

**Statement of William F. Benson, National Policy Advisor
National Adult Protective Services Association
To the
Elder Justice Coordinating Council
Washington, D.C.
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Thank you for the invitation to speak to you today. My name is Bill Benson and I serve as the National Policy Advisor to the National Adult Protective Services Association (NAPSA). We are grateful to again have this opportunity to provide testimony to the Elder Justice Coordinating Council, as we last did at your fall 2016 meeting. And we are delighted to have the Council meeting today in coordination with NAPSA's 4th Global Summit commemorating the 13th Anniversary of World Elder Abuse Awareness Day. We would like to thank Assistant Secretary Lance Robertson for his leadership in continuing the Administration for Community Living's (ACL's) focus on elder justice and the continued leadership by the Elder Justice Coordinating Council participants in addressing this crisis, as ACL rightfully labeled it in its May 7 release of the first ever data from the National Adult Maltreatment Reporting System (NAMRS).

NAPSA represents the nation's state and local Adult Protective Services (APS) programs. Adult Protective Services are the nation's only system of state-based statutorily-authorized programs to investigate vulnerable adult abuse, neglect, and exploitation and to respond to and protect its victims. APS differs from state to state and even county to county including in definitions, services, and data collection, which is the result of states historically establishing their APS programs to address the critical issue of elder and vulnerable adult abuse in the absence of direct federal funding and guidance from the federal level. Programs are also administratively different with about half in state units on aging, about half in state departments of social services, and a few in other arrangements. The majority of states serve all individuals with significant disabilities ages 18 and older; while several serve only older adults with disabilities or older adults regardless of disability. Despite the differences, all APS programs investigate abuse in home and community settings, and almost half also investigate reports of abuse in long-term care facilities.

We are grateful now for the federal leadership and resources related to APS since the 2010 enactment of the Elder Justice Act, including the creation of ACL's Office of Elder Justice and Adult Protective Services, the Voluntary Consensus Guidelines for State APS Systems and the National Adult Maltreatment Reporting System. However, the continuing variations make it

difficult to gather data, describe APS, educate the community, and develop standards or practice and training.

Despite these disparate structures and services, APS is essential to states and communities developing an adequate response system to protect vulnerable adults across the lifespan. Today, we would like to focus on being a voice for APS and its clients in responding to the current opioid abuse and misuse epidemic. In the last year, in addition to the Administration's declaration of an opioid public health emergency, eight states have issued emergency declarations on the opioid epidemic. Among the population APS serves, the brief issued by ACL earlier this year identifies national data that older adults are more likely to use prescription opioids and for longer periods of time creating a risk of potential misuse by the consumer or others including caregivers and family. Additionally, increased side effects of opioids in older individuals can lead to falls, injury, and fatalities¹. Comments collected and summarized by the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR) suggest that people with disabilities are at a higher risk of opioid abuse, as well².

Most APS programs and NAMRS collect data on substance abuse present in a case generally, not specific to opioid use, whether prescription or otherwise. However, discussions with states' APS administrators have shown that reports involving opioid abuse are increasing and complex. These cases often involve neglect, financial exploitation, medication theft, or self-neglect. Looking to the future, the opioid epidemic will not only continue to impact APS, but the impact is likely to be even greater. In rural counties, adults ages 45 and older comprise 43% of opioid related deaths. Soon this new generation of older adults struggling with addiction as well as caregivers will be seen by APS³.

To best inform the Council on the impact of the opioid epidemic on APS programs, supervisors, and workers – and the victims they serve – we decided to go straight to the source. We are grateful to the state APS administrators who took the time to identify and provide case examples and their insights. We are also appreciative of the numerous informal discussions with APS folk and during our bimonthly NAPSA regional APS program calls. While not nationally

¹ Tilly, J., Skowronski, S., & Ruiz, S. (2017, December). *The opioid public health emergency and older adults*. Retrieved from <https://www.acl.gov/>.

² NIDILRR. (2018, May). *Summary of responses from a request for information: People with disabilities and opioid use disorder*. Retrieved from <https://acl.gov/>.

³ Aldrich, N. & Benson, B. (2017, August). *Raising awareness and seeking solutions to the opioid epidemic's impact on rural older adults*. Retrieved from https://www.giaging.org/documents/170818_Benson-Aldrich_paper_for_GIA_web_FINAL.pdf.

comprehensive, the descriptions they've given provide a snapshot of challenges across a variety of program structures.

Allow me to cite excerpts from two cases shared with us by APS programs:

“Client taking opioids for chronic pain but medications were not found in the home. The daughter, who lived with the client, was suspected of taking and selling the medications. The client had been prescribed oxycodone and methadone by the pain clinic but lab tests from the pain clinic showed no presence of opioids in the client’s system.”

“The client was reported to be misusing pain medication and overmedicating on prescriptions given for pain and preparation for surgery. Home health aides reported witnessing overmedication though the older adult says this is not true. APS opened a case and was able to refer the older adult for treatment services.”

It is important to note that these examples show that opioid-related cases, whether involving prescription opioids or illicit opioids, are a microcosm of the larger APS caseloads. Analysis of contributed case snapshots largely reflect the nature of APS reports as a whole. The most frequent reports discussed in opioid-related cases are self-neglect, exploitation, and caregiver neglect. These allegations do not stand by themselves. As one APS administrator notes, “APS usually finds additional allegations that need to be investigated in addition to the missing narcotics.” Alleged perpetrators were most often family members followed by non-family caregivers stealing prescriptions for their own use. Cases also underscore the impact beyond APS with the need to coordinate with partners such as EMS, law enforcement, home and community-based services, nursing services, mental health crisis units, and hospitals.

The most profound impact of opioid-related cases on APS is their increased complexity. Case workers may face additional assessments and challenges including behavioral assessments, coordination with medical providers, navigating family dynamics and addictions, and impacts of overmedication of both consumers and alleged perpetrators. Criminal elements in a case may add further complexity in working with law enforcement. Workers note that overmedication can exacerbate underlying conditions and affect the client’s Activities of Daily Living (ADLs) such as basic toileting. Opioids can also create a safety risk for the consumer, the APS worker, and the neighborhood. One worker reported that clients may cause fires when smoking while over medicated. Cases were also reported to involve criminal elements in the house.

These challenges require time, expertise and resources. One worker gave a sample timeline for a case involving opioids and self-neglect.

“A timeline of events for APS when completing an involuntary hold affidavit on a client who is a harm to themselves or others due to over medicating/abusing narcotic prescriptions. It takes approximately 4-5 hours to initiate and complete an affidavit. That includes face to face interviews, home visit, assessing behaviors, investigating allegations, contacting law enforcement, contacting the mental health crisis mobile unit (if accessible), filling out the forms with law enforcement, EMS, transportation to the local hospital, travel to the hospital, notarizing affidavit, communicating with the hospital SW [social worker] and hospitalist, and requesting that a behavioral team assess the client. Then follow up the next day including referrals, family involvement, resources, etc. This takes 3-4 hours. Then type up APS contacts and services provided with evidence attached for another 3 hours.”

This account totals 12 hours over two days for one case. One case among an APS worker’s potential caseload of 25. Whether it is the client who self-neglects or an elder being abused by others, cases involving opioids require more time particularly in making referrals to appropriate services and potential coordination with law enforcement.

A challenge identified by APS programs that plagues APS generally is the lack of resources in the community and in the program. They face a lack of services to assist clients and family. Just as in domestic violence cases involving older adults in which shelters are often not available, communities often lack treatment options and support appropriate for older adults dealing with opioid-related issues. This is especially the case in rural communities. One APS worker noted, “The main issue I’ve noticed is it becomes a cycle and due to lack of resources/knowledge there is no one to intervene.” This repeat cycle is compounded by the ease of access to prescriptions whether through a doctor’s over-reliance on opioid treatments, “doctor shopping” both in and out of state, and limited tracking of prescriptions. As a result, an already under-resourced system is at risk of being overwhelmed with more complex and demanding cases. APS workers also noted that staff may not have enough training in identifying misuse or abuse or in advanced skills for complex cases.

The challenges brought by the opioid epidemic highlight the need to fully support and fund APS and the resources it relies upon. We applaud the modest increased funding for the Elder Justice Act in the recent Congressional omnibus package but must note that it still does not provide any form of a funding stream for APS services. The development of NAMRS and the grants for enhancing state programs remain crucial. More needs to be done to build on these accomplishments. Some APS programs are now receiving Victims of Crime Act grants from their

states, mostly possible because of the increased Crime Victims Fund distribution cap which has made more funding of innovative projects possible.

However, it remains that the majority of states' APS programs continue to rely on the Social Services Block Grant (SSBG) as the only source of federal funding for program operations – for paying the salaries and associated costs of investigators and case workers. SSBG is crucial to addressing the opioid epidemic across the lifespan as evidenced by the SSBG Coalition brief that we have provided. Despite the importance of SSBG to APS and other services, SSBG remains under continuing threat. Elimination of SSBG would be devastating to APS' ability to address the opioid epidemic, as well as the many other reports of abuse and exploitation they receive. APS administrators tell us that there is almost no likelihood state legislatures would be able to offset the revenue that would be lost without SSBG.

While there are many challenges and difficulties facing us in this current opioid epidemic, APS is a crucial support for vulnerable adults. States' APS programs are describing cases with positive outcomes including consumers receiving much needed addiction and mental health treatment, voluntary movement out of unsafe environments, and change from a rep payee situation to independent financial management. How we address the opioid epidemic and prevent vulnerable adults from falling through the cracks will help guide and provide lessons for future public health challenges. Supporting our frontline APS workers and the vulnerable adults they serve supports the entire community.