STAFF TRAINING IN
THE MANAGEMENT OF
CHALLENGING BEHAVIOUR

For staff working with young people with a
Learning Disability/Autistic Spectrum Disorder

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Studio III - Background

Studio III is a specialist research and training organisation which was founded over ten years ago. The overall aim of the organisation is to provide high quality training in the specialist field of managing aggressive and violent behaviour. To date the training courses have been developed in the following areas:

Management of Challenging Behaviours for staff working with:

- People with Acquired Brain Injury
- Young people with an ASD and/or a learning disabilities
- Young people with Emotional and Behavioural Difficulties
- Adults with learning disabilities:
  - residential care, respite care, day centres, Autistic and community based and supported living schemes.
- Psychiatric service users.
- Older Adults.
  *(These are three day courses and are discussed in the introduction)*

Workshops to augment our three-day courses include:

- Policy - Discussion & Development.
- Adult Protection
- Child Protection
- Issues around sexuality and relationships
- Reactive Planning Workshops - creating strategies for staff teams who work with clients presenting particularly severe challenges.

Management and Defusion of Threatening situations in:

- General Practice
- Pharmacy
- Dentistry
- NHS Trusts
- Social Work
- Housing
- Environmental

Personal safety and violence awareness courses have been conducted in over 30 academic institutions in the United Kingdom.

Studio III provides a fusion of skills between academic researchers, specialist movement skills trainers, applied clinicians, psychologists (educational and clinical), speech and language therapists, lawyers, doctors, teachers and nurses with RMN and RMNH qualifications.

The director of Studio III is Mr Andrew McDonnell BSc MSc, who is a consultant clinical psychologist with numerous research publications in this field. Profiles of our other trainers can be found at the back of this book.

Studio III Training Systems provides a non-aversive approach to challenging behaviour. We offer criterion-based training, working with staff to develop specific skills to meet the particular needs of the service user. It is essential that the background to the service users problems is understood by all staff and that this understanding is used to define the direction in which these problems may be addressed. Studio III is not a provider of generic physical intervention strategies as the majority of our work is designed to promote the management of challenging behaviour in a totally non-violent, gentle and dignified way by the use of ‘low-arousal’ techniques and gentle physical skills.
OTHER ORGANISATIONS WITHIN THE GROUP

Studio III Clinical Services

Studio III Clinical Services is a highly experienced multi-disciplinary organisation, operating throughout the UK and Ireland, with specialist consultants in psychology (clinical, educational and forensic), psychiatry, education and behavioural management.

Studio III Clinical Services provides specialist client-centred support to organisations working with adults and young people with severely challenging behaviour and clients who find their own behaviour difficult to manage.

Our work includes:

- Clinical supervision and team support
- Clinical assessments
- Risk assessments
- Non-aversive reactive plans
- Behavioural management plans
- Crisis management
- Service audit
- Placement and scheme development
- Legal work

Studio III Innovations

The aim of Studio III Innovations is to organise conferences and other events to give service providers the opportunity to broaden their knowledge base in areas which relate to behaviour management. A broad range of topics are addressed including: legal issues relating to behaviour management, the latest developments in understanding autism; psychopharmacology; dual diagnosis; communication, movement and challenging behaviour; Low-arousal workshops; Staff perceptions and attributions; Proactive strategies in managing challenging behaviours.
THE LAW IN RELATION TO ASSAULT

Most POLICIES and procedures are usually quite vague about what care staff should do when confronted by a violent or aggressive young person. There may be many reasons for this, but among the most likely is that our laws on the subject are equally vague. Due to the controversial nature of the subject, most services simply do not know what to suggest.

An ASSAULT can be as simple as a young person feeling threatened or unhappy with an action by a staff member. If touch occurs as part of the action it becomes ASSAULT and BATTERY. In practice it is generally rare for assault to be considered without battery. Under British law, there are two interrelated concepts that are considered prior to a ruling. The first is the ACT itself, and the second is the degree of INTENT. These two together can constitute a crime.

We may unwittingly ASSAULT a person or do so through restraint. Staff members cannot deny this ACT. Our defence would involve demonstrating that:

- Our INTENT was genuine
- We used REASONABLE FORCE in the circumstances.
- We were ACTING IN GOOD FAITH
- We were fulfilling our DUTY OF CARE for the young person.

There are no clear guidelines as to what constitutes reasonable force; it could be left to a jury to decide if the actions taken were reasonable. An agreed REACTIVE PLAN will help to support the actions taken to manage the behaviour. NEGLIGENCE may be considered if a reoccurring challenging situation is not planned for by the staff group.

Staff have in the past been prosecuted and imprisoned for assault on the clients in their care. It is essential, therefore, to have clear policies, risk assessments and reactive plans for staff to be adequately protected. This paperwork needs to be readily available to all staff.

The Human Rights Act (1998)

The Human Rights Act came into force in England on 2nd October 2000. Essentially it is ratification by the UK government of the European Convention on Human Rights. The rights enjoyed under the Convention have been transferred largely unchanged into the new Act. As a type of ‘higher law’ all other legislation – from local authority by-laws to acts of parliament – should be given a meaning that fits with the Convention rights. The most important function of the Act is that it should give all British citizens (including the young people we work with) easier access to the law, since Human Rights cases can now be brought before our own courts, rather than having to be referred to the European Court of Human Rights in Strasbourg.
Only public bodies like the police, local authorities or government departments can be directly sued or prosecuted under the Act, but having the Act in writing should make it easier to demonstrate to private individuals or bodies what our rights are and how they are infringing them. This means that clients or their advocates now have access to information on their rights and may be able to inform their carers when those rights are infringed or abused.

The Human Rights Act can be read in full on the following website: www.hmso.gov.uk/acts/acts1998/19980042.htm; however the following articles of the Act have particular relevance to the services provided by most care organisations:

- Article 3 – Prohibition of Torture. The wording of this article means that some commonly used physical intervention procedures, such as face-down floor restraint, or punishments like the withholding of food may be deemed ‘inhuman or degrading’.
- Article 5 – Right to Liberty and Security. Unless imprisoned for a criminal offence or ‘sectioned’ under the Mental Health Act we all fully enjoy this right. If a client insists on leaving the property it is unlawful to hold him/her against their will, however much carers may feel this conflicts with Duty of Care.
- Article 8 – Right to Respect for Private and Family Life. Carers do not have the right to interfere with a client’s access to their family or their private correspondence. Carers must also respect those spaces (like bedrooms) that could be designated as the client’s private space or home.
- Article 14 – Prohibition of Discrimination. The client’s condition (learning disability/autistic spectrum disorder) in no way diminishes their rights or the respect that carers should have for them.
- Article 1 of Protocol 1 – Protection of Property. The peaceful enjoyment of your possessions is protected. The confiscation of property has been a commonly used punishment that should no longer be used.

Complaints under the Human Rights Act can only be made by the person whose rights are being denied or their guardian/advocate. Since many learning disabled individuals have little or no knowledge of their rights or the procedures of complaint it becomes vital that their carers are both knowledgeable and respectful of those rights in order to avoid future abuses.

Any Questions?
Mental Capacity Act 2005

Five key principles

The whole Act is underpinned by a set of five key principles set out in Section 1 of the Act:

- A presumption of capacity – every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise;
- Individuals being supported to make their own decisions – a person must be given all practicable help before anyone treats them as not being able to make their own decisions;
- Unwise decisions – just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision;
- Best interests – an act done or decision made under the Act for or on behalf of a person who lacks capacity must be done in their best interests;
- Least restrictive option – anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms.

A Criminal Offence – The act introduces a new criminal offence of ill treatment or neglect of a person who lacks capacity. A person found guilty of such an offence may be liable to imprisonment for a term of up to five years

Acts in connection with care or treatment – Section 5 offers statutory protection from liability where a person is performing an act in connection with the care or treatment of someone who lacks capacity. This could cover actions that might otherwise attract criminal prosecution or civil liability if someone has to interfere with the person’s body or property in the course of providing care or treatment.
• **Restraint** - Section 6 of the Act sets out limitations on section 5. It defines restraint as the use or threat of force where a person who lacks capacity resists, and any restriction of liberty or movement whether or not the person resists. Restraint is only permitted if the person using it reasonably believes it is necessary to prevent harm to the person who lacks capacity, and if the restraint used is a proportionate response to the likelihood and seriousness of the harm.

Although the act is mainly concerning people aged 16 years and over the new criminal offence of ill treatment or neglect may apply to children in certain circumstances.

As with any new act, guidance in the form of a code of practice has also been published and people will be expected to work within this guidance. The full act and guidance can be found on [www.direct.gov.uk](http://www.direct.gov.uk) along with video clips of real life examples of the use of the act.

**Deprivation of Liberty Safeguards**

Introduced into Mental Capacity Act 2005 (MCA) through the Mental Health Act 2007

Will prevent arbitrary decisions that deprive vulnerable people of their liberty

Safeguards are to protect service users and if they do need to be deprived of their liberty give them representatives, rights of appeal and for the “deprivation” to be reviewed and monitored.

Safeguards cover people in hospital and care homes registered under the Care Standards Act 2000

**Any Questions?**
QUALITATIVE DIFFERENCES IN VIOLENCE

Whether we work with adults or children, it is crucial to understand the nature of the violence we are likely to be confronted with. Violence is itself an emotional word and can describe behaviours ranging from pushing a person to being attacked by a crowd of knife-wielding thugs.

If you were told that a person has been mugged, what thoughts would go through your mind? You might imagine a person being threatened or attacked with a weapon or being viciously kicked or punched. Images of violence such as these are entirely normal. Consider, for a moment, the place where you work ……

What are the most common incidents of violence? How often have you known clients use weapons or attack an individual in a premeditated manner?

As a general rule, the violence we tend to witness in most caring situations differs considerably from the sophisticated violence you may encounter. The mugger mentioned above has developed specific skills in obtaining what he or she wants, and would utilise anything to achieve this.

It is our experience that people with learning disabilities rarely use weapons, even if they are readily available. The most common kind of attacks involve the grabbing of clothing, or pulling of hair. The attacks have a less co-ordinated feel about them where a young person may strike out in rage because they cannot adequately communicate their needs. Many people with learning difficulties lack the necessary motor skills and co-ordination to attack a person in a planned and sophisticated manner.

Similarly, people with mental health problems vary in the degree of violence they use. Most often this violence is angry or explosive in nature, rather than premeditated or planned. There is obviously a clear difference between a person who plans to assault a member of staff as opposed to a person with a short fuse.

Any Questions?
THE CAUSES OF VIOLENCE

When a violent incident happens, one of the most common expressions used by staff is:

“It happened for no reason!”

Violence never occurs without a reason. We may not know the causes of a violent behaviour at the time, but this does not mean that no causes exist. We should always be attempting to understand human behaviour no matter how confusing or complicated it would appear to be on the surface.

Challenging behaviours are by their nature complicated and difficult to understand. From our experiences of working with challenging behaviours, we have put together a list of some of the most common causes. When you have read through them, try to think of some of the young people you work with and see if you can recognise any of the behaviours.

Common causes are:

1. **Being unable to communicate a need**

If a person cannot communicate their needs and wishes, this can lead to violent behaviour. Think how frustrating it must be to be unable to express your wishes. Bearing this in mind, we should always be aware of the communication problems for people with learning difficulties and/or an ASD.

2. **Being confused**

Violence can often occur where people do not understand the demands placed on them, so they become confused. This is particularly true for young people with a learning difficulty and/or an ASD. We frequently speak to people using grammatically complicated language and assume that we have been understood. Imagine that you were in a foreign country where no person spoke your language! If people shouted at you in this foreign language and seemed upset with you, it would be difficult for you to find the reason why. You would become confused and maybe a little frightened.
3. Being in pain

If a person has a communication problem, how do they tell you when they are in pain? A person may behave in an uncharacteristic manner, or even become aggressive, if they have a headache, stomach or dental problem. Illness should always be ruled out where possible when investigating the cause of a challenging behaviour.

4. Medication changes

Similar to the notion of being confused, changes in medication can have a number of behavioural side effects. Most people have a rough idea of what the medication they are taking is supposed to do. Psychological research has shown that an individual can easily be confused and excited if medication is administered without explaining the side effects. If you give somebody adrenaline and tell them it is aspirin, dramatic behavioural effects will occur that the person will not understand. This can be extremely frightening. A similar effect can happen to people with learning difficulties. Medication changes are often routine and well intentioned, but lack of adequate explanation may lead to a sequence of events that a person with learning disabilities may not understand. This may lead to confusion and can occasionally precipitate aggression and violence.

5. Inactivity

If people are inactive or do very little in the day, they will have more time to focus on their problems. We know from research that challenging behaviours decrease if we increase the activity schedules of people with learning difficulties. Providing a structured day with new experiences can have dramatic effects. Boredom is probably an important factor. If a person is bored, violent or aggressive behaviours can provide a great deal of attention for the individual concerned. If this is the case, we should try to provide that attention in a more positive manner appropriate to the behaviour displayed. Similarly, engagement in purposeful activities can serve to distract an individual from his or her problems.

6. Attention seeking behaviour

Whilst it is true that on some occasions violent and aggressive behaviour may be used to attract the attention of care staff, it is not always the case. Even if it is, why does that person need attention, and are there any positive methods they could use to achieve this aim?
7. Changes in routine

Changes in everyday routine can lead to violent and aggressive behaviour. This is particularly true for young people with an ASD. However, it is also an important factor for other people with learning difficulties. Routines help us to manage and understand our environment. Therefore changes in routine can lead to confusion and distress among some people with learning difficulties.

8. Environmental effects

The environment we live in can have dramatic effects on our behaviour. Many of these effects have been associated with violent and aggressive behaviour. Some of these include:

- the amount of personal space a person requires
- heat
- extreme noise
- seating arrangements

Any Questions?
LOW AROUSAL APPROACHES

Theoretical Assumptions:

Assumption One:

Most people who are challenging are usually extremely aroused at the time. Therefore, we should avoid doing things that will further arouse a person who is probably already upset.

Assumption Two:

A large proportion of challenging behaviours are usually preceded by demands/requests. Therefore, reducing these requests should help to defuse incidents.

Assumption Three:

Most common communication is predominately non-verbal rather than verbal. Therefore, we should be aware of the signals that we communicate to people who are upset.

“Don’t pour fuel on the fire!”

Any individual who is threatening or aggressive can be extremely frightening. Often the responses we give tend to increase that individual’s behaviour until something extreme happens.

A commonplace observation is that it is difficult to reason with an individual who does not wish to be reasoned with.

When a person is upset or angry, what you do or say or what you don’t do or don’t say could have an effect on the situation you are trying to manage.

We recommend the following interpersonal rules to promote a positive engagement approach to managing any incident:

Appear calm

We know that trying to stay calm in a tense situation can be difficult. But if we can try to appear calm to the individual in these times, this may lead to them feeling less confrontational.

To achieve this, we need to think of our body language:

Avoid tensing muscles, such as folding arms or clenching fists.

Breathe slowly and regularly.

Trying to appear calm on the outside when you are scared on the inside, takes practice.
Over time the more you practice, the more confident you will become.

**Personal space**

Try to maintain a safe distance between you and the individual concerned. The minimum acceptable distance is approximately three feet.

At this distance, you can communicate with the individual without “invading” their space. If you have to back away to achieve this, do so in an unhurried manner.

Also moving towards an individual can be seen as threatening.

**Eye contact**

Sustained eye contact (staring) is an almost universal sign for aggression in the animal kingdom. Avoid staring at an individual, but do try and maintain regular intermittent eye contact.

If you find this difficult, look somewhere else on the face, for example the forehead.

**Touch**

Touch is generally perceived by people as either a sign of warmth and friendliness or as a signal of dominance.

Even if you know the individual well always avoid touching them, at least initially.

When they appear to be calming down, it may well be appropriate to touch them, but be aware that they may not interpret this contact in the manner which you intended it.

**Noise**

When an individual is upset, the noise’s that surrounds them can make a situation worse. So think of the environment, turn the radio or television down or off.

**Listen**

Listen to what the individual is saying as they are often trying to tell you something. It may well be something very simple that is upsetting them and can be sorted out just by talking about it.
It is often a good idea to try sitting the person down to talk to them. But remember your body language and personal space, so do not sit too close to them and do not stand over them. Sit or kneel at a safe distance.

**Communication**

How we communicate with people is very important at anytime, more so when a person is upset.

**Verbal communication:**

Be aware of your tone of voice. Speak slowly, calmly and softly.

Keep your sentences short and simple. Using overlong sentences or explanation’s can make a person more confused.

**Non verbal communication**

Again, be aware of your body language, avoid arms folded and appearing distracted. Ensure you show the individual that they have your complete attention.

**Distract**

Opportunities to distract individuals often present themselves. Try to change the subject (avoid being obvious about this) and talk about things and subjects that the individual likes to.

Be aware if you promise the individual something you are morally obliged to provide it. So for example, do not promise to take them somewhere later, if it is not possible to do so.

**Remove other people**

To avoid an escalating situation, consider removing other people from the area. It is a lot easier to remove these people, than try to remove the individual who is upset.

Also removing these people may prevent any negative feelings and behaviours occurring with them.

**De-brief**

Talking about the incident is very important, as it can be a very emotional experience for everyone.

Remember to talk to everyone who was involved or even witnessed the incident. This means staff, family, carers, other residents and importantly the individual who was initially upset. Talking about the incident afterwards can
also help in understanding how and why the incident occurred and may provide information to manage future similar incidents more appropriately.

Remember, de-briefing is confidential and the listener should be non-judgemental. De-briefing is not a post-mortem it’s more about how you feel after an incident. If you were involved in the incident, it is your time to talk. Take as long as you need.

**Record the incident**

Try to do this as soon as possible after de-briefing. This will help you recall the incident more accurately and provide you with invaluable information on how to minimise or manage future incidents.

**PHYSICAL RESTRAINT PROCEDURE**

There are a number of principles which must be applied to physical restraint procedures:

1. The welfare of the individual who is behaving in a challenging manner is your *paramount* concern.

2. Physical restraint procedures must always be used as a last resort and cannot ever be considered as a therapeutic intervention. Last resort means that you have tried everything to keep the situation safe and there is now *an immediate danger of serious injury* that it is your responsibility to prevent.

3. The underlying principle of such procedures must never be to use pain as a means of control.

4. The procedures used must be such as to render their use as a punishment impossible.

5. It is our contention that all physical restraint methods should not only be effective but also socially acceptable.

A simple way of evaluating these methods is to ask the question:

*If I were a member of the public who walked into a room and saw a client being restrained, what would I think?*

The Walkaround procedure taught on this course is the most socially acceptable restraint method currently available. Below is some useful guidance to its use.

1. *Never attempt to restrain a person with an untrained member of staff.*

It can be tempting to restrain a client with an untrained member of staff and in effect train a fellow colleague ‘on the spot’. This can potentially lead to
everyone involved getting injured as quite literally the left hand doesn’t know what the right hand is doing.

The procedure taught on the course relies on the use of movement and untrained members of staff may well incorrectly use strength and try to immobilise the individual.

2. Use movement to calm the client down

Moving a client around allows energy to be burnt off and allows them the option of saying ‘I’m OK’ without having to resort to using restraint. Many of the individuals we care for lack the necessary motor skills to effectively resist this strategy. The individual may well be “angry” or “not calm” but we are only allowed to use physical skills when there is an immediate risk of serious injury. The adrenaline response or fight or flight reaction gives our bodies the ability to move. Restricting this inhibits our body’s main coping mechanism for handling stress.

3. Who is in charge?

The person who calls for restraint to be used is responsible for the procedure and becomes the co-ordinator. Regardless of grade, rank or gender. They will give directions like “forwards”, “backwards”, “round to me”, “round to you” and “let go” as shown on the course. You must also try to talk to the individual who is being restrained as well as talking to your assistant as you may find that this will calm the individual down more than holding onto them.

4. What do I do if I'm asked to help?

If you are the person assisting you may want to reassure the client as well as trying distracters. However, it will become very difficult for the client if both co-ordinator and assistant are talking at the same time. You are there to assist if your colleague asks. If you lose your grip or think you are about to lose your grip then you may call “let go”. If you don’t do this and you release your hold on the client, you may be putting your colleague at risk. When you do let go, give the person plenty of space and if they are lying or sitting on the floor drop down to their height and offer reassurance.

5. Disengagement

The rules for this are quite simple.

Q: Is the person who is behaving in a challenging manner presenting an immediate danger to the safety of themselves or others?

If the answer is ‘no’ then let go.

Q: Would this danger result in an immediate serious injury to someone if the procedure were stopped?

If the answer is ‘no’ then let go.

Remember
Everything you do will affect your relationship with an individual who is probably already upset.

The person may not be calm but you may find they will calm down when you let go of them. It's a good idea to ask yourself; 'Is this person in distress about what happened before restraint was instigated or are they now just distressed about being restrained?'

Finally...

We hope that you have enjoyed the course and that this information in this booklet has been a useful aid to have in conjunction with the training you have received. The skills you have learnt on the course will be kept up by attendance on refresher courses determined by your employing service. You can also keep up to date at our website or contact us at the address shown on the last page of this booklet.

STUDIO III TRAINING SYSTEMS

PHYSICAL SKILLS WHICH MAY BE TAUGHT ON THE THREE-DAY COURSE:
MANAGING CHALLENGING BEHAVIOUR

Release from wrist grabs – single
Release from wrist grabs – double on one wrist
Release from wrist grabs – both wrists
Release from hair grab – hair pulled from front
Release from hair grab – hair pulled from back
Protection of the airways
Avoidance of and release from biting
Avoiding punches/blocking
Managing service user who drops to the floor
Restraint – ‘walk-around’ procedure
Chair restraint (not a generically taught procedure)

Other specialist skills as prescribed in an individual’s behaviour management plan
COURSE READING LIST

PREVENTION OF FACE TO FACE VIOLENCE


PHYSICAL RESTRAINT


Allen, D. Training Carers in Physical Interventions – Research Towards Evidence-based Practice BILD Publications

BILD Code of Practice for Trainers in the use of Physical Interventions BILD Publications


MCB-YP V1.6

SECLUSION


STAFF TRAINING


FUNCTION ANALYSIS


SOCIAL VALIDATION OF INTERVENTION METHODS


MANAGING CHALLENGING BEHAVIOUR
THE LOW-AROUSAL WAY

THE NEW HIGHLY ACCLAIMED VIDEO/LEARNING PACK
FROM STUDIO III

This new ‘in house’ learning pack is designed to help staff who work with people who present challenging behaviours in a completely non-confrontational manner. There are specific packs relating to individual client groups.

The low-arousal approaches are research based and have been clinically tested by Studio III Training Systems, leaders in the field of behaviour management. Low arousal is the key to the philosophies and practices which underpin the Studio III training. These are now the chosen approaches of many services throughout the UK and Ireland.

From this pack you will learn:

• Many causes of frustration and anger which can lead to challenging behaviour
• What winds people up, what calms them down
• The least aversive ways of managing a behaviour
• How our behaviour can affect the behaviour of others
• How to move away from a demand culture – demands are not always what they appear to be
• Why is it a good idea to avoid confrontation
• An understanding of the arousal curve – being aware of the trigger zone

Each pack comprises of two videos and supporting literature which provides additional information and practical exercises designed to be used in conjunction with the videos. Whilst individuals can use the packs on their own, a facilitator’s handbook is included for group participation. Experience has shown that this is the best way to use the packs as many of the exercises are designed for group discussion. Group work also leads to greater consistency within staff teams.

Some topics covered in the exercises include:

• What challenges do you face in your work?
• What influences your perception of challenging behaviour?
• Causes of aggression
• Observing behaviours
• Developing Reactive Plans
• Understanding incidents
• Meeting communication needs

The first video is of a generic nature and introduces viewers to the concept of the low arousal can help in specific settings. Each video has contributions from leading Clinical Psychologists, Behavioural Consultants, Service Managers, each a specialist within their own client group. The videos are also richly interspersed with true to life role pays and a dramatic scenarios providing powerful illustrations of the key points.

This learning pack will be an invaluable resource for both the induction of new staff as well as promoting a consistent approach within experienced staff teams.
HAVE YOUR SAY....

READ WHAT OTHER PEOPLE ARE SAYING...

Register on the Studio III forum today by logging on to:

www.studio3.org/forum/

Here you will find:

- A forum on which you can join in a discussion or start one yourself
- The opportunity to feedback your experiences of Studio III – perhaps the course you have just been on
- Exclusive advance notice of forthcoming events – register for our newsletter on www.studio3.org/members/
- Updates on Studio III websites
- Even a Fun Corner
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