EQUINE FACILITATED THERAPY—HIPPOTHERAPY
A Reader

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Introduction

To The Jamaican Reader

This collection of web documents on hippotherapy and equine based or facilitated therapy is first and foremost intended for medical personnel, therapists, educators and
others who are responsible for assisting the physically and or mentally challenged in overcoming some of the constraints they face as a result of their conditions. This collection of documents is also aimed at those medical personnel and physical therapists whose job entails the facilitation of victims of trauma and or strokes in the rehabilitation of their members.

Hippotherapy and equine facilitated therapy are relatively new concepts to the average Jamaican, regardless of his or her educational attainment or social background, yet at the same time one finds a significant need in the care and educational industries for newer and possible more effective approaches in the treatment of the physically and or mentally challenged. Coupled with this need for more affordable and effective methods of rehabilitation and or therapy, there is a relatively available source of horses and individuals with experience in the training of horses and in some cases donkeys.

This “Reader” is intended to introduce you, the medical practitioner, educator and parents to the world of hippotherapy and equine facilitated therapy. The material presented here were drawn from various sources in order to provide with a broader look at the areas covered and the document also include material on the training and selection of horses for the purpose of therapy.

One can only but hope that within a few years time at most, it will be possible to find functional hippotherapy centers and other equine facilitate therapy centers in Jamaica. One can only but also hope that one will find within a relatively short period of time, institutions offering training in the area of animal based therapy, in particular equine based therapy.

End

Dedication:- This collection is dedicated to a young man who I met years ago. Your family made enormous sacrifices so that you could play your music in all parts of the world, so that your dreams and ambitions could be realized. It is my personal hope, that you will live your life in such a way that is becoming of you and in full realization and appreciation of the sacrifices made. When stones are to be placed, they should be placed, and memories cherished and held dear. Great sacrifices were made.

Animal-assisted therapy

Animal-assisted therapy (AAT) is a type of therapy that involves an animal with specific characteristics becoming a fundamental part of a person's treatment. Animal-assisted therapy is designed to improve the physical, social, emotional, and/or cognitive functioning of the patient, as well as provide educational and motivational effectiveness.
for participants\(^\text{[citation needed]}\). AAT can be provided on an individual or group basis. During AAT, therapists document records and evaluate the participant's progress.

Many kinds of animals are used in therapy, including dogs, cats, elephants, birds, dolphins, rabbits, lizards, and other small animals. Such animals are often referred to as comfort animals. AAT with horses is known specifically as equine-assisted psychotherapy (EAP), equine-assisted creative living (EACL), equine-assisted personal development (EAPD) or hippotherapy.

**Benefits**

People who have pets benefit in various ways, for example, the comfort of physical contact with animals, reducing loneliness, and increased opportunities for meeting others, via the pets. In addition, caring for pets encourages nurturance, responsibility, and adherence to a daily schedule.

**Physical**

- Improve fine motor skills.
- Improve wheelchair skills.
- Improve standing equilbriocception (balance).

May lower blood pressure, risk for stroke or heart attack, and decrease depression.

**Mental**

A 2007 meta-analysis found that animal-assisted therapy is associated with moderate effect sizes in improving outcomes in autism spectrum symptoms, medical difficulties, behavioral problems, and emotional well-being.\(^1\)

- Increase verbal interactions among group members.
- Increase attention skills (i.e., paying attention, staying on task).
- Develop leisure/recreation skills.
- Increase self-esteem.
- Reduce anxiety.
- Reduce loneliness.

**Educational**

- Increase vocabulary.
- Aid in long- or short-term memory.
- Improve knowledge of concepts, such as size, color, etc.

**Motivational**

- Improve willingness to be involved in a group activity.
• Improve interactions with others.
• Improve interactions with staff.

**Criticism**

Researchers at Emory University have concluded that Dolphin Assisted Therapy is "...a dangerous fad." and lacks any real efficacy. Furthermore, the practice of capturing dolphins can leave more injured or even dead.

**History**

During World War II, as a Corporal William Wynne was recovering in an Army Hospital in the Philippines, his pals brought his Yorkshire Terrier, Smoky, to the hospital to cheer the soldier up. Smoky immediately became such a hit with the other wounded soldiers that the Commanding Officer of the Hospital unit, Dr. Charles Mayo, of the now famous Mayo Clinic in Rochester, MN, decided to take Smoky on his rounds. Smoky’s work as a therapy dog continued for 12 years, during and after World War II.

The establishment of a systematic approach to the use of therapy dogs is attributed to Elaine Smith, an American who worked as a registered nurse for a time in England. Smith noticed how well patients responded to visits by a certain chaplain and his canine companion, a Golden Retriever. Upon returning to the United States in 1976, Smith started a program for training dogs to visit institutions. Over the years other health care professionals have noticed and documented the therapeutic effect of animal companionship, such as relieving stress, lowering blood pressure, and raising spirits. In recent years, therapy dogs have been enlisted to help children overcome speech and emotional disorders.

In 1982, Nancy Stanley, a San Diego mother of two, founded a non-profit organization called TLZ (Tender Loving Zoo). She got the idea while working as a volunteer in the Los Angeles Zoo, where she noticed how handicapped visitors responded eagerly to animals. She later read an article about the beneficial effects that animals can have on patients. Soon thereafter, she began taking her pet miniature poodle, Freeway, to the Revere Developmental Center for the severely handicapped.

Inspired by the response of the patients and the encouragement of the staff, she took $7,500 of her own money, bought a van, recruited helpers, and persuaded a pet store to lend baby animals of all kinds to the cause. Partly as a result of Ms. Stanley's work, the concept of dog-therapy has broadened to "animal-assisted therapy", including many other species, such as therapy cats, therapy rabbits, therapy birds and so on.\(^\text{12}\)

**THE POTENTIAL BENEFITS of ANIMAL ASSISTED THERAPY**

**FOR CHILDREN WITH SPECIAL NEEDS**

Dawn Oakley OTR/L and Gail Bardin, OTR/L

According to journalist Odean Cusack, "Anyone who has ever owned a pet will readily verify the benefits of associating with furred, feathered, or finned friends. Animals
are fun to be with and comforting to hold. Their antics inspire humor and a sense of carefreeness, a return to childhood with its buoyant spirits. Caring for pets encourages nurturance, responsibility, and adherence to a daily schedule. Pets enable owners to reach outside themselves and to put aside fears of an uncertain future. Pets live in the immediate moment, and interacting with them makes us keenly aware of the present with all its joys and idiosyncrasies.

For children with special needs, the ability to interact with a dog, cat, or other furry friend can have a very positive impact upon their quality of life. Interacting with a pet can sometimes enhance recovery following a serious illness. It can change behavior, create a sense of responsibility and even improve a child’s ability to participate in therapeutic treatment leading to achievement in relation to identified goals and objectives. Children are often extremely trusting and easily achieve a level of intimacy with animals. This special bond contributes to pets’ effectiveness as co-therapists.

The potential benefits of animal assisted therapy for children with special needs has been embraced by the Occupational Therapy staff at St. Mary’s Hospital for Children. The use of animal assisted therapy began as a pilot program in December 1998. The program was initiated with a monthly session using one dog and a small group of children. The program has evolved rapidly during the past two years to include several dogs visiting St. Mary’s Hospital for Children three or four times per month. Therapy is still conducted on a group level but an individual component has been added to include visits directly to the patient’s bedside.

During the session, each child works with their occupational therapist either in their wheelchair or on a therapy mat arranged in a circle. The therapist uses a variety of treatment techniques to enable the child to work on specific identified goals while interacting with the dog.

For example, a child recovering from a traumatic brain injury experiences considerable difficulty dressing and grooming him/herself due to the loss of function in one arm. The therapist may ask the child to reach out with the weak arm to pet, brush or even feed the dog. The therapist may add a wrist weight to the weak arm in order to develop strength, or use an adapted brush with a special handle to assist the child in holding the brush. The child becomes motivated and excited to participate in treatment; thus helping to achieve treatment goals quicker and easier.

The occupational therapist conducts the therapy session using the dog as a modality to facilitate the development of skills needed by the child to achieve independent functioning in the areas of self-help, play and learning. The children react with excitement and enthusiasm, always looking forward to the next visit from their “furry therapist.” The children are also highly motivated to interact with the dog, allowing the occupational therapist to facilitate the use of skills needed for independence in such areas as: dressing; grooming; play skills; cognitive skills and fine motor skills. The occupational therapists involve the children in motivating activities that help them achieve, to the greatest extent possible, the self-help, play and learning skills appropriate for their individual age level.

“As we accept animals as potential healers, as major contributors to our health, happiness, wellness, and vitality, can we in good conscience continue indiscriminately to exploit them and dispose of them at will,” wonders author Odean
Cusack. Dr. Albert Schweitzer noted for his humanitarian and scientific efforts on behalf of people in need of medical care once said, that we need a new and wiser concept of animals. If we continue to accept the potential value and benefits of utilizing pets in the provision of occupational therapy services for children with special needs in such settings as within the Animal Assisted Therapy Program at St. Mary’s Hospital for Children, we may long last establish Schweitzer’s vision.

For additional information about the Assisted Therapy Program at St. Mary’s Hospital for Children you can contact: Gail Bardin, OTR/L, Department of Occupational Therapy, St. Mary’s Hospital for Children, 29-01 216th Street, Bayside, New York 11360 (718) 281-8801

**Hippotherapy**

From Wikipedia, the free encyclopedia

**Hippotherapy** is a form of physical, occupational and speech therapy in which a therapist uses the characteristic movements of a horse to provide carefully graded sensory input. A foundation is established to improve neurological function and sensory processing, which can be generalized to a wide range of daily activities. Unlike in therapeutic horseback riding, where specific riding skills are taught, in hippotherapy the movement of the horse is a means to a treatment goal. Another name for hippotherapy is Aloka.

Horse drawn litter in use for hippotherapy
note: The carriage called "huifbed" or "hooded bed" shown in the picture is built in the Netherlands and used for "huifbedrijden" or wagon-bed riding with people that are often multiple disabled. They are lying on a canvas positioned over the horses so they feel all movements of both horses.

**History**

Derived from the word "hippos", the Greek word for horse, the term "hippotherapy" literally means treatment or therapy aided by a horse. The concept of hippotherapy finds its earliest recorded mention in the ancient Greek writings of Hippocrates. However, hippotherapy as a formalized discipline was not developed until the 1960s, when it began to be used in Germany, Austria, and Switzerland as an adjunct to traditional physical therapy. In Germany, hippotherapy was a treatment by two physiotherapists, a specially trained horse and horse handler. The theories of physiotherapy practice were applied, with the physiotherapist giving directives to the horse handler as to the gait, tempo, cadence, and direction for the horse to perform. The movement of the horse was carefully modulated to influence neuromuscular changes in the patient. The first standardized hippotherapy curriculum would be formulated in the late 1980s by a group of Canadian and American therapists who traveled to Germany to learn about hippotherapy and would bring the new discipline back to North America upon their return. The discipline was formalized in the United States in 1992, with the formation of the American Hippotherapy Association (AHA). Since its inception, the AHA has established official standards of practice and formalized therapist educational curriculum processes for occupational, physical and speech therapists in the United States.

**Modern Hippotherapy**

Equine-assisted therapy is the umbrella term for any specially trained licensed health professional who incorporates the equine environment into a treatment session within their scope of practice and professional designation. Equine assisted therapy is the umbrella term which lists hippotherapy and equine assisted psychotherapy. Licensed physical, occupational therapists, physical and occupational therapy assistants and speech and language pathologists incorporate the horse's movement (hippotherapy) into their total plan of care for their patients.

In the mental health industry, social workers, psychologists and mental health providers may incorporate equine assisted psychotherapy into their treatment sessions. This is different from hippotherapy where the movement of the horse influences or facilitates an adaptive response in the patient. Forms of equine assisted psychotherapy may have the patient on the horse or off the horse and the treatment is not focused on a set of specific movements for the horse to produce an adaptive response in the patient.

**The role of the horse**

The horse's pelvis has the same three dimensional movement of the human's pelvis at the walk. The horse's three dimensional movement is carefully graded at the walk in each
treatment for the patient. This three dimensional movement provides physical and sensory input, which is variable, rhythmic and repetitive. The variability of the horse's gait enables the therapist to grade the degree of input to the patient and use this movement in combination with other treatment strategies to achieve desired therapy goals or functional outcomes. In addition, the three-dimensional movement of the horse's pelvis leads to a movement response in the patient's pelvis which is similar to the movement patterns of human walking. A foundation is established to improve neurological function and sensory processing, which can be generalized to a wide range of daily activities and address functional outcomes and therapy goals.

Hippotherapy can only be provided by a licensed physical therapist, occupational therapist or speech and language pathologist. Adults and children with disabilities can improve their posture, muscle tone, coordination, balance, sensory/motor development as well as speech and language skills when hippotherapy is incorporated into a total care plan for a patient.

**Professional practice**

Equine Assisted Therapy services are provided by licensed medical professionals. In order to provide Equine Assisted Therapy, the professional providing the treatment does so within the scope of practice within his or her professional licensure, and must have additional training in the Equine Assisted Therapy field. Examples of Equine Assisted Therapy include Hippotherapy and Equine Assisted Psychotherapy. These therapists provide treatment by the medical model. Treatment is provided to patients based on the professional's area of expertise and utilizes the horses’ movement or equine environment to meet the patient's goals. The *American Hippotherapy Association, Inc. (AHA)* offers education to therapists and promotes research in Equine Assisted Therapy. The Faculty of the AHA, Inc., conduct Continuing Education Courses to teach PT's/PTA's/OT's/COTA's and SLP's nationally and internationally.

Hippotherapy is especially useful in a wide range of health disorders:

- Different types of paralysis
- Down Syndrome
- Multiple Sclerosis
- Epilepsy
- Alzheimer
- Autism
- Cerebral atrophy
- Cystic Fibrosis

It is also recommended in orthopedic disorders and injuries in general; rheumatologic problems such as arthritis and osteoarthritis, and psychiatric and psychological categories as phobias, stress and sensory disturbances.
What can hippotherapy help with?

- Gross motor skills
- Speech and language abilities
- Articulation
- Oral motor skills
- Respiration and postural/core control
- Fine motor skills
- Sensory processing
- Behavioral and cognitive abilities

Uses in Physical, Occupational, Speech & Language Therapies

Physical therapists who have had special training in hippotherapy will incorporate the three-dimensional movement of the horse to achieve gait training goals, balance goals, postural/core control goals, and strengthening and stretching. Improvement in gross motor skills and functional activities for developing children with disabilities are gained as the natural environment and variability of the horse's gait present as new and unique to a child. Coordination and balance as well as equilibrium skills are addressed through the variability of the horse's movement as well as the rhythm, tempo and cadence of the horses movement.

In Occupational therapy a specially trained occupational therapist will incorporate hippotherapy, the movement of the horse, to modulate and organize the sensory systems. Sensory processing via hippotherapy simultaneously addresses the vestibular, proprioceptive, tactile, visual, olfactory, and auditory systems. The occupational therapist will incorporate the movement of the horse, hippotherapy, to modulate the sensory system in preparation for a therapy or treatment goal and lead to a functional activity. The reciprocal three dimensional movement of the horse helps with the development of fine motor skills, visual motor skills, bilateral control and cognition as well.

Although many people associate hippotherapy with physical therapy, hippotherapy as a speech and language therapy strategy is growing more common. Hippotherapy uses a horse to accomplish traditional speech, language, cognitive, and swallowing goals. Carefully modulated, well-cadenced equine movement offers an effective means of addressing speech and language deficits through facilitation of the physiological systems that support speech and language function. Using hippotherapy, appropriate sensory processing strategies have been integrated into the treatment to facilitate successful communication.

Indications

Some medical conditions for which hippotherapy may be commonly indicated are listed below. However, hippotherapy is not for every patient; specially trained Physical or Occupational Therapists or Speech and Language Pathologists evaluate each potential patient on an individual basis as per their professional designation and within their scope.
of practice. There are specific contraindications and precautions for some conditions and diagnosis.

- Autism spectrum disorders
- Cerebral palsy
- Cerebral vascular accident (stroke)
- Developmental delay
- Down syndrome
- Functional spinal curvature (scoliosis)
- Learning or language disabilities
- Multiple sclerosis
- Sensory processing disorders
- Traumatic brain injury

**HPCS certification**

Hippotherapy Clinical Specialty (HPCS) Certification is a designation indicating board certification of therapists who have advanced knowledge and experience in hippotherapy. Physical therapists, occupational therapists, and speech and language pathologists who have been practicing their profession for at least three years (6,000 hours) and have 100 hours of hippotherapy practice within the three years prior are permitted to take the Hippotherapy Clinical Specialty Certification Examination. Those who pass become board certified in hippotherapy and are entitled to use the HPCS designation after their name. HPCS certification is for five years. After five years the therapist can either retake the exam, or show written evidence of 120 hours of continuing education distributed over the five years, with a relative balance of 50% (60 hours) in education related to equine subject matter: psychology, training, riding skills, etc., 25% (30 hours) in education related to direct service in your professional discipline and 25% (30 hours) in any other subject related to hippotherapy or show written evidence of scholarly activity appropriate to the field of hippotherapy. Acceptable scholarly activity includes graduate education in hippotherapy, publication of articles on hippotherapy in juried publications, scientific research related to hippotherapy, the teaching or development of hippotherapy, or acting as AHA-approved course faculty.

**References**

Hippotherapy Explained

California – The *Riverside Press-Enterprise* carried a story on August 8, 2000 by Mike Schwartz about a therapeutic riding program for physically disabled children:

Saara Duncan stands up in the stirrups as a handler leads her horse, Traveler, in slow circles around the corral of the Kern Therapeutic Riding Centre in Colton.

The bright, bespectacled 3-year-old rises up and down seven times at the prompting of Danelle Kern, the center's resident physical therapist.

Saara's derring-do is hardly what you'd expect from a child born three months premature with breathing problems, a malformed knee and hip, and severely crossed eyes.

"Look at me," the Yucaipa youngster shouts from atop the gentle Appaloosa, obviously having a ball and showing off.

All the while Saara is watched carefully by Kern, two volunteer assistants and Saara Uhl, the child's her grandmother and legal guardian. They stroll along at the front and sides of Traveler to encourage and protect his tiny rider. Everyone is laughing, cheering Saara on. and having a great time.

But this is no frivolous pony ride.

Rather, it is a specialized, unconventional and controversial form of physical therapy called hippotherapy, in which a horse is used as a treatment tool. The term derives from the Greek "hippos," which means horse.

Physical, emotional benefits

Specially trained, licensed physical therapists, occupational therapists and speech language pathologists use the "three-dimensional" motion of a walking horse to stimulate the rider and help enhance balance, posture, mobility, coordination and strength.

Often other benefits occur in the process. Mental functioning, mood and self-confidence may improve.
Logan Dunn, 4, was born with a severe and rare type of delayed development called Angelman Syndrome. Not long ago, the Loma Linda boy couldn't stand upright without a walker or grabbing a table for balance, says his mother DeAnna. After four months of hippotherapy Logan is showing more self-confidence in standing unassisted.

"Previously he held on with both hands. But now he'll let go with one hand to play with a toy," she says.

Tucked deep within rural Reche Canyon, Kern's 7-acre spread is one of a handful of therapeutic riding centers in the Inland Empire, and the only one dedicated to hippotherapy, says Penni Kern, the executive director and Danelle's mom.

According to Danelle Kern, hippotherapy can be used to treat a wide variety of neurological, skeletal, muscular and emotional disorders, including autism, cerebral palsy, multiple sclerosis, Down syndrome, traumatic brain or spinal cord injuries, stroke, attention deficit disorders, learning or language disabilities and visual or hearing impairments.

"Hippotherapy is totally special and unique," says Kern, who is on the physical therapy staff at Loma Linda University Medical Center and Children's Hospital. "No machine has ever been invented to take the place of a horse's muscle groups moving from side to side, forward and back and up and down. These closely mimic the human gait."

By trying to maintain balance in response to a horse's motion, riders tone, stretch and strengthen the same muscle groups they would use in walking, sitting and reaching on their own.

The warmth, smell, sound, sight and feel of a moving horse flood a rider's senses, says occupational therapist Bethany Lee, executive director of the National Center for Equine Facilitated Therapy, a hippotherapy facility in Woodside, north of San Jose.

"All this sensory information assists the body in normalizing itself," Lee says.

No less crucial is the bond between rider and horse. Like other forms of pet therapy, connecting emotionally with an animal seems to increase attention span, memory, concentration and speech in impaired children and adults, says Kern.

"Treatment is much more effective when you're having fun, especially for kids," she says. "You don't get anywhere with them unless they're having a good time."

* * *

Little acceptance, reimbursement
Nevertheless, relatively few physicians know much about hippotherapy, and many agencies that coordinate rehabilitative services for disabled children and adults don't endorse it.

Critics dismiss it as an alternative treatment backed by little scientific proof that it works.

"There's not enough well-researched evidence that hippotherapy will make a difference versus more established forms of physical therapy," says Dr. Eliana Lois, chief of medical services for the Inland Regional Center in San Bernardino, one of 21 private agencies under the California Department of Developmental Services that provide disabled persons with services fostering an independent lifestyle.

"You can do it as effectively without a horse . . . although it wouldn't be as much fun. I love horses," Lois says. "But I probably wouldn't refer."

Unlike the Inland Regional Center, the San Gabriel/Pomona Regional Center in Los Angeles approves some hippotherapy programs.

"It's up to the discretion of individual regional centers," says center spokeswoman Carmen Roman. "We even (approve) music and swimming therapy and summer camps offering services that aren't really mainstream as long as they fall within state law."

The San Gabriel/Pomona Regional Center tries to consider the needs and desires of clients and their families, says Letha Sellars, the director of children and family services. "Some children are very physically challenged and can't participate in a lot of stuff available to other kids. Hippotherapy for them may be a socialization experience. And families enjoy doing it with them."

Regional centers also consider whether clients have access to other well-proven therapy options, explains Deborah Millot, Inland's assistant chief of community services.

"Some communities may be rich in resources others don't have. We try to help consumers and families pick the option we think works best and that will enhance the quality of their lives."

In regions like the Inland Empire, where insurance and state agency support for hippotherapy is spotty, clients or family caregivers often must pay cash. Therapy sessions at Kern, which last up to one hour, cost $50-$120. Typically clients come once or twice a week for therapy that may last indefinitely, given their chronic problems.

The Denver-based North American Riding for the Handicapped Association, whose 1,200 members offer a variety of recreational and therapeutic riding programs, is confident hippotherapy will become widely accepted -- like acupuncture, chiropractic and other therapies once outside the mainstream.
"This is already happening," says Michael Kaufmann, the association's education and communications director. "Fifteen years ago when you talked about putting disabled patients on horses, most people said it was dangerous. Today health professionals and the general public are much more familiar with how therapeutic riding helps."

Gus LaZear, a program specialist at the Casa Colina Centers for Rehabilitation in Pomona, has referred several patients for hippotherapy.

"I've heard good stories about it," says LaZear, who takes disabled people on outdoor adventure treks. "Being around horses in general, touching them and combing them, is great therapy." Kaufmann acknowledges that better studies are needed. "The problem is that variables, such as different kinds of horses and instructors, complicate setting up a meaningful research design," he says.

* * *

Recognition slowly growing

"I'm confident that the quality of hippotherapy being done and continuing research will show it's a successful form of treatment," says Barbara Heine, president of the American Hippotherapy Association based at the national center in Woodside.

Perhaps the best evidence hippotherapy works was reported early last year by Dr. Daniel Bluestone, then a pediatric neurologist at UC San Francisco, who had been following the progress of children receiving the treatment.

Comparing MRI scans over time, Bluestone found that the repetitive movement of riding prompts physical changes in the brain.

"We think that hippotherapy is effective in helping rework networks within the cerebellum and within the motor system up in the cerebrum," he said in a Discovery Channel documentary. "The pathways within the brain that facilitate a particular movement become reinforced over time.

"The more pathways you reinforce, the better the brain compensates and the better motor function can improve."

Bluestone, who now practices in Fresno, said children do especially well in hippotherapy because the child's brain is constantly developing and changing. The "sensory inputs" children receive during therapy allow them to remodel their neural networks.

* * *

Deep historical roots
The therapeutic value of the horse was recognized by the Greeks as early as 460 B.C. Studies continued in 19th-century France and in the mid-1940s in Scandinavia. So-called classic hippotherapy evolved mainly in Germany during the 1960s before coming to the United States and Canada.

The classic technique can be performed by a licensed physical, occupational or speech therapist who first evaluates a patient, sets goals and selects exercises meeting specific needs, says Lee of the national equine therapy center.

For example, positioning a patient astride the horse facing sideways or backward helps improve balance and pelvis alignment. A prone position extends the trunk and neck, while lying supine stretches chest muscles and elicits a need to pull up into a sitting position, she says.

The therapist monitors responses and instructs a handler to change the horse's direction and tempo accordingly. The health professional keeps careful progress notes and reports regularly to the referring physician "just like in any therapy clinic," Lee says.

Bouncing along on Taco, an Arab gelding, Logan Dunn waves his arms, twists his torso, flashes a cherubic smile and makes happy sounds although he cannot speak. His mother, DeAnna, and father, Rob, tag alongside.

"At the very least he's having an adventure," DeAnna says. "He loves horseback riding. His attitude is, 'Let's go. Let's go.'"

Classic approach broadened

The Kern Therapeutic Riding Centre blends classic therapeutic principles with a modern, multidisciplinary form of hippotherapy. Sessions are embellished with imaginative exercises suggested by licensed therapists, physicians, clinical psychologists and students who volunteer at the ranch.

"What's this, Saara?" asks Danelle Kern, holding up a flash card.

"A boat," the child replies.

As Traveler strolls along, Saara, at one point lies flat on her back, and at another point while sitting up, assembles a jigsaw puzzle and strings beads of various shapes on a cord.

While most patients are children, adults also utilize hippotherapy.

John Kimber, 55, of Highland laughs as he leans forward on Dolly to wrap a curler in the quarter horse's mane.
Kimber, a retired attorney and teacher, had a stroke in 1996 that left him with poor balance and a weak, numb left side. A month of exercises on horseback has improved his balance and dexterity, he says.

"I know I'm making progress and doing great," Kimber says. He chuckles and adds, "I feel a little tired right now. Yeah, it's work. They work me here. But I enjoy it."

* * *

Safety measures

Each steed is guided by an experienced handler, with "sidewalkers" ready to steady riders who lose their balance or to assist in exercises and games.

Instead of a saddle, a hippotherapy horse wears a blanket and a surcingle -- a fleece or foam pad with gripping handles strapped around the belly. Part of the healing process is the warmth radiating from the horse's back, Danelle Kern explains.

"I don't know how you can ever simulate that with a machine," she says.

Safety equipment includes equestrian helmets, Devonshire stirrups that are closed in front to properly position feet and prevent them from sliding through, and quick-release "peacock" stirrups that unhook if a rider falls.

The program isn't for everyone, Kern says. She may exclude people who weigh more than 300 pounds or more than 20 percent of a horse's weight; quadriplegics lacking control over trunk muscles; brittle-boned osteoporosis patients and Down's syndrome cases with atlantoaxial instability (poor alignment of their first two neck bones due to loose ligaments).

Other reasons for excluding riders include acute herniated disks, degenerated hip joints, curvature of the spine greater than 30 degrees, acute arthritis and heart trouble requiring anticoagulant medication, says Lee of the National Center.

Although clients usually don't learn to ride on their own, the National Center teaches vaulting, or horseback gymnastics, to those who've met all hippotherapy goals.

"They still have handlers and sidewalkers," Lee says. "But when children flourish and get more mobile, they need something more challenging to do."

Therapeutic Riding Program
American Hippotherapy Association

What is Hippotherapy?

Hippotherapy is a treatment that uses the multidimensional movement of the horse; from the Greek word "hippos" which means horse. Specially trained physical, occupational and speech therapists use this medical treatment for clients who have movement dysfunction. Historically, the therapeutic benefits of the horse were recognized as early as 460 BC. The use of the horse as therapy evolved throughout Europe, the United States and Canada.

Hippotherapy uses activities on the horse that are meaningful to the client. Treatment takes place in a controlled environment where graded sensory input can elicit appropriate adaptive responses from the client. Specific riding skills are not taught (as in therapeutic riding), but rather a foundation is established to improve neurological function and sensory processing. This foundation can then be generalized to a wide range of daily activities.

Why the Horse?

The horse's walk provides sensory input through movement which is variable, rhythmic and repetitive. The resultant movement responses in the client are similar to human movement patterns of the pelvis while walking. The variability of the horse's gait enables the therapist to grade the degree of sensory input to the client, then use this movement in combination with other clinical treatments to achieve desired results. Clients respond enthusiastically to this enjoyable learning experience in a natural setting.

Physically, hippotherapy can improve balance, posture, mobility and function. Hippotherapy may also affect psychological, cognitive, behavioral and communication functions for clients of all ages. Clients who may benefit from hippotherapy can have a variety of diagnoses: examples include Cerebral Palsy, Multiple Sclerosis, Developmental Delay, Traumatic Brain Injury, Stroke, Autism and Learning or Language Disabilities. However, hippotherapy is not for every client. Each potential client must be evaluated on an individual basis by specially trained health professionals.

More about the American Hippotherapy Association

Formed in 1993, the American Hippotherapy Association's mission is to promote research, education and communication among physical and occupational therapists and others using the horse in a treatment approach based on principles of classic hippotherapy. Registered therapists in hippotherapy are located throughout the United States and Canada.
Hippotherapy Standards

The standards in this section are to be complied with in conjunction with the NARHA Core Standards. If one or more of these specialty disciplines are part of a center's program activities, the NARHA Core Standards are to be complied with at all times, in addition to these Specialty Standards.

HIPPOTHERAPY STANDARDS

H1 MANDATORY

Is there written evidence that the therapist/health professional who provides direct treatment services in a hippotherapy program meets the following qualifications:

1. Is licensed, registered or certified to practice a nationally recognized health care profession in accordance with their state practice acts?
2. Maintains current professional liability insurance?
3. Is a NARHA Registered Therapist or Hippotherapy Clinical Specialist (HPCS)? If not, is there a policy in practice that a NARHA Registered Therapist or HPCS supervises the treatment sessions conducted by non-NARHA Registered Therapists?
4. Has received training in the principles of hippotherapy, equine movement and equine psychology?

Yes / No

Interpretation: In part 1, therapists practicing hippotherapy have traditionally been occupational or physical therapists. However, hippotherapy may also be practiced by other licensed, registered or certified health professionals with a strong treatment background in posture and movement, neuromotor function and sensory processing.

In part 3, it is the NARHA Registered Therapist or HPCS’s responsibility to evaluate the skills of therapists/health professionals in the program and provide appropriate supervision and training. A NARHA Registered Therapist or HPCS does not need to be present during the hippotherapy
treatment sessions performed by non-NARHA Registered Therapist or HPCS. However, the supervising therapist/health professional must be available on a regular basis for consultation and education.

In part 4, the intent of the standard is to ensure that a non-NARHA Registered Therapist or HPCS has adequate training in order to carry out a safe and effective hippotherapy treatment. This information and training should be provided by a NARHA Registered Therapist, a HPCS, a NARHA Certified Instructor and other equine and therapy professional available to the program.

*Compliance Demonstration:* Visitor observation of WRITTEN documentation of therapist’s/health professionals licenses/registrations/certifications; professional liability insurance certificates; NARHA registration certificates or board certification, or log of therapist/health professional training by the program; director description of therapist/health professional training process.

**H2 MANDATORY**

DNA (does not apply): If center does not have a PTA and/or COTA providing treatment services.

Is there written evidence that the Physical Therapist Assistant (PTA) and/or Certified Occupational Therapy Assistant (COTA) who provides treatment services in a hippotherapy program meets the following qualifications:

1. Is certified, registered, or licensed to practice as a physical therapist assistant or certified occupational therapy assistant in accordance with the state/provincial regulations governing the respective practices?
2. Maintains current professional liability insurance?
3. Is a NARHA Registered COTA and/or PTA, and if not, the COTA and/or PTA has received training in the principles of hippotherapy, equine movement and equine physiology?
4. Has a written policy in practice at the center stating that a NARHA Registered Therapist or Hippotherapy Clinical Specialist (HPCS) of the respective field evaluates, develops the treatment plan and supervises the COTA and/or PTA in accordance with the regulatory laws of their respective states/provinces?

**Yes / No / DNA**

*Interpretation:* Part 1, therapists practicing hippotherapy have traditionally been occupational, physical therapists and speech therapists with a strong movement background. However, hippotherapy may also be practiced by PTAs and COTAs under the supervision of licensed or registered therapists of their respective fields, and in accordance with the state regulations governing the practice of occupational therapy and physical therapy. The requirement that PTAs and COTAs be licensed, registered or certified in the particular state or province in which they practice reflects that they are practicing their profession based on the standard of practice established in the particular state/province in which they reside.
In Part 3, the intent is to ensure that a PTA and/or COTA has adequate training in order to carry out a safe and effective hippotherapy treatment. This can be achieved by meeting the requirements delineated by the NARHA Registered Therapist process, or by specific training under the direction of a NARHA Registered Therapist or HPCS.

In Part 4, it is the responsibility of the supervising NARHA Registered Therapist or HPCS to develop the treatment plan of any patients that receive treatment from a PTA and/or COTA. It is the responsibility of the PTA and/or COTA and the respective supervising therapist to adhere to state regulations. Requirements for documentation and frequency of supervision may vary according to state law.

It is critical for personnel to realize that the supervising therapist is ultimately responsible for the provision of occupational and physical therapy services within the hippotherapy session.

Compliance Demonstration: Visitor observation of WRITTEN documentation of PTA's and/or COTA's licenses/registrations/certifications, professional liability insurance certificates; log of PTA and/or COTAs professional training; the WRITTEN policy on PTA and/or COTA supervision by a NARHA Registered Therapist or HPCS of the same profession.

H3

DNA (does not apply): If the therapist/health professional is a volunteer and not paid for services rendered.

Is there a written contractual agreement between the Therapist/Health Care Provider/Contracting agent and the center?

Yes / No / DNA

Interpretation: The employee contract may include salary or wages (if applicable), length of employment, benefits, who is responsible for provision of professional and general liability insurance coverage, termination standards (such as “at will”), and reference to job description and other personnel policies.

The independent contractor agreement should include: terms of payment, length of contract, who is responsible for professional liability and general liability coverage, who is responsible for paying the various taxes, services to be performed. Legal counsel should be consulted in regard to these and other possible provisions, such as releases of liability and indemnification language.

Compliance Demonstration: Visitor observation of randomly selected WRITTEN contracts.

H4

DNA (does not apply): If facility does not bill for services.

Is there written evidence of billing policies and procedures?
Yes / No / DNA

*Interpretation:* The fees should be reflective of the local treatment fee schedules.

Consultation with insurance companies and other therapy agencies is recommended to learn about third party reimbursement procedures.

*Compliance Demonstration:* Visitor observation of WRITTEN policies and procedures.

**H5**

Is there a written policy in practice on the number of hours that each equine can be worked in a hippotherapy program:

A. Per working session?
B. Per day?
C. Per week?

Yes / No

*Interpretation:* A "working session" is a period of continuous use without any lengthy break. Special consideration should be given to equines that are involved with hippotherapy. The rationale for the schedule of each equine should be based on the size and type of patients served.

*Compliance Demonstration:* Visitor observation of WRITTEN documentation and personnel description of scheduling procedures.

**H6**

Is there written evidence of a system in practice for training the therapist/hippo therapy team members which include the following:

1. Orientation to the hippotherapy program’s policies and procedures?
2. Hands-on training:
   a. Rehearse emergency procedures?
   b. Rehearse safety procedures?
   c. Transitions on and off equine?
   d. Practice patient handling techniques?
   e. Practice equine handling techniques?
   f. Rehearse a mock therapy session to ensure a coordinated team approach prior to patient participation?

Yes / No
Interpretation: In part 1, HPOT program policies and procedures may include: philosophy of the program, vision statement, intake and discharge criteria, fee schedules, cancellations, weight and size limits of patient, behavior management issues, administrative structure/lines of communication, releases of liability and informed consent forms.

In part 2:a, emergency procedures may include: a fall from an equine, seizures, an injury from a kick, acute illness, fire, and emergency dismounts in all treatment situations such as leading/long lining/T-HPOT.

In part 2:b, safety procedures may include: approaching equines, restraining equine for-grooming and tacking, working around the equine, checking condition of equipment, checking the fit and security of the equipment on the equine, transitioning patients on and off equine, stabilizing the patient on the equine, introducing extraneous pieces of equipment to the equine/patient during the lesson (e.g. balls, rings, towels, etc.).

In part 2:d, patient handling techniques may include: lifting and carrying, transitioning on and off equine including ‘handing off’ a patient to an already mounted Therapist/TA for T-HPOT session, stabilizing the patient on the equine, therapeutic handling techniques when the therapist can not be the person mounted behind the patient in a T-HPOT session, facilitating and inhibiting techniques, and other treatment techniques.

In part 2:e, equine handling techniques relevant to hippotherapy may include: leading by halter or bridle, therapeutic lunging, long lining, lunging.

Compliance Demonstration: Visitor observation of WRITTEN documents and materials. Personnel description of orientation and hands-on training.

H7

Are there training and conditioning methods specific to hippotherapy in practice for the equines placed in hippotherapy?

Yes / No

Interpretation: It is understood that the quality of the results achieved in hippotherapy are directly related to the quality of movement of the hippotherapy equine. Therefore, it is important to maintain the suppleness and strength of the hippotherapy equine through training and conditioning.

In T-HPOT, due to the increased stress, it is particularly important that the conditioning emphasize the elevation of the topline through strength and flexibility training. The equine has to be gradually accustomed to the distribution of weight behind the center of gravity and desensitized to the input of the additional leg pressure near the flank. emphasize the elevation of the topline through strength and flexibility training. The equine has to be gradually accustomed to the distribution of weight behind the center of gravity and desensitized to the input of the additional leg pressure near the flank.
Compliance Demonstration: Visitor interview and personnel description of training and conditioning methods.

H8

Are the following documents available on site for each patient?

A. Prescription from a physician IF required by the therapist's state practice act?
B. Treatment plan which includes long and short-term goals?
C. Progress notes, completed on a regular basis, which reflect the treatment and its modifications based on the response of the patient?
D. Re-evaluations, completed on a regular basis, which update the goals and plan, make recommendations for further treatment, discharge or transition into another program?

Yes / No

Interpretation: Patient documentation will reflect the practice acts of the therapist's/health professional's respective profession. The areas of evaluation, long and short-term goals, and the implementation of the principles of hippotherapy may differ based on the educational background of the therapist/health professional.

Compliance Demonstration: Visitor observation of randomly selected patient files of each therapist/health professional involved in hippotherapy.

*H9 MANDATORY

Is there a system in practice to ensure that the equine handler during all hippotherapy sessions has received training specific to the needs of a hippotherapy session?

Yes / No

Interpretation: In this instance the equine handler is the person in charge of the handling of the equine during the hippotherapy treatment. The person should have extra training in handling equines specifically for hippotherapy and recognizing signs of stress in equines.

Compliance Demonstration: Visitor observation of hippotherapy session and personnel interview.

H10

Is there a system in practice that requires the hippotherapy team to select the following prior to each patient treatment session:

1. Equine?
2. Equipment for equine?
3. Equipment for patient?
4. Number and role of volunteers/personnel?

**Yes / No**

*Interpretation:* The system in practice may include a posted written list of the required information that is readily available to the team at the treatment site.

d In part 2, the equipment for the equine may include: various saddles and surcingles, stirrups, halter, bridles and bits, various pads, side reins, leads, long lines, lunging equipment, boots or bandages for equines legs, various types of whips.

In part 3, the equipment for the patient may include belts, rings, balls, neck straps on the equine, etc.

*Compliance Demonstration:* Visitor observation and personnel explanation of the selection system.

**H11**

DNA (does not apply): If not offering T-HPOT.

Is there written documentation of:

1. The rationale for the use of T-HPOT rather than HPOT to address specific treatment goals?
2. Periodic re-assessment of the ongoing need for T-HPOT?

**Yes / No / DNA**

*Interpretation:* T-HPOT has potential for increased stress on the equine and increased risk for the patient and therapist or TA. There needs to be written justification that T-HPOT is the only option for treatment and that the potential benefit will outweigh the potential risk. In addition, significant patient progress is essential to justify the ongoing use of T-HPOT.

*Compliance Demonstration:* Visitor observation of WRITTEN documentation of rationale for treatment and re-assessment of the patient.

**H12**

DNA (does not apply): If not offering T-HPOT.

Is there a written policy in practice for patients who are deemed clinically appropriate for T-HPOT, which includes the following:
1. The combined weight of the equipment, patient and therapist or TA does not exceed 20% of the equine’s weight?
2. The patient participating in T-HPOT with helmet is not taller than the chin of the therapist or TA’s when mounted?
3. The patient does not exceed the weight of the therapist or TA?
4. The patient demonstrates physical behaviors (voluntary or involuntary) that can be safely managed by the therapist or TA?
5. The patient or parent/guardian signs an informed consent acknowledging the inherent risk of a T-HPOT session?

**Yes / No / DNA**

*Interpretation:* As the combined weight and positions of the patient and therapist or TA greatly increases stress on the equine’s back and loin area, there should be a determined limit based on the equine’s conformation, condition and the generally accepted figure of 20% of the equine’s weight. A 1000 pound horse, for example, should not carry more than 200 pounds of combined weight, assuming good conformation and conditioning. The height limitation for the patient helps to prevent injury to the therapist or TA’s face and head should the patient’s head move quickly backwards. This also helps to ensure that the size and weight of the patient is within the ability of the therapist or TA to safely handle. Physical movements and behaviors, such as extensor thrust, tantrums, flailing, etc., that are unable to be managed safely by the therapist or TA would be a contraindication for the use of T-HPOT. The patient’s family and treatment team needs to make an informed decision about participation in T-HPOT due to the increased risk of this activity.

*Compliance Demonstration:* Visitor observation of WRITTEN policy and signed forms, personnel description, and visitor observation of T-HPOT session.

**H13 MANDATORY**

DNA (does not apply): if not offering T-HPOT.

Is there written evidence of a procedure in practice to determine the duration and frequency of the T-HPOT equine’s schedule, including:

1. Maximum of 30 minutes per session inclusive of transitioning onto and off the equine?
2. Sessions scheduled on non-consecutive days?
3. No greater than 2 sessions per day in non-consecutive sessions?
4. Limited involvement in other equine assisted activities on the same day in which the equine is involved in T-HPOT?

**Yes / No / DNA**

*Interpretation:* A record should be kept of the number of times the equine works in T-HPOT and in other that T-HPOT is a stressful activity for the equine, consideration should be given to a lighter schedule for that equine on a T-HPOT day.
Compliance Demonstration: Visitor observation of WRITTEN documentation.

**H14**

DNA (does not apply): if not offering T-HPOT.

Is there written evidence of the competence of the therapist or TA on the equine, demonstrating a well-aligned, secure seat and position at all times, during the following:

1. Riding at a walk, trot, and canter with and without stirrups?
2. Sitting at a walk in the T-HPOT position (behind the equine’s center of gravity) while being led or long lined during changes of pace, serpentines, figure of 8 and transitions to and from halt?

*Yes / No / DNA*

Interpretation: Evidence of riding ability may include, but is not limited to, NARHA certification at the advanced level; Pony Club C-level or higher; Comparable CHA certification; a letter from another instructor who has NARHA Advanced certification, Pony Club C-level status or CHA comparable certification who has observed the therapist or TA demonstrate the above listed skills, in person or by video.

Compliance Demonstration: Visitor observation of WRITTEN documentation and interview of personnel.

**H15**

DNA (does not apply): If not offering T-HPOT and the individual providing the patient handling is the licensed therapist.

If the person providing the patient handling is the Therapist’s Aide (TA) and is not the therapist, is there written evidence that s/he has been trained in the use of therapeutic handling and is under the direct supervision of the therapist during all sessions?

*Yes / No / DNA*

Interpretation: In order for treatment to be effective, the individual providing the patient handling should have sufficient knowledge and skill to facilitate the patient’s progress according to the treatment plan. The therapist must directly supervise this individual during all T-HPOT sessions in accordance with their state practice act.

Compliance Demonstration: Interview of personnel and visitor observation of WRITTEN evidence of competence.

**H16**
Is there a procedure in practice for the use of tack that ensures the following:

1. The pad used to protect the equine’s back is large and long enough to accommodate both the patient and the therapist or TA on the equine?
2. The pad is safely secured to the equine?
3. There is a handle/handhold accessible to the therapist or TA on the equine?

**Yes / No / DNA**

**Interpretation:** Saddles, English or Western, are inappropriate for T-HPOT due to the displacement of the weight of the therapist or TA on the equine over the equine’s loin area, and the interference and possible cause for injury to the therapist or TA on the equine by the cantle of the saddle.

In T-HPOT the protection of the equine’s back is of prime importance. Size and length of the pads should cover the equine’s back and sides so that the patient and the therapist or TA on the equine sit comfortably on the pads and not onto the equine’s back. The pad should be of a material sufficient to protect the equine’s back with shock absorbing and weight distributing properties with consideration given to the balance and position of the patient. For safety, the pad must be secured so that it does not slide.

In an emergency, the therapist or TA on the equine should have easy access to a secure handle, for balance, not to control the equine or other reliable tack. Examples may be the handle of a surcingle, a properly fitting neck strap or other reliable tack.

**Compliance Demonstration:** Visitor observation and interview of personnel.

**H17**

Are there written policies and procedures in practice to ensure that a T-HPOT session has the following:

1. A team that includes a leader, 2 sidewalkers and the therapist or TA if the equine is led (personnel to patient ratio of 4:1); an equine handler, header, 2 sidewalkers and the therapist or TA if the equine is long lined (5:1)
2. The therapist or TA is not responsible for the equine?
3. The Sidewalkers who are matched in height and strength to the size of the patient, therapist or TA and equine?

**Yes / No / DNA**
Interpretation: SThe responsibility of the therapist or TA is the safety and handling of the patient not the control of the equine. The responsibility of the equine handler is the safe control of the equine. For the safety and comfort of all concerned, it is recommended that the sidewalkers’ shoulders are equal to or taller than the therapist or TA’s hips when the therapist or TA is on the equine.

Compliance Demonstration: Visitor observation of WRITTEN policies and procedures, interview with personnel; visitor observation of a T-HPOT session.

Glossary of Hippotherapy Terms

Hippotherapy: a term that refers to the use of the movement of the horse as a strategy by Physical Therapists, Occupational Therapists, and Speech-Language Pathologists to address impairments, functional limitations, and disabilities in patients with neuromusculoskeletal dysfunction. This strategy is used as part of an integrated treatment program to achieve functional outcomes.

Hippotherapy Team Members: those involved in the provision of hippotherapy services. The team will be the NARHA Registered Therapist or HPCS Therapist, NARHA Certified Instructor (if the therapist is not a NARHA Certified Instructor) and a horse and horse handler trained specially for hippotherapy. During the hippotherapy session, the hippotherapy team may include side walkers for safety and, of course, the patient. The therapist is in charge of the hippotherapy session with the main focus on the patient responses to the horse's movement and maintains direct communication with the horse handler and other team members.

Horse Handler: The person in charge of the handling of the hippotherapy horse during the treatment session. This person should have extra training in handling horses specifically for hippotherapy.

Introduction to Hippotherapy

By Barbara Heine, PT
By its very nature, therapeutic riding influences the whole person and the effect on all the body's systems can be profound. It was, therefore, a natural progression for therapeutic riding in North America to branch into the medical application of the horse -- hippotherapy. Unfortunately, the use of this overall term has led to many misconceptions among therapeutic riding professionals.

Any riding program using horse related activities for clients with physical, mental, cognitive, social or behavioral problems is a therapeutic riding program. But when does therapeutic riding become hippotherapy or classic hippotherapy, and what exactly is developmental riding therapy? The following common questions illustrate the confusion many people have about these areas:

* A physical therapist (PT) volunteers in a consulting capacity once a month. Does this mean your program offers hippotherapy?

* An occupational therapist (OT) with a solid horse background consults for your program once a week and works one-on-one with selected clients to address specific areas of motor planning and sensory integration. The horse for these clients has been selected carefully for its movement and behavioral qualities. You notice that the therapist uses a vaulting surcingle for these sessions and in each session the client assumes different positions on the horse, such as kneeling and quadruped (on all fours). Is this hippotherapy, developmental riding therapy or therapeutic riding?

* A PT who leases your facility and horses to provide hippotherapy for several clients each week. The therapist bills each client differently. The clients sit astride the horse facing forward and backward, and occasionally are placed prone over the barrel. The therapist directs the treatment by advising the horse handler when changes in tempo and direction are required. Is this classic hippotherapy or hippotherapy?

* Your program has recently acquired a trained vaulting horse, and you plan to select several clients who could benefit from this activity. One of your volunteers has had previous vaulting experience and is willing to work closely with your instructor to develop this group activity. Will this be hippotherapy, developmental riding therapy or therapeutic riding in the area of recreation and leisure?

* Your program would like to expand to include hippotherapy because there are several clients that you believe would benefit from a more specific one-on-one approach. A PT in a local sports medicine practice is very keen to become involved and he has ridden recreationally as a child. What additional qualifications would this therapist need to provide direct hippotherapy treatment for these clients?

Questions like these highlight the often subtle differences between these various applications of the horse in a therapeutic setting. In today's litigious society, it is essential that people involved with therapeutic riding are informed not only about the role that a therapist can play, but also the requirements, qualifications and training necessary if that
therapist is providing a direct service. It is the aim of this article to clarify these issues.

To begin with, we must define the word hippotherapy, which literally means treatment with the help of a horse. It originates from the Greek word "hippos" meaning horse. More specifically, it is the 3-dimensional movement of the horse's hips and pelvis as the hind legs move forward at the walk, that provides a movement challenge to the client.

**Classic Hippotherapy**

Classic hippotherapy reflects the German model of hippotherapy practiced widely throughout Europe since the 1960's. Since it is purely the horse's movement and the client's responses that constitute the treatment, classic hippotherapy should only be carried out by a PT, OT, or a speech language pathologist with a certificate of clinical competence (SLP/CCC), who has focused training in the following areas:

* Development of body systems and interaction with the development of movement.

* Effect of neuromuscular, musculoskeletal and cardiopulmonary dysfunction on growth and development, motor development and function.

In classic hippotherapy, it is purely the horse's movement that influences the client. The client may be positioned astride the horse facing forward, backward, prone or supine. The client passively interacts with, and responds to, the horse's movement. The therapist's responsibility is to constantly analyze the client's movement. The therapist must constantly analyze the client's responses and adjust accordingly the manner in which the horse is moving. This assumes that the therapist has sufficient understanding of the movement of the horse to direct the horse handler/instructor to alter the tempo and direction of the horse as indicated by the client's responses.

The primary focus of classic hippotherapy is the rider's posture and movement responses. However, other effects may occur in respiration, cognition and speech production. For example, if the treating therapist is a PT whose goal is to strengthen the trunk muscles and positively affect the client's posture, respiration and speech will improve due to the increased trunk strength. That is the beauty of the horse as a treatment tool -- these "other" changes occur even though you are not focusing on them.

**Hippotherapy**

Hippotherapy, on the other hand, is a treatment approach that uses the movement of the horse based on the methodology of classic hippotherapy with the addition of the treatment principles that apply to the particular profession of the therapist providing the service. The unique combination of the horse, the horse's movement and a non-clinical environment produces an extraordinary effort on all the systems of the body. Therefore, although hippotherapy is frequently used to achieve physical goals, it also affects psychological, cognitive, social, behavioral and communication outcomes. Hippotherapy is truly a multidisciplinary form of treatment and can be applied by a PT, OT, SLP/CCC, psychologist or psychotherapist.
It is a treatment approach that uses activities on the horse that are meaningful to the client and specifically address the individual's goals. Hippotherapy provides a controlled environment and graded sensory input designed to elicit appropriate adaptive responses from the client. It does not teach specific skills associated with being on a horse -- rather, it provides a foundation of improved neuromotor function and sensory processing that can be generalized to a wide variety of activities outside treatment. In other words, the client's adaptive responses to the environment and the horse's movement ultimately bring about improvements in function.

An example of a meaningful activity in which multiple systems of the body are affected could be the following: A young client may be asked to move from facing forward to facing backward and then to quadruped (on all fours). In this position, he may be asked to reach one hand down to pat the horse. This activity (the transition, the quadruped position and the reaching activity), is overlaid on the constant rhythmical 3-dimensional movement of the horse. Therefore, in addition to the facilitation of automatic postural responses and stimulation of trunk muscles, there are increases in sensory input to the following systems of the body:

* Vestibular -- because the client is facing backward while the horse is moving forward.
* Proprioceptive -- heavy touch pressure through the hip, knee, wrist, elbow and shoulder joints in the quadruped position.
* Tactile -- touching the soft warm coat of the horse.
* Cognitive -- higher level motor planning skills required to execute the transition.
* Motor (physical) -- stability of hips and pelvis required to maintain position while reaching forward with one hand.

This is a meaningful activity for any client who exhibits trunk weakness, poor pelvic control, decreased gross motor skills, poor motor planning and a diminished ability to process sensory information.

**Developmental Riding Therapy**

Developmental riding therapy is distinguished from either classic hippotherapy or hippotherapy by its broader professional participation, more diverse client population, and equine skills/training specific to the areas of dressage, horse-handling and vaulting.

Jan Spink, M.A. developed this technique in the late 1980's to address a growing need for a more specific philosophy and methodology that focused on a multidisciplinary approach to therapeutic riding. This approach incorporates the treatment techniques and expertise of six health or education professions: PT, OT, speech therapy, rehabilitation or psychomotricity, special education and psychology. Some fundamental and distinctive elements of developmental riding therapy are:
* Individual sessions with active therapist input, a client-centered focus, and graded
control of sensory stimuli during mounted and non-mounted activities.

* Use of developmental positions on the horse that directly correlate with specifically controlled movement challenges from the horse.

* Development of interrelationships among the client, therapist and horse.

* Selected components of riding and vaulting skills.

* Use of a horse that has been carefully screened for movement and behavioral qualities.

* Use of therapists or specialists who are thoroughly trained in horsemanship as well as in the philosophy and methods of equine-assisted therapy and the specific features of the system of developmental riding therapy (Spink 1987, 1990).

Developmental riding therapy can serve as an entry point for riders whose skills are not yet well enough developed for therapeutic group riding or vaulting. For the hippotherapy client who has met all long term goals, developmental riding therapy is an ideal transition to another program. The client is able to continue therapy in the motivating and pleasurable environment of the horse, but is provided with greater challenges through the use of specific riding or vaulting skills.

**The Therapist's Role in Therapeutic Riding**

If you currently run a therapeutic riding program and are considering expanding your services to include hippotherapy, here are some guidelines as to the qualifications, responsibilities and training requirements of therapists wishing to practice hippotherapy. Keep in mind, the use of the horse as a treatment tool does not mean that a therapist is a "hippotherapist" any more than an OT who uses sensory integration principles is a sensory integrationist (or a PT using a pool is a hydrotherapist).

Any therapist providing direct treatment services in a classic hippotherapy/hippotherapy program must meet the following qualifications:

* Is licensed or registered to practice a nationally recognized health care profession.

* Maintains current professional liability insurance.

* Has received training in the principles of classic hippotherapy, equine movement and equine psychology through attendance at a minimum of one American Hippotherapy Association (AHA) approved "Introduction to Classic Hippotherapy" course. The completion of this course is a requirement of any therapist wishing to become registered with AHA.

* Is a NARHA certified instructor (any level) and if not, has a NARHA certified instructor assisting with all treatment sessions.
Legally, a therapist must be in direct attendance to the client at all times during a session. If a therapist, operating within the scope of his professional practices act, conducts a group session, he will be actively engaged in the treatment of the whole group and focusing on each client, as and when appropriate. In such a case, treatment progress notes must be kept on each child in the group.

To practice hippotherapy, the treatment principles of a particular health profession are integrated into the hippotherapy setting. The actual treatment on the horse is only one part of a comprehensive treatment program that begins with an initial evaluation. A crucial part of this initial evaluation is the establishment of a treatment plan that incorporates both long and short term goals. Long term goals must be functional and relevant to each client's family/school/work situation. Therefore consultation with the client's family is necessary.

The treatment plan is developed based on the professional training and constraints of the professional practice act of the health professional providing the service. Choosing the horse whose movement best addresses the client's needs, and appropriate equipment to facilitate the desired responses is an integral part of the treatment plan. Regular documentation is provided through progress notes recorded after each treatment.

Re-evaluation of each client should be carried out at three to six month intervals (or less, depending on the reimbursement source) to ensure that the treatment plan and treatment goals remain appropriate for the client. There will be occasions when re-evaluation confirms whether a client has met the long term goals and in the therapist's professional opinion, hippotherapy can no longer address the needs of that client. In this case, the client should be discharged from hippotherapy. It is the responsibility of the treating therapist to write a discharge summary and to communicate directly with the client and/or client's family to recommend further treatment such as PT, OT or speech therapy, or a transition into another program. In the case of a client meeting all long term goals, an ideal opportunity is presented to transition that client to a therapeutic riding program where the learning of "real" riding (or vaulting) skills can add a new and exciting dimension to their lives. If the client's functional abilities and motivation are high it is quite likely that they can make the transition to able-bodied riding or vaulting classes, or competitive equine sports.

**Additional Roles for Therapists**
Therapists have much to offer any program and may become involved in roles other than direct client service. These can include:

* Consultation

* Staff and volunteer training in body mechanics, physical and cognitive impairments, basic handling/transfer skills, precautions and contraindications

* Community education
* Liaison with the medical community

* Recruitment of additional health care professionals

* Referral of clients

By helping in this way, a therapist has an opportunity to observe the innumerable qualities of the horse as a treatment tool. This can often be such an enlightening experience that the therapist will be motivated to gain the additional skills and training necessary to provide direct service to some of your clients. Instructors should remember that very few therapists come equipped with horse knowledge and riding skills. You can therefore help each other grow and learn.

The hippotherapy team of horse, client, sidewalkers, therapist and instructor is a wonderful example of a symbiotic relationship. No one part can operate without the other and the greater the harmony that exists between all members of the team, the greater the benefit to the client. After all, the client's safety, progress and happiness are the reasons all of us love what we do and continue to strive to be better at it.

Barbara Heine, PT, is the 1998 President of the American Hippotherapy Association. She is the executive director of the National Center for Equine Facilitated Therapy in Woodside, CA.

Equestrian vaulting

From Wikipedia, the free encyclopedia
A Dutch vaulting team

**Equestrian vaulting** is most often described as gymnastics and dance on horseback, and like these disciplines, it is an art and not a competitive sport. It is open to males and females. It is one of ten competitive equestrian events recognized by the International Federation for Equestrian Sports, along with: dressage, combined driving, endurance riding, eventing, horseball, paraequestrian, reining, and show jumping, and tent pegging. Therapeutic or Interactive Vaulting is also used as form of treatment for children and adults who may have balance, attention, gross motor skill, or social deficits.

Vaulting has many enthusiasts worldwide, but particularly in Germany, where it is often practiced as part of basic equestrian training. The German vaulting squads are highly ranked and very competitive on the world stage. Vaulting is also especially well established in France (where it is known as Voltige), Sweden, the UK, and the Netherlands. Enthusiasm for the sport is also growing in Brazil, Australia, and in the United States. American vaulters have been successful competing internationally and the US has produced several world champions and highly ranked vaulting teams.

China and South Africa also have vaulting clubs.
**Competitive vaulting**

Freestyle team vaulting

In competitive vaulting, vaulters compete as individuals, pairs or pas-de-deux, and teams. Beginning vaulters will compete at the walk (and in the US at the trot) but copper-, bronze-, silver-, and gold-medal level vaulters perform on the horse at a canter. The vaulting horse, which has been carefully trained, moves in a 15-metre circle and is controlled by a lunger. Vaulting competitions consist of compulsory exercises and choreographed freestyle exercises done to music. There are six compulsory exercises—basic seat, flag, mill, scissors, stand, and flank, in addition to the mount and dismount. Each exercise is scored on a scale from 0-10. Horses also receive a score and are judged on the quality of their gait.

Vaulters also compete in freestyle (previously known as Kur). The components of a freestyle vaulting routine MAY include mounts and dismounts, handstands, kneeling and standing and aerial moves such flips. Teams will also carry, lift, and even toss another vaulter in the air. Judging is based on technique, performance, form, difficulty, balance, security, and consideration of the horse—the horse as well as the vaulter earns a score.
A horse properly equipped for vaulting

Vaulting horses are not saddled, but they do wear a surcingle (or a roller) and a thick back pad. The surcingle has special handles which aid the vaulter in performing certain moves as well as leather loops called cossack stirrups. The horse wears a bridle and side reins. The lunge line is usually attached to the inside bit ring.

Vaulting horses typically move on the left rein (counterclockwise), but in certain kinds of competitions the horse will canter in the other direction. Two-phase classes of competition also work the horse to the right. While many European teams do not work to the right, many American vaulting clubs work to the right believing this benefits the horse and the vaulter.

The premier Vaulting competitions are the biannual World and Continental Championships and the World Equestrian Games (WEG) held every four years. In the United States, the American Vaulting Association organizes and sponsors national, regional and local events every year, such as Falconwood Springfest in Covington, Georgia.

Vaulting events were included in the 1920 Olympics.

**History**

Some trace the origins of vaulting to Roman games, including acrobatic displays on cantering horses. Others see roots in the bull dancers of ancient Crete. In either case, people have been performing acrobatic and dance-like movements on the backs of moving horses for more than 2,000 years. The first known depiction of vaulting was from stone painting, dated at around 1500 BC, of Scandinavian riders standing on horses.

Renaissance and Middle Ages history include numerous references to vaulting or similar activities, and it seems apparent that present-day gymnastics performed on the "vaulting horse" was developed from vaulting - allowing concentration on the gymnastics without the horse. The present name of the sport comes from the French "La Voltige," which it acquired during the Renaissance, when it was a form of riding drill and agility exercise for knights and noblemen, and also used as a symbol of status.

Vaulting was later used to help cavalry troops increase their abilities on the horse, and the troops would begin by working on a wooden horse before advancing to a live, moving mount. Modern vaulting was developed in post-war Germany as part of set of exercises for improving general riding. Cavalry officers introduced the sport at the 1920 Olympic Games in Antwerp as "Artistic Riding," although the sport was not continued in the Games. Vaulting is still much more popular in Europe, where it is still included in dressage training, than it is in other parts of the world, though vaulting is a growing sport in Brazil, Australia, Canada, and the United States.
In 1983, vaulting became one of the disciplines recognized by the Fédération équestre internationale (FEI), and the first FEI World Vaulting Championships were held in Switzerland in 1986. It was later demonstrated as a sport at the 1996 Atlanta Games and at the 1984 Olympic Games in Los Angeles, USA. More recently, the popular equestrian show Cavalia and other similar shows have introduced vaulting to many new audiences worldwide.

Movements

Vaulters perform various movements on the back of the horse. Novice and beginning vaulters may perform at the walk or the trot while higher level vaulters perform at the canter. There are six compulsory exercises in the individual competition that must be performed without dismounting:

<table>
<thead>
<tr>
<th>Movement</th>
<th>Description</th>
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<tbody>
<tr>
<td>Basic seat</td>
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<td>t</td>
<td>Basic Seat</td>
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<tr>
<td>Flag</td>
<td>From the astride position, the vaulter hops to his or her knees and extends the right leg straight out behind, holding it slightly above his or her head so the leg is parallel to the horse's spine. The other leg should have pressure distributed through the shin and foot, most weight should be on the back of the ankle, to avoid digging the knee into the horse's back. The left arm is then stretched straight forward, at a height nearly that of the right leg. The hand should be held as it is in basic seat (palm down, fingers together). The right foot should be arched and the sole should face skyward. This movement should be held for four full strides after the arm and leg are raised.</td>
</tr>
<tr>
<td>Mill</td>
<td>From the astride position, the vaulter brings the right leg over the horse's neck. The grips must be ungrasped and retaken as the leg is brought over. The left leg is then brought in a full arc over the croup, again with a change of grips, before the right leg follows it, and the left leg moves over the neck to complete the full turn of the vaulter. The vaulter performs each leg movement in four strides each, completing the Mill movement in sixteen full strides. During the leg passes, the legs should be held perfectly straight, with the toes pointed. When the legs are on the same side of the horse, they should be pressed together.[1]</td>
</tr>
<tr>
<td>Scissors</td>
<td>From the astride position, the vaulter swings into a handstand. At the apex, the vaulter's body should be turned to the longeur and the inner leg should be crossed over the outer leg. The vaulter then comes down and lands so that she is facing backward on the horse, toward the tail. The return scissors is then performed, so that the vaulter swings up with the outside leg over the inside leg, and lands facing forward once again. If the vaulter lands hard on the horse's back, they are severely penalized. Scissors is judged on the elevation of the movement. [2]</td>
</tr>
<tr>
<td>Stand</td>
<td>The vaulter moves from the astride position onto the shins and immediately onto both feet, and releases the grips. The vaulter then straightens up with</td>
</tr>
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</table>
both knees bent, the buttocks tucked forward, and the hands held as they are in basic seat. The vaulter must hold the position for four full strides. [3]

Flank

From the astride position, the legs are swung forward to create momentum, before swinging backward, and rolling onto the stomach in an arch, with a full extension of the legs so that the vaulter nearly reaches a handstand. At the apex, the vaulter jackknifes her body and turns the body to the inside, before sliding down into a side seat. The vaulter moves from the side seat with a straighten of the legs, keeping the legs together, bringing her body over the horse's back, and pushes off the hand grips, landing to the outside of the circle facing forward. The vaulter is judged on form, landing, and elevation. You need to be able to eventually swing your entire body over the horse.[4]

Demonstrating a half-flag movement at a practice session

The compulsories are performed in succession in the above order, without pause or dismounts. In addition, the mount onto the horse is also scored. At the walk, the Ground Jump is omitted.

In the team competition, each vaulter performs the required movements, one following the other. Each team member will do the first three moves and then dismount, and after everyone has done the first three, the team will get back on one by one and finish out the last three moves.
United States and the AVA

A young vaulter at the 2005 AVA Nationals

American vaulting can be traced to 1956, when Elizabeth Searle first saw the sport during a visit to Europe. Seeing a potential application for her pony club in California's Santa Cruz County, she obtained a 16mm film of the basic exercises, and took it back to the US.

Later, in 1966, the American Vaulting Association was founded by Searle and J. Ashton Moore, and in 1969, held the first official AVA competition at the Santa Cruz County fairgrounds in Watsonville, California. In 1974, US vaulters participating in the first international exchange in Stuttgart, Germany.

AVA members demonstrated vaulting at the 1984 Summer Olympics in Los Angeles, and again at the Atlanta Olympic games in 1996.

Today the AVA has more than 1,000 members in 100 AVA clubs and affiliates from Hawaii to Massachusetts, and Washington to Florida. Originally focused solely on competitive vaulting, the AVA today has programs for all types of vaulters, from recreational and pony club vaulters to therapeutic vaulters, from beginner to world championship levels.
Non-Competitive Vaulting

In addition to competition, vaulting is also a form of artistry and entertainment. Cavalia, the blockbuster equestrian theatrical show from Canada, includes a vaulting section.

Beyond Cavalia, vaulting is also used on a therapeutic level in some instances. People with disabilities can often benefit from interacting with the horse and team members, and by doing simple movements with the help of "spotters." Also, vaulting is often seen on a recreational level, through vaulting "demonstrations," and occasionally in local parades. For photographs and other information concerning vaulting in the United States, see the official American Vaulting Association's website: [5]

SELECTING AND TRAINING A VAULTING HORSE

This chapter is an excerpt from the AVA's Camps and Clubs Manual, written in 2004 specifically for beginning coaches and clubs. If you are an AVA member, you may download the complete Camps and Club Manual, found in the Resources section of the Members Only AVA website.

Become a member
Order the complete Camps and Clubs Manual

3.1 Selection and Evaluation of a Horse for Vaulting

Selection of a Suitable Horse - Initial Evaluation

It takes a lot of work to train a vaulting horse, so make sure your efforts are not wasted on an unsuitable horse.
Good vaulting horses can be found in nearly every breed and among grade (mixed breed) horses. The horse must be a gelding or mare and at least six years of age to attend a recognized vaulting competition.
The most important points to evaluate when selecting a vaulting horse are temperament, conformation, way of going, and training, in that order.
Temperament
Irreproachable character and good temperament in the presence of children are essential characteristics. A horse with a "baby-sitter" outlook is a treasure.
He must be willing to learn to accept one, two, or three riders all doing "strange" things at once.
He must be able to be trained to remain steady and unflappable in all situations.
He must be able to be trained to be responsive and obedient to the longeur's commands and willing to work so as not to repeatedly break gait.
There are a number of horses that do not have the balance, consistency or stamina to sustain work at the canter even if they are willing, but who may work quite satisfactorily at the trot.

**Conformation**

Conformation is so secondary to temperament in the search for a suitable horse that a potential vaulting horse should not be rejected for faults of conformation unless they are so extreme as to interfere with the safety of the vaulters or to cause the horse to become unsound or uncomfortable.

A good vaulting prospect should be thoroughly examined by a veterinarian for soundness and evaluated for conformation to establish if there are any problems which would make the horse unsuitable for vaulting.

Suitable size for the size of the vaulters; in general, 15.2 to 17 hands is preferable. Except for use with very small children, horses under 14.2 hands are not suitable.

A vaulting horse should also have: a strong back - broad, long, and well-attached at the loins; a broad, flat croup; good vision in both eyes.

**Way of Going**

The horse must walk and trot on an even 15 meter circle at a slow and constant pace. Note that this is the size circle used in competitions. Although a 13 meter circle gives the longeur more control, it can be harder on a horse new to vaulting.

The horse must have a slow, evenly paced canter that is always under control.

**Training**

The kind of previous training the horse may have had should be carefully considered. Only those horses that are already trained for riding and are experienced around children should be chosen.

Those horses that have been longed or driven in long lines will be most easily trained to go on the vaulting circle.

Note: Your goal to develop a successful equestrian vaulting program can only be achieved with a suitable, healthy, happy, and willing horse. Be particular; choose the right horse for you and your vaulters. It is nice to have a suitable horse, though it is not essential to begin a vaulting group. Many beginning vaulting programs utilize groundwork and barrel practice, if a suitable horse is unavailable.

**The Suitable Horse - Advanced Evaluation**

Try him first at the halt with an experienced vaulter or a good rider. (Refer to Chapter 2, Safe Horsemanship.)

Give the vaulter a leg-up from both sides.

With a surcingle, have the vaulter safely perform every sort of exercise that occurs to you. Have her kneel, stand, go "round-the-world," lay, pat, poke, and prod all parts of the horse's body. The vaulter should be encouraged to swing her arms and legs, but at all times must be careful not to hit the horse.

If the horse accepts all this activity on his back, you can begin a vaulting program quite satisfactorily with work at the walk with spotters.
Next, have the horse led at the walk and repeat the exercises performed at the halt. Do six compulsory exercises (excluding the mount) and include all kinds of dismounts from every position.

If the horse still accepts the vaulting work and already knows how to longe, proceed cautiously to test him at trot, first being led and then longed. Finally test him at canter.

Be advised. What the horse accepts readily at halt and walk, he may object to at trot or canter.

Be certain that the vaulter who is testing the horse is good enough to dismount quickly from any position if it becomes necessary.

Do not expect the horse to be perfect. He may have to be trained slowly to accept some of the work.

Finally, have the vaulters do any number of inventive exercises in doubles, at walk and trot, in order to determine what the horse's reaction will be.

If it is determined the horse is a suitable prospect and training will begin, review the following excerpts from "Safe Horsemanship," below.

### 3.2 Use and Adjustment of Equipment for the Horse

In order to assure the safety of the vaulters and comfort of the horse, only correct vaulting equipment, properly adjusted, should be used. Necessary equipment includes: a snaffle bridle, side reins, a vaulting surcingle, a thick pad, a longe line and a longe whip.

**Snaffle Bridle**

It is very important that vaulting horses not be longed in halters or longeing cavessons. It is not possible to exert proper control in a halter nor to achieve correct head and neck position in a cavesson or halter.

Use an eggbutt or loose ring bit or French snaffle bridle with a cavesson or a dropped noseband, and remove the reins.

Make sure the bridle fits properly.

Although a dropped noseband is preferred because it holds the bit in place, some horses will not accept it readily. Use a regular cavesson on these horses.

Many camp horses are customarily fitted with hackamore bits to prevent beginners yanking or pulling on their mouths by accident. However, these horses will readily accept a smooth snaffle mouthpiece without noticeable resistance. The same is true for western horses ordinarily ridden with half-breed bits.

Selection of the mouthpiece depends on the sensitivity and preference of each particular horse.

An eggbutt, loose ring or hollow-mouth snaffle of average thickness is a good starting point to transition a horse from a different bit.

A horse with a sensitive mouth may require a thinner, heavier, or copper-coated mouthpiece.

Never use a twisted wire snaffle or other severe bit. If the horse's mouth should suddenly be hurt by a severe bit, he might react in such a way as to cause injury to a vaulter.

The bit must be the correct width for the size of the horse's mouth:
If it is too narrow, the rings will pinch the corners of the mouth. If it is too wide, it will be pulled sideways by the longe line into an incorrect position in the mouth.

Adjust the bit so that there are two wrinkles in the corners of the mouth. A bit fitted too low does not allow for good control and may start undesirable habits. A bit fitted too high will pinch or chafe the corners of the mouth causing great discomfort for the horse and eventually creating sores. If at all possible each horse should have its own bridle and side reins, thus lessening the chances of improper fit and saving time.

**Side Reins**

Side reins with or without rubber rings are suitable; however, do not use the side reins which have elastic webbing as that type stretches too much and unequally. For the trained horse, side reins should be of equal length and adjusted so that his face approaches the vertical when he is moving. This position will vary with the amount of experience the horse has and its way of going. It is imperative that the side reins be adjusted loosely at first and gradually tightened over a period of weeks or months into their final position. Cranking horses in on side reins without proper preparation can cause some horses to throw themselves over backwards. Under no circumstances should vaulters be allowed near the horse until it accepts the side reins with no trace of resistance at all gaits. The horse should be warmed up on the circle in both directions without side reins so that he can freely stretch his neck and back muscles and so that he can get rid of any playful bucks, etc. During this warm-up attach the side reins to the rings on the surcingle. Do not let side reins hang loose or flip them over the horse's neck. Remember during rest periods to always unfasten the side reins, being careful to re-snap them to the surcingle rings.

**Longe Line**

The longe line should be of heavy material, not of light nylon, so that the longeur can maintain a steady, elastic contact with the horse. Never use a rope of any kind. It is too apt to tangle and cause injuries. Make sure the line is kept flat and free of twists so that the longeur can have the best possible feel of the horse's mouth. The longe line is customarily snapped into the near side ring of the snaffle bit. However, there are times when it is useful to put the line through the near bit ring and over the horse's head, then snap it to the far side bit ring. This method is used when greater control is needed or when a horse does not bend well on the circle.
Care must be exercised that this method does not create a "gag" effect. For more information, see 3.3, Techniques for Training the Horse to Longe.

**Longe Whip**

The whip should be 6-8 feet with a lash long enough to reach the horse.

**Vaulting Surcingle**

A vaulting surcingle is necessary for vaulting on horseback. Surcingles are commercially available. (See Appendix for list of suppliers.) They are manufactured with handles in various styles and sizes. They also come with or without loops called Cossack straps. Surcingles with two Cossack straps (one on each side) provide vaulters with the means to perform a number of freestyle (kür) exercises.

The surcingle should be placed on the horse's back (handles lean toward the front) so the girth will rest in the groove immediately behind the front legs. After warm-up, before vaulters begin work on the horse, check to see that the surcingle is placed correctly on the horse. It should be tight enough to stay in place without pinching, chafing, or turning the hair in the wrong direction.

Two items are especially important in tightening a surcingle in preparation for actual vaulting on the circle:

- The surcingle should always be checked at the top of the withers to be certain it does not contact the wither at any time during vaulting.
- This contact can happen easily as wear occurs on the surcingle back pads and they crush down.

If the rig cannot be repaired at that time, foam rubber or woolskin can be used in extra layers to raise the rig off the horse's withers until the surcingle back pads can be repaired. These layers should extend several inches beyond the surcingle or they will slide out frequently.

The surcingle should be checked to make sure there is enough clean padding to prevent chafing anywhere in the girth area.

Some surcingles require woolskin or foam girth covers to prevent chafing. Some horses have elbows that point inward and which may rub sore from striking the top of an unpadded surcingle. Woolskin sleeves may be used to correct this problem.

If the surcingle "heels over" toward the longeur after vaulting has been in progress for a while, never push the surcingle back into correct position without loosening it first. To do so drags the back pads across the most sensitive part of the withers and can cause soreness to develop.

**Pad**

The horse's back should be well padded, especially for beginning vaulters. Thick western-style pads are satisfactory. Two pads may be encased in fabric to provide additional thickness to the pad.

If properly fashioned, a terry-cloth cover over the pad provides soft contact for the vaulters and is easy to remove and launder.

Pads of fuzzy orthopedic material are not suitable because they slide around.
Foam rubber pads are not suitable because they will tear. If a foam rubber pad is used it must not be in direct contact with the horse and must be covered in suitable fabric. Uncovered foam will not properly release heat and will cause problems for the horse. The pad should be adjusted so that it extends well forward of the surcingle and far enough back to protect the horse's back and upper loin area without any wrinkling.

**Care of the Tack and Equipment**

The care and cleaning of tack is a part of good horsemanship. All vaulting equipment should be attended to each time it is used by whomever is in charge. The leather equipment (surcingle, bridle, side reins, and galloping boots) should be kept clean, oiled as required, and maintained in good repair. It is important to check for signs of wear, especially in the stitching, each day before vaulters begin work on the horse. Sweat will rot the stitches if not cleaned off with a damp sponge after each use. Back pads, girth covers, and bandages must be laundered so that the accumulated sweat does not cause sores. Be certain to rinse them well because any soap which remains in the material and mixes with the wet sweat will irritate the horse's skin. Clean the bit carefully, making sure there are no remains of dried saliva or food which could irritate the corners of the horse's mouth the next time the bit is used. Care should be exercised when putting the vaulting equipment away. The equipment should be stored in a cool place out of the sun and dampness. The surcingle should be kept on a saddle tree, never hung up or laid flat. Never lay the surcingle down on the handles. The leather covers on the handles damage easily and are expensive to repair, besides being uncomfortable to use after they are damaged. Never leave the surcingle lying on the horse's back with the girth unfastened for more than a moment. One good shake and a step forward will almost guarantee a repair bill. The longe line should be folded so that it will be free of tangles when let out the next time. The longe whip should never be left lying in the vaulting circle. A horse stepping on it spells the end of its usefulness. After vaulting practice, the knots should be untied from the lash, the popper checked for wear, and the whip done up neatly and stored in a vertical position or hung up. This care gives it a better chance of survival without damage, and it is ready for the next time.

.3 Techniques for Training the Horse to Longe

Introduction
After selecting a horse that may be suitable, he should receive longe line training before being asked to accept vaulters.

Remember, when he begins real work on the vaulting circle, he will have to:
- Travel in a perfect circle around the longeur to the left and right;
- Maintain a constant gait;
- Stop and start on command;
- Tolerate vaulters' mistakes without misbehavior;
- Be attentive and obedient to the longeur, even with vaulters constantly moving between them.

The techniques given here are for use with a horse that is already gentle and obedient under saddle.

Since no two horses are the same, these suggestions must be adapted to the responses of each particular animal. They are offered only as guidelines.

**Equipment**

For the first lesson on the longe line, fit the horse in a snaffle bridle and vaulting surcingle.

Do not start training the vaulting horse in a longeing cavesson or halter.

Be attentive that the girth remains tight to avoid sores on the horse and for the safety of the vaulters.

Adjust the length of whatever side reins you have chosen to use so they will allow the horse a natural head carriage at the walk, but will not flop loosely when attached to the bit from the surcingle, and so that they are the same length. Snap them up on the surcingle to begin the work.

When the horse finds his balance on the circle and learns to become obedient, the side reins may be shortened.

**Procedure**

### Getting started

If possible select a quiet, fenced area in which to train the horse.

Before you attempt to longe the horse, make sure he leads well and comfortably with the longe line snapped into the near snaffle ring. (May use a lead shank.) Ask him to start, stop, and turn with you walking around him as he turns.

The next step is to acquaint the horse with the longe whip.

At no time should the vaulting horse fear the mere sight of the whip. This fear can lead to accidents.

For starting a horse completely green to longeing, it is preferable to use a longe whip that is a few feet shorter than the standard one used on the 13 meter circle.

Hold the horse by his lead shank with your left hand, and stand a short distance away from the left front shoulder facing toward the horse's barrel.

If you have an assistant, have him hand you the longe whip in a vertical position with the lash done up. If you have no assistant, pick up the whip slowly, being careful to keep your eyes on the horse's eye at all times.

With a slow but deliberate motion, point to and rub the horse on the left shoulder with the handle of the whip.
If he shows no anxiety, proceed up over the withers, down the back, and over the hindquarters, gradually moving the whip away and toward the horse with a more pronounced motion but at no time in a threatening gesture. If the horse is very nervous, for whatever reason, continue reassuring him until you can move the whip around him with the lash undone, and he shows no sign of uneasiness.

**Use of voice commands**

Since vaulting horses must work on remote control, the use of the voice is of great importance. The horse learns to recognize the different intonations of your voice as much as the words you use, so try to always use the same intonation for the same command. The verbal commands you will need to teach are:

A tongue click to start the horse out or to move him on faster in the same gait; "brrrr" (a raspberry sound) or "Whoa" for stop; "brrrr" is preferred as it is not used in conversation, and you don't want to confuse the horse by something the vaulter might say.

"Walk" and "trot" in separate stages each with a specific intonation:

"Hup" for canter;
"Oust" or "out" for when the horse cuts in.

Give a voice command once only, then reinforce calmly but firmly with the whip. At this point you are ready to put the horse on the circle. The longeur must wear gloves and hold the longe line so that it cannot coil around his hand if the horse should make any sudden moves. Also the longeur must not let loops drag on the ground where his feet, or those of the horse, could be entangled.

Attach the longe line to the bit and have the assistant begin walking with the horse in a left-handed circle of perhaps 8 meters (25 feet) in diameter. At first walk parallel to and a few feet away from the assistant's left side. Follow the horse with the longe whip and use the longe line to guide the horse on the circle as he walks.

Little by little lengthen the longe line, keeping the whip pointed at the horse, and step away from him toward the center of the circle. Finally, have the assistant gradually move back away from the horse as he is encouraged to walk on alone.

As soon as the horse is walking calmly on a small circle, ask him to stop, using the voice command "brrrr" followed instantly by a gentle tug on the longe line. If not trained to the longe line, he will probably turn his hindquarters outward and try to face you.

Move toward him and make every effort to teach him to stop on the track of the circle, looking at you with the near eye only. Make him stand still until told to move forward again. Repeat the starting, walking, and stopping until this training step is mastered without hesitation.

At this point you may start using the side reins.
The assistant will no longer be needed when the horse goes forward from a cluck and accepts a tap of the whip with a generous but not violent forward response, and stops instantly to the command "brrr" given in a loud voice. Follow starting, walking and stopping with "trrrot," and teach the transition from trot to walk into trot again. Master a comfortable "brrrr" from either gait. Though the response should be immediate, it should not be so abrupt as to throw vaulters forward onto the neck. Do not start trying to canter until the horse is absolutely calm and cooperative at the trot. Get the working circle out to 13 meters as quickly as possible. It is hard for a horse to work on a small circle. The horse should keep the longe line stretched, maintaining a steady, light contact. If the horse tries to come into the circle, point the whip at his nose and walk toward him. In most cases this technique will make him remain on the circle. Always walk up to the horse when you finish or stop; never allow him to turn off the circle and come to the longeur because he will develop the habits of diminishing the circle and not remaining still at the halt.

Conclusion

Training a seasoned horse to something new should not differ much from teaching a completely green horse. Twenty minutes is usually enough at one time. The attention span will vary with different horses, but if the training is to be hurried through necessity, it is far better to work in two sessions, AM and PM, than one long one. Do not pursue the project with a horse who cannot be quickly discouraged from trying to kick. Practice, repeat, play it by ear. Reward with carrots and much patting - frequently. Remember, prevention of injury should be the goal of every vaulting instructor, and the correct training of the horse is vital to this end.

3.4 Horse Care and Special Considerations

Care of the Horse

It is not the purpose of this manual to give detailed instructions on animal husbandry or veterinary medicine. Suffice to say that a vaulting horse must be given the same conscientious care as any other working horse. In any equestrian sport, first priority must be given to the well-being of the horse, for without him nothing can be accomplished. Anyone who has the responsibility for a horse's care should learn as much as he can about how to keep his horse in top condition, both physically and mentally, and how to identify problems if they should appear. Overall sensitiveness to your horse's well-being can help you and your horse's career in vaulting be longer, safer, and much more pleasant.
Basic care must include:
Yearly inoculations
Regular worming
Regular hoof care
Yearly vet check for general health including the teeth
Daily grooming and hoof cleaning (best time to check for any heat, soreness, bumps, cuts, etc.)
Regular exercise
Good nutrition
Make sure the amount and type of hay and grain given is in proportion to the size of the horse and the amount of work he does. Both overfeeding and underfeeding can cause serious health problems.
Be sure to have salt and water available at all times.
Daily cleaning of stall or paddock. (Dirty living conditions will lead to health problems, especially with parasites and flies.)

Special Considerations for the Vaulting Horse

Uneven physical stress

Vaulting horses for beginning and even for advanced vaulters are often worked to the left much more than to the right. The horse is apt to suffer physical damage as a result of this uneven stress.
To prevent damage to the horse, work the horse to the right as often as he is worked to the left.
Make it a rule to warm up and cool out the horse by going to the right.
When training a vaulting horse, or just conditioning on the longe, always work in both directions.
Advanced vaulters can vault to the right when working on the compulsories.
Additional work under saddle is required to physically condition the horse off the vaulting circle. Such work will help to keep the horse's mental attitude fresh as well.

Care of the back

A vaulting horse's back must be protected from "pounding," especially from inexperienced vaulters. Training your vaulting horse under saddle and on the longe-line develops and strengthens his back and prevents soreness.
It is of utmost importance that the back be checked every day for soreness or strain.
Press with some force on both sides of the horse's backbone from the withers to the loins with the heel of your hand.
Soreness is present if the horse hollows his back or moves away from the pressure.
Measures must taken to completely eliminate any soreness.
Increasing the padding, massaging with a linament wash, or hosing down with cold water (hydrotherapy) can all help.
Encourage the horse to stretch the back without vaulters or riders. Of course, laying the horse off until the soreness is gone is the best treatment.

**Care of the legs and feet**

There are many things that can be done to help assure the soundness of the vaulting horse's legs and feet. Wrapping the legs with working bandages can help prevent strains. (Polo bandages are the safest to use). Using galloping or splint boots and bell boots can help prevent the injuries which may occur from the horse interfering or overreaching. The instructor must use his judgment in determining whether these protections are really needed. If bandages are used, the instructor must be careful to wrap the legs correctly so as not to cause tendon problems. Bandages should never be left on the legs while the horse is standing for more than 15 minutes. Hydrotherapy can be a great aid in maintaining tightness and strength in the legs. Cold water can be sprayed with some force on the legs below the knees and hocks after every workout. Linament may be used to increase blood circulation. Observe the horse's way of going throughout each workout for any signs of distress, and check his legs and feet after every session for any signs of excessive heat. Extra warmth in the joints or hoof indicates some kind of inflammation and should be treated with hydrotherapy and/or rest. This heat is usually the first sign of a developing problem which, if detected early, may be prevented. Seeking help from your local veterinarian should always be considered if any questionable condition develops.

**Shoeing**

A vaulting horse can work barefooted if it has naturally tough feet and the working surface is kept soft. A barefooted horse is less likely to cause injury if it steps on or kicks a vaulter. However, shoes, at least on the front feet, may be necessary if the horse's feet do not hold up.

**Maintenance of body condition**

Vaulting horses should have a bit too much rather than too little flesh. Using a horse that is in poor condition is not fair to either the horse or the vaulters. The damage is two-fold. On a thin horse the vaulters get painful bruises from exposed sharp bones. A thin horse has no fat to pad its back.
If a thin horse must be used, the padding should be doubled and the horse's diet improved. WARNING: Consult your veterinarian for a diet which will increase the horse's weight quickly without causing it to founder from over-eating. He can also determine when the horse is ready to begin work.

On the other hand, many horses tend to be naturally round and can suffer the problems associated with being overweight, such as additional strain on legs and feet and on heart and lungs when asked for strenuous work.

As with any athlete, a good vaulting horse should be kept in top condition with strong, supple muscles, neither too fat nor too thin. This ideal is the result of proper diet and exercise.

**Maintenance of a good attitude**

To maintain the vaulting horse's good attitude vaulting should be only 20% of his weekly workout routine. Trainers need to ride their vaulting horses the rest of the time and find additional activities for the horse.

Frequent rest periods during the vaulting session will help to keep him happy and in the right frame of mind.

Praising the horse constantly and really "fussing" over him can never be overdone.

Carrots or other treats at the end of a session can keep your horse looking forward to the next time.

**Care during rest periods**

After every 15 - 20 minutes of steady work on the circle, the horse should be allowed to stretch and relax. These rest periods should be even more frequent with a green horse.

The side reins should be unsnapped from the bit and hooked onto the surcingle; the surcingle should be loosened a few holes and the back pad raised off the back for a short time to allow air to the area under the pad.

Check any boots or working bandages which you may be using for sand or dirt which can accumulate on the inside. If it is a hot day, remove boots or bandages for a few minutes to avoid scalding the skin.

Be sure to walk the horse until its breathing returns to normal.
GUIDELINES FOR TRAINING THE VAULTING HORSE

Differences in lunging for vaulting, or using the horse as a lunge horse for training riders, to lunging a horse for exercise.

1. Immediate obedience is required
2. Use of the voice should be kept to a minimum and only used to reinforce specific whip signals.
3. Lunger should pivot on the spot to enable horse to work on a perfect circle.
4. Lunger should be able to influence the horse from that centre

Use of the Vaulting Whip as an aid:
The vaulting horse has to be very obedient and trustworthy. Obedience comes from consistent training, using the vaulting whip in a very meaningful way. It is an extended whip with leather thong capable of reaching the hind legs from the centre of a 15 metre circle whilst the lunger stands still. The following signals are fairly universal so that anyone taking a trained vaulting horse and using the known signals will have a successful session.

Specific whip signals:

- Must be consistent and only used when necessary.
- Must be controlled and meaningful
- To go up a pace use horse’s name then command
- Should point low for walk
- Should point at hock/stifle for trot
- Tip raised high for canter
- For canter use ‘name - canter hup’ and raise whip simultaneously. Then a quiet ‘hup’ and the whip raised will be sufficient, finally only the whip being raised will put him into canter.
• To energise horse, use with swirling motion.
• To move out on the circle, point to shoulder
• To slow pace or change down a pace, bring under lunge line and raise in front of his face.
• To stop, take whip behind your head and cast in front of horse like a fishing line. This is a powerful tool.

**Why use the whip like this:**
The horse has to differentiate from the chatter of vaulters and coaching instructions from the lunger, which commands apply to him. He can see the whip easily. A good vaulting/lunge horse will become very obedient to the whip.

**Voice aids:**
• For walk - use tongue on roof of mouth behind front teeth – ‘ts’
• For trot – one click
• For canter - 2 clicks or 'hup'


What is EFMHA?

Our Mission
EFMHA’s mission is to advance the field for individuals who partner with equines to promote human growth and development so that our members, clients and equines can succeed and flourish.

Equine Facilitated Mental Health
Equine Facilitated Mental Health Association (EFMHA) is a vibrant and fast growing section within NARHA. EFMHA promotes human growth and development by bringing people and equines together in mutually beneficial ways.

A very active NARHA section, EFMHA provides standards of professionalism and safety for people working in equine facilitated learning (EFL) and equine facilitated psychotherapy (EFP).

The equine is a critically important, sentient partner in the four-part team consisting of the equine, a mental health professional or educator, an equine specialist and a client. The participants or clients in equine facilitated learning or equine facilitated psychotherapy may include at-risk youth, victims of violence, veterans returning from war with post traumatic stress disorder (PTSD), and people with many other mental health challenges.

New EFMHA members have access to a broad range of resources, including:

- Immersion in the team approach to problem solving
- Training specific to the mental health and learning fields
- Opportunities for internships and mentoring
- Inclusion in a field of knowledgeable, seasoned professionals

Experienced mental health and learning team members can:

- Participate in advanced training
- Continue their professional understanding and implementation of NARHA’s ethics and standards
- Network with their peers and other professionals in the field of equine assisted activities and therapies.

EFMHA members have access to all that NARHA offers as well as the unique programs targeted to those involved in equine facilitated mental health and learning.

NARHA is an international voice for equine assisted activities and therapies. As the premier organization advocating for and providing standards for safe and professional equine interactions, NARHA celebrates ability, optimism, diversity and a shared loved of equines.
What are EFL and EFP?

**EFL (equine facilitated learning)** is an educational approach that includes equine facilitated activities incorporating the experience of equine/human interaction in an environment of learning or self discovery. EFL encourages personal explorations of feelings and behaviors to help promote human growth and development.

**EFP (equine facilitated psychotherapy)** is experiential psychotherapy that involves equines. It may include, but is not limited to, such mutually respectful equine activities as handling, grooming, longeing, riding, driving, and vaulting. EFP is facilitated by a licensed, credentialed mental health professional working with an appropriately credentialed equine professional. EFP may also be facilitated by a mental health professional who is also credentialed as an equine professional.
such as handling, grooming, longeing, riding, driving, and vaulting. Equine Facilitated Psychotherapy is a treatment approach within the classification of Equine Assisted Therapy that provides the client with opportunities to enhance self-awareness and re-pattern maladaptive behaviors, feelings and attitudes.

Equine Facilitated Psychotherapy may be used for people with psycho-social issues and mental health needs that result in any significant variation in cognition, mood, judgment, insight, anxiety level, perception, social skills, communication, behavior, or learning. Examples include but are not limited to:

- Anxiety Disorders
- Psychotic Disorders
- Mood Disorders
- Behavioral Difficulties
- Other Mental Illness, such as Schizophrenia, Attention Deficit Hyperactivity Disorder, Autism, Receptive or Expressive Language Disorders, Personality Disorders, Depression, Post Traumatic Stress Disorder, etc.

Major Life Changes such as environmental trauma, divorce, grief and loss, etc.

**Question:** What is the difference between Equine Facilitated Psychotherapy and Equine Facilitated Learning?

**Answer:** Equine Facilitated Learning promotes personal exploration of feelings and behaviors in an educational format, while Equine Facilitated Psychotherapy both promotes personal exploration of feelings and behaviors, and allows for clinical interpretation of feelings and behaviors. EFP denotes an ongoing therapeutic relationship with clearly established treatment goals and objectives developed by the therapist in conjunction with the client. The therapist must be an appropriately credentialed mental health professional to legally practice psychotherapy and EFP. Equine Facilitated Experiential Learning falls under the heading of Equine Assisted Activities and may be conducted by a NARHA Instructor, an educator or a therapist. Experiential Learning refers to a style of learning that occurs when a person is interacting with the environment, including the people, animals and situations involved. It is learning by doing and may take place during a short period of time, such as during a workshop, or during regularly scheduled sessions.

**Question:** How does Equine Facilitated Psychotherapy help clients with psychosocial healing and growth?

**Answer:** Specially designed EFP experiences may promote psychosocial healing and growth through:

- improving self-esteem and self-awareness;
- developing trust in a safe environment,
providing social skills training,

•

encouraging sensory stimulation and integration,

•

combining body awareness exercises with motor planning and verbal communication,

•

developing choice-making and goal-setting skills,

•

developing sequencing and problem-solving skills,

•

encouraging responsibility, and

•

Promoting pro-social attitudes through care-giving experiences.

**Question:** Are there any precautions or contraindications to EFP?

**Answer:** EFP Standards developed by the EFMHA Standards Committee are being field tested and they are available from NARHA. The EFMHA Standards Committee has suggested the following precautions and contraindications. These are guidelines only and should not be viewed as a substitute for clinical data collection and consultation with a mental health professional. The EFMHA Board of Directors and EFMHA Standards Committee are in agreement with Joff Barnett, MD:

Precautions and contraindications relate to functional capacity rather than the presence or absence of a diagnosis, disease, or specific sign/symptoms by history; many illnesses can be chronic and although there may at times be active symptoms there is also often compensatory coping and adaptation.

Thus, it is felt that clients should be assessed throughout the EFP process for readiness to safely participate on a case by case and moment by moment basis.

**EFP Contraindications**

Client is currently:

•
Actively dangerous to self or others (suicidal, homicidal, aggressive)

•

Actively delirious, demented, dissociative, psychotic, severely confused (including severe delusion involving horses)

•

Medically unstable

•

Actively substance abusing

**Narrative for Contraindications:**
"Dangerous to self or others" is the clinically accepted term to describe those clients experiencing a psychiatric emergency. Equine experiences cannot be safely facilitated for clients exhibiting these behaviors.

"Actively delirious, demented, dissociative, psychotic, or severely confused", as well as "actively substance abusing" reflects the committee's agreement that equine experiences cannot be safely facilitated when clients are exhibiting serious alterations in mental status.

"Medical instability" can be associated with a variety of psychosocial challenges. The committee seeks to enhance awareness that physical/medical issues must always be considered as part of a thorough clinical assessment.

**EFP Precautions**

**Precautions**
Client has:

•

History of animal abuse

•

History of fire setting

•

Suspected current or past history of physical, sexual and/or emotional abuse

•

History of seizure disorder
Gross obesity

- Medication side effects

- Stress-induced reactive airway disease (asthma)

Migraines

Narrative for Precautions:
"Animal abuse" concerns are included in the interest of the horse's welfare. If the horse is not safe, then the session cannot be safe.

"Fire setting" histories should be carefully assessed to ensure the promotion of a safe physical environment.

"Active abuse" suspicions should always be reported to the appropriate authorities. Such reporting does not always result in cessation of the abuse. Clients are unlikely to be able to safely explore deep psychic issues in the context of a pervasively unsafe environment.

"Gross obesity" is associated with eating disorders and various other medical conditions. Obesity is a safety concern. Guidelines on weight limits for equines are included in the NARHA Standards.

"Medication side effects" can lead to severe alterations in balance, arousal level, coordination, and strength as well as difficulties with speaking and breathing. Programs develop and implement procedures and process for remaining familiar with clients' medication regimen and clients' potential for and history of side effects.

An acute episode of "reactive airway disease" can be triggered by stress and anxiety. Although all medical conditions have a psychosocial component, RAD is singled out because of its prevalence and potential for sudden, severe onset of symptoms.

If "migraine" is in process; riding is not advised.

Insurance Checklist for Centers Providing EFMH

Cornerstone of Protection – Commercial General Liability Insurance

Commercial General Liability insurance protects your entity against Bodily Injury and Property Damage suits. Per Occurrence limits of at least $1,000,000 are normally recommended. A good General Liability policy pays investigation and legal fees outside the limits. This means that the policy pays to defend your entity without reducing the amount available to settle claims. There is never a deductible on a good General Liability policy.
Protecting Your Professional Exposure – Professional Liability for Therapists

General Liability insurance is triggered if suit is brought alleging Bodily Injury or Property Damage was caused by the center’s operation. If the suit alleges that a therapist used an incorrect course of treatment or did not use proper professional judgment, Professional Liability insurance (purchased by the therapist) is triggered. It is possible that a single suit could trigger both Professional and General Liability coverages.

If You Own Your Facility – Property Insurance

If you own your own facility, Property insurance is normally purchased. If an owned structure is damaged, property insurance pays to clean up and rebuild. Property insurance can also provide coverage for owned tack, tools and other equipment if these items are scheduled on the policy. There is normally a deductible on Property policies, and the deductible is applied to each loss.

Avoiding Minor Lawsuits – Excess Accident Medical Insurance

An Excess Accident Medical policy provides insured classes of individuals (normally riders and volunteers) reimbursement for medical expenses if injury occurs at the center. The injured person does not bring suit to obtain benefits under this coverage. Excess means the injured person's own medical coverage is accessed first. If the injured individual has no medical coverage, then this policy functions as primary coverage. The Excess Accident Medical policy is meant to deter liability lawsuits for minor medical expenses.

If You Have Employees – Workers Compensation Insurance

If the entity has employees, Workers Compensation insurance is normally required. Workers Compensation laws, rates for various classes of employment and penalties for non-compliance vary by state. It is important for every center to investigate their individual Workers Compensation needs.

If You Use an Automobile in Your Business – Commercial Auto Insurance

If the entity owns vehicles, and particularly if the entity transports employees or students, Commercial Auto insurance is required. A personal auto policy is not designed to cover the commercial exposures of a business entity. A personal auto policy will normally not respond if employees use a personally owned vehicle for center business.

If Higher Liability Limits Are Desired – Commercial Umbrella Liability Insurance

Some centers are not comfortable with only $1,000,000 Per Occurrence General Liability coverage. If higher limits are desired, Umbrella Liability insurance is purchased. Remember that an individual’s personal umbrella will respond only to suits arising out of personal activities. If the center desires liability coverage in excess of its primary Commercial General Liability coverage, a Commercial Umbrella is needed.

Protecting Board Members – Directors & Officers Liability Insurance
Directors & Officers insurance protects directors and board members if it is alleged they did not properly perform their duties as officers of the entity. It is important to remember that all Directors & Officers policies exclude coverage for any Bodily Injury suits. Board members are protected against Bodily Injury suits by the entity's General Liability policy. Directors & Officers policies protect against Employment Practices lawsuits, allegations of misuse of funds and other fiduciary-type claims.

**The Ekuus Stay**

![Image of a horse]

The principle idea is to treat young women between the ages of 12 to 18 years of age, having been victims of sexual abuse. These young women can address the foundation under the Youth Protections Act, or other organizations that will refer and work towards the same cause. The foundation is equally open to individual requests.

![Image of a person and horse]

The therapeutic period can take a few weeks to several months depending on the needs of each victim. At the end of each cycle psychologists determine the effectiveness of treatment and decide on the possibility of reintegration into the family environment or in an external monitoring.
The Pavilions
Our therapeutic approach also seeks to break the patients isolation and enable them to an active social life. Through programs of varied activities, residents can choose different occupations and modes of expression.

Their days are divided between the horses 5h.a day by weekdays and various activities pavilions activities. These activities provide subtle and complementary therapies in our program. We offer 40 hrs weeks of open pavilions. Some activities are mandatory as the study 3 hours per weekday, self-defense two hours a week and art therapy 4h. a week.

Therapy with horses

The interest in working with horses was due to his qualities as living being with a clean mental, relatively simple, soft and warm, rewarding and socially responsive, and capable of carrying, and not judging non-intrusive, able to accept the projections, ability to dialogue on an archaic, worthy of interest and care. These qualities do not make the horse a therapist, but it is able to open new opportunities for the therapist.

On the reliability plan

- Authenticity of the relationship of the (horse-rider). The animal will not lie or cheat, nor is there any artificial sense of SELF (very constructive for those whose issues stem back to unstable family relationships) The horse is either in a state of tension (need) = insecurity, or in a state of rest = security.
- Relationship without judgement, the horse is accepting without conditions
- He delivers or responds immediately
- The therapist being the intermediate object in the relationship with the "other allows yet another "good target" into the relationship

This type of therapy can touch upon base issues from the past as in regressive therapy (Winnicot)
- Symbol of strength (secure image or just the opposite can occur)
Not forgetting the mythological or surreal (fantasy) image

The therapeutic environment again, encompasses all interaction and work with the horse (of a global nature) It is hoped that the progression and stabilization on the psychological level will: improve one’s self image, gain confidence in one self, especially with reoccurring problems of confidence and self image issues because of the nature of the aggressions against them. Outside of the individual work with the horses, it is most definite that these young victims will find themselves having much in common with other patients; thus being able to share the same space as a small community to know that they are not alone being victims of sexual abuse.

**Horticultural Therapy**

Horticultural therapists have discovered that gardening allows patients to better express their emotions. It helps people to bind more easily to others. Horticultural therapists have found that gardening stimulates all senses providing views, sounds, textures and interesting perfums for individual development. In addition, gardening teaches the art of patience. In contrast to other activities, it does not produce instant results, but patience is often rewarded.

Studies called horticultural therapy are being conducted by physicians (Horticulture as Therapy: A Practical Guide, Mitchell L. Hewson, 1994). They are convinced that gardening helps to heal their patients not only physically but also emotionally.
Horticultural therapists have discovered that gardening allows patients to better express their emotions. It helps people to bind more easily to others. The psychological benefits to simply walking outside or working under the sun in fresh air are also indisputable. Indeed, studies have shown that simply watching the trees reduces stress, lowers blood pressure and relieves muscle tension. Horticultural therapists have found that gardening stimulates all senses providing views, sounds, textures and interesting perfums for individual development. In addition, gardening teaches the art of patience. In contrast to other activities, it does not produce instant results, but patience is often rewarded.

**Why the horse, what does it bring?**

The interest in working with horses was due to his qualities as living being with a clean mental, relatively simple, soft and warm, rewarding and socially responsive, and capable of carrying, and not judging non-intrusive, able to accept the projections, ability to dialogue on an archaic, worthy of interest and care. These qualities do not make the horse a therapist, but it is able to open new opportunities for the therapist.

**On the psychological plan**

- The initial contact awakens the sensations (affective), taking into immediate consideration his existence
- The movement allows the patient to become aware of the horses schemata
- There is a psychological revalorization when the patient takes control of the horse
- Birth of identification. Absolutely necessary for the rider to become aware of "the other"
- Security ensured thru the rythm of the horses steps
- Normal long drawn out therapeutic procedures for those with more serious character problems, will benefit immediatly

**On the relatability plan**

Authenticity of the relationship (horse-rider). The animal will not lie or cheat, nor is there any artificial sense of SELF (very constructive for those whose issues stem back to
unstable family relationships) The horse is either in a state of tension (need) = insecurity, or in a state of rest = security.

- Relationship without judgement, the horse is accepting without conditions
- Responds immediately
- Intermediate object in relation to "the other". This still allows the therapist to be the "proper purpose".
- Regressive type of therapy, using the basic needs (Winnicott).
- Symbol of strength (secure image or opposite)
- Not forgetting the mythological or surreal (fantasy) image

The therapeutic environment again, encompasses all interaction and work with the horse (of a global nature) It is hoped that the progression and stabilization on the psychological level will: improve one's self image, gain confidence in one self, especially with reoccurring problems of confidence and self image issues because of the nature of the aggressions against them.
Outside of the individual work with the horses, it is most definite that these young victims will find themselves having much in common with other patients; thus being able to share the same space as a small community to know that they are not alone being victims of sexual abuse.

**Therapy with the horses and psychiatry**

The Therapy with Horses consists of three basic principles necessary for the development of an individual according to M. Winnicot:

**Holding: or Integration**

A primary example is the acquisition of time and space and how to best utilize them both. This acquisition is a normal skill acquired from birth when a mother rears a child. However the re-learning of this security is of much importance.

In (TAC) the horse represents softness, warmth, and a gentle rocking action; the security necessary for the growth and existence of temporal - spacial acquisition that may not be present.
Handling: (Creating links-Relationship Objectives)

There exists a period of time where a child passes thru a fused state with parents onto autonomy or independance, by means of personal development of character of the individual.

Omnipotence (Psychological phenomena of object differentiation)

A small child has strong feelings of emotions. (the child cries, the mother reacts and tries to satisfy his/her needs)
In TE the distance between the will or wanting of action and the means to satify it are up to the trainer. Therefore to have this action-reaction relationship with the horse, the patient must be able to distinguish himself/herself from the horse.

The Therapy Program

Psychological

The goal of the treatment is based on the relationship and complicity that the patient may develop with the horse, which becomes therapeutic "tool". All daily work done by our therapist is aiming for an increase and stabilization of residents on the plans:

-Physical and motor

-Relational and emotional

-Psychic (self-image, confidence)

The team provides a permanent watch, day and night, seven days a week, providing a reassuring presence to residents.
**Physical**

Each patient is followed closely by the doctor and nurse from the center that provides daily medical assistance. Particular attention is paid to food. The menus are prepared and cooked to provide a healthy and balanced diet. Physical activity daily, horseback or not, are organized taking into account the needs and capabilities of each resident.

**Spiritual**

Residents can if they want, find the opening and spiritual assistance for their culture and beliefs.

**Social life and activities**
The therapeutic process also seeks to break the patients isolation and enable them to resume an active social life. Through the access of equipments and programs for various activities, residents can choose different occupations and modes of expression.

Their days are divided between the horses and the various activities:

- Music
- Art and creative activities
- Gardening and horticulture
- Ballads and discoveries
- Studies
- Entertainment
- Etc

**How Does Therapeutic Horseback Riding Help Autism?**

Therapeutic horseback riding (THR) is simply horseback riding lessons for individuals with disabilities.

THR builds on the foundation of hippotherapy. Hippotherapy uses the horse as a therapeutic tool just like any occupational therapy device except that the horse is a living creature. However, THR actually involves horseback riding lessons in addition to hippotherapy.

Thus, therapeutic horseback riding has the same advantages as hippotherapy. A deep bond is created between you and the horse which facilitates communication and social skills. And sensory integration dysfunction is improved considerably since the entire experience involves the senses of vision, hearing, smell, tactile, vestibular and proprioception.

However, auditory processing and cognition are improved considerably more with THR since the tasks are much more involved in horseback riding lessons.
Each lesson usually lasts about 1 hour. During this time, you will learn to groom, tack, mount, dismount, untack, and clean in addition to the riding lessons. You will also learn good safety practices. The actual riding time will be about 30 minutes.

Horseback riding lessons involve an **awareness of your total body** in relation to the horse. You must have good posture with legs, hip and head in a proper line. Then, you learn to follow the movements of the horse with your body to continue walking and stop following the motion when you want to stop. You use pressure with your legs when you want to turn. And you also learn to position the reins for each activity. It is amazing just how many **muscles** you use when you do these activities!

You can either find a place that officially offers therapeutic horseback riding and is affiliated with North American Riding for the Handicapped or Federation for Riding for the Disabled International, or you can just take **general horseback riding lessons**.

I opted to use a **local horse trainer** for my daughter with Pervasive Developmental Disorder-NOS. I explained PDD-NOS in detail to the trainer. In particular, I let her know that my daughter is not very aware of her body, and often does not comprehend verbal instructions readily. The trainer has been especially patient, and my daughter has improved tremendously. She can now walk and direct the horse herself, and she understands instructions extremely well.

Welcome to American Hippotherapy Association, Inc.

Hippotherapy is a physical, occupational or speech and language therapy treatment strategy that utilizes equine movement. This strategy has evolved over 30 years. Through education and clinical experience, physical, occupational and speech and language therapists continue to refine the use of hippotherapy as part of an integrated rehabilitation approach. Using the movement of the horse as the strategy of choice has resulted in improved functional outcomes for a wide variety of patients. These positive results ensure that hippotherapy will continue to be used in treatment for many years to come.

To learn more about AHA, you can also view our 990 tax forms on GuideStar.com: AHA 990 Forms (free registration is required).

**To Join AHA Inc., please call us toll-free at 877-851-4592 to ask for a membership form, or visit the Membership Page to download an online application.**

Our Mailing Address is:
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   9919 Towne Road
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Hippotherapy As A Treatment Strategy

Hippotherapy is a physical, occupational, and speech-language therapy treatment strategy that utilizes equine movement as part of an integrated intervention program to achieve functional outcomes.

Equine movement provides multidimensional movement, which is variable, rhythmic and repetitive. The horse provides a dynamic base of support, making it an excellent tool for increasing trunk strength and control, balance, building overall postural strength and endurance, addressing weight bearing, and motor planning. Equine movement offers well-modulated sensory input to vestibular, proprioceptive, tactile and visual channels. During gait transitions, the patient must perform subtle adjustments in the trunk to maintain a stable position. When a patient is sitting forward astride the horse, the horse's walking gait imparts movement responses remarkably similar to normal human gait. The effects of equine movement on postural control, sensory systems, and motor planning can be used to facilitate coordination and timing, grading of responses, respiratory control, sensory integration skills and attentional skills. Equine movement can be used to
facilitate the neurophysiologic systems that support all of our functional daily living skills.

**Physical Therapists:** The physical therapist can overlay a variety of motor tasks on the horse's movement to address the motor needs of each patient and to promote functional outcomes in skill areas related to gross motor ability such as sitting, standing, and walking.

**Occupational Therapists:** The occupational therapist is able to combine the effects of the equine movement with other standard intervention strategies for working on fine motor control, sensory integration, feeding skills, attentional skills, and functional daily living skills in a progressively challenging manner.

**Speech-Language Pathologists:** The speech-language pathologist is able to use equine movement to facilitate the physiologic systems that support speech and language. When combined with other standard speech-language intervention strategies, the speech-language pathologist is able generate effective remediation of communication disorders and promote functional communication outcomes.

*Specially trained therapy professionals evaluate each potential patient on an individual basis to determine the appropriateness of including hippotherapy as a treatment strategy.*

*The therapy professional works closely with the horse professional to manipulate various aspects of the horse's movement, position, management style, equipment and types of activities to generate effective remediation protocols and to promote functional outcomes.*

**Why the Horse?**

The horse's walk provides sensory input through movement, which is variable, rhythmic, and repetitive. The resultant movement responses in the patient are similar to human movement patterns of the pelvis while walking. The variability of the horse's gait enables the therapist to grade the degree of sensory input to the patient, and then utilize this movement in combination with other treatment strategies to achieve desired results. Patients respond enthusiastically to this enjoyable experience in a natural setting.

**Glossary of Terms:**

**Therapeutic Riding:** is a term that has been used for many years to encompass the variety of equine activities in which people with disabilities participate. Though still commonly used, this 'umbrella' term has caused confusion among the medical...
community. When the therapist utilizes the movement of the horse as a treatment strategy to improve neuromuscular function, it is important to consistently use the correct terminology and refer to it as "hippotherapy".

**Hippotherapist:** The term 'hippotherapist' is sometimes seen in print but is a misnomer. **There really is no such thing.** People conducting hippotherapy sessions are physical, occupational or speech therapists. Hippotherapy is merely a treatment strategy used by these skilled practitioners to achieve functional outcomes.

**Hippotherapy:** Hippotherapy is a physical, occupational, or speech and language therapy treatment strategy that utilizes equine movement. Hippotherapy literally means “treatment with the help of the horse” from the Greek word, “hippos” meaning horse. Specially trained physical and occupational therapists use this treatment for clients with movement dysfunction. In Hippotherapy, the horse influences the client rather than the client controlling the horse. The client is positioned on the horse and actively responds to its movement. The therapist directs the movement of the horse; analyzes the client’s responses; and adjusts the treatment accordingly. This strategy is used as part of an integrated treatment program to achieve functional outcomes.

**Horse Handler:** The person in charge of the handling of the hippotherapy horse during the treatment session. This person should have extra training in handling horses specifically for hippotherapy.

An Introduction to Hippotherapy  
**Joann Benjamin, PT, HPCS**  
PT Advance - Summer 2000

With an ever-increasing number of people seeking treatment in community, non-clinical settings, it comes as no surprise that hippotherapy is as popular as it is effective. Many patients, parents and doctors are requesting hippotherapy as part of a rehabilitation program. Therapists who integrate hippotherapy have found increasing demand for their services. Across the country, more and more therapists are learning about hippotherapy, and are including it in their practice.

Hippotherapy literally means treatment with the help of a horse, from the Greek word hippos meaning horse. The American Hippotherapy Association (AHA) has defined hippotherapy as “a term that refers to the use of the movement of the horse as a strategy by Physical Therapists, Occupational Therapists, and Speech-Language Pathologists to address impairments, functional limitations, and disabilities in patients with neuromusculoskeletal dysfunction. This strategy is used as part of an integrated treatment program to achieve functional outcomes.” (AHA, 2000)

Current concepts of Hippotherapy have developed from earlier principles, developed in Germany and practiced widely throughout Europe since the 1960's. This model formed the basis of the first curriculum established for Hippotherapy in the U.S. in 1987.
The movement of the horse is the strategy that a therapist uses to improve a patient's neuromotor function. The patient may be positioned astride the horse facing forward or backward, sitting sideways, lying prone or supine. The patient interacts with, and actively responds to, the horse's movement. The therapist's responsibility is to continuously analyze the patient's responses and adjust accordingly the manner in which the horse is moving. For this reason the therapist must have sufficient understanding of the movement of the horse to direct the experienced horse handler/therapeutic riding instructor to alter the tempo and direction of the horse as indicated by the patient's responses.

Often, the primary focus of a PT treatment is the patient's postural and motor responses. Positive effects from the movement of the horse can be seen in motor coordination, muscle tone, postural alignment, stiffness/flexibility and strength. Other effects on body systems can and do occur as well. Changes are often seen in the respiratory, cognitive, sensory processing, balance, affective, arousal and speech/language production functions. These changes may be a consequence of the postural and motor changes. For instance, the patient's respiration and speech will improve as a result of improvements in trunk alignment and motor coordination. Many times, however, the system changes are a direct result of the horse's movement. The focus of PT may not be to achieve changes in speech production, but it can often occur. That is the beauty of using the horse's movement as a treatment strategy and also why the varied disciplines of PT, OT and Speech can use hippotherapy so successfully as a part of their treatment programs.

The therapist will use activities on the horse that are meaningful to the patient and will specifically address the particular functional goals of that patient. Goals are function oriented, and would not include specific skills associated with being on a horse, such as riding. The movement of the horse provides a foundation of improved neuromotor function and sensory processing that can be generalized to a wide variety of activities outside the treatment setting. In other words, the patient's adaptive responses to the horse's movement ultimately bring about improvements in function. Because the environment is a natural one, often the challenges associated with being in a non-clinical setting add additional opportunities to make the hippotherapy portion of treatment beneficial for the patient's community integration.

Hippotherapy is part of a complete treatment program. It can be used as a preparatory activity such as using the movement of the horse to facilitate increased arousal and postural tone for a patient who is hypotonic, prior to gait training. It can be used to mobilize the spine and pelvis to allow for participation in developmental positions on the floor. Hippotherapy can be used as a primary strategy, leading to improved function off of the horse. Just a few examples might be the achievement of midline orientation, reciprocal weight bearing through the pelvis as is needed for gait or unilateral reaching, or improved sequencing/motor planning when asked to do activities on the horse. The movement of the horse may be used as a follow up to other PT procedures done off of the horse, to reinforce the input from the therapist and improve generalizability of a task. The possibilities of using the strategy are endless, as the input from the movement of the horse is so strong, and provides such a variety of sensory-motor experiences.
The Therapist's Role in Hippotherapy

There are guidelines as to the qualifications, responsibilities and training requirements of therapists wishing to practice Hippotherapy that have been established by the American Hippotherapy Association and approved by the North American Riding for the Handicapped Association (NARHA). Keep in mind, the use of the horse's movement as a treatment strategy does not mean that a therapist is a 'hippotherapist' any more than a physical therapist using the principles of NDT is a neurodevelopmental therapist, or a PT using a pool is an aquatherapist.

Any therapist providing direct treatment services in a Hippotherapy program should meet the following qualifications:

- Is licensed or registered to practice PT, OT, or SLP
- Has received training in the principles of Hippotherapy, equine movement and equine psychology. One way that this can be achieved is through attendance at an AHA approved 3-4 day course “Introduction to Hippotherapy”.
- Is the equivalent of a NARHA registered instructor (minimum level) and, if not, has a NARHA registered instructor assisting with the horse at all treatment sessions, assuring that the horse is handled effectively, humanely and with utmost safety.
- Maintains current professional and general liability insurance.

Because hippotherapy is part of the integrated treatment plan, the initial evaluation, documentation, discharge criteria, and billing will all follow the structure consistent with the profession of the therapist who is using the movement of the horse as a treatment strategy. Long and short term goals are established which are functional, measurable and relevant to the patient's needs.

Therapists who have completed an introductory hippotherapy course and have basic hippotherapy experience can become registered with the AHA. Registration is required for a therapist who uses hippotherapy at a NARHA accredited program and indicates a basic level of knowledge of hippotherapy. Once a therapist has achieved extensive clinical experience using hippotherapy as part of their professional practice, they are eligible to take the Hippotherapy Clinical Specialist Examination administered by the Professional Testing Corporation (PTC). A therapist who passes this advanced exam is a Hippotherapy Clinical Specialist (HPCS). There are currently fewer than 50 clinical specialists in the US, though this number is growing.

Additional Roles for Therapists

Therapists have much to offer any therapeutic riding program and may become involved in roles other than in hippotherapy or direct patient service. These can include:

- Consultation
- Staff and volunteer training in body mechanics, physical and cognitive impairments, basic handling/transfer skills, precautions and contraindications
- Community education regarding benefits of the horse in rehabilitation
- Liaison with the medical community
- Recruitment of additional health care professional
- Referral of patients/clients
- Competitive rider classification at the National and International levels

By helping in this way, a therapist has an opportunity to observe the innumerable qualities of the horse. This can often be such an enlightening experience that the therapist will be motivated to gain the additional skills and training necessary to provide direct service.

Hippotherapy offers the therapist a unique opportunity. The input that the movement of the horse provides to the patient is natural, rhythmical, multi-dimensional, and rich in sensory input. The therapist can use the tool in many ways to create a neuromotor experience unequal to any other tool the therapist has. It is no wonder hippotherapy continues to be requested by therapists, doctors and patients - as a part of a treatment program that will help therapists help their patients achieve their goals.

The History of Hippotherapy and AHA Inc.

Before 1900

- 460-377 B.C. - Hippocrates in ancient Greece wrote a chapter on 'Natural Exercise' and mentions riding
- 1569 - Merkurialis of Italy wrote on “The Art of Gymnastics' mentioning the horse and riding
- 1780 - Tissot of France in his book 'Medical and Surgical Gymnastics' regarded riding at the walk as the most beneficial gait. He was also the first to describe the effects of too much riding as well as contraindications.

Since 1900

- In 1952 at the Helsinki Olympics, Liz Hartel won a silver medal in equestrian sports and told the world how riding had helped her recover from polio.
- In the 1960's therapeutic riding centers developed throughout Europe, Canada and the US.
- In the 1960's the horse began to be viewed as an adjunct to physical therapy in Germany, Switzerland, and Austria. This endeavor was called 'hippotherapy'.
In 1969 the North American Riding for the Handicapped Association (NARHA) was established in the United States.

In the 1970's physical therapists in the United States began to develop treatment uses for the movement of the horse.

In 1987 a group of 18 American and Canadian therapists went to Germany to study hippotherapy and began development of a standardized hippotherapy curriculum.

1988-1992 - Further development of standardized curricula on hippotherapy by the National hippotherapy curriculum Development Committee.


1993 - The American Hippotherapy Association was approved as the first Section of NARHA.

1994 - AHA Inc. established therapist registration and set standards of practice for hippotherapy. 1999 - American Hippotherapy Certification Board was established. The first Hippotherapy Clinical Specialists (HPCS) examination was

**Founding Members:** These nationally registered and/or state licensed physical or occupational therapists have been involved in the National Hippotherapy Curriculum Development Committee the entire time since its inception in 1987
- Elizabeth Baker
- Terri Barnes
- Jane Copeland Fitzpatrick
- Gertrude Freeman
- Barbara Glasow
- Pippa Hodge
- Carolyn Jagielski
- Linda Mitchell
- Molly Lingua
- Nancy McGibbon
- Claudia Morin
- Marcee Rosenzweig

**Present Use of Hippotherapy In The United States**

*AHA 2000* Hippotherapy is a term that refers to the use of the movement of the horse as a strategy by Physical Therapists, Occupational Therapists, and Speech-Language Pathologists to address impairments, functional limitations, and disabilities in patients with neuromusculoskeletal dysfunction. This strategy is used as part of an integrated treatment program to achieve functional outcomes.

Physical therapists, occupational therapists and speech-language pathologists have used the movement of the horse in therapy in the United States since the 1970's. Internationally, physical therapists have been using hippotherapy for over 30 years. Recent review has shown that hippotherapy is currently used in 24 countries. In order to provide a forum of education, communication and research among health professionals
using the movement of the horse in treatment, the American Hippotherapy Association (AHA) was formed in 1992. It became an official section of the North American Riding for the Handicapped Association (NARHA) in 1993. The AHA membership is composed primarily of physical therapists, occupational therapists, and speech-language pathologists interested in the use of the horse in treatment.

The American Hippotherapy Association created a conceptual framework for the use of equine movement as a treatment strategy. The conceptual framework is based on dynamic systems theory, integrated with principles of motor learning, sensory integration, and psycholinguistics. The framework was developed to (a) provide therapists with a theoretical basis for the use of equine movement in an integrated treatment program, (b) promote effective clinical problem-solving, and (c) aid the generation of hypotheses for scientific research.

Therapists who use equine movement as a treatment strategy are encouraged to pursue specialized training in this area. AHA has developed two approved 3-day courses: Introduction to Hippotherapy - Principles and Applications and Intermediate Hippotherapy - Clinical Problem Solving. Clinicians in the United States have offered a number of continuing education programs directly related to hippotherapy since 1984. The American Hippotherapy Association published Hippotherapy Standards for use in the NARHA accreditation process for operating centers where licensed health professionals use equine movement as part of a patient's treatment plan. Through the Standards committee, AHA sponsors therapist registration which acknowledges that a therapist has met specific education and practice requirements in hippotherapy. The American Hippotherapy Certification Board (AHCB), in collaboration with an independent testing organization, established a certification process to recognize a higher level of hippotherapy knowledge and experience. The first candidates for the Hippotherapy Clinical Specialist (HPCS) designation sat for the exam in 1999.

Hippotherapy is used as one part of a patient's integrated treatment plan. The treatment program is based on the therapist's evaluation and the functional goals of the patient. The therapist may choose the horse's movement as a strategy to be used in the treatment plan if hippotherapy is the most effective and efficient means for the patient to achieve positive functional outcomes. This decision is reflective of the therapist's own profession and theoretical model of treatment. The therapist may use the horse in a variety of ways depending on the needs of the patient. Equine movement is continually modified during a treatment session and over a period of time in response to patient changes. The therapist provides hippotherapy most often in a one-on-one treatment, but sometimes in small groups. Standard documentation reflects progress of treatment, and follows the guidelines of the therapists' profession. Current Procedural Terminology (CPT) codes used for billing are chosen based on how this strategy is used to address specific goals of treatment.

The use of hippotherapy is consistent with standard practice for Physical Therapy, Occupational Therapy and Speech-Language Pathology as the activity is experiential, functional and in a natural environment. The movement of the horse, as the tool, can be
compared to other therapy tools such as balls, scooters or swings. The variability of the horse's movement, the rhythm, dimensionality, regularity, and the ability of the therapist to modify these movement qualities, is where the horse, as a tool, supersedes the others.

Horses used for patient treatment must meet specific selection criteria regarding movement quality, temperament and training. Even when an ideal horse is used, the treatment quality and results are based on the specialized hippotherapy training of the therapist, their clinical experience and expertise, and how well they integrate the use of the horse into a comprehensive treatment program.

There is widespread acceptance of hippotherapy within the medical/professional and educational communities. The American Physical Therapy Association (APTA), American Occupational Therapy Association (AOTA) and the American Speech and Hearing Association (ASHA) recognize hippotherapy. There are a number of universities that request placement of their health professional students in affiliations that include hippotherapy. A number of school districts pay for school based therapy that includes hippotherapy in a treatment plan because it produces educationally relevant functional outcomes. Major third party payers throughout the country reimburse for treatment that includes the movement of the horse as a treatment strategy. Continuing Education Units (CEU's) are routinely granted for AHA approved and other courses taught by clinicians with recognized expertise in hippotherapy. Articles on the use of the horse in treatment are published in peer reviewed journals such as Physical Therapy, Physical and Occupational Therapy in Pediatrics, and Developmental Medicine and Child Neurology in addition to numerous articles in clinical publications. Presentations on hippotherapy are given at many Regional, National and International professional conferences.

Hippotherapy, the use of equine movement as a treatment strategy, has evolved over 30 years. Through education and clinical experience, therapists will continue to refine the use of hippotherapy in treatment. Using the movement of the horse as the strategy of choice has resulted in improved functional outcomes for a wide variety of patients. These positive results ensure that hippotherapy will continue to be used in treatment for many years to come.

**Horse Power: When Riding Turns Into Treatment**

_Hippotherapy has begun to attract attention from the medical community. One physician even owns a program._

_By Greg Borzo_

AMNews correspondent.

June 17, 2002

Whoever put up the old sign in a corner of the stable probably had no idea how it would apply so poignantly. "Time spent in the saddle is never wasted," it reads. And some say
this adage sums up hippotherapy -- including the program run by the physician-owned EquiTherapy Center from the back arena of an elegant stable in suburban Chicago.

But many of the patients with developmental disorders, neuromuscular disabilities or skeletal impairments who receive hippotherapy here don't need to look to the sign for motivation. They're already fired up.

More likely, it's the therapists, volunteers and staff who take the message to heart. They are part of a growing, national effort to show hippotherapy makes a difference, at least for some patients some times.

Despite facing initial and widespread skepticism, HPOT supporters are increasingly having success demonstrating its value.

"Awareness and acceptance are growing," says Norman White, MD, medical director at Presbyterian Health Plan in Albuquerque, N.M., which recently began reimbursing for HPOT on a case-by-case basis.

"It may appear to have a recreational flavor, but hippotherapy holds immense promise of therapeutic benefit for a variety of conditions, when used in concert with other therapies," says Stephen T. Glass, MD, child neurologist in Woodinville, Wash. He refers patients for hippotherapy so frequently that it's printed on his prescription pad.

**Why a horse?**

Hippotherapy uses the multidimensional movements of a horse to achieve specific therapeutic functional outcomes. Specially trained physical therapists, occupational therapists and speech-language pathologists use selected horses as mobile therapeutic treatment tools.

A horse's rhythmic, repetitive movements work to improve muscle tone, balance, posture, coordination, strength, flexibility and cognitive skills. The movements also generate responses in the patient that are similar to and essential for walking. In addition, adjusting to and accommodating for the horse's movements increases sensorimotor integration.

Therapists address various therapeutic goals by having patients ride in different positions: sitting or laying forwards, backwards or sideways; standing in the stirrups; and riding without holding. In addition, therapists have patients stretch, reach or play games -- such as catch -- while on the horse.

Used widely in Europe for more than 50 years, HPOT was introduced in the United States in the 1970s. Today the North American Riding for the Handicapped Assn. has accredited some 700 therapeutic riding centers. About 150 offer HPOT, according to the
American Hippotherapy Assn. -- a section of the riding association formed in 1992. AHA has registered almost 400 therapists to provide HPOT and certified about 35 hippotherapy clinical specialists.

The difference between therapeutic riding and HPOT is important. Therapeutic riding is supervised recreational riding for people with disabilities. HPOT, on the other hand, is a medical therapy provided under a physician's prescription. Patients who are successful with HPOT often progress to therapeutic riding.

In most cases, sessions are weekly and last 30 minutes. Horses must be gentle, patient and trained. The horses are often small to accommodate the most typical HPOT patients: children, even as young as 18 months.

Supporters maintain a horse can provide better results than conventional methods for some outcomes. "In some cases HPOT is the only way I can achieve certain treatment goals," says Joann Benjamin, a physical therapist certified in hippotherapy who is also secretary of AHA.

"We're not talking about pony rides," says Don Vichick, MD, an Albuquerque orthopedic surgeon. "Hippotherapy can be an effective component of a total therapy package."

Able-bodied people don't realize how hard it is on kids with disabilities and their families, says emergency physician Jeff Lee, MD, the owner of EquiTherapy in Morton Grove, Ill. "Their disabilities are forever, but hippotherapy can make a difference, medically and functionally."

Motivation plays a big part. Many children with disabilities have spent a lot of time hospitalized, sometimes tethered to machines, says Bethany Lee, executive director of the National Center for Equine Facilitated Therapy in Woodside, Calif., the nation's largest HPOT program. "Many of them come to dislike their therapist, at least in a traditional setting."

Put kids on a horse, though, and they light up, says Ellen In, a physical therapist at EquiTherapy. "Sometimes they don't even realize they're working, because just sitting on a horse is comparable to working on a ball. Riding a horse presents constant yet engaging balance and postural challenges."

HPOT gets results because kids love the experience, Lee says. "Some have a picture of their horse on the wall. For countless kids, their first word was not 'mama' but 'giddy up' or the name of their horse!"
Limited but mounting evidence

Still, HPOT faces a certain degree of skepticism, mainly because there continues to be a lack of hard research supporting such heart-warming sentiments. "The lack of evidence-based research is hindering further acceptance," Dr. White says.

AHA calls promoting research one of its main challenges. Still, a growing body of scientific study is building a case.

A 1998 study in Developmental Medicine & Child Neurology investigated the effects of an eight-week course of twice-weekly HPOT on five children with spastic cerebral palsy. After HPOT, all children showed a significant decrease in energy expenditure during walking and a significant increase in scores on walking, running and jumping of the gross motor function measure. In addition, a trend toward increased stride length and decreased cadence was observed.

"The strong results warrant further investigation," says lead author Nancy McGibbon, a therapist at Therapeutic Riding of Tucson, Ariz. "Unfortunately, physical therapists are not, by nature, researchers."

One reason HPOT is hard to study is that scientists have yet to devise ways to measure its impact objectively. The Institute for Human Performance, Rehabilitation and Biomedical Research at the State University of New York's Upstate Medical University has set out to rectify this, combining clinical and applied research spaces. Two case studies using computerized gait analysis have demonstrated that HPOT improves kinematic parameters of gait in children with CP.

"Given the growing interest in hippotherapy, we'll continue to broaden our search for objective results," says Suchita Kulkarni-Lambore, PhD, an assistant professor at SUNY Upstate and a physical therapist who co-authored the studies.

In a yet-to-be published study, Bill Benda, MD, associate research scientist at the University of Arizona in Tucson, investigated the effect of eight minutes of hippotherapy on 15 children with spastic CP. They measured truncal and upper leg muscle activity during sitting, standing and walking using remote surface electromyography. All subjects were randomized to HPOT or sitting astride a stationary barrel.

Muscle activity in microvolts was recorded from electrodes placed on bilateral thoracic, lumbar, abductor and adductor muscles. The difference between each pretest and posttest asymmetry was calculated and converted to a percentage score.

The mean change toward symmetry was 65% after eight minutes of HPOT and no change after eight minutes astride a barrel. "The difference was statistically significant," Dr. Benda says. "The next step is to replicate the study with a larger sample size, followed by a multicenter study of 12 weeks."
Reimbursement issues, questions

Because scientific findings are limited, HPOT reimbursement policies and practices vary considerably. Although AHA does not track third-party payment, it recently launched a survey to determine which payers have HPOT reimbursement policies and what those policies are.

Typical of those who cover HPOT is Harvard Pilgrim Health Care, which pays only when HPOT is part of a supervised physical or occupational therapy program provided by one of the plan's contracted vendors.

On the other hand, Aetna Inc. does not cover HPOT. Its policy: "There is insufficient scientific data in peer-reviewed medical literature to support the effectiveness of hippotherapy for the treatment of patients with CP or other motor dysfunction."

Meanwhile, many payers do not have a policy or pay for therapy without determining the type of treatment. And in rare situations, this ambiguity has led to difficulties. One Maryland therapist was asked to return $56,000 in reimbursement payments because the payer felt the use of HPOT had been concealed. The therapist filed a complaint with the state insurance commission, maintaining that she had coded her work appropriately. This action first led to a ruling in the therapist's favor, which was later reversed on appeal.

Still, many HPOT programs, including EquiTherapy, accept only out-of-pocket payments. Rates range from $70 to $150 per half-hour session.

Even though billing questions persist, there is considerable agreement that when HPOT is provided it should be done under a physician's order. There are many contraindications for HPOT, and only a physician can determine whether HPOT is safe and appropriate for a given patient.

"In many cases, physicians are not aware of hippotherapy until a patient's family brings it to their attention, but a physician should be the one to evaluate the patient and approve the therapy," McGibbon says.

When they first hear about HPOT, many physicians question the safety of putting a person with disabilities on a horse. Nevertheless, HPOT's safety record is outstanding, according to AHA. Often, the therapist rides with a patient the first few sessions. And sidewalkers on each side of the horse ensure the rider's safety.

"We've had plenty of riders fall or get hurt on the able-bodied side of this stable, but none on the therapy side," says Nicholas Coyne, EquiTherapy manager and owner of the center's 12 horses. Coyne carefully selects suitable horses. Some are former police horses that are "unflappable." Thanks to the number of horses, therapists are able to match patients with the most appropriate horse in terms of gait, pace, size and character.
The quality of horses as well as the training and skills of therapists are crucial. Some programs are not reputable and others are not medically qualified, Dr. Vichick warns. "Hippotherapy can be effective, but check out any program before you make a referral."

"If someone invented a pill that achieved the benefits of hippotherapy, you can be sure it would be prescribed and reimbursed," Dr. Benda says.

**ADDITIONAL INFORMATION:**

Conditions most often treated by hippotherapy:

- Cerebral palsy
- Multiple sclerosis
- Down syndrome
- Developmental delay
- Autism
- Stroke
- Traumatic brain injury
- Spinal cord injury
- Spina bifida
- Convulsive disorders
- Amputation
- Muscular dystrophy

**Riders taught him value of HPOT**

When Jeff Lee, MD, bought the Morton Grove Equestrian Stables in 1995, he didn't know anything about hippotherapy. Some of his riders did, however, and he soon became intrigued.

Dr. Lee, an emergency physician, joined the North American Riding for the Handicapped Assn., took HPOT courses and worked as a sidewalker for several months. Then, in 1997, he started the EquiTherapy Center, hiring Nicholas Coyne as manager in 1999. Two therapists now work there part-time, but Coyne wants to hire several more.

The program's 12 horses, together with the automobile traffic they generate, kick up a lot of dust -- which sometimes triggers efforts by local residents to try to curtail his activities. "They want us to become invisible," he says.

Instead, Dr. Lee plans to expand. This summer, he hopes to begin operating from a large new stable he built expressly for HPOT. It may even include an area for conventional therapy. Meanwhile, he plans to affiliate with a university to train students and conduct HPOT research.
Dr. Lee understands why many physicians are skeptical about HPOT, in part because of its unconventionality and in part because of stories of nefarious activity surrounding horses.

**Semantics - To Be Exuberant Or To Be Correct**

**By Barbara L. Glasow, PT**

An exuberant therapist recently thought . . . “I just learned about the most wonderful new treatment that I have ever been involved with since becoming a therapist. It's called hippotherapy!! The movement of the horse is almost magical with the results that can be achieved! I'm hooked! I'm going to stop using most of the other treatment approaches that I've used for 10 years and I going to become a hippotherapist and devote myself to learning everything I can about it. Then, I'm going to open a clinic devoted exclusively to the practice of hippotherapy and achieve amazing results. And then, we'll need to do research to prove to everyone that this modality is the best treatment around for any patient with movement dysfunction. Where was this treatment when I needed inspiration in my career a few years ago?”

Enthusiasm and exuberance is wonderful. The energy we derive from something that excites us can carry us through some pretty rough times of rapid change in health care, increasing documentation demands, decreasing health insurance coverage and increasing scrutiny by managed care. Those of us who include hippotherapy in our practice would tend to agree that it is a very valuable treatment strategy and assists us in achieving functional outcomes sometimes more efficiently than with other means.

However, in these same times of increasing managed care, decreasing coverage and increasing scrutiny it is of critical importance that all therapists accurately state clearly what they are providing patients within their treatment plans and neither under nor overstate what is being done or why. Many of us have made hippotherapy out to be more than it really is and the word itself has not been helpful to us in gaining the recognition and reimbursement that we want for it.

Hippotherapy, from the word “hippos”, the Greek word for horse, was created by the Germans who use all kinds of compounds words in their language. Hippotherapy is a very logical word for them to create. It means “treatment with the help of the horse.” Physical therapists there get trained and certified and can say they are “hippotherapists”, physical therapists that treat with the horse, in the same manner as they have “hippologists”, people who train horses. As Americans, we have chosen to retain the use of the word, “hippotherapy”, thinking that it would be internationally easier to communicate with other professional colleagues around the world. Presently, over 24 countries are doing some type of medical treatment with the use of the horse and most are calling it hippotherapy.
In the United States, however, the use of the word “hippotherapy” is a very confusing term to physicians, researchers and third party payers. To them, the word hippotherapy implies that it is a unique and distinctly different treatment approach from what has ever been done before. In their eyes, it needs to be proven through research that it is effective; improves functional outcomes; and is as good as or better than other treatments. Until then they view hippotherapy as a new, emerging and investigational technology and so therefore it does not qualify for reimbursement at the present time.

When we argue that hippotherapy is a treatment strategy and not a modality or distinct treatment method it is argued back that other treatment tools don't have the word “therapy” in it. An easy reply is that “Swiss therapy balls” are used in a wide variety of treatment procedures and are clearly treatment tools. But this does not make our lives any easier. Unfortunately, we have done such a good job of spreading the word about hippotherapy that we are probably stuck with the word for better or worse. So, all we can do is to take care in what we say about it.

We have all been guilty in misrepresenting what hippotherapy is or is not from NARHA to AHA to myself who wrote an article in 1984 “Hippotherapy - The Horse as a Therapeutic Modality”. Many clinicians casually use the terms “treatment tool” and “modality” interchangeably. As innocent as that is, the two terms mean very different things. Therapists use a wide variety of treatment tools (any instrument or device necessary to one's profession or occupation) including gymnastic balls, scooters, balance beams, weights within the different treatment procedures of neuromuscular reeducation, therapeutic exercise or therapeutic activities. We expect to be reimbursed for the treatment procedure we provide NOT the treatment tool that is used. Modalities (“Any physical agent applied to produce therapeutic changes to biologic tissue; includes but not limited to thermal, acoustic, light, mechanical, or electric energy.”) are very different from procedures and each require their own CPT code for reimbursement. Modalities must also be FDA approved and go through the investigational technology review of insurance carriers. It is very clear, when carefully thought about, that the horse is not a modality, yet how often have we referred to hippotherapy as such?

Many of us feel that we are able to achieve quicker and better functional outcomes with the use of the horse, and in the future, hopefully sufficient research will support this conclusion. In the meantime though, we need to be educating others that hippotherapy is an inclusive term that refers to all the ways the horse can be used as a treatment strategy. Hippotherapy is NOT one separate new treatment method. Instead, therapists use the horse in a variety of treatment approaches that been used in the therapy field for years, including the neurodevelopmental treatment approach, sensory integration, motor learning, motor control, psycholinguistics. The way the horse is used for each patient depends on the needs of the specific patient, the expertise of the therapist and the training of the horse.

When we refer to using the horse or equine movement as a treatment strategy within a therapeutic procedure it is then very appropriate to bill for units of service depending on how the strategy is used. APTA and AOTA have both agreed that use of the CPT codes
97110 (therapeutic exercise), 97112 (neuromuscular education), 97530 (therapeutic activities) or 97770 (sensory integrative activities) could all be appropriate codes depending on how the tool of the horse is used by a therapist within a treatment procedure. However, when therapists call the reimbursement department of APTA to inquire how the treatment approach of “hippotherapy” should be coded, APTA has been reluctantly but correctly recommending recently (since the Korokti administrative insurance hearing occurred) that therapists use the code 97799 (for unlisted therapeutic procedure) which then requires that additional documentation be submitted in order to be reviewed for reimbursement. In this case, the therapist has presented hippotherapy as a unique treatment and since it does not have its own code number, the unlisted procedure code should be used. If instead, the therapist inquires how to code a treatment session in which neuromuscular reeducation is used in order to improve the patient's postural control, balance and body awareness and the horse is used as a treatment tool to assist in that process, APTA would concur that use of the code 97112 for neuromuscular reeducation would be appropriate. I think you begin to see the importance of how we state what we are doing.

Many of us state that we have hippotherapy practices or that we are hippotherapists. We offer hippotherapy programs and we often market hippotherapy as a unique treatment approach to potential patients. We probably all have stated something to that effect in the past. This is great from a marketing perspective but has helped in creating the insurance backlash that we are currently facing. How might we state more clearly and correctly what we are doing?

When we are trained in hippotherapy we do not become hippotherapists but remain therapists (physical therapists, occupational therapists, speech-language pathologists) that include hippotherapy in their practice.

We offer physical therapy services (or OT, SLP) that include:

- hippotherapy
- hippotherapy as a treatment strategy
- the use of the horse in treatment
- the movement of the horse in treatment
- equine movement in treatment. Hippotherapy can be a strategy of choice used by therapists within their treatments. The new definition of hippotherapy very succinctly states what it is and what it is used for. The hippotherapy certification exam, if passed, allows therapists to state that they are a hippotherapy clinical specialist, (a clinician that includes hippotherapy in their practice and has a high level of knowledge in hippotherapy). When we obtain prescriptions for treatment the prescriptions state PT, OT, or SLP not hippotherapy since the prescription needs to state the service that is being requested. (It may state “... that includes hippotherapy.”)

When we use semantics correctly it sometimes seems that it takes a lot spontaneity out of life. Is it really that important to be politically correct all the time? That's a hard question.
Many of us speak more casually when explaining to a lay person what treatment they will be getting and what it will do for them in less technical terms. However, if we want to get reimbursed for the treatment we need to document what we do in much more technical and medical terms. It seems that we need to clearly make the same distinction in semantics when we speak about hippotherapy. It may require a little reflection on our part to become aware of what we are saying and in doing so we may become better educators of others in what hippotherapy is really all about.

**Summary of the Do's & Don't of Hippotherapy Semantics**

- Hippotherapy is a treatment strategy NOT a modality, unique treatment approach, form of therapy or treatment.
- Hippotherapy is NOT new. It's been used for over 20 years in the U.S. in treatment.
- Therapists are NOT hippotherapists nor do they practice hippotherapy or have a hippotherapy practice.
- Therapists DO include hippotherapy in their practice; use the horse as a treatment tool; use the horse in treatment; use the movement of the horse in treatment or use equine movement in treatment.
- Hippotherapy can be considered a “strategy of choice”
- Hippotherapy can be considered an inclusive term that refers to all the ways the horse can be used as a treatment strategy by PT's, OT's and SLP's.

When certified by the American Hippotherapy Certification Board the therapist is a hippotherapy clinical specialist.

A Walk Down Memory Lane

**Reminiscences of a Early Pioneer**

by Barbara L. Glasow, PT

To have the moniker of “grandmother of Hippotherapy” in the US makes a person feel a little old sometimes. For it was only a few years ago . . . . that I was just a college student working on a research report on “Therapeutic Riding.” Back then, in 1973, it was more than a little difficult to do a literature search on a topic that was in its infancy. Virginia Martin of Winslow Unlimited and Borderland Farm in Warwick, NY was one of my chief supporters in this endeavor. What solidified my career-long interest in TR and HPOT was being at the premiere viewing of the Winslow film “Exceptional Equestrians” that was shown at the 1973 NARHA meeting in Washington, DC It was the fact that the film focused on how riding horses could be therapeutic as well as fun that hooked me.
After graduating from Ithaca College in PT, one of my many serendipitous decisions was to live in Warwick, NY and offer my PT services to Winslow as a consultant to the TR program. In those days TR was mostly about finding ways to adapt horseback riding for people with disabilities and trying to make it safe. However, it was not always therapeutic for the most physically involved riders. Within a few years, I had helped Winslow radically change their approach to TR by taking away saddles and reins, using surcingles and pads and using a more developmental approach with a focus on developing balance, symmetry, alignment and postural control in the rider and using progressive movement variations of the horse to challenge the rider before shifting focus back to developing riding skills. This turned into the beginnings of the specialization of TR with the foundations of developmental vaulting, remedial vaulting and HPOT, but without those names.

Virginia Martin was not one to hide anyone's light under a barrel. She felt we should share this new approach with everyone. By 1978 I was thrust into the “national” limelight and started to teach in one of many seminars offered by Winslow. Anyone attending my early seminars will tell you there were plenty of rough edges. One participant later told me she had counted 150 “ums” during the 3 day course. Nowadays, people tend to have more trouble getting me to be quiet.

By the early 1980's, I was doing courses in the Eastern US and Canada, having an impact on the quality of programs in the region. By 1982 I had the opportunity to accompany the US NASCP Equestrian Team as the PT with Jan Spink as one of the coaches, to the 5th International CP Games in Greve, Denmark with riding as a demonstration sport. By then, I also knew that the Germans were doing some interesting things with the medical application of the horse, something called “hippotherapy.” The trip to Europe gave me the excuse to stay eight weeks longer after the competition with Jan Spink to visit a variety of German HPOT programs. We ended up at the 4th International Congress on TR in Hamburg, Germany.

How enlightening! The Germans were doing the same thing on the other side of the ocean that I had been doing for the past 6 or 7 years without me knowing it! I must say the German horses might have had a little better quality of movement and training than I had been used to. The long lining was something I definitely wanted to learn. But they used the same progressions of movement (plus a few fancy ones like leg yield, side pass, and shoulder-in). However, I thought the American version, despite our horses, had a few pluses beyond the German approach. I was using more alternative positions than the Germans and had integrated principles of Sensory Integration which made it more available to a wider population of clients. I figured I could take the best of both worlds and end up with a better product.

The 4th International Congress on TR was probably the 1st congress that the Germans ever took any notice of the Americans. Beth Stanford, PT, was one of my early proteges and had started an excellent therapy program for clients with head trauma in Malvern, PA. She had enough gumption to present to this prestigious group. Well, there are head phones to listen to the simultaneous translations, which is a challenge in and of itself.
Beth started her presentation with great slides of her adult head trauma clients being backridden backwards on this wonderful, one-of-a-kind horse. (Don't try to do this in your program!) Within a few minutes the Germans were scrambling for head phones to hear her presentation with a number of questions posed at the end. Thanks to Beth, our American reputation was forever changed in a positive way. Realizing the importance of international exchange, Jan Spink and I composed a “Report on the United States” that was presented with the other country papers. The bonding was established. International relations progressed a bit further.

In 1984, NARHA sponsored Dr. Ingrid Strauss, a neurologist from Germany and a leader in HPOT, to give a 2 day course on HPOT in Amherst, MA. In November 1984, I taught my first 3 day clinical course on HPOT with the content and format that was the precursor to the present day AHA Introduction to HPOT course. The interest grew and a number of past and present AHA Board members took my early HPOT courses including Linda Mitchell, Liz Baker, Claudia Morin, and Marcee Rosenzweig.

By 1986, it was evident that more therapists were needed to be able to teach the basics of HPOT to make an impact and long term difference in the field. Enter Jean Tebay, the “mother of HPOT.” Jean was a great supporter of HPOT and had always been a visionary in TR. We were together at the 1986 NARHA annual awards banquet in Las Vegas when Jean decided to change history. Jean has many talents and is a great organizer. She pulled Jane Copeland (Fitzpatrick), PT, then prominent in the Delta Society, over to the table to confer on the idea that we needed to train a core group of PT's and OT's in the fundamentals of HPOT. We needed to keep the group together to develop a standardized curriculum that could be taught all across the country. Since the Germans already had a standardized curriculum in place for their PT's, it made the most sense to ask them to create a course designed for Americans. On that night, Jean made the commitment to organize a trip to Wildbad, Germany, and Jane and I made the commitment to be part of the adventure.

Within the year, with no money and no sponsoring organization other than Jean's non-profit Therapeutic Riding Services, Inc., Jean had made arrangements with the Kuratorium fur Therapeutische Reiten to custom tailor a composite 10 day course that combined elements of their two part course. The trio picked a cross section of 17 PT's and OT's from dozens who had applied; got Angela Dusenbury, PT, to be our wonderful translator; and, hired with grant money, Loretta Rowley, PhD, to be the Curriculum Development Specialist.

The infamous group from the US and Canada were:

Ellen Adolphson, PT
Liz Baker, PT
Teresa Barnes, PT
Jane Copeland Fitzpatrick, PT
Barbara Engel, OT
Barbara Glasow, PT
Jill Hansen-Byrne, OT
Judy Hillburn, OT
Pippa Hodge, PT
Carolyn Jagielski, PT
Neesa Johnson, OT
Molly Lingua-Mundy, PT
Nancy McGibbon, PT
Linda Mitchell, PT
Claudia Morin, OT
Christine Terry, PT
Colleen Zanin, OT

After the trip, Gertrude Freeman, PT, Teddy Parkinson, PT, Marcee Rosenzweig, PT and Jean Waldron, PT also played early and important roles in the group.

Further interest in HPOT was fueled in the US in June 1987, with a 6 day course taught by Frau Ursula Stamm, PT, from the Wildbad Clinic in Germany, at the National Center for Equine Facilitated Therapy in Woodside, CA, which I was fortunate enough to attend. Then, the momentous day arrived and “the group” flew from various parts of the country, and met, some for the first time, in Wildbad, for the American HPOT course of October 1987.

After long days of lessons, riding, and practicums presented by the Germans . . . the real work started. That's when Jean Tebay and Loretta Rawley got to lead us through the DACUM (Developing a Curriculum) process. DACUM is a formal group process of curriculum development that uses workers involved in the field; identifies the duties and tasks that are used in the field; and from that, develops objectives for each task and determines the education and training needed to achieve the objectives. There we were, sitting in a classroom, tired and brain dead, being cajoled to come up with the duties and tasks of a therapist doing HPOT, writing our brilliant ideas on pieces of paper taped up all around the room. Other than our fearless leaders, we had no idea where this was going to lead.

The trip to Wildbad over, the commitment to the project continued as the National Hippotherapy Curriculum Development Committee. In the next 2 years, 4 major meetings were held in Tucson, Toronto, San Francisco, and Warwick. By November 1989, pilot test copies of 3 core curricula were presented to the Delta Society (the sponsoring organization for grants) at its annual meeting in Parsippany, NJ. The curricula developed became the basis for the present AHA courses.

From 1990 to 1992, the group began to change and evolve and its purpose shifted. An average of 2 major meetings per year continued to be held in various parts of the country. The focus shifted to fleshing out the curricula and developing audiovisuals and materials to go with each course.
Participants in the courses being taught were responding positively. More and more people attending the courses were asking for more than just the course information. They wanted networking; information on topics outside of the courses; an intermediate level course; and assistance with research ideas.

It became obvious that a more formal and permanent organization needed to be formed. The field of TR was in transition. Many of the people that were more connected with health professions and academia had been attracted to the Delta Society and its tract for TR. Delta had been supportive of our group and welcomed the possibility of a more formal affiliation with us. NARHA was struggling over a variety of issues including the direction the organization should take. There were a number of elements within the NARHA membership that were pulling the organization in several directions.

Our group had many long and serious talks about what to do. We discussed becoming a separate organization, affiliating with the Delta Society; becoming a section of the APTA, AOTA or ASHA; developing a section under NARHA; or becoming a separate, non-profit, independent organization. None of us wanted the headaches of fund raising, or the responsibility of maintaining non-profit status. Section status within APTA or AOTA could develop into several separate professional organizations, potentially splintering the group. Questions arose concerning how we could maintain consistency among several groups; how we could foster quality across disciplines; how we could encourage teaming or transdisciplinary treatments. We kept coming back to either Delta Society or NARHA, which had the ability to house all the disciplines within one organization. Delta Society had the professionalism and the setting of standards that we wanted to foster. Though, TR was only one small aspect of it's focus. NARHA, on the other hand, was the organization that most people looked to as the national organization for TR. It housed all the various people and groups that HPOT included. And, there was a part of NARHA that was very supportive of our group and liked the direction we were taking.

By 1991, the group had developed a Mission statement, Philosophy statement and Vision and had worked on an in depth strategic plan and analysis of options. The analysis included: trends and events impacting HPOT; needs of people interested in HPOT; needs of the HPOT group as an organization; strengths and weaknesses of the group and strengths and weaknesses of Delta and NARHA. Based on this analysis, we decided to approach NARHA with the idea of developing a professional section with separate bylaws, finances and Board of Directors. The idea of a section had been researched based on the structures of APTA, AOTA, the NDTA and SII (Sensory Integration International). A meeting was held on July 21,1991 with NARHA with encouragement to have the proposal formally presented to the NARHA Board. It was a momentous meeting that I was pleased to be a part of.

On February 28, 1992, the national HPOT Curriculum Development Committee formally met in Sarasota, FL with myself as the Chair. At that meeting the Mission Statement, Vision and philosophy were formally approved. Jane Copeland (Fitzpatrick) made the motion to “form an organization that promotes professional growth among physical and
occupational therapists and others interested in utilizing the horse in a treatment approach based on principles of HPOT and to have the first meeting of the organization.” The motion was adopted unanimously. An additional motion made by Nancy McGibbon was that “this organization proceed as an independent organization pending the approval of Section status by the NARHA Board of Directors.” Founding member status was established as “those nationally registered and/or state licensed physical or occupational therapists who have been involved in the National HPOT Curriculum Development Committee the entire time since its inception in 1987.”

Founding members are:

Elizabeth Baker, PT
Terri Barnes, PT
Jane Copeland (Fitzpatrick), PT
Gertrude Freeman, PT
Barbara Glasow, PT
Pippa Hodge, PT
Carolyn Jagielski, PT
Linda Mitchell, PT
Molly Lingua-Mundy, PT
Nancy McGibbon, PT
Claudia Morin, OT
Marcee Rosenzweig, PT

The first meeting of the Board of Directors of the American Hippotherapy Association (AHA) was held the very next day. By the end of the meeting, Nancy McGibbon was elected as the first President, the bylaws were passed, and committee structures and goals were established. I got the role of continuing officially in the capacity of Secretary. The financial structure would be managed through support of a pass through fund working in liaison with Mary Nastan, PT and her therapeutic riding program, Suncoast Therapeutic Equestrian Program in Florida.

In the following months, a letter inviting AHA Charter membership was sent out with an invitation to get involved on the ground floor. On November 11, 1992, the first annual meeting of the membership of the AHA was held at Tyson's Corner, VA at the same time that the NARHA annual conference was held. During the NARHA annual conference, NARHA member signatures were gathered to support a petition for Section status within NARHA. At the January 30, 1993 NARHA Board of Directors meeting, a unanimous vote was cast to accept the proposal of AHA to become the first special interest Section of NARHA. It was a landmark occasion, soon to be followed by the acceptance of additional sections within NARHA. The AHA is forever grateful to former NARHA President, Marion May, for helping it to occur.

So where are we now? I stayed on the AHA Board until 1997 and then rotated off due to health and family issues. However, in this day of e-mail it seems I have almost as many AHA projects on my plate as in the past. Now, in its 7th year as a Section, AHA is operating under its 4th President. Out of the present 15 on the Board, only 3 are original Founding Members which is where we hoped we would be by now. It gives me great
pleasure to see a vision come into being and have it be as much or more than the original vision. We have achieved many of the original goals and many are in process. There are 3 established curricula that are in constant change when needed. There is a registration process, and now, a well thought out certification process. We developed competencies and then standards. HPOT is now part of the NARHA accreditation process. There is still more to do but it feels good that I no longer need to worry about whether HPOT will die out if I am no longer active in the field. It has been a long road and the road still extends far into the future with research to be done and efficacy studies to be completed. At times I feel like the “grandmother of hippotherapy” but also as a proud one, with many children and grandchildren that any grandmother would be proud of to call part of the family.

In Memorium: Barb Glasow, PT, HPCS

It is with great sadness that we pass along the news that Barb Glasow, PT, HPCS passed away on May 23, 2009, after a long battle with breast cancer. For those of us that saw Barb at the AHA conference earlier this month, it is hard to believe that she is no longer with us. Barb’s intelligence, wit and foresight, her strength of character and toughness were an inspiration to friends and colleagues.

In an email Pat Sayler, Barb’s partner of 23 years, wrote: “I cannot tell you how much the visit to the Conference meant to Barb; she was on such an upswing, planning her article, excited that people still appreciated her thoughts and insights. She truly missed being involved. She was thrilled to see so many new faces in the membership, knowing that as things evolve the work of AHA and hippotherapy will continue. It was a great 2 weeks for us both and, I, too, am so glad that we made the effort to come.”

Barb will be missed by all whose lives she has touched.

Obituary for Barbara L. Glasow, PT  May 23, 2009

Barbara L. Glasow, 55, passed away on Saturday morning, May 23rd in Pocono Medical Center after a long battle with breast cancer. Born in Rochester, NY she was the daughter of Robert and the late Muriel Glasow.

Barbara was Senior Class Valedictorian at Cardinal Mooney High School in Rochester, NY and graduated Summa Cum Laude in Physical Therapy from Ithaca College, NY.

After graduating college, she lived in Warwick, NY, where she began her private practice. A gifted pediatric physical therapist, she worked with Winslow Therapeutic Riding, LTD and initiated a developmental approach in the use of the movement of the horse to create functional changes in individuals with disabilities. In 1978 she began teaching seminars, and in 1982 traveled to Denmark as the PT with the US NASCP Equestrian Team to compete in the 5th International CP Games. Called the “grandmother of Hippotherapy” by her colleagues, Barbara was instrumental in fostering the creation of the American Hippotherapy Association (AHA) and the furtherance of the use of the horse in treatment by physical, occupational and speech therapists. She was the recipient
of the NARHA James Brady Professional Achievement Award and the perpetual Barbara Glasow Award for AHA Therapist of the Year.

Barbara was the PT and a former Board Member for Equi-librium, Inc. Equine Assisted Services. She was a member of Zion United Church of Christ in Stroudsburg, the American Physical Therapy Association, NARHA, and AHA.

She is survived by her partner of 23 years, Patricia J. Sayler, of Effort, PA, her father, Robert A. Glasow, her brother Timothy Glasow and his wife Maryann, her sister Andrea Glasow, her nephew, Jason Glasow and fiance Stephanie Ewert.

A Celebration of Barbara’s life will be held at 2:30pm on Sunday, June 14 at Zion United Church of Christ, 14 North 8th Street, Stroudsburg, PA with fellowship to follow after the service.

In remembrance of Barbara, memorial donations may be made to Equi-librium, Inc., P.O. Box 305, Sciota, PA 18354, Zion United Church of Christ, 14 North 8th Street, Stroudsburg, PA 18360 or American Hippotherapy Association, Inc. 9919 Towne Road Carmel, Indiana 46032. Condolences may be made online at www.poconorecord.com.
"Hippotherapy has improved Victoria's balance. After hippotherapy her muscles are more relaxed. The hippotherapy has given her much more confidence. Victoria was afraid of animals when she started and now loves horses as well as interacting with other animals. She enjoys the entire experience at NCEFT; the riding, the other activities, caring for and brushing the horses, the stables, etc… Hippotherapy has also helped Victoria's concentration and attention. This means more confidence and joy. What is different and so impressive about hippotherapy is its uniqueness. Our daughter does not show pictures of her other therapies or laugh and talk about them. Hippotherapy gives our daughter a unique experience to be proud of. It is the most important and beneficial therapy of the week. Victoria cannot do what her peers can in almost any way. With hippotherapy now she can do something that none of her peers ever think about trying. It is something she can be very proud of and others marvel at. Right now, Victoria's proudest possession is the little trophy presented to her by NCEFT for a job well done!"

Estevan

“The world outside one's own home can be a cruel reminder that the disabled continue to have a hard time fitting in. Hippotherapy is more effective than traditional therapies because horses have a unique ability to motivate children to try new things. The therapy team is also instrumental in tailoring the program to meet a child's particular needs. Fear is a looming threat -- Fear of exclusion; fear of disappointment, fear of failure; fear of pain; fear of risk taking and fear of the unknown. Hippotherapy provides a safe, supportive environment in which Estevan and us (his parents) can let go of some of our fears. Hippotherapy gives Estevan 'Joie de Vivre', Joy of living. Estevan is, in a word, Joyful.”

Patrick

"My child is 4 years old and has been receiving various forms of therapy since he was 8 months. We have been doing hippotherapy for roughly 2 years. It is always impossible to pinpoint which therapy is doing what when you have multiple, simultaneous therapies, but my gut has always been that the hippotherapy is the most effective. All you need to do is see my son on the horse and recognize the balance and strengthening skills that are being challenged to come to this conclusion."
"We travel over an hour for this service and this is a testament to how effective we think this is. In addition, the setting, interaction with beautiful, strong animals and incredible staff and volunteers make it an amazing experience."

**Stefan**

"We were referred for hippotherapy by an occupational therapist in our childhood development service program. Hippotherapy has helped Stefan develop his balance and coordination, build his self-confidence, learn an appreciation of horses and the outdoors. This setting seems to relax him like no other therapy is able to. He knows the drive to the center and can't wait to hop on the horse once he arrives.

"We have seen different results due to hippotherapy than through other traditional therapies. Besides Stefan's new joy of horses, animals (ducks and cats) and the calm outdoor setting, he has improved his attentiveness, his willingness to follow directions and his interaction with other children and adults. The therapists are obviously well trained and selected as I've never seen an angry child or a child so frustrated that he was made to ride a horse or asked to do something that he didn't want to do. Stefan is very comfortable with this staff and is confident that they are always looking out for his best interest so that he may be rehabilitated to his full potential. As parents, we are glad to see a staff so dedicated to the children and adults receiving therapy. They truly love their jobs.

"Hippotherapy has helped our family to learn that the alternative therapies that are available do work and are enjoyable for Stefan. We've seen many families that come together at events at our center and are able to bond with them and discuss the milestones that are children have achieved and hope to achieve."

- Jim, father of Stefan

END