ABSTRACT

MUSIC THERAPY PROGRAM FOR OLDER ADULTS:

A GRANT PROPOSAL

By

Emily Ann Blicha

May 2015

Older adults may face challenges during the aging process such as anxiety, depression, and decreased quality of life. The purpose of this project was to develop music therapy groups for older adults who experience symptoms of depression and/or anxiety, identify potential funding sources, and write a grant to fund this program for Jewish Family and Children's Service in Long Beach, California. The Eisner Foundation was deemed the most suitable foundation for this grant proposal. The proposed music therapy groups were designed to decrease anxiety and depression symptoms and improve the quality of life among older adults in the Long Beach area. Participants will engage in listening, singing, and playing music along with reminiscing with other group members. The group will culminate in a performance for family and friends. Implications for social work practice are discussed. The actual submission and/or funding of this grant was not required for the successful completion of this project.

MUSIC THERAPY PROGRAM FOR OLDER ADULTS:

A GRANT PROPOSAL

A THESIS

Presented to the School of Social Work

California State University, Long Beach

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

Committee Members:

Julie O'Donnell, Ph.D. (Chair)
Mimi Kim, Ph.D.
Steve Wilson, Ph.D.

College Designee:

Nancy Meyer-Adams, Ph.D.

By Emily Ann Blicha

B.A., 2013, California State University, Fresno

May 2015

UMI Number: 1587260

All rights reserved

INFORMATION TO ALL USERS
The quality of this reproduction is dependent upon the quality of the copy submitted.

In the unlikely event that the author did not send a complete manuscript
and there are missing pages, these will be noted. Also, if material had to be removed,
a note will indicate the deletion.

UMI 1587260

Published by ProQuest LLC (2015). Copyright in the Dissertation held by the Author.

Microform Edition © ProQuest LLC.
All rights reserved. This work is protected against
unauthorized copying under Title 17, United States Code

ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 - 1346

ACKNOWLEDGEMENTS

I thank God for all His grace and blessings that have gotten me to this point of my life, completing a thesis and a Master’s degree. I am so grateful for and blessed with the help and support of many important people in my life throughout this program and this thesis writing process.

Thank you Julie O’Donnell for being such an awesome advisor. You definitely pushed me to my limits, and my thesis would not have turned out as it did, had it not been for you. I appreciate you meeting with me on those early Wednesday mornings, and all the time you spent editing and proofreading my thesis. Thank you for all the work you put into my thesis and in the end making me feel proud and accomplished by my work. Not only did I just write a thesis, but what you taught me I will be able to use if I ever want to write grants in my future career. Also, thank you to Jewish Family and Children’s Service for providing the needed information to help me complete this thesis.

Thank you to my family and friends back home for supporting me in moving to Long Beach to get this Master’s degree. Thank you Mom and Dad for always being there for me even if it was just a phone call. Brittany, thank you for understanding all my emotions during the thesis writing process, and always knowing the right things to say. Nimar and Harneet, thank you for being there for me when I needed those moments of distraction.

I would like to give a special thanks to my girls Cristiana, Laura, Jesi, and Sonja for those many long weekends spent at the Library, and yes always the coffee shop and never the one on campus! Also, who knows how we would have gotten through thesis without our lovely group text messages! WE DID IT!

TABLE OF CONTENTS

Page

ACKNOWLEDGEMENTS iii

LIST OF TABLES vii

CHAPTER

1. INTRODUCTION 1

Successful Aging 1
Potential Challenges of Older Adults 2
Music Therapy 3
Purpose of Project 4
Jewish Family and Children's Service 5
Multicultural Relevance 5
Social Work Relevance 6

2. LITERATURE REVIEW 8

Determinants of Successful Aging 8
Potential Challenges Associated with Aging 11
Older Adults with Dementia and Alzheimer's Disease 11
Older Adults and Depression 13
Older Adults and Anxiety 17
Music Therapy 18
Theories of Music Therapy 19
Music Therapy and Dementia 20
Music Therapy and Depression 22
Music Therapy and Anxiety 23
Music Therapy and Well-being 25
Music and Culture 26
Conclusion 27

3. METHODS 28

Identification of Potential Funding Sources 28
The Eisner Foundation 29

CHAPTER Page

Target Population.......... 31
Sources for Grant Needs Assessment.......... 31
Collaboration with the Funding Source.......... 31

4. GRANT PROPOSAL.......... 32

Brief History of Jewish Family and Children's Service.......... 32
Population and Programs.......... 32
Explanation of Good Partner.......... 34
Project Description.......... 35
Goal.......... 35
Objective.......... 35
Expected Outcomes.......... 38
Proposed Budget Narrative.......... 38
Personnel.......... 38
Social worker.......... 38
Program Cost.......... 38
Program supplies.......... 38
Refreshments.......... 39
Travel.......... 39
Indirect Program Cost.......... 39

5. LESSONS LEARNED.......... 42

Identifying Funding Sources.......... 42
Program Design.......... 43
Grant Writing Process.......... 44
Collaboration.......... 45
Budgeting.......... 46
Implications for Social Work Practice.......... 46

REFERENCES.......... 49

LIST OF TABLES

TABLE Page

1. Detailed Budget for Proposed Program 41

CHAPTER 1

INTRODUCTION

The older adult population in the United States has experienced exponential growth. From 2000 to 2010, there was a 15.1% increase in people ages 65 and older and a 29.6% increase of people ages 85 years of older. In California alone, these percentages were higher with an 18.1% increase of people ages 65 years and older and a 41.2% increase of people 85 years and older, from 2000 to 2010 (Werner, 2011). California had the highest population of people ages 65 and older with 33,871,648 (Werner, 2011). According to Colby and Ortman (2014), by 2029 over 20% of the United States population will be 65 years or older. Working with older adults is the fastest growing specialty within the field of social work (Dittrich, 2009).

Successful Aging

Successful aging encompasses many components of one's life such as one's health, social life and social support, and the environment (Ferri, James, & Pruchno, 2009). An older adult's health, lifestyle, and environment, and how it is perceived, can help determine if they will age successfully. Being in good physical health is a critical aspect of successful aging because it allows for the older adult to be physically active (Stevens-Ratchford, 2011). Being emotionally healthy is important for older adults as well. Experiencing low levels of stress and having a positive attitude will contribute to older adults' sense of meaning and purpose of life (Depp, Vahia, & Jeste, 2010). Lacking

social interaction or access to community resources because of one's environment can negatively impact the achievement of successful aging since social support is a contributor to successful aging (McLaughlin, Connell, Heeringa, Li, & Roberts, 2010).

Potential Challenges of Older Adults

Dementia is a common issue that older adults may experience (Moyer, 2014). Alzheimer's disease is the most prevalent type of dementia (Alzheimer's Association, 2012). Memory loss may be common with the onset Alzheimer's disease and can inhibit older adults' mood, behavior, social life, and physical and functional abilities (Demakis, 2007; Mussele et al., 2013). As a result of Alzheimer's disease, older adults may experience depression (Espirtu et al., 2001) aggression, agitation and restlessness (Mussele et al., 2013). The most common treatments of dementia involve medications, but some have suggested that non-pharmacological approaches should be incorporated into interventions with this population due to the negative side effects of medication (Blackburn & Bradshaw, 2014; Svansdottir & Snaedal, 2006).

Depression is the most common mental health challenge among older adults (Alpert, 2014). Symptoms of depression in older adults can occur following the onset of health issues or recent losses in their lives (Alpert, 2014). Subthreshold depression the most prevalent type of depression that older adults may experience, and it occurs when depressive symptoms are present but not significant enough to be considered as a diagnosis for a major depressive episode (Adams & Moon, 2009). Dysthmia and major depression are other types of depression older adults can experience. Psychological and social risk factors such as behavioral and cognitive challenges, limited social network,

and feelings of loneliness can be contributors to the onset of these types of depressions (Vink, Aartsen, & Schoevers, 2008).

Anxiety is another issue older adults may experience. When experiencing anxiety, there are many negative feelings that older adults may go through such as unidentifiable sense of fear, irritability and memory impairment (Kastenschmidt & Kennedy, 2011). Having anxiety in late life can increase the chances of individuals experiencing other challenges (Brenes et al., 2005; Ostir & Goodwin, 2006). Life satisfaction can be negatively impacted when older adults experience anxiety (Brenes et al., 2009; Bryant, Jackson, & Ames, 2008). Music therapy is an intervention that has been shown to reduce the major challenges experienced older adults and has resulted in decreases in symptoms of dementia, depression and anxiety (Gold, Solli, Krüger, & Lie, 2009; Guétin, 2009; Yin Yi, Moon Fai, & Mok, 2010).

Music Therapy

Music therapy has been in existence for over 65 years in the United States (American Music Therapy Association, 2014). Music therapy is an innovative and creative way to help older adults accomplish their goals, as well as help treat and manage symptoms of potential challenges that older adults can face. Music therapy can include activities such as listening to music, singing songs, playing instruments, and dancing (Blackburn & Bradshaw, 2014; Grocke & Wigram, 2006). It can be used for people of all ages and cultures. Music therapy can be provided to older adults alongside the use other types of clinical treatments as well (Etoile, 2000). Music therapy is versatile and has resulted in positive findings among older adults in both institutional or community settings (Chan, Chan, Mok, & Kwan Tse, 2009; Yin et al., 2010).

Music therapy should be considered when working with older adults who experience symptoms since it has been found to reduce symptoms of anxiety, agitation, and depression among older adults experiencing dementia (Blackburn & Bradshaw, 2014; Guétin et al., 2009; Svansdottir & Snaedal, 2006). Music therapy can be a tool to use for reducing depression among older adults (Chan et al., 2009; Chan, Wong, Onishi, & Thayala, 2012; Gold et al., 2009). Anxiety among older adults is another challenge that can be positively influenced by music therapy (Eells, 2014; Sung, Chang, & Lee, 2010, Sung, Lee, Li, & Watson, 2012; Svansdottir & Snaedal, 2006). Music therapy with older adults with anxiety has resulted in physical improvements and reductions in anxiety symptoms and agitation (Sung et al., 2010; Sung et al., 2012, Yin et al., 2010). When music therapy participation reduces these symptoms, the quality of life and well-being of these individuals are improved (Blackburn & Bradshaw, 2014; Guétin et al., 2009). Older adults' well-being has also been shown to be improved through the use of music therapy (Clements-Cortés, 2014; Guétin et al., 2009; Skingley & Bungay, 2010). Improvements in mood, behavior, energy, physical health, and memory are some beneficial outcomes music therapy can provide to older adults, which, in turn, positively impact well-being (Clements-Cortés, 2014; Skingley & Bungay, 2010).

Purpose of Project

The purpose of this project was to develop music therapy groups for older adults experiencing symptoms of depression and/or anxiety, identify potential funding sources, and write a grant to fund this program for Jewish Family and Children's Service (JFCS).

Jewish Family and Children's Service

The Jewish Family and Children's Service (JFCS) is housed in the Alpert Jewish Community Center (AJCC) in the city of Long Beach, California. JFCS is a non-profit agency that was founded in 1957 following World War II by members of the National Council of Jewish Women due to the increase of the Jewish population in Long Beach (2014). These women recognized the need for counseling, emergency financial assistance, and the resettlement of refugee families. JFCS provides a variety of services such as older adult services, counseling, school counseling with children and adolescents, support groups, and domestic violence prevention and education (2014). The proposed music therapy group will be provided under the auspices of the JFCS Older Adult Services Program. The Older Adult Services programs currently offers assessment, referral, case management, money management, financial assistance, counseling, friendly visitations, support groups, financial assistance, services for Holocaust survivors, and services for caregivers (JFCS, 2014).

Multicultural Relevance

Long Beach is a multicultural community, which is inclusive of people who are of a variety of races, ethnicities, religions, sexual identities, and socioeconomic statuses. Jewish Family and Children's Service is an organization that is welcoming of the diversity that encompasses the population of Long Beach. There have been multiple studies from around the world that have shown that music therapy with older adults is beneficial to their physical and mental health (Clements-Cortés, 2014; Lesta & Petocz, 2006; Lee, Chan, & Mok, 2010). Therefore, it is important for social workers in the United States to pilot these interventions which have shown promise across cultures, and

tailor them to serve the diverse older adults living in this country. According to Shapiro (2005), the integration of multicultural elements is important to effective music therapy. Incorporating culture within the music therapy has been shown improve the therapeutic relationship between the client and the music therapist (Shapiro, 2005).

Culture should be incorporated into music therapy. For example, sessions can be individualized by the selection of music from the culture of the participants. Participants may then feel more comfortable and respected because the therapist has taken into account their cultural backgrounds (Molloy & Darrow, 1998). The inclusion of culture in music therapy, regardless of the setting, allows for the therapist to form a therapeutic relationship with the client (Shapiro, 2005). Cross-cultural music therapy should take into consideration an older adult's personal experiences, background, previous job, level of acculturation and song preference (Ip-Winfield & Grocke, 2011). Music therapy can help with cross-cultural understanding because it allows participants to confirm their identity and improve their feelings of worth (Shapiro, 2005).

Social Work Relevance

The older adult population is increasing, especially with the Baby Boomer population getting older. Due to this rapid growth, the demographics of this population will be rapidly changing and professions working with older adults need to be equipped with the right tools and interventions to provide the best service to these individuals (American Psychological Association, 2004). Unfortunately, those serving the geriatric population with mental health issues are not always appropriately trained to meet the health and mental health needs of these aging individuals (Institute of Medicine, 2012).

Therefore, social workers should be up to date and educated about new and innovative interventions within the field that have evidence of effectiveness in promoting successful aging. Social workers can then utilize and adapt these new interventions with the individuals they serve on a daily basis. Grants can also be written by social workers to obtain funding to develop and implement evidence-based interventions, such as music therapy, to meet the needs of this growing population.

CHAPTER 2

LITERATURE REVIEW

Rowe and Kahn coined the term successful aging in 1987 after they had analyzed and concluded that the majority of research in aging exaggerated the negative aspects of the process. In contrast to the well-documented declines associated with aging, they suggested that aging could also have a neutral or positive impact on one's life. To best achieve successful aging, one must have multiple types of support including emotional, material, and informational support (Rowe & Kahn, 1987). Also, it is vital to consider "…the effect of that support on other psychosocial predictors of success," such as autonomy and control (Rowe & Kahn, 1987, p. 147). According to a longitudinal study, McLauglin, et al. (2010) found the prevalence rates of successful aging among older adults decreased by 25%, between the years 1998 and 2004, after accounting for the changes in the older population. Therefore, efforts to promote successfully aging are needed (McLaughlin et al., 2010).

Determinants of Successful Aging

There are many determinants associated with successful aging such as biological health, emotional and psychological health, social and environmental determinants, and social support (Depp et al., 2010; Ferri et al., 2009; McLaughlin et. al., 2010; Stevens-Ratchford, 2011). Studies have shown the importance of biological health as a contributor to successful aging, and those who successfully age are typically healthier

than other older adults (Depp et. al, 2010; Ferri et. al, 2009; Stevens-Ratchford, 2011). Ferri et al. (2009) concluded that older adults perceived successful aging as being related to good physical health. Stress has been one of the most studied factors that could negatively impact one's brain health, therefore, Depp et al. (2010) suggested that having low levels of stress could improve brain health, which, in turn, may promote successful aging. One's health and well-being are also important to successful aging because being healthy contributes to being physically able to be active (Stevens-Ratchford, 2011).

Having good emotional health is another aspect of successful aging (Depp et al., 2010). Emotional health is not only defined as the absence of a psychiatric illness (Hendrie et al., 2006). Depp et al. (2010) found that successful aging includes emotional traits such as having a positive attitude and being optimistic and adaptable. Being optimistic and positive about aging and having a purpose in life are also indicators of longevity and can reduce the risk of early mortality and improve overall health (Boyle, Barnes, Buchman, & Bennett, 2009; Depp et al., 2010; Giltay, Geleijnse, Zitman, Hoekstra, & Schouten, 2004; Gruenewald, Karlamangla, Greendale, Singer, & Seeman, 2007). Within the public health sector, there have been a number of United States initiatives geared toward promoting cognitive and emotional health among older adults (Depp et al., 2010).

Studies have shown that older adults view being social, whether with friends, spouses or community resources, as one of the most important aspects of successful aging (Reichstadt, Depp, Palinkas, Folsom, & Jeste, 2007). The higher one's level of social support, the better are his or her chances of successful aging (Ferri et al., 2009). Social interaction and social support have also been shown to prevent emotional distress and

reduce stress (Depp et al., 2010). Reichstadt et al. (2007) conducted qualitative interviews with 22 adults over the age of 60 living in assisted-living facilities. Nearly all of the participants emphasized the importance of being engaged with life, particularly through social interaction and maintaining social relationships. Social interactions provided them with "a 'sense of connection' and 'feeling that somebody cares'" (Reichstadt et al., 2007, p. 571). Friends were most frequently mentioned as providing enjoyment and a sense of well-being (Reichstadt et al., 2007).

There are also social and environmental factors that can influence one's path to successful aging. Depending on the demographics of an older adult, finding ways to successfully age may look different and be harder to obtain since lower socioeconomic status has been found to be inversely related to successfully aging (Depp et al., 2010; McLaughlin et al., 2010; Rowe & Kahn, 1987). McLaughlin et al. (2010) found that Whites had substantially higher rates of successful aging than people of color. However, this finding was primarily influenced by socioeconomic status. The geographic location and environment of older adults can also affect their autonomy and their ability to obtain resources that promote successful aging (Depp et al., 2010; Rowe & Kahn, 1987).

In part, due to these reasons, the term successful aging has been critiqued (Depp et al., 2010; Dillaway & Byrnes, 2009). Research has shown that certain types of people, those who are wealthy, have a higher level of education, or live in nice neighborhoods, are more likely to successfully age (Depp et al., 2010; Dillaway & Byrnes, 2009; McLaughlin et al., 2010). Because successful aging is more easily attainable for certain populations, Dillaway and Byrnes (2009) cautioned that the use of this term could contribute to discrimination and ageism toward those who are not in those populations.

Therefore, it is important to recognize the potential difficulties related to conceptualizations of this term.

Quality of life is a frequently used term closely related to successful aging. The World Health Organization (WHO) indicated that factors that could affect one's quality of life (QOL) could be an individual's physical and mental health, social relationships, personal beliefs and relationship to the environment (1997). According to WHO, QOL is defined as "individuals' perception of their position of life in the context of the culture and value of systems in which they live and in relation to their goals, expectations, standards, and concerns" (p. 1). Studies on older adults use a variety of methods to measure QOL including health-related QOL (HQOL), psychological QOL, social QOL, environmental QOL, and physical QOL (Baernholdt, Hinton, Yan, Rose, & Mattos, 2012; Brown & Roose, 2011). Brown and Roose (2011) conducted a study of a community-based sample in St. Louis of adults (N = 443), ranging in age from 30 to 98, to explore whether age and QOL were related. They found that age was not a significant predictor of psychological, environmental or social quality of life, although it was predictive of lower HQOL.

Potential Challenges Associated with Aging

Older Adults with Dementia and Alzheimer's Disease

Dementia in America affects approximately 2.4 to 5.5 million people, and the prevalence of the disease increases with age (Moyer, 2014). Alzheimer's disease (AD) is the most common form of dementia. One in 8 Americans, ages 65 and older, have been diagnosed with this disease (Alzheimer's Association, 2012). Not only does AD affect one's memory, but it may also cause an individual to withdraw from society and result in

changes in mood and behaviors (Alzheimer's Association, 2012; Mussele et al., 2013). Risk factors for AD or other dementias among older adults are low education level, low level of social support, depression, and never being married (Moyer, 2014; Wierenga & Bondi, 2011).

Older adults with AD experience the loss of cognitive functioning which then can lead to physical and functional disabilities (Demakis, 2007). Those with AD will, at some point, need assistance with basic activities of daily living (ADLs) such as eating, dressing, and bathing (Dilworth-Anderson, Pierre, & Hilliard, 2012). With the increasing severity of AD, individuals will likely need assistance with their instrumental activities of daily living (IADLs) which are tasks that one must be able to do to live independently such as managing money and shopping (Dilworth-Anderson et al., 2012). During the final stages of AD, older adults may require 24-hour care due to being bedbound and unable to communicate effectively (Demakis, 2007; Dilworth-Anderson et al., 2012).

Older adults who experience dementia can also subsequently experience symptoms of depression (Dorenlot, Harboun, Bige, Henrard, & Ankri, 2005; Espiritu et al., 2001). Dorenlot et al. (2005) found that 40% of institutionalized individuals with dementia experienced major depression within the first year of being diagnosed. Depression is particularly troubling since it has been found to be predictive of greater cognitive decline in the dementia population (Espiritu et al., 2001). One study explored the prevalence of depressive symptoms of people who experienced a mild cognitive impairment (N = 270) and AD (N = 402; Mussele et al., 2013). A significantly higher proportion of those with AD were depressed. In both groups, when depression was

present, older adults were more likely to display behavior problems and verbally agitated behavior (Mussele et al., 2013).

Some of the more severe and prevalent behavioral symptoms, exhibited by those with AD are aggressiveness, agitation, and restlessness (Mussele et al., 2013; Svansdottir & Snaedal, 2006). In a United States longitudinal study, people who had been diagnosed with probable AD (N = 236) were followed over the course of a 5-year period (Holtzer et al., 2003). At the start of this study, 39% of those studied had experienced wandering and/or agitation symptoms, however, over the course of the study, the prevalence of these symptoms increased to 57% (Holtzer et al., 2003).

There has been some disagreement regarding the treatment approaches used with individuals with AD (Svansdottir & Snaedal, 2006; Talerico, 2002). The most common types of treatment are pharmacological, and many older adults who are in the latter stages of dementia will most likely be treated "with sedatives, neuroleptics, or antidepressants" (Svansdottir & Snaedal, 2006, p. 2). When using antipsychotic medication to treat symptoms of dementia, older adults may be more at risk for falls and injuries (Banerjee, 2009). Due to the side effects, these medications can have on individuals with AD, some suggest that non-pharmacological treatments should be considered (Blackburn & Bradshaw, 2014; Svansdottir & Snaedal, 2006).

Older Adults and Depression

Depression is one of the most common mental health issues older adults may experience (Alpert, 2014; Blazer, 2003). Approximately 6.5 million Americans, 65 years or older, may encounter depression (National Alliance on Mental Illness, 2009). Individuals who experience depression later in life may have had a previous depressive

episode but illnesses such as dementia, cancer, stroke, or recent life changes such as different types of loss and/ or retirement can also contribute to the onset of depression (Alpert, 2014). Within the oldest old population, depression can be seen alongside other physical conditions such as diabetes, strokes, heart-related issues, and hip fractures (Blazer, 2000). Unfortunately, among older adults, depression can be misunderstood and undertreated (Alpert, 2014; Devanand, 2014; Fann, Fan, & Unützer, 2009; Piek et al., 2012).

An older adult's quality of life may be negatively impacted if they experience depression (Baernholdt et al., 2012; Brown & Roose, 2011). Baernholdt et al. (2012) studied a nationally representative sample of adults 65 years and older (N = 911). Results indicated that individuals with more depression reported lower levels of HQOL (Baernholdt, et al., 2012). In the Brown and Roose (2011) study, lower levels of health, social and psychological QOL were significantly predicted by the occurrence of depression. They also found that a recurrent contributor to emotional distress in late life was depression.

The most prevalent type of depression among older adults is subthreshold depression (Adams & Moon, 2009; Devanand, 2014). Subthreshold depression occurs when someone has experienced depressive symptoms but does not meet the criteria for a major depressive episode or other depressive disorders (Adams & Moon, 2009; Gallo & Leibowitz, 1999). Subthreshold depression affects about 5 million older adults (National Institute of Mental Health, 2007), and 10% - 23% of those older adults are medically ill (Judd & Akiskal, 2002). Studies have shown that older adults with subthreshold depression can experience distress and a reduced quality of life (Adams & Moon, 2009;

Lavretsky & Kumar, 2002). In an epidemiological study, each year, about 8-10% of older adults who had experienced subthreshold depression developed major depression (Meeks, Vahia, Lavretsky, Kulkarni & Jeste, 2011).

According to the Centers for Disease Control and Prevention (2010), in 2006 and 2008, of 235,067 survey respondents, 25% of individuals, ages 65 and older, were diagnosed with major depression. In a study that followed older adults diagnosed with minor depression for 18 months, 25% developed major depressive disorder during that timeframe (Vuorilehto, Melartin, & Isometsä, 2009). Dysthmia, mild to moderate symptoms of depression lasting over 2 years, is another type of depression older adults can experience (Devanand, 2014). Older adults who have been diagnosed with minor depression for a year are at an increased risk of being diagnosed with major depressive disorder (Cui, Lyness, Tang, Tu, & Conwell, 2008; Lyness et al., 2006; Meeks et al., 2011).

A literature review was conducted to determine the most prominent contributors to depression occurring late in life (Vink et al., 2008). This review found similarities across cross-sectional and longitudinal studies. Older adults who had chronic health issues or experienced pain were more prone to depressive symptoms and depressive disorders. Having a family history of a psychiatric disorder or having a vision or hearing loss puts an older adult at higher risk for the development of a depressive disorder as well (Vink et al., 2008). In a review and commentary, Blazer (2003) suggested medical illness, particularly pain and multiple health conditions, contributes to depression among the elderly.

There are a number of psychological risk factors that have been associated with depressive disorders and depressive symptoms among older adults (Vink et al., 2008). Blazer (2003) suggested that some psychological factors that contribute to depression among older adults include behavioral, psychodynamic and cognitive challenges. These challenges can include learned helplessness, inability to complete the tasks they used to do, unrealistic expectations, and over generalizing and overreacting to certain life events (Blazer, 2003). Older adults with chronic diseases who experience a lack of self-efficacy and low self-esteem are also more likely to have depressive disorders and symptoms (Bisschop, Kriegsman, Beekman, & Deeg, 2004; Vink et al., 2008).

Social risk factors for depressive disorders and depressive symptoms among older adults can include having a small social network, feelings of loneliness, and a lack of social support (Adams & Moon, 2009; Vink et al., 2008). Older adults who are unsatisfied with their friendships or have been experiencing problems with their spouse, are at increased risk for depressive disorders. Recent negative life events and bereavement are also potential risk factors for an older adult to experience depressive symptoms or depressive disorders. Additionally, having a lower level of education, being an ethnic minority, and having a lower income may also increase the likelihood of depressive symptoms and depressive disorders among older adults (Vink et al., 2008).

Research suggests that older adults may experience depression and anxiety simultaneously (Cairney, Corna, Herrmann, Streinger & Veldhuizen, 2008; Lenze et al., 2000). Cairney et al. (2008) conducted an analysis of the co-morbidity of anxiety and depression among a sample of individuals 55 years or older (N = 12,792). They found that 23% of individuals who were diagnosed with depression met the criteria for an

anxiety disorder as well (Cairney et al., 2008). These findings were also similar to a study that showed 23% of 182 older adults seeking depression treatment also experienced symptoms of anxiety (Lenze et al., 2000).

Older Adults and Anxiety

Anxiety is also another challenge older adults may encounter. One study reported 18% of adults in America were diagnosed with anxiety within a 12-month period (Kessler, Chiu, Demler, & Walters, 2005). Another study found that 7% of older adults experienced anxiety of some type during a one-year period (King-Kallimanis, Gum, & Kohn, 2009). Generalized anxiety disorder is the most common anxiety disorder experienced by older adults (Gonçalves & Byrne, 2012; Grant et al., 2005).

Feelings of dread and apprehensiveness can occur among older adults experiencing anxiety (Kastenschmidt & Kennedy, 2011). Symptoms of anxiety can include restlessness, irritability, and/or memory impairment. Feelings of anxiousness can occur among older adults who have experienced medical illness, falls, and their health issues (Kastenschmidt & Kennedy, 2011). Older adults with anxiety symptoms may have a higher likelihood of experiencing sleep disturbances (Brenes et al., 2009), disability (Brenes et al., 2005), and mortality (Ostir & Goodwin, 2006). Anxiety in late-life also appears to be related to decreased life satisfaction (Brenes et al., 2005; Bryant, Jackson, & Ames, 2008).

Generalized anxiety disorder (GAD) can also contribute to the impairment of an older adult's cognitive functioning (Beaudreau & O'Hara, 2009; Mantella et al., 2007). One study compared the cognitive functioning of older adults with GAD (N = 19), the cognitive functioning of older adults with major depression (N = 68), and older adults

with no psychiatric illness (N = 40; Mantella et al., 2007). Those working in the mental health field have indicated that there is a need for improvement in the treatment of anxiety among older adults (Ayers, Sorrell, Thorp, & Wetherell, 2007). In a review examining the different evidence-based treatments for GAD, there have been positive outcomes among older adults who have participated in non-pharmacological treatment, such as cognitive-behavioral therapy (Wetherell, Lenze, & Stanley, 2005).

There is a great need for complementary interventions for older adults, especially those that differ from some of the more common mental health interventions (Vasionytė & Madison, 2013). According to Eells (2014), older adults are more open to receiving different types of treatment and discovering how they can therapeutically benefit through the use of arts, such as music. Thus, it is important to examine multiple strategies that may produce effective results and improve the well-being of older adults. Music therapy has been shown to be one effective method for reducing some of challenges faced by older adults and while improving their quality of life (Guétin, 2009; Lee et al., 2010).

Music Therapy

The National Association for Music Therapy was established in the United States in the mid 1950s (American Music Therapy Association, 2014). Music therapy is an intervention that has been used to treat those experiencing negative psychological, psychiatric and physical conditions (Vasionytė & Madison, 2013). Music therapy uses clinical and evidence-based interventions to help people accomplish their goals in a therapeutic way (American Music Therapy Association, 2014). Music therapy typically involves interdisciplinary collaboration (Etoile, 2000). The most prominent goals of music therapy, for older adults, are to address and identify the social and emotional

factors that they experience and help them enjoy their life despite their age or what they are going through (Cohen, 2014). Music therapy interventions with older adults have been designed to enhance wellness, manage stress, lighten pain, convey feelings, boost memory, promote communication, and improve physical functioning (American Music Therapy Association, 2014; Kemper & Danhauer, 2005).

Theories of Music Therapy

Cohen (2014) addressed some of the common sociological theories of aging that are used when providing music therapy to older adults. The Continuity Theory focuses on the value of the continuation of activities and social roles that the older adult finds of importance and meaning (Cohen, 2014). This theory suggests the importance of prolonging older adults' social roles, which, in turn, helps them live a more meaningful life. Following Continuity Theory, music therapists allow older adults to choose the type of music or activity in which they will engage. The music choice or activity can be individualized based upon the autonomy and personality of the older adult so it will be more meaningful (Cohen, 2014). Thus, older adults take an active role in the design of music therapy. This will help them feel they have a purpose and a role in the intervention and, most likely, will increase their social interaction in the group (Cohen, 2014).

The Innovation Theory of music therapy emphasizes the importance of older adults engaging in new activities throughout the aging process (Cohen, 2014; Nimrod & Kleiber, 2007). According to this theory, music therapists can offer musical suggestions that bring meaning, excitement, and fulfillment to the older adult (Cohen, 2014). Music therapy strategies that utilize the Innovation Theory offer different types of musical opportunities including traditional or ethnic ensembles, individual or group musical

instruction, community field trips that involve music, and involve the older adults in the music therapy decision making process (Cohen, 2014).

The two types of music therapy are active music therapy and passive (receptive) music therapy (Blackburn & Bradshaw, 2014). Active music therapy requires the participant to play musical instruments or to engage in singing with the therapist. This type of music therapy can be done individually or in a group setting (Aldridge, 1994). Passive music therapy involves participants listening to music without actively contributing to the making of music (Grocke & Wigram, 2006). There is some evidence to suggest that the most effective music therapy interventions require active rather than passive participation (Blackburn & Bradshaw, 2014) and that longer interventions may be more effective in bringing about desired changes (Blackburn & Bradshaw, 2014; Chan et al., 2009; Chan et al., 2012; Gold et al., 2009). Music therapy has been found to be helpful in mitigating many of the challenges faced by older adults including AD, depression and anxiety while promoting overall well-being (Blackburn & Bradshaw, 2014; Guétin et al., 2009).

Music Therapy and Dementia

Music therapy has been shown to help decrease AD symptoms among older adults (Blackburn & Bradshaw, 2014; Guétin et al., 2009; Svansdottir, & Snaedal, 2006). In a critical review of the literature on music therapy for individuals with dementia, Blackburn and Bradshaw (2014) concluded that music therapy can be effective in reducing anxiety, depression and agitated behavior, and could prove beneficial in improving quality of life among older adults with dementia. They also indicated that music therapy is a low-cost, non-pharmaceutical and safe intervention that can be useful

for medical and other helping professionals working with older adults within residential care settings (Blackburn & Bradshaw, 2014).

A randomized control study in France was implemented with residents at a nursing home who had either a mild or moderate severity of Alzheimer's Disease (Guétin et al., 2009). A total of 30 patients were assigned to either an intervention or a control group. In the music therapy group, the patients received receptive music therapy. They choose the music they preferred. The control group participated in a reading group. Both groups lasted 24 weeks and had a session once a week. After sessions one, four, eight, 16, and 24, the patient's level of anxiety and depression were assessed using the Hamilton Scale and Geriatric Depression Scale. After week 16, participants in the music therapy group had significantly lower levels of anxiety than the control group, and this difference was maintained at the two-month follow-up. When assessing levels of depression, those who participated in the music therapy group reported lower levels of depression, but the results were not significant due to the participants being more depressed than the control group at the beginning (Guétin et al., 2009).

Another study from Iceland investigated the effectiveness of music therapy using a sample of 38 participants who had moderate to severe AD (Svansdottir & Snaedal, 2006). Participants were randomly put into a music therapy group (N = 20) or a control group (N = 18). The music therapy group participated in 18 sessions, three times a week for six weeks. Each session lasted for 30 minutes. Sessions involved the participants and the therapist choosing songs to sing, each of which were sung twice. If participants were not singing, they were still actively participating, even if that meant holding the songbook or listening to others sing. This allowed for people who were experiencing different

severities of dementia to still participate in session. The participants also played instruments or moved or dance if they desired. The intervention was evaluated at weeks six and ten (Svansdottir & Snaedal, 2006). After six weeks, there was a significant decrease among symptoms related to a scale measuring activity disturbance, anxiety and depression within the music therapy but not in the control group; however, there were no changes in the other AD challenges investigated. Unfortunately, these gains were not maintained over time (Svansdottir & Snaedal, 2006).

Music Therapy and Depression

Music therapy has also been shown to reduce depression among older adults (Chan et al., 2009; Chan et al., 2012; Gold et al., 2009). In a meta-analysis examining the effectiveness of music therapy among older adults, Gold et al. (2009) reported there were beneficial outcomes related to music therapy for older adults who experienced symptoms of depression and anxiety. Positive outcomes were most likely to occur when there was more exposure to interventions. In this review, it was suggested that those with depressive symptoms were likely to experience small positive effects of the music therapy after the fourth session, while larger effects were more likely to occur after 16 sessions (Gold et al., 2009).

Chan et al. (2009) studied the effectiveness of music on reducing depression levels among a sample of community-based older adults (N = 47) in Hong Kong who were assigned to control and experimental groups. The experimental group involved participants choosing the types of music they would listen to for 30 minutes during their weekly session. Participants were also asked to listen to the same type of music for 30 minutes every night before they went to sleep. At week four, the control group had

statistically higher levels of depression than the experimental group. Also after week four, within the music therapy group, older adults' levels of depression decreased from mild to normal. Music seemed to have a calming effect on older adults who experienced stress (Chan et al., 2009).

Chan et al. (2012) discovered similar results in the reduction of depression levels among older adults in Singapore. In this study participants (N = 50) were assigned to a music group or a control group. Individuals in the music group were allowed to determine their music. Each music session lasted for 30 minutes and occurred one time a week for the duration of eight weeks. The results of the study showed a significant reduction of depression levels among music therapy participants at weeks four, six, seven, and eight. Within the non-music group, there were no signs of depression reduction. The music group also experienced a statistically significant reduction in diastolic blood pressure, heart rate, and respiratory rate during the third and fourth week (Chan et al., 2012).

Music Therapy and Anxiety

Music therapy has been found to have a positive impact on older adults experiencing anxiety (Eells, 2014; Sung et al., 2010; Sung et al., 2012; Svansdotttir & Snaedal, 2006; Lee et al., 2010). One study of music therapy and anxiety was conducted with Chinese participants in Hong Kong at a community center (Lee et al., 2010). The participants ranged from 65 to 90 years old, and were randomly assigned to the music therapy intervention group or the control group. The intervention consisted of participants listening to music of their choice for 30 minutes. This group met once a week for four weeks, and quality of life outcomes were assessed after each week. During

week three, those in the music group reported significantly higher levels of physical functioning, lower levels of daily role activity limitations, and better general health than those in the control group. After week four, music therapy participants reported significantly better scores on all of the subscales of "physical functioning, daily role activities due to their physical problem, bodily pain, general health, vitality, social functioning, daily role activities due to their emotional problem, and mental health" (Yin Lee et al., 2010, p. 2680).

Sung et al. (2010) conducted a music therapy study using 29 older adults with dementia in an institutional setting in Taiwan. Participants received a 30-minute session spent listening to music two times a week for six weeks. The music group was compared against the control group. After six weeks, individuals in the music group were significantly less anxious than those in the control group who received standard care. Thus, it appears, providing a preferred music intervention to older adults with dementia in nursing homes may be beneficial in reducing anxiety symptoms of patients (Sung et al., 2010).

In a second study, also in Taiwan, Sung et al. (2012) randomly assigned 60 older adults with dementia into an experimental or control group. The experimental group engaged in 30-minute group music sessions where they played percussion instruments. Participants chose the type of music. The control group received normal and standard care. Those receiving the musical intervention were significantly less anxious and somewhat less agitated than those in the control group over time (Sung et al., 2012). Svansdotttir and Snaedal (2006) also reported significantly lower activity disturbances

such as wandering, purposeless activities, and inappropriate sexual behaviors among older adults with dementia after they had engaged in six weeks of music therapy.

Music Therapy and Well-Being

Music therapy also seems to improve the well-being of older adults (Clements-Cortés, 2014; Guétin et al., 2009; Skingley & Bungay, 2010). Guétin et al. (2009) found that older adults with dementia experienced a decrease in anxiety symptoms, which had a positive impact on their quality of life. Sung et al. (2010) determined that music engagement can improve social interactions among individuals by providing a space to socialize and reminisce about past experiences.

In a Canadian study, Clements-Cortés (2014) studied the effects of a singing group on physical and social well-being using a sample of 16 older adults living in a long-term residential care facility. The group met for one hour weekly for 16 weeks but study participants had to have attended at least ten sessions. Two music therapists ran the sessions. The sessions began with a warm-up and then participants sang three to four songs from different genres. During the sessions, instruments and movements were incorporated, and after the 14th session, the participants performed for the long-term care facility where they resided while the audience sang along. At the beginning and end of singing sessions, mood, pain, anxiety, happiness, and energy were assessed.

The researchers collected both quantitative and qualitative data to explore program impact. Quantitative results included significant mood and happiness improvements at the end of each session as well as significant pain decreases and energy increases reported after 88% of the sessions. Common themes identified from the qualitative data included new friends and sense of community, special moments that

allowed them to share recollections or interests, the creation of a positive climate, belief singing makes one feel better, and better mood, energy and alertness levels (Clements-Cortés, 2014).

Researchers in the United Kingdom conducted 17 cross-sectional interviews with older adults who had participated in Silver Song Clubs (Skingley & Bungay, 2010). Silver Song Clubs involved sessions where participants were engaged in musical activities such as singing songs and playing instruments. These clubs met approximately once a month and were held in some type of a community center where older adults congregated. The songs the older adults sang included both familiar songs and challenging songs. Key benefits identified in the interviews were higher levels of social interaction, better well-being, increased enjoyment of life, better physical health, and improved memory, learning and recall (Skingley & Bungay, 2010).

Music and Culture

Music therapy has been widely studied within diverse Asian and European countries (Blackburn & Bradshaw; Chan et al., 2009; Gold et al., 2009; Sung et al., 2012). Consistent findings across these studies suggest music therapy can be an effective, non-conventional intervention for older adults. Incorporating multicultural knowledge and sensitivity is of great importance when practicing music therapy (Molloy & Darrow, 1998; Shapiro, 2005). Molloy and Darrow (1998) examined the use of multicultural practices by music therapists and student music therapists in culturally-diverse locations in the United States. They reviewed the literature, conference programs, National Association of Music Therapy requirements regarding music therapy and culture, and interviewed music therapy students and professionals (N = 219). Results

indicated that professionals were underprepared to work with diverse cultures, possibly due to the lack of this content in their education. Therapists in the study also stated that using multicultural music and being knowledgeable of multiple cultures was important to their clinical work. Music therapists mentioned that, when multicultural practices were used, it allowed for the clients to relate better to the therapist (Molloy & Darrow, 1998).

Conclusion

As individuals age, they can potentially experience some challenges which may require different types of interventions. It appears that some of the most common challenges older adults may experience can be treated through music therapy (Blackburn & Bradshaw, 2014), whether alone or in combination with other interventions. The majority of studies on music therapy and older adults have been conducted outside the United States (Chan et al., 2009; Guétin et al., 2009; Svansdottir & Snaedal, 2006; Lee et al., 2010). The positive outcomes of music therapy within these studies on diverse populations, suggest that music therapy can be effective among different cultures and languages. A limited amount of U.S. studies involving music therapy in older adults have been conducted (Holtzer et al., 2003) thus, it is important to develop and seek funding for music programs for older adults here and test their effectiveness.

CHAPTER 3

METHODS

Identification of Potential Funding Sources

The grant writer started with an Internet search to explore funding opportunities at the state and federal levels. Internet websites investigated included grants.gov, National Institute on Aging, National Institutes of Health and United States Department of Health and Human Services. When conducting the online search for federal and state grants, the grant writer used key search terms and phrases such as: grants for older adults, music therapy grants, aging, and grants for elderly. Most of the grants that fit the proposed music therapy program, were research grants and, therefore, were not appropriate for development of this program. Therefore, the grant writer moved on to searching for foundations.

The grant writer visited OneOC Nonprofit Services located in Santa Ana, California. This facility had the Foundation Center (FC) Search software, which is used to explore sources of foundation funding. One of the employees, familiar with the software, provided a short training about how to navigate the software. Through the use of FC search, the grant writer was able to search for foundations by identifying geographic area, type of support, areas of interest, purpose, activities, type of service, funding amount, and type of grants funded in the past. The grant writer searched the FC database using key terms such as aging, music therapy, program development, arts, and

older adults, aging centers, adults, continuing support, arts and music therapy. The FC search produced better results, more closely aligned with the proposed music therapy program. During this search, it was also easier to limit and define my search criteria. After visiting OneOC Nonprofit Services, the grant writer identified ten foundations that could be potential funders for this music therapy program, including American Honda Foundation, Walter and Elise Hass Foundation, Conrad N. Hilton Foundation, Keck Foundation, Ralph M. Parson Foundation, Weingart Foundation, Archstone Foundation, UniHealth Foundation, Ahmanson Foundation, and the Eisner Foundation.

Following the visit to OneOC Nonprofit Services, the grant writer met with the project advisor to determine the foundation that would best fit the proposed music therapy program. After looking thoroughly through the websites of the ten foundations, the grant writer choose the Eisner Foundation. The Eisner Foundation was selected based on the goodness of fit between the proposed project and the goals of the funding source, geographic location, and sufficient levels of funding. In particular, the Eisner Foundation was interested in both the target population and the cultural aspect of the intervention. After this decision was made, the grant writer connected with the Director of Older Adult Services at JFCS to see if there were any conflicts with choosing the Eisner Foundation. The Director did not foresee any conflicts and approved the selection.

The Eisner Foundation

The Eisner Foundation (n.d.) is a private family foundation that was started in 1996 by Michael D. Eisner and his wife Jane. They give approximately $7 million each year to non-profits in Los Angeles County. The Eisner Foundation's mission is to support and fund program services that help the populations of disadvantaged children

and those who are aging. When providing grants to organizations, the Eisner Foundation is interested in programs and services that enrich the lives of these disadvantaged populations. This foundation recognizes that disadvantaged children and the aging population in Southern California experience devastating things such as powerlessness, physical and emotional vulnerability, and most important for this grant, limited to access to the arts Eisner Foundation (n.d.).

The Eisner Foundation (n.d) looks to partner with organizations that serve older adults through advocacy and provide them with cultural enrichment and opportunity to age with dignity. They prefer to support organizations that provide older adults with a lasting change in their lives and want to support programs that will eliminate their problems Eisner Foundation (n.d.). The amount of funding provided ranges from $100,000 and $300,000. The types of organizations they want to fund are ones that achieve efficiency, effectiveness, exceptional leadership, and provide expected outcomes. Once the organization is established in these four categories, the application process begins with submitting a Letter of Inquiry (LOI).

In the LOI, applicants must include a brief history of the organization, the population the organization serves and the programs they provide, an explanation of why the organization would be a good fit for the Eisner Foundation, the amount of funding that is requested, a budget for the intended program and expected outcomes of the program. To meet the academic requirements of the project, the grant writer also added a program description, a budget narrative and an evaluation plan.

Target Population

The target population for the proposed program is adults, 65 years and older, who are experiencing anxiety and depression. AJCC members can be referred to the program by a JFCS clinician or come in as a self-referral. Referrals can also be made through outside agencies that serve the older adult population within the Long Beach area. JFCS will do program outreach to other older adults service agencies so their clients can take advantage of the program if appropriate. People of all ethnicities, races, religion, sexual identity and socioeconomic status are welcomed to participate in the music therapy program. It is anticipated that 120 older adults will be served during the first year.

Sources for Grant Needs Assessment

The grant writer used information from the National Alliance on Mental Illness, National Institute of Mental Health, and the Alzheimer's Association and the published literature to document challenges related to aging. The grant writer also gathered information from JFCS regarding demographics of the population served. Data on mental health problems and depression were gathered from the California Health Interview Survey.

Collaboration with the Funding Source

The grant writer collaborated with the Director of Older Adult Services when collecting demographic information about the clients JFCS serves and their latest annual report. The Director also provided the grant writer with input on funders that were currently supporting JFCS, approved the selected funding source and provided some feedback on program design and possible staffing.

CHAPTER 4

GRANT PROPOSAL

Brief History of Jewish Family and Children's Service

Jewish Family and Children's Service (JFCS) is housed in the Alpert Jewish Community Center (AJCC), which is located in the city of Long Beach, California. JFCS is a non-profit agency that was founded by members of the National Council of Jewish Women in 1957 following World War II and the increase of the Jewish population in Long Beach. These women recognized there was a need for counseling, emergency financial assistance, and resettlement of refugee families. Our mission is "to empower people to make positive changes through professional, affordable counseling and support services" (JFCS, 2014).

Population and Programs

Long Beach is a very diverse city although the older adult population is very different than the general population. Of the population of adults 65 years and older in Long Beach, 55% is White, 17% is Asian, 16% is Latino, and 9% is African American, (Crampon & Norman, 2014). Twelve percent of the total population of older adults 65 years and older in Long Beach are in poverty (Crampon & Norman, 2014). Clients who come through our doors are provided with a variety of services such as older adult services, counseling, school counseling, support groups, and domestic violence prevention and education. Clients from all walks of life receive services regardless of

race, gender, ethnicity or religious background. Older adult clients can benefit from a multitude of services such as assessment, referral, case management, money management, financial assistance, counseling, friendly visitations, support groups, financial assistance, services for Holocaust survivors, and services for caregivers.

Each year, over 1,000 seniors and their family members benefit from our services. Over 90% of seniors, and their caregivers, we served in 2012 and they said our organization positively impacted their lives and that they were satisfied with the services they received. We are committed to vulnerable populations and the vast majority (83%) of our clients are below 200% of the federal poverty level (JFCS, 2012). One gap in our current services is providing specific support to older adults experiencing the most prominent challenges of aging. Depression and anxiety are serious issues that impact older adults' well-being (Blackburn & Bradshaw, 2014; Guétin et al., 2009).

Long Beach is in need of more services and programs that enhance the quality of life and mental health of older adults, especially in regard to depression (City of Long Beach, 2005). In one study of the South Bay area, of which Long Beach is a part, 22% of older adults reported feeling downhearted and sad during some or all of the time (California Health Interview Survey, 2001). Within the past week, 11% also reported experiencing poor mental health (California Health Interview Survey, 2005). Our proposed music therapy program is just what this city needs to help with these issues because there is evidence to suggest music therapy can reduce depression and anxiety, while promoting well-being (Brenes et al., 2005; Brown & Roose, 2011). Like Eisner, we believe that this program will nurture and inspire the vulnerable and disadvantaged older adults in the Long Beach area.

Explanation of Good Partner

JFCS would be a great partner for the Eisner Foundation in a number of ways. Our proposed music therapy program will produce high quality results that promote the health and well-being of older adults, a priority of the Eisner Foundation. Effectiveness and exceptional leadership are embedded throughout JFCS. For 58 years, we have been providing services to older adults throughout the community of Long Beach. Our organization has been continually growing and diversifying. We now serve more people, more adults and families, and more low-income individuals than ever before. Our effectiveness is a major contributor to our continual growth. Exceptional leadership is a quality that all employees have when serving older adults within JFCS. Our values are aligned with Eisner's in that our motto is "Healing the world, one person, one family at a time," (JFCS, 2014). Also, we are currently in the process of developing a strategic plan to ensure we are using best practices when implementing programs and services while producing high quality outcomes.

Older individuals who experience health issues or poverty will have a spot waiting for them at JFCS where they will be provided a safe environment and the ability to age with dignity and cultural enrichment. The proposed music therapy program will allow members to explore their cultural values through the use of music. Since the program will include group processes, it will allow for members to create a personal and safe environment. Culture and music go hand in hand and provide great outcomes when used together in music therapy (Molloy & Darrow, 1998; Shapiro, 2005). We are excited to incorporate and promote culture, like Eisner, when serving clients in the music therapy program.

Project Description

We are currently seeking funding to start music therapy groups for older adults, especially those experiencing depression and anxiety, both of which can negatively impact the health of older adults (Kastenschmidt & Kennedy, 2011; Vink et al., 2008). We will implement the new music therapy program alongside the other beneficial services we are providing to the older adult community of Long Beach. Well-being and quality of life will be increased among the older adults who attend the music therapy groups while depression and anxiety symptoms will be reduced.

We are excited to implement such an effective and non-conventional intervention that addresses depression (Chan et al., 2012; Gold et al., 2009) and anxiety (Eells, 2014; Svansdotttir & Snaedal, 2006) especially since these are prevalent issues among older adults (Alpert, 2014; Kessler et al., 2005). Our music therapy groups will incorporate group members singing, playing percussion instruments, and engaging in reminisce. The grant funds requested will finance 12 months.

Goal

To promote positive and lasting changes in the well-being and quality of life of older adults.

Objective

To serve 120 adults within a single year by providing 12 music therapy groups that will each last 8 weeks.

We will hire one part-time social worker with a background in music therapy to run the music therapy groups at JFCS. The social worker will provide a training to other case managers and clinicians at JFCS to inform them of the new program. JFCS staff

working directly with older adults will refer their clients to the music therapy groups if they are experiencing depression and/or anxiety symptoms. We do not want the rest of the Long Beach community working with older adults to miss out on this new intervention. Therefore, our social worker will go out to other agencies serving older adults such as the Long Beach Multi-Service Center, local senior centers, and other mental health service agencies to explain and advertise our music therapy groups.

Members of our music therapy group are going to be older adults 65 years and older experiencing symptoms of anxiety and depression. They can be a self-referral, receiving services through JFCS, or receiving services through another agency. Two groups will run simultaneously, with ten members in each group. Our music therapy groups will be held an hour a week for 8 weeks. We are utilizing best practices because better outcomes are related to longer programs (Chan et al., 2009; Chan et al., 2012).

The group members will be in full control of what each music therapy group session will entail. To produce high quality results, our members will choose the songs because it is vital to the increase participants' social interaction and provide them a meaningful role in the group (Cohen, 2014). During the first group meeting, all the members will share the genre of music and songs they like and some information about themselves to the rest of the group members. The social worker will compile the shared genres of music and songs the members shared and create lyric books for the members. Group members will also receive a CD to take home so that they can practice singing the songs, and listen to on their own. The CDs are important because listening at home, and in session, can help reduce depression levels (Chan et al., 2009) and anxiety symptoms (Sung et al., 2010).

Our group members will be having fun while being actively engaged in a variety of musical activities, such as singing and playing music since active music therapy is most helpful (Skingley & Bungay, 2010; Lee et al., 2010). During the first 30 minutes of each group, members will sing a song, selected by the group during the previous week. Next, they will play the song by using the percussion instruments. Reminiscing will be incorporated throughout the last 30 minutes of the group session as participants will share how they felt when playing the instruments and/or singing the songs and their memories of the songs. Social interaction among our group members will be improved through because engaging in reminiscing music therapy (Ashida, 2000; Sung et al., 2010). This section of the group will mostly be ran by the group members themselves, but the social worker will be there to facilitate or direct on an as needed basis. The social worker will encourage them to help one another with personal struggles they may disclose. The social worker will be responsible for referring members to other services if he/she feels that is needed.

After the eighth group session, the group members will perform a concert with the songs they have chosen. This performance will encompass all that the members have learned during their time attending their music therapy group. By the end of the concert, we are looking forward to group members having improved mood, confidence, and sense of purpose (Clements-Cortés, 2014). This concert will be the last opportunity to reap all the possible benefits our music therapy program at JFCS. The concert will take place at the AJCC, and tickets will cost $5.00 each, and it will be held in the AJCC ballroom.

Expected Outcomes

Our music therapy group members will experience a 30% decrease in their anxiety and/or depression symptoms. Attendance will be kept at each session. Group members will complete pre/post-standardized measures of the Beck's Depression Scale and Hamilton's Anxiety Scale. Changes in anxiety and depression will be investigated by an outside evaluator.

Proposed Budget Narrative

Personnel

Social worker. A social worker will be hired for 8 hours per week for 52 weeks at .20 full-time equivalent (FTE). The social worker will have a minimum of a Bachelor's of Social Work Degree from an accredited university and a background in music therapy. This employee will be responsible for facilitating the music therapy groups twice a week for one hour as well as educating other agencies about the music therapy groups. Part time benefits will be 18% of the personnel cost including FICA, unemployment insurance, and workers compensation. The personnel will consist of salary ($10,000) and benefits ($1,800) at a total cost of $11,800.

Program Cost

Program Supplies. Instruments for group will include 2 tambourines at $7.16 each, 2 sets of hand cymbals at $13.56 each, 2 maracas at $10.66 each, 2 hand drums at $60.86 each, and a set of 2 claves at $3.99 each. The total cost for instruments is $192.46. Songs will be purchased online to play for each of the 120 participants during the group session at $.99 per song and will be calculated at a cost of $118.80. Two packs of 75 CDs are calculated at $11.75 per pack and will be purchased to give to the 120

participants and at a total cost of $23.49. Office supplies such as paper, stapler, and staples will be purchased at a total of $32.04. Flyer printing for advertising the music therapy groups will be at a cost of $50.00. A music player will be bought at $104.99 and used during music therapy groups and during the final performances. A set of three microphones will be purchased for a total of $39.99. Therefore the program cost will consist of musical instruments ($192.46), song purchases ($118.80), CDs ($23.49), office supplies ($32.04), flyer printing ($50.00), a music player ($104.99), and microphones ($39.99) calculating the total program supplies cost of $561.77

Refreshments. During the final performances there will be light refreshments offered for guests who are attending. The total calculated cost of refreshments is $480.00 at $40.00 per performance.

Travel. The social worker will get reimbursed for mileage when traveling in the Long Beach area to educate other agencies about the music therapy groups. The social worker will average 20 miles a month at $.52 per mile with a calculated total of $124.80.

Indirect Program Cost

An outside evaluator will be hired to conduct pre/post Beck's Depression Scales and Hamilton's Anxiety Scales to the group members before and after their participation in the group. This individual will be hired to ensure there will be no subjectivity in results of the program evaluation. The cost of this evaluator will be $3,000.

Administrative costs will be 10% of the total program cost. This percentage is from the space that is provided to hold the groups at JFCS, use of computer, printer, and copier, and program supervision from the Director of Older Adult Services. The total administrative cost is $1,296.66.

TABLE 1. Detailed Budget for Proposed Program

Expenses	
Direct Program Cost	
Personnel	
Part-time Social Worker 20% FTE	$10,000.00
Benefits @ 18% of FTE	$1,800.00
Total Salaries	$ 11,800.00
Program Cost	
Program Supplies	$561.77
Refreshments (final performance)	$480.00
Travel	$124.80
Total Direct Program Costs	$12,966.57
Indirect Program Cost	
Evaluator	$3,000.00
Administrative Costs	$1,296.66
Total Indirect Program Cost	$4,296.66
TOTAL PROJECT COST	$17,263.23

CHAPTER 5

LESSONS LEARNED

This chapter presents the lessons learned as well as implications for social work practice resulting from this grant writing project.

Identifying Funding Sources

The grant writer found that, before searching for potential funding sources, one should know, in detail, what the program or service they are requesting money for will entail. When beginning the search, the grant writer was trying to look for funders that would provide funding for programs for older adults. It was quickly realized, that the grant writer should know the focus of their grant before searching for a funder because funders have specific and detailed requirements such as financial amount limits and types of services they will fund. The grant writer had to keep in mind the mission and values of the funders to make sure they were aligned with the mission and values of the proposed music therapy program.

The grant writer looked at federal and state level funders and struggled with figuring out what types of programs or services they were looking to fund. Therefore, it was easier to search for foundation grants because they had websites that described their mission and what they would support in ways that were easier to understand than federal and state level funders. Foundation websites were also a lot easier to access than federal

and state funding opportunities. Thus, this grant writer learned that seeking and obtaining federal or state funding may prove more difficult than foundation funding.

A grant writer should take into consideration that, at any point, foundations might make changes to their application process or the types of grants they will fund. After not reviewing the foundation website on a regular basis, the grant writer found out there had been changes in the application process. This was unexpected, however, the grant writer will be prepared for this possibility in the future. She will check the website regularly, register for foundation newsletters if possible, and contact foundation staff directly to ensure her information is timely.

Program Design

Designing a music therapy program takes more critical thinking than the grant writer had anticipated. The grant writer utilized best practices from previous research taken from the literature review to help develop this music therapy program. Developing the program's goals and objectives were difficult because they needed to reflect one another, and the objectives needed to be clear and measurable. At first, the grant writer had multiple objectives, which were very general, and there was no way to see the program completing the objectives. After the grant writer realized that one objective could be used, it was evident that creating one clear and concise objective would make evaluating the purpose of objective a much more simpler task.

Once the grant writer created measurable objectives for the goal of the program, the designing became easier. The activities chosen for the music groups were guided by evidence-based practice. Using evidence-based practices in the proposed program made

the grant writer feel assured that the older adults will benefit positively from these groups and that there is an increased likelihood of funding.

During the researching process, the grant writer noted the characteristics that worked for different music therapy groups, and compiled a list to help design this proposed music therapy group including numbers of members in the groups, duration of program and sessions, and staffing to help develop the music therapy groups at JFCS. Also, the grant writer found it useful to look at qualitative studies of older adults and what they liked and disliked about music therapy groups to help design this program.

Grant Writing Process

The process of writing a grant was a new experience for this grant writer. Grant writers must be flexible to change and be comfortable with adaptability. There were certain aspects the grant writer wanted to incorporate in the music therapy groups, but in the funding world there needs to be accountability in that there should be evidence that your program and the activities that are being done will work. The grant writer learned that accountability is important because it increases the likelihood of program funding.

Another critical aspect of increasing the likelihood of program funding is the type of language that is needed when describing a grant and why it should be funded. The grant writer had become comfortable with writing in an academic way, but, when writing the grant, funders are not looking for academic writing. The funder is looking for exciting and persuasive language to be used. Grant writers should also try their best to incorporate key words that have been mentioned in the funder's values and mission. Writing in a non-academic language was a challenge the grant writer faced, and eventually took a while to get comfortable with this process.

For future grant writing, the grant writer will consider that there needs to be a logical flow between goals, objectives and activities. This is needed so that the potential funders can visualize the proposed program and understand its purpose. Throughout the grant writing process the grant writer needed to focus on the foundation guidelines and make sure that everything was addressed, and that it was stated in language that would be appealing and engaging to the funders. Grant writers need to remember that funders are reading multiple applications; therefore, a grant should stick out from all the rest. Incorporating consistent data and literature that lines up with the proposed program is important because the potential funder wants to see that the research has been done to ensure the program will be impactful to those it is serving.

Collaboration

Collaboration with the Director of the Older Adult Services program at JFCS was a bit challenging. When collaboration was effective the Director was very helpful in the process. The grant writer had to ask for vital information in order to write the grant and that was very helpful. The Director was able to share a copy of the agency's annual report and the names of other funders that JFCS was currently in partnership with. The grant writer's advisor suggested gathering the names of other funders of JFCS. It is good grant writing practice to not request funds from a funder that is already providing funding at the agency because they will be less likely to provide additional funds.

Being persistent when working in collaboration with an agency is a skill a grant writer may need to possess. Constant communication with someone at the agency one is writing a grant for is very important. For a strong grant to be written, the grant writer must work closely with the agency. For future grant writing, the grant writer will let the

agency know at the beginning how involved they will need to be in order to get the grant written.

Budgeting

At first, the grant writer wanted to work on the budget, but realized that the details of the music therapy groups needed to be completed first to determine what the amount of funding. Grant writers should have an estimate of what the budget will be prior to selecting a funder, because that is an important part of identifying a funder source since the final budget amount needs to be in a range that the funder will be willing to accept. Once, an estimated budget is determined the grant writer can figure out what the program will look like, see what they will need money for, and make sure enough money will be distributed in a way that can reach the goals of these music therapy groups.

The grant writer learned how to use new software and the definition of new terms in order to formulate a realistic budget. The use of Microsoft Excel was really helpful in the process of figuring numbers and percentages of costs when determining the budget. The grant writer learned how to create formulas in Excel that kept the amounts of line-items correct if things were changed. Also, the grant writer had to understand the terms of FTE (Full-Time Equivalent) and administrative costs because they are vital and needed parts of a line-item budget.

Implications for Social Work Practice

Social workers should be open to trying interventions that are used globally. Throughout the literature, it was apparent that there had not been a lot of studies showing the effectiveness of music therapy among older adults in the United States. Therefore, additional research is needed in the United States to show that music therapy is effective

as an alternative treatment for depression and anxiety among older adults. Variations for older adults who are cognitively impaired should be a considered when social workers utilize music therapy. Social workers should take it upon themselves to do research on best practices and treatments, even if it is internationally. The field of social work is forever evolving and, therefore, it is important for social workers to be informed about the latest evidence-based practices and treatments.

Social workers need to take on an advocacy role and formulate discussions about innovative interventions such as music therapy. Advocacy should occur on a policy level, to allow for music therapy to be supported within the social work field. Social workers can advocate for more policies that allow for more funding opportunities that support non-conventional interventions such as music therapy for treatment of mental health issues. Having more opportunities for funding innovative and creative interventions will help social workers provide the most effective services and program for older adults. Depression and anxiety are some of the top challenges older adults may face, and due to the aging population increasing and the Baby Boomer population getting older, there is going to be a need for more services to address the challenges of older adults. If there are more policies that are out there to fund services, this will give social workers opportunities to write grants that will provide music therapy services.

Since research has suggested positive outcomes of music therapy, social workers should write grants to implement and develop more music therapy programs, especially since it has not been practiced as much within the United States. Due to the prevalence of depression and anxiety among older adults, music therapy in a group format would be an effective way to serve multiple individuals at a time. Group format is also a cost

efficient way of direct services. In the profession of social work, in order to be committed to clients it is important to make sure they are being provided the most effective and efficient programs and services.

REFERENCES

REFERENCES

Adams, K., & Moon, H. (2009). Subthreshold depression: Characteristics and risk factors among vulnerable elders. *Aging & Mental Health*, *13*(5), 682-692. doi:10.180/13607860902774501

Aldridge, D. (1994). An overview of music therapy research. *Complementary Therapies in Medicine*, *2*(4), 204-216.

Alpert, P. T. (2014). Depression makes the golden years not so golden. *Home Health Care Management & Practice*, *26*(3), 182-185. doi:10.1177/1084822313514852

Alzheimer's Association. (2012). Alzheimer's disease facts and figures. *Alzheimer's & Dementia. 8*(2). Retrieved on September 15, 2014 from http://www.alz.org/downloads/facts_figures_2012.pdf

American Music Therapy Association. (2010). *The 2010 AMTA member sourcebook*. Silver Spring, MD: AMTA.

American Music Therapy Association. (2014). *About music therapy & AMTA.* Retrieved on September 15, 2014 from http://www.musictherapy.org/

American Psychological Association. (2004). Guidelines for psychological practice with older adults. *American Psychologist*, *59*(4), 236 –260. doi:10.1037/0003-006X.59.4.236

Ashida, S. (2000). The effect of reminiscence music therapy sessions on changes in depressive symptoms in elderly persons with dementia. *Journal of Music Therapy*, *37*(3), 170-182.

Ayers, C. R., Sorrell, J. T., Thorp, S. R., & Wetherell, J. (2007). Evidence-based psychological treatments for late-life anxiety. *Psychology and Aging*, *22*(1), 8-17. doi:10.1037/0882-7974.22.1.8

Baernholdt, M., Hinton, I., Yan, G., Rose, K., & Mattos, M. (2012). Factors associated with quality of life in older adults in the United States. *Quality of Life Research*, *21*(3), 527- 534. doi:10.1007/s11136-011-9954-z

Banerjee, S. (2009). *The use of antipsychotic medication for people with dementia: Time for action*. London, England: Department of Health.

Beaudreau, S. A., & O'Hara, R. (2009). The association of anxiety and depressive symptoms with cognitive performance in community-dwelling older adults. *Psychology and Aging*, *24*(2), 507-512. doi:10.1037/a0016035

Bisschop, M. I., Kriegsman, D. W., Beekman, A. F., & Deeg, D. H. (2004). Chronic diseases and depression: The modifying role of psychosocial resources. *Social Science & Medicine*, *59*(4), 721-733. doi:10.1016/j.socscimed.2003.11.038

Blackburn, R., & Bradshaw, T. (2014). Music therapy for service users with dementia: A critical review of the literature. *Journal of Psychiatric & Mental Health Nursing*, *21*(10), 879-888. doi:10.1111/jpm.12165

Blazer, D. G. (2000). Psychiatry and the oldest old. *The American Journal of Psychiatry*, *157*(12), 1915-1924. doi:10.1176/appi.ajp.157.12.1915

Blazer, D. (2003). Depression in late life: review and commentary. *Journals of Gerontology Series A: Biological Sciences & Medical Sciences*, *58A*(3), 249-265.

Boyle, P., Barnes, L., Buchman, A., & Bennett, D. (2009). Purpose in life is associated with mortality among community-dwelling older persons. *Psychosomatic Medicine*, *71*(5), 574-579. doi:10.1097/PSY.0b013e3181a5a7c0

Brenes, G., Guralnik, J., Williamson, J., Fried, L., Simpson, C., Simonsick, E., & Penninx, B. (2005). The influence of anxiety on the progression of disability. *Journal of the American Geriatrics Society*, *53*(1), 34-39. doi:10.1111/j.1532-5415.2005.53007.x

Brenes, G., Miller, M., Stanley, M., Williamson, J., Knudson, M., & McCall, W. (2009). Insomnia in older adults with generalized anxiety disorder. *American Journal of Geriatric Psychiatry*, *17*(6), 465-472.

Brown, P. J., & Roose, S. P. (2011). Age and anxiety and depressive symptoms: The effect on domains of quality of life. *International Journal of Geriatric Psychiatry*, *26*(12), 1260-1266. doi:10.1002/gps.2675

Bryant, C., Jackson, H., & Ames, D. (2008). The prevalence of anxiety in older adults: Methodological issues and a review of the literature. *Journal of Affective Disorders*, *109*(3), 233-250. doi:10.1016/j.jad.2007.11.008

Cairney, J., Corna, L., Veldhuizen, S., Herrmann, N., & Streiner, D. (2008). Comorbid depression and anxiety in later life: Patterns of association, subjective well-being, and impairment. *American Journal of Geriatric Psychiatry*, *16*(3), 201-208.

California Health Interview Survey. (2001). *Tools.* Retrieved from http://ask.chis.ucla.ed u/main/DQ3/output.asp?_rn=0.1897852

California Health Interview Survey. (2005). *Tools.* Retrieved from http://ask.chis.ucla.ed u/main/DQ3/output.asp?_rn=0.5589105

Centers for Disease Control and Prevention, (2010). Current depression among adults-United States, 2006 and 2008. *Morbidity and Mortality Weekly Report, 59*(38)*,* 1229-1258. Retrieved from http://www.cdc.gov/mmwr/pdf/wk/mm5938.pdf

Chan, M., Chan, E., Mok, E., & Kwan Tse, F. (2009). Effect of music on depression levels and physiological responses in community-based older adults. *International Journal of Mental Health Nursing*, *18*(4), 285-294. doi:10.111/j.144 7-0349.2009.00614.x

Chan, M. F., Wong, Z. Y., Onishi, H., & Thayala, N. V. (2012). Effects of music on depression in older people: A randomised controlled trial. *Journal of Clinical Nursing*, *21*(5/6), 776-783. doi:10.1111/j.1365-2702.2011.03954.x

City of Long Beach. (2005). *Long Beach strategic plan for older adults…strength through the ages.* Long Beach, CA: Department of Health and Human Services.

Clements-Cortés, A. (2014). Buddy's glee club two: Choral singing benefits for older adults. *Canadian Journal of Music Therapy*, *20*(1), 85-109.

Cohen, N. S. (2014). Music therapy and sociological theories of aging. *Music Therapy Perspectives*, *32*(1), 84-92. doi:10.1093/mtp/miu013

Colby, S. L., & Ortman, J. M. (2014). *The baby boom cohort in the United States: 2012 to 2060*. Retrieved from https://www.census.gov/prod/2014pubs/p25-1141.pdf

Crampon, W., & Norman, A. (2014). *Ethnic disparities in Long Beach, California.* Long Beach, CA: ReThining Greater Long Beach. Retrieved from http://www.rethinklongbeach.org/resources/Ethnic+Disparities+in+Long+Beach.pdf

Cui, X., Lyness, J., Tang, W., Tu, X., & Conwell, Y. (2008). Outcomes and predictors of late-life depression trajectories in older primary care patients. *American Journal of Geriatric Psychiatry*, *16*(5), 406-415.

Demakis, G. J. (2007). Disability in Alzheimer's disease: Causes, consequences, and economic considerations. *Journal of Health and Human Services Administration*, *30*(3), 293-305.

Depp, C., Vahia, I., & Jeste, D. (2010). Successful aging: Focus on cognitive and emotional health. *Annual Review of Clinical Psychology*, *6,* 527-550. doi:10.1146/a nnurev.clinpsy.121208.131449

Devanand, D. P. (2014). Dysthymic disorder in the elderly population. *International Psychogeriatrics*, *26*(1), 39-48. doi:10.1017/S104161021300166X

Dillaway, H., & Byrnes, M. (2009). Reconsidering successful aging: A call for renewed and expanded academic critiques and conceptualizations. *Journal of Applied Gerontology*, *28*(6), 702-722. doi:10.1177/0733464809333882

Dilworth-Anderson, P., Pierre, G., & Hilliard, T. S. (2012). Social justice, health disparities, and culture in the care of the elderly. *Journal of Law, Medicine & Ethics*, *40*(1), 26-32. doi:10.1111/j.1748-720X.2012.00642.x

Dittrich, K. (2009). *Social work with older adults: A biopsychosocial approach to assessment and intervention* (3rd ed.). Boston, MA: Allyn & Bacon.

Dorenlot, P., Harboun, M., Bige, V., Henrard, J., & Ankri, J. (2005). Major depression as a risk factor for early institutionalization of dementia patients living in the community. *International Journal of Geriatric Psychiatry*, *20*(5), 471-478.

Eells, K. (2014). The use of music and singing to help manage anxiety in older adult. *Mental Health Practice*, *17*(5), 10-17.

Eisner Foundation. (n.d.). *What we do.* Retrieved from http://www.eisnerfoundation.org/

Espiritu, D. V., Rashid, H., Mast, B. T., Fitzgerald, J., Steinberg, J., & Lichtenberg, P. A. (2001). Depression, cognitive impairment and function in Alzheimer's disease. *International Journal of Geriatric Psychiatry*, *16*(11), 1098-1103.

Etoile, S. L. (2000). The history of the undergraduate curriculum in music therapy. *Journal of Music Therapy*, *3, 7*51-71.

Fann, J. R., Fan, M., & Unützer, J. (2009). Improving primary care for older adults with cancer and depression. *Journal of General Internal Medicine*, *24*(2), S417-S424. doi:10.1007/s11606-009-0999-4

Ferri, C., James, I., & Pruchno, R. (2009). Successful aging: Definitions and subjective assessment according to older adults. *Clinical Gerontologist*, *32*(4), 379-388.

Gallo, J. J., & Lebowitz, B. D. (1999). The epidemiology of common late-life mental disorders in the community: Themes for the new century. *Psychiatric Services*, *50*(9), 1158-1166.

Giltay, E. J., Geleijnse, J. M., Zitman, F. G., Hoekstra, T., & Schouten, E. G. (2004). Dispositional optimism and all-cause and cardiovascular mortality in a prospective cohort of elderly dutch men and women. *Archives of General Psychiatry*, *61*(11), 1126-1135. doi:10.1001/archpsyc.61.11.1126

Gold, C., Solli, H. P., Krüger, V., & Lie, S. A. (2009). Dose–response relationship in music therapy for people with serious mental disorders: Systematic review and meta-analysis. *Clinical Psychology Review*, *29*(3), 193-207. doi:10.1016/j.cpr.200 9.01.001

Gonçalves, D. C., & Byrne, G. J. (2012). Interventions for generalized anxiety disorder in older adults: Systematic review and meta-analysis. *Journal of Anxiety Disorders*, *26*(1),1-11. doi:10.1016/j.janxdis.2011.08.010

Grant, B., Hasin, D., Stinson, F., Dawson, D., Ruan, W., Goldstein, R., ... Huang, B. (2005). Prevalence, correlates, co-morbidity, and comparative disability of DSM-IV generalized anxiety disorder in the USA: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Psychological Medicine*, *35*(12), 1747-1759.

Grocke, D., & Wigram, T. (2006). *Receptive methods in music therapy: Techniques and clinical applications for music therapy clinicians, educators and students*. London, England. Jessica Kingsley.

Gruenewald, T. L., Karlamangla, A. S., Greendale, G. A., Singer, B. H., & Seeman, T. E. (2007). Feelings of usefulness to others, disability, and mortality in older adults: The Macarthur study of successful aging. *Journals of Gerontology Series B: Psychological Sciences & Social Sciences*, *62B*(1), 28-P37.

Guétin, S. S., Portet, F. F., Picot, M. C., Pommié, C. C., Messaoudi, M. M., Djabelkir, L. L., & ... Touchon, J. J. (2009). Effect of music therapy on anxiety and depression in patients with Alzheimer's type dementia: Randomised, controlled study. *Dementia & Geriatric Cognitive Disorders*, *28*(1), 36-46. doi:10.1159/000229024

Hendrie, H. C., Albert, M. S., Butters, M. A., Gao, S., Knopman, D. S., Launer, L. J., ... Wagster, M. V. (2006). The NIH cognitive and emotional health project: Report of the critical evaluation study committee. *Alzheimer's & Dementia*, *2*(1),12-32. doi:10.1016/j.jalz.2005.11.004

Holtzer, R., Tang, M., Devanand, D. P., Albert, S. M., Wegesin, D. J., Marder, K., & ... Stern, Y. (2003). Psychopathological features in Alzheimer's disease: Course and relationship with cognitive status. *Journal of the American Geriatrics Society*, *51*(7), 953-960. doi:10.1046/j.1365-2389.2003.51308.x

Institute of Medicine. (2012). *The mental health and substance use workforce for older adults: In whose hands?* Retrieved from http://www.iom.edu/Reports/2012/The-Mental-Health-and-Substance-Use-Workforce-for-Older-Adults.aspx

Ip-Winfield, V., & Grocke, D. (2011). Group music therapy methods in cross-cultural aged care practice in Australia. *Australian Journal of Music Therapy*, *22,* 59-78.

Jewish Family and Children's Service (JFCS). (2012). *Annual report.* Long Beach, CA: Author.

Jewish Family and Children's Service (JFCS). (2014). *Learn: Our programs*. Retrieved from http://jfcslongbeachca.org/

Judd, L. J., & Akiskal, H. S. (2002). The clinical and public health relevance of current research on subthreshold depressive symptoms to elderly patients. *The American Journal of Geriatric Psychiatry*, *10*(3), 233-238. doi:10.1176/appi.ajgp.10.3.233

Kastenschmidt, E. K., & Kennedy, G. J. (2011). Depression and anxiety in late life: Diagnostic insights and therapeutic options. *Mount Sinai Journal of Medicine*, *78*(4), 527-545. doi:10.1002/msj.20266

Kemper, K. J., & Danhauer, S. C. (2005). Music as therapy. *Southern Medical Journal*, *98*(3), 282-288.

Kessler, R. C., Chiu, W., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry*, *62*(6), 617-627. doi: 10.1001/archpsyc.62.6.617

King-Kallimanis, B., Gum, A. M., & Kohn, R. (2009). Comorbidity of depressive and anxiety disorders for older Americans in the national comorbidity survey-replication. *The American Journal of Geriatric Psychiatry*, *17*(9), 782-792. doi: 10.1097/JGP.0b013e3181ad4d17

Lavretsky, H., & Kumar, A. (2002). Clinically significant non-major depression: Old concepts, new insights. *The American Journal of Geriatric Psychiatry*, *10*(3), 239-255. doi:10.1176/appi.ajgp.10.3.239

Lee, Y., Chan, C., & Mok, E. (2010). Effectiveness of music intervention on the quality of life of older people. *Journal of Advanced Nursing*, *66*(12), 2677-2687. doi:10.1111/j.1365-2648.2010.05445.x

Lenze, E. J., Mulsant, B. H., Shear, M. K., Schulberg, H. C., Dew, M. A., Begley, A. E., ... Reynolds, C. I. (2000). Comorbid anxiety disorders in depressed elderly patients. *The American Journal of Psychiatry*, *157*(5), 722-728. doi: 10.1176/appi.ajp.157.5.722

Lesta, B., & Petocz, P. (2006). Familiar group singing: Addressing mood and social behaviour of residents with dementia displaying sundowning. *Australian Journal of Music Therapy, 17,* 2-17.

Lin, Y., Chu, H., Yang, C., Chen, C., Chen, S., Chang, H., & ... Chou, K. (2011). Effectiveness of group music intervention against agitated behavior in elderly persons with dementia. *International Journal of Geriatric Psychiatry*, *26*(7), 670-678.

Lyness, J., Heo, M., Datto, C., Ten Have, T., Katz, I., Drayer, R., ... Bruce, M. (2006). Outcomes of minor and subsyndromal depression among elderly patients in primary care settings. *Annals of Internal Medicine*, *144*(7), 496.

Mantella, R. C., Butters, M. A., Dew, M. A., Mulsant, B. H., Begley, A. E., Tracey, B., ... Lenze, E. (2007). Cognitive impairment in late-life generalized anxiety disorder. *The American Journal of Geriatric Psychiatry*, *15*(8), 673-679. doi:10.1097/JGP.0b013e31803111f2

McLaughlin, S., Connell, C., Heeringa, S., Li, L., & Roberts, J. (2010). Successful aging in the United States: Prevalence estimates from a national sample of older adults. *Journals of Gerontology Series B: Psychological Sciences & Social Sciences*, *65B*(2), 216-226. doi:10.1093/geronb/gbp101

Meeks, T., Vahia, I., Lavretsky, H., Kulkarni, G., & Jeste, D. (2011). A tune in "a minor" can "b major": A review of epidemiology, illness course, and public health implications of subthreshold depression in older adults. *Journal of Affective Disorders*, *129*(1-3), 126-142. doi:10.1016/j.jad.2010.09.015

Molloy, D. & Darrow, A. (1998). Multicultural perspectives in music therapy: An examination of the literature, educational curricula, and clinical practices in culturally diverse cities of the United States. *Music Therapy Perspectives*, *16*(1), 27-32.

Moyer, V. A. (2014). Screening for cognitive impairment in older adults: U.S. preventive services task force recommendation statement. *Annals of Internal Medicine*, *160*(11), 791-797.

Mussele, S., Bekelaar, K., Le Bastard, N., Vermeiren, Y., Saerens, J., Somers, N., ... Engelborghs, S. (2013). Prevalence and associated behavioral symptoms of depression in mild cognitive impairment and dementia due to Alzheimer's disease. *International Journal of Geriatric Psychiatry*, *28*(9), 947-958. doi:10.1002/gps.3909

National Alliance on Mental Illness (2009). *Mental illnesses.* Retrieved from http://www.nami.org/Template.cfm?Section=By_Illness&template=/ContentManagement/ContentDisplay.cfm&ContentID=7515

National Institute of Mental Health. (2007). *Older adults: Depression and suicide facts.* Retrieved from http://www.nimh.nih.gov/health/publications/older-adults-depression-and-suicide-facts.shtml

Nimrod, G., & Kleiber, D. A. (2007). Reconsidering change and continuity in later life: Toward an innovation theory of successful aging. *International Journal of Aging and Human Development*, *65*(1), 1-22.

Ostir, G. V., & Goodwin, J. S. (2006). High anxiety is associated with an increased risk of death in an older tri-ethnic population. *Journal of Clinical Epidemiology*, *59*(5), 534-540. doi:10.1016/j.jclinepi.2005.10.008

Piek, E., Nolen, W., van der Meer, K., Joling, K., Kollen, B., Penninx, B., & ... van Hout, H. (2012). Determinants of (non-)recognition of depression by general practitioners: Results of the Netherlands study of depression and anxiety. *Journal of Affective Disorders*, *138*(3), 397-404. doi:10.1016/j.jad.2012.01.006

Reichstadt, J., Depp, C. A., Palinkas, L. A., Folsom, D. P., & Jeste, D. V. (2007). Building blocks of successful aging: A focus group study of older adults' perceived contributors to successful aging. *The American Journal of Geriatric Psychiatry*, *15*(3), 194-201. doi:10.1097/JGP.0b013e318030255f

Rowe, J. W., & Kahn, R. L. (1987). Human aging: Usual and successful. *Science*, *237*(4811), 143-49.

Rowe, J., & Kahn, R. (1997). Successful aging. *Gerontologist*, *37*(4), 433-440.

Shapiro, N. (2005). Sounds in the world: Multicultural influences in music therapy in clinical practice and training. *Music Therapy Perspectives*, *23*(1), 29-35.

Sing For Your Life (n.d.). *Silver song clubs.* Retrieved from http://www.singforyourlife.o rg.uk/silver-song-clubs

Skingley, A., & Bungay, H. (2010). The Silver Song Club Project: Singing to promote the health of older people. *British Journal of Community Nursing*, *15*(3), 135-140.

Stevens-Ratchford, R. G. (2011). Longstanding occupation: The relation of the continuity and meaning of productive occupation to life satisfaction and successful aging. *Activities, Adaptation & Aging*, *35*(2), 131-150.

Sung, H. C., Chang, A. M., & Lee, W. L. (2010). A preferred music listening intervention to reduce anxiety in older adults with dementia in nursing homes. *Journal of Clinical Nursing*, *19*(7‐8), 1056-1064.

Sung, H. C., Lee, W. L., Li, T. L., & Watson, R. (2012). A group music intervention using percussion instruments with familiar music to reduce anxiety and agitation of institutionalized older adults with dementia. *International Journal of Geriatric Psychiatry*, *27*(6), 621-627.

Svansdottir, H. B., & Snaedal, J. (2006). Music therapy in moderate and severe dementia of Alzheimer's type: A case–control study. *International Psychogeriatrics*, *18*(04), 613-621.

Talerico, K. A. (2002). A critique of research measures used to assess inappropriate psychoactive drug use in older adults. *Journal of the American Geriatrics Society*, *50*(2), 374-377.

Thornton, J. E. (2002). Myths of aging or ageist stereotypes. *Educational Gerontology*, *28*(4), 301-312. doi:10.1080/036012702753590415

Vasionytė, I., & Madison, G. (2013). Musical intervention for patients with dementia: a meta-analysis. *Journal of Clinical Nursing*, *22*(9/10), 1203-1216. doi: 10.1111/jocn.12166

Vink, D., Aartsen, M. J., & Schoevers, R. A. (2008). Risk factors for anxiety and depression in the elderly: A review. *Journal of Affective Disorders*, *106*(1-2), 29-44. doi:10.1016/j.jad.2007.06.005

Vuorilehto, M., Melartin, T., & Isometsä, E. (2009). Course and outcome of depressive disorders in primary care: A prospective 18-month study. *Psychological Medicine*, *39*(10), 1697-1707. doi:10.1017/S0033291709005182

Werner, C.A. (2011). *The older population: 2010.* Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-09.pdf

Wetherell, J. L., Lenze, E. J., & Stanley, M. A. (2005). Evidence-based treatment of geriatric anxiety disorders. *Psychiatric Clinics of North America*, *28*(4), 871-896. doi:10.1016/j.psc.2005.09.006

Wierenga, C. E., & Bondi, M. W. (2011). Dementia and Alzheimer's disease: What we know now. *Generations*, *35*(2), 37-45.

World Health Organization. (1997). *Measuring quality of life: The development of the world health organization quality of life instrument* (WHOQOL). Geneva, Switzerland: Author.