

Club Health

“Healthy and Safer Nightlife of Youth project”

Staff training for nightlife premises

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INTRODUCTION

"Nightlife is people's time to socialise and have fun... it will always exist. We just need to make it better for everyone; safer. We are glad this project exists."

LISBON DJ (Club health training session 2010)

Over the last few years the level of participation and involvement in nightlife and recreational activities around the world has increased significantly, especially amongst young people. Weekend nights, summer festivals and concerts have become important social contexts in which youths can acquire social capital. They have become the time and place to meet friends and potential sexual partners, dance, consume alcohol, take drugs and engage in other risky behaviours (Calafat 2010).

In an IREFREA study (1999) we found that European young people are away from home between 4 and 7 hours every weekend night; this is time devoted to recreational activities in pubs, bars and/or discos. They visit at least 2 or 3 venues per weekend night. Drunkenness and the use of illegal drugs are the risky behaviours most associated with nightlife but links also exist to other risky behaviours, including: sex under the influence of drink and/or illegal drugs effects (potentially risky, unsafe and involuntary sex), driving under the influence of drink and/or the effects of illegal drugs, violence, social nuisance (e.g. noise), street drinking and vandalism (Calafat 2010).

Nightlife in many parts of the world has acquired several common characteristics, although each country has its specific particularities. These common characteristics have been used by IREFREA to create a 'model of entertainment' which is widely observable in real-life contexts designated by : 'Hegemonic Recreational Nightlife Model' (HRNM) (Calafat et al. 2010).

According to IREFREA (Calafat 2010) HRNM has the following principal characteristics: i) it spreads very quickly; ii) its presence makes the local existence of other models of entertainment difficult; iii) a lot of different interests facilitate its existence, extension and consolidation; iv) the use of alcohol and illegal drugs is seen as "must do" due to the expectancies, intensity and longevity of a going out session; vi) it has a variety of associated risks - individual linkages, however, may not be well established; therefore, despite these risks, HRNM can be widely accepted by the general population; vii) the context (physical and cultural) becomes extremely important.

Nightlife and other recreational contexts play a key role in modern life. They are a critical aspect of youth recreation and are increasingly a major source of employment, economic development and tourism for communities, towns and cities. Nightlife activities, however, also create a wide range of health and social problems including alcohol and drug misuse, anti-social behaviour and crime.

The development of safe nightlife environments is a concern and a growing priority throughout Europe. As international tourism increases within Europe, regional, as well as town and city, authorities must manage not only the recreational habits of their own youth but also the recreational habits of tourists. Effectively managing nightlife settings is essential to effectively protect youth health and also to reduce the different burdens that problematic situations (e.g. those produced by night-time and anti-social behaviour) can place on public services (e.g. health and justice) and wider society.

To help contribute to a better understanding of this phenomenon, and to make some specific proposals, the 'Club Health – Healthy and Safer Nightlife of Youth' project was designed. It is supported by the European Commission, through the Executive Agency for Health and Consumers (EAHC), as part of its public health and other related strategies. These strategies aim to reduce the social costs and harm associated with youth nightlife risk behaviours. This project aims to facilitate in a more consistent way the implementation of strategies and laws in the field of youth risk behaviour, and to increase the sensitivity of the media and the advertising industry by involving politically relevant actors. This project also aims to reduce accidents, injuries, violence and diseases among youths by focussing specifically on nightlife environments. One of the aims of "The Club Health project" was to develop and produce a training manual for the owners and staff (e.g. public relations, bartenders, door supervisors) of discotheques, night clubs, bars, pubs, and others recreational contexts and increase their knowledge of, and help them to identify, different risk situations; thus helping them to create more effective, safer and healthier management strategies for nightlife settings.

Not always have these professionals been regarded as potential preventive agents or been much valued for their work as partners in this complex process. However if we want to promote and ensure healthier and safer nightlife entertainment for young people then we must also provide and make available adequate training for the staff who work in discotheques and nightclubs. This will be especially beneficial when preventive and harm reduction measures are required to deal with problematic and/or emergency situations. Training will help staff to improve their conflict resolution and communication skills, increase their assertiveness, and aid understanding of any legal frameworks linked to recreational activities. A special training session will be delivered to identify specific situations linked with health and safety. Depending on local situations and specific needs several related issues can be covered. Training can include dealing with first aid issues, sexual assaults and effectively managing aggression in nightlife settings.

This manual has been created to be a practical and useful instrument for training nightlife and other recreational professionals. It aims to empower staff and improve their interpersonal skills and abilities so that they can take the best and wisest decisions to reduce and prevent problematic situations. For the successful implementation of this preventive instrument it is necessary (and our priority) to involve the community, relevant actors (public and private), politicians, and local, regional and national stakeholders. Only by sharing and involving other community partners can this manual, and its associated training, produce the desired effects.

From the beginning of this project we organised our work into four distinct phases. At first we collected data and information from different cities and countries regarding existing training activities that involve staff of nightlife venues and some norms (formal and informal) that are related to nightlife issues. Then we developed a protocol, based on the analysis of information collected during phase one, for the implementation of training. As part of the protocol development, and in order to present the project and discuss key training concepts, during 2010 we organised training sessions in six European cities (Coimbra, Ljubljana, Budapest, Lisbon, Patras and Cologne) for local entities (mainly professionals from recreational settings). Unlike other approaches used for professional training linked to recreational night life, this manual is intended to address broader issues and their interconnection with the current situation. For example, incorporated throughout the manual and inbuilt into the design of the units, attention is drawn to the importance of the concept of 'environmental strategies as prevention strategies'. In this case environmental strategies are focused on changing aspects of the environment that contribute to, and facilitate the use of, alcohol and other drugs (e.g. more regulation and control) but can equally apply to other problematic situations. Specifically, environmental strategies aim to decrease the social and health consequences of substance abuse by limiting access to substances and changing social norms that are permissive and accept substance abuse.

To create the manual we conducted a detailed review of the literature related to nightlife and recreational contexts, e.g: i) the principal areas and main problems related to nightlife and recreational contexts; ii) legal and illegal drugs use, effects and consequences; and, iii) staff training interventions and interventions which target venues and recreational contexts.

Within the annex are summaries of some of the issues that we consider most relevant; these core topics should be analysed and evaluated by trainers before starting to provide training courses .

1. THE STRUCTURE OF THE MANUAL

We want this manual to be a useful and easy tool for trainers to use. This will allow our final beneficiaries (staff members) to be able reflect on their current practices and how they may be improved. This manual will help to promote the sharing of experiences, knowledge, create an increased awareness of preventive strategies and allow people to become more aware of situations that can be potentially dangerous. The main goals of this training manual are:

- To empower staff with the skills and abilities to make improved decisions to help prevent or reduce the frequency of problematic situations in recreational contexts.
- To discuss the risks associated with nightlife (e.g. consumption of legal and illegal drugs, violence, driving and accidents), the circumstances in which they occur and their potential consequences (how nightlife issues affect young people and other clients of venues within recreational contexts).
- To identify and understand the different strategies that have proved effective in preventing or managing risks linked to individual venues or events.
- To teach and train strategies (e.g. local control, interpersonal communication, conflict management, dispensing alcohol responsibly, first aid) that have been shown to be effective when handling different situations of risk.
- To increase the awareness to all participants (individuals and companies/organisations) of the legal frameworks that relate to a range of behaviours (e.g. event/venue management, the selling of goods and services, the consumption of psychoactive substances [PAS] and their consequences).
- To generate a “coalition” of different partners with the same interests and objectives who work in this field.

1.1 Target group

This manual has been specifically created for professionals and people who have responsibility for recreational activities as well as those professionals who have relationships with recreational contexts, including:

- Owners, managers, staff employed in hotel recreational activities, public relations personnel and other employees related to recreational contexts (e.g. holiday promoters);
- Waiters and dispensers of drinks (alcoholic and non-alcoholic);
- Security and access control personnel (door supervisors and private security agencies).
- Promoters and cultural facilitators (e.g. disk jockeys and animators).
- NGOs working in the field
- Local or regional associations of bars and clubs and other nightlife venues

To enhance the results of this training we think it useful to integrate the nightlife sector with professionals from other areas and services (from both the public and private sector - e.g. health and justice departments) whenever possible.

Some units of this manual have fixed content and should be used as basic training for all professionals. Other units are more related to specific situations and roles. However it is our opinion that all staff should receive training on all units and share all the knowledge and experiences within the manual as this will lead to increased effectiveness of responses and group cohesion.

1.2 Methodology

“Knowledge is of two kinds: that which is absorbed and that which is heard. And that which is heard does not profit if it is not absorbed.”

Ali Ibn Abi Talib

Pedagogic methodology should be adapted to the needs of each situation and training group, and should be mainly grounded on problem solving situations. This manual's methodology aims to help trainees clearly identify what they already know, what they need to know and how and where to access the required new information.

It is assumed that all participants have knowledge and experience to contribute and share. We intend to promote the development of skills that are complementary to the active discussion; dynamic activities and interactive games play a key role in the acquisition of knowledge. Ideally a training program should provide an environment that meets individual and collective needs, reduces defensiveness and allows for creativity and innovation.

It is recognised that some nightlife professionals may not be very receptive to training beyond what they see as their function, especially if the training is aimed at reducing alcohol (and other substances) abuse. This rejection can be related to both the belief that drinks are necessary to have fun and also with the (often) low level of education that these professionals have. Furthermore, nightlife entrepreneurs may consider that having their staff aware of the need to moderate a customer's consumption will lower their income. In some situations the high turnover of staff (due to a variety of different reasons) doesn't facilitate the enhanced commitment of employers and owners towards training.

For these reasons training should be simple, useful and focused on the needs of the professionals and take into account each venue/premises reality. Our training promotes reflection on an individual's current professional practices.

The trainer who intends to develop adult education, especially to modify or improve professional practice, must become a facilitator of learning processes; i.e. to mobilise people to reflect on their current practices. The trainer should be able to recognise the role of emotions in learning, and learn effective techniques for personal and social development. **It is important to recognise that our training model places less emphasis on storing information and increased emphasis on critical thinking, problem solving, innovation and creation.**

Learning takes place according to an individual's interest and, therefore, the trainer should plan the activities of each teaching/learning context so as to foster positive, cooperative, experiential training. This should facilitate openness, flexibility, empathy, a sense of comfort and emotional intelligence. Learning to learn and help means grasping and taking ownership of new ideas and concepts, as well as knowing different realities and mobilising capabilities. General and specific skills can be activated and developed enabling staff to know, understand, apply, transform and communicate through language or new skills.

Some core principles must be incorporated into training to ensure it is in accord with an individual's preferences, including: i) real and meaningful training must be provided; ii) training must facilitate the creation rather than the consumption of information; iii) training must be unique; and, iv) training must be rich and multisensory.

Keeping the training real. Training should begin with a dynamic presentation and a significant ice-breaker so that all participants feel warmly integrated into the course (this will exercise the host). In order to establish high quality links, when the objectives of training are presented to trainees the trainer should make sure that there are real and personal benefits for all participants. Training should be carefully planned to allow the clear formulation of learning goals.'

Training is to promote the creation of meaning. Education cannot be solely dependent on the trainer, with trainees being passive or mere recipients of knowledge. Rather training must be active and constructive resulting in productive learners. A dynamic space that mobilises the resources of all actors and factors involved in the process must be utilised. This view of learning is supported by the fact that information is increasingly easily accessible; there is no need for all information to be stored by every person. In educational terms we know today that everyone learns from each other, everyone has something to contribute and share if we create the conditions for this to happen. This implies a new way of educating and training using strategies that foster this exchange of knowledge.

Training must be unique. The process of personal construction of reality involves not only cognitive elements but also those of an emotional (e.g. interests, emotions, self-concepts, and anxieties) and moral nature (values, norms); these are potential activators or inhibitors of the process. Therefore training must have a meaning for each trainee, one that takes into account their own reality and is designed to respond to the individual needs of each trainee

Rich, multisensory training. Methodological requirements are considered essential for the renewal of educational practice. Thus the development of clear lines of communication between professionals is essential to encourage explanation, debate and confrontation of their own ideas as well as exploration of their wider implications. Training must promote an awareness of alternative perspectives in order to promote a critical analysis of the trainee's cognitive processes and allow subsequent restructuring and significant appropriation of knowledge and critical thinking. Educational technologies must therefore be based on proposed activities that should be viewed as personal projects by the trainees. These must include problem-solving activities that enable: i) the development of the predictive power of the resolution strategy and the construction of a number of possible solutions to a given problem; and, ii) the comparison, review and selection of alternatives considered acceptable by the group (including the trainer).

One of the trainer's key roles is to build an appropriate learning environment. Acknowledging that the adult/professional only learns by participating in the educational process we consider that:

- The content must be in accordance with the trainer's interests. The training must help them to reach their goals or to improve their professional practice;
- The training must be as exciting and attractive as possible, incorporating a wide variety of real practices and contexts. This will increase the motivation for learning, especially in informal environments;
- All assessment must relate to real practice and contexts.

The training methodology in this manual is based upon **Problem-Based Learning** techniques developed by McMaster University in the 1960s. It is a student/professional pedagogy in which students/professionals learn about a subject in the context of complex, multifaceted, and realistic problems. Working in groups, students/professionals identify what they already know, what they need to know, and how and where to access the required new information that may lead to a successful resolution of the problem. The role of the instructor is that of a facilitator of learning who provides the appropriate scaffolding for the process by (for example) asking probing questions, providing appropriate resources, and leading class discussions, as well as designing assessments undertaken by students/professionals. Unlike traditional instruction, Problem-Based Learning actively engages the students/professionals to self-construct knowledge in their own mind, and thus addresses many of the deficits of traditional knowledge.

Characteristics of Problem-Based Learning include: i) challenging, open-ended, ill-defined and ill-structured problems drive learning; ii) trainees generally work in collaborative groups; and, iii) trainers take on the role of learning 'facilitators'. Problem-Based Learning uses a combination of learning strategies to discover the nature of a problem, enabling an understanding of the constraints and requirements necessary for a successful resolution. This defines the required resources, and provides an understanding of different viewpoints. Trainees learn to negotiate the complex sociological nature of a problem and how different perspectives may inform decision-making. Advocates of Problem-Based Learning claim it can be used to enhance content knowledge while simultaneously fostering the development of communication, problem-solving, and self-directed learning skills.

The acquisition and structuring of knowledge in Problem-Based Learning is thought to work through the following cognitive effects (Schmidt 1993): i) the initial analysis of the problem and activation of prior knowledge is enabled through small-group discussion; ii) elaboration on prior knowledge through active processing of new information; iii) restructuring of knowledge and the construction of a semantic network; iv) social knowledge construction; v) learning in context; and, vi) stimulation of curiosity.

Applying this methodology to our training themes guided the design of our different units. The most important role played by the trainer is to predispose participants to adhere to preventive and harm reduction measures in nightlife contexts. To successfully achieve this trainers have to provide significant information to trainees and also enable trainees to be able to choose the correct course of action in critical situations.

This methodology enhances content knowledge while simultaneously fostering the development of communication, problem-solving, and self-directed learning skills. Our training intends to position participants in a scenario with ethical problems that need to be understood and resolved to create a successful outcome; this outcome requires working through policy decisions and implementing them in a professional context. By identifying and discussing a range of learning strategies the nature and root cause of a problem can be discovered. By understanding the constraints and options of each potential resolution and clearly defining the input variables, an appreciation of a range of viewpoints is attainable. Thus students/professionals learn to negotiate the complex sociological nature of the problem and how different perspectives can inform decision-making.

One of the aims of Problem-Based Learning is the development of self-directed learning skills. Problem-Based Learning can be defined as a process in which individuals take the initiative in diagnosing their learning needs, formulating goals, identifying human and material resources, choosing and implementing appropriate learning strategies and evaluating learning outcomes (Wood 2008). By being invited into the learning process, participants are also invited to take responsibility for their learning, which leads to an increase in self-directed learning skills.

In training activities '**role-playing games**' are an effective method of increasing awareness, enhancing participant analysis of field situations, and familiarising participants with the roles, aims, perspectives and positions of people whom they will meet in the field. Through role-play participants can experience and explore the feelings and potential outcomes of a personal, social or professional situation without suffering the actual consequences of their decisions. Within role-playing training activities knowledge absorption is faster, more concentrated and complete. This results in increased rates of knowledge retention. Participants should know how to work in small groups and be familiar with multi-step decision-making. Role-play is ideally suited to small groups; this fits well with our training model.

Role-play can provide an opportunity to:

- Broaden personal skills;
- Practice and reinforce new skills without fear of failure or criticism;
- Generate solutions to conflict situations in a safe environment;
- Reflect a range of responses to particular situations;
- Experiment with other roles and personalities in a non-threatening environment, and experience the feelings that may accompany decisions;
- Empathise with, and consider, the rights, values and feelings of others.

For the trainer, role-play may be used to explore the attitudes, values and skill levels of trainees; and also as an evaluation tool to assess any changes over time.

Role-play involves the adoption of a particular attitude, point-of-view or value stance for a particular purpose. It is essential that all participants are aware of the purpose of the role-play. Good group empathy, established ground rules and experience in working cooperatively in groups will contribute to the success of role-play activities. For role-play to be productive it must:

- Encourage both socially acceptable and unacceptable story lines – this will ensure the exploration of a wide range of real life and professional possibilities;
- Allow participants to withdraw at any time without explanation - participants must feel comfortable and safe;
- Include safeguards – for example, if the trainer assesses that participants have become anxious or disturbed they should stop the exercise;
- Use 'time-outs' to interrupt the role-play - enabling the drawing of attention or re-focussing of the activity or particular situation;
- Use short scenarios - thus keeping participants focused on the outcome and not the play-acting;
- Encourage participants to create their own scenarios to reflect real or professional life and whenever possible use real stories from the trainees own experience;
- Use role-play in small groups to maximize involvement and avoid the pressure of having an audience;
- Debrief participants after the role-play to ensure that anxiety or other feelings/emotions that have been generated are calmed down;
- Provide the potential for relaxation exercises both before and after a role-play;
- Constantly reinforce the idea of confidentiality within role-play sessions.

Despite the diversity of techniques that can be used in this course, the recurring characteristics of this training course are:

- Learning is driven by challenging, open-ended, ill-defined and ill-structured problems.
- Professionals generally work in collaborative groups.
- Trainers take on the role of 'facilitators' of learning.

According to the 'Life Skills Training Guide for Young People' (UN 2003), the key characteristics of an effective trainer are:

- A warm and open personality, with the ability/capacity to show the trainees approval and acceptance. **Trainers must be approachable;**
- In-depth knowledge of the subject matter;
- Good social, cultural and communications skills - including the ability to bring a group together and maintain control without causing adverse effects;
- The capacity to encourage participants to share their ideas, experiences and skills;
- Strong organisational skills that maximise all available resources;
- The skill to identify and subsequently resolve participant's problems, issues or situations;
- Genuine enthusiasm for the subject and the capacity to present material in an interesting and innovative way;
- Flexibility in response to the changing needs of participants;
- High capacity for confidentiality;
- The ability to build capacity for participants to develop 'critical thinking'.

1.3 The units

There are six units which can be programmed in a flexible manner (in content, time and order), but we recommend the order in which the units are presented in this manual. Each unit has theoretical and practical components. The methodology is of an interactive nature (role-playing, problem solving, case discussions). Each unit is described using a standardised format that we believe includes sufficient information on all the necessary variables for the trainer to ensure successful application. Also included in the manual is a list of questions/suggestions to help the trainer increase the productivity of the learning process.

All the units in total have the expected duration of about 15 hours (See Table 1). However the First Aid and Emergency Care unit may require an extended session of an extra 1.5 hours. The organisation of the course (duration and units) is negotiable depending on the make-up of each group and each individual situation. Training courses should be done in small groups (maximum of 20 participants). It is possible to offer support services and follow-up to companies or professionals who request it after training.

Important note

First Aid and Emergency Care training should only be delivered by a professionally qualified trainer. Procedures and best practice varies between countries and individuals should be aware of what is considered best practice within their localities. Best practice in First Aid is under a continual process of revision and improvement. Trainers should always check with the most recent literature what is the most up to date and effective practice.

This unit is intended only as a guide to a professional trainer towards those elements of first aid which are important to include in any course designed for those working in nightlife environments.

In no circumstances should this training module be self-administered or administered by someone without a professional First Aid qualification.

1.4 Tips to help the implementation of units

Work space. Allow enough space for the group to be comfortable, thus enabling demonstration techniques and group reflection to take place with ease.

Before starting. Review the rules of working groups (tasks and time)

Different methods of evaluation possible. The training course as a whole (and each individual unit) can be evaluated both quantitatively and qualitatively.

Work groups. Organise trainees in small groups. Each group should be constructed so that people from each venue/organisation/company are dispersed to enable the increased diversity of learning.

Be clear. Transmit clear information and give simple instructions.

Make Learning Fun. Fun learning is effective learning

Table 1: A brief summary of the content of each unit and their expected duration

Unit	Content	Time	
1	Psychoactive substances classification, definitions, concepts, effects and associated risks	2h20m	Day 1
2	Communication. Conflict resolution and preventive strategies	3h30m	
3	First aid (and emergency care*)	2h (1h30m)	Day 2
4	Training for the responsible dispensing of alcoholic beverages	2h30m	
5	Management of the physical context	2h20m	Day 3
6	Legislation	2h20m	
*optional training of emergency care		15h or *16h30m	

A final comment regarding this manual: Although this is a product of the Club Health project and is freely available, our expectation is that people who intend to use this manual should undertake training prior to use. Misuse or noncompliance of material can change both the intended objectives and the expected results.

UNITS

UNIT 1. PSYCHOACTIVE SUBSTANCES

OVERVIEW

Over the last few years the misuse of licit and illicit drugs has increased considerably. This has resulted in a number of health and socio-economic problems for our societies and has become an important health challenge. We have learned to live with drugs in our communities. Society's views of which drugs should be legal or illicit change over time and are dependent on economic, cultural, and political considerations. Over the last few years we have seen important changes in relation to substance-use trends.

New trends have appeared. Now different contexts of use/misuse exist and new groups of consumers have evolved; e.g. more women have entered the demographic and the age of initiation has decreased. Within the scientific literature it is possible to find a clear relationship between specific nightlife recreational environments and synthetic substance use, as well as evidence of a high prevalence of recreational substance use (e.g. Bellis et al. 2000; Calafat et al. 1999; Forsyth et al. 1997; Tossman et al. 1999). Licit and illicit drugs can cause a host of physical, psychological, social and economic harms not only to the individual but to families and the wider community. The 'language' of addiction, however, is often confusing. Different interpretations about terms, definitions and concepts exist, resulting in the fact that frequently the same subject/term has different/multiple understandings. For this reason it is essential to build a 'common language'. This will create a number of benefits; firstly to aid a better understanding of the complexities of drug abuse/misuse and secondly to facilitate and share knowledge and understanding. While standardising the language, concepts and definitions about the drug scene will bring multiple benefits, at the same time workers must teach and share knowledge, information and evidence concerning current issues. When training is undertaken with this perspective this unit becomes an integral part of training as it is essential that we provide professionals with credible information that meets their needs concerning substances and their effects and consequences.

CORE CONCEPTS OF THIS UNIT

- Drug use, abuse and misuse
- Psychoactive substances; Classification
- Licit and Illicit
- Tolerance
- Dependence: physical and psychological
- Effects and symptoms
- Myths and beliefs

Attached (Annex 2) is a brief description of the main subjects related to each most popular psychoactive substances - the trainer must have a solid knowledge background concerning these issues.

GOALS

- To identify the most common psychoactive substances and their effects and consequences.
- To clarify concepts and definitions
- To demystify myths and erroneous beliefs

TIME

2h 20m

MATERIALS

Work Sheet 'Psychoactive substances': Annex 1.

Additional information - 'Legal and illegal drugs - Their effects and consequences' (Annex 2)

PROCESS

Step 1. Introduction to Group Work. (5 minutes)

Make a clear general presentation of the training (Note - this may be the first contact trainees have with this course). (5 minutes)

Step 2. Group Work. (25 minutes)

- I. Unit introduction (5 minutes)
- II. Taking into account the total number of trainees, the trainer organises small groups of approximately 3 / 4 individuals
- III. Distribute one exercise sheet per group (Annex 1)
- IV. Each group selects a substance on which to work, then works as a group (20 minutes)

Step 3. Presentation of Group Work. (30 minutes)

Each group appoints a spokesperson to present their group's work. The trainer should only take notes concerning trainee's views and opinions.

Step 4. The trainer summarises trainees work within a presentation which integrates key definitions, concepts, substance classifications and their effects and consequences. If desired the trainer can use PowerPoint. (50 minutes)

Step 5. Participants will be asked to raise any questions or comments that they have. Reflection dialogue is extremely important. (10 minutes)

Step 6. Unit evaluation. (10 minutes)

The trainer will ask trainees to make verbal comments about the session before providing an anonymous evaluation questionnaire.

UNIT 2. COMMUNICATION, CONFLICT RESOLUTION AND PREVENTIVE STRATEGIES

OVERVIEW

Communication is a complex interactive process and should be thought of as the exchange and flow of information, thoughts and ideas from one-to-one or one-to-many; it involves a sender transmitting an idea, information, or feeling to a receiver. This process requires a vast repertoire of skills; e.g. intrapersonal and interpersonal processing, listening, observing, speaking, questioning, analysing and evaluating. Professionals may struggle to be effective communicators unless they are motivated by the understanding that competence in oral and non verbal communication is a lifetime skill that will: i) enhance their personal relationships; ii) their ability to obtain and progress in employment; and iii) their effectiveness in changing the ideas, beliefs, or actions of others (Chesebro et al. 1995). Conflict is part of our lives and we've all seen or experienced situations where different people with different interests and needs have come into conflict. In recreational contexts however, people with the same interests, tastes and needs can also engage in conflict.

Looking at the reality of recreational contexts makes us realise how very important communication is. It is through publicity (written, oral and visual communication) that customers are attracted to our recreational facilities and it is through communication (e.g. music/sound/images) that we respond to their needs and desires. Improving our staff's communication skills will allow us to reduce the problems that we know happen in our venues (e.g. violence, aggression, accidents), thus creating a healthier and safer environment. Conflict resolution training prepares staff for difficult or problematic situations that we know often happen. If situations can be anticipated then they can be avoided, thus preventing negative consequences for the venue and its staff and customers. In many cases effective conflict resolution in recreational contexts can make the difference between positive or negative outcomes for owners, staff and customers.

This unit can be divided into two sections: 1) communications skills; and 2) conflict resolution.

CORE CONCEPTS OF THIS UNIT

- Communication: both process and communication elements
- Verbal and non-verbal communication
- Body language
- Conflict
- Conflict resolution
- Assertiveness
- Communication styles

GOALS

- To recognise the importance of communication within human relationships
- To recognise different communication styles
- To identify, learn and discuss different styles of effective communication
- To increase communication skills in internal (between staff elements) and external relationships (between staff and customers)
- To identify signs associated with conflict or aggressive behaviour
- To identify, analyse and discuss physical and verbal behaviours that can help to avoid situations of conflict (preventative strategies)

TIME

3h 30m: Part 1(1h) / Part 2 (2h 30)

MATERIALS

Work sheet – ‘Conflict Situations’: Annex 3

Additional information ‘Role Playing Instructions’ - Annex 4

PROCESS

Part one – ‘Communication activity’

Step 1. Introduce the unit. (5 minutes)

Step 2. Pedagogical game. (45 minutes)

- Divide the group into two and ask trainees to maintain strict silence for the entire game. (3 minutes)
- Place trainees head-to-head - lined up facing each other separated by a space of about 3 meters between the two lines and about 0.5 meters between members of the same line. (2 minutes)

○ ○ ○ ○ ○ ○ ○ ○ ○ ○
○ ○ ○ ○ ○ ○ ○ ○ ○ ○

- Instruct trainees to note as much detail as possible about this person. Ask them to make intense eye contact, but never to establish verbal contact. (5 minutes)
- Now ask trainees to move forward one meter

and repeat action III. Mention to trainees that as they are now closer they should be able to notice much greater detail about the person in front. (5 minutes)

- Now ask trainees to advance to a position as close as possible from the other person but where they still feel comfortable with the other person. They should not physically touch the other person. In this position repeat action III. (3 minutes)
- Ask trainees to return to their starting position and relax. (2 minutes)
- Trainees must find (choose) another partner and repeat the step-by-step process. (15 minutes)
- At the end of the exercise all trainees must talk about and reflect upon the experience they have had. The trainer should discuss his perceptions of the exercise based on what the trainer has observed. (10 minutes)

Step 3. Using a PowerPoint presentation the trainer introduces the subject of communication skills. (10 minutes)

For the SECOND PART of the Unit the trainer should introduce the next theme with this question: “who has not already taken part in (or witnessed) a conflict within a recreational nightlife context?”

Step 4. Individual Work. Distribute one worksheet per trainee (Annex 3). (10 minutes)

Step 5. Group Work. (50 minutes)

- I. When everyone has finished the worksheet ask trainees to form groups of 2/3 (taking into account the number of participants on the training course).
- II. Ask trainees to compare their responses and comments and try to agree on one response per group - **responses must be agreed.** (20 minutes)
- III. Each group appoints a spokesperson to present their work.
- IV. Let the trainees present their responses. (The trainer should take notes of trainee’s opinions and comments from other trainees). (20 minutes)

Step 6. Role Play. (30 minutes)

- I. Propose a role-play using one story chosen by the group (review Annex 4).
- II. Ask trainees to take roles
- III. Role-play. (20 minutes)
- IV. The trainer leads an analysis of the role-play and the situations created. (10 minutes)

Step 7. The trainer should sum-up the work undertaken by trainees, integrating information about how to increase communication skills in both internal (between staff elements) and external relationship (between staff and customers). This presentation can utilise PowerPoint. (40 minutes)

Step 8. Participants will be asked to raise questions or comment on what they have seen and heard - reflection dialogue is very important. (10 minutes)

Step 9. Unit evaluation. (10 minutes)

The trainer will ask trainees to make verbal comments regarding the session before providing an anonymous evaluation questionnaire.

UNIT 3. FIRST AID AND EMERGENCY CARE SKILLS

OVERVIEW

FIRST AID is the provision of initial care for an acute illness or injury. It is usually performed by non-experts (but preferably by trained personnel), on a sick or injured person until professional medical treatment can be accessed. Within recreational contexts critical situations can occur that people try to resolve but not always in the best or most effective way. Bad or mis-applied first aid is not effective and can sometimes worsen situations.

Certain self-limiting illnesses or minor injuries may not require further medical care beyond a first aid intervention; but this decision should be taken carefully because some (apparently) simple situations can become serious.

FIRST AID generally consists of a series of simple, and in some cases potentially life-saving, techniques that an individual can be trained to perform with minimal equipment. FIRST AID training must be delivered by an accredited trainer (e.g. a doctor or other health professional) using appropriate materials.

The main aims of FIRST AID can be summarised in three key points:

1. To preserve life: this is the overriding aim of all health care/FIRST AID
2. Reduce harm: also sometimes called 'prevent further injury' or 'prevent the condition from worsening'. This covers factors such as: i) moving patients away from causes of harm; and, ii) applying FIRST AID techniques to prevent further worsening of the condition
3. Promote recovery: FIRST AID can be viewed as the start of the recovery process (from the acute illness or injury) and, in some cases, might involve the completion of treatment, e.g. applying a plaster to a small wound.

This unit aims to help nightlife premises staff develop the ability to deliver basic health care in a range of acute situations. Our FIRST AID training involves both:

- Providing the capacity to recognise a number of critical situations that frequently occur in nightlife contexts and to deliver safe and appropriate FIRST AID; and,
- Ensuring that relevant professional medical treatment is accessed

This unit focuses on FIRST AID training. Scenarios are presented in which trainees are asked to solve problems, thus exposing their first aid knowledge. The trainer should observe participants responses, identifying to trainees correct and incorrect procedures. After potential solutions have been discussed the trainer presents and demonstrates the correct procedures and informs trainees about the consequences of incorrect procedures. Each group should be asked to propose strategies to effectively manage emergency situations that they may encounter within their own context (e.g. night club, concert, rave, etc).

CORE CONCEPTS

- First aid and emergency care
- Trauma
- Overdose
- Intoxication
- Cardio Pulmonary Resuscitation techniques (CPR)

GOALS

- To identify critical situations; even when they appear non-critical;
- To acquire knowledge and skills to administer first aid care techniques;
- Creating the awareness to protect victims from other clients;
- Providing the knowledge and skills to maintain first aid facilities and to make sure any specific rooms/areas are appropriately equipped;
- To be aware of the need to abstain from value judgments about the victims behaviours and to refrain from guilt or moralising discourse;
- To effectively use the ambulance/emergency services referral guidelines;
- To influence people in need to access appropriate medical care.

TIME

2h without optional CPR training module (+ 1h 30m)

MATERIALS

Work sheet 'First Aid': Annex 5

Additional information 'First Aid Training Cards' - Annex 6

If an extended session (4h) is provided involving the training of Cardio Pulmonary Resuscitation techniques (CPR) then personal inflatable manikins (+ related hygienic material) are required (numbers are dependent on group size).

PROCESS

Step 1. Unit introduction. (5 minutes)

Trainer outlines the objectives/expectations of this unit. Trainer asks trainees if they are familiar with a number of situations (e.g. choking/suffocation, stabbing, cardiac arrest, falls, heroin overdose, alcohol overdose, haemorrhage, rape, etc) and discusses the frequency of their occurrence within recreational contexts.

Step 2. Group Work. (80 minutes)

- I. Trainer asks trainees to form groups of 3/4 (dependent on the number of participants).
- II. Each group is given a worksheet. 1 or 2 scenarios should be discussed (Annex 5) with each trainee individually describing a course of action. (5 minutes)
- III. Trainees are asked to compare their responses and to choose a group spokesperson and to create a single response per group. A single response must be agreed. (20 minutes)
- IV. Each group spokesperson presents their group's problem resolution strategy. For each scenario the group should highlight the most appropriate first aid techniques and any common mistakes. (5 minutes per group)
- V. After each presentation the trainer highlights what was correct and explains the reasons for each required First Aid procedure. The trainer must also focus on what is not correct then shows the correct procedure. The trainer must also explain the disadvantages of proceeding improperly (see Additional Information First Aid training cards - Annex 6). (5 minutes per group)

Step 3. Trainer reviews each objective of the FIRST AID training. (20 minutes)

Firstly, the skills required to recognise critical situations and to deliver safe and appropriate first aid. Secondly, the necessity of ensuring that definitive medical treatment can be accessed. The trainer discusses with the group:

- The common presenting features associated with various categories of recreational drugs;
- The key objectives of first aid (preserve life, reduce harm, promote recovery)
- Appropriate club medic room facilities and equipment;
- How and when to use the ambulance/emergency services;
- How to influence people in need to make sure they access the appropriate medical care.

The trainer should sum-up the work undertaken by trainees, integrating definitions, concepts and techniques. This presentation can utilise PowerPoint.

Step 4 OPTIONAL. The trainer demonstrates the multiple stages of the Cardio Pulmonary Resuscitation technique (CPR) using appropriate training aids. The group is organised into pairs. Each trainee **must** practice all of the multiple stages of the CPR technique using the personal inflatable manikins when required. Trainees perform the skills while their partner evaluates; trainees then switch roles. Trainees should get as much practice as possible (90 minutes).

Step 5. Unit evaluation. (15 minutes)

The trainer will ask trainees to make verbal comments regarding the session before providing an anonymous evaluation questionnaire.

UNIT 4. TRAINING FOR THE RESPONSIBLE DISPENSING OF ALCOHOLIC BEVERAGES

OVERVIEW

Alcohol is a part of many lives and cultures and is associated with several types of events within societies. Many situations serve as a pretext to drink one or more glasses of alcohol. Within many different situations alcohol is used to celebrate life (e.g. a victory, good news [personal or professional]) or because we want to forget the pain of a loss or failure. Most of the time people don't see alcohol as a psychoactive substance. However alcohol's addictive potential can result in physical, psychological, social, economic and legal consequences. As well as the potential for severe health risks (including death), alcohol misuse also has a significant impact on social and economic factors. Domestic violence, violent crimes, traffic accidents, injuries, absence from employment, workplace accidents and unsafe sexual practices are just some of the outcomes and consequences of alcohol misuse. Liquor and beverage companies use their power not only to directly promote alcoholic beverages but also to promote festivals (and other events) where alcohol has an important role.

For many young people alcohol consumption plays an integral part in weekend leisure activities. Young people very often look for places with cheap prices; however, the relative cheapness of alcohol can lead to over-consumption. Alcohol works like a social facilitator, or social lubricant, and encourages people to 'have fun'. The consumption of alcohol is known to also be a source of problems and conflicts, both for consumers and for those people who (in one way or another) come into contact with them (e.g. waiters, bar staff, door supervisors). The main responsibility for ensuring a safe environment lies with the owners, managers and staff of nightlife establishments. It is therefore very important to work with them; providing training and support can help to ensure a healthier, safer recreational context. In order to manage problem behaviour in public drinking settings, all staff need to be able to communicate effectively with each other and with customers and to be able to work as a team; plans need to be prepared in advance (staff must be proactive and not just reactive) to handle problematic or extreme situations. Staff need to be able to stay calm and non-violent even when provoked. This requires the training and development of good communication skills and situational and emotional control.

CORE CONCEPTS

- The effects and consequences of alcohol consumption (use and misuse)
- Drunkenness
- Vertical drinking
- Binge drinking
- Blood alcohol levels
- Traffic accidents
- Violence
- Myths and beliefs
- Training for the responsible dispensing of alcoholic beverages

GOALS

- To recognise the effects and consequences of alcohol consumption (use and misuse)
- To discuss the five reasons why women should drink differently to men
- To recognise the telltale signs of drunkenness
- To discuss strategies to enable the refusal of service to intoxicated persons and minors
- To discuss strategies to enable the avoidance of violence and traffic accidents

TIME

2h 30m

MATERIALS

Work sheet 'The responsible dispensing of alcoholic beverages': Annex 7
Additional information 'Role-playing Instructions' - Annex 4

PROCESS

Step 1. Unit introduction. (5 minutes)

Step 2. Individual Work. Distribute one worksheet per trainee (Annex 7). (10 minutes)

Step 3. Group Work. (45 minutes)

- I. When everyone has finished the worksheet ask trainees to form groups of 2/3 (dependent on the number of participants).
- II. Trainees are asked to compare their responses and to choose a group spokesperson and to create a single response per group. **A single response must be agreed** (20 minutes)
- III. Each group appoints a spokesperson to present their work.
- IV. Let the trainees present their responses. (The trainer should take notes of trainee's opinions and comments from other trainees) (20 minutes)

Step 4. Role-play. (30 minutes)

- I. Propose a role-play using part of the scenario, 'from the moment that Mr. Jose remembers what happened that night' (review Annex 7).
- II. Ask people to take roles: Mr. Jose/the customer/lady friend
- III. Role-play (20 minutes)
- IV. The trainer analyses the role-play (10 minutes)

Step 5. The trainer should sum-up the work undertaken by trainees, integrating the information about how to negotiate the responsible dispensing of alcoholic beverages to customers. This presentation can utilise PowerPoint. (40 minutes)

Step 6. Participants will be asked to raise any questions or comments they have on what they have heard. Reflection dialogue is very important. (10 minutes)

Step 7. Unit evaluation. (10 minutes)

The trainer will ask trainees to make verbal comments regarding the session before providing an anonymous evaluation questionnaire.

UNIT 5. MANAGEMENT OF THE PHYSICAL CONTEXT

OVERVIEW

Safety in nightlife, festivals and others recreational contexts has become a big issue; concern is growing regarding safety levels in recreational nightlife contexts. The majority of young people who go out look for a place to dance, meet other people, listen to music, have fun and enjoy a friendly atmosphere; they also certainly like to have access to cheap drinks. Bar/club/pub/disco owners and their staff have a social and legal responsibility to ensure the safety of their customers (and themselves). One response to this concern is a focus on the capacity of venues to offer security to staff and customers, and different strategies that can be deployed to deliver this. For example, well-managed drinking venues can provide some level of social protection to drinkers (e.g. preventing drunken customers from accessing more alcohol). It is accepted that the convergence of large numbers of drinkers in public places creates conditions conducive to harm (e.g. confrontation and encounters with aggressive strangers). Thus, public drinking environments experience high levels of alcohol-related harm, including; drunkenness, aggression, sexual assaults, public disorder, unintentional injuries, drink-driving and road traffic accidents (Hughes et al. 2011).

To reduce these high levels of alcohol-related harm it is increasingly seen as the responsibility of owners and staff to effectively manage the physical context of venues. This is related to the physical organization of recreational facilities and activities. Organization involves issues like: lighting, dark areas, seating, temperature, ventilation, control of problematic areas, access, bar queues, control of toilet facilities, door control, glassware policy, and multimedia control (e.g. violent images or images connected to sexually explicit behaviors).

CORE CONCEPTS

- Nightlife settings
- Management
- Safety
- Security
- Organization/Supervision

GOALS

- Awareness of how nightlife settings can function better
- To effectively identifying highly problematic situations within venues
- Improving the safety and comfort of venues

TIME

2h 20m

MATERIALS

Work sheet 'Physical context': Annex 8/8A/9/9A

PROCESS

Step 1. Unit introduction. (5 minutes)

Step 2. Individual Work. Distribute one worksheet per trainee. (20 minutes)

The worksheets distributed depends on whether the professional works in:

- a small venue (e.g. a bar) - They get the worksheet from Annex 8 and 8A
- a large venue (e.g. a disco) - They get the worksheet from Annex 9 and 9A

Step 3. Group Work. (55 minutes)

- I. When everyone has finished the worksheet ask trainees to form groups of 2/3 (dependent on the number of participants). If the training group is heterogeneous and includes people from other venues or facilities then groups should be constructed with trainees from a range of venues. (15 minutes)
- II. The group should reflect upon the responses and comments they gave and should build a list of important safety considerations. (20 minutes)
- III. Each group appoints a spokesperson to

present their work.

- IV. Let the trainees present their responses (The trainer should take notes of trainee's opinions and comments from other trainees). (20 minutes)

Step 4. The trainer should sum-up the work undertaken by trainees, integrating the information about how to negotiate the responsible dispensing of alcoholic beverages to customers. This presentation can utilise PowerPoint. (50 minutes)

Step 5. Participants will be asked to raise any questions or comments they have on what they have heard. Reflection dialogue is very important. (10 minutes)

Step 6. Unit evaluation. (10 minutes)

The trainer will ask trainees to make verbal comments regarding the session before providing an anonymous evaluation questionnaire.

UNIT 6. LEGISLATION

OVERVIEW

In most EU countries the legal system takes into account the type and 'harmfulness' of a drug and whether the offence relates to involvement in the drug market, to personal use or possession for personal use (EMCCDA Annual Report 2010).

This unit presents a set of scenarios/situations that are common occurrences during the everyday experience of nightlife workers (e.g. DJ's, bartenders, door supervisors and waiters); some of these scenarios/situations can have important legal consequences. It is therefore important that the potential legal consequences of some actions/strategies deployed by nightlife workers are discussed.

The fact that each European country is governed by its own laws led us to identify a set of issues that, despite not having identical answers in each jurisdiction, have certain themes that 'cross' territorial boundaries. Nevertheless this unit must be adapted by trainers to reflect local and/or national contexts and realities.

CORE CONCEPTS

- Offenders
- Criminalisation
- Video vigilance
- Fines / penalties
- Aggression

GOALS

- Awareness amongst professionals of the legal consequences of their behaviours or lack of them

TIME

2h 20m

MATERIALS

Work sheet 'Legislation': Annex 10

PROCESS

Step 1. Unit introduction. (5 minutes)

Step 2. Individual Work. Distribute one worksheet per trainee - Ask them to review the scenario and answer the questions (15 minutes):

Step 3. Group Work. (55 minutes)

- I. When everyone has finished the worksheet ask trainees to form groups of 2/3 (dependent on the number of participants). If the training group is heterogeneous and includes people from other venues or facilities then groups should be constructed with trainees from a range of venues. (15 minutes)
- II. The group should reflect about the responses and comments they made and should build a list of important safety considerations. (20 minutes)
- III. Each group appoints a spokesperson to present their work.
- IV. Let the trainees present their responses (The trainer should take notes of trainee's opinions and comments from other trainees). (20 minutes)

Step 4. The trainer should sum-up the work undertaken by trainees, integrating the information about how to negotiate the responsible dispensing of alcoholic beverages to customers. This presentation can utilise PowerPoint. (50 minutes)

Step 5. Participants will be asked to raise any questions or comments they have on what they have heard. Reflection dialogue is very important. (10 minutes)

Step 6. Unit evaluation. (10 minutes)

The trainer will ask trainees to make verbal comments regarding the session before providing an anonymous evaluation questionnaire.

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Irefrea (www.irefrea.org)

Liverpool's City Safe http://www.liverpool.gov.uk/Policing_and_public_safety/Citysafe/citysafe_partnership/index.asp

NIDA (<http://www.drugabuse.gov/NIDAHome.html>)

Nightlife Tool Box (<http://www.hnt-info.eu>)

Predatory Drugs: (<http://www.justice.gov/dea/concern/predatory.html>)

SAMSHA (<http://prevention.samhsa.gov/about/spf.aspx>)

STAD (<http://www.stad.org/default.aspx?id=4&epslanguage=EN>)

FIRST AID (<http://www.youtube.com/watch?v=tEliEAn7b-U>)

ANNEX 1. Psychoactive substances

Group Work about _____

Reflect on the most commonly consumed substances: Tobacco, Alcohol, Cannabis and Cocaine. Think about the type of consumption and the myths associated with substance use.

1. Each group should concentrate on a family of substances and explore everything they know about it
2. From the work produced, reflect on aspects related to beliefs, myths and risks associated with new substances and explore the pathways that can result in situations of abuse

CHARACTERISTICS OF THE SUBSTANCES/ Physical appearance	METHODS of administration	EXPECTED EFFECTS	UNEXPECTED EFFECTS	BELIEVES/MYTHS
Reasons and context for the use / abuse and misuse	Is it easy to purchase this substance?	PHYSICAL DEPENDENCIES	PSYCHOLOGICAL DEPENDENCIES	What to do in a situation of misuse?

Group ID

Name _____

Age _____

Name _____

Age _____

Name _____

Age _____

Name _____

Age _____

Name _____

Age _____

Name _____

Age _____

ANNEX 2. Legal and illegal drugs - Effects and consequences

The Illegal and legal drug use drug prevalence levels reported from surveys conducted within dance music settings inevitably vary according to the type of setting, the type of music played, the target group and also the year in which the survey was conducted (EMCDDA 2006). Research studies targeted at young people in the EU who attend dance music events consistently report much higher prevalence of drug use than that found in surveys of the general population. This appears to be the case in all of the countries where such surveys have been conducted (EMCDDA - Annual report 2006).

Caffeine. Caffeine acts as a central nervous system stimulant and is the world's most popular psychoactive substance. It is found in varying quantities in the seeds, leaves, and fruit of some plants. It is most commonly consumed by humans in infusions extracted from the bean of the coffee plant and the leaves of the tea bush, as well as from various foods and drinks containing products derived from the kola nut. Since the 1980s soft drinks have risen dramatically becoming significant source of caffeine (e.g. energy drinks) and are commonly associated with nightlife contexts.

Alcohol. Reducing alcohol use and related harm in young people is a major European public health priority (Commission of the European Communities 2006). This legal drug is the most commonly used, not only in recreational contexts but also at home, during meals and in different social celebrations or events (Calafat 2010).

Alcohol is actively promoted in many ways; in social, cultural, recreational and religious situations. Alcohol also provides a very important source of revenue for governments and local economies. Europe is the global region with the highest rate of alcohol consumption (Anderson and Baumberg 2006). In small amounts alcohol normally makes people more sociable, acting like a 'social lubricant' (Calafat 2010). However increased amounts of alcohol affect the drinkers mood, skills and performance; problems can arise even before a person becomes 'drunk' (Calafat 2010). Many people do not perceive alcohol as a psychoactive substance with a high addictive potential and a wide range of potential consequences. Typical alcohol-related problems are violence, risky sexual behavior and drink-driving. Comas can easily occur if too much alcohol is imbibed.

A study conducted by IREFREA (Sonar Project - 1998) within nine Europeans cities identified similarities and differences in the way young partygoers (age 16–30) enjoy night life. The Sonar Project tried to study different drug use patterns and sub-cultures; it was observed that seven out of ten informants had been drunk at least once during the last month. Between the ages of 23-25 hangovers are generally fairly easy to overcome; many people from this age-group also consider that a hangover is a fair price for a fantastic night (Calafat et al. 1999). The problem now is that young people tend to get intentionally drunk. Binge drinking has become a serious issue in European towns and cities.

Tobacco. Although smoking has been declining for some time in many European countries, the rate of decline is now slowing (Graham 1996). Women are smoking as much as men in many countries; particularly girls often smoke more than boys (Allender et al. 2009). Due to the nicotine content tobacco is very addictive; nicotine is the most active and toxic component. Several researchers have shown that tobacco is a better predictor of concurrent illicit drug use than cannabis (Rassol 2009). The health effects of high levels of exposure to 'second-hand' smoke (i.e. staff) may be close to those of active smoking; including the increased risk of lung cancer, diabetes, respiratory and cardiovascular diseases, hypertension, stroke and sexual health problems (Calafat 2010). Banning smoking inside premises is a crucial health prevention initiative, which is already in existence in some countries. This measure, however, is sometimes not enforced in discos, bars or other premises. This is commonly due to a lack of control or supervision of the law.

Cannabis. Cannabis is the most popular and widely used illegal drug among young people (and older people as well) and has a long history of medicinal, recreational, and industrial use (Calafat 2010). It is a drug used in a wide variety of very different settings, and for different purposes (e.g. to relax, to socialise, to sleep, etc). The euphoria potential of cannabis is probably the most important characteristic in sustaining its widespread and often chronic recreational use. Even when people do not use cannabis for recreational activities (due to its relaxing effects), for example where people are expected to be active and participative, some people use cannabis to 'end the night' and relax after a party or dancing session. For this reason it is not a typical recreational nightlife drug. Another reason that explains why it is not more frequently used inside nightlife premises is that its use is very easily detected by security personnel or others members of staff (Calafat 2010).

The short term effects of cannabis are subjective (depending on many things such as expectations and motivation) including; changes in perception, mood changes (most easily noted), talkativeness, cheerfulness and the intensity of colours and sound. Other common short-term physical effects include an increased heart rate, lowered blood pressure, impairment of short-term episodic memory, working memory, psychomotor coordination, and concentration. As a consequence of these effects, driving and other activities can be impaired, becoming critical and potentially very dangerous. The availability of stronger forms of cannabis can lead to an increase of cannabis-related problems. Cannabis addiction can also be a real problem.

Linked to issues surrounding the legalisation of cannabis is the increasing level of prohibition currently affecting tobacco use in many societies. This has led to the formulation of the question: *"Why should cannabis be legalised, when a legal drug like tobacco is so strongly prosecuted?"* (Calafat 2010).

Ecstasy. Known colloquially as the "love drug", ecstasy is an amphetamine with stimulant effects. Ecstasy also has an effect on perception; consumers describe ecstasy as making them empathetic. Ecstasy produces a temporary state of 'openness' with an enhanced perception to feel music and colors in a more intense way. Some users also report feeling more connected with other people in the venue, and that contact with them is more pleasurable. Ecstasy became very popular at the end of the 80s and during the 90s and is still popular in nightlife contexts (Calafat 2010). Ecstasy became the symbol for an entire culture (techno, dance and rave), and for that reason in some countries they speak of the ecstasy generation (Calafat 2010). Ecstasy is a recreational drug and is normally not used outside this context (Calafat 2010). In the past young people thought that ecstasy was not dangerous. Now, however, it is known that ecstasy can be addictive and that it can produce anxiety, panic attacks, confused episodes

and paranoid or psychotic states. There is also the possibility that it can cause brain damage. Its consumption is related to depression, personality change and memory loss even after its use has ceased. Ecstasy affects the body's temperature control mechanisms and its use can result in heat stroke and consequently a number of deaths have been related to ecstasy consumption (Calafat 2010).

Cocaine. Cocaine Hydrochloride is a white powder derived from the leaves of the coca plant and has become very popular amongst clubbers in recent years. Cocaine is the second most commonly used illicit drug in Europe (ECMDDA 2007). Cocaine is a very short-acting stimulant; this can lead to frequent cocaine usage and/or high doses. This is one important reason as to why cocaine is so addictive. When smoked in the form of "crack," the effects come on immediately but wear off much more quickly and when injected, the effects are felt immediately and much more intensely. Many users become compulsive in their use which means a "physical or psychological" addiction. Users feel wide-awake and very confident. Regular use, however, often results in the development of serious health problems (e.g. anxiety and paranoia) (Calafat 2010). Cocaine is a known cause of panic attacks. Cocaine has caused seizures, strokes and heart attacks. People under the influence of cocaine tend to have an increased prevalence of taking unnecessary risks (e.g. driving under the influence or having unprotected sex). Cocaine use is well correlated with the simultaneous use and abuse of other drugs (Calafat 2010). The negative effects of cocaine are not widely clearly perceived. Cocaine users are, in many cases, polydrug users. Cocaine is frequently mixed with alcohol and tobacco (and sometimes with heroin). Cocaine use in combination with alcohol 'helps' the consumer to increase their alcohol use (Calafat 2010). The end result of combining other drugs with cocaine is that the consumer takes more of both drugs. Cocaine use is related (directly or indirectly) to increased risks of mortality (e.g. accidents, suicides, homicides).

Amphetamines. In recent times amphetamine use has become very popular. Amphetamines are widely used by young people as a recreational drug and performance enhancer. A range of amphetamines exists such as amphetamine sulphate, dexedrine, methamphetamine and dexamphetamine; amphetamines are quite addictive (Calafat 2010). Probably the most popular slang term for amphetamine is 'speed', but terms such as whizz, 'sulph' and uppers are also widely used. Amphetamines, like cocaine, are stimulants used to increase alertness levels and to keep people awake, making them popular within recreational contexts. However their use is not restricted to recreational contexts; amphetamine use has been widely documented within other contexts (i.e. among college students, workplace and armed conflicts). Amphetamines are often distributed in pill format, but may also be widely available as a powder or small crystals. Users quickly generate tolerance (it therefore becomes necessary to increase the dosage to achieve the same effect). Effects can last for up to six hours. Amphetamines are normally swallowed, but they can be injected and when presented as crystals (e.g. 'ice' and 'crystal meth') they can also be smoked. The effect of amphetamine kicks in within half an hour of oral consumption; if injected or smoked the effects are experienced much more quickly. Amphetamines are much more addictive and dangerous when smoked, but this form of use is not very common in Europe.

Poppers. “Poppers” is the popular name for various alkyl nitrites, including isobutyl nitrite, butyl nitrite, and amyl nitrite and have been part of club culture since 1970. Poppers dilate blood vessels allowing more blood to reach the heart. A ‘poppers rush’ normally lasts 2-5 minutes, producing warm sensations and dizziness. Poppers are usually sniffed straight from a bottle. Male homosexuals often use poppers as a sexual enhancer. Because poppers cause blood vessels to open, it is easier to get an infection, including sexually transmitted diseases such as HIV or others. Poppers are frequently sold in sex shops, clubs, internet and gay bars. Poppers have a lower risk of harm than other recreational drugs, but taking poppers can be dangerous to anyone with chest or heart problems, anemia or glaucoma (Calafat 2010). Poppers can sometimes be dangerous when mixed with other medications (especially sexual stimulants), as they can cause blood pressure to drop to dangerous level (Calafat 2010). The use of poppers after taking alcohol, cannabis or cocaine may worsen the adverse effects of the other stimulants. Due to the potential for neurological damage serious adverse effects can also occur following heavy long-term use. Swallowing or aspirating the liquid rather than inhaling its vapours is particularly dangerous and can prove fatal (Calafat 2010). The exact contents of these products are not known, and they are not safety tested.

Predatory drugs & club drugs. Drugs such as Gamma-Hydroxybutyric acid (GHB)/Gamma Butyrolactone (GBL), Ketamine and Rohypnol have become a serious problem in recreational contexts and have gained notoriety as drugs used to facilitate sexual assaults, thus increasing the urgency to law enforcement efforts to pursue distributors of these drugs. These drugs render the victim incapable of resisting sexual advances. Sexual Assaults facilitated by these drugs can be difficult to prosecute or even recognise because:

- I. Victims may not be aware that a drug has been ingested. When dissolved these drugs are often invisible and odorless. They can be somewhat salty tasting, but are indiscernible when dissolved in beverages such as sodas, juice, liquor or beer.
- II. Due to memory problems induced by these drugs, victims may not be aware of the attack until 8-12 hours after it occurred.
- III. The drugs are metabolised quickly, so there may be little physical evidence to support a claim that the drugs had been administered.

Memory impairment caused by the drugs also eliminates evidence about the attack.

Legal highs are substances that replicate the effects of illegal drugs but do not fall under the remit of current misuse of drugs laws, and so are legal to possess or use (and maybe also freely distributed). ‘Legal highs’ mimic the effects of illegal drugs (such as cocaine, ecstasy and amphetamines), but their chemical structure is slightly different, meaning they avoid being classified as illegal.

Although these drugs are marketed as legal substances, this does not mean that they are safe or approved for people to use. It merely means that they’ve not been declared illegal to use and possess. The chemicals (often fertilisers) they contain have, in most cases, never been used in human medicines and therefore have never been properly tested. Thus there is the potential for serious health problems to accrue.

Some drugs marketed as legal highs actually contain some ingredients that are illegal to possess. In combination with alcohol or any other legal or illegal substance they can be very dangerous; potentially leading to decreased inhibitions, convulsions, sleepiness or coma. Risks are very unpredictable because there is no quality or ‘purity’ control.

ANNEX 3. Conflict situations

Consider each of these 5 conflict situations. Please make some comments to these 5 scenarios and try to respond to the following question: If you were a witness how would you act?

Case 1

On the dance floor, a man accidentally bumps into another spilling some drink on his clothes. The victim raises his arms and complains! The victim asks for an explanation then pushes the perpetrator. Insults are exchanged and a challenge to fight is made. One of the men appears intoxicated.

Case 2

A man and woman are dancing on the dance floor; they appear to be enjoying the music. Another man comes up behind the woman and starts disturbing her dancing. She pretends not to notice the situation but he persists with his provocative behavior. The companion of the woman asks the intruder to move away and leave her alone. The man says something, but it is not possible to hear because of the volume of the music. The situation becomes tense and both men become increasingly aggressive, pushing and insulting each other.

Case 3

A man in a bar queue is drunk and annoying other waiting customers by talking very loudly and insulting the barman for not serving him immediately. When the barman asking him to calm down and wait his turn the man says that he is 'guest listed', is a good costumer and that he will complain to the owner whom he then says is a close friend.

Case 4

A drunken girl climbs onto a table which is against the venues rules, and dances enthusiastically for several minutes. One member of staff asks her to get down. She doesn't respond and continues to dance. The member of staff tries again but is again ignored. Finally he tries to physically make her come down from the table. During the attempt the girl falls awkwardly to the ground.

Case 5

In a club next to the bar two members of staff are engaged in a very emotional discussion. One of them was caught smoking a joint in the bathroom by another colleague who said he would notify the manager. The man caught smoking a joint had unsuccessfully tried to dissuade his colleague from this course of action, and had then violently assaulted him with a punch to the head.

Case 6

A group of girls enters the toilets. They are talking very loudly. They begin to violently knock on the cubicle doors to check if they are vacant. One of the cubicles is engaged; loud screams and insults are exchanged.

ANNEX 4. Conducting role play

Introduction and warm-up (warm-up is optional)

Select a suitable warm-up/energiser (optional) activity to focus the attention of the group and renew group empathy.

Introduce the scenario and establish the purpose of the role-play. Scenarios can be drawn from previous lessons or suggested by participants.

Allocating roles.

It is very important to be careful about the characterization of the different characters. Ideally everybody will be engaged in the role-play, but sometimes you may wish to use observers to report on what actually happened and make comments.

Setting the scene

Players are informed of their roles and the time, place and situation to be enacted: however do not dictate every detail – allow for creativity. An example of a role-play scenario is: you are trying to persuade a customer not to drink any more alcohol.

Preparing the audience

If there is an audience, set them tasks so they become active participants in the role-play. As well as this they can provide feedback (e.g. on non-verbal communication, realism and the skills observed).

Role-playing

Once the scene is set, allow the role-play to proceed. It should be brief and focused on key issues.

Feedback

Following the role-play, small or large group discussions should address:

- What was the result of the role-play?
- How did you feel in your particular role?
- What attitudes were expressed?
- What are the other potential consequences of the role-play scenario?
- What did you learn about the character you played?
- What did you detect about how the characters behaved? (Observers or other characters can comment)
- What would you do differently? (If you were in their place or if you had a second chance)

Some of the feedback session may be used to help a person 'debrief', shed their former role, and diffuse any emotion associated with it. Questions used for this purpose could be:

- How do you feel about the role you played?
- What kind of person was your character?
- Did you like your character?
- Why did your character act the way they did?
- How would you react in that sort of situation?

When conducting role-play, avoid:

- making judgments about the role-play - focus on eliciting alternative actions
- commenting on or inhibiting actions - wait until it is finished and then discuss
- casting participants in roles too close to their real-life role or family situations
- scenarios which are too complex or have too many characters

To end the process make a final comment and sum-up the work done. It is important that all participants discuss their experiences.

ANNEX 5. First Aid group work

Consider the following situations, and for each one write down the procedures and resources which you deem essential to effectively manage the situation.

CRITICAL SITUATIONS	PROCEDURES AND RESOURCES
1. Choking or suffocation On the balcony of a nightclub a couple are talking while eating peanuts. The lady starts laughing, and then suddenly and violently chokes, showing signs of a blocked airway.	
2. Stabbing or knifing At the entrance to a bar, two young men argue and one stabs the other in the chest and abdomen, leaving the knife in the body. The young man begins to breathe with difficulty and shows signs of losing consciousness.	
3. Cardiac arrest At a trance party a young person who was dancing wildly falls without apparent cause. He is not breathing and has no pulse.	
4. Fall A young woman who was dancing on top of a podium two meters in height falls and shows signs of having fractured her collar bone. After 20 minutes she violently vomits.	
5. Heroin Overdose In the doorway of a building near a nightclub two young people have been injecting. One appears very distressed telling you that the other is "not breathing or responding, will not wake up and may be dead".	
6. Alcohol Overdose A young lady has been participating in a drinking game, drinking shots with some friends. She looks confused, starts showing signs of illness then shows signs of losing consciousness.	
7. Haemorrhage (cut glass) Two young people are leaving a bar when one of them cuts her foot on some broken glass that was lying on the floor. She starts to bleed profusely.	
8. Rape A door supervisor at a nightclub is approached by a distraught crying young woman. She reports having been raped by two men who followed her from this club.	

ANNEX 6. First Aid training cards

Consider the following situations, and for each one write down the procedures and resources which you deem essential to effectively manage the situation.

CRITICAL SITUATIONS	POPULAR PROCEDURES
<p>1. Choking or suffocation</p> <p>On the balcony of a nightclub a couple are talking while eating peanuts. The lady starts laughing, and then suddenly and violently chokes, showing signs of a blocked airway.</p>	<p>Slapping the back of the patient</p> <p>Give them a glass of water</p> <p>Putting fingers or a spoon in the mouth to dislodge any obstruction</p>
<p>Choking is the mechanical obstruction of the airflow into the lungs. Choking prevents breathing, and can be partial or complete; with partial choking some airflow is maintained although it is inadequate. Prolonged or complete choking results in asphyxia which leads to anoxia and is potentially fatal if not treated quickly. Oxygen stores within the lungs and blood can keep the victim alive for several minutes after breathing completely stops.</p> <p>Symptoms and clinical signs:</p> <ul style="list-style-type: none"> ☞ The person cannot speak, cry or has great difficulty and limited ability to do so; ☞ Breathing, if possible, is very laboured, producing gasping or wheezing noises; ☞ The patient emits a violent and involuntary cough, gurgle, or vomiting noise (more serious choking victims may only have a limited ability to produce these symptoms); ☞ The patient desperately clutches his or her throat or mouth, or attempts to induce vomiting; ☞ If breathing is not quickly restored, the person's face turns blue (cyanosis) due the lack of oxygen, unconscious can soon follow. <p>Choking can be caused by:</p> <ul style="list-style-type: none"> ☞ Physical obstruction of the airway by a foreign body; ☞ Respiratory diseases that involve obstruction of the airway; ☞ Compression of the throat 	
CORRECT PROCEDURES	RESOURCES NEEDED
<p>http://www.youtube.com/watch?v=tEliEAn7b-U</p>	
<p>1. Encouraging the victim to cough</p> <p>Many people are too quick to undertake potentially dangerous interventions (e.g. abdominal thrusts), for items which could have been dislodged without such a potentially serious intervention.</p> <p>If the choking is caused by an irritating substance rather than an obstructing one, and if conscious, the patient should be allowed to drink water on their own to try to clear the throat. Since the airway is already closed, there is very little danger of water entering the lungs.</p> <p>2. Back slaps</p> <p>Give hard blows - using the heel of the hand on the upper back of the victim, slap in an upward direction, usually between five and twenty blows are administered. The blows are given to create a build-up of pressure behind the blockage, thus assisting the patient to dislodge the article. In some cases the physical vibration of the action may be enough to cause sufficient movement of the article to allow the airway to clear.</p>	<p>Emergency barriers (e.g. gloves and face mask)</p>

CORRECT PROCEDURES http://www.youtube.com/watch?v=tEliEAn7b-U	RESOURCES NEEDED
<p>3. Abdominal thrusts or the ‘Heimlich Manoeuvre’ Performing abdominal thrusts involves a rescuer standing behind a patient and using their hands to exert pressure on the bottom of the diaphragm. This compresses the lungs and exerts pressure on any objects lodged in the trachea, hopefully expelling it. In essence this is a kind of ‘artificial cough’. A modified technique is used for pregnant and/or obese patients; the first-aider places their hand in the centre of the chest and applies pressure. Even when the Heimlich Manoeuvre is done correctly it can injure the person on whom it is performed: e.g. resulting in a fracture of the xiphoid or ribs.</p> <p>4. Self treatment with abdominal thrusts A person may also perform abdominal thrusts on themselves by using a fixed object such as a railing or the back of a chair to apply pressure where a rescuer’s hands would normally do so. As with other forms of the procedure, it is possible that internal injuries may result.</p> <p>5. Finger sweeping on an unconscious patient Once a choking victim becomes unconscious a first-aider can attempt to remove any blockage by sweeping their fingers across the back of the throat to dislodge any airway obstructions. With this technique there is a risk of causing further damage (e.g. inducing vomiting).</p> <p>6. CPR Once the patient has become unconscious and is no longer breathing, performing CPR may be necessary (CPR is a combination of chest compressions and rescue breathing). CPR may be enough to dislodge the item sufficiently for some of the airway to become clear, allowing gaseous exchange within the lungs.</p>	<p>Emergency barriers (e.g. gloves and face mask)</p>

CRITICAL SITUATIONS	POPULAR PROCEDURES
<p>2. Stabbing or knifing At the entrance to a bar, two young men argue and one stabs the other in the chest and abdomen, leaving the knife in the body. The young man begins to breathe with difficulty and shows signs of losing consciousness.</p>	<p>Take out the knife and place pressure on the wound Call emergency services</p>
<p>When a person is stabbed in the chest area, you may encounter the following symptoms or signs:</p> <ul style="list-style-type: none"> ☞ Serious bleeding and potentially copious blood loss; ☞ Breathing, if present, is laboured, producing a gasping or wheezing noise; ☞ If breathing is not quickly restored, the person's face turns blue (cyanosis) due the lack of oxygen, unconscious can soon follow. <p>When a person is stabbed in the abdominal area, you may encounter the following symptoms or signs:</p> <ul style="list-style-type: none"> ☞ Major haemorrhage in the abdominal area; ☞ Due to the massive loss of blood the person goes into hypovolemic shock, causing a rapid heartbeat and unconsciousness. 	
CORRECT PROCEDURES	RESOURCES NEEDED
<p>1. Do not remove the knife from the body of the individual Many people undertake a rapid intervention and attempt to remove the knife from the body. However this is a big mistake as removing the knife may significantly increase the amount of blood loss and can cause a major haemorrhage.</p> <p>2. Compression of open injuries At the site of the stabbing wound, pressure should be applied with material that is as clean as possible, to help prevent the onset of hypovolemic shock. If materials become blood-soaked do not remove and replace materials but instead just apply more material on top; removing blood-soaked materials can re-open the wound and destroy any blood coagulation that may be taking place.</p> <p>3. CPR Once the patient has become unconscious and is no longer breathing, performing CPR may be necessary (CPR is a combination of chest compressions and rescue breathing). If the knife is stuck in the chest compressions should not be attempted.</p> <p>4. Call for help When someone has been stabbed, the emergency responder should contact the medical emergency services explaining concisely, but with as much relevant detail as possible, what happened. It is important to pass on information such as the approximate time of the stabbing and the state of consciousness of the victim. The medical emergency services may give you directions on how to act or assist the victim.</p>	<p>Call emergency services Sterile dressing or clean cloth Emergency barriers (e.g. gloves and face mask)</p>

CORRECT PROCEDURES	RESOURCES NEEDED
<p>5. Evidence</p> <p>It is essential to keep all objects that belong to the perpetrators (e.g. cigarette butts, items of clothing, etc). After the incident try to remember as much detail as possible, writing down everything you remember of the situation and the circumstances in which the assault took place: e.g. place, time, people who were present, information about the perpetrator/s (e.g. hair colour and cut; eye colour, accents, smells, make/model of car, registration number, etc).</p> <p>NOTE – In most European countries the victim has no obligation to decide whether or not to complain immediately (e.g. they may have six months to do so).</p>	<p>Call emergency services Sterile dressing or clean cloth Emergency barriers (e.g. gloves and face mask)</p>

CRITICAL SITUATIONS	POPULAR PROCEDURES
<p>3. Cardiac arrest</p> <p>At a trance party a young person who was dancing wildly falls without apparent cause. He is not breathing and has no pulse.</p>	<p>Shake the person Call emergency services</p>
<p>When a person has a cardiac-respiratory arrest (CRA), the following signs or symptoms may be present:</p> <ul style="list-style-type: none"> ☞ Altered or absent heart rate; ☞ No breathing; ☞ Unconsciousness. <p>CRA can occur due to: e.g. breathing problems, problems associated with cardiovascular disease, or consumption of some drugs.</p>	

PROCEDURES	RESOURCES NEEDED
<p>1. CPR</p> <p>Once a CRA has been correctly identified, if required, CPR should be initiated as soon as possible (CPR is a combination of chest compressions and rescue breathing). 30 compressions should be provided for each 2 rescue breaths.</p> <p>2. Call for help</p> <p>Once a CRA has been identified you should contact the emergency medical services explaining what happened. It is important to provide the approximate time of the CRA and the state of consciousness of the individual. Emergency services should be given precise directions to the scene of the incident.</p>	<p>Call emergency services Sterile dressing or clean cloth Emergency barriers (e.g. gloves and face mask)</p>

CRITICAL SITUATIONS	POPULAR PROCEDURES
<p>4. Fall A young woman who was dancing on top of a podium two meters in height falls and shows signs of having fractured her collar bone. After 20 minutes she violently vomits.</p>	<p>Shake the person and help them to stand up Call emergency services</p>
<p>When a person falls from a considerable height, the following signs or symptoms may appear:</p> <ul style="list-style-type: none"> ☞ Signs of fracture in any part of the body, potentially causing a loss of mobility depending on where injuries occur; ☞ Head/spinal Injury; ☞ Unconsciousness. <p>Most head/spinal injuries require no treatment beyond analgesics. But close monitoring for potential complications such as intracranial bleeding or paraplegia is necessary. If the brain/spinal cord has been severely damaged by trauma then a complete neurosurgical evaluation is urgent.</p>	
CORRECT PROCEDURES	RESOURCES NEEDED
<p>1. If a person is unconscious on the floor, call the emergency medical services and do not immediately move the patient Many people choose to deploy a rapid intervention and attempt to raise the individual or place them in the 'recovery position' (turned onto one side). However, the patient should not be disturbed, and if possible immobilised in the position in which they were found. If the subject is unconscious this can be a sign of a head/neck/spinal injury, which in the case of movement can be further exacerbated potentially causing quadriplegia, paraplegia or even death. The emergency medical services should be immediately contacted, and a clear explanation of the situation given.</p> <p>2. If the individual is conscious and there is a evidence of damage to limbs Try to immobilise the limb and call the emergency medical services. If a bone has been exposed, do not try to put the bone back in place or return the limb to its original position; either of these strategies can cause injury to large blood vessels, potentially leading to hypovolemic shock.</p> <p>3. If the individual is conscious and able to move without apparent injury but has hit their head Vomiting is a sign of head/spinal injury. The patient should be placed in the recovery position so that any vomit will not be swallowed or block the airway; the head and neck should be immobilised, thus reducing the potential for further injury.</p> <p>4. Contact the emergency medical services Once a patient has been identified and their situation has been made safe you should contact the emergency medical services explaining the situation. It is important to give the approximate time of the incident and the state of consciousness of the individual. The emergency team may provide some directions for action.</p>	<p>Call emergency services Sterile dressing or clean cloth Emergency barriers (e.g. gloves and face mask)</p>

CRITICAL SITUATIONS	POPULAR PROCEDURES
<p>5. Heroin Overdose In the doorway of a building near a nightclub two young people have been injecting. One appears very distressed telling you that the other is “not breathing or responding, will not wake up and may be dead”</p>	<p>Shake the person Call emergency services</p>
<p>An overdose can occur when a dose taken is greater than what the user is used to. Taking an overdose may lead to an acute situation as consciousness may be lost. A tolerable dose for an addict could be fatal to a first-time user. Heroin works on the central nervous system and one of its effects is to slow down the heartbeat. Breathing rates also slow dramatically. Either of these effects can be fatal if the dose is too high.</p> <ul style="list-style-type: none"> Depending on purity and the user’s tolerance levels, a lethal dose of heroin may range from 200 to 500mg, but hardened addicts have survived doses of 1800mg and over. However, with street heroin there is no absolutely certain ‘safe dosage’. It depends on tolerance, purity and the amount taken. The primary sign of heroin overdose is a depression of breathing which can result in death from suffocation. <p>The type of drugs that are used by medical professionals to treat someone undergoing a heroin overdose are called ‘opioid antagonists’; common opioid antagonists are Naloxone and Naltrexone, which are non-scheduled prescription medication. While they are not currently available without a prescription, there are harm reduction programs that may distribute legal prescriptions of naloxone to heroin users (and their family and friends) as part of overdose prevention and education schemes.</p>	
CORRECT PROCEDURES	RESOURCES NEEDED
<p>1. If you have naloxone, inject it If you have to leave the victim, remember to put them in the recovery position. Draw the naloxone up into the syringe. 1cc of 0.4mg/mL naloxone may be enough, but you can always draw up more and administer 1cc first, evaluate and then give them another dose. Naloxone can be administered into the muscle, so don’t have to find a vein. The best places to inject are in the arm (deltoid), thigh (quadriceps) or butt (gluteus). If you have an alcohol swab, clean the area, if not administer the shot anyway at a 90° angle.</p> <p>2. Begin rescue breathing. Naloxone should kick in pretty quickly, but it could take a few minutes for the victim to come round. If they don’t wake up and resume breathing within a few minutes, give them a second dose. In the meantime, it’s important that you breathe for them.</p> <p>3. Contact the emergency medical services Once a patient has been identified and their situation has been made safe you should contact the emergency medical services explaining the situation. It is important to give the approximate time of the incident and the state of consciousness of the individual. The emergency team may provide some directions for action.</p>	<p>Call emergency services Emergency barriers (e.g. gloves and face mask) Naloxone and syringe</p>

CRITICAL SITUATIONS	POPULAR PROCEDURES
<p>6. Alcohol Overdose A young lady has been participating in a drinking game, drinking shots with some friends. She looks confused, starts showing signs of illness and then suddenly feels very feint.</p>	<p>Give a cold water bath/shower Give strong coffee Call emergency services</p>
<p>An overdose can occur when a dose taken is greater than what the user is used to. When a person drinks a considerable amount of alcoholic beverages certain signs or symptoms may appear (NOTE - There is a tremendous variation in tolerance levels of alcohol from person to person, and not all people exhibit all the effects). The following scale would apply to a typical social drinker:</p> <ul style="list-style-type: none"> ↻ 0.50g/dL: Loss of emotional restraint, vivaciousness, feeling of warmth, flushing of skin, mild impairment of judgment ↻ 1.00g/dL: Slight slurring of speech, loss of control of fine motor movements (such as writing), confusion when faced with tasks requiring thinking, emotionally unstable, inappropriate laughter ↻ 2.00g/dL: Very slurred speech, staggering gait, double vision, lethargic but able to be aroused by voice, difficulty sitting upright in a chair, memory loss ↻ 3.00g/dL: Stuporous, able to be aroused only briefly by strong physical stimulus (such as a face slap or deep pinch), deep snoring ↻ 4.00g/dL: Comatose, not able to be aroused, incontinent (wets self), low blood pressure, irregular breathing ↻ 5.00g/dL: Death possible, either from cessation of breathing, excessively low blood pressure, or vomit entering the lungs without the presence of the protective reflex to cough it out <p>There are other conditions that may present the same signs and symptoms as alcohol intoxication. It is important to recognise the symptoms of alcohol intoxication, not only to confirm the presence and severity of the alcohol effect, but also to be able to differentiate the symptoms from other conditions that may coexist, mimic, or mask the symptoms of alcohol intoxication. Admittedly, such a distinction can be exceedingly difficult for a lay-person (even someone with experience like a police officer) and may even be equally difficult for inexperienced doctors.</p> <p>In the case of an acute alcohol overdose to get an idea of the state of intoxication it is important to know what and when the patient drank; there may still be lots of alcohol in the stomach yet to be absorbed that could further exacerbate their position.</p> <p>The alcohol hangover is characterised by headache, tremulousness, nausea, diarrhoea, and fatigue combined with decreased occupational, cognitive, or visual-spatial skill performance. The symptoms of hangover seem to be caused by dehydration, hormonal alterations, and the toxic effects of alcohol.</p>	
CORRECT PROCEDURES	RESOURCES NEEDED
<p>The majority of people with simple cases of alcohol intoxication can be cared for by a friend or relative. Firstly remove the person from the bar or party to a calm, safe environment (e.g. keep them away from dangerous machines and objects, prevent them from falling and don't let them drive). Determine if the person has taken any medications, illegal drugs, or non-ethanol alcohols.</p>	<p>Sugary liquids Wooden spoon Call emergency services if patient does not recover quickly or if situation is very acute</p>

CORRECT PROCEDURES	RESOURCES NEEDED
<p>1. Force the person to vomit If he/she has recently drunk large quantities of alcohol, they should force themselves to vomit to prevent more alcohol from being absorbed – extra absorption of alcohol will increase the level of intoxication that they already experience. It is extremely common for an intoxicated person to vomit once. However vomiting more than twice may be a sign of a head injury or other serious illness. If a drunken person vomits more than twice and is not completely coherent, then he or she should be taken to a hospital's emergency department for evaluation.</p> <p>2. Force the intake of sugary liquids It is important that the patient drinks sugary liquids to avoid dehydration and hypoglycaemia that can be caused by acute alcohol intoxication. Sugary liquids have stimulant properties that can contradict the depressant effect of alcohol.</p> <p>3. Contact the emergency medical services In cases of an altered state of consciousness, when the patient is no longer reactive, emergency medical attention should be immediately sought. Make sure to provide clear and accurate data. The emergency team may provide some directions for action.</p> <p>4. Have someone in constant attendance It is necessary to maintain constant attendance with the patient to ensure that the person is improving/ not deteriorating and so that medical assistance can be obtained if needed. If the carer is not comfortable (or merely does not want to) monitoring the condition of the intoxicated person, then it would be best to take the person to the hospital.</p> <p>5. Sobering process No medications will speed up the sobering process. Caffeine (e.g. drinking coffee) and cold showers may have a minimal and very temporary effect.</p>	<p>Sugary liquids Wooden spoon Call emergency services if patient does not recover quickly or if situation is very acute</p>

CRITICAL SITUATIONS	POPULAR PROCEDURES
<p>7. Haemorrhage (cut glass) Two young people are leaving a bar when one of them cuts her foot on some broken glass that was lying on the floor. She starts to bleed profusely.</p>	<p>Remove the glass Call emergency services</p>
<p>When a person is cut with glass, the following signs or symptoms may appear:</p> <ul style="list-style-type: none"> ☞ Haemorrhage; ☞ Major bleeding; this may be associated with a loss of consciousness. <p>Most bleeding can be stopped with a combination of the application of direct pressure to the wound and time (rest and elevation of the wound are also helpful). Cleaning the wound with water and a gentle soap will help reduce the chance of bacterial infection.</p>	
CORRECT PROCEDURES	RESOURCES NEEDED
<p>1. Remove the glass Use gloves. It is important to remove any visible glass fragments so that pressure can be applied to the wound without further complicating the injury</p> <p>2. Apply direct pressure Direct pressure must be applied as quickly as possible using materials that are as clean as possible, thus preventing/reducing blood loss. If materials become blood-soaked do not remove and replace materials but instead just apply more material on top; removing blood-soaked materials can re-open the wound and destroy any blood coagulation that may be taking place</p> <p>3. Contact the emergency medical services If it is a deep cut with a large amount of blood loss then contact emergency medical care. The emergency team may provide some directions for action. If the cut is deep but the bleeding is controllable by compression, you should direct the individual to the nearest hospital emergency service so that they can be properly sutured.</p>	<p>Sterile dressing or clean cloth Plastic facial protection Gloves Call emergency services only at severe situations</p>

CRITICAL SITUATIONS	POPULAR PROCEDURES
<p>8. Rape A door supervisor at a nightclub is approached by a distraught crying young woman. She reports having been raped by two men who followed her from this club.</p>	<p>Bathe or clean the victim and get a change of clothes</p>
<p>The action of being raped is described as any sexual relation (anal, vaginal or oral), that is done by force, by using violence or any physical or psychological threats without the consent of one of the partners (which in most cases are women). Rape or sexual assault can happen to anyone at anytime in anyplace. While every victim reacts in a different way, the immediate reactions are commonly anger, disbelief, anxiety, and fear. Victims always need medical and psychological care.</p>	
CORRECT PROCEDURES	RESOURCES NEEDED
<p>No matter what the victim's reaction is, they will need to do several things:</p> <p>1. Seek medical attention The sooner he/she can get to a hospital's emergency services the better it is for obtaining evidence. Do not change clothes, bathe or douche the victim (the clothes that he/she were wearing at the time of the attack will become part of the evidence collected). Only if it is absolutely necessary should they change clothes – be sure to keep their original clothes in paper, not plastic, bags. Even if the victim is apparently not injured, he/she should receive medical care. This must include an assessment of the risks of exposure to pregnancy and/or sexually transmitted diseases, after which the appropriate precautions can be taken. If the victim suspects that they have been drugged they should provide a urine sample for testing.</p> <p>2. Get social support Victims do not have to face this situation alone. Contact a family member or a friend. They can help the victim to remember as much as possible about the attack, the attacker and the course of events. The victim should in no way worry that, at a later date, they may be unable to explain or prove what happened.</p> <p>3. Denounce the perpetrators Keep all objects that belong to the offenders (e.g. cigarette butts, items of clothing, etc). The gathering of as much evidence as possible is essential if the victim wants to make a complaint. Try to get them to remember as much detail as possible while you write down everything they remember of the situation and the circumstances in which the assault took place. For example, the location, time, people who were present, identifying characteristics of the perpetrators (e.g. accents, smells, the style and hair colour, eye colour, car registration number or brand, etc). There is no obligation to decide whether or not to complain immediately (the victim normally has six months to do so). If the victim wishes to immediately make a complaint they must contact the police.</p>	<p>Gloves Paper bags</p>

ANNEX 7. The responsible dispensing of alcoholic beverages

Like every other day Mr. Joseph, 57 years old and married with three children, collects the morning mail before opening his pub.

Mr. Joseph notices a strange envelope containing a letter from the local judicial authorities. As Mr. Joseph is not expecting this letter he curiously opens the letter. After reading it he is left is stunned and incredulous by its contents.

In short, the letter contains a 'summons' asking him to attend a court hearing. He is accused of being co-responsible for an accident involving one of his customers. The summons says that on the night of the accident his client had been drinking in Mr. Josephs establishment till approximately 2am. The customer then attempted to drive home in his car and had an accident that resulted in serious injuries and property losses to third parties. After analysis in the hospital laboratory, his blood alcohol level was observed to be far in excess of the level permitted by law.

The costumer admits that he had been drinking that night, but his lawyer says that Mr. Joseph has co-responsibility for the accident as, according to the customer, Mr. Joseph served him alcohol whenever it was requested, even when he showed signs of excessive consumption of alcohol and some altered behaviours (a glass was broken and his voice had been raised).

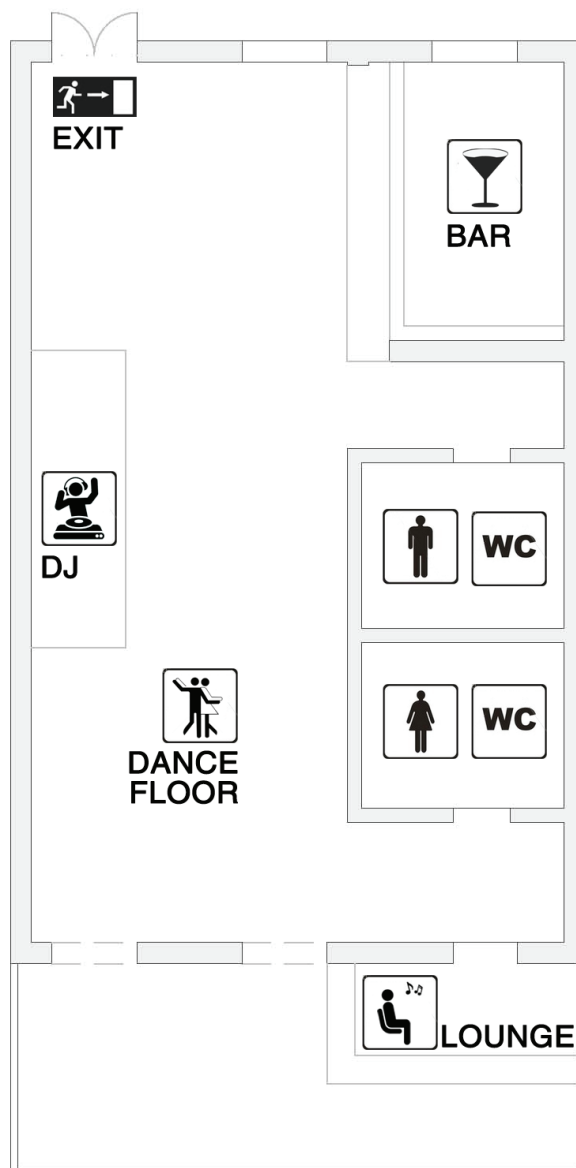
Worried about the summons Mr. Joseph makes a concerted effort to remember the events of the night in question. He vaguely remembers a client who only infrequently visits his establishment, who that night was accompanied by a lady. During the evening he had begun to gesture in an abnormal way and speak more loudly than usual.

Mr. Joseph remembers thinking that this was a matter between the couple and did not pay much attention to events. Mr. Joseph even has the recollection that a glass was unintentionally broken. When the customer left, Mr. Joseph watched him leave and could see he did not look well, but Mr. Joseph assumed the lady who was with him would took care of him and drive him home safely. Mr. Joseph quickly goes to phone his lawyer...

Please make some comments about this story and think about and respond to the following questions:

- In your opinion did Mr. Joseph understand the situation that night?
- Why didn't Mr. Joseph intervene?
- In your opinion, what could (and should) Mr. Joseph have done?
- If the situation had occurred in your establishment, how would you have responded to the situation?
- What strategies can be used to avoid situations like this?
- If there was a law that in this situation placed the responsibility with owners and bartenders, what steps could be taken to make sure situations like this do not occur?

ANNEX 8. Physical context (Form A1)



This is a possible floor plan of a venue similar to your venue. Please answer the following questions and adds comments where you think appropriate:

1. On this floor plan please note where you think the most problematic situations occur.
2. What kind of situations are these? How often will they occur? And who is likely to be involved?
3. How can you usually solve these issues?

ANNEX 9. Physical context (Form B)

Questions about my Venue

Name:

Location: in the city centre ☐; near the city centre ☐; in the suburbs ☐

Hours of business:

Number of employees:

What is your role in the venue?

Have you had some specific training for this role while working in this venue?

What do you like best about your venue?

What do you like least about your venue?

What kinds of customers attend your venue?

Why do customers come to your venue? (Please give a number of reasons)

Have you had before any training in related issues such as: Alcohol/Drugs ☐; Violence ☐; Safety ☐; First Aid ☐; Responsible dispensing of beverage services ☐; Communication ☐

If YES please tick the related boxes and provide some details about the kind of training you have had

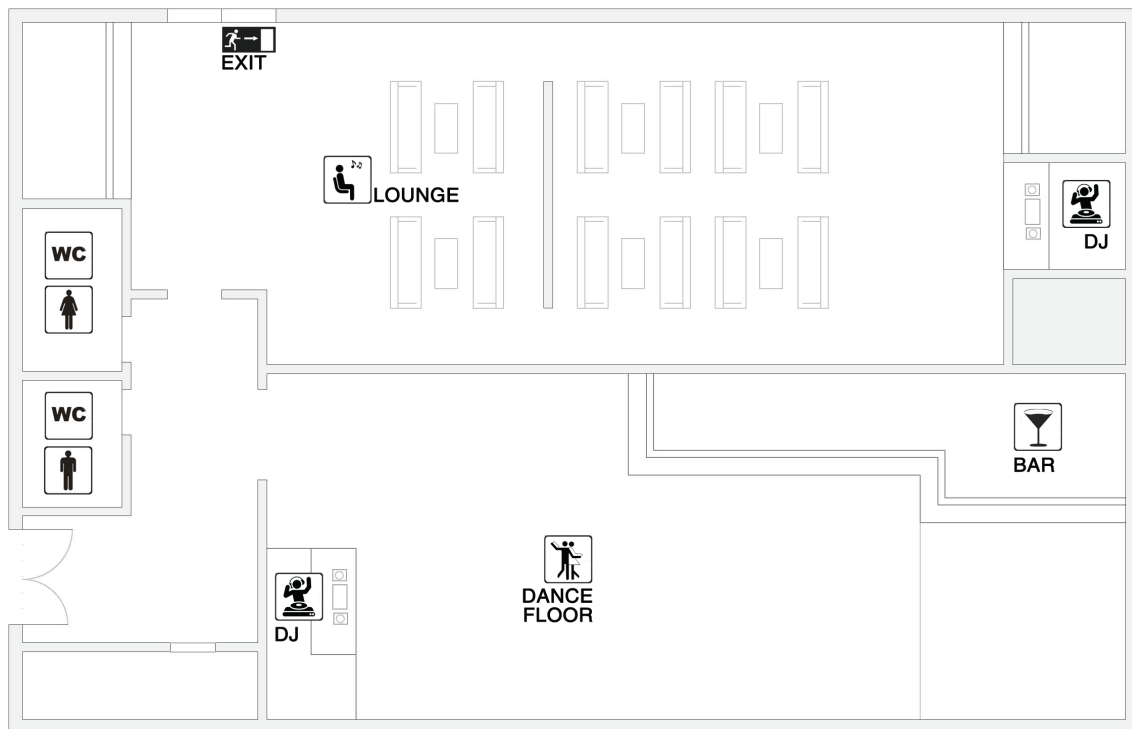
Has your venue ever been the target of an intervention/campaign of 'Harm Reduction' by an NGO or a health issue public service (e.g. HIV awareness; road traffic accidents; non alcoholic beverages)? If YES please provide some details regarding how many interventions and their topics:

In your venue do you have prevention flyers available to customers?

In your venue do you have condom vending machines?

If you could change some aspect/s of your venue (e.g. decorations, overall look, function or anything else) what kind of changes would you make?

ANNEX 9.1 Physical context (Form B1)



This is a possible floor plan of a venue similar to your venue. Please answer the following questions and adds comments where you think appropriate:

1. On this floor plan please note where you think the most problematic situations occur.
2. What kind of situations are these? How often will they occur? And who is likely to be involved?
3. How can you usually solve these issues?

ANNEX 10. Principal areas and main problems related to nightlife and recreational contexts

- Health problems: Tobacco, alcohol and illegal drug misuse, underage drinking, binge drinking, drunkenness, injuries, heat related problems, noise related problems, eyesight damages and mental disorders.
- Nightlife violence: Fighting, conflicts among clients, conflicts between clients and staff, sexual assaults.
- Unsafe and involuntary sex: inconsistent use of condoms, pregnancy, sexually transmitted infections.
- Transport to and from recreational areas: drink driving, drug use and driving.
- Public nuisance: noise, vandalism, drinking on the streets.
- Crime and others violations of the law: drug dealing, theft, burglary, underage selling/serving of alcohol, serving intoxicated people.
- Effective management of nightlife settings: absence or lack of control, supervision and inconsistent implementation of legislative measures, absence or lack of security measures, lack of house policies, lack of a code of practices and lack of (or inadequate) staff training.

Problematic situations identified.

- Research consistently shows that the peak period for violent offences is weekend nights and the peak location is in and around pubs and clubs (Allen et al. 2003).
- A low staff/customer ratio has been found to be associated with the increased frequency of aggressive behaviour (Homel and Clark 1994), due possibly to reduced vigilance and guardianship (Graham et al. 2005).
- Aggression in bars has also been found to be associated positively with staff serving alcohol to intoxicated customers (Homel and Clark 1994). Sometimes the refusal to serve alcohol to intoxicated patrons has precipitated an aggression (Felson et al 1997).
- The intoxication level of those within the bar, and bar policies that facilitate intoxication (e.g. very cheap drinks), are highly associated with aggression (Homel and Clark 1994).
- Hostile and aggressive staff (Homel et al. 1992).
- Staff who are poorly trained and poorly coordinated (Homel et al. 1992).
- A high proportion of male staff and the presence of 'bouncers' (Homel et al. 1992; Quigley et al. 2003)
- More than one third of violent incidents that occur inside licensed premises involve door staff, often as alleged perpetrators (Maguire and Nettleton 2003).
- Violence (mostly amongst males under 25) is mainly triggered by: conflict with staff; overcrowding; violating bar rules; offensive behaviour; and conflict over interpersonal relationships (Chikritzhs 2002; Homel et al. 2004; Macintyre and Homel 1997)
- In many bars and clubs where customers obtain their drinks from a large serving bar (with potentially many servers), it is not possible for servers to effectively monitor alcohol consumption as part of the drink service, and thus prevent problem behaviour (Kulis 1998).

Interventions targeting venues and recreational contexts and staff training interventions

Some interventions have already been implemented in some countries and cities: e.g.

- I. 'house policies';
- II. a code of practice and other agreements;
- III. control and restriction of opening hours;
- IV. interventions in physical and contextual venues areas; and
- V. individual harm reduction strategies.

Recently the most popular interventions have included responsible beverage services and training of door staff (a part of the Responsible Beverage Service). For example, *'The Safer Bars'* training is based on research about aggression in licensed premises as well as knowledge on general communication approaches. These include the effective use of personal space and body language (Sears et al. 1991), and techniques that were developed for police officers and others who work with violent individuals (Albrecht and Morrison 1992; Garner 1998).

Only a few programs have included rigorous evaluations with well defined outcomes; however, when evaluated these programs have generally proven to be effective in reducing young persons' access to alcohol, problematic drinking patterns, unintentional vehicular and no-vehicular injuries, and assaultive violence (Treno et al. 2005). Some examples of these programs are:

- Community Trials Project (Salinas, California, USA).
- The Surfers Paradise Safety Action Project (Queensland, Australia).
- Stockholm Prevents Alcohol and Drug Problems (STAD) (Sweden).
- Geelong Local Industry Accord in Australia (Geelong, Australia).

Although good programs do exist for training bar staff in responsible serving practices (i.e. refusing service to underage and intoxicated patrons) (Graham 2000), there are several reasons that specific training in managing problem behaviour is needed.

ANNEX 11. Legislation

In August, when the heat of the night attracts young people to the fervent streets of the capital city, many young people seek the best and most exciting opportunities for fun. Just after midnight a group of three male friends are leaving a bar when they receive a flyer for the disco 'Dance'. Excited about the reputation of the DJ who will be playing that night, they head to the disco.

At the door of the venue, the three friends are impressed with the size of the queue of people to enter. However, after a short while the queue starts to flow quickly. This is due to the fact that the security guards, pressured by the instructions of the nightclub owner (who wants to see the venue quickly filled), switch from making searches with a metal detector to a brief hand search of some customers.

Arriving at the front of the queue the three friends try to enter the disco. The security makes no search but, suspecting one of the boys to be under the legal age for entry, they ask for some identification. It turns out that the boy hasn't brought any identification out with him. However, after repeated pleas from his two friends, they eventually let the three friends enter.

Once inside the three friends head to the bar, where they start drinking shots. Throughout the event the friends continue drinking a range of beverages, mostly distilled. One of the boys becomes quickly drunk, evidenced by excessive euphoria.

The bartender, although aware of the state of inebriation of the boy, continues to serve more alcoholic drinks whenever he is asked.

At the end of the event, with the music finished, the security personnel start to ask customers to leave the establishment.

The drunken boy starts arguing with one of the security guards, claiming to not want to leave the club at the moment, declaring he wants to go to the bar to get more drinks. The guard insists that he has to leave; the boy reacts badly and begins to insult him. Rather than ignore the drunken youth, the security guard loses his patience and punches him, leaving him lying on the floor. The police are immediately called to the nightclub to investigate and ask the management to submit the images from the video surveillance system (CCTV). However the CCTV has not been activated that night due to an electrical problem. Later it is discovered that the security guard has no professional accreditation, and was merely a friend of the manager who had asked him to help out that night.

Questions to debate:

1. How would you describe the behavior of the door supervisors for not searching customers using the available metal detector, instead only doing hand searches (and even then only sporadically)?

1.2 What do you think are the fines that can be imposed by law (in euros or other currencies) for this scenario?

2. Do you consider that the door supervisor was right to allow entry into the nightclub without confirming whether the customer was the required legal minimum age?

2.1 What do you think are the fines that can be imposed by law (in euros or other currencies) for this scenario?

3. Was the bartender right to continue to serve alcoholic beverages to one of the friends, knowing that he was already very drunk?

3.1 What do you think are the fines that can be imposed by law (in euros or other currencies) for this scenario?

4. What do you think of the behavior of the manager of the club with respect to the fact that knowing what the legal requirements relating to surveillance were, they were not adhered to?

4.1 What do you think are the fines that can be imposed by law (in euros or other currencies) for this scenario?

5. Do you think that the manager was right to invite a friend to help provide the security for the event, even if it was only for one night?

5.1 What do you think are the fines that can be imposed by law (in euros or other currencies) for this scenario?

ANNEX 12. Evaluation Questionnaire

This form is intended to gather information about each individual unit from the participants. It will only take a couple of minutes to fill in, and will provide us with valuable feedback. Thank you for your cooperation.

I. IDENTIFICATION

1. Gender ____ 2. Age ____ 3. What is your role in your venue?

II. ABOUT THE UNIT

1. Organisation of the unit. Regarding this unit, please evaluate:

	Very Bad	Bad	Sufficient	Good	Very Good
Duration	1	2	3	4	5
Equipments and support material	1	2	3	4	5
Teaching support	1	2	3	4	5
Space	1	2	3	4	5

2. Techniques and methodologies. Regarding this unit, please evaluate:

	Very Bad	Bad	Sufficient	Good	Very Good
Appropriateness of the methodologies to the contents	1	2	3	4	5
Appropriateness of the methodologies to the group	1	2	3	4	5
Efficacy of the methodologies to the acquisition of knowledge	1	2	3	4	5
Relevance of the methodologies to practical applications	1	2	3	4	5

3. Contents. Regarding this unit, please evaluate:

	Very Bad	Bad	Sufficient	Good	Very Good
Clarity	1	2	3	4	5
Depth	1	2	3	4	5
Solidity of the Approach	1	2	3	4	5
Innovation of the Approach	1	2	3	4	5
Relevance to my work	1	2	3	4	5

4. Trainer/coordination team. Regarding this unit, please evaluate

	Very Bad	Bad	Sufficient	Good	Very Good
Knowledge of the trainer on the matters being discussed	1	2	3	4	5
The methodologies	1	2	3	4	5
Conduct of the group	1	2	3	4	5
The group attitude	1	2	3	4	5

5. Supporting materials of this unit. Regarding this unit, please evaluate:

	Very Bad	Bad	Sufficient	Good	Very Good
The quality of supporting materials distributed	1	2	3	4	5

6. Working group. Regarding this unit, please evaluate:

	Very Bad	Bad	Sufficient	Good	Very Good
Quality of the relationships established between group members	1	2	3	4	5
Group cooperation	1	2	3	4	5
Sharing of Experiences	1	2	3	4	5
The group attitude	1	2	3	4	5

7. Acquired knowledge. Regarding this unit, please evaluate:

	Very Bad	Bad	Sufficient	Good	Very Good
Your comprehension of the content	1	2	3	4	5
The relevance of the content	1	2	3	4	5
The relevance of the instruments used to make interventions	1	2	3	4	5
Your capability to apply newly acquired knowledge to your work	1	2	3	4	5

8. Describe the most relevant information that you learnt during this unit.

9. Identify how you will transfer any newly acquired knowledge to your practice/work.

10. Please note any other comments that you consider relevant for the continued improvement of training quality.

Thank You

Club Health

“Healthy and Safer Nightlife of Youth project”

Staff training for nightlife premises

Fernando Joaquim F. Mendes

Maria do Rosário Mendes

December 2011

