Club Health
The Health of the Clubbing Nation

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The health of the clubbing nation

'Club health' encompasses those aspects of nightclubs, the night-time environment and club culture which influence the health of those who work and 'play' in clubs. It is not difficult to identify a substantial list of potential health implications of clubbing:

Nightclubs are dark, noisy, unventilated and crowded. Facilities like clearly marked fire exits, a sufficient number of well maintained wash-rooms, proper ventilation and the use of toughened or plastic drinking glasses are often inadequate or even non-existent: the potential for club-goers and club workers sustaining minor injuries can be great (see Chapter 4).

Nightclubs often use extensive lighting and sound systems; they are often operated in non-purpose built premises (like converted warehouses). Faulty electrical systems and poor structural safety can cause major incidents like fires and building collapse (see Chapters 4&12).

Large quantities of alcohol are consumed in clubs, and all available evidence shows that recreational use of other, illicit psychoactive substances is increasingly widespread. Many recreational drug users appear to be engaging in poly-drug use: taking 'drugs cocktails' and consuming alcohol in combination with other substances. (See Chapters 2&7).

The proven short and long term health risks of drug and alcohol use are considerable, from acute medical problems (for example, alcoholic poisoning, overheating/dehydration, epileptic fits) to chronic physical and/or psychiatric conditions (for instance sclerosis of the liver, paranoid schizophrenia) (see Chapter 3). The long term effects of repeated use of new recreational drugs like Ecstasy are not yet known (see Chapter 7).

Alcohol and other drugs affect behaviour: they can enhance aggression, depression and a range of emotions; and hinder co-ordination and physical and/or mental self control. Use of these substances within the night-time environment can lead to violence (see Chapters 3,5,8&9); inhibit social skills; and can contribute to risk taking behaviour, for example through engaging in unsafe sex (see Chapters 6&9).

Many licensees fail to provide ‘safer dancing’ type facilities like free water and ‘chill out’ zones, which can reduce the harmful side effects of drugs. More will be reluctant to take pro-active measures to make their venues safer for drug-using clients in light of the success of the ‘Barry Legg Bill: under the Public Entertainments Licences (Drugs Misuse) Act 1997, local authorities have new powers to close down premises where there is evidence or suspicion of illicit drug use or dealing (see Chapter 10).

There is no statutory requirement for local authorities to vet, register, train or monitor door supervisors (or, more commonly ‘bouncers’) (see Chapters 5&10). Such staff may therefore be inappropriate guardians of a club’s security, and may in fact contribute to problems in and around premises, through violence (linked to the use of anabolic steroids, which have been associated with increased aggression) (see Chapter 3) or involvement in drug dealing and other criminal activities like extortion (see Chapters 2, &10).

Club managers and other members of
staff at nightclub venues may also be inadequately trained in dealing with intoxicated individuals; crowd control; first-aid; food hygiene; and evacuation, fire and other emergency/safety procedures.

Insufficient public transport, ill-maintained or a lack of public telephones, poorly lit streets and badly placed taxi ranks can combine to make individuals travelling to and from late night premises vulnerable to assault. Inadequate public transport facilities may also encourage clubbers to drive under the influence of alcohol and/or other drugs, and the consequences of car accidents can be fatal. (See Chapters 3&9).

There is no one age group, no single social, educational or professional background which defines the ‘clubbing population’. Clubbers are often pigeonholed as hard-core ‘ravers’ (see Chapter 2), who overwhelmingly take illicit drugs on a regular basis. It is difficult to disprove this idea in view of numerous surveys undertaken over the last few years. A Lifeline/Mixmag survey in 1996, for example, found that 81.3% of respondents described themselves as current ecstasy users, but these were individuals who had volunteered information, and were readers of a house music/dance scene publication; 97% stated they were regular clubbers. The response may have been very different if a random sample had been used. It must be acknowledged that a very wide diversity of individuals go to a number of different kinds of nightclubs: clubs within the ‘dance’ scene offer a variety of dance music genres, from house classics to speed garage; ‘70s Disco, Brit pop, northern soul, acid jazz, or mainstream chart music are played at different clubs at different times. Regardless of individual musical tastes, the risks inherent in the nightclub environment remain the same. Huge numbers of people now go to nightclubs each week, therefore these risks must be given serious consideration, and the opportunity to promote good health to a growing (cross-) section of the population exploited.

The concept of ‘healthy nightclubs’ creates a context within which club health issues may be examined; the health needs of clubbers and those who work in and around the night-time environment assessed; and pro-active measures discussed. Therefore a ‘settings’ approach has been adopted in this holistic review of club health. Through this multidisciplinary approach, effective measures can be taken both to minimise the health risks of clubbing and to promote clubbers’ well-being. Co-ordination between a large number of agencies, at government level, at local level and between the public and private sectors is needed (see Chapter 12).

For example, in relation to door registration, examples of good practice are being drawn from local arrangements, and will form the basis of the government’s forthcoming national guidelines on door registration (see Chapter 10). Guidelines may be useful for existing schemes, but the current situation of ‘voluntary’ schemes means that an individual rejected for door-staff registration in one local authority can simply move to an area where no scheme exists (see Chapter 5). There is wide support for a compulsory, national registration scheme for door supervisors overseen by central government, but a stronger network of communications between local authorities, police and night-club management might be effective (see Chapter 8). It is clear that in the area of security and door-staff, at least, co-ordination is paramount.

Local partnerships, like Drug Action Teams and working groups like the London Drug Policy Forum, can be effective in
addressing problems specific to particular areas and ‘scenes’ (see Chapter 7), but information on successful initiatives, advice and data could be fed into and accessed through a central source. Individual clubs can do much to make their venues safer: through adapting their venue (improving ventilation for example, or fitting condom machines); or teaming up with local hospitals to train staff in appropriate first-aid skills (see Chapter 3). Conversely, an industry wide ban on breakable glass in favour of plastic or toughened glass would reduce glass related injuries drastically, and even encourage brewers to fund research into producing non-breakable bottles (see Chapter 3). Again, co-ordination is the key to achieving any of these results.

Health protection measures go hand in hand with health promotion. Many aspects of clubbing involve risk taking, from walking alone to a club at night, to consuming illegal drugs, to having unsafe sex with a stranger met at a club. Accurate and unbiased information must be available, to make club-goers aware of these risks and to enable them to minimise harm to their health and well-being. A lot of material has been produced in recent years relating to harm reduction in relation to drugs and ‘safer dancing’ guidelines, and there have been successful sexual health campaigns. There is a risk that information from such a variety of sources will simply confuse and self-contradict. Collaboration between agencies and with the club industry is essential; and the wider commercial sector (advertising, the media, the fashion and music industries, for instance) can provide useful support in marketing health messages to clubbers in a credible and digestible way. (See Chapters 6&7).

Finally, the benefits of clubbing must not be forgotten. It is a leisure activity; dancing is an enjoyable physical exercise; clubs are a venue for socialising (see Chapters 3 and 9); and the club industry is an increasingly strong player in local economies. The message from the many individuals who have contributed to this report is that better communications, information sharing and joint working between all those concerned with what we might term ‘club health’ are needed if we are to protect and improve the health of our clubbing nation.
A great many people contributed to the Club Health 1997 conference and to this Report. The editors would like to acknowledge in particular the contributions of Professor John Ashton; Debbi Stanistreet and Victoria Jeffrey; Paula McIntosh and all the staff at SHEEU; staff at NHS North West Regional Office; and Dr. Qutub Syed and staff at CDSC North West.

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We thank Dr Chris Luke for his important contribution; Peter Kilfoyle MP who stepped in at the last minute to represent the government; and all of the speakers, both for their contributions to the conference and for their assistance in the compilation of this Report.

We would also like to show our appreciation for the support given by Granada Entertainments, and the organisations which provided information and literature, namely Lifeline (Manchester), Healthwise (Liverpool), HIT (Liverpool), Enhance RDP (Glasgow) and Healthy Gay Manchester. ¹

Finally, but by no means least, thanks go to the 250 delegates (including 40 club-goers) who attended the conference, and made Club Health 1997 a success.

¹To contact any of the individuals or organisations listed, please see List of Contributors overleaf and Appendix: Useful Addresses
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Club Health examined a number of public health issues within the context of nightclubs and the night-time environment. Amongst its objectives were:

1. to promote awareness of the health risks implicit in the nightclub environment and within club culture, whilst recognising the health and other benefits which can derive from clubbing
2. to demonstrate the diversity of approaches adopted by health workers, nightclub management and other professionals in preventing and/or dealing with these problems
3. and to contribute to improving safety conditions within the nightclub environment and the health of clubbers, by highlighting examples of good practice, including health protection measures for, and health promotion activities targeted at club-goers.

Through the exchange of information between individuals representing health services, club management and clubbers, drugs agencies, police, licensing authorities and other agencies, it was expected that new strategies could be developed both to protect health in the night-time environment and, more generally, to promote health among young people.

The conference was organised by the Sexual Health and Environmental Epidemiology Unit at the University of Liverpool, in collaboration with the NHS (North West) in celebration of 150 Years of Public Health. The North West of England boasts one of the leading club scenes in the UK, and Cream, as one of its largest and most successful nightclubs, was considered an appropriate venue for a conference on nightclubs. The use of such a venue demonstrated that the nightclub industry is open to working in partnership, and also provided some insight into the reality of the modern nightclub setting.

Over two hundred and fifty delegates participated in the event, from a diversity of professional backgrounds, namely: the nightclub industry (club owners, licensees, club promoters, DJs); clinicians (medics, drugs workers, sexual health workers); environmental health (EHOs, licensing authority officers); police (representatives from licensing, plain clothes, community safety, major crime); educational services (health promoters, drugs/sexual health advisers); and public health (health authority employees, directors of public health). Forty ‘clubbers’ were invited to attend to represent the club-going population. The guest speakers invited to address the conference were intended to represent the diverse perspectives of different fields involved in nightclubs, health, youth and social policy (see Chapters 2-10). The support given to the conference was overwhelming, and in itself encouragement that the night-time setting may be ideal for developing youth related health measures.

A one day conference does have limitations. The range of issues that could be highlighted was restricted, but it is hoped that the Club Health 1997 conference may initiate further examinations of wider issues. The media interest in the ‘Club Health’ conference and in the work around public health and nightclubs indicates that this is an important and under-explored area. This Report aims to summarise the information...
conveyed, the views expressed and the ideas shared at the conference and to elicit from responses some suggestions about how to proceed in developing a cohesive health-based approach to a complex set of issues. The organisers hope that the conference helped mark a beginning to a new, holistic approach to ‘nightclub health’ and that this Report can act as a reference resource for licensees, health professionals, local authorities, the police and other service providers interested in finding new ways of making nightclubs safer and healthier environments for clubgoers as well as using clubs as a platform for disseminating health-related information.

1 1997 marked the 150th Anniversary of the appointment of Dr William Henry Duncan (see Chapter 3.1).
2 We have tried to convey the meaning and words of the speakers as accurately as possible. Inevitably some sections have had to be edited but we hope that none of the meaning has altered.
CHAPTER 1

The Health of the Clubbing Nation

Mary Kilfoyle and Mark A. Bellis

“The first principle of life at night: messy; very bad for you; to be embraced completely and without a flicker of a doubt or a sense of self-preservation”
In its broadest terms ‘club health’ is about (night) clubs and health; about how these two often opposing themes may not only co-exist but actually complement each other to create a healthier and safer environment for club-goers. It has been suggested that the concept of a ‘healthy nightclub’ is a contradiction in terms; that millions of individuals across the UK go to clubs for sheer enjoyment, and that this enjoyment is due in some measure to those very aspects (like the consumption of alcohol, and listening to loud music) which might be considered unhealthy or unsafe. The term Health of the Clubbing Nation aims to create a context within which the seemingly incongruent issues of health and clubbing may be examined and integrated.

Club health embraces many different health issues which can affect young people and adults within the context of nightclubs, club culture and the night-time environment. There are behavioural aspects, social aspects, and environmental aspects which influence clubbers’ health; and importantly there are health and other benefits which derive from clubbing as a past-time, as a cultural phenomenon and as an industry.

Recreational Drug Use

One area which in recent years has been closely associated with clubbing is the use of recreational drugs. The writer Melanie McFadyean cites a typical headline - “Raving Mad: ecstasy club kids still dicing with death” - which highlights the kind of sensationalist slant which popular media coverage has given to the area of recreational drugs and clubs in recent years. Numerous studies have attempted to establish the true extent, nature and outcomes of recreational drug use. Although statistics differ, there is a consistent body of evidence that indicates a wider range of illicit drugs are being used by more individuals, at an earlier age, than ever before. There is no doubt that nightclubs over the last decade have become a centre for the widespread distribution and use of ‘new’ recreational drugs like ecstasy (or ‘E’, properly MDMA), but also of established drugs like amphetamine (speed), cocaine and LSD (acid). This is not to suggest that the popular press has it right. Figures from the latest British Crime Survey, suggest that in 1996 there was no significant rise in recreational drug use in the two years since the previous survey, in 1994.

Whatever the extent of current usage, drugs are being used on a recreational basis by a significant number of individuals. Drugs, by definition, have short-term and/or long-term physiological and/or psychological effects. Within the clinical environment this is precisely the purpose of drugs, in treating physical or mental ill health. Many prescribed drugs have side effects. If an individual exhibits an adverse reaction to a particular drug, his or her medical supervisor will administer an alternative treatment. In relation to illicit drugs no-one is responsible for assessing an individual’s suitability for or reaction to a particular substance. Furthermore, many kinds of illegal drugs are not quality controlled because they are manufactured outside of the clinical environment, and are therefore all the more dangerous. A user simply does not know if what he or she has bought as ecstasy, for example, contains any amount of MDMA, or what dose of MDMA it may contain. Many tablets seized by police and clinically tested have contained no MDMA, but instead different combinations of both...
active chemicals and substances which have little or no physiological effects (see Chapter 7), which have often been more harmful potentially than pure MDMA.

These different factors, which apply also to drugs like cocaine and LSD, can contribute to ill health on a number of levels. Injury may be sustained through adverse reactions, allergies, confusion, overdose or dehydration, depending on the drug (or combination of drugs) used, where an individual takes a drug, and individual responses. Habitual use, particularly of stimulant drugs like cocaine and speed (amphetamine) can cause exhaustion and weight loss, which can weaken the body’s defences against infections, and have a generally negative influence on the user’s quality of life. Long term use of drugs can lead to physical and/or psychological dependence; and certain individuals may progress from social use of ‘recreational’ drugs to more harmful drug use, like injecting. The legal status of the recreational drugs described must not be forgotten. A clubber in possession of illegal drugs is vulnerable to criminal arrest and charge, even if he/she is not carrying large amounts of such drugs: an individual caught with just a few ecstasy tablets for his friends, may be treated as a ‘dealer’. Week after week thousands of clubbers are putting themselves at risk in this way.

Alcohol

The focus on illicit drug use within the club scene has tended to deflect attention away from the most popular drug of all: alcohol (see Chapter 9). In Great Britain eleven percent of men aged 18-24 drink “above the level considered to be definitely dangerous to health”, and thirty eight percent (eighteen percent of women) drink “above the recommended sensible level”.

Huge quantities of alcohol are consumed within nightclubs and other night-time venues. According to figures from the British Crime Survey 1996, alcohol “appears to be ‘making a comeback’ at the expense of illegal drugs”.

The national alcohol charity Alcohol Concern highlights the extent of alcohol-related ill-health: “There were over 28,000 hospital admissions in one year (1994-95) due to alcohol dependence or the toxic effects of alcohol”. Excessive consumption of alcohol can cause acute injury and death as the result of accidental alcohol poisoning or drink-driving incidents, for example. Where individuals are intoxicated with excess amounts of alcohol (or illicit intoxicating substances), and their co-ordination and reflexes therefore hindered, the potential for minor injury through falling for example is increased within the dark and crowded nightclub setting. They may panic in an emergency situation, to the detriment of their own and other people’s safety. They may be vulnerable to assault, or may themselves experience increased aggression and endanger the health of others. In a recent study by the University of Wales’ College of Medicine of the relationship between injury and alcohol, it was found that “People who are sober or have drunk one or two units [of alcohol] sustained fewer injuries and were hit less frequently than someone who had drunk more than ten units”. In the long-term, immoderate patterns of alcohol consumption can cause serious damage to the liver, heart, stomach and brain. 3% of cancers may be attributed to alcohol use. Long term heavy drinking can lead to physical dependence, and the physical and psychological problems associated with any kind of drug addiction.

Alcohol-related problems tend to be treated in separation from problems related
In view of reported increases in poly-drug use of illicit drugs in combination with and not instead of alcohol, and worrying reports of alcohol injection in certain drug scenes (which directly links alcohol use to the worst forms of illicit drug use), it may be inappropriate to continue to tackle ‘drug use’ and ‘alcohol use’ as separate issues, when many younger recreational users of both what may be termed ‘soft drugs’ and alcohol fail to see any distinction between them.

**Smoking**

For many people, tobacco smoking is inextricably linked with socialising and/or the consumption of alcohol, both of which are major activities within nightclubs and bars. Nightclubs, and bars are a popular medium for publicity campaigns to promote tobacco, through giving away free packets of cigarettes in exchange for empty packets of other brands of cigarettes. Sponsorship by tobacco firms is common within the club industry (club ‘tours’ for example) and club oriented magazines often promote tobacco through advertising.

Tobacco is a carcinogen and can increase the risks of suffering from coronary heart disease, stroke and a variety of respiratory problems. According to a 1997 National opinion Poll survey carried out for the McMillan Cancer Relief charity “Almost half of the people in Britain do not associate smoking with cancer”. Nicotine is addictive and smoking can therefore present some of the psychological, physical and social problems associated with drug dependency.

For non-smokers the dangers of second-hand, or passive smoking may be an issue particularly relevant to the unventilated and crowded nightclub/bar environment. There is also a risk in smoking cannabis separate to its psychoactive effects: both tobacco and cannabis are carcinogens, and when smoked together have a multiplicatory effect (see Chapter 11). Within the dark and crowded nightclub or bar environment, lit cigarettes may cause accidental burns, and more seriously where highly flammable substances are stored could cause major fires.

**Sexual Health**

Nightclubs provide a social opportunity for many individuals to meet sexual partners. According to one recent study by the drugs agency Release, fifty four percent of club-goers surveyed “had had sex with someone they met at a dance event”, although when asked what they most enjoyed about clubbing sex did not feature as important. This actually suggests that levels of sexual activity may be higher because of the reported euphoric effects of stimulant drugs like ecstasy, amphetamine and cocaine, of which Chill Out...A Raver’s Guide warns:

> “Sometimes you feel so horny as [MDMA] heightens sensations and pleasures of touch...so have condoms with you”

The nightclub environment may therefore be a setting in which to examine sexual health issues.

AIDS, which is incurable, has become one of the top causes of premature death in England in a relatively short space of time. Ninety percent of the HIV infection which can lead to AIDS is sexually transmitted. Nevertheless, according to the 1996 Health Monitor Survey of 10,000 people,
“almost a third of [18-20 year olds] admitted having unprotected sex during the past year”\textsuperscript{21}. 149,954 women in England had abortions in 1995 \textsuperscript{22}. These cursory figures indicate that there are improvements that could be made in promoting safe sex and contraception. Condom machines are often not provided in night clubs and other licenced premises, or are not properly maintained. Sexual health issues specific to the gay and lesbian population may be addressed within the gay club scene: in a recent study of gay men and sex, “just over half of the whole sample had met someone new for sex at a pub or club”. Thirty one percent of gay men had had sex with men met in clubs, overwhelmingly the key venue for meeting sexual partners\textsuperscript{23}.

The nightclub

Nightclub premises can pose further risks to the health of club-goers. Subdued lighting, combined with makeshift venues (converted warehouses for instance) increases the potential for accidents\textsuperscript{24}. The same conditions mean that where emergency exits are inadequate or less than ideally placed or indicated, major incidents like fires could endanger the safety of thousands of people if evacuation procedures are not well rehearsed. Overcrowding of premises can seriously endanger the health of club-goers. In 1996, the owner of a Stratford nightclub was jailed for four months: a head count of clubbers evacuated from his venue following a fire alarm totalled 260, when the licencing conditions stated that numbers must not exceed 160. Had there been a real fire, the consequences may have been fatal\textsuperscript{25}.

The use of breakable glasses rather than plastic cups or toughened glasses (which shatter into small, blunt fragments) for serving drinks can increase the risk of minor accidental injuries, and more serious harm when used as a weapon of assault\textsuperscript{26}. The range of toughened glassware currently available is limited, and expensive, and there is currently no such thing as a ‘toughened bottle’\textsuperscript{27}. High noise levels can damage hearing (see Chapters 3\&4), triggering tinnitus (a ringing in the ears), and even contributing to long term deafness\textsuperscript{28}. Other features of the nightclub venue like smoke machines and strobe lights can have similarly detrimental effects on health (see Chapter 3).

Security

Nightclub staff, and in particular door staff, may contribute to health risks associated with nightclubs for a number of reasons. There is no statutory requirement for the vetting, registration or training of individuals seeking employment as door supervisors. Such staff may consequently have inadequate training or experience in dealing with crowd control and emergency situations arising from the combination of large numbers of people, heat, drugs, and alcohol. The absence of any regulatory body for door supervisors may mean that the individuals responsible for keeping violence and drugs out of clubs actually have a history of convictions for violence or drugs offences, or may be drug users and/or dealers themselves. (See Chapter 5). Individuals leaving club premises are not checked for carrying glasses, which may contribute to clubbers suffering glass-related injuries and assaults beyond club doors.

Private security companies can pose further problems to club-goers and club management alike: night-clubs are easy pickings for extortion rackets, and territorial drug dealing. In the wake of the ‘Barry
Legg Bill, club managers have sought new security measures to ensure that their premises are drugs free. The club magazine Mixmag highlighted a recent trend for using sniffer dogs to search club-goers for drugs on the doors of certain nightclubs. Such measures may be inappropriate, and relatively insensitive, within the drug- and alcohol-fuelled nightclub environment.

Health and Safety at Work

Conversely, there may be poor working and safety conditions for nightclub employees - including door staff. Many of the health risks outlined above apply to such staff, especially those relating to the environment of the nightclub. In addition, factors such as long working hours on ‘all-nighters’ especially; unsociable working hours, and poor working conditions in a noisy, crowded, and dark workplace should all be considered and addressed by licensees (see Chapter 3). The handling of broken glasses by bar staff and glass collectors may cause them injury; they also risk contracting Hepatitis B from dirty and broken glasses. According to a recent survey of individuals involved in the nightclub industry, “Club workers were keen to know more about rights and regulations with regards to the Barry Legg Bill and [safer dancing] guidelines”: there is clearly a lack of adequate training for night-club staff.

The night-time environment

Outside of nightclub premises, issues relating to transport and safety on the streets may affect the safety and well-being of club-goers travelling to or from premises. Access to public transport is often inadequate during the night hours: public buses may not run after midnight, and taxis may be insufficient or ranks poorly located, and there may be a lack of functioning public phone boxes from which to call home for a lift for a private taxi. Long queues of people waiting for taxis can create opportunities for intoxicated individuals to act aggressively, and police presence may not be concentrated on such problem locations. Long periods of standing in the cold after extensive exposure to high temperatures, often inadequately dressed, may contribute to clubbers’ ill health. If an individual decides to walk home rather than wait in the cold, poor street lighting may make him/her vulnerable to assault.

II The club-going population

The kinds of issues which have been outlined as areas of ‘club health’ affect large numbers of people on a regular basis, not only club-goers, but a large workforce across the country within an industry which is booming. There are no statistics to indicate how many individuals regularly go to nightclubs, nor the age, social background, income, frequency of club visits of the ‘average’ clubber. Although it could be estimated that many clubbers are between the ages of, say, 16 and 25, it is inappropriate to refer to clubbers as just ‘young people’.

Furthermore, although the extent of illicit drug use has been acknowledged, it is not useful to label these large numbers of individuals as drug users. A recent study of 520 attendees at clubs and dance events in London and the South East found that drugs were judged less important for a pleasurable experience than music, socialising, atmosphere and dancing. Many of the problems highlighted may affect individuals regardless of their drug of choice. Equally, nightclubs which offer ‘dance’ music should not be targeted as ‘bad clubs’; it cannot be assumed that the
brand of music played in a particular venue is indicative of the health problems which may arise in it. For example, a small venue which stages an ‘Eighties Disco’ night may not attract many ‘dance’ music devotees, but there may be a lot of alcohol consumed and the door-staff unskilled in dealing effectively with drunken clubbers. Conversely, a club which holds a fortnightly ‘speed garage’ night may have excellent facilities for dealing with intoxicated individuals.

Clubbing ‘crosses the boundaries’, perhaps as no other social activity does. This may be one of the positive aspects of clubbing as a leisure activity. Quality leisure time and facilities can also promote good health and in relation to nightclubs specifically can boost health through the physical activity of dancing (see Chapter 11). The nightclub industry has a positive impact in providing employment and boosting local economies, which both have a proven relationship with health. Nightclubs may therefore be a focal point for a number of health initiatives, both for protecting the health of club-goers, and in promoting good health.

**III Health policy and club-goers**

Current trends in health policy emphasise the importance of preventive measures. Major causes of ill health and premature death which have been termed ‘avoidable’ include coronary heart disease and stroke; mental illness; accidents; and cancers. Other areas of concern which merit separate health-based strategies include sexual health, drug misuse, tobacco smoking and alcohol use. Those issues identified as ‘club health’ concerns clearly fall within this existing framework of health priorities, and are thereby deemed to be largely ‘avoidable’ in health terms.

Current health policy places the responsibilities for improving health jointly on central government and national organisations; local agencies and organisations; and on individuals. Each has its role to play. The appointment of a Minister of State for Public Health highlights the public health focus of the current administration, and its recognition of the need for a multi-disciplinary approach, for the Public Health Minister is responsible for co-ordinating ‘health friendly’ policy across government. Club health, too, is the joint responsibility of many players at policymaking level (for example relating to regulation over door supervisors); at the level of local services (collaboration between hospitals and nightclub management in providing first-aid/welfare facilities, for instance); and on the personal level (through clubbers taking responsibility for their lifestyles and behaviours).

**IV Healthy Settings**

One strategy which might draw these different actors together to tackle club health issues and to promote good health among club-goers and the individuals who work within nightclubs may be to apply a ‘settings’ approach. The World Health Organisation introduced the concept of ‘Settings for Health’:

“Health status may be determined as much or more by the conditions in these settings [where people live and work] as by the provision of health care facilities... Living conditions can be improved if all the players and available resources are mobilized to work co-operatively.... health can be improved by modification of the physical environment, and social and economic determinants of health”.

11 The Health Of The Clubbing Nation
A number of ‘healthy settings’ within which health issues have been addressed in this way are healthy environments, healthy homes, healthy workplaces, healthy hospitals. A setting approach incorporates health protection, treatment, and health promotion. It is an effective perspective from which to examine the implications for health of a particular environment; to identify ways in which that environment (for example the prison environment, or the school environment) may be made safer by minimising the health risks inherent in that environment; and to look at the needs and listen to the opinions of individuals in that environment in order to identify the best way to encourage health and safe practices within that environment. A third aspect to the ‘settings’ approach is to target certain difficult to reach groups, so that wider health messages can be relayed in an environment where the targeted individuals may be accessible and more receptive.

V Healthier nightclubs

It may be useful therefore to look at the nightclub not only as a physical environment in which people work and play, but as a setting. ‘Healthy nightclubs’ involve the people who work and ‘play’ in this environment; a large number of agencies responsible for protecting these individuals in and near their places of work or leisure; and the wider community. The real potential health risks of the nightclub environment and means of reducing them, as well as measures individuals can take to minimise harm to themselves, need to be identified. Finally the socio-cultural environment of the nightclub ‘scene’, and those aspects of clubbing which can have positive effects on health and well-being must be considered if we are to improve the health of our clubbing nation.

2 Drugwise: A practical guide for concerned parents about the use of illegal drugs McFadyean M (Icon Books, 1997)
3 Responses to ‘dance culture’ and changing patterns of drug use are pre-dated by ‘Britain’s first drug panic’, in the 1920s, over the use of cocaine in West End nightclubs in London, it is asserted in The Chemical Generation and Its Ancestors: Dance crazes and drug panics across eight decades Kohn M (The International Journal of Drug Policy, Vol 8 (3), 1997). See also Dope Girls: The birth of the British drug underground Kohn M (Lawrence & Wishart)
4 In a recent survey, 60% of 14-16 year olds had been offered drugs and 30% had used drugs. Drug realities: National Drugs Campaign Survey (Health Education Authority/BRMB International, 1996)
5 British Crime Survey 1996 (Home Office, 1997)
6 Drugs which are abused, that is used for non-medical purposes, as defined in the Misuse of Drugs Act 1971
7 Health Related Behaviour: An epidemiological overview Department of Health (HMSO, 1996)
9 Measures for Measures (Alcohol Concern, 1997 ISBN 1 869814 26 6)
10 “One in seven road accident fatalities occurred in accidents where the driver had illegal blood alcohol levels” Health Related Behaviour: An epidemiological overview Department of Health (HMSO, 1996)
11 Authors’ italics
13 As footnote 10 above
14 Fad for injecting alcohol hits dance scene (Muzik magazine, No 31, December 1997); Youth inject vodka for an instant high McGinty S (Sunday Times, 5 October 1997)
15 For instance Club On and UK Club Guide, which are both club listings publications.
16 Many still fail to link cancer with smoking Mihill C (The Guardian, 25 March 1997)
17 Release drugs and dance survey (Release, 1997)
18 See Chapter 7
19 HIV/AIDS Fact Sheet (Health of the Nation Briefing Pack, Second Edition)
20 Health of the Nation: The way forward in sexual health Chin R (J Journal of the Royal Society of Health, 1993)
21 Young Shun Safe Sex Ahmed K (The Guardian, 14 February 1997)
22 HIV/AIDS Fact Sheet (Health of the Nation Briefing Pack, Second Edition)
23 Men who have sex with men in the North West: A peer-led regional study (Lancaster University, 1996, ISBN 1 86220 0173)
Nearly 50% of deaths in men and 30% of deaths in women aged 16-24 are due to accidents. Health Prospects for Young Citizens of the North West (University of Liverpool, 1998)

The principal Environmental Health Officer for Stratford said the licensee’s actions showed “a total disregard for the safety of everyone involved” Owner jailed for nightclub overcrowding (Environmental Health News, 6 December 1996)

“Glass is the most commonly used sharp weapon in Britain. One pint capacity glasses are a greater problem than bottles, but bottles are increasingly used.” An Epidemiological Perspective of Violence Shepherd J (Violence and Public Health: Developing a policy agenda ed. Stanistreet D, Jeffrey V & Bellis M, ISBN 1 874038 51 1, University of Liverpool, 1998)

The Brewers & Licensed Retailers Association recently called upon UK glass manufacturers “to take advantage of the growing market opportunities in toughened glass” in a press release which announced the BLRA’s switch to toughened pint and half-pint glasses (22 October 1997)

Health: E is for Ear ache Gatton A (The Guardian, 30 September 1997)

Public Entertainments Licenses (Drugs Misuse) Act 1997, which gives licensing authorities new powers to close down premises where there is evidence or suspicion of illicit drug use or dealing.


See footnote 30 above

The evaluation of the London Dance Safety Campaign Brannigan P, Kuper H & Wellings K (London School of Tropical Medicine, April 1997)

Release Drugs and Dance Survey (Release, 1997)

By ‘dance’ music, the editors mean music which is characterised by fast, repetitive beats, although they recognise that this can cover a huge range of ‘dance’ types, some of which are more melody based than others

“Leisure services which allow people to relax and take a break from the pressures of day to day life can also have a real influence on health” Our Healthier Nation Department of Health (HMSO, February 1998)

“By preventing avoidable illness we can enable the NHS to concentrate its resources on those conditions which are not yet preventable” Our Healthier Nation.

Health for All by the Year 2000 (World Health Organisation)
CHAPTER 2
Licensed Premises, False Premises
Anthony H Wilson
I The ‘demonisation of youth’

I have spent my life fascinated by youth culture. The role of clubs and the harmful drugs that can be consumed in clubs particularly obsesses me at this time. People can be harmed by drugs and can be harmed by music. People are most often harmed by lies and ignorance. This is exactly what surrounds issues of youth culture, its dance clubs and its drugs in the late 1990s.

Someone I have worked with over the years is the great documentary film-maker Roger Graeff. I would like to convey his message, to explain what is going on with our young people in Britain and in our clubs. We must remember that Britain does not like culture, and as a culture we do not like our children and we do not like what our children do. We wish they would become adult sooner rather than later. Roger Graeff describes it as the ‘demonisation of youth’.

Our problems with what young people do and especially with regard to drugs legislation, is to do with ‘otherness’. For example, the reason cannabis is illegal in the UK comes directly from American law, enacted in such a way in the early 1920s because gin and alcohol were what white people drank and cannabis was what the Hispanics and black people partook of. It is that ‘otherness’ of culture and of drug use that leads to legalisation or illegalisation.

As someone who adores a cold beer with Mexican food, red wine with Italian food, it is rather hypocritical to say it but isn’t it strange that the worst drug of them all is the one that is legal; the one Chaucer described as ‘the very sepulchre of your wit and your discretion’? If those British thugs who so exacerbated the atmosphere in Rome for four days with their drunken vio-

II No to ‘Just Say No’

I do not believe in decriminalisation, unlike the Manchester Police chief three years ago who said: “It should just be sold in shops”. This is not what people like me believe in. Adding one problem to another is not the answer.

The Reaganite myth that we can stop people taking drugs seems to be amply in the heart of the government. If you start from that point of view, or if you talk with that as a possibility, because that is a complete lie and is wrong everything that follows from that point will be a lie, will be dishonest and will be damaging. People think they can say “We will stop them. We will bomb the cocaine fields of Columbia and we will give extra hard sentences to drug dealers”. But there is no way human beings will be stopped from altering their consciousness. They want to do it and they will go on doing it.

III Manchester and ‘E culture’

In the same way that in macro terms it was the first city into the Industrial Revolution, Manchester is arguably one of the first cities to deal with the questions of coming out of the Industrial Revolution. The first tragic Ecstasy death happened in Manchester. Although it wasn’t a tablet that was bought or consumed within our club, the girl died in the Hacienda. So as the first people into the ‘acid house’ nightmare - the problems of the new youth culture that was born out of Ibiza and working class English kids, and house music from Chicago and
Detroit - it is fair to say that we in Manchester were the first to say “Let’s not just say we’ll stamp this out. Let’s accept that this is going to go on. So what do we do about it?”.

In a spirited example of communication, Greater Manchester Police, Manchester City Council, Lifeline and club owners all got together and several years ago created Greater Manchester’s Safer Dancing policy. Very simple, straightforward guidelines were issued on flyers (absolutely the right way to issue them). The guidelines I am sure everyone is aware of: water that is free, on access, at several points in a club; chill out rooms where people can relax and calm down; and most significantly doormen and bar staff who are trained to be aware of how people look when they are getting out of control. Since that policy went into place four years we have not had an Ecstasy related death in our lively city of Manchester.

IV The Government line

I hosted a number of election programmes [last year], and the first time I saw the words Drugs Tsar, I thought ‘My God, where is this all coming from?’. It comes from the British media and from the British Establishment. My anger is utterly unlimited in defence of the Liberal Democrat Party. The way this country works was demonstrated when the Liberal Democrats voted for a Royal Commission to discuss drugs. They dared to suggest that we should talk about what our young people do and about what is going on, and they were laughed out of the house by every single part of the media in Britain, and by other political parties. That is the lowest anyone has sunk. That someone should be so decried for daring to suggest we talk about it sums up the state of this country. I felt I was new Labour for a very long time, just wanting someone who would win the election. And then Mr Blair who could win was dropping Clause IV and saying ‘Drugs Tsar’ I thought “Well maybe this is just election-winning rhetoric. Surely they can’t mean that. They can’t be so utterly stupid as to make Reagan look like a Liberal”. Has Mr Hellsawell (see footnote 5) been gagged? Has he really kicked into touch his awareness? ‘I will follow the government’s drug policy’ he said. Is there really a puritanical streak, is that ‘demonisation of youth’ alive and kicking in Jack Straw and in Tony Blair?

V Gangsterism

We talk about sprained ankles and people getting tired. There is that other health problem we all talk about, which is getting shot. Sometimes I think it’s that ‘demonisation of youth’ again. There was a pub in Salford, when I lived there as a kid in the late 1950s, early 1960s, called The Ship. There was a stabbing there every Saturday night. In the 1980s we used to laugh about the fact that people used to worry about the Hacienda, when in all the little old-fashioned clubs in town people would get pissed and there would be stabbings and beatings-up.

I do ask myself whether our gangland problem is overstated with regards to the avant-garde clubs and the radical clubs. I think we have to tell people that to a great degree the gangs and the criminals do not do their business in the clubs. The gangs do their business outside; they have their protection rackets at the local fish and chip shops. The problem if you have a successful nightclub is that at the end of the week they come to your club and say: “We’re top gangsters, you’re a top club, and we can come in and, by the way, we can have
that bottle of champagne”. It’s more about ego and ‘face’ than gang activity within the club centres.

VI  P is for Prohibition

It should not surprise us about gangsters and how the culture is in the late 1990s. One of my groups (a little band called The Space Monkeys who are fantastic) have a line in a song, called Queen Judge and the Clown about Manchester in the late 1990s. There is a little line in there that I love (‘Little Jimmy Cagney pulls out a piece’) because it does actually sum up part of my city in the late 1990s, in that there are a lot of little Jimmy Cagneys. It is that kind of feel, that kind of face (“I want respect”), and it should be no surprise.

When you have between 25,000 and 50,000 people doing heroin you’ve got a drug problem, you’ve got a legal problem. When you have a major, major human social activity that is made illegal, that is the ‘P’ word. It is called prohibition. Our lives in some way resemble Chicago in the twenties. We should not be surprised: if you make something that wide, that open, that commonplace, illegal you are going to get this incredibly vast illegal trade. The concept of prohibition is terribly important.

VII  Fifteen years of Club Culture

There is a last historical note relating to my concern about our administration’s attitude. I follow culture quite closely and it was very amusing in the early to mid 1980s that marijuana and that kind of drug had almost died out. It remained in lower working class areas as a dormant culture but, by and large, everywhere else it was wiped out. If you saw someone smoke dope it was some kind of hippie throwback. The world had changed, people were buying Spandau Ballet albums.

But then this incredibly strange cultural event happened, which has thrown us into where we are now. I adore the history of it. People in Detroit and Chicago in the early 1980s were bored with black music and began playing tapes by Depeche Mode and New Order, little English bands using synthesisers. At the same time Ibiza, the island that British working class kids went on to for a good time in the summer, had a strange drug history going back to the Pink Floyd film More, which was all about Ibiza and drug-taking in the late 1960s. My friend [the DJ] Paul Oakenfold described people being on Ibiza dancing hysterically on this American drug Ecstasy (purloined from marriage guidance counsellors in Zurich), dancing to Balearic beats, which was everything including Cyndi Lauper records.

Then they got back in the winter of ‘87 to Britain. It wasn’t sunny. It was cold. They couldn’t possibly dance to Cyndi Lauper: they needed a hipper music. And you got house music. Suddenly there was this drug and this dance style, and the culture exploded. Unlike the ‘beat boom’ in Liverpool (The Beatles all went to grammar school), unlike punk (which pretended to be working class but was largely an art school fabrication), it was a working class revolution.

And so you have this explosion. The numbers of British children - middle class, upper class, working class, aged fourteen, sixteen, seventeen who smoke dope in their bedrooms while they do their homework - is massive, completely different to ten or fifteen years ago. This is what is happening in British culture right now. Come the year 2000, that culture will not have gone away, it will have grown. If the government does not wake up to the fact that this has to be talked about and if the British media still laugh at people who sug-
gest there should be a Royal Commission on drugs, then questions have to be asked. If we keep coming out with Reaganite bollocks that we can stop young people doing this because they ‘should’ be stopped, then British culture is on a collision course with its own young people.

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1 This refers violent clashes between supporters and police at the World Cup qualifying match between Italy and England in Italy, October 1997.
2 This is a reference to the death of Claire Leighton, aged 16, in July 1989. The Guardian newspaper (March 1997) cites the death of Ian Larcombe in June 1988 as the first Ecstasy death.
3 A Manchester based drugs agency (see Appendix: Useful Addresses)
4 During the UK General Election in May 1997
5 The true title is Anti-Drugs Co-ordinator, held by Keith Hellawell, formerly Chief Constable of South Yorkshire Police/Chair of the Association of Chief Police Officers (ACPO)
6 Anthony Wilson is head of Factory Records, in Manchester
CHAPTER 3
A Little Nightclub Medicine
Dr. Chris Luke
I Introduction

I am not going to dwell on the little fetishes with which the tabloid press have had so much fun. My wife was becoming a little concerned that I was becoming a rather tragic figure with all the recent titillating coverage in the media (see Chapter 3.III). There are two sound reasons for my interest in ‘club health’. The first is to join in the celebrations of the 150th anniversary of the appointment of Dr William Henry Duncan, a visionary public health physician. It was through a clever combination of environmental planning, legislation and a little simple medicine - who managed to save the lives and ease the plight of tens of thousands of destitute refugees from the Irish famine who came to Liverpool in 1848. As an Irishman I regard him as an obvious hero, but as a doctor in the late 1990s I also regard him as a genius and I think that the example of his public health manoeuvres is as important today as it was a century and a half ago.

The second reason is that I am passionate about my ‘hacienda’, the Accident and Emergency (or A&E) department of the Royal Liverpool University Hospital. It has seldom been more difficult for us at the front-line of healthcare in this country. We are surrounded by people relentlessly pursuing their pleasures, who regard two holidays to Florida a year as their birthright, get fighting drunk, and sniff, snort and shoot up every drug they can get their hands on. Unfortunately, few of the people who voted for constant tax cuts and deregulation over the past twenty years really considered the bill that would have to be paid. Consequently the inevitable tab for mass self-indulgence is being picked up by health-care staff who are under pressure. And that is ultimately why I am interested in ‘club health’: on behalf of the people whom I regard as the emerging heroes of the 1990s, those who continue to care when it has become neither fashionable nor profitable to do so.

II Nightclub Medicine

I must introduce a little bit of background to ‘nightclub medicine’ as well as a sense of its scale. The Royal Liverpool University Hospital is about a mile from Liverpool city centre and is surrounded by dozens of clubs and late bars. Cream is the best known but there are many other major clubs nearby.

A cursory glance at national statistics will reveal a huge population of potential patients who go clubbing every weekend in the UK, probably as many as a million people, and we know from recent surveys that in some dance scenes well over three quarters of clubbers are taking MDMA or Ecstasy. Social scientists have also established that environmental factors are a major issue. Heat, for example: of 16 nightclub fatalities that were recorded between 1988 and 1995, the vast majority were heat-related in the terminal stages. Locally, our own figures indicate a ‘guesstimate’ of between 700 and 1500 clubbers who come to the emergency department each year, of whom about 11% are sufficiently ill or injured to be admitted.

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<th>TABLE 1: Post-club hospital admittances</th>
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Club patients at the RLUH A&E Department (01.01.97-10.10.97)
So what do I - a straight-laced doctor - know about clubbing? I must confess that clubbing has come on somewhat since I boogied to Shalimar, Luther Vandross and Kool and the Gang. In fact club culture has become to this generation what street protest was to the generation of the Sixties. It is enormous. And again, a divide is opening up between the Establishment and “yoof” culture. Given my age (late thirties!) it seems inevitable that I must soon cross that divide and represent the Establishment despite my natural inclinations, but I am still attracted to some sort of bridge-building between generations.

The real problem with the chasm between the generations is that well intentioned and important messages from the establishment about health-care are being disregarded because young people simply do not trust the Establishment, which demonises them and puts out rather contradictory messages about tobacco, alcohol, cannabis and so forth. The result, whatever your politics may be, is that a massive amount of alcohol ingestion, drug taking and other habits are now firmly embedded within club culture, and have brought with them all the predictable consequences. Witness the tragedy of Leah Betts\(^2\). She did not die in a club but she epitomizes press paranoia about club culture. She is emblematic of what they regard as the noxious aspects of clubbing. But, as we have already heard, drugs are by no means the central issue overall in clubbing. The real problems for the healthcare system are the old ones of drink and drink-related violence.

It’s not just drink-related violence, of course. Often there is violence within clubs and clubbing for its own sake or for the purposes of intimidation. It is surely unacceptable that of the clubbers who are victims of assault, 10% are injured by bouncers who should be preventing just this sort of violence. We recognise that even real policemen are increasingly the victims of assault too.

It is this heady mixture of issues which has culminated over the last year or two in serious pressure from the government, local councils and the media on the whole club industry. In 1996, the club culture magazine MixMag\(^3\) described it as the government “declaring war on clubs”. Personally, I am ambivalent about politics and public health policy because they are both difficult and complex areas and simplistic responses are really unhelpful. What I am more concerned about is opening a debate about the impact of club culture on the creaking health-care system in this country.

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<th>TABLE 2: A weekend of clubbing at The Royal</th>
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Let me illustrate: on one weekend in our hospital, thirteen young people came into the A&E department in the early hours of Friday, Saturday and Sunday, with medical problems ranging from coma due to a cocktail of cocaine, ketamine, Ecstasy and alcohol, to repeated beatings by bouncers, to accidental cuts and bruises (see Table 2). Of course the figures do not reveal the full picture. Behind each of these statistics there are often tragedies. One young university student was assaulted in a club about half a mile from here by a female bouncer and was devastated by a disfiguring scar on her face. She had to take two weeks off her studies and needed to be followed up by plastic surgeons in her local hospital (see Picture 1). ‘Liverpool lovebite’ can mean many things - see Picture 2, which shows an ear partially amputated by a bite. Injuries like this are all too common outside clubs.

It is not just trivia. With forty-five shootings “under our belt” (many of them fatal) and with serious assaults coming into us every week, we remain deeply perturbed by the gangsterism at the interface of society and clubs. In addition to that, there have been many other serious cases ranging from the moribund amyl nitrate victim to the young man who broke his spine in a local club, falling from an unprotected stairway.

This stream of cases from local clubs naturally compounds the pressure from many other problems affecting A&E departments up and down the country, which include staff shortages, a rise in emergency admissions of up to 15% per annum and declining staff morale. Plainly, our ability to cope has become questionable. Consequently, many of us in Accident and Emergency Medicine have been seeking ways of dealing with what sometimes seems like an avalanche; looking for some way to ‘turn down the tap’ of cases. In
Liverpool, we have been involved for several years in public health-care initiatives dealing, for example, with joyriding, industrial injuries and accidental poisoning in children. So we were more than happy to respond to Cream’s invitation to analyse the immediate medical needs of clubbers there and elsewhere, and to consider preventive measures.

In discussing ‘night-club medicine’, I would like to describe what I regard as the two natural halves of medical care. The first half consists of the medical problems which present within a club and the sort of care which is immediately required; the second half comprises the problems which prompt a hospital visit, and the overall global impact on hospitals.

III First-aid within clubs

Enthusiastic clubbers will hardly need to be told that Cream is one of the best known clubs in the UK (it was voted Club of the Year in 1996). Once a month initially, and now almost every weekend, huge dance events at the club attract up to 2800 clubbers from all over the UK, Ireland and even continental Europe. They arrive in Liverpool in their hundreds by car, train and bus.

We too - a couple of doctors and a nurse - happily donned our glad-rags and mingled amongst the clubbers for a few nights. We were very glad to be the guests of Dave F.A., the superb Cream first-aider who kindly allowed us to observe club first-aid in operation and analyse the first-aid workload at the club over the years 1994-1996.

It is difficult to describe the conditions of care in clubs. Indeed it is particularly hard to get a handle on it if you’ve only ever worked in the sterile environment of a hospital. The contrast couldn’t be greater in terms of chaos, noise and heat, and to get some sort of glimpse of what’s going on medically you really have to base yourself in the First-Aid Room which acts as a ‘funnel’ for those who need immediate care.

Not surprisingly, alcohol was the main problem affecting first-aid victims, and about two thirds of the clubbers who required first-aid in 1995-6 in Cream were intoxicated with alcohol. This means that when people are dancing in a crowded, darkened environment for up to six hours (with or without Ecstasy which together with the sheer scale and pace of clubbing makes the dance scene so different from the 1970s), they’re going to have accidents all the more often, and any sort of dance injuries can and do result.

There are also some curiosities: for instance the so-called ‘nightclub finger’ (see Picture 3). This typically occurs when young men are dancing on the dance-floor and they bend down to pick off what they think is a cigarette butt from the sole of their trainer. The next thing they find is a wound at the tip of the finger, caused in fact by a
shard of broken glass. Oddly, we learned that this kind of injury is seen by the half dozen every night in clubs throughout the UK. Few of them come to hospital, but it is surprisingly common and often requires first-aid.

Other things caught our fancy, as it were. The sad fashion victim (see Picture 4) actually has the right idea because people waving cigarettes in the air while they dance blissfully in a crowd, may inflict small burns and wounds on others’ foreheads and eyes. Occasionally, these can be quite nasty and even threaten the eyesight.

Other problems that were unexpected but which - again in retrospect - should have been predictable were the irritation of the skin, eyes and lungs of some people when exposed to smoke machines and dry ice, CS gas occasionally and (as described recently in many newspapers) people flashing lasers at DJs and others.

Drugs were ubiquitous in our study of the club scene. We talked to first-aiders in other clubs in Liverpool and they all reported similar experiences with drugs. Surveys by Crew 2000, MixMag, HIT and Lifeline keep confirming the vastness of drug consumption in the UK. Interestingly, I think that the information about water and heat is beginning to have an effect and we are not really seeing that many problems with Ecstasy related heat-illness. What we do tend to see is panic attacks and, lately, the more worrying spectacle of convulsions and depression.

LSD (or Acid) is resurgent too. It is not a major medical problem apart perhaps from panic attacks and occasional psychiatric problems. The most important medical message is that doctors need to be aware that they can assume a threatening or bizarre demeanour to the hallucinating patient.

Poppers (or Amyl Nitrite) have moved over from the gay scene into the straight scene. They are relatively innocuous, although if you are inhaling poppers and...
somebody lights a cigarette in front of you, you can ignite your face. Clubbers can also sustain burns of the eye if popper fluid is splashed carelessly. Occasionally, people misguidedly drink the liquid and present to the emergency department in a (potentially irreversible) coma.

Cocaine is a terrifying problem medically. It causes strokes, heart attacks and collapsed lung in young people, but the most disturbing aspect is the violence which is so often associated with the drug. I am not talking about ‘crack’ but ordinary cocaine powder. I’m talking about young men coming to hospital from clubs and parties, ‘coked up’, causing an astonishing amount of damage. It’s extraordinarily frightening for all concerned and it is a massive threat to the care of others.

Incidentally, and sometimes amusingly, we were acquainted with the current language of substance misuse: “me drink wuz spiked”; “I only took a line”. The sheer variety of nicknames for drugs was fascinating along with the jargon that clubbers used for adverse effects: ‘beak’ for cocaine; ‘beaked up’ for having snorted cocaine; ‘sledgin’ to describe a dodgy feeling after taking a drug; and the truly politically incorrect term for gurning — ‘monging’.

Other curiosities were just that, interesting rarities, including the sort of fetishist things recently much covered by the tabloids. Issues for instance like ‘dancer’s nipple’ and ‘PVC bottom’. These problems of chafing and rubbing (against ribbed T-shirts and plastic clothing) are obviously hilarious to the tabloids but they rarely present to hospital and are usually self-limiting. Most first-aiders will be familiar with them and I suspect that the first-aid implications are rather straight-forward!

Since our visit to the club scene there has been a whole range of clubbing issues raised in the media: lasers are one example and a case was reported recently, in the British Medical Journal, in which an asthmatic successfully sued a major club in Sydney, Australia because her wheezing had been exacerbated by smoke. All sorts of things it seems are beginning to be reported, from the difficulties of gaining access to the gay Manchester club scene if you are ‘straight’ to the recent closure of the Hacienda because of its recurrent problems.

Nevertheless, I feel reasonably sure that the medical epidemiology and scale of ‘night-club medicine’ has remained largely unchanged since our exercise in Cream in 1995-6. In a nutshell, if you go to any big club in the UK and look at the first-aid requirements of clubbers you are likely to find that about half are intoxicated with alcohol or drugs, about a quarter have soft-tissue injuries and the rest of them have had fits, faints, funny turns and - occasionally - fractures.

**IV Prevention is better than cure**

In terms of the solutions that we would recommend to clubs, none of them is new except perhaps our exhortation to clubs and clubbers’ groups to liaise more with hospitals. Obviously there are the simple messages about eliminating or toughening glass, generous provision of water fountains and chill-out facilities and other health issues (especially drugs); and particularly about the need to somehow restrain the ‘relentless drinking syndrome’.

Our more particular recommendations would be that good first-aid and adequate first-aid facilities are what clubs should provide as a legal minimum. They should also
liaise regularly with hospitals because there is a lot of useful intelligence of mutual benefit to be gained from both sides about what’s going on with drugs and drug treatment, for instance. It is also likely that club first-aiders would benefit from a certain amount of training in hospital accident & emergency departments. Finally, everything possible should be done to get rid of violence and gangsterism in and around clubs through adequate door policing, regulation of doormen and liaison with local police forces (see Chapter 5).

V Nightclub medicine and the NHS

Coming to the other half of our review, what is the impact of ‘night-club medicine’ on hospitals? In the last year or two the NHS has been under enormous strain and we have been losing many nursing and medical staff because of the sheer stress of the work. It was against this background that we did our best to pluck out from the 100,000 or so patients that we see each year those who come to us from local clubs.

We ‘guesstimated’ that the club medicine workload was up to 1500 patients for the entire year, but given the current pressure on the department ‘club’ attendances weren’t always documented completely. In any event, this was our best entirely unfunded effort. We managed to establish an evolving database of 400 clubbers, with a mean age of 24.5 years; a male:female ratio of 1.5:1. The mean length of stay in hospital for clubbers was two hours, with the longest being six weeks for a spinal fracture.

Predictably, club attendances at hospital were a feature of the early hours of Fridays, Saturdays and Sundays. The vast majority of clubbers arrived within a few hours of sustaining their injury or ailment. Surprisingly, about 40% of them arrived in ambulances so there’s clearly a significant cost in terms of transport. Over half of the

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**TABLE 4: A Little Nightclub Medicine: Some key facts**

- up to 1 million people go clubbing each weekend in the UK
- thousands of these clubbers require first-aid in clubs
- the vast majority of patients needing first-aid in clubs do not attend hospital
- adequate first-aid facilities, health & safety issues are a major neglected area in club culture

In Liverpool...
- club patients account for about 0.5% of accident and emergency department attendances
- most clubbers require hospital care for injuries; half of these are due to violence
- glass is a major hazard in clubs
- of club patients need admission overnight
- around 85% of club patients are overtly intoxicated with alcohol
- substance misuse in clubbers attending hospital is less well recognised and more concealed
- around 10% of clubbers are admitted solely due to intoxication (alcohol and chemicals)
- 42% of injuries sustained were cranio-facial
- doormen account for about 11% of assault victims

The Health Of The Clubbing Nation 26
patients presented because they had been assaulted.

There is an interesting contrast between the nature of medical care in the clubs themselves and in hospitals. If you go to the clubs themselves, 90% of the problems are minor, for example: over-exertion, over-indulgence, little accidents, cuts, and so on. Just 10% of club patients need to come to hospital but those who do come because they have been significantly injured in an assault or (in a quarter of cases) accidentally, commonly in association with alcohol or other intoxicants. Interestingly, less than or round about 10% of people who come to hospital from clubs do so because of intoxication with drugs, so the message is perhaps that drugs have been somewhat ‘over-hyped’ in the past.

If you try to work out what clubbers are intoxicated with when they present to hospital, you’ll see again that alcohol is overwhelmingly the main agent of serious intoxication and is overwhelmingly the stuff which is associated with most injuries and assaults. If you try to look at the epidemiology of substance misuse you will see however that alcohol is not being displaced in the club scene by drugs as one would believe from the media coverage; rather it is being edged to one side but overlapping with the taking of drugs cocktails.

What are the logistics and costs associated with hospital care of club patients?

Most of them spend just two hours in the emergency department and only need wound care, stitches and so on. But a third need expensive x-rays, a further 10% have other expensive tests. In terms of what happens to these patients after they leave the hospital, just over half have no need of any follow up, but a third are referred to outpatient clinics because of limb, nasal and facial fractures, head injuries, plastic surgery requirements etc. This is a significant health-care cost.

**VI Conclusions**

In summary, the implications for A&E departments of clubbing nationally are quite substantial but they are almost certainly reducible. The medical management

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**TABLE 5: The take home message**

- Clubbing is fun and can be very good for you but....
- Thousands of clubbers end up in hospital each year probably unnecessarily.
- The risks of clubbing relate mainly to violence and accidents, fermented by alcohol and drugs.
- Other medical problems are very much in the minority.
- The environmental hazards in clubs are well recognised: they range from breakable glass to unprotected edges, ledges and stairs.
- Club medicine is a major, reducible burden on a struggling NHS. The burden must be reduced.
- Drugs are increasingly important but a balanced perspective is appropriate; alcohol, glass and violence are still the major medical issues in clubbing.
- We should move quickly towards a national club code or policy. But who should pay?
is simple, prevention is about addressing environment and people, and the only really new thing that we would advise is to reduce the misapprehension between the various groups involved. We are convinced that this can be done through regular communication between clubbers, the media, local government, police, healthcare workers, club owners and so forth. Happily, that has begun with Club Health.

[I am most grateful to Howard Morris, Dr Colin Dewar, Dr Mark Bailey, David McGreevy, Christine Kennedy & Jayne Casey for their contributions to this project]

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1 See Heat stress in night-clubs McNeill M & Parsons K (Department of Human Sciences, Loughborough University of Technology)
2 Leah, from Essex, took one Ecstasy tablet before a party to celebrate her 18th birthday in November 1995. She died from liver failure (through drinking too much water) 4 days later.
3 Mixmag is a club scene/dance music magazine
4 By Muzik magazine, a club/dance music magazine (Cream was also voted their Club of the Year 1997), and the British Entertainments and Discotheque Association (see Appendix: Useful Addresses).
5 An Edinburgh-based peer education dance drugs and clubbing project (see Appendix: Useful Addresses).
6 See footnote 3, this Chapter
7 Formerly the Merseyside Drug Training and Information Centre (see Chapter 7, and Appendix: Useful Addresses).
8 See footnote 3, Chapter 2
9 To ‘gum’ (or ‘gim’, from the verb grin) means to snarl; to grimace, pull grotesque faces. Certain drugs can cause the user to gum involuntarily.
10 “A number of important documents have been published which are relevant to club medicine. Probably foremost among them is Dance ‘til Dawn Safely, put out by the London Drug Policy Forum although this is more or less the same as that published in Scotland by Crew 2000 and in Manchester by Lifeline (see Appendix: Useful Addresses). It sets out clearly the measures that the club industry needs to address in order to reduce the burden of clubbing on the NHS (and society).” Dr Chris Luke
CHAPTER 4
Entertainment Safety: A Regulator’s View
Ian Foulkes
I Control of Entertainment: A New Issue?

Local authorities have been involved in the control of entertainments since the Disorderly Houses Act of 1767. The enforcement regime runs along two avenues. We have the basic ‘health and safety at work’ regime, looking as a regulator at the people who work in the club to make sure they are protected, and we also have a function as a licensing authority to give a public entertainments licence to nightclub venues to make sure they are safe to operate.

We also have a major role to play in the environmental protection of the area nearby. Some nightclubs are in the middle of residential areas, so there is a major impact on the club activity of the people who live in the area.

II Health and Safety

First of all, health and safety. Whose responsibility is it? The Health and Safety Act puts a number of obligations on a number of people. Section 2 is the bit that I primarily focus on, but club owners have to acknowledge under Section 3 that as an employer they have an obligation to those people they don’t employ. So they have an obligation to those people that go to his/her nightclub to enjoy themselves.

Many years ago I worked in Birmingham, and we carried out a big survey of nightclub health and safety. One of the issues was noise. On the middle of the dance-floor in one nightclub at 2am, the noise levels as measured were 139 decibels, that is 1 dB(A) away from the threshold of pain. It is not acceptable and extremely dangerous for an employer to impose that on people who have paid to be there. Club owners/managers have to play their full part if clubbers are to be protected.

<table>
<thead>
<tr>
<th>TABLE 1: Health and Safety at Work Act 1974</th>
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<tbody>
<tr>
<td>Main Sections</td>
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<tr>
<td>S2  Employer/employee</td>
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<td>S3  Employer/non-employees</td>
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<tr>
<td>S4  Person in control of non-domestic premises</td>
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<tr>
<td>S7  Employees</td>
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</table>

There is also an obligation on people who are in control of what is termed non-domestic premises made available for people, like the nightclub. Employees also have a role to play. It is not acceptable in our context for ‘bouncers’ (I will not call them door supervisors because they tend to be the trained end of the market) to beat up the punters. They are employees of the club and must be controlled and managed. Health and safety at work is an important aspect of our control regime.

<table>
<thead>
<tr>
<th>TABLE 2: Key issues</th>
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<tbody>
<tr>
<td>1. Access/Egress</td>
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<td>2. Emergency procedures</td>
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<td>3. Staff Training</td>
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<td>4. Special Effect Safety</td>
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<tr>
<td>5. Electrical Safety</td>
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<tr>
<td>6. Provision of sanitary accommodation/drinking water</td>
</tr>
<tr>
<td>7. First-aid provision</td>
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<tr>
<td>8. Noise (occupational and environmental)</td>
</tr>
<tr>
<td>9. Community Safety</td>
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</tbody>
</table>
Ill Key Issues

Advice & assistance is crucial. We may all be too old and crusty to come to clubs of an evening, but we’re not too old to give advice on basic health and safety systems. If things go pear-shaped we can take a number of statutory actions. We can serve a Prohibition Notice which actually closes the club or/and (they are not mutually exclusive) prosecute the owners of premises which deviate from sound health and safety standards. In my personal view that doesn’t happen perhaps as often as it should do.

1. Getting in and out safely - access and egress in techno-speak. We do this in liaison with the fire service. They usually give us fire certificates for nightclubs. We look at potential points of entry and exit, which should be clearly marked and sufficient for the capacity.

2. We look at the club’s emergency procedures and how effective they are for emergency evacuation and fire precautions. Training is vital for emergency situations, so staff know exactly what to do and how to do it.

3. We look at the stewarding and the safety training of staff. A nightclub is a slightly confused environment and staff should be fully competent in their duties (that could include first-aid training).

4. Laser eye problems and noise problems, should not be occurring. They are specifically regulated. Special effects are one thing we pay particular attention to, especially lasers.

5. The amount of electrics in a nightclub can be enormous. Fires/electrical problems are not uncommon. We pay particular attention to electrical safety.

6. When the [dance] club scene started, I think there was some kind of deal between manufacturers of mineral water and club owners because we did start to find that water supplies had been taken out of commission, and bottled water was being sold at clubs for £5.00 a bottle in Birmingham. People were actually drinking out of toilet bowls, they were that desperate for water. So we look at the integrity and numbers of sanitary accommodation (ie toilets) and the provision of drinking water.

7. We look at first-aid provision. I am very encouraged to hear about the measures taken by the Royal Liverpool University Hospital, and developments in terms of medical supervision, because we tend to ask for basic first-aid.

8. We look at noise. As the night goes on, the DJ gets deafer, and turns the sound up. The punters, get exposed to excessive levels of noise. We also have a role to play in looking at environmental regulations. What happens when the clubbers leave? The noise they make with cars, chatting, shouting, any break-out of sound from the club.

9. In a wider role, Local Authorities have a significant place to play in community safety. As a Local Authority regulator, we know clubs play an important part in our community. They are a place for young people to go, they generate lots of income, they are healthy things to have around. But that has to be balanced by the needs of the community as a whole for its safety.

IV Licensing

The real acid test is the licensing role of the Local Authority, a role which is considered very important by Councillors. It is a vital function; one of the primary tasks of Local Authorities as regulators. We can regulate entertainment under Public Entertainments legislation which says that public dancing, music or entertainment of any light kind requires a public entertainments licence. The licence is for the entertainment, not for the premises, though there
are premises-related issues in the licensing regime.

**TABLE 3: Licensing Procedure**

1. Application, with fee
2. Local Authority considers application
3. Licence granted with/without conditions
4. Appeal to Magistrate Courts

The licensing regime begins when an application is made, together with a suitable fee as set by the Local Authority. The fee is meant to cover the costs of this provision but rarely does. The Local Authority then considers the application. Usually the application is considered by Council members, your elected representatives. The Local Authority may then grant a licence, with or without conditions. If the licensee doesn’t like the conditions, or fails to get a licence, he can appeal the decision to the Magistrates’ Court.

**TABLE 4: Licensing Enforcement**

1. No licence - prosecution
2. Condition breached - prosecution
3. Continual breaches - revocation

It is illegal to operate without a public entertainments. If you are running a public entertainment and you have no licence you can be prosecuted. If conditions are breached, then again the licensee can be prosecuted. If those breaches are continual and the licence revoked, if the entertainment happens again we can take statutory action.

V Conclusions

The Local Authority is a key player in formulating a safety policy, and drugs policy with pressure groups and special interest groups. Use the skills officers of your local authority, and crucially its elected members, in terms of the views they have on safety in the community. We want to be more than just a regulator but now hopefully you understand the role that we do have as a regulator in club health and safety.
CHAPTER 5
Improving Security Within the Leisure Industry
Andrew Walker
I  The National Association of Registered Door Supervisors

The National Association of Registered Door Supervisors is a trade association which was started a couple of years ago to represent the interests of and to promote training for door supervisors at licensed premises around the country.

There are many jokes about door supervisors. For instance:
Q: ‘How many doormen does it take to break an egg?’
A: ‘None, it fell down the stairs on the way out’.

Dr Chris Luke estimates that 10% of assault victims are as the result of unruly doorstaff (see Chapter 3.II). Many people refer to the large men in dicky bows and dinner suits as ‘bouncers’, but the majority of security personnel nowadays are moving towards new levels of professionalism. The door supervision industry is working very hard to move away from the old thug image of yesteryear, towards that of dedicated, trained security operatives.

II  Aims

To help bring about these changes, our Association has a set of aims (see Table 1). We would like to ensure that only suitable, competent individuals are employed as security personnel on licensed premises. Just over half of the country now has registration schemes for door supervisors and ultimately what we would like to see is the whole of the country covered so that only suitable personnel are employed at nightclubs in this capacity. To do that we try to persuade local councils to ensure that they have a system of vetting, training and registering their supervisors in their particular area. We are also, as an association, working with the government and other authorities and organisations to bring about a national registration scheme. We promote high standards of training for our members and individual company members.

Pub and nightclub owners and managers and, indeed, the public are slowly coming to realise that the use of smart, polite and non-aggressive and truly security-conscious staff at licensed premises not only makes for a pleasant environment for people but can also make the premises a lot safer. In order for this new style of security to be provided, it is necessary that the

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**TABLE 1: The Aims of the National Association of Licensed Door Supervisors**

1. To ensure that only suitable, competent personnel are employed as security personnel at licensed premises
2. To persuade local authorities to ensure that pubs and nightclubs only use properly vetted, trained and registered door supervisors
3. To work with the government and other authorities and organisations to help bring about a National Registration Scheme
4. To promote high standards of training for its members
5. To provide the leisure security industry with any help or advice it requires
6. To represent and protect the interests of its individual and company members
right men and women are employed to do the job, and to ensure that they are properly trained with regards to their responsibilities, their powers, and their procedures. To help bring about these changes various forward thinking councils and police authorities have initiated ‘door supervisor registration schemes’. These schemes basically involve getting the owners and managers of pubs and clubs to employ only registered door supervisors. In order for those door supervisors to become registered they have to be positively vetted with regards to any previous convictions they have and they also have to go on suitable training courses in order that they can do the job properly.

III Door-staff registration schemes

The vetting procedures are usually performed within the partnership approach between the police and the Local Authority, particularly using the police national computer to research the applicants with regards to previous convictions. The Rehabilitation of Offenders Act needs to be taken into account in each case to ensure fair play to all applicants. But also taken into account are the number and the type of convictions that people have and how much time has elapsed since the offence was committed. Each case is taken on its own merit, but the overriding principle of the vetting procedure is the protection of the public.

The training provided on the schemes vary as well. They vary in length, subject matter and quality, depending on where you happen to be in the country. With some registration schemes, the police run the courses. Other schemes are actually coordinated by the local council with the police and ambulance services providing the various elements within it. Some schemes, Westminster in London, for example, use private security companies to provide their training. There are various ways to do it. Danny Brewington and I have spoken to quite a few of the doormen in Liverpool, and we were quite surprised that although they have a registration system here where the door staff have to register, they actually have no training, which to me seems like they only have half a scheme. So some schemes have full registration systems and training, some haven’t got anything.

One of the earliest registration schemes was started in Bradford in 1981, but since then many more have started; the recent estimate was that 54% of areas around the country are covered by door supervisor registration schemes. There will come a time when door supervisors will not be able to work on the door unless they are properly registered and trained. In the same way that people can’t legally drive a car unless they have got a driver’s licence, they just won’t be able to do it. In 1991 in a Home Office study of a group of these schemes from various parts of the country, all of these schemes reported that there were definite reductions in incidents of violence involving door supervisors, and all claimed that theses schemes were a great success with regards to crime prevention.

In areas where the schemes have been operating for quite a while there has been a noticeable change in the relations between the police and the door staff of the premises as well. Beforehand, police officers had generally thought that door supervisors had little or no training, which was true. They were not accountable to anybody and they were not supervised properly. Sometimes they started more problems than they actually prevented, and some of them were just out and out criminals. The door supervisors by the same token had
their own view on the police as well, often thinking the police were more keen on arresting the door supervisors than on the drunk punter who started the problem in the first place. Relationships between the police and door staff are slowly improving. With door supervisors learning and using their powers more professionally whilst protecting these licensed premises, and police officers realising that security does preserve already scarce police resources, it improves the protection of the public. We would like to think that in time there will be a newfound mutual respect and willingness to work together between doorman and police.

In 1995, the Home Office issued a circular entitled Registration Schemes for Door Supervisors. That was devised after a bit of research into schemes around the country. It is a package which basically advises councils and police authorities on how to produce these schemes and how to run them. There are a number of problems with these training schemes. As I say there are various schemes all over the country and they differ widely in how people are vetted and trained, who it’s run by, and that sort of thing. The new Labour government has said that it is keen to regulate the whole of the private security industry in time. We are obviously one sector of that. The door supervision sector has obviously - as has been said today - has often been seen as the rough end of the security market. We actually are slowly getting our act together at a far better rate than a lot of the other sectors of the industry. We have these registration schemes now. A lot of our door staff are actually better vetted than uniformed guards that you see patrolling around city centres.

Ultimately our aims as a national association would be to bring in a national registration scheme, one whereby every door supervisor in the country has to be registered and trained, and secondly that it is to a set standard. In order for us to be able to do that there has to be various elements in place. We have to have a national vetting procedure whereby everybody is vetted to the same standards; all door supervisors are checked off against the same list. That way if a door supervisor cannot get registered in London, he should not be able to get registered anywhere else in the country. That’s just common sense I would suggest. We have to have a national training standard. At the moment depending on where you are around the country, the training varies from none at all as in Liverpool to three hours in some areas, to six hours, to sixteen hours. Some areas have even got up to twenty four hours of training. You have to have a system of monitoring this training as well.

There is a national qualification coming out early next year from the British Institute of Innkeepers which is directly in relation to door supervision which will help along those aims. There will also have to be a central record base, so that all of the door staff can be registered under one place.

IV Training Recommendations

We have designed a proposal for the government which we will be putting to them in due course, with regards to what we think door supervisors should be trained in (see Table 2). We would consider this to be a good basic sixteen hour introduction course for door supervisors, whether they are trained by the police, by the local Council or by a private security company.

1. Social skills: How to talk to people, how to calm them down instead of winding
them up and making problems worse; trying to prevent aggression; understanding body language.

### TABLE 2: Recommended Training

<table>
<thead>
<tr>
<th>Topic</th>
<th>Hours</th>
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<tbody>
<tr>
<td>Introduction</td>
<td>0.5</td>
</tr>
<tr>
<td>Social Skills</td>
<td>2.0</td>
</tr>
<tr>
<td>Laws and Procedures</td>
<td>4.0</td>
</tr>
<tr>
<td>Licensing Laws</td>
<td>0.5</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>0.5</td>
</tr>
<tr>
<td>Emergency First Aid</td>
<td>4.0</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>2.0</td>
</tr>
<tr>
<td>Bombs</td>
<td>0.5</td>
</tr>
<tr>
<td>Equal Opportunities</td>
<td>0.5</td>
</tr>
<tr>
<td>Debrief</td>
<td>0.5</td>
</tr>
</tbody>
</table>

2. **Laws and Procedures**: The powers that door supervisors have, how to use these powers; how to arrest people if they need to; how to prevent violence; the use of force and how much force can be used (door staff are allowed to use force if they are within the law, but they have to justify how much force is used). We also cover a drugs section: preventing drugs from being brought into the premises; the power of arrest in relation to drugs; the different types of drugs that are available and their effects.

3. **Licensing Laws**: Door staff need to be aware of these in order to help the licensee enforce them.

4. **Health and Safety**: We explain health and safety issues in relation to employers, employees, and their responsibilities.

5. **Emergency First-aid**: What we would like to see (and it is working in a lot of areas) is that all door staff have a four hour emergency first-aid session, up to emergency first-aid qualification standards, whereby they get a three year certificate. It covers resuscitation and life-saving skills.

6. **Fire-Safety**: Fire exits, use of fire extinguishers, fire prevention, evacuation procedures. Door staff are going to be your front people when an emergency happens. They have to know what they are doing. We help them with that.

7. **Bombs**: How relevant this is depends on where in the country door supervisors work. For example, people in central London need to be aware of suspect packages and bomb procedures. People need to know what is going on and the procedures they should take.

8. **Equal Opportunities**: Door staff need to know what they can and can’t do, and how to treat people.

The emphasis is very much on safety. Door staff are in the front line, helping the licensees to make their premises safe. I appreciate some of the stories about some door staff committing assaults. Firstly, that is the thug element which, unfortunately, is still involved in some areas because there are no vetting procedures, and licensees will let anybody on the door; and secondly, it is because some of the time these door staff have not been trained as to how much force they can use and when. We train them how to use force, and how to do it legally.

### V Conclusion

We will be lobbying Parliament and the Home Office over the next year or so. We would like to see a national registration scheme brought in for door supervisors, so
that all door supervisors throughout the
country - whether they work in pubs, wine
bars, nightclubs, casinos - are trained to
at least a basic standard. Only via a nation-
al registration scheme will we get rid of the
bad element from the door supervision
industry.

In a couple of years’ time the old
‘bouncer’ image will be long gone. You will
have professional security operatives on
the door, who will assist the licensee in
keeping his/her licence and keeping the
punters safe, which is ultimately what we
are all working towards.

Copies of the NARDS’ proposal for a National
training Course can contact Andrew Walker at NARDS
National Headquarters (see List of Contributors), or by
telephone on 07050 605 750.

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1 “A decision was made to put the latest proposals through to the
full council meeting here in Liverpool, and we hope to have a
door registration scheme up and running within the next couple
of weeks. I have been on record as saying that we have some
undesirables working in licensed premises, but we are hopeful
that that will be rectified when the scheme comes into being. We
welcome a door registration scheme in Liverpool - we need a
door registration scheme.” Inspector Damien Walsh, Merseyside
Police, 31 October 1997
CHAPTER 6
Promoting Sexual Health Services in a Nightclub Setting
Lisa Knott
Manchester Brook Advisory Centre, part of a national network of 38 centres, opened its doors in May 1996. We were given a lovely, swanky, trendy clinic, but no marketing budget, and were told to go out and bring down the teenage pregnancy rate in Manchester. There was a lot of evidence when we opened, both nationally and also from Brook itself, that showed that there is a low uptake of young people in mainstream [sexual health] services. We were very keen from the beginning that we were going to market ourselves very differently from NHS providers.

We set about devising a communication strategy, asking ourselves “How we can actually get our message out to the young people of Manchester, bearing in mind that our target age group is actually the under-16s”. We thought long and hard about this. We decided that we wanted to target young people where they chose to socialise: not in schools, not in youth clubs, but actually where they decided they would spend their Saturday nights. The obvious place in Manchester is nightclubs, because its nightclub scene is huge.

II Targeting young people

Young people grow up with people telling them what to do, or usually what not to do. We did not want to go down the traditional, health promotion line of simply telling young people “This is how you use a condom”. We wanted to steer clear of that. We are quite pragmatic at Manchester Brook. If you look at evidence in the Netherlands the more information young people receive about sex education, the less likely they are to have unprotected sex, and the age of first sexual intercourse is a lot later. However, we are not talking about the Netherlands, we are talking about England. Sex education in a lot of the Manchester schools, for example is good but unfortunately in around 50% of them it is really bad, or actually non-existent.

We wanted to use some of the excellent marketing techniques that nightclubs use in promoting their services, and we wanted to be able to associate ourselves with them. We were quite realistic about what we wanted to achieve. Basically, we worked from gut instinct - we didn't look at any research - and from the personal experiences of some of our younger members of staff. Young people dress up, they go into town, they go dancing, they get pissed and they have sex. Full stop. Sometimes these young people have sex and it is unprotected; sometimes it's not, however. This was the starting point of the campaigns.

III The Campaigns

The first campaign was the Summer of Love Campaign; our aims were to reach out to young people where they socialise, and where they wouldn't expect to hear a
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safer sex message. A National Opinion Poll survey found that 81% of young people are likely to have unsafe sex on summer holidays, so the campaign took place over the summer months of 1996. We also wanted to raise our profile in Manchester because we were a new centre. At the time we were only seeing 5 or 6 young people in each clinical session. We wanted to say "Hey! We're Here!", and forge some links with the commercial sector, bearing in mind we had no budget at all for marketing. This involved a lot of knocking on doors saying "You will really benefit if you get involved with us. Give us a little bit of money and we will give you the kudos". And it seemed to work.

Our campaign partners for the Summer of Love were Sutherland Health (makers of Mates condoms), Fridays nightclub which provided a venue for an evening function, and Piccadilly Key 103, which is a really excellent radio station listened to by the majority of young people that we work with. The campaign involved a number of activities including distributing flyers, and going into clubs. We were reluctant to actually visit nightclubs: we went in on one particular night and I said to myself "If we are trying to raise our profile with young people, having a lot of middle aged people sat there looking really uncomfortable, saying ‘This is how you use a condom’ doesn't work”.

The second campaign we ran was the Fifth Emergency Service. We ran the campaign over Christmas 1996. The message was “We won't make a drama out of your crisis”: the purpose was to raise awareness that emergency contraception is a 72 hour contraceptive and not just for ‘the morning after’. Evidence shows that a lot of young people still do not know that they have 72 hours in which to use emergency contraceptives to avoid unwanted pregnancies. It also raised general issues around safer sex.

Our partners in this campaign were Airtours Holidays, who donated sweatshirts and flyers so that our staff could fly-leaflet Manchester city centre, and Discotheque Royale who gave us a venue for the Fifth Emergency Service evening which took place every Friday night through December 1996.

IV Benefits and Outcomes

The benefits have been huge to us in Manchester in getting to young people the message: ‘Hey! We are here, we are open. We will see you and it doesn’t matter if you are under 16’. We were able to access lots of marketing techniques which would have cost a fortune if we had had to pay for them ourselves. We used Discotheque Royale's direct mailing, throughout December 1996. Furthermore, Discotheque Royale target everyone turning eighteen, from the electoral register: every person in Greater Manchester who was coming up to their eighteenth birthday received details about our campaign and about our services.
We received huge media interest. Just Seventeen\(^1\) printed a huge feature article on us, which vastly increased our under-16 population. Granada TV broadcast a special programme on teenage pregnancy, showing us fly-leafleting in the city centre and working in clubs. Radio stations Key 103 and Kiss both promoted our campaign. We also received a lot of printed press coverage. Huge amounts of free literature (which was actually really trendy literature) were given to us, which again we would not have been able to afford ourselves.

We have probably distributed around 60,000 leaflets to young people in Manchester city centre. We are now staging our third campaign with Key 103 to keep our profile raised in Manchester. Young kids’ mums have the station on in the kitchen and it is on at the local news agent. We also have strong links with the commercial sector. We held a fund raising birthday party in May to celebrate the first anniversary of the opening of Manchester Brook, and the generosity of the commercial sector in Manchester was quite overwhelming. Huge gifts were donated to us for auctioning; Via Foster in Manchester's Gay Village gave us their venue free for the night; and a local jazz band came and played jazz music free of charge.

I think most important have been the activity figures. When we opened, we were seeing five or six people per session. Post Summer of Love, they had gone up to 15 or 18 per clinical session. Post Fifth Emergency Service, we were looking at between 25 and 30 clients per clinical session, and now we are looking at between 45 and 50. Basically, we are now turning away more people than we can see. For us, the nightclub setting has proven invaluable in promoting services to our target group.

\(^1\) A magazine targeted at teenage girls
Chapter 7
Thrills, Pills & Bellyaches
Andrew Bennet
I Introduction

In January 1991, The Liverpool Echo announced:

“1000 Are Hooked on Love Drug”

At this time the club scene and associated drug taking was at an important watershed. The ‘dance drug’ phenomenon moved from an underground, sub-cultural scene to one which increasingly was very much part and parcel of popular culture. Despite predictions at the beginning of the 1990s that the ‘dance drug phenomenon’ would be a short-lived ‘phase’, it clearly isn’t. It seems hardly to have declined: older, jaded and disillusioned clubbers are continually being replaced by younger ones.

We do not know how many people use Ecstasy (MDMA). Media estimates range from half a million to a million people each weekend. In a recent Home Office British Crime Survey, it was established that 9% of 16-29 year olds had used Ecstasy. In the North West, work by Howard Parker at the University of Manchester indicated that 20% of 18 year olds have used Ecstasy on at least one occasion.

II The drug ‘Ecstasy’

Ecstasy (MDMA) was discovered in 1912, patented in 1914, and apart from some animal experiments in the 1950s it did not emerge again until the end of the 1960s when both the recreational and therapeutic use of the drug were reported in the United States. It is important to note that the recreational use of the drug at that time in the States was very different from what we see today in the UK. It was primarily about: relaxation; personal development; friends and lovers being more intimate and open with each other. In the mid-1980s Ecstasy and a new form of dance music collided; the rest is history (see Chapter 2.VIII).

III Cycle of use

Matthew Collins, in his recent book Altered State: The story of Ecstasy culture and acid house, provides a ‘cycle of use’ pattern that is typical of an individual’s relationship with Ecstasy in the UK. A honeymoon phase of twelve months or so may find users enthusiastic about the experience. It is not uncommon to hear the expression ‘the best time of my life’ from many people who have tried Ecstasy in the context of clubs. Whether it is for cultural or pharmacological reasons diminishing returns often follow this ‘honeymoon phase’. A minority of people may move into an excess stage where drug use accelerates (and may be associated with a transition into other forms of potentially more harmful drug use). The comedown phase involves disillusionment. Finally there is a re-entry phase where an individual adjusts to a post-Ecstasy world.

IV Risks

There have been a relatively small number of deaths associated with Ecstasy in the UK. Most of these deaths have been caused by a combination of heatstroke,
exhaustion, dehydration, a hot club and the rise in body temperature brought about by MDMA. Research on animals suggests that MDMA damages the brain. It is unclear whether it affects humans in the same way and what doses over what time period would be needed for it to do so. The jury is still out on this point. Other health, social and legal risks associated with Ecstasy have been well documented.

V Does Ecstasy really exist?

The irony of our obsession with Ecstasy is that the likelihood of taking the ‘real thing’ (MDMA) is small since the majority of Ecstasy tablets sold does not contain MDMA. The tablets and capsules usually sold as ‘E’ will usually contain: other MDA type drugs; amphetamine; ephedrine; ketamine; caffeine; a combination of substances; no drug content whatsoever; and occasionally other potentially harmful substances. Efforts to quantify risks are obviously difficult when we don’t even know what people are taking.

Very recently in the Netherlands, different types of tablets, with particular little engravings on them (see Picture 2), containing a drug called Atropine emerged on the scene. Atropine does have some psychedelic properties, and is related to the nightshade and belladonna. It does not work for up to three or four hours after someone has taken the drug, so the temptation for people to perhaps take more drugs is very real. At high dosages Atropine can cause quite severe problems with rises in blood pressure. Dutch agencies are recommending anybody who has taken Atropine not to drive a car for four to seven days since it may still distort a driver’s sense of speed and distance. My organisation and many others really need to develop and implement an early warning system here to get information like this out to people very quickly.

VI Combinations and Transitions

Young people’s drug use goes beyond Ecstasy. There has been a significant increase in the use of a wide range of drugs associated with clubbing. Drugs are often used in combination with each other when we look at this particular culture. This may include actually within a club, where people may have taken not just MDMA but amphetamine, and also - more often than not now - alcohol. Mixing drugs can cloud a user’s judgement, alter the effects and, because the combined effect of two drugs or more is generally greater than the individual effects, increase the risk of problems developing.

Increasingly there is concern about the shift from Ecstasy and other drugs to cocaine (see Chapter 3.III). Over the last few years the price of cocaine has fallen to £50.00 per gramme. ‘Is Cocaine Killing Clubland?’ asked the clubbing magazine Mixmag in 1995. One Liverpool clubber explained:

‘With Ecstasy you can take one and you know you have had it the next day, you don’t really feel like doing more because it is such a club orientated drug. Cocaine though, you can do it anytime, anywhere. Before you know it you’re having a toot in the morning to kick start yourself after a heavy session the night before and things can get quite out of hand.’
VII Social Context

We must look at the social context, as indeed we must do with any drug scene. Although it is impossible to demonstrate in scientific terms, the ‘Ecstasy phenomenon’ at the end of the 1980s has acted as a promoter of the association between drugs, popular culture and the leisure market. It is appropriate to see people as consumers, as non-deviant. It is a normalised scene now, where most clubbers, apart from their drug-taking, are law abiding citizens and make sophisticated consumer choices as to whether to partake in it or not. Why do young people do it? It is hugely enjoyable. As Matthew Collin states in Altered State:

“...It is the best entertainment format on the market”

VIII Providing health information to young people

In the face of the increase in and changing patterns of young people’s drug use, HIT has developed innovative approaches to communicating with diverse target groups of drug users.

Recognising the social context, and recognising the benefits of clubbing, it is vital to provide health information to people in a credible way. Familiarity with the cultural codes of drug scenes forms an essential basis for both the production and distribution of a range of drug related materials. As Jock Young wrote, many years ago now:

“You cannot control an activity merely by shouting out that it is forbidden; you must base your measures on facts and these facts must come from sources that are valued by the people that you wish to influence...”

IX Campaigns

In September 1991, HIT (then the Merseyside Drug Training and Information Centre) produced Chill Out: A Raver’s Guide (see Picture 3) in response to a growing demand for information on drugs. Three categories of risk were identified - drug specific, situational and social - and it focussed on the three main drugs [then] used in the club scene - Ecstasy, amphetamine and LSD. This leaflet was designed to resemble and mimic a club flyer and, like flyers, was distributed through ‘underground’ clothes and record shops. There was enormous controversy over this innovative leaflet - its the style and content was not to everyone’s approval - but there were many benefits, in terms of getting information to club-goers and support from the broader community. The leaflet has since been updated.

PICTURE 3 : Chill Out leaflets
HIT believes in social marketing. We must try to mimic the very sophisticated techniques that the commercial sector uses in selling goods or services to a target group. The Daisy Campaign (1993) initially established a ‘brand’ image, an identity (see Picture 4) then secured that image with a whole range of information.

Information materials included flyers, swing tickets on clothes, matchbooks, posters, stickers, record bags, and T-shirts. Sheila Henderson, in an independent assessment of the Daisy campaign, wrote:

“It successfully integrated health messages within the culture...played an important role in achieving a considerable level of exposure and approval amongst the target group. Perception of the information as balanced...and the style of communication as fun, collectible and culturally recognisable would appear to have contributed to an improvement in drug knowledge and behaviour change amongst the target group.’

Over the 1996 Christmas period, the Know Limits campaign, as well as being culturally attuned to the club scene, also had a seasonal theme. Christmas cards, New Year cards and Advent calendars were produced with relevant health information messages (see Picture 5).

November 1997 saw the launch of a new initiative. ‘Relax 2001’ takes drugs information into the future! The campaign has been funded by the government’s Drug Challenge Fund initiative, and six local private sector sponsors. For an eight week period, posters, a series of flyers, T-shirts, ‘Adverscopes’", condoms and badges are being distributed throughout Liverpool city centre. A website will enable young people to access information via the internet. The icons which give the campaign materials an identity (see Picture 7) relate to the key messages of this campaign: the smiley badge is associated with looking after your friends; the comfy chair is about telling people to relax and calm down a little bit; E is for Ecstasy; the razor blade is for cocaine; and the whisk relate to the problems of mixing drugs.

X Summary

The distribution of appropriate information materials can:
1. provide an efficient and cost effective way of getting messages to different populations.
2. provide accurate, up to date and useful information to large numbers of people
3. promote peer education.
4. reduce drug related harm.

Drug information must be culturally attuned and credible to its target audience. Most of all, it needs to tell the truth about the effects, risks, and harms of drugs.

1 Presentation at Healthy Young People: The Region’s Future Conference (Liverpool, 1996)
2 The Drugtakers Young J (Paladin, 1972)
3 See Ecstasy in the UK: Recreational drug use and cultural change McDermott, Mathews & Bennett (1993) in Psychoactive Drugs and Harm Reduction: From faith to science Heather, Wodak, Nadelmann & O’Hare (Wurr)
4 DAISY: An Evaluation of a Drug Information Campaign in Liverpool S Henderson (HIT, 1994)
5 These are eye-catching visual displays.
CHAPTER 8
Licensing in Partnership
Inspector Paul Degan
I Blackpool: Booze Town

Blackpool. That's the place with the tower, the three piers, the Winter Garden Conference Centre and of course the famous Pleasure Beach, where you can get fish and chips, hot dogs, candy floss and all the other things that make up the 'fun town' of Blackpool. In fact, it is such a fun town that seventeen million people come to the town every year to sample all the goodies.

The town has in excess of two thousand licensed premises, including 410 'on' licences, and 78 late licences. I suppose you could call it the 'booze town'. In the holiday area alone (which is only a small part of what is a much smaller town than Liverpool), we have 114 pubs and clubs, which can deliver sixty thousand people onto the streets at any one time. How would you police that particular problem?

The holiday drinkers come to the town, start drinking at 11 o'clock in the morning, and carry on drinking until 2am the following morning. That's a hell of a lot of alcohol. The hoteliers need that custom, because from the end of the Illuminations in October of each year there is no custom until the following Easter; they have to balance their budgets for the whole year. The problems these drinkers cause for the town, and for the police are generally caused by them turning violent late at night. The under-age drinking problem is another problem we have to address.

People talk about drugs but my main message is about alcohol. I'm not saying that we don't have a drugs problem of a certain type in Blackpool, but it is not as great as the alcohol-related problem. Our aim is quite clearly defined. It is to work together with the licensing trade, to provide a safe environment for those persons who visit the town, and its 180,000 residents, so that there's a quality of life for members of the community local to the premises, and for the people who visit the licensed premises.

II High profile policing

I have two daughters in their early twenties and I want them to be safe in the nightclubs and pubs in Blackpool, like any other parent. How do we achieve this? We provide regular uniformed visits to licensed premises, a very high profile exercise putting policemen in full uniform walking around and checking the licensed premises. All the pubs and clubs can expect to see our dedicated 'licensing unit' walking around the night-clubs on a regular basis. We also attend incidents when they occur, to see what can be done to help other response officers.

If we have poorly-run premises we have to increase police presence and sort them out. The whole area of licensing must not be viewed in isolation because it impacts on every aspect of life in our towns and cities; this must be recognised by everyone.

III Partnerships

Close liaison is a very important issue. 'Partnership' is about close liaison with all agencies. It is also about regular contact with area managers. I meet all the brewery and nightclub managers on a quarterly basis and we sit around the table to iron out any problems that we and/or they might have. We have a seminar every year in Blackpool at the Savoy Hotel which every licensee in the town is invited to attend, where we talk about problems that have arisen during the year and may happen next year. Together we put a package together for the following year and so on. We also have very pro-active policing of individual

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premises. We go into premises which are causing slight problems and take action. The best way forward in solving problems is to go and talk to the management, to deal with the root cause. That is how we do it. The other thing is education of the licensees, the doorstaff, and everyone else involved; through the media (both by radio and by regular spots in the local newspaper) we educate the whole area of Blackpool as to the mission we are endeavouring to deliver for them. We actually have a very sensitive approach. We don’t use the ‘big stick’ and prosecute people, we talk to them and advise them. Prosecution is our last aim: what’s the point of prosecuting somebody when you’ve got to work closely with them? We feel this is the best message. Partnership is the main aim in Blackpool and should be in any town in this country.

IV Reducing Disorder

The first of Blackpool’s licensing department’s objectives is to reduce the number of incidences of violence in and around licensed premises. This actually came about in the late 1980s when I did quite a lot of research into the causes of violence in licensed premises in Blackpool. One of the main causes was door-staff bullying and knocking people about. We introduced the door-staff registration scheme in 1992. The door-staff (‘bouncers’ is definitely not a word I use) are now well-supervised, and trained by the police in Blackpool.

Moving on from the door staff registration scheme itself, we actually go round constantly and monitor the door staff. Not only do we monitor them, the local authority enforcement officers play a key part in the actual management of the premises. They are part of our door care committee. They do a lot of the on-the-door checks of door staff to make sure they are running things correctly; and we have to back up those with door staff talks.

We also have what we call a ‘pub watch’ scheme. ‘Pub watch’ schemes aren’t new to this country. In the past the ‘pub watch’ scheme, which helps in reducing violence, was operated by ‘phone: one landlord had to ring three other licensees and everyone had to spread a warning (about an incident) around. The more efficient way is to use a ‘one pager’ system. All the licensed premises now have a pager system and when a problem occurs in one particular spot the message goes round to all the others and it’s bleeped and they know there’s a problem - football crowds or whatever the disturbance might be. The ‘pub watch scheme’ is a very useful tool for the police and the licensing trade, one I would promote anywhere.

V Licensing

Because we have a dedicated unit, all licensing issues are standardised throughout Blackpool and the South Fylde area. We need a consistent, standardised approach so that every licensee knows he is going to be treated properly and fairly. This is extremely important.

Comprehensive processing of applications is what our dedicated unit do. We do an in-depth investigation into the background of not only the individual who applies for the licence but also of the finance behind that individual. We find that if you have an empty club in the town somebody with a bad background may want to bring drugs into the town and bring a certain type of nightclub into the town. So we look at the companies and see who are financing them. Right from the word go, if we’re not happy with it, they don’t get into the town. Basically we stop them at
licensing sessions. This makes licensing standards accepted throughout the town; whether an independent or a big company, you know quite clearly where you stand with our licensing policy and the licensing strategy.

We have to deal with the bad licensees and there’s only one way to deal with a bad licensee because he’s not looking after the safety of the people he should look after. That is to see that licensee is out of a job. I said we don’t like to prosecute, and we don’t. We just ask the brewery to move him and they do so.

VI Alcohol-related problems

With regard to reducing disorder, one of the problem areas is young people, so the Portman Group\(^1\), have just distributed two thousand packages of proof-of-age cards for 18-24 year olds to have an identification card. We support this in a big way. If an under-age drinking problem is identified, the ‘Prove It’ card is one of the answers to that problem.

Recently the people of Blackpool have said “We’ve got enough clubs, enough booze on the streets, please let’s have a by-law banning street drinking”. I am in the process of putting documents together with the local authority to actually introduce a by-law which will restrict drinking in public places and on public streets. It has come to the stage in Blackpool where we need a by-law to control a situation, which a few years ago would not have arisen.

VIII Tackling drugs - together

Another area we have to deal with is reducing the availability of drugs in licensed premises in the town. I quite honestly do not have a problem in Blackpool with drugs. Drugs do come into the town but we don’t fear them at all. We have a very good drug squad team. Not only do we take action, so does the leisure industry. One of our big companies (First Leisure) has actually put its own drugs policy together, and it helps us to deal with the drugs problem, as do all the other club owners in the town.

XI Conclusions

We talk about drugs affecting crime. They do affect crime, but alcohol should not be forgotten. In my town, alcohol affects crime figures more than drugs. To give you an example, last year we arrested 12,200 people through the custody office at Blackpool Central police station. Of those 2,600 (which represents 21.5% of all people arrested at Blackpool last year) were drunk at the time of arrival and unfit to be dealt with. This has an impact on police demands: a drunken person is in the cells for a few hours and we have to use more manpower to deal with that person.

We all need to recognise the need to work together in partnership, from parents to local authorities, from licensees to judges, to all the companies and the agencies. Everyone must play a part. There must be no weak links in this system. If you want to come and look at a good town [in terms of licensing] I invite you to come and look at Blackpool in the holiday season.

\(^1\) This is the drinks industry self-regulating body
CHAPTER 9
Alcohol: Our Favourite Drug
Shirley Ashton
I The changing face of alcohol in society

Merseyside and Cheshire Alcohol Services (MCAS) is a registered charity founded in Liverpool in 1963. The picture of alcohol misuse today is very different from how we had to respond in our early years. Over the past thirty years alcohol has secured its place in our society as our favourite legal drug. It is now so intertwined with our daily lives that it seems almost alien to pick it out as a single issue. Indeed, because of this familiarity, it is easy to ignore the damage, and what it is causing directly and indirectly, not only to individuals but to environments and communities.

MCAS started its life by providing services to individuals who needed help and support whether they were the drinker or the family member. Our case load then was mainly men in their late fifties and sixties, who had a long drinking history and whose bodies were beginning to feel the ravages of their long term drinking careers. In those days abstinence was the only answer on offer. Today, we still provide services to individuals who need help and support, whether they be the drinkers or the family members. Our case load is a mix of male and female, on average 53% male and 47% female. In 1996 the age range that we were responding to was between under 15 and 75 years plus. Today the outcome of our interventions have to be more flexible to the individual’s need.

As an alcohol charity we believe we have a duty to respond to the issues of alcohol in our society today. In order to do this we have had to add dimensions to our work such as education, work with women, families, young people, employers. We advocate for alcohol to have its rightful place on the political agenda and to ensure that the facts about alcohol and subsequent health messages are not corrupted by biased information, untruths and specific selected research.

II Some properties of alcohol

Alcohol has other names: ethyl alcohol, ethanol. It is a clear, colourless liquid with a mild odour and a burning taste; because of this property economists call it an ‘elastic’ product because it can be packaged in any colour, taste or shape and will suit anybody’s pallet. It is a drug. It is a dehydrating agent. It is a poison, it is a narcotic. It is an anaesthetic. Alcohol numbs the brain and the central nervous system, having a similar effect to morphine or chloroform. I’ll say it again: it is a drug; it is a mind altering drug; it is a dependency forming drug; it is a depressant. It is legal and it is readily available and relatively cheap.

When alcohol is drunk, the drug effects start straight away. The effects cannot be stopped. Judgement and self-control are the first brain junctions to be affected. These aspects of alcohol consumption must not be ignored; they happen and should be taken into account so that when people choose to drink they can do so with a minimum amount of risk to themselves or to others.

III Alcohol and the club scene

Clubs do not appear overnight: planning and licensing applications have to be approved; staff have to be interviewed and employed. It is from these early basic processes that responsible attitudes towards alcohol must be expected. It is in everyone’s interests that there is a commitment to good management and staff training.

The club will be the seller of the drug
alcohol and this should be taken seriously. National training schemes for bar and door staff should have minimum requirements and be made compulsory (see Chapter 5). Management and staff should monitor the trends in drinking styles and respond appropriately to ensure customer safety and well-being.

Currently, the ‘designer’ bottled drinks may save washing up but taken off the premises and left in streets, these designer bottles turn into designer weapons between 2am and 4am, when the euphoria of alcohol and its pleasure has tipped the balance to the side of negative, anti-social and dangerous behaviour.

Training should also include knowledge of law, and first-aid. It does not benefit the individual to be served while drunk, indeed it is in nobody’s interest. When alcohol is drunk it reaches the stomach and is quickly absorbed by the walls in the small intestine. To avoid direct injury to the stomach alcohol should not be taken in concentrated form without food. Club management could provide free and very cheap food so club users while consuming alcohol could also protect their health.

One of the criticisms I hear from people who choose not to drink alcohol is over the price of non-alcoholic drinks. The fashion of drinking bottled water should be encouraged but it can lead to be a very expensive night out. Club management should look at its pricing policies so those people who choose not to drink alcohol are not financially disadvantaged.

Going back to the impact of alcohol on the brain and how it affects judgement and self-control, the availability and easy accessibility of condoms available in clubs should go some way to preventing unprotected sex and unwanted pregnancies. If condoms are to be provided in machines, then the functioning of these machines must be addressed. I have heard some very unfortunate stories of people trying to use the condom machines only to find that the drawer gets stuck and they become very embarrassed and then decide to do nothing at all.

### IV New Responses

We need to ensure that we keep club users risk-free or at least reduce the risks in the club setting, but we must bear in mind that the club is only one part in a wider community and we need to highlight other issues. For example, people need to get to and from the club safely. There has to be joint responsibility. We need to take a strategic and planned view. Public transport needs to be available; it needs to be safe; it needs to be cheap after midnight; consideration needs to be given where we place taxi ranks so that people under the influence of alcohol can avoid scuffles while waiting in a queue. How many times have we heard of fights starting just because somebody looked at somebody in the wrong way? Telephone boxes that are well lit, so that if anybody runs into any difficulty there is a public telephone that actually works; the issue of street lighting; non-glass bottles; the policing of known hot spots in an unthreatening and unintimidating way all need our attention if we genuinely desire to have good quality leisure time.

There must be a point where the authorities accept that the anti-social behaviour that is displayed on the streets is the drug alcohol impacting on the brain. We have to question our current response, which is always ‘enforcement’. Why not care and support?
Individuals are doing nothing wrong. Alcohol is legal, and they are doing and following the norm of society. It seems so contradictory to me that we accept alcohol as our favourite drug of choice but as soon as the drug begins to impact on the brain and to develop behaviour we do not approve of, we go along the enforcement route. There are many individuals in the criminal justice system, yet the producers of the drug alcohol (which is the primary cause of these incidents) continue to produce the drug in a self-regulated form only.

Alcohol does have a place in our society. It enhances socialisation, it is pleasurable and clubs are very often the venues where partners meet and enjoy themselves and future relationships begin. What we must accept is the truth, if cities like Liverpool want to move forward.
CHAPTER 10
The Government Response
Peter Kilfoyle MP
Issues concerning drugs and young people, particularly in relation to drugs and clubs, are seldom out of media spotlight, I think that is self evident. We know drug dealers target clubs and similar venues where young people go to enjoy themselves. With the drug dealer comes serious criminal activity including extortion and violence.

Under present arrangements, places of entertainment open to the paying public are regulated by the Public Entertainment Licensing system (see Chapter 4). This exists to ensure, as far as possible, the health and the safety of customers at such places, as well as preventing nuisances in the wider community and that particular system has evolved over a number of years. But the rise in the threat posed by drug misuse has revealed a significant loophole in the arrangements. The problem with drug misuse in a club or similar venue is that once it has been identified, the local authority has to wait until the license comes up for renewal before it is able to take any action, unless of course, there is a conviction for breach of licensing conditions. Even then, if the decision is not to renew the license, the premises can stay open pending an appeal, first, to a magistrates court, then, to a crown court, that process can take many months and we as a government do not believe that can be right.

That is why we supported the introduction of the Public Entertainments Licenses (Drugs Misuse) Bill, a Private Member’s Bill introduced by a Conservative Member of Parliament under the last government which received Royal assent on 21 March 1997. Its effect will be to allow local authorities to close clubs immediately, where a serious problem of drug misuse has been identified. In future these clubs will stay closed pending any appeal.

We accept that this Act is a tough measure. Some would say that it is a Dickensian measure. We are very well aware of the concern expressed by some that local authorities and the police will use these new powers indiscriminately to shut down clubs. The government does not want this to happen. We don’t want to stop anybody enjoying themselves. Nor do we want to see the club scene driven underground. We don’t believe that this would be in the interest of anyone except, perhaps, drug dealers. Clearly, there has to be a balanced approach. Therefore, we believe that the new powers should be reserved for those comparatively rare occasions when a club cannot or will not deal with a serious problem of drug misuse on their premises.

The Act requires the Home Office to issue guidelines to local authorities before the new powers come into effect. A further draft of those guidelines will be circulated shortly to local authorities, to the police and to the club trade for final comments. These guidelines are not prescriptive. We believe that local arrangements should be developed to meet local circumstances. Within that process of consultation, as with so many other things that we are trying to do, we welcome a constructive input from anyone that has an interest. That includes clubbers themselves, through the clubs. We are very, very welcoming of contributions from all stakeholders in an issue as important, we believe, as this is to a whole generation.

Different things are happening in different geographic areas. There are many examples up and down the country, including in the North West, where local initiatives have already been established involving the local authority, the police and clubs in a given area. Drug Action Teams have been involved in setting up some of these initia-
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tives. We believe that the Teams are well placed to encourage partnership and co-ordination between local authorities, the police, club owners and promoters. I also acknowledge the work done in Liverpool by the local Drug Action Team in helping to develop an information campaign for clubbers (see Chapter 7.IX) and also in developing training for club staff. The government fully recognises the importance of clubbers having factual information in relation to drugs, and the local project was backed with government funding from the Drugs Challenge Fund which has provided further funding for the continuation of that particular campaign, in recognition that a majority of clubs are working hard in cooperation with police to keep drugs off their premises.

The British Entertainment and Discotheque Association is one of the organisations which is taking the threat posed by drugs in pubs and clubs seriously. I, on behalf of the government, applaud the initiatives of BEDA, and the measures individual clubs are taking to improve security, and I am confident that responsible club owners and operators will have nothing to fear from the new powers in the Act.

I should mention another development which is relevant to Club Health. This is the review currently taking place of the contract security industry of which door staff play a very important part. There are a number of very effective voluntary door-staff registration schemes in existence, the best of these involve good liaison between the police and clubs to ensure that only competent, reliable, well-trained personnel are employed in such jobs (see Chapter 5).

Recently the Home Office circulated ‘Best Practice Guidance’ to local authorities and police forces who wished to set up local registration schemes for door staff who work at clubs and this has been based upon the experiences of schemes run in various parts of the country and drawn up in consultation with the police, local authorities and the entertainments industry. In many of the schemes, registration involves criminal record checks by the police and satisfactory completion of an approved training course.

There are risks, certainly of the existing arrangements, and it is claimed that a national statutory scheme for vetting door staff is required in order to protect the safety of the public. In government we will be considering very carefully what needs to be done when the current consultation exercise has been completed.

Finally, guidance will be issued by the Home Office, along with guidance on the operation of the Public Entertainments Licenses (Drugs Misuse) Act to encourage local authorities to exercise their licensing responsibility in such a way as to safeguard the health and safety of young people at clubs. A draft version of this particular circular generated enormous interest and resulted in a very, very extended consultation period. It covers measures both to reduce the supply of drugs into clubs, as well as the demand for drugs. Emphasis is also given to health and safety aspects. These include availability of drinking water, provision of rest facilities in a cool environment and the monitoring to temperature and air quality. The circular will also be used to highlight existing examples of good local practice.

In conclusion, the new Act, the guidelines and the security staff review all have the protection of clubbers clearly in mind. We may be many things as politicians, but we are not stupid. We are clearly aware, firstly,
of the number of people that are involved in clubbing and of the ramifications of the issues involved. Speaking personally, and on behalf of the government, I support the research currently being undertaken in the area of ‘club health’, which I hope will be directly fed in, not only to the Home Office but also to the Department of Health and to Anne Taylor so that it can be considered in those further measures that will be under discussion in the very near future.  

1. Otherwise known as The ‘Barry Legg Bill’
2. Anne Taylor is President of the Council and Leader of the House of Commons. She is Chair of the cross-departmental Cabinet sub-committee on drugs.
3. Copies of this Report will be sent to the Secretaries of State at the Home Office and the Department of Health and to the Ministers of State for Local Government, Drugs, and Public Health.
CHAPTER 11
Promoting Health, Promoting Nightclubs
Moving towards a common agenda
This chapter provides a summary of the points raised, and responses from guest panellists and delegates, during an open debate. Several relate to contributors to previous chapters, and references are provided. Each panellist started by explaining his or her interest in ‘club health’.

Dr Ruth Hussey, Director of Public Health for Liverpool and Chair of Liverpool Drug Action Team:

“My job is to assess the health problems for the people who live in Liverpool, or visit the city, and to advise organisations with a responsibility for improving health in the city, specifically in terms of health services”

Ciaran O’Hagan, from the London-based drug service Release:

“I hope to impart some knowledge about the work we do, up and down the country. I truly believe that dance culture is one of the most positive forms of youth culture this country has ever seen and I want to do what I can to make sure it progresses in the right direction”

Chris Luke, Consultant in Accident and Emergency Medicine and Director of Education, Royal Liverpool University Hospital:

“My main interest in ‘club health’ is to try and reduce the workload of my department and departments all over the UK. The NHS is under a great deal of pressure and I think we need to look at the demand side of the supply and demand equation”

Tony Spragg, Divisional Managing Director (Nightclubs), First Leisure Corporation:

“I am responsible for night club and bars throughout the country. My interest is in all aspects of ‘club health’ which affects my business”

Paul Martin, Executive Director of Healthy Gay Manchester:

“HGM is a sexual health project for gay men in Greater Manchester. We’ve had quite a lot of experience in working in the club field over the past few years but I hope the ‘Club Health 1997’ conference can be a starting point to develop a national strategy for promoting the health of club-goers in this country”

Inspector Damien Walsh, Merseyside Police:

“I am responsible for the policing of all the clubs and pubs in Liverpool’s city centre”

Daniel Brewington, Chairman and Chief Executive of the National Association of Door Supervisors and Security Personnel (NARDS):

“We actively campaign for the training and registration of all door supervisors and security personnel within the leisure industry.”

Peter Kilfoyle MP, Minister for the Office of Public Service at the Cabinet Office, (see Chapter 10), was the final panellist.
DRUGS

Q1: People take illegal drugs; they take legal drugs; they take drugs that people have not heard of before and therefore are not covered by law. How will you stop people taking drugs unless you develop some kind of thought control? 
Anon

A: The Home Office and the Home Secretary in particular has seen to the allocation of an extra £26.1 million to deal with those areas we feel are important. This includes £7.1 million for education, £3.5 million for local arrangements and the development of good practice, and £6 million for health initiatives. I think we are being positive in those areas where we feel public money is being usefully spent.
Peter Kilfoyle MP

Q2: There is no control over the availability, strengths or purity of ‘controlled’ drugs. How can the word ‘controlled’ be used in the context of illegal drugs like Ecstasy and cannabis? 
Derek, clubber, Norwich

A: They are controlled drugs under the law, which means they are illegal drugs. They are freely available in the sense that they are traded illegally. You might say that the law is unworkable, you might argue that it is being subverted because it is not being properly enforced but that is what the law says.
Peter Kilfoyle MP

Q3: Are the government going to look at Ecstasy testing and if so, when might it be introduced? 
Steve, clubber, Liverpool

A: Are there going to be changes in the government’s approach to controlled drugs? I’ll be absolutely straight and honest with you, the answer is no. That is not contemplated in any shape or form.
Peter Kilfoyle MP

Q4: People are switching to cocaine due to the rubbish that has been put out as Ecstasy. Would Ecstasy testing bring down cocaine use and stop it being normalised as Ecstasy has? 
Ian, Masters student in drugs and addiction, Liverpool

A: You are touching on the issue of decriminalisation or substitution, and these are very complex issues. Witness the recent furore over methadone, the much trumpeted substitute for heroine. It was going to be the great stabiliser of the heroin using population but now we learn that there are more deaths from methadone in the overall population. So there are dangers with the substitution idea. There is no evidence that substitution has ever happened as far as the NHS is concerned, just multiplication and addition.

Nevertheless the status quo is not working in terms of drugs. Historically prohibition has never worked, medically speaking. It has always engendered gangsters and violence. I certainly see a time when we could experiment with the pharmaceuticalising of drugs, and that means giving drugs to the pharmaceutical companies with a twenty or thirty year history of purity, probity and very strict regulation. Having done that, and basically dislocated the gangster element, we could then regulate those pharmaceuticalised drugs in the same way as we begin to regulate alcohol, cigarettes and so forth. That is the hypothesis. I am not recommending it, but I do envisage that it might be a workable experiment we
could afford incrementally, and through experiment and scientific method rather than by black and white media arguments. Chris Luke

Q5: If there were cleaner drugs or safe and legal alternatives to currently illegal drugs, would there not be positive health benefits?
Andrew, clubber, Birmingham

A: Whether or not the government want to consider the whole question of making drugs safer and actually condoning the quality of the drugs that are supplied, in terms of public health, we have to look at methods which can be employed to reduce harm. I think we do need to debate how far that should go, what sorts of things we should consider in terms of reducing harm from badly cut drugs or whatever it might be. I think it is something we have to debate.
Ruth Hussey

A: Release was commissioned to do some research into young people’s recreational drug use. Whenever we have done research into this area, one of the main things the service provider is to look for is the needs of the client group. Within our survey we did actually raise the pill testing debate and 97% of people who answered our survey actually wanted us to make moves in that direction. Therefore, there is a clear need.

If as professionals we ignore that need; if we continue to work with people within clubs and dance culture and continue to ignore the needs that are presented, we are moving in the wrong direction. I think we need to take some progressive and really radical steps.

As a result of this research, myself and a colleague went to Amsterdam and had a look at their drugs information monitoring system and we are in the process of writing a paper about how the drug field and other related professionals could look towards introducing something within this country.

What we have to do is look at our European partners in Amsterdam and understand how clearly and well-advised they are on the current scene. We have to be looking for the future and breeding a new type of drug-user in this country. A drug-user who says on a Sunday morning “Oh, well. I took 120mg of MDMA, but I took a couple of pills and the last one was dodgy”.

People have to have a clear understanding about mixing drugs but let’s find out what they are taking in the first place. I wouldn’t suggest that we take pill-testing into clubs: it has to be taken away from that environment, because clubs are under enough pressure with the Barry Legg Bill (see Chapter 10) and everything else. We need to take pill-testing into the clinical environment. If we did have people coming in, we could say “Okay, that’s the result of your pill [test]. If you have made a conscious decision to take it, can you come back and can we do some research?”. We have to look forward.

I work with people on a regular basis who come to clubs, and the main thing they are saying to us is “We want to know what is in our drugs”. There is some excellent work being done up and down this country. We have gained credibility, we have gained access to our target groups. Let’s start giving them what they want and what they need.
Ciaran O’Hagan,
Q6: The war against drugs is a war against people like me, against a whole generation, not against shady pushers. Does the government realise this?
Anon

A: The Labour Party has taken the view that, on the balance of the evidence that is available, it sees no justification for misleading people into thinking that it will promote any change to the legalisation of hitherto controlled drugs but it is also subject to the Advisory Council on the Misuse of Drugs which regularly reports on what it feels is the expert opinion on developments in the area of drugs. We have to depend upon somebody and they are the people we depend upon.

Those who take a different view, those who have enunciated different arguments are very much in the minority, certainly in the House of Commons. You may not like that as a section of the community, but as representatives of the community that is what the overwhelming view is and I would do you a disfavour to sell you any other lie.
Peter Kilfoyle MP

Q7: Why are we still portraying drug dealers as evil people, when the Leah Betts case shows that drug dealers are actually young people, they are friends of people and they are not evil at all; they are not in it for the money, they are doing their friends a favour.
Helen Riches, Council On Addiction, Northamptonshire

A: The principle drug dealers we are concerned with are not those who pass one pill onto a friend (such as you pointed out in the Leah Betts case), but the kind of people from whom Customs lifted 79.9 tonnes of drugs in 1996; the people behind the scenes who are making huge amounts of money. There is a chain of command in terms of dealing: there are the big boys who seem to get away with the importation and the marketing of it within the country (and we’ve had some notable examples in the North West of the kind of money that has been made by those people); right down to the individual club or venue.

There is no intention on the part of this government to finger the individual who has been so misguided as to pass on a controlled substance to a friend. We are talking about those who are making a very substantial living out of it. They might not be evil by your definition but by mine they are.
Peter Kilfoyle MP

Q8: If we did keep drugs out of clubs where might drug-takers go, and would this involve more or different policing issues in terms of outdoor parties and underground parties?
Sarah Marshall, Merseyside Drugs Prevention Team

A: We cannot keep drugs out of prison, so how are we ever going to keep them out of clubs? We have to take responsibility for the fact that we are in the tenth year of dance culture. It is going to go on for another ten years. We have to start accepting that we must listen to the needs of our user group. We have to start looking at progressive, if not radical moves.

I think it is an important issue about festivals. We do a lot of work at festivals and in unlicensed venues. I would urge other drug services, if a rave does not have a licence, not to feel threatened about going
in there. Get involved with underground party scenes and get involved with as much dance culture as you can.
Ciaran O’Hagan

A: Any large build-up of people, whether it be on licensed premises or unlicensed, whether it is in a warehouse or in a field, can present the police with a number of problems. Thankfully, in this particular area, we do not have any locations like that, so much of our activities are confined to licensed outlets.

The police have to move with the times and we cannot have a narrow view of things. We have address problems as they arise, and try and find different ways of dealing with them. I cannot sit here with hand on heart and say that I actually solve the drug problem within the clubs in Liverpool, because I do not. We just use an ‘elasto-plast approach’ at times because we don’t have the answers. I think we have to tackle things as they come along and keep an open mind. We cannot progress otherwise.
Damien Walsh

Q9: Young people take Ecstasy, amphetamines, poppers all on one night. The next day they will take cannabis to calm them down. Is there a need for research into short-term and long-term effects on health of poly-drug use?
Calum McBride, medical student, Manchester

A: I certainly do think so. There is no doubt from the medical point of view (and first-aiders at Cream and elsewhere in the city would confirm it) that the use of cocktails of drugs is spiralling. It is not at all uncommon, as you say, to begin the night with some reefers, to take some cocaine and E, and to then come down with an acid tab, in addition perhaps to a few drinks. So obviously you have synergy¹ and you have multiplication. The more drugs you take, the more complications you get.
Chris Luke

Q10: If people stopped using Ecstasy and started to drink alcohol instead, would there be busier and bigger accident and emergency units on Friday and Saturday nights?
Bill Formby, Unit 51 drugs agency, Huddersfield

A: If the suggestion is that Ecstasy is more socially mellow and generally less destructive than alcohol, the answer is ‘no’. With regards to drinking and taking Ecstasy, the fundamental hype and misleading message coming across is that Ecstasy is somehow replacing alcohol. The problem for health care with regard to drugs is that nothing is replacing anything. They are all being taken together, and the amount of self-indulgence is escalating.
Chris Luke

ALCOHOL

Q11: Last summer 8,500 young foreign students came through our doors. There was not one single case of drunkenness. When we stage a club for our kids, they drink very, very strong alcohol; flashy ‘designer’ drinks that come in nice bottles. Should we be putting pressure on the government to start restricting these drinks?
Gary Woolley, The Junction nightclub, Cambridge
A: Alcopops and high-strength beers are very powerful drinks. We should really be asking parents “Do you allow your children to come home with drink on them? What have you done about it?”. Parental control is part of the package. We can only deliver what is within our powers as police officers, but we are inviting others to take part. For example, we have proof-of-age card schemes in off-licences and licensed superstores, because these are the people who sell the drinks. The ‘big stick’ from the police won’t work, we need to control the supply of drinks to these young people. A new law came in on 1 April 1997 which actually gives new powers to seize intoxicants from the under-eighteens. This is a step forward.

Inspector Paul Degnan (see Chapter 8)

Statement
I cannot speak for more affluent areas, but in Liverpool most thirteen, fourteen and fifteen year-olds cannot afford to buy ‘alcopops’. Four or five of them will club together and buy 99 pence bottles of Farm Stores cider because ‘alcopops’ are completely out of their price range. The whole idea of putting everything into the control of ‘alcopops’ means we don’t have to face up to the fact that we generally accept the particular drug alcohol, which actually causes more avoidable deaths than any sort of recreational drug use will probably ever do.

We carried out a survey in Liverpool a few years ago which was aimed at twelve and thirteen year-olds. Roughly one in ten children had taken illegal drugs, one in ten children had smoked tobacco, one in four children had taken alcohol in the previous week. At what age do we as a society condone this practice? What’s the message we are offering to young people? No doubt a lot of those children took alcohol in the previous week in the comfort of their own homes.

I think a much bigger question is the role of alcohol in our society: over 90% of adults drink alcohol. We have to start there and look at how young people relate to that. Controlling access to alcohol is one way of making it harder for people to get hold of it, but I think it is a fairly small way when you look at the readily available supply of alcohol in people’s homes.

Debbi Stanistreet, Lecturer in Public Health, University of Liverpool

Q12: I enjoy drinking ‘alcopops’ and I would like to ask why the government can tell me what I can and cannot choose to drink as an adult. Why can’t everyone who is under 25 years be asked for ID before they buy an alcoholic drink?

Anon

A: I don’t think the Portman Group were particularly happy about the initiative reviewing the marketing of ‘alcopops’, but it was forced through. I still wasn’t happy with some of the detail. For example, there is still a debate going on as to whether the strength of drinks ought to be advertised on the bottle, because young boys in particular will quickly graduate to what they think is the more ‘macho’ [ie higher strength] drink. So there is a real problem in terms of education and also in terms of enforcement, but we have to start somewhere.

With regards to proof of identity, we are coming into the world of the ‘smart card’ where everybody, whether they like it or not, will be unable to operate in the real society unless they have their virtual identi-
ty on their ‘smart card’. That is the simple truth. Nevertheless, there are deep and widespread objections to anything that remotely smells of a compulsory identity card. There are police ID schemes which ought to be applauded, encouraged and extended, particularly for under-age drinkers, but any suggestion that there would be any form of compulsion in that would cause the most almighty outcry.

The onus is on the person actually selling alcohol to satisfy themselves that somebody is of the right age. The real difficulty with it is with enforcement. One of the problems, as with so many of these things, is that there is no one able to enforce these laws and regulations. One of the things I am trying to do is improve regulation so that the people who actually enforce regulations, in whatever field it is, and those that are profiting out of whatever the area is, have an agreement between them to ensure that only the bad guys are isolated. Many of the regulations which impact in areas including clubs need to be revisited so that some of our most stupid licensing laws can be done away with.

Peter Kilfoyle MP

Q13: In the UK alcohol is freely available, but allegedly only to those over the age of 18. In most areas of the UK it is vastly easier for children and young teenagers to get hold of illegal drugs than it is to get hold of alcohol. Are drug efforts at the moment protecting children and young teenagers, who are arguably the most vulnerable section of society?

Anon

A: It may sound strange coming from a member of the police service, but we do try to protect children, in particular through keeping them away from the courts, deal-
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unacceptable. I do think there is a specific issue about promoting these products to very young children, but the wider point is that alcohol is freely available, you cannot ignore that. It is part of society and society has to make up its mind about the message it is giving to twelve-year-olds.

Ruth Hussey

Q15: When will the government be introducing a national strategy on alcohol?
Shirley Ashton, MCAS, Liverpool

A: I think that is developing already. For example, George Howarth has worked as Chair of the ‘alcopops’ committee, which targets young people and alcohol misuse together. I actually represent the Cabinet Office on that committee, and that is ongoing. We are hoping that issues which come out of that will feed into a much wider review.

Given the nature of how the government works across a number of departments, it is tremendously difficult to pull departments together on occasion. The strength of what Anne Taylor is doing [with regard to drugs] is that she is based like me in the Cabinet Office, which arches across government and can pull on the strengths of different departments. It only works if you have the personal support and enthusiasm of the Prime Minister of the day and that certainly is the case with her work on drugs. Whether that would be the case for an evolving initiative on alcohol, I really do not know at the moment.

Peter Kilfoyle MP

SMOKING

Q16: The most dangerous drug, tobacco - because it is dangerous in chronic use rather than in acute use like alco-

Q17: A lot of my friends are addicted to the most filthy drug on the face of the planet: nicotine. They say ‘I don’t smoke. I only have a joint’. They take their nicotine with cannabis in it. There is going to be a massive health problem in a few years. What should we do about it?
Claire Casey, clubber, North Wales

A: I was asked to write an article for The Nursing Times a few months ago, about decriminalising cannabis. Looking at figures for our admissions, cannabis admissions have increased by 300% in our hospital in the last year. In fact, all admissions with drugs have increased by 200%. I am all in favour of medicalised cannabis for multiple sclerosis, for agonising arthritis, for terminal cancer pain and so forth. I am very wary about decriminalising it, specifically because of its carcinogenic effects.
Cannabis is a very powerful carcinogen when smoked. It tends to have a multiplicative effect on tobacco smoking, and in
itself pure ganja is carcinogenic.
Chris Luke

A: I welcome the reminder that tobacco causes an immense amount of ill health right across the world. We are seeing increased rates in smoking in many countries. The question is how to control the uptake of tobacco when it is being used for taking cannabis as well.

Nobody knows how to control the uptake of tobacco. There are some very positive things, like not promoting it, but I think we have to look also at the culture around young people, which is actually fairly supportive of tobacco smoking. Ten years ago you would not see anybody in newspapers or fashion magazines smoking. But it is coming back, and I think we have to ask ourselves why that is, who is behind that, who is promoting that. We then have to be a bit more upfront about the debate about cannabis and its link with tobacco.
Ruth Hussey

VIOLENCE AND SECURITY

Q18: Security staff and other staff at clubs are being asked to take on the role that the police should be performing. Is this appropriate, and who is going to protect security staff if they are putting themselves into situations where their own personal safety and legal situation may be at risk?”
Stuart Bolton, youth drug project worker, Sheffield

A: To protecting our 3,500 members, training is essential: being able to invoke a citizen’s arrest; knowing the difference between different drugs; knowing when to arrest, when not to arrest; knowing different search procedures. It is also important that security staff liaise very closely with the local police, find out what their drug policy is, and what to do with any drugs found. Retraining on a yearly basis - continuing professional development - for security staff should be a must. Danny Brewington

A: We are always ‘strapped for cash’, but the security staff on club and pub doors are not doing the job for us. What they are doing is the management’s job, whereby they are refusing entry to people who are likely to get the licensee of the establishment (who may lose his/her licence if those people are allowed entry) into trouble with the law.

Cream have a publicised policy, a nice, glossy brochure that sets out what their door policy is, and what their searching policy is. Other clubs around Liverpool have similar documents. However, there are some which don’t have any [policy] documents at all. The doorstaff wouldn’t have a clue what drugs were, in fact.

We are reliant to a great extent on the training of doormen, and we are reliant on the management of clubs and pubs, but they are not doing our job for us. We (and I am sure it is the same for every police force across the country) want to work with them to ensure that clubs and pubs are safe for people to go to; that all licensed premises are safe.
Damien Walsh

Q19: I cannot believe that this country will still allow people to be granted a public entertainments licence without a stipulation that the doormen should be trained before the licence is granted. What are your opinions on that?
Lindsey Breckon, student, Derby

A: In Liverpool at the moment we have a door registration system which allows any-
one to work on a door in a club, pub or bar in the city: you can walk from Walton jail and get yourself a job on the door of any of the establishments in Liverpool. The reason for this is that individuals are not vetted. All they have to do is provide a photograph to the licensee, put their name in a book which is kept at the door, and they’ve got themselves a job. At the moment our scheme is not the best. Hopefully things will get better when the new scheme is approved, and part and parcel of the scheme in Liverpool. When it comes online in a couple of months’ time it will be a proper training programme.

The entertainments licence covers many aspects, from whether toilets are blocked, to unobstructed fire exits. It is not just about door supervisors. The scheme we will have in Liverpool is similar, I am sure, to every other place in the country, in that licensees have to provide a certain number of attendants, dependent on the size of the premises and how many floors there are and so forth. It does not stipulate training. It talks about being conversant with the fire evacuation procedures and very, very basic things like that.

When the scheme comes in here there will probably be a stipulation that they do not use people who are not trained. Licensees will have to train them at some point, but not necessarily from the outset. Once they have been vetted by the police, and approved to work on a door, then some sort of training will take place and they will have to be documented.

Damien Walsh

A: There are a lot of local authorities who incorporate a training course in their door staff registration. Part of the condition of registration is that individuals are trained before they are put into an operational role; they are not allowed to actually deal with the public unless they have been trained.

Incidentally, a lot of door supervisors are put at the bottom of the rung when it comes to the leisure security industry. All the rules coming into effect across the country due to registration schemes have bypassed the security professionals themselves. People do not think door supervisors can think for themselves, and maybe give some input on these registration schemes. I think it is time for the public and for club owners to go to their local councils and say “Look, registration schemes are not a revenue raising activity, they are a matter of public safety”.

The only way to protect young people in nightclubs and in pubs is to make sure that every single supervisor in this country is trained to an acceptable standard, and then put on a national register so we know that if they screw up in Liverpool, they can’t go to work in London.

Danny Brewington

Q20: I work with a research psychologist studying people who have alcohol-related injuries. Has there been any research ‘before and after’ people have had door supervision training, to see if there is any difference in the number of incidents relating to door supervisors post-training?

Alison Smith, Cardiff University

A: In Coventry city centre in 1992, 90% of all violent crime dealing with assaults in the city centre were related to door supervisors. They have since brought in a door registration scheme and it has dropped down to 10%. That generally applies across the entire country. If you train security staff, they are going to know what to do in every situation; they are going to be able
to deal with somebody who is drunk a lot better than just going in with their fists. Danny Brewington

Q21: The people who actually run the door, the owners of security companies, are overlooked. There are some really good guys who work for these criminals, who will get through registration because they haven't got criminal records. Isn't it the people who own the companies, the organised criminals, who set the culture? Jayne Casey, Cream, Liverpool

A: Ultimately we would like to see those people stopped from being in the industry as well, but at the moment we are having enough difficulties trying to get the individual door supervisors registered so that the people actually working your door for you are trained and are decent people. We can then maybe start to work on the security companies. I don't like to see criminals running security companies any more than anybody else, but for now door registration only concerns the individuals on the door. Andrew Walker

Q22: We have heard about the glass related injuries seen in hospitals on a typical Friday or Saturday night. Does the nightclub industry have plans to introduce toughened drinking glasses, which may minimise that sort of injury? Steve Pooler, police officer, Coventry.

A: The industry, through the organisation BEDA [The British Entertainments and Discotheque Association], is very much wanting to pursue toughened glass rules. Within my own company it is normal to have only toughened glass, which is invariably more expensive, and its only source France. I think if they do adopt that policy, then you will certainly see reduced accidents, damage and injury as far as glass is concerned.

With regards to bottles, there is no such thing as a toughened bottle, although within BEDA only a few weeks ago I was in discussion with brewers, who are very much interested and active in trying to ensure that within their industry they will get toughened bottles eventually. A lot of research has been done throughout the country and by BEDA, which suggests that there is minimal difference between accidents from either glass or bottles: neither one stands out as being more of a weapon. In fact, research carried out by Nottingham University suggests there are as many injuries that take place in bars, clubs and pubs from pieces of furniture, ashtrays and so on as from bottles and glasses. Tony Spragg

A: The majority of incidents that we have to deal with on Thursday to Saturday nights involve weapons such as bottles and glasses. As far as I am concerned and the police are concerned, bottles and glasses are weapons and have been used as weapons in Liverpool in recent times. Damien Walsh

A: As a door supervisor, pubs and clubs that do not have toughened glasses are probably our worst enemy. Last year over 122 door supervisors were seriously injured by cuts and lacerations from drinking glasses and bottles. Danny Brewington

Statement

Jack Straw when he was Shadow Home Secretary published a document called Calling Time in April 1996. It specifically says that Home Office research shows that about 10% of people injured by violence have been attacked with glasses. We have
found that between 20-30% of people who are injured either deliberately or accidentally were being injured with glass. We would like to get rid of glass as they do in football grounds, or certainly have toughened glass overall. There are examples of good practice, like the Coventry partnership where the licensing authorities, the actual proprietors and police have got together to eliminate drunkenness and drinking in public, and they have introduced a point system whereby clubs who are associated with a certain number of incidents of violence or medical mishap are increasingly penalised, leading eventually to revocation of licence. There’s the recipe. Just do it.

Steve Pooler, police officer, Coventry.

Q23: What measures could the nightclub industry take to reduce the enormous financial burden of alcohol-related violence on the NHS?

Colin Dewar, doctor in emergency medicine, Liverpool

A: It is not just between cities that we have these extraordinary variations between levels of violence. We get hardly any patients from Cream. Of perhaps five or six thousand clubbers per weekend I’d be very surprised if we handle a dozen patients from them per annum. So Cream is a very good example of independent door policy, zero-tolerance policy and so on, but I realise Cream is a major industry.

There are other big clubs in this city, run by different outfits, where there is a shocking display of violence and other alcohol-related problems. It is about the sort of people who actually run the clubs. Might I also add that pubs actually produce far more problems for the NHS than clubs, so the modern dance venue like Cream I can only applaud because they have got their act together as far as the NHS is concerned.

Chris Luke

A: My team is responsible for policing the pubs and clubs in Liverpool’s city centre. We have in excess of four hundred in a small geographical area. The Cream on a busy night may have three thousand people but the police are very rarely called to deal with disorder or drunkenness there. If I look at incidents in other premises across the city there are incidents of woundings, excess alcohol, excess drugs and so on.

We had an operation recently whereby we were stopping people carrying bottles around the city because, as we had worked out from our statistics, the majority of work for the uniformed officers as well as for ourselves in Plain Clothes, was due to the fact that 80% or so of all incidents involved woundings of one description or another, and the majority of woundings were taking place on Thursday to Saturday nights between midnight and 4am.

So the violence and disorder that takes place in the city places great demands on the police service, and I can only support establishments like Cream. The police work comes from all sorts of establishment, whether it be main-stream, whether someone is playing Abba. There’s a revival of seventies music in Liverpool at the moment and we are having problems with that. It doesn’t make any difference: problems come from the spectrum of club land.

Damien Walsh

Q24: Safety does not stop at the door. As a gay man, if I want to go clubbing in a straight club, I want my safety to be protected while I am dancing. Are there anti-homophobia policies relating to the training of door staff?
Bryan Carnegie, Kensington, Chelsea and Westminster Health Authority

A: We were approached last February by a security company in London to come up with an ‘anti-homophobia’ policy. Working in a nightclub, whether you are gay, or a straight person going into a gay club, I will treat you the same: as a member of the public. I will have your best interests in mind, and protect you to the best of my abilities. It is hard to get that message across to the old-style door supervisors who are probably still trying to shy away from these issues, but it will change, and the different aspects of gay lifestyles and straight lifestyles are being introduced into training programmes around the country.

Danny Brewington

A: We have a number of prominent gay clubs in Liverpool. Some of them started out as straight clubs and became ‘gay-friendly’, and are now something else altogether. I would like to think that our liaison with these clubs and the management at these clubs is as good as the liaison we have with Cream nightclub. Sergeant Paul Douglas with whom I work in Liverpool city centre is the police liaison officer for the Gay and Lesbian Association in this particular region, and I know that any incidents involving gay and lesbian people (where they may be assaulted en route to or on the way home from clubs) will be vigorously investigated and pursued. I would hope that we treat gay clubs as we treat other clubs.

Damien Walsh

A: The question is about the special safety requirements of gays and lesbians in clubs. We have been talking about taking drugs safely and drinking alcohol safely and so on, and perhaps there are other safety elements for lesbian and gay people in some clubs that need attention.

Paul Martin

HEALTH BENEFITS OF CLUBBING

Statement

There are extremely positive benefits that are coming out of this culture. Apart from the obvious one, exercise or stamina, it is building up the strength of your heart, you’re rushing and buzzing, and you don’t need drugs to do that. The other thing is the spiritual bonding that dancing achieves. When people are dancing together, it is whipping up the most enormous, powerful energy and I really think it needs to be taken note of, as well as the negative, bad side to drugs.

Claire, clubber, North Wales

Q25: Dancing is a good mask for numerous epidemic conditions within society (coronary heart disease, hypertension, cancer), and it is a form of exercise which must impart positive effects on social and psychological well-being; can it not play a positive role alleviating so many of these socially unacceptable conditions?

Scott, clubber, Liverpool John Moores University
A: The risk for doctors and others looking at the club scene is inevitably coming across as a kill-joys. I applaud clubbing, I think it is spectacular, superb, wonderful. In the UK it is a world leading culture, and I am very much in favour of it. I just think it is unfortunate that in the margins of clubbing there are problems with alcohol, injuries and so forth.

However, I would not want to distract from the message that dancing is a superb form of exercise. With reference to spirituality and bonding, there are a couple of obscure studies looking at the placebo effects of dancing, and as far as I can understand, dancing in the club scene can quickly emulate the taking of Ecstasy. Ultimately it is the process of bonding together and the communion that people really enjoy but I suspect in the late 20th century, they find it easier to make the entry into that communion - in the post-religious society - by taking a few drugs.

Chris Luke

A: I echo the idea that a sense of fun and well-being, having a good laugh is actually a healthy thing. We know exercise is good. We also know that some people when they take that exercise end up with sports injuries and other unwanted effects of that. I feel there are two issues: firstly, maybe we need to have some documentation and research into the health positive effects of dancing and the social support that appears to be around that; secondly, I think we have to look at the consequences of the things that go around it, the dis-benefits of some of that activity.

Ruth Hussey

MISCELLANEOUS

Q26: Frequently in my outreach work I come across young women of 14 and 15, who regularly attend clubs, regularly get drunk, regularly have access to the drug and dance culture. Should they be growing up thinking this is the norm?

Muriel O’Driscoll, family planning nurse, Merseyside

A: It is very much down to the management in the individual venues. There is a lot of management, a lot of door staff who are not trained as well as they could be and I think this is the area we should concentrate on. There are various ways in which you can tell certain ages and various checks you can do. Kids can get around that but well-trained management can alleviate it to an extent.

Tony Spragg

Q27: Different councils have different rules regarding first-aid staff: whereas a club with the capacity of two or three hundred might have none, a club with the capacity of five or six hundred should have at least one member of St John’s Ambulance, for example. Is there any government ruling on this?

Anon

A: One of the criticisms of the licensing regime is that it is not consistent across the UK. The rules in a particular area are set by the individual Local Authorities, so the licensing conditions in Liverpool, will/may/could be different to the licensing conditions in Manchester. What we would strive for is consistency in key areas.

There is guidance on first-aid provision, not specifically in clubs, but we can adapt other rules. In my view a club of any size should have at least one member of staff (and in the conditions we apply in Cambridge the majority of nightclub staff should be) trained in some basic emer-
ergency first-aid training. Over a certain critical mass in numbers we would require more trained provision by St John’s, Red Cross, or a local ambulance service.
Ian Foulkes (See Chapter 4)

Q28: I am in the process of trying to put into place a campaign promoting sexual health in nightclubs. Reaction from nightclubs has been mediocre. One of them in particular said “Send us posters and leaflets, but as regards actually setting up a stall in the nightclub, it’s too ‘in your face’”. How you would overcome this?
Anon

A: I wouldn’t put a stall up in a nightclub. I don’t think that wins you any favours with young people: they are there just to have a good time. I would just go in and be quite pushy and explain that a nightclub being involved with yourself does actually give the nightclub a sense of social responsibility towards its clients. Maybe look at some of the marketing techniques that a club uses and get on the back of that.

We went into nightclubs twice, but it just makes you look ridiculous. The direct mailing is about having your details on tickets, on flyer bags, being sent to people’s home addresses. The Saturdays in the December (with the Fifth Emergency Service Campaign), our details were on tickets. When young people bought their ticket, they’d stick it in their pocket, and it was amazing how many people came to the clinic on those weekends, hung-over, clutching a ticket with our address on it. Getting your leaflet into their sticky claws is more important than saying “This is how you use a condom”. Clubs have done it, clubs do really well and if we’re talking about health promotion, we should actually look at some of the ingenious ways the commercial sector use and learn from them.
Lisa Knott (See Chapter 6)

Q29: Bearing in mind the amount of imagery that people are bombarded with in and around the club scene, is there any chance of health information getting lost? How do you make sure it stands out?
Anon

A: We need to be realistic here. We are competing for space in the same bars, shops and clubs where other flyers are distributed. We try to be at least good as, if not better than, entrepreneurs associated with the club scene, in terms of quality and design. Lessons were drawn from the Know Limits campaign. Our cards were too big and the very time that we were trying to get shops to display them was commercially when most businesses make their money, just coming up to Christmas. We learnt a lot last time, and it is about establishing good communication with the commercial sector.
Andrew Bennett (See Chapter 7)

Q30: How is ‘club health’ approached in the gay club scene? Has there been similar advice from the experts, to deal with the ‘club health’ issues very specific to the gay club scene, which is a very important social aspect in the gay culture?
Zakia, trainee in public health, Cornwall

A: Manchester’s lesbian and gay commercial scene has benefitted from the ‘safer dancing’ campaign that was run in a number of agencies in Manchester a couple of years ago (see Chapter 2.V), and Healthy Gay Manchester has done a significant amount of work in licensed venues in Manchester in and around promoting sexu-
al health. There are a number of studies in the process of being launched at the moment, looking specifically at gay men, drug-taking and safer sex issues and general health and well-being issues. I haven’t seen that research at the moment, so I can’t draw any conclusions from it. But there has been very little research generally across the country.

Certainly gay clubs have benefitted from drugs campaigns, particularly the ones that Lifeline run in Manchester, and certainly the Healthy Gay Manchester/Manchester Health Promotion Service through their gay man worker. Lifeline are in the process of collaborating with us on a project about alcohol use and drug-taking among, which will be launched in the New Year.

Paul Martin

Q31: Much money is dedicated to the performing arts, literature, and the visual arts. Have any resources been earmarked which might give the young people of today some other format than just clubbing. Is there a gap within society for young people?
Leah, young people’s advice worker, Cornwall

A: In opposition, I voted for a paper on the options which ought to be made available to young people to enable them to embrace opportunities which are very much denied to them. In government it is not my particular brief, that resides in the Department for Education and Employment. But we are in piecemeal trying to put bits and pieces together.

Some of the things I would like to channel resources into are areas of what I would call youth issues; into trying to restore the kind of cohesive and socially responsible society that I believe this government is pledged to. Whether in fact that will embrace putting resources into the kind of areas that you would like to see them channelled into I just do not know simply because people are trying to square the circle of diminishing resources and increasing demands and it will always lead to conflict.
Peter Kilfoyle MP

Q32: Is there enough collaboration with advertisers, who, at the end of the day, have large amounts of cash? An example might be with using the Internet: research done with MTV quite recently showed that a large proportion of clubbers now use the Internet regularly. How can that kind of thing be progressed forward?
Benjamin Parr, advertising agency employee, London

A: On the voluntary sector side of things, there is always a problem with resources, but we do have to be quite innovative when it comes to our designs. We secured some Drug Challenge Fund money when we did the London Dance Safety project. Now we don’t necessarily have that money floating around, but we are in communication with design students from colleges and I think that is the way forward. There are a lot of young professionals who want to get into this area who have an amazing amount of passion and skill, and a commitment to this field. We all have to tap in and develop those resources.
Ciaran O’Hagan

Q33: We are all sitting on a lot of information which could be shared. Is there anyway we can form some sort of network to get this information passed round so we have some basic guidelines?
Liz Skelton, drugs project co-ordinator. Edinburgh

A: In the UK there is some excellent work
being done. The community sector is always restricted because of time and resources, but we should be moving more towards, not necessarily a nationalised, recognised body but towards having a look at the skills we have, and the levels that we are all working to and see whether all our training programmes are meeting the same criteria. Then we can work towards a recognised standard of the average worker.

I think it is a positive thing. We all need to pull together and get some kind of recognised symbols. In many respects, because people don’t necessarily stay within one area to do their clubbing we almost need to get some kind of recognised logo or whatever, which gives a seal of approval for that club. Maybe that could be one of the things to look for, but these things need funding and this is something maybe that the Drug Challenge funding has to look forward to, crossing all over the Drug Action Team boundaries and getting to where someone can go to a club and recognise a symbol and think ‘Well, it has got trained staff, drug workers and provision of all the Safer Dancing things’.

The Exodus Project is a community-based project we are working on at the moment. We are designing training around the whole collective and even introducing training to people who come to their events and I think that is the way forward. Training key individuals in clubs is good for the moment but we have to look at taking training to the individual people who go to dance events. There is no point in having five key individuals within the club who are highly trained; the people who are paying to go into clubs need to be aware of the issues.

Ciaran O’Hagan

A: When you are working in clubs there are a number of points to take into considera-
tion: I think the first thing is that working in clubs can be exceptionally positive and incredibly creative. Not being a drugs worker I don’t want to be controversial, but it strikes me that if we are going to move forward in a positive way then we have to be honest with each other.

People have a professional interest or commercial interest to protect; they are not being honest. We need to get around the table and put aside our professional and commercial interests and discuss proactive and positive steps forward. It is actually in the best interests of the clubbers themselves and clubbers’ health.

Paul Martin

Statement

Club owners must not become isolated. A lot of people are paid to service the needs of young people (this is the industry we are in too) but we don’t get together and talk enough. Cream has had problems in the past: we went out and were open about those problems. It was a big risk for us to be so open with the White Paper hanging over our heads but we found sympathetic ears, and together with the public sector we found totally new ways of operating.

Jayne Casey, Cream nightclub, Liverpool

Q34: There are a number of issues specific to Scotland, especially relating to the fact that there are legal differences. In Scotland we don’t have a Bill like the Barry Legg Bill, but we have a campaign against drugs. What is the future for this campaign when certain individuals within the campaign are calling themselves the Scottish Drugs Tsar?

Natalie Morel, recreational drugs project worker, Inverness
A: You do have a different legal system in Scotland and that will be increasingly so post-devolution. I would just hope that this is the first forum of many in which these issues will be debated by parties with very different interests, because in many cases there is not only a gap between the politicians and a section of the community but it could be argued, there is a generational gap and its only by this kind of interlocution that we might be able to strike some kind of understanding on these issues.

Peter Kilfoyle MP

Q35: The legal drug producers (alcohol companies, breweries, cigarette manufacturers) make a large profit. Should they be forced to put some of that profit into our young people, our new generation, and into culture?

Jenny Hand, National Youth Agency

A: There are some very hard questions to be asked. This is a multi-million pound industry. Places like Cream, The Ministry [of Sound]⁷ and [Miss] Moneypenny's⁸ are spectacular and wonderful places and when they behave themselves, it is great for all concerned, it is a win-win situation. But I do think that the club industry and the pub industry need to think about dipping hands into pockets and investing not a great amount of money, a small amount of money in terms of environmental adaptation, first-aid facilities and training, and a zero-tolerance of violence.

Chris Luke

A: Should the industry be asked to put money into the health service? I would much rather endorse the suggestion that the industry should look at the environment it is providing, and ensure that it is of the highest possible standard, and also support information-giving. We have heard about sharing truth, and I think it is terribly important as more and more young people come into the club scene, that they are actually exposed to health information. The sort of campaigns that HEA are running now are very much along those lines. Let’s look at the prevention and harm-reduction end rather than putting more money into patching things up when problems start.

Ruth Hussey

A: A very interesting point has been raised (see Chapter 6) regarding the connection and communication by that connection to the customer through certain nightclubs using their database. There is no reason why that cannot be progressed even further for communication to the public.

Tony Spragg

Q36: I am on a steering group of a ‘safer dance’ project in Brighton. A lot of our time is involved in trying to raise funds. First Leisure certainly make a lot of money out of the drug scene. Do they (a) pay or contribute to any funds, or (b) have any future intentions to do so?

Jon Ginsbury, Sussex Drugs Prevention Team

A: We do have a very close association with the local drug groups and of course with the local authority and police. We do not contribute, but that is certainly something I would like to look into it.

It can be seen as an over-riding impression that the level of violence and accidents throughout the country relates to clubbing. But there is quite a difference between styles of nightclubs and discotheques. ‘Dance’ music emanated from rave culture: it is a frenetic style of dance to a fast, con-
tinuous beat and you do need an awful lot of energy, and the (invariably young) people who have the energy required to last over a long period of time have often taken drugs.

The other side of the business is ‘main-stream’, where music policy is very much middle-of-the-road. Maybe there should be more main-stream operations and less dance venues. I am not saying that we don’t have our own particular problems. What I am saying is that the problems within dance venues against the main-stream venues do differ quite considerably. All credit to the organisation of Cream, but it doesn’t happen everywhere unfortunately. We are as active as anybody else (in many cases more so than certain groups of people) in trying to control the situation with regards to drugs, violence, or under-age drinking within our premises, whether they be mainstream or otherwise.

Tony Spragg

Statement
The big leisure groups must send their managers and directors out with ear plugs in. They sit and hear all the problems about alcohol abuse but still say “Maybe we should shut down all the dance clubs and go ‘middle-of-the-road’ because ‘Sharon and Tracy’ don’t take drugs”. ’Sharon and Tracy’ consume loads of alcohol, get themselves into terrible situations and create problems.

Jayne Casey, Cream nightclub, Liverpool

Statement
I am surprised at the suggestion that we should go away from the dance culture, back to more main-stream clubs. With dance culture, the police know exactly where they are, as indeed do the club own-
Chapter 12
Our Healthier Clubbing Nation
Professor John Ashton
I Club Health: A new public health challenge

When we originally conceived of a 'Club Health' conference at the beginning of 1997, it was in recognition that clubs are a growing sector of the economy in the North West and elsewhere over the last few years, and that this is an important area, as the massive public and media interest reflects. As a Regional Director of Public Health, it presents a classic public health challenge, in that there are environmental health aspects, social aspects and medical aspects to it.

It reminds me of the situation we faced in the mid 1980s when almost overnight, it seemed, glue sniffing stopped being the major pre-occupation and we were faced with more substantial issues like heroin. In Liverpool we convened a meeting of all the interested agencies, chaired by the Roman Catholic and Anglican bishops, to try and get some joint working on this. The interest in and the very multi-agency support for developing club health illustrates the sort of perspective needed to tackle these kinds of social questions. They raise issues of culture and philosophy, fundamental disagreements and issues to do with legislation, and the framework within which we operate in a society which is very mixed today; and we have to find ways of co-existing where we have very different ways of thinking about the world.

II Key considerations

'Club health' raises issues of prevention of particular problems, and also of preparedness and response to issues that may arise. For me, in terms of the 'settings' approach to public health, and nightclubs as a 'setting', it needs to be thought about in relation to some of the other work we have to do, which relates to things like Emergency Planning, and crowd safety. It is something I have been trying to boot up the agenda in this region over the last year or two.

In the North West, and in England generally, we are quite lucky in the sense that we don't often have typhoons or hurricanes or earthquakes. We sometimes get a lot of heavy rain but we don't tend to suffer from deluges. The sort of catastrophic situations we can face in a region like this tend to be related to transport and recreation. In this city we have the still very immediate memory of Hillsborough in relation to this.

One thing that has always petrified me is the prospect of a disaster in a night-club, because we have hundreds, if not thousands of them in the region, and many of them are actually unsatisfactory buildings. We know from international experience and literature that some of the worst disasters affecting teenagers have happened through fires taking place in clubs, where dozens and on occasion hundreds of teenagers have been injured or killed.

III The night-club as an environment

So we must bear in mind public health safety, physical safety and environmental safety. At times we get drawn into the drugs situation and the alcohol situation, and these are clearly very important parts of the picture. However, I hope we have begun to think about this as a context in which a million people nationally go clubbing and are exposed to an environment, a physical environment, which carries risks. The risks are fundamental sometimes. The sanitary situation in some clubs is abysmal; and we have heard about problems with club doormen, and about people getting safely to and from premises.
We have also been reminded that as a social phenomenon clubbing itself is an important means of socialising. I suspect clubs such as Cream are places where young people meet their future partners. The reconstruction of a social context in people's lives is important and it is an interesting reflection that at the end of a long period when there has been no such thing as society people have found ways to create their own societies of different kinds, and affinities of interest. Clubbing has obviously been a very potent part of that.

IV The need for information sharing

So a range of issues has emerged. First and foremost for me as a public health person there is a need for information in and out; a need for intelligence. We need to know what is going on. There is a need for research and for decent routine information. In view of Chris Luke's data from the Royal Liverpool University Hospital (see Chapter 3), said to have the busiest A&E department in the country, we should be routinely recording which clubs are actually having the problems when people come in. We should be using that intelligence system to focus down on the places where attention needs to be addressed. Equally, information out. The really pioneering work carried out by HIT over the years, about how to make contact with people in a non-patronising, truthful and culturally appropriate way (see Chapters 6&7) is something we have really tried to develop over the years in the North West, and particularly on Merseyside.

V Toughened glass

The issue of alcohol has emerged very strongly in the context of 'club health', and alcohol in relation to issues of glass. A simple enough message is that we don't have to wait any longer before saying that reinforced glasses should be made mandatory in licensed premises, and we should be very rapidly seeking to replace the kind of bottles we have at the moment. This is a simple public health measure that would have dramatic impact. Having seen the toll of facial injuries - really wicked and lifelong facial damage that people sustain from broken glass that cannot be adequately repaired by plastic surgery - this is something we should get on with.

VI Alcohol

It is very difficult for politicians in questions surrounding the club environment; it is the art of the possible. These are clearly very generational issues, and some of the questions we have been discussing today are very profound. It seems sometimes that in focussing in on alcopops (for example) it is a way of avoiding talking about drinks like port, or gin and tonic which older people use, and separating 'young' and 'old' drinks can be just another way of 'demonising' young people. Shirley Ashton (see Chapter 9) reminds us of the typical profile of someone seeking help for alcohol problems over the years (although this has changed more recently): people in their forties, fifties and sixties rather than younger people.

VII Regulation

The important points from the government perspective are the recognition that government has to be mature about these issues. They cannot risk driving underground social questions, and positive measures to do with door-staff registration, and the development of standards and training (see Chapter 5). I am personally shocked by the situation in Liverpool and I would regard it as an imperative that the regula-
tion of door-staff is sorted out as soon as possible, not just in Liverpool but throughout the region and throughout the country. The guidance which should be given to local authorities (see Chapter 10) and the strengthening of regulation is clearly an area which does need attention.

VIII A broad based response

In these big social questions there are things that government can and needs to do, but it is very much inter-departmental. Peter Kilfoyle represents one part of government, but has spoken on behalf of the Home Office; the Minister I work to is in the Department of Health. We are talking about many government departments that need to have joined up thoughts about these sorts of things, and joined up strategies.

At the local level, we are talking about things that have to be done together in a multi-agency way: police, education, health services, the private sector, and the clubs themselves. We can pride ourselves in this part of the country on our record on this, whilst recognising that people in other parts of the country are very often engaged in equally important and effective ways of getting together and crossing boundaries (see Chapters 6,7&9).

At the very individual level, at heart, the way in which we relate to a whole range of questions about our entertainments and privates lives need to be addressed at family level and at interpersonal level.

To return to the beginning, public health is about the combined efforts of society, and very much about getting the 'public' into 'public health'. That is why when an event like Club Health attracts such a fantastic turn-out, we recognise that we are probably on the right lines. If we are really concerned about tackling 'club health' issues, then it is through that sort of broad-based engagement that we must go forward.

1 This is a reference to the tragic incident in 1989 where 96 football fans were crushed to death (and many more seriously injured) due to overcrowding at a match between Liverpool and Nottingham Forest football clubs.
Appendix 1
Useful Addresses

National Organisations

**British Entertainments and Discotheque Association (BEDA)**
Waterloo Place
Watson Square
Stockport
Cheshire SK1 3AZ
Tel 0161 429 0012

**British Red Cross**
19 Coventry Road
Cubbington
Leamington Spa CV32 7UN
Tel 01926 832 446

**Central Drugs Co-ordination Unit**
Government Offices
Great George Street
London SW1P 3AL
Tel 0171 270 5776

**Central Drugs Prevention Unit**
Horseferry House
Dean Ryle Street
London SW1P 2AW
Tel 0171 217 8631

**Chartered Institute of Environmental Health**
Chadwick Court
15 Hatfields
London SE1 8DJ
Tel 0171 928 6006

**Health Education Authority**
Trevelyan House
30 Great Peter Street
London SW1P 2AW
Tel 0171 222 5300

**Institute for the Study of Drug Dependence (ISDD)**
32-36 Loman Street
London SE1 0EE
Tel 0171 928 1211

**Local Government Association**
26 Chapter Street
London SW1P 3ND
Tel 0171 235 1066

**The Magistrates Association**
28 Fitzroy Square
London W1P 6DD
Tel 0171 387 2353

**National Association of Licensed Door Supervisors and Security Personnel (NARDS)**
Baddow Park
Great Baddow
Essex CM2 7SY
Tel 01245 477 293

**Release**
388 Old Street
London EC1V 9LT
Tel 0171 729 9904

**Royal Society for the Prevention of Accidents**
Edgbaston Park
353 Bristol Road
Birmingham B5 7ST
0121 248 2000

**Standing Conference on Drug Abuse (SCODA)**
32-36 Loman Street
London SE1 0EE
Tel 0171 928 9500
TACADE (The Advisory Council on Alcohol and Drug Education)
1 Hulme Place
The Crescent
Salford
Manchester M5 4QA
Tel 0161 745 8925

North West

Communicable Disease Surveillance Centre (CDSC North West)
Public Health Laboratories
Fazakerley Hospital
Lower Lane
Liverpool L9 7AL
Tel 0151 525 4242

Department of Public Health
University of Liverpool
Whelan Building
Liverpool L69 3GB
Tel 0151 794 5576

Healthwise
First Floor
Cavern Court
8 Mathew Street
Liverpool L2 6RE
Tel 0151 227 4150

Healthy Gay Manchester
Ducie House
37 Ducie Street
Manchester M1 2JW
Tel 0161 236 7600

HIT
Cavern Court
8 Mathew Street
Liverpool L2 6RE
Tel 0151 227 4012

Department of Public Health
Liverpool John Moores University
School of Health
Liverpool L2 2ER
Tel 0151 231 4301

Lifeline
101-103 Oldham Street
Manchester M4 1LW
Tel 0161 839 2054

Merseyside and Cheshire Alcohol Services (MCAS)
30 Hope Street
Liverpool L1 9BX
Tel 0151 707 1221

NHS Executive North West
Millenium Boulevard
Birchwood Business Park
Warrington
Tel 01925 704 000

Scotland

Scottish Drugs Forum
5 Waterloo House
Glasgow G2 6AY
Tel 0141 221 1175

Crew 2000
32 Cockburn Street
Edinburgh EH1 1PB
Tel 0131 220 3404

Enhance Recreational Drugs Project
123 West Street
Glasgow G5 8BA
Tel 0141 429 8321