


A First (and Disturbing) Look at the Relationship Between the Opioid Epidemic and Elder Abuse: Insights of Human Service Professionals

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Abstract

This study explored the relationship between the opioid epidemic and elder abuse. Twenty professionals from four states with working knowledge of elder abuse cases participated in focus groups. Thematic analysis revealed four themes characterizing the relationship between opioid misuse and elder abuse: (a) *Opioid-Related Elder Abuse is an Escalating Problem*; (b) *Vulnerable Older Adults are Prisoners in Their Own Home*; (c) *Health Care Professionals Perpetrate Opioid-Related Elder Abuse*; and (d) *Older Adults Abuse and Deal Opiates*. In addition, all participants noted the lack of reliable, retrievable data to address cases of elder abuse when opioids are involved. Findings lay the groundwork for further research to understand the breadth and depth of the opioid-elder abuse relationship that can ultimately be used to develop prevention and intervention strategies and policies to address this hidden but widespread concern.

Keywords

elderly, opioids, facilities, families, rural, substance abuse

Older adults are a frequently forgotten cohort in the opioid epidemic. While older adults do not suffer the highest rate of opioid overdose deaths (Hedegaard et al., 2017), they are not immune to the consequences of opioid misuse. As a group, they experience multiple chronic conditions and high rates of chronic pain for which opioids are frequently prescribed (Frenk et al., 2015). About one fourth of long-term opioid users are aged 65 and older, with 2.2% of older adults reporting nonmedical use of prescription opioids during the past 12 months (Saha et al., 2016).

A hidden pathway by which the opioid epidemic appears to have infiltrated the lives of older adults is through the addiction of their children, grandchildren, and others in their lives. Theft is an all-too-common side effect of drug use; thus, individuals may view older relatives as having the financial means and other resources (i.e., medications) to support their addiction. While empirical evidence is lacking, experts believe that incidences of elder abuse have risen as the opioid epidemic has worsened (Benson & Aldrich, 2017). To begin to document the relationship between opioids and elder abuse, we sought the expertise of human service professionals in rural Appalachia, where the opioid crisis is particularly rampant (Moody et al., 2017).

Elder Abuse

Annually, about 10% of the U.S. older adult population experiences one or more forms of elder abuse (i.e., physical, sexual, and psychological abuse; financial exploitation; neglect; Acierno et al., 2009). Financial exploitation is the most prevalent abuse subtype reported (Acierno et al., 2009; Weissberger et al., 2019). Most elder abuse is perpetrated by relatives, yet little is known about how personal characteristics (e.g., age, gender) and life circumstances (e.g., dependency, isolation, substance abuse) of older adults and their family members (see Roberto, 2016, for review) converge to increase the risk of elder abuse.

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Method

Study Sample and Procedures

In November and December of 2017, four 1-hr telephone focus groups were held with 20 state and county-level senior administrative service professionals in Kentucky (KY; $n = 5$), Ohio (OH; $n = 4$), Virginia (VA; $n = 5$), and West Virginia (WV; $n = 6$). We selected these four adjacent states in Central Appalachia because they have some of the highest opioid misuse rates in the country. The second author worked with Adult Protective Service (APS) colleagues within each state to identify agency/organizational representatives most likely to understand how older adults are affected by the opioid epidemic and who could provide a macro-level perspective of elder abuse cases associated with opioid misuse. We sent email invitations with a description of the study to the individuals identified. Participants included representatives from APS, the State Attorney General's Office, Mental Health/Substance Abuse Services, Law Enforcement, Senior Services, and Medicaid Fraud Control. Virginia Tech Institutional Review Board approved the study (#17-866).

Focus groups are an effective and efficient methodology for gathering information about an emergent or understudied phenomenon. The focus groups were jointly facilitated by the first and second authors; both have extensive experience using this data collection approach. We followed standard focus group methodology to collect and analyze the data (Morgan & Krueger, 1997). Questions were designed to elicit predominant beliefs held by participants about the relationship between opioid misuse and elder abuse. After introductions and obtaining verbal consent from each participant, we began with general questions about the role of the participants' agencies in addressing the opioid epidemic and the prevalence of opioid-related elder abuse cases in their state. Participants were then asked a more specific set of questions about how older adults were adversely affected by perpetrators when opioids were involved and probed for information about the nature of the cases they encountered (e.g., stealing money or opioids from older adults; physically/psychologically abusing older adults to gain access to their money or opioids) and their outcomes. The next set of questions focused on caseworkers' responses to abuse (e.g., who are reporting the cases; agencies involved in investigations; availability of community support) and the challenges they face. We ended the focus groups by asking about the data agencies collected to document opioid-related elder abuse and what additional information they needed to better address such cases. Participants had ample time to respond to the questions/follow-up probes and opportunities to elaborate upon and clarify their answers.

Data analysis occurred in three phases. Phase 1 took place during the group sessions when the co-facilitators decided which responses to probe further (e.g., case examples) and which to redirect (e.g., general commentary). Phase 2 occurred following each focus group when the facilitators and observer (third author) shared their observations and

identified major themes of the session. At the completion of each focus group, the audio-recorded session was transcribed verbatim; however, speakers were not tracked individually.

Using thematic analysis procedures (Braun & Clarke, 2006) to analyze the 40 double-spaced transcribed data pages, the first two authors independently read the transcripts multiple times and made margin notes of emergent constructs. The first author then created a table organizing the constructs into preliminary categories to visualize patterns across the groups and shared the document with the second author. Both met regularly to establish a coding scheme and achieve consensus on the meaning of coding categories. Their discussions fostered development of a shared, detailed understanding of the data. Through an iterative process of constant comparison, primary themes were identified. We completed group-by-group comparisons to assess nuances across states and identified areas of congruence and difference. Specifically, we examined responses under the primary codes and compared quotes in the context of the participants' perception of opioid-related elder abuse in their respective states. Potential validity concerns were addressed through data immersion (i.e., multiple readings of transcripts), verification of the coding scheme across focus groups, and discussion of discrepancies until consensus was reached. Study participants and third author confirmed the study's collective findings.

Findings

Across groups, participants held comparable perceptions about the relationship between the rise in opioid addiction and elder abuse. Four themes emerged from the data analysis, highlighting participants' shared perspectives on opioid misuse and elder abuse. In addition, all participants commented on the need to better document the opioid-elder abuse phenomenon. Participant quotes and example cases illustrate their experiences and viewpoints.

Opioid-Related Elder Abuse is an Escalating Problem

VA participants collectively estimated a 25% to 35% increase in elder abuse associated with misuse of opioids and related drugs (e.g., fentanyl), whereas the KY participants perceived that as many as 75% of their cases involved opioids. Typical cases included family members stealing their older relatives' medications and financially exploiting them to support their addiction. While exploitation was the primary type of abuse investigated, participants indicated that drugs also opened the possibility for other types of abuse. A WV participant noted a co-occurrence of exploitation with "mostly verbal and mental abuse, but if perpetrators do not get what they want, [it] may escalate to physical abuse." In KY, a caregiver took their relative with dementia to multiple dentists to be treated for pain and eventually to have teeth pulled to gain access to more pain medications.

Opioid misuse often triggered reports of self-neglect. A VA participant explained that APS receives “complaints of self-neglect where bills are not getting paid or elders are missing appointments and after investigating, they [APS] find that there is a drug issue going on.” One OH participant noted, “when the money runs out, the victim does not have any resources to help with daily needs,” which leads to the service challenges articulated by a VA participant: “Some of the services . . . help the elders to solve their immediate problems of paying utilities bills but allows the perpetrator to stay in the house.”

Conversely, older adults often do not know about services or are afraid to ask for help because they are reluctant to cause trouble for their relative. In OH, home health nurses discovered that an elderly man cared for by his daughter had much of his methadone missing. When confronted, he refused to report the theft because he did not want to lose contact with his family. VA had seen several cases where hospice patients were exploited. In one case, “an elder with terminal cancer was on hospice and being exploited by his two daughters for his pain medicines. He refused services because he did not want to get his daughters in trouble.”

Vulnerable Older Adults are Prisoners in Their Own Homes

When opioids were intertwined with elder abuse, the older adult’s home became a safety hazard for the older adult, workers involved in the cases, and the community. A common scenario was a co-residing relative who was stealing medications for his or her own use and/or selling them, and gaining control of the older adult’s finances. Often, the relatives, typically an adult child or grandchild, were recently released from jail. Usually, older adults were unaware of the person’s drug problems when they moved in, but over time, their homes became a marketing location for drugs. A WV participant aptly described older adults as “prisoners in their own house.”

An OH participant explained that older adults allowed relatives in their home because that person helps or loves them. “Suddenly, there are multiple people living in the home, and the elder is shoved into a corner and isolated.” In addition to isolation, alleged perpetrators may use opioids to sedate the older persons, thereby making it easier to neglect them. A KY case is illustrative:

A grandson with a heroin addiction lived with his grandfather who had dementia. He exploited [grandfather] for \$85,000 to support his addiction. He was taking money out of his debit card, writing checks to his friends, and opening credit cards in his grandfather’s name.

Having a substance abuser in the home created an unsafe situation for professional caregivers and for case workers investigating allegations of abuse. An OH participant stressed, “It is difficult to get the ‘bad guy’ out of the house without

consent,” but emphasized that if drug abuse is suspected, law enforcement can enter the home with the APS worker and help relocate the older person to a safer environment.

Health Care Professionals Perpetrate Opioid-Related Elder Abuse

Participants also perceived increasing numbers of allegations of care facility employees taking medications prescribed for the residents. A KY participant described how older residents are harmed by a caregiver’s addiction:

An LPN at a nursing home took multiple medications off the cart one night and was found passed out at a nearby gas station after her shift . . . Residents whose medications were taken didn’t receive [their] medications and were in pain as consequence.

When asked how situations like the above were handled, a WV participant explained that criminal charges are unlikely because facilities either terminate or force out suspected employees by requiring them to take a drug test.

Physicians also contributed to the elder abuse-opioid problem. Some long-time doctors known to overprescribe opioids were viewed as being “intertwined into the community” and “unwilling to give alternative medications and work with APS,” even if they suspected that their older patients were handing over their pills to relatives. Furthermore, a KY participant indicated, “It is hard to target doctors who overprescribe because it’s a very lengthy process to report them . . . a 1.5 to 2-year process before anything is ever done.”

Older Adults Abuse and Deal Opiates

Participants noted that some older adults not only misused their opioid prescriptions (e.g., overmedicating) but also were abusing and dealing opiates. An OH participant relayed reports that “elders who have substance abuse issues are dying from overdoses in their home.” A concern in KY was grandparents raising grandchildren, illustrated by a case where

an older adult tested positive for heroin after taking in three grandchildren because she felt that she didn’t have the energy to keep up and take care of the children. She was using the heroin to help her have more energy.

In VA, an older adult who was not taking his medications refused services “because he was the one selling the drugs that were prescribed to him . . . His son was assisting with the distribution.”

Need for Reliable, Retrievable Data

All participants agreed that they have no reliable, retrievable data to document the scope of the opioid-elder abuse

problem. According to an OH participant, “it’s growing, but we do not have the figures to prove it.” Most states use a macro reporting system that does not track micro-level data. For instance, while “drugs” might be listed as a risk factor for an individual case, “they do not drill down to opioids as it relates to mistreatment of elder adults,” noted a KY participant. Both VA and WV participants noted that when drug use/abuse is uncovered, the information may be noted in the file, but it is not discernable from administrative database reports. Although some states or individual counties were developing reporting systems that, in the future, will capture information currently not accessible, most agencies have neither the funds nor staffing now to extract potential evidence connecting elder abuse and opioid misuse. Resigned that accessing and sharing data is limiting their response to the disquieting connection between opioid and elder abuse, a KY participant captured the concluding sentiment of each group: “The problem with elders and opioids is that is a hidden problem, and the only thing we can do is to talk about it and make it public.”

Discussion and Implications

The findings of this preliminary study paint a stark picture of a disturbing and heretofore silent problem that warrants further investigation. As discussed in the elder abuse literature, older adults who experience abuse are often directly or inadvertently stripped of their resources and quality of life because of the struggles of those around them (Roberto, 2016). Elder abuse scholars will recognize the inherent conundrums reflected by the focus group data—elder abuse (and substance misuse) is regarded primarily as a family matter, health care professionals are among the perpetrators of elder abuse, and some older victims of abuse misuse/abuse opioids. Furthermore, concerns about opioid misuse have been growing for more than 20 years and are not confined to the states studied. If perceptions of the current situation hold true, communities need to move swiftly to design and implement interventions to address this problem and reduce the repercussions of the opioid crises on the lives of older adults.

This volatile form of elder abuse has implications far beyond its victims. Education of individuals, families, professionals, and communities is key. Public awareness and culturally informed information about elder abuse continues to be lacking (Weissberger et al., 2019) as are community-based harm-reduction programs for opioid users in many rural areas (Moody et al., 2017). Ultimately, reducing opioid-related elder abuse requires better identification of elder abuse and treatment of its perpetrators within the context of the communities in which both occur.

While there is growing interest in, and an emergence of commentary on opioids and elder abuse, to our knowledge, our work provides the first data-based investigation of the opioid epidemic as a catalyst for elder abuse. Future research and concomitant funding must go forward and with alacrity.

It is imperative to gather reliable, retrievable data, analysis of which explores and explains the relationship of elder abuse and opioid misuse. We need more in-depth information about how older adults and their perpetrators are affected by opioid misuse. Only then will it be possible to develop meaningful intervention strategies and policies to address this insidious issue. We recognize that our findings are preliminary and may not be transferable to other communities in which opioid abuse is problematic. Nevertheless, they contribute critical initial insights about the potential link between elder abuse and the opioid epidemic and provide the scaffolding for future research, evidence-based protocols, and policies to address this disturbing, hidden, and pervasive concern.

Authors' Note

Virginia Tech Institutional Review Board approved the study (No. 17-866).

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