

Defending the Quality of RECC Training

(by Peter Ferns, Director of Ferns Associates)

Introduction

I would like to thank Melba for replying and clarifying what DRE Central's thinking is on RECC implementation. However, Melba's reply fails to answer some central questions in my article and important facts have been glossed over by her. DRE Central have recently adapted the original RECC materials for practitioners and developed a National Training Team (NTT) to train RECC trainers.

Why an adapted version of RECC?

Many people who have contacted me recently have asked why there was a need to adapt the RECC materials of which I was the main author in 2007. These materials were thoroughly tested and evaluated through four pilots and were then further developed by Ferns Associates over a two year period. They represent a menu of materials that properly trained RECC Trainers can choose their programmes from, according to the learning needs of staff. I have always advocated a flexible usage of the materials to ensure that they are adapted by trainers to reflect local practice, new research studies and their personal style and interests. We believe this is all about DRE appropriating ownership of an already successful initiative in our RECC Training for Trainers – our programme that was rejected by them over two years ago when I offered it to them.

We contend that the DRE programme is not RECC Training anymore as the changes have been substantial in the following ways:

- The theoretical underpinning of the materials has been devalued and substantially lost reducing the models to superficial 'gimmicks' rather than effective tools for critical analysis and improvement of practice.
- The design of the materials has been compromised with loss of the interlinking of concepts and the carefully constructed process of self-reflection and practice development.
- Many of the exercises have been rendered useless and incapable of achieving their learning outcomes through the introduction of some dubious materials such as a process model for dealing with racism called RELATE that has been cobbled on to every session.

The resulting materials are a poor imitation of the original materials that will be less effective in challenging discriminatory practice. The DRE's standardised 12-hour RECC programme will undermine the existing RECC materials and training for trainers based on them will result in poorer quality practitioner training and, most importantly, poorer outcomes for BME service users. We

would suggest that DRE change the name of their training initiative to something other than RECC Training.

We have independently developed our RECC Training for Trainers (T4T) programme and have made no demands for resources from DRE. Our T4T programme is being continually developed as we have now trained over 200 people including over 70 BME service users and carers. Our programme is far from 'static' and does not fall into a 'one-size-fits-all' trap. It continues to get high praise from trainers, practitioners, BME service users and carers across the country and excellent evaluation both for the T4T programme and the original RECC materials.

Courtesy around authorship

I have noted that Melba carefully avoids being clear about the genesis and authorship of the RECC materials which continues to fudge the issues and further confuse people about our programme. **The fact is that DRE were not actively involved in any way in the first two years of RECC** when the materials were written and developed by us through extensive piloting. This is despite my efforts to get comments on drafts, requests for case study materials and offering to attend REL meetings to update people about the written drafts. Even in planning meetings for the RECC Project, handled largely by CCAWI, DRE were conspicuous by their absence – the message was clear – **RECC was not a high priority for DRE**. The 'extensive resources' being marshalled now for the NTT initiative did not stretch to producing even a paper copy of the materials or a budget for implementation when I was involved. It is not wholly a DRE 'product' – it takes more than money to produce materials like this, it involves hard graft too.

Capability and effort are valuable human resources and I, as main author, with contributions from Premila Trivedi, Dr. Suman Fernando, Dominic Makuvachuma Walker and critical readership by Thurstine Bassett and Professor Hilary Brown deserve the courtesy of being credited as the true producers of RECC materials not DRE - or even CCAWI, who at least managed the project with efficiency and sensitivity. It has taken three years of our hard work and many more years of sometimes painful experience of delivering equality training to MH practitioners. There is no mention of most of the people above in the adapted materials and my name does not appear once. **Please extend us the courtesy of authorship of the original RECC materials – there are few enough Black authors out there at present in mental health.**

Cost

We have priced our Training for Trainers Programme extremely competitively at a level which is equivalent to less than half of the cost of a Mental Health First Aid - Train the Trainer programme – a major programme being funded by CSIP/NIMHE.

Fundamental flaws with the NTT design

The current design for the NTT is not fit for purpose. It is not possible or reasonable to expect people who are inexperienced race equality trainers (as several in the NTT are), or who do not have not a sufficiently deep understanding of the RECC materials, to go out and train trainers (as evidenced by the 12-hour RECC programme). Doing this will only result in spreading their confusion more widely and reduce the quality of training delivered to practitioners. This is a basic requirement for the complex activity of Training Trainers which I'm surprised has not been considered by DRE Central. I fear that some good and well-meaning people in the NTT will be set up to fail due to poor preparation for a very complex task and lack of knowledgeable support and skilled mentoring on RECC. Furthermore, it will undermine the excellent efforts of the current RECC Trainers out there who are working extremely hard to implement RECC to a high standard.

I note that the NTT's Train the Trainer programme makes usage of the publicity information for our programme which has led to many people thinking that the two programmes are one and the same – we have had to answer several queries lately of this nature at Ferns Associates. This feels like an attempt by DRE to take advantage of our programme's good reputation.

Quantity over quality

Melba's impressive estimate of over 1300 RECC Trainers may sound good but it is the issue of quality I was raising in my article not quantity. Bureaucratic, tokenistic and narrow technical approaches to RECC implementation totally misses the point of carefully nurturing genuinely equal MH practitioner and BME service user / carer co-training partnerships in the RECC roll-out. This is a complex skill for all to learn and is a central part of the Ferns Associates RECC T4T – co-training barely features at all in the NTT approach to training trainers. Ensuring BME service users are free to develop their own particular style of training is vital or else their contribution in training will be devalued. Having only 2 out of 17 trainers in a National Team is not a 'pass mark' for genuine BME service user participation I'm afraid.

Conclusion

Several questions remain unanswered and could be usefully discussed at the forthcoming DRE Conference in March:

- What is the justification to adapt the RECC materials and develop an alternative training for trainers when both these were well evaluated by CSIP/NIMHE and DRE?
- How will the mistakes that have been made in the design of NTT be rectified before further damage is done to the credibility of RECC?
- How will the threats to quality of RECC training posed by fragmented and confused materials and ill-prepared NTT trainers be addressed?
- How will the confusion caused by having two RECC training for trainers programmes and two sets of materials be resolved?
- Why has it taken two years, since having the original RECC materials, to get a national strategy for RECC implementation?

The whole RECC issue raises several wider concerns regarding DRE and its lack of sufficient transparency and accountability to its stakeholders. Indeed, from its inception BME service users and others, including myself, have argued for genuine service user and carer participation in the development and implementation of DRE. It has taken three years to reach the point of establishing some kind of infrastructure to even grow this participation process with Julie J Charles' Ambassadors' Programme. A difficult task now faces them in relation to DRE as the time limits are so tight now before the funding for DRE will no doubt be drastically reduced at the end of its five year period. Truly participative leadership of DRE from the start would have produced richer, more effective and sustainable results, where the social process of DRE would have been as important as the results. At present decisions still appear to be made 'behind closed doors' and neither the internal or external stakeholders of DRE seem to have any great influence on what is happening.

Melba ends her piece with a comment about 'choice' between the two Training for Trainers Programmes with her 'money' being on the DRE version. I must remind her that it is public money that is being 'gambled' here and as such DRE Central has to justify their decisions. Rather than gamble with this issue it would be better to stick with a tried and trusted approach to RECC and keep our 'eyes on the prize' of better services for BME people.

For further information about our RECC Training for Trainers, Practitioners and Team Leaders please visit our website on:

www.fernsassociates.co.uk

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