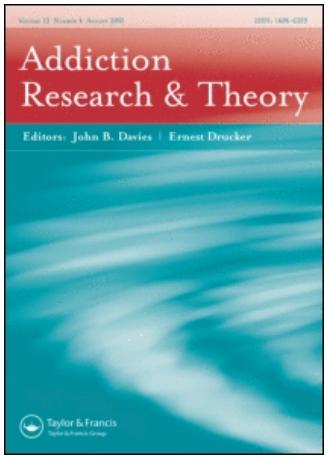

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HELP!!! An interactive experiential simulation of youth with concurrent disorders accessing help from "the system"

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Abstract
HELP!!! is an interactive, experiential simulation of the health care system that youth with concurrent mental health and addiction issues need to access for help. Using this exercise after a didactic teaching session reinforces the learning, synthesizes the knowledge for application and encourages group discussion and the sharing of participants' knowledge. This exercise was originally developed to create an opportunity for interprofessional learning groups to experience the gaps and barriers youth encounter as they attempt to navigate the system and to act as a catalyst for creative problem solving and system change. By participating, learners experience a simulation of what youth, family members, and various professionals usually encounter in the system. This exercise elicits key issues for discussion and provides a forum for networking and the initiation of collaborative ventures for healthcare providers.

Keywords: *Youth, concurrent disorders, training and education, healthcare systems, barriers, simulations*

Introduction

This article describes the HELP!!! simulation and its facilitation. This exercise provides an opportunity for health care and other service providers dealing with youth suffering from multiple concurrent issues to participate in a small-scale simulation of youth with mental health and addiction issues trying to access the system for help with their problems. An underlying goal of the exercise is to create networking opportunities for the participants so that they can begin to consider and create a holistic and shared-care approach to dealing with this complex population. The exercise was developed as a component for workshops

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on youth with concurrent mental health and addiction issues. These workshops were entitled ''Youth, Drugs and Mental Health'' and were offered across the province of Ontario, Canada, to managers and front line service providers from various programs and agencies that deal with either youth, addiction, mental health, or combinations of all three. A manual of the same title was distributed to participants that contain information on statistics, assessment and treatment approaches to working with youth with concurrent disorders (Centre for Addiction and Mental Health 2004). The simulation has been used as part of training health care providers in other workshops across Canada as well, including a series of workshops in a number of the British Columbia health regions. Data has been collected on participants' perceptions about the utility of the simulation in a total of 16 workshops of 30–50 learners each.

Interactivity and experiential learning

The authors, who have also been the facilitators at these workshops, have expertise in assessment and treatment of youth with concurrent disorders. As a games and simulation designer, one author also wished to create an interactive, experiential learning exercise for the interprofessional group of learners to simulate the difficulties these youth face when trying to access the health care system. It is well known that this population faces numerous barriers in accessing service and engaging with the system (Ballon et al. 2004). This exercise was designed to experientially demonstrate the barriers this population faces, the numerous types of programs and agencies that exist in the system and creative solutions that are possible, including shared care models.

Interactive teaching allows learners to understand and integrate the material in different ways through interacting with the content, facilitators, and fellow participants. HELP!!! is a ''frame game''. A frame game has a structure in which different content can be ''loaded''. The frame is the set of rules and procedures for the activity that contains the desired information/knowledge to be transferred. While this particular ''frame game'' was designed to explore the challenges and opportunities in the system for youth with concurrent disorders, it can easily be adapted to other populations such as a senior population, adults with developmental disorders, etc. Currently, HELP!!! is being adapted for use in a series of workshops for interprofessional learners who are interested in learning how to work effectively with the problem gambling population.

Simulations have been used in numerous ways for training in the business/corporate world (El-Shamy 2001). Similarly, they can be used in education for physicians and other health service providers to teach clinical information. Guidelines for utilizing innovative teaching techniques including games have been suggested in the medical education literature (Handfield-Jones et al. 1993). Using a number of different teaching modalities (e.g. didactic, interactive, media) within a lecture or workshop has been shown to be an effective way to engage learners (Brown and Manogue 2001). There is also evidence that interactive teaching enhances the depth of knowledge gained as well as retention (Davis et al. 1999; Grimshaw et al. 2002).

Students become active rather than passive learners by interacting experientially with the content being taught. This simulation energizes and motivates learners by allowing some physical movement and communication amongst all the participants. It is an effective teaching strategy when used after didactic teaching to help underscore the key points in an engaging and interactive manner. The simulation also facilitates the synthesis of new

knowledge, encourages the sharing of knowledge in a group and allows those who do not learn best by didactic methods to have an alternative/complementary means of learning. The roots of the simulation are based on the triad of factors that interact to create active learning, which include the learners, the teacher(s)/facilitators, and the material/content (Steinhert and Snell 1999).

The authors hope that it will be used and adapted by readers in their own settings. Although created in a Canadian context, facilitators can easily adapt the elements of the exercise to fit their own culture/context. This exercise can be used as a catalyst for services within or across systems to begin to work together to close gaps and discover ways to enhance the access and help that can be offered to people suffering from complex, multiple problems.

Results from the previous workshops

This simulation has been rated highly with respect to utility and applicability to the learner's work and learning objectives in each workshop where it has been featured. The participants of these workshops included representatives of a mix of health disciplines, including social workers, registered nurses, child and youth workers, addiction therapists, family doctors, and psychiatrists. The exercise has received excellent evaluations from workshop participants; learners have enthusiastically endorsed the game as a useful and enjoyable learning tool. There were 16 workshops averaging 30–50 participants each (with about 50% of each group being managers of agencies or programs) ($N = 547$ who returned feedback forms). These workshops were conducted over a span of a year. Due to the nature of the educational feedback forms, age and specific breakdown of the number of each professional could not be retrieved (unless the respondent wanted to include it). Thus the authors will report on the qualitative data obtained from the feedback in terms of satisfaction levels, learning endorsed, and key themes that emerged from the interactions.

Each workshop was evaluated using a participant satisfaction questionnaire. In the section for general comments, most respondents wrote narrative statements that were analyzed for pertinent themes related to the simulation exercise.

The majority of respondents (80%+) stated that the exercise was innovative and educational and that it complimented and expanded on the information from the didactic lecture portions of the workshop. Learners stated that participating in the exercise made them want to continue talking with fellow participants about dealing with the gaps in the system and developing strategies for working more collaboratively. Learners stated that the exercise helped them understood the realities of dealing with complex clinical cases in which the system has gaps. Importantly, the exercise stimulated the learners to experience actual feelings/emotions youth may have when negotiating the system and they reported feeling greater empathy for youth having to negotiate barriers inherent in the system. Participants playing the youth roles stated that they were ''amazed'' at how strong their own emotions became in trying to access the (simulated) system. Learners reported that they enjoyed sharing personal knowledge with the group to expand the experience; they felt less isolated from fellow learners and the facilitator/teacher than during didactic sessions.

In only 2 of the 16 workshops, was there any feedback containing negative comments. These included one learner's statement that the context of the simulation did not apply to

the learner as they felt addiction issues have nothing to do with mental health systems; a few stated that they did not like experiential exercises/role-plays but preferred pure didactic teaching. The latter stated that they still found the exercise somewhat useful and could see how others would find it helpful (i.e. adult learning style preference).

Based on the above feedback, this exercise seems to be perceived to be a very effective learning tool for most learners. There will always be a few learners who, given their learning styles, do not find interactive/experiential techniques instructive. One should consider this simulation as augmenting teaching on youth concurrent disorders and integration as opposed to using it as a stand-alone method.

Themes arising from the exercise

As above discussed, this exercise was repeated in the same format with groups of services providers representing many different settings, including different parts of the country. Despite this, similar patterns of behavior were enacted across simulations and similar themes arose repeatedly. Following are some actual run-through experiences that yielded interesting processing opportunities:

- *Barriers embedded in a service's mandate:* The youth were almost never referred to the addictions service table, and the few who were, never made it there. This gave rise to a discussion about the historical and political origins of the systems, their view of their mandate, lack of skill in screening for substance use and abuse and lack of knowledge about services and resources. It was clear that many service providers are either not aware of how addiction specific services can assist their clients either as an adjunct or instead of their service (mental health for the most part) or do not have it as part of their standard case management process to consider using addiction services. When referrals were made, the youth generally did not go. This generated a discussion of ways that referrals and transfers from one service to another can be made effectively.
- *"Bouncing youth syndrome":* Many times youth were sent to the other services without the referral source being involved in the process or tracking the youth. There were few attempts to engage in any type of shared care model. The ''youth'' in the simulation reported that this dynamic resulted in feelings of rejection and lack of caring in the system as they ''fell between the cracks'' while being ''bounced'' back and forth between services/systems that could not meet their needs. M any cases could have been handled in a more holistic way if the services were designed to work together to bridge the gaps in the system.
- *The important role of community:* In the simulations, Joe's Coffee Shop is a busy place. In one simulation, all the youth eventually felt they could not get help and ended up at Joe's coffee house. The importance of thinking about community resources/stakeholders was highlighted in all of the simulation debriefings. It was clear that such resources are often unacknowledged, overlooked and underutilized. Many businesses and community centres can and do play an important role in providing youth with what they perceive to be a comfortable and supportive environment. Many are untapped resources that would be willing to help improve their communities by supporting programs for youth through the donation of money or product.
- *Continuum of care/holistic approach:* This simulation underscores the importance of a holistic, full-spectrum system of care needed to meet the needs of youth with substance use and/or mental health issues. It quickly becomes clear that a range of services including emergency, outreach, drop-in, withdrawal management, outpatient, day

treatment, residential, and inpatient care are necessary. Which elements of the system are utilized by individual youth depends on the interaction between the youth's level of need, stage of change, willingness to engage and the service provider's ability to engage, motivate and connect the youth to the appropriate service. Perhaps one of the most important but often least acknowledged parts of the system, is outreach services. Creative and innovative ''service providers'' developed outreach services when they realized that youth were not accessing their well-resourced services. Some strategies they employed included going to places that youth in their community frequent including parks and coffee shops, advertising information or drop-in sessions that include provision of food and transportation (bus tickets). ''Youth'' and ''family members'' reported feeling cared about and less threatened by the outreach workers than by some of the more formal service providers. They found the outreach workers extremely helpful in bridging the gaps between informal and formal services. They also reported that provision of food, clothing, and transportation of money were a strong draw and an effective way to break down barriers between youth and service providers. Outreach services were initiated in all but one of the simulations run. This resulted in many youth ending up at Joe's coffee house until the end of the simulation, feeling frustrated due to their inability to access help.

The simulation guidelines

Simulation/not reality. A simulation strives to recreate, as closely as possible, the actual situation being examined. The focus is on setting the stage for learners to experience feelings and thoughts that mimic what would be experienced in ''the real world'' without having to recreate the scene in detail. This would not be feasible from the perspective of time or cost and could be very threatening as ''real work'' would be scrutinized. The simulation provides the opportunity to experiment with roles. For example, in the simulation, youth have a very short time frame, ~45 min. in which to ''experience'' the system while in reality, they may spend many hours, weeks, and months trying to access or avoid contact with the system. Service providers might spend hours talking to youth before referring them on. Thus a facilitator can help participants feel comfortable with their performances and to ''save face'' when they may not have performed well/provided good service, by reminding the group that the exercise is not reality. The facilitator can point out that ''in the real world, one might have had extra time, extra support, case files etc'' so may have served the youth differently. At the same time, it is evident from the discussions that the issues raised are actually very relevant and reflective of what happens in actual practice. The simulation provides a safe way to discuss what goes on and consider alternatives. In discussion of the example described above where all the youth characters had addiction issues but no agency referred any of them to the addiction service, the facilitators were able to process this by pointing out that, perhaps in the real world, with more time, the youth would have been referred to an addiction service, but also challenge the group in a nonthreatening way to consider that this may reflect lack of knowledge about community resources and what is needed to serve youth with concurrent disorders.

Preparation. Usually when running a workshop, the facilitators receive some information on the participants in advance. This can help in determining which agencies/programs/systems will be represented during the simulation. This can be modified during the

facilitator's instructions to the participants and soliciting any suggestions for any changes/additions/subtractions of an agency/program/system. The role descriptions and supplies should be ready for distribution to the participants. If budget permits, beverages and snacks should be provided as well. Consider the placement of this exercise after a didactic section, after lunch or just prior to the end of the day to revitalize learners.

It is best run with at least two facilitators to manage the numerous interactions that take place.

Supplies. Printed role descriptions for the actor volunteers; instructions and cards/signs for each agency/program/system table; marker and flip chart to write down points during the group processing time (see Appendix A).

Number of participants. For the example discussed here, youth concurrent mental health and addiction, ~30–50 learners are optimal. One can have fewer participants by dropping one youth role and limiting the number of agencies/programs/systems (see the subsequent text).

Duration of the simulation. Approximately 60 min: 5 min to explain rules; 5 min for participants to form agency/program tables and volunteer "youth" actors to play roles; 20 min of allowing "youth" to attempt to access system; 30 min of processing the exercise.

Setting the frame. The facilitator(s) explains that the exercise is to simulate the system youth try to access to get help. The word simulation is stressed to explain that this is not a precise re-creation of reality, since things are "sped up" i.e. no 6 months wait lists, etc. Also, participants should be told that they will likely not do everything they normally would do in the real situation – but that it has been shown in test simulations that the themes of barriers and gaps in service are illustrated in realistic and experiential ways. (Note: this is also important to say to prevent heated exchange amongst participants if they do something that may be perceived as offensive by another participant i.e. one agency "rejects" a youth – a mental health service provider tells a youth that until they are abstinent for 6 months they will not help them.) The facilitator's role is to help the group identify and explore system challenges, policy issues and the impact of the socio-political context, including stigma.

Assign youth roles. Five participants are asked to volunteer to role-play a youth with concurrent mental health and addiction issues. Each is given a short character sketch that includes the character's background, goals, and where they will start in the health care "system" (see Appendix A). These characters are based on composite cases seen by the authors in clinical practice in a youth concurrent disorders service. They are designed to contain many of the conditions and situations that are commonly seen in this population including early psychosis and/or substance induced symptoms, conduct disorder, drug use arising from trauma, depression,suicidal behaviours, self-harm behaviours, issues of street-involved youth, peer relationship issues, family issues, youth with cultural barrier issues, etc. Please refer to the character sketches in Appendix A. They can be modified easily to fit specific learner group's backgrounds/contexts.

Also, the character of MICHAEL has his mother present as part of the simulation as a separate character. The inclusion of a ''parent'' has generated discussion in all the simulations of how the system deals with family issues and how it is possible to ''demonize'' a caring but very stressed and desperate parent. This also provides the opportunity to discuss the complex issues and frustrations related to privacy and confidentiality.

As with all role-plays, the participants should be chosen carefully. It is important to establish a context of safety and mutual respect. Ensure that each participant will respect everyone's personal space, etc. (some characters are ''angry'': youth with conduct disorders!) and that everyone is aware that if there is any discomfort during the simulation, it can be halted at any time. The facilitators will also move through the room as participants and as observers to ensure that the simulation progresses smoothly and that everyone feels safe (see Appendix B).

Set up "The System"

The other participants will role-play different services/agencies/program staff. Tables or clusters of chairs are arranged with a sign stating what the agency/program is. Participants are asked to sit at the table representing the agency/system their regular job seems to fit in with best – although if some participants want to ''role-play'' another profession, this is allowed (e.g. a probation officer). The facilitators assist in assigning participants to tables and set up additional tables representing additional systems or clusters of agencies if some participants do not feel they fit – or if the participants request it. If too many people are at one table and not enough at another, the facilitators can suggest that some join another table if they are willing or the group can be split i.e. mental health could be broken into an outpatient clinic and a hospital. Many participants often can fit into several systems. For example, a street youth worker might say they work with addictions, mental health, youth, and shelters! In the processing of the action, discussions of mandates and funding sources often arise.

The exercise can be adapted by either adding or removing/collapsing tables to fit the number of participants. Adding tables will add to processing time. For collapsing, services such as ''Youth Outreach'' and ''Youth Addiction Service'' could be combined to ''Youth Services'' for example. For expanding, ''mental health'' could be turned into an ''outpatient psychiatric clinic'' and an ''inpatient psychiatric ward.''

The usual tables assigned are:

- Education
- Mental Health
- Addiction
- Housing/Shelters
- Juvenile Justice System
- Physical Medical Health
- Youth Program
- Joe's Coffee House

Joe's coffee house represents a place youth can hang out when not trying to engage the ''formal'' system. In fact, this may inspire some participants to develop their outreach capabilities. In one run, all the youth ended up at Joe's after feeling rejected by the system! Joe, the ''coffee barrista'' has a slightly modified instruction sheet (see Appendix C).

When coffee and other refreshments are available, as is generally the case at educational workshops, Joe's coffee house is set up at the refreshment table. In some simulations, participants have suggested additional or alternative tables depending on their backgrounds and communities. These have included:

- community centre
- community health centre
- youth drop-in
- hospital emergency department
- inpatient psychiatry ward
- spiritual care (i.e. a religious institution)
- child welfare agency

Instructions are given out at each table for a general goal (see Appendix D). It is intentional that not too many details are given and that the participants are left to come up with their own strategies to engage youth e.g. will a group come up with ''youth outreach'' services? In play, some do, some do not!

The facilitators need to limit the number of tables to allow enough time to process the exercise. Although, if one runs out of time, the facilitators can comment that this demonstrates the plethora of agencies, groups, etc. that can lead to confusion, fragmented systems, etc.

Roles for the facilitators: Health Ministers (or other "funders")

In this role, the ''minister'' ''drops in'' at various tables to check on their activities. If the table seems to have too many people at it not doing much – the minister may threaten to do some ''cuts to staffing''. However, the minister can also make suggestions for service providers to initiate collaboration with other tables and invite different members from different agencies/programs over to discuss ways to serve the youth more effectively together (see Appendix B). In play, most ministers seemed to lean toward the latter. Only once was a table's staff cut and the participants ended up at Joe's coffee house with some of the youth characters.

20 min of interactivity

Once everyone is ready, the facilitators start the action and keep track of the time. If the facilitators want a fun launch, they can start by saying ''Ready, set... HELP!!!''. The facilitators observe the interactions and can make notes for the processing section (see subsequently) to help guide the discussion afterwards. The facilitator will give a 5-min and 1-min warning before the activity is brought to an end and the process discussion begins.

Processing the simulation

The youth and family volunteers are brought to the front of the room and the other participants return to their original tables (if they are not at them). The facilitators moderate the discussion and elaborate on or underscore key messages that come out in the discussion. The order of the debriefing is as follows:

- The Youth roles: Each person playing a character reads their role to the group. (In the case of Michael and Michael's Mother (see Appendix A) both talk about their roles).

The volunteer is then asked to describe what happened to the character while trying to get help. Then, the volunteer is asked to share how they felt during the interactions. Afterwards, each volunteer is thanked, the group is asked to give the volunteer a round of applause and the person can take a seat back with the other learners. NB: it was noticed some participants like to get into the youth role so much that they try to continue ''staying in character'' throughout the debrief. Having this occur for a small amount of time usually adds to the power of the simulation – but if it continues also for too long a period it can interfere with the pacing and focus of the debriefing. Therefore, it is suggested the facilitators at the beginning mention the option of ''acting in role'' to talk about their character, but then ''come out of character'' for discussing their experiences interacting with the ''system''. (NB: this is not as infrequent a phenomenon as one might think. – It has been the experience of the authors that participants like stepping into these roles).

- The ''System'' – services/agencies/program: Each table is asked to briefly report on their activities and experiences during the simulation.
- The health ministers: Any participants or facilitators who acted as health ministers now discuss their actions and experiences during the simulation.

General discussion

The facilitator opens discussion up to the entire learner group. This is an opportunity to delve further into the many issues that are generally raised by the previous dialogue regarding barriers, gaps, stigma, youth-friendly settings, outreach, collaborations, etc.

Solicit general comments/highlight key learning points:

For the youth character volunteers:

- Did your characters feel threatened?
- Did your characters know where to go or did anyone feel confused?
- Was trust an issue for any of the characters?
- How many youth ended up at Joe's coffee shop?
- How did family involvement get addressed? Any issues around confidentiality?
- What was most/least helpful?

For the agencies/programs/systems:

- Did any table develop outreach capacity? Was it important?
- Were there any tables that did not see any of the youth characters during the simulation? Why do you think that happened?
- Where did the youth end up going?
- Did anyone develop any collaboration with any other table?
- If a youth was ''referred'' or sent over to another table, did anyone from the referring table come over with the youth?
- Was there any shared care developed?

Wrap-up

The facilitators wrap up the processing after about 30 min (or sooner if the energy of the discussion begins to dissipate). This would include: a summary of what the group

discussed; the complexity of trying to help youth with concurrent disorders in the current system; the need for collaboration, shared care, and communication amongst agencies, programs and systems to provide a holistic, full-spectrum care for an individual requiring help for multiple issues. The facilitators highlight key themes and creative initiatives that they observe or that are commented on in the debriefing. In many of the simulations run by the authors, the ''youth'' commented on finding outreach services and services that offered food as ''part of the package'' to be most inviting and engaging, particularly when they felt ambivalent about making changes or felt confused about what they wanted or needed. They reported being validated and listened to as key helpful interventions as opposed to being ''talked at'' and being given advice. In some of the simulations, service providers who were not busy, became quite creative and initiated outreach services, advertised pizza and information nights at the coffee shop, handed out flyers, set up peer led discussion groups and drop-ins and sought out nontraditional partnerships, e.g. a religious institution and an addiction service. The ''youth'' appeared to be more interested in and responsive to these ''new'' and innovative services than the traditional office based, ''institutional'' services that were represented at most of the tables.

Debriefing the simulation is usually a good segue into a discussion of practical networking, lobbying funders, and other collaborative projects that the participants can pursue after returning back to their home agency/program/system. If participants are from the same community, it is not unusual for some connections to be made during the exercise that continue after the workshop.

Conclusion

The early qualitative results of the use of the HELP!!! exercise have been extremely positive. Preliminary data suggests that this simulation is an effective educational tool for helping learners understand more fully the experience of individuals trying to access help as well as the challenges the entire system faces from multiple pressures. It works well with interprofessional groups and fosters learning about other health care providers and services that exist in the system in a powerful experiential way. Further empirical data must be gathered in order to assess the full potential of this exercise for enhancing education in this area. Such enhanced education may have a lasting impact on the development of professional attitudes toward people with mental health and addiction problems and in turn may result in more effective treatment. Participants have endorsed feeling motivated and eager to continue collaborations with others to deal with the system gaps. The exercise allows for the initiation of a process of collaboration and networking opportunities. Lastly, the basic elements of this exercise can be used for diverse populations, issues, and services by substitution of content by a facilitator.

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APPENDIX A: Youth character roles

The following characters are included: Michael (male); Michael's mother (female); Erin (female); Griffen (male); and ''Sponge Head'' (can be either male or female). The facilitator can modify the characters to change gender if need be (e.g. Michael's father can be created rather than use Michael's mother).

HELP!!!! CHARACTER ROLE: **"MICHAEL"**

Sketch:
You are a 17-year-old male with a 3-year history of daily marijuana use. Your mother has pressured you to come for an assessment for your addiction issues, as she feels that you have been acting ''strangely'' lately and feels that it is because of drugs. If you do not go, she threatens to throw you out of the house.

You are currently not in school, and not working. You have been thinking of ''flipping'' (trafficking) cannabis to keep your habit going.

You feel there is nothing wrong with you and that your mother is over-reacting. You use 2 joints/day to help you to cope with ''stress''. You have been thinking about cutting down, but are concerned about how you will cope. When you have tried to quit in the past you have become extremely anxious and depressed. You have been starting to hear weird voices at times no one else can hear – sometimes they distract you from conversations. You do not really want to tell anyone about it as you might be labeled ''CRAZY''.

FEEL FREE TO MAKE UP ANY OTHER DETAILS e.g. OF YOUR FAMILY BACKGROUND e.g. divorced parents, older sibling with drug dealing habits etc.) MAKE THE CHARACTER YOUR OWN!

Start Point:
Mother has dropped you off at a mental health clinic – please go to that table to begin

Your Goals:

(1) Get mother of your back! You want the counselors to call her and say you are in treatment and you can go home

(2) If you feel you are being treated well, you would like to get help for your mood, anxiety – and if you really feel treated well – you will mention the voices too

HELP!!!! CHARACTER ROLE: **"MICHAEL'S MOTHER"**

Sketch:
You are a 46-year-old female with an only son, Michael. You have pressured him to go for an assessment for addiction issues, as you feel that he has been acting ''strangely'' lately and maybe it is due to drugs. If he does not go, you threatened to throw him out of the house.

He has not attended school in weeks and is not working. He hangs around ''weird'' looking shady characters. Sometimes Michael seems to be talking to himself or seems paranoid. You are very concerned about him.

FEEL FREE TO MAKE UP ANY OTHER DETAILS e.g. OF YOUR FAMILY BACKGROUND e.g. divorced, dealing with own depression, etc.,) MAKE THE CHARACTER YOUR OWN! BUT PLEASE SHARE THIS INFORMATION WITH MICHAEL'S PLAYER SO YOU CAN HAVE SOME CONSISTNACY)

Start Point:
You bring Michael to the mental health clinic – please go to that table to begin

Your Goals:

(1) Get your son help.

(2) You are not interested in confidentiality – you want someone to tell you what is going on with your son – NOW!

''HELP!!!! CHARACTER ROLE: **"ERIN"**

Sketch:
You are a 16-year-old female who has just been mandated to attend an assessment by probation. You were charged with physical assault one year ago.

You are a polysubstance user, including cocaine, crystal methamphetamine, ketamine, and marijuana – whatever you can get your hands on to keep high and ''f*cked-up''. Usually you use marijuana ~4 times a week, and ''chemicals'' on the weekends. You have been using these drugs for 3 years, since becoming involved in the rave/party scene. You also used to cut yourself with razors and burn yourself with cigarettes before getting into the drug use. Your mood has been very ''poor''.

A secret you have never told anyone – and one of the reasons you have tried to keep drugged is the flashbacks you get when sober, of being sexually molested by a close family friend at the age of eight.

You were recently (mis)diagnosed with ADHD by her family doctor and have started taking Ritalin. You are having a lot of problems in school. In fact, you never had any problems in school before the sexual abuse occurred and were an A+ student.

FEEL FREE TO MAKE UP ANY OTHER DETAILS e.g. OF YOUR FAMILY BACKGROUND e.g. divorced parents, older sibling with drug dealing habits, etc.) MAKE THE CHARACTER YOUR OWN!

Start Point:
You are talking with your probation officer at the Juvenile Justice table

Your Goals:

(1) Get the law off your back! You want the counselors to call your probation officer and say you are in treatment

(2) If you feel you are being treated well, you would like to get help for your mood, anxiety – and if you really feel treated well – you will mention the trauma issues.

HELP!!!! CHARACTER ROLE: **"GRIFFEN"**

Sketch:
You are an 18-year-old aboriginal male who was recently admitted to a hospital after experiencing a ''manic episode''. You were discharged from hospital 2 weeks ago after being diagnosed with a cocaine-induced psychosis. You are currently living with your older sister.

You still use cannabis daily to ''keep away'' from cocaine. You are afraid to go to any institution because of how they certified you, put you in four-point restraints, and labeled you ''CRAZY''. You were also upset when they automatically assumed you drank alcohol and sniffed solvents because you are an aboriginal youth – so you do not want to be judged again!
You still get racing thoughts in your head and have a hard time staying still. You spend most of your time in the coffee shop near your sister's home.

FEEL FREE TO MAKE UP ANY OTHER DETAILS e.g. OF YOUR FAMILY BACKGROUND e.g. divorced parents, older sibling with drug dealing habits etc.) MAKE THE CHARACTER YOUR OWN!

Start Point:
Start at ''Joe's Coffee'' place and hang out there. See goals below.

Your Goals:

(1) Keep away from hospitals and doctors – cannot trust them

(2) You can wait to see if any service develops ''OUTREACH'' strategies . . . after 10 minutes, if no one has come to talk with you . . . you can call a ''help line'' i.e. go up to a service/table of choice and go improve a bit by saying ''RING RING'' and look like you are holding a phone – you can break character a bit if the person at the table does not get it and tell them their phone is ringing! Improvise from there!

HELP!!!! CHARACTER ROLE: **"KAREN"**
You are a 14-year-old girl who is about to be kicked out of school due to skipping classes and not doing any homework. You were born in (PICK A COUNTRY WITH DIFFERENT OVERALL CULTURAL VALUES THAN HERE), but you have been living in (Current city/town/etc. this simulation is taking place) for the past 5 years with your mother. Your mother came to Canada 10 years ago to make a living and bring you over from (COUNTRY YOU CHOSE).

You started drinking alcohol to fit in with other kids at school and now you binge drink. You also smoke a lot of cigarettes.

Besides having a lot of verbal and sometimes physical fights with your mother when you get angry outbursts, your mood keeps going down. You have been feeling more and more depressed. Sometimes you think jumping in front of a subway train might just end your troubles.

FEEL FREE TO MAKE UP ANY OTHER DETAILS e.g. OF YOUR FAMILY BACKGROUND e.g. divorced parents, older sibling with drug dealing habits etc.) MAKE THE CHARACTER YOUR OWN!

Start Point:
Education table – you can start there and ask to speak to the school counselor!

Your Goals:

(1) To get help from feeling so depressed all the time

(2) If you feel you are being treated well, you would talk about the physical fighting at home with your mother

"HELP!!!! CHARACTER ROLE: **"Sponge-Head"**

Sketch:
You are a 17-year-old person who deals cannabis to keep your habit going. You belong to a street gang. You have not seen your parents for years, having run away from home 2 years ago (they live in Vancouver). Your dad used to beat you physically and you have written off the family. You have not been in school for that time either.

Recently you have been getting panic attacks – great waves of fear, almost every day. You keep smoking 10 joints a day to try to keep calm.

You are afraid of the law and do not want to say anything to anyone that could get you arrested.

Your friends are worried about you and want you to get healthy so you can do business.

FEEL FREE TO MAKE UP ANY OTHER DETAILS e.g. OF YOUR FAMILY BACKGROUND e.g. divorced parents, older sibling with drug dealing habits etc.) MAKE THE CHARACTER YOUR OWN!

Start Point:
Where ever you want to go.

Your Goals:

(1) Get help for your panic attacks

(2) Avoid the law!

Appendix B: Health Ministers

An optional role for the facilitators, to add a bit more of drama to the proceedings. One or two are sufficient.

Health Minister
Please walk around the different services and observe interactions. Your role is to help motivate participants to do some action without directly suggesting what that action should be.

If a table has too many people at it not doing anything – you may threaten to do some "cuts to staffing". If so, take a few from the table and place them in another smaller or busier service. Do this if after 15 minutes go by and the same participants are still sitting around doing nothing.

You can also give some prompting that participants may want to form collaborations with other services.

Appendix C: Joe's Coffee House

The facilitator should make a large sign "Joe's Coffee House" that can be taped or stood up at the refreshment area. For this table, only one or two participants are needed. The following instructions are given to those at this table:

HELP!!! Joe's Coffee House

You are a "barrista" (coffee bartender) at the local coffee shop. You often talk to the regular customers in the place about their problems. You always wondered what you could do to help some of them.

Appendix D: Agencies/programs/systems

The facilitator should make large signs that can be taped or stood up at the various tables to represent the various services. The following instructions are left at the table:

HELP!!!! SERVICE: (Facilitator fills in the name of the service)

As part of this service, all of you can decide what you want to do in terms of how you offer help. You can send a member to talk to other agencies, or go anywhere – just make sure someone is left at the table or else if anyone shows up the place will be "closed"...

Watch out for the Health Ministry Inspectors (the facilitators)...you never know how they might make cuts in services if there seems to be no action.