After the ADA: Service Dogs on Inpatient Psychiatric Units

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This article explores the case histories of two disabled patients admitted with service dogs to an inpatient psychiatric unit in compliance with the Americans with Disabilities Act (ADA). These cases illustrate the clinical realities of provisions in this new law that affect inpatient practice. Federal, New York state, and case law that frame the issue are reviewed. The experience of living and working with service dogs in an inpatient milieu required many accommodations and exposed potentially dangerous consequences that were not immediately recognized. The authors examine the clinical and medicolegal issues raised by these cases. Recommendations for proactive planning and a screening questionnaire for decision making are offered to guide administrators and clinicians attempting to balance civil liberties with clinical common sense in making reasonable accommodations for the disabled.

This paper examines the clinical and medicolegal consequences of service dogs remaining with disabled patients during acute inpatient psychiatric admission. After the Americans with Disabilities Act (ADA) was signed into law in 1992, our inpatient unit was challenged to accommodate two patients who asserted a new "right" to have their dogs remain with them during admission. Their assertions initially were upheld by hospital administration over the objections of the inpatient administration. While studying the issue, we learned that we were not compelled by statute to allow service dogs. We review the legal context in which these patients presented, introduce their case histories as examples of the advantages and problems that bringing service dogs into an inpatient milieu may entail, and offer suggestions from our experience for future decision making. A search of the medical literature provided no guidance in this matter.

To provide a context for the extent to which the law has insisted on the accommodation of service dogs, it is important to review the New York state statutes, regulations, case law, and hospital policy that were relevant to our unit at the University of Rochester Strong Memorial Hospital in Rochester, NY, before the ADA. New York State Civil Rights Law mandated in 1986 that "no person shall be denied

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admittance and/or the equal use and enjoyment of any public facility solely because said person is a person with a disability and is accompanied by a guide dog, hearing dog, or service dog." The law required that guide dogs be properly harnessed and trained by a qualified person. It did not address hospitals or health care facilities directly in the definition of a public facility.[1]

The Supreme Court of Richmond County, New York, further defined "public facility" and the limits of accommodation in *Perino v. St. Vincent's Medical Center of Staten Island* in 1986. Mr. Perino contested the decision of the medical staff attending the birth of his child to refuse his seeing-eye dog admittance to the delivery room. The court found that areas such as the delivery room, labor rooms, and the maternity ward were not public facilities. It further commented that the law intended to prevent discrimination against the disabled was never intended to require hospitals to alter radically their mandates for controlling and preventing infectious disease and protecting the patient and staff from unacceptable dangers that the presence of a dog might pose.[2]

New York state health regulations address the issue of guide and service dogs, stating that they may accompany a disabled individual unless "the presence of such dog in a particular area is medically contraindicated; or the presence of such a dog would conflict with or imperil infection control efforts."[3]

Before the ADA, Strong Memorial Hospital developed a policy addressing restrictions and exceptions for allowing animals, specifically service dogs, into the hospital environment. This policy was particularly relevant to our hospital because the greater Rochester area has the largest per capita deaf population in the world.[4] The hearing-impaired are using service dogs with increasing frequency. The policy was intended to address both the risks of potential transmission of disease between animal and human and the potential for behavioral change that the pressure of unusual surroundings could evoke in an animal, leading to risk of injury. The director of the vivarium (a veterinarian), the hospital epidemiologist, and the chair of the Infection Control Committee were to oversee exceptions and exclusions on a case-by-case basis. There were no specific provisions for the special nature of inpatient psychiatric units.[5]

The Americans with Disabilities Act was signed into law by President Bush in 1992.[6] The Department of Justice technical manual, which interprets the ADA, included specific provisions for service animals with this language: "A public accommodation must modify its policies to permit the use of a service animal by an individual with a disability unless doing so would result in a fundamental alteration or jeopardize the safe operation of the public accommodation."[7]

Context

Our service is a 10-bed inpatient unit that is integrated with a partial hospital program serving an additional 24 patients. Both groups of patients are treated together in the partial hospital program. The inpatient unit is locked, with com-

mon space limited to a dining area and a lounge. Two private rooms on the unit also are used as seclusion rooms. Our cases presented to the emergency room shortly after the ADA became effective. Hospital administration, assuming that the ADA superseded the hospital policy, focused only on infection control in determining whether service dogs were allowable on the inpatient psychiatric unit. We were advised to allow the animals to remain with the patients on the unit. To limit disruptions, conflicts, and potential infection control problems, we used private rooms for the patients with service dogs.

Cases

Case 1 Ryan was a 26-year-old man, blind since childhood from complications of iritis. His life story was filled with tragedies that left him bitter and angry, often leading to violence or suicide attempts. Such was the case when he came to us for three admissions with his guide dog, a well-trained animal, whose major fault was a tendency to bite if he perceived a threat to Ryan. Ryan's stays were brief—the longest was eight days—but he could not walk the dog for parts of each admission because he was restricted until he surrendered suicide as an option. Impressing "volunteers" to walk the dog became a struggle, because few staff felt this activity was represented in the usual descriptions of their professional duties. Solving the problem of toileting the dog still left us with the dilemma of allowing Ryan to use a leash in supervised areas so that he and the dog could have access to the unit, even during a period when he was actively threatening to hang himself. The dog was docile and friendly, yet some patients and staff were frightened of him and always felt uncomfortable with his presence.

Case 2 Rachel was a 24-year-old woman who had overcome the challenges of congenital deafness to navigate college and a first job until chronic depressive symptoms and interpersonal problems increasingly disabled her. She had exhausted both her outpatient treaters and her limited social network when she presented to us with another of her many bouts of intense suicidality. When the emergency room called to admit her, we learned that she now had a hearing-ear dog. We did not know that she had the dog for only a few months and had not completed his training exercises. Still believing it was compulsory to allow the dog, struggling with our ambivalence over Ryan's stay a few short weeks before, and believing that we had the vivarium kennels available if needed, we accepted her, providing that she understood the dog would be removed from the unit if she was unable to care for it. This plan dissolved on the eve of admission when she was restrained for head banging, and the vivarium reneged on the agreement for emergency kenneling, citing the risk of exposing their animals to infection. She was restrained on four occasions during her 20-day admission followed by long periods of ward restriction, leaving us again caring for a dog. This dog had few redeeming qualities. Cute and friendly most of the time, he terrorized staff during restraint procedures and had to be ushered quickly into the patient's bathroom. He also had a nasty habit of soiling

when anxious, usually coincident with Rachel being restrained. Staff inherited the unsavory chore of cleanup. His propensity to bark excessively with any unusual sound and his aggression when anyone approached Rachel's room was a sign of his incomplete training and a major disruption to the function of the unit. When staff made safety checks at night, his displays made nurses reluctant and frightened to enter her room, expecting the calamity and risk of biting. Many patients were regularly awakened, some complained, and one requested transfer to another unit.

Discussion and Conclusions

The spirit of the ADA is to allow individuals with disabilities the same unencumbered access to the services of a public facility that a nonhandicapped individual enjoys. It does not require the facility to change its mission, disrupt its usual operating procedures, compromise safety, or absorb unusual expenses to make accommodations. From our cases, we came to understand the fundamental issues: a patient with a disability must be able to access our inpatient unit and receive the services of psychiatric evaluation and treatment with reasonable accommodations made to achieve these ends. As we discuss these cases, consider these questions: Did our patients require service dogs to access our environment and receive the fundamental services that it offers? Were the accommodations that we made reasonable, or did we fundamentally alter our usual services and at what cost? Did we jeopardize the safe operation of our unit?

There were clear advantages for these patients to having their dogs available; however, we did not perceive the dogs as necessary to gain access to the unit or to partake equally of its services. Navigating the environment was easier for Ryan, who on earlier admissions had used a cane. Rachel felt more secure when the dog warned of "intruders;" because she often worried about being victimized in the hospital. There were clearly other adequate means for her to be alerted to sounds and intrusions while in a hospital environment. In retrospect, it seemed that having her dog was more akin to a security blanket than a necessary requirement for her to navigate the environment and receive services.

Neither patient had to cope with separation or the anxieties and expenses of arranging care for the dogs when they were unable to provide for them. The Department of Justice interprets the ADA to insist that necessary steps be taken to ensure that individuals with disabilities are not separated from their service dogs but also comments that no facility is required to "supervise or care for any service animal." If separation must occur, "it is the responsibility of the individual with the disability to arrange for the care and supervision of the animal during the period of separation."[8] We eventually purchased a kennel crate to house the dogs when their owners were incapacitated. This did not solve the dilemma of providing for the remainder of the dogs' care, which defaulted to staff at a time when we were ignorant to the extent of our responsibilities for these animals. Our attempts to supervise and care for these animals went far

beyond the threshold expectations of the ADA. The care of dogs is clearly beyond the scope of the usual services provided by inpatient psychiatric units and also represents accommodations that begin to alter the usual operations of these facilities.

Reviewing our experiences with these cases, we found several examples in which we subtly or obviously altered our services to the index patients and other patients that shared the unit with them. Mere inconveniences are not enough to refuse a service dog admittance to an inpatient psychiatric unit; nevertheless, some staff refused to work with or around the dogs. Others felt the quantity or quality of their work with these patients change secondary to actual fears or strong feelings about the dogs and having to care for them. Without waxing overly defensive or overly judgmental, one can appreciate the complex interplay of countertransference in cases such as these. Managing countertransference is a professional responsibility, but despite one's best efforts it may negatively influence the care of patients with service dogs. Too often nurses' time with patients was consumed by animal care, more than nominally diluting the treatment of some patients. We were able to staff around these conflicts for the most part by reassignment or trading staff with other units, a luxury that a smaller facility may not be able to afford. Although few patients formally complained, we are certain that many were troubled in various ways, not the least of which was having their sleep regularly disrupted when Rachel's dog was on the unit.

Many readers would agree that the fundamental mission of an inpatient psychiatric unit is to ensure safety. After reviewing the patient care in our cases we believe that the presence of the dogs interfered with our usual conservative behavior and policy about safety. The dogs gave these socially isolated patients a healthy diversion; we thought of their affection and sense of responsibility for the animals as factors mitigating against acting on impulses to harm themselves. We gave them permission to leave the unit unescorted very soon after discontinuing precautions, potentially exposing both these patients to unnecessary risks possibly motivated by an interest in having them walk their own dogs rather than focusing on safety. In Rachel's case, there were more obvious lapses in the usual procedures for safety checks. Staff were understandably reluctant to enter the vestibule to her room, sometimes not completing a full visual inspection of her while avoiding the dog. Ryan was allowed to use a leash while still actively expressing ideas about hanging himself. These are examples of subtle changes in risk management behavior that went unnoticed at the time but were replete with dangers. We speculate that these changes were attributable to the presence of the animals. Do we not also have obligations to maintain an environment free of potential hazards for all patients and staff? The risks of dog bites and infection were largely ignored in the decision to allow the dogs. Rachel's dog provided obvious examples of these problems; however, any dog may become aggressive in the often high emotional tone of an inpatient psychiatric unit

where patients may exhibit behaviors that frighten, surprise, or otherwise provoke them. One must also consider the increasing prevalence of immunocompromised patients in inpatient psychiatric populations after the AIDS epidemic. These patients are placed at risk by introducing potential vectors for zoonotic infection.

From our experiences with these cases, we offer the following recommendations to guide others confronted with the need to make decisions about service dogs. Hospitals with inpatient psychiatric units should anticipate this issue and make policy and procedure decisions with the participation and guidance of clinical administrators and staff before patients with service dogs present. Until case law further defines the ADA's language, phrases such as "public accommodation," "fundamental alteration," and "jeopardize the safe operation of" will remain open to interpretation and ambiguity. We argue that even though the general areas of a hospital may be considered a public accommodation by the ADA, an inpatient psychiatric unit does not qualify as a public place. In fact, with its locked doors, special restrictions and rights, and extraordinary protection for confidentiality, it resembles a public place less than the labor and delivery suite that Mr. Perino's dog was excluded from at St. Vincent's Hospital. A hospital should struggle with whether it considers its inpatient psychiatric units public accommodations, what it considers its primary and essential services, how individuals without disabilities access these services, what reasonable accommodations would allow disabled individuals to access the services, and what modifications and accommodations may fundamentally alter the services or make the facility unsafe.

We suggest that a provision for screening cases be retained in any policy about service dogs. Decisions should be guided by concepts of medical necessity, reasonable accommodations, and reasonable alternatives, given the nature of the facility, the unit, and the patient population. The factors relevant to screening include: (1) can the patient safety and reasonably navigate the environment without the service dog?; (2) will the patient experience clinically significant anxiety or anger that will adversely affect an alliance with treatment if separated from the animal?; (3) will the presence of the dog adversely affect the care of the index patient or other patients?; (4) is the patient likely to be unable to care for the dog for substantial periods? If so, is there an available outlet for the dog's care?; (5) is the animal a legitimately trained service dog?; (6) has the dog had the necessary immunizations?; and (7) does the dog have any known behavioral problems, particularly regarding aggression? The latter questions can often be answered by a call to the animal's veterinarian.

This discussion is not intended to imply that there are only negative consequences of allowing service dogs on an inpatient psychiatric unit. There are potential benefits in having the dogs, especially the comfort they give to their owners at a time of distress. Although the ADA appears to mandate that public facilities make accommodations to permit the use of service dogs, it also limits the accommodations so as not to jeopardize the

fundamental operations and safety of the facility. The facts of each case must be weighed individually. Our hospital administration initially enforced a liberal interpretation of the ADA that may not ultimately be in the best interests of the patient, the staff, other patients, and even the animals. An open invitation permitting service dogs may expose institutions to greater risks of litigation from a variety of potential torts, whereas a conservative approach of case-by-case consideration based on informed clinical common sense still seems viable. If asked to make the decision again for our cases, we would refuse access to the dogs. The problems we experienced and the problems that might have occurred were weighty and argue for refusal in our opinion. Ultimately, case law will provide more definition and parameters for decision making. Meanwhile, we encourage hospitals to be guided by sensible case-by-case decisions and hope that courts will seek clinical opinion as they strive to define a balance between civil rights and reasonable accommodations for the disabled.

References

1. N.Y. Civil Rights Law §§ 47, 47a, 47b, 47c (McKinney 1992)
2. Perino v. St. Vincent's Medical Center of Staten Island, 502 NYS 2d 921 (NY Sup Ct. 1986)
3. N.Y. Comp. Codes R & Regs tit. 10, § 405.24(h) (1988)
4. Pollard RQ: Public mental health and diagnostic trends regarding individuals who are deaf or hard of hearing. Rehabilitation Psychol 39: 147–60, 1994
5. University of Rochester Strong Memorial Hospital Policy, sec. 10, subsec. 10.7 (1992)
6. Title III of the Americans with Disabilities Act (ADA) 42 USCA § 12181 et. seq. (West Supp 1993)
7. 28 C.F.R. § 36.302 (c) (2) (1992); 28 C.F.R. Pt. 36, App B at 604 (1993)
8. The Americans with Disabilities Act—Title III Technical Assistance Manual, U.S. Department of Justice, Civil Rights Division, Office of the Americans with Disabilities Act. Washington, DC: U.S. Government Printing Office, 1992, p 23