Mental Health First Response (MHFR) Program: Assessing the Mental Health First Response in the Colombian Population in Terms of Prevention and Intervention of Substance Use Disorder

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Marjorie Ramos-Salcedo

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Author Note

Marjorie Ramos-Salcedo, Department of Graduate Psychology, Purdue University Global.

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Correspondence concerning this thesis should be addressed to Marjorie Ramos-Salcedo, email address marjorieramossalcedo@gmail.com

Abstract

Colombia is a country with different social problems such as high politic violence since 1960. One of the huge issues is the fabric and selling of drugs. There are laboratories around the country. Many people at different levels of society have lived with this as a way of living, which has made violence sustainable and a way to support narcoterrorism. Since 1990 the problem has been not only about selling narcotics but also to start using them, including legal and illegal substances. The more used substance is alcohol, followed by nicotine and marijuana in young people. Additionally, there are some programs to prevent the use and abuse of substances. There is only one with supporting evidence called "Communities that Care." This program started about 20 years ago in different states of Colombia. It is a preventive program for elementary, middle, and high school students. The prevalence of drug addictions and suicide is mostly among 18 to 21 years old. Furthermore, there is a need to continue under the Communities that Care model to evaluate programs that help the community decrease and support those in need. The mental health first response course is a way to bring tools to the community leaders in how to intervene and prevent risks of addictions and suicide behaviors. The course of Mental Health First Response contributes to the Colombian society to bring some tools to intervene and prevent the use and abuse of drugs and suicidal thoughts and behaviors.

Keywords: addictions, suicide, Mental Health First Response, Colombia, prevention, intervention.

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Mental Health First Response (MHFR) Program: Assessing the Mental Health First Response of the Colombian Population in Terms of Prevention and Intervention of Substance Use Disorder

Programs such as mental health first aids, crisis intervention teams, or mental health first response are important training for health professionals, paramedics, people in the military, people involved in education, and the general population (Secretaría Distrital de Salud, 2019). Mental health crisis workers provide assistance and training to various fields both within and outside human services. People with addictions are exposed to a crisis at any moment of their substance abuse and/or withdrawal symptoms (Avery & Barnhill, 2018). A crisis could include suicidal ideation and suicide behaviors (Davis et al., 2020). I want to provide a mental health first response training program to leaders in the community of Colombia. Communities that Care (CTC) is a program that has provided education and support for substance use workers and leaders within the Colombian Government. It is important to consider that CTC is a preventive program for substance use disorder as a system in which leaders are involved (de Oliveira-Correa et al., 2020). The program has been implemented in Colombia for more than 10 years and brings together information on implementing a complete program for young people (de Oliveira-Correa et al., 2020).

For instance, the police could be leaders trained in the Communities that Care System or any other preventive program. Valencia-Puentes and Trejos-García (2013) state that there is a need for the Colombian police to train mental health first aid to support the community's needs with difficulties such as addictions. According to Trejos-García (2013), police as first responders did not have the skills to help the crisis in mental health. In the case of the Colombian militaries, they trained people in first aid, including some information on mental health such as stress

management. It is also important to point out the current situation of COVID-19, which brings emergencies for a long time, and the effects on the health professionals and the general population. Surprisingly, in Colombian scholarly articles' most recent studies about COVID-19 and mental health, there is only information about the effects on depression, burnout, and post-traumatic stress disorder (Ramírez-Ortiz et al., 2020). Other studies from the Colombian Psychological Association show the effects of COVID-19 on depression and anxiety (Sanabria-Mazo et al., 2021). Sanabria-Mazo et al. (2021) reviewed studies where the Colombian population suffered sleep difficulties, sadness, tiredness, headaches, stomach aches, loneliness, and irritability. Some of the population looked for professional help to support the others; 5% found a coping strategy in drinking alcohol and smoking nicotine (Sanabria-Mazo et al., 2021).

For this reason, early intervention with mental health first aid could decrease the problems in the first responders and the general population (Ramírez-Ortiz et al., 2020). The thesis aims to add to it the need to train those community leaders to support them in continuing doing psychoeducation on the importance of mental health, mental health support groups, and people trained in mental health first response to prevent the use and abuse of substances as well as to bring support to those with addictions (Booth et al., 2017). Consequently, this thesis will examine mental health, first response, mental health first response, prevention, and substance use disorder.

Mental health is still a controversial term that depends on the preconception of each researcher or organization (Palumbo & Galderisi, 2020). Mental health is defined by well-being, social and cultural constructs, and positive perspectives as opposed to sickness (Palumbo & Galderisi, 2020). For the current thesis, mental health will be defined by the Dictionary of the

American Psychological Association (n.d.) as the equilibrium in an individual's internal and external life with the capability to cope with and adapt to different situations.

Above all, this thesis is based on a prevention program that helps people develop healthy behaviors rather than focusing on illness (John et al., 2014). It is important to find early signs to support people before they decide to end their lives and/or harm themselves. Training first responders in mental health will help support crises to intervene on time. According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2018), first responders are people who support others emotionally and physically for the first time in the most difficult and challenging circumstances. First responders can also be called emergency response providers or public health workers at different levels of society who protect others' lives in risky situations (SAMHSA, 2018). They are also known to work in police departments, fire stations, military life, health paraprofessionals, and professionals (SAMHSA, 2018). First responders in health are people who help an individual who has suffered physical or mental damage or crisis (Ministerio de Salud, 2017). First responders could be part of the health system or not (Ministerio de Salud, 2017). This person could provide support in a crisis and refer the person in difficulties to the next level of care (Ministerio de Salud, 2017).

There are other things to note about first responders. They are vulnerable to exposure to high levels of acute stress (Larsson et al., 2016). Many of them may be trained on the physical and external help in crisis than in self-care and mental health first response. It is important to implement the program within these communities and provide psychological services to those alone in different Colombian cities. Providing training to increase mental health first response in the general population will save lives with people who are in a mental health crisis and prevent the risk of suicide by recognizing signs of emotional distress, learning strategies to save lives,

including people at high risk who use or abuse substances (Tolentino & Kovacs, 2020). Mental health first responders may learn about mental health challenges, substance use disorders, and how to consider health care to prevent secondary traumas.

Literature Review

The literature review goes from general to a specific topic within the areas of addictions, crisis, and suicide in the Colombian population. It covers four main topics, including a section on the Colombian context, the effectiveness of other addiction preventive programs, co-occurrence disorders, and training in a mental health crisis.

Colombian Context

The current population of Colombia comprises 48,258,494 people (Departamento Administrativo, 2021). Colombia has many social and individual difficulties that impact mental health and substance use. Colombia is an important country in producing drugs, such as cocaine and marijuana. Admittedly, Colombia is one of the highest cocaine producers in the world (United Nations, Office of Drugs and Crime, n.d). These cocaine productions have impacted all of society and, in the last two decades, became not only exported but abused by members of the Colombian population.

In Colombia, some children start taking drugs such as cigarettes with nicotine and alcohol at 12 years old and illegal drugs at 13 years old (Ministerio de Salud, 2018). Alcohol is the most prevalent substance used by the Colombian population; 6% of the population has a risky use of alcohol, followed by nicotine. Illicit drugs, such as marijuana, cocaine, bazuco, extasis, and heroin, are used by 5.7% of men and 4.5% of women. It is more predominant in the low-income population, with 58.3% of those with the lowest incomes and 25.5% of those with the highest

incomes using illicit drugs. The illegal substance used most is marijuana, with 3.2% of the population who answered the questionnaire (Ministerio de Salud, 2018).

Marijuana has been legal in Colombia since 2017 for medical and scientific purposes (Ministerio de Justicia, 2017). Other drugs used by the Colombian population are pain relief, cocaine, popper, hallucinogens, and yagé. The use of the substances referred to above is more common in territories where people have access to illegal substances (Ministerio de Salud, 2018).

Overall, the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, 2013) states that Substance Use Disorders have 11 criteria for making a diagnosis. The criteria are related to the difficulty of stopping using the substance. The difficulties in stopping using drugs and the time to obtain and stop using the substances are important. The desire to use the substance, the difficulty in stopping use of it, thoughts about the substance, and thoughts about how to obtain it make it difficult to focus on other things, such as focusing on work, family time, hobbies, or other activities. Sometimes the individual who uses or abuses the substance knows about the negative effects but continues using it. The person who uses the substance wants more and more each time (DSM 5, 2013). Mental health first responders should know that co-occurring disorders (COD) are when there is a Substance Use Disorder and a mental disorder simultaneously (Atkins, 2014). A co-occurring disorder could emerge due to the existing disorder or happen independently (Atkins, 2014).

In addition to substance use, suicide rates are also a rising concern in Colombia. According to the Ministerio de Salud (2018), the number of suicidal people from 2009 to 2016 was about 0.03% of the population. This statistic reflects about 2.190 cases per year. Of those cases, 81% are single men, and 19% are women. The higher rate of 14,6% occurs in 20-24 years

old, 12% in 25-29-year-olds, and 10% in 30-34 years old. 44,07% of the population was between 20-39 years old. The three departments with higher rates of suicide are Vaupés, Arauca, and Putumayo. Those with the lower rates were San Andrés and Santa Catalina, Chocó, and Vichada (Ministerio de Salud, 2018). In 2017, there were 0.05% of suicide attempts in the Colombian population; 6.6% of that population had a diagnosis of substance use disorders (Ministerio de Salud, 2018).

For this reason, First Responders in health have received training in the Bogotá Capital District of Colombia since 2019. In 2018, there were about 80.000 people attending emergencies in health (Secretaría de Salud, 2019). Half of them were common health issues, 13% were mental health issues, and 8% were housekeeping issues (Secretaría de Salud, 2019). In 2019 the Colombian Capital District decided to train people as part of the emergency medical system. The Health Department of Bogotá has trained 11.165 first responders in health per year (Secretaría Distrital de Salud, 2019). The training includes information related to supporting physical health, with only one module on treating individuals with mental health issues and suicidal tendencies (Secretaría de Salud, 2019). The training brings basic recommendations for the management of mental health crises. It does not mention anything related to substance use.

Accordingly, bringing the Mental Health First Responder (MHFR) model will help prevent, promote, and intervene in substance use disorders in Colombia and crises in mental health by training more mental health first responders in the community to respond faster to crisis circumstances. This program could be helpful also because, in different regions of Colombia, there is a lack of professionals in mental health or overwhelmed because there is only one in the community.

Addictions Assessment and Preventive Programs in Colombia

de Oliveira-Correa et al. (2020) described the importance of preventive strategies in decreasing addictions in young people in Colombia. The authors described the importance of implementing a readiness intervention in communities under the change model before preventing interventions. The interviews were conducted after applying the "Communities that care" strategy to 211 participants, leaders of three cities in Colombia who participated in three different moments in 2013, 2016, and 2018 (de Oliveira-Correa et al., 2020).

The researchers used seven measures translated from English to Spanish that are part of Colombian culture (de Oliveira-Correa et al., 2020). The measures were norms against youth substance use, openness to change, community support for prevention, cohesion, conflict resolutions, effective leadership, and shared responsibility (de Oliveira-Correa et al., 2020). With these measures, the authors researched the construct of interest. A main finding of the Communities that Care study was that it is important to implement preventive strategies in the Colombian community (de Oliveira-Correa et al., 2020). However, it is important to consider the need to identify different stages of change within the communities and where they are in that process by evaluating factors, such as those studied in the current research.

Brown et al. (2021) argued that to create evidence-based prevention programs for people with addictions, it is necessary to consider risk factors and risk populations. Understanding risk factors bring into consideration the need to work on protective factors from a community perspective (Brown et al., 2021). According to Brown et al. (2021), a preventive program for addictions is based on community support called Communities that Care (CTC). It has been implemented in different states of the US and different countries worldwide, including Colombia. One measurement is used to help identify 18 risk factors among youngsters in the US and Colombia. The subjects studied were more than 1,000,000 high school adolescents at the

moment of the research, living in 22% of States. There were 80.000 participants from 43% of the departments in Colombia, with information collected by the “Nuevos Rumbos” Corporation. Half of the population were boys, and the other half were girls at approximately 14 years old (Brown et al., 2021).

The survey used in the study was the same for the US and Colombia (Brown et al., 2021). However, the one used in Colombia was standardized for Colombian citizens. The Communities that Care (CTC) for youngsters questionnaire is designed to be completed in person in about an hour. It brings information about the population characteristics, use of different drugs within the last month or developmental, use of alcohol, and the protective factors that the person identified in their community. The scale shows high internal consistency and measurement properties (Brown et al., 2021).

Brown et al. (2021) highlighted the importance of cut points in the risk factors for the abuse of substances in the US and Colombian populations (Brown et al., 2021). The results showed that the risk factors in the two countries have different cut points in the adolescents showing different levels of high risk for each country (Brown et al., 2021). The current thesis found relevant the information by Brown et al. study because it shows the importance of the need to implement evidence-based programs to prevent addiction in the Colombian population. It also shows the importance of identifying and clarifying the use of standardized questionnaires for the Colombian population to better understand their risks in the addictions arena (Brown et al., 2021).

Martínez et al. (2019) stated the relevance of evaluating programs to prevent addictions in Colombia and the difficulty of implementing those programs because of the high costs. Preventive programs in Colombia are low, the same as evaluating some of the programs. There

are just 15 programs to prevent addictions, most without evaluations. The main reason for this is the high cost and low economic resources. “Sana Mente” is one of the addiction preventive programs based on intervening in the risk factors of adolescents between nine and eleven years old and the perception of the use of drugs in their peers and parents (Martínez et al., 2019).

The participants differed regarding the program in various cities and evaluation moments (Martínez et al., 2019). The first evaluation was in 2009 with more than 1500 students between 9 to 12 years old in Bogotá, D.C. The other evaluation was in Medellín in 2012, with more than 1280 students from seven to 17 years old. In Facatativá, the evaluation occurred from 2014 to 2015, with more than 500 4th and 5th-grade students. There was another evaluation in Bogotá in 2016 with more than 5400 students. The last evaluation was in Soacha in 2018, with more than 2000 high school students, half women and the other half men (Martínez et al., 2019).

Overall, the researchers used a survey developed specifically for that program (Martínez et al., 2019). They used it differently across cities. In most of the groups, they applied a pretest-posttest evaluation. They also measured vulnerability to alcohol. The study results highlighted the difficulties of evaluating preventive programs. The results were not conclusive. The research showed that the program should be implemented by those who were more aware of the risks of using drugs than those who did not take the program. A positive factor of this program was that Colombians created it for Colombians rather than bringing programs from other countries (Martínez et al., 2019).

Mejía-Trujillo et al. (2015) highlighted the need in Colombia to start an evidence-based preventive program. Mejía-Trujillo et al. (2015) found in “Communities that Care” (Comunidades Que se Cuidan) enough scientific support in the US and other countries to bring to Colombia. This research emphasized the role of the community in preventing the use of

substances in the young people of that community. Communities that Care was adapted to the Colombian population and its sociocultural needs and implemented.

The population for the study was about 37.000 Colombian students from 11 to 18 years old from five municipalities in Colombia from 28 public and three private schools. Half of the participants were female and half male in high school. The researchers administered a Communities that Care questionnaire (Comunidades que se Cuidan, CQC). To demonstrate construct reliability and validity, Mejía-Trujillo et al. (2015) applied it to more than 33,000 students. The survey showed protective and risk factors of the population for substance use (Mejía-Trujillo et al., 2015). The cut points from the U.S found a difference with the Colombian population. For this reason, Mejía-Trujillo et al. (2015) used around 37,000 surveys to calculate the cut point for the Colombian population. The survey was applied considering the consumption in the youngster's lifetime, yearly, and monthly.

The results showed the importance of implementing the CTC in Colombia as a prevention system for substance use. Mejía-Trujillo et al. (2015) showed that this is possible in the Colombian population, considering its cut-off points and using the scale for the Colombian population. The questionnaire showed that most youngsters use alcohol, nicotine, and marijuana. They found higher rates in the population than the ones made by the government, including cocaine consumption. (Mejía-Trujillo et al., 2015).

Communities that Care in Colombia (Comunidades que se Cuidan) was adapted from the U.S to the Colombian population shown in studies during this literature review with their statistical analysis, cut points, and translation (Montero-Zamora et al., 2020). The sample was 52,588 adolescents from 10-19 years old in secondary school. Half of the students were female, and the other half were male. The students were part of 23 low-income communities in Colombia

with 114 private and public schools. Montero-Zamora et al. (2020) stated that within these studies, they tried to show the importance of having preventive programs in Colombia. Therefore, the idea is to prove that Communities that Care (Comunidades que se Cuidan) in Colombia is an evidence-based approach to addiction prevention strategies. This perspective evaluates the risk and protective factors in substance use in the young population. The researchers state the importance of using the Communities That Care Youth Survey (CTCYS). The scale is the only one in Latin America for evaluation purposes, with the statistical analysis required (Montero-Zamora et al., 2020).

Montero-Zamora et al. (2020) affirm that alcohol was the most commonly used substance, with participants reporting using it in the last month (more than 40%), last year (70%), and lifetime (70% approximately). The next most used substance was nicotine cigarettes, with participants reporting using it in the last 30 days (10%), last year (21%), and lifetime (26%). The third substance was marijuana, with participants reporting having used it in the last 30 days (5%), last year (10%), and lifetime (12%). Men used more addictive substances than women, especially marijuana and nicotine. The community approach implies the evaluation and program in four domains: individual/peer, family, school, and community. One of the highest risk factors was the availability of the substance. Montero-Zamora et al. (2020) also stated that society is flexible with alcohol use in the early stages, including parents and the sale of alcohol, even though it is illegal. The relationship and parental skills are important protective factors in using substances. For this reason, trained parents are important under the Communities that Care model. Another risk factor in the individual/peer domain is that drinking alcohol helps the youngster socialize and accept a group of peers.

Effectiveness of Other Addiction´s Preventive Programs

Quintero-Ordóñez et al. (2015) measured the program's efficacy for preventing addictions in Spain from 2006 to 2010. It was applied to more than nine hundred students of first to fourth-grade secondary schools in Córdoba, Spain, on behalf of the Man Project (Proyecto hombre). The adolescents were between 12 to 16 years old. Quintero-Ordóñez et al. (2015) state that children started using tobacco, alcohol, and inhalants at thirteen years old. Children under the age of fourteen years old started using heroin and cannabis. People in Spain who use hard drugs such as cocaine typically start doing so when they are 15 years old and older (Quintero-Ordóñez et al., 2015).

Quintero-Ordóñez et al. (2015) stated that the methodology involved quantitative and qualitative data collection. The qualitative information is regarding the case studies from Córdoba, Spain. The researchers were sure that the Man Project was correctly applied in Córdoba to the students. The questionnaire was designed specifically to measure the program differently for each student's grade. The questions have five dimensions related to the adolescent's opinions about the use of substances, their use, the age when starting using it, the frequency of use, and the social aspect or pairs consumed (Quintero-Ordóñez et al., 2015).

The research results showed that alcohol use was high in adolescents between twelve to fourteen years old, with 78% use (Quintero-Ordóñez et al., 2015). The use of cannabis is stronger with age. It decreased by 11% after the implementation of the program. The reduction of alcohol use was 1% after applying to the program for four years. The use is usually when they are with pairs in their free time. Tobacco use decreased by 2% after the implementation of the Man Project. The program helped develop family feedback. The qualitative responses of this study showed that teachers changed their imagination regarding addictions, tools, and the idea

that providing the information is the only way to reduce the use or abuse of substances (Quintero-Ordóñez et al., 2015).

Co-occurring Disorders: Substance Use and Suicide

The information above shows the prevalence, risk factors, and protective factors in addictions. There is no information about co-occurring disorders or crises. For this research, these factors are important in using preventive and intervention programs in first aid or first response. Han et al. (2017) showed the importance of mental health and substance use disorder analysis in the US population. The study included more than 300.000 participants older than 18 years old from the U.S. The population participated in the national survey of drugs and mental health. All of them were civilians and were not part of any hospitalization system. The researchers administered the survey for six years, starting in 2008.

The method used in the study was a US national survey that included themes of "mental illness, mental health care, substance use disorders, and substance use treatment" (Han et al., 2017, p.1740). It was possible to use the survey from 2008 to 2014 because it has the same information. Since the survey of 2015, the information has changed, and it was not possible to use it for the research (Han et al., 2017).

The research results indicated that approximately 3% of the adult population of the U.S had a co-occurring mental illness and substance use disorder (Han et al., 2017). Half of that population received mental health care, 13% received substance use treatment, and 9% received mental health care and substance use treatment. Those who did not receive treatment, which is the 9% of the population, did not think they needed treatment for three main reasons. First, they did not want to stop using substances. Second, they do not have insurance. Third, they could not pay for the treatment.

Khani-Jeihooni et al. (2021) showed a high prevalence between addictions and suicide risk. This study occurred in Iran with the Irani population. The researchers found that the higher death cause for people with addictions is suicide, and those who commit a suicide attempt have a history of addiction (Khani-Jeihooni et al., 2021). Khani –Jeihoone et al. (2021) focused their research on the possible factors contributing to people with substance use disorder thinking about suicide. The sample comprised 2160 men in 10 private and public clinics in three cities from Iran with a substance use disorder diagnosis. Eighty percent of the population were married, and the rest were single. The median was 40 years old. Forty percent of the population had a history of arrest (Khani-Jeihooni et al., 2021).

The researchers administered one demographic questionnaire, the Beck Scale for Suicidal Ideation (BSSI), and the Theory of Planned Behavior Questionnaire (Khani-Jeihooni et al., 2021). They found that 20% of the participants had suicidal ideation, and 11% had a history of suicide attempts during their lifetime. There was a prediction of 55% suicidal ideation in the population. Khani-Jeihooni et al. (2021) stated that the results coincide with other research showing that the prevalence of suicidal ideation and addictions is significant. There were some predicted constructs of suicidal ideation in people with substance use disorder, such as attitude, subjective norms, perceived behavioral control, and intent based on the planned behavior theory, which could help preventative strategies. Focused on the individual, families bring support for people to help-seeking, reducing depression, hopelessness, and the social desirability of suicide among substance users. Another recommendation by Khani-Jeihooni et al. (2021) was to work with life skills such as resilience and anger management in people with addictions.

Another study that supports the high relationship between substance use and suicide shows a high prevalence of these mental health issues. Davis et al. (2020) stated that people with

addictions are stigmatized in society with difficulties, such as crime. This social identification makes them internalize these social constructs and more vulnerable to depression and suicide (Davis et al., 2020). The sample for the research was about 500 college students with a mean age of 21 years old. More than half of the population was female. The sample was diverse, with 65% Caucasian, 37% Greek, and 23% non-heterosexual participants. They attended one university in the U.S. The researcher's inclusion requirement was that participants used non-prescribed drugs in 2019. Another research about suicidality with 1000 students was also useful for the research. In case the students use a prescribed use, to be part of the study, the drug needs to be overused, considering the doctor´s prescription (Davis et al., 2020). Half of the population had some type of employment besides their study.

Davis et al. (2020) used a method based on scales to assess suicidal ideation with a Likert scale. Self-stigma adapted from the depression self-stigma scale. Depression with the Patient Health Questionnaire (PHQ-9). They found that 50% of the students had suicidal ideation, the same percentage for deep depression. Self-stigmatization was a predictor of depression and female gender and lower grade point in drug users. Davis et al. 's (2020) recommendation was to help people with addictions seek support rather than hide the addiction because of the stigma.

Training in Mental Health Crisis

It is important to bring more support to the community to help their residents prevent mental health issues, including substance use. If the influence of peers and leaders from the community is important in taking risks such as using drugs or making suicide attempts, there might be other strategies to train the community on mental health issues, including addictions. Marks et al. (2017) studied the effects of the REACT early intervention program to reduce risks in mental health for paraprofessionals. The program aims to reduce burnout effects in first

responders by training their peers to give support now that they receive it more naturally than trained psychologists in some circumstances. The training lasted six hours. The number of subjects studied was 30 in total. Seventy-five percent of the participants were male between 30 and 58 years old. All of them were part of directors' positions. Most of them have worked as first responders at fire departments for about 17 years (Marks et al., 2017).

The study involved four measures: the REACT PSP Self-efficacy Questionnaire, the Generalized Self Efficacy Scale, the Attitudes and Expectations of REACT, and the Brief Resilience Scale. The study showed that self-efficacy increased in all participants. The training helps participants increase technical knowledge in prosocial behaviors and stress management (Marks et al., 2017, p. 161). Paramedics, health care professionals such as psychiatrists, psychologists, counselors, and first responders receive more frequently patients with suicidal ideation and those who have committed suicide (Lyra et al., 2021).

Lyra et al. (2021) did not find diagnosis or differential diagnosis in patients with addictions. However, considering the risk for these professionals and first responders and their future implications such as guilt, sadness, legal responsibilities, feeling of lack of expertise with low support of peers and other professionals in many cases (Lyra et al., 2021). For this purpose, continuing education to health professionals and first responders is necessary to support their daily work not only to help them to reduce the risk of suicide, including population with substance use disorder but to have coping strategies to reduce its effects, such as posttraumatic stress disorder, abandonment of their career path, and/or addictive and suicidal ideation/behavior in them. At some point, other community leaders need to have this strategy as well in case there are no professionals trained in mental health in a town. For example, priests or other community leaders need to act in those cases. There is a need to train people in mental health crises (Booth et

al., 2017). However, in the systematic review, they did not find evidence-based in the program that they found in English. Most of the programs were training programs for first responders, teachers, and counselors. Most of them had instructions on mental health, including crisis, suicide, depression, and anti-stigma issues. The more extended plan among the U.S and other countries is called CIT. This program has multi interventions with insufficient evidence of its effectiveness (Booth et al., 2017). After the basic CIT training, there is a longer one about different topics in mental health, including addictions. This program was founded for police officers as first responders (Booth et al., 2017). Other programs use the ALGEE strategy in their training: the modified version of the You Mental Health Course, the Mental Health First Aids, and the Mental Health First Aids for the Swedish context (Booth et al., 2017). Therefore, the use of another option called Mental Health First Responder could be a good option now that it has a safety plan as part of its training and the E.S.T.I.M.A.T.E model (Tolentino, 2021).

Summary and Research Question

The current Pandemic of COVID-19 has negatively impacted the world's mental health, including the Colombian population (Ramírez-Ortiz, 2020). There are more depression and post-traumatic stress disorder problems than before the pandemic (Ramírez-Ortiz, 2020). Different studies about the problem in mental health are available; however, none reviewed articles on the effects of the pandemic on addictive behaviors in the Colombian population. Additionally, recent studies show preventive programs in Colombia in addictions, which is the opposite. It does not bring much information about co-occurrence disorders. Most of these programs are also provided to children and adolescents from 5 to 17 years old.

One of those programs is called Communities that Care, an evidence-based system established in Colombia that integrates the community and its leaders (Mejía-Trujillo, 2015). It

has frequent evaluations as a standardized evaluation validated for the Colombian population and its social-cultural needs (Mejía-Trujillo, 2015). Consequently, one of the most important findings of the program is that people in Colombia drink much alcohol since they are 8 to 9 years old with parents' support in many cases (Martínez, 2019). Above all, the authors show difficulties in the preventive programs in Colombia for the lack of evaluated programs due to deficient economic resources (de Oliveira-Correa, 2020). It is also found in countries like Colombia and Spain that those preventive programs in these countries do not show changes in society (Quintero-Ordóñez, 2015). Nonetheless, people continue taking drugs after implementing the programs and get worse with other substances such as marijuana (Quintero-Ordóñez, 2015).

Other studies from the U.S show the importance of working in crises with people with addictions who also have suicidal ideation or suicidal behaviors (Khani-Jeihooni et al., 2021). There is a high prevalence between addictions and suicide (Davis et al., 2020). A mental health crisis is usually shown by suicidal ideation and/or suicidal behaviors (Davis et al., 2020). There are high rates in Colombia for people with suicide, and there are not enough mental health providers, especially in Colombian towns and rural areas. This is one of the reasons that trained people as mental health first responders is an option to get to the crisis on time and refer patients on time (Ramírez-Ortíz et al., 2020). Many studies in the U.S show a lack of evaluation for first aid programs (Larsson et al., 2016). There are about 15 programs in the U.S that bring training in first aid (Larsson et al., 2016). The Crisis Intervention Team (CIT) program is the most useful, especially for the police who are first responders (Larsson et al., 2016). The idea of the program is to bring mental health support instead of sending all people to jail (Larsson et al., 2016). There is not enough scholarly support for the efficacy of these programs (Larsson et al., 2016). However, researchers keep saying how important it is to keep working in a crisis, especially

during the COVID-19 crisis. This thesis study addresses the research question: how does the mental health first response contribute to the prevention and intervention of substance use in the Colombian population?

Method

This thesis project, called Mental Health First Response (MHFR) Program: Assessing the Mental Health First Response course for the Colombian Population in Terms of Prevention and Intervention of Substance Use Disorder, is multicultural in scope. The current research recruited applicants from two organizations in Colombia, South America and recruited the general population interested in being trained in Mental Health First Response. The problems related to addictions, suicidal ideation, suicide behaviors, and mental health apply to the Colombian population. The study sample included civilian community leaders as well.

Participants

Participants from three organizations, as well as the general population interested in completing the MHFR course, were recruited. Participants were teachers from the Naval school for the children of service people linked with the Colombian armed services in Puerto Leguízamo, Putumayo, and leaders located around Colombia from Colombian National Bank volunteers. People were also recruited based on their interest in being trained in Mental Health First Response. The participants were Colombian citizens between 18 - 60 years old, male and female. The participants included members of the general public. The main inclusion criterion was being an active member and/or volunteer of the organizations. The main exclusion criterion was age, with those younger than 18 or older than 60 years old.

Additionally, there were three assessments provided to participants. Surveys included, first, the AUDIT questionnaire, second, the ASSIST questionnaire, and Columbia Suicide Risk

Assessment. The Columbia assessment was administered to participants with the permission of the organization, while the AUDIT and the ASSIST are free domains from the World Health Organization. Moreover, the information obtained by phone calls from the surveys brought an epidemiology profile of the participants. It was necessary to inform the population of the results. Participants who volunteered had a low risk of suicide and addictions and had leadership skills. Health providers and teachers also participated in the MHFR training overview. Following the training overview, they were assessed on knowledge of MHFR. Participants were assessed on the importance of the training to their daily activities with their communities, including the importance of mental health and if the MHFR training increased their confidence as mental health first responders (Scantlebury et al., 2017).

The participants learned of this study through a research announcement presented in a flier or a letter and by word-of-mouth. The participants found the research announcement through two WhatsApp groups, Facebook and LinkedIn announcements. The National Bank's WhatsApp group is called "Red de Mediadores LPSTLP (Cultural Mediators LPSTLP)." The leader of that organization gave permission to send the research announcement to the WhatsApp and Facebook groups. All the participants expressed interest through a form in the following link: https://forms.gle/hvetTuT3D8n4fQ9QA

In summary, once respondents agreed to participate in the study, they completed three questionnaires by a phone call. There were two weeks between administering the questionnaires and the participants beginning the training. When that information was analyzed, those who qualified, received the following link of the online course in Spanish at https://mhfr-basic-online.thinkific.com/enroll/1664500?price_id=2168385 as well as the Manual in Spanish. The researcher translated the Spanish version of the online course and the manual from English to

Spanish for this thesis. The participants found the free version for the period of the thesis with the written permission of Doctor Art Tolentino.

Intervention

The training was provided to the participants who wanted to continue in the process. Some of them declined for different reasons, such as lack of time, internet connection, different steps to get to the training, etc. The MHFR course aims to train people to prevent and intervene in mental health difficulties, including suicide and addictions prevention (Tolentino & Kovacs, 2020). The main focus of the course is to bring emotional support to peers, which will contribute to the ideas of the Communities that Care Project. The training includes eight objectives. The first objective is to prevent suicide within a crisis intervention. The second objective is to recognize the signs of emotional distress (Tolentino & Kovacs, 2020). The third objective is to learn and use E.S.T.I.M.A.T.E as core skills of MHFR. The fourth objective is to recognize and develop a safety plan (Tolentino & Kovacs, 2020). The fifth objective is to evaluate co-occurring disorders. The sixth objective is to build support systems. The seventh objective is to provide referrals according to the person's needs in a crisis. Finally, the eighth objective is to encourage self-care behaviors from the person in crisis (Tolentino & Kovacs, 2020). These objectives are part of the E.S.T.I.M.A.T.E model. According to Limjap (2021), volunteers of Mental Health First Response are “emotionally resilient, utilizing various self-care activities and coping mechanisms” (MHFR, 2021). Like other programs and courses in Mental Health First Response and/or Mental Health First Aids, this course has experience with the population and data. However, there is no information about the efficacy of this training.

The course is six hours of recorded, online training divided into segments with lectures, videos, and quizzes, translated into Spanish. It has an introduction, pretest (preview the pretest

here: https://es.surveymonkey.com/r/3JNW9DM), MHFR movement, five chapters, one assignment, a post-test (preview the post-test here:https://es.surveymonkey.com/r/3JNW9DM), and an evaluation (preview the evaluation here: https://es.surveymonkey.com/r/NVWZSZ3). The five chapters describe mental health in Colombia and in Latinamerica and the MHFR program, including what MHFR entails, MHFR theoretical foundations, other applications of MHFR, as well as capacity building, sustainability, and corporate social responsibility (Tolentino & Kovacs, 2020).

When the participants finish the course after 1-3 days, Dr. Tolentino will facilitate a live hour webinar to respond to their questions and explain the course content. This webinar will be conducted with a translator from English to Spanish because all of the participants will speak Spanish.

Measures

The measures used for this study were: the Columbia Suicide Severity Rating Scale, The Alcohol Use Disorder Identification Test, The Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST), pretests and post-tests for the MHFR program, and the MHFR evaluation.

Demographics Questionnaire

All 75 participants filled out the demographic questionnaire to assess the characteristics of my sample. The link used by them was the following https://forms.gle/hUQpF4hdztjZhy3x9 The demographic questionnaire was in Spanish because all participants in the sample speak Spanish as their first language. However, in Appendix F, there is an English-language version for the purposes of this thesis. The questionnaire was the same as the registration form to ensure the participants do not get confused by having more than one link. The questionnaire included a

description of the study. Participants responded to 11 questions with information about their demographic characteristics, as well as their interests in participating in the study. The complete questionnaire can be found in the Appendix F.

Columbia–Suicide Severity Rating Scale (C-SSRS)

Suicidal behavior and suicidal ideation were measured using the Columbia–Suicide Severity Rating Scale (C-SSRS; Posner et al., 2010) with approval from the authors by e-mail on November 17, 2021. I used the lifetime-Recent (Version 1/14/09) in Spanish, which was validated for the Spanish-speaking population, of LatinAmerica adolescents by Daniel Serrani-Azcurra (2017). It contains a dichotomous “yes/no" question scale that consists of 4 sections. Each section depends on the answers of the previous one. The sections are named as followed: suicidal ideation with five questions, the intensity of ideation with two questions, suicidal behavior with nine questions, and completed suicide with two questions. It has a lifetime answer and the last month and last three months answer to review current risk. See Appendix F for C-SSRS in English and in Spanish versions. According to Serrani-Azcurra (2017), “The C-SSRS ideation subscale yielded a Guttmann split-half reliability of .91 and a Cronbach’s alpha of 0.87, 0.89 and 0.93 for the whole sample, the suicide-risk and control groups respectively, with good internal consistency” (p. 177); confirmatory factor analysis indicates acceptable construct validity.

Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)

The risk factors in substance abuse was measured with the ASSIST test, and for early intervention in primary and general care. It has a free domain for users in Latinamerica. The test is approved for use in Colombia by the Health Department of the country as well as international validation. The version to be used in the research will be V3.0 in Spanish for the Spanish

speaking population which is recommended for research purposes. It has a header with the name of the interviewer and the participant´s name, date, and country. It has 8 questions, the seven first with 10 items. The first question is about the use of 9 different substances, from the second question to question number 7 is about the frequency and problematic of the substance used. The questionnaire ASSIST showed discriminant validity including the different levels of risk (World Health Organization, 2010).

Alcohol Use Disorders Identification Test (AUDIT)

The ASSIST brings information about alcohol use, however it was considered that the AUDIT is more detailed related to the use and abuse of alcohol in the population. Alcohol is the most common substance used among the Colombian population. This is why it was considered to be used in the current study. It is also a free domain for non commercial purposes. It is approved to be used in Colombia by the Health Department. The AUDIT has been validated in different countries in the world. The version used in this thesis is the Ecuadorian version in Spanish. The test has 10 questions regarding the use/abuse of alcohol and the type of responses are related to frequency of use and/or frequency of difficulties after or before its use. The AUDIT showed validation in different cultures, within genders and age (World Health Organization, 2001).

MHFR Pre-Test and Post-Test

The knowledge of Mental Health First Response (MHFR) was used before and after the online course, which Dr. Tolentino has approved to do with Survey Monkey. The participants completed the measure online, using the following link https://es.surveymonkey.com/r/3JNW9DM. The participant had to accept the consent that they found in the pretest in order to continue with the training. They also accepted the conditions of the thesis during the telephone conversation.

Most of the participants took the knowledge test to determine what they know about MHFR as a baseline. The participants who were eligible for the course comprised between 30-40 people. The pre-test and post-test have 10 multiple choice questions each, and the questions are identical between the two versions. The pre-test questionnaire was provided to all the participants, and the post-test will be for all the participants after the MHFR course. The links for both pretest and post-test are different. The link for the post-test is the following https://es.surveymonkey.com/r/H76XVM8 The test will be provided in Spanish for the Spanish-speaking population. The pre and post-tests measure the knowledge of the participants related to the MHFR program. The questions are about the MHFR program's content, including what emotional distress entails, the difference between emotional distress and mental health crisis, and other questions to measure the course content. There was attrition during the course, especially for the lack of time of the participants. However, because it was an asynchronous online course they could do it in their free time, probably for one week one or two hours daily. There were some participants without internet access, who had to receive the training on-site. There were about 15 people within this modality.

MHFR Online Course Evaluation - English

I administered the MHFR course evaluation, with the approval of Dr. Tolentino (see the measure here: https://es.surveymonkey.com/r/NVWZSZ3). The scale has 11 multiple-choice questions. The last two questions are open-ended questions. This measure assesses the importance of the course to the participants. For example, questions number 1 and 2 focus on the participants' knowledge of the subject matter and the ability to expand and illustrate concepts.

The participants who were able to do all the steps from the registration to the evaluation received a gift certificate of $8 for those first 10 people who did it first and $4 for the other participants.

Procedures

After the Institutional Review Board's final approval (Appendix E), the researchers sent the research announcement with a link to the demographic questionnaire and questions regarding their interest in participating in the participant pool. The participants of the “Cultural Mediator Project”" from the Colombian Republican Bank received the link through the WhatsApp and Facebook groups dedicated to the organization, which has 135 participants from 29 cities of Colombia in different regions (Cultural Mediators Network, 2017). The 17 teachers from the Naval School in Puerto Leguízamo, received the invitation through their personal WhatsApp. There were open invitations for the population who were interested in participating in the study and taking the course. These personnel are located in different towns and States in Colombia.

Following the recruitment and informed consent procedures, the participants took the ASSIST, the AUDIT test, the Columbia Suicide Severity Rating Scale (C-SSRS), and the MHFR pre-test. This information helps as a baseline with the community, providing insight into the status of their mental health in terms of suicidal ideation and addictions. It also provided an understanding of their predispositions and protective factors, as well as what information they already know about MHFR.

The assessment data was analyzed. The participants with suicidal ideation or behaviors had psychiatric attention already. The informed consent form notified participants that confidentiality was broken to protect the safety of the participants at risk. However, there was no need for this with the population.

After reviewing the assessment data, 40 participants were selected for the MHFR online course, which included the live webinar facilitated by Dr. Tolentino in English, with the translation of the researcher. Doctor Art Tolentino is the developer of the Mental Health First Response and Mental Health First Responder course. The course is certified for MHFR volunteers in the state of Washington through Pathways Mental Health Services and in the Philippines. Doctor Tolentino provided the training both online asynchronous and synchronous with the translation of the researcher. His role during the thesis and the workshop was to provide the hour course online to the participants who finish the whole training. The webinar was recorded with the participants' permission. Finally, the participants will complete the post-test for the MHFR course and the course evaluation. Those first 10 participants who got to this last step received a $8 dollars in Colombian pesos $30.000 gift certificate and the others received a $4 dollars in Colombian pesos $15.000 gift certificate.

Data Management

To ensure the anonymity of the survey participants, in using SurveyMonkey, IP addresses were not collected. For this study, the data from SurveyMonkey into an SPSS database for analysis, was transferred. The results were presented in aggregate form to protect participants' identities. Access to the data only in the form of physically completed surveys allowed me to have an encrypted flash drive, kept in a locked file cabinet in my home. The thesis advisor, and I were the only parties with access to the strong password that protected the SPSS dataset. The dataset contained no coded identifiers and, as such, was completely anonymous. The participants completed the SurveyMonkey version of the pretest, post-test, and the evaluation for confidential purposes.

I stored all electronic data on an encrypted flash drive and not on any computer hard drive. I retained the data set and related files for a minimum of five years after the study completion, in case questions arise about the analyses. After five years, I destroyed the data using the current Department of Defense data destruction standards. I chose an affordable technique, such as encryption, pending technology at the time.

Statistical Analysis

For the purpose of the current study, IBM's SPSS statistical software will be used, version 26. Descriptive statistics will be used, including frequencies, mean, range, standard deviation, skewness, and kurtosis. There will be a correlation analysis. The qualitative data will be analyzed under the QSR International and Nvivo, version 10. This will help to organize, analyze, explore, and visualize the patterns and help with the justification in a rigorous and evidence based way.

The measures used for the current study were 6. The first three were to have a baseline of the participants in addictions and suicidal behaviors. The first measures for the study were the Columbia-Suicide Severity Rating Scale (C-SSRS), the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST), and the Alcohol Use Disorders Identification Test (AUDIT). The three first measures have a scoring protocol and guide by the publisher. There is also a free course that the researcher of this work took for the Columbia test. The ASSIST scale includes subscales taking into consideration the number of drugs taken by the participants during their lives. If the participant took more than one drug during their life, the rest of the test should be measured according to it. The other 3 scales were used to do comparisons after taking the course pre-test and post-test with right or wrong questions. The same with the Evaluation of the course with a Likert scale to how important was for the participants taking the course as a

contribution to their knowledge and their tools to intervene in a crisis. Finally, in the evaluation test, there was a section for them to write about the participants' thoughts related to their learning process as well as how to improve the MHFR course.

Results

Participant and Demographic Characteristics

There were 75 adults between 22 and 75 years. Table 1.1 in Appendix F shows that most of the registered participants were in their twenties and thirties. All of the participants are from different cities in Colombia, most of them living in Puerto Leguízamo, Putumayo in the South of the country. Thirty-nine percent (29 participants) were males, and 61% (46 participants) were females of different races or ethnicities. Table 1.1 in Appendix F shows that the highest percentage of participants were Mestizos, which coincides with the majority Etnias of people in Colombia after the Spanish colonization. Also, most of them were married or in a relationship with different levels of education (see Table 1 and Figure 1.1). Figure 1.1 shows the difference between the level of education of those participants who initially registered as opposed to Figure 1.2 (See appendix F), which shows the difference between those participants who finished the course. Figure 1.1 shows that the four levels of education of participants who registered for the course were similar, while those that finished the course were mostly at the undergraduate level of education.

Their backgrounds were teachers, mental health providers, priests, leaders in the Catholic church, and other first responders. The people who registered for the thesis were 12 from the Colombian Republican Bank, 15 from the Naval school located in Puerto Leguízamo, Putumayo, 37 military family members, and the other 11 participants who accepted to be part of the research. All of the members got to different levels of the research for different reasons. First,

there was a rejection by the Health Department of the Colombian Navy after the inscription from military organization to work with military personnel in the Naval Base of Puerto Leguízamo. Second, other participants said that training was for psychologists rather than the general public. Third, other people who subscribed to the course did not have enough time to do the whole process. Fourth, some did not answer the phone and/or message after registering. Others said they lacked the time and/or had difficulties with an online connection. All the people who did the course online with the researcher's company finished it with more desertion than those who did it on their own. Finally, those participants who finished the whole course made some recommendations (see Table 6.3 of Appendix F). This recommendation may explain why other participants decline to continue with the course.

The different levels of the thesis were the inscription, the pretest with consent, the three psychological tests, 6 hours online course, the post-test, and the evaluation of the course. Eight participants did the pretest from the Republican Bank, 15 from the Naval Base of Puerto Leguízamo, 15 from the Naval school, and three from other locations. The total of participants who answered the pretest was 45. The next step was the application of the three tests, which are the (C-SSRS), the ASSIST, and the AUDIT. The three first measures were responded to by 45 participants, nine from the Republican Bank, 19 from the Naval Base, 15 from the Naval School, and two from other locations. The MHFR course was started by 38 participants. However, nine did not finish the course. Twenty-nine participants out of 75 who subscribed to the thesis finished the whole process, including the whole course, the post-test, and the evaluation. Those who finished the course included four of 11 participants from the Republican Bank, 10 of 38 from the Naval Base, and 15 of 15 from the Naval School. It is important to show all the population results considering that each step brings information such as the baseline, the

difference between the pretest and posttest, and course evaluation. Thirty-eight (28 participants) percent of participants were missing data after they registered.

Variable One - Columbia-Suicide Severity Rating Scale (C-SSRS)

Table 2.2 demonstrates the importance of administering the C-SSRS version. The measure asks about any suicidal ideation the participants experienced during the last month and suicidal behavior over the last three months, as well as in their lifetimes (see Table 2.2 in Appendix F). Besides assessing current suicide risks, which was the purpose of applying the test as a baseline, the measure reminds participants of those difficulties that led them to think about suicide. Completing the measure may increase participants' sensitivity towards this theme and others´ needs. In the case of ideation during their lifetime, 31 participants never thought of being dead, while 16 had a thought during their life with high ideation intensity. However, only four people with high ideation intensity were at risk in the last month. All of them were in treatment, and some already had a psychiatric diagnosis, as shown in Tables 2.3 and 2.4. Those with suicide behavior risk in their lives included five participants, with three at current risk. Those three people are in psychiatric treatment already. It is important to consider that those who were at risk of suicide in their life never took treatment and never told anyone until the moment of the interview. Some of them had thought about suicide for more than 10 years, and it was the first time that they had talked about that with some mental health specialist. None of those participants who were at risk continued with the MHFR course. It was important for them to continue with the treatment first.

Variable Two - The Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)

Forty-seven participants did the ASSIST. Table 3 shows a total of 68 because 11 of them use more than one substance throughout their lives. This means that 12 of the participants have tried tobacco, 44 alcohol, four cannabis, two cocaine, one inhalant, three sleep pills, and one hallucinogen. Following Table 3.1, there are different frequencies with different results. The results showed that the level of risk depends on if the substance is alcohol or others. Low risk for alcohol is in the frequency 0-10, medium risk is between 11-26, and high risk is 27 and more. Other substances are low risk, with the frequency between 0-3, medium risk 4-26, and high risk more than 27.

There were eight people with low, moderate, and high risk. Two of the participants showed medium risk in tobacco and alcohol. Two more participants with moderate risk in alcohol. One participant with moderate risk in tobacco. One participant with high risk in sleep pills. One participant in medium risk for tobacco, alcohol, and sleep pills. One participant with moderate risk for tobacco, alcohol, alcohol, cannabis, and hallucinogens. The participants stated that they are all working on reducing the abuse of the substances and are in current treatment. However, they were excluded from the MHFR course due to the exclusion requirements for participating in the study. Thirty-nine participants were eligible to participate.

Variable Three - Alcohol Use Disorder Identification Test (AUDIT)

Forty-seven of 75 participants answered the interview version of the AUDIT, and 13% (6) of the participants were abstainers, indicating that they never had any problems with alcohol. Low-risk consumption was shown by 81 % (38) of participants. Hazardous or harmful alcohol consumption was shown by 4.2% (2) of the participants. Alcohol dependence (moderate-severe alcohol use disorder) was shown by 2.1% (1) of the participants. These findings indicated that most of the participants could continue with the next step of the thesis. Forty-four participants

were eligible to do the MHFR course. The range of scores for this scale was 0-16. The standard deviation was 2.3, and the mean for the measure was 2.1. Those participants at risk said that they were in treatment to decrease the use and/or abuse of alcohol.

Variable 4 - Pretest and Post-test

Forty-one participants did the pre-test, while 26 participants completed the post-test, the same as those who finished the MHFR course. Participants scored a minimum of zero on the pretest, while the minimum score when participants completed the post-test was six. The reason for this difference is that the participants took the course between the pre and post-tests. In the pretest, Oonly four participants scored between 6-7, while in the posttest 22 participants scored 8-10, which was the maximum score. The median in the pretest was six, while in the posttest was nine, as shown in Table 5 (see Appendix F). This is a result of the course that helps the participants have more information about managing people in crisis and non-crisis issues as first responders. The mean for the pre-test was 0.41; while the mean for the post-test was 0.74, as shown in Table 5 (see Appendix F).

Variable Five - Evaluation

Twenty-eight participants of the study responded to the evaluation of the MHFR course with a minimum score of 4 equal to good or agree and a maximum score of 5 equal to Very good and completely agree. This means that 100% of the participants agree that the course gave them the skills as first responders in mental health and helped them be prepared to help a person in a crisis in mental health.

The 28 participants who finished the MHFR course also wrote answers to the last two questions of the questionnaire. The first question is what did they like about the MHFR course.

All of them answered in their own words. Table 6.2 shows participants' comments about how they liked the MHFR course. One-hundred percent of the participants agreed they liked the training for different reasons, such as stress management by helping others (6), the model (4), daily life use (2), the themes (10), self-help (2), self-efficacy skills (2), daily life skills (2), the public health perspective (1), and all (1). Table 6 of Appendix F shows the answers to the last question of the questionnaire about what they would like to improve in the course. Their responses were summarized within the following topics: include case videos, MHFR Clients' testimonies, more dynamism in the presentation, more intervention from Dr. Tolentino, take into consideration possible internet connection, difficulties, more time for discussion, include more information about the Colombian context, and some participants said it was all good.

Discussion

The mental health first response course contributes to the prevention and intervention of substance use of the Colombian population and the management of crisis in first responders. The participants who finished the MHFR course agreed that they received the skills needed to be more empathetic and to understand people in crisis and no crisis with mental health issues. The participants were in different organizations and with different roles in their communities. There were teachers, researchers, leaders in the libraries, psychologists, church leaders, family members of the Colombian Navy, and students. All of them agreed that the training gave them tools to work within mental health and addictions areas in their communities and manage their difficulties. MHFR course was a first step in helping them organize their communities applying a “communities that care” strategy to decrease, prevent, and intervene in social problems. Some participants reported that they wanted to continue with more tools and obtain deeper knowledge on how to help their families, friends, and co-workers in the prevention and intervention as

Mental Health First Response. This is a first opportunity to help people in need of support and to know when to guide the people who are in need to the next level of care before situations escalate. The course is open to all the population. However, in this study, those who finished the course were at the undergraduate education level. This coincides with some of the comments of those who finished the course shown in figure 6.2 who said that the course needed a level of instruction superior to secondary school to understand it.

Implications

In regions such as Puerto Leguízamo, Putumayo is not usual to find mental health providers, the same with the military population plus the low knowledge of mental health, lack of politics in mental health difficulties, as well as mental health providers. The stigma is another factor that carries that people do not want to attend or go to the psychologist. Having the opportunity to work within the colombian culture and translate the MHFR course bring those tools to people in the country. Training people as Mental Health First Responders will decrease the obstacles of those who need immediate care and do not go for help. This study gave some skills to ensure better help from first responders. There was a minor use and/or abuse of substances within the population who took the MHFR course. Some of them had suicidal ideation in their adolescence something that they see as a learning situation that does not happen in their present. However, that makes them feel scared about their own children and their possible vulnerabilities and the need to protect them with strategies as parents. Those who were having current ideation were having medication provided by psychiatrists with low assistance of psychologists. Showing that MHFR can help referring people to psychologists also is an option first than medications.

Similarities and Differences

The current study adds evidence-based information to the “Communities that Care” program that is running currently in Colombia as a preventive strategy for addictions. de Oliveira-Correa et al. (2020) suggested this program is an important factor to decrease the use and abuse of substances in Colombia. This study’s findings were similar to what was shown by Marks et al. (2017) when they found a positive way to implement the REACT program among pairs of paraprofessionals. The difference was that the MHFR course was open to the general public, including teachers, who found it important to use in schools with children and peers.

This strategy works as a protective factor in the community as it is the program called Communities that Care (Brown et al., 2021). The difference is that they used it for a different purpose than the current study because it is validated for children in the school until their 18 years old as it is common in preventive programs in Colombia such as “Sana Mente”.

The substance that is more commonly used in Colombia is alcohol (Montero-Zamora et al., 2020), which was found in the current study as well. However, most participants showed lower use of it. They only use alcohol occasionally when they have celebrations or share time with family and friends. In contrast, it was more frequent to find people with a history of suicidal ideation in the participant´s adolescence. This is different from the study shown by Khani-Jeihooni et al. (2021) where they found a high prevalence between addictions and suicide risk.

The results of the study of Marks et al. (2017) coincide with the results of this thesis in that participants increased the self-efficacy related to dealing with mental health crises, including the technical knowledge of how to intervene and prevent addictions and suicidal ideation and stress management.

Limitations

The study's limitations are related to the internet connection which is not good in this part of the country. It was needed to do it in groups. Other limitations were the words of the course and the invitation of the study. For many people, it was full of academic terms, and they thought the course and the thesis were for psychologists. The time of the course is about six hours, and people usually do not have that time to get trained in a theme that was known to them. One of the organizations that gave the authorization at the beginning of the study later rejected it, which made it difficult to find new participants in a short time period. It was necessary to do a baseline of the participants in addictions risk and suicide risk, however, this made it longer and difficult for those participants who did not have enough time. It was not easy to find validated instruments in Colombia. The instrument suggested to use in the beginning by the program "Communities that Care" was not possible to use because it is too long, and it is validated in Colombia for children in school. The current study was done for adults. The demographic characteristics of the sample reflect those of the research population. However, even though there were 75 people who started the process, 28 finished it which corresponded to 37% of the population. The demographics for this population coincides with the population who subscribed to the program in the majority etnia was mestizo (71%), woman (82%), married (50%), living in Puerto Leguízamo (79%) as it is shown in Table 1.2 of the Appendix F. On the other hand, the age of those who finished the program were mostly in their twenties, thirties, and forties; majority of them in their thirties with a lower difference than the others. The differences were with the level of education that the majority who finished the course were undergraduates, and with the organization of the participants. Those who started the program were the majority of the Navy unit, while those

who finished were the majority from the Colombian Naval School at Puerto Leguizamo. Finally, it is important to mention that none of the participants who subscribed to the course from different organizations than those with the letter of permission, finished the program as it is shown in Table 1.2 of the Appendix F

Conclusions

The importance of this study's findings is that peer support happens in real life with no resources to intervene in mental health. Training those peers in society brings tools to them to help as a bridge as first responders and decrease the risk of substance abuse and suicidal ideation. Therefore, the peer training is what the MHFR course is all about which is the fact that the participants in the study showed improvement in their ability to support peers as it is shown in table 6.3. Additionally, Table 5.1 shows that the MHFR course has a statistically significant effect on each of the individuals in the study. It was found that many adults had suicidal ideation in their childhood without any treatment and without telling anyone. No one is trained in asking directly about the situation of the person in crisis. Continuing training first responders also helps to reduce the stigma of mental health which is favorable for people in Colombia to get to mental health providers. It is important to provide this training to the first response population with a level of knowledge above technical studies. Colombia has its own culture, however, the MHFR is an integrative model with an international perspective which makes it easy to understand in the country.

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Appendix A

Letters of Authorization

"Redacted for Privacy/Copyright Reasons."

Appendix B

Research Announcement

My name is *Marjorie Ramos-Salcedo.*

I am conducting research through Purdue University Global to obtain a Master's Degree in Psychology.

The purpose of the research is to evaluate first responders on their knowledge of mental health of the Colombian population in terms of prevention and intervention of Psychoactive Substances. The research is looking to reduce the use and abuse of psychoactive substances and its co-occurrence effects in suicide behaviors and/or thoughts. I will apply psycho technical tests for military and civilian personnel in Puerto Leguízamo and cultural mediators

If you are interested in being part of this study, please click here for more information: https://forms.gle/hvetTuT3D8n4fQ9QA

The survey will take about 5 minutes of your time.

This study will be confidential, so your personal information will be protected securely. according to all applicable laws and regulations.

Click here to participate! https://forms.gle/hvetTuT3D8n4fQ9QA

Appendix B - Spanish

Anuncio de investigación

Mi nombre es Marjorie Ramos Salcedo.

Estoy realizando una investigación a través de Purdue University Global para obtener una Maestría en Psicología.

El propósito de la investigación es realizar una evaluación relacionada con los primeros respondientes en salud mental en la población colombiana en términos de prevención e intervención de Sustancias Psicoactivas. La investigación se basa en un sistema de prevención en salud que involucra a toda la comunidad como sistema de apoyo al bajo o nulo uso de sustancias psicoactivas. Para lo cual se pretende aplicar pruebas psicotécnicas para personal militar y civil de nacionalidad colombiana.

Si estás interesado en formar parte de este estudio, haz clic aquí para obtener más información: https://forms.gle/hvetTuT3D8n4fQ9QA

La encuesta tomará aproximadamente 5 minutos de su tiempo.

Este estudio será confidencial, por lo que su información personal estará protegida de manera segura de acuerdo con todas las leyes y regulaciones aplicables.

¡Haz clic aquí para participar! https://forms.gle/hvetTuT3D8n4fQ9QA

Research Announcement

My name is Marjorie Ramos-Salcedo.
I am conducting research through Purdue University Global to obtain a Master's Degree in Psychology.
The purpose of the research is to do an evaluation related to first responders in mental health in the Colombian population in terms of prevention and intervention of Psychoactive Substances. The research is based on a health prevention system that involves the entire community as a support system for the low or no use of psychoactive substances. For which it is intended to apply psycho technical tests for military and civilian personnel of Colombia
If you are interested in being part of this study, please click here for more information: https://forms.gle/hvetTuT3D8n4fQ9QA
The survey will take about 5 minutes of your time.
This study will be confidential, so your personal information will be protected securely according to all applicable laws and regulations.
Click here to participate! https://forms.gle/hvetTuT3D8n4fQ9QA

Anuncio de investigación

Mi nombre es Marjorie Ramos Salcedo.
Me encuentro realizando una investigación con la Universidad Purdue Global para obtener mi grado en Master en Psicología
El propósito de la investigación es la de evaluar a primeros respondientes en salud mental en la población colombiana en términos de prevención e intervención en Sustancias Psicoactivas.
La investigación está basada en un sistema de prevención que involucra grupos de apoyo para disminuir el uso o abuso de sustancias psicoactivas.
Para lo anterior se realizará la aplicación de pruebas y de un programa en Primer Respondiente en Salud mental a población militar y civil de Colombia.
Si están interesada en hacer parte de este estudio, por favor encuentra más información en el siguiente enlace: https://forms.gle/hvetTuT3D8n4fQ9QA Por favor diligencie la información que tomará 5 minutos de su tiempo. Este estudio será confidencial, su información personal será protegida según las leyes colombianas. Participa en el siguiente enlace!!!
https://forms.gle/hvetTuT3D8n4fQ9QA

Appendix C

Informed Consent

Purdue University Global

Consent for Participation in Research
Mental Health First Response (MHFR) Program: Assessing the Mental Health First Response of the Colombian Population in Terms of Prevention and Intervention of Substance Use Disorder

CONCISE SUMMARY

The research is based on a health prevention system that involves the entire community as a support system for the low or no use of psychoactive substances. t is intended to apply psycho technical tests. The assessment will be provided to all participants in the Communities that Care youth survey, as well as the Columbia Suicide Risk Assessment. This information will bring an epidemiology profile. It will be necessary to inform the population of the results of the tests. This will have an online live webinar with a MHFR overview and the training as basic MHFR online.

Why am I being asked?

. This research study is being conducted by Marjorie Ramos-Salcedo, a Master of Science in Psychology student at Purdue University Global. You have been asked to participate in the research because you decided to be part of it in order to have tools to be part of group support to help to reduce addictions in the town and may be eligible to participate. We ask that you read this form and ask any questions you may have before agreeing to be in the research.

Your participation in this research is voluntary. Your decision whether or not to participate will not affect your current or future relations with Purdue University Global. If you decide to participate, you are free to withdraw at any time without affecting that relationship.

What is the purpose of this research?

The purpose of this research is:

To find a way to bring group support as a preventive and intervention strategy for those who are struggling with addictions and are in mental health crises.

What procedures are involved?

If you agree to be in this research, we would ask you to do the following things:

The assessment will be provided to all participants in the Communities that Care youth survey as well as the Columbia suicide risk assessment. This information will bring an epidemiology profile. It will be necessary to inform the population about the results. Once the information is ready, those participants who volunteer and have a low risk of suicide and addictions and have leadership skills, as well as a background in health, will be part of the MHFR training. This will have an online live webinar with an MHFR overview and the training as basic MHFR online. After it, they will be assessed in satisfaction with training, change in attitude towards the importance of mental health, change in confidence, change in knowledge, and change in skills.

Approximately 100 may be involved in this research at Purdue University Global.

What are the potential risks and discomforts?

The research may:

If there is a high risk in suicide, there will be a need to refer you to your mental health provider

Are there benefits to taking part in the research?

The benefit of being part of this study is to help the community of Puerto Leguízamo to find other ways to solve social problems related to the consumption of different drugs, including alcohol and nicotine.

What about privacy and confidentiality?

The only people who will know that you are a research subject are members of the research team. No information about you, or provided by you during the research will be disclosed to others without your written permission. When the results of the research are published or discussed at conferences, no information will be included that would reveal your identity.

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. As a Colombian law requirement, the researcher must disclose information in case of any suicide risk which I will have to inform family members and/or your medical services

- Personal information, research data, and related records will be coded, stored, etc. to prevent access by unauthorized personnel. The recorded data of the live webinar will be saved only for research purposes.
- Specific consent will be solicited, if any other uses are contemplated.

Individual responses to survey questionnaires will be destroyed, following analyses of the data

Will I be reimbursed for any of my expenses or paid for my participation in this research?

At this time, no reimbursement nor gifts are available for participation in this research.

If there will be payment or gifts, use these guidelines:

Can I withdraw from the study?

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study.

Whom should I contact if I have questions?

The researcher conducting this study is Marjorie Ramos-Salcedo. You may ask any questions you have now. If you have questions later, you may contact the researchers at: Phone: 3103413778. You may also contact the researcher's thesis adviser, Dr. Gabrielle Blackman PhD, at gblackman@purdueglobal.edu.

What are my rights as a research subject?

If you feel you have not been treated according to the descriptions in this form, or you have any questions about your rights as a research subject, you may contact the Institutional Review Board (IRB) at Purdue University Global through the following representative:

Susan Pettine, IRB Chair

Email: spettine@purdueglobal.edu

Remember: Your participation in this research is voluntary. Your decision whether or not to participate will not affect your current or future relations with Purdue University Global. If you decide to participate, you are free to withdraw at any time without affecting that relationship.

You may keep a copy of this form for your information and your records.

Signature of Subject

I have read (or someone has read to me) the above information. I have been given an opportunity to ask questions and my questions have been answered to my satisfaction. I agree to participate in this research. I have been given a copy of this form.

Signature	Date
Printed Name	
Signature of Researcher	Date (must be same as subject's)

Appendix C- Spanish version

Apéndice C-Versión en español

Universidad Purdue Global

Consentimiento para participar en investigación
Programa primer respondiente en salud mental (MHFR): Evaluar en términos de

prevención e intervención en el uso de sustancias psicoactivas.

RESUMEN

La investigación se basa en un sistema de prevención en salud que involucra a toda la comunidad como sistema de apoyo al bajo o nulo uso de sustancias psicoactivas. Para lo cual se pretende aplicar pruebas psicotécnicas para personal militar y civil del municipio de Puerto Leguízamo. La evaluación se proporcionará a todos los participantes en la encuesta para jóvenes de Communities that Care, así como en la evaluación de riesgo de suicidio de Columbia. Esta información traerá un perfil epidemiológico. Será necesario informar a la población sobre los resultados. Una vez que la información esté lista, aquellos participantes que se ofrezcan como voluntarios y tengan bajo riesgo de suicidio y adicciones y tengan habilidades de liderazgo, así como antecedentes en salud, serán parte de la capacitación de MHFR. Esto tendrá un seminario web en vivo en línea con una descripción general de MHFR y la capacitación como MHFR básico en línea. Posteriormente, se evaluará la satisfacción con la capacitación, el cambio de actitud hacia la importancia de la salud mental, el cambio de confianza, el cambio de conocimiento y el cambio de habilidades. Los riesgos del estudio es que usted se encuentra en una condición en la que probablemente tendrá que atender a su proveedor de salud mental en caso de que encuentre problemas de suicidio y yo podría hacer la remisión para eso.

¿Por qué me preguntan?

Se le pide que participe en un estudio de investigación sobre un sistema de prevención de la salud que involucre a toda la comunidad como un sistema de apoyo al bajo o nulo uso de sustancias psicoactivas. Para lo cual se pretende aplicar pruebas psicotécnicas para personal militar y civil del municipio de Puerto Leguízamo, Putumayo, Colombia. Este estudio de investigación está siendo realizado por Marjorie Ramos-Salcedo, estudiante de Maestría en Ciencias en Psicología en Purdue University Global. Se le pidió que participara en la investigación porque decidió ser parte de ella para tener herramientas para ser parte del apoyo grupal para ayudar a reducir las adicciones en la ciudad y puede ser elegible para participar. Le

pedimos que lea este formulario y haga cualquier pregunta que pueda tener antes de aceptar participar en la investigación.

Su participación en esta investigación es voluntaria. Su decisión de participar o no no afectará sus relaciones actuales o futuras con Purdue University Global. Si decide participar, puede retirarse en cualquier momento sin afectar esa relación.

El propósito de esta investigación es:

Encontrar una manera de brindar apoyo grupal como una estrategia de prevención e intervención para quienes luchan contra las adicciones y se encuentran en crisis de salud mental.

¿Qué trámites están involucrados?

Si acepta participar en esta investigación, le pediremos que haga lo siguiente:

La evaluación se proporcionará a todos los participantes en la encuesta para jóvenes de Communities that Care, así como en la evaluación de riesgo de suicidio de Columbia. Esta información traerá un perfil epidemiológico. Será necesario informar a la población sobre los resultados. Una vez que la información esté lista, aquellos participantes que se ofrezcan como voluntarios y tengan un bajo riesgo de suicidio y adicciones y tengan habilidades de liderazgo, así como antecedentes en salud, serán parte de la capacitación de MHFR. Esto tendrá un seminario web en vivo en línea con una descripción general de MHFR y la capacitación como MHFR básico en línea. Posteriormente, se evaluará la satisfacción con la capacitación, el cambio de actitud hacia la importancia de la salud mental, el cambio de confianza, el cambio de conocimiento y el cambio de habilidades.

Aproximadamente 100 pueden participar en esta investigación en Purdue University Global.

¿Cuáles son los posibles riesgos y molestias?

La investigación puede:

Si existe un alto riesgo de suicidio, será necesario derivarlo a su proveedor de salud mental.

¿Hay beneficios por participar en la investigación?

El beneficio de ser parte de este estudio es ayudar a la comunidad militar y civil de Colombia incluyendo Puerto Leguízamo, Putumayo a encontrar otras formas de resolver problemas sociales relacionados con el consumo de diferentes sustancias psicoactivas.

¿Qué pasa con la privacidad y la confidencialidad?

Las únicas personas que sabrán que usted es un sujeto de investigación son los miembros del equipo de investigación. Ninguna información sobre usted, o proporcionada por usted durante la investigación, será divulgada a otros sin su permiso por escrito. Cuando los resultados de la investigación se publiquen o se discutan en conferencias, no se incluirá información que pueda revelar su identidad.

Cualquier información que se obtenga en relación con este estudio y que pueda identificarse con usted permanecerá confidencial y se divulgará solo con su permiso o según lo requiera la ley.

→ La información personal, los datos de investigación y los registros relacionados se codificarán, almacenarán, etc. para evitar el acceso de personal no autorizado.

→ Se solicitará consentimiento específico, si se contempla cualquier otro uso.

Las respuestas individuales a los cuestionarios de la encuesta serán destruidas, luego del análisis de los datos.

¿Se me reembolsará alguno de mis gastos o se me pagará por mi participación en esta investigación?

En este momento, no hay reembolsos ni obsequios disponibles por participar en esta investigación.

¿Puedo retirarme del estudio?

Puede elegir si desea participar en este estudio o no. Si se ofrece como voluntario para participar en este estudio, puede retirarse en cualquier momento sin consecuencias de ningún tipo. También puede negarse a responder cualquier pregunta que no desee responder y seguir participando en el estudio.

¿Con quién debo comunicarme si tengo preguntas?

La investigadora que realiza este estudio es Marjorie Ramos-Salcedo. Puede hacer cualquier pregunta que tenga ahora. Si tiene preguntas más adelante, puede comunicarse con los investigadores al: Teléfono: 3103413778 o al correo electrónico marjorieramos1@student.purdueglobal.edu. También puede comunicarse con la asesora de tesis del investigador, Dra. Gabrielle Blackman PhD, en gblackman@purdueglobal.edu.

¿Cuáles son mis derechos como sujeto de investigación?

Si cree que no ha sido tratado de acuerdo con las descripciones de este formulario, o si tiene alguna pregunta sobre sus derechos como sujeto de investigación, puede comunicarse con la

Junta de Revisión Institucional (IRB) de Purdue University Global a través del siguiente representante:

Susan Pettine, presidenta del IRB

Correo electrónico: spettine@purdueglobal.edu

Recuerde: su participación en esta investigación es voluntaria. Su decisión de participar o no, no afectará sus relaciones actuales o futuras con Purdue University Global. Si decide participar, puede retirarse en cualquier momento sin afectar esa relación. Puede conservar una copia de este formulario para su información y sus registros.

Firma del sujeto de investigación

He leído (o alguien me ha leído) la información anterior. Se me ha dado la oportunidad de hacer preguntas y mis preguntas han sido respondidas satisfactoriamente. Acepto participar en esta investigación. Se me ha dado una copia de este formulario.

_____ _____

Firma Fecha

_____

Nombre

_____ _____

Firma del investigador Fecha (la misma)

Appendix D

Measures

1.1. Interest and Socio Demographic survey in English

I invited you to fill out a form:

Mental Health First Respondent thesis !!!

Self-care and caring for others are a balance in our life. If you are interested in participating in the thesis "First Respondent in Mental Health: Evaluation in the Colombian population in terms of prevention and intervention of Psychoactive Substances" fill out the following form

What is the thesis about?

My name is Marjorie Ramos Salcedo, I am a Master's student at Purdue Global University. I am currently doing a research thesis for my degree in First Respondent in Mental Health. The research model is based on a health prevention system that involves the entire community as a support network, and intervention in crisis in young adults for the prevention of the use or abuse of psychoactive substances. It is intended to apply psychotechnical tests and the First Respondent in Mental Health program to people who are involved in the community. Once your registration is received, I will contact you.

Names and surnames

I.D. Number

City of residence

Contact phone number

Contact E-Mail

How did you find out about the thesis?

- Republican Bank, Peace Speaks Up project Cultural Affairs

- Republican Bank, Investigation program
- Colombian National Navy
- Colombian National Navy School
- Other

If you answered “Other,” please indicate where you learned about the study: _____

What is your race / ethnicity?

- White
- Afro-Colombian
- Raizal
- Palenquera
- Indigenous
- Rom
- Gypsy
- Mestizo
- Mulatto
- Zambo
- I prefer not to answer

What is your gender identity?

- Woman
- Man
- Transgender
- Non-binary / non-compliant
- He prefers not to answer

- Other

If you write another, which one?

Age

What is your educational level?

- Incomplete elementary
- Complete primary
- Incomplete high school
- Complete baccalaureate
- Technician
- Technologist
- Undergraduate
- Postgraduate - specialization
- Postgraduate - Master's
- Postgraduate - Doctorate
- Postgraduate - Postdoctoral

What is your last graduation diploma about?

What do you do for your daily living?

What is your marital status?

- Single
- In a relationship (without being married)
- Married
- Separated
- Widower

- I prefer not to answer
- Other

In case of answering “Other,” which one? _____

1.2. Interest and Socio Demographic survey in Spanish

1.1. Interest and Socio Demographic survey in Spanish

Encuesta de interés y sociodemográfica

Te invité a llenar un formulario:

Tesis primer respondiente en salud mental !!!

El autocuidado y el cuidado del otro son un balance en nuestra vida. Si estás interesado en participar en la tesis "Primer Respondiente en Salud Mental: Evaluación en la población colombiana en términos de prevención e intervención de Sustancias Psicoactivas" diligencia el siguiente formulario

Colombia, nuestro encanto de país

¿De qué se trata la tesis?

Mi nombre es Marjorie Ramos Salcedo, soy estudiante de Maestría de la Universidad Purdue Global. Actualmente me encuentro realizando una tesis de investigación para mi grado en Primer Respondiente en Salud Mental. La investigación tiene como modelo un sistema de prevención en salud que implica a toda la comunidad como red de apoyo, e intervención en crisis en adultos jóvenes para la prevención del uso o abuso de sustancias psicoactivas. Para lo cual se pretende aplicar pruebas psicotécnicas y el programa de Primer Respondiente en Salud Mental a personas que se encuentren involucradas en la comunidad. Una vez reciba su registro me pondré en contacto con usted.

Nombres y apellidos

Número de Cédula de Ciudadanía

Ciudad de residencia

Número de teléfono de contacto

Correo electrónico de contacto

¿Por qué medio se enteró sobre la tesis?

- Programa Mediadores Culturales Banco de la República
- Programa Investigadores Banco de la República
- Armada Nacional de Colombia
- Colegio Naval Armada Nacional
- Otro

En caso de contestar otro por favor indique dónde conoció sobre el estudio

¿Cuál es tu raza/etnia?

- Blanco/a
- Afro-Colombiano/a
- Raizal
- Palenquera
- Indígena
- Rom
- Gitana
- Mestizo
- Mulato
- Zambo
- Prefiero no contestar

¿Cuál es tu identidad de género?

- Mujer
- Hombre
- Transgénero

- No binaria/no conforme
- Prefiere no contestar
- Otra

En caso de escribir otra, ¿cuál?

Edad

¿Cuál es su nivel educativo?

- Primaria incompleta
- Primaria completa
- Bachillerato incompleto
- Bachillerato completo
- Técnico
- Tecnólogo
- Pregrado
- Posgrado - especialización
- Posgrado - maestría
- Posgrado - Doctorado
- Posgrado - Postdoctorado

¿Cuál es su último grado o diploma?

¿A qué se dedica en la actualidad?

¿Cuál es su estado civil?

- Soltero/a
- En una relación (sin estar casado/a)
- Casado/a

- Separado/a
- Viudo/a
- Prefiero no contestar
- Otro

En caso de contestar otro, ¿Cuál?

MHFR PRE-TEST AND POST-TEST IN ENGLISH

1. What is Mental Health First Response Training?

- Crisis and non-crisis mental health intervention skills training.
- Soliciting crisis response so that I could intervene and use my skills.
- A one-day or online training to those who would like to gain skills in mental health concerns, suicide prevention, and intervention.
- Feeling good about helping someone in crisis and able to display my new credentials.

2. What would be some of the signs of someone who is experiencing *emotional distress*?

- They are pacing back and forth.
- Their mood is down, sad, and they are talking about giving away their valuable possessions.
- They are feeling sad and depressed because they just lost their job, but they are not thinking of dying.
- I don't know.

3. What is one of the differences between a person experiencing a *mental health crisis situation* as opposed to someone experiencing *emotional distress*?

- During a mental health crisis, the life of the person might be in jeopardy, while someone in emotional distress is not actively thinking of ending their life.
- During a mental health crisis, the individual will not want to talk to you, while when in emotional distress they want to pour their heart out to you.
- There is no difference between a mental health crisis and emotional distress since both people are suffering.
- I don't know

4. Which statement is true about the MHFR crisis prevention & intervention model?

- It allows me to pinpoint their diagnosis in order to intervene.
- The model is reserved for those who are licensed to practice psychology, counseling, and psychotherapy.
- The model is available to the general public, it is flexible, easy to understand, and use.
- I don't know.

5. Is it more common to encounter a person in emotional distress rather than someone with a clear clinical diagnosis in daily life?

- Yes.
- No.
- I do not know.

6. Someone that you are working with needs to see someone for mental health – depression, anxiety, and PTSD. You would connect that person to see:

- A psychiatrist is the first thing that comes to mind for medication.
- Psychologist, Counselor or Mental Health Professional first and they could decide if they need to refer that person to a Psychiatrist.
- Social Worker.
- Pastor or Priest.

7. The person who is in crisis would be *more than likely* to be accompanied by their support system for further assessment and care.

- True.
- Falso.
- I do not know.

8. After a mental health crisis, follow-up care is important and the person should be encouraged to seek continuous care.

- Not at all.
- It will make them more embarrassed.
- Therapy is for those “may kaya” or rich.
- Follow-up care is important and resources should be offered while talking to them during the intervention.

9. The core skills of mental health first response training is the acronym?

- RULER
- ESTÍMATE
- ASSIST
- I don’t know.

10. Intervening in a crisis situation is only reserved for licensed mental health professionals like Psychologists, Counselors, and Psychiatrists.

- Yes
- No
- I do not know

MHFR PRE-TEST AND POST-TEST IN SPANISH

https://es.surveymonkey.com/r/3JNW9DM

1. ¿Qué es el entrenamiento de Primer Respondiente en Salud Mental?

- Un entrenamiento de habilidades para la intervención en crisis y no crisis
- Intervenir en respuesta a crisis para usar mis habilidades
- Un día de entrenamiento para aquellos que deseen obtener habilidades en problemas de salud mental, suicidio, prevención, e intervención.
- Sentirse bien para ayudar a otros en crisis y para obtener una credencial

2. ¿Cuáles son algunas señales de alguien que esté experimentando distrés emocional?

- Ellos están yendo de ida y vuelta
- Su emoción es baja, triste, y hablan de entregar sus posesiones más valiosas
- Se sienten tristes y deprimidos porque simplemente perdieron su trabajo, pero no están pensando en morir.
- No sé

3. ¿Cuál es una de las diferencias entre una persona que experimenta una situación de crisis en su salud mental y un que experimenta distrés emocional?

- Durante una crisis en salud mental, la vida de la persona se ve en peligro, mientras que en una situación de distrés emocional no hay un pensamiento activo de terminar con su vida.
- Durante una crisis en salud mental, el individuo no quisiera hablar contigo, mientras que en distrés emocional quisiera contarte todo lo que le pasa.
- No hay diferencia entre una crisis de salud mental y distrés emocional pues en cualquier caso la persona está sufriendo.
- No lo sé

4. ¿Qué frase es cierta sobre el modelo de prevención e intervención en crisis de MHFR?

- Me permite determinar con precisión el diagnóstico de un individuo para intervenir.
- El modelo está reservado para los psicólogos y psicoterapeutas
- El modelo está disponible para el público en general, es flexible y fácil de entender y usar.
- No lo sé

5. ¿Es más común encontrar a una persona con distrés emocional que una persona con un diagnóstico clínico en la vida cotidiana?

- Sí
- No
- No lo sé

6. Alguien con quien estás trabajando necesita un especialista en salud mental - depresión, ansiedad, y estrés postraumático. Puedes conectar a esa persona con:

- Un psiquiatra como primera opción para que lo medique.
- Un psicólogo, o profesional en salud mental primero y que decida si necesita referirlo a un psiquiatra.
- Un trabajador social
- Un sacerdote o pastor

7. Una persona en crisis deberá estar acompañada de su grupo de apoyo para futura evaluación y cuidado.

- Verdadero
- Falso
- No lo sé

8. Después de una crisis de salud mental, hacer seguimiento a la persona es importante y a la persona se le debe recomendar que busque cuidado continuo.

- Para nada
- Haré que la gente se sienta más avergonzada.
- La terapia es para los ricos
- El cuidado continuo es importante y los recursos deberían ser ofrecidos mientras se hable con la persona en la intervención

9. La sigla para las habilidades básicas del entrenamiento de primer respondiente en salud mental son:

- REGLA
- ESTÍMATE
- ASISTENCIA
- No lo sé

10. Intervenir en una situación de crisis está reservado solamente para los psicólogos o psiquiatras.

- Sí
- No
- No lo sé

MHFR ONLINE COURSE EVALUATION - ENGLISH

1. Knowledge of the subject matter.

- **Very Good**
- **Good**
- **Average**
- **Fair**
- **Needs Improvement**

2. Ability to explain and illustrate concepts.

- **Very Good**
- **Good**
- **Average**
- **Fair**
- **Needs Improvement**

3. The training helped me be more informed in terms of mental health awareness and intervention.

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

4. The training helped me understand that emotional distress, emotional support, or peer support is what I need to focus on instead of attempting to formulate a clinical diagnosis.

- Strongly Agree

- Agree
- Neutral
- Disagree
- Strongly Disagree

5. The training helped me understand that mental health awareness should be addressed in my community (work, school, church, Barangay, etc.) as a public health issue.

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

6. ***Prior*** *to this training* I had a good understanding of mental health in terms of crisis intervention.

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

7. During this training I *gained the basic skills* needed to intervene with someone who is having an emotional distress and/or suicidal ideation.

- Strongly Agree
- Agree
- Neutral

- Disagree
- Strongly Disagree

8. I have a *decent* understanding of the MHFR core skills, and I am ***willing*** to intervene appropriately in case of emotional distress, crisis, and provide peer support or emotional support.

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

9. The training enhanced my skills in terms of *creating a safety plan* when working with people who are in emotional distress.

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

10. What did you like about this training?

_____

_____

11. What do you recommend to improve the training?

_____

_____

_____

MHFR ONLINE COURSE EVALUATION - SPANISH

1. Conocimiento del tema de estudio.

- **Muy bueno**
- **Bueno**
- **Promedio**
- **Algo**
- **Necesita mejorar**

2. Habilidad para explicar e ilustrar conceptos.

- **Very Good**
- **Good**
- **Average**
- **Fair**
- **Needs Improvement**

3. La capacitación me ayudó a estar más informado en términos de concientización e intervención en salud mental.

- Completamente de acuerdo
- De acuerdo
- Neutral
- En desacuerdo
- Completamente en desacuerdo

4. La capacitación me ayudó a comprender que el distress emocional, el apoyo emocional o el apoyo a los compañeros son los factores en los que necesito concentrarme en lugar de intentar formular un diagnóstico clínico.

- Completamente de acuerdo
- De acuerdo
- Neutral
- En desacuerdo
- Completamente en desacuerdo

5. La capacitación me ayudó a comprender que la conciencia sobre la salud mental debe abordarse en mi comunidad (trabajo, escuela, iglesia, etc.) como un problema de salud pública.

- Completamente de acuerdo
- De acuerdo
- Neutral
- En desacuerdo
- Completamente en desacuerdo

6. ***Antes*** *de esta capacitación, tenía un buen conocimiento de la salud mental en términos de intervención en crisis.*

- Completamente de acuerdo
- De acuerdo
- Neutral
- En desacuerdo
- Completamente en desacuerdo

7. Durante esta capacitación, adquirí las habilidades básicas necesarias para intervenir con alguien que está teniendo distrés emocional y / o ideación suicida.

- Completamente de acuerdo
- De acuerdo

- Neutral
- En desacuerdo
- Completamente en desacuerdo

8. Tengo una comprensión general de las habilidades básicas de MHFR y estoy dispuesto a intervenir de manera apropiada en caso de distrés emocional, crisis, y brindar apoyo de pares o apoyo emocional.

- Completamente de acuerdo
- De acuerdo
- Neutral
- En desacuerdo
- Completamente en desacuerdo

9. La capacitación mejoró mis habilidades en términos de *crear un plan de seguridad* cuando trabajo con personas que se encuentran en problemas emocionales.

- Completamente de acuerdo
- De acuerdo
- Neutral
- En desacuerdo
- Completamente en desacuerdo

10. ¿Qué te gustó acerca del entrenamiento?

_____

11. ¿Qué recomiendas para que mejore el entrenamiento?

_____

_____

The Alcohol Use Disorders Identification Test: Interview Version - AUDIT

Read questions as written and record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks". Place the correct answer number in the box at the right.

1. How often do you have a drink containing alcohol? (0) Never (skip to Questions 9 and10) (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week	**6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?** (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
2. How many drinks containing alcohol do you have on a typical day when you are drinking? (0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more	**7. How often during the last year have you had a feeling of guilt or remorse after drinking?** (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

3. How often do you have six or more drinks on one occasion? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0	**8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?** (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	**9. Have you or someone else been injured as a result of your drinking?** (0) No (2) Yes but not in the last year (4) Yes during the last year
5. How often during the last year have you failed to do what was normally expected from you because of drinking? (0) Never (1) Less than monthly	**10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?** (0) No (2) Yes but not in the last year

(2) Monthly (3) Weekly (4) Daily or almost daily	(4) Yes during the last year
	Record total of specific items here

Cuadro 4

Test de Identificación de Trastornos por consumo de alcohol: versión de entrevista.

Lea las preguntas tal como están escritas. Registre las respuestas cuidadosamente. Empiece el AUDIT diciendo «Ahora voy a hacerle algunas preguntas sobre su consumo de bebidas alcohólicas durante el último año». Explique qué entiende por «bebidas alcohólicas» utilizando ejemplos típicos como cerveza, vino, vodka, etc. Codifique las respuestas en términos de consumiciones («bebidas estándar»). Marque la cifra de la respuesta adecuada en el recuadro de la derecha.

1. ¿Con qué frecuencia consume alguna bebida alcohólica?
   (0) Nunca (Pase a las preguntas 9-10)
   (1) Una o menos veces al mes
   (2) De 2 a 4 veces al mes
   (3) De 2 a 3 veces a la semana
   (4) 4 o más veces a la semana

2. ¿Cuantas consumiciones de bebidas alcohólicas suele realizar en un día de consumo normal?
   (0) 1 o 2
   (1) 3 o 4
   (2) 5 o 6
   (3) 7, 8, o 9
   (3) 10 o más

3. ¿ Con qué frecuencia toma 6 o más bebidas alcohólicas en un solo día?
   (0) Nunca
   (1) Menos de una vez al mes
   (2) Mensualmente
   (3) Semanalmente
   (4) A diario o casi a diario
   Pase a las preguntas 9 y 10 si la suma total de las preguntas 2 y 3 = 0

4. ¿Con qué frecuencia en el curso del último año ha sido incapaz de parar de beber una vez había empezado?
   (0) Nunca
   (1) Menos de una vez al mes
   (2) Mensualmente
   (3) Semanalmente
   (4) A diario o casi a diario

5. ¿Con qué frecuencia en el curso del último año no pudo hacer lo que se esperaba de usted porque había bebido?
   (0) Nunca
   (1) Menos de una vez al mes
   (2) Mensualmente
   (3) Semanalmente
   (4) A diario o casi a diario

6. ¿Con qué frecuencia en el curso del último año ha necesitado beber en ayunas para recuperarse después de haber bebido mucho el día anterior?
   (0) Nunca
   (1) Menos de una vez al mes
   (2) Mensualmente
   (3) Semanalmente
   (4) A diario o casi a diario

7. ¿Con qué frecuencia en el curso del último año ha tenido remordimientos o sentimientos de culpa después de haber bebido?.
   (0) Nunca
   (1) Menos de una vez al mes
   (2) Mensualmente
   (3) Semanalmente
   (4) A diario o casi a diario

8. ¿Con qué frecuencia en el curso del último año no ha podido recordar lo que sucedió la noche anterior porque había estado bebiendo?
   (0) Nunca
   (1) Menos de una vez al mes
   (2) Mensualmente
   (3) Semanalmente
   (4) A diario o casi a diario

9. ¿Usted o alguna otra persona ha resultado herido porque usted había bebido?
   (0) No
   (2) Sí, pero no en el curso del último año
   (4) Sí, el último año

10. ¿Algún familiar, amigo, médico o profesional sanitario ha mostrado preocupación por su consumo de bebidas alcohólicas o le han sugerido que deje de beber?
    (0) No
    (2) Sí, pero no en el curso del último año
    (4) Sí, el último año.

Registre la puntuación total aquí

Si la puntuación total es mayor que el punto de corte recomendado, consulte el Manual de Usuario

A. WHO - ASSIST V3.0

INTERVIEWER ID _____ COUNTRY _____ CLINIC _____

PATIENT ID _____ DATE _____

INTRODUCTION *(Please read to patient)*

Thank you for agreeing to take part in this brief interview about alcohol, tobacco products and other drugs. I am going to ask you some questions about your experience of using these substances across your lifetime and in the past three months. These substances can be smoked, swallowed, snorted, inhaled, injected or taken in the form of pills (show drug card).

Some of the substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, we will not record medications that are used as prescribed by your doctor. However, if you have taken such medications for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know. While we are also interested in knowing about your use of various illicit drugs, please be assured that information on such use will be treated as strictly confidential.

NOTE: BEFORE ASKING QUESTIONS, GIVE ASSIST RESPONSE CARD TO PATIENT

Question 1
(If completing follow-up please cross check the patient's answers with the answers given for Q1 at baseline. Any differences on this question should be queried)

In your life, which of the following substances have you ever used? *(NON-MEDICAL USE ONLY)*	No	Yes
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3
d. Cocaine (coke, crack, etc.)	0	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3
j. Other - specify:	0	3

Probe if all answers are negative:
"Not even when you were in school?"

If "No" to all items, stop interview.

If "Yes" to any of these items, ask Question 2 for each substance ever used.

Question 2

In the past three months, how often have you used the substances you mentioned *(FIRST DRUG, SECOND DRUG, ETC)*?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
d. Cocaine (coke, crack, etc.)	0	2	3	4	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	2	3	4	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	2	3	4	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	2	3	4	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	2	3	4	6
j. Other - specify:	0	2	3	4	6

If "Never" to all items in Question 2, skip to Question 6.

If any substances in Question 2 were used in the previous three months, continue with Questions 3, 4 & 5 for each substance used.

Question 3

During the past three months, how often have you had a strong desire or urge to use *(FIRST DRUG, SECOND DRUG, ETC)*?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3	4	5	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3	4	5	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
d. Cocaine (coke, crack, etc.)	0	3	4	5	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3	4	5	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3	4	5	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3	4	5	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3	4	5	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3	4	5	6
j. Other - specify:	0	3	4	5	6

Question 4

During the past three months, how often has your use of *(FIRST DRUG, SECOND DRUG, ETC)* led to health, social, legal or financial problems?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	4	5	6	7
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	4	5	6	7
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
d. Cocaine (coke, crack, etc.)	0	4	5	6	7
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	4	5	6	7
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	4	5	6	7
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	4	5	6	7
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	4	5	6	7
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	4	5	6	7
j. Other - specify:	0	4	5	6	7

Question 5

During the past three months, how often have you failed to do what was normally expected of you because of your use of *(FIRST DRUG, SECOND DRUG, ETC)*?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products					
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	5	6	7	8
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
d. Cocaine (coke, crack, etc.)	0	5	6	7	8
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	5	6	7	8
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	5	6	7	8
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	5	6	7	8
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	5	6	7	8
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	5	6	7	8
j. Other - specify:	0	5	6	7	8

Ask Questions 6 & 7 for all substances ever used (i.e. those endorsed in Question 1)

Question 6

Has a friend or relative or anyone else ever expressed concern about your use of *(FIRST DRUG, SECOND DRUG, ETC.)*?	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other – specify:	0	6	3

Question 7

Have you ever tried and failed to control, cut down or stop using *(FIRST DRUG, SECOND DRUG, ETC.)*?	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other – specify:	0	6	3

Question 8

	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
Have you ever used any drug by injection? *(NON-MEDICAL USE ONLY)*	0	2	1

IMPORTANT NOTE:

Patients who have injected drugs in the last 3 months should be asked about their pattern of injecting during this period, to determine their risk levels and the best course of intervention.

PATTERN OF INJECTING		INTERVENTION GUIDELINES
Once weekly or less Fewer than 3 days in a row	or	Brief intervention including "risks associated with injecting" card
More than once per week 3 or more days in a row	or	Further assessment and more intensive treatment*

HOW TO CALCULATE A SPECIFIC SUBSTANCE INVOLVEMENT SCORE.

For each substance (labelled a. to j.) add up the scores received for questions 2 through 7 inclusive. Do not include the results from either Q1 or Q8 in this score. For example, a score for cannabis would be calculated as: **Q2c + Q3c + Q4c + Q5c + Q6c + Q7c**

Note that Q5 for tobacco is not coded, and is calculated as: **Q2a + Q3a + Q4a + Q6a + Q7a**

THE TYPE OF INTERVENTION IS DETERMINED BY THE PATIENT'S SPECIFIC SUBSTANCE INVOLVEMENT SCORE

	Record specific substance score	no intervention	receive brief intervention	more intensive treatment *
a. tobacco		0 - 3	4 - 26	27+
b. alcohol		0 - 10	11 - 26	27+
c. cannabis		0 - 3	4 - 26	27+
d. cocaine		0 - 3	4 - 26	27+
e. amphetamine		0 - 3	4 - 26	27+
f. inhalants		0 - 3	4 - 26	27+
g. sedatives		0 - 3	4 - 26	27+
h. hallucinogens		0 - 3	4 - 26	27+
i. opioids		0 - 3	4 - 26	27+
j. other drugs		0 - 3	4 - 26	27+

NOTE: *FURTHER ASSESSMENT AND MORE INTENSIVE TREATMENT may be provided by the health professional(s) within your primary care setting, or, by a specialist drug and alcohol treatment service when available.

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ENTREVISTADOR _____ PAÍS ____ CLÍNICA _____

Nº PARTICIPANTE _____ FECHA ____/____/____

INTRODUCCIÓN *(Léalo por favor al participante)*

Gracias por aceptar a participar en esta breve entrevista sobre el alcohol, tabaco y otras drogas. Le voy hacer algunas preguntas sobre su experiencia de consumo de sustancias a lo largo de su vida, así como en los últimos tres meses. Estas sustancias pueden ser fumadas, ingeridas, inhaladas, inyectadas o consumidas en forma de pastillas (muestre la tarjeta de drogas).

Algunas de las sustancias incluidas pueden haber sido recetadas por un médico (p.ej. pastillas adelgazantes, tranquilizantes, o determinados medicamentos para el dolor). Para esta entrevista, no vamos a anotar fármacos que hayan sido consumidos tal como han sido prescritos por su médico. Sin embargo, si ha tomado alguno de estos medicamentos por motivos distintos a los que fueron prescritos o los toma más frecuentemente o a dosis más altas a las prescritas, entonces díganoslo. Si bien estamos interesados en conocer su consumo de diversas drogas, por favor tenga por seguro que esta información será tratada con absoluta confidencialidad.

NOTA: ANTES DE FORMULAR LAS PREGUNTAS, ENTREGUE LAS TARJETAS DE RESPUESTA A LOS PARTICIPANTES

Pregunta 1

(al completar el seguimiento compare por favor las respuestas del participante con las que dio a la P1 del cuestionario basal. Cualquier diferencia en esta pregunta deben ser exploradas)

A lo largo de su vida, ¿cual de las siguientes sustancias ha consumido alguna vez? *(SOLO PARA USOS NO-MÉDICOS)*	**No**	**Si**
a. Tabaco (cigarrillos, cigarros habanos, tabaco de mascar, pipa, etc.)	0	3
b. Bebidas alcohólicas (cerveza, vino, licores, destilados, etc.)	0	3
c. Cannabis (marihuana, costo, hierba, hashish, etc.)	0	3
d. Cocaína (coca, farlopa, crack, base, etc.)	0	3
e. Anfetaminas u otro tipo de estimulantes (speed, éxtasis, píldoras adelgazantes, etc.)	0	3
f. Inhalantes (colas, gasolina/nafta, pegamento, etc.)	0	3
g. Tranquilizantes o pastillas para dormir (valium/diazepam, Trankimazin/Alprazolam/Xanax, Orfidal/Lorazepam, Rohipnol, etc.)	0	3
h. Alucinógenos (LSD, ácidos, ketamina, PCP, etc.)	0	3
i. Opiáceos (heroína, metadona, codeína, morfina, dolantina/petidina, etc.)	0	3
j. Otros - especifique:	0	3

Compruebe si todas las respuestas son negativas:
"¿Tampoco incluso cuando iba al colegio?"

Si contestó "No" a todos los ítems, pare la entrevista.

Si contestó "Sí" a alguno de estos ítems, siga a la Pregunta 2 para cada sustancia que ha consumido alguna vez.

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Pregunta 2

¿Con qué frecuencia ha consumido las sustancias que ha mencionado en los <u>últimos tres meses</u>, *(PRIMERA DROGA, SEGUNDA DROGA, ETC)*?	Nunca	1 ó 2 veces	Cada mes	Cada semana	A diario o casi a diario
a. Tabaco (cigarrillos, cigarros habanos, tabaco de mascar, pipa, etc.)	0	2	3	4	6
b. Bebidas alcohólicas (cerveza, vino, licores, destilados, etc.)	0	2	3	4	6
c. Cannabis (marihuana, costo, hierba, hashish, etc.)	0	2	3	4	6
d. Cocaína (coca, farlopa, crack, etc.)	0	2	3	4	6
e. Anfetaminas u otro tipo de estimulantes (speed, éxtasis, píldoras adelgazantes, etc.)	0	2	3	4	6
f. Inhalantes (colas, gasolina/nafta, pegamento, etc.)	0	2	3	4	6
g. Tranquilizantes o pastillas para dormir (valium/diazepam, Trankimazin/Alprazolam/Xanax, Orfidal/Lorazepam, Rohipnol, etc.)	0	2	3	4	6
h. Alucinógenos (LSD, ácidos, ketamina, PCP, etc.)	0	2	3	4	6
i. Opiáceos (heroína, metadona, codeína, morfina, dolantina/petidina, etc.)	0	2	3	4	6
j. Otros - especifique:	0	2	3	4	6

Si ha respondido "Nunca" a todos los items en la Pregunta 2, salte a la Pregunta 6.

Si ha consumido alguna de las sustancias de la Pregunta 2 en los últimos tres meses, continúe con las preguntas 3, 4 & 5 para cada una de las sustancias que ha consumido.

Pregunta 3

En los <u>últimos tres meses</u>, ¿con qué frecuencia ha tenido deseos fuertes o ansias de consumir *(PRIMERA DROGA, SEGUNDA DROGA, ETC)*?	Nunca	1 ó 2 veces	Cada mes	Cada semana	A diario o casi a diario
a. Tabaco (cigarrillos, cigarros habanos, tabaco de mascar, pipa, etc.)	0	3	4	5	6
b. Bebidas alcohólicas (cerveza, vino, licores, destilados, etc.)	0	3	4	5	6
c. Cannabis (marihuana, costo, hierba, hashish, etc.)	0	3	4	5	6
d. Cocaína (coca, farlopa, crack, etc.)	0	3	4	5	6
e. Anfetaminas u otro tipo de estimulantes (speed, éxtasis, píldoras adelgazantes, etc.)	0	3	4	5	6
f. Inhalantes (colas, gasolina/nafta, pegamento, etc.)	0	3	4	5	6
g. Tranquilizantes o pastillas para dormir (valium/diazepam, Trankimazin/Alprazolam/Xanax, Orfidal/Lorazepam, Rohipnol, etc.)	0	3	4	5	6
h. Alucinógenos (LSD, ácidos, ketamina, PCP, etc.)	0	3	4	5	6
i. Opiáceos (heroína, metadona, codeína, morfina, dolantina/petidina, etc.)	0	3	4	5	6
j. Otros - especifique:	0	3	4	5	6

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Pregunta 4

En los <u>últimos tres meses</u>, ¿con qué frecuencia le ha llevado su consumo de *(PRIMERA DROGA, SEGUNDA DROGA, ETC)* a problemas de salud, sociales, legales o económicos?	Nunca	1 ó 2 veces	Cada mes	Cada semana	A diario o casi a diario
a. Tabaco (cigarrillos, cigarros habanos, tabaco de mascar, pipa, etc.)	0	4	5	6	7
b. Bebidas alcohólicas (cerveza, vino, licores, destilados, etc.)	0	4	5	6	7
c. Cannabis (marihuana, costo, hierba, hashish, etc.)	0	4	5	6	7
d. Cocaína (coca, farlopa, crack, etc.)	0	4	5	6	7
e. Anfetaminas u otro tipo de estimulantes (speed, éxtasis, píldoras adelgazantes, etc.)	0	4	5	6	7
f. Inhalantes (colas, gasolina/nafta, pegamento, etc.)	0	4	5	6	7
g. Tranquilizantes o pastillas para dormir (valium/diazepam, Trankimazin/Alprazolam/Xanax, Orfidal/Lorazepam, Rohipnol, etc.)	0	4	5	6	7
h. Alucinógenos (LSD, ácidos, ketamina, PCP, etc.)	0	4	5	6	7
i. Opiáceos (heroína, metadona, codeína, morfina, dolantina/petidina, etc.)	0	4	5	6	7
j. Otros - especifique:	0	4	5	6	7

Pregunta 5

En los <u>últimos tres meses</u>, ¿con qué frecuencia dejó de hacer lo que se esperaba de usted habitualmente por el consumo de *(PRIMERA DROGA, SEGUNDA DROGA, ETC)*?	Nunca	1 ó 2 veces	Cada mes	Cada semana	A diario o casi a diario
a. Tabaco					
b. Bebidas alcohólicas (cerveza, vino, licores, destilados, etc.)	0	5	6	7	8
c. Cannabis (marihuana, costo, hierba, hashish, etc.)	0	5	6	7	8
d. Cocaína (coca, farlopa, crack, etc.)	0	5	6	7	8
e. Anfetaminas u otro tipo de estimulantes (speed, éxtasis, píldoras adelgazantes, etc.)	0	5	6	7	8
f. Inhalantes (colas, gasolina/nafta, pegamento, etc.)	0	5	6	7	8
g. Tranquilizantes o pastillas para dormir (valium/diazepam, Trankimazin/Alprazolam/Xanax, Orfidal/Lorazepam, Rohipnol, etc.)	0	5	6	7	8
h. Alucinógenos (LSD, ácidos, ketamina, PCP, etc.)	0	5	6	7	8
i. Opiáceos (heroína, metadona, codeína, morfina, dolantina/petidina, etc.)	0	5	6	7	8
j. Otros - especifique:	0	5	6	7	8

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Haga las preguntas 6 y 7 para todas las sustancias que ha consumido alguna vez (es decir, aquellas abordadas en la Pregunta 1)

Pregunta 6

¿Un amigo, un familiar o alguien más alguna vez ha mostrado preocupación por su consume de *(PRIMERA DROGA, SEGUNDA DROGA, ETC)*?	No, Nunca	Si, en los últimos 3 meses	Si, pero no en los últimos 3 meses
a. Tabaco (cigarrillos, cigarros habanos, tabaco de mascar, pipa, etc.)	0	6	3
b. Bebidas alcohólicas (cerveza, vino, licores, destilados, etc.)	0	6	3
c. Cannabis (marihuana, costo, hierba, hashish, etc.)	0	6	3
d. Cocaína (coca, farlopa, crack, etc.)	0	6	3
e. Anfetaminas u otro tipo de estimulantes (speed, éxtasis, píldoras adelgazantes, etc.)	0	6	3
f. Inhalantes (colas, gasolina/nafta, pegamento, etc.)	0	6	3
g. Tranquilizantes o pastillas para dormir (valium/diazepam, Trankimazin/Alprazolam/Xanax, Orfidal/Lorazepam, Rohipnol, etc.)	0	6	3
h. Alucinógenos (LSD, ácidos, ketamina, PCP, etc.)	0	6	3
i. Opiáceos (heroína, metadona, codeína, morfina, dolantina/petidina, etc.)	0	6	3
j. Otros - especifique:	0	6	3

Pregunta 7

¿Ha intentado alguna vez controlar, reducir o dejar de consumir *(PRIMERA DROGA, SEGUNDA DROGA, ETC)* y no lo ha logrado?	No, Nunca	Si, en los últimos 3 meses	Si, pero no en los últimos 3 meses
a. Tabaco (cigarrillos, cigarros habanos, tabaco de mascar, pipa, etc.)	0	6	3
b. Bebidas alcohólicas (cerveza, vino, licores, destilados, etc.)	0	6	3
c. Cannabis (marihuana, costo, hierba, hashish, etc.)	0	6	3
d. Cocaína (coca, farlopa, crack, etc.)	0	6	3
e. Anfetaminas u otro tipo de estimulantes (speed, éxtasis, píldoras adelgazantes, etc.)	0	6	3
f. Inhalantes (colas, gasolina/nafta, pegamento, etc.)	0	6	3
g. Tranquilizantes o pastillas para dormir (valium/diazepam, Trankimazin/Alprazolam/Xanax, Orfidal/Lorazepam, Rohipnol, etc.)	0	6	3
h. Alucinógenos (LSD, ácidos, ketamina, PCP, etc.)	0	6	3
i. Opiáceos (heroína, metadona, codeína, morfina, dolantina/petidina, etc.)	0	6	3
j. Otros - especifique:	0	6	3

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Pregunta 8

	No, Nunca	Si, en los últimos 3 meses	Si, pero no en los últimos 3 meses
¿Ha consumido <u>alguna vez</u> alguna droga por via inyectada? *(ÚNICAMENTE PARA USOS NO MÉDICOS)*	0	2	1

NOTA IMPORTANTE:

A los pacientes que se han inyectado drogas en los últimos 3 meses se les debe preguntar sobre su patrón de inyección en este periodo, para determinar los niveles de riesgo y el mejor tipo de intervención.

PATRÓN DE INYECCIÓN	GUÍAS DE INTERVENCIÓN
Una vez a la semana o menos o Menos de 3 días seguidos	Intervención Breve, incluyendo la tarjeta "riesgos asociados con inyectarse"
Más de una vez a la semana o 3 o más días seguidos	Requiere mayor evaluación y tratamiento más intensivo *

CÓMO CALCULAR UNA PUNTUACIÓN ESPECÍFICA PARA CADA SUSTANCIA.

Para cada sustancia (etiquetadas de la **a.** la **j.**) sume las puntuaciones de las preguntas 2 a la 7, ambas inclusive. No incluya los resultados ni de la pregunta 1 ni de la 8 en esta puntuación. Por ejemplo, la puntuación para el cannabis se calcula como: **P2c + P3c + P4c + P5c + P6c + P7c**

Note que la P5 para el tabaco no está codificada, y se calcula como: **P2a + P3a + P4a + P6a + P7a**

EL TIPO DE INTERVENCIÓN SE DETERMINA POR LA PUNTUACIÓN ESPECÍFICA DEL PACIENTE PARA CADA SUSTANCIA

	Registre la puntuación para sustancia especifica	Sin intervención	Intervención Breve	Tratamiento más intensivo *
a. tabaco		0 – 3	4 – 26	27+
b. alcohol		0 – 10	11 – 26	27+
c. cannabis		0 – 3	4 – 26	27+
d. cocaína		0 – 3	4 – 26	27+
e. anfetaminas		0 – 3	4 – 26	27+
f. inhalantes		0 – 3	4 – 26	27+
g. sedantes		0 – 3	4 – 26	27+
h. alucinógenos		0 – 3	4 – 26	27+
i. opiáceos		0 – 3	4 – 26	27+
j. otras drogas		0 – 3	4 – 26	27+

NOTA: *UNA MAYOR EVALUACIÓN Y TRATAMIENTO MÁS INTENSIVO puede ser proporcionado por profesionales sanitarios dentro del ámbito de Atención Primaria, o por un servicio especializado para las adicciones cuando esté disponible.

APPENDIX E

PURDUE UNIVERSITY GLOBAL

Institutional Review Board
550 West Van Buren
Chicago, Illinois 60607

Expedited Review – Final Approval

March 17, 2022

Ms. Marjorie Ramos-Salcedo
Purdue University Global
marjorieramos1@student.purdueglobal.edu

Re: Protocol #22-13 – "**Mental Health First Response (MHFR) Program: Assessing the Mental Health First Response of the Colombian Population in Terms of Prevention and Intervention of Substance Use Disorder.**"

Dear Ms. Ramos-Salcedo:

Your proposed project was reviewed by the Purdue University Global Institutional Review Board (IRB) for the protection of human subjects under an Expedited Category. It was determined that your project activity meets the expedited criteria as defined by the DHHS Regulations for the Protection of Human Subjects (45 CFR 46), and is in compliance with this institution's Federal Wide Assurance 00010056.

Please notify the IRB immediately of any proposed changes that may affect the expedited status of your project. You should report any unanticipated problems involving risks to human subjects or others to the IRB.

If you have any questions or need additional information, please contact feel free to contact me at spettine@purdueglobal.edu. I wish you well with your project!

Sincerely,

Susan B. Pettine

Susan B. Pettine, Ph.D., CBM
IRB Chair
Purdue University Global

Appendix F

Tables and Figures

Table 1

Respondents' Sociodemographic Characteristics (N=75)

Statistics

		Etnia	Gender	Educat	Age	Marital Status	Org.	City
N	Valid	74	75	75	73	75	75	74
	Lost	1	0	0	2	0	0	1
Mean		3.50	1.39	3.23	35.65	2.35	1.92	4.12
Median		3.00	1.00	4.00	35.00	2.00	1.00	4.00
Mode		3	1	4	29[a]	2	1	4
Mínimum		1	1	1	22	1	1	1
Maximum		10	2	5	55	5	4	12

a. There are different modes. It shows the lower values.

Table 1.1

Respondents' Sociodemographic Characteristics (N=75)

Colombian etnia		**Frequency**	**Percentage**	**Valid Percentage**	**Cumulative Percentage**
Valid	White	9	12.0	12.2	12.2
	African-Colombian	7	9.3	9.5	21.6
	Mestizo	48	64.0	64.9	86.5
	Indigenous	2	2.7	2.7	89.2
	No response	8	10.7	10.8	100
	Total	74	98.7	100	
Participant failed to answer this question		1	1.3		
Total		75	100		
Gender					
Valid	Woman	46	61.3	61,3	61.3
	Man	29	38.7	38,7	100
	Total	75	100	100,0	
Level of education					
Valid	Technical	21	28	28	28

Secondary School	13	17.3	17.3	45.3
Undergraduate	23	30.7	30.7	76.0
Graduate	18	24	24.0	100
Total	75	100	100	

Age of the participant		Frecuencia	Porcentaje	Porcentaje válido	Porcentaje acumulado
Valid	22	1	1.3	1.4	1.4
	23	2	2.7	2.8	4.2
	24	4	5.3	5.6	9.7
	25	1	1.3	1.4	11.1
	26	4	5.3	5.6	16.7
	27	1	1.3	1.4	18.1
	28	2	2.7	2.8	20.8
	29	5	6.7	6.9	27.8
	30	1	1.3	1.4	29.2
	31	4	5.3	5.6	34.7
	32	5	6.7	6.9	41.7

33	3	4	4.2	45.8
34	1	1.3	1.4	47.2
35	3	4	4.2	51.4
36	3	4	4.2	55.6
37	3	4	4.2	59.7
38	5	6.7	6.9	66.7
39	3	4	4.2	70.8
40	2	2.7	2.8	73.6
41	4	5.3	5.6	79.2
43	1	1.3	1.4	80.6
44	2	2.7	2.8	83.3
45	2	2.7	2.8	86.1
47	2	2.7	2.8	88.9
49	3	4	4.2	93.1
50	1	1.3	1.4	94.4
51	1	1.3	1.4	95.8
53	2	2.7	2.8	98.6
55	1	1.3	1.4	100

	Total	72	96	100	
Participants failed to answer this question		3	4		
Total		75	100		

Marital Status

Valid	Single	18	24	24	24
	Married	38	50.7	50.7	74.7
	Divorced	6	8	8	82.7
	Widow	1	1.3	1.3	84
	Cohabiting	12	16	16	100
	Total	75	100	100	

Organization of the participant

Valid	Navy Unit	38	50.7	50.7	50.7
	Naval School	15	20	20	70.7
	Republican Bank	12	16	16	86.7
	Other	10	13.3	13.3	100

	Total	75	100	100	
		Frequency	%	Valido %	Cumulative %
Valid	Bogotá	6	8.0	8.1	8.1
	Barranquilla	2	2.7	2.7	10.8
	Cartagena	5	6.7	6.8	17.6
	Puerto Leguízamo	53	70.7	71.6	89.2
	Popayán	1	1.3	1.4	90.5
	Florencia	1	1.3	1.4	91.9
	Pasto	1	1.3	1.4	93.2
	Garzón	1	1.3	1.4	94.6
	Rivera	1	1.3	1.4	95.9
	Pamplona	1	1.3	1.4	97.3
	Pereira	1	1.3	1.4	98.6
	Other country	1	1.3	1.4	100
	Total	74	98.7	100	
Participant failed to		1	1.3		

answer this question		
Total	75	100

Table 1.2

Demographics of the participants who finished the course N=28

Colombian etnia	Frecuencia	Porcentaje	Porcentaje válido	Porcentaje acumulado
White	5	17,9	20,8	20,8
African-Colombian	1	3,6	4,2	25
Mestizo	17	60,7	70,8	95,8
Indigenous	1	3,6	4,2	100
Total	24	85,7	100	
Did not response	4	14,3		
Total	28	100		
Gender	Frecuencia	Porcentaje	Porcentaje válido	Porcentaje acumulado
Woman	23	82,1	82,1	82,1

Man	5	17,9	17,9	100
Total	28	100	100	
Level of education	Frecuencia	Porcentaje	Porcentaje válido	Porcentaje acumulado
Technical	4	14,3	14,3	14,3
Secondary School	3	10,7	10,7	25
Undergraduate	14	50	50	75
Graduate	7	25	25	100
Total	28	100	100	
Age	Frecuencia	Porcentaje	Porcentaje válido	Porcentaje acumulado
24	1	3,6	3,7	3,7
26	3	10,7	11,1	14,8
28	1	3,6	3,7	18,5
29	2	7,1	7,4	25,9
30	1	3,6	3,7	29,6
31	1	3,6	3,7	33,3
32	2	7,1	7,4	40,7
33	1	3,6	3,7	44,4

34	1	3,6	3,7	48,1
35	1	3,6	3,7	51,9
36	1	3,6	3,7	55,6
37	2	7,1	7,4	63
38	1	3,6	3,7	66,7
39	1	3,6	3,7	70,4
43	1	3,6	3,7	74,1
44	1	3,6	3,7	77,8
47	1	3,6	3,7	81,5
49	2	7,1	7,4	88,9
53	2	7,1	7,4	96,3
55	1	3,6	3,7	100
Total	27	96,4	100	
Did not response	1	3,6		
Total	28	100		

Marital Status	Frecuencia	Porcentaje	Porcentaje válido	Porcentaje acumulado
Single	7	25	25	25
Married	14	50	50	75

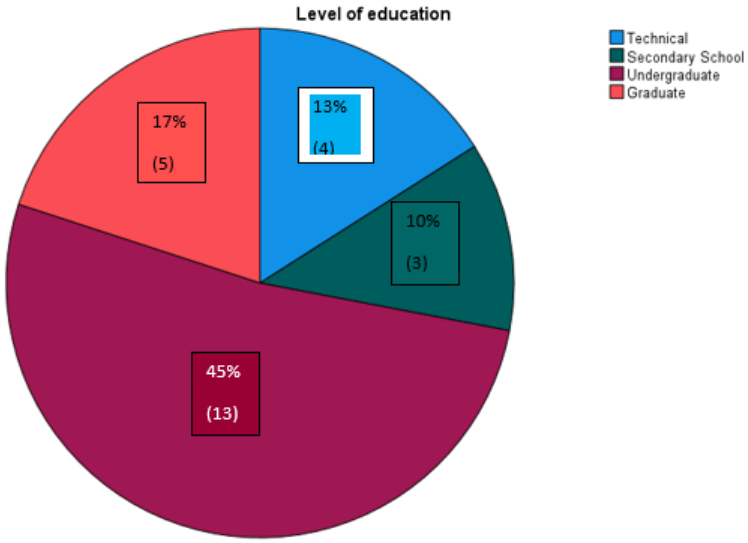
Divorced	3	10,7	10,7	85,7
Widow	1	3,6	3,6	89,3
Cohabiting	3	10,7	10,7	100
Total	28	100	100	

Organization	Frecuencia	Porcentaje	Porcentaje válido	Porcentaje acumulado
Navy Unit	9	32,1	32,1	32,1
Naval School	14	50	50	82,1
Republican Bank	5	17,9	17,9	100
Total	28	100	100	

Residence	Frecuencia	Porcentaje	Porcentaje válido	Porcentaje acumulado
Barranquilla	1	3,6	3,6	3,6
Cartagena	3	10,7	10,7	14,3
Puerto Leguízamo	22	78,6	78,6	92,9
Rivera	1	3,6	3,6	96,4
Pereira	1	3,6	3,6	100
Total	28	100	100	

Figure 1

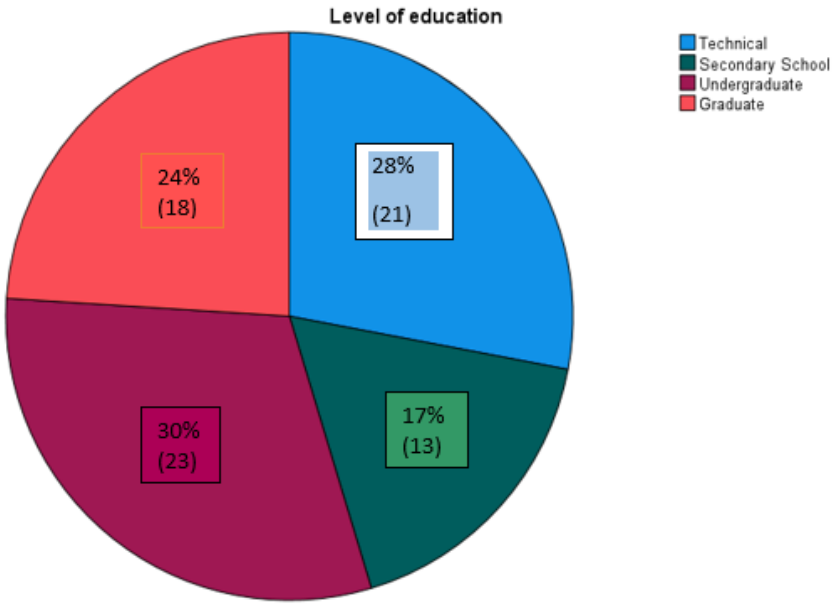
Level of Education



Note. The circle diagram is to show the level of education of the total population who initially register to the research

Figure 1.2

Level of Education



Note. The pie diagram of Figure 1.2 shows the level of education of the participants who did all the process including ending the training.

Table 2.

C-SSRS Statistics

		Q_Ideation_life	Q_Ideation_last_month	Q_Ideation_intensity_life	Q_Ideation_intensity_last_month	Q_Suicide_behavior_life	Q_Suicide_behavior_past3months	Q_letality_life	Q_letality_past_3_months
N	Valid	47	47	47	47	47	47	47	47
	Lost	0	0	0	0	0	0	0	0
Mean		0.7	0.15	3.38	1.53	0.32	0.13	0.21	0.13
Median		0	0	0	0	0	0	0	0

Mode	0	0	0	0	0	0	0	0
Standard Dev.	1.4	0.625	6.523	4.745	1.045	0.536	0.858	0.647
Minimum	0	0	0	0	0	0	0	0
Máximum	5	4	26	26	5	3	4	4

Table 2.2

C-SSRS Statistics

Ideation Life		Frequency	%	Valid %	Cumulative %
Valid	0	31	66.0	66.0	66.0
	1	8	17.0	17.0	83.0
	2	4	8.5	8.5	91.5
	4	1	2.1	2.1	93.6
	5	3	6.4	6.4	100
	Total	47	100	100	
Ideation Last Month					
Valid	0	43	91.5	91.5	91.5

	1	3	6.4	6.4	97.9
	4	1	2.1	2.1	100
	Total	47	100	100	

Q_Ideation_intensity_life

Valid	0	35	74.5	74.5	74.5
	5	1	2.1	2.1	76.6
	8	1	2.1	2.1	78.7
	10	3	6.4	6.4	85.1
	11	1	2.1	2.1	87.2
	12	2	4.3	4.3	91.5
	16	1	2.1	2.1	93.6
	18	1	2.1	2.1	95.7
	21	1	2.1	2.1	97.9
	26	1	2.1	2.1	100
	Total	47	100	100	

Q_Ideation_intensity_last_month

Valid	0	40	85.1	85.1	85.1
	1	1	2.1	2.1	87.2

	2	1	2.1	2.1	89.4
	10	2	4.3	4.3	93.6
	11	1	2.1	2.1	95.7
	12	1	2.1	2.1	97.9
	26	1	2.1	2.1	100
	Total	47	100	100	

Q_Suicide_behavior_life

Valid	0	42	89.4	89.4	89.4
	1	1	2.1	2.1	91.5
	2	1	2.1	2.1	93.6
	3	1	2.1	2.1	95.7
	4	1	2.1	2.1	97.9
	5	1	2.1	2.1	100
	Total	47	100	100	

Q_Suicide_behavior_past3months

Valid	0	44	93.6	93.6	93.6
	1	1	2.1	2.1	95.7
	2	1	2.1	2.1	97.9

	3	1	2.1	2.1	100
	Total	47	100	100	
Q_letality_life					
Valid	0	44	93.6	93.6	93.6
	2	1	2.1	2.1	95.7
	4	2	4.3	4.3	100
	Total	47	100	100	
Q_letality_past_3_months		Frecuencia	Porcentaje	Porcentaje válido	Porcentaje acumulado
Válido	0	45	95.7	95.7	95.7
	2	1	2.1	2.1	97.9
	4	1	2.1	2.1	100
	Total	47	100	100	

Table 3

Substances Used by the Participants through their life

Scores	Q_Total

N	Valid	68	68
	Lost	0	0
Mean		2.28	7.10
Median		2	5.00
Mode		2	3
Standard Deviation		1.495	6.244
Minimum		0	0
Maximum		8	29

Note. The substances used by the participants are shown in the table according to their self rapport in the ASSIST questionnaire.

Table 3.1

Substances Used by the Participants through their life

	N	%
None	1	1,5%

Tobacco	12	17,6%
Alcohol	44	64,7%
Cannabis	4	5,9%
Cocaine	2	2,9%
Inhalants	1	1,5%
Sleep pills	3	4,4%
Hallucinogens	1	1,5%

Note. The table shows 68 times were the participants used and/or abused the use of the substances mentioned in the table 3.1

Table 4

Descriptive statistics for the AUDIT test

Q_Total		
N	Valid	47
	Lost	0

Mean	2.62
Median	1.00
Mode	1
Standard Deviation	3.138
Minimum	0
Maximum	16

Note. The table 4 shows the media, median, mode, minimum, and maximum of the AUDIT test

Table 4.1

Frequency Table for the AUDIT test

Q_Total		Frequency	%	Valid %	Cumulative %
Valid	0	6	12.8	12.8	12.8
	1	19	40.4	40.4	53.2
	2	7	14.9	14.9	68.1
	3	3	6.4	6.4	74.5
	4	4	8.5	8.5	83.0

5	3	6.4	6.4	89.4
7	2	4.3	4.3	93.6
8	1	2.1	2.1	95.7
12	1	2.1	2.1	97.9
16	1	2.1	2.1	100
Total	47	100	100	

Note: Table 4.1 shows the frequencies of the use and or abuse of alcohol of the population as a base line

Table 5

Statistics for the pretest and post-test of the MHFR course

		PretestP1	PostestP1	PretestP2	PosttestP2	PretestP3	PosttestP3	PretestP4	PosttestP4	PretestP5	PosttestP5
N	Válido	25	25	25	25	25	25	25	25	25	25
	Perdidos	0	0	0	0	0	0	0	0	0	0
Mean		0.44	0.72	0.32	0.52	0.52	0.76	0.16	0.80	0.60	0.88
Median		0.00	1.00	0.00	1.00	1.00	1.00	0.00	1.00	1.00	1.00
Mode		0	1	0	1	1	1	0	1	1	1

Standard Deviation		0.507	0.458	0.476	0.510	0.51	0.436	0.374	0.408	0.500	0.332
Minimum		0	0	0	0	0	0	0	0	0	0
Maximum		1	1	1	1	1	1	1	1	1	1
		PretestP6	PoststP6	PrestestP7	PoststP7	PretestP8	PoststP8	PretestP9	PoststP9	PretestP10	PoststP10
N	Valid	25	25	25	25	25	25	25	25	25	25
	Lost	0	0	0	0	0	0	0	0	0	0
Mean		0.88	0.92	0.76	0.92	0.92	1.00	0.24	1.00	0.56	0.92
Median		1.00	1.00	1.00	1.00	1.00	1.00	0.00	1.00	1.00	1.00
Mode		1	1	1	1	1	1	0	1	1	1
Standard Deviation		0.332	0.277	0.436	0.277	0.28	0.00	0.436	0.000	0.507	0.277
Minimum		0	0	0	0	0	1	0	1	0	0
Maximum		1	1	1	1	1	1	1	1	1	1

Table 5.1

Frequencies for the pretest and the post-test of the MHFR course

PretestP1	N	%	PosttestP1	N	%
Wrong answer	14	56.0%	Wrong	7	28.0%
Right answer	11	44.0%	Right	18	72.0%
PretestP2	N	%	PosttestP2	N	%
Wrong answer	17	68.0%	Wrong	12	48.0%
Right answer	8	32.0%	Right	13	52.0%
PretestP3	N	%	PosttestP3	N	%
Wrong answer	12	48.0%	Wrong	6	24.0%
Right answer	13	52.0%	Right	19	76.0%
PretestP4	N	%	PosttestP4	N	%
Wrong answer	21	84.0%	Wrong	5	20.0%
Right answer	4	16.0%	Right	20	80.0%
PretestP5	N	%	PosttestP5	N	%
Wrong answer	10	40.0%	Wrong	3	12.0%

Right answer	15	60.0%	Right	22	88.0%
PretestP6	N	%	PosttestP6	N	%
Wrong	3	12.0%	Wrong	2	8.0%
Right	22	88.0%	Right	23	92.0%
PretestP7	N	%	PosttestP7	N	%
Wrong	6	24.0%	Wrong	2	8.0%
Right	19	76.0%	Right	23	92.0%
PretestP8	N	%	PosttestP8	N	%
Wrong	2	8.0%	Right	25	100.0%
Right	23	92.0%			
PretestP9	N	%	PosttestP9	N	%
Wrong	19	76.0%	Right	25	100.0%
Right	6	24.0%			
PretestP10	N	%	PosttestP10	N	%
Wrong	11	44.0%	Wrong	2	8.0%
Right	14	56.0%	Right	23	92.0%

Note. Table 5.1 shows Right and Wrong answers from the pretest and the posttest. The participants had to choose from 5 options of different answers and/or true and false answers. The right and wrong answers were determined by the author of the course. The researcher of the thesis reviewed each test and scored it using the SPSS program.

Table 5.2

Total of frequencies for the pretest and the post-test of the MHFR

	Pretest		Post-test	
Question	Wrong pre	Right pre	Wrong pre	Right pre
1	14	11	7	18
2	17	8	12	13
3	12	13	6	19
4	21	4	5	20
5	10	15	3	22
6	3	22	2	23
7	6	19	2	23
8	2	23	25	0
9	19	6	25	0
10	11	14	2	23

Note. The table 5.2 shows the total comparison of the participants who completed both the pretest and the post-test

Table 6

Statistics for the Evaluation of the MHFR course

N	Valid	28
	Lost	20
Mean		4.75
Median		5
Mode		5
Standard Deviation		0.441
Minimum		4
Maximum		5

Table 6.1

Frequencies for the Evaluation of the MHFR course

Answers	N	%
4	7	14,6%
5	21	43,8%
Participant failed to answer this question	20	41,7%

Table 6.2

Evaluation: Participants comments about how they like the MHFR course

Discourse and dimension	Quotes
Stress management (Help others)	"Identify that we are part of a society, where we can in one way or another, contribute to it and identify a plan to help people, colleagues, students, family members in a moment of crisis. We must all contribute to our society and most importantly to preserve human life."
	"We can all provide support as a first responder in mental health by following these recommendations and responsibly"
	"I liked that we learned how to help people who may have suicidal ideas due to difficult situations that they may not be experiencing"

	" I learned a lot about the topic of crisis and that it showed how to deal with certain situations without having to be a professional in the field, that is, we can be a help agent in situations that warrant it"
	"I like that we can serve as a support for our family and our community, LISTENING, totally forgetting to judge others and beginning to be kinder, more attentive to the need for relief, transforming that need to want to die because of how wonderful it is. is to live with love and emotional support"
	" I was able to extend useful information to one of my employees who has a daughter with some problems such as those discussed here in order to help her treatment"
Self-Efficacy Skills	"It gave me more tools to identify and intervene in crises and non-crises"
	"The tools given and the importance to take care of the mental health"
The model	"The information contained, since it was very clear on what we can do"
	" The way they offer the material is practical, attractive, understandable, punctual. It gives you all the tools to be useful and intervene in a crisis. Very good"
	"Know, understand, build and transform"
	" I liked the talk because I really didn't know much about the subject, but I really liked the methodology that was addressed about the types of mental disorders because in this way you help yourself by clarifying various points of view and you can

	help other people"
Daily Life Skills	"The facility to know and socialize the topics according to what is lived daily through our work"
	"I found it interesting in the work environment that I manage"
Technical knowledge	"it is very good to know and stay informed about these issues that at some point we do not see as important and once we know them we are able to detect how valuable they are for our development in a community or simply in our family"
	"To know some statistical and theoretical data on suicide problems that until now were unknown"
	"Security Plan (Anxiety)"
	" The way each topic was explained"
	"Clear and precisely explanations"
	" The strategy of the themes developed"

	"The approach of the theme is very complete"
	"I liked the methodology. The course is practical"
	"The acquisition of new terms and strategies for crisis moments"
	"The difference between mental health and emotional distress"
Self help	" The orientation or path of attention that we must follow when some type of case arises, also that as human beings we feel and transmit emotions that we must also know "
	" I understood my own issues from an objective perspective"
Public health	"When it is said that this is a public health issue, that suicide and related issues increase, and preparing the community and prepared makes the saw lie at hand. That it be insisted that this message reach the morning governments so that the investment investment in mental health issues is greater than that currently provided"
All	"I liked all about the course"

Table 6.3

Evaluation: Suggestions of the participants about the MHFR course

Discourse and dimensions	Quotes
Case videos	"With some videos of possible cases and what one should do and what not. Some examples"
	" I am very visual, for me it would be very good to show the whole subject: as in a small movie, where he is made before, during and after the intervention. ..I must emphasize that the videos and the explanations are very good, in fact the video that I liked the most was the one with the teenagers explaining how to act, almost at the end of the course, it was excellent"
Dr. Tolentino intervention	" I would like more intervention from Dr. Torentino until the end of the course. That it was giving feedback on the content until the end. Although Dr. Marjorie does very well; is to accompany the course to the end and listen to the closing words, reinforcing the original message of the ESTIMATE"
MHFR Clients testimonies	" I think that if we include testimonies from those who have given this type of support or from those who have received it, it would be very motivating and would contribute to raising awareness among those who can support it"
Time to discuss about MHFR	"Perhaps we will have more time and space to discuss this very important issue in our community"
	"I would say that the course should have lasted about two more sections because I found the topic very interesting, but due to time it was not possible to delve into all the topics"
Dynamism in the presentation	" It can be improved by presenting the information a little more dynamically. The videos were interesting and I understood them more than the readings"

	"Should have slides with less text"
	"More dynamics and practical exercises during the course"
	"Instruct with practice"
	"Slightly more pleasant explanations can be presented since sometimes, because it is a heavy topic, treating it with a very flat tone of voice allows me to disperse as an auditor"
Internet connection difficulties	"I had some internet connection difficulties"
Colombian Context	Expand a little more regarding the Colombian context