

What We Don't Know Can Hurt Them:  
Addressing Alcohol Abuse and  
Prescription Drug Misuse Among  
Seniors 65 and Better

Cultural Subpopulations Needs & Resources Assessments  
For the Maine Office of Substance Abuse  
September 2006

By  
The Knox County Community Health Coalition (KCCHC)

Funding Provided by the SAMHSA, Center for Substance Abuse Prevention, Strategic Prevention Framework State  
Incentive Grant to the Maine Office of Substance Abuse, Department of Health and Human Services

## Executive Summary

1	Background/Overview	1
2	Findings on Needs, Resources, and Readiness	2
3	Summary References	15

## Appendix

A	Literature Review	17
B	Methodology and Results	21
C	Credits	43
D	Brief Commentary	43
E	References	44

## Attachments

A	KCCHC Senior Survey	46
B	Tri-Ethnic Center Interview/Small Group Questions	51

## Executive Summary

### **1. Background/Overview:**

#### **a. *Description of the subpopulation and overview of relevant cultural characteristics***

This participatory action research pilot project of the Knox County Community Health Coalition (KCCHC) focused on non-institutionalized adults age 65 years and better. Due to limitations in resources and awareness of cultural variables, seniors living on islands within Knox County were excluded. This assessment collected survey data from a sample of convenience of 80 socially active older adults. Additionally, a total of 20 key informant interviews were conducted; 9 related to alcohol abuse and 11 related to prescription drug misuse among this subpopulation in the county. The term key informant interview includes one-on-one contact and small groups of 2-4 participants. A small group was considered one interview.

The cultural characteristics of Knox County adults age 65 years and older emerge when reviewing the geographic factors, services available, perceptions of risk associated with alcohol abuse, strengths of the subpopulation, and barriers faced by prevention programs.

#### **b. *Analysis of inter-related geographic and cultural factors: Where does this subpopulation live (concentrated or dispersed)?***

As noted from the most recent Census, 12% of county households include individuals 65 years or older and 5.3% of seniors over 65 live alone.<sup>1</sup> Senior-specific housing in Knox County is limited. Subsidized housing through the Maine State Housing Authority includes eighteen complexes with a total of 416 units for elderly people and people with disabilities. There are four complexes in Camden, seven complexes in Rockland, three complexes in Thomaston, one complex in Union, two complexes on Vinalhaven, and one complex in Warren. Additionally, there are three retirement communities within the county providing a variety of services to older adults from independent living to total care: Bartlett Woods in Rockland; Camden Gardens in Camden; and Quarry Hill in Camden.

#### ***Where do they tend to access services in general?***

The only hospital in Knox County, Penobscot Bay Medical Center, is located six miles north of Rockland, in Rockport. Waldo County Hospital is approximately 24 miles north of Rockland in Belfast, Maine and Miles Memorial Hospital in Lincoln County is 27 miles south of Rockland in Damariscotta, Maine. Doctors' offices are concentrated near Penobscot Bay Medical Center in Rockport and Rockland. There are some practices in Camden, Warren, and Waldoboro (Lincoln County). It is likely people who live near the borders of Knox County drive to the services most convenient to them and thus may be accessing services outside of Knox County.

Likewise, almost all the pharmacies in Knox County are in coastal towns: Rockland has six pharmacies; Rockport has one pharmacy; Camden has three pharmacies. According to the seniors who responded to the KCCHC Senior Survey, 41 (51.3%)

obtain their own prescriptions at a local pharmacy, 24 (30%) rely upon mail order to receive their medications, and 12 (15%) have someone else such as a family member, home health aide, or personal care assistant pick up medications for them.

***How do geographic factors affect the cultural ties of the subpopulation?  
How do they affect the accessibility of culturally competent services?***

The rural geography of Knox County has an impact on people age 65 years and better in regard to transportation issues. Public transportation is nominally existent. The Methodist Conference Home in Rockland administers Coastal Trans, a non-profit transportation service using vans and private automobiles driven by volunteers. The Door to Door program of Coastal Trans provides rides for the elderly in Knox County for approximately half the cost of a taxi. Most people rely on private vehicles to get from their homes to health care and support services. Some have their own vehicle and others may rely upon people within their social networks such as family members, friends, volunteers, or members of a church community. Some people hire a taxi. Emergency responders provided anecdotes during interviews about some people who rely upon the town rescue service to bring them to the hospital (when their situation has gotten to emergency proportions).

Living in a rural area can be isolating for seniors. According to Miltiades and Kaye,<sup>2</sup> the majority of elders in Maine live in rural areas and those who reside in rural areas have poorer access to care, poorer health status, and require greater levels of care compared to their urban counterparts. Of the 80 seniors who responded to the KCCHC Senior Survey, 47.5% live alone. Thirty eight and seven tenths percent (38.7%) visit family about twice a month or less frequently and 13.75% visit with friends about twice a month or less frequently. It is important to note this sample of convenience is representative of more socially and/or physically active older adults who are involved in group activities and their communities.

Rural areas do not offer as many options for culturally competent services as urban areas, especially with regard to aging issues. There are four physicians specializing in geriatrics at Penobscot Bay Medical Center. Senior Spectrum, the Central Maine Area Agency on Aging, has a satellite office in Rockland offering a variety of culturally competent services including coordination for the Meal-On-Wheels program in conjunction with the Methodist Conference Home. The TRIAD, a coalition of law enforcement, senior services and seniors in the community to reduce criminal risks to the senior population also is active in Knox County. Other health and social service programs simply incorporate older adults into their practices or programming.

**2. Findings on needs, resources, and readiness**

**a. Substance abuse prevalence data**

**i. Core Measures:**

***Alcohol use in past month***

For the purposes of this study an alcoholic drink is defined as 12 ounces of beer, 5 ounces of wine, 1.5 ounces of spirits, or 4 ounces of aperitif.

Definition of Alcohol Abuse
-----------------------------

**Chronic Heavy Drinking:** Two or more drinks daily for the past 30 days

**Binge Drinking:** Five or more drinks on one or more occasions over the past 30 days

The KCCHC Senior Survey (n=80) shows 27 respondents (33.75%) had an alcoholic drink on at least one occasion in the past month. Fifty three seniors (66.25%) reported abstaining from alcoholic drinks in the past month. Of the seniors who consumed alcohol in the past month, 14 reported (51.85%) their intake in number of days per week and 10 (37%) reported consumption in number of days per month. One person reported drinking within the definition of chronic heavy drinking. Graph 1 shows rates of alcohol consumption among respondents, including binge drinking.

Graph 1. Alcohol Consumption by Seniors Responding to the KCCHC Survey

Number of Drinks Per Occasion	5+	1	2									
	4	3	2	1	0	1	2	3	4	5	6	7
4												
3												
2								1				1
1		4	5	1	4	1			1			3
0	53 of 80											
	None	1 Day Per Mo	2 Days Per Mo	3 Days Per Mo	1 Day Per Wk	2 Days per Wk	3 Days per Wk	4 Days per Wk	5 Days per Wk	6 Days Per Wk	7 Days Per Wk	

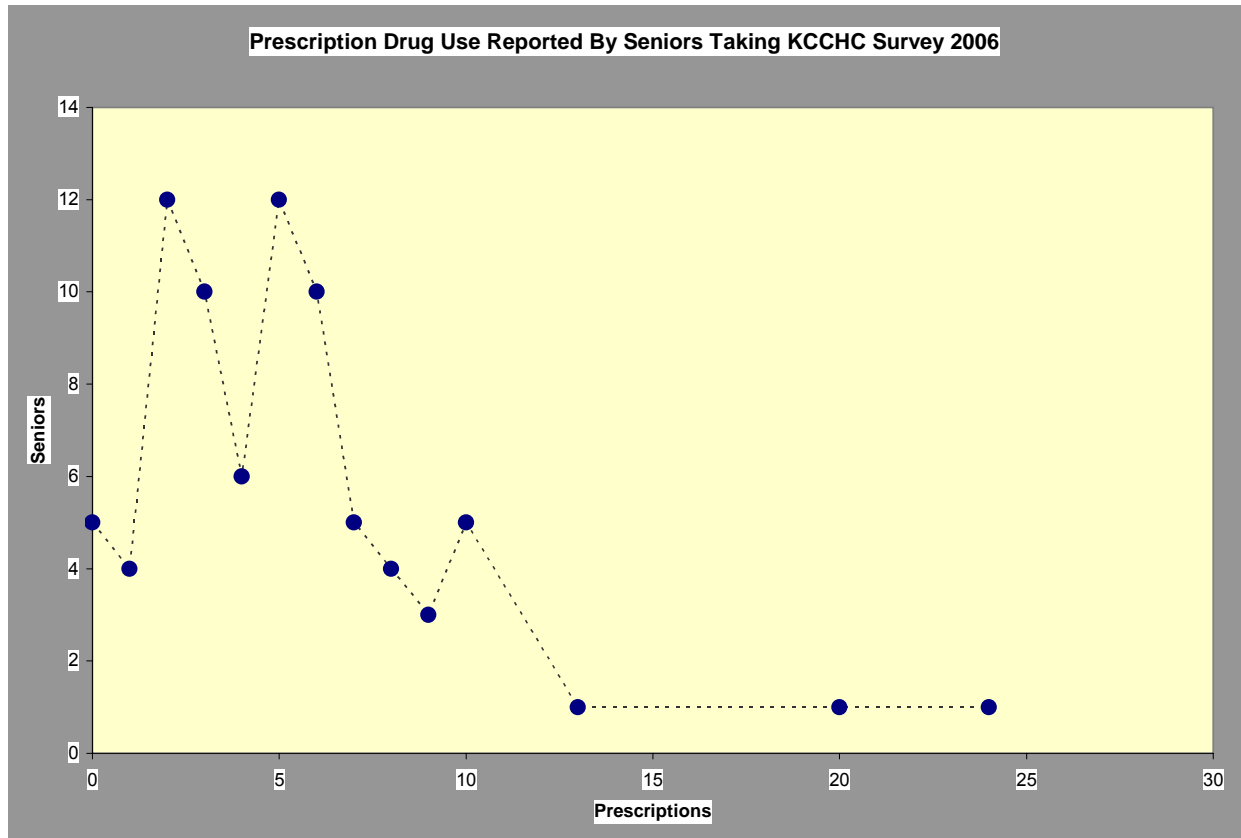
### ***Binge alcohol use in past month***

Three survey respondents (3.75%) reported binge drinking in the past month. One person reported one binge and two people reported two binges. Each of these individuals reported regular consumption of alcohol for the previous item in addition to binge drinking.

### ***Prescription drug use and misuse in past month***

Seventy five respondents (93.8%) reported taking one or more prescription medications and five (6.2%) reported not taking any prescription medications. Of those who take prescriptions, seventy one (94.6%) have a list of their medications and instructions for taking each. The average number of prescriptions taken by this sample is 5.45. Seventy four of those who reported taking prescriptions also identified the number of prescriptions they take as shown in Graph 2.

Graph 2. Prescription Drug Use by Respondents to KCCHC Senior Survey



***b. Unique patterns of substance abuse that have implications for prevention***

Based on nine key informant interviews of alcohol abuse among seniors, five described alcohol abuse that began in a person's youth and one alluded to abuse that began in later life subsequent to caregiver stress. Age of onset can have implications for prevention programming. Interviewees also shared anecdotes of people who drink in the privacy of their homes and who are able to hide an issue from people who visit at irregular intervals. Finally, it can be inferred that seniors who drink also take prescription medications. Interventions and prevention programs need to be prepared to address alcohol use in conjunction with other physical and/or mental health issues.

Eleven interviews regarding prescription drug misuse among seniors resulted in six key reasons for not adhering to medication administration protocols: memory problems; side effects; concern over theft of pain killers; expense of prescriptions; confusion over directions; and grief/depression. Prevention of prescription misuse among adults 65 and older has to do with improving health literacy, providing adequate monitoring, supporting access to Medicare Part D and other cost containment strategies, and addressing mental health issues among this population.

***c. Analysis of risk and protective factors that influence substance abuse pattern in the subpopulation specifically***

Data on risk and protective factors that influence alcohol abuse and prescription drug misuse among adults age 65 and better were gathered from the 80 senior surveys, nine

key informant interviews about alcohol abuse, and eleven key informant interviews about prescription drug misuse. The senior surveys were limited to only risk factors in an effort to keep the written survey to a manageable length and to avoid confusion over the definition of protective factors.

For the purpose of this study, protective factors were defined for all respondents, seniors and key informants, as something within a person or due to his or her culture that decreases his or her chance of developing problems related to alcohol abuse or prescription drug misuse. Seven of the nine key informant interviews generated a list of protective factors for preventing alcohol abuse. Nine of the eleven key informant interviews resulted in a list of protective factors for preventing prescription drug misuse. All topics mentioned at least twice are listed in the table below. The number after each factor shows the frequency with which each factor was mentioned across the interviews.

Table 1. Protective Factors Identified by Key Informant Interviews

Protective Factors	
For Preventing Alcohol Abuse	For Preventing Prescription Drug Misuse
Prevent loneliness; social events, activities, community involvement, volunteering [8]	Education by physicians [6]
Discussion of alcohol issues in families and by health care providers [4]	Oversight (of medication administration) by District Nursing or Kno-Wal-Lin [4]
Knowledge, awareness, education [2]	Knowledge about drugs and abuse of drugs [3]
Plan for retirement (before it happens) [2]	Communication with family [3]
Visits for shut-in's [2]	Social support [3]

The primary tool for preventing alcohol abuse among seniors is to prevent loneliness among this group of people. Subsequent protective factors all directly or indirectly address preventing loneliness either through relationships with others (family members, health care professionals, or friends and volunteers), better information about alcohol's effect on aging bodies and self-awareness, and good planning for retirement both socially and financially.

Building protective factors for preventing prescription drug misuse among seniors lies with physicians. Physicians must become effective in educating their patients about proper prescription use and in prescribing the correct dosages and combination of medications to their older patients. Many seniors would benefit from oversight of medication administration in order to remain independent and properly medicated within the community. Key informants suggested programs such as District Nursing or Kno-Wal-Lin but not exclusively. These are simply the programs with which respondents are more familiar. People must be better informed about prescriptions and what constitutes misuse and be able to communicate honestly with their family members who can offer

support. Finally, adults age 65 years and older need social support and on-going interaction to prevent loneliness and decreased functioning.

Risk factors for alcohol abuse or prescription drug misuse among adults 65 years and better were defined for study participants as situations, actions, or beliefs that lead to misuse or abuse. There were 28 surveys, or 35% of respondents, that provided one or more risk factors for alcohol abuse and 26 surveys, or 32.5% of respondents, who identified one or more risk factors for prescription drug misuse. Seven of the nine key informant interviews for alcohol abuse and 9 of the 11 key informant interviews about prescription drug misuse resulted in a list of risk factors for each situation. The top 5 risk factors for each issue are outlined in Table 2 showing how many respondents from each data source mentioned the respective risk factors.

Table 2. Risk Factors Identified by Senior Surveys and Key Informant Interviews

Risk Factors	
For Alcohol Abuse	For Prescription Drug Misuse
Loneliness, isolation [20 surveys; 4 interviews]	Cost of prescriptions, lack of money [15 surveys; 5 interviews]
Lack of money, economic issues [11 surveys; 1 interview]	Forgetfulness, dementia [9 surveys; 3 interviews]
Alcohol addiction, long term habit [10 surveys; 2 interviews]	Loneliness, lack of oversight [8 surveys; 3 interviews]
Stress, emotional or mental illness [9 surveys; 3 interviews]	Not understanding how to take prescriptions &/or polypharmacy [7 surveys; 6 interviews]
Transportation, inability to get around [4 surveys; 2 interviews]	Vision or literacy problems [3 surveys; 4 interviews]

Risk factors other than loneliness are more challenging to address. If seniors are at risk for abusing alcohol due to economic issues, habit/addiction, in response to stress or illness, or lack of transportation, they are reacting to situations by drinking instead of implementing a more constructive coping strategy. The challenge for prevention programs, family members, and friends is to encourage or instill a different way to respond to negative life situations or events.

Again, the risk factors for prescription drug misuse are more difficult to address within the current fiscal and social environment. Many seniors are misusing prescriptions due to financial constraints – they are not taking medications as prescribed because they cannot afford full dosages or any dosage. Memory issues, lack of oversight, inability to understand medication instructions for one or many drugs, and/or vision/literacy problems all require external intervention for affected adults. Many times providing help or support requires sensitivity so the person does not feel their independence is at risk. In order to address these risk factors in a meaningful way, local resources will need to be committed to supporting family members, volunteers, and social service programs in helping seniors access Medicare Part D and obtaining necessary oversight for taking medications accurately.



***d. Analysis of perceived risk and common consequences related to substance abuse in this group***

***i. Core Measures***

***Perceptions of great risk of having five or more drinks of an alcoholic beverage once or twice a week***

There is not a perception of great risk associated with having five or more drinks of an alcoholic beverage once or twice per week, or engaging in chronic heavy drinking. Anecdotal statements during five of the nine informant interviews mention attitudes associated with adults 65 years and better. Many people 65 years and older were members of the culture who enjoyed a cocktail hour before supper nightly. Still other seniors were members of a culture that drank at a bar after a hard day of physical labor. There is a feeling among the community at large and among members of this age group that they are adults and drinking is socially acceptable behavior. The cohort of people age 65 years and better is associated with not talking about drinking problems. These people are proud and very private. Alcohol problems are an invisible issue.

Some interviewees gave details about a drinking culture in coastal fishing communities. It has always been socially acceptable to go to bars two or more times per week and drink heavily. Many people started this behavior when they were young and only when they begin having health issues in their seventies and eighties are they confronted with the consequences of long term alcohol abuse. Additionally, drinking is socially acceptable among veterans of World War II and Vietnam. One respondent noted high rates of domestic violence in Knox County and cited a probable link between the violence and alcohol abuse.

Two of the interview sessions mentioned in detail the issue of socioeconomic class associated with problem drinking. There are two groups of problem drinkers, those who are affluent and those who are poor. The people who are affluent can keep their problem hidden from the public and seek treatment from private facilities away from the watchful eye of a tight-knit rural community. Members of the community ignore the poor “fall-down-drunk bum” that everyone views distastefully who gets picked up by Emergency Response Services and dropped off at the Psychiatric and Addiction Recovery Unit (at Penobscot Bay Hospital). Community members who are not members of either of those social circles do not recognize an alcohol problem among seniors within Knox County.

One of the key informants works in law enforcement and feels his view of an alcohol abuse problem among adults 65 years and better would be skewed in the direction of over-reporting an issue because of his work.

***Drug-related crime***

In 2004 in Knox County there were no murders, two (2) rapes, no robberies, eight (8) assaults, forty eight (48) burglaries, one hundred nineteen (119) thefts, and eight (8) auto thefts.<sup>3</sup> Crime rates are low. These data do not describe whether or not drugs were involved.

A recently released report commissioned by the Knox County Jail Study Committee found there were four inmates age 65 years and older who spent between 0-8 days in the Knox County Jail during 2005.<sup>4</sup> All four were white males, two were being held for operating under the influence (OUI), one was held for violation of conditions of release, and one was held for failure to appear. Overall there were 1,638 men admitted to the jail in 2005.<sup>5</sup>

The KCCHC Senior Survey had within it two items related to crime and prescription drugs. One item asked respondents to state the frequency with which their prescription medications have been stolen. All of the 53 people (100%) who answered this item said they have never had prescriptions stolen. The other item asked respondents to state the frequency with which they sold their medications to earn money. One of the 54 people (1.8%) who replied stated s/he always sells their prescription medications and the other 53 respondents stated they never sell their prescription medications.

### ***Alcohol-related injuries and traffic crashes***

There were not any items on either the KCCHC Senior Survey or the Tri-Ethnic Center's interview questions that addressed alcohol-related injuries and traffic crashes among adults age 65 years and better. Some anecdotes surfaced while key informants were describing how alcohol abuse among older adults is a hidden issue.

A respondent who works in law enforcement shared a story about an older woman who was driving her car erratically in town. He shared his initial perception about thinking she may be confused because she was older. After pulling her over and assessing the situation, he arrested her and later learned her blood alcohol level was three times the legal limit. He admitted buying into the attitude that someone who is older probably would not be driving drunk.

Another respondent spoke about a situation at a local agency that provides direct aid to community members. One of the volunteers who was an older woman came to her shift drunk. The manager of the agency confronted the volunteer and drove her home, before she started her shift or had a chance to drive anywhere else. This volunteer is involved in other local organizations as a helper. Does she even know she has a problem?

### ***e. Assessment of the strengths of the subpopulation, especially related to self-care and problem solving on substance abuse issues, how have people in this subpopulation who have been successful in preventing/reducing substance abuse done it?***

These Americans, who came of age during the Great Depression and WWII, have a lot to do with what the United States is today. And that era was training for how they conduct their lives as seniors in today's society. It is said that this group of Americans was united not only by a common purpose, but also by common values – duty, honor, economy, courage, service, love of family and country (community), and responsibility for oneself. This strength of character is what has, and continues to, see them through.

Our Knox county residents exhibited these traits as they proudly maintained their independence, either by living in their own homes, or, by still driving their own cars. The importance of family and social contacts helped many of them avoid the boredom or loneliness that often can be a breeding ground for substance abuse. Service to community was still evident as many shared their time and talents by volunteering in the community, and looking out for one another. Self-absorption was not common.

Ageism is deeply ingrained in our society by everyone, older people included. Many people expect changes in function as part of the normal aging process. However, some changes are not, and those who knew the difference were the ones who tended to age the most successfully. Having that awareness, coupled with the knowledge of alcohol abuse and prescription drug misuse issues, and being able to talk about these issues was fundamental.

Another avenue for these senior years to be successful was to plan ahead for retirement, hence, avoiding difficulties with finances, boredom, or loneliness. Financially, it was important to have the resources to provide for daily needs, a safe and functional residence, adequate food and medications, and transportation. The seniors who had a plan generally experienced better physical, mental, and emotional well being as they aged. A couple who retired to the Camden area, away from family and familiar support systems, had an extremely difficult time when the spouse became ill. Fortunately, strong ties with their local church saw them through a stressful time.

Another strategy evidenced by this group was good adherence to prescribed medication regimes, good working relationships with caregivers (paid and otherwise) and physicians who valued open, honest discussion about medications such as administration schedule, intended benefits, adverse effects, and costs. Patients who had, or were willing to create good working relationship between themselves and their physicians, as well as assume some of the responsibility for their own health fared better. Also, having oversight for medication from local agencies such as District Area Nursing, Kno-Wal-Lin, or pharmacists was a boost. Most of these seniors wanted to be perceived as a “good patient”, and attempted to have some kind of system in place.

Perhaps one of this group’s strongest assets was their belief system; their sense of spirituality, even beyond a personal religious code. Most exhibited overall feelings of optimism and hope, along with a good sense of humor.

***f. Description of resources available to and within this subpopulation***

Participants of small group and key informant interviews provided a list of Knox County resources available. A search of the internet and telephone book confirmed these agencies and organizations. Table 3 lists the resources identified in order of frequency mentioned. Only Senior Spectrum and TRIAD provide services targeted specifically to older adults and their caregivers, all others serve broader age groups. Although some interviewees were members of the TRIAD, a coalition of law enforcement, senior

services and seniors in the community to reduce criminal risks to the senior population, only one mentioned it as a resource.

Table 3. Knox County Resources Available to Adults 65 Years and Better

Resource for Addressing Alcohol Abuse	Number of interviews in which resource was mentioned (N=9)	Resource for Addressing Prescription Drug Misuse	Number of interviews in which resource was mentioned (N=11)
Alcoholics Anonymous	6	Midcoast Mental Health	4
Psychiatric & Addictions Recovery Center (PARC)	3	Choice Skyward	3
Midcoast Substance Abuse	2	Private Counselors	3
Alanon	2	Pharmacies / Pharmacists	2
Choice Skyward	2	Alcoholics Anonymous	1
Midcoast Mental Health	2	Psychiatric & Addictions Recovery Center (PARC)	1
Camden District Nursing	1	Kno-Wal-Lin	1
Tobacco Alliance (a.k.a. KCCHC)	1	Local Medical Facilities	1
Senior Spectrum	1	ME Drug Enforcement Agency	1
Doctor's Offices	1	Senior Spectrum	1
Private Counselors	1	Midcoast Charities	1
		Narcotics Anonymous	1
		TRIAD	1
		Family Members	1
		Physicians	1

***g. Analysis of barriers programs/coalitions in Maine commonly face in trying to provide culturally competent services for this subpopulation***

Factors that act as barriers to coalitions' and programs' ability to provide culturally competent services for adults age 65 years and better fall into the categories of the culture at-large, inadequate awareness or resources among professionals and leaders, and inadequate awareness or resources among individuals within the 65 years and better cohort.

***Culture At-large***

There are beliefs within our culture that act as barriers not only to coalitions and programs that seek to provide culturally competent services, but community leaders, family members, and older adults themselves. These beliefs have to do with what constitutes "normal" aging and mistaking signs and symptoms of conditions for consequences of aging. We hear it all the time when someone says, "I'm having a senior moment" to excuse an episode of forgetfulness as if one should expect to become forgetful or demented simply because a certain age threshold has been passed.

We live in a youth-oriented culture and place a priority on providing education and prevention services and treatment for children, adolescents, and young adults. There is an unspoken belief that services can make a difference in the lives of the young but it might be a waste of resources to provide the same for our elders. Nine of 13 key informant interviews mentioned awareness of alcohol and drug prevention messages among youth but an absence of the same for older adults. One interviewee said, “Even physicians look at their patients and say, ‘They are 82, if they want to drink, let them drink. They’ve done this their whole lives and I’m not going to change them now.’”

Overlapping with the previous belief in a youth culture, our culture espouses independence and individuals making decisions for themselves. Interview respondents stated, “Older people should know better [than to abuse alcohol]” and, “It’s your own choice and your own life.” While these basic rights need to be protected, many families and the health care system could benefit from resources and supports for intervening when older adults cannot continue doing things they have always done previously.

The cultural notion of independence and individuality along with isolation of many rural seniors plays into families bearing the burden of alcohol abuse and prescription drug misuse. These issues are not viewed as community issues because they are not perceived by citizens as affecting all of us. Since such a large number of older adults are retired, community members do not notice if their daily schedules are upset by alcohol abuse and workplace safety is not compromised by older people abusing substances. People age 65 and better spend a smaller proportion of time driving on roads than their younger counterparts. Alcohol abuse and prescription misuse are issues typically handled by individual families and social or health care services.

#### *Inadequate Awareness/Resources Among Professionals and Leaders*

Miltiades and Kaye found that rural seniors have poorer health status and require greater levels of care.<sup>6</sup> Additionally, 50% of adults 65 years and older in the Knox-Waldo region were found to have three more chronic diseases.<sup>7</sup> Health care providers may overlook alcohol abuse or prescription misuse issues that either get masked by pre-existing medical or psychological conditions, or must address higher priority medical conditions within the patient’s plan of care.

Kaplan found physicians may prescribe higher doses of medication to seniors than they should and without adequate monitoring.<sup>8</sup> The elderly metabolize medication differently and are more likely to suffer side effects which tend to be more severe with advancing age. These issues coupled with potential misunderstandings by patients’ who are unaware of interactions between drugs and alcohol can lead to adverse consequences for some seniors. Not only do health care providers need to be well informed about medication dosages, alcohol interactions, and aging bodies, they need to be adept at obtaining meaningful medical histories from older patients and conveying complex information to their patients who may have low levels of health literacy.

There are additional costs associated with addressing these issues for county leadership and for health and social service professionals. This places competing

demands on the time of professionals and funds (institutional, county, town) for managing other important public health and safety concerns.

### **Inadequate Awareness/Resources Among Members of the Cultural Sub-population**

Many members of the subpopulation hold personal beliefs and may maintain behaviors that are detrimental to their health status. Key informants have described beliefs held by members of this generational cohort of adults over 65 years as reluctant to speak with others since it may be a sign of weakness or a threat to their independence. Many people self-medicate with alcohol and/or remain in denial that there may be a problem with their alcohol use or prescription misuse.

There may also be a lack of knowledge about changes in metabolism with aging or a lack of knowledge about the interaction between alcohol and medications. It is easy to misunderstand instructions for taking medications or to become confused over how to manage multiple medications with various regimens. Additionally some members of the subpopulation suffer from discouragement over failing health, grief over losses, inadequate coping mechanisms, and failing memory whether due to organic conditions or as a side effect to medications. Finally a lack of financial resources and/or access to transportation on demand can result in prescription medication misuse.

#### ***h. Assessment of readiness stage of this subpopulation to address substance abuse issues (Tri-ethnic Center tool)***

Analysis of recordings from the focus groups and interviews according to the Tri-Ethnic Center's tools and protocols resulted in a community readiness of Stage Two for both alcohol abuse and prescription drug misuse among adults 65 years and better. Stage two is called Denial/Resistance by the Tri-Ethnic Center. There are specific goals and strategies that can be implemented to build momentum and support the community in addressing these issues.

Not only are many of the causes and consequences of alcohol abuse and prescription drug misuse among our elders are different, there are differences in how community members perceive each of these issues. Alcohol abuse seems to be more taboo than prescription drug misuse. While the goal of raising awareness among community leaders and members for both of these topics is the same, the willingness of community members to listen and take action is expected to be greater for addressing prescription misuse than alcohol abuse.

#### ***e. Recommendations for prevention programs/coalitions and other service providers to help them better serve the needs and draw on the resources of this subpopulation. This section should also include brief information about any model/evidence-based programs that have been developed for this subpopulation or adapted (successfully) specifically for this subpopulation.***

Recommendations to better serve the needs and draw on the resources of seniors within Knox County rely upon a grassroots approach and implementation of stage

appropriate strategies from the Tri-Ethnic Center's model to address alcohol abuse and prescription drug misuse. To raise awareness of these two issues among citizens coalition members and key informants can: [a] continue one-on-one visits with other influential professionals and leaders to educate them and obtain local anecdotes of people and families coping with these issues; [b] create consistent low intensity media of critical events in weekly newspapers, church bulletins, and community radio shows; [c] distribute flyers, posters, and brochures among local social service, outreach, and health care facilities; and [d] present information during town meetings, service club meetings such as Rotary and Kiwanis, and church social groups. Concurrent with these efforts, social marketing efforts to re-acquaint community members with culturally appropriate services already available within the county such as Senior Spectrum, TRIAD, and the Penquis Community Action Program/Retired Senior Volunteer Program (RSVP) need to take place.

Local prevention professionals and coalition members should advocate for implementation of the Institute of Medicine's (IOM) recommendation to institute electronically written prescriptions by 2010 and electronic medical record-keeping among health care providers and Penobscot Bay Medical Center. Electronic prescriptions would help eliminate many medication errors and begin the process of improving health literacy among seniors and their families. Electronic medical record-keeping would encourage consistent and thorough histories on patients and help identify patterns of alcohol use and abuse among adults age 65 and better, creating opportunities to recognize and address this issue more readily.

According to seniors and key informants, many adults 65 years and older need additional social support, interaction, and formal or informal monitoring. These relationships have been identified as an important protective factor for seniors related to preventing alcohol abuse and prescription misuse. Through continued grassroots efforts, social marketing, and outreach efforts, the KCCHC, caregivers, and social services can effectively involve older adults by encouraging participation in social groups, activities, and volunteer opportunities. For people who are not active or healthy enough to leave their homes, current resources such as church groups, Meals On Wheels, and Senior Spectrum can be coordinated for seniors on a one-by-one basis through social networks.

Transportation continues to be a factor for many seniors with regard to their ability to access services or participate in social activities. There are no easy solutions to this issue. Family, friends, community members, and social service providers will need to continue coordinating the tenuous and informal network that gets people from one location to another.

Related to alcohol abuse specifically, family members and caregivers need support and resources to cope with the challenges of having a loved one struggle with this form of dependency. The interviews highlighted that families currently suffer in silence and do not know of available support. As the grassroots efforts suggested above go into effect, it will be necessary to encourage the loved ones of seniors with alcohol dependency to

participate in accessing support and talking about their challenges to incorporate community involvement in the care they provide.

A final recommendation is to continue to study adults 65 years and better in Knox County. The seniors on the island communities could benefit from an assessment similar to this one completed on the mainland. Another direction in which this research should move is to study the effects of the combination of alcohol and prescription medications among this age group.

#### References

1. U.S. Census Bureau. DP-1. *Profile of General Demographic Characteristics: 2000. Data Set: Census 2000 Summary File 1 (SF1) 100-Percent Data. Geographic Area. Maine.* 2000a. (Retrieved May 10, 2005 from <http://www.census.gov/prod/cen2000/dpl/2khus.pdf>)
2. Miltiades, H and Kaye, L. The Aging Imperative in Maine: Present Realities and Future Prospects. *Maine Policy Review*. Fall 2003: 10-23.
3. City-Data.com website retrieved September 25, 2006 from <http://www.city-data.com/city/Rockland-Maine.html>
4. Correspondence with William Post, Administrator of Knox County Jail. September 28, 2006 and October 2, 2006.
5. Ibid.
6. Miltiades, H and Kaye, L. The Aging Imperative in Maine: Present realities and future prospects. *Maine Policy Review*. Fall 2003: 10-23.
7. Public Health Resource Group. *Health Planning Report for the Knox-Waldo Region.* The Eastern Maine Healthcare Community Needs Assessment With a Special Focus on Substance Abuse. January 15, 2002.
8. Kaplan, A. Alcohol and drug dependence in older adults. *Geriatric Times*. Sept/Oct 2000:1(3).



## Appendix

## A. Literature Review

Much of the research on older adults in the United States comes from the secondary analysis of data that have been developed for other purposes. Surveys sampled are often from the general population such as the National Health Interview Survey (NHIS) and the Behavioral Risk Factor Surveillance System (BRFSS) and data from administrative records such as death records, hospital discharge records, or insurance claims. When these kinds of data are used, one needs to be concerned if the dataset is representative of all older persons in the United States, and if the sample size is large enough for meaningful analyses.<sup>1</sup> In the subpopulation for the Knox County study, this was apparent.

### *Alcohol Misuse and Abuse*

Because of age-related physiological changes, declining health and functional status, and medication use, older adults can incur problems at low levels of alcohol consumption.<sup>2</sup> The National Institute on Alcohol Abuse and Alcoholism recommends that older adults limit alcohol consumption to one drink per day.

Estimated rates of alcohol dependence among this subpopulation vary widely. Memmott states that estimates of alcohol dependence in the population over age 65 range from 1-5%, while the prevalence of problem drinking in the elderly varies from 10-15%.<sup>3</sup> Kraemer, et al., found the national prevalence rates of alcohol abuse among the same group range from an estimated 5-10% among primary care outpatients<sup>4</sup> and Fink, et al., found the highest estimates in a recent survey in the Journal of the American Geriatric Society at 20-22%.<sup>5</sup> Varying standards for defining alcohol dependence and abuse may contribute to disparities in prevalence rates.

One method used by researchers to identify alcohol abuse among seniors is to analyze medical records after hospital visits. Lazow reports that within the high percentage of adults 65 and older who are admitted to a hospital at least once a year (20% of the population of this age), 20-50% who entered the hospital for non-alcohol or other drug-related problems were identified as having such problems.<sup>6</sup> A study by Adams, Yuan, Barboriak, and Rimm analyzed national 1989 Medicare claims data, and found that alcohol-related hospitalizations were more common among elderly people than hospitalizations for myocardial infarction.<sup>7</sup>

Fink et al. developed the Alcohol-Related Problems Survey (ARPS) to detect older people who are at risk for or are experiencing problems because of their use of alcohol alone or in conjunction with their co-morbidities, medication use, and functional status.<sup>8</sup> The Alcohol-Related Problems Survey (ARPS)<sup>9</sup> was administered to 549 current drinkers 65 and older; who were mostly Caucasian (87%) with high school or higher education (94%). Eligible participants reported drinking at least one alcoholic beverage in the past 12 months. Based on the ARPS score, drinkers were classified into three categories: harmful drinkers (alcohol abuse or dependence, or the presence of

problems such as hypertension, adverse drug events, or legal problems due to drinking); hazardous drinkers (drinking poses a likely risk for problems); or nonhazardous drinkers (drinking poses no known risks for problems). Eleven percent of subjects were harmful drinkers, and 35% were hazardous drinkers. Most harmful drinkers were identified by their use of alcohol with their comorbidity (e.g., 3 or more drinks, 2-3 times per week and having hypertension, depression or other psychiatric condition, or gout; or, any amount of alcohol plus having had hepatitis in the past 12 months, cirrhosis or other liver condition, or gastritis in the past 12 months). More men than women were classified as harmful drinkers, and more women than men were classified as nonhazardous drinkers. Most hazardous drinkers were identified by their use of alcohol with medications. Similar proportions of men and women, and older (age 75+) and younger (age 65 to 74) age groups were hazardous drinkers.

Drinking problems in older people are often neglected by families, doctors, and the public.<sup>10</sup> In addition, alcohol use and misuse can be mistaken as common signs of aging and dementia. Alcohol abuse among older adults is believed to be symptomatic of other chronic and mental health conditions or may resemble other medical conditions leading to misdiagnosis.<sup>11</sup> Also, medical problems combined with alcohol abuse can lead to depression.<sup>12</sup> Like seniors across the nation, fewer seniors in Maine are identified as substance users because of co-existing conditions and pervasive beliefs that aging carries a consequence of emotional and mental disorders. It is estimated that 10% to 15% of older adults in Maine have alcohol related problems.<sup>13</sup>

### *Prescription Drug Misuse*

When looking at prescription drug misuse, multiple determinants, causes, and consequences become evident. For example, older adults may be experiencing problems related to overuse of prescription drugs. They may be prescribed more medication than they can tolerate at that age, or they are seeking prescriptions for a particular medication from multiple providers. Compared with younger people, the elderly metabolize medication differently and are more likely to suffer side effects that tend to be more severe with advancing age.

Misunderstanding doctor's instructions, poor memory function that can accompany aging, discouragement over failing health and the cost of prescription medications, are likely all additional contributors to this misuse. Considering many people are unaware of interactions between drugs and alcohol, the elderly may encounter adverse consequences of such combinations. A connection between the misuse of medications and age-related morbidity likely exists. For example, elderly persons who take benzodiazepine are at an increased risk for falls that cause hip and thigh fractures as well as cognitive impairment that contributes to vehicle and household accidents.<sup>14</sup> Unlike younger people, the elderly are reticent when speaking about mental illnesses, addiction, or medication dependence and may perceive help as a threat to their independence. They fear the inability to care for themselves and grew up thinking that if you're sad, you just need to "pull yourself up by your bootstraps." Denial is a common

cause for not seeking help and even when the need is recognized, elders are often less likely to seek help for fear of being stigmatized.

Older Americans use prescription medication approximately three times as often as the general population.<sup>15-16</sup> Gurwitz estimates more than 40% of adults age 65 and older take five or more prescriptions per week and that 12% use 10 or more medications.<sup>17</sup> Up to 17% of Americans over age 60 misuse prescription drugs.<sup>18</sup> Additionally, physicians may prescribe higher doses of medication to seniors than they should and without adequate monitoring.<sup>19</sup>

Medication mistakes injure well over 1.5 million Americans every year.<sup>20</sup> In a report released on September 14, 2006, the Institute of Medicine (IOM) found at least one quarter of these errors are preventable and urged major steps by the government, health providers, and patients alike.<sup>21</sup> At the top of the list is the recommendation that all prescriptions should be written electronically by 2010.

The report spoke critically of the number of preventable prescription errors within a hospital setting and the author's maintain that there's "too little incentive for health providers to invest in technology that could prevent some errors today." Although this new IOM paper does not say how many of the injuries are serious, or how many victims die, a 1999 estimate put deaths, conservatively, at 7,000 a year. The nation's fragmented health care system is conducive to drug errors. Medications' sheer volume and complexity illustrate the difficulty. There are more than 10,000 prescription drugs on the market, and 300,000 over-the-counter products. It's impossible for professionals writing prescriptions to memorize their different usage and dosage instructions, which may vary according to the patient's age, weight and other risk factors, such as bad kidneys.

### *Maine*

When looking at the state of Maine, one must take into account its rural geography coupled with its high percentage of senior citizens. Maine is the seventh oldest state in the country<sup>22</sup> and is tied with West Virginia in having the nation's oldest median age.<sup>23</sup> Over 50% of elders in Maine live in rural areas, and those who reside in rural areas have poorer access to care, poorer health status, and require greater levels of care compared to their urban counterparts.<sup>24</sup> Rural residents travel from between 13 and 30 miles to get to a substance abuse treatment facility<sup>25</sup>; 49 percent of metropolitan residents live within one mile from a treatment facility, only 9 percent of rural residents have such an opportunity for care.<sup>26</sup> Specific and accurate up-to-date information about substance abuse services for older individuals in Maine is difficult to obtain or is not available.

Even though substance abuse rates among older adults are less prevalent than that of younger people, research shows that it is more difficult to detect. Like seniors across the nation, fewer seniors in Maine are identified as substance users because of co-existing conditions and pervasive beliefs that aging carries a consequence of emotional

and mental disorders. Analyses of statewide Maine Medicaid data identified 1,312 individuals with a substance abuse diagnosis and an additional 424 were identified with dual diagnoses of substance abuse and mental illness.<sup>27</sup>

It is estimated that 10% to 15% of older adults in Maine have alcohol related problems; two thirds of these developed alcohol dependence in later life.<sup>28</sup> Seniors are more likely to receive detoxification services and less likely to receive outpatient treatment. Currently, the Maine Office of Substance Abuse does not tailor or fund programs specifically targeted toward older adults.<sup>29</sup> Effective prevention measures must be designed to address the needs of this sub-population.

The Eastern Maine Healthcare Needs Assessment found that elderly men in the Knox-Waldo Region were almost three times more likely than their peers throughout the state to report chronic heavy drinking. Rates of binge drinking among adults age 65 years and older in this region were notably lower (1.3 per 1,000) than throughout the state (3.5 per 1,000).<sup>30</sup> The same assessment found 50% of Knox-Waldo County residents age 65 and better reported a diagnosis of three or more chronic diseases such as diabetes, arthritis, hypertension, hypercholesterol, heart disease, lung disease, cancer, asthma, depression, substance abuse, and psychiatric conditions other than depression.<sup>31</sup> Since access to primary and preventive care is high the Knox-Waldo Region, it was suspected that these seniors take multiple prescription medications. Although the results of the Eastern Maine Healthcare Assessment are useful, the data are from two distinctly different geographic areas and have been combined.

While data regarding prescription misuse for older persons in Maine is unavailable, there is no reason to assume Maine's statistics are considerably different than national findings described earlier.

There are slightly over 41,000 people living within Knox County's 365.7 square mile area. Of these 17.2%, or 7,052, are adults 65 years and better. This number rates Knox County as the second highest older population in the state behind adjacent Lincoln County by 1%. Twelve percent of county households include individuals 65 years or older, 5.3% of seniors over 65 live alone, and 35% of individuals over the age of 65 are disabled.<sup>32-33</sup>

The area lacks racial diversity, 98.3% of residents are white. An estimated 1,115 citizens are institutionalized. The median age of residents within the county is 41.4 years and the median household income in 2000 was \$36,774.<sup>34</sup>

Rockland is the county seat and the only city. There are approximately 7,600 residents within Rockland's 12.9 square mile area. The median resident age in the city is 40.9 years. In 2000, the average household income was \$30,209 and the median house value was \$82,400. There are two other towns of notable size in Knox County, both along the coastal Route 1 corridor. Camden has approximately 5,254 residents in a 3.8 square mile area. The median age of Camden residents is 47.0 years, the median household income is \$39,877, and the median house value is \$164,200. Thomaston

has approximately 3,748 residents residing within 2 square miles. The median age of Thomaston residents is 39.4 years, the median household income is \$33,306, and the median house value is \$94,100.<sup>35</sup>

The following towns fall within Knox County, some of which are on islands: Appleton, Cushing, Friendship, Hope, Isle au Haut, North Haven, Union, Warren, and Washington. Matinicus Island is a plantation. Due to limitations on resources, this pilot project did not collect data from or about island seniors in Isle au Haut, North Haven, Vinalhaven, and Matinicus.

## **B. Methodology and Results**

### **Study Procedures/Methods**

This descriptive participatory action research pilot study describes: [a] the issues of alcohol abuse and prescription drug misuse among adults age 65 and better in Knox County; [b] risk and protective factors associated with these behaviors among the target population; [c] perceptions of and knowledge about current resources available to seniors and their caregivers to address these issues; and [d] stage of readiness to address these issues by key leaders and service providers in Knox County.

The Knox County Community Health Coalition (KCCHC) defines alcohol abuse as [1] chronic heavy drinking (consumption of two or more alcoholic drinks daily for the past 30 days) and [2] binge drinking (five or more alcoholic drinks on one or more occasions over the past 30 days). For the purposes of the study, one alcoholic drink is 12 ounces of beer, 5 ounces of wine, 1.5 ounces of spirits, or 4 ounces of liquor or aperitif. Prescription drug misuse has been defined as not taking medications as prescribed and includes: [1] Missing doses in order to save money; [2] Missing doses to avoid side effects; [3] Missing doses due to memory problems; [4] Taking more medication than prescribed; [5] Having medication stolen; or [6] Selling medication to earn additional income.

Data was collected from the sources outlined in Table 1. Two instruments were used to collect data from respondents. First, a survey was prepared to identify behaviors and knowledge of older adults in Knox County (Attachment A). Second, the Tri-Ethnic Center's Community Readiness Assessment has been developed into a one-on-one telephone interview format and focus group questions.

Table 1. Original Project Design

Subjects	Data Collection Tool	Measures	Data Collection Method	Notes
<b>Adults 65+ years</b> Independent living housing for seniors; churches; organizations with meetings of seniors; senior exercise classes	Written Survey with protocols of options for 1:1 in-person and telephone interviews	Demographics; Social Contact; Alcohol Use; Rx Use <sup>a</sup> & Understanding; Resource Knowledge; Risk Factors	Written with option for private 1:1 or scheduled telephone interview	A team of trained coalition members/volunteers administer surveys after a brief presentation and offer mixed mode of survey administration.
<b>Caregivers</b> (personal care attendants, certified nurse assistants, home health aides, paid companions, family, friends)	Tri-Ethnic Center Community Readiness Tool	Readiness for Change on: Community Efforts; Community Knowledge of Efforts; Leadership; Community Climate; Community Knowledge about the Issue; Resources Related to Issue; Risk & Protective Factors	Focus Groups	Project evaluator, trained coalition members, and volunteers collect focus group data.
<b>Professionals Working Directly with Target Population</b> Pharmacists; Dr. Office Support Staff; Visiting RN's & Home Health Care; PT <sup>d</sup> & OT <sup>e</sup> Outpatient Clinics; ER <sup>f</sup> Admissions Associates; Rescue & Law Enforcement Workers; Social Workers/Counselors; Sr. Living Administrators	Tri-Ethnic Center Community Readiness Tool	Readiness for Change on: Community Efforts; Community Knowledge of Efforts; Leadership; Community Climate; Community Knowledge about the Issue; Resources Related to Issue; Risk & Protective Factors	In-person Interview or Telephone Interview	Trained coalition members/volunteers contact and interview individuals from each of these different groups.

<sup>a</sup> RX use: Prescription use; <sup>b</sup> RSVP: Retired Senior Volunteer Program;

<sup>c</sup> TRIAD: coalition of law enforcement, senior services, community members;

<sup>d</sup> PT: Physical Therapy; <sup>e</sup> OT: Occupational Therapy; <sup>f</sup> ER: Emergency Room

The KCCHC followed the timeline in Table 2 to accomplish the needs and resources assessment. Subsequently there will be a period of dissemination to support the coalition, social and health care services, and community members in addressing alcohol abuse and prescription drug misuse among older adults in Knox County.

Table 2. Project Timeline

Project Activity	Aug '05	Sep '05	Oct '05	Nov '05	Dec '05	Jan '06	Feb '06	Mar '06	Apr '06	May '06	Jun '06	Jul '06	Aug '06	Sep '06	Oct '06 – Jun '07
Instrument Development															
IRB Application															
Train Coalition Members															
Focus Groups															
1:1 Interviews															
Senior Surveys															
Analyze Data															
Write Report															
Disseminate Results															

### Data Collection Teams and Training

KCCHC is a community/school partnership comprised of agencies and organizations representing numerous facets of our population. The coalition relied upon its dozens of established collaborative relationships with various area non-profit organizations including hospitals and health organizations, religious organizations, schools, community groups, and civic clubs. Members of the coalition, two graduate students, and paid staff were trained by the project evaluation consultant to follow project protocols and maintain confidentiality while conducting this descriptive participatory action pilot project. Human subjects research approval was gained through the Maine Department of Health and Human Services.

Teams of two data collection volunteers coordinated to collect survey data from seniors throughout Knox County and to hold the five small focus groups (referred to as key informant interviews subsequent to data collection and analysis.) Individuals who were trained to follow protocols carried out eight one-on-one interviews of key informants throughout the county. All small groups and one-on-one interviews were audio recorded in order to analyze the data according to the protocol outlined by the Tri-Ethnic Center for Prevention Studies.<sup>36</sup>

An influential partner of KCCHC was the Retired Senior Volunteer Program (RSVP) of the Community Action Program (CAP). Leadership within RSVP and CAP committed to implementing a social marketing strategy to introduce the purpose of this needs and resources assessment and collect data from peers. Although the KCCHC sought to recruit a RSVP volunteer to assist with data collection for this project, no one was identified in the community during the project period.



## Senior Survey

Potential subjects for the survey among older adults in Knox County were identified by active coalition members and the Volunteer Coordinator from the RSVP. Project resources and timelines limited data collection to a sample of convenience among already formed groups of non-institutionalized seniors on the mainland of Knox County. The original plan was to collect 100-150 completed surveys although only 94 surveys were collected and 80 were used for the analysis. Surveys were excluded if the respondent had not reached 65 years or did not live in Knox County.

The KCCHC Senior Survey was designed to describe: [a] self-reported alcohol and prescription drug use patterns; [b] local resources known to members of this population; [c] needs that are currently unmet with regard to medical and social services; and [d] risk factors for misuse/abuse among seniors (Attachment A). The survey was pilot tested among KCCHC members and the RSVP Board of Directors. Feedback from these groups was incorporated into the final instrument.

A brief educational seminar informed individuals of the pilot study's definitions and aims. A pamphlet of local resources was distributed also among seniors in case discussing these issues motivated anyone to seek support.

A concern during data collection for this research was that older adults who are substantially impaired, regardless of residence, would be more likely to make errors in survey responses, less likely to respond to specific items, and might be generally less likely to participate in surveys, compared to non-impaired older adults.<sup>37-38</sup> Several reasons have been offered, including low levels of comprehension and concentration; fear of interacting with strangers; sensory or cognitive impairment; other health problems that might make some older adults reluctant to participate; or gate-keeping activities by household members, which might limit interviewers' access to older adults.<sup>39-41</sup> Regardless of the reasons, no response and incomplete response are problems in research focused on health status. But failure to include the older, more physically and cognitively impaired in samples reduces the accuracy of population estimates and the ability to study these important target groups. Techniques such as mixed modes of data collection and reliance on proxy reporters (as was done in the National Health Interview Survey and Longitudinal Survey on Aging) have been suggested as techniques to maximize sample coverage.<sup>42</sup>

To partially address some of the limitations of survey research, this project offered seniors the option to complete the survey verbally with one of the data collection team members, in-person or over the telephone. Seven participants took advantage of one-on-one survey completion interviews. No one took advantage of scheduling a telephone meeting to complete a survey. Surveys completed with assistance have been treated in the same manner as surveys completed by respondents in writing.

What is hoped is that the geographic representativeness of the data collected will help to fill gaps found in previous studies. Generally, the available datasets are designed to be nationally or regionally representative, not locally representative. Adequate state-specific or local data on the health status and service needs of older persons are often not available. Health planners too often use national findings to estimate the needs of older people in smaller or rural areas. This pilot study gives some insight into the demographics and behaviors of socially active seniors throughout the mainland of Knox County.

Twenty-seven groups of seniors in Knox County representing a variety of organizations such as senior social groups, church groups, independent living facilities/apartment complexes, exercise groups, and social service organizations were approached to participate. Seventeen did not respond and four groups refused to participate after leaders learned about the aims and methods of this study. One survey administration session was scheduled to which no one attended. Five groups participated in the collection of 94 surveys, of which 80 were used in the analysis. Table 3 details the geographic area covered to obtain Senior Survey data.

Table 3 Groups Participating in KCCHC Senior Survey

Date	Group	Location	Number of Surveys Collected
2/7/2006	Rockland Senior Group	Union	23
3/3/2006	Methodist Church	Camden	32
3/22/2006	YMCA Exercise Class	Rockport	4
3/23/2006	Methodist Conference Home	Rockland	23
4/11/2006	Friendship United Methodist Church	Friendship	12

Senior survey data were entered into an Excel file template and coded by type of location: senior club; senior apartment complex; exercise group; or church group. Frequencies were conducted to describe alcohol abuse and prescription drug misuse among the sample of senior citizens in Knox County based on demographic and social interaction information. Limitations in sample size and response rates on some items limited the analysis of respondent perceptions of social services available and willingness to access services if needed. Due to the small number of seniors reporting alcohol abuse and prescription misuse behaviors, cross-tabs were not calculated. Survey fatigue seemed to be a factor in respondents' ability to fully complete the instrument.

One limitation of this study could be the representativeness of the general population of seniors 65 years and better in Knox County. When numbers are small, estimates can be made for subgroups of particular interest, but the standard errors for those estimates are so large that they are unreliable, difficult to interpret, and of limited use for understanding the characteristics of the subgroup in the underlying population. For example, even in a large random sample of the U.S. population in which no special provisions were made to over-sample the elderly, approximately 13% of the respondents will be aged greater than or equal to 65 years and only 5% will be aged

greater than or equal to 75 years.<sup>43</sup> When the sample is limited to a geographic area or when an event of interest is rare (e.g., binge drinking among persons aged greater than or equal to 85 years), the problem is magnified. This needs to be taken into account when reviewing the data from the KCCHC Senior Survey.

## Senior Survey Results

Defining the appropriate population and a sampling frame that accurately represents the study population was a critical element of this study. This analysis was limited to the adult non-institutionalized subpopulation of Knox County, with data gathered through a convenience sample from 80 seniors living in Knox County. Surveys were conducted from December, 2005 through April, 2006.

Of the 80 respondents to the KCCHC Senior Survey, only 17.5% were men, while 73.7% were women. Our folks reported 47.5% as living alone while the 2000 US Census found only 5.3% of seniors in this age bracket live alone. Other living situations included: 28.8% live with another person; 10% in an “other” living situation; and 13.7% non-respondents.

Quite remarkably, 30% of respondents to the KCCHC Senior Survey fell in the age bracket between 80-84 years, making this the best represented age group in the sample. Chromatically, the breakdown follows: 3.75% were between 65-69 years; 8.75% were 70-74 years; 21.25% were between 75-79 years; the previously mentioned 30% between 80-84 years; 16.25% were between 85-89 years; 13.75% were between 90-94 years; and 5% were between 95-99 years.

The snapshot of our subpopulation reveals that 82.5% retired sometime between 1967 and 2005 and 15% still are not retired from paid work. Quite a good number of these seniors volunteer, and of the 43.75% who do, 29 reported donating an average of 5.5 hours per week.

Social life appeared still important to our respondents who reported spending even more time with friends than with family. Contact with friends amounted to between two and seven days per week by 70% of the seniors; 16.25% stated weekly contact with friends; 6.25% had contact once or twice a month with friends. Time with family was reported to be between two to seven days per week by 31.25%; 15% had contact once or twice per month; 12.5% had contact with family approximately every other month or quarterly.

## Alcohol Use

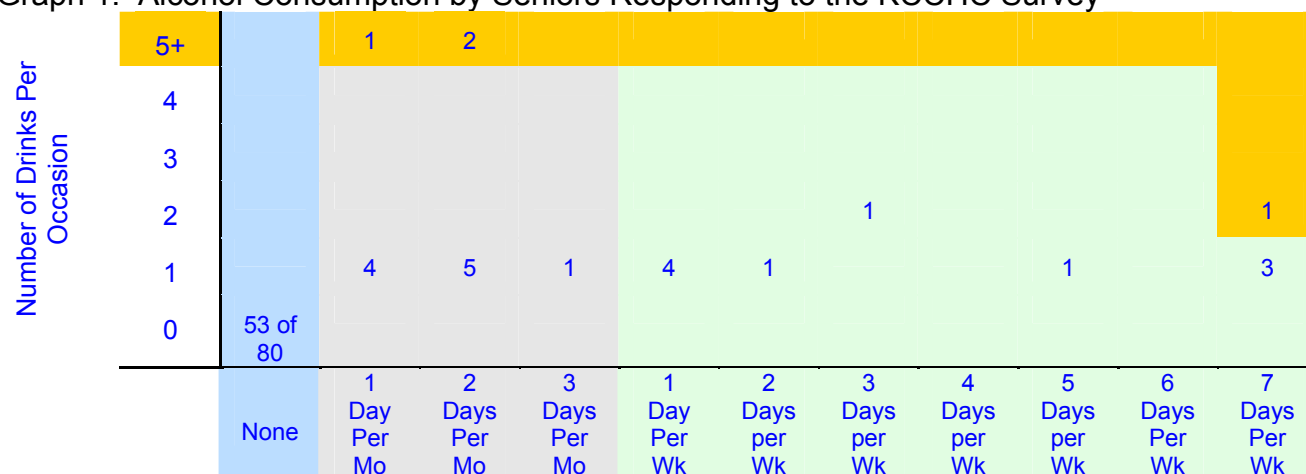
For the purposes of this study an alcoholic drink is defined as 12 ounces of beer, 5 ounces of wine, 1.5 ounces of spirits, or 4 ounces of aperitif. Twenty seven (33.75%) of respondents had an alcoholic drink on at least one occasion in the past month. Fifty three (66.25%) seniors reported abstaining from alcoholic drinks in the past month.

Of the seniors who consumed alcohol in the past month, 14 reported their intake in number of days per week and 10 reported consumption in number of days per month. The breakdown of alcohol consumption is in Table 4. Only one respondent (1.25%) reported chronic heavy drinking in the past month. Graph 1 shows the data in a different format.

Table 4 Alcohol Use by Respondents to the KCCHC Senior Survey

Frequency of alcohol consumption	Number of alcoholic drinks per occasion	Number of respondents reporting combination of frequency and number of drinks	Definition of Alcohol Abuse
None	0	53	<p><u>Chronic Heavy Drinking</u> Two or more drinks daily for the past 30 days</p> <p><u>Binge Drinking</u> Five or more drinks on one or more occasions over the past 30 days</p>
1 day/month	1	4	
1 day/month	5+	1*	
2 days/month	1	5	
2 days/month	5+	2*	
3 days/month	1	1	
1 day/week	1	4	
2 days/week	1	1	
3 days/week	2	1	
5 days/week	1	4	
7 days/week	1	3	
7 days/week	2	1	
* The 3 people reporting binge drinking also reported within a non-asterisk combination of frequency and number of drinks.			

Graph 1. Alcohol Consumption by Seniors Responding to the KCCHC Survey



## Binge alcohol use in past month

Three seniors (3.75%) reported binge drinking in the past month. One person reported one binge and two people reported two binges. All of the binge drinkers also reported alcohol consumption during the week although none of them was the chronic heavy drinker.

## Prescription drug use and misuse in past month

Seventy five respondents (93.8%) reported taking one or more prescription medications and 5 (6.2%) reported not taking any prescription medications. Of those who take prescriptions, 71 (94.6%) have a list of their medications and instructions for taking each. The average number of prescriptions taken by this sample is 5.45. Seventy four of those who reported taking prescriptions also identified the number of prescriptions they take as shown in Table 5 and Graph 2.

Table 5 Prescription Use by Respondents to the KCCHC Senior Survey

Number of prescription medications	Number of people reporting this number of prescriptions
0	5
1	4
2	12
3	10
4	6
5	12
6	10
7	5
8	4
9	3
10	5
13	1
20	1
24	1

There were some notable responses to Likert scale items within the survey related to prescription drug taking behaviors that provide insight into how socially active seniors behave:

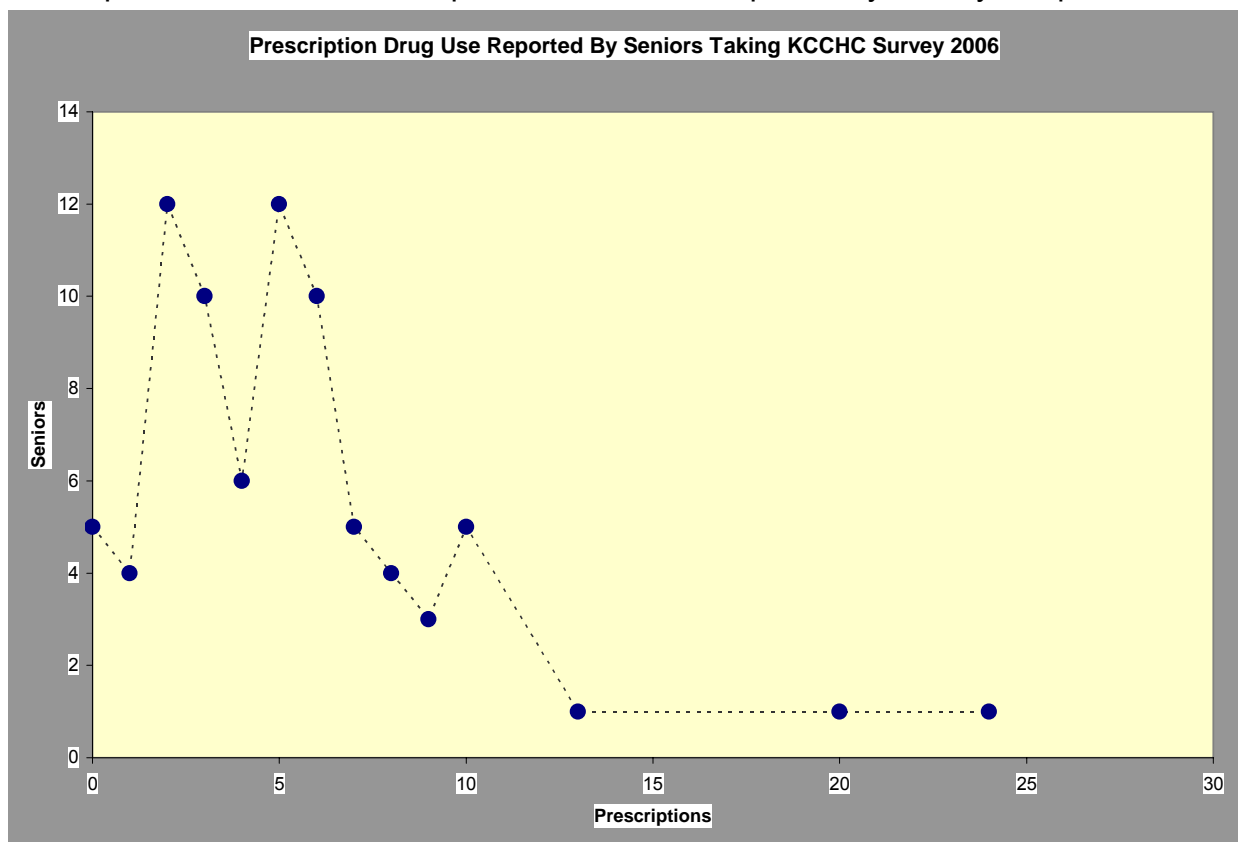
*“If I do not understand how to take my medications, I ask questions to get the answers I need.”* Sixty one and three tenths percent (61.3%; n=49) get answers most or all of the time while 11.2% (n=9) never ask questions to get answers and 12.5% (n=10) did not respond to this item.

*“I do not take my medication as prescribed in order to make it last longer.”* Five percent (5%; n=4) of seniors report this is true some of the time or all of the time for them and 36.3% (n=29) abstained from responding to this question.

*“I explain any medication side effects I have to my doctor.”* Sixty one and two tenths percent (61.2%; n=49) explain side effects most or all of the time although 10% (n=8) only discuss side effects with their doctor some of the time (n=2), once in awhile (n=2), or never (n=4). Twenty eight and eight tenths percent (28.8%; n=23) of seniors did not respond to this item.

*“I explain any medication side effects I have to my pharmacist.”* Only eighteen and eight tenths percent (18.8%; n=15) discuss side effects most or all of the time with a pharmacist while 20% (n=16) reported sharing side effects once in awhile and 28.7% (n=23) never discuss side effects with a pharmacist.

Graph 2. Number of Prescription Medications Reported by Survey Respondents



### Focus Groups of Paid Caregivers

Focus group questions came from the Tri-Ethnic Center’s Community Readiness Model. This model is based on the Transtheoretical Model, commonly known as the stages of readiness for change. Researchers from the Tri-Ethnic Center have developed an instrument to ask a series of questions related to: [a] current community efforts; [b] community knowledge of efforts; [c] leadership; [d] community climate; [e] community knowledge about the issue; and [f] resources related to the issue. The KCCHC used protocols and scoring instructions from the Tri-Ethnic Center to determine the stage of

readiness for change with regard to alcohol abuse and prescription drug misuse among older adults in Knox County. The data collection contacted the developers to implement the short version of the instrument and learned how to add the items related to risk and protective factors that were not included in the original interviews from the Tri-Ethnic Center.

The KCCHC data collection teams planned to hold between four to eight focus groups of three to twelve paid caregivers each. The goal was to collect data from a total of 12-96 focus group participants. Each focus group session consisted of questions related to one of the topics under study: alcohol abuse or prescription drug misuse. This was done to limit the time commitment of respondents to no more than 80 minutes.

Using the Tri-Ethnic Center's protocols, the KCCHC data collection teams scheduled a total of ten focus groups, six for discussing alcohol abuse and four for discussing prescription drug misuse. Only five of the groups resulted in participants providing data. Each focus group had 2-4 participants. Ultimately there were three focus groups for each of the topics with a total of nine participants discussing the issue of alcohol abuse and seven participants discussing the issue of prescription drug misuse. One group agreed to respond to both topics. The protocol for data collection was followed such that this group responded to questions on one topic, took a break, and discussed the other topic. Table 6 highlights the composition of the focus groups.

Table 6. Focus Group Composition

Tri-Ethnic Center's Community Readiness Model Focus Group Data Collection	
Alcohol Abuse among Seniors	Prescription Drug Misuse among Seniors
<p>Rockport YMCA 1/28/06</p> <p>3 participants (community volunteer, in-home cleaning business, business owner/in-home senior services program provider)</p>	<p>Rockport YMCA 1/28/06</p> <p>3 participants (community volunteer; in-home cleaning business; business owner/in-home senior services program provider)</p>
<p>Camden Emergency Response 2/16/06</p> <p>2 participants (Emergency Medical Technicians)</p>	<p>Gibbs Library in Washington 2/6/06</p> <p>2 participants (Washington Town Employee/volunteer caregiver/active church member; paid staff for elderly individuals)</p>
<p>Bartlett Woods in Rockland 3/2/06</p> <p>4 participants (housing facility administrator; paid caregiver; paid senior activities professional; co-owner and manager of senior in-home services program)</p>	<p>Camden Public Library 2/11/06</p> <p>2 participants (employee of senior housing/paid caregiver; staff member of local church)</p>

By knowing the stage of readiness for change among professional stakeholders and paid caregivers, the KCCHC can more efficiently target resources for building momentum for future prevention efforts to reduce substance abuse among adults age 65 years and better. Additionally, these data provide important details regarding knowledge about and availability of current prevention programs and social services.

### One-on-One Interviews of Professionals

The same list of questions and statements used for the focus groups were used to conduct one-on-one interviews. Trained coalition members initiated phone contact with 18 targeted community members who had been placed on a list of professionals who work closely with older adults and have their fingers on the pulse of the Knox County. Eight of the people participated providing a cross-section of leadership and service roles throughout the community in Table 7. Pharmacists, church leaders, and social workers from the hospital were targeted but none agreed to participate.

The KCCHC data collection teams conducted six interviews for alcohol abuse among seniors in the county and eight interviews for prescription drug misuse among seniors in the county. Respondents had the choice of one or both topics; therefore, all of the people who provided responses to the issue of alcohol abuse chose to discuss prescription drug misuse also.

Interviewers obtained verbal consent for data collection and recorded the telephone interview. Recorded interviews were necessary to follow the scoring instructions provided by the Tri-Ethnic Center.

Table 7. One-On-One Interviews Using the Tri-Ethnic Center's Tool

Tri-Ethnic Center's Community Readiness Model Interview Data Collection		
Person/Role	Alcohol Abuse among Seniors	Prescription Drug Misuse among Seniors
Leader within the Rockland Chapter of National Association of the Mentally Ill (NAMI) 1/2006		X
Leader from Camden District Nursing 2/2006	X	X
Representative from the Knox County Sheriffs' Department 2/2006	X	X
Representative from the Penquis Community Action Program 2/2006	X	X
Representative from the		



Central Maine Area Agency on Aging 2/2006		X
Selectman from a community within the county 2/2006	X	X
Representative from elderly home care service/senior independent housing 3/2006	X	X
Law enforcement officer in Knox County	X	X

For the sake of protecting the identity of the individuals who participated in the key informant interviews, multiple associations based on their professional and/or volunteer positions have not been reported together. In addition to primary affiliations outlined above, some of the key informants had one or more additional roles such as: member of the Knox County TRIAD, business owner, clergy member, nurse, community volunteer, and family member of someone within the cultural sub-population under study.

Recordings from focus groups and one-on-one interviews were listened to and analyzed by Jayne Harper, Nancy Laite, and Cheryl Cichowski following the analysis plan outlined in the book, *Tri-Ethnic Center for Prevention Research: Handbook for using the community assessment model* by B. Plested, R. Edwards, and P. Jumper-Thurman.

The focus group/interview questions have been designed to assess interviewee perception of the community's readiness to take action on the issues of alcohol abuse and prescription drug misuse among seniors in Knox County. There are nine stages of community readiness to address an issue: no awareness; denial/resistance; vague awareness; preplanning; preparation; initiation; stabilization; confirmation/expansion; and high level of community awareness.

Due to the difficulty in holding focus groups among paid caregivers, a decision was made to combine data from small focus groups and one-on-one interviews for each of the topics. For the purposes of data analysis and reporting a small group interview has been referred to as a key informant interview.

## Results

Small focus groups and one-on-one interviewees were asked to state the names of local resources such as agencies, programs, activities, and policies available to people age 65 years and better to address the issues under study: alcohol abuse and prescription misuse. The results are listed in Table 8 for each issue in order of the frequency with which the programs or resources were mentioned.

All of the resources listed have been confirmed by KCCHC members and/or the telephone book. Only Senior Spectrum and TRIAD provide services targeted

specifically to older adults and their caregivers, all others serve broader age groups. Although some interviewees were members of the TRIAD, a coalition of law enforcement, senior services and seniors in the community to reduce criminal risks to the senior population, only one mentioned it as a resource. There are support groups within the community such as those led by Penobscot Bay Medical Center, National Alliance on Mental Illness, and Senior Spectrum although no one mentioned support groups specifically.

Table 8. Knox County Resources Available to Adults 65 Years and Better

Resource for Addressing Alcohol Abuse	Number of interviews in which resource was mentioned (N=9)	Resource for Addressing Prescription Drug Misuse	Number of interviews in which resource was mentioned (N=11)
Alcoholics Anonymous	6	Midcoast Mental Health	4
Psychiatric & Addictions Recovery Center (PARC)	3	Choice Skyward	3
Midcoast Substance Abuse	2	Private Counselors	3
Alanon	2	Pharmacies / Pharmacists	2
Choice Skyward	2	Alcoholics Anonymous	1
Midcoast Mental Health	2	Psychiatric & Addictions Recovery Center (PARC)	1
Camden District Nursing	1	Kno-Wal-Lin	1
Tobacco Alliance (a.k.a. KCCHC)	1	Local Medical Facilities	1
Senior Spectrum	1	ME Drug Enforcement Agency	1
Doctor's Offices	1	Senior Spectrum	1
Private Counselors	1	Midcoast Charities	1
		Narcotics Anonymous	1
		TRIAD	1
		Family Members	1
		Physicians	1

## Risk and Protective Factors

Risk factors for alcohol abuse or prescription drug misuse among adults 65 years and better were defined for study participants as situations, actions, or beliefs that lead to misuse or abuse. There were 28 surveys, or 35% of respondents, that provided one or more risk factors for alcohol abuse and 26 surveys, or 32.5% of respondents, who identified one or more risk factors for prescription drug misuse. Seven of the nine key informant interviews for alcohol abuse and nine of the eleven key informant interviews about prescription drug misuse resulted in a list of risk factors for each situation. The top five risk factors for each issue are outlined in Table 9 showing how many respondents from each data source mentioned the respective risk factors. Responses from both groups of people were complimentary.

Table 9. Risk Factors Identified by Senior Surveys and Key Informant Interviews

Risk Factors	
For Alcohol Abuse	For Prescription Drug Misuse
Loneliness, isolation [20 surveys; 4 interviews]	Cost of prescriptions, lack of money [15 surveys; 5 interviews]
Lack of money, economic issues [11 surveys; 1 interview]	Forgetfulness, dementia [9 surveys; 3 interviews]
Alcohol addiction, long term habit [10 surveys; 2 interviews]	Loneliness, lack of oversight [8 surveys; 3 interviews]
Stress, emotional or mental illness [9 surveys; 3 interviews]	Not understanding how to take prescriptions &/or polypharmacy [7 surveys; 6 interviews]
Transportation, inability to get around [4 surveys; 2 interviews]	Vision or literacy problems [3 surveys; 4 interviews]

Risk factors other than loneliness are more challenging to address. If seniors are at risk for abusing alcohol due to economic issues, habit/addiction, in response to stress or illness, or lack of transportation, they are reacting to situations by drinking instead of implementing a more constructive coping strategy. The challenge for prevention programs, family members, and friends is to encourage or instill a different way to respond to negative life situations or events.

The risk factors for prescription drug misuse are more difficult to address within the current fiscal and social environment. Many seniors are misusing prescriptions due to financial constraints – they are not taking medications as prescribed because they cannot afford full dosages or any dosage. Memory issues, lack of oversight, inability to understand medication instructions for one or many drugs, and/or vision/literacy problems all require external intervention for affected adults. Many times providing help or support requires sensitivity so the person does not feel their independence is at risk. In order to address these risk factors in a meaningful way, local resources will need to be committed to supporting family members, volunteers, and social service programs in helping seniors access Medicare Part D and obtaining necessary oversight for taking medications accurately.

For the purpose of this study, protective factors were defined for all respondents, seniors and key informants, as something within a person or due to his or her culture that decreases his or her chance of developing problems related to alcohol abuse or prescription drug misuse. Seven of the nine key informant interviews generated a list of protective factors for preventing alcohol abuse. Nine of the eleven key informant interviews resulted in a list of protective factors for preventing prescription drug misuse. All topics mentioned at least twice are listed in Table 10 below. The number after each factor shows the frequency with which each factor was mentioned across the interviews.

Table 10. Protective Factors Identified by Key Informant Interviews

Protective Factors	
For Preventing Alcohol Abuse	For Preventing Prescription Drug Misuse
Prevent loneliness; social events, activities, community involvement, volunteering [8]	Education by physicians [6]
Discussion of alcohol issues in families and by health care providers [4]	Oversight (of medication administration) by District Nursing or Kno-Wal-Lin [4]
Knowledge, awareness, education [2]	Knowledge about drugs and abuse of drugs [3]
Plan for retirement (before it happens) [2]	Communication with family [3]
Visits for shut-in's [2]	Social support [3]

The primary tool for preventing alcohol abuse among seniors is to prevent loneliness among this group of people. Subsequent protective factors all directly or indirectly address preventing loneliness either through relationships with others (family members, health care professionals, or friends and volunteers), better information about alcohol's effect on aging bodies and self-awareness, and good planning for retirement both socially and financially.

Building protective factors for preventing prescription drug misuse among seniors lies with physicians. Physicians must become effective in educating their patients about proper prescription use and in prescribing the correct dosages and combination of medications to their older patients. Many seniors would benefit from oversight of medication administration in order to remain independent and properly medicated within the community. Key informants suggested programs such as District Nursing or Kno-Wal-Lin but not exclusively. These are simply the programs with which respondents are more familiar. People must be better informed about prescriptions and what constitutes misuse and be able to communicate honestly with their family members who can offer support. Finally, adults age 65 years and older need social support and on-going interaction to prevent loneliness and decreased functioning.

#### Unique Patterns of Substance Abuse

Based on nine key informant interviews of alcohol abuse among seniors, five described alcohol abuse that began in a person's youth and one alluded to abuse that began in later life subsequent to caregiver stress. Age of onset can have implications for prevention programming. Interviewees also shared anecdotes of people who drink in the privacy of their homes and who are able to hide an issue from people who visit at irregular intervals. Finally, it can be inferred that seniors who drink also take prescription medications. Interventions and prevention programs need to be prepared to address alcohol use in conjunction with other physical and/or mental health issues.

Eleven interviews regarding prescription drug misuse among seniors resulted in six key reasons for not adhering to medication administration protocols: memory problems; side effects; concern over theft of pain killers; expense of prescriptions; confusion over directions; and grief/depression. Prevention of prescription misuse among adults 65 and older has to do with improving health literacy, providing adequate monitoring, supporting access to Medicare Part D and other cost containment strategies, and addressing mental health issues among this population.

### Perceptions of Great Risk Associated with Having Five or More Drinks Once or Twice a Week

There is not a perception of great risk associated with having five or more drinks of an alcoholic beverage once or twice per week, or engaging in chronic heavy drinking. Anecdotal statements during five of the nine key informant interviews mention attitudes associated with adults 65 years and better. Many people 65 years and older were members of the culture who enjoyed a cocktail hour before supper nightly. Still other seniors were members of a culture that drank at a bar after a hard day of physical labor. There is a feeling among the community at large and among members of this age group that they are adults and drinking is socially acceptable behavior. The cohort of people age 65 years and better is associated with not talking about drinking problems. These people are proud and very private. Alcohol problems are an invisible issue.

Some interviewees gave details about a drinking culture in coastal fishing communities. It has always been socially acceptable to go to bars two or more times per week and drink heavily. Many people started this behavior when they were young and only when they begin having health issues in their seventies and eighties are they confronted with the consequences of long term alcohol abuse. Additionally, drinking is socially acceptable among veterans of World War II and Vietnam. One respondent noted high rates of domestic violence in Knox County and cited a probable link between the violence and alcohol abuse.

Two of the interview sessions mentioned in detail the issue of socioeconomic class associated with problem drinking. There are two groups of problem drinkers, those who are affluent and those who are poor. The people who are affluent can keep their problem hidden from the public and seek treatment from private facilities away from the watchful eye of a tight-knit rural community. Members of the community ignore the poor “fall-down-drunk bum” that everyone views distastefully who gets picked up by Emergency Response Services and dropped off at the Psychiatric and Addiction Recovery Unit (at Penobscot Bay Hospital). Community members who are not members of either of those social circles do not recognize an alcohol problem among seniors within Knox County.

One of the key informants works in law enforcement and feels his view of an alcohol abuse problem among adults 65 years and better would be skewed in the direction of over-reporting an issue because of his work.

## Strengths of the subpopulation related to self-care and problem solving on substance abuse issues

These Americans, who came of age during the Great Depression and WWII, have a lot to do with what the United States is today. And that era was training for how they conduct their lives as seniors in today's society. It is said that this group of Americans was united not only by a common purpose, but also by common values – duty, honor, economy, courage, service, love of family and country (community), and responsibility for oneself. This strength of character is what has, and continues to, see them through.

Our Knox county residents exhibited these traits as they proudly maintained their independence, either by living in their own homes, or, by still driving their own cars. The importance of family and social contacts helped many of them avoid the boredom or loneliness that often can be a breeding ground for substance abuse. Service to community was still evident as many shared their time and talents by volunteering in the community, and looking out for one another. Self-absorption was not common.

Ageism is deeply ingrained in our society by everyone, older people included. Many people expect changes in function as part of the normal aging process. However, some changes are not, and those who knew the difference were the ones who tended to age the most successfully. Having that awareness, coupled with the knowledge of alcohol abuse and prescription drug misuse issues, and being able to talk about these issues was fundamental.

Another avenue for these senior years to be successful was to plan ahead for retirement, hence, avoiding difficulties with finances, boredom, or loneliness. Financially, it was important to have the resources to provide for daily needs, a safe and functional residence, adequate food and medications, and transportation. The seniors who had a plan generally experienced better physical, mental, and emotional well being as they aged. A couple who retired to the Camden area, away from family and familiar support systems, had an extremely difficult time when the spouse became ill. Fortunately, strong ties with their local church saw them through a stressful time.

Another strategy evidenced by this group was good adherence to prescribed medication regimes, good working relationships with caregivers (paid and otherwise) and physicians who valued open, honest discussion about medications such as administration schedule, intended benefits, adverse effects, and costs. Patients who had, or were willing to create good working relationship between themselves and their physicians, as well as assume some of the responsibility for their own health fared better. Also, having oversight for medication from local agencies such as District Area Nursing, Kno-Wal-Lin, or pharmacists was a boost. Most of these seniors wanted to be perceived as a “good patient”, and attempted to have some kind of system in place.

Perhaps one of this group's strongest assets was their belief system; their sense of spirituality, even beyond a personal religious code. Most exhibited overall feelings of optimism and hope, along with a good sense of humor.

## Analysis of Barriers Programs/Coalitions Commonly Face in Trying to Provide Culturally Competent Services for This Subpopulation

Factors that act as barriers to coalitions' and programs' ability to provide culturally competent services for adults age 65 years and better fall into the categories of the culture at-large, inadequate awareness or resources among professionals and leaders, and inadequate awareness or resources among individuals within the 65 years and better cohort.

### *Culture At-large*

There are beliefs within our culture that act as barriers not only to coalitions and programs that seek to provide culturally competent services, but community leaders, family members, and older adults themselves. These beliefs have to do with what constitutes "normal" aging and mistaking signs and symptoms of conditions for consequences of aging. We hear it all the time when someone says, "I'm having a senior moment" to excuse an episode of forgetfulness as if one should expect to become forgetful or demented simply because a certain age threshold has been passed.

We live in a youth-oriented culture and place a priority on providing education and prevention services and treatment for children, adolescents, and young adults. There is an unspoken belief that services can make a difference in the lives of the young but it might be a waste of resources to provide the same for our elders. Nine of thirteen key informant interviews mentioned awareness of alcohol and drug prevention messages among youth but an absence of the same for older adults. One interviewee said, "Even physicians look at their patients and say, 'They are 82, if they want to drink, let them drink. They've done this their whole lives and I'm not going to change them now.'"

Overlapping with the previous belief in a youth culture, our culture espouses independence and individuals making decisions for themselves. Interview respondents stated, "Older people should know better [than to abuse alcohol]" and, "It's your own choice and your own life." While these basic rights need to be protected, many families and the health care system could benefit from resources and supports for intervening when older adults cannot continue doing things they have always done previously.

The cultural notion of independence and individuality along with isolation of many rural seniors plays into families bearing the burden of alcohol abuse and prescription drug misuse. These issues are not viewed as community issues because they are not perceived by citizens as affecting all of us. Since such a large number of older adults are retired, community members do not notice if their daily schedules are upset by alcohol abuse and workplace safety is not compromised by older people abusing substances. People age 65 and better spend a smaller proportion of time driving on roads than their younger counterparts. Alcohol abuse and prescription misuse are issues typically handled by individual families and social or health care services.

### *Inadequate Awareness/Resources Among Professionals and Leaders*

Miltiades and Kaye found that rural seniors have poorer health status and require greater levels of care.<sup>44</sup> Additionally, 50% of adults 65 years and older in the Knox-Waldo region were found to have three more chronic diseases.<sup>45</sup> Health care providers may overlook alcohol abuse or prescription misuse issues that either get masked by pre-existing medical or psychological conditions, or must address higher priority medical conditions within the patient's plan of care.

Kaplan found physicians may prescribe higher doses of medication to seniors than they should and without adequate monitoring.<sup>46</sup> The elderly metabolize medication differently and are more likely to suffer side effects that tend to be more severe with advancing age. These issues coupled with potential misunderstandings by patients' who are unaware of interactions between drugs and alcohol can lead to adverse consequences for some seniors. Not only do health care providers need to be well informed about medication dosages, alcohol interactions, and aging bodies, they need to be adept at obtaining meaningful medical histories from older patients and conveying complex information to their patients who may have low levels of health literacy.

There are additional costs associated with addressing these issues for county leadership and for health and social service professionals. This places competing demands on the time of professionals and funds (institutional, county, town) for managing other important public health and safety concerns.

### *Inadequate Awareness/Resources Among Members of the Cultural Sub-population*

Many members of the subpopulation hold personal beliefs and may maintain behaviors that are detrimental to their health status. Key informants have described beliefs held by members of this generational cohort of adults over 65 years as reluctant to speak with others since it may be a sign of weakness or a threat to their independence. Many people self-medicate with alcohol and/or remain in denial that there may be a problem with their alcohol use or prescription misuse.

There may also be a lack of knowledge about changes in metabolism with aging or a lack of knowledge about the interaction between alcohol and medications. It is easy to misunderstand instructions for taking medications or to become confused over how to manage multiple medications with various regimens. Additionally some members of the subpopulation suffer from discouragement over failing health, grief over losses, inadequate coping mechanisms, and failing memory whether due to organic conditions or as a side effect to medications. Finally a lack of financial resources and/or access to transportation on demand can result in prescription medication misuse.

### *Assessment of Readiness Stage (Tri-ethnic Center tool)*

Analysis of recordings from the focus groups and interviews according to the Tri-Ethnic Center's tools and protocols resulted in a community readiness of Stage Two for both alcohol abuse and prescription drug misuse among adults 65 years and better. Stage two is called Denial/Resistance by the Tri-Ethnic Center. There are specific goals and



strategies that can be implemented to build momentum and support the community in addressing these issues.

Not only are many of the causes and consequences of alcohol abuse and prescription drug misuse among our elders are different, there are differences in how community members perceive each of these issues. Alcohol abuse seems to be more taboo than prescription drug misuse. While the goal of raising awareness among community leaders and members for both of these topics is the same, the willingness of community members to listen and take action is expected to be greater for addressing prescription misuse than alcohol abuse.

#### Recommendations for Prevention Programs/Coalitions to Serve the Needs and Draw on the Resources of this Subpopulation

Recommendations to better serve the needs and draw on the resources of seniors within Knox County rely upon a grassroots approach and implementation of stage appropriate strategies from the Tri-Ethnic Center's model to address alcohol abuse and prescription drug misuse. To raise awareness of these two issues among citizens coalition members and key informants can: [a] continue one-on-one visits with other influential professionals and leaders to educate them and obtain local anecdotes of people and families coping with these issues; [b] create consistent low intensity media of critical events in weekly newspapers, church bulletins, and community radio shows; [c] distribute flyers, posters, and brochures among local social service, outreach, and health care facilities; and [d] present information during town meetings, service club meetings such as Rotary and Kiwanis, and church social groups. Concurrent with these efforts, social marketing efforts to re-acquaint community members with culturally appropriate services already available within the county such as Senior Spectrum, TRIAD, and the Penquis Community Action Program/Retired Senior Volunteer Program (RSVP) need to take place.

Local prevention professionals and coalition members should advocate for implementation of the Institute of Medicine's (IOM) recommendation to institute electronically written prescriptions by 2010 and electronic medical record-keeping among health care providers and Penobscot Bay Medical Center. Electronic prescriptions would help eliminate many medication errors and begin the process of improving health literacy among seniors and their families. Electronic medical record-keeping would encourage consistent and thorough histories on patients and help identify patterns of alcohol use and abuse among adults age 65 and better, creating opportunities to recognize and address this issue more readily.

According to seniors and key informants, many adults 65 years and older need additional social support, interaction, and formal or informal monitoring. These relationships have been identified as an important protective factor for seniors related to preventing alcohol abuse and prescription misuse. Through continued grassroots efforts, social marketing, and outreach efforts, the KCCHC, caregivers, and social services can effectively involve older adults by encouraging participation in social

groups, activities, and volunteer opportunities. For people who are not active or healthy enough to leave their homes, current resources such as church groups, Meals On Wheels, and Senior Spectrum can be coordinated for seniors on a one-by-one basis through social networks.

Transportation continues to be a factor for many seniors with regard to their ability to access services or participate in social activities. There are no easy solutions to this issue. Family, friends, community members, and social service providers will need to continue coordinating the tenuous and informal network that gets people from one location to another.

Related to alcohol abuse specifically, family members and caregivers need support and resources to cope with the challenges of having a loved one struggle with this form of dependency. The interviews highlighted that families currently suffer in silence and do not know of available support. As the grassroots efforts suggested above go into effect, it will be necessary to encourage the loved ones of seniors with alcohol dependency to participate in accessing support and talking about their challenges to incorporate community involvement in the care they provide.

A final recommendation is to continue to study adults 65 years and better in Knox County. The seniors on the island communities could benefit from an assessment similar to this one completed on the mainland. Another direction in which this research should move is to study the effects of the combination of alcohol and prescription medications among this age group.

### **C. Credits**

This needs and resources assessment would not have been possible without the dedication, hard work, and social networking skills of:

**Cheryl Cichowski**, Program Director, Knox County Community Health Coalition

**Nancy L. Laite**, Graduate Assistant and Member, Knox County Community Health Coalition

**Elwood D. Moore III**, MSAD #5 School Health Coordinator; Member, Knox County Community Health Coalition

**Connie Putnam**, Program Director, Knox County Community Health Coalition

**Ann Smarrella**, RSVP Volunteer Coordinator, Penquis Community Action Program

**Kristin Robinson-White**, Intern/MSW Student, Midcoast Mental Health

**Jayne Harper**, Evaluation Consultant; Member, Knox County Community Health Coalition

Thanks to all of the people who participated in the key informant interviews and senior surveys. You have done a great service to the community.

#### **D. Brief Commentary: Lessons learned in process of conducting this study**

- It was a challenge to gain active involvement from a larger number of coalition members to conduct participatory action research. People are already actively involved in their professional and volunteer commitments.
- It was a challenge to gain access to a larger number of senior groups for participation in senior survey due to fear of divulging personal information, distaste with discussing or thinking about these issues, and uncertainty about the funding source of this project.
- It was a challenge to conduct written survey research among this age group. Research teams needed to be mindful to ensure respondent comprehension or needed to assist when individuals had challenges seeing, reading, or holding a pen due a condition such as Parkinson's Disease.
- The KCCHC was called the Knox County Coalition Against Tobacco during the data collection phase of this pilot project. Many people misunderstood our objectives and financial backing due to our name.
- It was a challenge to gain participation from paid caregivers for the focus groups. Agencies that provide paid caregiver services in Knox County such as Kno-Wal-Lin, PALS, and District Nursing were approached and invited to participate in focus groups but caregivers have demanding schedules and competing demands on their time.
- There were not enough resources to expend this project to include island communities and they were left out – again.
- It is important to educate people/gatekeepers of groups in person or over the phone instead of sending written information about the project.
- Rely upon the social networks of the people involved in the project. Cold calls, even for important public health research, do not work.
- Thank goodness for graduate students. They added a richness to the study that would not have been there otherwise.
- Thank goodness for the commitment and passion of the KCCHC staff.

#### **References**

1. Thacker SB and Berkelman RL. History of public health surveillance. In: Halperin W, Baker EL, Monson RR, eds. *Public health surveillance*. New York, NY: Van Nostrand Reinhold, 1992:1-15.
2. Fink, et al., 2002 as cited in Ruffin, L. and Kaye, L. Alcohol & Aging. *Social Work Today*. May/June 2004: 24-27.
3. Memmott, JL. Social work practices with the elderly substance abuser. *Journal of Social Work Practice in Addictions*, 2003: 3(2), 85-103.
4. Kraemer, et al., 1999 as cited in Ruffin, L. and Kaye, L. Alcohol & Aging. *Social Work Today*. May/June 2004: 24-27.
5. Fink A, Morton SC, Beck JC, Hays RD, Spritzer K, Oishi S, and Moore AA. The alcohol-related problems survey: Identifying Hazardous and Harmful Drinking in Older Primary Care Patients. *Journal of the American Geriatrics Society*, 2002: 50, 1717-1722.

6. Lazow, RB. Alcohol and other drug problems in older adults: Health and Human Service Professionals Need to Be Aware. *Journal of Prevention and Intervention in the Community*, 2001: 21(1), 79-96.
7. Adams WL, Yuan Z, Barboriak JJ, and Rimm AA. Alcohol-related hospitalizations in elderly people: Prevalence and Geographic Variation in the United States. *Journal of the American Medical Association*, 1993: 270, 1222-1225.
8. Fink A, Morton SC, Beck JC, Hays RD, Spritzer K, Oishi S, and Moore AA. The alcohol-related problems survey: Identifying Hazardous and Harmful Drinking in Older Primary Care Patients. *Journal of the American Geriatrics Society*, 2002: 50, 1717-1722.
9. Ibid.
10. Wildlitz and Marin, 2002 as cited in Ruffin, L. and Kaye, L. Alcohol & Aging. *Social Work Today*. May/June 2004: 24-27.
11. Hinkin, et al., 2001 as cited in Ruffin, L. and Kaye, L. Alcohol & Aging. *Social Work Today*. May/June 2004: 24-27.
12. Kaplan, A. Alcohol and drug dependence in older adults. *Geriatric Times*. Sept/Oct 2000:1(3).
13. Trites, D. *Needs of Middle Age and Aging Individuals with Mental Retardation or Autism*. Augusta, ME: Department of Mental Health, Mental Retardation and Substance Abuse Services, 2000.
14. Sanchez-Way, R. *The View From the Beltway*. Center for Substance Abuse Research, Substance Abuse and Mental Health Services Administration. 2003.
15. Ibid.
16. National Clearinghouse for Alcohol and Drug Information (NCADI) Reporter, April 15, 2003. (Retrieved April 28, 2005 from <http://www.health.org/usercontrols/printpage.aspx?FromPage=http%3A%2F%2Fwww.health.org%2Fnewsro>)
17. Gurwitz, JH. Polypharmacy: A New Paradigm or Quality Drug Therapy in the Elderly. *Archives of Internal Medicine*, 2004: 164(18), 1957-1959.
18. Martin, S. Millions misuse prescription drugs. *WebMD Medical News*, April 10, 2001. (Retrieved May 1, 2005 from [http://my.webmd.com/content/article/31/1728\\_77029?printing=true](http://my.webmd.com/content/article/31/1728_77029?printing=true))
19. Kaplan, A. Alcohol and drug dependence in older adults. *Geriatric Times*. Sept/Oct 2000:1(3).
20. Wu, A and Bootman, JL. *Institute of Medicine (IOM)*, September 14, 2006.
21. Ibid.
22. U.S. Census Bureau. DP-1. Profile of General Demographic Characteristics: 2000. Data Set: *Census 2000 Summary File 1 (SFI) 100-Percent Data. Geographic Area. Maine*. 2000a. (Retrieved May 10, 2005 from <http://www.census.gov/prod/cen2000/dpl/2khus.pdf>)
23. U.S. Census Bureau. Data Profiles 2002. *American Community Survey*. 2002. (Individual state profiles retrieved from <http://www.census.gov/acs/www/Products/Profiles/Single/2002/ACS/index.htm>)
24. Miltiades, H and Kaye, L. The Aging Imperative in Maine: Present realities and future prospects. *Maine Policy Review*. Fall 2003: 10-23.

25. The term "substance abuse" includes alcohol and other drugs, unless specified otherwise.
26. CDC. Ten great public health achievements--United States, 1900-1999. *MMWR* 1999; 48:241-3.
27. Joint Advisory Committee on Select Services of Older Persons. *Mental Health Services for the Elderly in Maine: A Status Report*. Augusta, ME: Bureau of Elder and Adult Services, 2000.
28. Trites, D. *Needs of Middle Age and Aging Individuals with Mental Retardation or Autism*. Augusta, ME: Department of Mental Health, Mental Retardation and Substance Abuse Services, 2000.
29. Joint Advisory Committee on Select Services of Older Persons. *Mental Health Services for the Elderly in Maine: A Status Report*. Augusta, ME: Bureau of Elder and Adult Services, 2000.
30. Public Health Resource Group. Health Planning Report for the Knox-Waldo Region. *The Eastern Maine Healthcare Community Needs Assessment With a Special Focus on Substance Abuse*. January 15, 2002.
31. Ibid.
32. U.S. Census Bureau. DP-1. Profile of General Demographic Characteristics: 2000. Data Set: *Census 2000 Summary File 1 (SFI) 100-Percent Data. Geographic Area. Maine*. 2000a. (Retrieved May 10, 2005 from <http://www.census.gov/prod/cen2000/dpl/2khus.pdf>)
33. City-Data.com website retrieved September 25, 2006 from <http://www.city-data.com/city/Rockland-Maine.html>
34. Ibid.
35. Ibid.
36. Plested, BA, Edwards, RW, & Jumper-Thurman, P. *Community Readiness: A handbook for successful change*. Fort Collins, CO. May 2005: Tri-Ethnic Center for Prevention Research. [www.TriEthnicCenter.ColoState.edu](http://www.TriEthnicCenter.ColoState.edu)
37. Liang J, Lawrence RH. Secondary analysis of sample surveys in gerontological research. In: Lawton MP, Herzog AR, Hendricks JA, eds. *Special research methods for gerontology*. Amityville, NY: Baywood Publishing Co, 1989:31-61.
38. Freeman DH, Bruce ML, Leaf P, and Berkman LF. Sampling strategies for studying older populations. In: Wallace RB, Woolson RF, Eds. *The epidemiologic study of the elderly*. New York, NY: Oxford University Press, 1992:46-59.
39. Kalton G, Anderson DW. Sampling rare populations. In: Lawton MP, Herzog AR, Hendricks JA, eds. *Special research methods for gerontology*. Amityville, NY: Baywood Publishing Co, 1989:7-30.
40. US Bureau of the Census. *Statistical abstract of the United States, 1992*. 112th ed. Washington, DC: US Department of Commerce, Economics and Statistics Administration, 1992.
41. Jackson JS. Methodological issues in survey research on older minority adults. In: Lawton MP, Herzog AR, Hendricks JA, Eds. *Special research methods for gerontology*. Amityville, NY: Baywood Publishing Co, 1989:137-61.
42. Herzog AR, Kulka RA. Telephone and mail surveys with older populations: a methodological overview. In: Lawton MP, Herzog AR, Hendricks JA, eds. *Special*

- research methods for gerontology*. Amityville, NY: Baywood Publishing Co, 1989:63-89.
43. US Bureau of the Census. *Statistical abstract of the United States, 1992*. 112th ed. Washington, DC: US Department of Commerce, Economics and Statistics Administration, 1992.
  44. Miltiades, H and Kaye, L. The Aging Imperative in Maine: Present realities and future prospects. *Maine Policy Review*. Fall 2003: 10-23.
  45. Public Health Resource Group. Health Planning Report for the Knox-Waldo Region. *The Eastern Maine Healthcare Community Needs Assessment With a Special Focus on Substance Abuse*. January 15, 2002.
  46. Kaplan, A. Alcohol and drug dependence in older adults. *Geriatric Times*. Sept/Oct 2000:1(3).

## Attachments

## Attachment A

This is a confidential survey of people age 65 years and better in Knox County. Alcohol abuse and prescription drug misuse are sensitive topics although these are important and hidden issues among seniors. Please respond honestly so that family, health care providers and social service providers can learn more about how to meet the needs of our community members age 65 years and better. Your answers may help someone like you in the future. After you complete this survey, please return it in the envelope provided to one of the project volunteers or staff members.

1. What best describes your living situation?

Please check all that apply.

- ☐ Home/Trailer with at least one other person
- ☐ Home/Trailer by myself
- ☐ Apartment/Condominium with at least one other person
- ☐ Apartment/Condominium by myself
- ☐ Other: \_\_\_\_\_

2. Gender: ☐ Male ☐ Female

3. Age group:

<input type="checkbox"/> 65-69 years	<input type="checkbox"/> 70-74 years
<input type="checkbox"/> 75-79 years	<input type="checkbox"/> 80-84 years
<input type="checkbox"/> 85-89 years	<input type="checkbox"/> 90-94 years
<input type="checkbox"/> 95-99 years	<input type="checkbox"/> 100+ years

4. Are you retired from paid work?

☐ Yes ☐ No



What year did you retire?

\_\_\_\_\_

5. Do you do volunteer work?

☐ Yes ☐ No



How many hours per week?

\_\_\_\_\_

6. Do you have family members who live within 50 miles of you?

☐ Yes ☐ No

7. How often do you and family members visit?

- ☐ Daily
- ☐ 4-5 times a week
- ☐ 2-3 times a week
- ☐ Weekly
- ☐ About twice a month
- ☐ About once a month



- ☐ About once every other month
- ☐ About once every 3 months
- ☐ About twice a year
- ☐ About once a year
- ☐ Less than once a year

8. How often do you visit with friends?

- ☐ Daily
- ☐ 4-5 times a week
- ☐ 2-3 times a week
- ☐ Weekly
- ☐ About twice a month
- ☐ About once a month
- ☐ About once every other month
- ☐ About once every 3 months
- ☐ About twice a year
- ☐ About once a year
- ☐ Less than once a year

For the purposes of this study, one alcoholic drink is 12 oz. of beer, 5 oz. of wine, 1.5 oz. of spirits, or 4 oz. of liqueur or aperitif.

9. During the past month, have you had at least one drink of any alcoholic beverage such as beer, wine, wine coolers, or liquor?

- ☐ Yes      ☐ No (skip to #13)

For the purposes of this study, one alcoholic drink is 12 oz. of beer, 5 oz. of wine, 1.5 oz. of spirits, or 4 oz. of liqueur or aperitif.

10. During the past month, how many days per week did you drink any alcoholic beverages, on average?

Days per week \_\_\_\_\_

If you do not drink alcohol weekly but drink occasionally, how many days in the past month did you drink?

\_\_\_\_\_

11. On the days when you drank, about how many drinks did you have?

Number of drinks \_\_\_\_\_

12. Considering all types of alcoholic beverages, how many times during the past month did you have 5 or more drinks on an occasion?

Number of times \_\_\_\_\_

13. Do you take prescription medications?  
☐ Yes ☐ No (Skip to #18)
14. Do you have a list of your prescription medications and instructions for taking each medication?  
☐ Yes ☐ No
15. How many different prescriptions do you take? \_\_\_\_\_
16. How do you get your prescription medications? (check all that apply)  
☐ I pick them up at the pharmacy or hospital.  
☐ I order them through the mail.  
☐ A personal care assistant or home health aide brings them.  
☐ A family member picks them up for me.  
☐ Other: \_\_\_\_\_
17. Please answer each statement within the table to the best of your ability by placing a check or "x" in the box that best describes your response.

Statement	All of the Time	Most of the Time	Some of the Time	Once in Awhile	Never
My doctor has explained clearly how to take each prescription.					
I understand how to take each drug that is prescribed.					
If I do not understand how to take my medications, I ask questions to get the answers I need.					
I take each drug exactly as prescribed.					
I do not take my medication as prescribed in order to make it last longer.					
I do not take my medication as prescribed because it causes side effects.					
I forget to take my medication as prescribed.					
I take more medication than prescribed.					
I have had prescription drugs stolen from my home.					
I have sold prescription drugs to earn extra income.					
I explain any medication side effects I have to my doctor.					
I explain any medication side effects I have to my pharmacist.					

18. Please answer each statement within the table to the best of your ability by placing a check or "x" in the box that best describes your response.

Statement	All of the Time	Most of the Time	Some of the Time	Once in Awhile	Never
-----------	-----------------------	------------------------	------------------------	----------------------	-------

I take non-prescription drugs such as aspirin, cold medicine or laxatives.  
My doctor or pharmacist asks me which non-prescription drugs I take.  
I explain any medication side effects I have to my doctor.  
I explain any medication side effects I have to my pharmacist.

19. What types of health care services, social services, or transportation services are available to people age 65 years and better in Knox County?

Service	Service Available Y=yes; N=no; O=unsure	I would use this if I needed it: Y=yes; N=no; O=unsure
---------	--------------------------------------------------	--------------------------------------------------------------------

Consultations at Home for Assistance  
Medical Care or Consultation  
Social Service Agency Support  
Home Health Care  
Outreach Services  
Psychiatric Day Treatment  
Psychiatric Evaluation  
Respite  
Substance Abuse Treatment Program (all ages)  
Substance Abuse Treatment Program (ages 65 years and older)  
Other:  
Other:

20. What services (medical, substance abuse, transportation, etc.) are needed to help people age 65 years and better that are not currently available in Knox County?

21. Based on your experience, what are the reasons that people age 65 years and better do not use the available services?

22. There are things in people's lives that put them at risk for *abusing alcohol* such as financial problems or loneliness. Please state the top five reasons you believe people in Knox County age 65 years and better abuse alcohol:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

23. What is your opinion about how to solve the issues you mentioned in Question #22? (Pretend there is enough money in the town, county or State budget to make your solutions happen.) ☺

24. There are things in people's lives that put them at risk for *misusing prescription drugs* such as financial problems or loneliness. Please state the top five reasons you believe people in Knox County age 65 years and better misuse prescription drugs:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

25. What is your opinion about how to solve the issues you mentioned in Question #24? (Pretend there is enough money in the town, county or State budget to make your solutions happen.) ☺

Thank you for completing this survey!  
The answers you provided may help someone in the future.

## Attachment B

### Knox County Coalition Against Tobacco Needs and Resources Assessment of Substance Abuse Among Adults Age 65 Years and Better

#### Telephone Interview and Small Focus Group Question

- A. PREVENTION PROGRAMMING FOR PEOPLE IN KNOX COUNTY AGE 65 YEARS AND BETTER.** *We are interested in learning which local resources are available to people age 65 years and better with regard to alcohol abuse prevention and treatment. Please state the names of agencies or programs of which you are aware that serve this population here in Knox County. Are there local activities or policies of which you are aware that address prevention or treatment of alcohol abuse among people age 65 years and better?*

#### **B. COMMUNITY KNOWLEDGE ABOUT PREVENTION – ALCOHOL ABUSE**

For the purposes of this study, one alcoholic drink is 12 oz. of beer, 5 oz. of wine, 1.5 oz. of spirits, or 4 oz. of liqueur or aperitif.

**Alcohol Abuse** among people age 65 years and older is defined as...

Chronic Heavy Drinking: Two or more drinks daily for the past 30 days

Binge Drinking: Five or more drinks on one or more occasions over the past 30 days

1. Using a scale from 1 to 10, how much of a concern is **alcohol abuse** among seniors in Knox County, with one being not at all and ten being a very large concern. Please explain.
2. Please describe the efforts that are available in Knox County to address **alcohol abuse** among seniors. How long have they been available? [If none, skip to #5]
3. What are the strengths of these efforts related to **alcohol abuse**?
4. What are the weaknesses of these efforts related to **alcohol abuse**?
5. Using a scale from 1 to 10, with one being not at all and 10 being a great deal, how aware are people in Knox County of these efforts related to **alcohol abuse** among seniors?
6. Please describe what type of information/awareness residents of Knox County have about these efforts related to **alcohol abuse** among seniors?  
PROMPT: Where have you seen or heard about **alcohol abuse** among seniors? (i.e. newspapers, internet, radio, TV)  
PROMPT: When did you see or hear about this topic – how long ago was it? Is this information currently available?

### **C. LEADERSHIP**

7. Using a scale from 1 to 10, how much of a concern is [alcohol abuse](#) among senior citizens to the leadership of Knox County, with one being not at all and ten being a very large concern? Please explain.
8. How are the “leaders” in Knox County involved in prevention efforts? Please explain. [Leaders include policy-makers and decision-makers such as, but not limited to, Town Managers, selectmen/women, hospital administrators, sheriff department personnel, executive directors of social service agencies, etc.]
9. Would the leadership support additional efforts? Please explain.

### **D. COMMUNITY CLIMATE**

10. What is the attitude of Knox County residents about [alcohol abuse](#) among senior citizens?
11. What are the primary obstacles to [alcohol abuse](#) prevention efforts in Knox County?

### **E. KNOWLEDGE ABOUT THE PROBLEM**

12. In Knox County, what type of information is available about [alcohol abuse](#) among senior citizens?
13. How knowledgeable are Knox County residents about local [alcohol abuse](#) by senior citizen's and the signs and symptoms? Please explain.
14. What local data on this issue is available in Knox County?
15. How do people in Knox County obtain this information?
16. Research findings guide prevention science by identifying risk and protective factors that respectively increase and decrease the likelihood of [alcohol abuse](#).  
[a] Based on your professional opinion, what are *protective factors* for seniors in our community? Protective factors are things that would keep someone from drinking abusively. [b] Based on your professional opinion, what are *risk factors* for [alcohol abuse](#) among seniors in our community? Risk factors are situations, actions, or beliefs that lead to unhealthy behavior.

### **F. RESOURCES FOR PREVENTION EFFORTS**

17. Who would a senior citizen [abusing alcohol](#) turn to first for help and why?

18. What are Knox County residents' attitudes about volunteering time, making financial donations, and providing space to address this issue? Is there a distinction between residents' willingness to participate in any of these ways? Please explain.
19. Are you aware of any proposals or action plans that have been written to address the issue of **alcohol abuse** among seniors in Knox County? If yes, please explain.
20. Do you know if there is any evaluation of these efforts? If yes, using a scale from 1 to 10, how sophisticated is the evaluation effort, with one being not at all and ten being very sophisticated.

**If interviewee is only responding to alcohol abuse questions, please flip to the last page of this script and complete it.**

---

### **PRESCRIPTION DRUG MISUSE INTERVIEW QUESTIONS**

- A. **PREVENTION PROGRAMMING FOR PEOPLE IN KNOX COUNTY AGE 65 YEARS AND OLDER.** *We are interested in learning which local resources are available to people age 65 years and better with regard to prescription drug misuse prevention and treatment. Please state the names of agencies or programs of which you are aware that serve this population here in Knox County. Are there local activities or policies of which you are aware that address prevention or treatment of prescription drug misuse among people age 65 years and better?*
- B.
- C. **COMMUNITY KNOWLEDGE ABOUT PREVENTION – PRESCRIPTION DRUG MISUSE**

**Prescription Drug Misuse** among people age 65 years and older is defined as not taking medications as prescribed and includes...

- Missing doses in order to save money
- Missing doses to avoid side effects
- Missing doses due to memory problems
- Taking more medication than prescribed
- Having medication stolen
- Selling medication to earn additional income

1. Using a scale from 1 to 10, how much of a concern is **prescription drug misuse** among seniors in Knox County, with one being not at all and ten being a very large concern. Please explain.
2. Please describe the efforts that are available in Knox County to address **prescription drug misuse** among seniors. How long have they been available?

3. What are the strengths of these efforts related to **prescription drug misuse**?
4. What are the weaknesses of these efforts related to **prescription drug misuse**?
5. Using a scale from 1 to 10, with one being not at all and 10 being a great deal, how aware are people in Knox County of these efforts related to **prescription drug misuse** among seniors?
6. Please describe what type of information/awareness residents of Knox County have about these efforts related to **prescription drug misuse** among seniors?  
PROMPT: Where have you seen or heard about **prescription drug misuse** among seniors? (i.e. newspapers, internet, radio, TV)  
PROMPT: When did you see or hear about this topic – how long ago was it? Is this information currently available?

### **C. LEADERSHIP**

7. Using a scale from 1 to 10, how much of a concern is **prescription drug misuse** among senior citizens to the leadership of Knox County, with one being not at all and ten being a very large concern? Please explain.
8. How are the “leaders” in Knox County involved in prevention efforts? Please explain.  
[Leaders include policy-makers and decision-makers such as, but not limited to, Town Managers, selectmen/women, hospital administrators, sheriff department personnel, executive directors of social service agencies, etc.]
9. Would the leadership support additional efforts? Please explain.

### **D. COMMUNITY CLIMATE**

10. What is the attitude of Knox County residents about **prescription drug misuse** among senior citizens?
11. What are the primary obstacles to **prescription drug misuse** prevention efforts in Knox County?

### **E. KNOWLEDGE ABOUT THE PROBLEM**

12. In Knox County, what type of information is available about **prescription drug misuse** among senior citizens?
13. How knowledgeable are Knox County residents about **prescription drug misuse** by local senior citizens and the signs and symptoms? Please explain.



14. What local data on this issue is available in Knox County?
15. How do people in Knox County obtain this information?
16. Research findings guide prevention science by identifying risk and protective factors that respectively increase and decrease the likelihood of **prescription drug misuse**.  
[a] Based on your professional opinion, what are *protective factors* for seniors in our community? Protective factors are things that would keep someone from misusing prescription drugs.  
[b] Based on your professional opinion, what are *risk factors* for **prescription drug misuse** among seniors in our community? Risk factors are situations, actions, or beliefs that lead to unhealthy behavior.

#### **F. RESOURCES FOR PREVENTION EFFORTS**

17. Who would a senior citizen **misusing prescription drugs** turn to first for help and why?
18. What are Knox County residents' attitudes about volunteering time, making financial donations, and providing space to address this issue?
19. Are you aware of any proposals or action plans that have been written to address the issue of **prescription drug misuse** among seniors in Knox County? If yes, please explain.
20. Do you know if there is any evaluation of these efforts? If yes, using a scale from 1 to 10, how sophisticated is the evaluation effort, with one being not at all and ten being very sophisticated.