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Ethno-Racial Variation in Recovery from Severe Mental Illness: A Qualitative Comparison

Variation ethno-raciale dans le rétablissement d'une maladie mentale grave : une comparaison qualitative

Rob Whitley, PhD[1]

Abstract

Objective: Purpose-driven studies examining the relationship between ethnicity, culture, and recovery are absent from the empirical literature. As such, the overall aim of this study was to examine ethno-racial variations in recovery perspectives. Specific objectives consist of comparing and contrasting ethno-racial variations in 1) definitions of recovery, 2) barriers to recovery, and 3) facilitators of recovery.

Methods: We recruited people with severe mental illness from 2 broad ethno-racial groups (Caribbean-Canadian and Euro-Canadian) to partake in a qualitative interview on recovery ($n = 47$). Participants were asked to give their own definitions of recovery, as well as self-perceived barriers and facilitators. Interview transcripts were then subjected to thematic analysis. We compared and contrasted the distribution and salience of emerging themes between the Euro-Canadian and Caribbean-Canadian participants.

Results: Recovery was consistently defined as a gradual process involving progress in key life domains including employment, social engagement, and community participation by both groups. This was underpinned by a growing future orientation. Stigma, financial strain, and psychiatric hospitalization were considered major barriers to recovery in both groups. Participants from both groups generally considered stated definitions of recovery to be simultaneous facilitators of recovery—employment and social engagement being the most frequently mentioned. God and religion were key facilitators for the Caribbean-Canadian group but not for Euro-Canadians.

Conclusions: Definitions, barriers, and facilitators to recovery were generally shared among our sample, regardless of ethno-racial status, with the exception of God and religion.

Abrégé

Objectif : Les études axées sur les buts qui examinent la relation entre ethnicité, culture et rétablissement sont absentes de la littérature empirique. À ce titre, le but général de cette étude était d'examiner les variations ethno-raciales dans les perspectives de rétablissement. Les objectifs spécifiques consistent à comparer et à contraster les variations ethno-raciales dans (i) les définitions du rétablissement; (ii) les obstacles au rétablissement; et (iii) les facilitateurs du rétablissement.

Méthodes : Nous avons recruté des personnes souffrant de maladie mentale grave dans deux larges groupes ethno-raciaux (caribéen canadien et euro-canadien) pour participer à une entrevue qualitative sur le rétablissement (n = 47). On a demandé aux participants de donner leurs propres définitions du rétablissement, ainsi que les obstacles et les facilitateurs auto-perçus. Les transcriptions des entrevues ont ensuite fait l'objet d'une analyse thématique. Nous avons comparé et contrasté la distribution et l'importance des thèmes dégagés entre les participants euro-canadiens et caribéens canadiens.

[1] Department of Psychiatry, Douglas Mental Health University Institute, McGill University, Montreal, QC, Canada

Corresponding Author:
Rob Whitley, PhD, Department of Psychiatry, Douglas Mental Health University Institute, McGill University, 6875 LaSalle Boulevard, Montreal, Quebec, Canada.
Email: robert.whitley@mcgill.ca

Résultats : Le rétablissement était régulièrement défini comme étant un processus graduel impliquant des progrès dans les principaux domaines de vie dont l'emploi, l'engagement social, et la participation communautaire par les deux groupes. Ceci était appuyé par une orientation future croissante. Les stigmates, les difficultés financières et l'hospitalisation psychiatrique étaient vus comme étant des obstacles majeurs au rétablissement dans les deux groupes. Les participants des deux groupes ont généralement considéré les définitions proposées du rétablissement, les plus souvent mentionnées étant les facilitateurs simultanés du rétablissement, l'emploi et l'engagement social. Dieu et la religion étaient un facilitateur clé pour le groupe caribéen-canadien, mais pas pour le groupe euro-canadien.

Conclusions : Les définitions, les obstacles et les facilitateurs du rétablissement étaient généralement partagés dans notre échantillon, sans égard au statut ethno-racial, à l'exception de Dieu et de la religion.

Keywords
recovery, severe mental illness, ethnicity, race, cultural psychiatry, social psychiatry, Canada, Caribbean, immigrant mental health

Clinical Implications

- Interventions and strategies that facilitate employment and reduce financial strain (for example, supported employment services) can foster recovery.
- The application of "religious competence" in the clinical encounter may assist in recovery, especially among Caribbean immigrants.
- Inpatient settings as currently configured are not perceived to be recovery-oriented, implying more research and action in this domain.

Limitations of the Study

- Only 1 immigrant group was sampled: Caribbean-Canadians.
- Many of these were second-generation immigrants or had lived in Canada for some time.
- Bias may have occurred inasmuch as this was a clinical sample relying on staff to filter participants into the study.

Introduction

There is a broad consensus across the English-speaking world that mental health interventions for people with severe mental illness should promote the renewed concept of "recovery."[1] A small amount of largely theoretical scholarship suggests that ethno-racial minorities may define, conceptualize, and experience recovery differently.[2-4] As part of a comprehensive literature review, Leamy et al noted that this small amount of literature suggests that recovery in ethno-racial minorities may be defined similarly as for the majority group, but with a greater emphasis on spirituality and stigma.[5] Other literature, mainly from the United Kingdom and the Netherlands, indicates that ethno-racial minorities, especially those of Afro-Caribbean descent, suffer from inequities within the mental health system and wider society.[6,7] These inequities may theoretically interact with cultural factors to produce variations in recovery definitions, barriers, and facilitators.

However, the empirical literature is lacking in purpose-driven comparative studies examining the relationship between ethno-racial status and recovery. This is especially the case here in Canada. As such, the overall aim of this study was to conduct purpose-driven research examining ethno-racial variations in recovery perspectives. Specific objectives consist of comparing and contrasting ethno-racial variations in 1) definitions of recovery, 2) barriers to recovery, and 3) facilitators of recovery.

Methods

Participants

We purposely recruited 47 people (23 women) living with a diagnosis of severe mental illness to partake in a qualitative in-depth interview about recovery. To provide a solid basis for comparison, we purposely sampled individuals who self-identified with one of two broad ethno-racial groups: Euro-Canadian or Caribbean-Canadian. This resulted in 28 Euro-Canadian participants (10 Anglophones, 18 Francophones). This group consisted of Canadian-born individuals of European ancestry. It also resulted in 19 Caribbean-Canadian participants (12 Anglophones, 7 Francophones). This group contained 12 first-generation and 7 second-generation immigrants from various Caribbean countries and territories. More detailed characteristics are reported in Table 1.

Procedures

We recruited participants, who self-identified as having Euro-Canadian or Caribbean-Canadian ancestry, from several Montreal psychiatric outpatient clinics. Further inclusion criteria were 1) a diagnosis of schizophrenia, major depression, schizoaffective disorder, or bipolar disorder during the last 5 years; 2) this must have lasted at least 3 years; 3) must currently be using mental health or rehabilitative services; 4) must be able to give informed consent; 5) must speak either English or French; 6) must be 18 years or older.

Clinicians identified potential participants from their clientele who fell into the study inclusion criteria. They then

Table 1. Participants demographics.

			Male		Female		Age		Single		Employed		Canadian-Born	
		n	*n*	%	*n*	%	Mean	Range	*n*	%	*n*	%	*n*	%
Euro-Canadian	Anglophone	10	5	50	5	50	45.8	27–69	5	50	2	20	9	90
	Francophone	18	7	39	11	61	40.7	20–60	18	100	0	0	18	100
	Total	28	12	43	16	57	42.5	20–69	23	82	2	7	27	96
Caribbean-Canadian	Anglophone	12	6	50	6	50	41.7	22–62	9	75	2	17	6	50
	Francophone	7	4	57	3	43	40.7	25–49	4	57	2	29	1	14
	Total	19	10	53	9	47	41.3	22–62	13	68	4	21	7	37
Total		47	22	47	25	53	42	22–69	36	77	6	13	34	72

asked the potential participants if they would consider participating in a research interview on recovery. Names of those assenting were then passed to the research team, who contacted the potential participants. After complete explanation of the study to the participants, they were asked if they would like to participate. Those answering yes gave written informed consent. Consent forms and study protocol were approved by the McGill University Faculty of Medicine Research Ethics Board.

All participants partook in a semi-structured interview at a time and place of their choosing, including their homes, hospitals, and day treatment centres. Participants also chose the preferred language of their interview (English or French). Two bilingual graduate students conducted all of the interviews—one of European ancestry and the other Afro-Caribbean ancestry. They used a short topic guide created by the author. Core questions on this topic guide included, "What does the term *recovery* mean to you?" "What are the main barriers to your recovery?" and "What is helping your recovery?" The interviews built on these questions to explore the whole topic of recovery, with the interviewers probing participants for examples to general assertions made. Interviews typically lasted from 60 to 120 minutes. Participants were compensated $20 for their time. All interviews were audio-recorded and transcribed, with transcriptions imported into Atlas-ti software. All data were collected between 2011 and 2013.

Analysis

Analysis was propelled by the thematic analysis approach.[8] This involves a series of steps starting with total immersion in the data, followed by the creation of specific codes that can then be collapsed into meaningful themes. As such, the author listened to sound recordings of the interviews and read the transcripts. In collaboration with the graduate students, the author developed a grounded framework containing 3 superordinate codes: 1) definitions, 2) barriers, and 3) facilitators. Focused subcodes were created within each superordinate code. The graduate students then coded each interview with this framework in Atlas-ti. At the end of this process, the codes were examined for similarity, overlap, difference, redundancy, and prominence. Related codes were subsequently collapsed into broader themes representing key definitions, barriers, and facilitators. We then compared and contrasted the broad pattern of distribution and salience between Caribbean-Canadians and European-Canadians, paying attention to any subgroup differences between Francophones and Anglophones in both groups. Transcripts were analyzed in their original language; French language data presented in the results were translated by the author.

Standard procedure in qualitative research is to identify broad patterns in the data rather than exact frequency counts.[8] Frequency counts would be misleading, as a few individuals repeatedly mentioning the same factor can inflate the code count for the said factor. As such, representative quotes, rather than frequency counts, are given to support assertions made.

Results

The results are divided into 3 sections. These sections describe 1) definitions of recovery, 2) perceived barriers toward recovery, and 3) perceived facilitators of recovery. Within each section, commonalities across ethno-racial groups are discussed, as are any divergences.

Definitions

Participants defined recovery in terms of conducting everyday normative activities such as work, socializing, and being active in the community. This was summed up by a 46-year-old Anglo-European man who stated: "Recovery means getting your ass out of bed and go do stuff . . . positive stuff, you get out, have a life like everybody else. . . . Go to a job . . . be happy with the road your life is going." Such sentiments were echoed by participants from all the ethno-racial groups sampled. For example, a 40-year-old Franco-Caribbean woman noted that "recovery means being able to lead a productive life, being able to work, kind of being resilient." Similarly, a 61-year-old Anglo-Caribbean woman noted that "recovery means getting out there and do things. . . . It could be an exercise program. It could be working also. It could be going to the library. It could be going swimming. It could be talking to friends." A 31-year-old Anglo-Caribbean woman noted that "recovery . . . is just getting back to being who you

usually are on your regular day-to-day basis. Getting back into routine." The importance of routine, regularity, and everyday activities was stated across all ethno-racial groups, with no between-group differences.

Another important commonality across the ethno-racial groups was the belief that a strong future orientation was an essential component of recovery. A 52-year-old Anglo-European man defined recovery as "having plans and goals that are gonna make them happy, that are going to make them prosper and make them happier." Such a sentiment was repeated by other participants. For example, a 42-year-old Anglo-Caribbean woman noted that recovery "means having targets, goals and objectives. Achieving them. Having an action plan, having priorities, directionality, short-term goals, long-term goals . . . and being able to achieve them." A 22-year-old Franco-European woman stated:

> Recovery means that you had a period when you were not able to function. . . . You couldn't do very much. . . . And recovery is very gradual . . . gradually getting back the life you want, to all your dreams and goals, but very gradually, so you start a bit at school, then you start working and stuff like that.

Indeed, the notion that recovery was a gradual process, involving effort, action, momentum, and time, was also shared across participants from the various ethno-racial groups. A 57-year-old Anglo-European man noted that recovery involved "going uphill, making progress. . . . Progress may be hard at first, but you have to be proud of yourself." This was echoed by a 25-year-old Anglo-Caribbean woman who noted that "time helped me a lot. Time helped me get from plan A to plan B. Oh Lord, how much praises I could do for that! It takes patience to end up somewhere. . . . When you really want something . . . it takes time."

Participants from all ethno-racial groups frequently noted behaviors or attitudes that were considered inconsistent with their notions of recovery. This included remaining home all day or being psychologically withdrawn. For example, a 25-year-old Franco-Caribbean man noted that "when I fell ill, I was very lazy and couldn't do anything. . . . I could not drive my car. I could not go the gym. . . . But now I can do virtually anything, and that is a big change." This was echoed by a 60-year-old Franco-European man who stated that recovery is "not feeling rejected or staying all alone in your cave, but leave your cave to go and speak to and meet other people." Likewise, a 37-year-old Anglo-European man noted,

> Rather than be home alone and in the hamster cage—the hamster go. I just find it more interesting to get out of the house and be around people and spend time. It's an escape for a couple hours every day when I go.

There were no obvious differences between the ethno-racial groups in their definitions and conceptualizations of recovery.

Barriers

Participants from both ethno-racial groups reported 1 overwhelming barrier to recovery: stigma. Participants reported that such stigma manifested itself in every layer of social life, including in interactions with family, friends, clinicians, potential employers, and the general public. Caribbean-Canadian participants were acutely aware of the common misunderstandings of mental illness. For example, a 25-year-old Franco-Caribbean man noted:

> People, they have fear. . . . They think, "That man there, he is crazy. He could kill us!" They think, "He is not like us!" They think you are lower than them. If I say to some, "Yes, I am schizophrenic," for sure they are going to have another idea of me. I am scared of saying that to people. I do not want them to judge me.

This was echoed by a 37-year-old Franco-Caribbean man who stated that "you cannot say to anybody that you are schizophrenic. There are many women who will have a lot of fear. That was an obstacle [to recovery], not everybody understands schizophrenia. They judge that illness."

Again, these sentiments were echoed across the ethno-racial groups. A 45-year-old Anglo-Caribbean man noted that "people said I never should have had kids. And I told them, 'Others have told me that.'" Importantly, stigma negatively affected the quality and quantity of social interaction, which, as outlined previously, was considered essential for recovery. For example, a 34-year-old Anglo-Caribbean woman noted:

> Some of my friends, they stopped inviting me to go out. . . . I have 2 girlfriends that I am really close with, and it would always be the 3 of us. . . . They stopped inviting me to go out . . . because I would hear from other people, "Hey, I saw them out! I was wondering where you were?" and I was like, "Oh really?"

Interestingly, such stigma was equally noted as the most important barrier to recovery among Euro-Canadian participants. For example, a 46-year-old Anglo-European man noted that "there is a lot of discrimination against mentally ill people. I get on the bus, [and] people look at me strange like I am some kind of weirdo!" A 52-year-old Anglo-European man stated:

> People do judge you. They say. "Look at that nut! Look at him! Injections! Shock therapy! This and that! He's a fucking nut. He belongs, wherever!" Because you are a schizophrenic, they think you are a lunatic . . . somebody that's locked up in a hospital or something, or you should be locked up or something.

Such stigma was seen as a particular barrier to employment, again negatively affecting what was widely considered by participants as an essential component of recovery. For example, a 20-year-old Franco European woman noted:

> Mental illness is very, very badly viewed. . . . If someone knows you have a mental illness, it is like, "Stay away! Stay in your little corner!" Ninety percent of people with a mental health problem have a lot of difficulty finding employment. . . . If you say to people you have a mental illness, forget it. You will lose everything.

A 58-year-old Franco-European woman talked about her unwillingness to disclose the fact that she has a mental illness, a common thread throughout the data set, stating:

> I would not say it to people I do not know. Above all, I would not say it to an employer during an interview—never! Because I know the general opinion out there. . . . People, they look at you differently all of a sudden. . . . There is still a lot of stigma. There is a way to go.

Others stated that clinicians and even family members often manifested stigmatizing attitudes and behavior. A 29-year-old Franco-European woman talked about mental health services received: "I wish people would stop talking to me like I am a baby! That would be good. Some people talk to me like I am 15 years old!" A 61-year-old Anglo-Caribbean woman noted:

> My daughter views mental illness as something she should keep away from and avoid. . . . She is ashamed . . . so when she sees me, she will see me in places that are very, very remote—places where her friends wouldn't come.

That being said, other participants reported that clinicians and family were very helpful and a source of social support and community integration. Indeed, family was a factor with considerable heterogeneity. As such, the complexities surrounding family have been discussed in another article.[9]

Another common (although less prominent) barrier to recovery frequently mentioned by participants across the ethno-racial groups related to financial strain, perhaps due to the fact that almost 90% of the sample were on welfare. Lack of financial resources prevented participation in some of the valued recovery-promoting activities discussed in the introduction. For example, a 42-year-old Franco-European woman noted:

> The biggest barrier [to recovery] is poverty. You have to pay your rent. You have to buy your food. You eat spaghetti 3 times a day. You try to survive. It's not easy. How are you going to pay for a bus ticket to do something? Or take a course or anything? We want to socialise, but how often can we do that living like this?

A 29-year-old Franco-European woman shared these sentiments, noting that "I would like to be richer, then you have less misery. You are not obliged to wait till the 1st of the month to have your welfare cheque. You have it during the week, in place!"

Such financial strain was also acutely felt in the Caribbean-Canadian participants. For example, a 41-year-old Anglo-Caribbean man noted that "I would like to come out the house a little bit, function, socialize with people, interact. . . . I went to a rehabilitation program once. I liked it. I got to see people. But I don't have the bus fare." A 46-year-old Anglo-Caribbean man noted:

> There ain't no black person from the Caribbean who has money here. With money you would get shit done! You are here by yourself, you get it? Once you got power in that, everything goes smooth for you. . . . The more rich you get, the more respect you get.

A final barrier that emerged from the data related to hospitalization. Perhaps surprisingly, many participants from across the sample stated that they thought hospitalization had a negative effect on their recovery and overall mental health. For example, a 52-year-old Anglo-European man noted how being on a locked ward negatively affected him, stating that "it kind of depressed me even heavier to find that I'm at the door all day long and I'm not able to go beyond the door. . . . It's very depressing." A 42-year-old Franco-European woman, when asked about her experience in hospital, noted:

> I would rather not talk about it; it's too negative. They are memories that torture me and traumatise me. . . . What hurt my recovery? I will repeat again. Keeping me enclosed in that hospital! Instead of letting me take a walk!

Such attitudes were shared by participants in the Caribbean subsample. A 37-year-old Anglo-Caribbean man stated that "I just started getting bored. I just wanted to head for home. I was getting tired of the place, just walking about, just drove me crazy. . . . So anyone with a mental illness . . . try your best . . . and try to keep away from hospitals." Another Anglo-Caribbean man, 45 years old, put it more harshly, stating:

> The first time I was hospitalized, I was scared out of my mind. I was like, "Oh my God!" You lie in there at night and hear screaming, people yelling. I thought I was in hell. And I was hospitalized to get help! Each time I said, "I will never go back. I will never go back. I will never go back." It was scary. Very scary.

Facilitators

Reported facilitators of recovery considerably overlapped with the conceptualizations described in the first part of the results. In other words, participants generally considered stated indicators of recovery to simultaneously be facilitators of recovery—mutually reinforcing the recovery process. For example, employment and social engagement were 2 of the most frequently mentioned facilitators. Again, this was mentioned across the ethno-racial groups with no obvious

differences. For example, a 46-year-old Anglo-European man noted that recovery was facilitated by "getting out there, going to a job. It makes you feel good about yourself... instead of just going day by day sleeping in your bedroom looking at the 4 walls." Similarly, a 46-year-old Franco-European man noted that "I worked for one and a half years.... It gave me a kind of stability.... You can eat better, pay your rent, all that stuff." Likewise, a 37-year-old Anglo-Caribbean man noted, "Don't stay at home. That is no good. It just rocks the mind, doing nothing all day."

God and religiosity were frequently mentioned as important facilitators in the Caribbean-Canadian group but was rarely mentioned by the Euro-Canadian group. For example, a 25-year-old Anglo-Caribbean woman noted that "prayers help, because you put your belief in something and you look forward for it to work. So right there is already putting a footstep forward, and you end up somewhere." Another Anglo-Caribbean woman, 34 years old, noted:

> I will always be praying, like almost every night. I will read my bible and whatever. I have a lot of friends from church that I talk to. But he always sees me through... so most definitely I would have to say that God has helped see me through many a times.

A 40-year-old Franco-Caribbean man noted, "My religion keeps me in constant contact with God, and does not allow me to go and do bad things on the street. I must pay attention to what I do, what I eat. If you pay attention to those things, you win!" Similarly, a 25-year-old Franco-Caribbean man noted:

> I returned to the church after I fell ill. That gave me an interior peace. People came to pray with me. I think that truly helped me in my recovery. It is God that helps me day after day. It is him who gives me the strength when I am discouraged or when I am sad.... I pray, and then I feel good. I feel free. I no longer have a weight on me.

Discussion

This study reveals numerous commonalities regarding conceptualizations, barriers, and facilitators of recovery. Participants from across the groups defined recovery as attaining a level of everyday routine and normalcy associated with the general population. This centered on working, getting "out and about," as well as making and executing plans for the future. There was an acknowledgement across both groups studied that recovery was a long and sometimes slow process involving considerable effort. These perspectives overlap considerably with ones reported elsewhere in the literature.[1,10,11] Certain theoretical literature discussed in the introduction suggests that conceptualizations of recovery among minority and immigrant populations may be different from European ancestry populations.[2-4] However, a key finding of this study is that core definitions and conceptualizations of recovery were shared in this diverse sample.

The overwhelming barrier toward recovery reported in this sample was stigma, a well-studied and well-known impediment to recovery.[12-14] This appeared to negatively influence factors deemed essential for recovery progress by participants, including finding employment and social activity. Leamy et al report that stigma may be more marked in minority populations.[5] However, the results from the present study suggest that stigma was equally severe and debilitating across the ethno-racial groups.

Financial strain was considered a barrier by individuals from both the ethno-racial groups sampled. This is consistent with previous quantitative research that indicates that financial strain is predictive of worse recovery outcomes.[15] Again, lack of financial resources prevented participation in activities deemed essential to recovery, such as attending rehabilitation services.

Another common barrier was hospitalization, perhaps surprising given that hospitals are by definition intended to be places of healing and recovery. Many participants believed that hospitalization hindered their recovery. This may be related to the fact that the average length of stay in a Quebec psychiatric hospital is significantly higher than in other Canadian provinces.[16] Relatedly, a recent review indicated that there is little action or research regarding recovery in inpatient settings.[17] This is an important area for further action and research.

The only prominent factors that showed considerable variance were God and religion. These were considered very influential facilitators in the Caribbean-Canadian group but were absent from the Euro-Canadian group. This finding is consistent with literature suggesting that spirituality is often an important factor for recovery among ethno-racial minorities.[5] Such a finding is also consistent with other studies suggesting that Caribbean immigrants with mental illness often deploy religiosity as a social and functional resource.[18] Interestingly, factors such as racism, cultural competence, or linguistic issues did not emerge as significant themes within the Caribbean-Canadian groups. The facilitating effects of God and religion were the only major differences to emerge from the data set.

Clinical and Public Health Implications

The results have numerous clinical and public health implications. Interventions and strategies that facilitate employment and reduce financial strain (for example, supported employment services) can assist recovery and should be made more readily available and accessible.[19,20] Addressing macro-level factors such as stigma may be critical to facilitating recovery. The Mental Health Commission of Canada is currently sponsoring numerous evidence-based anti-stigma initiatives, which may need to be expanded.[21] The finding that hospitalization is perceived as a barrier to recovery reinforces recent calls for

the urgent development and implementation of recovery-oriented practice in inpatient settings.[17] It also suggests that the common practice of lengthy hospital stays in Quebec is incommensurable with the recovery paradigm. Finally, the findings indicate that recent calls for more "religious competence" in the clinic may assist in recovery among Caribbean immigrants.[22]

Limitations of the Study

There are numerous limitations to this study. We sampled from only 1 minority group: Caribbean-Canadians. Immigrants from other parts of the world may have given different results. Relatedly, a number of the participants were second-generation immigrants, thus growing up in Canada. Other participants had lived in Canada for an extensive period of time. More recent immigrants may have given different results. Also, we relied on staff to filter participants into the study. This may have introduced a bias inasmuch as staff may have missed or excluded certain types of patients (for example, more disenfranchised ones) who may have given different perspectives. Moreover, this was a clinical sample. Factors such as racism, cultural competence, or linguistic issues may have been reported differently by people who had dropped out of services. As a qualitative study, representative quotations are given to support assertions made, rather than frequency counts. New quantitative research with a larger sample could examine the differential distribution of barriers and facilitators through comparing responses by ethno-racial status to a purpose-built questionnaire. Such rigorous enumeration would build on the findings of the present study, which indicate broad patterns rather than precise frequencies.

Conclusion

There is a general consensus across the English-speaking world that mental health services must focus on the renewed concept of recovery.[1] The present study is one of the first to deliberately compare and contrast recovery perspectives by ethno-racial status. It found much more commonalities than differences, suggesting that barriers and facilitators to recovery were generally shared among the sample, despite diversity in ethno-racial status. This suggests that the common and all-pervading experience of severe stigmatization and serious financial strain has a levelling effect on the recovery experience of people living with a severe mental illness in Montreal, regardless of ethnicity. Common responses include a quest for employment, meaningful daytime activity, and social engagement. Mental health services that are truly recovery oriented must address these barriers and foster these facilitators.

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References

1. Slade M. Personal recovery and mental illness: a guide for mental health professionals. Cambridge (GB): Cambridge University Press; 2009.
2. Myers NL. Culture, stress and recovery from schizophrenia: lessons from the field for global mental health. Cult Med Psychiatry. 2010;34(3):500-528.
3. Adeponle A, Whitley R, Kirmayer LJ. Recovery in cultural context. In: Rudnick A, editor. Recovery of people with mental illness: philosophical and related perspectives. Oxford (UK): Oxford University Press, 2012. p 109-132.
4. Jacobson N, Farah D. Recovery through the lens of cultural diversity. Psychiatr Rehabil J. 2012;35(4):333-335.
5. Leamy M, Bird V, Le Boutillier C, et al. Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. Br J Psychiatry. 2011; 199(6): 445-452.
6. Henry F. The Caribbean diaspora in Toronto: learning to live with racism. Toronto (ON): University of Toronto Press; 1994.
7. McKenzie K, Bhui K. Institutional racism in mental health care. BMJ. 2007;334(7595):649-650.
8. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3(2):77-101.
9. Aldersey HM, Whitley R. Family influence in recovery from severe mental illness. Commun Ment Health J. 2015;51(4): 467-476.
10. Whitley R, Campbell RD. Stigma, agency and recovery amongst people with severe mental illness. Soc Sci Med. 2014;107:1-8.
11. Davidson L. Living outside mental illness: qualitative studies of recovery in schizophrenia. New York (NY): NYU Press; 2003.
12. Dinos S, Stevens S, Serfaty M, et al. Stigma: the feelings and experiences of 46 people with mental illness. Qualitative study. Br J Psychiatry. 2004;184(2):176-181.
13. Link BG, Struening EL, Neese-Todd S, et al. Stigma as a barrier to recovery: the consequences of stigma for the self-esteem of people with mental illnesses. Psychiatr Serv. 2001; 52(12):1621-1626.
14. Thornicroft GJ. Shunned: discrimination against people with mental illness. Oxford (GB): Oxford University Press; 2006.

15. Mattsson M, Topor A, Cullberg J, et al. Association between financial strain, social network and five-year recovery from first episode psychosis. Soc Psychiatry Psychiatr Epidemiol. 2008;43(12):947-952.
16. Sealy P, Whitehead PC. Forty years of deinstitutionalization of psychiatric services in Canada: an empirical assessment. Can J Psychiatry. 2004;49(4):249-257.
17. Kidd SA, McKenzie KJ, Virdee G. Mental health reform at a systems level: widening the lens on recovery-oriented care. Can J Psychiatry. 2014;59(5):243-249.
18. Whitley R, Kirmayer LJ, Groleau D. Understanding immigrants' reluctance to use mental health services: a qualitative study from Montréal. Can J Psychiatry. 2006;51(4):205-209.
19. Burns T, Catty J, Becker T, et al. The effectiveness of supported employment for people with severe mental illness: a randomised controlled trial. Lancet. 2007;370(9593):1146-1152.
20. Catty J, Lissouba P, White S, et al. Predictors of employment for people with severe mental illness: results of an international six-centre randomised controlled trial. Br J Psychiatry. 2008;192(3):224-231.
21. Stuart H, Chen SP, Christie R, et al. Opening minds in Canada: targeting change. Can J Psychiatry. 2014;59(10 Suppl 1):S13-S18.
22. Whitley R. Religious competence as cultural competence. Transcult Psychiatry. 2012;49:245-260.