PTSD/TBI Dogs and Tags Of Wyoming Service Dog Training

Volunteer Handbook

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First I would like to thank you for volunteering with Dogs and Tags. The most important thing to rememberer is that we are working with people with PTSD/TBI. People with PTSD don't like a few things.

Number one Never Surprise a person with PTSD and do not walk up behind them if possible. Below you will find some information that may help to explain what PTSD and TBI are.

Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI)

1. What is PTSD?

The Diagnostic and Statistical Manual of Mental Disorders, the publication that defines the criteria used in diagnosing mental disorder, classifies PTSD as an anxiety disorder that arises from "exposure to a traumatic event that involved actual or threatened death or serious injury" (American Psychiatric Association 1994).

Standing in line at the check out stand the feeling was almost unbearable, like a low electric current was flowing through my body, not enough to hurt but enough to make me really uncomfortable. The people behind me were standing way too close to me, their kid making way too much noise. I thought of the children I had seen in Iraq and how I never saw one cry, even the wounded ones.

*It felt like I was suffocating in the store, near panic, but I was going to maintain, I could do this, JUST BUY YOUR **** AND GET TO THE CAR.*

Just then was when the boy behind me popped the balloon he was playing with.

I was on the floor, clawing at the fake marble colored tiles, attempting to crawl under a magazine rack. I may have yelled INCOMING I don't know but when I came back into my body everyone was looking at me.

A 32-year-old OIF Army Veteran. From his blog "This is Your War II."

A. Symptoms

Symptoms vary considerably from person to person, but the essential features of PTSD include the following (description based on Helpguide 2008):

- *Re-experiencing:* The most disruptive symptoms of PTSD involve flashbacks, nightmares, and intrusive memories of the traumatic event. The veteran may be flooded with horrifying images, sounds, and recollections of what happened. He or she may even feel like it is happening again. These symptoms are sometimes referred to as intrusions, since memories of the past intrude on the present. These symptoms can appear at any time, sometimes seemingly out of

the blue. At other times, something triggers a memory of the original traumatic event: a noise, an image, certain words, or a smell.

- *Avoidance/Numbing:* Patients with PTSD may attempt to avoid thoughts or activities that could remind them of the traumatic event. In addition, they may lose their ability to experience pleasure and may seem emotionally “flat” or nonresponsive. They may feel detached or estranged from others. Often, they have a sense of a “foreshortened future” feeling that tomorrow may never exist.
- *Hyperarousal/Hypervigilance:* Individuals with PTSD may feel and react as if they are constantly in danger. This increased arousal may disrupt sleep, contribute to irritability and anger, and impair concentration. Hypervigilance may coexist with an exaggerated startle response.

B. The Science

PTSD has a biological basis. It is associated with a host of chemical changes in the body’s hormonal system, immune system, and autonomic nervous system. Medical research suggests that the intense bursts of brain activity during traumatic experiences may lay down new neural pathways in the brain (Johnson 2005).

Individuals respond to traumatic experiences along a continuum. Most people have a sudden increased arousal and vigilance. This is a “normal stress response” to danger and generally dissipates with time. For some, the symptoms intensify, become chronic, and interfere with their ability to function (Davidson et al. 2004).

The challenge for mental health professionals and the veterans themselves is to recognize the difference between what has been termed “a normal response to abnormal circumstances” and PTSD. While it is important to avoid “pathologizing” normal reactions, it is equally important to identify when these normal stress reactions are likely to lead to functional limitations. Early intervention will reduce the chance that the stress reaction will become chronic PTSD. In addition, if treatment is delayed, veterans may develop unhealthy coping strategies and may damage their relationships and social support network, leaving them very isolated (Hirsel 2007).

The timing of the onset of stress symptoms varies. These symptoms tend to be heightened by events that elicit memories of the trauma such as anniversary dates or noteworthy "time anchors;” media exposure to war zone events; sights, sounds, or smells that are suggestive of the warzone; certain melodies or lyrics; experiences involving significant losses (such as death of a loved one, etc.); or conflicts with authority (Scurfield 2006).

Some will feel the effects of the trauma while they are still deployed. This is referred to as a combat stress reaction (CSR). Reports from a survey of deployed army revealed that a substantial number of military personnel were experiencing emotional problems during their service in Iraq. For example, 15 percent of those surveyed screened positive for acute stress symptoms and 18 percent screened positive on a combined measure of acute stress, depression, or anxiety. Others may have symptoms immediately upon return from combat, while others may experience a delay of six months to many years, or when they leave the military troops (US Army Surgeon General 2008).

In response to concerns that claims of delayed onset PTSD are attempts to unfairly receive disability compensation, The Institute of Medicine, at the request of the Veterans Benefit Administration, conducted a comprehensive review of the scientific literature and concluded that "considerable evidence suggests that rates of PTSD increase over time following deployment." (Institute of Medicine and National Research Council 2007)

C. Comorbidity

PTSD usually occurs in conjunction with other psychiatric, behavioral and medical conditions. Several studies have found that more than 80 percent of people who have been diagnosed with PTSD also have a generalized anxiety disorder, social anxiety disorder, major depressive disorder, or one of a range of psychiatric or substance-related conditions. (Institute of Medicine and National Research Council 2007). The conditions may be triggered by PTSD (e.g., many people turn to alcohol and drugs in an attempt to self-medicate the symptoms of PTSD), or preexisting disorders may increase the risk of PTSD.

Functional Difficulties

PTSD can affect an individual's ability to maintain relationships, work, and in some cases, interact with their environment and those around them.

Relationships: Research with Vietnam veterans clearly documents the adverse effects of PTSD on intimate relationships. Vietnam veterans with PTSD are twice as likely as veterans without PTSD to have been divorced and three times as likely to experience multiple divorces. Veterans with PTSD perpetrate domestic violence at greater rates than comparable veterans without PTSD. (American Psychological Association 2007).

Although many couples are able to withstand the stress of PTSD, some military spouses, in their blogs, describe a similar dynamic. The veteran gets anxious and angry over little things, making everyday life for the family incredibly stressful. Compounding the everyday stress, the veteran may feel emotionally numb and "put up a wall," becoming uninterested in social and sexual activities. The spouse, hurt and stressed, may "snap" at the veteran and the anger escalates as the cycle continues. In other situations, the veteran with PTSD may have a sharp temper or violent streak that scares or angers the spouse.

Work: A diagnosis of war-related PTSD has been linked consistently to poor employment outcomes (Smith et al. 2005). Many symptoms of PTSD can directly affect job performance, such as difficulty concentrating on job tasks, handling stress, working with others, taking instructions from a supervisor, or maintaining reliable attendance.

Interacting with the environment: For people with PTSD, memories may be triggered by sights, sounds, smells, or feelings that remind them of the traumatic event. This reaction may cause them to become isolated.

D. Comorbidity

According to current estimates, between 10 and 30 percent of service members develop PTSD within a year of combat. When one considers a range of mental health issues including depression, generalized anxiety disorder, and substance abuse, the number increases to between 16 and 49

percent (Hoge et al 2004, Milliken et al 2007, Tanielian and Jaycox 2008, US DoD Task Force on Mental Health 2007, Army Surgeon General 2008).

The precise prevalence of PTSD among service members who have returned from deployment to Iraq and Afghanistan cannot be determined at this time. The estimates of probable PTSD are affected by a number of factors including the sensitivity and specificity of the screening instruments used in the study; the time period after combat when the questionnaire or assessment is administered; and response bias among service members who may be reluctant to acknowledge symptoms due to factors such as stigma or fear of impact on their career.

Although estimates vary, all conclude that a significant number of service members and veterans are at risk for various degrees of stress reaction, including for some diagnosable PTSD.

2. What is TBI?

Traumatic brain injury (TBI), also called acquired brain injury or simply head injury, occurs when a sudden trauma causes damage to the brain. TBI can result when the head suddenly and violently hits an object, or when an object pierces the skull and enters brain tissue.

A. Symptoms

Symptoms of TBI can be mild, moderate, or severe, depending on the extent of the damage to the brain. The term “mild TBI” is synonymous with “concussion.” (Hoge et al 2008). A person with a mild TBI may remain conscious or may experience a loss of consciousness for a few seconds or minutes. Other symptoms of mild TBI include headache, confusion, lightheadedness, dizziness, blurred vision or tired eyes, ringing in the ears, bad taste in the mouth, fatigue or lethargy, a change in sleep patterns, behavioral or mood changes, and trouble with memory, concentration, attention, or thinking. A person with a moderate or severe TBI may show these same symptoms, but may also have a headache that gets worse or does not go away, repeated vomiting or nausea, convulsions or seizures, an inability to awaken from sleep, dilation of one or both pupils, slurred speech, weakness or numbness in the extremities, loss of coordination, and increased confusion, restlessness, or agitation (National Institute of Neurological Disorders and Stroke 2008).

Most brain injuries are mild, and many soldiers with mild TBI can recover with rest and time away from the battlefield. However, the military estimates that one-fifth of the troops with these mild injuries will have prolonged—even lifelong—symptoms requiring continuing care (US Army Surgeon General 2008). They may have cognitive issues such as difficulty thinking, memory problems, attention deficits, mood swings, frustrations, headaches, fatigue, or many other symptoms.

B. Prevalence

VA only recently began a widespread TBI screening program and DoD has only recently begun documenting TBIs in each service member’s medical record. As a result, neither DoD nor VA can estimate the prevalence of TBIs based on screenings. Based on available survey data, an estimated 11 to 20 percent of service members sustained a mild TBI/concussion while serving in OEF/OIF (US Army Surgeon General 2008, Hoge et al. 2008, Taneilian and Jaycox 2008).

3. Relationship Between PTSD and TBI

PTSD and TBI are often addressed together for two reasons. First, the symptoms may be similar, so it is difficult to distinguish between the two injuries. Second, many people with TBI also have PTSD.

Although PTSD is a biological/psychological injury and TBI is a neurological trauma, the symptoms of the two injuries have some parallel features. In both injuries, the symptoms may show up months after someone has returned from war, and in both injuries, the veteran may "self medicate" and present as someone with a substance abuse problem. Overlapping symptoms include sleep disturbances, irritability, physical restlessness, difficulty concentrating, and some memory disturbances. While there are similarities, there are also significant differences. For example, with PTSD individuals may have trouble remembering the traumatic event, but otherwise their memory and ability to learn is intact. With TBI the individual has preserved older memories, but may have difficulty retaining new memories and new learning.

Research indicates that people with TBI are more likely to develop PTSD than those who have not incurred a brain injury (Hoge 2008). Two scientific theories attempt to explain this relationship. First, TBI can damage a person's cognitive function and hinder their ability to manage the consequences of his or her psychological trauma, thus leading to a greater incidence of PTSD (Bryant 2008). Second, a mild TBI injury in the combat environment, particularly when associated with loss of consciousness, reflects exposure to a very intense traumatic event that threatens loss of life and significantly increases the risk of PTSD (Hoge 2008).

Exposure therapy: The client repeatedly confronts feared situations, sensations, memories, or thoughts in a planned, often step-by-step manner. With repeated, prolonged exposure to previously feared situations, the fear tends to dissipate. ET usually lasts from 8 to 12 sessions depending on the trauma and treatment protocol.

Exposure therapy may be very intimidating for clients to contemplate and can be time consuming and emotionally wrenching for them to complete. The client may have homework in which they write down a nightmare, script a new ending and read the script repeatedly. During the therapy, the client may begin to have more symptoms before the symptoms begin to subside. Thus, it is important to have a strategy to ensure that the client will continue through the entire therapeutic protocol.

In addition, although exposure therapy is highly successful in reducing the key symptoms associated with PTSD, such as intrusive memories, it does not address other issues such as feelings of detachment from others, excessive anger and feelings of alienation. To treat these, the therapist must draw on other therapeutic approaches.

Waiting lists and waiting times: VA recently completed an analysis of gaps in mental health care throughout the system. This analysis underscored the reality that access to services is still unacceptably variable across the VA system, despite considerable augmentation of programming in the past few years. In response VA is beginning to fund additional initiatives to fill these gaps. For example in September 2008 VA announced it was adding substance use disorder clinicians to PTSD teams at a cost of $13.3 million per year and that it will provide approximately $17 million per

year to establish Intensive Outpatient Substance Use Disorder Programs at 28 additional medical centers, bringing the total number of facilities with these programs to 105.

4. Access

Even when service members or veterans decide to seek care, they need to find the "right" provider at the "right" time. As described in section 5, this is not always possible. When care is not readily available the "window of opportunity" may be lost.

In contrast to the data collected by DoD on barriers to mental health care, there is currently a dearth of information on barriers to care for OIF/OEF veterans seeking VA care. VA publishes patient satisfaction data, but by definition this data only reflects the views of veterans who have overcome whatever barriers that exist and succeeded in gaining access to care. A feedback loop which includes the systematic collection of data on the perception of consumers about the ease of access to care is crucial to identify and decrease barriers to care. No such mechanism for VA care currently exists.

A recurring survey of a national sample of OIF/OEF veterans, including those who do not currently utilize VA services could identify barriers to care, such as: distance from required specialized services; availability of specified types of service including early intervention services; bureaucratic obstacles to accessing care; user friendliness; clinic hours and policies; perceived stigma and concerns with impact on job or reserve unit status; and lack of information about what services are available.

A. Women

Women make up about 10 percent of the US forces in Iraq and Afghanistan. Some of these women have been returning from Iraq not only with combat-related trauma, but also with Military Sexual Trauma (MST). Although estimates vary, between 13 percent and 30 percent of women veterans experienced rape, and a higher percentage experienced some type of sexual trauma over the course of their military careers. The sexual trauma combined with combat trauma makes women far more likely to experience PTSD (Yeager et al. 2006).

The military's response to individual reports of MST, and the barriers that women face in reporting this trauma, is beyond the scope of this report. VA has established a number of programs to address the impact, including Military Sexual Trauma counseling, Women Veterans Stress Disorders Treatment Teams, and MST centers.

About PTSD Service Dogs

Training service dogs for individuals living with Post-Traumatic Stress Disorder (PTSD) requires very specialized knowledge and skills – in both the trainer and the dog. These service dogs must possess a perceptive nature, a courteous, compliant temperament and an intuitive spirit in order to perform their duties independently when the individual is facing a crisis. Dogs and Tags training team works to identify and evaluate these unique dogs, and then assist the client in training them to recognize and interrupt the behaviors associated with anxiety, panic attacks and nightmares.

Dogs and Tags trainers evaluate both dogs and applicants in order to effectively pair a successful team.

Legal (The Americans with Disabilities Act)

The Americans with Disabilities Act (ADA) guarantees a blind, deaf, or physically disabled person the legal right to be accompanied by a service animal in all areas open to the general public. Service animal means any guide dog, signal dog, or other animal individually trained to do work or perform tasks for the benefit of an individual with a disability, including but not limited to guiding individuals with impaired hearing to intruders or sounds, providing minimal protection or rescue work, pulling a wheelchair or fetching items. The Difference Between a Psychiatric Service Dog and an Emotional Support Dog

It is not always clear—to staff at public places, and even to some people with disabilities—whether an animal accompanying an individual with a psychiatric disability or impairment is performing a psychiatric service or "merely" providing emotional support. Confusion may result in unlawful and discriminatory treatment of people with disabilities.

The key distinction to remember is that a psychiatric service animal is actually trained to perform certain tasks that are directly related to an individual's psychiatric disability. The dog's primary role is not to provide emotional support. It is to assist the owner with the accomplishment of vital tasks they otherwise would not be able to perform independently. In addition, a psychiatric service dog must not only respond to an owner's need for help, the dog must also be trained to recognize the need for help in the first place. A dog must be able to respond and recognize to be a service dog. By contrast, an emotional support dog is a pet that is not trained to perform specific acts directly related to an individual's psychiatric disability. Instead, the pet's owner simply derives a sense of well-being, safety, or calm from the dog's companionship and physical presence.

The animal companionship of an emotional support dog can have genuine therapeutic benefits for individuals with psychiatric disabilities and less severe mental impairments. But unless the dog is also trained to work—to independently recognize and respond to its owner's psychiatric disability—the dog does not qualify as a psychiatric service dog and does not receive the protections of the ADA.

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Public Access

At a recent demonstration an individual posed a very good question. "What do you mean by Public Access training and testing". This is a good question and worth discussing, in depth, with our readers.

Public Access refers to the rights given to individuals with disabilities to be accompanied by an assistance dog. In summary The Americans with Disabilities Act [ADA] states:

Any blind, deaf, or physically disabled person has the right to be accompanied by a service animal in all areas open to the general public. Service animal means any guide dog, signal dog, or other animal individually trained to do work or perform tasks for the benefit of an individual with a disability, including but not limited to guiding individuals with impaired vision, alerting individuals with impaired hearing to intruders or sounds, providing minimal protection or rescue work, pulling a wheelchair, or fetching dropped items.

Please note that this law makes mention that the dog must be "individually trained", however it does not state who should train it nor does it give a standard to which the dog should be trained. This should be of concern to anyone interested in the assistance dog field. This federal law refers to "individually trained" dogs in regards to performing tasks, but no where does it mention to what level it should be trained in regards to public access, although it clearly gives public access rights. Within much of the assistance dog community this is of grave concern.

Through the evolution of the guide dog industry dating back to the beginning of this century, those partnered with guide dogs struggled, demanded, and fought for their right to be accompanied by their guide dogs. In the early years this of course was incredibly difficult. 1920's America was not ready for dogs in their restaurants, stores, and work places. Public Access rights were slow coming and the battle was hard fought, but finally state by state those who used guide dogs received this right.

In the early 70's dawned a new phenomenon, that of the Hearing and Service Dog. As beneficial to their human counterparts these dogs were being trained by competent and capable trainers and being placed throughout the U.S. There existed no public access rights for these individuals and their dogs however. Again battles were fought and legislators contacted in an effort to add Hearing and Service Dogs to existing legislation. By this time the public was [for the most part] aware of what purpose a guide dog served and that they were allowed public access. However, the concept of a dog trained to assist an individual with an auditory impairment this was a different issue altogether.

Through the years since that time assistance dog providers and those partnered with these dogs worked diligently to gain the same rights extended to guide dogs and their partners. Eventually each state modified their laws to include Signal [hearing] and Service Dogs. Even today we still struggle with public access issues. "If it's not one of them blind-seeing eye dogs it can't come in here", is a statement commonly heard by service and hearing dog partners and providers alike. The ADA has stood in effect for more than 7 years now and yet the problem persists. However, public access issues seem to improve as time goes by and as providers and partners alike educate the public.

Understanding a little about the history of access rights is important in order to fully comprehend the seriousness of public access. Given many decades of fighting to establish laws and in turn to gain this right, the thought of losing these rights is horrific. The largest threat to these established rights is poorly or untrained assistance dogs and assistance dog partners. The general public has come to expect a standard of behavior for the working assistance dog. Assistance dogs that fall short of this standard bring criticism to the entire assistance dog field [inclusive of guide dogs]. This fact has kept the older guide dog schools separate from the rest of the assistance dog field, and manifests itself in new training providers receiving a cold shoulder from those more well established providers.

The fore mentioned is a component of public access training and testing and why it is so absolutely necessary. Each responsible and reputable training provider has their own training and testing methods. Throughout the 1990's the membership of Assistance Dog International decided to establish uniform minimum standards and a public access test.

This was done in an effort to ensure that established programs and newcomers alike were aware of the importance of public access rights. Further that a minimum standard was reached while encouragement was given to exceed that standard. Public access rights are provide the motive to all of this, meanwhile the safety of the general public, as well as that of those partnered with assistance dogs, is also of great concern.

Public access training and testing revolves around several areas. Aggression, whether it is natural or trained, is the first and foremost concern. Overall control: that an assistance dog and his partner move easily amongst the general population without being obtrusive [even during incredible distraction]. Partner related hazards include the safety of the individual partnered with the dog. A

dog pulling hard against the leash of his master in a wheelchair is positively dangerous. Dog related hazards generally include positioning of a dog while performing obedience skills or trained tasks.

A dog awkwardly tethered to his partners chair may be forced to walk in an unnatural manner, causing early deterioration of the musculoskeletal system.

Aggression, within ADI standards, is strictly prohibited. Anything much beyond a “speak” on command is not tolerated. Training of protection dogs to be partnered with an individual with a disability is also strictly prohibited among ADI member programs. It is thought that the risk of injury to the general public, to the handler, or to the dog himself is simply too great. This is not without debate; in 1997 ADI addressed this issue and came to the above conclusion.

Partner related hazards focus on the safety of the person partnered with the assistance dog. An individual with blindness pulled haphazardly into the street by his dog that was lured by food scents is an example. Someone using a wheelchair pulled off of a curb is just as dangerous. The hearing dog that growls at other dogs brings the threat of a dog attack to an unsuspecting master. The seizure response/alert dog “protecting” his master may be responsible for delayed medical attention needed by his master with severe seizure activity. All of these examples need to be addressed by the providing entity, specific to the classification of assistance dog.

Dog related hazards are those threats to the dogs’ health, life, and overall longevity. Humane training methods are all the rage these days. However, an assistance dog performing a skill or task in a manner which causes him (the dog) harm negates the humanness of the training method used. These dogs perform a wonderful service to their master and they deserve our respect and compassion lest they become nothing more than slaves.

Public access training often begins with the puppy raiser of a guide, service, or hearing dog. In other cases, particularly with dogs acquired at an older age, screening and thorough training by professionals is necessary. Dogs acquired from shelters and private owners often fail to “make the grade” due to these public access concerns. Public access is a concern from the very beginning and remains such through the placement period and on into follow-up. The tasks an assistance dog performs for his master become irrelevant if the dog is lunging for solicited pats on the head. A guide dog that growls every time he sees another dog becomes a threat to his masters’ safety regardless of how nicely he guides with no other dogs around.

Training providers have fielded many phone calls through the years from individuals wanting certification for their “helper” dog. Self-trained, the dog performs one or two tasks which are in fact helpful to the owner. About then he divulges that the dog is a Wolf/Pit-Bull/Doberman cross who has on occasion (once or twice a year) bitten small children, and ate the neighbors Chihuahua last week. Although the dog is providing a service and is performing the tasks flawlessly, the dog is not in the eyes of the assistance dog industry a “service” dog. Interestingly enough, according to the

letter of the law (ADA) this individual has a right to be accompanied by his “service” animal. This dog was after all “individually trained”. Scary isn’t it!

There are persons living with a disability who have done a fantastic job in training their own assistance dog. Maintaining the right of these individuals to do so is also important. Somehow that must be done while simultaneously making sure that Billy Joe Bob and Cujo are kept off the streets.

It is the opinion of Dogs and Tags that in the future the general public will demand their right to be safe and at ease while in the company of working assistance dogs. Unfortunately, I speculate that it will be prompted by an unfortunate incident. Legislators will be forced to come up with an answer. It is my sincere hope that whomever is charged with fixing this dilemma will contact the industry that has wrestled with this problem for decades. Given that, the assistance dog field is facing the potential of a federally regulated certification process.

As you are now aware, public access training and testing is the largest component of the assistance dog training, placement, certification, and follow-up process. Responsible and respectable providers know this and live with it every single day. Well-schooled assistance dog partners are also fully aware of the intense importance of public access issues. There is, after all, an awful lot at stake here!

Each responsible and reputable (assistance dog) training provider has their own training and testing methods. Throughout the 1990’s the membership of ADI (Assistance Dogs International) decided to establish uniform standards and a public access test.
Essentially the dog must maintain the highest degree of control and attention to his master regardless of food distractions, noise distractions, the human population, motor vehicles and others.

KENNEL DUTIES

As a volunteer you maybe asked to complete any of the following tasks on any given day.

Morning Duties

The first staff on duty each morning is responsible for feeding the animals. After the animals are fed, morning clean up starts. All staff are to follow the instructions on the assignment board at Information Central regarding what areas they are assigned. Staff cannot change these assignments. If you are not able to work in the area assigned, discuss the situation with the Master Trainer.

Afternoon Duties

Kennel Inventory - The Master Trainer will walk through the kennels and make decisions about what, if any, animals are to be moved.

The Master Trainer will use “stickies” to indicate to the facility staff “move to isolation.” This way, the staff can, during clean up, move the animal to the new area and ensure the old kennel is thoroughly disinfected.

After Clean-up, On-going Duties

- Spot clean animals after morning clean-up and three times during the afternoon
- Disinfect and set up dirty cages; see *EMPTY CAGE DISINFECTING (AFTER ANIMAL LEAVES).*
- Sweep/mop floors
- Walk the dogs
- Check water for all animals
- Clean toys from exercise yard
- Socialize those animals that are frightened or scared
- Other duties as assigned
- Feed between 4:00 and 7:00 p.m.

Closing Duties

- Spot check dogs one last time/scoop kennels
- Check water
- Walk all housebroken dogs
- Put away supplies in the appropriate place
- Turn off the lights in the facility
- Lock the door as you exit

FEEDING

Morning Feeding

Each dog has the name of the food and quantity listed on kennel card.
Keep the area clean as you make the food; discard the cans and can tops in the trash.

CLEAN UP

Morning Clean Up

The morning scrub begins right after the dogs are all fed

Equipment needed:

- 5 gallon bucket lined with a trash bag and secured with a bungee cord
- Pooper scooper
- Foamer with disinfectant Triple Two
- Long handled scrub brush

- Squeegee

Daily Cleaning Process

- For single sided runs, leave one run open at all times at the end of each row. In the morning, the staff will move the dog(s) in the dirty run that is next to the clean run into that clean run (that is, move down one run). Clean/disinfect the run the dogs were in, squeegee the floor and move the next dog(s) into the one just cleaned. Repeat that until you have moved each dog into a clean run, and you will have an empty run at the other end from where you started. The next morning do the same thing, only start with the empty run.

- Use runs that you build outside to correspond in number with the number of runs you have inside. These should have cement floors and covers. Staff walks each dog to the corresponding cleaning run outside and then cleans inside in the manner illustrated below. After the runs are clean and dry, walk the dog(s) back to their original run.

- Incorrect use of disinfecting and detergent products is a very frequent factor in the spread of disease in facilities. For example, many disinfecting products do not have detergent action, so additional cleaning steps with a detergent are needed. Also, many disinfecting agents require a 10-minute contact time. Verify the instructions for the products that you use.

Call all the dogs to the same side of the cage in one row. Close the guillotine door behind them.

DO NOT LET IT DROP.

- Scoop up all the solid fecal material or toy parts with the scooper in each run all at once.
- Spray detergent Triple Two on every surface of the run.
- Scrub with a stiff brush all the areas, removing the organic material.
- Rinse run/cage.
- Go back to the start of the run section, and spray the walls, floor, and the gate of each run with the disinfectant solution.
- When you are finished with the entire row, and it has been at least 10 minutes to ensure proper contact time for disinfectant to work, go back to the first run and rinse with clear water.
- Fill clean water bucket/pails.
- Squeegee each run and walkway.
- Replace beds if needed.
- Provide toy.
- Move all the dogs back to the clean side, close the guillotine door after them and repeat above process on the other side.
- When finished, open the guillotine door and let the dogs have access to both sides.
- Empty the poop pail into the dumpster.

FOSTER PROGRAM

Volunteer fostering:

- When an animal is a candidate for foster, we use trained and supervised volunteers who are approved for foster.
- The approval for the animal to be fostered must first be obtained by the Master Trainer. The status of the animal is changed to “ready for foster.”
- The Master Trainer will work to find a foster provider.
- Volunteers that are approved to foster are organized by the Master Trainer.
- Volunteers fostering the animals need to understand that ongoing decisions about care will remain in the hands of the facility and are dependent on financial resources and prognosis for recovery.
- Volunteers also need to be aware that the Master Trainer makes all medical/ surgical decisions about foster animals. The Master Trainer provides a contact for medical emergencies. Volunteers **will not** be reimbursed if they take an animal to another veterinarian for exam, diagnostic testing, treatment, etc.
- Any animal that leaves the facility in foster care must be recorded as such. The hard copy of the animal’s record is put in the Master Trainer’s box with the name and contact person who is the foster provider and a record about where the animal is and the date the animal went into foster and the date that the next examination/recheck is due.
- When the animal is returned to the facility, the file hard copy is retrieved and placed with the animal and the record is updated showing the animal has been returned.

WALKING

When removing a dog from the cage or run, always use a thick slip lead. Never use the clip end of a leash on the collar. Frightened animals may pull back when being walked, and they can easily slip out of the clip collar and run away.

As you walk outside, keep the dog on a short leash and do not allow the dog to interact, sniff, touch noses, etc. with any other dog or person.

Trained volunteers can walk dogs if the dogs have been behavior evaluated. Any dog in with a sign that says “do not walk” should be walked only by staff.

Dogs that are indicated by the staff as being housebroken should be walked at least twice a day. Please keep poop bags with you and pick up any feces.

If a dog gets away from a staff person or volunteer, never chase the dog. Instead, alert the staff and encourage the dog to come back to you with soft voices and treats.

When a dog has been walked, please indicate the time in the binder.

Deposit the feces in the trash can.

Walk dogs in the designated area. Follow the protocols posted on the gate of the dog exercise area.

GENERAL

- Please keep this facility clean and neat.
- If supplies or training treats and biscuits run low, re-stock the area from main inventory supplies.
- Immediately take all dirty dishes to the dish washing station for disinfection.
- Please do not leave open bags of dog food lying around. All food should be in the rolling bin either labeled “dog food” or “puppy food.”
- Keep the tops tight on the food holders for adult and puppy food.
- When these food holding containers are empty, roll them over to the supply corner and refill with appropriate food type.
- Sweep up any spilled dog food after each feeding.

Filling Water Pails

- The water at the facility is potable.
- Fill the watering can with water.
- The water pails are to be hung on the inside front of the cage to the side of the gate, so it is easy to fill the bowl without opening the cage.
- Do not fill with hose in case there are left over chemicals on the nozzle.

Disinfecting Dishes:

- Clean any food particles from the dishes by wiping them out into the trash.
- Place dishes in the detergent solution and scrub completely with a green scrubbie (no sponges) inside and place the bowl in a clear water rinse:
- Stack dishes upside down so they can drain on the racks next to the dish area.
- When dishes are dry, take them back to the proper area: clean dish area for dogs and cats or the food prep area. Do this by the end of the day so there are clean dishes for the next day.

Benefits of Canine Enrichment:

Enrichment helps dogs and puppies maintain their mental, physical, and emotional health so that they remain good candidates for clients and don’t become behaviorally at risk.

Examples of Enrichment for Dogs and Puppies:

- Very hard rubber chewable toys. Kong toys, if the appropriate size is given to each dog, are too rigid to be chewed into pieces.
- In addition, volunteers should be encouraged to use “dog walk time” to its greatest advantage and as much more than simply the chance to eliminate.
- Individual exercise opportunities should average 15-20 minutes, including leash time, talking, petting, and interactive play. Active “people time” allows an outlet for mental AND physical energy through focused, interactive play.
- By focusing on a specific task (repeatedly returning a ball, Kong, or Frisbee; playing “hide-and-seek” with treats or toys, etc.), dogs are able to expel much more pent-up mental and physical energy in a limited amount of time and space. Therefore, they greatly reduce stress due to confinement, isolation, and boredom.

Here are some basic health and safety requirements for dog and puppy toys:

- Toys must be easily and thoroughly able to be disinfected, or be disposable after single use. Disinfect toys before giving to another animal using the procedure used to disinfect dishes.
- Toys must be of sturdy construction and appropriate materials so that they pose no danger if ingested or damaged.

Aggressive Animals (Other Facility Dogs)

Any animal regardless of its size, sex, or breed who is known to be aggressive or exhibits signs of aggression towards people or other animals may be euthanized.

Aggression includes:

- defensive and threatening behaviors
- actual attacks
- lunging at humans
- baring teeth
- exhibiting other characteristics that may make it a poor family companion for the average adopter

PERSONAL SAFETY

Following these common sense rules will help prevent many accidents.

- **Report all injuries**, no matter how slight, to the Master Trainer.
- Do not attempt to lift/push objects or animals that are too heavy--ask for help. Bend at the knees and hips and lift with your legs. Adjustable tables should be

lowered to the floor for animals weighing over 75 lbs., or for any staff or volunteer unable to lift an animal.

- Identify and remember the location of fire extinguishers, or exits. NEVER block these areas with materials or equipment. Keep floors and aisles free of debris at all times.
- Use personal protective equipment as described below:
    - Goggles, safety glasses, gloves must be worn when working with chemicals
    - Safety glasses are also to be worn when preparing rabies specimens.
    - Maintenance staff will wear customary safety equipment when performing applicable tasks.
    - Ear protection is provided and should be worn when working in Dog Holding, Kennels, or any other high noise area.
- Horseplay is prohibited.
- Seat belts are to be worn at all times when driving on business, whether in facility vehicles or personal automobiles.
- When restraining animals over 60 lbs. seek assistance if necessary. (See the Animal Handling SOP for detailed instructions.)
- Any person known or observed to be under the apparent influence of drugs or alcohol will not be allowed to work, and will be subject to discipline, up to and including termination.
- **Any person willfully violating safety procedures and/or endangering the safety of others will be subject to discipline, up to and including termination.**

Staff or volunteers who observe animals exhibiting any signs of illness (such as diarrhea, vomiting, sneezing, coughing, nasal discharge, etc.) should immediately notify the Master Trainer.

HOUSEKEEPING AND CLEANING

- All staff and volunteers are responsible for maintaining the general orderliness and cleanliness of the facility. Keep floors and aisles free of debris at all times. Housekeeping is an important part of maintaining a safe work environment. It reduces the spread of disease harbored by clutter and waste and eliminates tripping and falling hazards.
- ALWAYS wash your hands in between handling animals to minimize the transmission of disease, and after handling chemicals to avoid potential allergic reactions.
- Non-hazardous spills are to be cleaned up promptly, and a "**Wet Floor/Caution**" sign placed in the area until the floor is dry. Aisles should be kept clear at all times.

HAZARDS AND HAZARDOUS SUBSTANCES

- Report all hazards to a supervisor immediately.

- Only properly trained staff are to undertake any repair work involving electrical equipment.
- Do not overload outlets.
- Know the safety precautions for each chemical BEFORE you use it. The Material Safety Data Sheets (MSDS) can be found in the office.
- Refer to the Hazard Communication Program SOP for more specific policies for dealing with workplace hazards.

ANIMAL HANDLING SAFETY

It is required for all staff and volunteers to watch the body language video which is available upon request.

This information is a general overview of safe animal handling practices. **It is not intended to replace actual safe animal handling training conducted by the Master Trainer**. When handling animals, be sure to:

- take your time,
- don't over stimulate the animal, and
- remember that the animal may *perceive* a threat, even though you do not intend to threaten.

If you do not feel comfortable handling an animal, **DON'T**!! Get the Master Trainer to help you--don't risk getting dragged, scratched, or bitten!

DOGS

- When removing a dog from a kennel, distract the dog, and enter the kennel with your leash ready.
- Attempting to "noose" a dog through the gap in the gate can lead to an escape by the dog.
- Approach the dog from the side. Do not attempt to "noose" it over the top of its head, as this will only intimidate the dog. If the dog has a kennel mate, remove the kennel mate from the kennel if he or she is making it difficult to get the dog you need. Talk calmly to the dog to avoid over-stimulating him or her.
- When moving the dog, keep the dog away from other kennels, and break his or her line of vision. Use proper leash techniques, looping the handle of the leash over your thumb and across your palm (like a joystick). Keep the leash short, bend your arms and knees and use both hands for better control.
- Only small dogs and puppies should be carried, and then only as you carry a cat. Carrying a dog like a baby is not permitted. If the dog won't move on the leash, coax the dog by moving in front and down low. Dragging a dog is never permitted.
- Watch for signs of stress/fear:
    - ears back,
    - hackles raised, tail down,

- dilated pupils,
- lifted lip,
- submissive posture,
- growling, snarling, barking, or lunging.

If these signs appear, remove the dog from the source of the stress--out of the visiting room, away from other animals, or into a less stressful kennel.

- If a dog is fearful, do not make direct eye contact. Approach the dog at his or her level. Do not reach over the dog's head. Move slowly because rushing the dog only adds more stress, leading to unpredictable behavior and increasing the likelihood of injury.

WITH ANY ANIMAL

- Inform the Master Trainer immediately if an animal is displaying signs of aggression and/or may be a threat to other animals or people.
- Wear protective gloves, long-sleeved shirts, and shoes with closed toes (no sandals) to reduce the degree of injury from bites and scratches.
- **If you have questions, ask the Master Trainer. If you feel uncomfortable handling an animal, DON'T!**

RESTRAINT OF ANIMALS

It is the goal of Dogs and Tags to treat all animals as humanely as possible. We expect everyone to use the least amount of restraint necessary to both secure the animal and protect the staff and volunteers. The following policies for restraint, from least to most restraint, are the only ones that are appropriate to use:

- All staff must have a slip leash on their belt at all times.
- Pick up and carry or place the animal in an appropriate sized carrier. No dragging, ever.
- If necessary, use a leash muzzle wrap when picking up an animal.
- Frightened dogs that try to bite or are fearful can be safely and humanely moved by wrapping the animal in a heavy blanket or towel and carrying the animal to the run or cage.
- When lifting animals, work in teams of two. Both people lift the animal: one supports the animal's weight and the other controls the animal's head.

APPROACHING FEARFUL KENNELED ANIMALS

When approaching a fearful animal, you should make every effort to be as non-threatening as possible. Remember that a caged animal may not show you signs of fear until it feels cornered (i.e. when you close off the only visible exit path).

Consider your purpose: Are you evaluating the animal, attempting socialization, or trying to catch the animal to move and/or treat it?...and only approach as close as is absolutely necessary.

- **Remember that the animal may PERCEIVE a threat,** even though you do not intend to threaten.
- **Move slowly and deliberately.** Quick, sudden, or tentative movements may produce more fearful reactions. Be sure that the animal sees you.
- **Do not make direct eye contact.** While you obviously need to watch where you are going and what you are doing, direct eye contact is very intimidating and threatening to the animal. Look to the side, above the head, or toward the floor.
- **Approach at the animal's level.** Even if you are not a very large person, you are taller than the animal and may seem to loom over it. Crouch down (bending at the knees) or kneel or sit on the floor; you should be stable in whatever position you choose. (When working with higher cages, try to bring your hand in from the bottom, rather than the top, of the cage.
- **Do not reach over the animal's head.** Reach out and touch under the chest or chin, or behind and under the ears, rather than over the head. Allow the animal to sniff your fingers first if he wants to investigate you.

Rushing an animal increases stress for the animal and the situation. Increased stress means more unpredictable circumstances, which lead to dangerous situations.

HAZARD COMMUNICATION PROGRAM

Material Safety Data Sheets (MSDS)

MSDS SHEETS ARE LOCATED IN OFFICE

Dogs and Tags does not expect its staff or volunteers to use a chemical that does not have a MSDS to explain the hazards and safety precautions that should be used with the chemical.

The Director of Training will be responsible for obtaining MSDS for each new chemical used at the facility. If an MSDS is not delivered with the first shipment of a new chemical, the Director of Training will call the company providing the service and request an MSDS to be faxed over immediately.

The Director of Training will also maintain hard copies of each MSDS in the MSDS folder hanging in the facility office, a place accessible to all staff and volunteers at all times.

Container Labeling

The Master Trainer is responsible for checking arriving containers in the facility to verify that they are appropriately labeled. If a container is not labeled, the Master Trainer will obtain a label for the chemical immediately.

Any container with a worn or missing label needs to be brought to the Master Trainer who will then label the container before it goes back into use. The Master Trainer is also responsible for ensuring that “in-facility” containers are labeled.

Non-Routine Tasks
Before any staff or volunteer engages in a non-routine task they shall consult the SOP for that particular task.

Information Exchange with Other Employees
Dogs and Tags will verbally give the information on where our MSDS binder is located to all staff and volunteers.

Employee Training and Information

Hazard Communication Training for staff and volunteers will be given at the time of initial assignment, twice a year, and whenever a new hazard is introduced. Training will include the following:

- The nature of hazards posed by chemicals in the facility.
- Right to Know
- Measures that staff and volunteers can take to protect themselves from these hazards.
- Instructions on work practices, personal protection equipment, and any special procedures to be followed in an emergency.
- An explanation of the hazard communication program, including information on labeling and MSDS.

As a Volunteer your duties may vary

You may be asked to help clean kennels and training area
Wash dishes and clean food prep area
Do laundry
Help with clerical things
Walk Dogs
Socialize dogs
Train with dogs
Supervise play time
Supervise pasture time

Clean up toys and trash out of pasture
Build and fix things
Help at events

On any given day we have things that we may need your assistance with. Remember even if you think your not helping much every thing you do is very appreciated.

It is required that you sign a volunteer contract, confidentiality contract, read all Operating Procedure manuals, read all training manuals, and watch all training and cleaning videos.

For any emergency phone numbers are listed on the refrigerator in training area.