Walden University
ScholarWorks

Selected Social Change Portfolios in Prevention, Intervention, and Consultation

Social Change Collection

Summer 2021

Addressing Deaths of Despair in Central Appalachia

Lillian McHenry

Follow this and additional works at: https://scholarworks.waldenu.edu/picportfolios

COUN 6785: Social Change in Action:

Prevention, Consultation, and Advocacy

Social Change Portfolio

Lillian McHenry

Contents

Overview

Introduction

Scope and Consequences

Social-ecological Model

Theories of Prevention

Diversity and Ethical Considerations

Advocacy

References

ScholarWorks Contributor Agreement

OVERVIEW

Keywords: Appalachia, deaths of despair, suicide, substance abuse overdose, alcohol liver disease, prevention

Addressing Deaths of Despair in Central Appalachia

Goal Statement: This social change portfolio aims to increase awareness of deaths of despair and address prevention on the individual, family, and social levels, including advocacy in the broader community.

Significant Findings: The Appalachian Region contains 420 counties across 13 states (Appalachian Regional Commission, n.d) and represents 30% of the national population but accounts for 50% of the premature mortality rate within the United States, in part, due to rising rates of deaths of despair (Scutchfield, 2018). The poverty rate in Appalachia is 1.5 times higher than the national average, with a suicide rate 17.1% higher than the national average. Moreover, an accidental poisoning rate (including alcohol and substances) is 37% higher than the national average, with alcoholic liver disease 1.5% higher. There is also a disproportionately higher rate of mental illness than non-Appalachian regions, and it significantly impacts individuals between the ages of 15-64 (American Psychological Association, 2018). Key findings suggest various risk and protective factors on all levels of the social-ecological model. Research supports the bioecological model for school-based programs that aim to reduce behaviors of despair such as learning disorders, conduct disorders, parenting factors, and social skills (Halsal et al., 2018).

Objectives/Strategies/Interventions/Next Steps: The objective is to educate and inform the audience of the need for more insight into deaths of despair and more complete research data, so prevention and intervention program planning can occur. Strategies should focus on building resiliency in early education through programs that involve a bioecological model of prevention and intervention, such as the longitudinal research program Fast Track. Community partnerships with an agency, such as Fast Track, bring all community forces into action while supporting the most vulnerable stakeholder in the community, the children, who are the most likely to be negatively impacted by all levels of an impoverished environment. The next step is to develop an action plan for advocacy that reaches all levels of local governments and agencies.

INTRODUCTION

Addressing Deaths of Despair in Central Appalachia

The Appalachian region consists of 420 counties across thirteen states extending from southern New York to northern Mississippi in the eastern United States (ARC, n.d). According to the APA (2018), 42% of the population of the region is rural compared to the national rate of 20%, and the poverty rate in the Appalachia region is 17.1% higher than the national average of 14.7%; that is a poverty rate 1.5 times higher than the rest of the nation. In addition, there has been an alarming trend beginning in the late 90s of an actual reduction in life expectancy in the US. Scutchfield (2019) explains that although the Appalachia region only represents 30% of the United States population, it accounts for 50% of the premature mortality rate, with a significant percentage due to deaths of despair. According to Rehder et al. (2021), this trend is related to a considerable increase in deaths caused by suicide, substance and alcohol overdose, and liver diseases caused by alcohol use. These deaths have been termed deaths of despair and occur most

often in rural communities with lower socioeconomic status with individuals who are also less educated. The purpose of this paper is to bring awareness to deaths of despair and encourage community collaboration on preventative measures within central Appalachia.

PART 1: SCOPE AND CONSEQUENCES

Addressing Deaths of Despair in Central Appalachia

The poverty rate in central Appalachia is 1.5 times higher than the national average, and 90% of the population has a high school diploma or less, with a suicide rate 17.1% higher than the national average. The accidental poisoning rate (including drug and alcohol overdose) is 37% higher than the national average, and alcoholic liver disease is 1.5% higher than the national average (APA, 2018). The data shows that the Appalachian region has disproportionately higher mental health problems than non-Appalachian regions, except for alcoholism. The APA (2018) suggests that the exclusion of alcoholism could be partly due to religious beliefs or preferences, stating that "more educated people tend to drink wine" and that opioids have replaced alcohol.

Diseases and deaths of despair have far-reaching and cascading consequences that include economic development, health and healthcare costs, the health and well-being of children, and the social support system (Scutchfeild, 2019). Most deaths of despair occur between the ages 15-64, with a disproportionately higher percentage in the Appalachia's between ages 25-34 at 55% higher than the national average and 59% higher than Appalachian's between ages 35-44. Mortality in these age ranges that make up most of the available workforce causes economic disparity within a community. As noted, prior deaths of despair have also had a disproportionate effect on the nation's life expectancy, with more than 50% of the decline caused by deaths of despair and health-related premature deaths in the Appalachia region (Scutchfeild,

2019). This social change portfolio aims to increase awareness of deaths of despair and address prevention on the individual, family, and social levels, including advocacy in the broader community.

PART 2: SOCIAL-ECOLOGICAL MODEL

Addressing Deaths of Despair in Central Appalachia

The social-ecological model is a four-level model used by the CDC to understand social problems and how prevention strategies may be effective (Dahlberg et al., 2002). The social-ecological model helps create understanding through examining the complex interplay between relationships, community, societal factors, and the interaction with individuals (Dahlberg et al., 2002). Each level of the social-ecological models helps identify risk factors that increase harmful behaviors and protective factors that reduce destructive behaviors. The behaviors that lead to deaths of despair are suicide, substance and alcohol overdose, and liver diseases caused by alcohol use. To understand and implement preventative measures, we must first examine the causes behind these behaviors and potential risk and protective factors.

On the individual level, many factors can lead to substance abuse and suicide. According to the APA (2018), individuals in the Appalachia region report higher Adverse Childhood Experiences (ACEs) instances, including emotional, physical, or sexual child abuse, physical or emotional neglect, household violence, divorce, parental incarceration, substance abuse, or mental illness. The more ACEs children experience includes an increased risk of developing "chronic health conditions, anxiety disorders, low life potential, and even early death" (APA, 2018). Another risk factor is the stigma surrounding and the ability to access mental health care. The Appalachians often view people not from their community as "other," which basically translates as not being trusted (APA, 2018). Much of the Appalachian region is rural and

mountainous, resulting in inadequate health care access. On average, the Appalachian regions report 14% more mentally unhealthy days than the national average, with approximately one mental health professional per 1000 individuals (APA, 2018). Other individual factors that contribute to risk include being a member of a lower socioeconomic group which can cause a cascade effect. For example, a lower socioeconomic status could increase the chances of poor healthcare during pregnancy, affecting the development of the cognitive function, which can lead to challenges in education and future employment (Rehder et al., 2019). Risk factors also include a family history of depression, significant life changes, physical health, stress, and medication (Marshall et al., 2021). Protective factors that likely reduce negative behaviors are strong family bonds, education, strong social skills, religious beliefs, self-image, and self-control (APA, 2018).

There are several risk factors on the relationship level. Some of the risk factors include a parental history of violence, substance abuse, and mental illness (SAMHSA, n.d). In addition, the Appalachian people have struggled with diversity, unemployment, and high rates of poverty for many years due to the geographical location of the region mainly being mountainous. There are relatively few well-paying jobs available, causing high poverty rates for families with only a high school diploma. Many absentee landowners intentionally created economies around a single workforce in the coal mines, which exerted complete control over the people (Burris, 2014). It is suggested that due to the constant struggle to survive for generations, deep-seated despair gets passed down to each new generation. Therefore, protective factors for this level would include a strong family bond, higher-wage employment, education opportunities, and access to mental health resources (APA, 2018).

The third level is the community. The community involves neighborhoods, schools, and workplaces. The risk factors within the community include inadequate housing resources,

poverty, violence, and drugs within the community, school and workplace atmosphere, and community involvement (SAMHSA, n.d). Protective factors for the community are the availability of faith-based organizations, after-school activities, housing initiatives, and community watch programs (APA, 2018).

The fourth level is societal. The culture of the Appalachian people is collectivistic due to many generations living in difficult-to-access mountainous regions; they developed a sense of individuality, self-sufficiency, and creative problem solving (APA, 2018). Societal risk factors are poverty, fear of others and losing their cultural ways, lack of education, health disparities due to lack of access to medical insurance and providers, and deliberate targeting in the 90s by pharmaceutical companies pushing the use of opioids through samples and advertising (APA, 2018). The APA (2018) lists protective factors like family, self-reliance, religious beliefs and practices, and having a culture of honor. Other protective factors are prevention strategies for substance use, workforce and education initiatives, access to healthcare, and social policies and practices targeted at inequality and economic disparity.

Deaths of despair can be prevented or reduced if underlying causes, such as, to name a few, unemployment or underemployment, having no sense of purpose, and hopelessness for the future, are addressed from the individual to the societal level.

PART 3: THEORIES OF PREVENTION

Addressing Deaths of Despair in Central Appalachia

Theories of prevention help develop health models with goals to help understand the underlying behaviors of public health to create models of prevention. There are many prevention theories, so finding one that works takes much time, effort, and planning. SAMHSA (2018)

suggests that a prevention model should include the Strategic Prevention Framework (FPF), which calls for assessment, capacity, planning, implementation, and evaluation, which encourages developing a sustainable model that addresses cultural needs. SAMHSA (2018) cautions that the model used to manage the population's needs is a solid conceptual and practical fit with evidence-based practice.

Following the goal of this portfolio to increase awareness of deaths of despair and address prevention on the individual, family, and social levels, the bioecological model of prevention will be applied to prevention in central Appalachia. Bronfenbrenner first introduced the bioecological theory of development, which suggests that an individual's development is a transactional process in which interactions within the environment influence development (Halsal et al., 2018). Thus, the bioecological model indicates that an individual's disposition is biologically influenced, which combines with environmental interactions to shape development (Berk, 2018 p. 24).

According to Berk (2018), bioecological systems are comprised of four levels. The first level is the microsystem, which includes the individual's interactions with their immediate surroundings, such as the home environment and family involvement. The microsystem is anything that the child or individual directly experiences the most. The interactions with members in the microsystem are bidirectional, which means that in a child-parent exchange, "biologically and socially influenced characteristics" affect the other participant's behavior and vice versa (Berk, 2018). In this context, the child's biological behaviors like personality, intelligence, and capacities affect the behaviors of the adults who interact with them, eliciting specific responses; for instance, positivity and patience or impatience and punishment depending on the child's temperament. These reciprocal interactions happen daily and have an impact on

development. Berk (2018) notes third parties in the microsystem, such as parental partnerships, also affect the child. Parents who support one another in their parenting roles create more effective parenting than when there is a marital conflict which can cause children to react with more fear, anxiety, anger, and aggression, which also causes the parent to suffer in return.

The next level of the system is the mesosystem which overlaps with the microsystem. The mesosystem includes the immediate family, school and childcare centers, and neighborhood play areas that the child directly experiences. The child's interactions within the mesosystem directly affect parents, teachers, and peers. A child's progress in these areas is overseen by the parent through scheduling and directing playtime, schoolwork, and the interactions necessary for development. In summation, how a child behaves at home is directly affected by school and peer relationships and vice versa (Berk, 2018, p 25).

The third level of bioecological systems is the exosystem. The exosystem generally does not contain the developing individual and includes extended family, friends and neighbors, parental workplace, religious institutions, and health and welfare organizations (Berk, 2018, p 25). Positive values for a healthy exosystem include flexible work schedules, paid sick leave for parents to care for sick children, extended family networks that provide advice and support, companionship, and even financial assistance when needed (Berk, 2018, p 25). Studies indicate that a breakdown in the activities of the exosystem can have a negative impact that includes higher rates of conflict and child abuse (Berk, 2018, p 25)

The macrosystem's fourth and final level consists of cultural values, laws, customs, and resources available within a community (Berk, 2018). Although the developing individual has no decision-making ability or direct link to these institutions, they directly affect the level of support a child receives in the inner system (Berk, 2018, p 25). The macrosystem can affect the child by

impacting workplace benefits a parent gets, standards of care in childcare and educational institutions, medical access, and social welfare programs that help low-income families and social programs for older people (Berk, 2018, p 25). In essence, the macrosystem can help each inner system by providing the necessary tools to facilitate the child's developmental growth.

According to SAMHA (2016), There are shared risk and protective factors for substance misuse and suicide that indicate a need for prevention beginning in childhood. Childhood risk factors include academic struggle, aggression or violent behaviors, family conflict, history of abuse or trauma, depression, impulsivity, low self-esteem, mental illness, physical illness, relational, social, work or financial losses, and social withdrawal (SAMHSA, 2016). These risk factors will be addressed using the bioecological model of prevention. According to Halsal et al. (2018), communities can develop integrated youth services through the bioecological lens that incorporates a purposeful design that "represent a breadth of contextual systems, including factors from micro-, meso-, exo-, and macro-system levels." On the micro-level, community-based programs can be implemented to influence development directly, such as primary care, school-based programs, community services, youth-friendly hubs, peer-to-peer support, and family engagement (Halsal et al., 2018). Halsal et al. (2018) state that "family micro-system plays a fundamental role in influencing development, particularly early development, consideration of this context is of significant importance." At the mesosystem level, sharing of information and collaboration, and integration of services should be implemented throughout the system to ensure needs are addressed and met (Halsal et al., 2018). Although much of the exo-system does not directly influence the individual's development, it is required to develop healthy communication and collaboration within families, communities, and the agencies involved within support programs and influence policy-making decisions (Halsal et al., 2018). On the

macrosystem level, cultural norms and stigmatization of mental health have been noted as having a "major influence" on access to services (Halsal et al., 2018). According to Halsal et al. (2018), using the internet via social media can help promote healthy behaviors through health promotions campaigns. The internet can also be used to access telehealth and telemental health services online and in the privacy of one's own home, which may help individuals concerned about stigma.

A current longitudinal research study on an evidence-based program that uses the bioecological model of prevention for deaths of despair is called Fast Track (FT). The results of the FT program are significant and promising and have produced long-term results. The program chose students from high-risk elementary schools in North Carolina, Tennessee, Pennsylvania, and Washington State based on neighborhood crime and poverty rates. The schools were matched on demographics and randomly assigned intervention or control conditions (Goodwin et al., 2020). There were three consecutive cohorts in 1991, 1992, and 1993 of high-risk kindergarten children. The children were assessed for conduct problems in a class by a teacher then by the parents, and comparisons were made to create a severity of risk score (Goodwin et al., 2020). FT accepted 891 into the program. The factors that were considered negatively impacting child development on the micro-level were "poor executive function, impulsivity, and social-cognitive skills related to effective peer relationships. A second set, parenting factors, includes harsh and inconsistent discipline, lack of parental monitoring and involvement, and aversive parent-child interactions. A final set includes struggles to keep up with academic demands. FT targeted the children's intrapersonal, interpersonal, and academic skills and their parent's parenting skills and behaviors through two intervention phases: elementary (grades 1 to 5) and secondary (grades 6 to 10) school" (Goodwin et al., 2020). The researchers followed the

youths, and data were collected after the prevention program was completed. Follow-ups were conducted at ages 15 to 20 and 25 with a 78% follow-up rate (Godwin et al., 2020). There was an approximately 10% decrease overall for any behavior of despair. As shown with the research of FT, programs directed towards building resiliency and self-efficacy in childhood can be an effective prevention strategy with lifelong effects on deaths of despair.

PART 4: DIVERSITY AND ETHICAL CONSIDERATIONS

Addressing Deaths of Despair in Central Appalachia

Central Appalachia is not as diverse regarding race and culture as most of the nation. According to Pollard & Jacobsen (2021), Central Appalachia has less than 5% non-Hispanic black and less than 5% Hispanic or Latinx population, and less than 1% listed as "other." That leaves a population that is 90% or more non-Hispanic white. Due to the densely white population in this region, there has been very little or no research on minorities suffering from diseases of despair or succumbing to deaths of despair in Central Appalachia. There is no evidence that deaths of despair do not occur within the non-Hispanic Black community or Hispanic/Latinx communities. Still, this lack of data shows there is a need for further research in this area. Also, there is no research on the LGBTQ population and deaths of despair in Central Appalachia; for this reason, and the purpose of this portfolio, the discussion on diversity will contain information on deaths of despair within the LGBTQ population across the nation.

According to Terrell et al. (2021), the LGBTQ community has "consistently evidenced high rates" of deaths of despair at rates 4-7 times higher than their heterosexual peers. The LGBTQ community suffers more significant distress due to heterosexism, homophobia, and

emotional abuse, which may cause increased use of alcohol, illicit drugs, and suicide (Terrell et al., 2021). In their research study, Terrell et al. (2021) identified three factors that increased the risk for deaths of despair: stigma, demographics, and identity development.

These risk factors present intersectionality for those of the LGBTQ community because each element can influence the others. Each one of these risk factors can be multiplicitous. LGBTQ individuals are often stigmatized for their sexual orientation, circumstances of birth, dressing, appearance, and even where they live or come from, etc. Demographics are essential because these factors take into account ethnic minorities, women, sexual minorities, and age. Both stigma and demographics play a role in an individual's identity development. Then, according to Terrell et al. (2021), there are what they have termed risk amplifiers listed as psychological vulnerabilities: internalized homophobia, depression, interpersonal vulnerabilities, victimization, and isolation or rejection.

Suicide is the third highest cause of death in the United States among youths 15-24 years, which, according to Vaugn (2018), makes it a public health concern. Vaugn (2018) points to research data that suggest 6.4% of heterosexual, 29.4% of gay, lesbian, and bisexual, and 13.7% who were gender-questioning students had attempted suicide in the previous 12 months at least one or more times. These statistics show that stronger, evidence-based prevention methods need to be implemented for the youth exposed to diseases of despair and that the impact may be much higher on the LGBTQ population in Central Appalachia due to the excess poverty, difficulty in attaining physical or mental healthcare because of inaccessibility, low employment rates, social-cultural factors that stigmatize LGBTQ, and a high religious concentration. Any prevention programs implemented within the greater population will need to consider the varied ethnic, cultural, and socio-cultural groups within its people to be sustainable. In this, there are

recommendations by the Center for Disease Control and Prevention (2020) (CDC) recommends that schools should create an inclusive atmosphere that promotes anti-bullying and aggression policies, confidentiality, and community programs to help parents and LGBTQ youth.

There are ethical considerations that need to be addressed when working within a multicultural community. The majority population within the Appalachia region is more than 81% percent white non-Hispanic leaving less than 19% of the population considered a minority whereas, the national average for diverse populations within a community is 39% (ARC, 2021). Within these diverse cultural populations also exist other minority populations divided by sex, sexual orientation, religion, and age that are not often accounted for within demographic reports. For instance, there are no reported demographics on the percentage of LGBTQ minorities within Appalachia, but they exist there. When considering the ethical issues that can arise from working within an even minimally diverse population such as the Appalachia's, it is essential to consider these secondary minority groups when developing and implementing prevention programs.

Other ethical considerations when developing and implementing prevention programs within a community are also key ethical considerations within the counseling community. The American Counseling Association Code of ethics section A.4.b (ACA, 2014) states that counselors should avoid imposing their individual beliefs or bias when developing a prevention program. Forcing one's worldview upon other individuals could cause harm to the client, which the ACA also addresses in section A.4.a. Another factor when developing a prevention program and working with the target population is confidentiality and informed consent. Section A.1.a of the ACA (2014) Code of Ethics states, "The primary responsibility of counselors is to respect the dignity and promote the welfare of clients." Part of this responsibility is maintaining the client's confidentiality and getting informed consent. Hence, the client understands their rights and

responsibilities, such as ending the counseling relationship if they want to, and understands the counselor's rights and responsibilities. Maintaining a client's right to confidentiality is an essential factor within counseling, advocacy, and prevention. The individual would be very limited in what they would open up about to the counselor or advocate if they were not guaranteed confidentiality. Still, an explanation on the limits of confidentiality should also be discussed per ACA (2014) Code of Ethics section B.2. Counselors should discuss and implement practices with the stakeholders to uphold confidentiality and gain informed consent when implementing prevention programs.

PART 5: ADVOCACY

Addressing Deaths of Despair in Central Appalachia

When developing any prevention program, the first step is advocating for the need for such a program, but advocacy does not just stop there. According to Merriam-Webster (n.d.), advocacy is defined as "the act or process of supporting a cause or proposal." In this context, the proposal is the prevention of deaths of despair. According to the Multicultural and Social Justice Counseling Competencies (MSJCC) (2015), there are four developmental domains associated with becoming multicultural and social justice competent as a counselor; counselor self-awareness, client worldview, counseling relationship, and counseling and advocacy interventions. We will discuss only three areas of the last domain of the MSJCC counseling and advocacy interventions for this social justice portfolio: institutional, community, and public policy (MSJCC, 2015).

The institutional level of counseling and advocacy intervention represents social organizations such as "schools, churches, (and) community organizations" (MSJCC, 2015). ARC

(2008) reported a higher prevalence of mental health disorders in Appalachia than the rest of the nation, with the highest majority in Central Appalachia compared to Northern and Southern Appalachia independent from substance abuse. This higher rate means that these mental health disparities do not occur due to the co-occurrence of substance abuse (ARC, 2008). Subsequently, although opioid use is higher in Appalachia than nationally, alcohol abuse is most reported for admission to a treatment program and aligns with national percentages. There are various institutional and community-level barriers to the prevention of deaths of despair in Central Appalachia. Much of the Appalachian community is rural and mountainous, making it challenging to attract needed commerce which would draw in more medical agencies. According to ARC (2018), inaccessibility to care is one of the barriers in addressing deaths of despair in Appalachia. There is approximately one mental health care professional per 1000 residents in the Appalachian region, with a slightly higher percentage in metro areas and few inpatient programs for substance abuse and mental health (ARC, 2008). One advocacy action that could help address the mental health disparity on an institutional level would be to advocate for more mental health and substance abuse programs in rural Appalachian areas, allowing rural Appalachians to seek help perhaps before they seek to commit suicide or turn to drugs and alcohol.

MSJCC (2015) the community-level is represented by cultural spoken and unspoken norms, values, and regulations and may either empower or oppress human growth and development. Appalachia's cultural norms place a stigma on mental health problems and substance use; many see addiction as a moral failing (ARC, 2008; ARC, 2018). For many years the Appalachian communities mainly were left alone due to the mountainous regions being cut off from much of the rest of the nation, and the people of the Appalachia's developed unique cultural values and their own form of community individualism and self-reliance (ARC, 2018).

The people of Appalachia also suffered due to absentee landowners who exploited natural resources and the people who worked for them, causing skepticism of people from outside the area, including medical and mental health professionals that create barriers to prevention and treatment strategies (ARC, 2018). In this instance, one advocacy action that an advocate could take is to address mental health facts through the local community. Pamphlets, commercials, television adverts, local physicians, and valued community members could help reduce the stigma surrounding mental health care and substance abuse through open discussion and forums. Using this type of approach will also bring the stakeholders into the debate and prevention strategy planning.

The public policy level reflects policies and laws on the local, state, and federal levels that regulate or influence human growth and development within a region (MSJCC, 2015). Public policy and federal and state laws directly affect how effective a prevention policy will be. Public policy determines the amount of funding local governments receive for prevention programs, local health departments, medical programs like Medicaid, and many other programs. When funding is not available, the public sector, especially the low-income earners, is directly affected. Funding is a severe barrier to advocacy and prevention. By educating lawmakers on the issues at hand, such as deaths of despair, advocates could help improve funding and policy to improve access to care.

REFERENCES

Appalachian Regional Commission. (2021, May 20). About the Appalachian Region. https://www.arc.gov/about-the-appalachian-region/.

Appalachian Regional Commission. (2008, August 1). *An Analysis of Mental Health and Substance Abuse Disparities & Access to Treatment Services in the Appalachian Region*. Research, Evaluations, Maps, and Data. https://www.arc.gov/report/an-analysis-of-mental-health-and-substance-abuse-disparities-access-to-treatment-services-in-the-appalachian-region/.

Berk, L. E. (2018). *Development through the lifespan* (7th ed.). Upper Saddle River, NJ: Pearson Education.

Burris, T. L. (2014, January). Appalachian cultural consequences from the War on Poverty. *The SES Indicator Newsletter*. http://www.apa.org/pi/ses/resources/indicator/2014/01/consequences

Center for Disease Control and Prevention. (2020, December 9). *LGBTQ Youth Resources*. Centers for Disease Control and Prevention. https://www.cdc.gov/lgbthealth/youth-resources.htm.

Elder, M., & Robinson, D. (2018). Mental Health Disparities: Diverse Populations. https://www.psychiatry.org/psychiatrists/cultural-competency/education/mental-health-facts.

Godwin, J. W. (2020). The Fast Track intervention's impact on behaviors of despair in adolescence and young adulthood. *Proceedings of the National Academy of Sciences of the United States*, *117*(50), 31748. https://doi-org.ezp.waldenulibrary.org/10.1073/pnas.2016234117

Halsall, T., Manion, I., & Henderson, J. (2018). Examining Integrated Youth Services Using the Bioecological Model: Alignments and Opportunities. *International journal of integrated care*, *18*(4), 10. https://doi.org/10.5334/ijic.4165

Marshall, A. J. L., & PDA, A. O. (2021, February 3). *Health Disparities in Appalachia*. Appalachian Regional Commission. https://www.arc.gov/report/health-disparities-in-appalachia/.

Meit, M., Heiffernan, M., Tanenbaum, E., & Hauffman, T. (2017). Appalachian Diseases of Despair. NORC at the University of Chicago. https://www.norc.org/Research/Projects/Pages/appalachian-diseases-of-despair.aspx.

Merriam-Webster. (n.d.). Advocacy. In *Merriam-Webster.com dictionary*. Retrieved July 08, 2021, from https://www.merriam-webster.com/dictionary/advocacy

Multicultural and Social Justice Counseling Competencies. (2015). Retrieved October 27, 2015, from http://www.counseling.org/docs/default-source/competencies/multicultural-and-social-justice-counseling-competencies.pdf?sfvrsn=20

Pollard, K., & Jacobsen, L. A. (2021, June). *The Appalachian Region: A Data Overview From The 2015-2019 American Community Survey Chartbook*. Appalachian Regional Commission. https://www.arc.gov/appalachias-population/

Rehder, K., Lusk, J., & Chen, J. I. (2019). Deaths of despair: Conceptual and clinical implications. Cognitive and Behavioral Practice. https://doi-org.ezp.waldenulibrary.org/10.1016/j.cbpra.2019.10.002

Substance Abuse and Mental Health Services Administration (SAMHSA). (2018, September). *Selecting best-fit programs and practices: Guidance for substance misuse prevention practitioners.* https://www.samhsa.gov/sites/default/files/ebp_prevention_guidance_document_241.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA). (2016, March). *In Brief: Substance Use and Suicide: A Nexus Requiring A Public Health Approach*. In

Brief: Substance Use and Suicide: | SAMHSA Publications and Digital Products. https://store.samhsa.gov/product/In-Brief-Substance-Use-and-Suicide-/sma16-4935.

Scutchfield, F.D. (2019). Root Causes of Appalachia's Deaths of Despair. Journal of Appalachian Health 1(2), 1-6. https://www.muse.jhu.edu/article/753236.

Susan C. Vaughan (2018) Suicidality in LGBTQ+ Youth, The Psychoanalytic Study of the Child, 71:1, 40-54, DOI: 10.1080/00797308.2017.1416866

SCHOLARWORKS CONTRIBUTOR AGREEMENT

ScholarWorks Publication Consideration

ScholarWorks makes the intellectual output of the Walden University community publicly available to the wider world. By highlighting the scholarly and professional activities of our students and faculty, ScholarWorks' rich repository encourages new ideas, preserves past knowledge, and fosters new connections to improve human and social conditions.

If you would like your portfolio from your Counseling 6785 course to be considered for submission to ScholarWorks, please review the ScholarWorks Contributor Agreement below and agree to the terms and conditions.

Acceptance of the policies and terms of the ScholarWorks Contributor agreement

- will not impact your grade
- will not guarantee publication

ScholarWorks Contributor Agreement

To administer this repository and preserve the contents for future use, *ScholarWorks* requires certain permissions from you, the contributor. By making a submission to *ScholarWorks*, you are accepting the terms of this license. However, you do not give up the copyright to your work. You do not give up the right to submit the work to publishers or other repositories.

By including an email contact below, you hereby grant Walden a limited license to review the submission for the purposes of review of scholarly content; to distribute the submission to the public on the Website; to make and retain copies of the submission, and to archive the submission in a publicly accessible collection.

You agree to defend, indemnify and hold Walden harmless from and against any and all claims, suits or proceedings, demands, losses, damages, liabilities, and costs and expenses (including, without limitation, reasonable attorney's fees) arising out of or resulting from the actual or alleged infringement of any patent, trademark, copyright, trade secret or any other intellectual property right in connection with any Submission. Walden will not be required to treat any Submission as confidential. For more information, see the Contributor FAQ.

By executing this Agreement, you represent and agree that:

- You are the author or of the submitted work, or you have been authorized by the copyright holder, and the submission is original work.
- You hold the copyright to this document, and you agree to permit this document to be posted and made available to the public in any format in perpetuity.
- The submission contains no libelous or other unlawful matter and makes no improper invasion of the privacy of any other person.
- The submission will be maintained in an open-access online digital environment via the *ScholarWorks* portal. Because works on *ScholarWorks* are openly available online to anyone with internet access, you do not hold Walden University responsible for third-party use of the submission.

ScholarWorks (the Website) is owned and maintained by Walden University, LLC (Walden). All content that you upload to this Website (a Submission) will be available to the public. You represent and warrant that you have the right to upload any such Submission and make it available to the public.

I have read the Scholarworks agreement above, and I agree to have my COUN 6785 portfolio document considered for inclusion in Scholarworks; I also grant my permission for representatives from Walden University to submit this work on my behalf.

By signing again below, I agree to allow my email contact information below to be included in the published document so that others may contact me about this work.

SIGNATURE:
DATE: 7/30/2021
DIRECT EMAIL ADDRESS: beautifulchaos71@gmail.com