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Social Enterprise as a Pathway to Work, Wellness, and Social Inclusion for Canadians with Mental Illnesses and/or Substance Use Disorders

Rosemary Lysaght, Kelley Packalen, & Terry Krupa Queen's University
Lori Ross, University of Toronto
Agnieszka Fecica, Queen's University
Michael Roy, University of Sterling
Kathy Brock, Queen's University

ABSTRACT

People with serious and persistent mental illnesses and/or substance use disorders are among the most economically and socially disenfranchised populations in Canada, and often present with long histories of labour market detachment and underemployment. Work engagement has the potential to improve social determinants of health while also harnessing productive capacity. This article reports on a five-year study examining the social, economic, and health impacts of Work Integration Social Enterprises (WISEs) in the mental health sector in Ontario, Canada. The findings shed light on the population that works in WISEs, its levels of social and labour market integration, and organizational features that influence worker outcomes. Results highlight both the importance of WISEs as a means of supporting employment, and challenges to organizational sustainability.

RÉSUMÉ

Les personnes atteintes de troubles mentaux graves et persistants et/ou de troubles liés à l'usage de substances psychoactives font partie des populations les plus défavorisées économiquement et socialement au Canada et présentent souvent de longs antécédents de sous-emploi et de décrochage par rapport au marché du travail. L'engagement au travail a pourtant le potentiel d'améliorer les déterminants sociaux de la santé tout en augmentant la capacité productive. Cet article rend compte d'une étude de cinq ans examinant les impacts sociaux, économiques et sanitaires des entreprises sociales d'insertion par le travail (ESIT) dans le secteur de la santé mentale en Ontario (Canada). Les résultats jettent de la lumière sur la population qui travaille dans les ESIT, y compris son niveau d'intégration en société et au travail, et sur les caractéristiques organisationnelles influençant le rendement de ces travailleurs. Les résultats soulignent à la fois l'importance des ESIT pour soutenir l'emploi et les défis liés à la durabilité organisationnelle.

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People with serious and persistent mental illnesses[1] and/or substance use disorders often experience recurrent periods of labour market detachment and exceptionally high rates of unemployment (Luciano & Meara, 2014). The health challenges they experience typically appear early in adult life, are of long duration, and impact social functioning (Zumstein & Riese, 2020). The episodic nature of these conditions often produces intermittent work capacity (Emsley, Chiliza, Asmal & Harvey, 2013), making job retention challenging.

Employment can promote recovery for people with serious mental illness (Dunn, Wewiorski, & Rogers, 2008). The work to which they are often relegated, however, tends toward low-quality and high-pressure service industry work, which many find to be insecure, stressful, conflict-laden, and meaningless (Saavedra, López, Gonzáles, & Cubero, 2016; Gewurtz, Harlos, Tompa, Oldfield, Lysaght, Moll, Kirsh, Sultan-Taïeb Cook, & Rueda, 2022). Moreover, they are regularly subject to workplace stigma based on a range of negative assumptions about their suitability as employees (Krupa, Kirsh, Cockburn, & Gewurtz, 2009). From an employer perspective, worker retention can be difficult due to the uncertainty that emerges in relation to unpredictable work availability and capacity (Lysaght, Krupa, & Gregory, 2022).

Work Integration Social Enterprises (WISEs) offer an alternative employment model to conventional work options and overcome some of these obstacles. They are commercial entities that produce goods and/or services for the broader community and have a mandate to employ work-challenged populations, such as persons experiencing addiction, ill-health, significant periods of homelessness, incarceration, and/or hospitalization (Vidal, 2005). WISEs are designed to offer a more supportive and responsive employment option than the inflexible and stressful work conditions typically found in conventional workplaces (Evans & Wilton, 2019; Gewurtz et al., 2022). In addition, WISEs can increase the diversity of the broader labour economy, reduce stigma related to marginalized populations, and contribute to poverty reduction (Roy, Donaldson, Baker, & Kerr, 2014). Despite their growing prevalence, however, relatively little research has examined outcomes for WISE workers. To address this gap, the authors examined the work and socio-economic outcomes experienced by WISE employees with mental illnesses and/or substance use disorders. The authors also investigated the evolving structure of WISEs within the Ontario mental health sector.

LITERATURE REVIEW

The use of WISEs in the mental health sector originated in response to the historic exclusion of persons with mental illness and addictions from employment (Elmes, 2019; Gidron, 2017; Pache & Santos, 2013). Specific advantages of WISEs for these populations identified in past research include enhanced social integration and reduced stigma (Krupa, Sabetti, & Lysaght, 2019; Lysaght, Jakobsen, & Granhaug, 2012; Villotti, Zaniboni, Corbière, Guay, & Fraccaroli, 2018); improved incomes and social position (Elmes, 2019); improved work behaviours (Chan, Ryan, & Quarter, 2017); enhanced social connections (Hartley, Yeowell, & Powell, 2019); improved self-confidence (Chan

et al., 2017; Villotti et al., 2018); and improved mental health (Martinelli, Bonetto, Bonora, Cristofalo, Killaspy, & Ruggeri, 2022). More specifically, Roy, Baker, and Kerr (2017) identified seven ways in which working in WISEs can contribute to the improved health and wellbeing of vulnerable workers: 1) engaging people in meaningful work; 2) engendering a supportive and safe work environment; 3) improving knowledge and skills; 4) expanding social networks; 5) enabling access to information and welfare; 6) raising public awareness; and 7) building self-worth.

Research to date on individual outcomes has generally been qualitative, primarily in the form of single or multiple case studies, with some small-sample quantitative studies. Organization-level studies have included social return-on-investment studies of enterprises (e.g., Akingbola, Phaetthayanan, & Brown, 2015; Vieta, Schatz, & Kasparian, 2015), descriptive case studies (e.g., Pizarro Escribano & Miranda González, 2023; Sacchetti, 2023), and those based on extant government data (e.g. Battilana, Sengul, Pache, & Model, 2015).

Although multiple studies speak to the potential contributions of WISEs, some studies raise questions as to whether WISEs can deliver on their goals of improving incomes (Chan et al., 2017) and mental health (Saavedra et al., 2016) for the populations they serve. Further, the WISEs model can be difficult to deliver due to a number of challenges inherent to the hybrid model they function within (Battilana, 2018). In the inevitable struggle to serve both the demands of operating a sustainable business and the humanitarian mandate that is their reason for existence, WISEs risk taking actions that threaten success on both ends (Sparviero, 2019). In particular, to avoid the high rates of business failure (Roumpi, Magrizos, & Nicolopoulou, 2020), these businesses may inadvertently resort to practices that reinforce the very workforce factors that have historically contributed to the exclusion of workers with mental illnesses, such as isolating workers from the general public, favouring those who are stronger performers, stigmatizing the workforce by positioning them as recipients of charity rather than legitimate workers, and providing little opportunity for career advancement (Garrow & Hasenfeld, 2014; Krupa et al., 2019). Success requires balancing the business and social mandates with adherence to sound business practices, ensuring fair and culturally responsive employment practices, and creating opportunities for worker growth and development (Bull, 2007; Lysaght, Roy, Rendall, Krupa, Ball, & Davis, 2018).

CONTEXT FOR THE CURRENT STUDY

Work Integration Social Enterprises in the mental health sector developed along two tracks in Ontario starting in the early 1990s. One group of WISEs was developed by psychiatric consumers/survivors. They were funded under local government grants and operated as co-operatives (see, for example, Trainor & Tremblay, 1992). The second form of WISE was developed by hospitals and non-governmental organizations (NGOs) (mostly mental health agencies) as a means of creating employment and job training opportunities for their clients (see Krupa, Lagarde, & Carmichael, 2003). In the 2020s, WISEs in the mental health sector include businesses of various sizes and operational models, offering an optimal context to investigate their impact and operational structures.

METHODS

The project used a multiphase mixed-methods longitudinal design (Creswell & Plano-Clark, 2017)

to build in-depth knowledge concerning WISE as it is applied within the mental health sector. The multiple case study approach provided the opportunity to investigate different WISE models and the outcomes for the workers they employ (Creswell & Plano-Clark, 2017).

Study partners and participants

Table 1 provides an overview of the seven Southern Ontario WISEs that joined the research study as partners. All the organizations provide goods and services to the public, employ individuals who experience serious and persistent mental illness and/or substance use disorders as a primary employment barrier, adhere to provincial employment regulations, including minimum wage requirements, and are financially viable.

Table 1: Demographic profiles of WISEs at intake in 2017

Name	Partner/Parent organization	FY2017 oversight organization revenue	FY2017 social enterprise revenue	Social enterprises operated (*N*)	Primary areas of business	Employees (*N*)
Causeway	Non-government organization	$3,609,582	$728,197	5	Food Services, Bicycle Repair, Landscaping, Janitorial	57
Fresh Start	Consumer/ survivor operated	$1,304,132	$1,304,132	1	Janitorial, Landscaping	100
Goodwill	Non-government organization	$26,060,579[1]	n/a	4	Food Services, Retail, Light Manufacturing	700
Impact Junk	Non-government organization	$21,489,722	$265,014	1	Waste Removal, Cleaning Services	25
Rainbow's End	Healthcare facility	$593,778,144[2]	$590,850	6	Food Services, Landscaping, Sewing, Janitorial	76
JobWell[3]	Healthcare facility	$27,388,766[4]	$589,246	6	Carwash, Food Services, Janitorial	75
Working for Change	Consumer/ survivor operated	$2,392,382	$2,392,382	5	Food Services, Landscaping, Research	96

Notes: Information obtained from WISE and partner/parent organization annual reports, Section D of the T3010 Registered Charity Information Return filed with the Canadian Revenue Agency and intake interviews with WISE administrators. [1] Includes revenue from social enterprise sales, job training, corporate donations, and other sources [2] Includes all organizational revenues, including healthcare system transfers from provincial government. [3] Formerly operated as Voices, Opportunities and Choices Employment Club (VOCEC). [4] Includes revenues for only the facility unit responsible for social enterprise operations.

The following groups of individuals served as primary data sources:

- 16 WISE administrators: structured intake and exit interviews with one to two administrators from each WISE in fall 2017 and spring 2022. Administrative turnover resulted in four of the interviewees being different at follow-up than intake.
- 106 WISE workers: 43 had ongoing WISE employment of two years or more, and 63 were recruited upon hiring ("new hires").
    - All 106 workers participated in the Time 1 (T1) quantitative interview between fall 2017 and spring 2019.

- 86 workers completed the Time 2 (T2) quantitative interview approximately 18 months after their T1 quantitative interview.
- 78 workers completed the Time 3 (T3) quantitative interview approximately three years after their T1 quantitative interview.
- 22 purposively selected workers participated in a qualitative interview concerning their WISE working experience between July and December 2020.
- WISE front-line supervisors: 14 supervises participated in individual interviews between April and May 2021.

Data collection and measures

Quantitative data collection tools

A 188-question interview protocol was administered to each worker three times at approximately 18-month intervals. Table 2 provides an overview of the health, wellness, work, and income-related measures gathered in addition to standard demographic variables.

Table 2: Overview of Health, Wellness and Income Measures

Measure of scale	Source	Cronbach's alpha		Notes
		T1	T2	
Health- and wellness-related measures				
The RAND 36-Item Short Form Survey Instrument (SF-36)	McHorney, Ware, Lu & Sherbourne, (1994)			All scores are reported out of 100 with higher scores representing fewer limitations.
Limitations in physical activities due to health problems		0.86	0.93	
Limitations in usual activities due to physical health problems		0.83	0.89	
Limitations in activities due to energy levels		0.79	0.79	
Limitations due to general mental health and psychological distress		0.87	0.87	
Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)	World Health Organization (2002)	n/a	n/a	Diagnostic tool for practitioners to identify risk for abusing a variety of substances. We report on the risk scores for tobacco, alcohol and cannabis. For alcohol, 0-10 is classified as lower risk, between 11–26 as moderate risk and 27+ as higher risk. For all other substances the ranges are 0-3, 4-26 and 27+, respectively.
Satisfaction with Life Scale	Diener, Emmons, Larsen & Griffin, 1985	0.89	0.89	Five-item scale scored using a 7-point Likert scale with a higher average score indicating greater overall satisfaction with life

Table 2 (continued)

Measure of scale	Source	Cronbach's alpha		Notes
		T1	T2	
Work- and income-related measures				
Work Intention Inventory Short Form	Nimon & Zigarmi, 2015			All scores are reported out of 100 with higher scores representing fewer limitations.
• Intent to endorse their current employer		0.78	0.79	
• Intent to stay at their current employer		0.78	0.88	
Monthly income from employment	Self-report	n/a	n/a	
Monthly income from all source	Self-report	n/a	n/a	Includes e.g. employment, social assistance (e.g. Ontario Disability Support Program (ODSP)), other family members
Below low-income cut-off level	Statistics Canada (2023)	n/a	n/a	Scored as 1 if a participant's monthly pre-tax income from all sources multiplied by 12 was at or below the low-income cut-off (LICO) level value associated with the year in which they were interviewed, size of city of residence, and the number of individuals reported as dependent on their income. For 2022 because LICO levels were not released we calculated approximate levels by adding the average yearly increase for the previous 5-year period to 2021 LICO values.

Qualitative data collection tools

Administrative interviews concerning each WISE's mission, vision, and operations followed a semi-structured guide (Lysaght et al., 2018) that included a checklist prompting reflections on three dimensions: employment practices, business structure and practices, and worker growth and development. End-of-study interviews documented changes that occurred in WISE functioning since intake and explored trends observed in the study findings for the individual WISEs.

The qualitative interviews used semi-structured guides. For workers, the guide probed the pathway of the worker to WISE employment, their experiences in the WISEs, why they left (if applicable), personal employment motivations, and future goals. Supervisor interviews focused on employment practices and support structures within the WISEs, and supervisor impressions of best practices.

Data analysis

Quantitative measures

Worker quantitative measures were analyzed using descriptive and comparative statistics (both parametric and non-parametric, as appropriate) to profile the population characteristics, identify changes in participant status over time, and to compare sub-components of the population (i.e.,

those who at T3 were working in WISEs, those who had shifted to other conventional employment, and those who had dropped out of the workforce). Differences in average scores per group (including the group of those who did not interview at T3) were tested using the Kruskal-Wallis equality-of-population rank $\chi^2(3)$ with ties test (Kruskal & Wallis, 1952). This test indicates significant differences among the groups but does not identify between which specific group(s) the differences lie. Thus, the authors also used Dunn's (1964) test (with a Bonferroni adjustment)**]** for stochastic dominance among multiple pairwise comparisons to determine which pairs of groups were significantly different from one another. The exception to this was for the T3 comparisons of work-related variables for which the two-sample Wilcoxon rank-sum (Mann-Whitney) test was used (Wilcoxon, 1945; Mann & Whitney, 1947). The authors also compared within-group changes over time using *t*-tests. Significant results are noted as applicable in these analyses.

Qualitative data

Worker qualitative interviews were analyzed by five members of the project team using an analytical approach consistent with Yin's case study methodology (2014). Interview transcripts were imported into nVIVO software and team members reviewed them independently, looking for data patterns. The team discussed observations and initial codes until a provisional coding framework was established. Each team member then re-reviewed a set of transcripts until all interviews had been coded in detail by at least two members. Files were combined and emerging central themes were reviewed. Researchers then examined a matrix that contained demographic and other baseline quantitative details for each participant. This information provided additional context and contributed to explanation building across cases (Yin, 2014).

Administrator interviews analysis included calculating descriptive statistics on responses to scaled interview items as well as creating qualitative summaries of responses to open-ended questions.

Frontline supervisor qualitative interviews were analyzed by five team members using a thematic analysis approach (Braun & Clarke, 2006) and a team-based approach.

Finally, as part of the knowledge translation process, findings were presented to a mixed forum of 17 workers and staff from participating WISEs and subjected to small- and large-group interpretation and discussion. This process helped integrate findings across measures and data sources and highlighted key points for reporting and future action.

FINDINGS

Worker characteristics and outcomes

Population characteristics

Table 3 provides information on key demographic population features for both the entire sample and the three main comparison groups—those in conventional employment at the time of their third interview, those still working in a WISE, and those who were unemployed. As can be seen in Table 3, the average worker at intake was a single, 40-year-old, white, heterosexual male with no dependents and a high-school diploma who had been hospitalized at least once in the past for reasons related to mental health. Significant demographic differences between the three main comparison groups are explored in more depth below.

Table 3: Demographics by full sample (*n* = 106) and outcome employment status at Time 3

Variable	Employment status at Time 3[a]				
	Full sample (*n* = 106)	Conventional (*n* = 11)	WISE (*n* = 35)	Unemployed (*n* = 26)	No interview at T3 (*n* = 28)
Average age (at interview 1)	40 years	37 years	44 years	35 years	41 years
Identify as female	40%	36%	43%	42%	32%
Identify as heterosexual	84%	82%	89%	81%	86%
Cultural identity					
Caucasian	64%	63%	77%	69%	54%
Indigenous	8%	0%	0%	19%	11%
Other	27%	36%	23%	12%	36%
Visible minority	25%	27%	17%	19%	29%
Marital status					
Single	76%	63%	71%	77%	89%
Married/Common-law	16%	27%	20%	15%	7%
Status changes during study	8%	9%	9%	8%	4%
Dependents					
Yes	5%	0%	0%	4%	11%
No	86%	100%	89%	81%	89%
Changes during study	9%	0%	11%	15%	0%
At least some college &/or university	29%	64%	31%	19%	29%
Primary work prior to T1[b]					
Conventional employment	25%	64%	9%	31%	29%
WISE (long-term employee)	41%	18%	63%	35%	32%
Unemployed	23%	9%	20%	15%	36%
Other (e.g., job program, school)	11%	9%	9%	19%	4%
Self-reported diagnosis[c]					
Psychosis (e.g., BPD, Schizophrenia)	30%	9%	43%	46%	11%
Anxiety/Depression	40%	73%	40%	50%	18%
Substance use disorder	14%	18%	9%	27%	7%
No diagnosis disclosed	32%	9%	20%	15%	71%
Past mental health hospitalization	58%	36%	60%	65%	60%

Notes: Demographic questions were repeated at each interview. When a participant responded inconsistently to what are typically stable demographic features (e.g., visible minority) such discrepancies were noted and the more marginalized status is reported in this table; [a] Six individuals were not included as part of T3 comparison groups as they had retired (*n* =3) or were in school (*n* =3); [b] Participants were asked to provide a five-year work history. We used this information to identify an individual's primary employment status prior to entering the study. WISE employment were the long-term employees recruited to participate in the study; individuals were categorized as having entered WISE employment from conventional employment if they had held an outside job on a part-time or full-time basis in the six months leading up to their WISE employment. Workers were categorized as unemployed if there was no form of community employment and no alternative productivity-related activity (e.g., childcare, education, participation in a job program). [c] This self-report question was introduced at Time 2. Responses were grouped into three non-exclusive categories. The high percentage of no diagnosis disclosed among the group who did not interview at T3 reflects the fact that 10 of the 28 individuals in this group also did not interview at T2.

Table 4 profiles quantitative health, wellness, and work-related indicators for the 78 workers who interviewed at both T1 and T3. Inclusion of the additional 28 individuals who were not interviewed at T3 does not meaningfully change overall baseline levels; thus, for ease of comparison between

T1 and T3, only those who interviewed at both time points are included. By way of comparison, the T1 RAND SF-36 measures all fell within one standard deviation below the mean values for Canadians in the 35–44 and 45–54 age categories, which were 90.9 for limitations in physical activities due to health problems, 83.4 for limitations in usual activities due to physical health problems, 66.1 for limitations in activities due to energy levels, and 83.2 for limitations due to general mental health and psychological distress (Hopman, Towheed, Anastassiades, Tenenhouse, Poliquin, Berger, et al., 2000). The highest substance-use risk score was for tobacco, followed by alcohol and cannabis, and overall, mean scores fell within the lower risk range. The mean satisfaction with life score was in the mid-range ("slightly satisfied"), while worker intention to endorse their employer and to stay at the WISE were both above the scale mid-range ("moderately positive").

Table 4: Health, wellness, and work-related measures by outcome employment status at Time 3

Variable	All T3 participants (*n* = 78)	Employment status at Time 3[a]			
		Conventional (*n* = 11)	WISE (*n* = 35)	Unemployed (*n* = 26)	$\chi^2(3)$ with ties[c]
Time 1 Measures					
RAND-36 Health Measures (0-100)					
• Physical functioning limitations	85.87	94.55	85.57	85.10	3.47
• Role limitations due to physical health	74.68	88.64	79.29	67.31	5.15†
• Activity limitations due to low energy	53.72	55.45	57.29	46.73	4.70†
• General emotional well being	68.31	66.18	70.97	64.00	2.12
ASSIST					
• Risk score for tobacco (0-31)	10.68	4.90	7.37	17.42	14.43**
• Risk score for alcohol (0-39)	5.67	7.00	3.14	9.36	15.11**
• Risk score for cannabis (0-39)	5.54	6.60	3.40	8.84	8.05*
Satisfaction with Life Scale (1-7)	4.36	3.71	4.87	3.98	6.57*
Work Intention Inventory (1-6)					
• Intent to endorse	5.03	5.00	5.07	5.10	0.40
• Intent to stay	4.41	3.61	4.73	4.32	6.58*
Monthly income from work (median)	$672.00	$810.00	$864.00	$400.00	6.76*
Monthly income from all sources (median)	$1510.60	$1585.19	$1600.00	$1466.50	2.43
Hours worked last week (median)	16	16	17	13	1.31
ODSP recipient	51%	56%	54%	50%	0.12
At or below pre-tax low-income cut-off level	81%	73%	74%	88%	2.12
Time 3 Measures[b]					
RAND-36 Health Measures (0-100)					
• Physical functioning limitations	75.88	79.90	85.29	65.00	6.90*
• Role limitations due to physical health	70.83	63.64	77.14	58.65	4.05
• Activity limitations due to low energy	53.91	45.45	55.71	52.31	1.45
• General emotional well being	64.92	58.18	70.97	58.31	6.77*
ASSIST					
• Risk score for tobacco (0-31)	8.63	6.00	7.00	11.54	4.51
• Risk score for alcohol (0-39)	6.46	11.91	3.43	8.35	15.06**
• Risk score for cannabis (0-39)	5.59	7.18	3.54	8.27	6.87*

Table 4 (continued)

Variable	All T3 participants (n = 78)	Employment status at Time 3[a]			
		Conventional (n = 11)	WISE (n = 35)	Unemployed (n = 26)	$\chi^2(3)$ with ties[c]
Satisfaction with Life Scale (1-7)	4.47	3.95	4.75	4.25	2.66
Work Intention Inventory (1-6) • Intent to endorse • Intent to stay	 4.93 4.63	 4.18 3.61	 5.18 4.97		 -2.65** -3.05**
Monthly income from work (median)	$850.00	$1351.68	$790.00		1.86†
Monthly income from all sources (median)	$1536.00	$2500.00	$1700.00	$1134.50	12.14**
Hours worked last week (median)	16.75	35.00	14.00		3.48**
ODSP recipient	54%	27%	60%	62%	4.16
At or below pre-tax low-income cut-off level	77%	36%	86%	85%	12.71**

Notes: [a] Six individuals were not included as part of T3 comparison groups as they had retired (n = 3) or were in school (n = 3). [b] N = 46 for work-related variables, as the unemployed, retired & those in school did not answer these questions. [c] For the Time 3 comparisons of work-related variables we used the two-sample Wilcoxon rank-sum (Mann-Whitney) test (Wilcoxon 1945; Mann & Whitney 1947) instead of the Kruskal-Wallis equality-of-population rank $\chi 2(3)$ with ties test (Kruskal & Wallis, 1952, 1953). † $p < .10$; * $p < .05$ ** $p < .01$

At $18,127, the median annual income of the workers in the sample falls within the bottom decile of Canadian's 2017 after-tax income (Statistics Canada, 2019). Seventy-two percent of the workers in the sample accessed one or more of the following government income supports: Ontario Disability Support Program (ODSP) (51%), Ontario Works (19%), and/or the Canadian Pension Program–Disability supplement (CPP-D) (7%). For many workers, these forms of social assistance made up a substantial proportion of their total income differing sharply from the average Canadian, who in 2017 received approximately 13 percent of their total income from government transfers (Statistics Canada, 2019). Finally, 81 percent were at or below the low-income cut-off (LICO) level compared with approximately 12 percent of Canadians who, based on a similar measure to LICO, were living in poverty in 2017 (Statistics Canada, 2019).

Differences in health, wellness, and work-related measures based on employment status at T3

Eleven participants were *employed in the conventional labour market* at T3. For seven, this represented a return to the type of employment they held prior to WISE work. Two of the remaining four individuals had transitioned to conventional employment after working in a WISE for at least six years, one had been unemployed, and one had entered the WISE through a job program.

As Table 3 highlights, those who transitioned to conventional employment were younger than those remaining in WISEs, were more educated than those who remained in WISEs ($p < .1$) or became unemployed ($p < .05$), were more likely to have previously been in a conventional sector job than those who remained in WISEs ($p < .01$) or did not interview ($p < .1$), were less likely to self-report psychosis than either of the other groups ($p < .10$), and were less likely to have been hospitalized for mental health reasons prior to the study.

Turning to Table 4, analysis of substance use risk revealed those who transitioned to conventional employment had lower tobacco use than those unemployed at the end of the study ($p < .01$) and higher alcohol use than those in WISEs ($p < .01$). Finally, conventional workers at T3 earned more at baseline than those who became unemployed, reported lower intentions to stay (in the WISE) than all respondents other than those who were lost to follow-up, and had satisfaction with life scores at baseline that were lower than for those who stayed in WISEs ($p < .10$).

The second half of Table 4 highlights how the conventional employee group had changed approximately 36 months after intake. Noteworthy within-group changes (i.e., from T1 to T3) included decreased physical functioning ($p < .05$) and increased role limitations ($p < .10$) due to physical health and a decrease in alcohol risk scores ($p < .05$). The hours worked in the previous week increased over time ($p < .05$), and accordingly, the percentage of persons who were below low-income cut-offs decreased ($p < .05$).

Of the 35 workers *who remained employed at a WISE at T3*, Table 3 highlights that 22 (68%) had been working in WISEs for at least three years prior to study intake, seven had been unemployed, and three had been in conventional employment. The mean age of this group was higher than those unemployed at T3 ($p < .05$) and they had lower levels of post-secondary education than those who eventually moved to conventional employment ($p < .10$). This group was more likely to report having psychosis than those who were in conventional employment at T3 ($p < .10$) and less likely to report anxiety or depression as a primary diagnosis ($p < .10$).

As Table 4 shows, those who remained WISE workers were less likely than unemployed workers at T3 to report a substance use disorder ($p < .10$), and their initial substance use risk scores were lower for tobacco, alcohol, and cannabis than the unemployed group (all $p < .05$). T1 satisfaction with life scores were higher than both those who migrated to conventional employment ($p < .05$) and those who became unemployed ($p < .10$).

Comparing the T1 and T3 measures in Table 4, there were no significant changes in health, wellness, and work-related functioning for WISE workers after 36 months, other than a reduction in hours worked in the previous week ($p < .05$). Monthly employment income, while less than those in conventional employment ($p < .01$), was higher than the unemployed group ($p < .05$). The overall finding is that in general, a meaningful benefit of continued WISE employment was stability with respect to multiple measures of wellness. This stability in wellness measures is in contrast not only to those who were unemployed at T3 but also relative to those who had moved to conventional employment.

The *unemployed participants at T3* ($n = 26$) had the most diverse backgrounds prior to entering the study, with eight coming from conventional employment, nine from long-term WISE employment, and the rest from situations such as unemployment, job programs, or "other" (e.g., stay-at-home parent).

Overall, 10 of the unemployed individuals reported factors related to COVID-19 as having impacted their employment. Among the 10, eight said they were choosing not to return to work due to physical health concerns or other circumstances they related to the pandemic (e.g., childcare responsibilities, anxiety, perceived lack of available opportunities). Two had been laid off at some point during the pandemic and had not returned for personal reasons.

Nine of the unemployed participants reported they were not working at 36 months because their mental health or substance use impacted their ability to maintain steady employment. These individuals had been in hospital at least once during the study period, experienced debilitating medication side effects, and/or had substantial cognitive challenges. Individuals among this group of nine reported they valued being connected to a WISE that would allow them time off when unwell and welcome them back when they were ready for work.

Demographically, as highlighted in Table 3, the group unemployed at 36 months was younger ($p < .05$) and more likely to be Indigenous ($p < .05$) than participants who ended the study employed in WISE. They were less likely to have completed post-secondary education than participants who were in conventional employment at T3 ($p < .05$).

In terms of health and wellness measures, Table 4 shows that the unemployed group had lower physical functioning than people who moved to conventional employment ($p < .10$) and lower energy than those who remained in WISEs ($p < .05$). Their tobacco use risk scores were higher than both other groups ($p < .01$) and they had higher alcohol ($p < .01$) and cannabis risk scores ($p < .05$) at the outset than those who remained in WISEs. Workers who became unemployed had lower satisfaction with life scores at T1 than those who remained in WISEs ($p < .10$), and their monthly income through employment at the outset (i.e., at T1 when they were working in a WISE) was less than the WISE ($p < .05$) or conventional employment ($p < .05$) groups.

Comparing the T1 and T3 measures in Table 4, the group unemployed at T3 showed a decrease in physical functioning ($p < .01$), and a decrease in tobacco use risk scores ($p < .01$) over their three-year study involvement. Because they were now unemployed, this group also showed decreases between T1 and T3 in hours worked last week ($p < .01$), monthly income from employment ($p < .01$), and total monthly income ($p < .05$).

PERCEPTIONS OF WISE EMPLOYMENT

The 22 worker qualitative interviews offered a range of perspectives on the experience of working within a WISE and why workers remain or move on. The main incentive for most entering a WISE was to obtain paid employment, with some workers not knowing in advance that the job they were starting was in a social enterprise. Some saw WISE as a place for ongoing, supportive employment, while for others it was a place to re-group, build confidence, and position oneself for a return to the conventional labour market.

Although the qualitative interview participants had been selected to represent the three main outcome categories of interest (conventional employment, continued WISE employment, unemployed), it was clear that there was no definitive pathway through WISE to any of these results. Several interviewees spoke of moving in and out of WISE employment, with periods in-between either spent in the conventional labour market or unemployed due to deteriorated mental health or other employment barriers (e.g., lack of childcare).

Reported benefits and challenges of WISE employment

The primary recurrent benefit raised by participants was the strong support structure available within

WISEs. Support came from both supervisors and co-workers, and was often embedded in the administrative practices of the WISE (e.g., flexible hours, allowance for performance errors without job loss, connections to healthcare support). As one worker described it, "There was a couple of times that I had my anxiety attacks and stuff like that, and they were just like overall so supporting and stuff like, and yeah, like just kind of gave me like options … they would say, 'take a break, do that,' and then yeah, overall just very supportive" (W18). Even workers who left WISE employment often reported that the WISE provided supports that made employment more tenable and sustainable.

Workers also described a positive organizational culture within WISE. It was seen as a work option that values "people over profits." One worker stated, "I'm not sure if it's part of a mission statement or if it's just part of the organization structure, but it's sort of like not a 'get in and get out,' but it's a 'come in, get trained, and then blossom out into the community' kind of atmosphere for clients to work in" (W3). There was a sense that people are treated with more consideration than in the conventional labour market, and that workers are valued for what they can contribute versus a focus on their deficiencies.

The WISE experience for many served as a venue for skill development. Employment in the WISE provided the opportunity to either acquire new work skills or build the resiliency needed to sustain employment. As one worker who ultimately moved to conventional employment stated, "I had to also learn—like marketing and communication skills were not good. And I felt I was constantly going like upstairs to say, hey can you help me, like talk to this person or how do I approach this person and things like that" (W1). This evolution in work capacity was also attributed to developing confidence in one's skills. One worker noted, "I also have trust that my work skills, like my ability to work well, are not dependant on my mental health, and that this is a healthy place for me" (W8), while another stated, "It gave me back some normalcy and peace of mind, mindfulness, confidence. So, you know, all important skills that create a strong foundation for someone. Like I said I think it's part of the recovery mix" (W21).

A final key benefit was the presence of a stigma-free environment within WISEs. Workers who remained in or returned to a WISE discussed the value of a work environment where there was openness and acceptance of mental illness, such that illness-related needs could be accommodated, and disclosure of mental illness was not a concern. One worker stated, "I mean like with [supervisor] I could totally be myself. If I was having an issue, all I needed to do was to call him up, explain to him what was going on, and I knew that I would not be judged. I knew that I would still be valued as a good employee" (W12).

Some participants described challenges in working within their WISE. For example, many participants who moved to conventional employment did so due to dissatisfaction with their WISE earnings (either wages or hours available). One noted this frustration, stating, "It's a good place to work, you know its good people. It's just it's hard to work so hard and get paid crap for it" (W7). Other reasons for moving to conventional employment included desire for upward or lateral mobility (i.e., a perceived lack of growth opportunities within the WISE), frustration with a supervisor or co-worker, a poor match between their work tolerances and the type of work available (e.g., contracts where work triggered mental health symptoms), or purely logistical reasons (e.g., transportation issues). One worker noted that the WISE employment culture may even have been too different

from what one finds in conventional employment: "I think what I liked about them was that they were very accommodating, but I guess to find a way to kind of mirror a regular workforce while still being supportive might be beneficial to people who are transitioning into the workforce" (W22).

Organizational elements

Information on how the structure of a WISE can influence the WISE experience was also gleaned by analyzing salient organizational features through the administrator and supervisor interviews or organizational documents.

Administrative structure

As summarized in Table 1, at intake in 2017, the seven WISEs in this study were vastly different in terms of size (ranging from one to seven businesses within a WISE), annual revenue, number of workers (25 to 700), and areas of commercial engagement. Administrator titles ranged from Executive Director (for stand-alone WISEs) to Operations Lead for a small WISE operated by a non-profit organization. All the administrators reported to a Board of Directors and had authority to make operational decisions within an approved budget. All led entrepreneurial planning, partner outreach, and marketing, and three of the seven noted they regularly contributed hands-on work alongside crew members and supervisors. The role of supervisor also varied based on the size and commercial activity of the WISEs; however, all performed a wide array of duties that included training, social support, and engaging in work alongside their employees. For some, scheduling and product/service innovation were also job expectations. These differences in scale and operational structure seemed to influence some of the work and support options available to workers, as noted in the following section.

Career development opportunities for WISE workers

Opportunity for career and personal advancement differed based on the size of the WISE or if the nature of the work available created participation barriers based on sex, age, or physical capacity (e.g., physically demanding work). Some WISEs presented limited opportunity to move into a supervisory position, particularly if such roles were paid through the partner/parent organization. Other WISEs, however, had examples of a few workers who had been promoted and assumed a supervisory or administrative role within a business or the broader administrative structure, and this was particularly true of consumer-led businesses. Most WISEs were working to create a broader range of options for their workers by attempting to create administrative work options, developing a range of businesses to allow for transfers within, growing their product lines, and/or through pivots (e.g., from private catering to ongoing meal preparation contracts with NGOs) and/or partnerships that developed during the pandemic. Some WISEs reported they provided basic workplace safety and first-aid certification for workers, and the larger WISEs had opportunities for focused skill enhancement in job-related skills (e.g., deep cleaning, cash transactions) but little to no scaffolding to further education was evident.

Challenges to WISE operation in the mental health sector

The hybrid mission of WISE necessitates attention to both the social goal of promoting employment

within the target population but also the core necessity of operating a successful business. For most, the social mission predominated, this being their reason for existence. One administrator stated that they help people find a path toward not only employment, but life, breaking a cycle of failures in the process. Another commented, "For some, not working magnifies their identity as a mental health patient. They can now say to others they have a job. Even if you are only working four hours, you can look forward to it all week. If every day is a Saturday, then Saturdays aren't special" (A6).

That said, all the WISE administrators and most supervisors spoke to the challenge of honouring the hybrid mission of employing a work-challenged population, while striving to satisfy customer needs and meet industry quality and production standards. One solution was to increase the hours and level of responsibility for workers who were strong producers. This allowed them to retain workers with more severe work capacity challenges, albeit with a limited number of hours and shifts, ensuring that the more productive workers were present to provide expected service or product quality and output.

Most participating WISEs had witnessed changes in their worker populations in recent years, particularly since the COVID-19 disruption. As in the general labour market, older workers had retired and some who experienced increased social or mental health disruption during COVID-19 or established alternate life patterns chose not to return to work. With increasingly low unemployment rates in the general labour market, some administrators had noticed it was the more employment-barriered workers who were arriving at and staying in a WISE. One stated, "[They are]" much, much more unwell. … The people who are coming through our doors are mostly referrals from ODSP or Ontario Works, mental health and regional health centres, the incarceration stream—they're harder to employ people, which is exactly what [WISE name] should be doing (A3).

Another administrator noted that increased competitiveness in the market has led them to turn away job applicants who proved unable to adequately perform basic job duties during the screening process.

Supports needed to remain solvent

Work Integration Social Enterprises that were heavily subsidized by municipal and/or provincial funds noted the need for this support to continue, whereas WISEs with secure internal funding believed that additional supports—by way of funding for social service workers or connections to community supports—would make a critical difference in their ability to support workers through to sustained workforce attachment. As one administrator noted, "it's not about simply 'finding them a job'—it's about providing the supports needed to get through challenging times and transitioning to a job that is a good fit" (A1). Inadequate incomes were raised by another administrator, who noted that it is difficult for people living in poverty to work, and is advocating for improved OSDP pension allocations.

DISCUSSION

Contributions of WISE to workforce participation

The multiple methods used in this case study provided the opportunity to gain new insights into both WISEs and their workers. All data sources spoke to the importance of WISE in the mental

health sector. Administrators suggested that without WISE, many of their workers would simply drop out of the labour market. Quantitative findings supported this notion of enhanced employment attachment, with the majority of T3 participants being engaged in productive work, either in a WISE (45%) or in conventional employment (11%). This finding is also consistent with previous research where WISE employment was perceived to contribute to mental health recovery through improved self perception and an enhanced sense of capability and identity as a worker (Evans & Wilton, 2019; Krupa & Lysaght, 2016). A unique contribution of this longitudinal study is the non-linearity of the employment trajectory for these workers. As noted earlier, there was evidence of several participants who moved seamlessly in and out of WISE, the conventional labour market, and periods of unemployment, demonstrating dynamic work histories and fluid relations with the conventional labour market. The findings also suggest that in general, there is a population of highly vulnerable workers (e.g., those who are older, less educated, and with a history of psychosis) for whom WISE remains an important employment option, and one that produced the highest life satisfaction ratings.

Many of the study participants, including workers and administrators, identified skills gaps in incoming workers as an employment barrier. This is a common finding with this population due to the age of onset of many major mental illnesses, which frequently results in fractured educational histories (O'Shea & Salzer, 2019; Seabury, Axeen, Pauley, Tysinger, Schlosser, Hernandz, et al., 2019). Despite limited evidence of formal education participation by WISE workers, the confidence and work behaviours gained through WISE employment led to many workers retaining their jobs, even if working for a limited number of hours. For some, the very existence of a position that they could maintain without expectation of increased demand or work hours was what helped them remain employed.

That said, both quantitative and qualitative findings suggest that WISE employment is not for everyone in this population. In particular, those with substance use concerns were more likely to be unemployed after three years. This is not unexpected, as substance use has been demonstrated to present a significant barrier to employment success (Huang, Evans, Hara, Weiss, & Hser, 2011) and may require specialized services not currently available in the WISEs studied. Some industries that are prone to high levels of substance use among employees, such as the food and beverage and automotive industries, build in options for treatment as part of employee assistance programs (Lysaght et al., 2022), which are services that smaller organizations such as the WISEs in the sample may be unable to afford. These and other findings speak to the need identified by some administrators for greater access to social supports, external to usual work supervision, to help workers deal with these and other social issues, which commonly derail work commitments.

Even for participants still working after three years, most incomes remained below the poverty line. Since the time when data were collected, changes have been implemented to the ODSP, which are intended to improve overall income levels by allowing for higher levels of earned income. Changes to minimum wage law, which have been ongoing in Ontario and other jurisdictions, have had mixed impact (Banks, Blundell, & Emmerson, 2015; Vance, 2016). Clearly, WISE wage rates are unlikely to rise meaningfully given the nature of the jobs, but some wages within this study exceeded minimum wage levels. There may be opportunity to develop positions that lead to more lucrative work in WISEs in employment sectors that are less typical, or to build career counselling into the WISE framework as part of an enhanced employee assistance system.

Impact of WISE on individual wellbeing

While individual gains were noted, this study did not identify significant change in most health and wellbeing measures for workers. It is notable that there was no significant decline observed in most wellbeing indices over three years, particularly for those who remained in a WISE. The fact that workers in conventional jobs and those who were unemployed showed significantly lower life satisfaction scores than those in WISEs suggests that WISE workers may find improved work-life balance in a more supportive work environment, and through finding the "just-right fit" of work demand. Other research has identified challenges associated with conventional employment for persons with mental health and/or substance use disorders, many of them inherent in the types of workplaces many find themselves in due to interrupted career trajectories (Gewurtz et al., 2021).

Factors impacting the sector

Small businesses in general have high rates of failure. Thus, the environment in which WISEs exist is precarious, and it is perhaps remarkable that most of the WISEs in this study have had such long histories. All operate with some level of subsidy, however, and described struggles with survival from a business perspective. The financial struggles facing social enterprises have been widely documented (e.g., Battilana et al., 2015; Gidron, 2017; Horrocks, 2015; Mustafa, Khan, & Grecco, 2020); within this study, although all have survived, changing market conditions forced the businesses to innovate and seek partnerships but also required them to frequently seek additional sources of funding. Well-developed employee assistance programs (providing services such as counselling, therapeutic services, addiction management, etc.) are not available to these organizations, and this was identified as a factor that could help increase employment success rates for workers.

Key points of consideration for sector development and sustainability

Work Integration Social Enterprises employment emerged in this study as an important bridge to employment for workers experiencing loss of work capacity due to mental illness and/or substance use disorders, and a source of supportive work. Stakeholders within this study raised several points to be considered by policymakers to ensure sustainability.

Funding approaches. Survival is feasible for WISEs given prudent business management. As Cooney (2016) notes, modern social enterprises typically work with declining levels of public assistance, while serving clients with high levels of social disadvantage, placing them in a high level of risk. It is clear that publicly sourced financial subsidy is required to underwrite the high costs of worker support and other challenges to human resource management (e.g., managing a largely part-time workforce, frequent sick/wellness leaves) and to build in employee assistance strategies to address challenges associated with financial and social maintenance. Any requirements for ongoing accountability should be streamlined such that administrative time to maintain supports is not excessive. Resources to support grant writing and donation solicitation and outcomes evaluation would be particularly helpful for smaller organizations.

Communication between government policy-planning departments. Government departments responsible for WISE, working together with provincial disability benefit providers, can develop thoughtful approaches to ensure that monthly earnings do not place benefits payments in jeopardy.

Worker choices concerning when and how much to work should not imperil receipt of disability benefits, and increased work involvement should be supported with appropriate compensation. The goals of WISE overall can best be enhanced by a flexible disability support program that allows quick reinstatement of benefits as needed and incentives to work to maximal capacity.

WISE resource development. Resources to foster business success might include business guides and templates, tax guides, and WISE-specific educational resources. From a human resource perspective, supporting government agencies could provide templates for employee standards and responses in the case of injuries, illness, and other emergencies, and protocols for promoting employee career development. Networking and knowledge exchange opportunities for WISE administrators and staff could help build strength and innovation within the sector. Importantly, many small WISEs require ready access to external social supports to draw on when employees are in need.

LIMITATIONS

The relatively small sample size and the differences in group size across outcome categories limited the flexibility of the statistical analysis. The study also lacked comparative data for adults with mental illnesses and/or substance use disorders who did not enter a WISE; therefore, the benefit of WISE relative to alternatives cannot be determined.

Another major limitation is the challenge the authors faced in determining outcome status of the study participants. As noted, the analysis of worker status at each time point did not always reveal a linear trajectory from unemployed to a WISE to conventional employment. Rather, some in the sample moved back and forth between employment types (e.g., WISE to conventional to WISE). Thus, the "outcome" status at any point is only that: a snapshot of where individuals were positioned relative to the job market at the time of interviewing. A longer longitudinal study of worker employment might serve to capture these fluctuations and identify patterns, but it would likely be fraught with even more loss to follow-up. In addition, there was overlap between statuses for a portion of the population. For example, half of those who were officially unemployed at T3 reported "informal" income. Similarly, a quarter of those employed in WISEs earned income elsewhere, whether through a conventional job, informally, or at another WISE outside this study sample.

The authors anticipate that higher numbers of workers would have been employed after 36 months in the absence of COVID-19-related layoffs in spring 2020, COVID-19-related changes in personal and life circumstances, and other factors, such as the availability of the Canada Emergency Relief Benefit, which may have reduced the financial urgency for some to return to work. The pandemic-associated disruption in livelihoods and work limited the authors' ability to draw causal conclusions on changes in measures over time.

Outcome data may be skewed in favour of those who remained in a WISE due to the relative ease of finding these individuals for follow-up interviews. Income-level data were limited by inconsistencies associated with self-reporting and the multiplicity of income sources possible for each participant. Respondents had difficulty in identifying specific data within each income category, and although they had been encouraged to bring relevant pay stubs to the interview, most did not. Thus, financial reporting here represents gross estimates at best.

The mental health challenges experienced by WISE workers were self-reported, and it is likely that certain mental illnesses, such as psychosis and substance use disorders, were underreported. While participants did report on how mental health challenges presented in the workplace, it may be that participant reporting was shaped by social and self-stigma, or reflected the mental health experiences that impacted them the most in their day-to-day lives.

Lastly, the authors had hoped to draw linkages between WISE organizational structures and operational practices and population characteristics (e.g., fit between WISE models and workers of varying capabilities, interests, etc.) and worker outcomes. It was discovered, however, that despite major differences between participating WISEs "on paper," it was impossible to identify discernable patterns or typologies amongst them. As Wilton and Evans (2018) note, WISEs tend to be organized and delivered under diverse and constantly evolving models, and thus a larger sample would be necessary to begin to identify broader patterns of difference.

SUMMARY AND CONCLUSIONS

This study offers important contributions to our understanding of the role of WISEs in the mental health sector. The demographic profile of the population with mental illnesses and substance use disorders who work in WISE adds insights concerning this group, including distinct worker pathways within WISE. Additional research should address the experience of persons who struggle to maintain employment despite WISE intervention, notably workers with substance use disorders and Indigenous persons, with consideration given to ways that their WISE experience can be maximized.

This study highlighted the role WISE plays in maintaining workforce attachment for a highly vulnerable population. Future research should consider ways to maximize work and lifestyle benefits for workers within WISEs, including career development strategies, connections to outside sources of health and wellness support, and ways to improve the incomes of this population. The latter will require focused exploration of the interplay between financial support systems and WISE wages, and innovative ways to raise workers to above poverty-line income levels. Particular areas for investigation in this sector include point-in-time comparisons between WISE workers and workers with mental illness and/or substance use disorders in conventional employment. This study revealed a multidirectional flow of workers between conventional and WISE employment, which suggests that these should not be considered distinct and rival outcomes, but rather an array of options.

Finally, this study highlighted the urgent need for ongoing research to identify ways to increase the resiliency and success of WISEs themselves. Ongoing evaluation can be achieved through partnerships and/or mentoring with academics and evaluation specialists. Research could also examine working conditions in conventional work settings with a view to replicating WISE accommodation strategies and organizational culture.

NOTE

1. We acknowledge that use of this terminology risks medicalizing the health situation of these workers, and that preferred terminology continues to evolve over time. We use this term to indicate that the health situations of most WISE workers differ from what are referred to as "common mental disorders."

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ABOUT THE AUTHORS

Rosemary Lysaght is Professor Emerita at the School of Rehabilitation Therapy, Queen's University. Email: lysaght @queensu.ca

Kelley Packalen is Associate Professor of Strategy, Organization and Entrepreneurship at the Smith School of Business, Queen's University. Email: kelley.packalen@queensu.ca

Terry Krupa is Professor Emerita at the School of Rehabilitation Therapy, Queen's University. Email: terry.krupa@queensu.ca

Lori Ross is Associate Professor in the Dalla Lana School of Public Health, Social & Behavioural Health Sciences Division, University of Toronto. Email: l.ross@utoronto.ca

Agnieszka Fecica is Research Associate at the School of Rehabilitation Therapy, Queen's University. Email: a.fecica @queensu.ca

Michael Roy is Professor of Social Innovation and Sustainable Organisations at the University of Stirling. Email: michael .roy1@stir.ac.uk

Kathy Brock is Professor at the School of Policy Studies and Department of Political Studies, Queen's University. Email: kathy.brock@queensu.ca