The Impact of the Opioid Epidemic on Adult Protective Services

Final Report

National Adult Protective Services Technical Assistance Resource Center
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Executive Summary

Purpose

This study aimed to understand the nature, extent, and challenges confronted by adult protective services (APS) staff in providing services to clients affected by opioids. In consultation with Administration for Community Living (ACL), the study team developed the following objectives:

- Identify the scope and characteristics of APS caseloads involving opioid abuse
- Identify interventions used and challenges to implementing these interventions
- Identify additional services needed
- Identify characteristics and challenges particular to the impact of the COVID-19 pandemic

Methods

The study design involved a two-step (Phases I and II) process for identifying challenges, successes, and issues of concern when investigating and intervening in cases of opioid-related elder abuse. Phase I involved telephone interviews with 11 state-level APS administrators from states considered to be hotbeds for the opioid epidemic at the time of the interviews. This informed questions for Phase II, individual and small group interviews with local APS workers from 10 states. To supplement information gathered from the interviews, data collected in 2020 through the National Adult Maltreatment Reporting System (NAMRS) for Missouri was used to characterize similarities and differences in characteristics, methods, and interventions for opioid-related and non-opioid-related cases.

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 description). Next, facilitators shared their observations of the information gleaned and how the participants' experiences compared with previous interviews. After each interview, the audio-recorded session was transcribed verbatim. Finally, 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-related cases of elder abuse. NAMRS provided de-identified, tabulated data for Missouri. To compare Missouri's opioid-related maltreatment cases and total maltreatment, we tested differences in proportions between the two groups of cases using the proportion test.

Key Findings

- No APS program we interviewed had a policy specific to older adults and opioids.

- Most APS administrators were unable to provide data-driven responses related to the number of APS reports in a year's time involving opioids.
- When opioids were involved, allegations most often concerned self-neglect, followed by caretaker neglect, and facility drug diversion.
- As with most types of elder abuse, perpetrators of opioid abuse were mostly family members, but at times facility staff were involved.
- A major challenge working cases involving opioids was that the alleged perpetrator would also be present in the home as APS field staff attempted to interview the alleged victim. Other challenges included addressing the victim's pain level 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.
- The COVID-19 pandemic made it more difficult for most field staff to investigate opioid-related cases.
- Most APS staff thought cases involving opioids were harder to substantiate due to the difficulty of proving if and how medication was missing and the victim's denial if the perpetrator was a family member.
- APS staff identified long-term impacts that opioid misuse had on their clients: inability to have their pain managed adequately, homelessness, poverty, and, in more than one case, a hastened death.
- Frequently suggested mechanisms for prevention were formal and informal supports and services, particularly in medication management. Older adults' inability to manage prescribed medications was the most common explanation of how they became victims of opioid abuse.
- Intervention improvements for cases involving opioids included giving APS the ability to perform background checks, more frequent use of electronic medical boxes for appropriate and timely dispensing of medications, holding perpetrators accountable to timeframes, and policies to facilitate greater access and trust.
- Working with community partners was a critical component to maximally helping older adults involved with opioid misuse.
- APS 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.

Conclusions

APS serves as a central lifeline in preventing and intervening in abuse, neglect, and exploitation associated with the problems of opioids and related drugs for older adults and vulnerable younger adults. APS programs need to collect consistent and quality data on opioid-related APS cases. Thorough research is another critical factor in preventing and intervening in cases of abuse involving older adults and opioids. 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 its clients, as well as client homelessness, chronic pain and suffering, neglect of care, and untimely death.

Introduction

Opioids are a significant contributor to the U.S. addiction and overdose crisis. Older adults are an important but frequently forgotten cohort affected by the opioid epidemic. As a group, older adults experience multiple chronic conditions and high rates of chronic pain (Frenk et al., 2015). Opioids and related prescription and non-prescription drugs frequently are the treatment of choice for these older adults, which can lead to a life of addiction fraught with emotional distress, diminished relationships, criminal activity, and often death.

While data sources vary on the number of older adults who use opioids, research agrees 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) (DHHS/OIG, 2017). The most commonly prescribed opioid for this group was oxycodone 30 mg, accounting for one in five beneficiaries who received a high amount of opioids. In addition, nearly 70,000 beneficiaries who receive extreme amounts of opioids (e.g., average daily MED greater than 240 mg for 12 months) were at serious risk of opioid misuse or overdose (DHHS/OIG, 2017).

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 percent for people aged 60 and over, compared to 4.7 percent for people aged 20–39 (Frenk et al., 2015). 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 percent of older adults prescribed opioids reported that health providers counsel them about addiction, risk of overdose, or how to safely dispose of excess medication. About one-fourth of long-term opioid users are aged 65 and older, with 2.2 percent of older adults reporting non-medical use of prescription opioids during the past 12 months (Saha et al., 2017).

A hidden pathway by which the opioid epidemic infiltrates the lives of older adults is though the addiction of their children, grandchildren, and others who rely on them for money, childcare, food, shelter, and the like, as well as those upon whom the older adults rely. Older adults may be directly or inadvertently stripped of their resources and quality of life because of these struggles. While empirical evidence is lacking, experts believe that incidences of elder abuse have risen as the opioid epidemic has worsened (Benson & Aldrich, 2017; Roberto et al., 2020).

This study, sponsored by the Administration for Community Living (ACL), investigated the opioid epidemic's impact on adult protective services (APS) programs across the country. 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 (ACL, 2020).

Purpose

This study aimed to understand the nature, extent, and challenges confronted by APS staff in providing services to clients affected by opioids. In consultation with ACL, the study team developed the following objectives:

- Identify the scope and characteristics of APS caseloads involving opioid abuse
- Identify interventions used and challenges to implementing these interventions
- Identify additional services needed
- Identify characteristics and challenges particular to the impact of the COVID-19 pandemic

Methods

The study design involved a two-step (Phases I and II) process for identifying challenges, successes, and specific issues of concern when investigating and intervening in cases of opioid-related elder abuse. Phase I involved telephone interviews in April 2021 with 11 state-level APS administrators from states considered to be hotbeds for the opioid epidemic at the time. The findings were used to inform questions for Phase II, which involved individual and small group interviews with local APS workers from 10 states conducted in May through June 2021. APS administrators helped the research team identify local staff who would be willing, helpful, and able to answer questions concerning their experiences with the problem. See Table 1 for the number and classification of APS staff who participated in the study.

Table 1. State-Level Administrators and Local APS Case Workers Interviewed

U.S. Region	State or Regional Administrators	Supervisor/ Manager	Social Worker/Case Manager/Investigator	Total
West (two states)	2	3	9	14
Midwest (three states)	8	3	5	16
Northeast (one state)	4	2	4	10
South (five states)	9	7	4	20
Total	23	15	22	60

The study team developed core questions for Phase I interviews (Appendix A). Based on the findings, they adapted questions for use in Phase II data collection (Appendix B). The interview questions aimed to gather information about opioid-related elder abuse cases from a state perspective. The interviews with local staff (supervisors, caseworkers, etc.) allowed for an "on-the-ground" view of challenges, concerns, and what worked well to address the needs of APS clients. When appropriate, both

administrators and local staff were asked to reflect on how COVID-19 contributed to the opioid-related cases and influenced how APS managed these cases.

To supplement the information gathered from the interviews, we used de-identified federal fiscal year 2020 case data collected by Missouri and submitted it to the National Adult Maltreatment Reporting System (NAMRS). Comparing opioid-related cases with overall case data allowed for the analysis of similarities and differences in characteristics, methods, and interventions for opioid-related and non-opioid-related cases. Missouri was selected because it was the only state that collected opioid-specific information in its data system.

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 it compared with previous interviews. After each interview, facilitators transcribed the audio-recorded session verbatim. Finally, researchers reviewed the transcribed sessions, with particular attention given to commonalities among the states' challenges and the ways in which they managed and intervened in opioid-related cases of elder abuse. They used participant quotes to demonstrate how the data led to the findings and illuminate the APS experience (Sandelowski, 1994) in responding to opioid-related abuse.

Using Missouri NAMRS data, APS TARC staff provided the research team with de-identified, tabulated data for all Missouri APS cases and matching data tables for cases involving opioids. To compare Missouri's opioid-related maltreatment cases and total maltreatment, researchers tested the differences in proportions between the two groups of cases using the proportion test. Conceptually, the proportion test is very similar to t-test statistics, wherein the null hypothesis is that the two groups or populations have the same proportions. We report the z-statistics and p-value where there were significant differences in proportions.

Interview Findings

This section presents findings from interviews with APS administrators at the state or regional level and local field staff. We began this part of the inquiry to obtain a high-level, 40,000-foot view of the issue and discuss any policies and procedures for addressing opioid-related cases. Our second source of data was interviews capturing the experience and expertise of APS staff at the local level. These participants were directly involved with opioid-related cases and thus contributed greatly to our core findings. An important aspect of the local interviews was the participants' candor and recognition that the field staff were the real experts who had already done a lot related to the opioid epidemic.

One field staff member had this to say about the far-reaching aspects of a case involving older adults and opioids.

> ***But the reality of my experience in dealing with people with opiates is, it's not one aspect, it's not one time.***
>
> *It's a constant battle, and it may be a constant battle for them for the rest of their lives. And support, education, there's so many different things, but a lot of it is just out of the realm of what we physically do in there with our jobs. We wear many hats when we go in. We need to identify the concerns and risks to the client and take steps to eliminate or reduce those risks and provide services for our client. But typically, we can give, "OK, here's a list of people you can call, and they will help you with your addiction." But typically, our services that are offered are for the client. And so, it's a client-centered thing, which is a good thing, and they need it. But it just becomes this overwhelming thing when you've got a caregiver that needs help, and we can refer them all day long, but we can't make them go. And a lot of times they'll get a start, but they won't finish. And then they'll be right back in the same place again. And gosh, I saw this with Children's Services, too. And it was just ... It's a cycle that is vicious and violent and unforgiving.*

Policies and Procedures Specific to Reports Involving Older Adults and Opioids

We asked APS administrators if their state had a policy or set of procedures to follow when allegations involved opioids. No one we interviewed 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. One state considered an investigation involving opioids as an exploitation case.

> *In terms of, if there is a 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.***

Additionally, several states had policies about safety protocols when drugs such as opioids were involved because investigating these cases can be quite dangerous. Policies concerned reaching out to law enforcement to accompany APS investigators. Others reached out to medical professionals, particularly if the report concerned self-neglect.

> ***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.*

> ***We would involve law enforcement.*** *Let's say it was an alleged perpetrator caretaker, get law enforcement involved and let them intervene as appropriate. 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.*

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. The majority of administrators thought the number of reports involving opioids was trending upward, mainly because staff are becoming aware and looking more closely at warning signs such as missing pills or odd behavior. One state suggested that legislation limiting the supply of opioids that can be prescribed by doctors has lowered its opioid-related cases.

Typically, administrators were unable to provide data-driven responses; however, two states were the recipients of ACL grants related to opioids and noted that they would have more empirical information to provide in the future because they were adjusting data collection systems to track reports, investigations, and case outcomes involving opioids. One state was adding opioids into its data collection after seeing a rise in cases in the past few years.

Field staff also estimated how many investigations they had conducted in the previous year that involved opioids in some way. Because most states were not collecting data on opioid-related reports, they 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.

Types of Allegations/Reports

When opioids were involved, allegations most often concerned self-neglect, followed by caretaker neglect and facility drug diversion. All 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.

> *It's primarily neighbors.* ***I've had one 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.*

Another type of report involving opioids was a caretaker neglect allegation that, upon investigation, 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 best type of thing, and they just won't allow the supports and won't allow the help.*

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.*

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.

> ***In a facility, there are so many other factors, other employees.*** *It becomes the "he said, she said" kind of thing, and one that I … in the end, refer to law enforcement. They can look into it, especially in the facilities, law enforcement will investigate those. But yeah, 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.*

Perpetrators in Opioid-related Cases

As with most types of elder abuse, perpetrators were mostly family members, but at times facility staff were involved.

> *I've been working protective services now for 11 years, and 90 percent 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.***

I would see [perpetrators] more than the alleged victims. *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. They just keep getting assigned different people, so yes, I saw perpetrators more frequently than I did see alleged victims. Different victims. 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, they don't check with APS, even if it was substantiated, they can get hired at another place.*

Challenges of Investigating Reports

Local APS staff were asked to identify challenges they faced when investigating cases involving opioids. One major challenge was that the alleged perpetrator would also be present in the home as APS field staff attempted to interview the alleged victim.

I think the biggest challenge is the face-to-face visit with that older person in their home without the alleged perpetrator being there. *Because many times, if you have someone living with them that's using the drugs, they're sleeping all morning long and then hanging out in the afternoon.*

Other challenges included addressing the level of pain of the 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.

One of the things that I've always struggled with, and it's just the nature of adult protective services, is in two aspects, is that if we have a victim who we either feel like is being overmedicated, undermedicated 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. ***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.*

Facility cases often presented additional challenges because of the number of people who were involved.

Well, I think one of the hardest parts about the opioid use, especially when I have to investigate in a facility, there are so many other factors, other employees. It's one of those things they can't just blame someone else, and I don't have the capability to make someone do a UA [urine analysis] or actually drug test anyone.

The COVID-19 pandemic made it even more difficult for most field staff to investigate opioid-related cases. Most 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 also reluctant to visit healthcare settings.

It made it harder because we weren't doing home visits unless it was an emergency situation. So, it's really important in those type of situations to get eyes in the home on the client because the client can tell us whatever they want over the phone. 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****.*

Challenges of Substantiating Cases Involving Opioids

In addition to investigation challenges, the research team asked APS field staff if they thought substantiating cases involving opioids was easier, harder, or the same as substantiating other types of allegations. Most thought they were harder to substantiate due to the difficulty of proving if and how medication is missing and the victim's denial if the perpetrator is a family member.

A lot of times, the perpetrator will deny it, and medication may be missing. *If you've got a victim who cannot provide any information or maybe they don't count their pills, they just take what someone gives them, I think that's what makes it very difficult to prove that that individual took it.*

> *If grandma's got a grandson that is taking them and grandson's going, "Oh, grandma. I have to have this 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."* ***Those are the ones that are harder for me.***

Conversely, one field worker described how surveillance cameras were useful in substantiating cases in facilities.

> *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, but in home—I mean, again, in both the group homes and the skilled nursing facilities, it was easy to substantiate because there was clear footage. I could send that over to law enforcement and they could do their end.* ***If you don't have that video footage, it's tricky.***

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. Alternately, if the client lacked capacity, then 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.

> ***I informed [the client], it's your treatment, your medication, it's up to you whether or not you wish to intervene,*** *I can't force you. So, if you go get tested at your next pain management appointment and you don't have the appropriate levels, then most likely your treatment's going to stop. So, to help yourself and I'm here to help you as best I can, but I can't force you to do anything.*

> ***Because 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. It's frustrating.*

Related to the issue of the right of a capacitated person to refuse services, nearly every interview 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.

> ***I can recall cases from the past, nothing recent, where the perpetrator is the one with an opioid addiction.*** *And let's say it's an adult child or a grandchild of an elderly person that may visit the home or even reside in the home. I have found oftentimes our client is reluctant to want to report it. And even if it's been reported to us, there is an attempt to minimize what's occurred.*

> ***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.*

Long-Term Impacts of the Abuse

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

> *I think the long-term effect that I've seen with some of my elderly clients is these particular clients that 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, and I think 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.***

> ***I think homelessness is a big one, 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.*

Long-term effects that I see are the older adults, 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.

Prevention

Frequently suggested mechanisms for prevention were formal and informal supports and services, particularly in medication management. Older adults' inability to manage prescribed medications was the most common explanation of how they became victims of opioid abuse.

> *I saw an instance last week, I had a hotline on a guy last week who had been in a hospital … and had been discharged from the hospital after a psych evaluation, and he had three pages—three pages of prescription medication they wanted him to fill. And I'm thinking, "Holy cow! I can't even comprehend how to take this stuff. How's this guy going to manage?" There was like 21 different prescription medications they were prescribing to him when he was discharged from that hospital. And I told him, "You need to speak to your primary care physician." Because that many (pills) just caused me a lot of concerns and raised red flags for all kinds of abuse that could take place as a result of that.* ***And I'm not a doctor so I don't know what he might need and what he wouldn't need, but it just seemed to me that 21 prescriptions seemed to be a lot.***

Another important route to prevention mentioned by both administrators and field staff is more education on opioid addiction.

> ***In some cases, I feel like if they had more family, more support*** *to where someone would be willing to step in to stop it from occurring. But the reality is sometimes they don't have anyone, and that one person who's exploiting them, abusing them is all they have.*

Maybe if other family was more involved. ***Sometimes other family members are estranged from the client because the client will side with the alleged perpetrator or defend them.*** *But education I think would be key in helping people to understand what options they have to reach out to stop something bad from happening if they know it's happening.*

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 unique. Suggestions included giving APS the ability to perform background checks, more frequent use of electronic medication boxes for controlled and appropriately timed dispensing to help manage pill dispensing and hold perpetrators accountable to timeframes, and relaxed dress policies to facilitate access and trust, thus enhancing the ability of APS to investigate cases.

But it would have to also go case by case because you have to understand, some of these addicts are functioning addicts *and they go to work every day and they do what they need to do every day, but yet here's this underlying thing. And it can be, and most of the time is the reason why appointments are missed, certain things aren't done when they're supposed to be done. And those things over time add up, and the results of those negative things negatively impact the life of our clients.*

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.*

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.***

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.

> ***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 was thought was a satisfactory answer over the phone.*

> ***APS in [Place] has a pretty good working relationship with law enforcement****, which, again, does help. You can call in and see if they can run any, through their searches, they have had experience with this person, and if those concerns are drug related.*

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

> *I think it's always important to realize with opioids, is this problem was created a long time ago by doctors overly prescribing this stuff. These people are addicted because they were given something that they were told would help them, and then they just kept giving it to them.* ***People have been on these medications for a lifetime.***

>  ***Some of the pain management clinics*** *do a real good job of bringing people in and doing pill counts and doing some bloodwork and things like that, whereas the average family practitioner does not do these things.*

Many of the field staff talked about working with other professionals, including home healthcare professionals, outpatient clinic staff, pharmacists, community paramedics, and church pastors who had frequent interactions with older adults that were deemed critical.

>  *I think a follow up to that is also checking with the pharmacies that are prescribing these medications. 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.***

Being able to rely on a network of professionals was sorely missed when typical practices were disrupted due to the COVID-19 pandemic.

>  *We have a lot of community partners with* ***home health outpatient clinics*** *that just weren't going into the home [during COVID-19]. So, we don't have as many eyes on clients, and that has been a barrier. ... Now we're starting to go back in person, and home health is coming back to where they're working with folks here in my area at least. Our referrals have increased in the pandemic because whereas I have community partners who would go into the homes and work before they call us, now they just call us.*

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 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 have said. It's not a solution to the entire problem, but it is helping with some resources.*

Acute Need for Resources

Field staff emphasized that addiction affects every type of person in every situation—although a number said 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, addiction specialists, and resources for homeless people. Staff mentioned often an especially acute need for mental health services, transportation to medical providers to help with pain-related problems, and greater staffing for healthcare providers.

Until you deal with the underlying issue or whatever is feeding the need for that addiction, you're not going to be able to control the addiction. *But without the resources, and the programs, and the treatment opportunities, what are you going to do? How do you help these people stay clean when there are no services out there, unless you're able to pay for it? But if you don't have a job, and there are no good-paying jobs, you don't have the money to pay for it. You get a good-paying job in the area, what if they want to do a drug test on somebody, on their employees? Well, how are you going to get enough employees to staff your factory or whatever when two-thirds of the people are on some sort of illegal substance?*

And so, we're always getting a skewed response, right? Because their M.O. is to manipulate, not tell the truth, to lie, however you want to package it, to get what they need. And so, if we're already in the one down position and ***if we don't have training from law enforcement on what's happening, then it makes our job even harder.***

I get a lot of clients from the homeless shelter, and this is mostly because maybe of their addiction, that ***they are homeless****. And we also have meetings with an area agency who is involved with the community, a lot of our clients. I think that, I don't know if you do brochures or things like that to send because brochures, we give them out all the time to a lot of our clients. And like I said, the homeless, they're the ones that need the resources. We do have a resource book but nothing on opiates is in there.*

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, I know for me, and I'm quite sure for my two co-workers on here. Our frustration is we're often put in a position as the solution finder, and we have no solution and it's frustrating.*

Transportation is a problem. *It can be 60 or 70 miles from a rural area to a doctor in [place]. And [place] is an exploding area that is just growing by leaps and bounds, it has very good medical care, but oftentimes we don't have transportation to even get them there. So, the problem just, as I said earlier, it just becomes a snowball effect and just begins to compound itself.*

One thing, before the pandemic hit, what we were seeing at least in our area … is ***a shortage of home healthcare workers.*** *OK? We had that shortage anyway. 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. There is nonexistent to find home care. Now, we have seniors out there who need people to come in there to homes to take care of them. It's nonexistent.*

Research Suggestions

APS field staff made insightful suggestions regarding research. Suggestions included investigating the long-term effect of opioids, how best to intervene in cases involving a number of drugs (e.g., alcohol, meth, and opioids) coupled with polyvictimization (e.g., self-neglect, exploitation, caretaker neglect, physical abuse), the effects of opioids on tribal older adults, and the intergenerational effects of opioid misuse on families dependent on the resources of an older adult.

The struggle is real with APS, this population, and prescription drugs. I'm always curious about the ***long-term effects of prescriptions*** *on the body, but with opioids, I guess, I mean, the biggest concern is the addiction aspect. I would just be curious, any long-term physical health issues. ... I don't know how things are in other places, as well as, in regards to the tribe. I know the tribe I work with is ... I'm curious, because I've never asked* ***the tribal APS worker what their experience is like with opioids.*** *I know they get a lot of self-neglect stuff, but I don't know how much of that is revolved around opioids.*

> *I've not heard anybody else mentioned before,* ***multi-generational dysfunctionality****. If you look at these families and the generations that are using drugs, it doesn't just start. I mean, it has to start somewhere. At some point it does start with the generation that you're working with.*

Opioids were also not the only drug problem that plagued older adults. In addition to alcohol misuse, two sets of staff mentioned methamphetamines.

> *I mean, there is a lot of meth in the area that I cover. I know it's not an opioid, but there is a ton of meth in this area, which can cause some volatile behaviors. But again, your whole life is focused on feeding that addiction. So, you let a lot of other things slide, whether it's the meth, alcoholism, or opioids, I mean, it's all ...* ***The effect on your life is the same regardless of the substance.***

> ***Most of our repeat clients*** *that we get multiple cases on generally* ***have some element of substance abuse****. Not always opioids, but lots of alcohol, other drugs. Those are the ones that we generally get a lot of repeats on.*

Missouri: One State's Snapshot of Opioid-Related Abuse

A final source of information came from data collected by Missouri APS, which provided federal fiscal year 2020 administrative data. Using its NAMRS file as a baseline, we compared cases involving opioids with overall cases.

Missouri staff identified 118 investigations involving opioids, of which 24 were substantiated. For the discussion in this report, we focus on substantiated cases only, comparing the 24 substantiated cases to all investigations that Missouri substantiated in 2020. Tables 2-5 show data for all substantiated cases compared to the substantiated opioid-related cases.

For the substantiated cases involving opioids, approximately 63 percent (*n*=15) of cases involved self-neglect. Other known types of maltreatment were financial exploitation (8.3 percent, *n*=2), physical abuse (8.3 percent, *n*=2), emotional abuse (4.2 percent, *n*=1), and neglect (4.2 percent, *n*=1). Maltreatment type was unknown for 25 percent of the cases (*n*=6).

Table 2. Substantiated Cases by Maltreatment Types

Maltreatment Type	Missouri Opioid Cases		All Missouri Cases	
	Number of Victims	Percentage of Victims (N=24)	Number of Victims	Percentage of Victims (N=9,406)
Abandonment	0	0.0%	219	2.3%
Emotional Abuse	1	4.2%	315	3.3%
Exploitation (non-specific)	0	0.0%	0	0
Financial Exploitation	2	8.3%	642	6.8%
Neglect	1	4.2%	336	3.6%
Other	6	25.0%	1,699	18.1%
Other Exploitation	0	0%	0	0.0%
Physical Abuse	2	8.3%	468	5.0%
Self-neglect	15	62.5%	6,304	67.0%
Sexual Abuse	0	0.0%	57	0.6%

The majority of victims were female (70.8 percent, n=17), between 50-69 years of age (66.7 percent, *n*=16), white (75 percent, *n*=18), and living in their own home or the private residence of a relative or caregiver (96 percent, *n* =23). APS had received a prior report on over half of the victims (58 percent, *n*= 14). Professionals typically reported the maltreatment (67 percent, *n*=16). See tables 3 and 4.

Table 3. Victim Characteristics

Gender	Missouri Opioid Cases			Missouri Total Cases	
	Number of Victims	Percentage of Victims		Number of Victims	Percentage of Victims
Female	17	70.8%		5,338	56.8%
Male	7	29.2%		4,043	43.0%
Unknown	-	0.0%		25	0.3%
Age					
18-29	-	0.0%		444	4.7%
30-39	-	0.0%		365	3.9%
40-49	2	28.6%		560	6.0%
50-59	7	100.0%		1,299	13.8%
60-69	9	128.6%		2,466	26.2%
70-74	2	28.6%		1,296	13.8%
75-84	3	42.9%		1,875	19.9%
85+	1	14.3%		988	10.5%
Unknown	-	0.0%		113	1.2%
Living Arrangement					
Own residence or private residence of relative or caregiver	23	95.8%		8,116	86.3%
Residential care	0	0.0%		308	3.3%
Business/community service provider	0	0.0%		0	0.0%
Other	1	4.2%		939	10.0%
Unknown	0	0.0%		43	0.5%

Table 4. Case Reports

Previous Report	Missouri Opioid Cases			Missouri Total Cases	
	Number of Victims	**Percentage of Victims**		**Number of Victims**	**Percentage of Victims**
No	10	41.7%		4,064	43.2%
Yes	14	58.3%		5,342	56.8%
Report Source					
Professional	16	66.7%		5,598	59.5%
Relative	2	8.3%		1,072	11.4%
Other Nonprofessional	1	4.2%		691	7.3%
Self	1	4.2%		511	5.4%
In-Home Caregiver or Substitute Decision-maker	0	0.0%		493	5.2%
None	4	16.7%		1,092	11.6%
Unknown	0	0.0%		0	0.0%

Very little information was gathered about perpetrators; consequently (see Table 5), the available data about them were often incomplete. For the 11 substantiated opioid-related cases that included perpetrator information, perpetrators ranged in age from younger than 17 to 84 years, with most being between the ages of 50-59 (27 percent; *n*=3/11) and 60-69 (36 percent; *n*=4/11). Most often, perpetrators were not related to the victims (63.6 percent; *n*=7/11). When family members were the perpetrators, spouses (18.2 percent; *n*=2/11) and adult children (18.2 percent; *n*=2/11) were identified.

Table 5. Perpetrator Characteristics

Age	Missouri Opioid Cases			Missouri Total Cases	
	Number of Perpetrators	Percentage of Perpetrators (N=11)		Number of Perpetrators	Percentage of Perpetrators (N=3,700)
17 and younger	1	9.1%		26	0.7%
18-29	-	0.0%		362	9.8%
30-39	-	0.0%		380	10.3%
40-49	1	9.1%		398	10.8%
50-59	3	27.3%		481	13.0%
60-69	4	36.4%		531	14.4%
70-74	1	9.1%		266	7.2%
75-84	1	9.1%		383	10.4%
85 and older	-	0.0%		186	5.0%
Unknown	-	0.0%		687	18.6%
Relationship					
Child	2	18.2%		507	13.7%
Domestic partner, including civil union	-	0.0%		-	0.0%
Grandchild	-	0.0%		120	3.2%
Grandparent	-	0.0%		-	0.0%
None	7	63.6%		2,635	71.2%
Other relative	-	0.0%		126	3.4%
Parent	-	0.0%		108	2.9%
Sibling	-	0.0%		56	1.5%
Spouse	2	18.2%		148	4.0%

The data show one notable difference in the characteristics of the substantiated opioid-related cases compared to the total substantiated cases Missouri reported. There were significantly (z=2.11, p=0.03) more victims of opioid-related abuse in the age group of 50-59 years (n=7; 29 percent) compared to victims in this age range among the total cases (n=1,299; 14 percent). Similarly, there were significantly (z=2.10, p=0.04) more perpetrators in the age group of 60-69 years (n=4; 36 percent) compared to perpetrators in this age range among the total cases (n=531; 14%). Note that opioid-related cases were significantly fewer than the total cases reported (n=24 and n=9,406, respectively). Moreover, once researchers applied corrections for multiple comparisons, these minor differences between the two populations were not statistically significant.

Discussion

Types of Cases

Although the research team anticipated that most reports of maltreatment 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, 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 staff stressed that it was challenging to intervene in these cases—frequently, adults and 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. Staff found these cases discouraging and frustrating.

The case workers often 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 stop the cycle of neglect and help the older adults reduce opioid dependency. Older adults misusing pain medication led to more reports of self-neglect. 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 older adult's money. When the money and drugs were gone, the older adults were out of resources and left with inadequate food, clothing, and shelter.

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

Drug diversion by healthcare staff was mentioned less frequently. 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.

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 victim's home, 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-related 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 their reluctance to implicate a family member. Many older victims chose to suffer the misuse (and in many instances, pain) to shield a family member from prosecution and/or imprisonment. They willingly protected their family members, not wanting to lose them as a caregiver (no matter how poor), 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. Instituting better strategies to help older adults with capacity to receive services and to assist perpetrators with drug dependencies are critical to resolving issues related to the abuse of older adults where opioids are concerned.

Any contemporary study would be incomplete without addressing the impact of COVID-19. Indeed, this study was delayed a year to make way for a study deemed more prevalent, *Adult Protective Services Study on the Impact of COVID-19: Findings from State Administrator Survey and Interviews with Local APS Staff* (Teaster et al., 2020). That study revealed that, because 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 vulnerability to the virus.

To protect APS staff and clients, for a period of time most programs significantly reduced or stopped entirely 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 had more scrutiny were more leniently dispensed. In fact, nationally, overdose related to prescription opioids and heroin remained high during the pandemic, and these drugs were increasingly adulterated with illicit fentanyl (American Medical Association, 2021).

Fewer clients visited medical professionals due to fears of contracting the virus and impediments in making appointments because of lengthy visit protocols. 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 were substantiated as their perpetrator.

Opioid cases also involved misusing other substances, making the entire investigation more difficult to disentangle. Concurrent with opioid was misuse of alcohol. Also, the specter of methamphetamine misuse has begun rearing its head once again (Goodnough, 2019). All too frequently, investigations revealed several drugs and abuses at the same time.

Solutions

Prevention of and intervention into cases involving opioids go together. Participants stressed that opioid-related cases involving older adults were highly individualized and would be poorly resolved using a cookie-cutter approach. In many cases, opioid misuse had been ongoing for a long period of time. Many people with addictions were functioning, albeit at a baseline level, and were competent to live their lives in the manner they chose. On the macro level, 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 monitoring of the use of opioids would impede access to them, and legislation instituted in many states was increasing this ability.

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.

Increasing Resources to Address the Problem

The most consistent need identified by APS staff was for training about opioid addiction and its effects on older adults and on those in a position to provide care. APS staff emphasized the need for training from law enforcement to learn how to identify if a person was abusing substances, to remain as safe as possible (for APS staff and the people they served), and better methods for investigating cases.

Older adults who had become enmeshed in the opioid epidemic need additional resources, such as addiction specialists to assist with such complex cases. A consistent theme sounded across our interviews is the lack of resources dedicated to critical mental health services. Other resource needs include medical professionals to provide better healthcare in general and prevent doctor shopping in particular; a need for transportation for older adults to medical professionals to help them manage pain; and having enough staffing for healthcare and social services. Finally, participants mentioned the need for more services for older adults left homeless because of the opioid problem.

Insights from the Missouri Data

The Missouri data provided a snapshot of the opioid problem that APS faces in one state. Although one should not draw conclusions from incomplete data on 24 substantiated cases over a year's time in one state, the information provided is instructive. It is worth noting and exploring that, unlike in many states, substantiated perpetrators were not family members, which is usually the case where mistreatment is concerned. Also notable and worth investigating is that many of Missouri's opioid cases involved polyvictimization, as well as the fact that professionals typically made the reports. Exploring all these topics could guide strategies for intervention and prevention of these complex (and dangerous) cases. Adding a field or fields in NAMRS that specifies the drugs involved would be important for tracking the problem and developing the most robust intervention and prevention efforts possible.

More consistent and quality data collection on opioid-related cases needs to occur. In 2020, in response to the opioid crisis, ACL awarded $1.7 million for two-year state APS enhancement grants to Montana and Nevada. Among the awarded activities is for improved data collection and reporting. Montana's APS

program proposes to improve data and information gathering processes by utilizing a tracking system to document and better understand opioid misuse by alleged victims and alleged perpetrators. Nevada APS will include developing a screening tool and improve the process of referring clients to opioid misuse services. These data collection efforts by Missouri, Montana, and Nevada have long been awaited and will further bring attention to opioid abuse among older adults and highlight gaps and solutions to tackling this complex problem.

Future Research

Another critical way to prevent and intervene in cases of abuse involving older adults and opioids is thorough 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 who repeatedly need help. Additionally, staff suggested examining the trajectory of intergenerational opioid misuse and how it intersects with APS.

Three other studies are particularly important to conduct, as they have notable implications for intervention and prevention efforts. First, 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 should compare case intervention outcomes in rural, urban, and tribal areas and frame the study using the *Contextual Theory of Elder Abuse* to include micro-macrosystem aspects of the problem.

Second and equally important is a study that deeply examines perpetrators. Notably missing in much of the opioid data in Missouri as well as other studies concerning older adults and opioids (Roberto, et al., 2020) is robust data on perpetrators. Gathering this information is especially important for guiding intervention for the victim and the perpetrator as well as stopping the cycle of recidivism particular to these cases. Deeply examining perpetrators will help give APS staff tools to better investigate perpetrators in all cases of older adult abuse. 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.

We also look forward to the examination of efforts made by Montana and Nevada with their APS grants. Montana will be using the demonstration grant to create innovative and enhanced practices, services, data collection, and reporting to better serve and assist clients affected by the opioid crisis. Montana will partner with Purdue University, the University of Illinois-Chicago, and other key Montana stakeholders and will report opioid-related data to NAMRS. Nevada's APS program will educate staff and the community on opioid misuse and available services, expand its NAMRS data collection, and demonstrate APS outcome measures related to opioid misuse. Nevada APS will partner with the University of Nevada-Reno's Center for the Application of Substance Abuse Technologies and key stakeholders.

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. In addition, only one state was identified as collecting data on opioid-related cases. Missouri volunteered its state-level opioid-related data collected through NAMRS, but there were limitations on the data Missouri APS could offer.

Conclusion

According to the Centers for Disease Control and Prevention, deaths from drug overdoses in 2020 increased 29 percent from the previous year. The genesis of the problem lies in an industry that was far too eager to stop pain through medications initially touted as nonaddictive. This problem has killed more than 800,000 Americans in 20 years, with far more suffering the effects of addictions and inadequate resources to help. Drug settlement money and state legislation implementing monitoring systems is beginning to turn the tide in the war against opioid misuse in some states, with certain areas of the country more affected than others (e.g., rural, tribes, low income). The problem is still far reaching and easily spreads to other areas, affecting older adults and those who seek to intervene—seen Aug. 6, 2021, in the example of the police trainee who nearly died from exposure to fentanyl (Kucher & Figueroa, 2021).

For older adults and vulnerable younger adults, APS serves as a central lifeline in preventing and intervening in abuse, neglect, and exploitation associated with 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 their clients in addition to client homelessness, chronic pain and suffering, neglect of care, and untimely death.

The following quote from a study participant sums up the opioid problem and the APS connection powerfully and insightfully.

> *But I do know that it is a terrible thing, and I do know that there are some folks who this journey, this unfortunate opioid journey, started for them through no fault of their own initially—surgery, accidents. Whatever happens that gets them where they are, they're still there, and they're still having to deal with it every day. And you've got different dynamics from different people, from different family cultures, from different walks of life, from all these different things that impact their use and impact their inability to stop using. And there's no one answer for everything, I know that.* ***It's got to be a multifaceted thing and come from all angles.***

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Appendix A. Core Interview Questions for State Administrators

1	Roughly, how many cases of abuse involving opioids would you say that your state has handled in the past year?
2	Did the number increase, decrease, or are they about the same in the last year, before COVID-19? Why do you think so?
3	In these cases, was it most likely that the victim is misusing opioids, or was the perpetrator misusing, or were both the victim and perpetrator misusing opioids?
4	What are some characteristics of these opioid cases?
5	Does your state have a policy or set of procedures to follow when cases involve opioids? If yes, please describe. If no, please describe how your staff respond to opioid cases.
6	What are the challenges encountered in investigating the allegations of abuse of these cases involving opioids?
7	Was your APS program able to provide any intervention(s) that assisted these clients to achieve increased safety and relief from continued abuse? If yes, please describe intervention(s) provided and specifically how intervention(s) assisted the victims. If no, what barriers blocked efforts to assist the victims?
8	Overall, do you find that substantiated cases of abuse involving opioids are generally more, less, or equally as difficult to intervene as other types of allegations?
9	Is it easier or harder to substantiate these cases?
10	When opioids are involved, is abuse, neglect, or exploitation easier or harder to miss than abuse, neglect, or exploitation when opioids are not involved?
11	Are there ways that APS and other agencies should be working cases differently when opioids are involved?
12	Do you have recommendations regarding how suspected victims of abuse involving opioids can be better served? That is, how can these cases better handled?
13	What are ways to improve prevention of the abuse of older people when opioids are involved?
14	Are there any other comments you would like to make about cases of abuse involving opioids in general?
15	Do you have any recommendations for further research on abuse involving opioids?
16	Would you be interested in participating in the Phase II of the study involving interviews with your local staff?

Appendix B. Core Interview Questions for Local APS Caseworks

1	Roughly, how many cases of abuse involving opioids would you say that you handled in the past year?
2	How were these clients in these cases harmed by the abuse that involved opioids?
3	What were the long-term impact of the abuse on the clients?
4	Did the clients or the perpetrators ever have other allegations of abuse?
5	What challenges, if any, did you encounter in investigating the allegations of abuse of these particular clients?
6	Was your APS program able to provide any intervention(s) that assisted these clients to achieve increased safety and relief from continued abuse? If yes, please describe intervention(s) provided and specifically how intervention(s) assisted the victims. If no, what barriers blocked efforts to assist the victims?
7	Do you have any thoughts or observations from these cases about what might have prevented the abuse by the perpetrators from occurring?
8	Overall, do you find that substantiated cases of abuse involving opioids are generally more, less, or equally as difficult to work as other types of allegations?
9	Is it easier or harder to substantiate these cases?
10	Do you find that intervening and achieving a positive outcome is harder for these cases?
11	When opioids are involved, is abuse easier to miss than abuse when opioids are not involved?
12	Based on your experience working these cases, are there ways that APS and other agencies should be handling them differently when opioids are involved? In other words, what are ways to improve prevention of the abuse of older people when opioids are involved?
13	Do you have recommendations regarding how suspected victims of abuse involving opioids can be better served or how these cases can be better handled?
14	Are there any other comments you would like to make about cases involving opioids?
15	Do you have any recommendations for further research on abuse involving opioids?