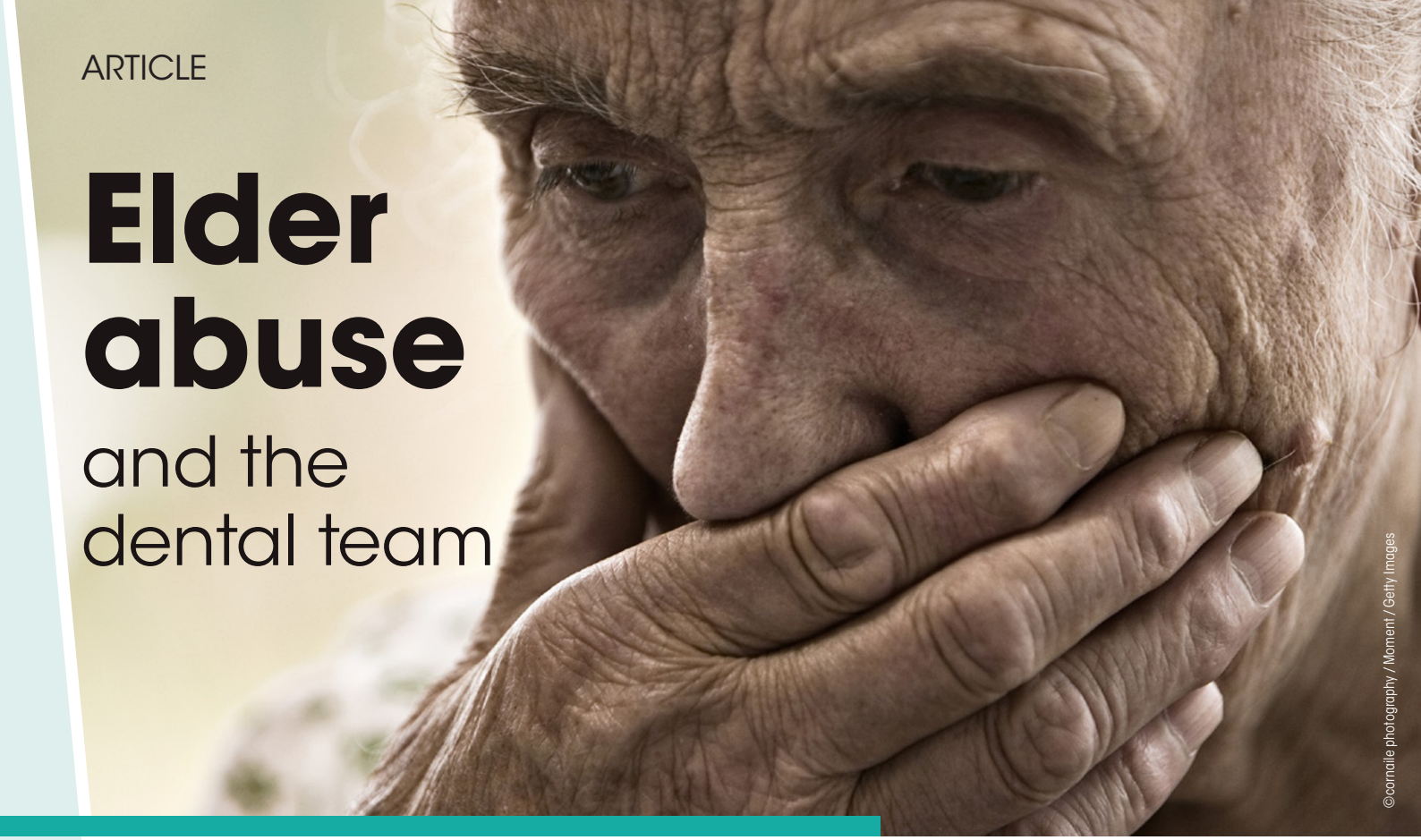
Elder abuse and the dental team



By Paul Hellyer[1]

The population of the United Kingdom is ageing. More people are living for longer. Many of those older people want to retain their natural teeth and will continue to be regular attenders at the dentist. However, Age UK estimates that one in 20 older people are abused by a family member or carer. As health care professionals, the dental team have a responsibility to identify the signs of elder abuse and report them as appropriate. This article explains some of the causes and signs of abuse and the dental team's responsibilities to act.

INTRODUCTION

More of our patients are living for longer. The UK Office of National Statistics states that men reaching retirement age have a life expectancy of about an additional 18 years. For women life expectancy is a little longer. Of these post retirement years, however, about 40% of them can be expected to be spent in declining health.[1] This increasing frailty towards the end of life usually leads to dependency on others for assistance with the activities of daily living. This might be anything from some help with cleaning and shopping to more personal tasks such as washing and dressing. Increasing frailty may eventually lead to a person needing help with feeding and toileting.

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Any person, child or adult is at risk of abuse. However, dependency on others, for whatever reason, be it as a child or an adult dependent on others for everyday living, increases that risk.

The abuse of older people has become an increasing problem in recent years.[2] The dental team, from receptionist to clinicians, are in a particularly strong position to able to identify cases of elder abuse. People tend to come to the dentist at regular intervals and changes in behaviour may be observed. These may also be people who have infrequent contact with other care services.

How many?

A national UK study which was published in 2007[3] reported that 2.6% of people over 66 and living in the community (that is, not in care homes or rest homes) had experienced some form of mistreatment during the year of study. That equates to 227,000 people over 66 years experiencing some form of abuse, about the same number as the population of, for instance, Newcastle-upon-Tyne.

However, Age UK estimates that in 2015 the number of those subject to abuse has risen to 342,000. If residents of care homes are taken into consideration then 500,000 older people are abused each year – approximately 5% of the older population in the UK.[4] That means one in 20 of our older patients can be anticipated to have suffered some form of abuse.

Many older people are also now keeping their teeth for longer, and are often expecting to keep them till the end of life. Consequently it is expected that older people will become an increasing part of the dental professional's workload in the decades to come. It therefore becomes increasingly likely that some of these patients will be being abused.

What is elder abuse?

Elder abuse is defined as: 'A single or repeated act or lack of appropriate action, occurring in any relationship where there is an expectation of trust that causes harm or distress to an older person.'*

This definition was proposed by the charity Action on Elder Abuse in 1993 and has subsequently been adopted by the World Health Organisation.

It is important to note that abuse is carried out 'in any relationship where there is an expectation of trust'. The abuser may be the patient's carer,

whether through a formal arrangement with statutory services or an informal carer such as a neighbour 'who just pops in now and again to check'. The abuser may also be a family member, such as a spouse, partner, sibling, son, daughter or even grandchild. The abuser may therefore be the person who brings an older, dependent patient to the practice.

Why abuse someone you care for?

Many carers, whether family, friend or professional, find looking after an older person to be a deeply satisfying and gratifying experience. However, sometimes these relationships become strained and difficult. If that relationship descends into an abusive one, then whatever the reason, elder abuse, just like child abuse, is always unacceptable and must be investigated.

The causes of elder abuse are often multi-factorial. For instance:

- Financial difficulties – if the caring responsibilities are time consuming, leading to the carer being able to work less hours and thus reduce the family income
- Lack of respite care – the perception that there is no hope of a break from the continuity of providing care
- Inadequate support to give high quality care – the carer may be managing alone, with no support from family members or statutory services
- Heavy physical or emotional costs of being a carer – seeing a loved one decline physically or mentally and have no power to arrest the process
- Lack of recognition for the role of carers takes a heavy toll on the health and well-being of the carer
- Personal stress - the carer may be looking after two generations, his or her own children and a dependent parent. This 'sandwich' effect can create extreme stress
- Unfamiliarity with the caring role and its responsibilities – many people simply fall into the role of carer, as there is no one else available, and until maybe too late, they are unaware of what it entails.

A family history of abuse, whether as a child or an adult, increases the risk of abusive behaviour, as does drug or alcohol dependency.[5]

What form does it take?

Elder abuse can take many forms. In general, changes in personality or behavior may be signs of abuse, although, of course, other causes must also be considered.

- Physical – any non-accidental use of force, such as hitting or punching the victim or any form of restraint or confinement is considered to be abuse. The signs visible to the dental team may be unexplained bruising on the face, arms or legs, broken spectacles or even broken bones
- Financial – any form of misappropriation of funds from an older person is abuse. This can include misuse of bank accounts, forging of signatures or stealing state benefits intended for the older person. The signs may be a change in the patient's ability to pay for dental treatment. A patient who for instance has always been happy to pay for treatment becomes unwilling to do so, or apparently no longer has access to their own cheque book, credit or debit cards
- Sexual – this includes not only sexual assault in any form, but forcing the older person to undress or to watch sex acts. This may be an unlikely abuse to become apparent in a dental practice, but a change in behaviour, for instance a previously amenable patient who suddenly dislikes being touched in any way or who develops a gag reflex, may be a significant sign
- Emotional – any form of verbal abuse, including shouting and intimidation, bullying or threatening behaviour is abuse. However, this may occur in more subtle forms such as humiliation or isolation of the victim, or continually making them the scapegoat. This may become apparent in a dental practice if the victim is brought for an appointment by a caregiver who appears controlling or threatening towards the victim
- Neglect – failure to provide adequate care is the cause of more than half reported cases of abuse. Signs may include dirty or soiled clothing on a previously well-groomed patient. Malnutrition and dehydration may have oral signs and symptoms of relevance to oral health. A sharp decline on oral hygiene in an increasingly dependent patient may be a sign of inadvertent neglect, due to ignorance of the need to provide mouth care for the patient
- Institutional – if the routines of a care home, for instance, override the care needs of a resident, this would be considered abuse.

A carer for a patient brought in from such a home claiming that there was regularly insufficient time for mouth care of patients, might be a case for further enquiry at the home.

Some organisations consider that discrimination on the grounds of age can be considered to be abuse.

The dental team's responsibilities

The Care Act (2014) lays down specific responsibilities on health care professionals to act on suspected abuse and report it as appropriate. The local authority has specific responsibilities for investigating suspected abuse and while the pathway will differ from local authority to local authority, and be different within the individual nations of the United Kingdom, it is incumbent on dental practices to be aware of the pathway of referral for their area. Safeguarding procedures are applicable to any adult who:

- Has care and support needs
- Is experiencing, or is at risk of, abuse or neglect
- Is unable to protect themselves because of their care and support needs.

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Each practice should have in place a policy for safeguarding adults, including vulnerable older people and all staff should be aware of their responsibilities in reporting such issues to the appointed person within the practice.[6]

The General Dental Council (GDC) has recently added the safeguarding of vulnerable adults to its guidance for recommended continuing professional development (CPD) topics for registrants (Table 1).[7]

The Care Quality Commission (CQC) lays down clear responsibilities for service providers with regard to safeguarding.

All providers must make sure that they have, and implement, robust procedures and processes that make sure that people are protected. Safeguarding must have the right level of scrutiny and oversight, with overall responsibility held at board level or equivalent.[8]

The CQC goes on to stress the importance

Table 1 Standards for the dental team

The GDC's *Standards for the dental team* states:
8.5.1 'You must raise any concerns you may have about the possible abuse or neglect of children or vulnerable adults. You must know who to contact for further advice and how to refer concerns to an appropriate authority such as your local social services department.'
8.5.2 'You must find out about local procedures for the protection of children and vulnerable adults. You must follow these procedures if you suspect that a child or vulnerable adult might be at risk because of abuse or neglect.'

of staff training, understanding procedures for reporting and working with other agencies. They state that 'Staff must be aware of their individual responsibilities to prevent, identify and report abuse when providing care and treatment. This includes referral to other providers.'

Clearly the whole dental team has a role to play in observing changes in patient behaviour which *might* indicate an abusive relationship is present. From the receptionist noting the relationship between patient and carers, to hygienists observing deterioration in oral health, to a dental nurse noting unexplained bruising – everyone should be aware that one in 20 of our older patients appears to be at risk of abuse and everyone needs to know the signs and understand how to raise a concern.

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CASE STUDY

An 85-year-old patient whom you have seen regularly for the past ten years attends for his six-monthly hygienist appointment.

You know that he has a complete upper denture which he manages well, and a partial lower denture replacing his lower incisors. His remaining lower teeth (46, 45, 44, 43, 33, 34, 35) are all grade 1-2 mobile but have been symptomless for many years.

The patient is co-operative and allows a full examination of his mouth. However, he keeps repeating that all his lower teeth should be removed as he is frightened of swallowing them and 'doesn't want to be a bother to anyone anymore'. His oral hygiene deteriorated since his last visit. Extra-orally, he has a bruise on his cheek on the left side.

The patient still lives at home, and has carers who now come in daily to assist with his personal care but none of them attends with him. He was dropped off by his son who does not stay for the appointment. When he collects the patient you try to speak to him. However, he is in a rush and tells the receptionist he does not have time to speak to you.

The importance of observing changes in a regular patient cannot be overstressed. None of the presenting issues individually necessarily raise alarm bells. The bruise on the cheek may be as a result of a fall or walking into a cupboard door. The request to remove all his teeth may be an early sign of confusion. The son may indeed be busy. The deterioration in oral hygiene may be a result of increasingly arthritic fingers.

However, all these issues may require further questioning. Opening a discussion about the bruise on the cheek may give a sense of the patient's mental state and short term memory. Showing the patient how his oral hygiene had deteriorated and explaining the consequences may again give the clinician a sense of the patient's mental capacity. Asking why he doesn't want to be a bother to anyone may elicit an idea of the state of the relationships with his carers and family. Seeking the receptionist's view of how the patient had appeared to relate to the son when he was dropped off and collected would be helpful. All discussions and observations should be carefully recorded.

Assuming that the patient can explain the bruising, or doesn't reveal information that his family are making it clear they cannot cope with him (in which an immediate referral to the Local Authority would be appropriate), then a further appointment could be arranged, requesting that a family member or carer attends with the patient. A discussion with the patient's dentist and the practice safeguarding lead is indicated. If the patient consents, a phone call to the family may be indicated, expressing your concerns about his oral health.

At the follow up appointment, a better assessment of relationships can hopefully be made. If no one attends with him again and there appears to be little change or further deterioration in his condition, then sharing your concerns again with the dentist is essential. With consent, a discussion with the patient's medical practitioner would be helpful and a referral to the local adult safeguarding team may be appropriate. However, if a family member or carer attends with him, and genuinely appreciates the concern being shown, then again, clearly noting the conversations, dental care can proceed in co-operation with his home carers and an appropriate review date set.

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**Action on Elder Abuse* works to protect, and prevent the abuse of, vulnerable older adults and by doing so also protects other adults at risk of abuse. They were the first charity to address these problems and are the only charity in the UK and in Ireland working exclusively on the issue today.

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