importance of animals to the institutionalized elderly, whether in nursing homes or in hospitals. When nursing homes are mentioned, the image that comes to mind is that which is well documented in Bruce E. Vladeck's book, Unloving Care: The Nursing Home Tragedy. He talks about the mountains of regulations, the administrators and nurses who spend more time with papers than patients, the inspections that

don't work, and the health providers whose interest in their work seems to be diminishing. In review of Vladeck's book, Robert Dickman points out that health care for the elderly is much more than a provision of direct medical services. "Failure to understand and deal with loneliness, frustration, isolation, and disruptive external environment is a failure to do geriatric medicine. The therapeutic value of restoring dignity or autonomy, relieving boredom, and providing appropriate stimuli to the frail elderly is unequivocal." He goes on to point out that, "The measure of our society will be in the care that we give to our most debilitated elderly."

Samuel and Elizabeth Corson also speak about the vicious cycle of debilitation, social degradation, and dehumanization which can envelope the institutionalized elderly. They delineate the psychosocial structure of a typical nursing home in their article, "Companion Animals as Bonding Catalysts in Geriatric Institutions." These structures include:

1. Closed social group
2. Low staff-resident ratio
3. Highly regimented
4. Mass oriented with little privacy
5. A loss of a sense of purpose and a chance for goal-directed activities
6. Fails to furnish feelings of being needed, loved and respected.
7. Lack of tactile comfort

They also talk about the impact of relocation of the elderly in nursing homes. Upon this background, they describe their studies resulting from the placement of dogs in an 800-bed nursing home which also had apartment

buildings and cottages for skilled nursing care of the mentally retarded. They found that the dogs offered positive, nonverbal communication signals. They offered love and tactile reassurance, tactile comfort, and an innocent dependence. Their child-like play was stress-reducing and rejuvenating. The presence of the pets improved morale and created a sense of community. They provided an opportunity for exercise and served as social catalysts. When used in reality therapy, the pets led people toward more responsible, self-reliant behavior.

The Corsons outlined their method of introducing animals. It involved first talking about the animals with the residents, then introducing them in the presence of and/or through a staff member. They offered cages of puppies in dormitory-type wards, dogs in individual dogs houses in the cottage settings, and attached kennels with grooming and bathing facilities for the nursing home. The Corsons emphasized the importance of an annual examination by the veterinarian, of allowing the dog to relieve itself before it is taken in to visit with the patients, and of carefully selecting dogs for the purpose intended. They also talked about the necessity of educating the residents, patients, and staff on the care of the animals at the time of their introduction.

The Corsons added some important material to the study of the effects of animals on the institutionalized elderly by formulating an evaluative questionnaire to be used by nurses and by employing videotapes to document the people/pet interactions.

Jules Cass, in his article, "Pet Facilitated Therapy and Human Health Care," offers some very specific conditions and circumstances for successful use of Pet Facilitated Therapy (PFT), and for failure of or opposition to the

use of PFT. He emphasizes that the animals in institutions do not offer a potential threat to health. He delineates rules for sanitation and maintenance of the pets and suggest that for the elderly, small dogs which are sedate with quiet temperaments should be chosen.

Boris Levinson (1970) was one of the first to describe the potential of nursing home pets. He points out the need of the elderly to have someone to love and "Lord it over." Pets can restore a sense of identity to the elderly and, he speculates, can cut down the demands placed by the residents on the staff. The pets serve as a love object which the patient can hug and kiss. The pet also restores communion with nature, which is increasingly lost in contemporary society. Caring for a pet can offer a sense of peace and completion and, according to Levinson, can provide an important link with reality.

Carl Brickle, in, "The Therapeutic Roles of Cat Mascots with a Hospital-Based Geriatric Population," looked at the potential use of pets in institutional settings other than a nursing home. He studied pets placed in a dayroom in a hospital geriatric ward and found that they stimulated patient responsiveness, gave pleasure, enhanced the treatment milieu, and helped staff morale.

SUBJECTS FOR FUTURE RESEARCH

To some extent, reading current literature in the area of animals and the aging is like reading the introduction of a book with blank pages. As the pioneer investigators themselves realize, many studies must yet be conducted to substantiate, in a scientifically credible way, the benefits of pets to the elderly both in and out of institutions. Sam Corson has called for a variety

of studies to increase our knowledge in this area. He would like to see controlled studies involving several comparable institutions in which pets were introduced into 50% of the institutions. He urges long-term, follow-up studies and suggests an intra-individual method with a longitudinal, process-oriented design using each individual as his or her own control. He points out that we need to monitor cardiac and respiratory reactions, electrical skin resistance, and circadian rhythms of the psychophysiologic parameters before and during pet facilitated psychotherapy. we need long-term studies on the socializing and health maintenance effects of dogs and cats on older people living alone or in family settings in different urban and different socioeconomic strata.

We need to expand the survival studies by Friedmann (1980) and others to a larger number of patients for a longer period of time and include personality assessment recordings and family and other social interactions. We should investigate the extent to which PFT decreases the dosages and/or duration of use of psychotropic drugs. We need data on the extent of which pets are useful to the aged with sensory deficits, and we need to understand if PFT helps restore individuals to more independent forms of living. Corson also suggests we look at the ways in which pets can serve as catalysts for introducing other positive activities, such as gardening and music. And we can investigate the extent to which animals help bridge the generation gap. Jules Cass points out the very great need for a manual with explicit guidelines for establishing and operating Pet Facilitated Therapy programs.

In looking at the importance of pets to the institutionalized elderly, we need to undertake well-planned, applied research centering on refining methods of introducing pets into different types of institutions to maximize positive

results. We need to relate institutional characteristics to people/pet matching and resultant effects. Under what conditions do pets contribute positively to the well-being of the institutionalized elderly individuals (resource levels of the individuals, social networks of the institutions)? There is a need for comparative evaluative research on the effects of pet therapy as opposed to, and in conjunction with, other therapeutic modalities in terms of such factors as criteria, cost effectiveness, and impact on well-being and health of the residents.

Some other questions for study are as follows: What is the precise cost of maintaining animals of each species in an institutional setting and a home setting? In an institutional setting, who can benefit most from caring for the animals? Is there an increase in the incidence of any diseases when a pet is introduced into an institution? What is the incidence of allergies? How do we deal with people with animal phobias or dislikes in an institutional setting? What benefits, and to whom, are derived from each of the following methods of using pets in institutions: Pets introduced in selected areas or under very carefully controlled conditions (as with Brickle and Corson); pets assigned to specific people in a therapy room; pets allowed free range of a facility (except for food areas); nonresident pets brought in for visits? What role can pets play in day care centers for the elderly?

Is the success of the pet in meeting the needs of the elderly determined by the strength of a bond with a pet which the person established as a child? Is it related to continuous ownership of a pet? Is it more effective to introduce the same species that the person owned before? At what period in a person's lifespan will possession of an animal companion have the most influence? What different effects are produced by having a dog, cat, bird, or

fish? Can lifelong associations or associations after sixty years of age with animals extend life span? What specific procedures should be followed if the elderly are allowed to bring their own pets into nursing homes?

Explorations of the importance of pets to the noninstitutionalized elderly might begin with research on human/animal bonding in natural settings. We could explore: (1) Is there a critical period for learning how to communicate with and interact with pet companions? When are children most receptive to pet bonds, and can effective learning vehicles be delivered at that time for their long-term benefit? (2) Is access to different types of pets differential for various sub-groups of society (e.g., rural and urban), and if so, how does this affect later social and human/animal bonding? (3) What are the roles of pets in family settings and how do these roles relate to conflict resolution, interpersonal bonding, and teaching of social skills within the family? (4) How does the significance of the human/animal companion and other social bonds vary over the life cycle, the work cycle, and the family cycle in terms of social well-being, mortality, health, and related phenomena.

STRATEGIES

Anyone who reads the popular press realizes that the public interest in programs placing animals with the elderly is at an all-time high. Newspapers and magazines profile innumerable programs involving companion animal visitation or placement. In our extensive travels, we have found people in almost every small town or large city who enthusiastically relate to us their rewarding experiences using animals to help the elderly. They vary from a Girl Scout who takes her small dog regularly to a nursing home, or a couple who successfully placed a cat in a Veterans Hospital, to well-organized volunteers in humane society or junior league programs. The most memorable

vignette involved a distinguished financier who was a board member of a large hospital complex; he would sneak his small dog under his overcoat when he visited his 85-year-old mother who was confined to the hospital. He confided that his mother wasn't particularly interested in seeing him, but she was certainly excited about seeing the dog.

We also read about existing or pending legislation to enable pet placement. Minnesota has a law allowing residents to bring their pets into institutions. California has adopted a law forbidding discrimination against elderly pet owners in government-subsidized housing. A similar law has been proposed nationally.

In spite of the lack of data on pet selection, placement, and benefits, such laws will probably spread and programs will spring up at a phenomenal rate. What should our strategies be to insure safe, effective programs?

First, we must impress upon the scientific community the importance of undertaking critically needed research. A good example of a negative attitude that must be modified occurred at Washington State University. A social scientist visiting from one of the best known universities in the midwest was reviewing her data from a research project on the support network in the lives of the elderly. When asked about pets, she indicated they deleted all references to animals or God as irrelevant in their study.

For those scientists who already recognize the importance of such research, we need to convince public and private agencies and individuals of the urgency of funding well-planned research projects. Certainly the Dodge Foundation has been a leader in recognizing the importance of such work at the University of Pennsylvania.

We should also offer immediate direction to people who are not research scientists but who want to promote or assist in bringing animals and the elderly together. For the noninstitutionalized elderly, we can suggest ways to overcome barriers that keep them from enjoying an animal companion:

1. Provide low-cost care similar to San Francisco SPCA's Pet-a-Care, encourage pet insurance plans, and investigate subsidies for maintaining medically prescribed animals.

2. Provide short-term, minimal cost care for animals when the owner is hospitalized. All hospital admission forms could identify such owners in an emergency with three questions: Do you live alone? Do you have animals (kind ____ number ____)? Who should be called to care for them?

3. Recruit volunteers (e.g., members of youth organizations) to exercise animals and transport them to a veterinarian when the owner is unable to do so (or seek a veterinarian who makes house calls).

4. Arrange for foster home placement of the animal after the owner's death so the elderly will not refuse to get animals they need because they're afraid of dying before the animal does.

5. Seek to liberalize no-pet restrictions in low-cost housing units for the elderly, perhaps by offering consultants to assist with problem animals or by suggesting no-pet floors or wings in large units.

In this regard, vote of the majority is not appropriate on "either/or" propositions relative to the issue of pet/no-pet rules in certain retirement units and other housing units for the elderly. The issue is too complex for a "yes" or "no" answer. If a resident has an animal that may be a source of some problem, a vote of the unit resident and pet or euthanizing the animal at great physiological and psychological trauma for the owner. Clearly there

should be responsible action by both parties to avoid such confrontations. Here is where a consultant on animal behavior should be called in. Responsible pet ownership is mandatory and, with that assured, the resident management should provide a situation that would respect the rights of the animal and its owner, as well as the rights of the residents who wish no animal contact for whatever reason.

People in their early 60's might benefit from pre-retirement counseling on the value of animal companions. Many newly retired people suffer a loss of identity. An animal companion can furnish a degree of continuity to relieve this loss if the animal is obtained before retirement. Some newly retired persons who own a quality purebred animal may find breeding and showing the animal a rewarding experience. Others may find that visiting homes for the disabled or the elderly with their well-trained animal is a very satisfying endeavor.

Our strategies for the institutionalized elderly involve learning from the many existing programs so that we can help beginning programs. We need a central clearing house for specific details on each of these programs. Perhaps the Delta Society can provide a service in contacting each program and compiling the following information:

1. Where are you using animals? (Size of nursing home, description of hospital ward, etc.)

2. How did you begin? (Contact with administration, proposal, selection and training of volunteers, financing.)

3. How did you select and train the animals involved?

4. How are you evaluating or measuring the benefits? Submit sample data.

5. What problems did you encounter? How were they solved?

6. Describe the exact procedures of a visiting pet program.

7. If the animals are resident animals, are they confined to a few areas, assigned to specific individuals, kept outside in kennels?

8. What are the future plans for your program?

From these and similar questions, we could learn from experience so that others can benefit.

Finally, we need to document even anecdotal accounts of what is happening where pets live with the elderly. Such observations, even though of limited usefulness as scientific data, can nonetheless provide insights into areas where more precise studies can be undertaken. Our experiences in the People Pet Partnership Program have provided us with such observational data. Three are particularly noteworthy.

The first involves a mistake in placement that encouraged us to develop precise selection criteria. The activity director in a local nursing home decided she would like some resident animals and selected gerbils. The placement was a disaster. Several residents beat on the cage and tried to let them out to stomp on them. We discovered that the residents with farm backgrounds saw them as rats--something to be exterminated. Since that time we have devised profiles and questionnaires (Bustad, 1980) to enable more effective animal selection and placement.

The second anecdote involves our work with a nursing home which has a pet therapy room containing Handsome, the Persian cat. The health care team at the home meets to decide which resident can derive the greatest benefit from living in the private therapy room. The current resident, Marie, was chosen because she had no family or firends, would not communicate, and remained

curled in the fetal position with no interest in living. She also had sores on her legs from continual scratching. When other measures failed, she was moved in with Handsome. Whenever she began to scratch her legs, the cat played with her hands and distracted her. Within a month the sores were healed. She began to watch the cat and to talk with the staff about him. Gradually she invited other residents in to visit with him. Now she converses with strangers, as well as the nursing home staff about the cat and other subjects.

The third episode is even more dramatic. A frail, elderly man was brought to the nursing home from the local hospital. He had been discovered in a severely malnourished and confused state in a rural farmhouse, living alone in filth. Once his condition stabilized, he was brought in restraints to the nursing home since he refused to eat. Each day he worked to free himself from restraints and remove the feeding tube. It then was reinstated since he refused to eat. The staff was unable to break this cycle until an aide found the Center's three kittens in bed with him. When the cats were removed, he became agitated. A reward system was devised whereby the cats would be returned to him if he ate. He gained 40 pounds and interacted with other residents. The cats were the bridge that brought him back to reality. The director of nursing stated that otherwise she believes he would have died.

We are continuing to work with four nursing homes in our area. Once we secure the necessary funding, we hope to assist one nursing home to select and train a mascot dog. For another that has had mascot cats for six years, we will help them devise procedures to allow the frail elderly to bring their own pets when they move into a facility being readied for them. This might

include dutch doors to enable conversation without letting the pet out, and perhaps attached kennels appropriately soundproofed if necessary. It also includes remedial measures to correct any behavior abnormalities that are offensive. For a third home that has resident fish, a bird, cat and dog, we are serving as resource persons in helping them solve problems. The most recent involved getting the dog to stop chasing cars. The fourth home can offer us the opportunity to explore the use of pets in their hospice. (The importance of animal companions for the terminally ill has been shown by Dame Cecily Saunders and associates at St. Christopher's in London.) In three of the homes we will continue our visiting pet program and summer farm days. We document and share what we learn from these efforts, and we encourage others involved in such activities to do so. By working together, we can increase our knowledge and evaluative techniques with the aim of enabling many more elderly to know the joys that come from having an animal companion--a friend you like who likes you right back.

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APPENDIX B

PET PREFERENCES

The health care professionals of this facility are interested in whether or not pets should be allowed in the facility, or considered when developing a treatment program. There are several ways in which animals can be available. They can be brought into the facility by family, friends, or staff and leave when the patient tires, or at a predetermined time. A pet can be present full time (as an owned animal), or provided as a full-time mascot (which means ownership is not transferred to the patient). An animal could be provided as a pet for a group of patients, with responsibility for care shared by the patients and staff. The pet could be confined to one area, or restricted from special areas, like the kitchen, dining room, linen room, or rooms where patients with allergies may frequent.

Please place a checkmark (X) indicating your feelings about each of the following animals in the situations (or ways) that they could be available.

ANIMAL	NOT ALLOWED TO VISIT	*ALLOWED TO VISIT	*OWNED PET	*MASCOT PET	
				INDIV	GROUP
Dog					
Cat					
Bird					
Fish					
Guinea Pig					
Hamster					
Gerbil					
Rat					
Mouse					
Rabbit					
Snake					
Turtle					
Small Farm Animal-Outside					
Wild Bird Feeder					
Outside Windows					
Other Animals (specify please)					

*If you put an "X" into any of these columns, please use the reverse side for optional comments.

COMMENTS:

We are interested in your comments about three animals you would MOST like to have

	1st Animal:_____	2nd Animal:_____	3rd Animal:_____
Benefits:			
Problems:			
Care of the Animal:			
Other Comments:			

APPENDIX C

HEALTH CARE FACILITY CHARACTERISTICS INVENTORY

Name of Facility: _____
Name and Title of Action Officer: _____
Location of Facility: _____ Date: _____

I. General Information About the Facility

1. Which best describes the facility's ownership status? (circle one)
   a. Voluntary (non-profit)
   b. Government/Public (non-profit)
   c. Proprietary (for profit)

2. Please indicate the total number of patient rooms in each category listed below:
   a. Rooms with 1 bed..... _____
   b. Rooms with 2 beds..... _____
   c. Rooms with 3 beds..... _____
   d. Rooms with 4 beds or more beds..... _____

II. Patients

3. What is the average number of outpatients per day?
   a. In adolescent..... _____
   b. In social work clinic..... _____
   c. In psychiatry..... _____
   d. In occupational/physical therapy..... _____
   e. In hypertension clinic..... _____
   f. In ALL outpatient clinics (including above)..... _____

4. What is the average bed occupancy rate per day?
   a. In 1 bed rooms..... _____
   b. In 2 bed rooms..... _____
   c. In 3 bed rooms..... _____
   d. In 4 bed rooms or more rooms..... _____

5. How many of today's patients are in each of the listed age categories (inpatient and outpatient combined):

a. Under 12.....	_____	e. 61-70.....	_____
b. 12-20	_____	f. 71-80.....	_____
c. 21-40	_____	g. 81-90	_____
d. 41-60	_____	h. Over 90	_____

6. How many of today's patients are self-reliant for feeding, dressing, and daily activities? ....._____

7. How many patients, in an average day, would be classified as confused or disoriented? ....._____

III. Staff

8. Please indicate for each category of staff listed below, the number of persons currently employed by the facility (Note: 35 or more hours per week = full time; less than 35 hours per week is considered part time; a person that serves in two or more jobs must be reported as part-time in both jobs):

	Day Shift		PMs & Night Shift	
CATEGORY OF STAFF	Full-time	Part-time	Full-time	Part-time
Social Workers.....	_____	_____	_____	_____
Psychologists.....	_____	_____	_____	_____
Psychiatrists.....	_____	_____	_____	_____
Occupational Therapists	_____	_____	_____	_____
Physical Therapists.....	_____	_____	_____	_____
Associate Administrators	_____	_____	_____	_____
Registered Nurses.....	_____	_____	_____	_____
LPNs/LVNs.....	_____	_____	_____	_____
Nurses Aides.....	_____	_____	_____	_____
Orderlies.....	_____	_____	_____	_____
Housekeeping.....	_____	_____	_____	_____
Maintenance.....	_____	_____	_____	_____
Activities Coordinator..	_____	_____	_____	_____
Volunteer Coordinators..	_____	_____	_____	_____

IV. Animal Histories

9. If your facility has ever utilized animals with any treatment modality, please describe below the circumstances and results:

10. If the above program(s) has been curtailed, please explain the reason for each category of animal eliminated from the program:

11. If there are animals currently being utilized in any treatment modality or as adjunctive therapy in any program, please list the appropriate points of contact for a health professional in charge of each such program.

Appendix D

COMPANION ANIMAL TEMPERAMENT EVALUATION FOR ANIMAL FACILITATED THERAPY USE (CANINE)

These suggestions are applicable primarily for animals with unknown backgrounds; the great variances in therapy use and animal behavior do not allow these concepts to guarantee a correct selection. It would be advisable to utilize an experienced consultant, such as an animal behaviorist or veterinarian, when assessing the final animal candidates for an animal facilitated therapy program.

Initial Observations of a Dog

The test area should be enclosed with minimal distractions; the dog needs to be allowed to freely investigate the area before evaluation by a tester unknown to the animal. These observations should be made in the first 15-30 seconds, from a discrete distance.

ACCEPTABLE BEHAVIOR	QUESTIONABLE BEHAVIOR
Holds ground	Crouches or whines
Approaches tester	Hackles up
Hackles normal	Growls or barks
Sniffs tester	Stares or avoids eye contact
Lips normal	Lips curling or puffing
Tail held up or out	Tail held between legs
Ears up and alert	Ears back
Retreats after encounter	Moves about "stiff legged"

Approaching the Dog

Done by approaching dog slowly, with hand extended, palm and fingers pointing downward, allowing dog to sniff at the back of the hand.

ACCEPTABLE BEHAVIOR	QUESTIONABLE BEHAVIOR
Extends head or steps forward to sniff hand	Turns head away or tries to ignore hand
Seeks attention by nudging or leaning into hand	Pulls back or retreats
Acts playful by action or vocal expressions	Growls or barks (threatening)
Licks hand	Raises hackles, drops tail
	Overly exuberant, overwhelming
	Bares teeth

NOTE: It is essential that the use of the dog be known by this stage. A companion animal for a teenage athlete must be active and outgoing, while a companion for a geriatric patient should be docile and unassuming. The animal must be fit to the needs of the patient and the goals of the primary therapy program. If the animal has passed the previous requirements, please proceed; if the animal has shown questionable behavior, retire that animal and start anew.

Handling the Dog

Use the same body approach as the previous test, then attempt to slowly pet and brush the dog, especially noting the responses to contact with sensitive areas, like the eyes, ears, or mouth.

ACCEPTABLE BEHAVIOR	QUESTIONABLE BEHAVIOR
Enjoys the attention	Pulls backs or retreats
Tries to make friends	Quivers, cowers, snaps, bites
Becomes playful	Rolls over on back
Enjoys brushing	Overly sensitive to grooming
Leans into petting/brushing	Submissively urinates
	Shows white of eyes
	Stays aloof through process

Interacting with the Dog

If the dog still is showing acceptable behavior, proceed with a few simple elementary tests to determine aptitude and trainability.

- See if the dog will retrieve a ball
- Walk away briskly, sit on floor, then call dog
- Lay the dog down, then roll him over, and rub the belly (the dog should tolerate this submissive behavior)
- Have assistant place a stuffed animal behind dog while the dog is distracted; encourage the dog to investigate
- Attempt to play tug of war with a rag; watch aggressiveness
- How does the dog react to sudden arm movements
- Have assistant hit a pan with a spoon without warning and watch sound sensitivity; being startled with a quick recovery is okay
- While playing with dog, briefly pinch the webbing between the flank; evaluate reaction to sudden pain; forgiveness, yelps without aggression, or trust are desirable traits

Interaction by the Dog with Unexpected Events

Leaving the test area, find an area where an assistant can startle the dog, with such common events as snapping open an umbrella from a hiding place, or rolling a cart close in front of the dog's nose from an unexpected angle while waiting at an intersection. Rate the interaction based on predetermined signs/traits desired in the treatment program, use a scale of adequate width to determine degrees of response (e.g., 1 to 5, with 5 being full display of the preferred sign or trait, and 1 being none).

Possible traits to evaluate include: Self-assured, anxious, apprehensive, fear/alarm shown, assertive, calm, tranquil, composed, dignified, poised, extroverted, interest in others, exuberant, gentle, tame, easily handled, noisy, barking/whining, playful, willing to participate in fun, reaction time, sociability, enjoys people, trusting, confident, willing to be handled, acceptance of body contact, and time to return to normal behavior.

APPENDIX E

COMPANION ANIMAL TEMPERAMENT EVALUATION
FOR
ANIMAL FACILITATED THERAPY USE
(FELINE)

These tests will assist in evaluating the cat's general levels of sociability, agressiveness, and adaptability; but patience is a critical element of the feline evaluation. The cat will require more time than a dog to become accustomed to a new environment, so insure you give the cat adequate time to become comfortable in the testing area. Again, as with the dog, the final use of the animal in the therapy program will determine how the evaluation results are to be weighted, and a veterinarian or animal behaviorist consultant would be advisable.

Initial Observations of the Cat

Release the cage door and let the cat come out freely of its own accord; give the cat several minutes to explore the room. The evaluator should enter wearing street-type clothes and squat down about 6 feet from the cat, barely extending one hand, palm down.

ACCEPTABLE BEHAVIOR	QUESTIONABLE BEHAVIOR
Makes eye contact	Avoids eye contact
Vocalizes	Hisses, ears back
Approaches slowly	Retreats
Watches and rolls	Assumes defensive position
Comes and sniffs hand	Watches, w/o approaching

If the cat does not approach, move to within three feet of the cat and repeat the above evaluation. Retire the cat that doesn't approach from 3 feet within 10 to 14 minutes. After getting the cat to come, and while the evaluator is still squatting, extend one hand (palm down) to a point lower than the cat's head.

ACCEPTABLE BEHAVIOR	QUESTIONABLE BEHAVIOR
Sniffs hand	Retreats
Licks or rubs against hand	Threatens to strike hand
Rolls submissively	Attempts to bite
Vocalizes	Hisses or arches back

NOTE: It is essential that the use of the cat, and the type therapy environment be known by this point. Cat's with questionable behavior should be retired, to save time and for the safety of the evaluator. With those cats that have acceptable behavior, proceed to the next phase of testing.

Handling the Cat

While talking to the "acceptable behavior" cat, as identified from the initial observations, begin to stroke the cat along the head, back, and sides. Evaluate for traits desired.

ACCEPTABLE BEHAVIOR	QUESTIONABLE BEHAVIOR
Rubs against leg or hand	Assumes defensive posture
Begins to purr or chirrup	Acts threatening
Head bumps or circling	Attempts to strike
Circles around attentively	Withdraws
Initial fear overcome and cat relaxes soon	Attempts to bite

Interacting with the Cat

While the cat is still showing acceptable behavior, try the following tests to better evaluate character traits.

- -Move away from the cat, then move a piece of string slowly along the floor to initiate play.
- -Call the cat until it approaches, or approach the cat slowly; then calm the cat, gently pick it up and cradle it closely to chest and watch reaction.
- -Sit down on a chair prepositioned in the room and place the cat on your lap, facing you; stroke gently and watch reaction
- -Place the cat on floor next to the chair; then call and motion with hands for cat to come. Watch response.
- -Place the cat on the floor; grab the tail firmly, pull with a steady pressure without yanking, and observe tolerance/forgiveness
- -Have an assistant make a startling noise when the cat is not looking; evaluate recovery from a sudden loud event.

Rate the interactions on a scale from 1 to 5, with 5 being the most desirable reaction, and 1 being the least desirable.

APPENDIX F

Summary Sheet For Pet Preference Form (Appendix B)

Type of Pet	Not Allowed at All Number	Allowed to Visit Number	%	Owned Pet Number	%	Mascot Pet Number Indiv	% Group
Dog							
Cat							
Bird							
Fish							
Guinea Pig							
Hamster							
Gerbil							
Rat							
Mouse							
Rabbit							
Snake							
Turtle							
Small farm animals outside							
Wildbird feeders outside windows							

Other _____

Use three separate sheets for listing comments from the back of the Survey sheet; title them "BENEFITS," "PROBLEMS," and "CARE FOR THE ANIMAL." On each sheet, write the comment down the first time it occurs, and place a mark for each occurrence under either staff or residents. A sample is shown below:

Comments: Benefits	Staff	Patients
Animals provide companionship	1	111
I'd get exercise walking a dog		
Comment: Problems		
I might trip over a small animal	111	1

APPENDIX G

Pets In Nursing Homes:

Pilot Project and Proposed Guidelines

by Dawn S. Ayers, Betty W. Franklin
and William F. McCulloch, DVM, MPH

The topic of pets and their relationship to human health and well being has been the subject of much research (1) (2). The initial concept for this project came from interest in the human/animal bond.

The primary goal of this project was to offer positive interaction and companionship for institutionalized elderly by the use of visiting pets. This project calls for an interdisciplinary approach. Consequently, many people from diverse backgrounds were involved. Dr. William McCulloch, DVM, MPH, of Texas A&M University, Department of Veterinary Public Health, originally proposed and promoted the project.

Dawn Ayers, then a Social Service Worker with the Texas Department of Health, Long Term Care Unit, and Betty Franklin, then Activity Director at Sherwood Health Care, Inc., collaborated with Dr. McCulloch in the development and implementation.

After reviewing published research on this area and extensive planning sessions, the initial steps were agreed upon. The first step was to arrange a pet show at Sherwood Health Care, Inc., to assess the level of interest by the residents. Due to the positive response during and after the show, it was determined that the project should be initiated.

Guidelines were then drafted for the pilot to insure the safety and health of both the residents and animals. The following items were addressed: Nursing Home Administrator approval, volunteer orientation, health care plan for animals, screening residents for phobias, allergies and preferences, activity director coordination, off-limit areas defined, and insuring humane treatment of animals.

The guidelines were submitted to E. P. Sulik, President of Sherwood Health Care, Inc., Howard Allen, Texas Department of Health, Bureau of Long-Term Care, and Dr. Foy McCasland and Dr. Keith Clark, Veterinary Public Health in Austin.

The pilot project guidelines were approved in July, 1982. Screening of animals for appropriate behavior and health, volunteer orientation and

screening of residents and staff for phobias and allergies were done prior to program initiation. All visits were pre-arranged and supervised. Visits were scheduled for three times a week at 9:00 and 10:00 a.m. on Tuesdays and 7:00 p.m. on the same day for a 12-week period. This was to allow for the most flexibility for the residents and volunteers.

At the onset of the program it was noted that some residents were hesitant to interact with the animals. They would follow the animals with their eyes but would not reach out or express a desire to touch the pets. This, however, was the exception, not the rule. The majority of residents were very responsive and willing to take an active role with the pets and their owners. For most of the residents it appeared to be very positive and enjoyable activity. A few residents did react very emotionally to the pets as they reminisced about animals they themselves had owned.

As the project progressed, changes were gradual but overwhelmingly positive. The hesitant residents became comfortable and appeared receptive to the pets. Eye contact improved. Reaching, stretching, and petting also became more frequent. The pets also appeared to act as a catalyst for conversation and the level of interaction between residents was increased. Several residents became attached to "their pets" and took an active interest in activities such as grooming, tricks, and dog shows. The value of the laughter and amusement generated by this activity is also noteworthy. Only one resident out of the three groups did not appear to respond positively to the animals.

At the onset of the program it had been planned to keep each group small to maximize contact and allow for data collection. However, due to the responsiveness of the residents, anyone who expressed a desire to participate was involved in the program.

After completion of the project, the pilot guidelines were reviewed and modified following further discussion with Dr. Leo Bustad and Ms. Linda Hines, Washington State University and the Delta Society, and Dr. Robert K. Anderson, University of Minnesota. The following guidelines were submitted to the Texas Department of Health for their review.

PROPOSED GUIDELINES FOR VISITING PET PROGRAMS IN LONG-TERM CARE FACILITIES IN THE STATE OF TEXAS

1. Visiting Animal Programs will be approved by the Nursing Home Administrator. Each family which permits pet animals shall develop written policies and plans to assure reasonable safeguards for the health and safety of people and animals in the facility, without unduly limiting the proven health benefits of pets and with due consideration of individual differences among health care facilities. The policy should be specific about the

person(s) responsible for the animal. Animal species should be named in the plan.

2. As part of the Health Care Plan, all involved residents and staff will be questioned about allergies and phobias to animals. The rights and preferences of all residents will be acknowledged. Steps will be taken to accommodate those who desire to avoid animals while not denying the rights of those wishing to have access to them for recreational or therapeutic health benefits.

3. A Health Care Plan for the animal(s) shall be developed by the Administrator with consultation of a veterinarian and medical staff. The plan for the visiting animals should include, but not be limited to:

a) Admitting and monitoring the health and behavior. Animals that are selected must be healthy, well-trained, temperamentally suitable, and appropriately immunized.

b) Current Compendium of Animal Rabies Vaccines and/or State Guidelines must be followed.

c) The use of psittacine birds must be carefully evaluated on an individual basis because of risk of transmitting psittacosis.

d) No wild or exotic carnivores will be brought into any nursing home except when specific written permission is provided by the Texas Department of Health.

e) Pets must be effectively controlled by leash, command or cage.

4. Care will be taken to assure humane treatment of all animals used in any program.

5. In accord with objectives, conditions, and people in the health care facility, the Health Care Plan shall identify any restricted areas of the facility in which pet animals are not permitted. However, such restrictions shall not apply to guide dogs accompanying a blind or deaf individual.

The visiting pet project at Sherwood Health Care, Inc. has been maintained as an ongoing part of the activity program. It has also provided a continuing opportunity for evaluation.

REFERENCES

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2. Hogarth-Scott,S., Salmon, I. and Lavelle, R., "A Dog in Residence". People-Animals Environment (Delta Society). Vol. 1, No. 1, Spring, 1983.

APPLICATION FOR MEMBERSHIP

Texas Public Health Association
4000 Medical Parkway
Suite 206
Austin, Texas 78756

Mr( )
Mrs.( )
Ms ( )

NAME Last, First, Middle please print clearly

ADDRESS. Please check Preferred Mailing Address

( ) BUSINESS _____
(Title) (Organization)

(Street) (City) (State) Zip Code

( ) RESIDENCE _____
(Street) (City) (State) Zip Code

PRESENT JOB TITLE _____

SECTION AFFILIATION IN WHICH MEMBERSHIP IS DESIRED (CHECK ONE ONLY)

Administration & Management
Dental Health
Emergency Medical Service
Engineering
Food & Nutrition
Health Education
Health Officers
Laboratory
Long Term Care
Nursing Care
☐ Pharmacy
Sanitarian
Supportive Services
Veterinary Public Health
Vital Statistics
Unaffiliated

EDUCATION: Please Circle the numbers(s) completed & list degree(s)

High School 1 2 3 4 Diploma Graduate (Number years) _ _
Undergraduate 1 2 3 4 Degree(s) _____ Degree(s) _ _

CLASSES OF MEMBERSHIP: Dues are payable on December 31 each year

Active . . . $30.00 yr.
For those actively engaged in public health, school health & related professional fields

Associate . . . $30.00 yr.
For those interested in but not actively engaged in public health

Sustaining . . . . . $100.00 yr.
For individuals or corporations interested in public health

Life Members . . . $200.00
For active members recommended by the governing council

Fellow . . . $30.00 yr.
For active members who have rendered superior service & have made special contributions to public health

Affiliated Societies . . . $15.00
Allied health organizations which meet the criteria

Honorary Exempt
For distinguished service

Signature of applicant _____ Date _ _

Sponsor: Signature of one TPHA member _____

Return this Application with proper fees to TPHA office

TEXAS DEPARTMENT OF HEALTH
AUSTIN TEXAS
INTER-OFFICE

THRU: Associate Commissioner, Special Health Services
THRU: Associate Commissioner, Community and Rural Health
THRU: All Public Health Regional Directors
THRU: All LTCU Chiefs

FROM Howard C. Allen, Chief, Bureau of Long-Term Care

TO All LTCU Program Administrators

SUBJECT: Guidelines for Animal Mascot/Visiting Pet Programs in long-term care Facilities in Texas.

Attached are guidelines for animal mascot/visiting pet programs in Long Term Care facilities in Texas which have been developed in a coordination effort between this Bureau, W.F. McCulloch, DVM, Texas A&M University, and Foy V. McCasland, DVM, Chief, Bureau of Veterinary Public Health. These guidelines shall be used in assessing these type programs in long-term care facilities.

If you have requests for information concerning such programs, copies of the attached guidelines may be reproduced for distribution. If you have questions concerning these guidelines, please contact this office. Please share these with your staff.

This deletes 80-040.1N and 82.040.4N.

DVP: ck

Attachment

SIGNED HOWARD C. ALLEN

DATE April 3, 1984

Guidelines for Animal Mascot/Visiting Pet Programs in Long-Term Care Facilities in Texas

1. Animal Mascot/Visiting Pet Programs in long term care facilities shall be as approved by the facility administrator. Each facility which permits pet animals shall develop written policies and plans to assure reasonable safeguards for the health and safety of people and animals in the facility, without unduly limiting the proven health benefits of pets and with due consideration of individual differences among health care facilities. the policy shall be specific about the person(s) responsible for the animal(s).

2. As part of the plan, all involved residents and staff shall be questioned about allergies and phobias to animals. The rights and preferences of all residents shall be acknowledged. Steps shall be taken to accommodate those who desire to avoid animals while not denying the rights of those wishing to have access to them for recreational or therapeutic health benefits.

3. A plan for the animal(s) shall be developed by the administrator with consultation of a veterinarian and the facility or other appropriate medical staff. The plan for the visiting/resident animals shall include, but not necessarily be limited to, the following:

a) Animals that are selected must be healthy and free of parasites as determined by a licensed veterinarian.

b) Animals must be well-trained, temperamentally suitable, and appropriately immunized.

c) The use of psittacine birds must be carefully evaluated on an individual basis because of risk of transmitting psittacosis.

d) No wild or exotic carnivores shall be brought into any facility except when specific written advance permission is provided by the Texas Department of Health.

e) Pets must be effectively controlled by leash, command, or cage.

f) It is recommended (but not required) that dogs and cats as resident animals be neutered. This does not apply to visiting animals.

4. Care shall be taken to assure humane treatment of all animals used in any program.

5. In accord with objectives, conditions, and people in the health care facility, the plan shall identify the restricted areas of the facility in which pet animals are not permitted. Animals shall not be permitted in food preparation areas, treatment rooms, and isolation rooms. However, such restrictions shall not apply to guide dogs accompanying a blind or deaf individual.

APPENDIX H

SAMPLE PET POLICY FOR ANIMALS IN HEALTH CARE FACILITIES

A. Purpose

An animal can reach an individual in many ways and does not expect anything in return, except love. It can fill a void of loneliness and can give a sense of belonging to someone else. Not all patients can or desire an attachment to an animal, but as with all activities, they are based on individual needs.

B. Definitions:

a. "Health care facility" means a hospital, nursing home, health clinic, boarding care home, or supervised living facility.

b. "Animal Facilitated Therapy" means using an animal as an adjunct to another treatment modality to improve possibilities for improvement of the patient's condition or to potentially improve the quality of life for the patient.

C. Philosophy

1. Companionship. Friendships can be formed between patient and pet.

2. Concern and motivation. Caring for the pet, i.e., grooming, feeding, etc., gives the patients a feeling of usefulness. It provides for something else to think about besides themselves.

3. Touch. Petting and stroking the animal provide good sensory stimulation and physical exercise.

4. Attention. Watching the activities of the animal gives the patient something to observe and something to do, and is a soothing pastime with patients.

6. Social Influence. Staff, administration, patient, and visitors can become involved with something in common.

7. Homelike Atmosphere. Having an animal within the facility can bring back memories of pet ownership in the past.

D. General Procedures:

1. Every health care facility section shall establish a written policy specifying whether or not pet animals can be kept within the section's area.

2. If pet animals are allowed to be kept on the premises, the policy must:

a. Specify whether or not individual patients or staff will be permitted to keep pets; and

b. Specify the restrictions established by the health care facility regarding keeping of pet animals.

c. A written policy must be developed which specifies the types of pet animals that are allowed to be kept within the health care facility.

d. The policy required by 2c. shall be developed in consultation with a veterinarian and physician to assure that pets which, in their opinion, present a higher risk of transmitting diseases to human beings are not allowed to be kept within the facility.

3. This policy must be developed only after consultation with facility staff and with patients, as appropriate.

E. Facility Policies.

1. If pet animals are allowed to be kept within the facility, the following requirements must be met:

a. All animals must be in good health.

b. The health care staff shall ensure that pets are examined and receive any necessary immunizations or treatments in accordance with a veterinarian's recommendations.

c. A copy of the veterinarian's recommendations as well as records of all examinations, treatments, and immunizations shall be retained in the supporting health care facility section.

d. Regardless of the ownership of any pet, the health care section staff shall assume overall responsibility for any pets kept within or on the premises of the facility.

e. Each health care section staff shall ensure that no pet creates a nuisance or otherwise jeopardizes the health, safety, comfort, treatment, or well-being of the patients, visitors, or staff.

f. A section employee shall be designated as being responsible for insuring the care of all pet animals and for insuring the cleanliness and maintenance of cages, tanks, and other areas to house pets.

g. Except for guide dogs accompanying a blind or deaf individual, pets shall not be permitted in areas where food is prepared, served, or stored; in dishwashing areas, dish storage areas, in medication storage areas; in clean or sterile supply storage area, in nurses' stations; or in any other areas where cleanliness and sanitary precautions are necessary to protect the health, comfort, safety, and well-being of patients or visitors.

2. Legal and Public Requirements

a. The dog must be currently licensed, be neutered, have all the necessary vaccinations, and be under the supervision of a veterinarian.

b. The cat must also meet all health vaccination requirements and be neutered.

c. Certain species of birds are restricted by state health law due to psittacosis and other disease problems. Most small cage birds, such as parakeets, canaries, budgies, etc., may be considered safe. Birds must remain caged, and cage waste must be cleaned regularly.

d. Rights and preferences of all residents should be acknowledged for example, fears, phobias, allergies. Steps will be taken to accommodate those who desire to avoid pets. Suggested means may be restricting animals to certain spaces or training animals to avoid persons who dislike them.

e. Pets not acceptable by virtue of their hazard to residents include all wild animals and primates, such as skunks, raccoons and monkeys. Administrators should check with a veterinarian or a reliable pet store if they have any questions. Psittacine birds are acceptable if a veterinarian verifies that they have met USDA quarantine procedures (45 days on tetracycline seed) and are certified free of psittacosis or other diseases, which can be transmitted to people. Canaries, if they are purchased from a reliable dealer and examined by a veterianarian, are acceptable.

3. Animal Care and Maintenance

a. Housing

(1) The fenced-in yard between the_____ and the_____ wing has been designated for the dog's living and walking areas. The gate is locked at all times to prevent the dog from wandering away from the property, or from coming inside the facility at the improper time.

(2) There is a dog house for sleeping, providing warmth and shelter during all types of inclement weather. The yard is large enough for exercise.

b. Feeding

(1) All food and water for the dog is provided within the fenced yard. Under no circumstances is she to be fed elsewhere. She is now considered an adult dog and needs to be fed once a day. She receives dry kibble. She is also given chew sticks and dog biscuits, and her water is changed daily.

(2) The cat is fed and watered daily, and her food is provided for her in the housekeeper's utility room.

(3) The birds are fed and watered daily within their cages.

C. Daily Time Schedule

(1) The dog is to remain in the yard during the night, sleeping in her house. She may come into the facility between mealtimes for the residents (9:00 a.m. to 10:45 a.m., 1:30 p.m. to 3:45 p.m., and at 6:30 p.m. until bedtime, usually 9:30 to 10:00 p.m.). Under no circumstances is she allowed to come in at mealtime. She is to be put in the yard by the responsible staff member, not just let out the door.

(2) The cat is kept in ward_____, and the litter box cleaned daily; she is not allowed outside or off the ward.

(3) The bird cages will be covered from 9 p.m. to 7 a.m. daily; the bottom paper will be changed daily.

4. Responsibilities

a. Documentation of services of a veterinarian will be maintained in the supporting health care section. It will include: Yearly exam that reflects general health of the animal, blood test, fecal exams, at least a

vaccination, and freedom from vermin. All four-legged pets should be properly vaccinated. Dogs and cats will be neutered, unless an exception is granted by the Administrators.

b. Administrator insures the sanitary conditions of the living area of the pet(s).

c. Section staff will insure aseptic techniques are stringently supervised; for example, hand washing, no uniform contact, animal not to be allowed to crawl over tables or over stored clean or soiled linen, nursing supplies or medications.

d. Visiting pets are permitted in the facility if they are part of scheduled activities and are appropriately supervised by an owner or handler. Personal pets may be kept as one means to improve patients' well-being if concurrence of physician and roommates precede admission. Only animals that are well-trained and temperamentally suitable should be allowed into the facility; any staff member that observes an unsafe or unsanitary animal has the immediate responsibility to see that it is removed from the facility then report the infraction to their superior.

(1) Consideration for retention of four-legged pets should be based on breed and temperament of the animal.

(2) Safety of patients for pets under foot must be considered.

e. Nursing Staff is not to be responsible for maintenance of pets.

f. Residents, auxiliary staff (for example, activities director, janitor, secretary, according to interest), or a reliable volunteer should give the necessary care for the pets.

NOTE: These suggested policies are in the forefront of the movement for new public health regulations concerning pets in health care facilities. Before considering an animal placement, the rules affecting each particular facility must be considered carefully. If unduly restrictive rules exist, discover the procedures by which they can be modified, and develop a detailed plan to accomplish the modifications.

SAMPLE PET POLICY
The Delta Society

The following is the pet policy of (name of housing authority) which was developed in cooperation with tenants of (housing group) and in keeping with federal law. The purpose of this policy is to provide standards to insure the best possible environment for both pet owners and non-pet owners and to insure the responsible care of pets. All tenants and applicants will read and sign a copy of this policy.

1. Any tenant or applicant who wishes to keep a pet shall so inform management.

2. A Pet Rider shall be signed immediately by the tenant.

3. Common household pets shall include domesticated dogs, cats, rodents, fish, birds, and turtles kept for pleasure. No tenant shall have more than two cats or dogs.

4. The size of pets is not specifically limited; however, owners must be able to maintain control over the pets.

5. All female dogs over the age of six months and all female cats over the age of five months must be spayed. All male dogs over the age of eight months and all male cats over the age of ten months must be neutered. If health problems prevent such spaying or neutering, a veterinarian's certificate will be necessary to allow the pet to become or continue to be a resident of the development.

   a. A voluntary community screening committee may be established to review the suitability of the pet and the ability of the tenant to keep the pet, and forward its recommendations to the Housing Management Department so that they can be alerted to potential problems and discuss them with the tenant or applicant. Screening committee membership should include a veterinarian, a member of the pet committee in the housing unit, if such a group exists, and representatives of responsible and knowledgeable community pet groups (e.g., animal trainers, animal behavior specialists, humane society personnel). They shall use written procedures for the screening process. The committee could also assist tenants seeking to acquire a suitable pet.

   b. Size of a dog is not directly related to its desirability as a resident. Larger dogs are often more docile, quieter, and more affectionate than smaller dogs. An older dog will probably be quieter than a younger no matter what its size.

6. Pets shall be restrained (cats and dogs must be leashed) when on development property outside the owner's apartment or visiting in the

apartment of another resident. (If the housing manager designates a specific fenced pet walking area, pets could be unrestrained in those areas.)

7. Pet owners shall be liable for damage caused by their pets. While it is strongly suggested that pet owners obtain liability insurance, it is recognized that this is not possible for many tenants. The landlord may require of the tenant payment of a pet deposit for each dog or cat of $50 ($100 in carpeted apartments). Arrangements may be made to allow the tenant to pay the deposit over a period of months.

8. Pet owners shall provide the name and address of a pet caretaker who will assume responsibility for the care of their pets should the owner be unable to, as well as the name and address of the veterinarian responsible for the pets' health care. If the tenant is unable to provide the name of a pet caretaker, he/she shall make alternative arrangements for pet care in an emergency and shall notify management of these arrangements. This information will be updated annually.

TENANT MAINTENANCE OBLIGATIONS

Tenant agrees to promptly and regularly perform the following obligations in respect to ownership of a pet:

Keep the unit and its patios, if any, clean and free of pet odors, insect infestation and pet feces, urine, waste, and litter.

Restrain and prevent the pet from gnawing, chewing, scratching or otherwise defacing the doors, walls, windows, and floor coverings of the unit, other units and the common area, buildings, landscaping, and shrubs.

Immediately remove, clean up and appropriately dispose of any pet feces, waste, and litter deposited by tenant's pet on the common grounds, shrubs, flower beds, sidewalks, accessways, parking lots, and streets of the project. Dispose of pet waste and litter using procedures for the tenant's specific building (see attached instructions).

An owner's absence or inability to care for a pet in a short-term emergency should not mean that the pet is necessarily removed from the apartment. Some animals, especially cats, become very attached to their homes and are better off if they are cared for in the home.

RESTRICTIONS

Tenant agrees to properly and at all times observe the following restrictions on ownership of a pet:

- Tenant shall exercise proper restraint of a pet so as to prevent it from becoming a nuisance to any other tenant or person. Cats and dogs will wear an identification collar at all times.

- The pet shall be maintained and properly licensed and inoculated as required by local, county, or state statute, ordinance or health code

- Pets of vicious or dangerous disposition shall not be permitted. Any pet duly determined to constitute under state or local law a nuisance or threat may be required to be immediately removed.

- A pet will not be permitted to disturb the health, safety, rights, comfort or peaceful and quiet enjoyment of other tenants.

- Pets will not be permitted to enter eating or gathering areas, except where properly restrained and where such is not offensive to the other tenants of the the project. Pets will not enter areas designated as no-pet areas by the housing manager (see attached list).

- Tenants shall be responsible for the proper care and feeding of their pets. If the health or safety of the pet is threatened by the death or incapacity of the pet owner, or if the pet is left unattended for 24 hours, the project manager may contact the responsible party designated by the pet owner in the pet registration. If that person is unavailable or unwilling to care for the pet, the project manager may contact the appropriate state or local authority to remove and care for the pet. If neither source of aid is available, the manager may enter the premises, remove the pet, and arrange for pet care for no less than 30 days to protect the pet. Funds for such care will come from the tenant's pet deposit.

PET COMMITTEE

Each housing project shall consider establishing a Pet Committee made up of interested owners of pets in the project. The Pet Committee could visit with each new pet owner to explain specific procedures in the project and distribute a Pet Owner's Packet containing helpful materials, such as a document listing telephone numbers of community resource groups that can assist pet owners.

The Committee could receive any written complaints against pet owners given to the management and work with the pet owner to resolve the complaints. The Committee could also suggest policies appropriate to their particular building, and might compile a list of non-pet owners willing to exercise or care for pets in an emergency for a reasonable fee.

SIGNATURES

Manager _____

Tenant _____

Date _____

NOTE: Animals that assist handicapped persons are excluded from this policy.

SAMPLE PET RIDER
The Delta Society

This pet rider to the lease between _____(tenant)_____ and _____(management)_____ is made part of the lease entered into between the parties on _____(date)_____.

1. Both parties have read and signed the pet policy in effect for the complex which is attached.

2. The tenant shall keep the following pet(s) in a responsible manner and provide proper care for them.

TYPE OF PET	NUMBER	INOCULATIONS (Types & Dates)	DATE-SPAY NEUTER	LICENSE (Date)
Dog	_____	_____	_____	_____
Cat	_____	_____	_____	_____
Other (List)	_____	_____	_____	_____

	TYPE	NUMBER
Birds	_____	_____

	SIZE IN GALLONS	
Aquarium	_____	(May not exceed 20 gallons)

3. The tenant shall be liable for any damage or injury caused by his/her pet(s). If the tenantis security deposit does not cover the damages, management and the tenant will agree on a payment plan to pay for the damage as well as replace the security deposit.

4. Resident shall show proof of spaying or neutering, licensing, and inoculations if such procedures are required for the animal(s) (see above).

5. Resident shall provide the following information (to be updated annually):

Pet Caretaker

Name_____
Address_____
Telephone _____

Veterinarian

Name _____
Address _____
Telephone _____

If the tenant is unable to provide the name of a pet caretaker, he/she has made the following arrangements for care of the pet(s).

_____
_____
_____
_____

6. Tenant shall keep the pet(s) in a manner which is in keeping with the cleanliness standards of the complex. Tenant shall clean up after a dog and properly dispose of cat box filler and litter from birds or rodents.

7. Tenant shall not leave the pet(s) unattended outside his/her apartment.

8. Management shall inform the tenant of any written and signed complaint received concerning tenant's pet(s). No credence shall be given by management to verbal or unsigned complaints. Management shall also inform the tenant in writing of any violations of this pet rider or the pet policy which management observes the tenant or his/her pet(s) committing. If a Pet Committee exists, it may be actively involved in attempting to resolve any problems which arise concerning pets.

9. Management and the tenant shall confer informally concerning any written and signed complaints received by management. If the complaints are not resolved informally and if there have been three serious violations of the pet rider or pet policy which have not been resolved within the previous 12 months, management may inform the tenants that procedures will be initiated within 10 days to have the pet removed, terminate the pet owner's tenancy, or both. Any unresolved complaints may be the subject of a grievance by the tenant under the established grievance procedure.

AVMA GUIDELINES FOR VETERINARIANS: ANIMAL-FACILITATED THERAPY PROGRAMS

Statement of Position

When the AVMA officially recognized the importance of the human/animal bond to client and community health in 1982, it really acknowledged that the human/animal bond has existed for thousands of years and that this relationship has major significance for veterinary medicine. As veterinary medicine serves society, it fulfills both human and animal needs. The veterinarian, as an individual and a professional, is in a position to provide community

service and to aid in the scientific evaluation and documentation of the health benefits of the human/animal bond.

Animal Facilitated Therapy

Today, animals provide many positive human health benefits: "Companionship, a friend to care for and to keep one occupied, something alive and warm to touch, a focus of attention, a reason for exercise and to provide protection. Therapy programs using animals have evolved worldwide in many forms and with many names whenever a need or an opportunity has arisen. Usually these programs are directed toward people with health problems requiring rehabilitation, such as the elderly, physically handicapped, deaf, blind, emotionally or physically ill, or persons in correctional institutions. However, most individuals and families can and do benefit from human/animal relationships.

Locations

Programs may take place at home on a one-to-one basis with a hearing-ear dog, at a nursing home with an animal-visitation program, at a correctional institution with a resident mascot, or at a horseback riding center for the mentally or physically impaired.

Veterinary Involvement

Veterinarians may be asked to participate in programs in a variety of ways:

a) Approached by a client that has read about Animal Facilitated Therapy, wishes to start a program for a parent in a nursing home, and asks a practitioner for advice.

b) Approached by the director of a nursing home or day care center who wishes to develop a program and seeks guidance from a local veterinary medical association.

c) Approached by the director of a humane society or animal shelter who wishes to use adoptable random-source animals in a program and would like the veterinarian to aid in animal selection and provide health care for the animals.

d) As part of a community service project, a veterinarian may initiate a visiting pet program by encouraging the cooperation of the local veterinary association, a humane society, a scout troop, and a health-care facility.

The field of Animal Facilitated Therapy is open to innovative and creative thinking. Many situations exist in which Animal Facilitated Therapy has yet to be tried.

How To Get Started

An Animal Facilitated Therapy program should be started only after there has been adequate advanced preparation and discussion by everyone that will be involved. Simply bringing animals in contact with the target population is not sufficient. On the other hand, programs can become so structured with regulations that they never get off the ground or subsequently flounder. Each program has its own potential benefits and problems.

Animal Selection

Animals should be selected on the basis of type, breed, size, age, sex, and especially behavior appropriate for the intended use. The animal should be chosen with the target population in mind. Experience shows a boisterous, overactive dog may be friendly but inappropriate for a nursing home in which most patients are using walkers. A visiting calf or lamb may be more effective with patients who have rural backgrounds than would a caged rodent.

Health Care

a) Animals that are healthy, well trained, temperamentally suitable, and appropriately immunized should be selected.

b) A health care plan is needed to prevent and/or to minimize the risk from common zoonotic diseases such as rabies, psittacosis, and salmonellosis, as well as internal and external parasites.

c) The current Compendium of Animal Rabies Vaccines (prepared by the National Association of State Public Health Veterinarians, Inc., P.O. Box 13528, Baltimore, MD 21203, and published yearly in the Journal of the AVMA) and/or state guidelines should be followed.

d) Humane animal care should include appropriate grooming, feeding, watering, and exercise schedules. Animals should be monitored for clinical signs of stress and their well-being should be ensured.

Client Education

No one is in a better position than the veterinarian to monitor the health and welfare of the animal used in an Animal Facilitated Therapy program. Fundamental animal handling, behavior, housing, and husbandry may have to be explained. Feeding, watering, and exercise schedules should be established. A specific individual, such as a staff member, should be responsible for the animal and its well-being. Animals should be monitored for clinical signs of stress and their humane treatment should be ensured. Potential health hazards of common zoonoses should be discussed and evaluated with the facility staff.

Fundamental Steps

a) Become informed about Animal Facilitated Therapy concepts and current programs.

b) Be knowledgeable about local and state laws concerning use of animals in the designated facility. Federal regulations do not prohibit use of animals in federally funded health care facilities.

c) Contact and encourage cooperation and participation of facility directors, activities directors, and facility staff. This is vital to a successful Animal Facilitated program.

d) Establish realistic program goals. An unstructured rush of enthusiasm can lead to early people burnout and abandonment of the program.

e) Employ a team approach. Recruit help from community resources, such as psychiatrists, psychologists, social workers, occupational therapists, humane groups, 4-H clubs, riding clubs, civic and church groups, foundations, nurses, and your clients.

f) Talk about it.

Suggested Reading

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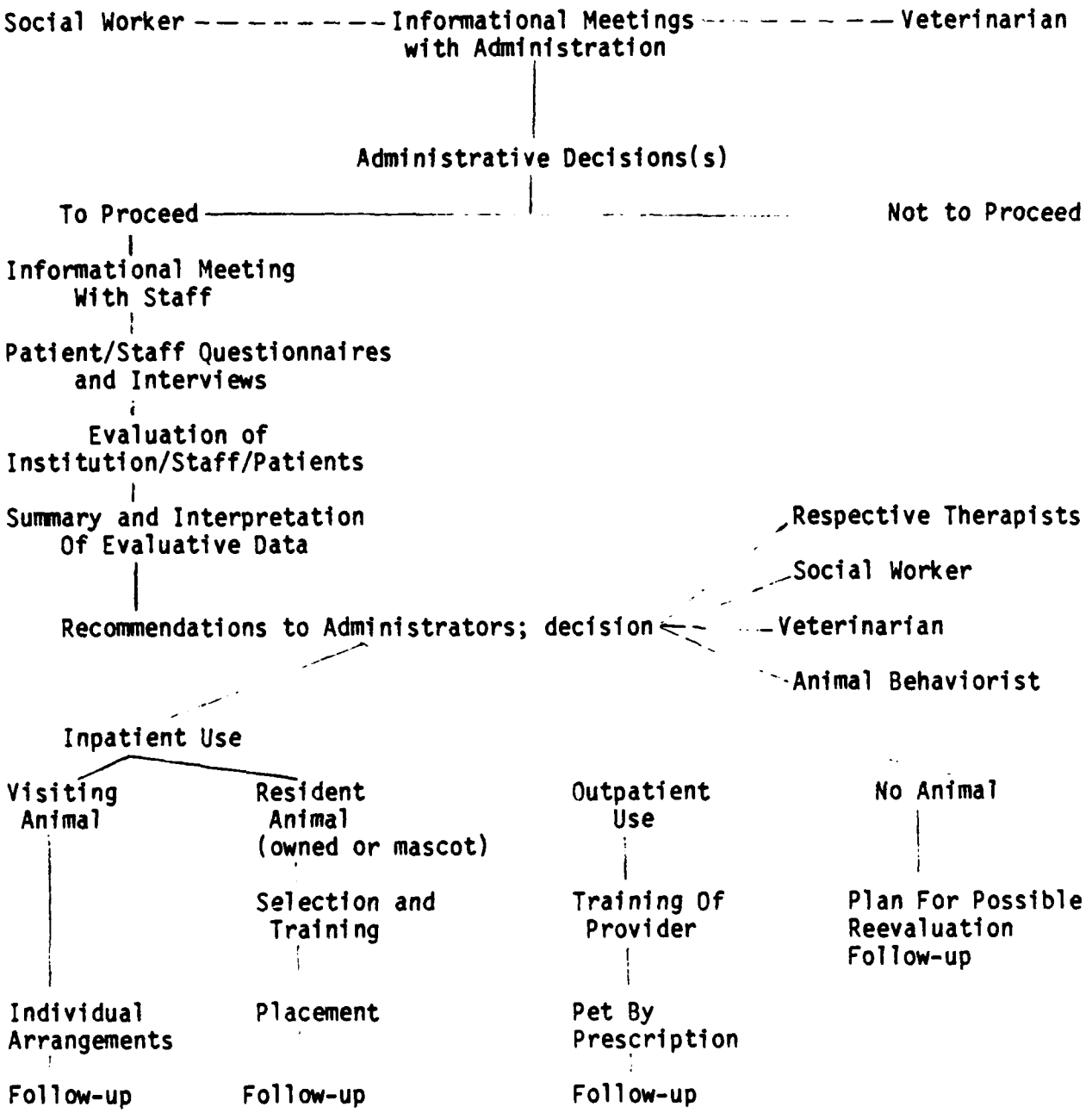
APPENDIX I

PROCEDURAL FLOWCHART



APPENDIX J

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