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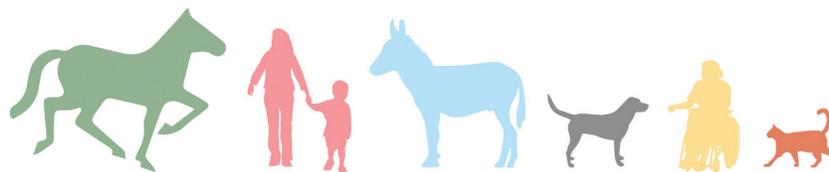
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Stakeholders' Perspectives on the Safety of an Adaptive Riding Program for Adults Living with Dementia and Care Partners

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Keywords: human–animal interactions, equine-assisted services, nonpharmacological interventions, community-based services and supports, qualitative research

Abstract: The purpose of this qualitative community-based participatory research was to explore the safety perspectives of stakeholders involved in an adaptive horseback riding program designed to enhance the quality of life of adults living with dementia and their care partners. Human–animal interactions are becoming increasingly popular therapeutic interventions; however, there is still a lack of understanding about the safety considerations for providing adults living with dementia opportunities to interact with horses and the equine environment. To advance our understanding, researchers analyzed 10 semistructured interviews and two focus groups with therapeutic riding program instructors and staff, aging network specialists, and care partners of adults living with dementia. The Professional Association of Therapeutic Horsemanship International's Core Standards served as a framework for analyzing main themes that emerged. Regarding administration and business, stakeholders expressed the need for enrollment procedures, such as screening to determine riding eligibility, comfort around horses, functional capacities, and clearance by their doctor to ride. In relation to facility and equine management, stakeholders shared questions about accessibility, including mounting procedures, space and equipment considerations, and horse training. Information gleaned from this study may help researchers, instructors, and community stakeholders develop optimal safety practices and, in turn, provide reassurance to facilitate expansion of these services, offering more opportunities to safely enhance the quality of life of adults living with dementia and their care partners.

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There are approximately 50 million people living with dementia worldwide and nearly 10 million new cases reported each year (World Health Organization, 2020). Currently, there is no cure for dementia. Thus, nonpharmacological approaches, such as human–animal interaction programs, provide beneficial, affordable, community-based opportunities that improve the quality of life and well-being of those living with dementia and their care partners (“family members and friends”) (Travers et al., 2013). The powerful relationship between animals and adults living with dementia has also been shown to improve cognition and depressive symptoms (Moretti et al., 2011), increase physical activity and function (Wood et al., 2017), decrease aggression and agitation (Richeson, 2003), and even address care partner stress (Tournier et al., 2017). Human–animal interaction program leaders most commonly partner with dogs to deliver services (Peluso et al., 2018); however, a growing body of evidence suggests that adults living with dementia may also experience positive outcomes when interacting with horses. Such services, in which professionals incorporate horses and other equines to benefit people, are referred to as “equine-assisted services” (Professional Association of Therapeutic Horsemanship International, 2020a).

Dabelko-Schoeny et al. (2014) studied the impact of equine-assisted services for adults living with dementia and found that interactions with horses can reduce problematic behaviors and positively impact quality of life. Likewise, Duggan et al. (2008) and Fields et al. (2019) also support the advantages of the enriched, outdoor farm environment for enhancing the quality of life for this specific population, as it offers opportunities for exercise, fresh air, and experiencing surroundings that they may not encounter in daily life. These benefits support the biophilia hypothesis, the belief that humans tend to focus on and affiliate with nature and are often healthier when they do so (Rogers, 2019). These interactions with horses also occur outside institutional walls, allowing more active engagement of care partners.

In 2011, a therapeutic riding center in the Mountain West region of the United States established a program called Riding in the Moment (herein

referred to as RM), which offers equine-assisted services in the form of an adaptive horseback riding program to enhance the quality of life of adults living with dementia and their care partners. The program, over four to eight once-weekly sessions, engages participants in a series of interactive ground and mounted activities that are equine- and nature-based, such as grooming, petting, riding, and farm activities. Not only does it provide an opportunity for participants and their care partners to enjoy these activities “in the moment” together, but it also allows for opportunities to reminisce. RM helps to “enhance engagement, promote physical and cognitive strengthening, relive old memories and make new ones” (T. Merritt, personal communication, April 14, 2021).

Studies demonstrate support for the benefits of RM on emotional well-being and engagement (Lassell et al., 2021) as well as acceptability from providers’ perspectives (Fields et al., 2019). Interviews from therapeutic riding center and long-term care facility staff that delivered RM revealed positive observed outcomes, ideas about why the program was working, and dementia care musts during implementation (Fields et al., 2019). Providers’ perspectives about good practice for dementia care included recognizing the individual, effective communication with patience and respect, and minor safety implications, such as supervision, structured plans for emergencies, and wearing proper gear (Fields et al., 2019). While this work is a notable addition to the literature, there is still a need for further exploration of equine-assisted services for this population.

Indeed, one of the largest reasons for lack of literature support for equine-assisted services for adults living with dementia may be due to safety concerns. As dementia progresses, people often experience heightened safety concerns because of changes in their judgment, perception of time and place, emotions, physical abilities, and senses (Fields et al., 2019). Pairing this progression with involvement of large animals may at first appear disconcerting, yet with proper standardized safety policies and procedures implemented, risk can be mitigated. To our knowledge, no adapted horseback riding program, including RM, has formally explored and documented

safety considerations for the dementia population. Therefore, we asked, how do key stakeholders perceive the safety of RM for adults living with dementia and their care partners? Information gleaned from this study may help alleviate barriers to acceptance and implementation of adaptive horseback riding programs like RM, especially for community members that are unfamiliar with equine-assisted services designed to enhance the quality of life of adults living with dementia and their care partners.

Methods

Study Design and Rationale

This secondary qualitative data analysis was performed using baseline data from a community-based participatory study (IRB protocol #2020-0702, Fields & Oestreich, 2020). The purpose of the community-based participatory study was to develop implementation and curriculum manuals in order to standardize the RM program. Community-academic research offers a shared commitment to providing high-quality services to the community—advancing knowledge, demonstrating outcomes, and improving overall health and well-being (Fields et al., 2021). Defining features of this design are that it builds on partnerships and available resources, offers expert input, provides rigor with the quality and validity of research, and combines mutually beneficial knowledge that will then be shared to positively improve communities (Israel et al., 1998; Kwon et al., 2017). Overall, a community-based participatory design is an advantageous strategy for developing dementia-friendly initiatives and promoting recruitment, funding, performance, and success of programs (Shannon et al., 2019). Based on previous literature reviews, Fields et al. (2021) remarked on the lack of community-academic partnership approaches to research on equine-assisted services and stressed the need for this type of work.

Both the community-based participatory study and this secondary qualitative analysis were reviewed and approved as exempt by the University of Wisconsin–Madison Institutional Review Board

and followed the design and reporting guidelines for qualitative research outlined by Tong, Sainsbury, and Craig (2007).

Setting and Stakeholders

Purposive sampling was used to recruit key stakeholders from the therapeutic riding center in the Mountain West region of the United States, as well as two therapeutic riding centers in the Midwest region, that were interested in expanding their programming to serve adults living with dementia and their care partners. The larger community-based participatory research study also worked with the Community-Academic Aging Research Network (CAARN) to bridge university and community aging entities. CAARN digitally connected researchers to social service providers at two aging networks near the therapeutic riding centers, an Aging and Disability Resource Center and a Senior Center. These partners then helped the researchers identify care partners of adults living with dementia who could be interested in, or had previously been involved in RM. If they were interested in offering their perspective about the program, their contact information was forwarded to the study team who then contacted the individuals. Table 1 describes reasons for inclusion and eligibility criteria for stakeholders. There was no exclusion of stakeholders based on sex, race, ethnicity, education, socioeconomic status, or disability type. Prior to data collection, participants were given study information and informed that they could withdraw at any time. All participants provided verbal consent.

Data Collection

Community-based participatory research entails multiple methods of data collection, such as surveys, interviews, and focus groups, which increases the likelihood of capturing a range of results (Israel et al., 1998). This secondary data analysis explored perspectives from 14 stakeholders, surpassing the recommended standard of at least 12 to achieve saturation (Vasileiou et al., 2018). The 10 individual semistructured recorded phone interviews and two

Table 1. Sampling Plan

Stakeholder	Reason for Inclusion	Eligibility Criteria
Therapeutic riding center staff and aging network specialists	Community partners offer knowledge, expertise, guidance, and resources (Israel et al., 1998) that helped the researchers better understand perceived safety considerations as they relate to the implementation of RM.	1. Spoke English 2. At least 18 years of age or older Must also have worked at the partnered organization for at least one year prior to the start of the study.
Care partners	Care partners observe firsthand the safety considerations that must be taken into account with their loved ones.	1. Spoke English 2. At least 18 years of age or older Must have provided unpaid care to a relative or friend with Alzheimer’s disease or other form of dementia.

Table 2. Example Interview and Focus Group Questions

Stakeholder	Data Collection Method	
	Interview	Focus Group
Therapeutic riding center staff and aging network specialists	<ul style="list-style-type: none"> • Do you have any dementia care training/ experience? • What special arrangements would you imagine needing to do to implement RM? • How would you prepare providers to deliver RM? • What challenges would you expect from implementing RM? 	<ul style="list-style-type: none"> • Should all centers be PATH accredited? • Should transportation be the responsibility of the family or friends? • How many people within that hour time slot [of a visit] is it reasonable to offer a riding experience?
Care partners of adults with dementia	<ul style="list-style-type: none"> • Did you have any initial safety concerns with RM? • Tell me about any challenges that you experienced while participating in RM with your loved one. For example, scheduling sessions with both you and your care partner present or identifying and working on shared goals with the providers during RM or safety concerns. 	

focus group meetings (consisting of therapeutic riding center staff and aging network specialists) were considered loose and flexible in nature to truly allow dialogue to capture stakeholders’ voices (Kallio et al., 2016). The main purpose of the interviews and focus groups was to evaluate the safety considerations of RM program implementation for adults living with dementia and their care partners, mostly from an

administration and business standpoint. The interview and focus group guides were developed by the principal investigator (BF), and sample questions can be found in Table 2. While individual interviews explored personal safety considerations, focus groups allowed for collaborative discussions about safety from the perspectives of stakeholders that have, or would be implementing RM.

Due to the coronavirus pandemic and associated public health recommendations during the time of the study, interviews and focus group meetings were conducted over the phone or Zoom rather than in-person, each lasting approximately 30 to 60 minutes, respectively. The partnered organizations (i.e., therapeutic riding centers, Aging and Disability Resource Center, and Senior Center) received a monetary stipend for their involvement in the individual interviews and focus groups, while the care partners received a \$50 electronic gift card for their time to complete an individual interview.

Members of the study team manually transcribed the audio files of the interviews and focus groups verbatim and created memos summarizing the key points from each data source. Study team members also cross-checked the recordings and transcriptions to ensure accuracy of information shared by stakeholders.

Data Analysis and Dependability

All data were stored, managed, and analyzed using NVivo 12 Pro qualitative software. Data were coded used a predetermined coding structure (see Table 3). The research team used the Core Standards of Professional Association of Therapeutic Horsemanship International (PATH Intl.) to create the coding structure and guide data analysis; namely, (1) administration and business (i.e., policies, procedures, training, precautions); (2) facility (i.e., requirements for equipment, activity areas, accessible spaces); and (3) equine welfare and management (i.e., selection, care, and training of horses) (PATH Intl., 2018). The purpose of these standards is to guide nonprofit organizations that deliver equine-assisted services to individuals of all ages with physical, cognitive, and emotional challenges and uphold the safety standards for therapeutic riding centers across the world (PATH Intl., 2018, PATH Intl., 2020b). While coding the data following this structure, the research team remained open to new ideas that emerged throughout the coding process, ensuring that concepts represented the stakeholders' own words (Given, 2008).

Table 3. Coding from Interviews and Focus Groups

Codes and Subcodes	Count
Administration and business	93
Enrollment policies and procedures	49
Training	44
Logistics of delivery	34
Safe activities	27
Facility	21
Environment and equipment	12
Safety policies and procedures	9
Equine welfare and management	9

To enhance trustworthiness and dependability of the results, intercoder reliability was used as two researchers completed their coding separately and then compared their analyses to find areas of agreement and disagreement (Taylor, 2017). After coding four interviews separately, the average kappa coefficient, representing the amount of agreement between raters from random chance to perfect agreement, was calculated in NVivo and Excel software to be at moderate agreement (McHugh, 2012). Peer debriefing was used to review and assess the final emerging categories. Lastly, an audit trail of documentation was maintained so examiners can review all aspects of the study process, follow the researcher's logic, and replicate the study to yield similar results (Portney & Watkins, 2015).

Results

A total of 14 stakeholders were recruited for this study. The stakeholders in the sample were predominately female (86%) and white (100%). Variability existed in the geographical location (21% from the Mountain West region and 79% from the Midwest region of the United States) and backgrounds of the stakeholders (36% were from therapeutic riding centers, 36% were from aging networks, and 28% were care partners of adults living with dementia). Main themes and succeeding subthemes are presented next in order of coding frequency.

Administration and Business

Stakeholders shared their perspectives about necessary steps to take to ensure program safety and success, confirming that foundational administrative guidelines and expectations were essential.

Enrollment Policies and Procedures

Precautions and contraindications, transportation, enrollment forms, and a mounted barrel test were each mentioned by nearly every stakeholder. For starters, aging and physical contraindications for adults living with dementia included the background of the person, balance deficits, and brittle bones. After the moderator explained the overview of RM to an aging network specialist, the stakeholder voiced their thoughts:

I guess my concern with large horses is, for some people that never had experience with horses, having dementia could be a scary experience. But, from what you've just described, it sounds like you really take your time to get to know the person and what, what they're interested in, what they can handle, and there sounds like a lot of other opportunities for them if getting right up close to the horse right away isn't something they want to do. And I think, I just really like that, and just having that opportunity to get out in the sun and be with other people is so important too. (S1)

Stages and symptoms of dementia may impact engagement in RM, yet stakeholders discussed enrollment forms, assessments, and medical clearance to determine participants' eligibility. To be considered for mounted activities, several stakeholders welcomed the idea of mounted barrel testing, which involves sitting on a barrel to determine hip flexibility and comfort prior to riding, as well as assessing a participant's ability to follow directions. One therapeutic riding instructor mentioned, "We have a pony that we do it with, but I think that if we're going to have the geriatric group, we need to have something that for sure won't move its feet" (S3). Lastly, it was unanimous that "we encourage everybody to

come with a care partner. Especially transportation-wise, we don't want people with dementia driving themselves" (S3).

Training

Training of therapeutic riding center staff, volunteers, and care partners was expressed most frequently to ensure the safety of adults living with dementia. Stakeholders resonated with the idea of participating in dementia-friendly training with partnering organizations, such as the Alzheimer's Association and dementia care specialists from local Aging and Disability Resource Centers:

Kind of walk people through what the program's gonna look like, how to interact and communicate in a positive way with individuals with dementia. We talk about how to, you know, redirect if a behavior comes up, and, you know, maybe what that behavior likely might mean—could be pain. So, you know, we just kind of walk people through different scenarios. But just, you know, partnering with different community, different agencies to educate everyone. (S5)

Furthermore, general and dementia-friendly training of staff, volunteers, and care partners was expressed as vital to ensuring consistent and formal delivery of the program, as personnel can better serve these participants when they have a proper choice of involvement, knowledge about horse safety, and clear expectations, roles, and responsibilities. Stakeholders also mentioned the idea of involving health care students in RM because of their training in safely delivering community interventions to vulnerable populations, such as those living with dementia.

Logistics of Delivery

Following the curriculum of RM, the most common expected duration of each visit was consistently 30–60 minutes, delivered over 4–8 consecutive weeks. One care partner expressed that after more than one hour of activity, her mother living with dementia would get too tired. Respecting PATH Intl. guidelines, a therapeutic riding center staff member

stated, “We have two side walkers, and we have one horse handler” (S3) per participant, with at least one instructor per group session. The agreed-upon number of participants per session was no more than 12.

Stakeholders voiced the desire to have therapeutic riding center staff and volunteers debrief the care partners with a summary after each visit. When recollecting previous experiences with RM, a care partner stated:

I actually wouldn't have minded some feedback. Sometimes I would chat with them. There was stuff going on I didn't know about. Sometimes they might even be the volunteers, they might say she responded like appropriately to the verbal cues. Like I didn't know that. Because sometimes with me she wouldn't. Or she would answer appropriate to like yes, no. So, there was no formalized way of doing that. It wasn't upsetting that I didn't get it, but I found that I did enjoy when I did get that feedback. (S7)

Adequate communication between center staff, volunteers, and care partners was viewed as particularly essential to serving this population because the participants themselves may have diminished abilities to communicate about their own safety, engagement, wishes, and discomforts.

Safe Activities

Several ideas about safe activities were shared, such as ground and riding components, as well as sensory, art, and outdoor activities. For instance, staff from a partner therapeutic riding center hosted an event for adults living with dementia and their care partners a few months before the interview and described the activities that were enjoyed during the event:

Feeding the horses. [name] had made up these ah, shish kabobs with apples and you know, hay or whatever, and they put them on ropes and they could hold the ropes on the end and put it in the horse stall. And their hand wouldn't be close to the horse, and the horse, you know, would eat snacks, and people loved that. They thought that was great. (S3)

Other activities included brushing/grooming, petting, singing, riding, and nature walks. General tailoring of activities needs to be considerate of many facets, offering the participants choice, comfort, and activities that match their desires and abilities.

Facility

Facility standards encourage instructors and staff to provide a high level of service while ensuring the safety of the participants. Not all therapeutic riding centers are PATH member or accredited centers; however, if they are, PATH Intl. holds them to specific “standards to make sure that equine welfare, human safety, instructor knowledge, facility condition, all comport to very high standards focused on safety” (S4).

Environment and Equipment

Stakeholders agreed that RM ought to be delivered by PATH members or accredited centers to be held accountable for the utmost safety of these participants. Various environment and equipment expectations entailed the following:

You really need to make sure that the infrastructure at your center, that you have everything you need, right? To be able to safely do that. So, like, “Do we have a safe space for them to be moving around off the horse, where there's not, you know, uneven footing? Is there a good ramp?” (S5)

Safety Policies and Procedures

Stakeholders shared that the therapeutic riding centers that already abide by PATH Intl. standards would allow for a much safer and smoother transition to offering this program compared to those facilities that do not. The two partner therapeutic riding centers in the Midwest region of the United States are PATH member or accredited, and one staff member shared:

It's a riding or an unmounted horse activity that requires the special training on the part of instructors, special training on the part of the horses, and also takes people and horses that have sort

of a mission-base in their hearts. So, I see elderly people with dementia as being an audience that requires very much similar care skills and support that we already offer. (S4)

While therapeutic riding centers may not have programs specifically for adults living with dementia in place, there is some carryover from their current equine-assisted services for individuals of various ages with physical, cognitive, and emotional challenges.

Equine Welfare and Management

While equine welfare and management was mentioned the least out of the three PATH Intl. Core Standards, equine training, selection, and care is crucial to delivering safe services. Therapeutic riding center staff shared that:

Our horse herd ranges, you know, anywhere from 7 to 12 horses that are especially selected and trained to be therapeutic riding horses. They, you know, obviously have lots of patience, they're not flighty or reactive, they generally like people. They're eager to learn new things and they're usually older. . . . And, you know, we bring you out and spend 30 or more minutes with you, you know, trying to assess what kind of horse . . . what your goals might be, what kind of horse might make sense for you. (S4)

Another staff member made a point that centers must consider, "Do you have a couple horses that will tolerate standing in the ramp during a very difficult mount?" (S5), as adults living with dementia tend to be off balance. As PATH Intl. member or accredited centers, facilities are already expected to maintain excellent equine welfare and management.

Discussion

This study examined safety-related concepts from the perspective of stakeholders involved in RM, an

adaptive horseback riding program that aimed to enhance the quality of life of adults living with dementia and their care partners. Main themes that emerged from the data were organized to align with the three Core Standards of PATH Intl. (administration and business; facility; and equine welfare and management) (PATH Intl., 2018). These results provide researchers, instructors, and community stakeholders guidance for developing optimal safety practices when implementing an adaptive horseback riding program like RM for adults living with dementia and their care partners; namely, training staff and horses, encouraging safe transportation, delivering eligibility screenings, and utilizing skilled providers.

The importance of best dementia safety practices was recognized as crucial to implementing RM in previous findings (Fields et al., 2019) and was confirmed by this study. According to Lin and Lewis (2015), an ideal dementia-friendly community program involves highly trained staff and providers, people who interact respectfully and offer support, and our stakeholders concurred. Stakeholders in this study mentioned the importance of staff that are educated about what to do when adults living with dementia experience worry about getting lost or confused, display challenging behaviors, or feel overwhelmed in certain situations, which reflects major themes from Shannon et al. (2019). Training for staff around delivery of dementia-friendly modalities is a viable option to be offered either virtually or in-person and is often a complementary service presented by aging networks. For further development of adaptive horseback riding programs like RM, community-academic teams could facilitate best dementia care trainings.

To expand on these ideals for best care practices, stakeholders generated discussion throughout the interviews and focus groups about safe transportation to and from therapeutic riding centers (i.e., care partner vehicle, public transportation, facility handicap-accessible vans), enrollment forms and eligibility criteria, and careful matching of participants with horses, which had not been explored in previous literature. While Dabelko-Schoeny et al. (2014) stated that "the medical records of our participants were

thoroughly examined before enrollment” (p. 152), no specific information was provided on how to assess eligibility or use a mounted barrel for testing. These requirements may limit some participants' suitability or level of engagement in the program, but it is vital to be aware of precautions and contraindications with this population because of their risk of personal and medical complications, such as risks of falls, broken bones, or other injuries (Fernando et al., 2017). Future research could develop and test eligibility assessments and protocols for determining suitability for adaptive horseback riding programs for this population.

As previously mentioned, the collection of safety considerations of RM in this study mainly came from an administration and business standpoint. This may have been due to the reality that therapeutic riding centers following PATH Intl. guidelines already maintain standards for their facility, as well as equine welfare and management. To ensure core standards align with and optimize dementia-specific safety, skilled health care providers, such as occupational therapists, could be involved in evaluations of the environment and participants before therapeutic riding centers begin delivering adaptive horseback riding programs like RM. Occupational therapists are trained in the complex and dynamic interplay between people, activities (or occupations), and environments, and the necessary tools to promote successful engagement (Fields et al., 2018; Strong et al., 1999). Some occupational therapists are even certified by PATH Intl. or the American Hippotherapy Association (Erdman, 2020) and could provide advanced knowledge about various other equine-assisted service aspects, such as the selection and training of the horses, as well as matching participants with suitable horses. Though it is difficult to objectively determine a horse's suitability for a program because there are many factors to consider (Anderson et al., 1999), qualities such as reactivity, size, and willingness to stand quietly during difficult mounts were voiced as particularly important safety considerations for delivering RM. Future research could examine the influence of specific horse factors on quality of life and health outcomes of the dementia population.

Limitations

Methods and strategies were implemented to enhance rigor; however, there are still limitations to consider. According to Creswell (2013), semistructured interviews, in general, can influence stakeholders' responses to questions and direct the amount and quality of information they share. The interviews were approximately 30 minutes in length, which perhaps limited the extent of discussion. Researchers anticipated negligible adverse events from the interviews as they presented no more than minimal risk of harm to those involved. However, stakeholders may have had reservations about sharing certain perceptions and views in the researcher's (virtual) presence or may have felt mild distress when asked about personal, potentially emotional, experiences. With data analysis, there is room for subjectivity while coding, though measures were taken to combat that with intercoder reliability, peer debriefing, and an audit trail.

Overall, there may be a lack of generalizability as stakeholders involved in this study represent those who understand the purpose and process of RM, and thus are not representative of other adaptive horseback riding programs. The stakeholders were also all white and nearly exclusively female. To improve generalizability, future studies could further explore perceptions and opinions around safety considerations at a larger, more diverse scale from other adaptive horseback riding programs and communities across the United States.

Conclusion

This study is one of the first to qualitatively describe how to safely implement an adaptive horseback riding program for adults living with dementia and their care partners. Our findings demonstrate that stakeholders, including therapeutic riding program instructors and staff, aging network specialists, and care partners of adults living with dementia, value the need for enrollment procedures (i.e., riding eligibility, comfort around horses, functional capacities,

and clearance by a doctor), accessibility (i.e., mounting procedures, space, and equipment), and horse training. Information gleaned from this study can be used by researchers, therapeutic riding center staff, and aging network specialists as they corroborate and expand upon the safety policies, procedures, and trainings for RM and similar programs. Stakeholders may apply these ideas to provide reassurance and facilitate involvement with members of their communities and health care providers as well.

Author Note

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