Open Access

OBM Geriatrics

LIDSEN Publishing Inc.

Original Research

Opioid-Involved Elder Abuse in the United States: Perspectives from Adult Protective Services

Karen A. Roberto [1,*], Pamela B. Teaster [1], Imogen Fua [1,2]

1. Virginia Tech, USA; E-Mails: kroberto@vt.edu; pteaster@vt.edu; ifua@wrma.com
2. WRMA, Inc., a TriMetrix Company, USA

* **Correspondence:** Karen A. Roberto; E-Mail: kroberto@vt.edu

Academic Editor: Pietro Gareri

Special Issue: Elder Abuse: Global Situation, Risk Factors, and Prevention Strategies

OBM Geriatrics
2025, volume 9, issue 1
doi:10.21926/obm.geriatr.2501294

Received: August 23, 2024
Accepted: December 26, 2024
Published: January 09, 2025

Abstract

The purpose of this descriptive study was to understand the nature, extent, and challenges confronted by APS programs in the United States in providing services to older clients affected by opioids. The study design involved a two-step process: Phase I involved telephone interviews with state-level Adult Protective Services administrators from 11 states considered to be "hot-bed states" for the opioid epidemic. Findings from the administrator interviews informed questions for Phase II telephone interviews with individual and small groups of local APS workers from the same states. Key findings that emerged from the interviews indicated that when opioids were involved in cases of elder abuse, allegations most often concerned self-neglect, followed by caretaker neglect and facility drug diversion. Perpetrators of opioid-involved abuse were mostly family members followed by facility staff; and cases involving opioids were perceived as harder to substantiate due to the difficulty of proving if and how medication was missing and the denial of the older victim if the perpetrator was a family member. The inability of older adults to manage medications prescribed to them was the most common explanation of how they became victims of opioid abuse. Improvements to intervention for cases involving opioids include giving APS the ability to perform background checks, more frequent use of electronic medical boxes for appropriate and timely dispensing

© 2025 by the author. This is an open access article distributed under the conditions of the Creative Commons by Attribution License, which permits unrestricted use, distribution, and reproduction in any medium or format, provided the original work is correctly cited.

of medications, holding perpetrators accountable to timeframes, and policies to facilitate greater access and trust of APS. In addition, working with community partners was a critical component to maximally helping older adults involved with opioid misuse. APS field staff stressed that available resources were inadequate for the complexities involved in working cases involving opioids and older adults, highlighting needs for greater financial assistance, enhanced and targeted training, specialists in addiction, and resources for homeless people.

Keywords
Opioids; older adults; perpetrators; elder abuse; adult protective services

1. Introduction

Opioids are a significant contributor to the addiction and overdose crisis in the United States (U.S.). In 2022, an average of 224 Americans died each day from opioid misuse, resulting in over 82,000 fatalities [1]. This figure represents a tenfold increase in opioid-involved deaths compared to the number recorded in 1999 [1]. Initially driven by prescription opioids and heroin, the source of the opioid epidemic shifted with the rise of illicitly manufactured synthetic opioids (e.g., fentanyl, tramadol) [2, 3] and changes in opioid prescribing patterns [4]. While nearly every state has been measurably affected by the opioid crisis, the highest deaths rates from natural and synthetic opioids are primarily concentrated in the eastern portion of the U.S. [5], with rural communities disproportionately affected compared to urban communities [6]. Seven out of 10 opioid overdose deaths occur among males, and nearly three-fourths of opioid-related deaths occur among individuals ages 25 to 54 [7].

1.1 Older Adults' Use of Opioids

An important but frequently forgotten demographic in the opioid epidemic is older adults. As a group, older adults experience multiple chronic conditions and high rates of chronic pain [8]. Frequently, opioids and related prescription and non-prescription drugs are the treatment of choice for these older adults and in their "golden years," can lead to a life of addiction fraught with emotional distress, diminished relationships, criminal activity, and often, death [8].

Although the number of older adults who use opioids varies by data source, researchers conclude that older adults use opioids at high rates. For example, one-third of Medicare Part D beneficiaries, or 14.4 million people, had at least one opioid prescription in 2016, with over 500,000 beneficiaries using very high amounts (i.e., average morphine equivalent dose (MED) of greater than 120 mg a day for at least three months of the medication [9]. The most prescribed opioid for beneficiaries was oxycodone. One in five beneficiaries who received a high number of opioids had at least one 30 mg prescription for oxycodone. In addition, nearly 70,000 beneficiaries who receive extreme amounts of opioids (i.e., average daily MED greater than 240 mg for 12 months) were at serious risk of opioid misuse or overdose [9].

The Centers for Disease Control and Prevention's analysis of data from the National Health and Nutrition Examination Survey (2007–2012) found that the rate of opioid analgesic use in the past 30 days was 7.9% for persons aged 60 and over compared to 4.7 percent for persons aged 20–39 [10].

The same study found that women aged 60 and over were more likely to use opioids than their male peers (8.6 percent vs. 6.9 percent). Less than 50% of older adults prescribed opioids reported that health providers counsel them about addiction, risk of overdose, and how to safely dispose of excess medication. About one-fourth of long-term opioid users are aged 65 and older, with 2.2% of older adults reporting non-medical use of prescription opioids during the past 12 months [11].

1.2 Opioid-Involved Elder Abuse

A hidden pathway by which the opioid epidemic has infiltrated the lives of older adults is through the addiction of their children, grandchildren, and others who rely on them for money, childcare, food, shelter, and the like, as well as paid service providers and facility employees upon whom the older adults rely for care. Incidence reports of substance abuse and misuse among perpetrators of elder abuse are higher than in the general population (21–56% vs. 11%, respectively) [12]. Substance abuse is most often associated with financial exploitation, physical abuse, and emotional abuse, compared to other types of abuse [13]. Thus, because of opioid misuse by individuals they most trust, older adults may be stripped of their resources and experience a diminished quality of life.

While empirical evidence is limited, experts believe that incidences of elder abuse rose as the opioid epidemic worsened [14]. Focus groups with 20 professionals from Kentucky, Ohio, Virginia, and West Virginia with working knowledge of elder abuse highlighted participants' shared perspectives on opioid misuse and elder abuse [15]. Like elder abuse and substance abuse in general, elder abuse associated with opioid misuse was initially viewed as a family matter, health care professionals were among the perpetrators of opioid-involved elder abuse, and some older victims of abuse also misused/abused opioids. A mixed-methods multi-year study of elder abuse investigations in Maine revealed that opioid-involved cases ranged between 2.5-2.9% of all elder abuse cases [16]. About one-half of the opioid-involved investigations included allegations of exploitation in which the alleged perpetrators were accused of stealing the older adults' opioid prescription as well as their money or property to purchase drugs. An in-depth analysis of 25 cases of opioid-involved elder abuse in Kentucky revealed that cases frequently involved community dwelling older women as victims of abuse and non-spousal family members as perpetrators [17]. Despite multiple types of abuse allegations (e.g., exploitation, neglect, and physical abuse), exploitation was the single allegation substantiated across all cases of opioid-involved elder abuse. To our knowledge, these three studies are the first data-based investigations of the opioid epidemic as a catalyst for elder abuse in the U.S.

The purpose of the current study was to explore the nature, extent, and challenges of opioid-involved elder abuse cases referred specifically to adult protective services (APS) programs. In the U.S, APS is a social services program provided by state and local governments serving older adults and adults with disabilities who need assistance because of abuse, neglect, self-neglect, or financial exploitation. In all states, APS is charged with receiving and responding to reports of adult maltreatment and working closely with clients and a wide variety of allied professionals to maximize client safety and independence [18]. APS is increasingly confronting issues of elder maltreatment where opioids are involved, including older adults who were exploited for their prescribed opioids and older adults who became unwitting participants in opioid transactions. Recognizing the gravity and scope of this problem, the Administration for Community Living awarded grants involving state APS and partner organizations to address the impact of the opioid crisis on elder abuse [19].

2. Methods

The study design involved a two-phase process for identifying challenges, successes, and issues of concern of APS when investigating and intervening in cases of opioid-involved elder abuse. Data were collected via open-ended telephone interviews between April and June 2021.

2.1 Study Participants

Phase I involved telephone interviews with state-level APS administrators from 11 states considered to be "hot-bed states" for the opioid epidemic in the U.S. at the time of the interviews [20]. By region, the 38 administrator-participants were from one state in the Northeast, two states in the West, five states in the Midwest, and five states in the South.

The second source of data was obtained from telephone interviews capturing the experience and expertise of APS staff from the local level. APS administrators from Phase I identified field staff in their respective states who would be willing, helpful, and able to answer questions concerning their experiences with opioid-involved elder abuse cases. An important aspect of the local interviews was the candor of the participants and recognition that the field staff were the real experts because of their experiences in a variety of elder abuse cases involved to the opioid epidemic. Twenty-two field staff participated in individual and small group telephone interviews.

2.2 Interview Questions

We began our inquiry with the APS administrators to obtain a broad overview of the problem and to discuss any policies and procedures for addressing opioid-involved cases. Based on the research literature and the study team's knowledge about and experience working with the APS, we followed standard procedures to develop a set of open-ended interview questions [21] for the Phase I interviews. Questions focused primarily on the scope and characteristics of APS caseloads involving opioid abuse and policies and procedures they had in-place for investigating and intervening in elder abuse cases that involved opioids (See supplement material).

Using the findings from the Phase I interviews, the interview questions were adapted for Phase II of the project, which involved interviews with local APS field staff (e.g., supervisors, caseworkers). These interviews provided an "on-the-ground" view of challenges, concerns, and strategies that worked well (or not) to address the needs of APS clients (see supplemental material). Where appropriate, both administrators and field staff were asked to reflect on how COVID-19 contributed to the opioid-involved cases and influenced how APS managed them [22].

2.3 Data Analysis

Data analysis for both sets of interviews occurred in three stages. The first stage took place during the interviews when the co-facilitators decided which responses to probe further (e.g., case examples) and which to redirect (e.g., general commentary). Next, after each session, the facilitators shared their observations of the information gleaned and how the experiences participants shared compared with previous interviews. At the completion of each interview, the audio-recorded session was transcribed verbatim. Finally, the transcribed sessions were reviewed, with particular attention given to commonalities among the states' challenges and the ways in which they managed and intervened in opioid-involved cases of elder abuse. De-identified

participant quotes were used to demonstrate how the findings arose from the data and to illuminate the APS experience in responding to opioid-involved elder abuse.

2.4 Ethical Statement

This study was approved by the Virginia Tech Institutional Review Board (20-028).

3. Results

Except for information about policies and procedures, which was ascertained from the administrators only, similar interview questions were asked of both the state administrators and local field staff. Findings from both sets of interviews were categorized and are presented collectively. We stated when a response only came from participants from the state or local level.

3.1 Policies and Procedures Involving Older Adults and Opioids

None of the states had a policy specific to older adults and opioids. If any policy existed at all, it was generic for substance abuse and concerned routing cases to mental and behavioral health programs. As one state administrator explained:

If there is substance abuse only, then those get routed to mental health. That's what our policy states. Now, if there's substance abuse and something else that we would do, we would work those cases. And they're joint investigations a lot of times.

Several states had safety protocols in place when drugs, such as opioids, were involved because investigating these cases can be quite dangerous. Reaching out to law enforcement to accompany APS investigators was a standard operating procedure for most states in these cases.

One of our newer procedures involves a safety assessment that is required during the first face-to-face visit with the client. And there are a number of defined factors, affecting safety — things like, is someone preventing access to the individuals for us to have a one-on-one conversation and things like that.

Other state administrators discussed reaching out to medical professionals, particularly if the report concerned self-neglect.

If we were working with the alleged victim and it was a self-neglect type situation, we're going to coordinate with medical providers and offer substance abuse services as appropriate.

3.2 Number of Opioid Cases

At the outset of each interview, the research team asked about the number of opioid cases that each state had during a year’s time and if the number was trending upward, downward, or staying the same. Typically, administrators were unable to provide data-driven responses because information specifically about opioids is not recorded. Most administrators thought the number of reports involving opioids were trending upward mainly because field staff were becoming aware and looking more closely at warning signs such as missing pills or the client’s odd behavior. One state suggested that legislation limiting the supply of opioids that can be prescribed by doctors had lowered their opioid-involved cases. Similarly, because of the lack of opioid-specific data, field staff

could only estimate the number of investigations per worker in a year, which varied from a low of one to a high of over 20.

Two states were the recipients of a federal grant from the Administration for Community Living related to opioids and noted that, in the future, they would have more empirical information to provide because they were adjusting data collection systems to track reports, investigations, and case outcomes involving opioids. One state was adding opioids into their data collection system after seeing a rise in cases in the last few years.

3.3 Types of Allegations/Reports

When opioids were involved, allegations most often concerned self-neglect, followed by caretaker neglect and facility drug diversion. Field staff stressed that allegations that came into APS offices involving opioids and older adults concerned self-neglect. These self-neglect cases commonly were about an older adult unable to attend to self-care due to either misusing pain medication or because a family member was taking the medications for their own use or selling them. In these cases, the older adult could be over/under medicating, often with neighbors making a report.

> *I've had one [case] where it was a landlord who noticed the client misusing medication. It's primarily on that end. It never comes from a provider, it's mostly either a community member or law enforcement, if they had a driving while under the influence or something like that.*

APS also received reports of caretaker neglect. Several field staff indicated that such cases were frequently hospice cases involving patients receiving strong narcotics for pain.

> *We saw a lot of those going missing, we got a lot of calls in from some of our hospice providers who were also seeing those medications being taken, probably at times being used, other times being sold. I think a lot of those fell into some caretaker neglect cases as well.*

In addition, upon investigation, some caretaker neglect allegations turned out to be self-neglect.

> *There might be a caretaker involved, who's trying, sometimes desperately, to help somebody and help the situation get better, but that person won't listen. And that person is taking their medication, they won't let the caretaker help them with the medications, they won't let that caretaker manage those things, and they think they can still do it themselves, and they think they know the best type of thing, and they just won't allow the supports and won't allow the help.*

Cases of paid staff perpetrators were the least frequently reported but occurred in long-term care facilities when staff took and/or stole a resident’s medication. The facility staff member would say they were giving the residents their medications, but they stole them and either took them themselves or sold them elsewhere. As one field staff explained, “It's tricky, because it becomes the “he said, she said” [problem] and having to actually try and figure out where the medication is going [is difficult].”

3.4 Perpetrators in Opioid-Involved Cases

As with most types of elder abuse, perpetrators were mostly family members, but at times facility staff were involved. One field staff member said that they had been working in protective services

for 11 years and “90% of the time, if there's any allegation of theft or abuse or medical neglect, it's almost always a family member or a friend, especially with regard to opioids.”

Field staff often discussed how paid care worker perpetrators were often unknown repeat offenders.

> *There was one perpetrator who was assigned as an in-home caregiver, and I saw their name come up a couple of times with different people. It's like he was assigned, but because in [place], they don't really do APS background checks when people get hired. Sometimes, I see them a lot, but employers don't know. . . A couple of times, it was at facilities, they would just hop around from one skilled nursing facility to an assisted living facility. Again, because the background checks aren't done through [APS], they don't check with APS, even if it [the abuse] was substantiated, they can get hired at another place.*

3.5 Challenges of Investigating Reports

One major challenge of investigating cases involving opioids was that the alleged perpetrator would also be present in the home when APS field staff attempted to interview the older adult. Other challenges included addressing the level of pain of the older victim and getting physicians to order lab work or having delays in lab work that would confirm the presence or absence of opioids in the bloodstream.

> *If we have a victim who we either feel like is being overmedicated, under medicated, or themselves are misusing the medication, getting the physicians to work with us to get them in for an appointment and do lab work, trying to see what the levels are to be able to have even the evidence to say if it's occurring or not [is a struggle]. And then the second part to that would be on the perpetrators who maybe are stealing the medication and misusing it is that you're very unlikely to get them to go take a drug test. And they may then be prescribed the medication. There again, you're going to need levels to be able to get that.*

The COVID-19 pandemic made it even more difficult for most field staff to investigate opioid-involved cases. Most field staff already thought that opioid investigations were far more difficult to work because they needed to see the client. In addition, COVID-19 conditions eased some requirements to fill or refill prescriptions, older adults feared allowing someone in their home due to risk of infection, and clients were reticent to go to healthcare settings.

> *[COVID] made it harder because we weren't doing home visits unless it was an emergency situation. . .They can say on the phone, "Oh, yeah. I've got all my prescriptions, and all my pain pills are here." Whereas if we go to the home and I ask to see the bottle of pain pills, I can look at the date it was filled and I can see, "Oh, it was only filled three days ago, but half of the pills are gone." Over the phone, because of COVID, I don't have any way to verify that other than what the client tells me.*

3.6 Challenges of Substantiating Cases

Most APS field staff thought opioid-involved cases were harder to substantiate due to the difficulty of proving if and how medication is missing and the denial of the victim if the perpetrator is a family member. Nearly every interview session included mention of an older adult’s reluctance

to admit that a family member was taking their medications, abusing them, neglecting them, exploiting them, or all of these.

> *If Grandma's got a grandson that is taking them [her medications] and Grandson's going, "Oh, Grandma. I have to have these pain medicine to survive, but I don't have insurance, so I'm going to take yours." Well, Grandma's not going to tell me, "Yeah. Well, my grandson little Jimmy's doing it." She just says, "Well, my pills are missing, but I don't know where."*

Conversely, another field worker described how the use of surveillance cameras was helpful in substantiating cases in facilities.

> *I've had a couple where they were able to substantiate because they had video footage of the nurse or the staff popping out the bubble packs. Those were super easy to substantiate because I had video evidence of them taking the pills. . . I could send that over to law enforcement, and they could do their end.*

Often, older adults did not want APS to intervene. A competent older adult can refuse services as their right to exercise self-determination. This situation was highly frustrating to APS field staff, something mentioned frequently during the interviews.

> *What I've learned over the years is that grandparents, they would turn in their own child before they're going to turn in their grandchild. We see a lot of cycling. When the adult has capacity to make their own decisions, they're going to put their life in danger for the grandchild that's using the opioid.*

> *There's nothing more difficult than…seeing the writing on the wall and walking out of that house knowing that there's nothing I can do. There's nothing the judge is going to do. There is nothing that anybody is going to be able to do, and here we are 30 days later, 90 days later, with the same call.*

Alternatively, if the client lacked capacity, various remedies could be put into place such as a court order to remove the perpetrator or the older adult from the home setting to increase safety and reduce pain.

3.7 Long-Term Impacts of Opioid-Involved Abuse

APS field staff were asked to describe long-term impacts that opioid misuse had on their clients. These included the inability to have their pain managed adequately, homelessness, poverty, and, in more than one case, a hastened death.

> *The long-term effect that I've seen with some of my elderly clients is these particular clients have been prescribed opioids for a long period of time, and then, when they were no longer able to receive those, they didn't have the means to cope with pain; they became so dependent on it. And even when they were sent to the pain clinic, I would hear right away, it 'doesn't help, it doesn't help' or whatever new med that they were being prescribed, it just wasn't enough to control their pain.*

> *Homelessness is a big one [consequence], and poor family support because they burnt all their bridges a lot of times. No income on many occasions, and sometimes they end up in long-term care facilities, and they don't ever come out. But homelessness and housing are big issues.*

I've seen death, quite honestly. I've seen that three times. I see the correlation of an early death just because of the fact that the family member and sometimes [perpetrators are] grandchildren, which hits the older adult even harder when it's their grandchild.

3.8 Prevention

Frequently suggested mechanisms for prevention were formal and informal supports and services, particularly in medication management. The inability of the older adult to manage medications prescribed to them was the most common explanation of how older adults became victims of opioid abuse. Administrators and field staff both agreed that more education on opioid addiction was an important mechanism for preventing opioid abuse.

Education, I think would be key in helping people to understand what options they have and to reach out to stop something bad from happening if they know it's happening.

3.9 Intervention

APS field staff suggested ways that they might better intervene in cases involving older people and opioids. Woven through their suggestions was the important recognition that such cases were highly unique. Suggestions included giving APS the ability to perform background checks and more frequent use of an electronic medication box for controlling and appropriately timing the dispensing of medications, which helps manage dispensing of pills and holds perpetrators accountable to timeframes. For example, one field worker described the value of older adults having an electronic medication box.

In the case of theft of opioids, our most frequent intervention then is to offer an electronic med box, and not just any kind of electronic med box. We want the med box that is pretty sophisticated, so it's going to have a number of slots with an alarm that goes off and a door that opens. It's only going to dispense that morning's set of pills or that evening's set of pills, so there's no way to get into the box and take additional doses.

One field staff from a rural area also mentioned relaxed dress policies to facilitate access and trust, thereby enhancing their ability to investigate cases.

I've noticed since they've changed our dress policy to where we can wear jeans every day, the public, in general, instead of seeing us in our khakis and such like that, they're more at ease with us. They think, because like I said I'm in a rural area like my co-worker is. And so, they just think I'm one of these good old boys, because I'll tell them, "Hey, I've lived around here my whole life. I'm just like you. I'm here to help you." And that seems to really help.

3.10 Working with Community Partners

Working with community partners was a critical component to maximally helping older adults involved with opioid misuse. Most field staff had extremely positive relationships with law enforcement officers. One field staff member noted,

I'm very, very fortunate to have that really good relationship with law enforcement. During the pandemic, law enforcement became my eyes and ears many, many times. And I can't give enough credit to the deputies of the [Name] County Sheriff's Department and the officers of

the [Name] Police Department for the number of times they've made well-being checks for me just because I suspected something and couldn't get what I thought was a satisfactory answer over the phone.

Physicians also were actively trying to help APS assist the older person misusing drugs; APS worked with them to make changes to the prescribed medications. In addition, pain management clinics often helped in managing medication. However, some field staff recognized that working with physicians was a double-edged sword. Some physicians had over-prescribed medications for older adults, and, as a result, the older adults had become addicted to them.

Many of the field staff talked about working with other professionals, including home health care professionals, outpatient clinic staff, pharmacists, community paramedics, and church pastors who had frequent interactions with older adults, which was deemed critical. The following illustrates the importance of working with these community partners.

In one situation that we had here, it was the social worker that contacted the pharmacy, and the pharmacist said, "We need to look deeper into this, because I've never seen this prescribed outside of a hospital setting." And when that happened, we knew that we had an issue. At that point, there was something going on.

In addition to working with the professionals they mentioned, APS field staff stressed the worth of establishing or continuing nontraditional multidisciplinary teams.

One of those partners would be our community paramedics team that we have here, and they actually see a lot of those self-neglect cases... But being able to pull all those partners to have the table together and talk about how things are looking throughout the county and connecting those pieces is a crucial part.

In my county, there's now a [Name] Opioid Crisis Task Force that I'm a member of, and we've been working the last year. . .We've put several different things in place into our community which has helped some, but it's like the other gentlemen [study participants] have said, it's not a solution to the entire problem, but it is helping with some resources.

3.11 Acute Need for Resources

Field staff emphasized that addiction affects every type of person in every situation — a number stressed that the problem was worse in rural areas. They stressed that available resources were inadequate for the complexities involved in working cases involving opioids and older adults. Highlighted were needs for greater financial assistance, enhanced and targeted training, specialists in addiction, and resources for homeless people. The need for resources mentioned often and especially acute were for mental health services, transportation to medical providers to help with problems stemming from pain, and greater staffing for healthcare providers.

We don't have enough resources for mental health care, for opioid abuse care, or any other type of drug or alcohol abuse. and without the support structure, without the resources to address the need many times results in poverty that is enhanced by lack of appropriate nutrition, appropriate medical care that just kind of becomes a snowball effect that one problem becomes another problem becomes another problem, and becomes another problem.

And our frustration . . . is we're often put in a position as the solution finder, and we have no solution, and it's frustrating.

Before the pandemic hit, what we were seeing at least in our area, is a shortage of home healthcare workers. . . We have seniors in their home who need the help coming in, but there's a shortage of home healthcare workers. Now, when COVID hit, oh my gosh, there's not a shortage . . .. It's non-existent.

4. Study Limitations

Study limitations include that the APS programs participating in the interviews, both state-level and field staff, were selected from states cited in the 2019 CDC-published report on high rates of opioid deaths and were invited in the spring of 2021. Their participation was entirely voluntary and may not reflect the views of APS programs in states unable to participate.

5. Discussion

5.1 Types of Cases

Although the research team anticipated that most reports of elder abuse involving opioids would be cases in which a younger perpetrator (e.g., adult child or grandchild) was stealing drugs from an older adult and then sequestering them in their own homes, as was the case of a study in Maine [16], interviews revealed that most reports involving opioids concerned self-neglect. Often, self-neglect resulted when older adults were misusing their prescribed opioid medication; they become addicted to the drugs and were often overdosing. APS field staff stressed that it was challenging to intervene in these cases — frequently, older adults failed to understand that they were addicted. Also, if the self-neglecting older adult addicted to opioids had the capacity to make decisions and refused APS intervention, APS, by law, was unable to intervene. Field staff found these cases discouraging and frustrating.

More often than not, the case workers encountered a caseload revolving door that continued to spin around with allegations, investigations, substantiations, and refusal of services by older adults. Only when the older adult lost capacity could APS lawfully intervene to both stop the cycle of neglect [18] and help the older adults reduce dependency on opioids [8]. Self-neglect also was reported when older adults were misusing pain medication. In other reports of self-neglect by an older adult, a family member was misusing and/or selling the drugs as well as using the money of the older adult. When the money and the drugs were gone, the older adults were out of resources and left with inadequate food, clothing, and shelter.

A smaller number of allegations involved caretaker neglect. In these cases, family members (e.g., adult children, grandchildren) responsible for providing care for older adults were stealing the older adults' medication to support their own addiction and/or sell the drugs to others. Tragically, hospice patients seemed especially vulnerable to this type of opioid-involved abuse because of the strong narcotics prescribed to help ease rising levels of pain at the end of life.

Mentioned less frequently was drug diversion by healthcare staff. This type of opioid abuse involving older adults may occur with the least frequency or may be a consequence of the fact that, in many states, APS does not have the authority to investigate cases of abuse in facilities.

5.2 Challenges for APS

A challenge APS faced was delay in receiving results from necessary lab work that confirmed levels of drugs in victims' systems. Another was that perpetrators were highly unlikely to confess that they were taking an older person's drugs or agree to a blood test. Also, perpetrators often remained in the home of the victim, which thwarted the investigation. Consequently, many cases went unsubstantiated. Similarly, when opioid cases involved healthcare staff, it was difficult to trace the misuse to the employee or employees who were misusing. An infusion of opioid-involved training and resources would increase the ability of APS to intervene appropriately and speedily.

In addition to the right of capacitated older adults to exercise self-determination and refuse services was the reticence by the older adult to implicate a family member. Many older victims chose to suffer the misuse (in many instances, pain) to shield a family member from prosecution and/or imprisonment. As with most abuse where family members are perpetrators, older adults willingly protected their family members, not wanting to lose them as a caregiver (no matter how poor the care), not wanting to confront their own guilt that a family member was harming them, and not wanting to leave their home to live with others or in a facility [23, 24].

Cases involving opioids also involved the misuse of other substances, making the entire investigation more difficult to disentangle. Concurrent with misuse of prescription opioids was misuse of alcohol [25]. In addition, around the start of the COVID pandemic, use of synthetic opioids, like fentanyl and methamphetamine, began to grow [26]. All too frequently, investigations revealed the presence of not one, but several drugs and abuses occurring at the same time.

Any contemporary study would be incomplete without addressing the impact of COVID-19. Most APS programs experienced a decline in overall reports because there were fewer eyes and ears that might suspect abuse in a population advised to self-isolate because of their propensity to succumb to the effects of the virus [27]. To protect APS field staff and clients, for a period of time, most programs stopped entirely or significantly reduced face-to-face investigations, an important hallmark of the program. In addition to affecting the number of reports received, COVID-19 frustrated APS casework by making it more difficult to see the client's environment (e.g., investigations conducted virtually allowed the perpetrator to remain in the home). Prescription refills that might have received greater scrutiny were more leniently dispensed. In addition, fewer clients visited medical professionals due to real fears of contracting the virus and impediments in making appointments because of lengthy protocols required for conducting visits. The same situation affected the already scarce availability of social services and mental health resources (some shuttered entirely), including the number of staff for home health care and acute and long-term care. In some cases, victims had no caretaker or place to go if their only caretaker would be substantiated as their perpetrator.

5.3 Practice Implications

For older adults and for vulnerable younger adults, APS serves as a central lifeline in preventing and intervening in abuse, neglect, and exploitation that is associated with the problems of opioids and related drugs. It is clear from APS administrators and workers we interviewed that current training and resources are highly inadequate to address a problem that, in certain areas of the country, contributes to unsafe conditions for APS and the clients they serve in addition to client homelessness, chronic pain and suffering, neglect of care, and untimely death.

Prevention of and intervention into cases involving opioids go together. Field staff stressed that opioid-involved cases involving older adults were highly individualized and would be poorly resolved using a cookie cutter approach. In many cases, the misuse of opioids had been ongoing for an extended period. Many people with addictions were functioning, albeit at a baseline level, and were competent to live their lives in the manner they chose. On a macro level, field staff recognized that the presence of a stronger family and friend network would prevent many cases of opioid misuse and associated self-neglect. They also thought that overall public knowledge of the problem would intensify prevention efforts. Specific suggestions for intervention included the ability of APS to perform background checks for caregivers and the increased use of electronic medicine boxes, as well as a greater variety of resources from which to draw. It was apparent that current mental health resources were ineffective and in extremely short supply, especially in rural areas. More effective and coordinated monitoring by APS, law enforcement, and pharmacies would help obstruct perpetrators' illicit access to opioids, as would government legislation controlling their distribution [28].

Particularly where opioid misuse and older adults are concerned, it is vitally important to enhance APS collaboration with community partners and build stronger relationships with medical professionals, law enforcement, first responders, pharmacists, home health providers, mental health counselors, and faith communities. Working with these professionals through multidisciplinary teams continues to be a viable approach for improving communication and cooperation.

It became clear that for every state and local community, there were simply not enough resources to assist older adults who had become enmeshed in the opioid epidemic. More financial resources need to be dedicated to hiring addiction specialists to assist with such complex cases. In addition, the paucity of resources dedicated to critical mental health services was consistently mentioned across interviews. It is important that medical professionals provide better healthcare in general and prevent doctor shopping in particular. APS identified a dire need for older adults' transportation to medical professionals to help them manage pain as well as to have enough staffing for healthcare and social services to help with the problems caused by opioid addiction and misuse. Also mentioned was the need for more services for older adults left homeless because of the opioid epidemic.

6. Future Research

Study participants provided insightful suggestions for future research that included studying the long-term effects of opioid addiction on older adults and their families and the need to assess short- and long-term effects of APS intervention for clients new to the system as well as for those that are repeatedly in need of help. Additionally, both administrators and field staff suggested examining the trajectory of intergenerational opioid misuse and how it intersects with APS cases.

Further, future research should critically examine aspects of cases involving a combination of opioids with other drugs, such as methamphetamines and alcohol, and cases in which polyvictimization is involved. Moreover, such research needs to be guided by theoretical frameworks such as a *Lifecourse Perspective* [29] and *Contextual Theory of Elder Abuse* [30] so that micro-macrosystem aspects of the problem are included. In addition, and equally important is research that deeply examines perpetrators. Notably missing is robust data on perpetrators of elder

abuse in general [24], and specifically when opioids are involved. Gathering this information is especially important for guiding intervention for the victim and for the perpetrator as well as stopping the cycle of recidivism peculiar to opioid-involved cases. Deeply examining perpetrators will help give APS field staff tools to better investigate perpetrators in all cases of the abuse of older adults. Finally, studying the aspects of self-neglect where opioids are involved is also crucial, specifically studying similarities and differences between opioid-driven self-neglect and other forms of self-neglect.

7. Conclusion

For older adults and for vulnerable younger adults, APS programs serve as a central lifeline in preventing and intervening in abuse, neglect, and exploitation that is associated with the problems of opioids and related drugs. It is clear from the APS administrators and workers we interviewed that current training and resources are highly inadequate to address a problem that, in certain areas of the country, contributes to unsafe conditions for APS and the clients they serve in addition to client homelessness, chronic pain and suffering, neglect of care, and untimely death.

Acknowledgments

We gratefully acknowledge the voluntary participation in the interviews and survey by the states, District of Columbia (D.C.), and the U.S territories, all of which was accomplished during a global pandemic. This study would not have been possible without the support of the APS field staff, supervisors, and program administrators.

Author Contributions

Each author reviewed the results and approved of the final manuscript. Roberto assisted with the study design, co-facilitated the interviews, and was responsible for the preparation of the manuscript. Teaster was the overall lead on the project design and implementation, co-facilitated the interviews, served as primary author of the final report for the funder, contributed to the conceptualization of all aspects of the manuscript, and edited the manuscript. Fua provided logistic support for the research including participating, curating, and transcribing the interviews, and editing the manuscript.

Funding

The Administration for Community Living provided funding to the National Adult Protective Services Technical Assistance Resource Center (HHSP 233201500042I), which is administered by WRMA, Inc., for this project. WRMA contracted and collaborated with The Center for Gerontology at Virginia Tech to conduct the research. Disclaimer: Contractor’s findings, conclusions, and points of view do not necessarily represent U.S. Administration for Community Living, Administration on Aging, Department of Health and Human Services official policy.

Competing Interests

The authors have declared that no competing interests exist.

Additional Materials

The following additional materials are uploaded at the page of this paper.

1. Interview guides.

References

1. Centers for Disease Control and Prevention. Understanding the opioid overdose epidemic [Internet]. Atlanta, GA: Centers for Disease Control and Prevention; 2024 [cited date 2024 December 4]. Available from: https://www.cdc.gov/overdose-prevention/about/understanding-the-opioid-overdose-epidemic.html?CDC_AAref_Val=https://www.cdc.gov/opioids/basics/epidemic.html.
2. Gladden RM, Martinez P, Seth P. Fentanyl law enforcement submissions and increases in synthetic opioid-involved overdose deaths—27 states, 2013–2014. Morb Mortal Wkly Rep. 2016; 65: 837-843.
3. O'Donnell JK, Halpin J, Mattson CL, Goldberger BA, Gladden RM. Deaths involving fentanyl, fentanyl analogs, and U-47700 – 10 States, July–December 2016. Morb Mortal Wkly Rep. 2017; 66: 1197-1202.
4. Williams E, Saunders H. A look at changes in opioid prescribing patterns in Medicaid from 2016 to 2019 [Internet]. Washington, DC: KFF; 2023 [cited date 2024 December 4]. Available from: https://www.kff.org/medicaid/issue-brief/a-look-at-changes-in-opioid-prescribing-patterns-in-medicaid-from-2016-to-2019/.
5. Hest R, Planalp C, Lahr M. The opioid epidemic: State trends in opioid-related overdose deaths from 2000 to 2017 [Internet]. Minneapolis, MN: State Health Access Data Assistance Center; 2019 [cited date 2024 December 4]. Available from: https://www.shadac.org/sites/default/files/publications/2019%20STATE%20opioid%20brief%20FINAL%20VERSION.pdf.
6. Palombi LC, St Hill CA, Lipsky MS, Swanoski MT, Lutfiyya MN. A scoping review of opioid misuse in the rural United States. Ann Epidemiol. 2018; 28: 641-652.
7. National Safety Council. Drug overdoses [Internet]. Itasca, IL: National Safety Council; [cited date 2024 December 4]. Available from: https://injuryfacts.nsc.org/home-and-community/safety-topics/drugoverdoses/.
8. Friello ER. A Growing Concern: Substance use disorders, medication misuse, and older adults. Alb Gov't L Rev. 2017; 11. Available from: https://www.albanygovernmentlawreview.org/article/23992-a-growing-concern-substance-use-disorders-medication-misuse-and-older-adults.
9. Department of Health and Human Services/Office of the Inspector General. Opioids in Medicare Part D: Concerns about extreme use and questionable prescribing. Washington, DC: Department of Health and Human Services/Office of the Inspector General; 2017; Report No. OEI-02-17-00250.
10. Frenk SM, Porter KS, Paulozzi L. Prescription opioid analgesic use among adults: United States, 1999-2012. Hyattsville, MD: National Center for Health Statistics; 2015; NHCS Data Brief No. 189.

11. Shah A, Hayes CJ, Martin BC. Characteristics of initial prescription episodes and likelihood of long-term opioid use – United States, 2006–2015. Morb Mortal Wkly Rep. 2017; 66: 265-269.
12. Amstadter AB, Cisler JM, McCauley JL, Hernandez MA, Muzzy W, Acierno R. Do incident and perpetrator characteristics of elder mistreatment differ by gender of the victim? Results from the National Elder Mistreatment Study. J Elder Abuse Negl. 2011; 23: 43-57.
13. Conrad KJ, Liu PJ, Iris M. Examining the role of substance abuse in elder mistreatment: Results from mistreatment investigations. J Interpers Violence. 2019; 34: 366-391.
14. Grantmakers In Aging. Heartache, pain, and hope: Rural communities, older people, and the opioid crisis, an introduction for funders [Internet]. White Plains, NY: Grantmakers in Aging; 2017 [cited date 2024 June 11]. Available from: https://www.giaging.org/resources/heartache-pain-and-hope-rural-communities-older-people-and-opioid-crisis.
15. Roberto KA, Teaster PB, Lindberg BW, Blancato R. A first (and disturbing) look at the relationship between the opioid epidemic and elder abuse: Insights of human service professionals. J Appl Gerontol. 2021; 40: 1231-1235.
16. Snow KI, Pratt JL, Bratesman S. The role of the opioid crisis in elder abuse: An analysis of Maine adult protective services investigations, 2015-2018 [Internet]. University of Southern Maine, Muskie School of Public Service, Cutler Institute; 2020. Available from: https://digitalcommons.usm.maine.edu/cgi/viewcontent.cgi?article=1128&context=aging.
17. Roberto KA, McCann BR, Teaster PB, Hoyt E. Elder abuse and the opioid epidemic: Evidence from APS cases in central Appalachia. J Rural Ment Health. 2022; 46: 50-62.
18. Otto JM. The role of adult protective services in addressing abuse. Generations. 2000; 24: 33-38.
19. Administration for Community Living. New APS grants address impact of opioid crisis on elder abuse [Internet]. Washington, DC: Administration for Community Living; 2020 [cited date 2024 June 11]. Available from: https://acl.gov/news-and-events/announcements/new-aps-grants-address-impact-opioid-crisis-elder-abuse.
20. American Medical Association. Issue brief: National snapshot of overdose epidemic [Internet]. Chicago, IL: American Medical Association; 2024 [cited date 2024 December 4]. Available from: https://www.ama-assn.org/system/files/issue-brief-national-snapshot-overdose-epidemic.pdf.
21. Denzin NK, Lincoln YS. The Sage handbook of qualitative research. Sage Publishing; 2011.
22. Liu PJ, Delagrammatikas L. Adult Protective Service's role in addressing older and dependent adult abuse in the age of COVID. Front Public Health. 2021; 9: 659640.
23. Storey JE. Risk factors for elder abuse and neglect: A review of the literature. Aggress Violent Behav. 2020; 50; 101339.
24. Jackson SL, Heisler C, Urban K. A narrative review of U.S. elder abuse perpetrator research and its implications for developing alternative perpetrator interventions for use by prosecutors. Aggress Violent Behav. 2024; 76; 101921.
25. Schepis TS, McCabe SE. Prescription opioid misuse in US older adults: Associated comorbidities and reduced quality of life in the National Epidemiological Survey of alcohol and related conditions-III. J Clin Psychiatry. 2019; 80: 13246.
26. Goodnough A. A new drug scourge: Deaths involving meth are rising fast [Internet]. New York, NY: The New York Times; 2019 [cited date 2024 June 11]. Available from: https://www.nytimes.com/2019/12/17/health/meth-deaths-opioids.html.

27. Teaster PB, Roberto KA, Hoyt E, Savla J, Fua I, Kebede B. Adult Protective Services study on the impact of COVID-19: Findings from state administrator survey and interviews with local APS staff. Washington, DC: Administration for Community Living, U.S. Department of Health and Human Services; 2020.
28. Soelberg CD, Brown RE, Du Vivier D, Meyer JE, Ramachandran BK. The US opioid crisis: Current federal and state legal issues. Anesth Analg. 2017; 125: 1675-1681.
29. McDonald L, Thomas C. Elder abuse through a life course lens. Int Psychogeriatr. 2013; 25: 1235-1243.
30. Roberto KA, Teaster PB. Theorizing elder abuse. In: Elder Abuse: Research, Practice and Policy. Cham: Springer; 2017. pp. 21-41.