Social entrepreneurship and services for marginalized groups

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Abstract

Purpose – *The purpose of this paper is to examine the usefulness of the social entrepreneurship (SE) framework in highlighting effective models of service development and practice in mental health equity.*
Design/methodology/approach – *Using a rigorous SE search process and a multiple case study design, core themes underlying the effectiveness of five services in Toronto, Canada for transgender, Aboriginal, immigrant, refugee, and homeless populations were determined.*
Findings – *It was found that the SE construct is highly applicable in the context of services addressing mental health inequities. In the analysis five core themes emerged that characterized the development of these organizations: the personal investment of leaders within a social justice framework; a very active period of clarifying values and mission, engaging partners, and establishing structure; applying a highly innovative approach; maintaining focus, keeping current, and exceeding expectations; and acting more as a service working from within a community than a service for a community.*
Practical implications – *These findings may have utility as a guide for individuals early in their trajectories of SE in the area of mental health equity and as a tool that can be used by decision maker "champions" to better identify and support SE endeavours.*
Originality/value – *In a context characterized by increasing attention given to models of SE in health equity, this study is the first to directly examine applicability to mental health equity.*

Keywords *Community, Inequalities, Diversity in health and social care provision*

Paper type *Research paper*

Background

Mental health services across the world face the twin challenges of tight fiscal governance while delivering equitable services for increasingly diverse populations and marginalized sub-populations (Standing Senate Committee on Social Affairs, Science and Technology, 2006; Department of Health UK, 2005; Department of Health UK, 2009; Mental Health Commission of Canada, 2012). In this context, marginalized groups face greatly heightened morbidity and mortality as a function of poor mental health (Cochran and Mays, 2009; Kirmayer *et al.*, 2007; Roy *et al.*, 2004) and there are indications of heightened risk among immigrant groups, particularly visible minority migrants (Cantor-Graae and Selton, 2005).

Such findings, while reflective of the many determinants of health that lead to differing needs and poorer outcomes, also reflect the shortcomings of service systems (Department of Health UK, 2005). Mainstream services have struggled to develop an effective service response to diversity and marginalization despite substantial service, policy, research, and personal resources expended (Senate Committee, 2006; Department of Health UK, 2005, 2009; Mental Health Commission of Canada 2012). Clinical trials are scarce (Aisenberg, 2008), and the evidence for some of the most commonly discussed interventions, such as example cultural competence training, is modest (Bhui *et al.*, 2007).

One strategy for trying to deal with the challenge of improving services without significantly increasing costs is for mainstream providers to support local communities to develop

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and deliver better supports. For instance, in the UK, *The Big Society* is a centre-piece policy idea. The UK Government's stated aim is to create a climate that empowers local people and communities: "Only when people and communities are given more power and take more responsibility can we achieve fairness and opportunities for all" (The Cabinet Office, 2010, p. 1). The priorities are: to give communities more powers and encourage people to take an active role in their communities, transfer power from central to local government, and to support co-ops, mutuals, charities, and social enterprises (The Cabinet Office, 2010). The Canadian mental health strategy echoes the theme by calling for mainstream services to "Support immigrant, refugee, ethno-cultural and racialised community organisations in assessing local mental health needs and strengths and in taking action on local priorities, in collaboration with mental health and other service systems" (Mental Health Commission of Canada, 2012, p. 87).

There may be concerns about whether hard-pressed marginalized communities have the capacity and can garner the resources to build the required services. In addition, those who develop services in marginalized groups often do not document their models, processes, and outcomes, which makes them hard to evaluate and less attractive to systems that are invested in offering high quality evidence-based interventions (Drake *et al.*, 2001). Furthermore, services developed by community groups may have a modest longevity. However, at least anecdotally, many service providers, clients and families can readily identify a provider, programme, or service that has very effectively addressed the mental health needs of a minority or marginalized community. These are providers have found innovative ways to engage communities and groups that experience mental health inequity, successfully navigating the complexity of the individual, social, and political problems faced with few resources and in some cases active opposition to their efforts.

Social entrepreneurship (SE)

The challenge for those aiming to develop practices and policies that feature collaboration with marginalized community groups is to be able to identify partnerships that are more likely to be effective and sustainable. The literature on initiating and sustaining specific mental health services for marginalized populations by non-profits is not well developed. One way of considering the attributes of non-profit organisations who have succeeded in delivering services to marginalized groups despite limited resources is to use the lens of SE. Social entrepreneurs are:

> People with new ideas to address major problems who are relentless in the pursuit of their visions, people who simply will not take "no" for an answer, who will not give up until they have spread their ideas as far as they possibly can (Bornstein, 2007, p. 1).

The concept of SE emerged in the early 1980s, growing largely out of Bill Drayton's work in identifying and supporting individuals who were addressing major social problems in developing countries (Bornstein, 2007). He and others sought to identify persons who had developed innovative ways of unraveling complex systems of oppression, apathy, and dependency to mobilize communities and effect change. These were persons who employed highly leveraged approaches – having identified a focused effort that might yield large systemic change.

While there is some contention as to the meaning of SE, it is generally taken to be the equivalent of a business entrepreneur albeit one who focuses on creating social value in their efforts rather than monetary gain. These are individuals and groups who identify and develop a solution that addresses an unmet need; are "relentless" in their effort to create social value; are continuously engaged in innovation and modification and act despite adversity and resource limitations; are highly embedded in the communities and networks related to their work; generate social capital; and have developed sustainable and transferable solutions (Paredo and McLean, 2006; Myers and Nelson, 2011; Shaw and Carter, 2007).

SE and health

There have been several recent calls for the use of the SE framework to address health equity (e.g. Drayton *et al.*, 2006; Germak and Singh, 2010; Savaya *et al.*, 2008; Wei-Skillern, 2010), in large part driven by its applicability to the problems underlying health inequity. Social

entrepreneurs are highly effective in connecting multiple sectors and bridging siloed systems (Drayton *et al.*, 2006; Harting *et al.*, 2011). Such an approach is directly relevant to mental health equity which is a function of many health determinants and suffers in most contexts due to fragmented and poorly coordinated service systems. Social entrepreneurs also generate community-based solutions to problems, an approach that is relevant if not necessary to effectively addressing mental illness in many ethno-cultural contexts.

While SE is a framework would seem useful in articulating models through which mental health equity can be addressed, investigation into its applicability to health is very limited. One exploratory study that examined the work of rural healthcare providers from an SE perspective highlighted factors such as the credibility of the providers and their ability to bridge different sectors (Farmer and Kilpatrick, 2009). Another study in Holland examined the use of health brokers for marginalized groups and likewise emphasized their role in building social capital, also noting the importance of systemic entrepreneurship – or SE principles embedded in service systems (Harting *et al.*, 2011). Overall, and as was the case in a recent systematic review (Short *et al.*, 2009), research into SE in health is minimal and we were unable to find a single example that focused specifically on mental health.

Study aims

The aim of this study is to examine the meaning of SE in the context of mental health services for persons experiencing mental health inequity and to examine which SE components are present in services that have proven to be effective and sustainable.

The goal of this line of inquiry is twofold:

1. to develop a SE roadmap for mental health equity – providing a template for those seeking to develop effective services in this area; and
2. by identifying models of entrepreneurship we might enhance the ability of decision makers to recognize and cultivate such individuals and services.

Using the search framework of Ashoka (www.Ashoka.org; Bornstein, 2007), we identified organizations that embody SE principles in addressing mental health equity in Toronto, Canada and employed a multiple case study design to articulate the key components that underlie their effectiveness. The services studied focused on Aboriginal, immigrant, refugee, homeless, and lesbian, gay, bisexual, transgender, and queer persons (LGBTQ) populations.

Methods

Context

This project focused on services targeting Aboriginal, homeless, LGBTQ, immigrant, and refugee groups as each of these groups face pervasive inequity in many domains including mental health. In this search we concentrated on services operating in Toronto, Ontario. The population of Toronto is 5.5 million and it is one of the most diverse cities in the world with half of this population having been born outside of Canada (City of Toronto, 2011).

Participating organizations

The first step of this project was to use a purposeful sampling strategy to identify service providers who could be considered among the most effective social entrepreneurs working to promote equity in mental health. The search process was modelled after that of Ashoka (Bornstein, 2007). A search committee was assembled of nine recognized leaders in service provision in one or more of the sectors of interest. These committee members had extensive experience in service delivery and management and also had an extensive knowledge of and contact with Toronto providers in each sector. They were oriented to the key criteria characterizing social entrepreneurs and given the task of using their knowledge base and networks to identify services that aligned with these core criteria.

A total of 46 services were recommended by the committee. Each of these organizations were contacted, the nature of the project described to them, and they were asked to submit a brief

written description outlining the types of services offered, how their work is innovative, challenges faced and how they have been overcome, how they engage the communities served, the impact of their work, and their vision for the future of their work. They were advised that they could be helped to produce the brief. In total, 21 of the services contacted expressed an interest in participating and provided us with the written description.

The committee reviewed the descriptions provided by the organizations with the goal of determining services that would go on to be interviewed. A consensus process was used, reviewing the key components of SE as they applied to each of the organizations making use of both the written descriptions and the committee's knowledge about the organizations. Through this process three organizations in each sector were chosen to participate in interviews to gather further details about their work.

The directors of the organizations selected for interviews were interviewed by two people involved in the project – one member of the research team and a member of the committee with expertise in the relevant service sector. These interviews revolved largely around obtaining story of their organization – how it emerged and developed, challenges and successes that occurred in their development, and the model through which they did their work. Through these interviews we sought elaboration on the key domains of SE and we also sought to determine if they were able to articulate the process of development clearly. Since a primary goal of this project was to describe models of SE in mental health equity, if those details could not be derived we would be much less able to identify key components. The selection process was then based on a nine question rating scale (Table I).

In our final meeting with the committee the selections of one representative organization in each sector were made. Organizations were chosen that were highly representative of the key concepts of social entrepreneurism, and able to articulate their development in detail. The selected organizations included:

1. a centre providing an array of services to survivors of torture and war;
2. a group of people with lived experience of mental illness who use their personal stories and experiences to successfully influence housing policy;
3. a service grounded in Indigenous values and self-determination that offers extensive and wide-ranging programmes to Aboriginal families;
4. a coalition of 15 health and social service agencies working in partnership with the goal of coordinating services and influencing public policy concerning accessibility and appropriate care for marginalized and vulnerable populations; and

Table I Evaluation template

Domain	*1 = Yes definitely, 2 = To some degree, 3 = No/not much*
1. Is there a coherent story of development, from the beginnings to the present time?	
2. Did they begin with few resources and/or substantial barriers and are they able to articulate how they overcame them?	
3. Have they been successful in mobilizing people to support them (community members; organizational leaders; policy makers)?	
4. Have they been effective in developing a service that truly engages their community?	
5. Do they have a compelling vision for where their service/services need to go? Do they have a compelling vision for what is needed to promote equity for the people they are serving?	
6. Can the process of development, manner of engaging clients and community, mechanisms of intervention, and need areas for further development be clearly articulated for this service?	
7. Is the intervention/service having a beneficial effect for clients, but also more broadly for the community (e.g. impacting the work of other organizations, impacting policy, etc.)?	
8. Is what they are doing portable? Is it a model that could be replicated elsewhere?	
9. Was hearing about their work interesting/engaging/inspiring?	

5. a multi-service programme with a focus on lower-income, street-involved, homeless, sex-working, and marginalized members of trans communities.

Case studies

Case studies were conducted with each of the organizations identified in the selection process in a multiple case study analysis (Stake, 2006). This approach was chosen as it provides an effective framework for integrating a set of case studies in an instrumental design, one in which a case or cases are used to provide insight into a broader issue. Since the focus of the project was on the developmental trajectory of the organizations and their model of service delivery, the analysis was situated within a narrative/developmental framework. The sources of information were semi-structured interviews with senior management and direct service staff and a review of documentation (reports; web sites; policies; mission/values statements). The investigation did not extend to interviews with clients. In each organization the service leader or leaders were interviewed, in most cases on multiple occasions over two to three hours, past leaders were sought out for interviews, and direct service staff (range from two to ten direct service staff per organization) participated in individual and group interviews. Investigators also attended meetings and events held by the organization, taking ethnographic field notes. The project was reviewed and approved by an institutional ethics review board.

In each case, audio recorded interviews, ethnographic observation, and document analysis focused on obtaining the following. First, a detailed history tracking the trajectories and turning points in services offered, service structures/models, goals and values, leveraging support, and relationships with stakeholders, and supporters. Second, identifying instances of adversity and how they were overcome and instances of achievement and how they were attained. Third, inquiry into the roles and activities of key people within the organization and external partners. Fourth, examination of their relationships with other services and place within the larger service system. Fifth, discussion of the impacts of their work. Sixth, inquiry into their vision for the future of their organization.

Data analysis

Data analysis proceeded in three stages, using the rigorous content analysis procedure articulated by Charmaz (1995) in the context of grounded theory, though the analysis in this study did not extend to theory generation. First, for each of the organizations all of the materials were analysed for recurrent themes through a content analysis triangulated by source of information (interview respondent and written materials). Through this content analysis a detailed organizational narrative was developed, with key themes and processes highlighted with quotes, field note entries, and extracts from documents. These narratives were further revised as a second investigator examined the coding structure and in some instances requested further information and clarification. In the second step the reports were given to the members of the organizations who were interviewed in a member checking process that led to further revision and expansion of the content in some areas. In the third step, all of the reports were examined through content analysis to identify common themes running across all of the organizations with attention paid to patterns of variability that emerged in some themes/areas of inquiry. This integrated analysis was in turn reviewed by all of the investigators with feedback given to ensure reliable linkages with the individual case study data. Feedback on the integrated analysis was also sought from the directors of each of the participating organizations.

Results

Overview

Five core themes emerged in the analysis:

1. how the service started, including the types of people involved and the problems they sought to address;
2. a very active period of clarifying values and mission, conceptualizing an approach, and engaging community and partners;
3. applying a highly innovative approach;

4. maintaining focus, keeping current, and exceeding expectations and;
5. acting more as a service working from within a community than a service for a community.

While the five organizations varied widely in the problems that they addressed, their organizational structure, and in their specific activities, there was a remarkable degree of similarity in the components that were described as crucial to their effectiveness and success. These components are as follows.

When the right people meet the specific problem

Each of the case studies revealed that these organizations began in response to a very specific problem, which may have lent to the development of a clear purpose as is described in the subsequent section. Specific problems included the closing of a hospital, the murders of two trans sex trade workers, large numbers of Aboriginal children being placed in white families, poor housing quality for persons with severe mental illness, and the challenges South American torture victims faced in the immigration process.

There were also a number of shared characteristics across the founders of these organizations. All had a very personal investment. This was not seen as a job so much as "a mission" that held a deep personal meaning. In all cases the founders invested large amounts of time and resources on a volunteer basis and there was an active involvement if not membership in the communities served:

> Almost everybody in that room could name a relative with a negative experience of child welfare (Interviewee speaking about the founding of the Aboriginal service).

All of the founders of these services had experience in service delivery and they all had an extensive network of helpful contacts. These were individuals with access to large amounts of social capital. The founders of all of these organizations knew how to work with political systems, were angry and passionate while still able to build a broad base of supporters, and they were both patient and extremely persistent – in some cases maintaining focus through years of setbacks.

Getting aligned, oriented to an approach, and connected

All of the organizations commented on the importance of a social justice framework as the foundation of all of their activities. Most saw themselves as advocates, if not activists, working to address social inequity. All worked to explicitly develop a clear focus or mission, seeking out board members and staff who shared their investment and aligned with the agreed upon mission:

> We responded with […] a burning concern with social justice, political action, and the impatience and frustration against a confused world of passive bystanders (Interviewee from the victims of torture service).

A key component of this effort to clarify their purpose and gain consensus was a close consultation with their communities. Through both formal research and informal contact all of these organizations constantly consult and involve their communities. In many ways, these organizations operate from within the community – through volunteers, former clients coming back and working as staff, and an active involvement of members of the communities in decision making. This ranged from staff in essence being the community to services which acted at the systems level with each member being a leader of a service within a community of services:

> The key to our impact is that it is by community for community (Interviewee from the service that works with trans clients).

Along with the strong community-based and social justice foundations, they had a holistic approach to their work. None saw their work as being focused on the mental illness of a person, they all work at individual, family, social, cultural, and political levels in an integrated manner:

> What we want to do is help them to build their own community, and slowly move to coalition building […] so it is a circle from the individual to the group, from the group to the community, and from the community to civic responsibility and advocacy (Interviewee from the centre that works with victims of torture).

They also had a strong orientation towards action. In each case– they all are "doers" – preferring to attempt something that might fail rather than continue to just talk about doing something:

> The time for studies is over. There have been numerous studies of Native people already (At a planning meeting in 1985 for the service for Aboriginal populations).

Another element shared and emphasized by these organizations is the degree to which they sought out strategic partnerships. Within the organizations, this meant a careful consideration of the composition of staffing and boards – looking to bring on people with expertise in service delivery, connections with decision makers, legal experts, and skilled grant writers. What was most remarkable was the extent to which they all actively if not aggressively pursued partnerships outside of their organizations. They all worked to develop close relationships with policy makers, academics, leaders of other service organizations, and community leaders. They also all actively sought to have a maximum amount of visibility in the community. Holding events open to the public, getting media attention, and consistently working to raise awareness about the problem being addressed:

> What the (services) has very successfully done is they have built a strong cadre of supporters, whether its advisors or coordinators or sponsors […] they continually work to maintain those relationships (Interviewee from the advocacy organization that influences housing policy).

The innovative approach

The proposal of highly innovative approaches to the problem being considered was another commonality between the five organizations. Having assembled extremely strong groups, developed strategic partnerships, and assessed the needs of their communities, the solutions that they proposed were in each case unique. The service for victims of torture was one of two such services in the world when it was developed. The Aboriginal service is still the only urban Aboriginal-run child protection service in Canada. In each case these organizations offered a solution grounded in the needs of the community that was a fresh approach to the problem and that was a compelling and convincing alternative.

Keeping focused, keeping current, and exceeding expectations

Once established, each of these organizations put in place processes to regularly revisit and maintain the original focus/mission whether it be embedded in the structure of meetings or through key advisory groups and retreats. Also critical, however, was the longevity of a core person or group. All of the organizations described the importance of having people involved, whether staff or partners, for a long period of time to provide stability and a memory of the "original marching orders". Not only was this critical in keeping focus, this organizational memory and longevity helped to deepen the informal and formal connections with partners. Having such established relationships greatly increases efficiency:

> It's about collaboration. It's about how those interpersonal relationships at those very high levels allow for things to be dealt with really quickly: It allows for someone to just pick up the phone, and call a director, so there can be a coordinated network for care (Interviewee from the service coalition).

While all of these organizations successfully maintained a stable focus in their mission, in their activities and engagement with the communities they serve they are highly reflexive and organic. In each case, they continued to deepen existing relationships with partners, cultivated relationships with new partners and communities, and remained sensitive to the ebb and flow of the communities they serve. This ability to be sensitive to the needs of the community is greatly enhanced by the blurring of boundaries between "service providers" and "those served".

Through advisory boards, extensive networks of volunteers from the community, former clients coming back as staff, and highly active outreach activities, these organizations are embedded more than connected. For instance, the centre that treats victims of torture was developed for South American refugees but has embraced each new wave of refugees and their unique needs whether they came from Eastern Europe or Somalia. In each case, whether they be new services, new projects, or new methods of working, these organizations carefully do their research, collaborate, develop an effective practice, and rapidly implement it. For services working within larger organizations, such flexibility and ability to rapidly implement services was

described as being greatly aided by there being in place a "buffer". This buffer between the SE service and the large organization allowed for a degree of flexibility that would be lost in the context of the bureaucratic processes present in large organizations.

Another critical ingredient shared by these five organizations is their effectiveness and efficiency. In each case they radically outperform what is expected of them by partners, funders, and the public. The centre that treats victims of torture with a small staff and budget, serves 1,500 clients annually with their coming from over 100 countries. The trans community service delivered training on trans issues to 3,000 providers on a budget for 300.

More a community than a service for a community

The final point that unites these organizations, and one less tangible than some of the other uniting factors, is the manner in which their shared passion and focus, their embeddedness in community and reflexivity, and their ability to welcome new partners, creates a "vital" community in and of itself. All of the organizations cultivate a sense of "family", of shared and united purpose, of safety, and of a valued identity:

> Our uniqueness is as a result of creating the sense of the lost village of survivors left behind and we have created a safe haven (Interviewee from the service for victims of torture).

Discussion

This study aimed to articulate, using a SE framework, the characteristics shared by service organizations that are highly effective in their ability to address mental health inequity for marginalized groups. This, to our knowledge, is the first research application of an SE approach in mental health.

The organisations' creativity, relentless effort to create social value, continuous engagement despite adversity and limited resources, integration with community, and social capital were readily evident. The work of the organizations chosen was also reflected in aspects of entrepreneurial orientation that receive more commentary in the business literature than the SE literature (Rauch *et al.*, 2009). These include a willingness to take risks by venturing into new and uncertain domains of service delivery and aggressiveness. While not necessarily framed in the light of "competitive aggressiveness" (Rauch *et al.*, 2009, p. 763), these services were indeed aggressive in their advocacy and awareness raising activities (e.g. taking the Province of Ontario to court on discrimination charges) as well as their outputs.

A major finding of this study lies in the highly strategic and coherent approach to their work. A complex and nuanced set of characteristics emerged that, while fundamentally grounded in the communities from which they work, also reads like a guide to effective management. Their efficiency and effectiveness would seem to be driven by three core attributes.

First, the personal investment and involvement of the leaders and staff in the communities that they are serving leads them to readily recognize what is needed by the communities they serve; to recognize the importance of being flexible to those needs and implement changes; to use highly leveraged approaches in which interventions can have the largest impacts on the many determinants of health thus increasing efficiency; and to have an intense and personally invested focus and shared passion about the problems at hand since these are their own problems– lending to an action orientation and an emphasis upon rapid implementation. All of these characteristics, aside from personal involvement being highlighted as the key motivator, are also closely associated with the success of these organizations as they are in business (Rauch *et al.*, 2009) and organizations in general (Barrett *et al.*, 2005).

Second the work is driven by a social justice framework. All of the organizations focus on specific problems and work actively to adhere to and maintain their core values through policy, organization structure, and the longevity of leaders. While adherence to a clear and simple primary goal is also a characteristic of successful businesses (Heath and Heath, 2007), it is not surprising that these organizations need to be extremely active in their efforts to avoid "drift" given the complexity of the problems being addressed, the need to work closely with and be responsive to a range of funders with at times disparate agendas, and factors

such as low pay and extremely high work levels. The latter point would seem to be addressed both by personal investment and the "family" type of relationships cultivated by staff and leadership.

The third and final major attribute can be described as social capital. While fundamentally grounded in the communities served "by the community for the community", all of these organizations are extremely active in their efforts to make meaningful and lasting connections with other providers, policy makers, researchers, and the public. They focused on building shared interest and investment in their cause and creating large amounts of social capital around their work. This ability to create bridges between stakeholders has likewise been commented on by the few other studies examining SE and health (Farmer and Kilpatrick, 2009; Harting *et al.*, 2011; Myers and Nelson, 2011) and social capital has been found in the business literature to reduce transaction costs, facilitate information flow, and foster creativity as it did in the present study (Arregle *et al.*, 2007).

Limitations and conclusions

This study had several limitations. We were not able to examine associations between the characteristics identified and the outcomes in a causal design and we also cannot comment on how common such organizations and traits are within Toronto or on their frequency or applicability outside of Toronto.

This work can, however, begin a dialogue about how the SE structure might be used to recognize and promote more effective means of addressing mental health equity. First, while the present study is an initial exploration of these concepts, the components identified here all have a solid basis in the business and management literatures albeit with a different focus. This work, while needing expansion, could be used as a guide for those seeking to develop SE-oriented approaches to mental health equity. All of the services studied here had in many ways arrived in their success and all agreed that these findings would have been very useful to have had access to earlier in their trajectories. These findings might also facilitate "champions" better recognizing social entrepreneurs that they might support be it in policy or within larger organizations. This latter point is likely the most difficult aspect of transferability. As several selection committee members in this study commented, large organizations have a tendency to stifle innovation through bureaucracy and resistance to change. Some potential solutions to this difficulty is to create "buffered" organizational spaces. In such a context the social entrepreneur can benefit from the larger structure (e.g. stability, profile, funding) while having a degree of autonomy and flexibility that is in effect "unhitched" from much of the culture and policies that might otherwise stifle their work Greenhalgh *et al.* (2004).

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