Understanding how Social Businesses Influence the Stigma of Mental Illness

Judith Sabetti

School of Social Work

McGill University, Montreal

A thesis submitted to McGill University in partial fulfillment of the requirements of the degree of Doctor of Philosophy

ACKNOWLEDGEMENTS

The completion of this doctoral research project is a tribute to the dedication, guidance and support of many people at McGill University and beyond. I am grateful to Dr. Wendy Thomson, the teaching staff, and fellow graduate students at the McGill School of Social Work for a challenging and very enriching academic experience. My thanks extends most especially to the members of my doctoral committee, Dr. Lucyna M. Lach, and Dr. Myra Piat at McGill, and Dr. Terry Krupa at the Queen`s University School of Rehabilitation Therapy, for sharing unstintingly their expert knowledge and experience. I wish especially to thank Myra, who has nurtured my passion for research as my employer at the Douglas Hospital Research Centre, and who cheerfully endured many inconveniences connected with this back-to-school adventure.

My doctoral studies were also made possible thanks to essential financial support over the past five years provided by McGill University, and by a doctoral research award from the Fonds de recherche du Québec – Société et culture (FQRSC). Research and travel costs associated with fieldwork were funded by a grant from the Mental Health Commission of Canada, for which I am very appreciative. The Douglas Institute provided an environment very conducive to productive work through opportunities to participate in ongoing research activities as well as material support that included a fully equipped office and on-call IT services.

A number of individuals played a crucial role at different junctures of the research process. My erstwhile co-worker, Simon Cloutier, transcribed the French language interviews and translated the interview guides, consent forms and

recruitment materials with his usual diligence and attention to detail. Dr. Katherine Moertl, a licensed but rare Atlas.ti trainer, gave me six crucial hours of instruction on Atlas days before returning to Vienna, demystifying the program enough that I could function on my own. Michelle Savoie and Antonia Cal provided warm hospitality and friendship during the out-of-town phases of fieldwork. Dr. Franco Carnevale from the McGill School of Nursing stepped in to read my methods chapter and provide some helpful and timely advice at another decision point. My Douglas co-workers and fellow grad students, Jessica Spagnolo and Alexis Pearson, are a delight to work and commiserate with; their high spirits often sustained me. My sincere thanks also goes to our heroically patient secretary, Louise Bénard, for all her help and friendship over the years.

Finally, I am deeply indebted to my family and closest friends for giving meaning and purpose to this effort. My debt of gratitude also extends in a special way to the social business employees in this study for sharing the best of themselves through their stories, reflections and hopes. If this work can contribute in some small way to a better future for them, it will have achieved its objective.

ABSTRACT

Social businesses have been developed outside of formal mental health systems in order to improve the employment prospects of people with mental illness whose unemployment rates are the highest of all disability groups. This study aims to better understand how social businesses experience, and influence, the stigma of mental illness in employment, where stigma is thought to be operating with particular force. A comparative case study of five social businesses located in three Canadian cities was conducted. Data sources included participant observation; 44 individual and group interviews with 76 study participants; and documents. Based on a multiple-case analysis of the data using a constant comparative method, the findings describe the efforts of social business promoters to create legitimate, economically viable, and stigma-reduced workplaces where employees with mental illness may identify as capable workers and ordinary citizens. Risks for the stigma of mental illness emerged in the context of business conditions and social marketing; in connections between social businesses and the mental health system; and in the impact of public stigma, and employee self stigma, on business operations and environments. Elements that might reduce or neutralize the stigma of mental illness in employment, as well as implications for Social Work, are discussed.

RÉSUMÉ

Les entreprises sociales ont été développées à l'extérieur du système de santé mentale officiel afin d'augmenter les perspectives d'embauche des personnes avec un problème de santé mentale qui, par ailleurs, détiennent le taux de chômage le plus élevé de tous les groupes de personnes ayant un handicap. Cette étude a pour but de mieux comprendre comment ces entreprises sociales expérimentent et influencent la stigmatisation des personnes atteintes de maladies mentales où celle-ci est connue pour être particulièrement présente et bien ancrée. Une étude de cas comparative a été menée auprès de cinq entreprises sociales situées dans des villes canadiennes. Des sources de données incluaient l'observation de participants; 44 interviews individuels et de groupe avec 76 participants à l'étude; et documents. Basés sur une analyse de cas multiple des données utilisant une méthode comparative constante, les résultats décrivent les efforts des promoteurs d'entreprises sociales de créer un lieu de travail légitime et économiquement viable où la stigmatisation est réduite, et où les employés atteints de maladie mentale peuvent s'identifier comme des travaillants capables et comme des citoyens ordinaires. Les risques de stigmatisation de la maladie mentale ont émergé dans le contexte des conditions d'affaires et du marketing social; par rapport avec les entreprises sociales et le système en santé mentale, l'impact de la stigmatisation provenant du public et la stigmatisation de l'employé sur les opérations d'affaires et d'environnements. Les éléments qui pourraient réduire ou neutraliser la stigmatisation de personnes atteintes de maladie mentale ayant un emploi, aussi bien que des implications de l`étude pour le Service Social, sont discutés.

TABLE OF CONTENTS

CHAPTER 5: CASE DESCRIPTION

CHAPTER 6: BALANCING ECONOMIC AND SOCIAL OBJECTIVES

CHAPTER 7: CONNECTING WITH THE MENTAL HEALTH SYSTEM

CHAPTER 8 : BUILDING A WORKFORCE

CHAPTER 9: DISCUSSION AND CONCLUSIONS

LIST OF TABLES

LIST OF APPENDICES

CHAPTER 1: OVERVIEW OF THE STUDY

Introduction

The overall objective of this study is to better understand how Canadian social businesses experience and influence the stigma of mental illness in employment. Social businesses, also known as social enterprises or social firms, are registered, affirmative businesses that combine conventional market activities with a social purpose[1, 2]. Social businesses have been developed outside of formal mental health systems as a means to improve employment opportunities and outcomes for people with mental illness who are marginalized from the regular labor force.

Stigma has been identified as a major barrier to employment for people with mental illness[3]. Stigma was originally described as "spoiled identity" by Goffman[4], whose seminal work focused on how a stigmatized label affects the personal and social identity of the individual. The conceptualization of stigma in this study emphasizes the stigma of mental illness as a social process. We define stigma broadly as "the disposition to act in a discriminating way"[3]. Research evidence suggests that stigma may be operating with particular force in the area of employment[5-9].

Work is critically important for people with mental illness as a way out of poverty, and an opportunity for social connection and citizenship. Work provides a powerful force in enabling people with mental illness to achieve meaningful and productive lives. We know very little about how processes of stigma related to mental illness operate in workplaces, and, specifically, how community employment initiatives such as social businesses influence stigma. The proposed

study will advance our understanding of how social businesses for people with mental illness encounter and influence stigma through their daily operations, and how these businesses may potentially inform anti-stigma efforts in this domain.

Statement of the Problem

Roughly one fifth of the North American population is affected with some form of mental illness. Rates of schizophrenia in Canada are estimated at 1% [10], while the incidence of mood or bipolar disorders, major depression, anxiety disorder and social phobia were projected at 1/20 (or 5.4 million individuals) in the 2002 Canadian Health and Wellbeing Survey[11]. U.S estimates for these conditions are similar[12]. Research reveals that people with mental illness are both willing and able to work [6, 13-17]. Yet their rates of unemployment, ranging from 75-90% in North America[18, 19], are exceptionally high as compared with those of the general population, and are the highest unemployment rates among all disability groups[20].

Negative perceptions, and treatment, of people with mental illness have changed very little since the onset of deinstitutionalization over fifty years ago. As Keleman & Vanhala[21] point out, people with mental illness and other disabilities have long been treated as objects of charity at the expense of their basic citizenship rights. The cultural and structural biases that exclude people with mental illness from employment remain deeply embedded in policy, in mental health programs and services, as well as in societal institutions and environments[6, 15]. People with mental illness, more than those with other disabilities, continue to be viewed by the public as dangerous, unpredictable, unreliable, and incompetent – in a word, unemployable.

The Stigma of Mental Illness in Employment

Overall, the stigma of mental illness is perpetuated in any number of social contexts by the intolerance of human differences and the inability to meaningfully capitalize on them. Research has begun to focus on understanding how stigma operates within specific domains of daily life critical to full community participation, such as employment[3]. We define employment in this study as either competitive or adapted work, providing fair wage standards, and located in community-based settings[22].

The proposed study will focus on understanding how social businesses developed for people with mental illness both experience and influence public stigma, or the role of "others" in sustaining stigmatizing processes, as well as the influence of the businesses on self-stigmatization among employees themselves. Social businesses provide unique, naturalistic workplaces where people with, and without, mental illness have the possibility to come together as equals and participate meaningfully in the Canadian economy. Social businesses provide a veritable laboratory for the study of stigma in employment.

Employment and Shifting Perspectives in Mental Health

Employment is crucial to wellbeing from a variety of perspectives, but most fundamentally as an expression of the inherent dignity and uniqueness of the person. Vocational psychologists maintain that work plays a central role in fostering psychological health[23]. It is also important to note that employment is a fundamental human right, and a responsibility of citizenship – it's "part of the deal"[24]. For these and other reasons, employment has particular significance for individuals with mental illness. Marrone & Golowka[24] advanced a powerful

argument for integrating people with mental illness into work, asserting against conventional wisdom that unemployment is more stressful than employment. Unemployment increases rates of depression, feelings of worthlessness and self-pity, while increasing the risk of poverty, isolation and substance abuse. On the other hand, meaningful work allows people with mental illness to access other dimensions of a quality life, including participation in the larger society, and provides a welcome distraction from disability. In short, employment promotes mental health recovery and wellness for persons with mental illness[25-28].

The issue of stigma in employment needs to be viewed through a critical assessment of social, political and economic structures in terms of their potentially disabling effects. Recent studies based on social perspectives of stigma and mental illness have redirected attention from presumed deficiencies in the person toward understanding public attitudes and beliefs, and the social structural conditions that underlie discriminatory practices[29, 30]. Social perspectives on the stigma of mental illness, whether concerning employment or other social determinants of health, reflect the view that disability is created, not by individual impairment, but by the disabling construction of society and problematic societal responses to impairment[31, 32].

Social Businesses and the Stigma of Mental Illness

Community-based employment initiatives for people with mental illness, and other disabilities, have proliferated over the past 25 years. Social businesses have emerged as a promising option. They have been developed internationally to address the employment needs of a range of populations that experience high rates of exclusion from labour markets. For example, the International Labour

Organization has endorsed similar entrepreneurship development activities for people with physical disabilities[33]. Recent evidence demonstrates that there has been considerable uptake of the approach in Canada as well, where over 70 social businesses across the country address the needs of people with mental illness [34].

While a variety of models for social business have been described, they generally include the following characteristics: 1) hiring at least one-third of employees with a disability or social disadvantage; 2) paying fair market wages regardless of productivity; 3) providing workplace accommodations; and 4) ensuring equal rights and opportunities to all workers[35]. It is assumed that social businesses have the potential to decrease stigma for people with mental illness, and promote social inclusion and recovery, while enhancing their employment prospects.

The impact of social businesses on the stigma of mental illness in employment has not been subject to systematic study. The relationship between social businesses and stigma is complex. On the one hand, the businesses should improve societal attitudes towards mental illness by providing opportunities for positive interaction between people with mental illness and the public. Yet on the other hand, because social businesses are part of the "third sector" economy as distinct from both the private and public sectors[36], it is unclear how social businesses are understood by the public or business communities. The only Canadian study to evaluate outcomes related to social economy businesses for people with mental illness found that business employees were unsure how their participation in these businesses would actually be perceived by other employers[37].

A number of unanswered questions remain within the larger issue of how social businesses understand and experience stigma. Do social businesses actually decrease the stigma of mental illness for their employees, or militate against the tendency of employees to self-stigmatize; and, if so, how? What are the strengths, weaknesses and tensions in social businesses related to changing the stigmatizing attitudes of their customers, or those of local employers who deal with the businesses directly, or mental health service providers whose clients are employed by the businesses? What perceptions of social businesses do managers and employees convey in their interactions with the general public or with mainstream employers? Do people involved with social businesses in various ways perceive this form of employment as "real" work?

Questions also arise concerning the actual or potential involvement of social work in social businesses as a profession historically committed to alleviating social disadvantage, and to empowering individuals and communities[38]. How are social workers, as mental health providers, involved with social businesses, and what, if anything, is their influence on stigma processes occurring in the businesses?

The impetus for this study grew out of my experience as a research assistant working in the mental health field over several years on projects related to the recovery perspective in mental health. Many conversations with people who live with serious mental illness convinced me that people are more troubled by the consequences of mental illness – poverty, isolation, disentitlement – than the illness itself. I also sympathize deeply with the view of many people with serious mental illness that recovery precludes indefinite engagement with formal

mental health services and programs where they never cease to be a "client" – hence my preference for community-based and consumer-driven solutions to unemployment over clinical or formal rehabilitative approaches. People with mental health problems yearn to work, and often equate the possibility to work at a real job in the community with their recovery. Community-based social businesses provide people with precisely this opportunity to step outside of the mental health system, become self-sufficient, and begin to redefine themselves as ordinary citizens connected to others – making employment the final frontier in deinstitutionalization[39]. Whether, and how, social businesses succeed in dismantling stigmatizing stereotypes toward people with mental illness, and open the way to authentic social inclusion, is a burning question shared by everyone I encountered in the course of doing this research.

Study Objective and Research Questions

The overall objective of this study is to describe the influence of social businesses on the stigma of mental illness in the domain of employment. The research addresses the following questions:

> *How is the stigma of mental illness experienced in the everyday operations of social businesses?*
>
> *What influence do social businesses have on the stigma of mental illness within the workplace and beyond?*

Organization of the Thesis

The remainder of the thesis follows the standard format for an empirical research study: Chapter 2 reviews the literature on stigma in terms of conceptualizations of stigma over time, and issues emanating from literature on

the stigma of mental illness in employment. Chapter 3 explores community economic development (CED) as the conceptual framework for the study, highlighting the relationship between CED and the social economy, and the role of social enterprises for the work integration of people with mental illness or other disadvantages as a CED process. Chapter 4 describes the overall research approach and methods used in the study. Chapters 5-8 present the research findings in the form of a comparative case study. Chapter 5 is an overall case description encompassing the three research sites, while Chapters 6-8 present cross-case findings in terms of three overarching themes. Chapter 9, the discussion section, brings together the main findings, providing an assessment of how social businesses experience, and act upon, stigma, as well as how stigma in social businesses may be reduced or eliminated. Implications for the social work profession and recommendations for future research are also provided.

CHAPTER 2: LITERATURE ON THE STIGMA OF MENTAL ILLNESS

Introduction

The stigma of mental illness is widespread and deeply entrenched in societal structures across developed as well as developing countries[30]. Stigma is understood in everyday language as the negative and prejudicial attitudes of the general public directed toward people with mental illness, and is expressed through a variety of behaviors and labels. As "patients", people with mental illness have been viewed traditionally through the lens of the Parsonian "sick role", which forces them to remain passive and compliant, and to identify their illness as both personal tragedy and an aberration[40]. As welfare recipients, they continue to be thrust into the category of "deserving poor"[41]. At a cultural level, the stigmatizing identity associated with mental illness emanates from media reporting[42, 43], and, as Michael Oliver[44] laments, through stereotypic portrayals of people with mental illness as either superheroes or pathetic victims, but rarely as ordinary people doing ordinary things.

Research shows that both stigma and overt discrimination against individuals with mental illness emerge from a variety of sources, including families, communities, churches, coworkers and mental health caregivers[8]. There is evidence that stigmatizing attitudes toward people with mental illness translate into more formal, public domains as well, for example through legislation[45] and law enforcement[42, 46]. Finally, the stigma of mental illness affects access to important social determinants of health including health resources, housing and employment[5, 7, 47-49].

Public stigma intensifies when a mental health condition is viewed as unstable[50-52]. Research has found the attitudes of mental health professionals as negative as those of the general public in attributing dangerousness and unpredictability to people with mental illness[53]. Psychiatrists in particular held more negative stereotypes than others about people with mental illness, and were more likely to accept restrictions on their civil rights[54]. Yet, as the following discussion will demonstrate, the concept of stigma has evolved from this colloquial understanding to reflect a more complex social process.

Most large surveys with mental health consumers tend to focus on discrimination, defined as the behavioral component of stigmatization that limits peoples' rights[42]. Over half of 1,824 persons with serious mental illness in one US study reported some experience with discrimination, emanating not only from mental disability, but also physical disability, race and sexual orientation[46]. A survey of people with schizophrenia in 27 European countries found consistently high rates of experienced discrimination[55].

The literature relevant to the present study includes: 1) conceptualizations and theoretical work on the stigma of mental illness; 2) self-stigma; 3) stigma and discrimination in employment; and 4) stigma and the question of disclosure. This chapter will review each of these areas in turn. There is no known literature related to the stigma of mental illness specifically in social businesses.

Conceptualizations and Theories of Stigma

Stigma was originally understood as an attribute of the individual. In his seminal work on *Stigma: Notes on the management of spoiled identity,* Goffman defined stigma as "an attribute that links a person to an undesirable stereotype,

leading other people to reduce the bearer from a whole and usual person to a tainted, discounted one"[4: 11]. From this early perspective, both mental illness and unemployment were viewed as elements emanating from the "blemish of individual character" that contributed to a stigmatized identity[56].

The differentiating "mark" of the stigmatized person has three major characteristics that may affect the extent to which the person with mental illness is stigmatized: 1) visibility of the condition; 2) degree of controllability; and 3) impact on others, particularly in terms the degree of fear it provokes. Yet despite individual differences in the level of visible disability or impairment, people with mental illness tend to be classified as a single group, and stigmatized by association[56]. It is here that the relational aspect of stigma comes to the fore, as stigma necessarily involves comparisons between the tainted or "marked" person, and others. According to a definition advanced by Thornicroft, stigma is "any attribute, trait or disorder that marks an individual as being unacceptably different from the "normal" people with whom he or she routinely interacts, and that elicits some form of community sanction" [57: 331].

While individual-level psychological paradigms continue to inform current models of stigma[29], leading theorists have further conceptualized stigma as a cognitive-emotional process linking stereotyped attributions to prejudice and discrimination. According to attribution theory, the stigma of mental illness may take the form of blame (the belief that people with mental illness have weak moral backbone, or get everything handed to them); or benevolence (the idea that people with mental illness can't decide things for themselves, or are incapable). Both types of attitudes, whether authoritarian or benevolent, lead to rejecting behaviors

by others expressed as social distance or avoidance, coercion, segregation, or withholding help[58, 59]. The greatest stigma, however, is the public stereotype that people with mental illness are dangerous and unpredictable, which promotes public reactions of fear [60, 61]. Interestingly, fear and social distance are exacerbated when biological, rather than social or environmental, factors are endorsed as the cause of mental illness[62, 63].

Research has also begun to identify remedies to stigma. For example, familiarity, defined as knowledge and experience with mental illness, was associated with less prejudicial attitudes in one study[58]. Those more familiar with mental illness were less likely to avoid people with mental illness; they were more sympathetic and more likely to offer interpersonal help. Direct contact with persons who have mental illness also reduces fear. Contact-stigma theory, proposed by Patrick Corrigan and colleagues, suggests that personal experience with people who have psychiatric disabilities may reduce stigmatizing attitudes: that is, as contact increases, perceived dangerousness and desired social distance will decrease[64-66]. More than public education or protest, personal contact was found to be effective, and lasting, under a number of conditions: when the contact is voluntary and involves a face-to-face or real-world connection; when contact is experienced as cooperative or pleasant; and when the relationship is empathetic and based on relatively equal social status [61, 65, 67-69]. Counter-stereotypic imagery and the sharing of personal narratives also foster mutual understanding between people with and without mental illness[42]. In an organizational or workplace context, other factors that facilitate interpersonal contact are: 1) casual, and regular, as opposed to formally arranged and occasional contact; 2) shared goals

and objectives; and 3) supportive employers who promote meaningful contact among their employees.

Finally, beyond the recognition of stigmatization as simply a product of cognitive processes and biases, stigma theory is beginning to take structural and macro-level factors into account. Following the earlier insights of Link & Phelan[70], Hindshaw & Stier[42] observed that stigma exists, and perpetuates itself, in the exercise of social power where a group with power denigrates a less powerful group, such as people with mental illness, who in turn experience social and political disenfranchisement. Corrigan et al[29] used concepts of structural discrimination to better understand stigma as a process in a their study of large private and public institutions where rules, policies, and procedures might consciously, or unconsciously, restrict the rights and opportunities of people with mental illness. These authors argue that structural models go beyond individual-focused anti-stigma strategies such as education and contact to suggest, instead, that radical social policies promoting affirmative action are necessary in order to root out systemic forms of stigma.

Stuart's definition of stigma from a public health perspective brings the discussion full circle. Here, stigma is described as a complex social process involving interactions between individual level factors (such as cognition, attributions, stereotypes, and behavior) with social structural elements (such as laws, policies, institutional practices, power imbalances, and norms) that create and maintain social inequities based on individual psychiatric status[71: 304-305.].

Self Stigma

Self stigma, understood as internalized stigma or the loss of one's previously held or desired identity[72], is rampant among people with mental illness, and is said to express itself with particular force in the domain of employment[73]. Stigma, as a moral condition, threatens what is most at stake in people's lives[74], and often results in demoralization and reduced self esteem[75-77]. Two large, cross-national surveys conducted in Europe by Brohan et al[72, 78] measured rates of self-stigma and perceived discrimination among people with schizophrenia, bipolar disorder and depression. Nearly half (41.7%) of respondents with schizophrenia reported moderate or high levels of self stigma; whereas for the sample with bipolar disorder or depression in the second survey, rates were approximately one in five. Perceived discrimination was higher, and rates were very similar, among the three participant groups: moderate to high measures of perceived discrimination were 69.4% for the schizophrenia group, and 71.6% among respondents with bipolar disorder or depression. Importantly, these studies revealed that internalizing negative stereotypes about mental illness, or accepting diminished expectations for oneself, was less problematic than the tendency of people with mental illness to experience alienation and to engage in social withdrawal. In this connection, an early study among ex-patients of psychiatric hospitals in Eastern Canada documented patterns of "institutional retreatism", in which the great majority of ex-patients employed various strategies to return to hospital, "self segregated", or actively retreated to the margins of society. Some turned to deviant cultures, or committed suicide[79].

Yet, as the Brohan et al studies and other research have found, stigmatizing attitudes from the public do not necessarily translate into sentiments of self-stigma for individuals with mental illness. There are many mitigating factors that may induce people to respond to stigmatizing attitudes or discriminatory behaviors in other ways, such as righteous anger, or even indifference[80-82]. A major review of theoretical literature on the social psychology of stigma by Major & O'Brien[83] revealed that, while self stigma does have a very negative effect on stigmatized individuals, the literature identifies three major coping mechanisms that may reduce its impact: 1) the targeted person may attribute negative events to discriminating attitudes on the part of another, or to some other external attribution, rather than to the self; 2) the targeted person may disengage from domains in which his/her group is negatively stereotyped or unfairly treated so that their performance in that domain is no longer important to self-worth; and 3) the targeted person may begin to identify more closely with his/her group, as a source of support and social validation. Of course, as the authors point out, retreating from important life domains comes at a price. Other research has found that group identification is positively associated with self-esteem among stigmatized groups[83].

The other interesting finding concerning self-stigma is that, while many people with mental illness both fear stigma, and expect to be stigmatized and poorly treated by others[84-86], anticipated stigma does not always correspond to the actual experience of stigma. For instance, in the aforementioned cross sectional survey of people with schizophrenia in 27 European countries, where rates of experienced discrimination were high and consistent across countries, slightly

more than half of the study participants anticipated discrimination in the domains of work and personal relationships but did not actually experience stigma. Based on these findings, the authors suggested the importance of introducing stigma reduction strategies that increase the self esteem of people with mental illness in addition to promoting employment[55]. These findings correspond to results of another study which analyzed 35,763 allegations of workplace discrimination filed by people with physical and psychiatric disabilities in the US under the Americans with Disabilities Act. Comparing the cases of people with physical versus psychiatric conditions, perceived workplace discrimination was higher in the group that included controllable but unstable conditions such as depression and schizophrenia, whereas actual discrimination occurred at higher levels among people with physical impairments or medical conditions[87].

Stigma in Employment

Stigmatizing perceptions as well as structural and policy barriers have a deleterious effect on the employability of people with mental illness[7]. Individual "labor market liabilities" among people with mental illness, including lower average levels of education and training, weak social networks (i.e. lack of influential contacts), gender and race, as well as the need to rely on social assistance programs due to intermittent health issues, reduce employment prospects for this population[88, 89]. In fact, people with mental illness who are employed have reported workplace discrimination related to issues of reasonable accommodation, promotion decisions and performance reviews, training opportunities, compensation and benefits[5]. Canadian workers with mental illness

suffer greater stigmatization in the workplace than do other disabled people, according to the Canadian Psychiatric Association[90].

Other research on the employment experiences of this population suggests that people with mental illness cannot expect much support in moving into the competitive labor market, whether from their mental health service providers or associates in the workplace. One study found that service providers have low expectations that their clients would be hired, and often fail to capitalize on clients' motivation for work. As well, service providers tend to have limited contact with either vocational services or employers[19]. Other research suggests that relationships with co-workers and supervisors, among employees with mental illness, are often unaccommodating[6-8]. By contrast, in one Canadian study 80% of respondents reported that they expected to enjoy interacting with co-workers, and even more thought they would have no problem asking for help on the job, suggesting that they viewed work as an important social activity[15]. Another study suggested the crucial importance of employment for reducing public stigma: respondents in this study reacted positively to a vignette that featured a person with schizophrenia who was gainfully employed; perceptions remained positive even when the condition of having a prior criminal record (misdemeanor) was added[91].

Research with employers reveals considerable uncertainty among them toward hiring people with mental illness, as well as concerns about providing workplace accommodations. According to Stuart[7], surveys on employer attitudes and behaviors in the US reveal that 70% of employers would hesitate to hire anyone with a history of substance abuse or currently taking antipsychotic

medications, while half would rarely employ someone with a psychotic disability; they prefer instead to hire people with physical disabilities. Almost a quarter of employers would dismiss someone for not disclosing a mental illness. As the author points out, all these attitudes contravene US disability legislation. The concerns of 502 employers in a survey conducted in the UK centered on: 1) psychiatric symptoms as threats to safety or the source of strange and unpredictable behaviors; 2) work performance; 3) work personality concerns; and 4) administrative concerns such as the level of monitoring required for an employee with mental illness[92]. These attitudes did not change after employers experienced hiring persons with mental illness, although their knowledge of the law increased and as did their likelihood of developing a hiring policy for persons with disabilities[93]. By contrast, a Canadian study found more accepting attitudes among small business employers in cases where the employer had previously hired an employee with mental illness, or had experienced personal contact with mental illness[94].

Stigma and the Question of Disclosure

Label avoidance, another possible reaction to mental illness, is what drives many people to avoid disclosure of their mental health status. Disclosure is a major issue in the workplace, as in other social arenas[95], and not surprisingly, given the injurious effects of stigma in the lives of people with mental illness. An early survey of 1301 mental health consumers on their experiences of stigma and discrimination revealed that most respondents tried to conceal their disorders, and worried that others would find out about their illnesses and treat them unfavorably. Most avoided situations where they could be exposed to stigma, for

example by seeking employment only in mental health programs, living with parents, and not even applying for volunteer positions. The aforementioned survey involving 27 European countries also reported that 72% of respondents felt the need to conceal their diagnosis[55].

Vocational rehabilitation and mental health specialists usually promote disclosure of psychiatric disability at work. Respondents in one qualitative study[96] expressed the belief that not disclosing will exacerbate symptoms. As well, disclosure is necessary in order to invoke individual rights to accommodation under available disability legislation (e.g. the Americans with Disabilities Act), and to protect disability benefits. This study further explored decision-making processes among employees with mental illness in terms of what kinds of information they would disclose to employers, and whether or not they would seek a workplace accommodation for psychiatric disability. Disclosure was more prevalent among respondents who relied on a vocational rehabilitation counsellor in finding work, and often involved a job in the mental health sector which was considered a "safe" area for disclosure. Not all who disclosed were satisfied with the results, however. Some employees believed that supervisors made them work harder in order to "prove themselves". Those who didn't disclose were more interested in passing as "normal" or blending in, yet sometimes came to believe that the employer knew about their disability and discriminated against them anyway. Yet, selective disclosure often resulted in successful accommodation. These results complement UK findings that employees with mental illness usually will disclose only in crisis situations, or when they perceive that their jobs are secure[92].

The increasing difficulty of enforcing workplace accommodations for psychiatric disability under protective legislation in the US casts further doubt on the efficacy of such legislation and the advisability of disclosure[97, 98]. As reported by Stuart[7], only 2% of 263 disability cases brought to trial under the ADA in 2004 favored the worker. Of the 54 cases brought forward by people with mental disability, none favored the employee. Part of the difficulty in making claims about discriminatory treatment or the employer's failure to accommodate was the inability to convince the court that a mental impairment results in significant disability. No protective legislation of this kind exists in Canada, yet Section 15.1 of the Canadian Charter of Rights recognizes equality rights for all Canadian citizens before the law, including people with physical or mental disabilities. This has opened up a broad discussion in this country about the rights of people with mental illness to participate in work[21].

Employers often have the power and means to circumvent the rights of people with mental illness to employment and workplace accommodation. Harlan & Robert[99] analyzed patterns of employer resistance to workplace accommodation, pointing to an organizational logic that maintains their authority and control. Employer strategies aimed at maintaining the status quo and avoiding changes or modifications in areas that they considered crucial to their domination of the employer-employee relationship. For instance, the staff hierarchy could be disrupted if any accommodation was perceived as elevating the employee with a disability over able-bodied employees, or was out of proportion to their worth in the organization. Low-status workers in particular must adhere to rigid rules regarding work schedules, time and attendance, and they are used by employers to

maintain the boundaries around which work routines are normal and acceptable in the organization, and which are not. Another employer concern was that making accommodations might signal that change in the organization is possible, that employees can expect greater autonomy and flexibility and can have a say in how they do their jobs This was perceived by employers as a potential threat to their authority. This said, employers were also anxious to understand their responsibilities under the ADA, as they wished to reduce the financial, public relations, and opportunity costs resulting from charges of discrimination from their employees[87].

Combatting the stigma of mental illness is essential to the promotion of employment and viable workplaces where people with mental illness can participate fully. Krupa et al[3] proposed a conceptual model of workplace stigma, based on an analysis of over 500 Canadian documents on work and mental illness. The model includes the following assumptions about the employability of people with mental illness: 1) that people with mental illness lack competence for work; 2) that people with mental illness are dangerous or unpredictable in workplaces; 3) that mental illness is not a legitimate illness; 4) that working is not healthy for people with mental illness; and 5) that providing employment for people with mental illness is an act of charity. The model also develops the salience of these assumptions for different stakeholders in the workforce, and suggests a range of work-related consequences that occur as a result of stigmatizing processes.

Gaps in Research on the Stigma of Mental Illness

The aforementioned literature review points to important gaps in research on the stigma of mental illness. Most obvious is the lack of research on stigma in

social businesses. Researchers familiar with supported employment programs, such as the Individual Placement and Support model, tend to view social businesses as "stigma-safe environments", whether as a fall-back option for people with mental illness who have had negative experiences of stigma in mainstream employment, or as a protected environment for those unwilling to consider "open" employment[19]. Following Link and Phelan[70], and others cited above, there is a need for research based on multilevel conceptualizations of stigma as both an individual and structural issue, and as a process. In a similar vein, structural discrimination – institutional practices and processes that disadvantage people with mental illness – is almost entirely unaddressed in the literature. Further research is also needed on the actual experiences of people with mental illness regarding the behavior of others toward them[100], and particularly more qualitative research focused on how stigma is constructed in social interaction[101]. This doctoral study attempts to address some of these unexplored areas through an examination of stigma processes in social businesses.

CHAPTER 3: COMMUNITY ECONOMIC DEVELOPMENT AND WORK INTEGRATION THROUGH SOCIAL BUSINESS

Introduction

Community economic development, a field of study concerned with multifaceted and comprehensive approaches to poverty reduction and community-level change[102], provides a broad theoretical orientation for the present study. The community economic development approach builds on the assumption that economic and labor market forces based on competition, individualism and profit maximization systematically disadvantage and exclude certain groups, such as people with mental illness, from participation in the mainstream economy. Community economic development focuses on the local: on using local resources and holistic, participatory processes to foster the economic, social, cultural, and ecological wellbeing of communities. This chapter describes the main principles and practices of CED in the context of the wider social economy, or "third sector". The discussion then turns to an overview of the social enterprise sector within CED, where a variety of social business forms have been developed to address problems affecting local communities and disadvantaged populations, including people with mental illness who struggle with the effects of chronic unemployment, poverty, and social exclusion.

Community Economic Development and the Social Economy

Overall, welfare state economies include a private, profit-motivated business sector, a public sector owned by the state, and a community-based social economy sector which comprises both commercial and voluntary organizations. The social economy tends to be viewed either from a social movement

perspective, or more narrowly, as a family of different organizational forms that operate between private business and the state[103]. While the more radical social movement perspective views the social economy as an alternative form of economic and social organization in opposition to advanced capitalism, the more limited conceptualization of the social economy focuses on particular problems that emerge from the uneven impact of economic systems on different groups, and the ability of communities to deal with these problems[104].

The social economy originated in civil society movements as far back as the 19th century, and persisted through the emergence of new social movements in the 20th century[103, 105]. However, most analysts associate the emergence of the social economy and CED organizations in North America with the worldwide economic recession of the early 1980s and with economic globalization[106]. Shragge & Toye[107], for instance, link the emergence of the social economy with the workings of capitalist economies in this period that aimed to expand and conquer new international markets at the expense of full employment and planning at home. According to these authors, widespread loss of blue collar jobs, high youth unemployment, and more contingent work characterized by greater job insecurity, limited benefits, lower wages and health risks, ensued. Wallace[105] points to the failure of urban renewal and "model city" projects in the US as another precursor.

It should be noted that the social movement perspective on the social economy has its origins in Europe, but in Canada is indigenous to Quebec. The Quebec social economy is represented by the "*Chantier de l'économie sociale*"[108]. Founded in 1996, the *Chantier* develops social businesses, but also

serves as a political lobby at all levels of government. While greater numbers of organizations and practices associated with the social economy may actually exist outside of Québec, only in Québec do these organizations fly under the banner of "l'économie sociale", and claim to represent a social movement. Leaders in the Quebec social economy movement advance an oppositional political definition of CED that aims to promote democratic, ecological and critical values, while forcing policies that will reduce inequalities[107]. From their perspective, single purpose organizations operating independent of a multipurpose strategy for an entire territory may not be considered, in themselves, as CED[109].

By contrast, the second, more politically neutral, perspective conceptualizes the social economy as a set of institutions in relation to other parts of the economy and the broader society. Quarter et al[1], who represent this position, define the social economy as "a bridging concept for organizations that have social objectives central to their mission and their practice, and either have explicit economic objectives or generate some economic value through the services they provide and purchases they undertake". These authors locate community economic development at the convergence of the social economy, public sector and private sector. In their view, social economy organizations share four common characteristics: 1) social objectives in their missions; 2) social ownership; 3) volunteer/social participation; and 4) civic or democratic engagement. The social component inherent in these principles is what distinguishes organizations in the social economy from those in the private and public sectors.

Perspectives on Community Economic Development

As an interdisciplinary concept, there is no shared definition of CED in the literature. CED takes in economic, social and political theories of community change. For example, Shaffer et al[110] refer to CED as the confluence of two traditions: economic development, focused on jobs, income and business growth, and community development, which is more concerned with equal rights, institutional organization, and political processes. At a practice level, CED differs from orthodox local economic development approaches mainly by viewing the economy within a social context, and not as an end in itself[108].

Yet, however it is practiced, CED aims to take back from the market and the state some measure of control of the local economy. CED is a "bottom-up process", or the development of the community by the community, in response to complex economic and social needs that can be addressed only partially through the market. Many CED practices occur in regions that have a below average standard of living, or involve groups who experience extraordinary challenges. One of the more straightforward definitions of CED appropriate to the present study comes from the Toronto CED Learning Network: "CED is a community-led, multi-faceted activity or strategy which seeks to improve the social and economic circumstances of a select population"[109].

Understanding CED is also bound up with the meaning of "community", which may be viewed as either a limited geographical locality or a community of interest. Space, or the geo-political boundaries of a municipality or county, play a vital role in the definitions of analysts interested in CED as area-based regeneration. Haughton[111], for example, refers to "geographic equity" in

describing CED as the development of an alternative local economy using local resources and involving local people in the process. Yet a survey of 364 CED organizations in Canada revealed that relatively few organizations could be said to engage in comprehensive, long term planning for the renewal of entire geographic areas. Most respondents were representatives of single purpose organizations focused on the betterment of a particular community of interest, such as disability groups[109]. This gets back to the earlier question about whether initiatives taken on behalf of a particular community of interest outside of a comprehensive plan for an entire locality can be considered as CED.

Boothroyd & Davis[106] provide a synthesis in their description of "communalization" as one of three possible approaches to CED. In communalization, "community" is defined as "a group of people who know each other personally and who plan together over time for their long-term common betterment". This description would cover both geographically defined communities and communities based on common interests. Within the communalization approach, economic institutions were said to promote cooperation rather than competition, as well as community solidarity, distributive justice and quality of life. The local economy in this perspective encompasses market transactions, but also includes production and distribution based on nonmarket principles such as common ownership, sharing, mutual aid, and the improvement of productive life, even at the expense of efficiency.

Social Enterprise as a CED Process

Social enterprise is an umbrella term for a variety of social business types that have emerged as part of CED processes in third sector economies of countries

across Europe and North America. Social enterprises have emerged in response to the economic and social conditions of the 1980s and 1990s described above, and the lack of policies to deal with the increasing exclusion of some groups from the labor market and from society itself. While social enterprises first appeared in Italy and Germany as early as the 1960s[112], the concept itself came into usage around 1990[113]. A Confederation of European Social Firms Employment Initiatives and Social Co-operatives was established in 1994 (CEFEC)[112]. By 2005 there were 8000 social enterprises in Europe that employed some 80,000 workers, 30,000 of whom had psychiatric or other disabilities[2].

In Canada, Lysaght et al[114] conducted an environmental scan in 2011 that identified 122 social businesses for people with disabilities incorporated as non-profit businesses, cooperatives and charities operating within the social economy. Seventy-five (61.2%) were developed specifically for people with mental health problems and/or addictions. One quarter of Canadian social businesses were established as subsidiaries of a parent organization. This section provides a brief overview of the origins and myriad business forms that have developed under the banner of "social enterprise" in Europe and North America, taking into account the socio-political environments of countries where they are located[113, 115].

Social enterprise is broadly defined as a form of community economic development in which an organization exchanges goods and services in the market as a means of realizing its social mission or objectives[1]. The European Research Network EMES suggests that, in addition to economic activity, social enterprises enjoy a high degree of autonomy despite their dependence on outside funding; but they also experience a high level of economic risk. As well, these

businesses must offer a minimum amount of paid, as opposed to volunteer, work. The social dimensions that distinguish social businesses from regular business include a participatory element; limited profit distribution that precludes profit maximizing behavior, and the explicit aim of benefiting a particular community or group of people[116].

According to Kirsh et al[117], the disadvantages and marginalization of certain groups from employment at the local level occurs because of mainstream business practices that promote individualism and competition, standardized work qualifications, and established networks to work entry. Social businesses are designed to neutralize these forces of disadvantage on the assumption that people with mental illness have social and vocational potential as well as the right to employment. Labor market participation through social business improves the economic conditions of individuals and contributes to the development of the local community economy, while at the same time promoting a broader social agenda of inclusion, accommodation, and opportunity for people disadvantaged by mental illness or other conditions.

The creation of social enterprises for people with mental illness also marks an important shift toward permanent, integrated and meaningful employment in the community for them, as well as a departure from traditional employment opportunities tied to pre-employment programs or to participation in clinical mental health services[118, 119]. Social businesses have been described as "change agents" in creating a necessary bridge into the mainstream business community and an open door to the job market for people who lack job-related skills[120].

Yet the opinion persists that that people with mental illness would continue to need intensive training and particular supports in order to replace the care that was formerly provided through large-scale psychiatric facilities. Researchers writing on the Canadian social economy tend to make a distinction between social businesses that emphasize training, and include mental health service providers in their operations, versus businesses that provide permanent employment. Most employment in Canadian social enterprises is also part-time, as employees continue to depend on disability pensions for subsistence[1, 121]. Regardless of overall business aims, the need for intensive training is viewed as the main reason why social enterprises for people with mental illness are likely to need external financial support on an ongoing basis. This support usually comes from government, foundations and individual philanthropists.

The main distinction between social enterprises in North America and those in European countries seems to turn on the extent of government support for social enterprise as well as the policy and legislative contexts of different countries. Social enterprises in Europe benefit from greater government recognition and involvement in the social economy sector than do their North American counterparts[122]. European businesses in countries such as Italy, the UK, Sweden, and Spain include commercial ventures such as social co-ops that offer permanent jobs. There are also transitional employment enterprises; community owned businesses such as those in the UK that feature both training and employment initiatives as well as strong local involvement; and other associative structures for employment that emanate from collaboration between government and the civil sector[115, 116].

A major article by Defournay & Nyssens[113] traced the evolution of social businesses in Europe within three types of welfare state using the classic Epsing-Anderson typology. These are: 1) liberal or Anglo-Saxon regimes where welfare services are provided mainly through the market (e.g. the UK); 2) socio-democratic regimes offering a wide spectrum of universal welfare services organized by the state (e.g. Sweden, Denmark, Norway) ; and 3) conservative or corporatist welfare states concerned primarily with maintaining order and the status quo (e.g. France, Belgium, Germany). In line with this typology, social enterprises in the UK, as the liberal model, have developed in a more competitive environment due to increasing government reliance on quasi-market mechanisms and the contracting of services to private providers, including both for-profit and voluntary associations. Social firms in the UK also emerged relatively late, the first four in 1997, and have their roots in psychiatric rehabilitation. Some were developed by health and social service providers following on the closure of long stay institutions.

In social democratic systems, which include the Scandinavian countries, a strong tradition of worker co-operatives has developed within the third sector. By contrast, corporatist countries (France, Belgium) tend to favor labor policies that promote work integration through training programs and individual employment subsidies rather than unemployment policies based on cash benefits. A large "second labor market" offering intermediate employment has emerged within the third sector in countries like France and Belgium, and is known as the social economy (économie sociale) or solidarity economy (économie solidaire).

Defornay & Nyssens also conceptualized a fourth type of welfare regime for the Mediterranean countries where state provision of welfare services is generally less developed (Italy; Spain, Portugal). Italian social enterprises, emblematic of the Mediterranean typology, are organized as cooperatives. Although not government funded, the Italian businesses enjoy special tax status, and have thrived as private sector initiatives. There were already 2215 cooperatives in Italy by 1993[123]. These businesses are also of particular interest because of their early development in conjunction with the anti-psychiatry movement in the 1970s[35].

Turning to North America, social enterprises in the United States tend to be organized as for-profit subsidiaries or companies operated by non-profit organizations; they are mainly concentrated in urban communities[120]. In local US economies, "community" often refers to a target group of individuals, usually those economically marginalized, rather than to a geographic locality[124]. Social enterprise in this context is part of a continuum of mainly civil-society driven initiatives aimed at reducing poverty, building social capital and revitalizing communities, while effecting social change in the process. With little government involvement, foundations play a major role in supporting and shaping the design of US social enterprises.

The "American archetype" in social enterprise with its high predominance of market-led strategies and commercialization has become highly influential worldwide. For instance, the Johns Hopkins Comparative Nonprofit Sector Project developed an approach that views social enterprise as structurally separate from government, among other characteristics, and does not explicitly

recognize the goal of democratic control by members of social economy organizations. The Hopkins criteria also emphasize non-distribution of net income to members, which would eliminate co-operatives from their classification. Twenty-six countries have committed to developing this system[103]. However, as the author suggests, there are important disjunctions between this approach and the European experience, where there is more use of nonprofit and co-operative legal forms and where there is more of a political project to broaden the third sector. In Europe, as in Quebec, the different forms of social enterprise (co-operatives, mutual aid organizations, associations, foundations) are all subsumed under the umbrella of an overarching "social economy."

In Canada, various business forms have emerged under the broader heading of social enterprise since the late 1980s. Some businesses began as worker cooperatives and evolved into consumer-survivor run businesses operating with little or no input from mental health professionals[39, 125]. Church[126] characterizes the 1990s as the decade when the psychiatric survivor movement become "entrepreneurial" in response to the presumed failure of mental health service systems, and economic restructuring more generally. Consumer leaders used the language and processes of community economic development as a vehicle in their community organizing. What became known as "alternative businesses" operated according to a self-help philosophy and separatist mentality linked with anti-psychiatry. Participatory management and learning by trial and error were key, as well as commitment to the most vulnerable members of the survivor community.

Affirmative social businesses also developed in Canada through collaboration among people with mental illness, vocational rehabilitation professionals and local business leaders. A community economic development model was used here as well in order to promote community integration through the daily operations of businesses that aimed to meet the real needs of employees and to develop skills that could be transferred to the competitive market[37, 127-129].

The lack of formal government support for social businesses in most Canadian provinces offers some explanation for the variety in the businesses that have emerged. The practice field is different in Canada than in countries where specific policies and legislation govern organizations for work integration[121]. As mentioned earlier, social enterprise development in Quebec has differed from elsewhere in Canada, as the institutional context in Quebec has favored collaboration between government, the private sector, community organizations, the labor movement and social movements to advance the socio-professional development of marginalized groups[130]. Inspired by European models, the first CED organizations in Quebec were established in the early 1980s as training businesses mandated to address social exclusion as well as employability and job creation[131]. These training businesses still exist, and are considered the precursors of Quebec's social enterprises. Training businesses incorporate a training-based social integration framework within an enterprise that produces goods and services while aiming to move trainees to regular employment. Social enterprises are distinguished from training businesses by their focus on creating an alternative job market for people with special conditions such as mental illness[121].

Mendell[115] argues that social businesses can better meet their objectives if they are integrated into a locally rooted socio-economic development strategy that represents a reconfiguration of relations between government and civil society. Otherwise, social businesses risk being separated from their social and community roots. The macro-social impact of businesses within the social economy is not well articulated, according to this author, suggesting that their social, political and economic impact needs to be further explored.

Other research has examined micro-processes within social businesses, revealing important tensions that may emerge in the course of operating businesses with a dual economic and social purpose. Hudson[132], for example, documented difficulties connected with the overriding concern of social businesses for providing socially useful and environmentally sustainable goods and services not provided in the mainstream economy particularly when this aim runs up against their interest in generating wealth and creating more jobs. Tensions mount as social firms begin to focus more on their economic role and on market activities as the route to growth. UK social firms provide an example where social businesses become locked into an increasingly dependent relationship on the state for infrastructure funding as they began to compete directly with competitive, mainstream businesses. The pressures of meeting the "economic" outcome targets required by multiple funders in order to qualify for funding also diverts time and energy from the socially useful work of social businesses, while potentially encroaching on their original mission.

Other analysts identify issues that have arisen in UK social businesses due to the origins of many social businesses in a rehabilitation context. Managers were

usually service providers who lacked business skills, and whose social care agencies featured organizational cultures and contexts that made it difficult to develop independent businesses[133]. As well, there is a general view that social businesses, in both the UK and elsewhere, are not always well linked with agencies and networks involved with local economic development.

Many social businesses in the US have also taken the decision to pursue financial sustainability through trading activities independent of government or donor support. How social businesses cope with the stress of managing their social and economic aims in the competitive US business environment, or, more specifically, how they acquire resources in resource-scarce environments, was described by Di Domenico et al[134] as "social bricolage", based on Lévi-Strauss` concept of "making due with what is at hand". This study identified three forms of "social bricolage" based on the idea that relationships between individuals, their interactions, and reliance on social networks are central to the social dimension of entrepreneurship.

The first element in the social bricolage framework is social value creation, which necessitates the creation of resources, including direct funding, as a response to the pressures of resource scarcity. Social value creation might include altering existing arrangements as needs arise, as well as improvising and adapting rather than remaining rigidly tied to predetermined business plans or formulae. Second is stakeholder participation, or the active involvement of stakeholders in the creation, management and governance of their social business. Building up close relationships with stakeholders worked to reinforce the rootedness and legitimacy of the social enterprise in the community. Third is

persuasion, or the role of the social assets of friendship, liking, trust, obligation, and gratitude in co-opting resources into an entrepreneurial venture. The stakeholder-based governance structure of social enterprises determined the efficacy of their persuasion, and was most prominent in lobbying and advocacy efforts.

Finally, a study of social business development by Cooney[135] documented strategies used by social business directors or managers in the US to balance their business and social aims. One strategy was slow growth, whereby managers carefully absorbed every new worker and offered him/her meaningful work. Second, cross-subsidization, or the search for a variety of funding sources, allowed social businesses to provide improved client-centered training. Finally, the businesses in this study pursued diversification strategies, in terms of both products and services offered and the organization of multiple business ventures. Multiple businesses working collaboratively allowed stronger businesses to support the weaker businesses, but also provided a broader range of training experiences for employees.

Implications for the Present Study

The foregoing discussion suggests that the stigma of mental illness, as a process within social businesses, is embedded within a larger set of operational business-level concerns as well as a very broad institutional context. Viewing social businesses within a community economic development perspective raises a number of questions regarding their connections with the communities and economies in which they operate and, further, in what ways these connections

may have some bearing on how social businesses experience, and influence, stigma.

Initially, we would want to know how, and to what extent, the CED language and approach have been consciously adopted by the different businesses in this study. How do these businesses understand "community", for instance? To what extent do the businesses identify as part of local economic development or as part of a larger social movement? In what ways do social businesses in this study aim to influence social change as part of their mission?

The involvement of various community stakeholders was identified as an important factor in establishing the legitimacy of businesses in the social economy. For example, what is the role of government and other funders who provide ongoing external support in shaping the prospects of social businesses in this study? Developing businesses for people with mental health issues also suggests a major role for mental health organizations and providers. What forms of community infrastructure, such as lobbying, advocacy, fundraising and advertising, do social businesses in this study pursue in order to enhance their presence and standing in their communities?

It would be important to know more about how the social and economic objectives of these businesses are described within their respective missions, and how the businesses have pursued their core objectives over the years. For example, how do social businesses position themselves within the local economy, in view of their need to create wealth and hire people, and with what implications for possible tension between their concern for wealth creation and their social mission? How do the businesses in this study "make do" with scarce resources?

What strategies do they adopt in diversifying their funding and building capacity? How do the economic and social objectives of the businesses intersect with an active concern for stigma reduction?

The other aspect to explore is what kind of employment experience social businesses provide for their employees, particularly in terms of influencing stigma as a major barrier to employment. How do social businesses in this study enhance the integration of their employees into the community, which is a question that will depend largely on whether the businesses aim to integrate employees into competitive employment, or whether they view social business as a permanent, alternative labor market for people with mental illness. With these questions in mind, we turn to a description of the research process and to the findings of the study.

CHAPTER 4: RESEARCH APPROACH AND METHODS

Paradigm and Research Approach

This research is a qualitative descriptive study based on the naturalistic paradigm first articulated by Lincoln & Guba[136]. Naturalistic inquiry assumes the existence of multiple, constructed realities, and aims at understanding, as opposed to predicting or controlling, reality. The inquirer and object of inquiry are mutually influencing and inseparable. At an operational level, naturalistic inquiry favors the use of mainly qualitative research methods, purposive or theoretical sampling, inductive data collection, emergent (vs. constructed) design, and interpretation that is both "idiographic" (based on the particulars of the case) and negotiated with the human subjects from whom data have been drawn.

The research is exploratory, aiming to understand the stigma of mental illness as a concept that is not deeply embedded in any established theoretical framework. Community economic development, described above as the cultural field for social businesses, provides the only "theoretical positioning"[137] for the study. Padgett[138: 12] proposed one reason to forego theory-driven approaches in favor of a more generic, or pragmatist approach to qualitative research: "allowing one or more theories to drive the inquiry deprives a study of what qualitative methods do best – explore the unknown or find new ways of understanding what is known." Patton[139] further asserts that the traditional methodological traditions (i.e. ethnography, grounded theory, phenomenology) are so divergent that results from the same studied phenomenon using these approaches may not be mutually meaningful. Hence, this study also eschews adherence to the available methodological traditions in favor of case study methodology as "the reporting

mode of choice" for the naturalist, and the primary vehicle for emic inquiry[136: 357-359], or the reconstruction of respondents' realities which is so important for giving voice to disadvantaged people.

Overview of Case Study Methodology

Within this framework, a comparative case study of social businesses at three sites was conducted. Unlike most types of qualitative methodology that are defined by the focus of the study (e.g. theory building), case studies are defined by the object of study -- the case or unit of analysis. Most authors refer to the case as a "bounded system"[140]. Creswell, for example, defines case study research as a qualitative approach in which the investigator explores a bounded system (a single case), or multiple bounded systems (multiple cases), through in-depth data collection involving various sources of information (interviews, observation, documents, artifacts); and reports a case-based description and case-based themes. According to Yin, case studies are the preferred method when: 1) "how" or "why" questions are posed; 2) the investigator has little control over events, and 3) the focus is on a contemporary phenomenon within a real-life context[141: 13]. He adds that the boundaries between the phenomenon of interest, and context, are not always evident.

Important distinctions between single case and multiple case studies should be underlined in terms of intent and methodology. The single case study is "intrinsic", aimed primarily at learning about the case for its own sake. Merriam[140] characterizes single case studies as 1) particularistic (focused on a particular situation, event, program or phenomenon; what the case reveals about the phenomenon and what it might represent); 2) descriptive (a rich, "thick

description" of the phenomenon as the end product); and 3) heuristic (illuminating understanding and meaning of the phenomenon). Stake[142] adds that the object of the single case study is not to know how the case is different from others; but to emphasize its uniqueness. By contrast, multiple case studies are "instrumental". They start from one or more research questions, and employ a number of cases, each used mainly for the purpose of understanding something beyond the particular case. The researcher concentrates on relationships identified within the research question, as well as further issues or problematic situations emerging from the cases that reveal their complexity and context. While an important task is to understand how the main phenomenon of interest (e.g. stigma) appears in the ordinary activities and functioning of each case, the ultimate objective of the multiple case study is to understand the phenomenon in terms of what it reveals about the cases as a collectivity[143] (the "quintain" in Stake's language, or, in this study, social businesses in general).

Case studies are written at different analytic levels: factual, interpretive, and evaluative[136, 141]. While there are no set rules or procedures to follow in the analysis of case studies, Simons[144] suggests selecting data that will tell an eventual story. Analysis includes coding and categorizing (or "categorical aggregation"[145]), concept mapping, and theme generation, followed by the complex activity of interpreting the data through metaphors, imaging, reflective thinking, puzzling over incidents and observations, exploring alternative perceptions, seeing through different lenses, lateral thinking – in a word, total immersion in the data until a sense of the whole emerges. Comparative case studies include both within-case and cross-case analysis.

Writing the case report takes a myriad of forms, and comprises varying amounts of description versus analysis, depending largely on the purpose and audience for which the case is prepared[141, 145]. Lincoln & Guba[136], among others, suggest that case studies should include the same methods and standards of trustworthiness as other qualitative studies. The case report should include: an explication of the problem, thorough description of the context or setting; a description of transactions or processes observed; "saliences" at each site (elements studied in depth); and outcomes or "lessons learned." Methods are often written as a separate appendix. The case and its themes tell a story grounded in evidence that should fairly and accurately represent the judgments and perspectives of participants. The writing style is informal and should convey the sense of "being there"[140] through the liberal use of vignettes, cameos of individuals, narrative descriptions, Socratic dialogue, and "telling tales" from the field[144]. A tendency to raise more questions than it solves makes the case study an ideal device for exploring the stigma of mental illness.

Methods

Methods used in the present study include identification of the setting; sampling techniques; as well data collection and analysis procedures. They are described below

Setting. Five social businesses located in three Canadian cities were included in the study. The businesses represent three recognized models of social business: 1) alternative businesses, which are fully owned and operated by people with mental illness; 2) affirmative businesses, which bring together mental health consumers, service providers attached to a local mental health organization, and

community leaders; and 3) a social enterprise that employs both people with, and without, mental illness. Pseudonyms were used to identify individual businesses in order to protect their anonymity; as such, the two alternative businesses are known as the "Gardeners", and the "Hospital Café"; the two affirmative businesses are the "Car Wash", and the "Library Café"; and the "Manufacturer" is the one social enterprise in the study. However, due to important differences in provincial social welfare laws and employment integration subsidies for people with disabilities, it needs to be mentioned that the alternative and affirmative businesses are located in Ontario; while the social enterprise is in Quebec.

Sample. The selection of businesses for the study was purposeful within the three different business models described above. From a pool of 75 social businesses for people with mental illness, which represents 61.5% of all social businesses in Canada according to a recent environmental scan[114], the five businesses in this study were selected for maximum variation in terms of geographic location/community size; types of goods and services produced; business size; revenue; and proximity to/possible involvement with mental health systems and local communities. To be included in the study all businesses had to: 1) be registered; 2) be established for at least 3 years; 3) pay minimum wage or higher; 4) provide regular contact with non-disabled people within the work context; 5) be open during regular business hours, and 6) employ at least 5 people.

Study participants were also selected purposively, but more in line with the evolving needs of the study. The size and composition of the sample were not pre-determined, and efforts were made to avoid an "elite bias" by seeking to include

participants who were involved with social businesses in every possible capacity[146]. In order to be eligible for the study, participants had to: 1) be at least 18 years old; 2) be associated with a business in their current capacity for at least 3 months; 3) be willing, and able, to answer questions about their knowledge and/or experiences of stigma in relation to the businesses; and 4) sign a consent form.

Data collection. Fieldwork lasted approximately one month in each of the three sites, and took place in July-August; September and November, 2011. The four sources of data for the study are: 1) individual interviews; 2) group interviews (n= 2-6 participants each); 3) participant observation; and 4) documents. Group interviews were chosen exclusively for business employees with mental illness, and employee co-workers, in order to maximize their participation as study participants of particular interest. Fieldwork at each site began with a brief period of participant observation, in order to learn as much as possible about the nature of the businesses, their daily operations, and whatever people working in the businesses chose to reveal about their issues and concerns. Detailed field notes were recorded and transcribed as part of the documentation collected for each site.

Recruitment of study participants for both individual and group interviews was conducted on site, starting from the initial observation period. A letter of introduction was distributed to anyone potentially interested in participating in the research (See letter: Appendix A). While some participants were invited directly into the study, most recruitment was through a snowball, or

nominated, technique[147]. The aim was to obtain a wide, diverse sample that would ensure extensive data coverage and include as much information as possible from various points of view[148]. At the outset of the study, it is likely that more ”typical” participants were identified: they included employees with mental illness working in the businesses; co-workers without mental illness; business directors, managers, supervisors and board members, all of whom are business “insiders”. Eventually “outsiders” were also brought in, including individual customers and contractors who purchased goods and services from the social businesses; regular business owners from local communities with some connection to the social businesses, and mental health service providers.

As the interviewing proceeded, less typical participants who could offer perspectives on social businesses based on their unique experiences began to emerge: for example, there were social business employees who also held outside jobs in regular businesses; employment counsellors working in local community employment agencies whose clients included individuals with mental illness looking for regular jobs in the community; local business owners who had hired one or more employees with a mental illness; providers from community-based mental health agencies that operated vocational programs; a clinician from a hospital-based “first episode psychosis” service; and outside business consultants with particular expertise in the social economy. In all, 44 interviews were conducted across the three sites. Table 1 (pg. 47) presents the distribution of the sample by business type and ten respondent categories.

Table 1: Stakeholder Interviews by Type of Business[1]

Stakeholder Groups	Alternative Businesses	Affirmative Businesses	Social Enterprise	Totals
Board Members	1	3	1	5
Directors/Managers	4	2	1	7
Business Specialists/Consultants	1	1	1	3
Workplace Supervisors	1	2	1	4
Employees with mental illness	2	4	1	7
Employee Co-workers	--	--	2	2
Social Business Customers	2	2	--	4
Regular Business Owners	1	1	2	4
Mental Health Service Providers	--	3	1	4
Local Employment Counsellors	1	2	1	4
Totals	13	20	11	**44**

In-depth, semi-structured interview guides were developed for the study in English and translated into French. The in-depth interview "elicits as complete a report as possible on what was involved in the experience of a particular situation"[149]. Two elements guided development of the guides: 1) the use of open-ended questions which capture points of view without pre-determined questionnaire categories; and 2) in-depth focused interviewing[139]. Interview questions were structured around the experiences of different stakeholders with social businesses and, in this context, with the stigma of mental illness; as well as relations between social businesses and the community. Business managers, directors and board members were also questioned about the business mission and goals; organizational history; their management strategies, hiring, and resource issues; as well as accommodations provided for mental illness. The

[1] Individual interviews were conducted in all respondent categories, except for the employee and employee co-worker categories, where group interviews were conducted. The number of participants in the study, as opposed to the number of interviews, was n=76.

questions were also designed to elicit possible stigmatizing beliefs and behaviors among study participants. I started with a small number of core questions for each individual or group interview, and developed further lines of questioning as the interviewing progressed. There was no pretest, as the questions evolved over time. A composite set of the most frequently asked interview questions is provided in Appendix B.

Interviews lasted between 45 and 90 minutes, and were held in locations convenient to study participants, often in the workplace itself. All interviews were conducted by the researcher, audio recorded and transcribed verbatim. A hired research assistant transcribed the 8 French interviews in the interests of time. Notes were taken after the interviews in order to formulate further questions, verify interview content, or support later analysis[138]. Social business employees with mental illness were given a $50 honorarium for their participation.

While socio-demographic questionnaires would normally be administered to each study participant, we declined to do this for two reasons. First, this research is structured around social businesses as the unit of analysis, and seeks to understand the stigma of mental illness as a process occurring primarily at the organizational level. The socio-demographic composition of respondents was of minor importance as long as they met eligibility criteria. Second, collecting socio-demographic information on participants would have been inappropriate in a context that does not label people in terms of their mental health status as a matter of principle, but encourages them to identify as workers and citizens. It is even likely that collecting information on participants' diagnosis, or mental health

history in relation to employment, would not have been allowed in some businesses.

Each business director was asked to furnish documents pertaining to his/her business. Documents ranged from annual reports and minutes of board meetings, to business plans and financial reports, media stories and internet items on the businesses. The degree of access to documents, and the types and extent of documentation collected, varied across the three research sites.

Data analysis. Data analysis was inductive and took place over a seven-month period, from March to September 2012. The analysis involved four distinct stages: the first three stages concerned with analysis of the 44 interviews, and a fourth stage for indexing and presenting descriptive material from document and observational sources. The analysis is described below:

Stage 1: Each of the transcribed individual and group interviews was read several times. Three interviews that provided an especially rich and insightful description of the different businesses, were selected, one from each site. These interviews were coded line by line, using Atlas.ti software as a data management tool, which produced 1,024 data fragments. These data fragments from the first three interviews were sorted and recombined through several iterations into a set of 329 substantive or "first" codes (code families in Atlas language). These first codes were used as a basis for coding further interviews.

Stage 2: Nineteen additional interviews were coded based on the 329 code families from stage 1. In the course of coding this material, which takes in half of

the total interviews, new material emerged. Thirty more code families were created in stage 2 of the analysis, bringing the total number of codes to 359. At this point, each of the 359 code families was examined, and all code families that did not relate in any way to the concept of stigma were removed. A total of 265 substantive "stigma families" remained. All of the code families were then recombined and subsumed under 32 large categories similar to what Charmaz identifies as "focused codes". These are " . . . more directed, selective, and conceptual than word-by-word, line-by-line and incident-by incident coding"[150:57].

Extensive memos were written for each of the 32 focused codes. Memos included 1) a definition of the code, 2) delineation of its properties somewhat as described for axial coding[151]; and 3) an analytic summary of the content of the code, retaining any direct quotations that could be potentially useful in the write-up of the report. Within each of the focused codes, a constant comparative method was then used to analyze the data in relation to the problem of stigma within and across interviews, across stakeholder groups and across business types (i.e., alternative, affirmative, social enterprise). Possible relationships between the focused codes and their categories were developed; negative cases were also taken into account. Personal reflections on each focused code were included within brackets.

Stage 3: The third stage of the analysis involved integrating data from the second half of the interviews into the analysis. All of the remaining interviews (n=22) were coded in terms of the 265 "stigma" families, and the output kept separate from the Stage 2 analysis. These new data were compared, piece by piece

with the existing code families from Stage 2, now organized under the 32 focused codes; but only data that added something new to the analysis were retained.

Data saturation was then assessed. As described by Lincoln & Guba[136: 350], data saturation refers to the saturation of categories (not interviews), such that "continuing data collection produces tiny increments of new information in comparison to the effort expended to get them". Saturation here also implies the emergence of "regularities" or a sense of "integration" within the focused codes, as well as "overextension" – the sense that the new information being unearthed is very far removed from the core of the category. Based on these considerations, 75% of the data from the entire set of 44 interviews had been integrated into the analysis when saturation occurred.

Appendix C presents the final code structure used in writing up the cross case findings, that is, the combined data from Stages 2 and 3 of the analysis. Each of the 32 focused codes is listed (upper case headings), as well as the subgroup of code families under each focused code[2]. In the process of further refining the code families as the data were integrated, the total number of families was reduced from 265 to 261. The number of quotations associated with each code family is also listed as indication of the density of these code families. Atlas registered a total of 3,734 quotations used in the analysis.

The data from the 32 focused codes were then reconstructed under three major themes which form the basis for three separate chapters of cross-case

[2] In a few cases, the code name had to be altered slightly in order to obscure the identities of businesses or their corporations.

findings (chap. 6-8). The major themes, sub-themes, and some illustrative quotations are presented below in Table 2.

Table 2: Major Themes, Sub-themes and Sample Quotations

Major Themes	Sub-themes	Quotations
Balancing Economic and Social Objectives	-Economic sustainability -Business legitimacy -Hiring practices -Marketing products and services -Customer relations -Workplace environment	". . . there are a lot of exceptions that you've gotta' make for people that have difficulties with mental illness. So at the same time as trying to be flexible, they're also trying to make the businesses viable. It's a difficult dilemma." -*social business employee*
Connecting with the Mental Health System	-The mental health system as customer -The mental health system as partner and sponsor -The mental health system and service provider influence	"People from the hospital go out into the broader community and say 'Look at what we're doing; aren't we great!' -*social business manager* "People are assailed from all sides with professional help until (they) begin to think: 'I'm a real case . . . I'm really sick!" -*social business manager*
Building a Workforce	-Believing in people -Empowering people through work -Setting standards training & skill building -Accommodating mental illness on the job -Maximizing employee potential.	"It's about identity. . . . I no longer wear the 'sick hat', but take on the 'worker hat' . . . I leave behind the identity of a sick person, at home in a rocking chair, smoking, watching television – someone who can't accomplish anything." -*social business director*

Stage 4: The final stage of analysis involved organizing the remaining sources of data in the study for purposes of preparing a descriptive case report. These sources included: 1) a number of codes identified as "domains" on Atlas where descriptive information from the interviews was stored; and 2) documents obtained from the businesses, and business corporations at each site. The descriptive domains created in Atlas are listed in Appendix D. The types of documents obtained from each of the three sites are presented in Appendix E.

Following indications from Lincoln & Guba[136], elements of interest for the study were identified from this mass of material. Each element was given a reference number then indexed according to a topical list, as in a book index. Topics were then cross-referenced and organized into a provisional outline for the case description, providing a basis for a systematic writing of the case description. The coding system is incorporated throughout the case description (chapter 5)

Ethical Considerations

The research protocol was submitted to, and approved, by the McGill University Institutional Review Board. Two of the three research sites accepted the McGill ethics certificate; whereas at the third site the mental health organization, and the board of directors of the social business corporation, performed independent ethics reviews of their own. Written, informed consent was secured from all study participants. Confidentiality was maintained throughout the research process, and measures were taken to ensure that the individual businesses, and study participants, would not be identified.[136] Study participants are identified by site (A,B,C) and business (1-5) where applicable,

and by interview number (1-44). The type of business (affirmative, social enterprise, alternative), or individual businesses (identified by pseudonym) were singled out only where necessary.

Trustworthiness of the Study

A number of procedures were invoked to ensure trustworthiness of the study: they concern the credibility; coherence; transferability; and confirmability of the study. Saturation, another element of trustworthiness, was described in the previous section.

Credibility. Credibility refers to the "truth value" of the study, viewed as the extent to which the researcher's account is faithful to the experiences of the research participants[152]. One way to achieve credibility is by grounding the results in examples in order to demonstrate coherence between the data and the researcher's understanding of them[153]. Other specific measures taken to enhance the credibility of the study were: 1) triangulation among the three sites/business types; and among participant stakeholder groups. The design also allows for methodological triangulation (interviews, documents, observation notes); and 2) peer debriefing: an academic (and doctoral committee member) with expertise on social businesses was invited to critique an early draft of the findings for errors, omissions and possible bias.

Coherence. The coherence of the research is demonstrated through a nuanced, data-rich presentation of the findings, that further illustrates the logical-hierarchical relationships among key themes and categories[153]. Efforts were made to represent all the data, thus avoiding Sandelowski's "holistic fallacy"[146].

Transferability. The potential transferability of the results was enhanced by thick description of the data, but most especially in the use of multiple settings where distinctions can be made between transferable phenomena versus what is bound to a specific context[152]. A careful description of each setting aimed to "situate the sample", another feature of transferability[153].

As Stake points out, generalization in case study research is less an activity of the researcher than that of the reader, who builds on his/her tacit knowledge about the case through the case report. Case studies, such as the present one, aim to provide people with a vicarious experience that will be useful for transferring assertions from those cases to others[154: 88].

Confirmability. Confirmability, or auditability, of the data is greatly facilitated by the use of computer software, which provides a complete record of raw data; data reduction and analysis products; data reconstruction and synthesis products (structure of categories, themes). A record of the research decision process was also created through specific memos on analytic procedures using Atlas technology. The audit trail for the interview data is included in Appendices C (Coding Structure) and D (descriptive domains). The indexing procedure used in stage 4 of the analysis created an easily retrievable audit trail for the document sources presented in Appendix E. Thus, all the "facts" reported in the findings are grounded in evidence that can be independently confirmed.

Pertinence of the Study

The originality of this doctoral study lies in focusing our understanding of the stigma of mental illness within a specific life domain, -- employment -- and on using social businesses as the research cases. Multiple stakeholder perspectives

are brought to bear on the problem of stigma in employment. The study opens a new avenue of research in addition to the important work being conducted on stigma by the Opening Minds initiative of the Mental Health Commission of Canada. The study seeks to develop support for the assumption that social economy businesses can positively influence the stigma of mental illness in employment, and to develop other interpretations with respect to findings that are inconsistent or contradictory with this view. As well, emerging findings about how stigma operates in the social economy may have important implications for understanding stigma in mainstream Canadian workplaces, where the economic and human costs of mental illness are staggering[155, 156]. This research builds on, and hopefully extends in some way, the work of others aimed at reversing the tide for people with mental illness who aspire toward a better life through employment.

CHAPTER 5: CASE DESCRIPTION

Introduction

The three research sites in this study are located in two Canadian provinces with a history of supporting the establishment of social businesses for people with employment disadvantages. The sites include both large urban centers and smaller city environments. This chapter introduces the real life context of each site through the eyes of the researcher entering the field, with emphasis on the unique characteristics of each setting. My aim is to relate how the different businesses, and their parent corporations, got started and have evolved over time, while foreshadowing some of the issues and tensions that will return in later chapters[3].

Affirmative Businesses

My earliest encounter with the affirmative businesses occurred two months before fieldwork actually began at this first of three research sites. Upon arrival from Montreal, I ventured by taxi to the address provided, passing through an older, worn-out looking residential area and heading toward the outskirts of town. I was dropped off in front of a one story building set back from the main road, and identified as "Community Support Services" for a large mental health provider.

Inside the building was a very familiar looking mental health services site[4]. A glassed-in reception area separated corridors on either side, and a few

[3] The data sources for this chapter are mainly internal documents, and field notes, some interview data on business origins, history, and operations, as well as internet sources. This material has been classified and is cited by code in order to maintain the anonymity of the businesses.
[4] VPC-F :4-5.

people were waiting around for appointments. After announcing my presence to the receptionist, I sat down wondering what this setting had to do with social businesses. As it turned out, the administrative offices of the affirmative business parent corporation, and several of its nine social businesses[5], occupy the extensive rear section of this facility. The social business corporation has no entrance, or signage, of its own. A side entrance leading directly to the business area is locked, as I later learned; and a security guard stationed inside. People better acquainted with the affirmative businesses often come in through the Car Wash at the back, avoiding the mental health frontage entirely.

Late July was a less than opportune time to observe social businesses in action, and recruit participants to a research study. Four business supervisors were away when I arrived, and a fifth was filling in elsewhere; most of the employees had been "let go" to take their holidays until more work came in. Three or four staff from the mental health provider had been hired to fill in for the summer[6]. Managers were keeping a close eye on profit margins, and had reduced operating hours in some businesses[7]. Meanwhile, they were trying to spread the shifts that summer so that the employees, virtually all of whom combine work with social assistance, could work enough to benefit from a $100/month government supplement[8].

The non-profit parent Corporation overseeing the affirmative businesses was incorporated in late 1993, and has two stated objectives: 1) to provide

[5] VPC-F :3a
[6] VPC-F : 18c
[7] VPC-F :6a; 14a
[8] VPC-F :19a

meaningful employment opportunities for consumers of mental health services; and 2) to encourage a variety of employment opportunities that promote personal growth through participation, decision making and financial benefit[9]. An eleven member Board of Directors includes three appointees, one of them a representative from the mental health provider. Of the nine elected members, at least 50% must have a history of mental illness and the rest come mainly from the local business community[10]. Each business contributes a percentage of its revenue to the Corporation[11].

The Corporation and the mental health provider form a partnership. Rent and utilities are paid by the provider, and key staff members in the affirmative businesses are provider staff: they include the Executive Director; individual business support staff who act as supervisors; and the Business Operations Officer[12]. In return for this support, the Corporation's Letters Patent stipulate that each business must hire at least 60% of its employees from among clients of the mental health provider[13]; although, in practice over 90% are "in-house" employees. By 2008, the fifteenth year of the Corporation, the businesses had employed over 320 consumers of mental health[14]. The various businesses also supply a number of important services to the mental health provider at fair market value, such as cleaning their fleet vehicles, operating hospital cafes, landscaping,

[9] VPC-ID : 1, 2; VPC-HM : 4
[10] VPC-HM : 3-4
[11] VPC-ID : 50
[12] VPC-HM : 7
[13] VPC-ID : 15; VPC-HM: 3
[14] VPC-AR : 9-12

and creating corporate cards, which makes the provider the businesses' best customer[15].

The affirmative businesses registered under the parent corporation fall into two categories: 1) a partnership model where the employees own and operate the business, dividing the profits according to a profit sharing arrangement; and 2) an employer-employee model where the businesses are owned by the parent corporation and employees are hired in the traditional manner consistent with relevant legislation. As of 2005, the employer-employee model was adopted as the standard business form, which insured that all employees would be paid at least minimum wage[16]. Each individual involved with the Corporation, whether manager, employee or Board member, is called an "associate." The term "associate" will not be used here in the interest of clarity[17].

The timing of business development and incorporation at this site was determined by provincial government healthcare restructuring. Two government reports published in the early 1990s mandated hospitals in the mental health system to transform their vocational services from an industrial model (sheltered workshops) to a psychosocial framework. The decision to dismantle the existing sheltered workshops and develop affirmative businesses was taken following site visits to other social businesses in Canada by staff from the mental health provider, and corporation board members, and after a year of training and education on business themes that also included clients from the workshops[18]. A

[15] VPC-HM : 3
[16] VPC-ID : 15
[17] VPC-HM :7
[18] VPC-PH :3b

former vocational services manager recalls that the transformation wasn't easy, as staff had a tendency to take over and clients were used to being told what to do; everyone had to learn to work differently. Staff were given "empowerment" training in which they were instructed to get involved in the businesses only at the "expressed request" of employees, and to withdraw their support gradually over time[19]. This manager began to realize that the plan was succeeding when a customer entered the Car Wash one day, and asked, "Where are the patients that used to work here?"[20].

It is important to note that, while the affirmative business corporation recognizes social businesses as employment for people with mental illness, numerous documents and articles testify to the perspective of the mental health provider on the businesses as "a new wave in vocational rehabilitation"[21], and one that is more effective and economical than the vocational system it replaced[22]. One document describes the social businesses and their support staff as part of the "community economic development stream within vocational rehabilitation services" of the mental health provider[23].

My obvious reason for deciding to focus research on the "Car Wash" and the "Library Café" was that these particular businesses would be operating at full capacity in August. They also provided an interesting contrast: the Car Wash was located at the mental health site, whereas the Library Café was out in the community at the central branch of the city public library in the downtown core.

[19] VPC-HM :7-8
[20] VPC-PH: 4a
[21] VPC-HM :129
[22] VPC-HM :7
[23] VPC-HM : 1

Wanting to create a community-based business, the Corporation had bid successfully on a tender from the public library in 1996 to provide food and beverage services. Library volunteers, the "Friends of the Library", have provided two shifts of volunteer help in the café since its beginnings[24]. The Car Wash, originally a sheltered workshops, also seemed especially interesting as the only business where the employees voted to remain a profit share. As the actual business owners, the Car Wash employees are involved in all aspects of running the business except hiring and firing (they didn't have the guts to tell their friends who had failed probation to leave[25]). The Car wash guys are also well known for their dedication and for the immense pride they take in their business.

Social Enterprise

Fieldwork continued at the second research site almost immediately, by mid-September, 2011. The social enterprise in the study is a factory located in a working class district of another Canadian city. The "Manufacturer" occupies the entire fourth floor of a fairly new building, and employed 53 people by 2011[26]. I walked up, noting the absence of an elevator which gave the impression of a "no frills" operation. Yet the small sign directing me to the business, and the company logo, had a professional, modern look. I exited the stairwell into a bright reception area that barely disguised a very busy shop behind the scenes. I was met by a rather shy young woman stationed behind the desk, who took my name and went off to find the human resources officer. While waiting, I perused the latest edition of the company catalogue. The HR person turned out to be cordial,

[24] VPC –LCCW : 178
[25] VPC-PH :6-7
[26] IES-AD :9

informative and very efficient; she quickly ascertained my needs and tasks for the following three weeks, and proceeded to organize my schedule. Unlike the environment at the affirmative businesses, this was clearly not a place where one could just "hang out" and chat with people.

Beyond the administrative offices, which are glassed in, is the factory floor where rows of employees sit at their machines; and a supervisor floats among them. Further back is another large room with big work tables, storage space, and a delivery area where the truck can pull up and load outgoing orders. The open concept of the factory brings together the administration and the employees, who see each other working and contributing to the business. The accent is on practicality and productivity, with every space in the factory used to the maximum. For example, the "conference room" is a multipurpose space, and not nearly as elegant as the term implies. A big meeting table also serves as a lunch table for managers; there's a microwave and coffee station to one side. Should customers call, the conference room becomes a showroom for products, samples of which line the walls. It is also a meeting place for visiting mental health service providers whose clients are allowed to have appointments on work time. In my case, the conference room was the usual interview room.

The noise of machinery in the background was mixed with music from a radio. There was very little conversation among the employees who were working intensely; they barely looked up from their machines as I was escorted through the production chain on a guided tour the following week. Work groups were distinguishable by their color-coded creations. The employees, mostly women, were friendly and gave the impression of being happy in their work. By 10 a.m.,

some employees were already starting to cram into the lunch room for their break, since the workday starts at 7:30 a.m. and ends at 3:00. Break time is closely followed by lunch, which occurs in three shifts due to the crowded conditions.

The unique feature of the Manufacturer, and my main reason for including this business in the study, is that they hire employees both with, and without, mental illness, who work alongside each other. Around 65% of the employees, including a few in government-sponsored training programs, have mental health problems. As in other social businesses, most employees were out of work for at least five years before coming to the Manufacturer, some as long as 10-15 years[27]. Employees at the Manufacturer also tend to be older; the average age is 40, according to the HR person. While the older employee age in the affirmative businesses fits client demographics at the mental health provider, the age of employees at the Manufacturer reflects more a lack of interest, and training, in manual trades among younger people. These kinds of manufacturing jobs are increasingly outsourced and many companies in the sector have closed. This trend is actually fortunate for the Manufacturer in being able to draw on a constant pool of outside workers needing jobs. The ”regulars” make up the other 40% of the company workforce[28]. After my tour, the Director asked somewhat triumphantly whether I was able to distinguish the workers who had mental illness from those who did not. With a couple of exceptions, I could not tell the difference; mixing everyone together was like magic!

[27] IES-LP: :4
[28] IES-F :2c

Jobs at the Manufacturer are more skilled than those in a café or a landscaping business; because running the machinery requires precision and considerable dexterity. One reason why the Manufacturer makes every effort to keep the employees with mental illness on payroll is to preserve their hard-earned skills, and to keep stress levels in check[29]. The "regulars" are hired with the understanding that they will be the first laid off in low production periods, and the jobs of those with mental illness protected. Yet another reason for actively recruiting people with mental illness is that they come with individualized salary subsidies provided by the ministry of employment in this province[30]. These subsidies, also available to mainstream employers, compensate employers for additional training costs, and potentially lower levels of productivity, among individuals with mental illness or other disabilities who are integrating into the workforce.

The Manufacture opened in December 1999, partly in response to the continuing deinstitutionalization of psychiatric inpatients to the community, and their needs related to socio-professional integration. The regional ministry of health mandated rehabilitation professionals from a local psychiatric hospital to implement a social enterprise project, and released funding for this purpose when the hospital closed an additional 130 beds[31]. A non-profit social enterprise organization charged with promoting the social mission of the project had been incorporated earlier that year[32]. Patterned after social enterprises in Europe, the

[29] IES-F :3a
[30] IES-LP : 5
[31] IES-LP : 6
[32] IES-LP : 1

establishment of the Manufacturer as a commercial enterprise followed site visits by mental health vocational specialists to social businesses in Germany, and involved a long process of intersectoral cooperation back home among regional government officials and others involved in developing a social economy for all kinds of marginalized groups.

An eight member Board of Directors oversees the social enterprise organization as well as its two commercial satellites, the Manufacturer and a boutique. Board members represent the public health sector, community organizations, the private sector, academia, and also include the Director of the Manufacturer and an employee with mental illness, as well as two members at large, one of them a mental health consumer[33].

The Manufacturer aims to help people with serious mental illness acquire an active role as employees, actualize their potential, and promote their socio-professional integration. Once hired, employees are classified according to training and experience, level of specialization and degree of autonomy[34]. Each worker has an individual training plan and is evaluated periodically throughout four stages: orientation, training, integration, and maintenance[35]. Salary scales are commensurate with industry standards; and most employees at the Manufacturer work full time[36]. The Manufacturer once entered a government competition that was offering a prize for service to vulnerable populations. In their proposal, the

[33] IES-AD :2
[34] IES-LP:4
[35] IES –AD: 33-34
[36] IES-LP :4

Manufacturer claimed to have created a sensitized workplace where employees with mental illness are not victims of stigma.

Alternative Businesses

It was early November when I landed in front of the alternative business headquarters in another urban center of Canada. I was immediately accosted by a woman wearing sandals, asking for spare change, or a cigarette, and looking very desperate. Encounters with homeless people and dire poverty were to become a regular feature of my month-long stay in this third setting, where the cost of living is probably double that in the other research sites while social assistance rates remain the same. Folks sitting on grates in the sidewalks for warmth, loitering in front of downtown hotels, and sleeping between the back pews of a local church were even more conspicuous than those on the streets of another neighborhood well known for its disproportionate number of mental health services and users. Most of the alternative businesses are located in this district.

The main offices of the alternative businesses are also a nerve center for the mental health consumer survivor movement. They share quarters with an addictions program for youth; a drop in center for homeless people, and a food bank on the first floor[37]. A larger than life-size poster of a defiant aboriginal woman at the front door provoked anxiety every time I passed by her. Inside, the hallways were clean, but dimly lit and decorated with artwork that was for sale. The business offices are on the second floor and accessible by elevator; doors are supposed to be locked if there are less than three people in the office. The furniture was shabby; and I was advised not to sit on the one sofa in case of bed

[37] WCO-F : 3c

bugs. The director had been away the previous day, and "ten thousand things had happened"[38]. Nonetheless, she met with me for over an hour, introduced me to others in the office, and then drove me around on a tour of different businesses. We ended up at the Hospital Café, and had a really good sandwich that half convinced me to study that business. I was on my own afterward, but was invited to make full use of the office, which is always a buzz of activity between everyone's regular work, meetings of various sizes, and lots of catered lunches[39].

While the affirmative businesses and the social enterprise were largely spearheaded by government, and mental health professionals, the alternative businesses emerged from the failure of those systems in the eyes of people who consider themselves "psychiatric survivors". The original alternative businesses pre-dated the incorporation of their non-profit parent organization in 1993[40] by several years. These businesses grew out of meetings held by survivors living in dire poverty, who came together to find ways to make money[41]. Consumer leaders with a lot of savvy tapped into existing service industries for business opportunities. They won cleaning contracts from public housing providers after promising to hire the tenants to clean up their own buildings; and harnessed public transit as a good delivery system for a courier company. They developed a horticultural business after making a successful bid with a local business

[38] WCO-F : 1b
[39] WCO-F : 3c
[40] WCO-00-01 : 102
[41] WCO-94-99 : 1

improvement district to beautify the same neighborhoods where survivors had previously been sleeping in store entrances and "mooching money"[42].

Alternative businesses are, by definition, a type of social purpose enterprise created through a community economic development process. They are operated exclusively by consumer/survivors who are both managers and employees[43]. A majority of members on the Board of Directors that oversees the alternative businesses and their non-profit parent corporation must be psychiatric survivors, and are often founding members of existing alternative businesses[44]. These businesses have always been "purist" in excluding anyone without lived experience of mental illness from their ranks[45]. This choice reflects a deep distrust of mental health service providers for undermining the capacity of people with lived experience, as well as the belief that independently operated businesses are a way for survivors to gain some control over their social and economic circumstances, and show the world what they can do[46].

Over the years, the alternative business organization has devoted as much energy to community engagement and advocacy as running businesses. For example, a service plan for 2010 reported that over 70 public presentations had been given the previous year on issues related to mental health, stigma, addictions and poverty. The parent organization had offered leadership and learning events,

[42] WCO-PH: 2a
[43] WCO-0809 : 65
[44] WCO—0001: 102
[45] WCO-94-99: 99
[46] WCO94-99 : 125

and was an active member of a local social enterprise organization[47]. Staff had also participated in several research projects and international conferences.

On the business expansion front, in addition to employing over 200 psychiatric survivors by the early 2000s through four businesses and a partnership with another survivor organization[48], the alternative business corporation had completed environmental scans across the province, and had received numerous business offers[49] thanks to a million dollar government grant. Their plan was to develop nine regional community economic development corporations by 2003 that would provide business training and help sustain alternative businesses for consumer survivors across the province[50]. However, with a change in government and new political winds, funding for this project ceased along with the hopes of realizing this greatly expanded vision. The provincial ministry of health, a major funder of the alternative businesses, also blocked the expansion by resisting the idea that new social businesses developed by the parent corporation should be allowed to run independently with their own funding streams[51]. Since then, the corporation has shifted back to strengthening the local business infrastructure, and to training. Building community and advancing the civil and citizenship rights of individuals with mental illness have also remained priority areas, including, for instance, participation in a "people's review of social assistance"[52].

I chose to study two alternative businesses that operate in very different settings. The "Hospital Café" is the only known alternative business in North

[47] WCO-1011 : 33
[48] WCO-0407 : 118
[49] WCO-PH : 6
[50] WCO-0304 : 237
[51] WCO-0001 : 2
[52] WCO-1011 : 20

America located within a psychiatric hospital; while the "Gardeners", a horticultural business offering streetscaping, indoor plant maintenance and residential lawn services, works across a variety of organizations and neighborhoods.

The Hospital Cafe, originally part of vocational services at a local psychiatric hospital, was divested to the alternative business corporation in 2000[53]. At the time of the research, the Café was in an exciting period of transformation as part of a major hospital reconstruction project, and anticipated a move to a new street-front location. The 23 Café staff were already in training for their scheduled relocation to the new facility several months later. An expanded, higher-end menu was envisioned; and a new marketing strategy touted the new café as the hospital's "flagship food purveyor", and a proud example of how social enterprise is changing the world of business as well as relationships between mental health consumers and the mental health system[54]. Authors of a planning document asserted that the new café would combine the "cleanliness and efficiency of a Starbucks, the value of a Tim Horton's, and the flexible creativity . . . of many local cafes in the area"[55].

The Gardeners were established in 2001. Over the years, this business has employed as many as 24 survivors at any one time; although it now employs fewer workers who put in more hours per week, and earn higher wages, than in earlier years. A core group of reliable employees has been with the Gardeners for

[53] WCO-1011: 43
[54] WCO-1011 : 41
[55] WCO-1011 : 41

several years[56]. Balancing employee skills is a major dilemma for all of the alternative businesses[57]. Initially, the businesses tended to hire anyone and let them stay; but eventually managers had to become more selective as people who were heavily medicated couldn't do the job, and others with addictions problems could be disruptive.

The Gardeners' main sources of income come from providing outdoor horticultural services to 4 business improvement districts, in one case taking care of 170 hanging baskets and a number of gardens along a main street[58]. They also maintain indoor plants at other locations, including the hospital, and have a year-long contract washing boxes for a food share program. Odd jobs come up as well, ranging from work on the outdoor tree lights for one of the business districts, and tree planting at a shopping mall in a neighboring city, to interior painting, poster and pamphlet assembly to janitorial services. The Gardeners do lots of outreach; they enjoy good media coverage, and have received "glorious reviews" from city counsellors, local businesses and residents[59].

Business Incorporation and Legal Structures

It is important for later discussion to clarify the incorporation status of the social businesses in the study, as well as the legal relationship between the businesses and their parent organizations. All the social businesses share the primary mission of creating employment for people marginalized from the regular workforce due to mental illness. They are all owned, or sponsored, by larger non-

[56] WCO-1011 : 345
[57] WCO-F :
[58] WCO-0001 : 104
[59] WCO-0203 : 22

profit corporations[60]. However, as suggested in the preceding description, the different origins and evolution of the businesses, and varying perspectives of their founders on how to carry forward their mission, became associated with different incorporation, business, and funding models[61].

The affirmative businesses in this study, the Car Wash and the Library Café, are registered businesses that are owned by the non-profit Corporation. As described earlier, the usual business model is an employer-employee relationship between the Corporation and individual businesses, except in the case of the Car Wash where employees voted to remain a profit share. Driven in part by a desire to maintain economic independence from government, the affirmative business Corporation entered into partnership with a large mental health provider, which sustains the Corporation and its businesses through substantial in-kind support as described. The Corporation does not receive any outside financial support, but pays the employees mainly from business revenues.

By contrast, the Manufacturer is an independent business. The government required that a sponsoring organization, called a "social enterprise", be created to support the Manufacturer[62]; yet the two entities were established as separate, non-

[60] A non-profit organization, as defined by the Canadian Income Tax Act is "a club, society, or association that is organized and operated solely for social welfare, civic improvement, pleasure or recreation; or any other purpose except profit." **108.** Mook L, Quarter J, Ryan S. "What's in a name?". In: Mook L, Quarter J, Ryan S, eds. *Researching the social economy*. Toronto: University of Toronto Press; 2010:3-24.. Like charitable organizations, non-profits are exempt from paying tax on most types of income. However, unlike a charity, the non-profit organization cannot issue receipts for income tax purposes, and is not required to disburse a certain percentage of its revenues. Nor does the non-profit have to register either federally or provincially to maintain its privileged tax status. None of the non-profit corporations in the study is a registered charity.

[61] A comprehensive classification of all social businesses in Canada has been catalogued by Lysaght et al, 2011 **114.** Lysaght R, Krupa T. *Social business: Advancing the viability of a model for economic and occupational justice for people with disabilities.* Kingston: School of Rehabilitation Therapy, Queen's University; 2011.

[62] IES-PH : 2b

profit corporations[63]. They are described as operating "in tandem"; while taking on separate responsibilities for advancing the social and the economic mission respectively[64]: that is, the social enterprise is mandated by government to promote the social integration of people with mental illness through employment; whereas the Manufacturer, as a "satellite" of the social enterprise, is charged exclusively with providing the economic activity. The commercialization of the Manufacturer purportedly puts the business at par with the competition[65]. The advantages of separating responsibilities between the two corporations in this way are twofold: first, should the Manufacturer go bankrupt, the social enterprise could create another business and thus maintain the job security of employees with mental illness; and second, should government cut funding to the social enterprise for any reason, the Manufacturer would be able to search elsewhere for financial support and keep people employed[66].

The two alternative businesses, the Hospital Café and the Gardeners, are owned by the non-profit corporation; but have been described as "subsidiaries" of the parent organization by Lysaght et al[114]. They appear to have been given this designation because of their independence from the parent organization in raising outside operating funds, and in having financial responsibility for keeping their workers employed. For example, the Gardeners receive in-kind contributions from the parent corporation in the form of free rent and administration[67]; whereas the Hospital Café rents their space from the hospital, at minimal cost. The parent

[63] IES-PH : ab; IES-IB : 1
[64] IES-PH : 2g
[65] IES-LP : 7
[66] IES-PH : 4b-c
[67] WCO-I : 2

organization pays the salaries of the managers and full time staff at both the Gardeners the Hospital Café; whereas the two businesses raise their own funds for other operating costs, and pay the part time employee salaries out of business revenues. The following three chapters present cross-case findings on major issues and challenges that emerge in advancing social businesses, with particular attention to stigmatizing processes.

CHAPTER 6: BALANCING ECONOMIC AND SOCIAL OBJECTIVES

Introduction

Social businesses provide employment for people with mental illness who are marginalized from the regular workforce. This involves a social, as well as economic, mission which people describe as "the double bottom line". As one business manager suggested, "you have to look at the economic viability and health of the business corporation; . . . just as the health and wellbeing of people that work in the businesses; both are absolutely equal" (A, 20)[68]. Pushing forward both objectives isn't easy, as this chapter will reveal, and may at times convey an impression of trade-off rather than balance. Daily tensions arise between responding to the needs of individuals, and to business considerations, as one employee aptly described: ". . . they're having to accommodate us. And there are a lot of exceptions that you've gotta' make for people that have difficulties with mental illness. So at the same time as trying to be flexible, they're also trying to make the businesses viable; it's a difficult dilemma" (A, 16).

This chapter presents findings on a number of major issues related to the operation of social businesses. They include: 1) economic sustainability; 2) business legitimacy; 3) employees and hiring practices; 4) marketing products and services; 5) customer relations; and 6) workplace environment. The first part of the chapter describes each of these areas and their importance in pursuing the dual objectives of social businesses. The second part of the chapter reviews the

[68] The references in the three findings chapters (chap. 6-8) are based on interviews identified by site (A,B, or C) and interview number; or by business (1,2,3,4, or 5) and interview number, as appropriate.

stigma processes that emerge from each operation to challenge its viability, or alter perceptions of the businesses themselves.

Business Operations and Objectives

Economic sustainability. As with any business, economic sustainability was an important concern for the social businesses in this study. Economic sustainability refers to various business strategies that optimize the use of different assets, whether generated by the business, acquired or borrowed, so that the business may continue to function and remain profitable. The viability of social businesses depends on their ability to meet costs, either through the sale of products and services, or by developing other strategies such as outside funding streams to support the businesses. Economic sustainability is an overriding concern, even when a business is not-for-profit, as "more sales translate directly into more employment" (5, 31).

Three types of costs associated with running social businesses include: 1) production costs such as rent, equipment and materials; insurance, licenses and salaries; 2) costs of employee benefits; and 3) management and administrative costs. As mentioned in the previous chapter, the legal structure of the Manufacturer requires that all of its profits, over and above production costs, be relinquished to the social enterprise corporation, which, in turn, provides manpower to the Manufacturer as well as salaries and employee benefits. The other businesses pay employee salaries and benefits directly out of their revenues. One board member commented that social businesses find compliance with the same employment regulations that apply to for-profit businesses a challenge: ". . .

you have to maintain government regulations, pay minimum wage, which is going up, and deal with deductions such as unemployment insurance, and pension plans"; she added that, in order to meet these costs, the businesses need to be profitable (A, 5). Management and administrative costs are largely associated with training, and advocacy. These costs are high due to the complications of scheduling many part time workers rather than a few full timers, and the challenges of "sticking with people" (C, 32) who have substantial needs. Training and administrative tasks were viewed by managers as more complex for social businesses than for regular businesses because of who they employ.

Most of the businesses in this study were able to meet the costs of providing goods and services, and paying wages, through their revenues. Yet, as non-profit corporations, they faced limitations not shared by for-profit companies; for example the inability to access business loans or private investment, restrictions on how much profit they can generate and retain, as well as disadvantages in competing for contracts in competitive markets. For these reasons, all social businesses need some level of secure, and ongoing, outside funding or other support in order to remain economically viable. The need to subsidize the permanent learning, or training, environment of the businesses was also viewed by one manager as especially acute (C, 37).

The development of the larger, sponsoring corporations comprises one source of economic sustainability; yet, as described in chapter 5, the nature and extent of the support provided by these parent organizations varied considerably. For example, the affirmative business corporation, as owner of the individual

affirmative businesses, is able to protect any business under their purview that may be struggling by redistributing funds from corporation fees and investments. By contrast, support by the alternative business corporation for individual alternative businesses was limited to providing manager salaries, and, in the case of the Gardeners, office facilities. The alternative businesses needed to generate enough business, or find their own outside sources of revenue, in order to pay their employees and stay in business. Job security at the Manufacturer is guaranteed through fiscal arrangements with the government-supported social enterprise, as described.

In terms of outside sources of funding, the findings identified three types of subsidies available to social businesses: 1) annualized government or foundation grants to the parent corporations for discretionary use; 2) individualized employee work integration subsidies provided by government; and 3) in-kind support obtained through the partnership between the affirmative businesses and the mental health service provider. Regarding the first source of funding, both the Manufacturer and the alternative business corporation receive annualized government funding and foundation grants, part of which is disbursed to individual businesses to cover managerial salaries, as described earlier. Individual alternative businesses are entitled to raise funds independently, and have done so successfully. Funding from individualized employee subsidies, the second source, is dispensed through a program run by one provincial ministry of employment. The Manufacturer benefits from this program, and aggressively recruits employees for these "integration contracts". Estimates are that 65-70% of

employees at the Manufacturer come to work on a government subsidy (3, 22). As these subsidies are not time limited, they were described as protecting the jobs of people with mental illness at the Manufacturer while contributing to its economic and social mission. Employees with mental illness are "the last ones touched" in periods of lay-off at the Manufacturer because of this incentive (3, 24). The third type of subsidy, in-kind support from the partnership between the affirmative business corporation and the mental health provider, was described in the previous chapter as the major source of financial security for the affirmative businesses in the form of substantial staff and infrastructure support, what one study participant described as these businesses' "financially competitive advantage." (A,8). All three parent corporations take major responsibility for advancing the social mission in addition to business development.

Business legitimacy. Social businesses are viewed as legitimate to the extent that they are "normalized", or at par with mainstream businesses. Social businesses have developed a number of strategies in order to increase their legitimacy. These include: 1) presenting as "regular" businesses; 2) setting high standards; 3) filling a market niche; 4) building a reputation for good quality and service; and 5) participating in research, education and advocacy. Identifying and operating as a "real" business is expected to militate against paternalism and stigma.

Social businesses are set up as "regular businesses" in terms of what they do, and regardless of who they employ. Social business employees would be the first to contend that their mental health status has nothing to do with running a

business: “We don’t really regard it as relevant; it’s what kind of job we do”, said one (1, 10). If the mental health aspect comes up, it’s unintentional; for example when a customer at one of the cafes asked where the nice sandwiches and squares came from, the employee behind the counter tried the explanation “the mental health services kitchen”, then began to panic as “their eyes got sort of big . . . “ (2, 18). In fact, satisfied customers find that the mental health connection in social businesses tends to disappear after a while. As someone explained: “Once they’re providing the service, and once you’ve formed a relationship, it’s there, but it’s not there either. You know what I mean? I don’t stop to think about it anymore. It’s just ‘Oh damn those flowers look good!” (C, 35).

Establishing and maintaining high business standards greatly enhances legitimacy as well; but is a constant challenge. The Manufacturer provides a good example, in aiming to form “a real enterprise, with real jobs, the same expectations of people as elsewhere, and with the overall aim of making profit. . . .” (B, 24). Yet in setting employee standards, the social mission becomes an important intervening variable. Standards at the Manufacturer are set at par with its mainstream counterparts, and prices are set according to employee productivity; yet intensive training, supervision, and accommodations are needed for people with mental illness who tend to work more slowly than the “regulars” (B, 44). Performance standards are understood less as a set of uniform standards for all workers, than as an ideal to strive for. The Manufacturer encourages and supports its employees with mental illness to do their personal best, become more competitive, and improve over time; and usually with good results (B, 22).

As business legitimacy also depends on fitting into a particular market niche, all the social businesses were found to have specialized in particular product lines. The Car Wash staff, for example, were well aware of the importance of their service for certain sectors of the community. As one pointed out, "There's some people that they don't have time to do (their cars) themselves . . . other people, like the elderly that can't do their cars, or if they're disabled . . . so they bring their vehicles to us" (1,10). Library staff members rely on the handy food services offered at the Library Café. One staff figured that, ". . . in terms of what's available in the immediate geography, there's nothing for about three blocks . . . and nothing good for four" (A, 11).

Reputation is also paramount for social businesses, as in any business, and hinges on having been around for years, or on "having a name" (C, 37). Word of mouth and participation in community events are the best approaches in advertising social businesses; although, at the time of the research, the Car Wash employees were just about ready for Hollywood after being interviewed for a televised report on the local evening news, which described the Car Wash as a "hidden gem" in the community. Satisfied customers play a large role in promoting social businesses by word of mouth, "whereas if (someone) goes to 411 and goes down the list, they might not give them a second look" (C, 35).

The other area where social businesses have developed a high profile is in supporting research, public education on mental health, and in advocacy. Social businesses have often been asked to make the economic case for the positive impact of employment among people with mental illness. There has been a fair

amount of research in this area, which shows a sharp decline in hospital admissions after people with mental illness achieve work (C, 41). Funders are always interested in research that documents the social return on their investment, for example in terms of quality of life after people with mental illness achieve employment. Published research and media reports may have a subtle, positive impact on public anti-stigma education as well (C, 41).

While all social businesses aim to influence public perceptions concerning the employability of people with mental illness, the alternative businesses focus more strongly than others on advocacy. This is in line with their overriding social mission of using business as a driver for pushing a broader social change agenda; as well as the constant need to generate outside funding. A business director explains:

> I mean being employed is good for people; it's healthy for people; it gives them hope. But we can do so much more. The resources are hard to get today. To get the support dollars, there's an awful lot of advocacy that goes on in those businesses. But, again, the whole reason was to build community (C, 32).

Alternative business leaders struggle increasingly to maintain the link between doing business and building the psychiatric survivor community. They acknowledge the tensions between these sometimes competing demands due to the energy and resources required to form activists as well as employees. Yet, as one participant argued, without a strong community development and advocacy component, a social business begins to look like "just another business" (C, 32).

Employees and hiring practices. While the constituency of employees varies across the three types of social business, all have serious mental illness. Except at the Manufacturer, most employees tend to work part time, mainly because their hours of work need to be tailored to the restrictive social assistance policy existing in the province where most of the businesses were located. As employee turn-over is very low in social businesses, managers make little effort to recruit new employees. One stated that he has enough applications on hand that he could fire his entire staff the following day (5, 31). This section describes characteristics of social business employees, and some business implications of hiring them.

Supervisors and managers across the board described most social business employees as people who lived through deinstitutionalization, and thus strongly identify with the mental health system. Employees tend to be middle aged, and have lived on social assistance for years. They come to social businesses due to the lack of other employment opportunities (C, 41). The implication of these widespread perceptions is that nobody would come to work in a social business by choice. Younger people with mental illness are viewed as having much better employment prospects than "that group that got kicked out of the institutions" (C, 42).

Managers tend to describe social business employees as significantly disabled. Long-term hospitalization is said to create passivity and lack of initiative, which is why one manager has a predilection for hiring people with addictions. He considers them less "chronic", and feels they have a "different

perspective" on their work, as they come into hospital for brief treatment but otherwise live on the outside (5, 31). Another manager felt that social business employees were too disabled to do well in community-based vocational programs, stating: ". . . we're fitting that niche of people that have perhaps more serious disability, or more symptomatology, or a greater need for support . . ." (A, 20).

At the same time, there is a great need for skilled workers in social businesses; and some managers do seek ways to create advancement opportunities for their employees. For the alternative businesses, in particular, where all employees and managers identify as having a mental illness, finding managers with lived experience who have the requisite managerial, interpersonal, and leadership skills, knowledge of community development, "and are also crazy" is especially challenging (C, 32). Affirmative business leaders have foreseen hiring people with lived experience to work as business support staff (A, 2). The Manufacturer also makes a particular effort to hire people with mental illness to fill administrative positions, as well as production jobs. (B, 22). One employee with a psychotic disorder occupies a key position in the Manufacturer. As one manager quipped: "she really has a reason to get up in the morning" (3, 24).

Marketing products and services. Balancing business and social objectives is clearly reflected in debates over the question of how to market products and services, and set prices, in social businesses. The findings reveal competing perspectives on how to lead with the product while bringing in social marketing – how, when, and how much to "tell the story of mental illness." This section looks at the case for, and against, social marketing. A comparison between

the alternative businesses and the Manufacturer illustrates the main issues in this debate. Interestingly, these businesses started from opposite positions on the question of social marketing, then, over time, did an about-face on the question.

The alternative businesses initially promoted their social mission in a strong way. The idea that people with mental illness could operate businesses was so radical in the early days of the alternative businesses that it attracted both customers and publicity. As a veteran board member explained, social businesses were not in any way unique, but their social mission was very novel, if not revolutionary. The social mission became their best advertisement:

> So, for me, our marketing was really based on who we were that delivered the service. And I tell you, most businesses couldn't afford the media coverage we got. I think I had every television network at (one business or another). We had tons of magazine and newspaper articles on us. And that always improved our revenue . . . (C, 32).

For years, this focus on the social mission masked some "quirkiness and poor performance . . ." in the alternative businesses (C, 37). Managers eventually realized that their marketing strategy had to shift toward promoting quality service and products, as the businesses would otherwise be confused with charities. By contrast, in the case of the Manufacturer, marketing strategies were completely product-driven until recently, in an effort to promote the business for product quality, and to establish a particular market niche. This business made a clear choice to sell a product, not the social mission. Only recently the Manufacturer has begun to advertise two social "causes": namely, that they are helping people integrate into the workforce; and that their product is made locally (B, 23).

Managers at the affirmative businesses have always viewed the social mission, and their ties to the mental health provider, as their "unfair advantage." Early advisors, including schools of business, recommended to the board that the social mission was a selling point, arguing that: " . . . if people have a choice, giving money to this business versus that business, they might opt to go for you" (A, 5). While the effectiveness of this kind of social marketing is unclear, the strategy worked well for one loyal customer of an alternative business, who stated that the mental health pitch "tugged at my heart strings" (C,35).

Not everyone agrees with the idea of marketing "people with problems", however, especially social business advocates with a strong business orientation. One of the business consultants asserted that "social marketing doesn't particularly sell . . . . if you try to push (the social angle), and then the product and service, I see it as failing." The solution proposed by this participant was to use social marketing only in business to business negotiations, but to push product and service quality with individual customers (C, 37). Another manager stressed the importance of presenting as a business, with the accent on professionalism: ". . . we want to put ourselves forward as professional people first; and then tell our story. . . . we want you to think that if you order from us, you'll get the same product as if you ordered from anyone . . ." (5, 31). An affirmative business advisor lamented that everyone gets "hung up" on the social marketing idea. "I mean why do people buy our dog food (another business)? Because it's good dog food; the dogs love it!" In short, for many social business promoters a good

product doesn't need any "add-on." The only usefulness of the mental health angle in this view might be to get in the door.

Customer relations. Customer relations in social businesses involve two levels: 1) business-to-business negotiations with contractors to provide products and services; and 2) face-to-face interactions between social business employees and individual customers. As mentioned earlier, social businesses tend to seek business contracts in either internal markets connected with mental health systems, or in the non-profit sector where the businesses are better known (C,37). Social businesses may owe their success in negotiating contracts with corporate customers in part to a lack of interest among larger competitors for small projects. So, for example, the affirmative businesses likely won the bid for the Library Cafe in the absence of interest from a Second Cup or a Starbucks; so would only have had to contend with competition from other small business operations. The Gardeners similarly focused on winning small contracts in a large municipality through a . "secondary list" until the city discontinued this system of "social comparative practices" that had provided the Gardeners with a somewhat protected market.

The fortunes of social businesses that attempt to operate outside of "internal markets" are more vulnerable. Years ago, the affirmative business watched their large contract with a manufacturer that employed 40 of their people fade gradually, as the manufacturer improved its technology and no longer needed to hire extra manpower from the social businesses (A, 2). An important contract for the Gardeners foundered when the company mandated to hire social

businesses for horticultural services found a way to elude city regulations by funneling their subcontracting through a "side organization" (4, 30). By contrast, the Manufacturer has been able to hold its own in a very specialized market against a major competitor, thanks to the available supports such as employee subsidies and consistent government funding.

Social businesses tend to attract a certain breed of customers, who are presumed to be more loyal, and more forgiving of mistakes, than others (C,37). "Social customers" are people who like to use their money to contribute to a worthy cause, while also expecting to get value, at a good price. Social customers in this study touched on several important considerations for social businesses in attracting customers, including business reputation, pricing, quality and courteous service, as well as special incentives to attract customer loyalty. One long-time customer described his experience with the Car Wash, lavishing praise on all counts:

> . . . actually the time I found them, a friend of mine had told me that he got a hell of a good deal . . . he thought it was a better than average job; and the price was, to his thinking, less than it would have cost him at another station. . . . It's the detailing . . . they do the extras. I noticed that they made sure they vacuumed your trunk . . . most places wouldn't even think of that! . . . . and I think the fact that it is done by hand makes a difference. . . . just the general attitude. . . . There's always a couple of cars ahead of you. But they're very nice. They tell you the time that you're going to be waiting, and it's amazing how fast they get through. And then boom! . . . they're right on time! . . . . Furthermore, there is a card they give you that if you're back there more than ten times, the tenth is free! (A,13).

The customer's niece brought up the other important value for social customers: helping people with disabilities was her main reason for supporting the Car Wash. Asked how the Car Wash might advertise their service, she suggested that there was a "double add on" at the Car Wash: "it's by people with problems AND they do a good job." (A, 13).

Other findings suggest, however, that the "unfair" advantage of attracting social customers has another side, which seems more of a curse. The Car Wash staff have considerable experience with exploitation by not-so-nice social customers. Some customers think they're getting a "steal", for instance, as prices are very competitive at the Car Wash. Customers have been known to bring in their own shampooing machines, demanding shampooing service, or attempt to exploit their customer loyalty cards. They never seem to be satisfied, according to one employee who, like the others, takes his work very personally:

> . . . that's another thing about people, they know they're getting a good deal; and still they want a better deal. And if they don't get it, they're angry. They're pissed off. They're mad . . . . and then they don't come back, you know, and it's like WE'VE done something wrong!" (1, 10).

Probably the worst incidents involve costly, and sometimes questionable, claims against the Car Wash for damages to vehicles. After one incident which ended in compensation to a customer for a new paint job, the business developed a checklist system and started to document any scratches, dings, or dents before working on any car. The question of whether the stigma of mental illness may be operating behind these customer behaviors is taken up below.

Workplace environment. Social businesses stand out most clearly from regular commercial businesses in attending to their social mission, even at times prioritizing the needs of individual employees over concerns for the "bottom line". This section presents four approaches adopted by social businesses that aim to change the world of business through a more positive workplace. They include: 1) creating an environment more open to mental illness; 2) treating all employees well, and accommodating everyone; 3) redefining the meaning of competition; and 4) creating a community.

Overall, work environments in social businesses are very open, especially with respect to the reality of mental illness. For employees, this saves all the energy that would otherwise be expended in deliberating over whether, and how, to disclose their health-related needs (B, 22). Social business environments also "create space for people to talk about their experiences" and get support (C, 42). Employees at one business felt reassured that they were not being judged (B, 27). Openness to peoples' needs had equally good effects on the "regulars" at the Manufacturer, some of whom had been treated harshly in other factories. As one "regular" commented, "there isn't stress. You work normally; nobody forces us to do things. . ." (B, 43).

Managers attempting to harmonize the two groups at the Manufacturer also make particular efforts to treat everyone equally, and offer the same accommodations to all the employees. For example, the issue arose at the Manufacturer about how to accommodate Muslim employees who stopped work periodically to say their prayers. Somewhat horrified when employees set their

prayer mats on the factory floor, and began to pray in public, managers responded by adjusting break time for everyone to coincide with prayer time; and made the employee lounge available for this purpose. A revealing comment by one Muslim employee indicates that having coworkers with mental illness alleviated her own concerns about being stigmatized: "You know, people who are sick don't watch you all the time . . . they don't ask you stupid questions. . . " (B, 43).

Social businesses also promote an ethic of solidarity rather than competition among workers. Competition can be very divisive in any business, but especially when some have mental illness and others don't. Managers constantly promote the idea that every employee at the Manufacturer is equal, and that their personal contributions to the company are equally valued. In particular, they attempt to dispel any idea among the "regulars" that "I'm better" than the others, or "I'm here because the person next to me can't manage" (B, 22). Solidarity, which is also a characteristic of other social businesses, promotes a spirit of mutual support among employees. As one employee described this, "it's like family; we take care of each other . . . a work family" (4, 33).

All social businesses have the overarching aim of building community; they work hard to build and maintain connections among employees. Social interaction and friendships develop outside of work as well. Of particular interest to this research were the friendships that crossed illness lines in the one business that has experimented with integrating the two groups. Two of the "regulars" at the Manufacturer stated that their co-workers with mental illness, who have job security, take it very hard when they are laid off (B, 43).

Stigma Processes in Relation to Social Business Operations and Objectives

Challenges to economic sustainability. Virtually all the above-mentioned strategies used by social businesses to enhance their economic sustainability met with some form of stigma, whether from the public or from business competitors. The findings suggest that stigma emerges in relation to: 1) business capacity issues; 2) the benefits connected with receiving outside funding; 3) in-kind support that links the businesses to the mental health context; and, 4) the experience of receiving subsidies from the perspective of social business employees.

A social business may experience negative public perceptions due to certain capacity issues. For instance, the business manager at the Gardeners lamented that they do not have "all this huge, really expensive equipment that a landscaper would have". As well, the employees who haul 20 gallon water tanks along the city streets on foot tend to be middle-aged women, rather than young men (4,30). Not much could be done, as social businesses will usually lack the financial resources to upgrade their equipment, or provide transportation in a company vehicle for example, unless its "charity" status can be used to secure donations or resources from supporters in the community. The heavy training and supervision components in social businesses may also be very evident, creating possible perceptions of inexperience, or incompetence, that undermine customer confidence. Social business employees may simply "look different" to the general public, as compared with mainstream businesses employees. The Gardeners had

an interesting early experience that reveals the potential to manage a stigmatizing public image due to capacity issues.

The Gardeners weren't doing well in terms of public relations when they first hit the streets of "Tweedsville". According to a customer, they were " a small group, looking a bit rag tagged . . ." They raised a lot of eyebrows because "their appearance wasn't like the last Joe Gardener we had . . . . and so the public took a step back. . . . . There was something that screamed out to people, 'I'm not like everyone else.'" Things changed radically when the manager finally came up with the idea of getting a new golf shirt for the workers with the name of the business written on it. The Gardeners hit the streets, this time wearing their new shirts, and "(a)ll of a sudden the merchants were out there, talking to them, giving them coffees – 'How can we help you?' 'You're doing a great job!' It was miraculous, it really was," according to the customer (C, 35). Once the professional identity of the business was established, the public began to look at the Gardeners for the quality of their work; and a very strong relationship developed eventually between the social business and the local community.

Receiving outside funding posed a different risk for stigma, as business competitors accused one social business of "unfair competition". In this instance, the Manufacturer's main competitor launched a complaint (unsuccessfully), when he learned that the Manufacturer was receiving subsidies for their employees with mental illness (B, 23). A social business leader in another city expressed similar concerns around the risk for stigma in relation to procurement rules. While better procurement rules were expected to increase the competitiveness of social

businesses in the open market, he found that they are also a "negative approach" in their propensity to provoke stigma among competitors. This participant remained in favor of procurement rules, but suggested that any financial advantages accrued by social businesses should be as unobtrusive as possible (C, 37). In other words, attempting to neutralize their economic disadvantage required sensitivity to related risks for stigma in beliefs that receiving external funding makes social businesses less competitive than regular businesses. One respondent reacted vehemently to this idea, asserting that her product makes her business as competitive as any other:

> We are in a competitive market. I'll tell you why . . . because my product is competitive. Okay? Yes, I give, I organize, I reorganize; this is true, but . . . I sell all over Quebec, in the Maritimes. We sell this product in Ontario – listen, because it is a quality product; it is because it is well made. . . (B, 23).

What should matter, from this perspective, is the product itself, not the extra costs or financial supports involved in producing it.

The benefits of receiving in-kind support in the form of free overhead, and other material supports accruing from the partnership between the affirmative businesses and the mental health provider, also incurred stigmatizing public perceptions of the affirmative businesses as "mental health" businesses. As mentioned in the case description, the Car Wash is attached to the back of a facility owned by the mental health provider. Nothing deflects from customers' awareness that they are entering a mental health site to get their vehicles washed, as the business can't afford the costs of commercial signage. Yet, having made

this deliberate choice, people connected with the affirmative businesses tended to downplay the significance of their association with the mental health provider as entailing any risk for stigma; or they argued that the benefits of the partnership outweighed this concern (1, 21).

The possibility that individual subsidies may have a stigmatizing effect on employees who receive them, especially those entering the regular job market with subsidies, was another issue that was hotly debated among respondents. Employment subsidies, like social assistance, require that people self identify to the employer as having a permanent disability. One vocational service provider argued that these "integration contracts" send employees the message that "we will ask for a subsidy because you are not going to be productive." One of her clients complained all the time that "the employer takes advantage of me;' and, as a result, he felt "different" from his co-workers (B, 28). The administrator of the subsidy program disagreed fiercely with this view, arguing that the subsidies are not stigmatizing because they encourage personal responsibility and are tailored to increasing productivity. Reducing the subsidies over time also recognizes the employee's progress and increased competence (B, 26).

Challenges to business legitimacy. Three types of negative perceptions challenge the legitimacy of social businesses and create major risks for stigma at the business level. These perceptions are that social businesses: 1) aren't "real" businesses, or don't provide "real" work; 2) are the same as vocational rehabilitation programs; and 3) are "sheltered", or segregated from the

community, making them a kind of "social ghetto" for people living outside the mental health system.

Some of the strongest attacks on social businesses allege that they don't provide "real" work, as in the case of a local merchant who griped that the Gardeners should go out and get real jobs, rather than using his tax dollars to beautify the neighborhood (C, 30). However, more serious lapses were evident in the comments of individuals closely associated with the businesses themselves. A manager at one site made running comparisons between social businesses and "the real world" (A,4), while a service provider referred to the businesses as more of a social activity where people "who are comfortable with their limitations" – and with living on social assistance -- could come in, do as much or little work as they felt like, and make a little pocket money (A,3; A,7). Their expectations of social business employees were low. As for the employees themselves, working part time raised doubts that they were doing a "real job". One described her work as "a volunteer job with pay" (2, 18). Her co-worker described how stigmatizing it was for him to work part time, and how uncomfortable having to explain this status to others (2, 18). A related perception was that employment in a social business is not actual work, but a "first step toward work" (A, 7), or, as one manager put it, ". . . as close as they'll ever get, some of them, to having true, real, meaningful employment" (A, 21).

Some study participants also tended to confuse social businesses with pre-vocational or rehabilitation programs given their presumably "therapeutic" or rehabilitative function. This misperception is understandably stronger at the

affirmative businesses which were originally sheltered workshops, and still struggle to overcome that earlier identity. One hospital manager affirmed that, after twenty years, he is still correcting staff who refer to social businesses as a "program" (A, 2). Another complained that calls come in from hospital service providers who are still unaware of the competitive hiring process at the affirmative businesses. It was clear in the interviews that some social business managers were themselves heavily influenced by the mindset and language of hospital clinicians, referring to social business employees as "the clients" and speaking about their "functioning".

A lot of the stigma connected with the identity confusion between business and vocational program emanates from the fact that social businesses provide permanent work. From the perspective of business managers, permanence and job security are part of what makes social businesses real businesses. One described this: "We don't expect people to come here, train and leave, (as in) a lot of places that are programs" and furthermore, "programs do not really teach skills, whereas businesses definitely do . . ." (4,30). Yet, ironically, mental health vocational service providers who offer time-limited pre-vocational and transitional employment programs in the community, view this permanence and security in social businesses from a stigmatizing perspective: as indication that people working in social businesses may not be ready for full fledged employment in the regular job market (A, 17). In one such program, vocational service providers viewed clients who failed to take the step into regular employment as more appropriate candidates for the social businesses where they could receive more

long-term support. In short, working in a social business was seen by vocational providers elsewhere in the mental health system as a step backward. In another curious twist, social businesses were labelled as a "program" because of the people who work there. One social business customer stated that he had always thought of his morning coffee place as "just another business", but began to think of it as a "program" after learning that the employees had mental health issues (A, 11).

The third challenge to the legitimacy of social businesses, based on the stigma of mental illness, stems from the view that social businesses are "sheltered" or a kind of "social ghetto" for people with mental illness. The major stigmas here are that people are segregated from others; they are working with their peers, and getting all kinds of accommodations. A "social ghetto" is created when people get comfortable working in a protected environment and decline to move on. While some study participants suggested that social businesses were inherently stigmatizing for all these reasons (C,39; B,28), defenders of social businesses denied that social businesses were segregated from the community. Social business managers advanced a number of counter arguments to the "social ghetto" theory. One argument asserts that social businesses could never survive without a connection to their communities, and considerable business acumen:

> If you're a segregated group, you can't run the business. . . Running and marketing a business, you have to know your customers. You have to be out there walking the pavement. You are relating to other people all the time, or you can't run the business, right? . . . . And they have to do (the

> business) well, or, trust me, their doors wouldn't be open . . . (C,32).

A business consultant at one site considered the "social ghetto" question as an operational issue that social businesses could manage by carefully thinking through how they want to connect, and integrate, with the community (C, 37). As well, the nature of many businesses is such that people with mental illness have ongoing contact with the public in the normal course of their work. The Library Café, for instance, was viewed by an employment counsellor in a community agency as "front line" service and a great experience on anyone's resume (A, 9). As well, social businesses are able to create a mixed social environment by hiring some employees without mental illness, accommodating all employees equally, and ensuring that no employee is labelled as "mentally ill", which is the strategy adopted by the Manufacturer.

The position of some alternative business leaders on the "social ghetto" question took a more ideological angle. They argued that their mission of providing employment for people with mental illness came as a response to the lack of opportunities for people with mental illness in the mainstream labor market (C, 31). One comment suggests the depth of alienation underlying the conscious choice of alternative business founders to identify people with mental illness as a marginalized community:

> . . . every single marginalized group organizes around identity to create safe places. . . . the majority of businesses out there tend to be organized along very specific lines in terms of community. . . . (W)e say that integration is the

> answer . . . . but we don't live in that world . . . . the multicultural society is a myth. . . (C, 42).

For this respondent, the overriding concern is not whether people work in a social ghetto or not, but that they are comfortable in their work: "it's like who cares?", he said, "when you're pushing a broom, you're pushing a broom . . . whether it's in a social business, or . . . in the hallway of Bell Canada" (C, 42). Regardless of different reasoning, defenders of social businesses found the notion that any business could operate successfully in the kind of social vacuum suggested by the "social ghetto" argument simply outrageous.

Challenges in hiring employees with mental illness. A number of stigmatizing public stereotypes about people with mental illness tend to carry over into social businesses. This section describes four stereotypes about people with mental illness that detract from their value as employees. According to these stereotypes, employees with mental illness are: 1) less capable than others, even intellectually deficient; 2) unproductive; 3) unable to withstand stress because of illness; and 4) unreliable, unpredictable, or potentially dangerous. The findings further suggest that these stigmatizing stereotypes may affect the ability of social businesses to attract good employees and to expand.

A very prevalent stereotype in the findings is that people with mental illness don't have the mental capacity for work. Customers, in particular, often confused mental illness with intellectual impairment. For instance, one contractor described the stereotypical person with mental illness as ". . . somebody on medication (who) walks around with a helmet on; and that you can't really teach

anything to . . . like a child in an adult body" (A, 6). Business supervisors were accused of holding employees back because of mental illness (A, 8). One social business employee who wanted to return to university felt "categorized" as only capable of low level employment (C, 33). Other employees interpreted attempts by their customers to oversee or "supervise" their work as a challenge to their competence (1, 10).

Another rampant stigmatizing belief was that employees with mental illness are not productive. While medications make employee "slowness" an issue in most social businesses, the prevailing stigma about employees among their supervisors as expressed by one observer, is: "Well they only have very low endurance; so they can't do it" (A, 8). The Manufacturer had a particular problem with staff that tended to blame production problems, delays or errors on the employees with mental illness, especially when things were going less well for the business more generally (3, 24). More enlightened managers were constantly fighting against the discourse that "this person can't produce", because such thinking could create division, and friction, among employees (3,22). One manager set out to actually calibrate the productivity of employees, with and without mental illness, at the Manufacturer, and confirmed that employees with mental illness eventually reach the same level of productivity as the "regulars". He argued that people do indeed work less well when they are ill, which may be two months out of twelve; yet the tendency was to generalize and exaggerate their deficits. In the experience of this manager, the stigma of mental illness became a

convenient excuse, or expedient, to avoid investigating the real causes of production problems when they occurred (B, 24).

The stigmatizing perception that stress induces illness, and that people with mental illness are too sick to work, is almost legendary, and also found its way into these findings. Both managers and service providers suggested that most employees with mental illness would be unable to endure the stresses of regular employment, some telling aspiring workers that "you will never go on the job market" (B, 23; A, 7). While alternative business leaders with lived experience had successfully fought against this prophesy, ordinary employees frequently bought into the argument. One stated that "he might last a month" if faced with the "mental stress" of working full time; and his workmates wholeheartedly agreed (1, 10). Social business employees who had made the transition to the mainstream labor market, and later returned, also reinforced this stigma.

Finally, there were abundant findings emanating from public perceptions that people with mental illness are unpredictable, and potentially violent. Media sensationalism does a great deal of harm generally, but also in social businesses. Managers across the board observed a certain "coolness" in the businesses after news reports linked a person with mental illness to a violent crime. Outsiders coming to work in social businesses for the first time tended to share the same prejudices as the general public; like the new manager who confided to her boss: "it could be dangerous; there are knives and scissors around here . . ." (B, 23). Customers of the Car Wash since the days when it was a sheltered workshop

could barely find polite words to disguise their alarm at the idea that people with mental illness could work in the regular job market. One asked:

> Are they mainstream people? Is that really what you're thinking? . . . that these are people that can go and get a job any place else in the community? . . . .You bring a person like that into a group of other people who are all normal, and what do you create? They don't want a person to show up like a firecracker! (1, 13)

The link between mental illness and violence probably has the most impact on individual employees and the self stigma they suffer. As one asserted, ". . . people are ignorant . . . they don't distinguish between different mental illnesses. If you're mentally ill, it just means you're probably violent, or could be violent; you have no credibility; you're irrational" (A, 14). Employees in this study also affirmed that they are not allowed to express anger because of this stereotype: ". . . people know my (mental health) background", said one, a board member and professional, "and (if) I get angry, they just go like, 'Oh, he's nuts,' you know; and it becomes a big ISSUE!! Rather than, most people get angry now and again, and . . . it's just taken as normal" (A, 12).

The stigma of mental illness, as expressed in these stereotypes, has consequences for the ability of the businesses to attract qualified employees. One is the powerful, negative effect of these stereotypes on young people with mental illness who would be deterred from looking to a social business for employment. A service provider speculated about how her young clients in a first psychosis program might react to a social business:

> I would think that an eighteen year old who has just undergone an episode of psychosis . . . would walk in there (the business), and say, 'That's what I don't want to become.' You know, horrible as that sounds, they would . . . feel, 'I should give up on everything, because this is what life is going to hold for me' . . . . Our clients would tend to run for the hills if they hear something like 'social business' (A, 15).

This provider also suggested that other professionals in her field would be "trying to actually prevent clients from having to pursue (a social business) as their type of occupation". Young people with mental illness, except for those most resistant to treatment, are considered too "high functioning" for social businesses.

Similar to the literature on avoidance behavior in the general public toward people with mental illness, employees with mental illness working in social businesses sometimes have a tendency to avoid their peers. Administrators at the Manufacturer observed that the employees with mental illness often declined to interact with their peers; they don't want to be bothered with lunch table discussions about medications and the like, or otherwise reminded about mental illness. Someone noted that employees who left the Manufacturer, were usually those with mental illness, not the "regulars", and in part for this reason (B, 23).

One remedy to these stigmatizing stereotypes might be for social businesses to adopt the same practice as regular businesses, which is to showcase their employees as their greatest asset. Instead, findings revealed that some social business managers feel the need to apologize for their employees, even after customers praised their work (A, 21). Faced with legitimate fears of stigma and

reprisal, employees, supervisors, and even board members with a history of mental illness, have a strong incentive to conceal their mental health status. The high quality work of social business employees thus goes unrecognized, and the stigma of mental illness lives on. One manager strongly endorsed the idea of promoting the strengths of social business employees, and counteracting stigmatizing stereotypes, through marketing plans that would introduce themes focused on putting employees with mental illness in a good light (C, 37).

Challenges in marketing and pricing practices. Other risks for stigma occur when marketing or pricing practices adopted by social businesses deviate from conventional market-driven practices, especially when the businesses either undersell, or oversell, their social mission. Stigma was found to emerge in three types of situations, when: 1) the costs of products or services were set too low or too high; 2) when the businesses failed to identify and meet customer expectations, or lowered the quality of products; and 3) when businesses overpromised and over delivered on their products and services. A final issue was the stigmatizing effects of social marketing from the perspective of employees.

Findings suggest that pricing in social businesses needs to be determined by the market, as a general rule, despite the incentive to lower prices because overhead or manpower costs in social businesses may be lower than those of their competitors due to their external financial support (A, 8). One manager found that pricing lower in order to increase their competitive edge raised questions, and possible stigmatizing perceptions, from prospective customers about whether the business would do a proper job (4, 30). The challenge for another business was

that their prices were somewhat higher than those of competitors, mainly because they used better quality materials. Customers needed to be convinced to pay a little more in order to support the local economy, and employ people with mental illness (B, 25).

On the second point about meeting customer expectations, the rule given by some managers is that products, and prices, should match the caliber of the customer base. Comparing the two cafes in the study, the findings showed that both cafes tended to adjust their pricing to the modest means of psychiatric populations who patronized the cafes – whether hospital inpatients in the case of the Hospital Cafe, or the local homeless population who were regulars at the Library Cafe. However, keeping prices low at the Library Cafe in order to cater to mental health patrons tended to ignore the preferences of other customers, who expressed dissatisfaction with product quality (5, 11). This approach also ran against the better judgment of board members who maintained, against the stigmatizing beliefs of café managers, that the employees were capable of preparing better products (A, 8). A general belief that the Library Cafe was stuck with the mental health demographic, and couldn't expand, was becoming a self-fulfilling prophesy at the time of the research (5, 19). By contrast, managers involved with the Hospital Cafe were making efforts to capture a prospective, higher-end clientele, working on plans to upgrade their products and doing intensive training with the employees. Managers didn't want customers to support the Hospital Café out of charity – because "it's a worthy cause"; or because the

hospital had a vested interest in its success (C, 31), let alone because they couldn't afford anything better.

Social businesses also risk incurring stigmatizing attitudes from customers, when they over-sell or over-deliver on their products and services. Despite all the accolades about the great work, and very competitive prices offered by one of the businesses, a loyal customer expressed her sense that the business was over-performing, and implies that this may be due to an underlying sense of inferiority within the business:

> . . . could it be that they're coming from a further away place, so they have to work harder in order to keep us a happy customer? 'Cause they do . . . they promise but they over deliver at what I'm getting from them (C, 35).

Employees also voiced self-stigmatizing beliefs about the need to "over-deliver" in terms of their individual performance. One expressed a common complaint among social business employees that "We always have to prove ourselves to other people. . . "; adding that she never really feels at ease in what she can do. Others employees apparently felt the need to "explain" themselves to customers: "This is who we are; this is why we're a little different. This is why we might not be like everybody else" (C, 35). Yet, in the early days of one business, it was the manager who instilled the idea in employees that their performance had to be exceptional because of who they were:

> And I would often get on my soapbox – 'anytime we do something wrong (it) will be viewed quadruple times (worse) because we're crazy, and customers expect it anyway'. So I really put a lot of responsibility on workers to remember who we

> were, and how we were looked at. . . . we had to be better than best all the time. . . . I think that eventually wore off (C,32).

A final consideration related to the stigmatizing impact of social marketing from the perspective of social business employees. Engaging in social marketing in the form of published articles or displays of pamphlets on the social mission at some businesses provoked fierce opposition from employees, who didn't want the businesses, or themselves, to be linked with mental illness (A,5; 2,18). Board members recognized that advertising as a social business for people with mental illness occurs necessarily at the price of stigmatizing them; and yet they gave in to the idea that advertising the social mission would bring in business (A,12). These publicity campaigns had a certain irony, however, given that most board members with a mental health connection were just as opposed to disclosing their own status as were the business employees. This brings the discussion to the issue of how social businesses manage customer relations, and the stigma associated with this aspect of business.

Challenges in engaging with social customers. Both managers, and employees suggest that attributing exploitative customer behaviors to the stigma of mental illness is not always an easy call. In some instances contract negotiators or individual customers may clearly be attempting to take advantage of social businesses because of who works there; while in other cases stigma is more subtle and difficult to establish. This section looks at different types of stigmatizing situations that offer a range of possible interpretations.

Findings involving business-level negotiations suggest that some contractors equate hiring a social business with giving "charity". As one manager experienced this, "they think they're doing us a favor . . . . (or) 'Oh geez, you know, mental health issues. If we're socially minded we'll give them a chance!' When, in fact, we're a competitive company!" (4, 30). Charity aside, one long-standing contractor was reluctant to give the business a raise after years of good service and rising costs. Another contractor called the social business manager screaming because the employees left a job site after waiting two hours in a snow storm to get let into the building. As this manager sees it, there's an assumption on the part of contractors that "they need the money. . . We have a job for them and they should darn well be here, and just wait" (4, 30). Another stigma that occurred throughout the history of social businesses was the attitude that people with mental illness don't deserve the same wages as others. In some cases, employers would attempt to use "allowable earnings" (the limits imposed by disability benefits) as an excuse to pay people with mental illness less than others (C, 32).

Social business employees, and their bosses, are of different minds about whether stigmatizing attitudes are motivating their more disagreeable customers to try to exploit the employees. According to one employee, the prevailing customer attitude is: "'Well these guys are ill; so I'm gonna try and take advantage of them as much as I can.'" Managers have similar suspicions when customers accuse the Car Wash of causing damage to their vehicles. Their fear is that customers may try to take advantage of employees' vulnerability (A, 20). Not

everyone sees stigma, however. Other social business employees viewed their nasty customers with more equanimity. As one stated.

> I don't know if it's totally – that's what's behind it. People just – like some people maybe they just aren't happy people. Maybe they just, everywhere they go they leave a trail of unhappiness . . . And we have to deal with them. They're not looking at us as mentally ill . . . they have their own problems (1, 9).

The final example involves a kind of stigma that comes from some of the best social customers, despite their kind intentions. In these cases, social customers have ways of altering their behavior that signal to employees that they are being subtly stigmatized. One customer described how he "reformed" himself to make his behavior more "appropriate":

> I did notice that there were some people who didn't 'get' me; like didn't get my sense of humor and stuff . . . I'm quite flippant and sarcastic sometimes; and now I don't do that with them because it's easily misunderstood, I think. So I just fall back to the nice manners and 'please and thank you', and 'have a nice day', and that's it. . . . I want them to like me; and . . . I don't want to be one of their problem people, right? Ya . . . probably after I knew that (about mental illness), I moderated my own behavior a little bit. . . (2, 11).

This customer also described feeling pressured to see one of the café employees every day: "Ya, she calls me 'honey', and wishes me good day. . . . I guess I do change my behavior because I know she's mentally ill. I try to make sure I see her 'cause I don't want her to feel I'm avoiding her . . ." The findings also described cases where a kind of collusion developed between business managers and longstanding customers to be "understanding" toward the employees because everyone views them as people with limitations (1, 21).

Social business employees sense at times the artificiality of relationships with their customers. One began to suspect that her customers may realize that she has mental health problems, precisely because of the their politeness and patience. As she stated,

> I wonder if people – the clients that come in . . . like if they think about it (mental illness) when they're in the store, you know? Because I find that the customers are very patient; they're very understanding. They don't press you too much, you know? So I don't know if that's a part of it; if they know or not" (3, 27).

Other employees spoke about receiving tips from customers out of pity, because of their poverty (4, 18; 1, 10).

Challenges in aiming for more humane workplaces. Interestingly, regular employers who have had the experience of hiring employees with mental illness seem to view the social mission of social businesses somewhat enviously – or are such attitudes really an expression of stigma? For all their commitment to work integration, regular employers who had hired someone with mental illness complained that, unlike social businesses, they don't have the resources to support a person with particular needs in the workplace. As one stated, "I'm not a volunteer" (B, 29). Her altruism and patience hinged on being able to procure a subsidy before she would consider hiring an employee with mental illness.

The other possibly stigmatizing perception among mainstream employers was that social businesses play a "therapeutic role" with their employees. One employer noted an inherent contradiction between the mission of the social

service agency, which she equates with the mission of social businesses, and the mission of regular business, which is strictly to make money. As she put it:

> . . . the margins are tiny, tiny, tiny . . . . So you have to have people doin' their jobs. You can't take a lot of time sittin' around and talkin' about feelings, and how difficult, and missing days of work . . . . "; and furthermore: ". . . I can't be a counselor, and an employer, and a broker of the world for individuals who need that kind of support (C, 40).

The next chapter takes a closer look at one of the most important connections that bears on both the economic and social objectives of social businesses, which is their relationship with the mental health system.

CHAPTER 7: CONNECTING WITH THE MENTAL HEALTH SYSTEM

Introduction

Relationships established between social businesses and mental health institutions are mutually beneficial. Social businesses benefit from their connections with the mental health system as a relatively safe market for their products and services. For mental health institutions, promoting employment for people with mental illness creates cost savings in terms of reduced hospital and emergency room use, and enhances the institution's public image. The findings presented in this chapter reveal that social businesses connect with mental health institutions in three ways: 1) through customer or contractual business relationships; 2) through a partnership between social businesses and a mental health institution; and 3) through connections between individual business employees with mental illness and their mental health service providers. This chapter examines these three types of association, as well as some of the complexities and tensions related to the stigma of mental illness that emerge from doing business in the mental health context.

The Mental Health System as Customer

How social businesses experience the stigma of mental illness through the attitudes and behaviors of their customers emerges in sharp relief when businesses operate within a mental health facility. The Hospital Café, which is located within a large psychiatric institution in an urban area, provides a good example. It should be recalled that the Hospital Café has no formal link with the hospital. Originally a hospital vocational program, the Café was divested to become independently

owned and operated by the alternative business corporation over a decade ago. Employees at the Café are mainly former, or current, hospital inpatients, as are many of their customers. Other customers include front line hospital service providers and, occasionally, hospital managers. Once the Café was divested to become a stand-alone business, it evolved from a place that was selling coffee, candy and pop to a business that now earns a quarter of a million dollars a year (4, 31).

In many ways the hospital strongly supports the Café, while enjoying the public relations benefits of housing a successful, consumer-driven business. A manager described this:

> People from the hospital go out into the broader community, and say 'Look at what we're doing; aren't we great! They're very supportive, and they're saying all the right things; and, you know, 'We're going to change people's perceptions (of mental illness).' And . . . I mean, if you go out on (the street) and see on the boarding the pictures they put up; we're featured front and center. So, organizationally . . . ya, they're incredibly supportive (5, 31).

Yet people close to the operation of the Hospital Café allege that the external and internal politics of the hospital are often in contradiction, and that the Café has been especially hard hit by stigma over the years (C, 42; 5, 31). The findings reveal that the stigma of mental illness has occurred throughout the history of the Café, and occurs in relation to: 1) location; 2) a legacy of inexperience; 3) mental illness and incompetence; 4) the "medical model" perspective on social businesses; and 5) food handling. This section presents findings in each of these areas.

Stigma Related to Doing Business in a Mental Health Site

Location. Locating any business in a psychiatric setting raises the possibility of stigma by association; unless, perhaps, the business carries a brand name like Second Cup. One question was whether, and how, the location of the Café in a hospital environment could be stigmatizing, whether for the business itself or for employees in particular as they are usually patients. Against all expectation, the answer tends to be "no" at least in the case of employees. Whereas one manager found, personally, that the Hospital Café is a very difficult place to work because of the "depressing" conditions, she also recognized that Café employees would be very empowered by that work experience:

> Like imagine . . . always being in that power dynamic of being the patient; and then all of a sudden having an opportunity to be working. Because you get a badge that identifies you as a hospital staff; and you get like for a period of time, to not be a patient. I mean, I think it's an incredibly empowering experience for them (C, 42).

Another manager asked where else in the world people would be allowed to get off of the forensic unit and go to a real job? (C, 32)

In fact, employees at the Hospital Café not only experience little sense of stigma in relation to their work, but even consider themselves as "role models for everyone in the hospital" (C, 41). One employee at the Hospital Café claimed that "everyone loves us". Others spoke in glowing terms about some of their best dishes: the cranberry chicken salad "really gets them." They also have a famous pizza with capers, named "the Fred pizza" in honor of its creator. Customers have

been known to call through the hospital switchboard in order to have Fred pizza delivered (5, 38).

An important factor related to employee identity at the Hospital Café should be noted, which is their awareness, and pride, at being "psychiatric survivors". One employee specially trained in leadership and advocacy described the meaning of this term in his life:

> Knowing that you have a tag as a consumer survivor, it gives me that dignity to say 'I've been through something, and I'm goin' through it' . . . . And now I know that I'm at that point where I can function, work, contribute, and be reintegrated back into society, into the community, and . . . contribute to my family, contribute to myself; I seen myself and identify as a survivor (5, 38).

However, whether the general public would be able to overcome the stigma attached to the psychiatric institution and use the Hospital Café for their morning coffee is another question. The depth of public stigma toward people with mental illness and their organizations is reflected in the pessimistic projections of one study participant:

> People aren't going to stop their cars, and hop out, and go into the new Hospital Café and have some food with the patients. They just are not. I know it. 'Cause . . . that space has been there for a hundred years; there's nursery rhymes about it. I ride the bus back and forth a million times; and I would say that one in ten times I pass by, somebody makes a joke. . . So it's just -- you can't change attitudes by changing architecture (5, 31).

She may have a point, recalling another story about construction workers on the hospital grounds who smelled great food as take out orders emerged from the Café; yet refused to go into the hospital to get some.

Legacy of inexperience. Stigmatizing perceptions of the Hospital Café, and its negative reputation within the hospital, date back to the early days of business operation. Certain episodes occurred – "horror stories"– that were a reflection of inexperience and poor management by erstwhile "social service providers on a learning curve". (C, 37) At times, the manager position became vacant, and employees were left to fend for themselves until the arrival of the next manager. The present manager of the Hospital Café recalled that things fell through the cracks: "I mean somebody sends you an order, and you don't deliver it. That's pretty bad. That's about as bad as it gets. . . . and it creates a really negative perception." He added that even today, "a lot of that early reputation still hangs over us." When a mistake occurs, "we're back to those days" (5, 31).

The other stigma related to inexperience is the widespread perception that the Hospital Café is a permanent training environment. Hospital staff, especially those who still remember the Café as a vocational program, may continue to view the Café in this way. They expect service to be slow, which aggravates them even more. The word around the hospital is "allow time for the wait" when using the Hospital Cafe for lunch. (C, 36) One participant contrasted this scenario to what often happens at a Tim Horton's or Starbucks at high noon:

> . . . You see there's a lot of people there . . . and they're a little late; and you kind of know this happens. Starbucks has that reputation . . . . And we kind of let them go with that. You go into (our café), or a social business and you see the line . . . . (but) you think that we've got a bunch of trainees here . . . They've got mental illness . . . . And you say 'Oh, this is going to happen every time' (C, 37).

An added annoyance related to the training aspect is the tendency at the Café to over schedule people. According to a sharp observer, "they have too many people over lunch, and they're just standing around. That's not a good thing to show either, right?" (C, 32)

From a purely business perspective, others argue that stigma is not operating at the Hospital Café at all. One observer acknowledged that some subtle stigma may be operating, but also pointed out that the Hospital Café has been supported through "growing pains" that could have driven a mainstream business into bankruptcy. Yet managers at the Manufacturer would agree that problems such as slow customer service are always due to poor management, not poor employee performance (C, 37).

Mental illness and incompetence. Another prevailing stigma is that social businesses operated by people with mental health problems are less efficient than regular businesses; and this applies to the Hospital Café in a clear way. For example, those involved in negotiations with the hospital administration for the new Café venue claimed that the hospital had "no faith in our business acumen", and no understanding that Café staff actually considered themselves competent. The hospital's perception was that they "weren't ready to operate the new Café" (C, 42). Moreover, business managers assert that the Café has been held to standards that the hospital wouldn't have applied elsewhere, even to its own staff cafeteria. Based on his dealings with hospital personnel, a manager observed that stigmatizing attitudes haven't changed a lot (5, 31).

Within the general hospital community, the prevailing attitude toward the Hospital Cafe is: "when are they going to get it together?" (C, 41) The manager

complained that every error made at the Café is greeted with: "here they go again -- *those people* just can't get it right!" He finds a total lack of forgiveness, or any benefit of the doubt, in the hospital for the kinds of mistakes that might occur from time to time in any catering business – for example, an order shows up five minutes late; or the napkins are missing; or someone orders fifteen sandwiches and fourteen arrive. Instead, "it's either 100%", or it's "here they go again"; and "*those people* just can't get it right" (5, 31). Another observer asserted that the problem of stigma not only involves the content of complaints, but also the "patronizing" or "condescending" tone with which they are delivered (C, 42).

As in other social businesses, the main, overarching belief about employees with mental illness at the Hospital Cafe is that they are "slow"; and it is "a constant battle" to convince customers otherwise (5, 31). A visiting administrator attributed the problem to medication: "There's no question about it," she stated. Standing in line at the Hospital Café, she had the sense that "it takes a long time for an order to come through . . . or , you know, the employees can be not very focused at times" (C,41). Yet, ignoring the differences in culture between the Hospital Cafe and Starbucks, where the ambiance is more relaxed, someone else complained that "(i)t took twenty minutes to get a standard cup of coffee" at Starbucks (5, 31) as proof that the intolerance over wait times at the Hospital Café contains an element of stigma.

By contrast, employees at the Hospital Café provide a very different perspective on "slow service". First, as people with mental illness themselves, Café employees feel the responsibility to treat their customers with respect: ". . . we understand them, you know -- what they need; we respect their dignity," said

one, adding: ". . . we have to be very sensitive with people . . . and we have to be very careful" (5, 38). Employees also recognize that good service involves a lot of patience, skill, and tolerance for anxiety, as one described:

> I have to use my mind . . . like I'm a psychologist! . . . . Sometimes they come and they're arguing. And I have to stop them, and say . . . . 'How are you doin' today?' And I reason with them; and I take my time with them. . . . One lady, if there's more people around and she's like 'Ahhhhhh!! Hurry up!!' And I have to say, 'Ah hold on one second!' You attend to her; you address her; you be with her; and she's like 'I can't stand the wait!!' I say, 'Okay.' I deal with her (5, 38).

As implied in the above comments, customer service at the Hospital Café may also be "slow" because of the underlying social importance of transactions between Café employees and their customers. Café staff will engage with customers in lengthy discussions about the day's lunch options, seemingly unconcerned that several other customers are waiting in line to place their orders. One indecisive customer dressed in pyjamas under her raincoat, who received a full-blown explanation and recommendations about the menu, was observed returning to the counter two or three times in the space of two hours for snacks, and each time received the same attentive service[69]. The arrival of the coffee cart twice a day on the wards is another social event that breaks the monotony of hospital life; people are waiting and flock around the cart as it emerges from the elevator.

Employees readily admit that some of their peers do make for challenging customers. A veteran employee stated that anger is not advisable with unpleasant

[69] WCO-F : 5c

customers, but also claimed that "it's pretty hard to tell me off." She described her approach with a well known character:

> I took an interest in him, and that's all that he wanted . . . someone to pay attention to him, even though he's rude and mean, arrogant and sometimes smells bad. He just needs someone to say, 'Gee, I'm sorry you hear voices' (5, 38).

Customers also have their own preferences about who shall serve them. According to the Café employees, only one of them is allowed to serve the following customer whom he described:

> Every day he's a different character. And he dressed like that character. Sometimes he's a police officer; so I call him 'chief.' And another day he comes in . . . he's different . . . but in his mind he's all of these things . . . So, of lately now, he comes dressed in his pirate hat. So when I see him now, I say 'How's you doin' most feared pirate, Captain Black Beard?" – Captain Black Beard! And he laughs!! (5, 38)

The "medical model" perspective. Another view is that stigmatizing perceptions of the Hospital Café emerge because hospital management, and staff, see everything that goes wrong at the Hospital Café through the lens of mental illness. An alternative business director ascertained that hospital service providers, with their "medicalized" approach to the world, express their complaints about service at the Café in a patronizing tone, relaying messages indirectly, and rarely getting to the point. He further noted that hospital staff members tend to deliver customer service complaints as if they were still at their work: preferring large, "case conference" style meetings which allow them to rain down complaints in a group context rather than risk offending anyone in particular (C, 42).

One example of a typical customer complaint at the Hospital Café concerns a hypothetical customer's "medicalized" reaction to an ostensibly bad tasting tuna sandwich (C, 42). Rather than attribute the problem to personal taste, the staff person begins to reflect on whether mental illness somehow prevented the employee from discerning that something went a bit "off" in the recipe. Unlike a normal customer who would simply return the sandwich and say straight out: "tastes bad; not happy; give me a credit", the staff member suggests a meeting about the tuna sandwich. By contrast, a customer at the Library Café decided that their egg salad was "yucky"; but, having no medical background, asked no questions about the origins of the sandwich or the mental state of the person who made it. This customer further stated that he would be first in line if the Café employees decided to make their own homemade sandwiches and baked goods, while fully aware that employees of the Library Cafe have mental illness (A, 11).

Much as the behavior of the Hospital Café customer in the earlier example appears abnormal, it is actually typical of all social customers to avoid making direct complaints, and to conceal their stigmatizing views behind polite manners and camouflaging tactics. For this reason, the Hospital Café, like other social businesses, has trouble getting direct, honest and timely feedback on its products and performance (C, 37).

Food handling. The stigma of mental illness as expressed in squeamishness among mental health providers toward consuming food prepared by their clients deserves a section of its own, as this problem has occurred in all social businesses engaged in food service delivery. "Horrible comments" were

received from staff at another mental health provider following a proposal to transform their hospital-based café into an affirmative business operated by mental health consumers. Staff were threatening to boycott the café, which had been run for years by regular hospital personnel, saying that clients were "dirty." As a social business advocate recalled,

> We were getting nasty letters back . . . some of the professionals saying they wouldn't buy if there were clients behind the counter. And interestingly enough, we also had clients who didn't want to work there because of the history they had. So it was mutual . . . (A, 5).

An alternative business manager supplied another instance of stigma related to food handling that came from a wait staff at another café run as an alternative business:

> . . . a lot of social workers and OTs would come in, and bring their clients, or bring a group of folks just to save a bit – it's what your peers did, right? But (the wait staff) told me, 'Grilled cheese; they always order grilled cheese.' And I thought about that, and you know, she's probably right. Grilled cheese is perceived to be safe, and toast . . . . all the professionals, grilled cheese! (C, 32)

Anticipating this kind of stigmatizing behavior at the Hospital Café, upper management at the hospital adopted a "very iron-fisted kind of 'we don't want to see outside food coming into this hospital" policy as a way of supporting the fledgling Café. This reverse stigma or "affirmative actionism" which didn't allow the Café to run on its own merits was as well intentioned as it was damaging to the early business. The social business advocate who told this story interpreted this exercise of administrative prerogative as "bullying", fully convinced that the

policy would only succeed in irritating the staff (C, 42). Time seems to have rectified the situation. According to one estimate, hospital staff now have about a 50/50 chance of eating lunch at the Hospital Café, depending on the daily special (5, 31). The uproar over clients behind the counter at the affirmative business café also resolved itself when managers simply went ahead with the planned transfer of the café to the social business corporation. There too, staff continued to buy their morning coffee and muffin as usual.

The Mental Health System as Partner and Sponsor

Risks for the emergence of stigma where social businesses enter into partnership with the mental health system are quite different than dealing with the system as a customer or contractor. In another city, a partnership was created over twenty years ago between an independent corporation which operates a number of social businesses for people with serious mental illness (henceforth, the Corporation), and a large mental health service provider (henceforth, the Provider). The partnership recognizes the Corporation as a separately incorporated entity from the Provider. One manager described the relationship as "synergistic": the social businesses benefit from the support they receive, while the mental health provider benefits from the positive impact of the businesses in the community as well as their earning potential (A, 20).

As described in Chapter 5, the partnership involves the provision by the Provider of substantial in-kind support in the form of space, and resources to the Corporation, as well as allocation of its own unionized employees to serve as managers and support staff in the individual affirmative businesses. This section describes the impact of the partnership, particularly for business support workers

who supervise the affirmative businesses on a daily basis in terms of their dual roles, professional relationships, and the organizational context. Risks for the stigma of mental illness emerged in relation to: 1) role confusion; 2) organizational conventions; and 3) "benevolent paternalism".

Expectations of business support staff within the Corporation. The original mandate, and overarching aim, of the affirmative business Corporation is to provide opportunities for business employees, who are individuals with serious mental illness, to work, as well as to maximize their control and ownership of the affirmative businesses (A, 2). Within this mandate, the Corporation has defined the role of the business support staff as follows: to focus on training and developing social business employees primarily in the start up phase of the businesses, but to diminish that support over time as the employees become more adept at handling business operations. Managers at the Corporation make a concerted effort to "look at each step along the way – (at) what role (support) staff is playing, and how can we work toward that role being diminished" (A, 2). The Corporation aims to shift the focus of the business support staff increasingly away from direct supervision, and toward expansion of the existing businesses, while involving them in the development of larger projects and new businesses.

At the time of the research, however, the support workers remained very tied to their daily supervision of the businesses. This created a dilemma for Corporation administrators interested in expanding the businesses. "I don't think they get that part", someone commented (A, 8). The Corporation further encouraged the business support workers to step back and diminish their supervisory role by assigning each support worker to supervise two or more

businesses, rather than only one. Considerable progress had been made over the years in this area. According to a board member, there were fewer support workers covering the businesses than in previous years (A, 8).

The other way to reduce staff involvement, and support the Corporation mandate, would be to hire people with lived experience to fill positions as business support workers, bearing in mind that hiring supervisory staff is the prerogative of the Provider. Findings in the next section reveal that the affiliation of business support workers with the Provider, particularly through their relationships with treating professionals, is in significant tension with the objectives and expectations of the Corporation just described.

Functions of business support staff as Provider employees. The social business support staff in the study were veteran non-clinical, unionized employees of the Provider. While support staff supervise the businesses, they report to managers within the Provider organization, and maintain close and ongoing contact with clinical professionals on the outpatient treating teams. This establishes the employment of people with mental illness in the affirmative businesses within the larger context of psychosocial care at the Provider, and tends to reinforce everyone's perception of the business employees as "clients first." According to findings from the support workers in the social businesses, their working arrangements with clinical staff include collaboration in managing mental health issues that may arise in the workplace; access to clinical files and case conferences; and reliance on clinician support in the employee recruitment process, as most prospective employees are clients of the Provider who are

followed by outpatient clinical teams. This section examines each of these aspects against the competing expectations of the Corporation.

Both of the business support workers in the study described the nature of their relationships with clinicians on the treating teams at the Provider. They described their responsibilities, as employees of the Provider, to report and consult with the treating professionals when employees are unwell, or seem agitated, or don't show up for work, or are "a bit off" because they aren't taking their medications properly (2, 19; 1, 21). Support workers seemed to take comfort in the close physical proximity of the clinical services as well. One described his appreciation of this feature: "it meshes really well to have the clinics here, as well as the businesses", because people get "terribly sick . . . physically or mentally and may need immediate attention" (1, 21). This collaboration provides support workers with a clear rationale for taking a therapeutic orientation in their work.

Support workers were also given the prerogative of attending report meetings of the clinical teams when the cases of their employees come up for discussion (A, 20), and, in another round of contract negotiations, status as "paramedics" which allows them access to employees' clinical files (1, 21). Support workers stated that they rarely avail themselves either prerogative, due to time constraints, but tend rely more on their on instincts, experience and personal interactions with employees in assessing them. Yet this status distinguishes business supervisors in this setting from those in the alternative businesses, or at the Manufacturer, where business supervisors do not have direct access to employee medical information (5, 31; 3, 22); and further explains what emerged

as a continual preoccupation among affirmative businesses support staff with the mental health condition of the employees.

The third area of collaboration between the support workers and clinicians is in hiring business employees; and here, again, mental health considerations predominated. The following informal description of how clinicians assist in the recruitment process reveals a understanding of employment from both sides of the partnership primarily as a form of rehabilitation:

> Some of the clinicians will come to us and say, 'Look, you know, we've got this gentleman who just came onto the team; fairly high functioning; feels like he might want to do some work and get out of the house. Do you think that we might get him involved with the business?' . . . . even some of the doctors . . . will find out that, you know, maybe one of the biggest setbacks or problems the client is having is that they need to socialize. They need to be involved in something where they feel like they're giving back to the community (1, 21).

Often the business support workers will invite clinicians or other social service providers who are well acquainted with potential employees to accompany the applicant to a "pre-interview", which is more of a mental health assessment. As one described the benefits of this assessment, ". I can get a sense of what concerns I might have down the road. Either like anger management type things that I might have to worry about, or any little characterizations that I have to kind of look for when they're working" (1, 21). Some business support workers have concerns about dealing with mental health issues on the job, according to another manager: ". . . (they) are a little bit nervous working with people . . . who are hearing voices, for instance. . . . 'Like what do I do when someone is feeling a bit

paranoid?' How can I support them?" (A, 20) Training may be provided on these issues.

Role tensions among business support staff within the partnership. Administrators with the Corporation expressed concern that the affirmative business support workers tend to take on a "therapist" role in the businesses. While the appropriate extent of involvement by support support staff in each business was thought to depend somewhat on "who the employees are at the time" (A, 2), Corporation administrators emphasized that support workers should focus on creating needed accommodations in the workplace, but that mental health issues should be referred elsewhere; support workers were not supposed to help people directly (A, 2). Additional findings on how the support workers view their work indicates the extent to which these concerns expressed by Corporation administrators were justified.

Both affirmative business support workers stated that their psychosocial support functions are the crucial aspect of their work, while managing the businesses is secondary. One acknowledged that employees are able to run the business independently, and problem solve, yet also suggested that they need ongoing psychosocial support:

> So how I support is . . . if they're having a hard time with one of their co-workers, or a customer; they're having a bad day; they're not feeling well; they have voices; they're agitated; we talk through it, and get them through their shift . . . . They can phone up at the drop of a hat, and say. 'I'm not doing well. Can you come over and help me?' (2, 19)

Another support worker described doing "interventions" such as counselling employees, or dealing with mood swings or dealing with instances where

employees are "acting out," which were described by this worker as "my biggest reason to be around" (1, 21). As a business manager observed disapprovingly, considerable psychosocial support, or counseling, takes place in the businesses, and usually on work time:

> I think it isn't beneficial for them (the employees). I realize that there is a different level of each person's illness. However . . . certain employees come in, and they want support and counseling, or to talk to someone about their issues on work time . . . . they've had a rough week. They come in and they get paid for a few hours, and they get more support than they've actually done work (A, 4).

Part of the reason for this type of scenario is the long tenure of most employees in their businesses; many of the working relationships between the business support workers and employees go back a long way (2, 19).

The prevailing view of the business support workers toward the employees reflects most of the stigma stereotypes connected with mental illness described in chapter 6: namely, that the employees are "sick" people, who are inherently unstable, vulnerable and highly susceptible to stress. These shared assumptions among clinicians and business support workers make support workers reticent to transfer responsibility and control to the employees. This attitude persists, even though lead hand positions have been created and employees have demonstrated a capacity to manage their businesses independently –on weekends, for example, when the support workers are off duty. Nonetheless, the support workers consider themselves permanent managers of the businesses, as the following passage indicates, and do not understand why their involvement should be reduced:

> . . . if we had a few more resources available, I think that would be a winning situation where you could have – instead of me scattered over two businesses all of the time, and here and there on a few others – have one support worker concentrating on one business; staying on one business; paying attention to it as they need. And, you know, the only time anybody else would have to have any responsibility for that business would be when I'm on holiday; or when I would be ill. That's the perfect picture, right? But obviously the money has to come from somewhere; and . . . you just do with what you have, I guess. . . (1, 21).

This support worker clearly appreciates his employees, their ability and their dedication – "they make me look good", he joked; but also makes clear who should be in charge.

The extent of the support workers' proprietary claims over their businesses also emerged in relation to the question of whether a person with lived experience could be hired as an affirmative business support worker. Corporation administrators were unreservedly enthusiastic about the idea: "Absolutely, absolutely, absolutely perfect!," one exclaimed, "because someone with a lived experience has an understanding that someone without the lived experience may not have . . . so we should encourage it. . ." (A, 5). Yet the support workers had mixed reactions: they tended to privilege their own professional expertise over the expertise of lived experience. One found the question disturbing, and pointed to the support worker's need for management experience, knowledge of psychology, and ability to handle others' stress levels, which get very high in social businesses. As this worker concluded, ". . . we have that understanding of the employees, their illnesses, what they may be going through . . . our relationships

with the teams, with our colleagues . . .” (2, 20). Another support worker agreed with the idea, but suggested in the end that “. . . you still should have someone owning and operating the business that has . . . a bit of clinical background, like us support workers. . . and .. . access to all the (clinical services) . . .” (1, 21).

The perceptions of employees who weighed in on the question of whether they are capable of operating the businesses independently were mixed. In one business employees were adamant that they could never run the business without their current support worker. Yet in another business an employee stated: “I was told years ago that the whole idea was that the mental health workers would be gone; and that people with mental illness would do the (support worker’s) job.” In this employee’s opinion, a person with mental illness could fill the position of business support worker, and she wondered why this has never happened. Her comments caused some uneasiness in the group; others countered that they needed a supervisor with an understanding and sympathetic ear, like the current supervisor who has been with the business from the beginning. In the end, the group agreed that having a Provider staff as supervisor was a cost-saving measure (2, 18).

The question of underutilized employee capacity. The issue of whether business support workers overstep the boundaries of their mandate with the Corporation in exerting too much control over the businesses raises the related question of whether the capacity of social business employees is fully utilized. One administrator argued that employees were held back, that they should receive training in business functions such as purchasing, computer technology and accounting (A, 8). Interestingly, one of the employees had the same impression

that the skills and capacity of his peers were underestimated: in his words, ". . . their resources are ignored, or not utilized. And they could be a lot more productive" (A, 14). Nor were the business support workers very open to suggestions for improving business performance, as this employee reveals:

> (the support worker) will just say. 'Oh you wouldn't believe the amount of red tape involved in that . . . or 'we can't afford that' . . . Or she often says 'I tried that', you know (before I worked there), and 'nobody bought it.' She seems very glad to get suggestions. . . . but then she just says 'thank you', or 'I already tried it' or 'I've looked into it and found that it costs too much' (A, 14).

Another employee seconded this view, saying "We don't really have an opportunity – well, at least I've never been invited to put out two cents worth. . . . I think there is room for improvement definitely in that area. Because everyone has ideas. . ." (A, 16). A board member speculated that employees are "programmed to accept it the way it is," although she didn't think this happens through any bad intent (A, 8).

Stigma Processes Emerging from the Partnership

Role confusion. The above findings suggest that the affirmative business support staff adopt a mental health service provider orientation in their work, which arguably emanates from their identification with, and deference toward, their clinician colleagues at the Provider. In the collaboration between the two parties, the treating professionals tend to exert considerable influence over the business support workers. The clinicians' understanding of the businesses as a therapeutic setting, and the stigmatizing language characteristically used in rehabilitation programs, tend to carry over to the support staff. A board member

described the entrenched view among business support workers toward the business employees as: “you’re mentally ill for life and should be satisfied living on your disability pension”. She also decried the idea that affirmative business employees need to be “treated with kid gloves”, or that they can’t be disciplined or held to standards in the same way as others (A, 8).

Collaboration between the business support workers and treating professionals has a particularly stigmatizing and stressful impact on the employees, whose identities as clients and workers become enmeshed in the process. For example, not all employees wanted their bosses to be privy to the details of their mental health status, but preferred to keep their work identity and client identity separate. As one described this:

> . . . the bosses are invited to attend the morning meetings; so they hear all about the person’s issues and health; how it is going . . . . And you signed a questionnaire about confidentiality that anyone in your “circle of care” can discuss it . . . . I would like to know specifically who is and who isn’t in this circle of care . . . . (A, 14).

Knowing that the business and treating professionals were sharing information inhibited employees from discussing issues arising in the workplace with their treating professionals due to their fears of possible misunderstanding and reprisal.

Organizational conventions. Another risk for stigma in some affirmative businesses results from operating them within a large, bureaucratic organization. The Provider, as a mental health organization, exposes the businesses to strong principles of hierarchy, inclusion and exclusion, and power dynamics that clash with the egalitarian and community ethos of social businesses. One supervisor was very struck by some of the more informal social conventions operating at the

Provider, as a medical setting, that promote the stigma of mental illness. He described the Provider staff, including the social business support workers, and the affirmative business employees as "two separate worlds". As in any large bureaucracy, Provider staff were socialized into a whole series of exclusionary practices, including separate holiday functions held on work time where social business employees were present but not included in the festivities. One staff described being invited by a social business employee to play tennis; yet before he could respond a colleague warned him ". . . don't do anything outside of work with one of the employees" (A, 4). Discussions about collective agreements and wage increases took place in the presence of business employees living in poverty, as if they weren't there. As this staff member stated, ",. . . the two worlds don't mix. . . it's like you work for (the mental health provider) and they work for (the social businesses). And this stigma is coming from within . . ." (A, 4).

Nor were the effects of the "us and them" mentality at the Provider lost on business employees. The findings reveal that social business employees were complicit with Provider staff in enforcing strict social divisions. For example, a social business employee who attempted to engage in conversation with Provider staff members during their morning coffee, was soundly rapped by her peers, who noticed these interactions and demanded at one point, "Who do you think you are?" Then, from the other side of the divide, a staff member in the coffee circle allegedly referred to the social business employee as "miss smarty pants" for using words with more than two syllables (A, 14). Chances are that many expressions of stigma in the social environment of the Provider occur

inadvertently. As one administrator commented, the Provider staff ". . .have probably not sat and really reflected a lot on stigma" (A, 2).

Their immersion in the organizational environment of the Provider, through shared staff and services, sharply distinguishes the affirmative businesses from social businesses at other sites, which are all organizationally distinct from the mental health system. For example, while the Hospital Café is also physically located in a mental health site, Café managers and hospital staff have no working relationship in terms of daily business operations. Hospital clinicians were banished from the kitchen years ago and now do little more than write reference letters for clients as prospective employees. For their part, managers at the café follow the employees for strictly business-related issues and have no medical information on them. Anyone who becomes ill is simply advised to "go get themselves checked out" (C, 31). The Manufacturer also maintains a degree of separation from the mental health system, as will become more apparent in the final section of this chapter.

"Benevolent paternalism". The Corporation mandate for business support workers to move away from a therapeutic role, and focus on the development and expansion of the affirmative businesses, creates considerable tension, even contradiction, for the support staff. What one administrator defined as "well intended paternalism" – i.e. support staff investing in the businesses, and wanting them to succeed, and "being right there beside people" (A, 2), also has a stigmatizing side which speaks more to maintaining control and reinforcing the message that 'you can't do this without us.' While part of the reason for this

attitude stems from support workers' stigmatizing assumptions about the capacity of social business employees, and misperceptions of their role, another possibility emerging from the findings was that the threat of employment insecurity may be creating perverse incentives for business support workers to make themselves seem more "indispensable".

At the time of the research, a major reorganization of mental health services in the area was underway, and involved a merger between two large mental health providers. Support workers, particularly those with more brief tenure in the businesses, were working under conditions of job insecurity. Some hired for the summer had been bumped from other jobs, terminated and the like (A, 2). In this kind of scenario, one fear would be that that, if the social business employees are well trained, become competent and the businesses do well, then the support staff will no longer be needed. On the other hand, if the businesses don't do well and fail, their jobs might also disappear. It is unclear to what extent job insecurity may have played into support workers' courses of action. Yet the safest option for all support workers, and what would come most naturally in the context of the partnership, is to build the case for their significance based on the ingrained belief that business employees have significant mental health deficits, and need permanent mental health support.

The expectation that support workers will invest their energies into new business ventures asks them to tie their jobs to an even more uncertain fate. Everyone knows that a high percentage of even the best business ventures fails. Not surprisingly, support workers were found to be less than proactive when it came to embracing business expansion, especially given the fact that some of the

existing businesses were hanging on by a thread financially. What some business advisors saw as viable opportunities to expand the businesses often met with the "we've tried everything; it can't work" attitude; or the "you know, I'm in the union; I work seven hours a day" mentality (A, 8). Even more stigmatizing was the tendency for support workers, like Provider clinicians, to take the stigma of mental illness on themselves, as employees of a mental health institution. New business ideas met with reactions like: "this can't work because *we're* mental health", as yet another excuse for inaction (A, 8). While support workers did promote stigmatizing perceptions of employees with mental illness and could be accused of holding people back, we might conclude that their attitudes and behaviors were at least "rational" given the countervailing pressures and influences on them in the context of service reorganization.

The Mental Health System and Influence of Individual Service Providers

The third major connection between social businesses and the mental health system occurs through the input of individual mental health service providers from various agencies whose clients happen to work in social businesses. While social businesses commonly receive referrals from service providers on behalf of their clients, the businesses in this study varied greatly in their acceptance of involvement by outside service providers – from zero tolerance in the alternative businesses, to the close collaboration in the affirmative business partnership just described, to a more arms-length acceptance of service provider input at the Manufacturer, where provider involvement was viewed as a kind of business accommodation.

Findings from both social business managers, and mainstream employers, on the issue of service provider involvement with their employees were especially intense, and point to another source of stigma for social businesses through the involvement of service providers acting as case managers. Managers and employers suggested that individual service providers stigmatize, infantilize, and seriously undermine the work ethic of employees with mental illness. The final section of this chapter looks at their concerns for the stigma of mental illness to emerge in a system that creates "career clients", who are "serviced to death", as well as the insensitivity of service providers toward the risks of "special treatment" in workplaces for setting employees with mental illness apart from others.

Stigma Processes Associated with Mental Health Services and Providers

The "career client". The findings across the businesses and respondent groups suggest that a long association with mental health systems, and with service providers, fosters in people with mental illness a permanent, self-stigmatizing identity as "client of the mental health system". This was documented at the Hospital Café, for example, where managers perceived that employees with long-term experience as inpatients had internalized their client status, and were most comfortable in the familiar environment of the hospital. "So there's a stigma", observed one manager, "and an acceptance of almost a lower (social) status that comes with that – with viewing oneself as a mental patient"(C, 41). Managers at the Manufacturer also noted that employees identify strongly with their illnesses (B, 22; B 44); while employees themselves often self-identified as "high functioning mental patients" (1, 10).

The client identity, or "sick role", plays out beyond the social business context as well. One employment specialist recounted how well versed her clients were at discussing their own "case" with others, clinical language and all: ". . . often they are so used to being in our services, and stigmatizing themselves, that they can sit down with someone and talk about their diagnosis, their difficulties, their illness, social assistance, the food bank, medications. . . " (B, 28). A mainstream employer who had hired an employee through an IPS program had to contend with the employee's habit of calling in sick at the slightest impulse. The employer described her ongoing struggle with this employee:

> She would phone in the morning: 'I don't feel well today.' And so I would say, 'Well, take an aspirin, and come in to work like the rest of us.' 'I didn't sleep well.' And I said, 'You know what? You know how many . . . ? Have a cup of coffee! Have a cup of tea! Get – suck it in!!" (B, 29)

"Serviced to death". One social business manager marvelled at the sheer number of providers involved with her employees, complaining that people are "assailed from all sides" with "help". Her perception was that the involvement of so many providers works against personal responsibility and agency among her staff, and also contributes to stigma:

> I think of a person who has a social worker, an IPS agent, a psychiatrist, a foster home supervisor, and all that. And for these four persons, the social worker asks her to work on an objective; the IPS worker asks another objective; the psychiatrist (the same); and the housing person . . . and maybe an occupational therapist . . . I find that this contributes to stigma in the sense that this person is surrounded by too many mental health providers. So the person has all these people telling her about her problems

> until the person begins to think, 'I'm a real case, because there are five people working on me . . . I'm really sick!' (B, 22)

For employees who live in foster homes, this kind of follow-up becomes 24/7 infantilization. "Imagine, as an adult, that you get up in the morning and don't make your lunch", she exclaimed, "or you have to ask permission to go into the fridge, and follow rules as if you were an adolescent!" This manager found it "almost frightening" when two full-time employees, aged 46 and 54 respectively, announced that a replacement was coming in to "take care of them" when their caregiver went out for the evening.

The "regulars", as coworkers of employees with mental illness, also found that personal responsibility is seriously lacking among their peers. One decried the fact that some employees with mental illness at the Manufacturer come to work, yet are not capable of passing by a grocery store on the way home to buy what they need. This "regular" cited the case of a workmate with mental illness who never has money on her, but just deposits her check in the bank and never touches it again. "Forget about having them do anything out of their routine", she added, "I think it would be valuable if someone would take the time to show them other things. . . . But you can't talk like that, because they are lost. I find this a real shame" (B, 45).

Another anecdote in the findings indicates that medical professionals have little concept of what it might mean for their patients to work, and how to accommodate their employment. A regular employer almost lost a customer after assigning her employee with mental illness to work in their garden. The employee was asking to using the bathroom frequently, encroaching on the

customer's privacy and tracking dirt into the house. After this problem went on all summer, the employer finally got the psychiatrist involved and was told that the problem could be easily averted by taking the medication in the evening, which evoked the following rant from the employer:

> This is a man who's been a psychiatrist for thirty, years, or whatever; and 'I never thought of it' -- because they never brought it up! They just sat at home on their "tooshes" (phon.), on welfare, for the rest of their lives, and it didn't matter! So it was a simple, incredibly simple adaption . . . . But he didn't think of it. -- and that's because he's used to these people not mattering. They're not part of society. They're being helped. It's that responsibility piece again. . . (B, 29).

Service providers are often subjected to the counter-stigma that says they discourage their clients from working. In their defense, employees interviewed at the Manufacturer all confirmed that their mental health providers were very supportive of their employment (B, 27).

"Special treatment". A further risk for stigma occurs when "you send (employees with mental illness) out into a workplace with some job developer trailing them, and like judging their every move" (C, 42). Managers at the Manufacturer, who are always on guard to ensure that employees with mental illness are indistinguishable from the "regulars", are especially sensitive to the risks for stigma in giving outside mental health providers access to the workplace and allowing them to assist employees with their tasks (B, 23). They found that providers tended to speak, and act, for their clients. The presence of service providers also undermined efforts at the Manufacturer to apply workplace

accommodations for the employees with mental illness in such a way that their mental health status would not be apparent to others.

Another cautionary tale from the businesses world involved the stigma that arises when co-workers sense that certain employees are treated differently, or have special privileges, in the workplace. An employment specialist in the study had a salutary experience where he fell into this error:

> I went into this company because my client wasn't doing so good. And . . . some Greek ladies were working there . . . and they didn't know I was Greek; so she's basically – 'Oh, look! The Queen is receiving her court!' You know? She's getting special treatment. I sat there, and it was like 'from now on, you're going to meet me at lunch hour . . . . I'm never coming in here again!' (B, 26)

The regular employer who recounted the garden incident had so much difficulty with jealousy among her other employees toward the one treated differently because of mental illness, that she finally had to disclose the fact to them. As she described the situation:

> They complained to me bitterly. They resented her, and they told me they resent her. 'Why should she be able to go off every hour to go to the bathroom, and she get's nothing done? And I get more done in fifteen minutes than she gets done in a day. . . . 'Why should she work less hours? Why should she work more slowly? I'm killing myself, and she's getting the same amount of money.' . . . . this went on for a while until I finally told them what was going on (B, 29).

Although this solution went against the advice of the mental health providers, who insisted that disclosure must be entirely the prerogative of the employee, this employer maintains that people will only stop their stigmatizing attitudes, accept

differences and work with a person who has mental health issues, once they understand the person's limitations. "If you try to hide that," she asserted, "then the people -- the coworkers get very irritated because they feel they're carrying the load." As the next chapter highlights, disclosure is a pivotal issue in addressing the stigma of mental illness.

The Manufacturer fights back

The philosophy of managers at the Manufacturer is that, in addition to building employee skills, the demands of businesses should be harnessed to help employees appropriate responsibility and combat self-stigma (B, 22). Administrators at the Manufacturer decided that they had a whole education to pursue with mental health service providers.

The first remedy to provider "over-protection" was to ensure that employees were hired only after their case managers had inquired about their job interests, and ascertained whether they would want to work in a setting where 60% of employees have a mental illness. Managers also required that mental health service providers allow their clients to visit the Manufacturer and decide for themselves about whether they would fit into that work environment. Second, employees at the Manufacturer were now allowed to meet with their service providers in the workplace but only at certain times; providers couldn't just drop in. Having an HR officer on site at the Manufacturer who makes a practice of communicating with, and providing support, to all the employees equally also helps to neutralize the possibility of stigma in the workplace. Finally, a policy was instituted whereby employees must call in personally to report their absence, rather than delegating this task to the service provider. Business managers were

determined to convince service providers that each of their clients is very important to business operations; that their clients cannot take time off from work without a serious reason. As one manager complained, "They minimize the importance of work. They don't understand that this person has competence; that she is truly working! 'Don't come to work? That isn't serious?' Yes, it is very serious!'" (B, 23) Just as in regular businesses, managers in social businesses insisted that bad weather, or a poor night's sleep, are insufficient reason for a valued employee, whose work is essential to the production line, to stay home.

Reactions among social business employees to their reality as long term "mental health clients" vary. As described above, some become socialized into this self-stigmatizing identity and, over time, relinquish personal responsibility. Others capitalize on the more insidious "advantages" of having mental health problems – "using illness as a protection against certain pressures" (B, 22). More rarely, people with mental illness make a determined effort to break out of the mental health system. As one social business employee stated: ". . . you need to talk yourself out of (mental illness) too. You can't just have everyone else doing it for you. You've got to take responsibility yourself, and say, 'Hey, this is not the way it's going to be" (A, 16). How social businesses work together with their employees to transform them into a viable workforce, including the battle against self-stigma, is the topic of the next chapter.

CHAPTER 8 : BUILDING A WORKFORCE

Introduction

In addition to balancing objectives and negotiating their relationships with the mental health system, social businesses need to make the most of their human resources. How social businesses develop people with a history of mental illness, long-term unemployment and social marginalization into skilled and confident employees, and the barriers posed by the stigma of mental illness, are the subject of this chapter. The findings include issues, and associated risks for stigma, related to: 1) employee identity; and 2) employee management. We then close the presentation of cross-case findings with two sets of findings on how to remedy to the stigma of mental illness in employment. They include: opening social businesses to employees without mental illness; and privileging a business focus over rehabilitation.

Employee Identity and Self Stigma

Social businesses face a major challenge in developing their human resources due to the widespread occurrence of self stigma among social business employees. Self stigma is reinforced by public stigma toward people with mental illness. This section presents findings on the elements of self stigma that shape employee identity and their perceptions of limited opportunity, as well as findings on the stigmatizing attitudes of others. Successful adjustment to employment, whether in social businesses or the mainstream job market, depends on addressing stigma from both sides of the coin.

Falling short. Mental illness is associated with a deep sense of personal failure according to the accounts of individuals working in the businesses. A successful alternative business director spoke about "growing up ashamed", and being driven to self-hatred from not living up to societal expectations that a person should be working, and contributing, and able to enjoy "the nicer things in life" (C, 42). A supervisor revealed that ". . . most of us feel that we don't fit into the mainstream of things . . . I don't feel like I fit in the world sometimes, never mind the job" (C, 34). Three social business employees had left small towns for the more comfortable anonymity of larger cities due to a similar sense of failure and social rejection. A vocational counsellor commented that people with mental illness are similar to anyone who is chronically unemployed in experiencing the low self esteem associated with repeated failure:

> You have absolutely no confidence in yourself . . . . They go into an interview, and all they can tell the person is what they can't do . . . . They don't work out in this job; they don't work out in this relationship; they didn't work out at home. I mean, 'what am I going to say that's positive about myself to employers?' (B, 26)

Social business employees identify themselves as "different" in a society that doesn't easily integrate differences (A, 11). The feeling of being different from others, or the "us and them" mentality associated with mental illness creates obstacles for people in facing the outside world. "It changes them," suggested another vocational specialist, ". . . They're enfolded into themselves . . . you know, it's THEM doing it to themselves. And so the self stigma is there" (A, 17). A service provider described the reticence of her clients to engage with potential

employers, or with others, as "anticipatory" stigma, or the fear of being stigmatized even though the person has never reported actually being stigmatized (A, 3). The fear of stigma also seems to motivate some people with mental illness to feel they need to "explain" or "excuse" themselves with others, as observed in Chapter 6.

Social business employees have a tendency to make self-depreciating comments, while, at the same time, showing extreme sensitivity to being "judged" by others. One manager recited a litany of self-stigmatizing generalizations that he hears from his employees on a regular basis: "'Oh my God, I'm good for nothing; I'm not intelligent; I'm not capable; I can't do anything . . . .' We do a lot to build them up," he added, "and they fall again. Build them up, and they fall again. Their self confidence is very fragile. . . " (B, 24) A mainstream employer who hires staff with mental illness faces similar attitudes: "Are you going to fire me?" "Am I doing my job right?" "I know you don't like me . . ." (C, 40). Another manager described how self stigma translates into a whole series of performance issues in the workplace: ". . . it becomes that self-fulfilling prophesy . . . 'I'm not good enough', so I won't try. And if I don't try, then I won't screw up; and then I'll be okay'" (C, 31).

A number of employees spoke of social businesses as a protected environment where they are less likely to be judged, and more likely to be understood. Yet removing "judgment" in the case of the Manufacturer put additional pressure on co-workers who complained that they were expected to make up for the sometimes less than satisfactory performance of their peers with

mental illness without uttering a word of complaint (3, 45). Managers also have to be very delicate in their dealings with employees who do not trust others easily after having been "burned, criticized, or called low-functioning" (C, 30). One social business customer who had the temerity to point out an oversight to one of the employees was given the "silent treatment" by the employee in question for over a year. The situation became so awkward that the customer would avoid getting her coffee at that café on days that the employee in question was working (A, 11).

Self stigma is one of the major reasons why people with mental illness avoid competitive employment, according to vocational counsellors (A, 17). Many employees have bought into the idea that they are disabled for life, so are not "pounding the pavement looking for work" (C, 42). One manager who asked the affirmative business employees about their interest in moving to the mainstream job market reported that the answer was "not interested" at least half the time (A, 2).

"Odd ducks." Public attitudes toward people with mental illness tend to reinforce self stigma, and confirm our initial designation of stigma as originating in the intolerance of human differences. The stigma of mental illness emerged in the findings in response to people looking, sounding, or acting differently from expectation, and tended to set them apart. One service provider put it succinctly: "You know, when I think of stigma, I think of blending in, not standing out" (A, 7). One customer wasn't immediately aware that a certain social business in the community employed people with mental illness. After learning about the social

mission of the business, he reflected about the employee who usually served him, saying: ". . . I just thought that So-and-So was a bit of a weirdo, but nothing out of the ordinary really. . . . this place attracts a lot of 'odd ducks' anyway" (A, 11).

The point emerged frequently that, while mental illness isn't written on people's faces, people with mental health problems may present as "strange." Physical appearance can be an obvious "give-away". As one participant commented, some people's appearance is such that "one look, and another company would not take them; they wouldn't even give them an interview" (3, 45). Communication is another hurdle, as a manager explained: ". . . you can't see a mental illness, but you can hear it when people start to speak . . . " (C, 31). A "regular" co-worker at the Manufacturer commented: ". . . you see from the way they work that there is a little problem" (3, 45). Such statements suggest in one way or another that people with mental illness are not quite at par with the general population.

Social business employees themselves were often each others' harshest critics, and could be equally hard on themselves. One observed that the women working in another business looked "downtrodden", and that they generally neglected their appearance. Others readily acknowledged that "the socializing part" may be most challenging for employees, or the need to be more discreet. As one employee explained, ". . . I'm the kind of person, I don't like to talk about my sickness, but I do anyway" (3, 27). Managers confirmed that they often had to ask employees to "change their approach with people" (B, 22). Some employees were needy, or hungry for attention, behaving in ways that forced well-intentioned

coworkers to avoid relationships with them (3, 45). One of the Gardeners, who shares a workspace with some hostile housekeepers in a local hospital, had this advice for her peers since the world isn't likely to change very soon:

> . . . I think you've got to realize yourself that . . . you are different from others . . . and cope with it, and use your common sense; and don't get mad; and just try to get through the day and befriend the person. It makes the job easier (4, 33).

Disability benefits. The availability of disability-related benefits in the form of employee subsidies or social assistance creates another risk for the emergence of stigma. Employee participants invariably viewed social assistance as highly stigmatizing, both in terms of the stigma of mental illness and the stigma of poverty. Virtually all employees in the study had to rely on social assistance in order to afford their medications and make ends meet, which was a source of shame. They experienced stigma from being labelled "welfare recipients" even though they were also tax paying citizens; and had also been socialized to the idea that they are an economic burden on society. One employee stated that she "struggles all the time" over the contradiction between working, but receiving "disability" money. Another felt "pensioned off" like an elderly person at age 23 or 24; her co-workers used the program acronym when referring to social assistance, as the word "disability" in the title was so stigmatizing for them (A, 18).

From the perspective of one manager, social assistance is the biggest barrier to people succeeding, not only as a contributing factor to the stigma of

mental illness, but because of the poverty trap it engenders: "the actual pension says to people who are living with a disability, 'We are going to assign you to live in poverty,' . . . . And then 'We're also going to set up barriers so that you can't get out of it'" (A, 2). Worse, social assistance fosters dependency and a fear of life, as the comments of one participant reveal: ". . . "I've come to want social assistance because, you know, it is never going to stop coming. But if you go out tomorrow and get a great job working forty hours a week, and trips planned; and then the company folds, you start over again" (2, 18).

Findings from employees support the view that the welfare system destroys the monetary value of employment in social businesses. One employee gave a detailed accounting of his monthly earnings: while he earns $600 a month for 18 hours of work per week in a very responsible position, he brings home only $50 a week after deductions, the government claw back, and money owed due to an earlier accounting error (1, 10). This employee and others agreed that money can't be people's motivation for working. "It's coffee and cigarette money", he stated. Another employee, who works full time but still finds herself "running around to food banks", summed up people's sense of disenfranchisement:

> it surprises me . . . you know, I don't know why they want to keep you poor, rather than give you a leg up. . . . it's just evil; they want to put you on the edge of the bridge, and push you off; because they're sick and tired of looking after you. That's how it feels (4, 34).

Reactions were mixed among employees about whether having to disclose that they receive disability benefits was stigmatizing. For example, individual

employment subsidies provided by government are tied to disclosure of a person's mental illness to prospective employers. For some employees, this was highly stigmatizing, whereas other employees stated that they would have no qualms about disclosing their illness in order to obtain this benefit. As one employee put it, laughing, "I'd see it as an advantage I've got over the normal person. I'd say, 'Hey . . . there's something going for having mental illness after all!'" (A, 16)

In one province, citizens with mental illness are allowed to retain all their benefits for 4 years after going off social assistance. This prompted one manager to recommend strongly that her employees take advantage of this grace period because of how their family, neighbors, and co-workers will otherwise view them. In her opinion, the great advantage to working, even if the earnings are equal to social assistance, lies in the opportunity to combat self stigma:

> . . . it's about their identity. It's about changing hats. I no longer wear the 'social assistance hat', with all its connotations of laziness and everything. I no longer wear the 'sick hat'; but I take on the "worker hat" . . . I leave behind the identity of a sick person, at home in a rocking chair, smoking, watching television -- someone who can't accomplish anything . . . (3, 23).

For social businesses, combatting self stigma while attempting to develop marginalized people into a viable workforce may be as daunting as the economic challenges of running a social business. We turn to findings on how the businesses develop their human resources.

Management Practices in Social Businesses

Developing people who come from a disadvantaged starting point requires more than the usual investment of time and effort on the part of business managers and supervisors. This section presents findings on a series of management practices in social businesses: first, "believing in people" as the fundamental value adopted by managers in supporting their employees with mental illness. This value translates into specific efforts to empower people through their work. Second are findings on employee standards, training, and skill building in social businesses, followed by a discussion of specific business accommodations for mental illness; and, finally, the issue of how social businesses maximize employee potential. The stigma of mental illness emerged within five related themes: 1) work-related stress; 2) work accommodation; 3) protectionism; 4) the move to the regular labor market; and 5) the issue of disclosure. These findings are presented below.

Believing in people. Social business managers counter the negativity arising from self stigma with unshakeable belief in the person and his/her potential. Belief in the person begins with the awareness that every individual is distinct, and is "more than" his or her illness. As someone put it, "(P)eople . . . are not just mental health; they are all sorts of things" (3, 22). Belief is closely related to "respect for the person", which must apply to every employee without distinction, especially in the "mixed" environment of the Manufacturer (3, 23).

Belief in the person also means holding to the principle that everyone has abilities or competencies; and then working with people's strengths. One administrator spoke for a number of others in stating: "I happen to think that

people are driven to want to master things, and to succeed, and contribute; and, if given a chance, they will" (A, 2) .

Yet the capacity to maintain a positive regard toward people with mental illness, and their abilities, is a constant struggle. Managers admitted that they have to confront their own stigmatizing attitudes every day. One confessed that he sometimes falls short: "Sometimes I look at an employee and say to myself that things aren't working . . . she'll never be good. I have a tendency to be impatient" (3, 24). A social business customer, who is also a clinician in training, struggles with the notion that mental illness diminishes peoples' capacity; she appreciates the Hospital Café for being ". . .just there 'in your face' as a reminder that the reality is different" (C, 36).

People with mental illness need to be given a chance; or, in the language of recovery, allowed "the dignity of risk". This sometimes takes great forbearance on the part of business managers and employment counsellors. One manager who had initial reservations about placing employees with mental illness in sales positions decided that "unless you try people, you can't say 'it doesn't work'" (3, 22). Another agreed that ". . . in the big picture, you're perhaps accepting some risks . . . But there's risks everywhere . . . . we can choose to sit here and do nothing, and that percentage of the community that's unemployed remains unemployed." This affirmation was seriously tested in the case of a vocational specialist. The stakes became very high when one of his clients, on leave from his delivery job after a relapse, went into the company one morning and drove off with a $75,000 truck. Convincing the frantic employer not to call the police

immediately was the counsellor's first hurdle. The second (after the employee made his run perfectly and returned the truck safely) was to prevent the employer from firing the employee on the spot, and falling back on some very stigmatizing attitudes toward people with mental illness (B, 26).

Empowering people through work. The concept of empowerment is a powerful form of "anti-stigma." Social businesses empower their employees by presenting them as capable in the workplace, and as "regular" people. Empowerment may take very concrete forms, as in the affirmative businesses where the Corporation established an education fund and a dental plan for employees (A, 5). The goal is to present social business employees as indistinguishable from other people, or "just regular guys" as one manager put it: ". . . it's that day to day interaction, seeing people working, and performing, and being regular people that is the key to making de-stigmatization happen" (A, 2).

Empowerment is most effective when it is driven by the economic pressures of doing business: that is, when managers see business challenges as opportunities to promote their employees' personal growth. In this connection, it was at the Manufacturer that the urgent necessity of empowering people in response to the demands of doing business occurred early on. One manager explained this: "We couldn't do everything in their place . . . . the pressure of running the economic enterprise forced us to solicit their participation, interest, and abilities." She would look at a worker, and say, "This person is going to be capable, and I will have to train her, because I have no time. I can't cope otherwise" (3, 22). It became a company norm to resist the idea that "so and so

can't do such and such a job", and not to tolerate self-stigmatizing attitudes among employees. A board member in the affirmative businesses insisted that the profit share model, which makes employees the owners of their businesses, best fulfils the mission of growing businesses by growing the people who work in them (A, 8). How managers dealt with the problem of stress in the workplace is another issue that will be discussed below .

Everyone in close contact with social businesses has an appreciation of how working in social business changes people's lives. Someone commented: ". . . there are employees here today that, to see the difference in them, it's crazy; just unbelievable . . . there was one . . . she arrived here and I said to (the Director): 'We can't hire her!' . . . " But at some point she became super autonomous" (B, 25). Employees themselves underlined how having a work schedule supports self-discipline and creates the opportunity to participate in a community. One employee summarized especially well the life-changing experience of work:

> I gradually learned that I was a lot more competent, and capable, than I ever thought I was. . . I learned (that) I could talk myself out of a panic attack . . . I could rely on myself . . . I could bake muffins . . . and just taking better care of my finances – because I had some! . . . . I learned that caring about other peoples' problems makes me less worried about my own (A, 14).

We now turn to findings on how social businesses operationalize the concept of empowerment through work standards, training and skill building.

Setting standards, training and skill building. According to findings, the overarching aim in setting and maintaining work standards, as well as in

training social business employees, is that their performance will reach the same level as expected from employees in mainstream businesses. Adhering to standards encourages a business, rather than rehabilitative, approach to management, and militates against the stigma of mental illness. This section describes how social business managers develop their employees, while highlighting similarities and differences between social businesses and mainstream businesses in certain respects.

Work standards in social businesses compare with those in mainstream businesses. Standards at the Manufacturer, for example, include punctuality, industriousness, personal responsibility, and good attendance. As an alternative business leader boasted, her people were so well trained that she would get calls from the local jail when employees who had landed there couldn't show up for their shift (C, 32). As in regular businesses, social business managers endorse the creation of job descriptions with specific eligibility criteria, from which performance can be measured (A, 2).

Managers with a strong business orientation, whether in social or mainstream businesses, emphasize that hiring should be based strictly on whether the person can do the job. As one mainstream employer described her philosophy: "I . . . started my café with the firm belief that employment should be open . . . I hire people based on their ability to accomplish a job, without ruling out people with mental illness" (C, 40). She insisted however that people need to fit in, and behave appropriately – no obscenities or harassment of customers; no taking a French fry off someone's plate; good personal hygiene. Another employment

specialist agreed with this view, stating that mental illness is no more than an "added pressure" on the potential employee looking to integrate into the workforce (B, 26).

Maintaining standards is equally important in social and mainstream businesses; yet the findings from these two sectors on reasons for maintaining standards differ somewhat. For mainstream employers, slowness or lack of employee productivity becomes an issue strictly in terms of their bottom line. By contrast, social business managers try to maintain standards for the additional reason that lower expectations of employees with mental illness would stigmatize them vis-à-vis regular workers, and also foster self-stigma. A service provider in the study began to appreciate how low expectations at a pre-vocational program fostered self-stigma and poor performance after a former client landed a regular job and became a very productive worker. Surprised after several weeks elapsed that the client had not yet been fired, the provider commented, "When you were at the rehabilitation centre, you worked so slowly." The former client replied, "well sure, but nobody asked me to work quickly" (B, 28).

Training and skill building in social businesses are tailored to the individual interests and professional development of each employee. This brings in other values that distinguish social businesses from mainstream businesses, as a manager described,

> We're not trying to think, 'well great, so and so runs the cash register;' we'll just leave them there for the next five years, so we won't have to worry about the cash register," . . . which you can do over at Wal-

> Mart. Here, we're trying to say, 'Well that's great. This person is doing well with customer interaction . . . do they want another job? . . . almost invariably, some get good at something; you want to find out, 'is that what they want to do? Can they do more?' (C, 37)

This kind of individualized training promotes the development of transferable skills among employees, which, in turn, provides another antidote to stigma. A vocational counsellor explained:

> It's not a question of mental health, or working in a mental health place. The question is 'what did she learn?' She learned to operate that machine; she knows how to take a pattern and from the pattern build something. And that's it. That's her job, and she can transfer that. . . . So where's the stigma? There is no stigma. . . (B, 26).

The intensity of running a permanent training environment within a business also means that management takes more responsibility for people's mistakes than in a mainstream business. As a business director reasoned: ". . . perhaps we evaluated the person inappropriately for the job; if we had evaluated them better there would be fewer mistakes" (3, 23).

Whereas stigma tends to define certain people as "less than" others, the overarching aim of setting standards, training and skill building in social businesses is to refocus such comparisons by encouraging people to compete with themselves, and to aim at doing their personal best. From a management perspective, this means pushing everyone equally and making sure the system is fair (C, 37). The value of peer pressure for training social business employees should also be mentioned. One social business manager recalled the instance of a

worker who used to "whine" over having to wear plastic gloves until his peers got fed up and told him to "get them on or go home". She contrasted this approach with what happens in the mental health system:

> In the service system you could be coddled for that, or 'counselled' . . . . We didn't do what most vocational programs do, all this 'did you make your bed today?' . . . that is totally irrelevant to the workplace. I find that the carrot and the stick work really well. And they work best when delivered by a peer (C, 32).

Accommodating mental illness on the job. Workplace accommodations, whether in social or mainstream businesses, respond to the performance issues that arise in the workplace, as well as to individual productivity issues. The first question that social business managers ask, as a matter of policy, is what to accommodate in the businesses and how. Beyond this, a manager will ask: "what are the person's limits according to their individual profile; what can we expect of the person and where do we have to offer accommodation?" (3, 22)

As mentioned in earlier chapters, social business managers emphasized that low standards, or low productivity, are ultimately the responsibility of management, and not a mental health issue. Workplace accommodations involve organizing tasks, and production lines, around people's capabilities, for example placing people who work more slowly in the middle of a production chain, or assigning those disturbed by noise to work on the more quiet floors of a building (B, 26). Managers at the Manufacturer described their efforts to adjust the training trajectories of the employees with mental illness, who tend to get off to a slower

start, and take longer to adapt to their jobs, but who do eventually arrive at the same level of productivity as their peers without mental illness (3, 24). One supervisor explained that she assigns tasks according to whether the employee learns quickly, or "goes left when you want them to go right" (3, 44).

A major accommodation in social businesses involves making allowances for periods of illness. When employees aren't feeling well, managers will start by reducing their hours of work. Low morale is often cyclical, according to managers in different businesses. ". . . I realize that there are certain periods where they are more sensitive", said one, ". . . I can see it coming" (3, 44). Sending people who are not well home in a taxi is another accommodation appropriate to a "humane" working environment (3, 23).

Other accommodations are built into business standards and practices. A common practice is to allow employees take time off for appointments, usually on condition that they make up the lost time. Other accommodations in the workplace are more a question of "taking the person where she is at" (3, 22). Job descriptions are sometimes altered, removing criteria such as requiring certain years of experience that would make many people with mental illness ineligible for jobs. Two managers gave examples of how they divide work differently in order to facilitate learning on the job; but also to insure that the person who is slow won't block the entire production process. One employer in a regular business needed to segregate her employee with mental illness from the other workers for some time until she learned to talk less on the job (B, 29). An employment specialist who negotiates accommodations for clients with mental

illness employed in the regular labor market, made the important point that requests for workplace accommodations were more effective if they were presented without making a direct link to mental illness. For example,

> Someone . . . who hears voices and can't function in a place where there's a lot of noise; well that's criteria number one (for accommodation). The problem isn't that he suffers from schizophrenia, and he has hallucinations. The problem is he can't work in places where there's a lot of noise. And so that's where we're gonna' compensate (B, 26).

Participants agreed that accommodating employees with disruptive behaviors was more challenging than accommodating for productivity issues. One supervisor recited a list of problem behaviors that she needs to contend with on a daily basis: people who constantly demand attention; those who "poison the atmosphere" with their negativity; those who are stubborn and pick fights, or who can't concentrate and distract others from doing their work; some who occasionally need to be brought back to reality. She spoke about stepping in to avert fights, and "walking on egg shells" with certain people who are so moody or unpredictable that, as she put it, "I just don't go there, I'm not a specialist" (3, 44).

Social, and regular, businesses differ sharply in their level of commitment to accommodation for mental health issues; although it is important to note that the regular business owners who participated in this study were remarkably tenacious in supporting their employees with mental illness. Yet one of them with staff who had mental health issues was happy to have support from a job placement supervisor, who could serve as a "conduit" in cases where an employee was having difficulty showing up on time, or lacked the right equipment, shoes, or

a bus pass. As a business owner, she felt that such issues were inappropriate for her to handle (C, 40) .

Maximizing employee potential. There was considerable tension in the findings on the question of whether the role of social businesses is to provide permanent employment, or to provide employees with a "stepping stone" or bridge to the mainstream labor market. While there is no fixed policy in any of the social businesses on whether employees should stay, or move on, most managers were cautious in their support for individuals who took initiatives to look for competitive work. This section presents findings on both realities from different stakeholder perspectives.

Social business managers across the board seem to favor developing employees for the long term. As discussed previously, many have reservations about their employees' ability to meet the demands of employment in the regular labor market. In the case of the affirmative businesses, for instance, the Provider exercises considerable influence in directing clients toward "in-house" employment. The vast majority of clients will "wait it out" for the next opening in one of the affirmative businesses rather than pursue mainstream work (A, 3). Managers at the Manufacturer asserted that they should replicate their successful model of social enterprise rather than develop their people for mainstream employment (3, 24).

Among social business employees, most will say that "this is where I want to be" (A, 5), mainly because of the security and comfort that social businesses

provide. Employees at two different sites expressed their feeling of being "catered to" by their businesses (5, 38; 1, 10). An employee at the Manufacturer referred to her workplace as "a security blanket" and "a replacement for the hospital" (3, 27). The fact is that people get very comfortable with the status quo, by their own admission, and that, according to managers, "people rarely leave" social businesses (5, 31). Yet the findings also indicate that employees have some misperceptions about the demands of work in mainstream businesses, seeing competitive work as unattainable (1, 10). Self stigma seems to operate behind their preferences for remaining in social businesses over the long term. One employee who works with a social business by choice, but has also held outside jobs, observed that many of her peers are letting life pass them by: "I might be wrong," she stated, "but my interpretation is that they don't believe in themselves. And I just think that (social business) is what they think they can do . . . . it's kind of what they have accepted" (A, 16).

Yet other social business employees are no different from mainstream employees in having higher career ambitions. Many people working in social businesses have no interest in landscaping, washing cars or food services, as one manager pointed out (C, 42), any more than the lifetime ambitions of employees in one mainstream establishment were to be a line cook or wait staff (C, 40). Whether or not employees take initiative to advance their employment prospects is a very individual decision, however. Some left social businesses for mainstream employment, and returned, two or three times before they succeeded in landing a stable mainstream job (3, 23). As a later section will reveal, the stigma of mental

illness begins to emerge as social business managers and mental health service providers deal with the question of whether, and how, to disclose their own connections with mental health in presenting their employees to prospective mainstream employers. The discussion now turns to findings on the stigma of mental illness inherent in managing social businesses, followed by some business-oriented solutions.

Stigma Connected with Managing Social Business Employees

Dealing with work-related stress. As discussed in Chapter 6, one of the prevalent stigmatizing stereotypes about mental illness is that people cannot handle stress and that stress induces symptoms; this further suggests that people with mental illness can not endure the pressures of employment. Findings revealed that many employees, service providers, and employers in the present study have internalized these beliefs. By contrast, other social business managers contend that employees with mental illness can and should be trained to work through their stress. Any other approach would be stigmatizing. One manager put the problem of stress in context: "we all live stress . . . . the entire working population needs to find ways to manage stress, not only those with mental illness" (3, 23).

Managers described the connection between self stigma and stress, offering solutions to the problem. One suggested the need for a constant raising of expectations:

> . . . because people do internalize what they've been taught. And so people think they have nothing to offer . . . they're used to getting sick any time something got stressful. So raising the bar on that,

> and reminding people of the expectations on them is really important (C, 32).

A production supervisor gave a graphic example of her dogged insistence with an employee who starts to panic even before approaching a new task that this person should learn to manage her stress:

> . . . I'll say 'no, relax, breathe; think of other things. It's easy what I'm going to explain to you.' Then, it's ''I don't understand!' I come back with a re-explanation of everything. After that, she tells me: 'no, it's too difficult.' I say, 'no, it's going to work; you're capable. If I ask you to do this task, it's because I know that you're able to do it. You're going to do it!' And sometimes I feel a bit like a mother . . . . I say to myself, 'okay, this person needs me to be more firm. I need to convince them that they are capable. Otherwise she's going to act like a baby. . . . (3, 44).

Another manager deliberately placed an employee with mental illness at the end of the production line. As she explained, this is the worst place for inducing stress, when you're "the last link in the chain." After studying the situation carefully, the manager developed four anti-stress measures: 1) not to delay what you can do today; 2) not to deal with anything unless it's necessary; 3) to be realistic, and not to panic; and 4) to avoid pessimism. The manager's thinking was that if the employee can learn to get her stress under control, she can translate this learning to other areas of her life (3, 22).

Recognizing stress on the job as a management issue rather than a mental health problem contributes to de-stigmatization. From a management perspective, "the most monumental, huge errors made because of stress can often be corrected,

or at least learned from" (3, 23). Another manager further observed that stress and occasional "anger issues" are not particular to social businesses, but are "a normal part of life". He might have been speaking as the manager of any business in describing as his responsibility the problem of stress in the workplace:

> . . . everybody feels that way when they are overwhelmed. . . you can see it in yourselves, I think. So we try hard to make sure that it doesn't happen in the first place by giving people the support they need. And if it does happen, then that's a mistake. We need to do things differently to prevent that problem from happening in the first place (A, 20).

Providing work accommodation. Workplace accommodation may be stigmatizing, depending on whether the concept of accommodation is understood as the responsibility of any good employer, as opposed to the stigmatizing view that workplace accommodations serve to compensate for employees who can't otherwise meet standards and expectations. An interesting contrast emerged in the findings between the perceptions of social business employees, and those of managers or employers, on this issue.

Social business employees, particularly those who work exclusively with their peers, tended to assume that they were accommodated at work because of mental illness. One employee had an equally stigmatizing impression that workplace accommodations are a compensation for low wages, suggesting that social businesses should "at least accommodate their employees", because the jobs are low-paying and because government claws back the "pennies" they earn (4, 34). Yet accommodations are not intended to compensate for lower wages. In

fact, accommodations are measures that respond to the needs of all employees for flexibility in the interests of better work-life balance, as detailed below.

Both social business managers, and mainstream employers, spoke about allowing flexibility for all their employees within the limits allowed by their businesses as the responsibility of any good employer. The Manufacturer treats all employees alike, by offering accommodations for health or personal reasons to any employee, and applying the same sick day policy for everyone (3, 23). The challenge for employers is to balance accommodation with reasonable expectations. A mainstream employer recognized the possibility that accommodations may stigmatize employees despite the best of intentions, particularly when employees have vulnerabilities:

> . . . it's all about accommodating without coddling; 'cause if you coddle, you know what? You've done them no good. I don't think you've done anyone a service . . . But, again, I would say that's true for all my staff . . . And I have to think it that way. Because if I don't, then . . . I start stigmatizing without being conscious of it. 'Oh, they're my 'special staff.' I can't do that (C, 40).

An employment counselor strongly agreed that assuming responsibility for people because of illness will not help them. He stated that people with mental illness have added pressure, but need to function regardless (B, 26).

Engaging in protectionism. Evidence of the stigma of mental illness in different forms of protectionism toward social business employees emerged across all the businesses. The belief that people with mental illness are vulnerable, and in need of protection, underlies much of the "well intended

paternalism" (A, 2) that is rife in diverse situations both in and beyond the mental health system. Protectionism is reflected in the tension between supervising employees closely and over-supervising them. As this section shows, employers, service providers, and others in supportive roles may stigmatize employees with mental illness by holding them back from greater responsibility for fear of inducing stress; or by avoiding learning situations that may risk failure; or in deciding for them and doing things in their place.

The alternative businesses are well known for using business to create community, or "safe places", for psychiatric survivors. A manager spoke about the "constant battle (against) . . . the politics of the outside" that has engaged the alternative businesses. He concluded that ". . . for the most part I think that we have just protected people, given them a safe place really, while giving them the ability to say they are going to work" (C, 42). Managers elsewhere expressed similar concerns that their employees would never be able to manage on "the outside". One argued that bringing together people who are "ill and sensitive" with others who are "mean and bad" in a mainstream work environment would create a lot of conflict:

> It won't work . . . it's in the competitive market where you really get arguments; where peoples' fights are 'for real' . . . that's where a person who is sensitive won't last. He's going to quit work because he doesn't feel well; he won't get along with those people. That's where I find people are more at risk (3, 44).

Other stories about protectionism arose from the collusion between public library staff and the affirmative business corporation. Their concern for protecting

"vulnerable" employees at the Library Café was particularly emblematic. As a customer and library staff member described, library patrons include a difficult inner city population some of whom are people with mental illness who arrive daily from the local homeless shelter. There have been many incidents of bold theft and misdemeanor in the library. Library staff were feeling increasingly responsible for the safety of social business employees working at the Library Café, partly because the business operates on library premises and partly because the café workers seem so defenseless. This participant described the bind the library staff were in:

> It's tough for us, because it's their business . . . literally . . . and they rent the space from us, and do their thing. On the other hand, they're in our house. It involves people that are in our immediate community. And we feel that we can't let stuff go on if it's a bad scene . . . it's bad for the people involved, and also people see that we let it go on. So it's not good for our business, right? (A, 11)

While the Provider was helping to train the library staff on issues such as how to deal with aggressive behavior, this study participant doubted that Café employees were getting the same training. In fact, they were not. Library Café employees were simply instructed to go to the library staff with their issues (2, 19). This reinforced the stigmatizing impression of library staff that café employees are vulnerable, unable to stand up for themselves against aggressive customers, and needing protection. While promoting the stigma of mental illness, this lack of training also deprived café employees of valuable customer service skills that could be transferred elsewhere.

Protectionism in one particular instance led managers to intervene in the personal affairs of a café employee by putting an end to a situation where "someone fell in love with someone" (A, 5). The rumor among library staff was that one of their employees "was getting too inappropriately friendly with one of the women (café employees) . . . (and). . . was seeing her outside of work" (A, 11). As described by this participant, the supposed aggressor was "a person who can smell vulnerability . . . and can smell an opportunity." Forces at the Provider and the library came together to protect this café employee whom they apparently considered unable to manage her own affairs. The library proceeded to fire their employee, an action that did not strike social business managers as stigmatizing. In one view, "putting in measures that would eliminate (the problem) was a way of supporting both the person behind the counter, and the library staff". The participant concluded, ". . . I don't know that that would be stigma, . . . it's a support on both sides" (A, 5). Interestingly, café employees interpreted this incident as an example of stigmatizing behavior on the part of the library staff toward them (A, 18).

The main antidote to protectionism suggested in the findings was described as "letting bad things happen – at least some of the time" (A, 8). A veteran manager described the process of learning by trial and error, or "failing forward", as a strategy used by alternative businesses to break down stigma:

> . . . because often when you're in the (mental health) system, people don't want you to make mistakes. And unfortunately, that's how people learn. Hopefully you don't make the same mistake over and over . . .. (in) the alternative businesses, we

> really went a long way in demonstrating to the general public, to families, to people still stuck in the system, that we could rise to the occasion, and deliver services and products. And it was a real eye-opener to a lot of people (C, 32).

Moving to the regular labor market. The rudiments of stigma emerged among both social business managers, and mental health providers working in vocational services in cases where they were called on to advocate for their employees or clients who were seeking competitive work. Contrary to expectation, social business managers did not seem to believe that working in a social business would enhance employees' work history when it came to applying for a mainstream job. Instead, managers became very concerned to disguise their own connections with social businesses out of their fear that the employee would be stigmatized. One manager declared that he would do his best to disguise the identity of the business on employee resumes and in his direct dealings with prospective employers (5, 31). Even more striking in the findings was the extent to which mental health service providers shared the stigma of mental illness with their clients. Those working in clinical services hesitated to assist clients who wanted to look for mainstream work on the pretext that their interventions, as staff in a mental health institution, would force disclosure. For the same reason, clients rarely approached service providers for assistance with job development in the community (A, 3).

A typical way around stigma and the mental health connection for mental health service providers was to refer their clients interested in mainstream employment to vocational services in the community that are open to anyone in

the general public. This allowed clients to better disguise their mental health status. Community-based vocational counsellors confirmed that they service a broad spectrum of clients, which preserves "anonymity" for those with mental illness. One vocational counsellor acknowledged that placing people with mental illness in employment is more challenging than placing those with physical disabilities, saying of employers: ". . . as soon as it's something that's internal, that they can't see; it scares people" (A, 9).

Dealing with disclosure. Closely related to self stigma is the issue of whether or not to disclose one's mental health status. One service provider described the personal dilemma that this entails for people with mental illness: ". . . it's the battle between . . . 'I want to be honest with people; but, on the other hand, I know people don't understand what mental illness is. And I don't want my life to be defined by this . . . ." (A, 15). For many, it's a "trial and error" process, where self stigma plays a large role. As another participant explained:

> . . . (mental illness) is part of their reality; and when mental illness is a big part of my life, I want to talk about it. Sometimes I ask myself if (not talking about it) is more stigmatizing . . . feeling stigmatized has a lot to do with whether I will disclose or not (3, 22).

The findings revealed strong views both in favor of, and against, the disclosure of mental illness to prospective or actual employers in the regular labor market. One supervisor came down squarely in favor of full disclosure, because not disclosing will "make things worse" and jeopardize the employee's chances of success on the job (C, 44). The director at her business observed that "honesty paid off" for individuals who had disclosed (C, 39). Another added that disclosure

was "liberating" for employees (B, 25). A mental health service provider suggested that disclosure by one of her clients who works, and interacts, very well with others despite her mental health problems would help dismantle the stigma of mental illness (A, 14). Yet the client was afraid to do so. Those against disclosure, including both a social business director and a mainstream employer, made equally convincing arguments that disclosure, unless absolutely necessary, is an invasion of privacy (3, 23; C, 40). One manager pointed out that timing is important – that the employee should prove herself before disclosing (3, 22). A vocational counsellor's take on the issue was: "Don't give (employers) another headache" (by disclosing) (B, 26).

Remedies for the stigma of mental illness

The findings raised two possible avenues for neutralizing the stigma of mental illness in employment that should be underlined. One is the overall strategy adopted by the Manufacturer in hiring people both with and without mental illness. This practice tends to "level the playing field", by neutralizing certain stigmatizing assumptions about the differences between the two groups. The second solution is to focus on business concerns rather than rehabilitation in operating social businesses or employment agencies for people with mental illness. We examine these two proposals briefly.

Neutralizing stigma through workplace contact. As experience in the Manufacturer shows, the stigma of mental illness begins to dissipate when people with and without mental illness work together on a daily basis. Contact brings to the fore the positive qualities of people with mental illness, and, by contrast, the

mental health, or behavioral, problems of those presumed to be free of mental illness. A more realistic appreciation of the similarities between these two groups, otherwise considered very different, results.

Employees with mental illness have their own virtues, according to the comments of managers and supervisors. They are more respectful of authority than their counterparts without mental illness. One manager observed that it is much easier to deal with people who have a diagnosis than with those who do not (3, 24). In fact, he observed that the so-called "regular" workers are not immune from mental health problems, such as depression. His experience suggests that managing the "regulars" who come to work with mental health problems is probably very similar to the challenges faced by managers in regular competitive businesses who have to deal with people who resist, or deny, that they have problems. People with schizophrenia do especially well, he added. They may need to be given "reality checks" at times – to be told that they are hearing voices and that what they are hearing is not normal. Yet this is not too difficult. As this manager explained, " . . . they are already open to the fact that they have a mental health problem; they already work on themselves." Someone with a mental illness who provokes a crisis will later come and excuse herself; whereas the only solution for the "regular" who does the same is usually to fire her.

Personal contact also demystifies mental illness for the employees themselves. Most "regular" employees who come to the Manufacturer, many after being bumped from other jobs, actually showed little interest in mental illness. One was shocked when someone told her later that only six employees in her

section did not have a mental illness: “it can’t be true!” she said, but added: “that doesn’t bother me. We’re here to work” (3, 43). A regular business owner had the same experience with her workers. Asked how they reacted to the news that their co-worker had a mental illness, the answer was: “Neutral; couldn’t care less – not at all” (B, 29).

As a supervisor noted, there is less stigma or discrimination operating among workers at the Manufacturer than the occasional misunderstanding (3, 44). When disagreements, or conflicts involving mental illness, arise between employees at the Manufacturer, people are taken aside and given explanations privately so that they can better understand each other’s behaviors. Stigma at the Manufacturer, if any, was described by the same participant as taking the form of a double work standard that stigmatizes the “regular” workers, not those with mental illness:

> . . . we give the ‘regular’ person three months (probation); if I see that the person we just hired is not capable of doing what is required, we feel bad, but we can’t keep the person. Whereas, for those in mental health, we are there for them, and have to be patient (3, 44).

Keeping the focus on business. Another important distinction in the findings concerns differences between employment services for people with mental illness that operate from a mental health orientation versus those with a business orientation. In the view of one study participant, mental health services and employment services have very different aims and responsibilities that should be kept separate at both organizational and practice levels.

Operating employment services from a business orientation involves certain de-stigmatizing measures that might serve social businesses well. The first concerns the expectations of potential employees. According to the director of a very successful work placement agency for people with mental illness, the person on the other side of the desk is not interested in work as a therapeutic activity, but has the same motivations to improve his financial situation as others. In his words,

> . . . someone who has a mental health problem . . . . who wants to work, he's not here for a rehabilitation process. He comes here, and he's going to work . . . the fact that it's an employment service, and not a rehabilitation service changes everything . . . . The clients come in here; they don't see themselves as patients . . . It's not a question of 'well this is better for my mental health,' They see themselves as wanting an employment service that meets the needs of the potential worker . . . . it's like 'Listen I want to be able to go to this movie on Saturday night'. I'd like to sit down with my parents and say, 'Ya, mom, I'm working, you don't have to worry.' They're just like everyone else (B, 26).

Another de-stigmatizing feature stems from maintaining degrees of separation between employers, mental health service providers, and the employment agency, which in this case was funded by a provincial ministry of employment, not a health ministry. As explained in the findings, the employment service acts as a go-between for employers and mental health services/professionals. The employment counselors make sure that "information circulates", but that employers, and mental health professionals are kept entirely separate, out of consideration for the stigma of mental illness. Until the employee with mental illness is hired, no assumptions are made about how the person will perform, or what accommodations and mental health services will be needed.

Mental health professionals are brought in as stressors arise in the workplace for the employee. As mentioned in an earlier chapter, the need for accommodation is explained in terms of general adaptation to the workplace, not in connection with the employee's mental health issues.

The employment counselor in question, whose agency places over 300 people with serious mental illness in mainstream jobs annually and competes with every employment service, clinical and mental health vocational program in the area, attributes his success to excellent "customer service". Good rapport between the job counselor and local employers is critical. Social business managers could benefit from the confident attitude expressed by employment counsellors who pride themselves on being able to "sell" anyone to a prospective employer, provided that the job seeker has the requisite skills for the position. In that case, "it doesn't matter if there's mental illness" (A, 9).

CHAPTER 9: DISCUSSION AND CONCLUSIONS

Introduction

This doctoral research project aimed to better understand how social businesses created for people with mental illness experience, and influence, the stigma of mental illness. While little research has been done in this area, it was assumed that social businesses have the potential to decrease stigma, promote recovery and enhance social inclusion for people marginalized from the regular workforce. Data collection ranged across the public and the business community, yet focused mainly on interviews with stakeholders directly involved in the five social businesses in the study, and, in particular, on the experience of employees with mental illness. A comparative case study approach was used to address the research questions in terms of each business as an intrinsic whole, and across the businesses collectively.

Conceptual challenges. A major challenge in approaching this topic was how to relate previous research on the stigma of mental illness to the level of business or the organizational level. The literature mainly concerns the social psychology of stigma, which would inform the construction of stigma through interpersonal relationships in the course of doing business, but provides little insight into how individual attitudes relate to the various organization-level elements that emerged in the study. Stigma as a process was shaped by such features as the business mission, sources of financial support, internal policies, structures, and decision-making; the environment and culture of social businesses; and marketing strategies. Participants tended to filter their perceptions of stigma through anecdotes about the challenges of operating social businesses and

managing people, or what it was like to work in these places. Most interesting is the overall finding that operational decisions taken by social business managers have the potential to counteract stigmatizing attitudes held by various stakeholders, yet may also risk reinforcing stigma and disadvantage for both the businesses and the people who work in them.

A further challenge in understanding how stigma operates in social businesses concerns the very fluid nature of the concept itself. Stigma as "the disposition to act in a discriminating way" is highly perceptual and interpretive, and reflects the standpoints of stakeholders with various relationships to the businesses. Underlying various perceptions of stigma were two distinct mindsets that ran through the findings: namely, a "business" orientation versus a "mental health" orientation. To borrow the language of Thornicroft[57], study participants tended to stigmatize social businesses as being "unacceptably different" from "real" business, if their frame of reference was "business", or as being "unacceptably similar" to mental health organizations if they viewed social businesses through a mental health or medical lens. How social businesses influence the stigma of mental illness had a lot to do with how the businesses managed perceptions on both sides.

The rest of the discussion weighs in on the major findings of the study, and their significance, under three main headings: 1) contributions of social businesses to the de-stigmatization of mental illness; 2) risks for perpetuating the stigma of mental illness in advancing social businesses; and 3) social businesses and stigma in the context of vocational rehabilitation. We then review the findings

for elements that would support the creation of stigma-free social businesses, including degrees of separation from mental health systems.

Contributions of Social Businesses to the De-stigmatization of Mental Illness

The social businesses in this study have employed hundreds of people with mental illness in Canada for nearly twenty-five years, while producing quality products and services. Most social business employees are long-term clients of the mental health system who come to the businesses with little or no prior work history. The businesses change lives by providing employment, as well as ongoing training in work-related and social skills, in a non-clinical context where employees can begin to develop a new identity as workers and citizens. Leaving aside the perceptions of those with more "theoretical" knowledge than lived experience, employees themselves described their jobs as a source of personal satisfaction and pride. Nearly all had been successfully employed in their businesses for a number of years and were happy in their work, which in itself speaks volumes.

Social businesses foster core values based on the intrinsic worth of the person and the belief that everyone has strengths and abilities. As the findings reveal, social businesses managers and directors struggle to uphold these principles in the face of business challenges, and against the constant pressure of their own stigmatizing beliefs and the self-stigmatizing beliefs of their employees. There is no self-fulfilling prophesy operating in social businesses that says anyone cannot change or improve. Giving priority to developing and empowering all employees over individualism and the interests of generating profit, is what distinguishes social businesses from regular, competitive businesses. Social

businesses also stand out from clinical mental health services in exercising the principle that everyone has potential. According to mental health service providers, even state of the art approaches such as first episode programs use diagnosis, premorbid functioning and individual disposition as criteria for decision making around whether to "invest" in particular clients. That is, clinical approaches tend to prioritize those who are already on a good trajectory; whereas, in social businesses, the logic is often reversed.

Social businesses also make a concerted effort to create positive work environments for people with mental illness. This aspect of the social mission aligns with findings by Kirsh[157] that showed a significant relationship between both workplace climate and person-environment fit for predicting longer job tenure among people with mental illness in integrated work settings. At the Manufacturer, the integrated setting in this study where it was possible to observe people with and without mental illness on a more level playing field, the findings brought to light more similarities than differences in problem behaviors attributed to the two groups. These findings suggest that individual needs, and issues related to disability or stress, are perhaps more universal than usually assumed. Interestingly, employees with mental illness in this study were described as more amenable to change than their peers, and more respectful of authority. Their overall satisfaction with the workplace environment was undoubtedly a factor in the extended work tenure of most social business employees.

While both social business and regular businesses employers and managers described workplace accommodation as the responsibility of any good employer, the responsiveness of social businesses to individual capabilities, needs

and differences is particularly high, as accommodation is another essential aspect of their social mission. Standards in social businesses aim at being realistic and fair, attuned to individual differences and to variable performance. As well, social businesses value cooperation and solidarity over competition, and tend to redefine the concept of competition as "competition with oneself", or the effort to surpass one's personal best. By contrast, the issue for mainstream business owners seemed to be how much they could "afford" to accommodate, and where to draw the line in taking on people's personal and social issues. The communitarian spirit and focus on individual accommodation were features of social businesses that evoked some stigmatizing reactions among regular employers, and the perception that social businesses had a strong rehabilitation focus. Yet, given the level and cost of mental distress in mainstream workplaces, the findings of this study suggest that social businesses have something to teach their mainstream counterparts about the economies of operating business with the wellbeing of workers in mind.

Presenting social business employees as capable workers and ordinary people in the public domain is another powerful form of anti-stigma. There was considerable evidence in the findings that social businesses have a good profile in their communities, and have contributed to public education over the years not only through their business operations but also through media reporting on the businesses, advocacy activities, and varying degrees of community engagement including participation in research. Community leaders were well represented on the Boards of all social businesses in the study. The discussion in the CED literature about how social businesses engage in "social bricolage"[134] as a way of

augmenting resources and raising the profile of social businesses and their employees in local communities also resonated with these findings.

Risks for the Stigma of Mental Illness in Advancing Social Businesses

Overall, the findings suggest that the legitimacy of social businesses hinges on the extent to which they are seen as "normalized" or at par with mainstream businesses, and with the kinds of connections made by social businesses with the local community. Yet the comparison may be somewhat unfair, as social businesses operate under constraints not applicable to mainstream businesses. Social businesses experience a higher level of economic risk in pursuing the social aim of benefitting a particular community over maximizing profit[116]. They require ongoing financial support in order to remain viable, especially in order to offset the high costs of training people with little or no employment history. The businesses in this study were no exception. While social businesses do compete with for-profit businesses that produce similar products and services, comparisons with competitive business would need to consider differences in business structures and legal form. Social businesses, like other non-profit social venture corporations, operate under restrictions in terms of where, and how, they can raise money and for what purposes; how the businesses are taxed, and the like[158]. Without shareholders, investment in a social business is, by definition, charity.

In terms of stigma, social businesses are usually seen as "poor", and may be stigmatized in relation to capacity issues, apart from the stigma of mental illness. Businesses in this study lacked resources and equipment, or had ways of operating that sometimes appeared less than professional. While inefficiencies

were often due to the accommodation needs of a part time workforce or other employee liabilities, resource scarcity could underlie what makes a social business appear more like a self-help organization or a mental health agency in an impoverished neighborhood. In this connection, one of the businesses had the dubious distinction of sharing the same name as a city district whose proud tradition had been sullied in recent history by an influx of mental health facilities, run down boarding homes, poverty, itinerancy and crime.

Risks for stigma may occur in the context of business structures, economic relations, and the external policy context. These elements are difficult to grasp, in part because there is no clearly defined, single model of social business. It should be recalled that the businesses in this study comprise three different conceptualizations of social business, with different structures, sources of support and affiliations; although they were bound by the single aim of creating real employment opportunities for people with mental illness. Government policy concerning social businesses, even those in the present study, has been applied differently across jurisdictions. Future research would need to provide a closer analysis of these complexities in relation to stigma

One issue that did emerge in the findings involved government procurement policies, which need to be understood in terms of their effectiveness for social businesses competing in the open market, and how certain businesses may become disadvantaged in relation to others. Findings showed that procurement policies in one community did not prevent a social business from being shut out of the competition for landscaping contracts despite the availability of a secondary list for smaller businesses; while, in another instance, municipal

contractors took the attitude that they were doing the social business a favor in hiring them and treated the employees badly. The Manufacturer was challenged by a complaint from its main competitor when it came to light that the business was receiving government subsidies as a social enterprise. Whether any of these instances was motivated by the stigma of mental illness would require closer examination.

The strongest findings on policy in relation to stigma concerned social assistance policies that tended to shape hiring and scheduling practices in social businesses, and had a great impact on their ability to realize operational efficiencies and reduce costs. From the employee perspective, social assistance rules are inflexible and punitive, drastically reducing the number of hours people can work and jeopardizing their basic subsistence. Tying income support to medication allowances further traps social business employees into the welfare system, with the result that they are stigmatized three times over, as welfare recipients, disabled and poor, when, in fact, they are working and paying taxes! Social assistance and other forms of income support such as work integration subsidies, also force disclosure of peoples' mental health status to prospective employers, which is inherently stigmatizing and anxiety provoking for employees, and provides yet another incentive for them to avoid competitive employment.

It was apparent in the findings that the degree of government support for a social economy, and for the work integration of people with mental illness, varied considerably between the two provinces where the social businesses in the study were located. The Manufacturer enjoyed considerable support from its inception as part of an intersectoral initiative coordinated by a regional government;

whereas other businesses in the study were independent initiatives in competition with other social economy organizations for public funds. Yet, the findings did not necessarily support the argument that social businesses better meet their objectives within a larger socio-economic development strategy without which they may become separated from their social and community roots[115]. The businesses in this study continued to make inroads into their communities in a capillary fashion with or without an overarching development plan or government support.

An issue of perhaps greater relevance for stigma is to what extent the social businesses in the study succeeded in positively influencing public opinion about the employability of people with mental illness, and their social inclusion. The community legitimacy of social businesses, as well as their relations with the private and non-profit sectors, are crucial to the survival of social businesses in their need for a loyal customer base, as well as sources of in-kind support and financial donations[132]. While this is a question for future research, we do know from the Gardeners' surge in popularity after they descended upon "Tweedsville" in their new golf shirts that a bit of public relations ingenuity can shift public opinion considerably.

This brings the discussion on the risks for stigma to the question of social marketing in the businesses. Considerable tension emerged in the findings around whether and how to promote the cause of creating employment for people with mental illness as a marketing tool. It was interesting that each site took a different approach to the marketing issue – the alternative businesses playing heavily on the mental health angle in the early years, versus the Manufacturer, which until

recently promoted their quality products exclusively. The hospital systems that support both the affirmative businesses and the Hospital Café also stood to enhance their public image by promoting the employment of their patients. Yet marketing products while promoting a good cause sometimes invited the "charity stigma", as mentioned above in relation to local contractors who pretended that social business employees, because they are needy, disadvantaged, or disabled, are less deserving of a proper wage than others. Similarly, combining social marketing with pricing that is too low, or overpromising and over-delivering on services, may also convey the impression that the business is weak, or desperate for a contract. Thus, while promotion of the social mission was understood in theory as an "unfair advantage", most managers came to the conclusion that the business line needed to prevail sooner or later in marketing strategies or risk the prospect of confusing social businesses with charitable organizations or job training programs.

Evidence is beginning to emerge that social marketing campaigns help reduce stigmatizing public perceptions of mental illness. For example, a recent study on the Time to Change program in the UK demonstrated that social contact with mental health consumers through educational events, and particularly the quality of contact, had a positive effect on attitude change in the public and gave people greater confidence to challenge stigma[159]. This finding is in line with stigma theory and augers well for social businesses as naturalistic settings where employees with mental illness interact on a daily basis with the public. Yet the findings in the present study caution that the stigma of mental illness may operate subtly, and a bit insidiously, in these social interactions despite the best intentions

of enlightened, social customers, who bend over backward to be polite, patient, and deliberately unaware of interpersonal differences. What often resulted were formalized or somewhat artificial relationships that employees themselves recognized as stigmatizing.

Social businesses for people with mental illness need to brand and market themselves with more sensitivity than would other social businesses, as well as eco-friendly or fair trade companies that promote more stigma-neutral causes with which most people can agree, and support. However powerful social marketing on a mental health theme may be for leveraging an economic advantage or promoting an image of corporate responsibility, the message needs to be particularly attuned to the sensitivities of employees with mental illness, and build a strong association of good employees into the label. It would be especially desirable if experiences of pro-social contact between social business employees and the public could be reinforced in advertising along lines such as: "brought to you by great employees"; or "good business great employees"; or "building business with a difference". With the exception of employees at the Hospital Café who, in the hospital context, could take pride in being psychiatric survivors and role models, and who enjoyed the esteem of other patients, most social business employees working with the public were struggling with self-stigma and felt strongly that social marketing around mental illness promoted the business mission at their expense.

Another major risk for the emergence of stigma in social businesses arises from their connections with the mental health system. Most businesses in this study relied on the mental health system as a major customer, or the customer.

Yet, as findings revealed, this choice brought with it a whole array of stigmatizing attitudes and tensions that dogged relationships between Hospital Café managers and hospital management over the years, and created a stigmatizing image of the business. Stigma is likely to persist in this, or other businesses on mental health sites, to the extent that hospital personnel hold stigmatizing attitudes or fail to work alongside, and purchase from, businesses run by mental health consumers on their premises. After all, location inside a mental health institution makes it difficult to attract customers from elsewhere. Nor is it always easy for customers to distinguish between a hospital-based business and some kind of therapeutic program or sheltered workshop, unless someone redesigns the business to look efficient, and convincingly "un-hospital".

Findings document the especially difficult trade-offs for the affirmative businesses in relation to stigma in their partnership with the mental health provider. There was a basic disjunction between the aim of the affirmative business Corporation to provide employment, and the perspective of the mental health provider that the social business initiative was a new wave in rehabilitation, or a "community economic development stream within vocational rehabilitation services". Overlaying so much medical model thinking and clinician influence on the businesses made them more like rehabilitation programs to most observers, i.e. not providing "real" work; hiring people with "problems"; and creating segregated workplaces or a "social ghetto".

Other risks for stigma were apparent in the organizational environment and social conventions of the mental health provider, as a large bureaucratic organization, where social business employees were the inferior of "two separate

worlds." The complicity of social business employees in keeping these two worlds apart was especially interesting. At the same time. all businesses in the study struggled against stigma to the extent that they, and their employees, were directly exposed to the paternalism of mental health service providers.

It seems that many of the problems faced by social businesses operating in the mental health context may be surmountable, at least in part, by working from a strictly business model and by imposing degrees of separation between the businesses and the mental health systems in which they are embedded. Helpful measures might include a complete severing of functions between business managers/supervisors and clinical staff; hiring social business managers with business background and skills; raising employee work standards and expectations; and increasing community outreach by seeking contracts and marketing products and services outside of the hospital system. It stands to reason that social businesses will continue to seek the stability of the mental health system as a "safe" and lucrative source of business. Indeed, if social businesses were to move away from mental health sites then some other businesses would likely move in and take that business away.

Finally, social businesses in the present study tended to share somewhat the stigmatizing stereotypes levelled at their employees by the general public. Most of the stigmatizing assumptions about people with mental illness identified by Krupa et al[3] in their literature-based study relevant to stigma in mainstream workplaces, emerged in these findings. The stigma of mental illness in social businesses, whether emanating from outside the businesses or operating internally, included the assumption that employees lacked competence for work;

that they were unreliable or potentially dangerous; and susceptible enough to stress that their productivity or ability to work were compromised. Employees told that working was not healthy for them frequently internalized that advice.

An additional expression of stigma not included by Krupa et al, yet very pronounced in the present findings, was the attitude that people with mental illness are "odd", or different from others in terms of appearance, speech, and interpersonal or communications skills. Interestingly, the assumption identified in the Krupa et al study that mental illness is not really illness, and the related attribution from the stigma literature that people with mental illness are somehow responsible for their condition[58], did not emerge in this study. Perhaps the direct contact afforded by social businesses eliminates doubt about what it takes to persevere with employment while struggling with mental illness.

The other major challenge for social businesses in relation to their employees involved the widespread persistence of self-stigma as a serious barrier to personal empowerment. Social business employees live with a deep sense of personal failure and the perception that they don't fit in a society that doesn't easily integrate differences. Self-stigma based on the belief that they are disabled for life and unemployable also deters most social business employees from seeking regular work. Employee findings suggest that self stigma may depend on the strength of individual self concept, but also on the extent to which individuals let others define their personal worth. The problem of feeling victimized and anticipating stigma that may never transpire is a feature of the literature, but was also present in these findings, as was the tendency of self stigma to push people into the vicious circle of secrecy concerning their illnesses.

Coping mechanisms in self stigma reported in the literature include reliance on a strong identification with a peer group as a source of support and social validation[83]. This finding resonates with the "purist" or "separatist" orientation of the alternative businesses, in their aim to provide safety and build a protective community around psychiatric survivors. In the past few years, alternative business directors have expanded their identification with the stigma of mental illness to identification with poverty as what links the psychiatric community with other marginalized social groups. This philosophical shift seems problematic in effectively generating a kind of marginalization within marginalization among people with mental illness, which further reinforces the insular identity of this group vis-à-vis the larger community –expressed in the findings as "we don`t belong to that world". Some alternative business employees may not wish to identify with this perspective, yet may find it difficult to resist without seeming disloyal. Ironically, while employees trained in the consumer survivor philosophy expressed pride in their survivor affiliation, their managers were more aware of, and concerned about, the liabilities attached to the survivor label.

Social businesses and Stigma in the Context of Vocational Rehabilitation

Comparing social businesses with supported employment as the dominant approach in vocational rehabilitation for people with mental illness suggests that social businesses and clinical programs share many of the same programming issues and conditions that might entail stigma for employees. Among the models of supported employment, Individual Placement and Support (IPS) makes a good comparator, as the major, evidence-based model of supported employment for

people with psychiatric disabilities. IPS was originally developed within the US mental health system but has been implemented internationally and researched extensively[160, 161]. The IPS model places people with serious mental illness exclusively into competitive employment and without prevocational training, then offers indefinite, individualized support. A central tenet of the IPS model is that vocational rehabilitation and mental health services should be closely integrated[162]. One implementation study in the UK provided an example where extensive cross training was conducted with providers in participating community mental health services on the IPS model [163]. A literature review on IPS suggested that hiring employment specialists with previous experience in clinical, mental health services is a key to program success [164].

Outcomes reported for IPS suggest that many of the barriers to employment and concerns related to the stigma of mental illness reported in the present study may cut across different types of employment approaches. For example, while reported employment rates for people receiving IPS are as high as 61%, job tenure rates were 22 weeks, on average[165]. A more recent study found that job tenure for IPS clients was nearly 10 months in a first job[166]. Yet despite the intensity of clinical follow-up, one review of the literature pointed out that about half of people in supported employment fail to find any job, and another 25% are unable to sustain employment; as well, 75% of IPS clients require additional psychosocial services in addition to the basic IPS program[167]. By contrast, job tenure in social businesses is likely to span a number of years, according to present findings, due to the provision of workplace accommodations, including measures that ensured rapid job coverage and job security for all

employees. One implication of this difference in job tenure rates is that the barriers to work may not be as health related as clinical programs would suggest.

Employees who secure work through IPS also face the same issues in relation to stigma as do social businesses employees. For example, program originators have acknowledged that most IPS jobs are entry level, and part time[165]. IPS employees also face the same disincentives to employment emanating from social assistance policies as do social business employees. As Campbell et al found[168], IPS clients favored part-time work, and tailored their hours to their disability benefits, as was seen in the present study. IPS clients would presumably face the same stigmatization, or self-stigma associated with part-time work as a marginal status for employment.

The further question arises whether working in a competitive business ensures that IPS clients would feel part of their workplaces, and be able to interact on an equal footing with their co-workers. The literature on self stigma suggested that employees with mental illness, whether or not they disclose their condition, often feel that employers or co-workers are discriminating against them[72]. Nor is there any reason to expect that IPS employees who combine employment with disability benefits would be any more likely than social business employees to experience a sense of parity with their co-workers who are employed full time. It should also be recalled that IPS employees have the same high needs for social skills training and support in order to function in competitive employment[169], as would social business employees. By contrast, social businesses have the advantage of providing a workplace where employees are not under pressure to conceal the realities of mental illness. The findings in this study make the further

argument that social businesses are not the segregated, "social ghetto" that their detractors like to pretend, particularly when the businesses include employees without mental illness.

IPS service providers placing clients in competitive work will face the same issues as social business managers in terms of how to market individuals as good employees, and how to deal with the label of mental illness. This brings the discussion around to the disclosure conundrum, where the widely held fear of stigma reinforces secrecy and further entrenches the problem. As service providers in the present study, including an IPS worker, affirmed, most prospective employees with mental illness prefer not to disclose their mental health status in a regular employment setting, whether they are social business employees or IPS clients.

In line with the literature, participants in the present study offered an array of suggestions on the art of disclosure, whereby employees could reveal their mental health conditions "selectively" and with good effect. Strategies included disclosing only as needed; disclosing only after proving oneself on the job; and/or after a good rapport had been established with the employer. While one regular employer made a strong argument for disclosure as an issue of trust between employer and employee, and as essential information for co-workers in order to prevent misunderstandings, others made an equally compelling case for privacy, and the right of persons with any kind of disability to work. Managers and job developers with a business mindset insisted that the decisive issue in disclosure is whether the person can do the job, and their fit with the work environment[170].

Should accommodation be required, the reasons do not need to be presented as mental health issues.

In light of the above comparisons between social businesses and supported employment (IPS), it is surprising the extent to which social business managers and supervisors held the view that social business employees are not suited for competitive employment, or that the experience of working in an identified social business would not help a person with mental illness achieve competitive work. As compared with a job applicant backed by a clinical program closely aligned with the mental health system, it seems that real work experience would give the social business applicant a clear advantage.

Toward Stigma-free Social Businesses

Social businesses may be structured in ways that reduce the stigma of mental illness. As suggested in the previous discussion, specific anti-stigma measures may be taken within the businesses: they include promoting contact by hiring a proportion of employees without mental illness and selecting them for compatible socio-demographic characteristics[171]; providing the same workplace regulations, accommodations, and psychosocial support to all employees; focusing on business over rehabilitation functions; and marketing employee strengths. This section considers further opportunities for neutralizing the stigma of mental illness associated with social businesses that might involve building their connections to local communities; making the businesses more inclusive; and offering possibilities for current employees to move into competitive employment.

Social businesses need to build more, and varied, connections with local economies. One type of arrangement might involve a partnership between a social business corporation and a large private industry or corporation to create a new social business in the community to which the corporation would outsource some aspect of its production and engage in social purchasing as the primary customer. The social business corporation would take responsibility for hiring and human resources activities, provide psychosocial support to all employees with and without mental illness, and secure outside funding for infrastructure and employee salary subsidies. Another option is for social businesses to contract with non-profit organizations in the community to provide services in areas where they have established expertise. The affirmative businesses, for instance, have a tradition of subcontracting work from other organizations, and recently contracted with a local daycare to provide daily lunches and snacks for 60 children.

Second, social businesses need to address the stigma that says they are geared to low-functioning, formerly institutionalized folks by making the businesses more relevant and inclusive. This especially implies making social businesses more attractive for young people with mental health issues, whose relationship to the mental health system will be very different from those who lived through deinstitutionalization, and who are an important potential workforce for the future. Research by Ferguson[172, 173] on the development of a social enterprise for homeless youth provides important insights on how to engage young people with multiple challenges in productive employment by closely aligning business development with their needs, interests, and previous skills. Education in small business skills and vocational training, the core of the program

studied by this author, was premised on the idea that the often destructive street-survival skills of homeless youth could be redirected into business skills. A mental health component was integrated into the program, yet young people were expected to identify, and take ownership of, their personal goals. Young people also had input into the development of the new social enterprise, which operated through a community drop-in center. The youth received monthly gift cards for local stores, and coverage of their transportation costs, giving them another incentive to complete the 7-month training program and pursue employment. Social businesses such as those in the present study need to build likewise on employee strengths, expect more from them, and move beyond manual and service activities to include jobs that utilize technology and other skills more transferable to the regular labor market.

Finally, while social businesses should continue to provide permanent work and job security, in keeping with their value as an "alternative" labor market for people with mental illness, the social value of the businesses would be greatly enhanced, and stigmatizing perceptions of them further neutralized, if they were also perceived as a conduit to competitive employment for interested employees. It may be that more social business employees would seek to move into competitive employment if there were better support for this option, such as job development services within the business corporations or offered in partnership with community employment agencies. In fact, the one study that explored the future employment intentions of social business employees found that 30% of the sample intended to work in a competitive labor market; whereas a majority (58%) would continue working at a social business and 12% would stop working

altogether[174]. Thus, designing social businesses as a "stepping stone" to competitive employment is as important for the current generation of younger workers as it is for the image of the businesses.

The question arises, why the reticence among social business managers and supervisors when it comes to helping social business employees achieve competitive employment? The findings reflect the fierce protectionism of most social business supervisors and managers toward their employees, undoubtedly tinged with some stigmatizing perceptions of what employees with mental illness can achieve. Yet the views of social business promoters also reflect their firm belief that social businesses are a viable, legitimate, and promising alternative labor market for this population. The achievements of social businesses, alone and in relation to clinical programs in vocational rehabilitation, suggest that they have a point.

Implications for Social Work

The core values of the social work profession, such as the integrity and worth of the person, self-determination, empowerment and the alleviation of oppression lend themselves well to the involvement of social workers in community-based social businesses for people with mental illness. Social work has historically challenged social inequities and promoted democratic ideals, recognizing more than other helping professions that disadvantage is rooted in the overall social context, and needs to be addressed holistically. Social workers are ideally placed by virtue of their professional norms, and person-in-environment orientation, to work in the area of community development[175], as well as in agencies and larger service delivery systems[176, 177].

It is noteworthy that social workers in this particular study were not among the promoters of social business, but tended to be clinicians whose views reflected the traditional rehabilitative approaches of the agencies that employed them. While this seems an accidental occurrence, one of the few existing studies on social work in mental health went as far as to suggest that the longstanding interest of social work in community organization, and in issues of social justice and anti-oppressive practice, has not extended to mental health populations or to issues of stigma and discrimination[178]. Yet the concept of social enterprise for the work integration of people with mental illness is in its infancy, at least in North America; and social enterprise development does benefit from the leadership of social work researcher-clinicians, notably in the work of Ferguson cited above.

This said, there are legitimate issues related to the evolution of social work in mental health that may have deterred the profession from fully developing roles and practice models that support community integration for people with mental illness. Some literature describes social work intervention in mental health in the context of deinstitutionalization, and the shift to community care and treatment of people with mental illness, as evidence of a contradictory process at work. That is, while there is increasingly greater concern for human rights at a policy level, state-mandated professional and legal control of people with mental illness living outside of institutional settings is increasing in a number of countries[179, 180]. In this overall political context, the activities of clinical social workers in mental health have become mainly concerned with risk management and coercive functions related to treatment compliance and involuntary hospital admission[181].

Some authors have further attributed this traditional social work role to the historical alignment of social work with psychiatry, as the dominant field in mental health, and the involvement of social workers on multidisciplinary mental health teams. They view social work as assimilating psychiatry's traditional biomedical framework and reliance on medication as the primary, if not exclusive, treatment option, at the expense of developing authentic social work approaches based on core professional values and social work theories[182-184]. Meanwhile, a range of mental health professionals in other disciplines, and even non-professional workers, are taking over responsibility for developing the social dimensions of mental health services in countries such as the UK[185, 186].

Social work practice is also increasingly affected by welfare state retrenchment and fiscal restraint, which has led governments in many English-speaking countries to define themselves as partners in the provision of services, rather than primary providers, and to engage in the economic rationalist marketization of human services through contracting-out, privatization and the empowerment of business and quasi-business actors[187, 188]. As Gray et al[189] describe, social enterprises have emerged in this context of fiscal austerity as an alternative source of financial support for community social service organizations. Yet there is considerable debate in the literature over whether social enterprise is a complement to government provision, and an enhancement to economic and social participation by marginalized persons, or whether social economy initiatives, including social businesses for work integration, could become a replacement for essential government involvement and service provision on behalf of people with mental health issues or other disabilities.

Midgley[38] is a main proponent of social businesses not only as a pathway out of disadvantage for individuals who have been locked into dependency as recipients of income support and social support services, but also as an opportunity for the social work profession to capitalize on its expertise in community development and commitment to alleviating social disadvantage. For people with mental health problems who must rely on some level of support against recurring illness, social work has an important advocacy role to play in promoting more flexible social assistance policies that will facilitate access to work, and promote job tenure. The success of social businesses for this population depends on the ability of employees to access a wide range of flexible income assistance measures and social supports, including rapid re-qualification for disability benefits in the event of relapse, and unlimited work reinstatement thereafter[190].

Incorporating social business as a new avenue for social work practice in the community, and in domains of ordinary life such as employment, presupposes the establishment of a nonclinical and nonmedical vision for social work in mental health. Doing social work among people with mental illness who aspire to live and work in the community requires firm grounding in a social justice perspective and approaches more in line with social models of disability where individual disadvantage is understood in the context of larger sociopolitical, economic and cultural systems, and where the propensity of these structures to impede community integration is acknowledged[44, 191]. A social work approach should be grounded in empowerment theory, the strengths model, structural and ecological theories, as well as the mental health recovery perspective. Ideally, the

work of risk assessment and policing social deviancy could be replaced by other models of practice.

The articulation of a leadership role for the social work profession in social enterprise would also require research establishing links between core social work values, as articulated in the CASW professional codes, and major policies and legislation concerned with human rights and disability. For example, Section 15.1 of the Canadian Charter of Rights and Freedoms[192], once described as the most comprehensive statement of human rights produced by any nation in the world[193], goes far beyond specific legislation such as the US Americans with Disability Act in affirming the equality and equal protection of persons with mental or physical disabilities under Canadian law. Section 15.1 foreshadowed the conceptual shift in disability policy from traditional medical or welfare models, to a more recent socio-political framework based on equality rights[41].

While the pace of disability policy reform in Canada since promulgation of the Charter has been slow and fraught with difficulties[194], major reports such as In Unison[195], and Canada's first comprehensive report on disability, Advancing the inclusion of persons with disabilities[196], endorse a social model of disability, and underline the goal of full citizenship. As Krupa et al[22] argue further, both the Charter and the 1995 Employment Equity Act provide a strong legislative foundation for promoting the participation of people with mental illness or other disabilities in employment. Social workers are ideally placed to work across the community, public and private sectors in order to understand, and combat, existing financial disincentives to paid employment that affect people with mental illness, and to promote both community-based work initiatives for this population

as well as fair employment standards and career opportunities for those employed in the regular labor market.

The international community provides yet another powerful incentive for the social work profession to involve itself with social enterprise, and the employment of people with mental illness more generally. The 2006 United Nations Convention on the rights of persons with disabilities[197], to which Canada is a signatory nation, affirms:

> . . . the right of persons with disabilities to work, on an equal basis with others; this includes the right to the opportunity to gain a living by work freely chosen or accepted in a labor market and work environment that is open, inclusive and accessible to persons with disabilities. States Parties shall safeguard and promote the realization of the right to work . . .

This policy statement, which refers equally to people with physical or psychiatric disabilities, is an invitation for the social work profession to align itself with the real concerns and aspirations of people with mental illness in promoting employment as a human right and social determinant of health.

Strengths and Limitations of the Study.

This research advances our understanding of how the stigma of mental illness operates in the important life domain of employment, and specifically in the context of social businesses, using a case study methodology. The findings are based on information gleaned from the local conditions of five businesses and cannot be generalized beyond these cases. This said, a number of procedures were adopted in order to enhance the trustworthiness of the study, and transferability of the findings, given that the conventional considerations of internal and external

validity, reliability and objectivity are inconsistent with the axioms and procedures of naturalistic inquiry[136]. A thick description was provided for each site, or type of social business, multiple comparisons drawn across the sites, and efforts made to make the values underpinning the study transparent. All these measures allow readers to evaluate, and judge for themselves, the extent to which the results are "fitting" or transferable to other contexts. Another caution against drawing firm conclusions is that the study took place at one point in time so doesn't account for shifting conditions in the businesses since the initial data collection. As well, the possibility that researcher involvement might evoke socially desirable responses from study participants must be acknowledged.

A more iterative approach to data collection and analysis might have allowed for more focused and theoretical sampling, and greater parsimony in the overall study. Under more ideal conditions, the coding and data analysis could start earlier, while questions arising from the interviews and emerging hypotheses could be explored through repeat interviews with study participants. The aspect of emergent design in naturalistic inquiry also presupposes continuous member checking throughout the analytic process, often culminating in a critical review by panels of local respondents. Time and financial constraints in the context of a doctoral study did not allow for this level and extent of peer debriefing.

Finally, conducting a largely interview-based study could only suggest, but not account fully for the social structural or systemic elements that might contribute to, and maintain, stigma, both within the businesses through organizational norms, policies and practices, or coming from the outside in the

form of policies that disadvantage social businesses in relation to others. It is at this level that stigma theory most needs further articulation.

Questions for Further Research.

This study suggests a number of possible directions for future research. As suggestive of the study limitations, an institutional ethnography[198] of a social business might provide a more in-depth understanding of how organizational structures, processes and environments interact with external institutional systems, including relevant policy and economic realities, to impact stigma at the business level. Another line of research might capitalize on the working relationships between people with and without mental illness in social businesses where both groups are employed, in order to better understand the nature of interpersonal contact in the workplace, and how ongoing contact influences mutual perceptions and stigmatizing attitudes or behaviors. Similar research could be conducted among individuals with mental illness working in mainstream businesses and their non-disabled co-workers as another natural context where social contact occurs.

There is a definite need for back-to-back studies comparing social businesses with clinical vocational rehabilitation services such as Individual Placement and Support (IPS) on stigma issues. It would be interesting to know more about the work experiences of employees in social businesses and those working in competitive jobs with clinical (IPS) support in terms of major issues that have emerged in the present study, including job satisfaction, stigma and self-stigma, disclosure, workplace relationships and future career prospects. Our recommendation that social businesses support employees to move into

mainstream businesses also suggests the need for research on how regular employers might view the experience of working in a social business in their hiring decisions.

Conclusions

This study on social businesses for people with mental illness confirms that the stigma of mental illness does pose an additional challenge to the viability and legitimacy of social businesses as well as to the achievement of their social purpose. Yet the insights gained through this research suggest that social businesses have considerable potential to manage stigmatizing perceptions of both the businesses, and their employees, and that this is achieved to the extent that social business transcend their mental health orientation and build community connections to "become what they are" – real businesses providing real employment and a gateway to social inclusion. As social businesses evolve and engage more fully with their communities, they continue to be the best hope for people with mental illness to break through social marginalization and leave the stigma of mental illness behind.

REFERENCES

1. Quarter J, Mook L, Armstrong A. *Understanding the social economy. A Canadian perspective*. Toronto: University of Toronto Press; 2009.

2. Warner R, Mandiberg J. An update on affirmative businesses or social firms for people with mental illness. *Psychiatric Services* 2006;57(10):1488-1492.

3. Krupa T, Kirsh B, Cockburn L, Gewurtz R. Understanding the stigma of mental illness in employment. *Work* 2009;33(4):413-425.

4. Goffman E. *Stigma. Notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice Hall; 1963.

5. Balser DB. Perceptions of on-the-job discrimination and employees with disabilities. *Employee Responsibilities and Rights Journal* 2000;12(4):179-197.

6. Cook JA. Employment barriers for persons with psychiatric disabilities: update of a report for the President's Commission. *Psychiatric Services* Oct 2006;57(10):1391-1405.

7. Stuart H. Mental illness and employment discrimination. *Current Opinion in Psychiatry* 2006;19(5):522-526.

8. Wahl OF. Mental health consumers' experience of stigma. *Schizophrenia Bulletin* 1999;25(3):467-478.

9. Yellin EH, Cisternas MG. Employment patterns among persons with and without mental conditions. In: Bonnie RJ, Monahan J, eds. *Mental disorder, work disability, and the law*. Chicago: University of Chicago Press; 1996.

10. Centre for Addiction and Mental Health (CAMH). 2011. Mental health and addiction statistics. *Periodical* 2011.

11. Minister of Health. *The human face of mental health and mental illness in Canada 2006.* Ottawa: Minister of Public Works and Government Services Canada; 2006.

12. Frank RG, Glied SA. *Better but not well: Mental health policy in the United States since 1950*. Baltimore: Johns Hopkins University Press; 2006.

13. Gates LB, Akabas SH, Zwelling E. Have I got a worker for you: creating employment opportunities for people with psychiatric disability. *Administration and Policy in Mental Health* Mar 2001;28(4):319-325.

14. Secker J, Grove B, Seebohm P. Challenging barriers to employment, training and education for mental health service users: The service user's perspective. *Journal of Mental Health* 2001;10(4):395-404.

15. Sundar P, Ochocka J. Bridging the gap between dreams and realities related to employment and mental health: Implications for policy and practice. *Canadian journal of community mental health* 2004;23(1):75-89.

16. Harrison G, Hopper K, Craig T, et al. Recovery from psychotic illness: a 15- and 25-year international follow-up study. *British Journal of Psychiatry* 2001;178:506-517.

17. Grove B. Mental health and employment: Shaping a new agenda. *Journal of Mental Health* 1999;8(2):131-140.

18. Mechanic D, Blider S, McAlpine DD. Employing persons with serious mental illness. *Health Affairs* Sep-Oct 2002;21(5):242-253.

19. Waghorn C, Lloyd C. Employment and people with mental illness. In: Lloyd C, ed. *Vocational rehabilitation and mental illness*. Oxford: Wiley-Blackwell; 2010:1-17.

20. Corbière M, Lecomte T. Vocational services offered to people with severe mental illness. *Journal of Mental Health* 2009;18(1):38-50.
21. Kelemen RD, Vanhala L. The shift to the rights model of disability in the EU and Canada. *Regional and Federal Studies* 2010;20(1):1-18.
22. Krupa T, Kirsh B, Gewurtz R, Cockburn L. Improving the employment prospects of people with serious mental illness: Five challenges for a national mental health strategy. *Canadian public policy special electronic issue* 2005.
23. Blustein DL. The Role of Work in Psychological Health and Well-Being: A Conceptual, Historical, and Public Policy Perspective. *American Psychologist* 2008;63(4):228-240.
24. Marrone J, Golowka E. If work makes people with mental illness sick, what do unemployment, poverty, and social isolation cause? *Psychiatric Rehabilitation Journal* 1999;23(2):187-193.
25. Dunn EC, Wewiorski NJ, Rogers ES. The meaning and importance of employment to people in recovery from serious mental illness: results of a qualitative study. *Psychiatric Rehabilitation Journal* Summer 2008;32(1):59-62.
26. Kirsh B. Work, workers, and workplaces: A qualitative analysis of narratives of mental health consumers. *Journal of Rehabilitation* 2000;66(4):24-30.
27. Krupa T. Employment, recovery, and schizophrenia: integrating health and disorder at work. *Psychiatric Rehabilitation Journal* Summer 2004;28(1):8-15.
28. Svanberg J, Gumley A, Wilson A. How do social firms contribute to recovery from mental illness? A qualitative study. *Clinical Psychology and Psychotherapy* 2010;17(6):482-496.
29. Corrigan PW, Markowitz FE, Watson AC. Structural levels of mental illness stigma and discrimination. *Schizophrenia Bulletin* 2004;30(3):481-491.
30. Stuart H, Arboleda-Florez J, Sartorious N. *Paradigms lost. Fighting stigma and the lessons learned*. New York: Oxford University Press; 2012.
31. Finkelstein V. The social model of disability repossessed. *Coalition: Greater Manchester Coalition of Disabled People* February, 2002.
32. Thomas C. How is disability understood? An examination of sociological approaches. *Disability and Society* 2004;19(6):569-583.
33. International Labour Organization. Job creation and enterprise development. 2011.
34. Lysaght R, Krupa T. Social Business: Advancing the viability of a model for economic and occupational justice for people with disabilities. Project Final Report-Phase 1. Kingston, ON: School of Rehabilitation Therapy, Queen's University; 2011.
35. Ducci G, Stentella C, Vulterini P. The social enterprise in Europe: The state of art. *International Journal of Mental Health* 2002;31(3):76-91.
36. Bridge S, Murtagh B, O'Neill K. *Understanding the social economy and the third sector*. Hampshire, England: McMillan Publishers; 2008.
37. Krupa T, Lagarde M, Carmichael K. Transforming sheltered workshops into affirmative businesses: an outcome evaluation. *Psychiatric Rehabilitation Journal* Spring 2003;26(4):359-367.
38. Midgley J. Involving social work in economic development. *International Social Work* 1996;39(1):13-25.

39. Trainor J, Tremblay J. Consumer/survivor businesses in Ontario: Challenging the rehabilitation model. *Canadian journal of community mental health* 1992;11(2):65-71.
40. DeJong G. Independent living: From social movement to analytic paradigm. *Archives of Physical Medicine and Rehabilitation* 1979;60(10):435-446.
41. Jongbloed L, Crichton A. Difficulties in Shifting from Individualistic to Socio-Political Policy Regarding Disability in Canada. *Disability, Handicap & Society* 1990;5(1):25-36.
42. Hinshaw SP, Stier A. Stigma as related to mental disorders. Vol 4; 2008:367-393.
43. Whitley R, Berry S. Trends in newspaper coverage of mental illness in Canada: 2005-2010. *Canadian Journal of Psychiatry* 2013;58(2):107-112.
44. Oliver M. *The politics of disablement*. London: Macmillan; 1990.
45. Corrigan PW, Watson AC, Heyrman ML, Warpinski A, Gracia G, Slopen N, Hall LL. Structural stigma in state legislation. *Psychiatric Services* May 2005;56(5):557-563.
46. Corrigan P, Thompson V, Lambert D, Sangster Y, Noel JG, Campbell J. Perceptions of discrimination among persons with serious mental illness. *Psychiatric Services* Aug 2003;54(8):1105-1110.
47. Baldwin ML, Marcus SC. Perceived and measured stigma among workers with serious mental illness. *Psychiatric Services* 2006;57(3):388-392.
48. Browne G, Hemsley M. Housing and living with a mental illness: Exploring carers' views. *International Journal of Mental Health Nursing* 2010;19(1):22-29.
49. Corrigan PW, Watson AC, Warpinski AC, Gracia G. Stigmatizing attitudes about mental illness and allocation of resources to mental health services. *Community Mental Health Journal* Aug 2004;40(4):297-307.
50. Albrecht GL, Walker VG, Levy JA. 1982. Social distance from the stigmatized. A test of two theories. *Periodical* 1982;16:1319-1327.
51. Bogardus ES. Social distance scale. *Sociology and social research* 1933;17:265-271.
52. Fishbein M, Ajzen I. *Belief, attitude, intentions and behaviour: An introduction to theory and research*. Reading, MA: Addison Wesley; 1975.
53. Björkman T, Angelman T, Jönsson M. Attitudes towards people with mental illness: A cross-sectional study among nursing staff in psychiatric and somatic care. *Scandinavian Journal of Caring Sciences* 2008;22(2):170-177.
54. Nordt C, Rossler W, Lauber C. Attitudes of mental health professionals toward people with schizophrenia and major depression. *Schizophrenia Bulletin* Oct 2006;32(4):709-714.
55. Thornicroft G, Brohan E, Rose D, Sartorius N, Leese M. Global pattern of experienced and anticipated discrimination against people with schizophrenia: a cross-sectional survey. *The Lancet* 2009;373(9661):408-415.
56. Arboleda-Florez J. Considerations on the Stigma of Mental Illness. *Canadian Journal of Psychiatry* 2003;48(10):645-650.
57. Thornicroft G, Mehta N, Brohan E, Kassan A. Stigma and discrimination. In: Morgan C, Bhugra D, eds. *Principles of social psychiatry*. 2nd ed. Chichester, UK John Wiley & Son Ltd.; 2010:331-340.
58. Corrigan P, Markowitz FE, Watson A, Rowan D, Kubiak MA. An attribution model of public discrimination towards persons with mental illness. *Journal of Health and Social Behavior* 2003;44(2):162-179.

59. Corrigan PW, Edwards AB, Green A, Diwan SL, Penn DL. Prejudice, Social Distance, and Familiarity with Mental Illness. *Schizophrenia Bulletin* 2001;27(2):219-225.

60. Corrigan PW, Rowan D, Green A, Lundin R, River P, Uphoff-Wasowski K, White K, Kubiak MA. Challenging two mental illness stigmas: personal responsibility and dangerousness. *Schizophrenia Bulletin* 2002;28(2):293-309.

61. Corrigan PW, Wassel A. Understanding and influencing the stigma of mental illness. *Journal of Psychosocial Nursing* Jan 2008;46(1):42-48.

62. Dietrich S, Beck M, Bujantugs B, Kenzine D, Matschinger H, Angermeyer MC. The relationship between public causal beliefs and social distance toward mentally ill people. *Australian and New Zealand Journal of Psychiatry* 2004;38(5):348-354.

63. Griffiths KM, Christensen H. Commentary on 'The relationship between public causal beliefs and social distance toward mentally ill people'. *Australian and New Zealand Journal of Psychiatry* 2004;38(5):355-357.

64. Alexander LA, Link BG. The impact of contact on stigmatizing attitudes toward people with mental illness. *Journal of Mental Health* 2003;12(3):271-289.

65. Desforges DM, Lord CG, Ramsey SL, Mason JA, Van Leeuwen MD, West SC, Lepper MR. Effects of Structured Cooperative Contact on Changing Negative Attitudes Toward Stigmatized Social Groups. *Journal of Personality and Social Psychology* 1991;60(4):531-544.

66. Link BG, Cullen FT. Contact with the mentally ill and perceptions of how dangerous they are. *Journal of Health and Social Behavior* 1986;27(4):289-302.

67. Estroff SE, Penn DL, Toporek JR. From stigma to discrimination: an analysis of community efforts to reduce the negative consequences of having a psychiatric disorder and label. *Schizophrenia Bulletin* 2004;30(3):493-509.

68. Islam MR, Hewstone M. Intergroup Attributions and Affective Consequences in Majority and Minority Groups. *Journal of Personality and Social Psychology* 1993;64(6):936-950.

69. Couture SM, Penn DL. Interpersonal contact and the stigma of mental illness: A review of the literature. *Journal of Mental Health* 2003;12(3):291-305.

70. Link BG, Phelan JC. Conceptualizing stigma. *Annual Review of Sociology.* Vol 27; 2001:363-385.

71. Stuart H. Mental disorders and social stigma: Three moments in Canadian history. In: Cairney J, Streiner DL, eds. *Mental disorder in Canada. An epidemiological perspective*. Toronto: University of Toronto Press; 2010:304-330.

72. Brohan E, Elgie R, Sartorious N, Thornicroft G. Self-stigma, empowerment and perceived discrimination among people with schizophrenia in 14 European countries: The GAMIAN-Europe study. *Schizophrenia Research* 2010;122:232-238.

73. Angermeyer MC, Beck M, Dietrich S, Holzinger A. The stigma of mental illness: patients' anticipations and experiences. *International Journal of Social Psychiatry* Jun 2004;50(2):153-162.

74. Yang LH, Kleinman A, Link BG, Phelan JC, Lee S, Good B. Culture and stigma: Adding moral experience to stigma theory. *Social Science & Medicine* Apr 2007;64(7):1524-1535.

75. Link BG, Struening EL, Neese-Todd S, Asmussen S, Phelan JC. Stigma as a barrier to recovery: The consequences of stigma for the self-esteem of people with mental illnesses. *Psychiatric Services* Dec 2001;52(12):1621-1626.

76. Rosenfield S. Labeling mental illness: The effects of received services and perceived stigma on life satisfaction. *American Sociological Review* 1997;62(4):660-672.

77. Verhaeghe M, Bracke P, Bruynooghe K. Stigmatization and self-esteem of persons in recovery from mental illness: the role of peer support. *International Journal of Social Psychiatry* May 2008;54(3):206-218.

78. Brohan E, Gauci D, Sartorious N, Thornicroft G. Self-stigma, empowerment and perceived discrimination among people with bipolar disorder or depression in 13 European countries: The GAMIAN-Europe study. *Journal of Affective Disorders* 2010:1-8.

79. Herman NJ, Smith CM. Mental hospital depopulation in Canada: Patient perspectives. *Canadian Journal of Psychiatry* 1989;34:386-391.

80. Camp DL, Finlay WM, Lyons E. Is low self-esteem an inevitable consequence of stigma? An example from women with chronic mental health problems. *Social Science & Medicine* Sep 2002;55(5):823-834.

81. Corrigan PW, Watson AC. The paradox of self-stigma and mental illness. *Clinical Psychology: Science and Practice* 2002;9(1):35-53.

82. Rusch N, Lieb K, Bohus M, Corrigan PW. Self-stigma, empowerment, and perceived legitimacy of discrimination among women with mental illness. *Psychiatric Services* Mar 2006;57(3):399-402.

83. Major B, O'Brien LT. The social psychology of stigma. Vol 56; 2005:393-421.

84. Green G, Hayes C, Dickinson D, Whittaker A, Gilheany B. A mental health service users perspective to stigmatisation. *Journal of Mental Health* 2003;12(3):223-234.

85. Link BG, Cullen FT, Frank J, Wozniak JF. The Social Rejection of Former Mental Patients: Understanding Why Labels Matter. *American Journal of Sociology* 1987;92(6):1461-1500.

86. Mueller B, Nordt C, Lauber C, Rueesch P, Meyer PC, Roessler W. Social support modifies perceived stigmatization in the first years of mental illness: a longitudinal approach. *Social Science & Medicine* Jan 2006;62(1):39-49.

87. Chan F, McMahon BT, Cheing G, Rosenthal DA, Bezyak J. Drivers of workplace discrimination against people with disabilities: The utility of Attribution Theory. *Work* 2005;25(1):77-88.

88. Ali M, Schur L, Blanck P. What types of jobs do people with disabilities want? *Journal of Occupational Rehabilitation* 2011;21(2):199-210.

89. Baron RC, Salzer MS. Accounting for unemployment among people with mental illness. *Behavioral Sciences and the Law* 2002;20(6):585-599.

90. Kirsh B, Stergiou-Kita M, Gewurtz R, Dawson D, Krupa T, Lysaght R, Shaw L. From margins to mainstream: What do we know about work integration for persons with brain injury, mental illness and intellectual disability? *Work* 2009;32(4):391-405.

91. Perkins DV, Raines JA, Tschopp MK, Warner TC. Gainful employment reduces stigma toward people recovering from schizophrenia. *Community Mental Health Journal* Jun 2009;45(3):158-162.

92. Brohan E, Thornicroft G. Stigma and discrimination of mental health problems: Workplace implications. *Occupational Medicine* 2010;60(6):414-415.
93. Brohan E, Henderson C, Little K, Thornicroft G. Employees with mental health problems: Survey of UK employers' knowledge, attitudes and workplace practices. *Epidemiologia e Psichiatria Sociale* 2010;19(4):326-332.
94. Hand C, Tryssenaar J. Small business employers' views on hiring individuals with mental illness. *Psychiatric Rehabilitation Journal* Winter 2006;29(3):166-173.
95. Wheat K, Brohan E, Henderson C, Thornicroft G. Mental illness and the workplace: Conceal or reveal? *Journal of the Royal Society of Medicine* 2010;103(3):83-86.
96. Goldberg SG, Killeen MB, O'Day B. The disclosure conundrum: How people with psychiatric disabilities navigate employment. *Psychology, Public Policy, and Law* 2005;11(3):463-500.
97. Paetzold RL. Mental illness and reasonable accommodations at work: Definition of a mental disability under the ADA. *Psychiatric Services* 2005;56(10):1188-1190.
98. Petrila J, Brink T. Mental illness and changing definitions of disability under the Americans with disabilities act. *Psychiatric Services* 2001;52(5):626-630.
99. Harlan SL, Robert PM. The social construction of disability in organizations: Why employers resist reasonable accommodation. *Work and Occupations* 1998;25(4):397-435.
100. Thornicroft G, Rose D, Kassam A, Sartorius N. Stigma: Ignorance, prejudice or discrimination? *British Journal of Psychiatry* 2007;190(MAR.):192-193.
101. Link BG, Yang LH, Phelan JC, Collins PY. Measuring mental illness stigma. *Schizophrenia Bulletin* 2004;30(3):511-541.
102. Shaffer R, Deller S, Marcouiller D. *Community economics. Linking theory and practice*. 2nd ed. Oxford: Blackwell Publishing; 2004.
103. Spear R. The social economy in Europe: Trends and challenges. In: Mook L, Quarter J, Ryan S, eds. *Researching the social economy*. Toronto: University of Toronto Press; 2010:84-105.
104. Loxley J, Lamb L. Economics for CED practitioners. In: Shragge E, Toye M, eds. *Community economic devleopment. Building for social change*. Sydney, NS: Cape Breton University Press; 2006:42-54.
105. Wallace SL. Social entrepreneurship: The role of social purpose enterprises in facilitating community economic development. *Journal of Developmental Entrepreneurship* 1999;4(2):153-174.
106. Boothroyd P, Davis HC. Community economic development: three approaches. *Journal of Planning Education & Research* 1993;12(3):230-240.
107. Shragge E, Toye M, eds. *Community economic development. Building for social change*. Sydney, NS: Cape Breton University Press; 2006.
108. Mook L, Quarter J, Ryan S. "What's in a name?". In: Mook L, Quarter J, Ryan S, eds. *Researching the social economy*. Toronto: University of Toronto Press; 2010:3-24.
109. Toye M, Chaland N. CED in Canada: Review of definitions and profile of practice. In: Shragge E, Toye M, eds. *Community economic development. Building for social change*. Sydney, NS: Cape Breton University Press; 2006:21-41.
110. Shaffer R, Deller S, Marcouiller D. Rethinking community economic development. *Economic Development Quarterly* 2006;20(1):59-74.

111. Haughton G. Principles and practice of community economic development. *Regional Studies* 1998;32(9):872-877.
112. Jeffery S. Social firms: Developing business, economic viability, stakeholder value and worker inclusion. *International Congress Series* 2005;1282:1153-1157.
113. Defourny J, Nyssens M. Social enterprise in Europe: At the crossroads of market, public policies and third sector. *Policy and Society* 2010;29(3):231-242.
114. Lysaght R, Krupa T. *Social business: Advancing the viability of a model for economic and occupational justice for people with disabilities.* Kingston: School of Rehabilitation Therapy, Queen's University; 2011.
115. Mendell M. Reflections on the evolving landscape of social enterprise in North America. *Policy and Society* 2010;29(3):243-256.
116. Spear R, Bidet E. Social enterprise for work integration in 12 European countries: A descriptive analysis. *Annals of Public and Cooperative Economics* 2005;76(2):195-231.
117. Kirsh B, Krupa T, Cockburn L, Gewurtz R. A Canadian model of work integration for persons with mental illnesses. *Disability and Rehabilitation* 2010;32(22):1833-1846.
118. Bond GR. Principles of the Individual Placement and Support Model: Empirical Support. *Psychiatric Rehabilitation Journal* 1998;22(1):11-23.
119. Herron JD, Gioia D, Dohrn B. A social enterprise model for employment. *Psychiatric Services* 2009;60(8):1140.
120. Wallace CJ, Tauber R, Wilde J. Teaching fundamental workplace skills to persons with serious mental illness. *Psychiatric Services* 1999;50(9).
121. Ninacs WA, Toye M. Overview of integration-through-work practices in Canada outside of Quebec. *Économie et solidarités* 2002;33(1):74-92.
122. Kerlin JA. Social Enterprise in the United States and Europe: Understanding and Learning from the Differences. *Voluntas: International Journal of Voluntary and Nonprofit Organizations* 2006;17(3):247-263.
123. Savio M, Righetti A. Cooperatives as a social enterprise in Italy: a place for social integration and rehabilitation. *Acta Psychiatrica Scandinavica* Oct 1993;88(4):238-242.
124. Mathie A, Cunningham G. From clients to citizens: Asset-based Community Development as a strategy for community-driven development. *Development in Practice* 2003;13(5):474-486.
125. Hartl K. A-Way Express: A way to empowerment through competitive employment. *Canadian journal of community mental health* 1992;11(2):73-77.
126. Church K. Learning to walk between worlds: Informal learning in psychiatric survivor businesses: A retrospective reading of research process and outcomes: 1993-1999. : Network for New Approaches to Lifelong Learning (NALL). 2001.
127. Krupa T. Affirmative Businesses. In: Albrecht G, ed. *Dictionary of Disability*. Thousand Oaks, CA: Sage; 2006.
128. Krupa T, McCourty K, Bonner D, Von Briesen B, Scott R. Voices, Opportunities and Choices Employment Club: Transforming sheltered workshops using an affirmative business approach. *Canadian journal of community mental health* 1999;18(2 SPEC. ISS.):87-98.
129. Priest A. *Removing barriers to work. Flexible employment options for people with disabilities in BC.* Vancouver: Canadian Centre for Policy Alternatives BC Office; 2008.

130. Lal S, Mercier C. Intersectoral action to employ individuals with mental illness: Lessons learned from a local development initiative. *Work* 2009;33(4):427-437.
131. Mendell M, Neamtan N. The social economy in Quebec: Towards a new political economy. In: Mook L, Quarter J, Ryan S, eds. *Researching the social economy*. Toronto: University of Toronto Press; 2010:63-83.
132. Hudson R. Life on the edge: Navigating the competitive tensions between the 'social' and the 'economic' in the social economy and in its relations to the mainstream. *Journal of Economic Geography* 2009;9(4):493-510.
133. Secker J, Dass S, Grove B. Developing Social Firms in the UK: A contribution to identifying good practice. *Disability and Society* 2003;18(5):659-674.
134. Di Domenico M, Haugh H, Tracey P. Social bricolage: Theorizing social value creation in social enterprises. *Entrepreneurship: Theory and Practice* 2010;34(4):681-703.
135. Cooney K. An exploratory study of social purpose business models in the United States. *Nonprofit and Voluntary Sector Quarterly* 2011;40(1):185-196.
136. Lincoln YS, Guba EG. *Naturalistic inquiry*. Beverly Hills: Sage publications; 1985.
137. Caelli K, Ray L, Mill J. 'Clear as Mud': Toward Greater Clarity in Generic Qualitative Research. *The International Journal of Qualitative Methods* 2003;2(2).
138. Padgett DK. *Qualitative methods in social work research*. 2nd ed. Los Angeles: Sage; 2008.
139. Patton MQ. *Qualitative evaluation research methods.* 2nd ed. Newbury Park: Sage Publications; 1990.
140. Merriam SB. *Qualitative research. A guide to design and implementation*. San Francisco: Jossey-Bass; 2009.
141. Yin RK. *Case study research. Design and methods*. 4th ed. Los Angeles: Sage; 2009.
142. Stake RE. *The art of case study research*. Thousand Oaks, CA: Sage; 1995.
143. Biber SN, Leavy P. Case study. In: Biber SN, Leavy P, eds. *The practice of qualitative research*. Los Angeles, CA: Sage; 2011:255-276.
144. Simons H. Case study research in practice. Los Angeles, CA: Sage; 2009.
145. Creswell JW. *Qualitative inquiry & research design. Choosing among five approaches*. 2nd ed. Thousand Oaks, CA: Sage; 2007.
146. Sandelowski M. The problem of rigor in qualitative research. *ANS Advances in nursing science* 1986;8(3):27-37.
147. Morse JM. Strategies for sampling. In: Morse JM, ed. *Qualitative nursing research. A contemporary dialogue*. Newbury Park: Sage 1981:127-145.
148. Cutcliffe JR. Methodological issues in grounded theory. *Journal of Advanced Nursing* 2000;31(6):1476-1484.
149. Merton RK, Fiske M, Kendall P. *The focused interview: A manual of problems and procedures*. 2nd ed. New-York: The Free Press; 1990.
150. Charmaz K. *Constructing grounded theory. A practical guide through qualitative analysis*. London: Sage; 2006.
151. Strauss AL, Corbin J. *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park: Sage Publications; 1990.
152. Carnevale FA. Authentic Qualitative Research and the Quest for Methodological Rigour. *Canadian Journal of Nursing Research* 2002;34(2):XI-XII.

153. Elliott R, Fischer CT, Rennie DL. Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology* 1999;38(3):215-229.
154. Stake RE. *Multiple case study analysis*. New York: The Guilford Press; 2006.
155. Dewa CS, McDaid D, Ettner SL. An international perspective on worker mental health problems: Who bears the burden and how are costs addressed? *Canadian Journal of Psychiatry* 2007;52(6):346-356.
156. Marlow I, Picard A. Bell CEO launches $50-million mental-health initiative. *The Globe and Mail.* September 22, 2010: A1.
157. Kirsh B. Factors associated with employment for mental health consumers. *Psychiatric Rehabilitation Journal* 2000;24(1):13-21.
158. Easterly L, Miesing P. Social venture business strategies for reducing poverty. In: Stoner JAF, Wankel C, eds. *Innovative approaches to reducing global poverty*. Charlotte, N.C.: IAP/Information Age Publications; 2007:3-26.
159. Evans-Lacko S, Malcolm E, West K, et al. Influence of Time to Change's social marketing interventions on stigma in England 2009-2011. *British Journal of Psychiatry* 2013;202(SUPPL.55):s77-s88.
160. Anthony WA. Supported employment in the context of psychiatric rehabilitation. *Psychiatric Rehabilitation Journal* Spring 2008;31(4):271-272.
161. Burns T, Catty J, Becker T, et al. The effectiveness of supported employment for people with severe mental illness: a randomised controlled trial. *Lancet* Sep 29 2007;370(9593):1146-1152.
162. Evans LJ, Bond GR. Expert ratings on the critical ingredients of supported employment for people with severe mental illness. *Psychiatric Rehabilitation Journal* Spring 2008;31(4):318-331.
163. Schneider J, Akhtar A. Implementation of individual placement and support: the Nottingham experience. *Psychiatric Rehabilitation Journal* 2012;35(4):325-332.
164. Marshall T, Rapp CA, Becker DR, Bond GR. Key factors for implementing supported employment. *Psychiatric Services* Aug 2008;59(8):886-892.
165. Bond GR, Drake RE, Becker DR. An update on randomized controlled trials of evidence-based supported employment. *Psychiatric Rehabilitation Journal* Spring 2008;31(4):280-290.
166. Bond GR, Kukla M. Is job tenure brief in Individual Placement and Support (IPS) employment programs? *Psychiatric Services* 2011;62(8):950-953.
167. Loveland D, Driscoll H, Boyle M. Enhancing supported employment services for individuals with a serious mental illness: A review of the literature. *Journal of Vocational Rehabilitation* 2007;27(3):177-189.
168. Campbell K, Bond GR, Drake RE, McHugo GJ, Xie H. Client predictors of employment outcomes in high-fidelity supported employment: A regression analysis. *Journal of Nervous and Mental Disease* 2010;198(8):556-563.
169. Tsang HWH, Chan A, Wong A, Liberman RP. Vocational outcomes of an integrated supported employment program for individuals with persistent and severe mental illness. *Journal of Behavior Therapy and Experimental Psychiatry* 2009;40(2):292-305.
170. Kirsh B. Organizational culture, climate and person-environment fit: Relationships with employment outcomes for mental health consumers. *Work* 2000;14(2):109-122.

171. Gaertner SL, Dovidio JF, Bachman BA. Revisiting the contact hypothesis: The induction of a common ingroup identity. *International Journal of Intercultural Relations* 1996;20(3-4):271-290.
172. Ferguson KM. Implementing a social enterprise intervention with homeless, street-living youths in Los Angeles. *Social Work* 2007;52(2):103-112.
173. Ferguson KM, Islam N. Conceptualizing outcomes with street-living young adults: Grounded theory approach to evaluating the social enterprise intervention. *Qualitative Social Work* 2008;7(2):217-237.
174. Zaniboni S, Fraccaroli F, Villotti P, Corbière M. Working plans of people with mental disorders employed in Italian social enterprises. *Psychiatric Rehabilitation Journal* 2011;35(1):55-58.
175. Ife J. The future of community development. *SACOSS Community Development Conference*. Adelaide, SA; 2012.
176. Reichert E. *Social Work and human rights. A foundation for policy and practice*. New York: Columbia University Press; 2003.
177. Shankar J, Martin J, McDonald C. Emerging areas of practice for mental health social workers: Education and employment. *Australian Social Work* 2009;62(1):28-44.
178. Scheyett A. The mark of madness: Stigma, serious mental illnesses, and social work. *Social Work in Mental Health* 2005;3(4):79-97.
179. Campbell J, Healy B, Brophy L. Mental health policy, law and risk: Finding a balance between state paternalism and citizenship rights for people with mental health problems. In: Sapouna L, Herrmann P, eds. *Knowledge in mental health. Reclaiming the social*. New York: Nova Science Publishers, Inc.; 2006:25-38.
180. Pilgrim D. 'Recovery' and current mental health policy. *Chronic Illness* Dec 2008;4(4):295-304.
181. Ramon S. Risk avoidance and risk taking in mental health social work. In: Sapouna L, Herrmann P, eds. *Knowledge in mental health. Reclaiming the social*. New York: Nova Science Publishers, Inc.; 2006:39-55.
182. Ramon S. Adult mental health in a changing international context: The relevance to social work. *British Journal of Social Work* 2009;39(8):1615-1622.
183. Gomory T, Wong SE, Cohen D, Lacasse JR. Clinical social work and the biomedical industrial complex. *Journal of Sociology and Social Welfare* 2011;38(4):135-165.
184. Swain J, French S, Cameron C. *Controversial issues in a disabling society*. Buckingham: Open University Press; 2003.
185. Carpenter J. Mental health recovery paradigm: implications for social work. *Health and Social Work* 2002;27(2):86-94.
186. Buckles B, Brewer E, Kerecman J, Mildred L, Ellis A, Ryan J. Beyond stigma and discrimination: challenges for social work practice in psychiatric rehabilitation and recovery. *Journal of Social Work Disability & Rehabilitation* 2008;7(3-4):232-283.
187. Considine M. Competition, quasi-markets and the new welfare state. In: O'Connor I, Smiyth P, Warburton J, eds. *Contemporary perspectives on Social Work and the human service: Challenges and change*. Surrey Hills: Longman; 2000.
188. Crimeen K, Wilson L. Economic rationalism or social justice: A challenge for social workers. *Australian Social Work* 1997;50(4):47-52.

189. Gray M, Healy K, Crofts P. Social Enterprise: Is It the Business of Social Work? *Australian Social Work* 2003;56(2):141-154.

190. Morrow M, Wasik A, Cohen M, Perry KME. Removing barriers to work: Building economic security for people with psychiatric disabilities. *Critical Social Policy* 2009;29(4):655-676.

191. West T. Psychosocial practice in community mental health services. In: Webber M, Nathan J, eds. *Reflective practice in mental health. Advanced psychosocial practice with children, adolescents and adults*. London: Jessica Kingsley Publishers; 2010:223-233.

192. Canada. *Canadian Charter of Rights and Freedoms*. Ottawa: Dept. of the Secretary of State of Canada; 1987.

193. Hahn H. Adapting the environment to people with disabilities: Constitutional issues in Canada. *International Journal of Rehabilitation Research* 1987;10(4):363-372.

194. Prince MJ. Canadian Disability Policy: Still a Hit-and-Miss Affair. *Canadian Journal of Sociology* 2004;29(1):59-82+vi.

195. Federal/Provincial/Territorial Ministers Responsible for Social Services. In unison. A Canadian approach to disability issues. Hull, QC: HRDC; 1998.

196. Office for Disability Issues. *Advancing the inclusion of persons with disabilities.* Ottawa: Her Majesty the Queen in Right of Canada; 2002.

197. United Nations General Assembly. *Convention on the Rights of Persons with Disabilities*: New York, United Nations; 2006.

198. Smith DE. *Institutional ethnography: A sociology for people*. Lanham, MD: AltaMira Press; 2005.

APPENDIX A: Sample letter of invitation to the study

Date, 2011

To: All Employees and staff
Business Name

Re: Invitation to participate in the study:
Understanding How Social Economy Businesses Influence the Stigma of Mental Illness

You are cordially invited to participate in this research study. The objective of the research is to learn about how social businesses, such as (Company X), influence the stigma of mental illness, both in the workplace and in the wider community.

Research has identified stigma as an important barrier to employment for people with mental illness. Yet we know very little about how processes of stigma operate in the area of employment. We would like to explore this question from the perspectives of different groups involved with social businesses; including employees, work supervisors, company managers, board members and business owners. We will also seek the opinions of customers, local employers in similar businesses and mental health service providers. By sharing your own experience as a stakeholder involved with a social business, you will help to improve employment outcomes for people with mental illness, and contribute to anti-stigma efforts in the important domain of employment.

The Principal Investigator of the project is Judith Sabetti, a Ph.D. candidate at the McGill University School of Social Work, and Research Assistant at the Douglas Mental Health University Institute in Montreal, Qc. The present study is her doctoral research. The project is supervised by Dr. Lucyna M. Lach at the McGill School of Social Work, Dr. Myra Piat, a researcher at the Douglas Institute, and Dr. Terry Krupa, from the School of Rehabilitation Therapy, Queen's University, Kingston, On. The research is funded by the Québec Fonds de recherche sur la société et la culture, and the Mental Health Commission of Canada.

We are looking for employees at Company XX who would like to participate in a focus group interview lasting from 60 to 90 minutes. We are also looking for supervisors, managers and board members from the company who would be willing to participate in individual interviews, lasting 45-60 minutes. The focus groups and interviews will be held at convenient times/locations for participants. Questions for both focus groups and individual Interviews will focus on your work experiences; your opinions about the stigma of mental illness; and

about how your company influences stigma both in the workplace and in the community. We will also ask for your opinions on ways to reduce stigma in employment for people with mental illness. Employees participating in focus groups will be paid $25. for their participation. Please note that your participation in this study is entirely voluntary, confidential, and will not affect your employment.

If you are interested in participating in this study, please contact me: Judith Sabetti at (local number for Kingston/Toronto/Montreal), or send an email to judith.sabetti@douglas.mcgill.ca with your name and a telephone number where you can be reached. I will return your call or answer your email shortly.

If you have further questions about this study, you may contact (add name).

Thank you very much for considering this request, and I look forward to hearing from you.

Sincerely,

Judith Sabetti, MSW
Ph.D. Candidate
McGill University School of Social Work
Montreal, Quebec

APPENDIX B: Composite interview guide: Frequently asked questions

Introduction:

A lot of people are talking these days about mental illness and stigma. We are interested in understanding how stigma occurs, and how it is dealt with, in social businesses. I am going to ask you some general questions about the influence of the (BUSINESS) on stigma both in the workplace, and in the wider community, based on your experience as (POSITION). There are no right or wrong answers. Everyone will have different attitudes and opinions based on their own experiences.

Typical questions:

1. I'd like to start by asking you to describe the mission and objectives of the (BUSINESS).
    a. Then their particular role, responsibilities . . .

2. How does the (BUSINESS) influence public perceptions of people with mental illness? In terms of their capacity for employment? (how about in the business community; government)
    a. How would you present the (BUSINESS) and its mission to the public through publicity or media reports?

3. (direct question on stigma – may or may not yield a lot of information) What stories, or critical incidents, can you tell me about where the problem of stigma has emerged in the (BUSINESS)? These could be stories related to individuals, or the business itself. (probe on customer stigma; interpersonal situations in the business, e.g. employee-supervisor-manager incidents; co-workers; self-stigma among employees; general public)

4. Some people argue that the social and economic aims pursued by social economy businesses are competing aims. How would you reconcile the two?

5. Some people with experience working in social businesses have wondered if employers in the community would hire them. What do you think about this possibility?

a. What would be some of the concerns for employers in hiring a person with mental illness?

6. Imagine that I have a friend, a young woman living with mental illness. She wants to return to work, but is unsure about joining the (BUSINESS) because they hire only people with mental illness, and she is concerned about being stigmatized. How would you advise the person about what to do?

7. I'm going to play devil's advocate for a moment. Some research suggests that social businesses actually perpetuate social marginalization for people with mental illness. The argument says that this is so because: 1) people with mental illness work together in a segregated setting; 2) work accommodations and government social assistance programs have a stigmatizing effect on people with mental illness; and 3) they are only earning minimum wage usually, and can't advance in the businesses. In effect, social businesses are a traditional model, and a kind of "ghetto" outside of the mental health system. How would you respond to these kinds of affirmations?

8. What do you think about the potentially stigmatizing effects of locating a social business inside of a psychiatric facility or other mental health agency?

9. There is a perception that young people with mental illness avoid seeking employment in social businesses. Do you have any ideas about why this might be so?

10. The Mental Health Commission of Canada is focusing anti-stigma efforts in three areas, including workplaces. What would be your thoughts on how the (BUSINESS) addresses: 1) stigma in the workplace? 2) stigma among mental health providers?

11. (standard ending question) What am I missing? What else do I need to know in order to better understand the problem of stigma in social businesses?

    (May I contact you again if there are further questions?)

APPENDIX C: Final coding structure

CONNECTING WITH MENTAL HEALTH SYSTEM

17 Families; 150 Quotations

Creating cost savings to mental health system through employment (7 quotations)

Connecting businesses to mental health system through referrals (17 quotations)

Recognizing two separate and autonomous entities in the partnership (15 quotations)

Finding managers who can connect employees to services and work (6 quotations)

Negotiating between XX Corporation and mental health organizations (4 quotations)

Attempting to create business manager position for affirmative businesses (6 quotations)

Suggesting that Provider managers haven't reflected about stigma (9 quotations)

Collaborating with outside providers to promote job maintenance (14 quotations)

Deliberating establishment of a formal service agreement for partnership (5 quotations)

Discouraging service provider mentality and behavior among staff (18 quotations)

Divesting psychiatric hospitals to public system after partnership created (4 quotations)

Explaining Provider staff resistance to affirmative businesses (3 quotations)

Suggesting that most Provider staff recognize the businesses as separate (9 quotations)

Requiring more manager availability to expand businesses (4 quotations)

Perpetuating self stigma from contact with the mental health system (15 quotations)

Sharing stigma between Provider staff and clients (10 quotations)

Identifying with 'everyone else not in mental health' (4 quotations)

STAFFING SOCIAL BUSINESSES

7 Families; 40 quotations

Seeing staff from an outsider perspective (7 quotations)

Providing support to business personnel (12 quotations)

Limiting supervisor access to employee health files (7 quotations)

Having dual reporting responsibilities within VOCEC-PC partnership (6 quotations)

Identifying Provider staff concerns about job security (2 quotations)

Needing employee authorization to access medical files (1 quotation)

Needing support in their work as business supervisors (5 quotations)

DOING BUSINESS IN A PSYCHIATRIC HOSPITAL

9 Families; 73 Quotations

Being especially hard hit by stigma in mental health setting (8 quotations)

Sensing no faith in business acumen from hospital management (10 quotations)

Threatening to boycott social businesses (6 quotations)

Treating business problems as mental health issues (8 quotations)

Finding it difficult to work inside the mental health system (5 quotations)

Holding social businesses to unfair standards (15 quotations)

Bullying hospital staff into using on-site social businesses (11 quotations)

'Knowing what we're doing because we're not social workers doing business' (6 quotes)

Leading anti-stigma by example (4 quotations)

CONNECTING WITH LOCAL ORGANIZATIONS

3 Families; 92 Quotations

Doing business in a public library (39 quotations)

Identifying and involving local advocates (13 quotations)

Working with local employment agencies (40 quotations)

CONNECTING WITH OTHER BUSINESSES

8 Families; 227 Quotations

Developing business connections (30 quotations)

Speculating that employers need to face their ignorance about mental illness (24 quotations)

Knowing little about employer attitudes to mental illness (32 quotations)

Recruiting Board members with business connections (3 quotations)

Speculating about employer attitudes to experience in social businesses (42 quotations)

Identifying employer issues in hiring people with mental illness (82 quotations)

Arousing stigma from competitors (5 quotations)

Wondering about government and business perceptions about businesses (9 quotations)

NEGOTIATING BUSINESS CONTRACTS

6 Families; 38 quotations

Being target of questionable business dealings (10 quotations)

Negotiating business contracts (13 quotations)

Identifying stigma in business negotiations (4 quotations)

Meeting with opposition to the library café (1 quotation)

Believing that stigma possibility shouldn't preclude action (1 quotation)

Revisiting the failed DuPont contract (9 quotations)

LEGITIMIZING SOCIAL BUSINESSES

13 Families; 340 quotations

Viewing social businesses as "sheltered" or "social ghetto" (36 quotations)

Presenting social businesses as "regular businesses" (58 quotations)

Building business reputation (38 quotations)

Legitimizing business through good work and advocacy (16 quotations)

Legitimizing business through research (14 quotations)

Trying to pre-empt stigma toward new businesses (4 quotations)

Confusing social businesses with vocational programs (60 quotations)

Strengthening the business focus through careful planning (13 quotations)

Meeting a need as a business (17 quotations)

Hoping social businesses will not be identified as such (32 quotations)

Denying that social businesses provide real work (27 quotations)

Describing XX neighborhood's mental health legacy (22 quotations)

Seeing failed XX contract as legitimization of business (3 quotations)

SUSTAINING SOCIAL BUSINESSES

8 Families; 145 Quotations

Struggling in a competitive environment (37 quotations)

Looking for subsidies to develop social businesses and hire people (24 quotations)

Providing in-kind support to businesses (13 quotations)

Receiving government funding in social businesses (27 quotations)

Self-financing in social businesses (27 quotations)

Needing to rely on outside financial support (12 quotations)

Lobbying in favor of social business (3 quotations)

Operating without outside funding is "a big stretch" (2 quotations)

MARKETING PRODUCTS AND SERVICES

4 Families; 134 Quotations

Ensuring product quality and value (42 quotations)

Delivering quality and cost effective service as a business (39 quotations)

Avoiding the charity line in publicity (11 quotations)

Marketing social objectives (42 quotations)

DOING BUSINESS IN DIFFERENT ECONOMIES

4 Families; 27 Quotations

Staying in safe markets (10 quotations)

Contracting business through an internal economy (14 quotations)

Anticipating difficulties doing business in private markets (1 quotation)

Doing business exclusively with non-profits puts it in a "bubble" (2 quotations)

CREATING A POSITIVE WORKPLACE

12 Families; 138 Quotations

Creating business environments that promote healing (18 quotations)

Providing social interaction and activities in business (21 quotations)

Providing a lounge for employees (3 quotations)

Changing the world through workplaces that meet individual needs (10 quotations)

Addressing ignorance and stigma through contact and friendship (31 quotations)

Creating solidarity among workers (27 quotations)

Accepting mental illness in workplace saves having to hide it (6 quotations)

Recognizing organizational culture within social businesses (4 quotations)

Feeling stigmatized in having to hide illness (6 quotations)

Openness about illness experience as empowering (7 quotations)

Sharing information and resources among employees (2 quotations)

Treating all employees with equal consideration (3 quotations)

DEALING WITH CUSTOMERS

8 Families; 176 Quotations

Lacking honest feedback from customers (10 quotations)

Acknowledging legitimate errors and complaints about businesses (19 quotations)

Being a good social business customer (38 quotations)

Lacking direct feedback from customers (7 quotations)

Observing social divisions between customer groups (18 quotations)

Dealing with difficult customers and the “unfair advantage” (71 quotations)

Managing trouble cases involving customers (2 quotations)

Hiring business or treating employees as if giving charity (11 quotations)

CONNECTING WITH THE PUBLIC

7 Families; 124 Quotations

Promoting social and community integration through employment (21 quotations)

Suggesting that social businesses decrease stigma (26 quotations)

Educating the public on mental illness and stigma (23 quotations)

Educating about mental illness will not change negative views (2 quotations)

Avoiding interpersonal contact (22 quotations)

Suggesting that public perceptions of mental illness remain negative (27 quotations)

Exposing people's problems to promote social change (3 quotations)

MAINTAINING BELIEF IN PEOPLE

6 Families; 85 Quotations

Believing in people (13 quotations)

Giving people a chance to prove themselves (21 quotations)

Confronting own stigma as supervisor (10 quotations)

Seeing people as more than their mental illness (14 quotations)

Focusing on the future after 1st psychosis (11 quotations)

Managing young people through 1st psychosis programs (16 quotations)

IDENTIFYING STIGMA STEREOTYPES

13 Families; 210 Quotations

Expressing stigmatizing beliefs about mental illness (32 quotations)

Holding stigmatizing beliefs about mental illness from lack of interaction (5 quotations)

Wondering if people with mental illness are productive (10 quotations)

Blaming production problems on employees with mental illness (11 quotations)

Denying people are capable as workers (28 quotations)

Believing that people with mental illness can't contribute (7 quotations)

Believing that people with mental illness are violent (18 quotations)

Stigmatizing people because of appearance, speech, or idiosyncrasies (34 quotations)

Believing people with mental illness are too sick or stressed for work (36 quotations)

Believing that people with mental illness are unpredictable (7 quotations)

Believing that people with mental illness are lazy (9 quotations)

Identifying social consciousness and openness on the Board (6 quotations)

Commenting that people with mental illness are dirty (7 quotations)

EMPOWERING PEOPLE THROUGH WORK

12 Families; 22 Quotations

Pushing personal capacity (13 quotations)

Empowering employees through business (17 quotations)

Seeking employee participation and dedication in response to economic pressure (7 quotations)

Building employee capacity as economic mission grew (5 quotations)

Fostering employee participation in business (38 quotations)

Seeing employees as “regular people” (36 quotations)

Seeing people grow through employment (17 quotations)

Taking collective action (3 quotations)

Being empowered through employment (41 quotations)

Presenting employees as capable in the workplace (33 quotations)

Identifying personally with business success (10 quotations)

Seeing business challenges as opportunities for personal growth (3 quotations)

ENGAGING STAFF WITH LIVED EXPERIENCE

9 Families; 179 Quotations)

Describing workers with mental health issues (21 quotations)

Hiring people with lived experience in skilled jobs (25 quotations)

Hiring issues in businesses (51 quotations)

Suggesting people with different backgrounds can supervise businesses (14 quotations)

Winning respect from mangers, co-workers and customers (42 quotations)

Hearing about a job opening (14 quotations)

Hiring Provider clients as condition of partnership (4 quotations)

Managing like a professional not “regular old survivor” (4 quotations)

Placing employees with lived experience in all business areas (4 quotations)

INTEGRATING PEOPLE INTO WORK

14 Families; 224 quotations

Integrating and reintegrating people into work (10 quotations)

Working in social business as a stepping stone (58 quotations)

Using economic mission to integrate people into workforce (6 quotations)

Hiring people marginalized from the mainstream workforce (22 quotations)

Integrating people into the workforce gradually (24 quotations)

Losing connectedness to work after long absence (7 quotations)

Predicting that job history doesn't determine facility of work integration (9 quotations)

Addressing isolation and marginalization associated with unemployment (3 quotations)

Asserting from experience that working in mainstream isn't automatically de-stigmatizing (16 quotations)

Observing that people who moved to the mainstream returned (21 quotations)

Identifying personal impediments to work (31 quotations)

Asserting that employees have no interest in their fields of work (1 quotation)

Working in social business doesn't lead to better job (13 quotations)

Finding low wage service job (3 quotations)

ACCOMMODATING MENTAL ILLNESS AT WORK

9 Families; 144 Quotations

Accommodating health issues and personal issues alike (27 quotations)

Tailoring eligibility and work expectations to the individual (22 quotations)

Facilitating employee follow-up with outside providers (9 quotations)

Accommodating periods of illness (21 quotations)

Viewing outside psychosocial follow-up as a business accommodation (7 quotations)

Identifying and finding solutions to employee anxiety and stress (42 quotations)

Hiring additional 'regular' workers in rush periods (5 quotations)

Providing psychosocial follow-up for employees (6 quotations)

Reorganizing production around employee needs and limitations (5 quotations)

ADDRESSING PERSONAL AND SOCIAL ISSUES

9 Families; 132 Quotations

Sensitizing employees about improving interpersonal skills (28 quotations)

Tackling people's social issues before employment issues (13 quotations)

Building personal and social skills (6 quotations)

Observing little previous exposure to mental illness among employees (28 quotations)

Dealing unavoidably with employee problems (40 quotations)

Eliciting greater personal responsibility (11 quotations)

Finding that homelessness demoralizes people quickly (1 quotation)

Transferring improved work performance to other areas of life (4 quotations)

Using economic mission to help mental health recovery (1 quotation)

SETTING EMPLOYEE STANDARDS

10 Families; 147 Quotations

Setting standards and expectations for employees (44 quotations)

Recognizing employee strengths and limitations (33 quotations)

Downplaying differences in employee work capacity (5 quotations)

Acknowledging illness but focusing on person as worker (5 quotations)

Using employee evaluations as a positive exercise (12 quotations)

Experiencing employee evaluations as positive (4 quotations)

Strengthening business focus by adhering to hiring and performance standards (9 quotations)

Sensitizing employees about the need to work faster (16 quotations)

Describing various employee eligibility criteria (6 quotations)

Focusing on responsibility to work well (13 quotations)

TRAINING AND SKILL BUILDING

3 Families; 62 Quotations

Investing in employee training and development (50 quotations)

Preventing stigma by building skills (10 quotations)

Developing a work routine by starting early (2 quotations)

INCREASING EMPLOYEE CONTROL IN BUSINESS

6 Families; 122 Quotations

Increasing employee control of business (44 quotations)

Shifting responsibilities from supervisors to employees (24 quotations)

Reducing or eliminating supervisor roles (11 quotations)

Needing additional management and supervision in social businesses (18 quotations)

Avoiding therapist role as supervisors (17 quotations)

Reducing provider involvement in single businesses (8 quotations)

PROTECTING SOCIAL BUSINESS EMPLOYEES

9 Families; 232 Quotations

Stigmatizing employees through protectionist attitudes and behaviors (27 quotations)

Over-supervising social business employees (17 quotations)

Enhancing job security for workers with mental health issues (57 quotations)

Providing protection and safety through businesses (59 quotations)

Enhancing financial security for workers with mental health issues (12 quotations)

Protecting people through accommodations (7 quotations)

Being unable to protect people from the outside world (19 quotations)

"Living in a bubble" and feeling safe as survivor (2 quotations)

Preferring work in social business for the comfort level (32 quotations)

DEPENDING ON ILLNESS AND SERVICES

6 Families; 88 Quotations

Using interventions to shirk responsibilities (2 quotations)

Defining wellness by absence of providers (9 quotations)

Being stigmatized by providers who should understand (35 quotations)

Being "more than followed" by the mental health system (26 quotations)

Celebrating exit from psychiatry (5 quotations

Using mental illness to advantage (11 quotations)

BEING PROTECTED BY NATURAL SUPPORTS

3 Families, 23 Quotations

Being protected by families and caregivers (15 quotations)

Having limited responsibilities and privileges in foster homes (4 quotations)

Losing family support (4 quotations)

STIGMATIZING PEOPLE THROUGH SOCIAL ASSISTANCE

3 Families; 68 Quotations

Blaming unemployment on social assistance trap (12 quotations)

Suggesting that social assistance maintains poverty (36 quotations)

Stigmatizing people through social assistance rules (20 quotations)

AVOIDING COMPETITIVE EMPLOYMENT

6 Families; 58 Quotations

Avoiding competitive employment (15 quotations)

Avoiding competitive employment for fear of relapse (12 quotations)

Believing that achieving mainstream work depends on the individual (11 quotations)

Moving conditionally to mainstream employment (6 quotations)

Avoiding competitive employment for fear of losing benefits (13 quotations)

Suggesting people with mental illness are not "pounding the pavement" for work (1 quotation)

NEEDING TO ATTRACT YOUNG WORKERS

11 Families' 44 Quotations

Lacking younger workers (2 quotations)

Attracting younger workers depends on the business (5 quotations)

Suggesting that younger workers don't like part time or manual work (4 quotations)

Identifying generational differences in relation to work (10 quotations)

Identifying attitudes to social business among young people (2 quotations)

Suggesting young people don't relate to social business culture (2 quotations)

Predicting better employment prospects for younger generation (8 quotations)

Describing workers in social businesses as at career end (6 quotations)

Describing younger workers n social businesses as more educated (1 quotation)

Pointing out that youth unemployment is a massive issue generally (2 quotations)

Suggesting that some young workers in social business are fine (2 quotations)

RECOGNIZING SELF STIGMA

14 Families; 145 Quotations

Engaging in self stigma (43 quotations)

Growing up ashamed (3 quotations)

Losing value as members of society (6 quotations)

Denying social integration is possible as “we don’t live in that world” (6 quotations)

Feeling labelled by working in social business (16 quotations)

Feeling stigmatized by not fitting in and falling short (15 quotations)

Hiding survivor identity out of self hate (1 quotation)

Viewing multicultural society as an illusion (1 quotation)

Suggesting preference for working with nonjudgmental people (7 quotations)

Developing new identity through employment (5 quotations)

Gaining structure and purpose from work (14 quotations)

Escaping the patient identity through work (10 quotations)

Achieving citizenship through employment (4 quotations)

Suggesting that young people reject psychiatric identity (14 quotations)

RECOGNIZING DISCLOSURE ISSUES

9 Families; 179 Quotations

Suggesting that many people choose not to disclose mental health history (45 quotations)

Arguing for and against disclosure (54 quotations)

Feeling stigmatized in having to hide illness (6 quotations)

Questioning stigma in employment as people don’t disclose (5 quotations)

Hiding illness from employers and coworkers (54 quotations)

Sharing stigma between providers and clients (10 quotations)

Having confident identity but never disclosing survivor history (3 quotations)

Imagining difficulties of “coming out” when living as a failure (1 quotation)

Suggesting that mental illness is still taboo on university campuses (1 quotation)

ACQUIRING SURVIVOR IDENTITY

3 Families; 36 Quotations

Suggesting that self awareness as consumer survivor is learned through the businesses (11 quotations)

Suggesting that survivor identity among alternative business employees has diminished (5 quotations)

Establishing identity as consumer survivor (20 quotations)

TOTAL FOCUSED CODES: 32

TOTAL FAMILIES: 261

TOTAL QUOTATIONS: 3,734

APPENDIX D: Descriptive domains created in Atlas.ti

02.0 BUSINESS OR ORGANIZATION MISSION
02.1 economic vs. social objectives
02.2 public presentation of business

03.0 PERSONAL INVOLVEMENT IN BUSINESS
03.1 professional background
03.2 role and responsibilities
03.3 contributions and impact

04.0 BUSINESS OR ORGANIZATION HISTORY AND EVOLUTION
04.1 business origins
04.2 business rationale
04.3 favorable business conditions
04.4 obstacles encountered
04.5 current issues and challenges

APPENDIX E: Documents collected from the three research sites

Alternative Businesses:

- Field notes
- Minutes of Board meetings
- Internal correspondence
- Newspaper articles
- Internet articles
- Promotional materials
- Internal reports & planning documents
- Monthly business reports to the Board
- Financial statements

Affirmative Businesses

- Field notes
- Business Corporation Annual Reports
- Minutes of Board meetings/financial statements
- Internal documents (planning and legal documents)
- Media reports
- Promotional materials; brochures
- Internal Provider documents, re history of the businesses
- Business plans
- Scholarly journal articles
- Sample job posting

Social Enterprise

- Field notes
- Business Annual Reports
- Scholarly journal articles
- Sample job posting
- Social enterprise information brochure
- Social enterprise grant application
- Products catalogue
- PowerPoint presentation slides
- Employee evaluation forms