

FIRST AID INTERVENTIONS AT NIGHTCLUBS AND DANCE PARTIES: A NEW DIMENSION TO FIRST AID PRACTICE GUIDANCE

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First aid services are being increasingly used in nightclubs and at dance parties as a risk management and harm reduction strategy. In this presentation we are going to have a look at how these services are provided and some of the challenges that are presented operating in this unique environment.

Just to give you a bit of background about first aid - as a discipline it first appeared in its modern form in the 1870s as a response to traumatic injury, within both military and civilian populations. This led to the establishment of civil ambulance services within that same decade and, virtually simultaneously, first-aiders started attending public events to help ensure the health and safety of patrons attending those events.

Essentially the role of first aiders at events and at venues is initially to provide recognition of medical emergencies and medical conditions; to provide an assessment of those conditions, both in terms of the nature and the severity of those medical conditions; to provide initial treatment and stabilisation; and to provide referral to ensure that people move on to appropriate services.

We can look at first aid against the health care model known as the crisis model; within the crisis model, you essentially have two aspects of health: There is psychosocial health, which deals with your emotional and psychological well-being and biophysical health, which looks at the actual organism itself and how it is functioning. Wellness is essentially a balance within these two aspects and if either your psychosocial and/or your bio-psychical health are challenged by an event or an insult, then that creates a heightened level of tension, which leads to some form of dysfunction.

So, when we apply it to the dance club environment, we are met by certain challenges; first aiders at dance parties are regularly required to deal with the effects of people who have taken recreational drugs. And within our traditional first aid paradigm our psychosocial and our biophysical insult are generally fairly well matched - if you break your leg, there's an organic problem and there's also an associated psychosocial problem, where your distressed and you are in pain. So they are fairly well matched, and when we have high levels of biophysical insult and psychosocial dysfunction, our referral patterns tend to be to send people to hospital generally in an ambulance.

Now, when we are dealing with a non complicated recreation drug intoxication, that is not necessarily the case; we often find that people have a very high level of psychosocial dysfunction, but they may have a very low level of biophysical insult - so essentially your patron who is 'gurning off his nut' and thinks he is a monkey, definitely has a psychosocial issue, but might not be that unwell - until he fell out of the tree.

Likewise the nature of recreation drug use is that the symptoms may quite readily resolve themselves in a fairly short period of time; so while you may have someone who is acutely distressed, they may not necessarily be distressed for a long time.

Now if we were to indiscriminately refer these people to hospital, that creates a whole range of issues; firstly there would be an inability of the public health system to actually manage the sheer volume of patients that would be created - if everybody who had a recreational drug problem went to hospital, we would fill up the hospitals every weekend, and they would not be able to resource that level of patient care.

Likewise the actual style of patient care that uncomplicated recreational drug intoxications require is often very individualised and hospital emergency departments are not actually resourced to provide that type of individualised coping support. Also, if people are a bit paranoid, or have other sort of psychosocial dysfunctions associated with there intoxication, throwing them in the back of an ambulance may not necessarily be all that beneficial to supporting their coping mechanisms.

To give you an idea of what kind of proportion of people go to hospitals: I took a sample of fourteen events that Unimeds provided volunteer first aiders to in Sydney, and these are events that ranged in size from 3,500 to 20,000. Across these fourteen events we had a total population of about 96,000 patrons, and we had just over a 1,000 first aid presentations. Within this thousand first aid presentations, 67 of them had a chief complaint of either drug overdose or intoxication - and this is actually excluding people who may have presented with another chief complaint but had a history that involved recreational drug use; so if they have presented with stomach cramps or headache or something like that, they do not actually sit into that 67 - so anecdotally you could probably double that number - but 67 of them had, as their chief presentation, a recreational drug issue; 13 of those went to hospital in an ambulance, and as an side (and probably not surprisingly), 11 of those 13 were for GHB overdose. So you can see, there is a reasonable population of people who have recreational drug issues, not possibly as many as you may have thought but still a fair few. And had we sent them all to hospital, it would of created some resource issues.

We can train first aiders to more appropriately manage these people by teaching them a range of skills; firstly by improving their assessment skills, so they can make more objective assessments of their patients, of their level of wellness and of their history; by giving them some context in recreation drugs use so they understand the scene, they understand why people are taking drugs and how it is part of the dance party and clubbing experience; to look at the agents themselves; to look at the drugs, their actions and t their effects; to improve the first aiders' decision making skills, because that is one of the unique things about working in the dance party area, is that traditional first aid decision making skills are very clear cut - people are sick they go to hospital. But we are beginning to part from that traditional paradigm when we're looking at the dance party environment. Looking at skills for communication and coping support, so allowing them to provide supportive care to people who have some controllable degree of psychosocial dysfunction; and most importantly looking at some exclusion criteria.

Our exclusion criteria are essentially criteria that we have in place to ensure that people who are actually sick end up in a hospital; so some of the criteria that we use,

both at Home nightclub and Unimed, are looking at things like significant altered conscious state - so if they have a Glasgow Coma score of less than 9 then they go to hospital; if they have an airway obstruction or a potential airway obstruction; if they have got bradycardia or un-resolving tachycardia; respiratory distress with abnormal efforts – so if they are not breathing effectively, then that is not something we can manage on site; fitting or seizure activity; hyperthermia or hypothermia, so if their temperature control has gone out of the window, then that is something that needs to be managed in hospital.

Essentially, we find a lot of people do end up with friends or people who can look after them, but if we get to the end of the night and we still have someone who cannot effectively function within society, who still has a high degree of psychosocial dysfunction, and nobody to take them home to look after them, then we do not have many choices other than to send them to hospital. Also, if they have any secondary injuries as a result of their activities, especially if we suspect that they cannot fully appreciate the nature of those injuries, or if they are unlikely to comply with any post-release instructions that we give them.

Once we have trained first aiders to operate within this environment, and once we have given them some support to ensure that sick people will go to hospital, these are some of the management techniques that we use in dealing with recreational drug intoxication (referring to screen). There is always an assessment process, where we assess the persons overall wellness; we look at their clinical presentation and ensure that they do not meet any of the exclusion criteria; we provide supportive care, which is essentially acute counselling to support their coping mechanisms and try and minimise their level of psychosocial dysfunction. We look at the mobilisation of external coping support, so we look for friend, for family, for people that they have come with - we find that there is normally someone within a group of people who is sort of the mother figure, who has it together and can help sit with them and help with the coping support, and also someone who can continue that, providing that they are eligible for release.

Obviously constant monitoring of the patient's condition is important because we need to ensure that, while they may not meet the exclusion criteria at their initial presentation, that their condition does not deteriorate; so we need to watch the way that they are trending – whether they are improving and are likely to become safe for release at some point, or whether they are trending downwards, and are likely to move into any of the exclusion criteria. Finally, we need to ensure that we are making effective decisions; and we also try as much as possible to involve the patient in that decision-making – you would be amazed that the option of their mother coming to get them does not seem to be a very popular choice when someone is having a recreational drug intoxication.

When we manage patients on site, we find we have a number of outcomes. First of all, we are effectively discharging 'duty of care' for the event or the venue, and most of the responsible promoters and venues that we deal with in Sydney are very keen to ensure that their patrons are looked after, even if the nature of their condition is a result of their own recreational drug activities. There is a positive health outcome for the patient, we either ensure that they have appropriate coping support, to ensure that they are able to be released safely, or we ensure that they end up in hospital if they

have a clinical presentation which warrants that. And it helps us ensure that we are effectively using our public health infrastructure - it means that, sick people go to hospital, people who are not sick do not go to hospital, unless something changes.

Finally, we are finding increasingly it creates opportunities for harm minimisation education - so people who have had a severe intoxication and have recovered up to a point where they are able to deal with you fairly rationally, are often very interested in avoiding the experience again, are often very interested in how the experience occurred, and we find a lot of opportunities to avoid future incidents with that patient by giving them some guidance.

Appropriate training of first-aiders to work in dance parties and clubs will ensure that they respond appropriately to the unique challenges presented by patients in these environments. Managing drug related conditions in a way that's sensitive to their temporary effects, but also mindful of their potential severity, will ensure that patients get the most appropriate style and level of care. This in turn will ensure more positive patient experiences, and more effective use of our health infrastructure.

Thank you