To what extent does Sussex Recovery College reflect its community? 
An equalities and diversity audit 

Sara Meddings, Lucy Walsh, Louise Patmore, Katie Louise Emily McKenzie and Sophie Holmes 

Abstract 

Purpose – The purpose of this paper is to explore whether one Recovery College reflects its community. 
Design/methodology/approach – Recovery College students’ demographics and protected characteristics were compared with the general population and the population of people using local mental health services. 
Findings – Recovery College students were representative of the local community in terms of ethnicity, religion or belief and sexual orientation. Fewer Recovery College students were over 60 years old or men. 
Practical implications – Recovery Colleges may be more accessible to people who are often under-served and under-represented in mainstream mental health services, including people from BAME backgrounds and people who identify as LGBT. Recovery Colleges may need to engage more men and more older people. 
Originality/value – This is the first study to explore who accesses Recovery Colleges and whether they are inclusive and open to all. 
Keywords Education, Mental health, Recovery, Diversity, Equalities, Recovery College 

Ten years on from the development of the first Recovery Colleges there are now Recovery Colleges in 22 countries internationally (King and Meddings, 2009) with over 80 in the UK alone (Anfossi, 2017). One of the defining features of Recovery Colleges is “They are inclusive and open to all” (Perkins et al., 2018, p. 31). 

The Public Sector Equality duty means organisations must eliminate discrimination and harassment, advance equality of opportunity and foster good relations between people with protected characteristics and other people (Equality and Human Rights Commission, n.d.). Promoting equality and addressing health inequalities are at the core of NHS England’s values (NHS England, 2019). 

People with protected characteristics access services less and report poorer experiences of services. The National Institute for Mental Health in England (2003) highlights institutional racism within healthcare. People from BAME communities experience difficulties accessing mental health services and are under-represented in primary care, psychological and community services. Black men, in particular, are over-represented at the harder end of mental health services such as compulsory treatment and the criminal justice system (Fitzpatrick et al., 2014). People from BAME backgrounds who use services are also under-represented in service user involvement (Kalathil, 2011). Fewer older people are referred to mental health services and ageism is a problem in the NHS (RCPsych, 2018). The UK population is ageing; the number of people aged 65 or over rose by nearly half in the past 30 years (Mental Health Foundation, 2019), particularly relevant for future planning. LGBT people also use mainstream mental health services less, experiencing them as less accessible and less positive when they do use them (Browne and Lim, 2008). Both increased mental distress and barriers to 

The authors would like to thank Amanda Woodham, Tina Lee, Sylvee Barr, Karen Swain, Paul Neale and members of the Recovery College Innovations group. 

Sara Meddings is based at Psychology and Psychological Therapies, Sussex Partnership NHS Foundation Trust, Sussex, UK; and ImROC, Nottingham, UK. 
Lucy Walsh is based at Brighton and Hove Recovery College, Southdown Housing Association, Brighton and Hove, UK 
Louise Patmore and Katie Louise Emily McKenzie are both based at Sussex Recovery College, Sussex Partnership NHS Foundation Trust, Sussex, UK. 
Sophie Holmes is based at Psychology and Psychological Therapies, Sussex Partnership NHS Foundation Trust, Sussex, UK.
accessing treatment are associated with experience of discrimination against LGBT people (Nodin et al., 2015), racism (Fitzpatrick et al., 2014) and ageism (RCPsych, 2018).

Recovery Colleges aim to reflect the mental health needs of their communities and include the lived experience of those in the community in their development and delivery. The auditing of Recovery Colleges is arguably vital to assess if they are truly representative and inclusive.

Sussex Recovery College is inclusive of those experiencing mental health challenges, staff and carers. We have previously reported that 60 per cent students are using secondary care, 18 per cent primary care, 11 per cent are relatives or carers and 16 per cent staff (Meddings et al., 2014). Recovery College students using mental health services had similar HoNOS scores to the Trust population overall. Fewer students had mild/moderate mental health challenges (8 per cent students vs 25 per cent Trust population); more had severe and complex non-psychosis (52 per cent vs 25 per cent) and similar numbers experienced psychosis (39 per cent vs 43 per cent) (Bourne et al., 2018).

Sussex Recovery College operates campuses across East Sussex, Brighton and Hove and West Sussex, serving a population of 1.6 million, with areas of high rural and urban deprivation and areas of wealth. It is committed to inclusion of people across the community. The aim of this audit is to explore whether different groups of people are accessing the college equitably, and whether Recovery College students are representative of the local population and those using mental health services.

This is the first published paper to focus on whether Recovery Colleges are inclusive and open to all.

Method
Students’ demographics and protected characteristics were collected from the Recovery College registration form: age, disability, gender, gender identity, ethnicity, religion or belief and sexual orientation. Further information about disabilities was obtained from the reasonable adjustments section.

Local population data were obtained from the 2011 census: gender, ethnicity, religion or belief, age (Office of National Statistics, 2011). Data not collected by the census was obtained from other official sources: sexual orientation (Brighton and Hove City Council, 2014; West Sussex County Council, 2018), gender identity (Sussex Police, n.d.) and disability (Department for Work and Pensions, 2018).

Data about adults using Sussex Partnership NHS Trust secondary mental health services were obtained from the Trust Clinical Care Intelligence Team.

Descriptive statistics were produced. Recovery College students, people using mental health services and the general population were compared using $\chi^2$ goodness of fit.

Findings
Detailed findings and statistics can be seen in Table I.

Age
There were significant differences in the ages of people accessing the Recovery College compared with the general population ($\chi^2 = 639.7, p < 0.001$). Most Recovery College students were 31–60 years old. Fewer people aged over 60 years old accessed the Recovery College than would be expected if it were representative of the general population (12.3 per cent vs 31.9 per cent) and fewer 16–20 year olds (2.9 per cent vs 7.1 per cent).

Compared with people using mental health services, fewer Recovery College students were over 70 years old (3.4 vs 25.9 per cent) ($\chi^2 = 733.6, p < 0.001$). There were fewer people aged 16–21 and more over 70 years old (25.9 per cent) accessing mental health services than the general population (17.5) ($\chi^2 = 1,013.9, p < 0.001$).
All campuses had fewer people over 70 years old than the general population. Brighton and Hove also had fewer younger students aged 16–20 (0.9 per cent) than the general population (8.8 per cent).

**Gender**

There were significant differences between the gender of people accessing the Recovery College and the general population or people using mental health services.

---

**Table I.** Demographic statistics for Sussex Recovery College, the NHS Trust and general population

<table>
<thead>
<tr>
<th></th>
<th>RC group</th>
<th>Trust group</th>
<th>Sussex general population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Valid %</td>
<td>N</td>
</tr>
<tr>
<td><strong>Gender</strong>&lt;sup&gt;b,c,d&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1,060</td>
<td>36.3</td>
<td>5,133</td>
</tr>
<tr>
<td>Female</td>
<td>1,860</td>
<td>63.7</td>
<td>6,998</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>4</td>
<td>0.1</td>
<td></td>
</tr>
<tr>
<td>Undefined/missing</td>
<td>152</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (adults only)&lt;sup&gt;b,c,d&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16–20</td>
<td>74</td>
<td>2.9</td>
<td>236</td>
</tr>
<tr>
<td>21–30</td>
<td>434</td>
<td>16.9</td>
<td>1,565</td>
</tr>
<tr>
<td>31–40</td>
<td>514</td>
<td>20.1</td>
<td>1,820</td>
</tr>
<tr>
<td>41–50</td>
<td>645</td>
<td>25.2</td>
<td>2,348</td>
</tr>
<tr>
<td>51–60</td>
<td>581</td>
<td>22.7</td>
<td>1,839</td>
</tr>
<tr>
<td>61–70</td>
<td>227</td>
<td>8.9</td>
<td>1,233</td>
</tr>
<tr>
<td>71+</td>
<td>88</td>
<td>3.4</td>
<td>3,166</td>
</tr>
<tr>
<td>Undefined/missing</td>
<td>230</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ethnicity</strong>&lt;sup&gt;c,d&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White (British)</td>
<td>2,258</td>
<td>86.8</td>
<td>9,507</td>
</tr>
<tr>
<td>White (Irish, Other)</td>
<td>171</td>
<td>6.6</td>
<td>539</td>
</tr>
<tr>
<td>Black or Black British (African, Caribbean, Other)</td>
<td>51</td>
<td>2.0</td>
<td>119</td>
</tr>
<tr>
<td>Asian or Asian British (Bangladeshi, Pakistani, Other)</td>
<td>33</td>
<td>1.3</td>
<td>118</td>
</tr>
<tr>
<td>Mixed (White and Asian, Black African, Black Caribbean, Other)</td>
<td>57</td>
<td>2.2</td>
<td>174</td>
</tr>
<tr>
<td>Other Ethnic groups (Chinese, Other)</td>
<td>32</td>
<td>1.2</td>
<td>101</td>
</tr>
<tr>
<td>Not known/missing</td>
<td>254</td>
<td>1,576</td>
<td></td>
</tr>
<tr>
<td><strong>Religion</strong>&lt;sup&gt;c,d&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christian</td>
<td>1,000</td>
<td>47.3</td>
<td>4,212</td>
</tr>
<tr>
<td>Jewish</td>
<td>16</td>
<td>0.8</td>
<td>31</td>
</tr>
<tr>
<td>Muslim</td>
<td>24</td>
<td>1.1</td>
<td>65</td>
</tr>
<tr>
<td>Buddhist</td>
<td>74</td>
<td>3.5</td>
<td>54</td>
</tr>
<tr>
<td>Spiritualist</td>
<td>64</td>
<td>3</td>
<td>35</td>
</tr>
<tr>
<td>Any other&lt;sup&gt;a&lt;/sup&gt;</td>
<td>214</td>
<td>10.1</td>
<td>473</td>
</tr>
<tr>
<td>Atheist/no religion</td>
<td>458</td>
<td>21.6</td>
<td>358</td>
</tr>
<tr>
<td>Not stated or known</td>
<td>266</td>
<td>12.6</td>
<td>7,194</td>
</tr>
<tr>
<td><strong>Sexual Orientation</strong>&lt;sup&gt;c,d&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heterosexual</td>
<td>2,192</td>
<td>88.9</td>
<td>2,109</td>
</tr>
<tr>
<td>Lesbian</td>
<td>84</td>
<td>3.4</td>
<td>23</td>
</tr>
<tr>
<td>Gay</td>
<td>82</td>
<td>3.3</td>
<td>23</td>
</tr>
<tr>
<td>Bi-sexual</td>
<td>108</td>
<td>4.4</td>
<td>24</td>
</tr>
<tr>
<td>Undecided</td>
<td>96</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>156</td>
<td>171</td>
<td></td>
</tr>
<tr>
<td>Not known</td>
<td>1,231</td>
<td>9,776</td>
<td></td>
</tr>
<tr>
<td>Transgender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>23</td>
<td>0.8</td>
<td>76</td>
</tr>
<tr>
<td>No</td>
<td>2,701</td>
<td>92.5</td>
<td>1,348</td>
</tr>
<tr>
<td>Disability&lt;sup&gt;b,c,d&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2,701</td>
<td>92.5</td>
<td>1,348</td>
</tr>
<tr>
<td>No</td>
<td>220</td>
<td>7.5</td>
<td>10,786</td>
</tr>
</tbody>
</table>

**Notes:**

- Categories with small numbers of participants were collapsed.
- Significant difference between Recovery College and general populations (<p < 0.001).
- Significant difference between Recovery College and Trust populations (<p < 0.001).
- Significant difference between Trust and general populations (<p < 0.001)
More women and fewer men accessed the Recovery College than would be expected from the general population (63.7 per cent students vs 51.4 per cent general population are women) ($\chi^2 = 188.4, p < 0.001$).

More women than men also accessed mental health services (57.7 per cent) ($\chi^2 = 366.3, p < 0.001$). Significantly more women accessed the Recovery College than would be expected from the numbers using mental health services ($\chi^2 = 564.4, p < 0.001$).

The ratio of female and male students was similar across the three campuses.

**Ethnicity**

There were no significant differences in the ethnicity of Recovery College students and the general population.

The majority of Recovery College students (86.8 per cent) and the general population (87.6 per cent) were white British. People from BAME backgrounds made up 6.6 per cent Recovery College and 6.2 per cent general population.

Fewer people from BAME (4.8 per cent vs 6.1 per cent) or white other backgrounds (5.1 per cent vs 6.3 per cent) used mental health services than would be expected from the local population ($\chi^2 = 42.4, p < 0.001$). More people from BAME and white other backgrounds accessed the Recovery College than the mental health service ($\chi^2 = 30.0, p < 0.001$).

When looked at separately, all campuses were representative of the local population in terms of ethnicity.

**Religion or belief**

Recovery College students reflected the general population regarding religious beliefs.

Recovery College students most commonly described themselves as Christian (47.3 per cent), 18.5 per cent reported another religion and 21.6 per cent no religion.

Recovery College students were significantly different from those accessing mental health services as a whole. More people using services described themselves as Christians and fewer no religion than the general population ($\chi^2 = 2,303.1, p < 0.001$) or Recovery College ($\chi^2 = 1,094.6, p < 0.001$).

**LGBT – sexual orientation**

The Recovery College reaches representative numbers of LGB people. There were no significant differences in proportions of LGB people at the Recovery College and general population.

The majority of Recovery College students were heterosexual (88.9 per cent); 11.1 per cent students were LGB: lesbian (3.4 per cent), gay (3.3 per cent) or bisexual (4.4 per cent). This is consistent with 11 per cent of the general population in Sussex.

Fewer people accessing mental health services overall said they were LGB (1 per cent) than would be expected from the general population ($\chi^2 = 135.0, p < 0.001$). This is significantly different from the Recovery College ($\chi^2 = 574.5, p < 0.001$).

More students identified as lesbian, gay or bisexual who attended Brighton campus (20 per cent) than East (8.2 per cent) or West Sussex (7.9 per cent) mostly reflecting differences in their populations.

A high number of people did not give their sexual orientation – 41 per cent Recovery College students and 81 per cent people using mental health services.

**People who identify as transgendered**

The Recovery College reached representative numbers of people who identify as transgendered.

Of Recovery College students, 0.8 per cent identified as transgendered.
Fewer people using Trust mental health services said they were transgendered or selected a gender of “other” (0.1 per cent) compared with the general population ($\chi^2 = 116.6, p < 0.001$) or Recovery College ($\chi^2 = 853.5, p < 0.00001$).

The majority of students who identified as transgendered attended Brighton campus.

Disability

The majority of Recovery College students shared that they had a disability (92.5 per cent). Of these, 69.4 per cent said they had a disability relating to mental health and 23.1 per cent another type of disability such as a learning disability or dyslexia (6.9 per cent), sensory disability (4.5 per cent), mobility issues (3.6 per cent), autistic spectrum (2.4 per cent) or unseen illness (6.4 per cent).

Even when only non-mental health-related disabilities were included, more Recovery College students (23.1 per cent) reported a disability than the general population (19 per cent) ($\chi^2 = 8.3, p < 0.01$).

Mental health services as a whole reached fewer people with disabilities (11.1 per cent) than either the Recovery College ($\chi^2 = 376.5, p < 0.001$) or general population ($\chi^2 = 490.9, p < 0.001$).

More students said they had a disability in East and West Sussex than Brighton.

Discussion

Sussex Recovery College is representative of the general population in terms of ethnicity, religion or belief, gender identity and sexual orientation. It is accessible to people who are often under-represented and under-served such as people from BAME backgrounds or who identify as LGBT. Furthermore, the Recovery College is reaching more people from BAME backgrounds, people who identify as LGBT and people with disabilities than mental health services generally. The Recovery College is reaching people with moderate to severe mental health challenges including psychosis. Nevertheless, older people and men are under-represented.

East and West Sussex have a particularly large older adult population. In this age group over 25 per cent of people are affected by depression, rising to 40 per cent in care homes (Age UK, 2016) yet far fewer older people are referred to mental health services and there are high unmet needs (RCPsych, 2018). “Ageism remains a major problem in the National Health Service and discrimination may have been exacerbated by generic services for adults of all ages” (RCPsych, 2018, p. 1).

Older people are also under-represented in adult education (Department for Education, 2017). The Recovery College intends to be open to all and does not exclude older people, however it is not reaching representative numbers of older people. Attention needs to be paid to ensure people are not indirectly discriminated against. Erroneously, public attitudes are that it is normal for older people to be depressed, older people find it difficult to learn new skills and forgetfulness is part of older age (RSPH, 2018). People also think older people are less likely to recover (You Gov, 2018). These attitudes may mean that fewer older people are signposted to the Recovery College.

Older people are more likely to have two or more long-term conditions and are therefore more likely to be socially isolated and experience economic deprivation. A total of 10 per cent people over 65 are frail (NHS England, 2016, cited by RCPsych, 2018) and may need additional help to attend classes. Older people are also more likely to be carers (Smith et al., 2014) so courses open to people and those they care about may be valuable, as well as considering times when carers may be more able to get respite to attend. Recovery Colleges are especially important given the importance of social networks and that the mental health of “older people” is impacted by discrimination, meaningful activities and relationships (Age Concern and The Mental Health Foundation, 2006).

Courses are being co-produced about dementia and some courses are specifically for people and their carers together. We are working with older people, their families and specialist services to explore what they would value, such as courses on mental and physical wellbeing or confidence in taking control of social care needs using direct payments. There may be benefit in
recruiting more older trainers and improving publicity for older people. Sensory and mobility issues need to be considered when choosing venues and older people might benefit from buddies or other reasonable adjustments both in class and in order to travel to class. We can learn from CNWL’s Recovery and Wellbeing College in Practice where more older people used classes held in GP practices (Cable and Tutton, 2018).

Men are also under-represented at the Recovery College. They are also less likely to seek help from GP or mental health services (Galdas et al., 2005) and less likely to attend adult education (Department for Education, 2017). Yet men are more likely to take their own lives, more likely to become homeless or use alcohol or drugs and more likely to be compulsorily admitted to psychiatric hospital than women. Cultural conceptions of masculinity may reduce help-seeking, for example, the need to appear strong and in control, not needing help or expressing anxieties (Courtenay, 2000). Men are more likely to seek help if a concern is normalised as something many men would experience (Addis and Mahalik, 2003). Robertson et al. (2015) summarise how to be effective in mental health work with men: the focus should be strengths-based and solution-focused, using male friendly language such as “activity”, “goals” and “regaining control”; male friendly spaces such as sports or workplace settings; sports-based or shared activities as a way in to talking; co-production, peers and hearing other people’s stories of mental distress and steps towards recovery. Recovery Colleges could be well placed to provide a service to men experiencing mental health issues.

One campus has started to address the under-representation of male students by trialling men only courses. It provides a “Men in the Wilderness” course which engages male students, creating a space to openly discuss their mental health. Elsewhere in Sussex men have engaged more with clinically focussed courses such as suicide prevention. More men have also attended courses taught by men. The College is reviewing which courses have engaged more men, the language used to describe them and the venues where they were held.

All Sussex Recovery College campuses are building on and developing partnerships with organisations in the community that represent marginalised groups. For example, we addressed under-representation of LGBT people by working with MindOUT who also ran courses particularly aimed at LGBT people. The college is promoted at BAME engagement events. Similarly, working with older people and men and groups that support them may support their inclusion. Attention has been paid to representative images in the prospectus of people from BAME backgrounds and now similar attention needs to be paid to ensure older people and men are visible in the prospectus and on the website.

Sussex Recovery College provides materials in Easyread format and additional languages. It is one of the few Recovery Colleges to have a Buddy Project to assist with reasonable adjustments, where volunteers support other students to travel to and attend classes. The college may benefit from a more diverse group of buddies including those who are older or men.

Older people, BAME, LGBT and disabled people experience multiple disadvantage and discrimination relating to mental health and historically socially excluded identities. It is important to consider the intersectionality of gender, age, disability, BAME and LGBT identities and how systems of privilege and oppression intersect (Bowleg, 2012). The experience of black gay men accessing the Recovery College might be different from white heterosexual men or black women. It may differ for older women compared with older men and older people from BAME backgrounds.

To harness the benefits of Recovery College for under-represented communities it is important to understand and build relationships with those communities, to include members in employment, co-production and service development and to develop courses that they want. Staff may benefit from equalities training. The majority of Recovery College staff are women under 60 years old. There would be benefits to employing more men and older staff.

Caveats

Missing data make it difficult to draw conclusions. A large number of people did not give their sexual orientation. Caution should be applied in drawing conclusions about how well the
Recovery College or mental health services reach LGBT populations. This may be a finding in itself as people may feel reluctant to share this information.

Further research and audit might look at whether the outcomes shown by Recovery Colleges are equally positive for people with protected characteristics and at the intersectionality of students attending Recovery College. For example, we need to investigate whether the College seems accessible to black gay men or older lesbian women and whether they have similar outcomes to other students.

The College studied here is based in a largely white British context and it would be useful to repeat this audit in colleges with higher BAME populations.

**Implications**

Recovery Colleges need to reach out to people over 70 by specifically promoting the college for older people, using language such as wellbeing, ensuring venues are accessible, providing reasonable adjustments and support, and working with older people, their carers and staff working in specialist older people’s services to co-produce courses which might particularly benefit them.

Recovery Colleges could engage more men by paying attention to language, using venues accessible to men, considering the gender of trainers and ensuring promotional materials reflect the population they serve.

We must not be complacent about Recovery Colleges’ accessibility to those who identify as LGBT and people from BAME backgrounds. We must ensure the emphasis on reaching older people and men does not lead to poorer access to other groups of people who are historically socially excluded, under-represented and under-served.

In conclusion, Sussex Recovery College reflects its community in terms of ethnicity, religion or belief and sexual orientation and is taking actions to engage more male and older students. The college is also inclusive of people with a range of mental health challenges and to carers and staff. Recovery Colleges aim to be inclusive and open to all but care needs to be taken to ensure that this is a reality in practice.

**Note**

Post script – data from the most recent Recovery College terms (Spring and Summer 2019) shows that more men and older people are already registering with and attending the college since we have started to address their access and representation.

**References**


Perkins, R., Meddings, S., Williams, S. and Repper, J. (2018), Recovery Colleges: Ten Years on, ImROCs, Nottingham.

RCPsych (2018), Suffering in Silence: Age Inequality in Older People’s Mental Health Care, College Report CR221, Royal College of Psychiatry.


About the authors

Sara Meddings is Psychology and Psychological Therapies Consultant Lead for recovery and wellbeing at Sussex Partnership NHS Foundation Trust. She is also a Consultant with ImROC. Sara Meddings is the corresponding author and can be contacted at: sara.meddings@sussexpartnership.nhs.uk

Lucy Walsh is Volunteer and Student Union Lead at Brighton and Hove Recovery College and Southdown Housing Association.

Louise Patmore is Lead Peer Trainer with Sussex Recovery College and Patient Lead at Sussex Partnership.

Katie Louise Emily McKenzie is Psychology Graduate Volunteer at Sussex Recovery College.

Sophie Holmes is Professional Lead for Psychology and Psychological Therapies at Sussex Partnership.

For instructions on how to order reprints of this article, please visit our website:
www.emergalgrouppublishing.com/licensing/reprints.htm
Or contact us for further details: permissions@emeraldinsight.com