



Major Article

Animal-assisted interventions: A national survey of health and safety policies in hospitals, eldercare facilities, and therapy animal organizations



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Background: Animal-assisted intervention (AAI) programs are increasing in popularity, but it is unknown to what extent therapy animal organizations that provide AAI and the hospitals and eldercare facilities they work with implement effective animal health and safety policies to ensure safety of both animals and humans. Our study objective was to survey hospitals, eldercare facilities, and therapy animal organizations on their AAI policies and procedures.

Methods: A survey of United States hospitals, eldercare facilities, and therapy animal organizations was administered to assess existing health and safety policies related to AAI programs.

Results: Forty-five eldercare facilities, 45 hospitals, and 27 therapy animal organizations were surveyed. Health and safety policies varied widely and potentially compromised human and animal safety. For example, 70% of therapy animal organizations potentially put patients at risk by allowing therapy animals eating raw meat diets to visit facilities. In general, hospitals had stricter requirements than eldercare facilities.

Discussion: This information suggests that there are gaps between the policies of facilities and therapy animal organizations compared with recent guidelines for animal visitation in hospitals.

Conclusions: Facilities with AAI programs need to review their policies to address recent AAI guidelines to ensure the safety of animals and humans involved.

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The use of pets in animal-assisted interventions (AAIs) for the benefit of human recipients of therapy has become increasingly popular.¹ According to the International Association of Human-Animal Interaction Organizations, AAI is “a goal oriented intervention that intentionally includes or incorporates animals in health, education and human service (eg, social work) for the purpose of therapeutic gains in humans.”² For the purposes of this article, animals that are performing under the premise of the AAI activities

described by the International Association of Human-Animal Interaction Organizations are referred to as therapy animals.

Therapy animals should be distinguished from service animals or emotional support animals. Service animals are defined by the Americans with Disabilities Act as those trained in a specific task (eg, guiding, signal response, or alert dogs) to assist an individual with a disability and are regulated. According to the Americans with Disabilities Act, emotional support animals are often used “as part of a medical treatment plan as therapy animals. . . [but are] not considered service animals under the [Americans with Disabilities Act]. These support animals provide companionship, relieve loneliness, and sometimes help with depression, anxiety, and certain phobias, but do not have special training to perform tasks that assist people with disabilities.”³

Many health care facilities, including hospitals and eldercare facilities, have introduced programs that promote interactions between residents or patients and therapy animals in AAI. These programs can result in positive health outcomes, including reductions in blood pressure, improved mood, and delayed onset of dementia.^{1,4-6}

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However, these programs are not without some risk if not conducted carefully, including patient allergies, fear of animals, bites, and potential for zoonotic disease transmission.⁴ Several studies have identified pathogens carried by animals, particularly those fed raw meat diets, that may pose risks to immunocompromised patients, including *Campylobacter*, *Salmonella*, and *Cryptosporidium*.⁷⁻⁹ Studies have shown, for example, prevalence rates for contamination of commercial raw meat diets with *Salmonella* spp between 21% and 48%,¹⁰ with high rates of resistance to antibiotics.⁸ Even in therapy animals, in which one would expect higher levels of safety, one study found that zoonotic agents could be isolated from 80% of therapy dogs, including *Clostridium*, *Giardia*, and *Salmonella*.¹¹ Beyond recommended guidelines from working groups,¹²⁻¹⁴ no human or animal health regulatory agencies are currently responsible for monitoring or regulating AAI programs. The Society for Healthcare Epidemiology of America (SHEA) has produced guidelines for animals in health care facilities that include important steps such as establishment of written policies, designated AAI visit liaisons, and formal training programs for both animals and handlers. However, there is no legal incentive to establish such parameters in health care facilities. Furthermore, therapy animal organizations are self-regulated and thus have no mandated behavior training or health requirements. Standards range from very rigorous (ie, some national therapy animal organizations require that volunteers be trained; undergo recurring evaluation with their animal and attend ongoing education for professionalism, safety, and animal welfare; and have rigorous animal health and grooming requirements) to nonexistent.

Among the handful of national organizations that register handlers and therapy animals, Pet Partners is the only national therapy animal organization that requires volunteer training, recurring evaluation of animal-handler teams every 2 years, as well as prohibiting raw meat diets.¹⁵ Other AAI organizations do not require all of these standards, and specific policies vary widely between groups. For example, whereas one organization prohibits animals eating raw meat diets from being registered,¹⁵ another explicitly allows it,¹⁶ and another has no policy on the issue.¹⁷ Similar variation in other practices of the national therapy animal organizations (eg, training and re-evaluation of teams) also exists. Anecdotally, the practices of the regional and local therapy animal organizations appear to be even more variable.

Although results of a limited sample of health care facility policies related to animals in the United States were recently reported,¹⁴ there is a dearth of studies documenting national trends in health and safety policies for AAI in hospitals and particularly in eldercare facilities. It is essential to understand if health care facilities are incorporating elements of the recent SHEA guidelines into their existing AAI policies. In addition, it is important to understand the standards that are used by regional and local therapy animal organizations. Vulnerable patient populations exist not only in hospitals, but also in eldercare facilities where AAI has become popular. It is thus important to more fully understand where existing policies fall short of best-practice guidelines for protecting patients or residents and animals from harm. Therefore, the aim of this study was to investigate the AAI program policies in hospitals and eldercare facilities across the United States, as well as policies and procedures of regional and local therapy animal organizations.

MATERIALS AND METHODS

Two surveys were conducted: 1 to hospital and eldercare facilities and 1 to therapy animal organizations across the United States about existing policies related to animal health and behavioral prerequisites for therapy animals and AAI programs. The study protocol was determined to be excluded from review by the university institutional review board.

National hospital and eldercare facility animal policy survey

The first cross-sectional telephone/e-mail survey was conducted in hospital and eldercare facilities. Hospitals included public, private, and teaching hospitals. Eldercare facilities included independent living communities, assisted living facilities, and full-time nursing care facilities. These facilities were located in 9 geographic regions of the United States that were defined using the American Pet Products Association Pet Owners Survey: Pacific, Mountain, West North Central, West South Central, East North Central, East South Central, New England, Mid Atlantic, and South Atlantic.¹⁸ One state was randomly selected from each of the 9 regions, numbering the states 1 through X (number of states in the region) and using a computer generated random number selector to correspond with 1 of the numbered states. Within the selected state, 5 eldercare facilities and 5 hospitals were selected using an Internet search for “eldercare facilities in [state]” and “hospitals in [state].” Multiple search engine pages were scanned and a random sample was selected, in which facilities were listed in alphabetical order, numbered, and selected using a computerized random number generator as described above. Upon selection from the list, hospitals or eldercare facilities that had neither a listed telephone number nor an e-mail address on their Web site or online directory were excluded for the purposes of this study, and a randomly selected replacement from the list of facilities was used. However, if a facility had only an e-mail or a telephone contact, the facility was included and only that method was used to contact them. This process was repeated until 5 facilities from each region were selected.

Facilities were contacted by telephone (if available) and study investigators asked to speak with the staff member responsible for AAI policies (often the volunteer program coordinator at the hospital or eldercare facility) or the eldercare facility manager. For those facilities with existing AAI programs, the volunteer coordinator was contacted to discuss animal and handler visitation policies. If the facility did not have a designated AAI coordinator on staff, any member of staff familiar with pet visitation policies could be contacted. If no telephone number was available for a selected facility, an e-mail message was sent to volunteer services (when an address was listed on the Web site) or to general inquiries.

Participants were provided a brief introduction from the researcher, verbally or in the form of an e-mail message, explaining the confidential nature of the study and the goal to improve current understanding of national AAI policies. Participants were first asked whether their facility had an animal visitation policy. If yes, details on animal health requirements and behavioral assessment were requested. Both e-mail and telephone responses were compiled and tallied into 6 policy strength categories: no animals allowed, no existing policy, verbal confirmation that the animal was healthy, written confirmation of animal health, written confirmation of animal health and meeting animal/handler team, or registered animals only allowed. Initial telephone calls were made between November and December 2013, with 1 follow-up call for nonrespondents during January 2014. E-mail surveys (to facilities without telephone numbers) were distributed during December 2013, with 1 follow-up reminder during January 2014. Failure to respond after a follow-up call or e-mail (n = 17 facilities of those contacted) resulted in disqualification of the facility from the study, and the randomized selection process was repeated until responses from 5 eldercare facilities and 5 hospitals from the selected state were obtained.

Therapy animal organization policy survey

The second national cross-sectional study was conducted assessing regional and local therapy animal organizations using the same 9 states randomly selected for the facility survey. Three therapy

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